The DSM-5-TR: What's New and What Has Changed?

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Disclosures

- I have no conflicts of interest to report.
- I am not receiving payment for this presentation.
- Any of the materials, tests, or articles mentioned by me today are mentioned based on my opinion of their merit.
- I sought approval from the American Psychiatric Association Publishing Company to cite the parts of the DSM-5-TR reported in this presentation.
- I sought permission to use the case studies from the author/editor of the *DSM-5/DSM-5-TR Clinical Cases* text.

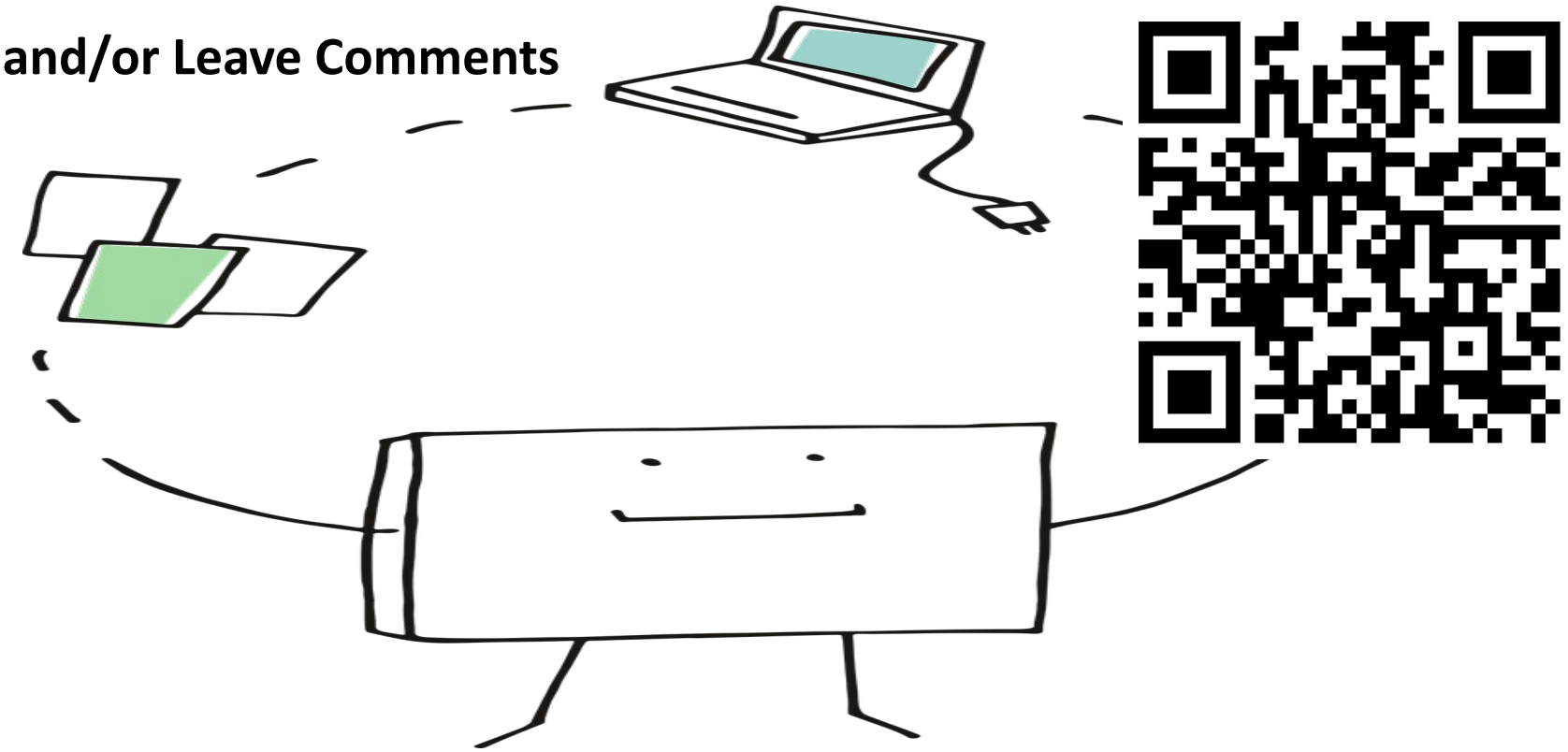
Presentation Outcomes

- ***Participants will:***
  - Learn about recent research supporting the need for increased mental health services to children and adolescents
  - Learn about new disorders and changes in criteria sets for select chapters of the DSM-5-TR
  - Learn the primary changes in the organization of and diagnostic process for the DSM-5/DSM-5-TR compared to previous editions of the DSM
  - Acquire a working knowledge of the DSM-5-TR diagnoses that present frequently in school and pediatric settings
  - Learn how the DSM-5-TR can be used when determining eligibility for specific categories under the IDEIA and Section 504
  - Review case studies to apply diagnostic decision-making skills

Questions and Comments

Scan QR Code to Ask Questions

and/or Leave Comments



COVID-19's Impact on Mental Health

Global Prevalence of Depressive and Anxiety Symptoms in Children and Adolescents During COVID-19: A Meta-analysis

- *JAMA Pediatrics* - 2021
- Meta-analysis of 29 studies including 80,879 youth globally
- Prevalence rates of clinically elevated depression and anxiety in children and adolescents (age ≤ 18) are *double of pre-pandemic estimates (i.e., 11.6 and 12.9% respectively)*
- One in four youth (25.2%) globally are experiencing clinically elevated depression symptoms
- One in five youth (20.5%) are experiencing clinically elevated anxiety
- Symptoms were higher later in the pandemic and in girls
- Depression symptoms were higher in older children

Youth Suicide During the First Year of the COVID-19 Pandemic

- *Pediatrics,* 2023
  - Cross-sectional study analyzed national suicide data for US youth aged 5 to 24 years from 2015 to 2020
  - Among *5568* identified youth suicides during the 2020 pandemic:
    - 4408 (79.2%): Male
    - 3321 (59.6%): White
    - 1009 (18.1%): Hispanic
    - 801 (14.4%): Black
    - 262 (4.7%): Asian/Pacific Islander
    - 170 (3.3%): Non-Hispanic American Indian (AI)/Alaska Native (AN)
- Significant increase in overall observed vs. expected youth suicides during the pandemic, specifically among *males*, *youth aged 5 to 12 years* and *18-24 years*, *non-Hispanic AI/AN youth*, *black youth*, and *youth who died by firearms*
- Prevention strategies must be tailored to better address the disparities in youth suicide risk

Youth Risk Behavior Surveillance System (YRBSS)

High School YRBS 2021[a]
High School YRBS 2021[b]

South Carolina Data

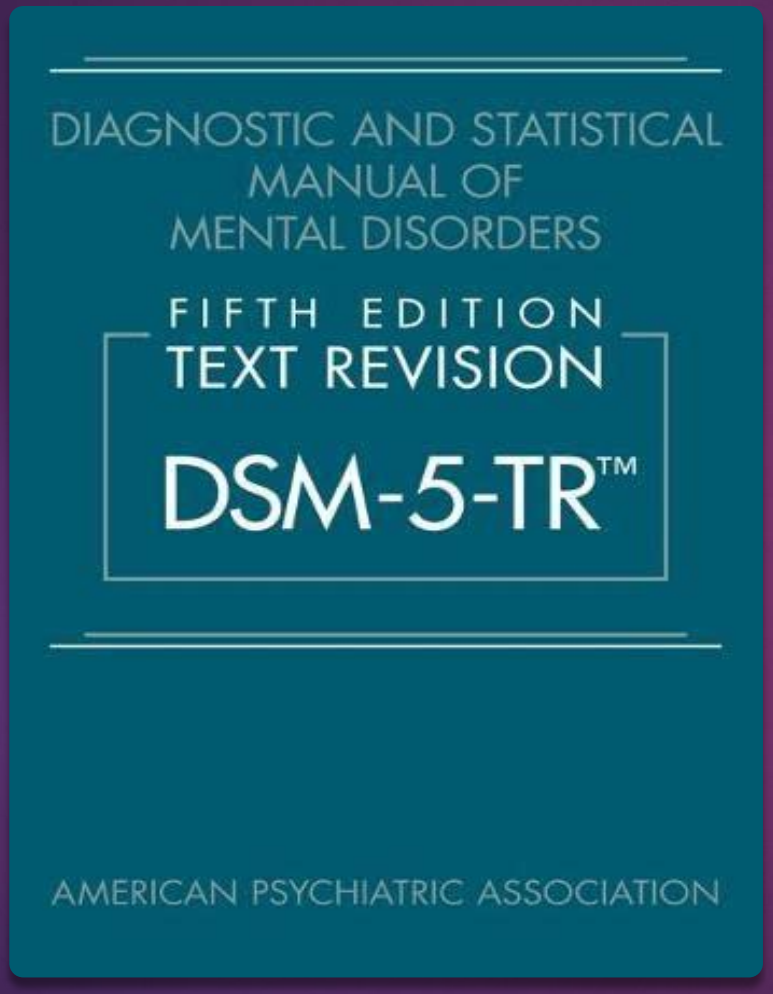
The Youth Mental Health Crisis

Neurological mismatch…

Systemic mismatch…

Racism…

ACEs…



Overview of What's New and What Has Changed

New Diagnoses and Additions

- ***New Diagnoses***
  - Prolonged Grief Disorder
  - Unspecified Mood Disorder(Taken out of DSM-5; restored in DSM-5-TR)
  - Stimulant Induced Mild Neurocognitive Disorder
- ***New Additions***
  - Symptom codes for suicial behavior and and non-suicidal self-injury in “Other Conditions that May Be a Focus of Clinical Attention” chapter
  - Changes in diagnostic criteria or specifier definitions for more than 70 disorders; most disorder texts had some or significant revisions
  - Updated DSM-5 terminology to conform to current preferred usage

Emphasis on Culture, Racism, and Discrimination

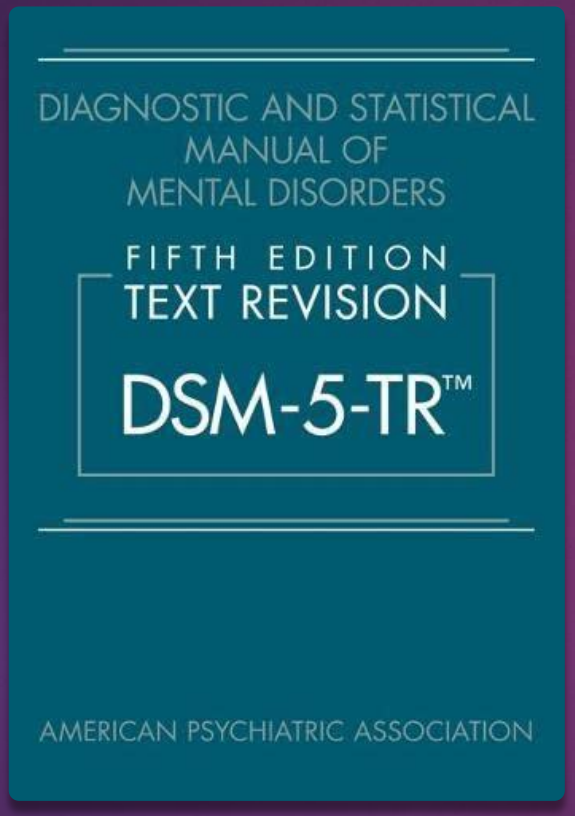
- Language is used that challenges the view that races are discrete and natural entities
  - Various terms were replaced, for example:
    - "Racialized" is used vs. "race/racial,"
    - "Minority" and "non-white" are avoided
    - "Latinx" is used vs. "Latino/Latina" and Caucasian is not used
- Variations in symptom expressions, attributions for disorder causes or precipitants, and factors associated with differential prevalence across demographic groups are provided
- Cultural norms that may impact the level of perceived pathology are reported
- The risk of misdiagnosis when evaluating individuals from socially oppressed ethno-racial groups is considered

Sex and Gender Differences

- Sex and gender differences are established for a growing number of mental disorders
  - Sex: An individual's reproductive organs and XX or XY chromosomal complement
  - Gender: Reproductive organs and individual's self-representation
- Inclusion of information on sex and gender at multiple levels
  - Gender and sex-related symptoms and specifiers added to diagnostic criteria, when applicable
  - Prevalence estimates based on gender and sex included in "Prevalence" section of each disorder text
  - "Sex- and Gender-Related Diagnostic Issues" in the text for relevant disorders

Association of Suicidal Thoughts/Behavior

- A new text section for each diagnosis, “Association with Suicidal Thoughts or Behavior” when such information is available in the literature
- Addresses the wide range of psychopathology within groups of individuals with the same diagnosis, which could impact the risk of suicide
- Having this information about each diagnosis informs evaluators about known risk factors vs. relying only on the presence of a diagnosis that has been associated with suicidal thoughts or behavior



The Organization and Development of the DSM-5-TR

Organization of the DSM-5-TR

- A developmental lifespan approach is embedded both within and across the DSM-5 and DSM-5-TR disorders.

- The DSM-5 and DSM-5-TR are organized beginning with diagnoses that manifest early in life, followed by diagnoses that occur more commonly in adolescence and young adulthood, followed by diagnoses that occur later in life.

- Childhood disorders are integrated throughout the DSM-5 and DSM-5-TR manuals

Organization of the DSM-5-TR

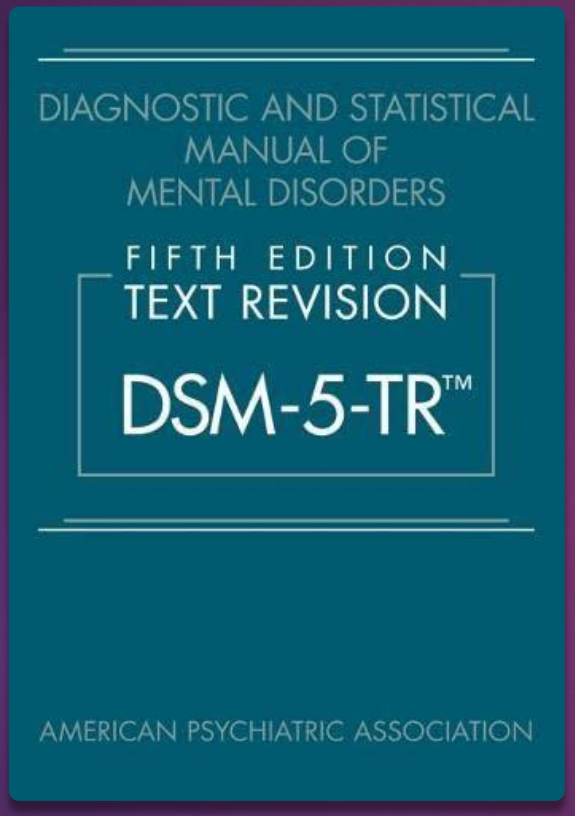
- Section I: DSM-5 Basics
- Section II: Diagnostic Criteria and Codes
- Section III: Emerging Models and Measures
  - Assessment Measures
  - Culture and Psychiatric Diagnosis
  - Alternative DSM-5-TR Model for Personality Disorders
  - Conditions for Further Study
- Appendix

Development of the DSM-5

- The DSM-5 is the result of a 14-year process.
- Participants in the revision process represent 16 countries.
- The DSM-5 Task Force and 13 work groups reviewed the scientific advances and research-based evidence that forms the basis of the content of the DSM-5.
- The work group members represent more than 90 academic and mental health institutions throughout the world.
- More than 300 outside advisers contributed to the DSM-5.
- Two independent panels reviewed the proposed content: A scientific review committee and a clinical and public health committee.
- The draft criteria were made available for public review and comment three separate times throughout the development process.
- Thousands of clinicians tested the feasibility and clinical utility of the proposed criteria to ensure that changes in the DSM-5 enhance patient care.
- **Changes required scientific support.**
- **If the research was inadequate, no change could be made.**

Development of the DSM-5-TR

- The DSM-5-TR reflects the scientific advances made in the years since the publication of the DSM-5.
- The development of the DSM-5-TR involved the work of over 200 subject matter experts, including many who were involved in developing the DSM-5.
- The DSM-5-TR is the product of the following three separate revision processes:
  - The development of the original DSM-5 diagnostic criteria by the DSM-5 Task Force
  - Updates to the DSM-5 diagnostic criteria and text overseen by the DSM Steering Committee
  - Full updates to the DSM-5 text overseen by the Revision Subcommittee
- A review of conflicts of interest for all proposed changes to the text was conducted.
- Proposals for changes were reviewed and approved by the DSM Steering Committee, and the APA Assembly and Board of Trustees.



Changes in the Diagnostic Process

Changes in the Diagnostic Process

- Coding
- Mental Disorder Definition and Requirements
- Non-Axial Documentation of Diagnosis
- Inclusion of Dimensional and Categorical Approaches to Diagnosis
- Increased Use of Subtypes, Specifiers, and Severity Levels
- Replacement of *Not Otherwise Specified (NOS)* Designation with *Other Specified Disorder* or *Unspecified Disorder*

Synchronization with ICD Systems

- The DSM and the International Classification of Diseases (ICD) are companion publications.
- DSM-5 codes are aligned with the ICD 9th Revision-Clinical Modification (CM; ICD-9-CM) codes.
- On October 1, 2015, the ICD-10th Revision-CM (ICD-10-CM) coding system was implemented.
- DSM-5-TR codes are aligned with the ICD-10-CM codes; there are no DSM codes.
- The ICD-11th Edition-CM (ICD-11-CM) system will be implemented in the future and will utilize an expanded coding system that is synchronized with the ICD-10-CM system of coding.

Coding in the DSM-5-TR

- Diagnostic codes were added for suicidal behavior and non-suicidal self-injury in "Other Conditions That May Be a Focus of Clinical Attention"
- Examples of coding specific disorders:
- **Autism Spectrum Disorder (F84.0)**
  - F84.0 is the ICD-10-CM code, which is enclosed in parentheses.
  - Coding Note: For Autism Spectrum Disorder, an additional code, F06.1, should be used to identify comorbid catatonia.
- **Intellectual Developmental Disorder (Intellectual Disability)**
  - The ICD-10-CM code is based on the current level of severity:
    - F70 Mild
    - F71 Moderate
    - F72 Severe
    - F73 Profound

Definition of a Mental Disorder

- "A mental disorder is a syndrome characterized by clinically significant disturbance in an **individual's** cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities..." (pg. 14)

Each disorder in Section II must meet this definition (excluding disorders in the chapters "Medication-Induced Movement Disorders and Other Adverse Effects of Medication" and "Other Conditions That May Be a Focus of Clinical Attention").

Caveat # 1: The diagnosis of a mental disorder is not equivalent to a need for treatment, as the need for treatment is a complex clinical decision.

Caveat # 2: Treatment should not be withheld from individuals whose symptoms do not meet the full criteria for a mental disorder but who demonstrate a need for treatment.

Non-Axial Documentation of Diagnosis

- Multi-axial approach is no longer used
- DSM-5 and DSM-5-TR combine what was formerly Axes I, II, and III with separate notations for influential psychosocial factors (formerly Axis IV) and level of disability (formerly Axis V – GAF)
- Psychosocial factors are delineated in the Z codes in the DSM-5-TR chapter “Other Conditions That May Be a Focus of Clinical Attention”
- Level of Disability is assessed via the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)

Dimensional and Categorical Approaches

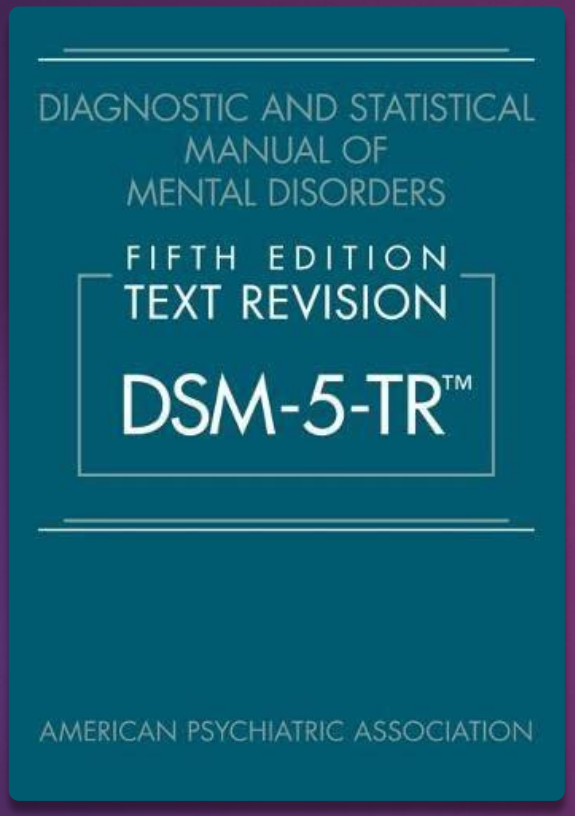
- The DSM categorical approach to diagnosis depicts psychopathology as absent or present (approach utilized prior to DSM-5).
- The dimensional approach incorporates dimensional assessments that provide information on severity and frequency of clinical conditions that can assist in determining and modifying treatment (new in DSM-5).
- The DSM-5 and DSM-5-TR encompass both dimensional and categorical approaches to diagnosis.

Increased Use of Subtypes, Specifiers, and Severity Levels

- Aligned with a dimensional approach to diagnosis
- To be used only if diagnostic criteria are met
- Offered for increased specificity
- **Subtypes are mutually exclusive**, e.g., "specify whether" Attention-Deficit/Hyperactivity Disorder is: a) combined presentation, b) predominantly inattentive presentation, or c) predominantly hyperactive/impulsive presentation.
- **Specifiers are not mutually exclusive**; more than one specifier may be given, e.g., "specify or specify if" Autism Spectrum Disorder is: With or without accompanying intellectual impairment, with or without accompanying language impairment, etc.

Replacement of *Not Otherwise Specified (NOS)* Designation

- To enhance diagnostic specificity, the DSM-5 replaced the Not Otherwise Specified (NOS) designation with two options for clinical use:
  - Other Specified Disorder – conveys specific reason that the criteria are not met for a specific diagnosis within a diagnostic category, e.g., "Other Specified Anxiety Disorder – symptoms for Generalized Anxiety Disorder have occurred for two (vs. required six) months"
  - Unspecified Disorder – used when the clinician is either unable to further specify the presenting problem or chooses not to specify the reason that the criteria are not met for a specific disorder, e.g., "Unspecified Anxiety Disorder"



Considerations in Making a Diagnosis

Signs, Symptoms, Syndromes, and Disorders

Signs	Objective indication(s) about the affected individual observed by the clinician or others
Symptoms	Subjective indication(s) reported by the affected individual and interpreted by the clinician
Syndromes	Collection of signs and symptoms occurring together that are necessary for a diagnosis
Disorders	Well-defined group of signs, symptoms, and syndromes recognized as necessary for a diagnosis, and that meet additional criteria

The Clinical Interview

- The clinical interview is the central process for sound diagnostic practice.

- Texts such as the *DSM-5 Pocket Guide for Child and Adolescent Mental Health,* the *Structured Clinical Interview for DSM-5 Disorders* (SCID-5), and the *Interview Guide for Evaluating DSM-5 Psychiatric Disorders and the Mental Status Examination* are all excellent resources for conducting clinical interviews.

  - Note: Stay tuned for updated versions of the texts above to reflect the modified criteria sets in the DSM-5-TR.

Assessment

- In addition to using the DSM-5-TR, a multi-method approach to assessment is integral to the work of psychologists and sound diagnostic practice.
- A multi-method assessment approach includes the use of reliable and valid:
  - Checklists and rating forms
  - Self-report measures
  - Standardized personality instruments and IQ/cognitive measures

Differential Diagnosis

- Differential diagnosis involves the consideration of multiple diagnoses that may account for a client's presenting problem, and subsequently identifying or excluding from consideration select diagnoses.
- Most major diagnoses in the DSM-5-TR list alternative diagnoses to consider.
- IMPORTANT for diagnostic fidelity!

Neurodevelopmental Disorders

Neurodevelopmental Disorders

- Intellectual Disability
- Communication Disorders
- Autism Spectrum Disorder
- Specific Learning Disorder
- Attention-Deficit/Hyperactivity Disorder
- Motor Disorders

Neurodevelopmental Disorders

- Onset in the developmental period
- Disorders typically manifest early in development, often before the child enters grade school
- Deficits produce impairments in personal, social, academic, and/or occupational functioning
- High rate of comorbidity among disorders

Intellectual Disability
(Intellectual Developmental Disorder)*

DSM-IV Criteria

- The term Mental Retardation (MR) was used
- Age of onset before or by age 18 years
- Severity = Function of IQ

DSM-5 Criteria

- The term Intellectual Disability (ID) replaces MR*
  - * Intellectual Disability is the equivalent term for the ICD-11 diagnosis of Intellectual Developmental Disorder ... a federal statute ... (Public Law 111-256, Rosa's Law) replaces the term mental retardation with intellectual disability …
- Age of onset during developmental period
- Severity = Function of Adaptive Behavior, not IQ

Intellectual Developmental Disorder
(Intellectual Disability)

- Intellectual developmental disorder (IDD), a term aligned with the ICD-11, is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:
  - A. Deficits in intellectual functions ... confirmed by both clinical assessment and individualized, standardized intelligence testing.
  - B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. ***Without ongoing support***, the adaptive deficits limit functioning in one or more activities of daily life…
  - C. Onset of intellectual and adaptive deficits during the developmental period.

Intellectual Developmental Disorder (Intellectual Disability) Specifiers

The DSM-5 and DSM-5-TR define the four levels of severity (i.e., mild, moderate, severe, and profound) according to three domains of adaptive behavior:

- **Conceptual** – includes skills in language, reading, writing, math, reasoning, knowledge, and memory
- **Social** – refers to empathy, social judgment, interpersonal communication skills, the ability to make and retain friendships, and similar capacities
- **Practical** – centers on self-management in areas such as personal care, job responsibilities, money management, recreation, and organizing school and work tasks

Intellectual Developmental Disorder (Intellectual Disability) Text Changes

- ***Phrase in DSM-5 removed from DSM-5-TR:*** "To meet diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A" in *Diagnostic Features*
  Rationale: Inadvertently added a fourth criterion to the ID/IDD diagnostic criteria
- ***Revised text in DSM-5-TR (Pg. 42):*** "For example, a person with deficits in intellectual functioning whose IQ score is somewhat above 65-75 may nevertheless have such substantial adaptive behavior problems in social judgment or other areas of adaptive functioning that the person's actual functioning is clinically comparable to that of individuals with a lower IQ score. Thus, clinical judgment is important in interpreting the results of IQ tests, and using them as the sole criteria for the diagnosis of an intellectual developmental disorder is insufficient."

SC SEED Intellectual Disability Criteria
5/30/23

A condition characterized by significant deficits in adaptive behavior and cognitive functioning that manifest in the developmental period (i.e., childhood) and adversely affect a child's educational performance.

There must be evidence of all of the following:

- A significant impairment in adaptive functioning that is at least two standard deviations below the mean (+/- the standard error of measurement) in at least two of the following adaptive skills domains:
  - Communication, b. Social skills, c. Personal independence at home and/or in community settings, and d. School or work functioning
- A significant limitation in intellectual functioning … as indicated by a FSIQ, GAI, or equivalent that are at least two standard deviations below the mean (+/- the standard error of measurement) on a...norm-referenced measure of intelligence.

Global Developmental Delay

- Reserved for individuals *under* the age of 5 years who:
  - Fail to meet expected developmental milestones in several areas of intellectual functioning

    AND/OR
  - Are unable to undergo systematic assessments of intellectual functioning, including being too young to participate in standardized testing
- Requires re-assessment after a period of time

Unspecified Intellectual Developmental Disorder (Intellectual Disability)

- A diagnosis in the DSM-5/DSM-5-TR that is reserved for individuals *over* the age of 5 years when:
  - Assessment of the degree of intellectual disability via available procedures is determined to be difficult or impossible due to:
    - Associated sensory or physical impairments, as in blindness or prelingual deafness
    - Locomotor disability, or
    - Presence of severe problem behaviors or co-occurring mental disorder
- This category should be used only in exceptional circumstances and requires reassessment after a period of time.

Communication Disorders

- Language Disorder
  - Replaces subtypes of “Expressive” and “Mixed Expressive-Receptive” Language Disorders in the DSM-IV
- Speech Sound Disorder
  - Replaces “Phonological Disorder” in DSM-IV
- Childhood-Onset Fluency Disorder
  - Replaces “Stuttering” in DSM-IV
- Social (Pragmatic) Communication Disorder
  - New diagnosis in the DSM-5

Language Disorder

- A. Persistent difficulties in the acquisition and use of language across modalities (i.e., spoken, written, sign language, or other) due to deficits in comprehension or production that include the following: 1) Reduced vocabulary, 2) limited sentence structure, and 3) impairments in discourse.
- B. Language abilities are substantially and quantifiably below those expected for age, resulting in functional limitations in effective communication, social participation, academic achievement, or occupational performance, individually or in any combination.
- C. The onset of symptoms is in the developmental period.
- D. The difficulties are not attributable to hearing or other sensory impairment, motor dysfunction, or another medical or neurological condition and are not better explained by intellectual developmental disorder (intellectual disability) or global developmental delay.

Speech Sound Disorder

- A. Persistent difficulty with speech sound production that interferes with speech intelligibility or prevents verbal communication of messages.
- B. The disturbance causes limitations in effective communication that interfere with social participation, academic achievement, or occupational performance, individually or in combination.
- C. The onset of symptoms is in the early developmental period.
- D. The difficulties are not attributable to congenital or acquired conditions, such as cerebral palsy, cleft palate, deafness or hearing loss, traumatic brain injury, or other medical or neurological conditions.

Childhood-Onset Fluency Disorder (Stuttering)

- A. Disturbances in the normal fluency and time patterning of speech that are inappropriate for the individual's age and language skills, persist over time, and are characterized by frequent and marked occurrences of one (or more) of the following:
  - 1. Sound and syllable repetitions
  - 2. Sound prolongations of consonants as well as vowels
  - 3. Broken words (e.g., pauses within a word)
  - 4. Audible or silent blocking (filled or unfilled pauses in speech)
  - 5. Circumlocutions (word substitutions to avoid problematic words)
  - 6. Words produced with an excess of physical tension
  - 7. Monosyllabic whole-word repetitions (e.g., "I-I-I-I see him")

Childhood-Onset Fluency Disorder (Stuttering)

- B. The disturbance causes anxiety about speaking or limitations in effective communication, social participation, or academic or occupational performance, individually or in any combination.
- C. The onset of symptoms is in the early developmental period. (**Note**: Later-onset cases are diagnosed as F98.5 adult-onset fluency disorder).
- D. The disturbance is not attributable to a speech-motor or sensory deficit, dysfluency associated with neurological insult (e.g., stroke, tumor, trauma), or another medical condition and is not better explained by another mental disorder.

Social (Pragmatic) Communication Disorder

- A. Persistent difficulties in the social use of verbal and nonverbal communication as manifested by all the following:
  - 1. Deficits in using communication for social purposes
  - 2. Impairment of the ability to change communication to match context or the needs of the listener
  - 3. Difficulties following rules for conversation and storytelling
  - 4. Difficulties understanding what is not explicitly stated and non-literal or ambiguous meanings of language
- B. The deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement, or occupational performance.
- C. The onset of symptoms is in the developmental period **(but deficits may not become fully manifest until social communication demands exceed limited capacities)** **.**
- 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 ASD, IDD/ID, global developmental delay, or another mental disorder.**

SC SEED Speech-Language Impairment
5/30/23

Speech or language impairment refers to a communication disorder, such as stuttering, impaired articulation (speech sound), language, or voice impairment that adversely affects a child's educational performance.

A Speech or Language Impairment includes demonstration of impairments in one or more of the following areas:

- Speech Sound
- Language
- Fluency (DSM-5-TR equivalent: Childhood-Onset Fluency Disorder)
- Voice

Autism Spectrum Disorder

DSM-IV Criteria

- **Pervasive Developmental Disorders**
  - Five Separate Disorders:
    1) Autistic Disorder
    2) Asperger's Disorder
    3) Childhood Disintegrative Disorder
    4) Rett's Disorder
    5) Pervasive Developmental Disorder NOS
- **Three criteria :**
  - Impairment in social interaction
  - Impairments in communication
  - Restrictive, repetitive behavior, interests, and activities

DSM-5 Criteria

- **Autism Spectrum Disorder** is a single umbrella disorder that encompasses all DSM-IV disorders except Rett's Disorder.
- **Two criteria:**
  - Deficits in social communication and social interaction
  - Restricted, repetitive behavior
- **Specifiers** define characteristics or dimensions of the disorder.
- **Severity levels** are defined for social communication and restrictive, repetitive behaviors.

Autism Spectrum Disorder

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all of the following**, currently or by history** (examples are illustrative, not exhaustive; see text):
  - 1. Deficits in social-emotional reciprocity
  - 2. Deficits in non-verbal communicative behaviors used for social interaction
  - 3. Deficits in developing, maintaining, and understanding relationships
- 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
  - 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior
  - 3. Highly restricted, fixated interests that are abnormal in intensity or focus
  - 4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment

Autism Spectrum Disorder

- 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 developmental disorder (intellectual disability) or global developmental delay. Intellectual developmental disorder and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual developmental disorder, 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 PDD-NOS should be given the diagnosis of ASD. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for ASD, should be evaluated for social (pragmatic) communication disorder.**

Autism Spectrum Disorder Severity Levels and Specifiers

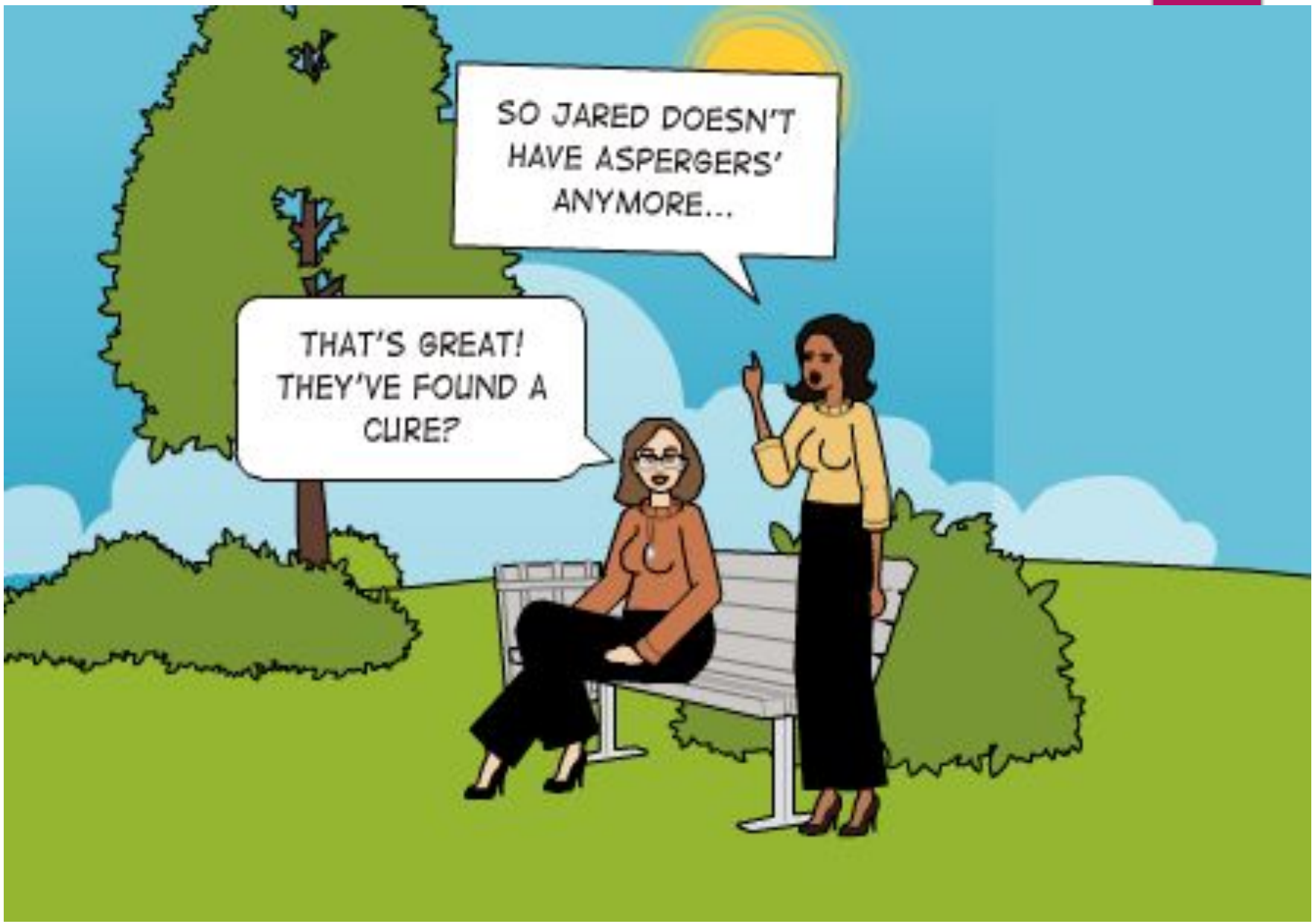
- Specify current severity based on social communication impairments and restricted, repetitive patterns of behavior
  - Level 1: Requiring support
  - Level 2: Requiring substantial support
  - Level 3: Requiring very substantial support
- Specify if:
  - With or without accompanying intellectual impairment
  - With or without accompanying language impairment
  - Associated with a known genetic or other medical condition or environmental factor (**Coding note:** Use additional code to identify the associated genetic or other medical condition.)
  - Associated with a neurodevelopmental, mental, or behavioral problem
  - With catatonia (refer to the criteria for catatonia associated with another mental disorder, p. 135, for definition) (**Coding note:** Use additional code F06.1 catatonia associated with ASD to indicate the presence of the comorbid catatonia.)

SC SEED Autism Spectrum Disorder Criteria

5/30/23

A developmental disability characterized by significant deficits in social communication and interaction as well as significant restricted interests and repetitive behaviors that are not primarily caused by an emotional disability and are typically, though not always, evident before age three.

- There is evidence that the child meets educational criteria for ASD indicated by:
  - a. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by <u>all</u> of the following (currently or by history):
    - Deficits in social-emotional reciprocity, deficits in nonverbal communicative behaviors used for social interaction, and deficits in developing, maintaining, and understanding relationships
  - b. Restricted, repetitive patterns of behaviors, interests, or activities, as manifested by at least two of the following (currently or by history):
    - Stereotyped or repetitive motor movements, use of objects, or speech; highly restricted, fixated interests abnormal in intensity or focus; insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior; or hyper- or hypo-activity to sensory input or unusual interest in sensory aspects of the environment


SO JARED DOESN'T HAVE ASPERGERS' ANYMORE...
THAT'S GREAT! THEY'VE FOUND A CURE?

Attention-Deficit/Hyperactivity Disorder

- ADHD Predominantly Inattentive Presentation
- ADHD Predominantly Hyperactive-Impulsive Presentation
- ADHD Combined Presentation
- Other Specified ADHD
- Unspecified ADHD

Attention-Deficit/Hyperactivity Disorder

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) inattention and/or (2) hyperactivity and impulsivity:

- **1. <u>Inattention</u>**: Six (or more) of the following symptoms have persisted for at least six 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 and older), at least five symptoms are required.
  - a. Often fails to give close attention to details or make careless mistakes in schoolwork, at work …
  - b. Often has difficulty sustaining attention in tasks or play activities …
  - c. Often does not seem to listen when spoken to directly …
  - d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace …
  - e. Often has difficulty organizing tasks and activities …
  - f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort …
  - g. Often loses things necessary for tasks or activities …
  - h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
  - i. Is often forgetful in daily activities …

Attention-Deficit/Hyperactivity Disorder

- 2. **Hyperactivity and impulsivity**: Six (or more) of the following symptoms have persisted for at least six 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 and older), at least five symptoms are required.

  - a. Often fidgets with or taps hands or feet or squirms in seat.
  - b. Often leaves seat in situations when remaining seated is expected …
  - 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 engage in leisure activities quietly.
  - e. Is often "on the go," acting as if "driven by a motor" …
  - f. Often talks excessively
  - g. Often blurts out an answer before a question has been completed …
  - h. Often has difficulty waiting his or her turn …
  - i. Often interrupts or intrudes on others …

Attention-Deficit/Hyperactivity Disorder

- B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
- 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 is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
- 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)
- <u>Specify whether:</u> F90.2 Combined presentation

  F90.0 Predominantly inattentive presentation

  F90.1 Predominantly hyperactive/impulsive presentation
- <u>Specify if:</u> In partial remission
- <u>Specify current severity:</u> Mild, moderate, or severe

Attention-Deficit/Hyperactivity Disorder

- Other Specified ADHD – Diagnosis given when the full criteria for ADHD or any other neurodevelopmental disorder are not met, and the specific reason is provided, e.g., "with insufficient inattentive and hyperactive-impulsive symptoms"

- Unspecified ADHD – Diagnosis given when the full criteria for ADHD or any other neurodevelopmental disorder are not met, and the specific reason is not provided

Comorbid Disorders of ADHD

- Comorbidity or co-existing disorders are the rule rather than the exception in DSM-5 disorders.

- The most common comorbid disorder for ADHD is ***oppositional defiant disorder*** (it co-occurs with ADHD in approximately 50% of children with the combined presentation and approximately 25%, with the predominantly inattentive presentation).

- ***Conduct disorder*** co-occurs in approximately 25% of children or adolescents with the combined presentation, depending on age and setting.

- Most children and adolescents with ***disruptive mood dysregulation disorder*** also meet the criteria for ADHD, although a lesser percentage of children with ADHD meet the criteria for DMDD.

- ***Specific learning disorder*** is a common coexisting condition with ADHD.

Specific Learning Disorder (SLD)

DSM-IV Criteria

- **Three Separate Diagnoses:**
  - Reading Disorder
  - Mathematics Disorder
  - Disorder of Written Expression

DSM-5 Criteria

- SLD is a single diagnosis that encompasses the DSM-IV disorders, as well as general academic skill deficits.
- Specifiers are provided for impairments in reading, mathematics, and written expression.
- Severity levels are defined for mild, moderate, and severe learning disorder[s].
- Acknowledges interventions that target impairments

Specific Learning Disorder

- A. Difficulties learning and using academic skills, as indicated by the presence of at least one of the following symptoms that have persisted for at least six months despite the provision of interventions that target those difficulties:

  1. Inaccurate or slow … word reading …
  2. Difficulty understanding the meaning of what is read …
  3. Difficulties with spelling …
  4. Difficulties with written expression …
  5. Difficulties mastering … math calculation …
  6. Difficulties with mathematical reasoning …

- B. The affected academic skills are substantially and quantifiably below those expected for the individual's chronological age, and cause significant interference with academic or occupational performance, or with activities of daily living, as confirmed by individually administered standardized achievement measures and comprehensive clinical assessment. For individuals aged 17 years and older, a documented history of impairing learning difficulties may be substituted for the standardized assessment.

Specific Learning Disorder

- C. The learning difficulties begin during school-age years but may not become fully manifest until the demands for those affected academic skills exceed the individual's limited capacities.
- D. The learning difficulties are not better accounted for by intellectual disabilities, uncorrected visual or auditory acuity, other mental or neurological disorders, psychosocial adversity, **lack of proficiency in the language of academic instruction, or inadequate educational instruction**.
- Specify if: With Impairment in Reading
  With Impairment in Written Expression
  With Impairment in Mathematics
- Specify current severity: Mild, Moderate, or Severe

SC SEED SLD Criteria
5/30/23

A disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken, or written, that may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Specific learning disability does not include learning problems that are primarily the result of: Visual impairment, including blindness; hearing impairment, including deafness; orthopedic impairment; intellectual disability; serious emotional disability; cultural factors; environmental or economic disadvantage; or limited English proficiency.

SC SEED SLD Criteria
5/30/23

Criteria:

1. **Significantly subaverage academic skills:** The child does not achieve adequately for the child's age or to meet State-approved grade-level standards in one or more of the following areas:
   - Basic reading skills; reading fluency; reading comprehension; math calculation; math problem-solving; written expression; oral expression; listening comprehension
2. **Learning experiences:** The child has been provided with learning experiences and instruction appropriate for the child's age or state-approved grade level standards in the area(s) of concern.
3. **Exclusionary factors:** The underachievement must not be the primary result of:
   - Limited English proficiency; visual, hearing, or motor disability; intellectual disabilities; emotional disabilities; cultural factors; environmental or economic disadvantage; atypical educational history such as irregular school attendance or attendance at multiple schools; lack of appropriate evidence-based instruction in writing…; math…; or reading…

Motor Disorders

- Developmental Coordination Disorder
- Stereotypic Movement Disorder
- Tic Disorders
  - Tourette's Disorder
  - Persistent (Chronic) Motor or Vocal Tic Disorder
  - Provisional Tic Disorder
  - Other Specified Tic Disorder
  - Unspecified Tic Disorder

Developmental Coordination Disorder

A. The acquisition and execution of coordinated motor skills is substantially below that expected given the individual's chronological age and opportunity for skill learning and use. Difficulties are manifested as clumsiness … as well as slowness and inaccuracy of performance of motor skills …

B. The motor skills deficit in Criterion A significantly and persistently interferes with activities of daily living appropriate to chronological age … and impacts academic/school productivity, prevocational, and vocational activities, leisure, and play.

C. Onset of symptoms is in the early developmental period.

D. The motor skills deficits are not better explained by intellectual developmental disorder … or visual impairment and are not attributable to a neurological condition affecting movement …

Stereotypic Movement Disorder

- A. Repetitive, seemingly driven, and apparently purposeless motor behavior (e.g., hand shaking or waving, body rocking, head banging, self-biting, hitting own body).
- B. The repetitive motor behavior interferes with social, academic, or other activities and may result in self-injury.
- C. Onset is in the early developmental period.
- D. The repetitive motor behavior is not attributable to the physiological effects of a substance or neurological condition and is not better explained by another neurodevelopmental or mental disorder …
- Specify if: 1) With self-injurious behavior, or 2) Without self-injurious behavior
- Specify if: Associated with a known genetic or other medical condition, neurodevelopmental disorder, or environmental factor
  - **Coding note**: Use additional code to identify the associated genetic or other medical condition, neurodevelopmental disorder, or environmental factor.
- Specify current severity: Mild, moderate, or severe

Tic Disorders

Note: A tic is a sudden, rapid, recurrent, nonrhythmic motor movement or vocalization.

Tourette's Disorder

A. Both multiple motor and one or more vocal tics have been present at some time during the illness, although not necessarily concurrently.

B. The tics may wax and wane in frequency but have persisted for more than one year since first tic onset.

C. Onset is before age 18 years.

D. The disturbance is not attributable to the physiological effects of a substance … or another medical condition …

Tic Disorders

Note: A tic is a sudden, rapid, recurrent, nonrhythmic motor movement or vocalization.

Persistent (Chronic) Motor or Vocal Tic Disorder

A. Single or multiple motor or vocal tics have been present during the illness, but not both motor and vocal.

B. The tics may wax and wane in frequency but have persisted for more than one year since first tic onset.

C. Onset is before age 18 years.

D. The disturbance is not attributable to the physiological effects of a substance … or another medical condition …

E. Criteria have never been met for Tourette's disorder.

Specify if: 1) With motor tics only or 2) With vocal tics only

Tic Disorders

Note: A tic is a sudden, rapid, recurrent, nonrhythmic motor movement or vocalization.

Provisional Tic Disorder

A. Single or multiple motor and/or vocal tics.

B. The tics have been present for less than one year since first tic onset.

C. Onset is before age 18 years.

D. The disturbance is not attributable to the physiological effects of a substance … or another medical condition …

E. Criteria have never been met for Tourette's disorder or persistent (chronic) motor or vocal tic disorder.

Tic Disorders

- **Other Specified Tic Disorder** – Diagnosis given when symptoms characteristic of a tic disorder that cause clinically significant distress or impairment predominate but do not meet the full criteria for a tic disorder or any of the disorders in the neurodevelopmental disorders diagnostic class. When assigning this diagnosis, the clinician chooses to specify a specific reason for doing so, e.g., with onset after age 18 years.

- **Unspecified Tic Disorder** – Diagnosis given when symptoms characteristic of a tic disorder that cause clinically significant distress or impairment predominate but do not meet the full criteria for a tic disorder or any of the disorders in the neurodevelopmental disorders diagnostic class. When assigning this diagnosis, the clinician chooses not to specify the reason that the criteria are not met for a tic disorder or a specific neurodevelopmental disorder; this diagnosis includes presentations in which there is insufficient information to make a more specific diagnosis.

Other Specified and Unspecified Neurodevelopmental Disorders

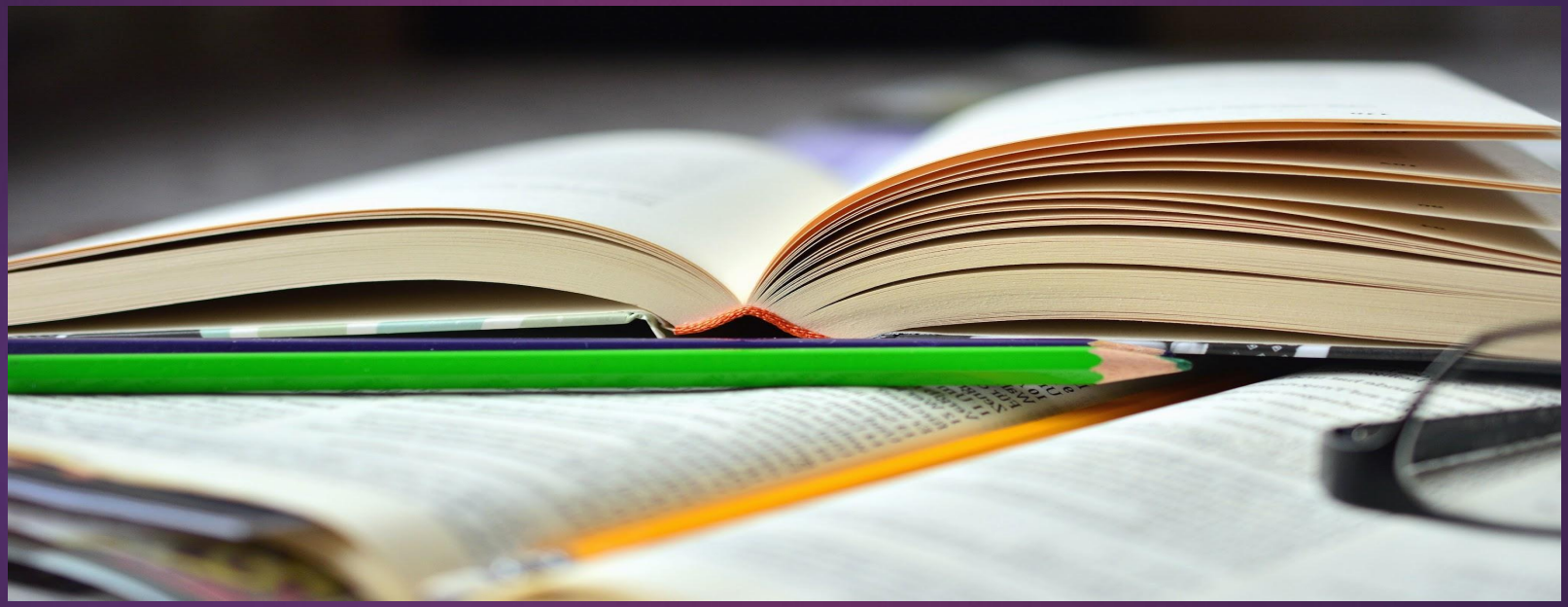
- **Other Specified Neurodevelopmental Disorder** – Diagnosis given when symptoms characteristic of a neurodevelopmental disorder that cause impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the neurodevelopmental disorders diagnostic class. When assigning this diagnosis, the clinician chooses to specify a specific reason for doing so, e.g., neurodevelopmental disorder associated with prenatal alcohol exposure.

- **Unspecified Neurodevelopmental Disorder** – Diagnosis given when symptoms characteristic of a neurodevelopmental disorder that cause impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the neurodevelopmental disorders diagnostic class. When assigning this diagnosis, the clinician chooses not to specify the reason that the criteria are not met for a specific neurodevelopmental disorder; this diagnosis includes presentations in which there is insufficient information to make a more specific diagnosis.
  - A situation or setting which may lend itself to the clinician either not choosing to specify the reason or in which there is insufficient information to make a more specific diagnosis is emergency room settings.

Why was the Roman Numeral Dropped from the DSM title?

Questions

Case # 1



Case # 1 Answers

- **Diagnosis: Autism spectrum disorder**
  - Without accompanying intellectual impairment
  - With accompanying language impairment - childhood onset fluency disorder (aka stuttering)
  - Requires support for deficits in social communication and for restricted, repetitive behaviors

- Due to Brandon experiencing passive suicidal thoughts, monitoring of his mood is important, as individuals with ASD are at elevated risk for suicidal thoughts and completed suicide.

Trauma- and Stressor-Related Disorders

Trauma- and Stressor-Related Disorders

- **Overview of diagnoses:**
  - Reactive Attachment Disorder
  - Disinhibited Social Engagement Disorder
  - Posttraumatic Stress Disorder
  - Acute Stress Disorder
  - Adjustment Disorders
  - Prolonged Grief Disorder - **New!**
  - Other Specified Trauma- and Stressor-Related Disorder
  - Unspecified Trauma- and Stressor-Related Disorder

Reactive Attachment Disorder

- A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:
  - 1. The child rarely or minimally seeks comfort when distressed.
  - 2. The child rarely or minimally responds to comfort when distressed.
- B. A persistent social and emotional disturbance characterized by at least two of the following:
  - 1. Minimal social and emotional responsiveness to others
  - 2. Limited positive affect
  - 3. Episodes of unexplained irritability, sadness, or fearfulness that are evident even during non-threatening interactions with adult caregivers
- C. The child has experienced a pattern of extremes of insufficient care, as evidenced by at least one of the following:
  - 1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs … met by caregiving adults
  - 2. Repeated changes of primary caregivers that limit opportunities to form stable attachments
  - 3. Rearing in unusual settings that severely limit opportunities to form selective attachments

Reactive Attachment Disorder

- D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).
- E. The criteria are not met for autism spectrum disorder.
- F. The disturbance is evident before age 5 years.
- G. The child has a developmental age of at least 9 months.

- *Specify* if:
  - Persistent: The disorder has been present for more than 12 months.
- *Specify* current severity: RAD is specified as severe when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

Disinhibited Social Engagement Disorder

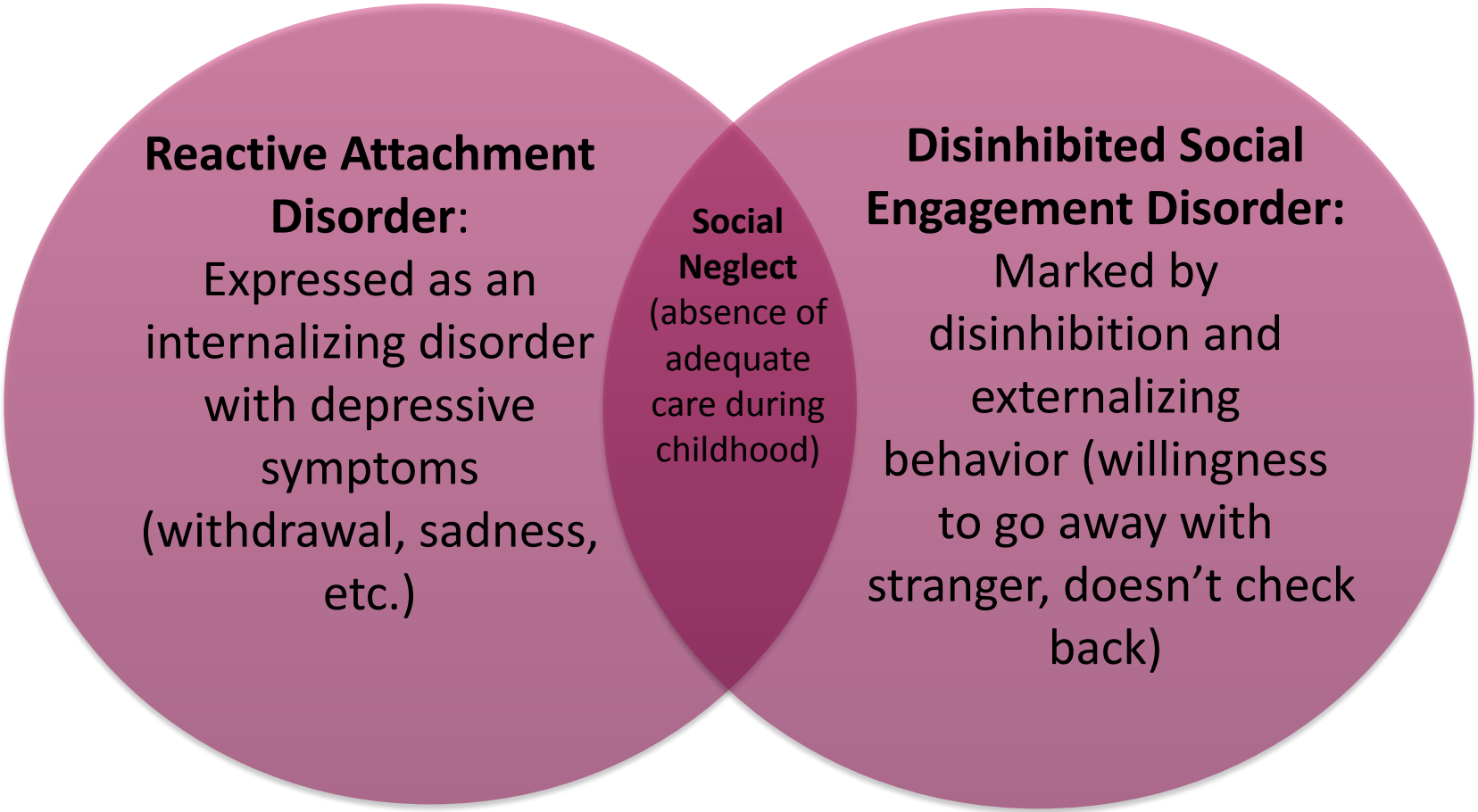
- A. A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two of the following:
  - 1. Reduced or absent reticence in approaching and interacting with unfamiliar adults
  - 2. Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries)
  - 3. Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings
  - 4. Willingness to go off with an unfamiliar adult with minimal or no hesitation
- B. The behaviors in Criterion A are not limited to impulsivity (as in ADHD) but include socially disinhibited behavior.
- C. The child has experienced a pattern of extremes of insufficient care, as evidenced by at least one of the following:

Disinhibited Social Engagement Disorder

- 1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
- 2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
- 3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

- D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).
- E. The child has a developmental age of at least 9 months.
- *Specify* if: **Persistent** (i.e., present > 12 months)
- *Specify* current severity: Specified as **severe** when the child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

Trauma and Stressor Related Disorders



Posttraumatic Stress Disorder

Note: The following criteria apply to adults, adolescents, and children older than age 6 years:

- 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
  3. Learning that the traumatic event(s) occurred to a close family member or close friend; in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental
  4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless work-related.

Posttraumatic Stress Disorder

- 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: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s)
    - Note: In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring
    - Note: In children, trauma-specific 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 physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)

Posttraumatic Stress Disorder

- C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
  - 1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)
  - 2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic events
- D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
  - 1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs)
  - 2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world
  - 3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others
  - 4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame)
  - 5. Markedly diminished interest or participation in significant activities
  - 6. Feelings of detachment or estrangement from others
  - 7. Persistent inability to experience positive emotions

Posttraumatic Stress Disorder

- E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
  - 1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects
  - 2. Reckless or self-destructive behavior
  - 3. Hypervigilance
  - 4. Exaggerated startle response
  - 5. Problems with concentration
  - 6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep)
- F. Duration of the disturbance (Criteria B, C, D, and E) is more than one month.
- G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

► *Specify* whether: With dissociative symptoms, i.e., either depersonalization or derealization not attributable to effects of substance or another medical condition

► *Specify* if: With delayed expression

Posttraumatic Stress Disorder for Children 6 Years and Younger

- A. In children 6 years and younger, 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 (excludes events that are witnessed only in media, pictures, television or movies)
    - 3. Learning that the traumatic event(s) occurred to a parent or caregiver figure

Posttraumatic Stress Disorder for Children 6 Years and Younger

- 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 affect of the dream are related to the traumatic event(s)
    - **Note:** It may not be possible to ascertain that the frightening content is related to the traumatic event
  - 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-specific 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 physiological reactions to reminders of the traumatic event(s)

Posttraumatic Stress Disorder for Children 6 Years and Younger

- 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(s), must be present, beginning after the event(s) or worsening after the event(s):
  - Persistent Avoidance of Stimuli:
    - 1. Avoidance of or efforts to avoid activities, 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 of play.
  - 5. Socially withdrawn behavior
  - 6. Persistent reduction in expression of positive emotions

Posttraumatic Stress Disorder for Children 6 Years and Younger

- D. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
  - 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)
  - 2. Hypervigilance
  - 3. Exaggerated startle response
  - 4. Problems with concentration
  - 5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep)
- E. The duration of the disturbance is more than one month.
- F. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.
- G. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition.

► *Specify* whether: With dissociative symptoms, i.e., either depersonalization or derealization □ not attributable to the effects of substance or another medical condition

► *Specify* if: With delayed expression

Posttraumatic Stress Disorder for Children 6 Years and Younger

- Tobin and House (2016) state that the accurate diagnosis of PTSD centers around three issues:
  - **1. Nature of the traumatic stress**
    - Common causes: Physical and sexual abuse, community and domestic violence, natural disasters, and war
  - **2. Defining symptom pattern**
    - Symptoms must represent a change in the individual's typical behavior
    - Do repeated or "serial" assessments of children, who may not meet full criteria or who demonstrate sub-syndromal signs/symptoms, especially young children
  - **3. Course of the disorder**
    - Complete recovery occurs in approximately half of clinical cases within three months; some cases persist for many years
    - Re-experiencing of trauma is the core of the diagnosis; retain diagnosis as long as re-experiencing is evident

National Institute of Mental Health

Helping Children and Adolescents Cope with Disasters and Other Traumatic Events/Children and Adolescents' Responses to Traumatic Stress

Acute Stress Disorder

- A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:
  - 1. Directly experiencing the traumatic events
  - 2. Witnessing, in person, the event(s) as it occurred to others
  - 3. Learning that the event(s) occurred to a close family member or close friend; **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
  - 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s); **Note**: This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.
- B. Presence of nine or more symptoms from any of the following five categories:
  - Intrusion symptoms
  - Negative Mood
  - Dissociative Symptoms
  - Avoidance Symptoms
  - Arousal Symptoms
- C. The duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.

Adjustment Disorders

- A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within three months of the onset of the stressor(s)
- B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:

  1. Marked distress that is out of proportion to the severity or intensity of the stressor(s), considering the external context and the cultural factors that might influence symptom severity and presentation

  2. Significant impairment in social, occupational, or other important areas of functioning
- C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.
-

Adjustment Disorders

- D. The symptoms do not represent normal bereavement and are not better explained by prolonged grief disorder.
- E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional six months.
- **Specify whether with:**
  - Depressed mood
  - Anxiety
  - Mixed anxiety and depressed mood
  - Disturbance of conduct
  - Mixed disturbance of emotions and conduct
  - Unspecified

- **Specify if:**
  - Acute: If the disturbance lasts less than six months
  - Persistent (chronic): If the disturbance lasts for six months or longer

Prolonged Grief Disorder -New!

- A. The death, at least 12 months ago, of a person who was close to the bereaved individual (for children and adolescents, at least 6 months ago)
- B. Since the death, the development of a persistent grief response characterized by one or both of the following symptoms, which have been present most days to a clinically significant degree; in addition, the symptom(s) has occurred nearly every day for at least the last month:
  - 1. Intense yearning/longing for the deceased person
  - 2. Preoccupation with thoughts or memories of the deceased person (in children and adolescents, preoccupation may focus on the circumstances of the death)

Prolonged Grief Disorder

- C. Since the death, at least three of the following symptoms have been present most days to a clinically significant degree; in addition, the symptoms have occurred nearly every day for at least the last month:
  - 1. Identity disruption (e.g., feeling as though part of oneself has died) since the death
  - 2. Marked sense of disbelief about the death
  - 3. Avoidance of reminders that the person is dead (in children and adolescents, may be characterized by efforts to avoid reminders)
  - 4. Intense emotional pain (e.g., anger, bitterness, sorrow) related to the death
  - 5. Difficulty reintegrating into one's relationships and activities after the death (e.g., problems engaging with friends, pursuing interests, or planning for the future)
  - 6. Emotional numbness (absence or marked reduction of emotional experience) as a result of the death
  - 7. Feeling that life is meaningless as a result of the death
  - 8. Intense loneliness as a result of the death

Prolonged Grief Disorder

- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The duration and severity of the bereavement reaction clearly exceed expected social, cultural, or religious norms for the individual's culture and context.
- F. The symptoms are not better explained by another mental disorder, such as major depressive disorder or posttraumatic stress disorder, and are not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Prolonged Grief Disorder in Children and Adolescents

- Distress may be expressed in play and behavior, developmental regressions, and anxious or protest behavior at times of separation and reunion.
- Protest or anger may result when daily care activities are performed differently than by the deceased.
- Searching for the deceased may occur due to not understanding the permanence of death.
- Somatic manifestations may occur, including problems with eating, sleeping, level of energy, etc.
- Failure to achieve age-appropriate developmental milestones and transitions may result from failure to reintegrate into life roles.

Other Specified and Unspecified Trauma- and Stressor-Related Disorders

- The other specified trauma- and stressor-related disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific trauma- and stressor-related disorder. This is done by recording "other specified trauma- and stressor-related disorder" followed by the specific reason (e.g., "persistent response to trauma with PTSD-like symptoms").

- The unspecified trauma- and stressor-related disorder category is used in situations in which the clinician chooses ***not*** to specify the reason that the criteria are not met for a specific trauma- and stressor-related disorder and includes presentations in which there is insufficient information to make a more specific diagnosis.

Trauma Sensitive Schools

TLPI Trauma Sensitive Schools Website

TLPI Publications - Helping Traumatized Children Learn

Why We Need Trauma Sensitive Schools - The Video

Questions

Depressive Disorders

Depressive Disorders

- **Overview of diagnoses:**

  - Disruptive Mood Dysregulation Disorder
  - Major Depressive Disorder
  - Persistent Depressive Disorder
  - Premenstrual Dysphoric Disorder
  - Substance/Medication-Induced Depressive Disorder
  - Depressive Disorder Due to Another Medical Condition
  - Other Specified Depressive Disorder
  - Unspecified Depressive Disorder
  - Unspecified Mood Disorder **(New)**

Depressive Disorders

DSM-IV Criteria

- Both depressive and bipolar disorders were in one chapter.
- The depressive disorders included a bereavement exclusion.
- Dysthymia was the name of the disorder for chronic depression.
- Premenstrual dysphoric disorder was a criteria set in need of further study.

DSM-5 Criteria

- There are separate chapters for the depressive and bipolar disorders.
- The bereavement exclusion is deleted.
- Three new diagnoses were added:
  - Disruptive mood dysregulation disorder
  - Persistent depressive disorder (a name change vs. a new diagnosis; previously called dysthymia)
  - Premenstrual dysphoric disorder
- Two new specifiers:
  - With mixed features
  - With anxious distress

Disruptive Mood Dysregulation Disorder

- A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation
- B. The temper outbursts are inconsistent w/developmental level.
- 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 is observable by others (e.g., parents, teachers, peers).
- E. Criteria A-D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting three or more consecutive months without all of the symptoms in Criteria A-D.

Disruptive Mood Dysregulation Disorder

- F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.

- G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.

- H. By history or observation, the age at onset of Criteria A-E is before 10 years [of age].

- I. There has never been a distinct period lasting more than one 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.

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, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder).

- **Note: This diagnosis cannot co-exist with oppositional defiant disorder (ODD), intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, ADHD, conduct disorder, and substance use disorders. Individuals whose symptoms meet criteria for both DMDD and ODD should only be given the diagnosis of DMDD. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of DMDD should not be assigned.**

- K. The symptoms are not attributable to the physiological effects of a substance or another medical or neurological condition.

Major Depressive Disorder

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. **Note:** Do not include symptoms that are clearly attributable to another medical condition.

- **1.** Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (**Note: In children and adolescents, can be irritable mood)**
- **2.** Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (per subjective account or observation)
- **3.** Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day. (**Note: In children, consider failure to make expected weight gain.)**
- **4.** Insomnia or hypersomnia nearly every day
- **5**. Psychomotor agitation or retardation nearly every day
- **6.** Fatigue or loss of energy nearly every day
- **7.** Feelings of worthlessness or excessive or inappropriate guilt nearly every day
- **8**. Diminished ability to think or concentrate, or indecisiveness, nearly every day (per subjective account or as observed by others)
- **9**. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Major Depressive Disorder

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

D. At least one major depressive episode is not better explained by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode. Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Note: Criteria A-C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Major Depressive Disorder

Coding and Recording Procedures:

- Specify severity/course and whether it is a single or recurrent episode

Specify if:

- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern

Persistent Depressive Disorder

This diagnosis represents a consolidation of DSM-IV defined chronic major depressive disorder and dysthymic disorder.

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least two years. **Note: In children and adolescents, mood can be irritable, and duration must be at least one year.**

B. 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

C. During the 2-year period **(one year for children or adolescents)** of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than two months at a time.

Persistent Depressive Disorder

This diagnosis represents a consolidation of DSM-IV defined chronic major depressive disorder and dysthymic disorder.

D. Criteria for a major depressive disorder may be continuously present for two years.

E. There has never been a manic episode or a hypomanic episode.

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: If criteria are sufficient for a diagnosis of a major depressive episode at any time during the two-year period of depressed mood, then a separate diagnosis of major depression should be made in addition to the diagnosis of persistent depressive disorder along with the relevant specifier (e.g., with intermittent major depressive episodes, with current episode).

Persistent Depressive Disorder

***Specify* if:**

- With anxious distress
- With atypical features
- In partial remission
- In full remission
- Early onset
- Late onset
- With pure dysthymic syndrome
- With persistent major depressive episode
- With intermittent major depressive episodes, with current episode
- With intermittent major depressive episodes, without current episode

- *Specify* current severity: Mild, Moderate, or Severe

Premenstrual Dysphoric Disorder

A. In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to *improve* within a few days after the onset of menses, and become *minimal* or absent in the week post-menses.

B. One (or more) of the following must be present:

1. Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection)
2. Marked irritability or anger or increased interpersonal conflicts
3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts
4. Marked anxiety, tension, and/or feelings of being keyed up or on edge

C. One (or more) of the following symptoms must additionally be present, to reach a total of *five* symptoms when combined with symptoms from Criterion B above.

1. Decreased interest in usual activities (e.g., work, school, friends, hobbies)
2. Subjective difficulty in concentration
3. Lethargy, easy fatigability, or marked lack of energy
4. Marked change in appetite; overeating; or specific food cravings
5. Hypersomnia or insomnia
6. A sense of being overwhelmed or out of control
7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of “bloating or weight gain

Premenstrual Dysphoric Disorder

Note: The symptoms in Criteria A-C must have been met for most menstrual cycles that occurred in the preceding year.

D. The symptoms cause clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home).

E. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, persistent depressive disorder, or a personality disorder (although it may co-occur with any of these disorders).

F. Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles (**Note:** The diagnosis may be made provisionally prior to this confirmation.)

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism).

Substance/Medication-Induced Depressive Disorder

- A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by depressed mood or markedly diminished interest or pleasure in all, or almost all, activities.
- B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
  - 1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to or withdrawal from a medication.
  - 2. The involved substance/medication is capable of producing the symptoms in Criterion A.
- C. The disturbance is not better explained by a depressive disorder that is not substance/medication-induced. Such evidence of an independent depressive disorder could include the following:
  - The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about one month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced depressive disorder (e.g., a history of recurrent non-substance/medication-related episodes).
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- **Note**: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.
- Specify: With onset during intoxication, with onset during withdrawal, or with onset after medication use.

Depressive Disorder Due to Another Medical Condition

- A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by depressed mood or markedly diminished interest or pleasure in all, or almost all, activities.
- B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
- C. The disturbance is not better explained by another mental disorder (e.g., adjustment disorder, with depressed mood, in which the stressor is a serious medical condition).
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Specify if: With depressive features or with major depressive-like episode or with mixed features

Other Specified and Unspecified Depressive Disorders

- The other specified depressive disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the full criteria for any of the disorders in the depressive disorders diagnostic class and does not meet criteria for adjustment disorder with depressed mood or adjustment disorder with mixed anxiety and depressed mood.
  - Please refer to the DSM-5-TR on pages 209-210 for examples of presentations that can be specified using the "other specified" designation.
- The unspecified depressive disorder category is used in situations in which the clinician chooses ***not*** to specify the reason that the criteria are not met for a specific depressive disorder and includes presentations in which there is insufficient information to make a more specific diagnosis. A common setting in which this occurs is a hospital emergency department.
- Please refer to the DSM-5-TR on pages 210-214 for the specifiers for the depressive disorders.

Unspecified Mood Disorder

- This diagnosis is given when symptoms characteristic of a mood disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not at the time of the evaluation meet the full criteria for any of the disorders in either the bipolar or the depressive disorders diagnostic classes, and in which it is difficult to choose between unspecified bipolar and related disorder and unspecified depressive disorder (e.g., acute agitation).
- **This diagnosis is being restored in the DSM-5-TR.**

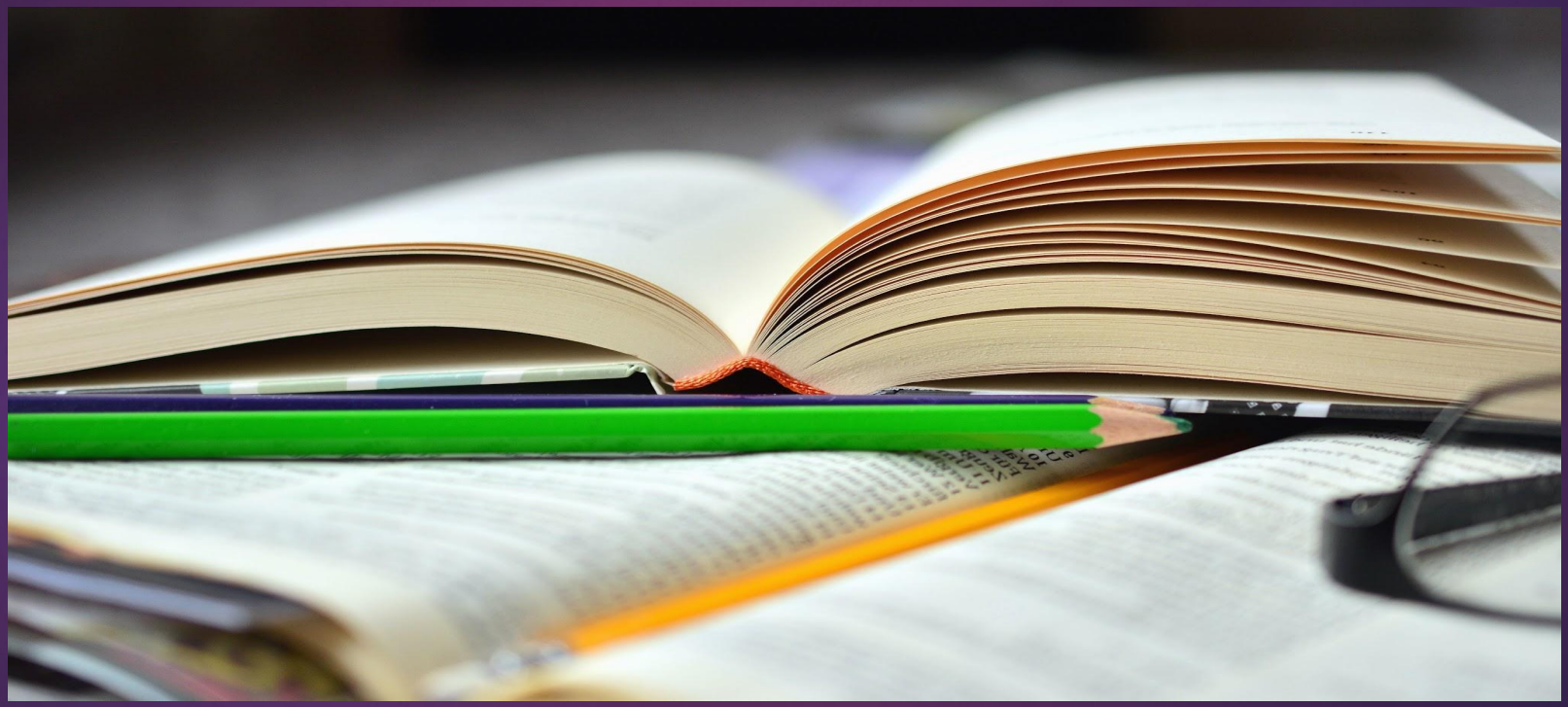
Specifiers for Depressive Disorders

- ***Specify* if:**
  - With anxious distress
  - With mixed features
  - With melancholic features
  - With atypical features
  - With psychotic features
    - With mood-congruent psychotic features
    - With mood-incongruent psychotic features
  - With catatonia
  - With peripartum onset
  - With seasonal pattern
  - In partial remission or full remission
- *Specify* current severity: Mild, moderate, or severe

"People always feel happier when a dog licks their face, so we're developing a new antidepressant made from dog drool!"

Questions

Case # 2



Case # 2 Answers

- **Diagnosis:**
  - Disinhibited social engagement disorder

- All four of the core symptomatic criteria are present (only two are required):
  - Reduced or absent reticence in approaching and interacting with unfamiliar adults
  - Overly familiar behavior
  - Diminished or absent checking back with an adult caregiver after venturing away
  - Willingness to go off with an unfamiliar adult with minimal or no hesitation

Anxiety Disorders

Anxiety Disorders

- **Overview of diagnoses:**
  - Separation Anxiety Disorder
  - Selective Mutism
  - Specific Phobia
  - Social Anxiety Disorder
  - Panic Disorder
  - Agoraphobia
  - Generalized Anxiety Disorder
  - Substance/Medication-Induced Anxiety Disorder
  - Anxiety Disorder Due to Another Medical Condition
  - Other Specified Anxiety Disorder
  - Unspecified Anxiety Disorder

Anxiety Disorders
Changes from the DSM-IV to DSM-5

- **Selective mutism** was moved to this category from Communication Disorders - criteria were unchanged
- **Obsessive-compulsive disorder** - removed from Anxiety Disorders and placed in the *OCD and Related Disorders* chapter
- **Generalized anxiety disorder** – no changes to the diagnostic criteria
- **Separation anxiety disorder** – criteria were slightly modified to make them more applicable to adults – moved to *Anxiety Disorders* from the DSM-IV *Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence* chapter
- **Panic disorder** – now one disorder; no longer two diagnoses of "with agoraphobia" and "without agoraphobia"; clarifies that panic disorder can arise from a calm or anxious state; some culture-specific symptoms are identified

Anxiety Disorders
Changes from the DSM-IV to DSM-5

- Social phobia re-named **social anxiety disorder**
- Increased consistency across the phobias, i.e., **agoraphobia, specific phobia, and social anxiety disorder** □ all emphasize fear, anxiety, and avoidance
- Six-month duration added to the criteria for phobias to rule out transient experiences
- Social anxiety disorder and specific phobia no longer require that the patient recognize that the fear is excessive or unreasonable – the clinician makes this judgment

Separation Anxiety Disorder

- 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. Repeated nightmares involving the theme of separation
8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated

Separation Anxiety Disorder

- B. The fear, anxiety, or avoidance is persistent, lasting at least four weeks in children and adolescents, and typically six months or more in adults.
- C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.
- 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.

Selective Mutism

- A. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.
- B. The disturbance interferes with educational or occupational achievement or with social communication.
- C. The duration of the disturbance is at least one month (not limited to the first month of school).
- D. Failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- E. The disturbance is not better explained by a communication disorder and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.

Specific Phobia

- A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
  - **Note**: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.
- B. The phobic object or situation almost always provokes immediate fear or anxiety.
- C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.
- D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
- E. The fear, anxiety, or avoidance is persistent, typically lasting for six months or more.
- F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specific Phobia

- G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia); objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).
- **Specify the phobic stimulus, e.g., animal, natural environment, blood-injection-injury, situational, and other; accordingly, assign the appropriate code.**

Social Anxiety Disorder

- A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possibly 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.
- B. 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).
- 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.
- D. The social situations are avoided or endured with intense fear or anxiety.
- E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

Social Anxiety Disorder

- F. The fear, anxiety, or avoidance is persistent, typically lasting for six months or more.
- G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- 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.
- 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.
- **Specify if:** **Performance only:** If the fear is restricted to speaking or performing in public.

Panic Disorder

- A. Recurrent unexpected panic attacks. A panic attack is 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:
- **Note:** The abrupt surge can occur from a calm state or an anxious state.
  - 1. Palpitations, pounding heart, or accelerated heart rate; 2. Sweating; 3. Trembling or shaking; 4. Sensations of shortness of breath or smothering; 5. Feelings of choking; 6. Chest pain or discomfort; 7. Nausea or abdominal distress; 8. Feeling dizzy, unsteady, light-headed, or faint; 9. Chills or heat sensations; 10. Paresthesias (numbness or tingling sensations); 11. Derealization or depersonalization; 12. Fear of losing control or "going crazy"; 13. Fear of dying
- B. At least one of the attacks has been followed by one month (or more) of one or both of the following:
  - 1. Persistent concern or worry about additional panic attacks or their consequences
  - 2. A significant maladaptive change in behavior related to the attacks (e.g., avoidance of exercise or unfamiliar situations)
- C. 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, cardiopulmonary disorders).
- D. The disturbance is not better explained by another mental disorder.

Agoraphobia

- A. Marked fear or anxiety about two (or more) of the following five situations:
  - 1. Using public transportation (e.g., automobiles, buses, trains, ships, planes); 2. Being in open spaces (e.g., parking lots, marketplaces, bridges); 3. Being in enclosed places (e.g., shops, theaters, cinemas); 4. Standing in line or being in a crowd; 5. Being outside of the home alone.
- B. 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 (e.g., fear of falling in the elderly; fear of incontinence).
- C. The agoraphobic situations almost always provoke fear or anxiety.
- D. The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.
- E. The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.

Agoraphobia

- F. The fear, anxiety, or avoidance is persistent, typically lasting for six months or more.
- G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. If another medical condition (e.g., inflammatory bowel disease, Parkinson's disease) is present, the fear, anxiety, or avoidance is clearly excessive.
- I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder.
  - **Note:** Agoraphobia is diagnosed irrespective of the presence of panic disorder. If an individual's presentation meets the criteria for panic disorder and agoraphobia, both diagnoses should be assigned.

Generalized Anxiety Disorder

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least six months, about a number of events or activities (such as work or school performance).
- B. The individual finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past six 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).
- D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- 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).
- F. The disturbance is not better explained by another mental disorder.

Substance/Medication-Induced Anxiety Disorder

- A. Panic attacks or anxiety is predominant in the clinical picture.
- B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
  - 1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to or withdrawal from a medication.
  - 2. The involved substance/medication is capable of producing the symptoms in Criterion A.
- C. The disturbance is not better explained by an anxiety disorder that is not substance/medication-induced. Such evidence of an independent anxiety disorder could include the following:
  - The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about one month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced anxiety disorder (e.g., a history of recurrent non-substance/medication-related episodes).
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- **Note**: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.
- Specify: With onset during intoxication, with onset during withdrawal, or with onset after medication use.

Anxiety Disorder Due to Another Medical Condition

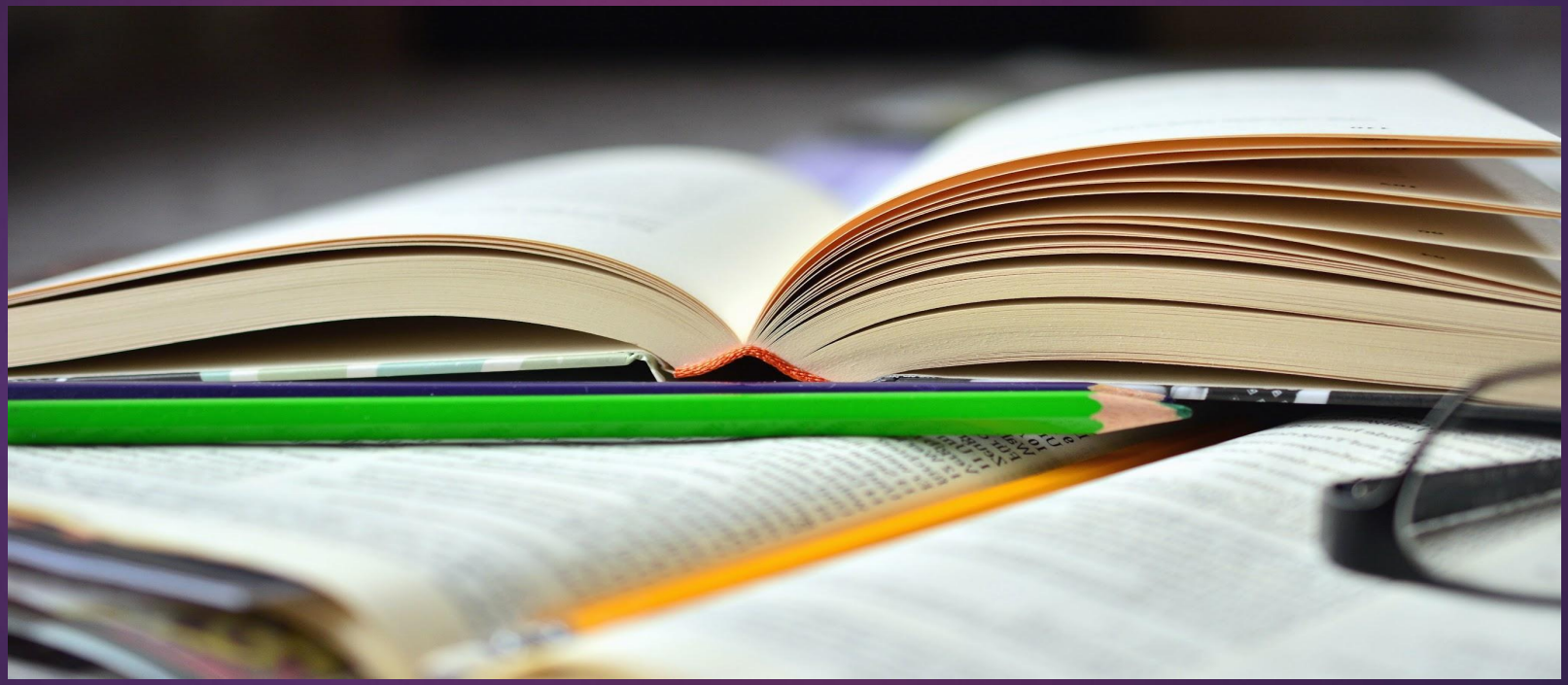
- A. Panic attacks or anxiety is predominant in the clinical picture.
- B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
- C. The disturbance is not better explained by another mental disorder.
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- **Coding note:** Please refer to the text in the DSM-5-TR.

Other Specified and Unspecified Anxiety Disorders

- The other specified anxiety disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the full criteria for any of the disorders in the anxiety disorders diagnostic class and does not meet criteria for adjustment disorder with depressed mood or adjustment disorder with mixed anxiety and depressed mood.
  - Please refer to the DSM-5-TR on page 261 for examples of presentations that can be specified using the "other specified" designation.
- The unspecified anxiety disorder category is used in situations in which the clinician chooses ***not*** to specify the reason that the criteria are not met for a specific anxiety disorder and includes presentations in which there is insufficient information to make a more specific diagnosis. A common setting in which this occurs is a hospital emergency department.

Questions

Case # 3



Case # 3 Answers

- **Diagnosis:**
  - Social anxiety disorder, severe
  - Posttraumatic stress disorder, moderate
  - Agoraphobia, servere
- Marked and excessive anxiety about multiple social situations, including those with her peers
- Intense and prolonged bullying (the trauma), intrusion (nightly nightmares), avoidance (of peers), negative alterations of cognitions and mood (exaggerated and negative self-views, panic attacks due to fear of reexposure to the trauma), and alterations in arousal and reactivity (always being on her guard)
- The social anxiety expanded and exploded, leading to panic attacks if she tried to leave home by herself and go to a nearby park

Disruptive, Impulse-Control, and Conduct Disorders

Other Conditions That May Be a Focus of Clinical Attention

Disruptive, Impulse-Control, and Conduct Disorders

Oppositional Defiant Disorder

- A. A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least six months, as evidenced by at least four symptoms from any 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

Oppositional Defiant Disorder

- **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 8). For individuals 5 years or older, the behavior should occur at least once per week for at least 6 months unless otherwise noted (Criterion 8). 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.
- 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 behaviors do 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.
- *Specify* current severity: **Mild** (symptoms are confined to only one setting); **Moderate** (some symptoms are present in at least two settings), or **Severe** (some symptoms are present in three or more settings).

Intermittent Explosive Disorder

- A. Recurrent behavioral outbursts representing a failure to control impulses, as manifested by either of the following:

    1. Verbal aggression (e.g., temper tantrums, tirades, verbal arguments or fights) or physical aggression toward property, animals, or other individuals, occurring twice weekly, on average, for a period of three months. The physical aggression does not result in damage or destruction of property and does not result in physical injury to animals or other individuals.

    2. Three behavioral outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring within a 12-month period.

- B. The magnitude of aggressiveness expressed during the recurrent outbursts is grossly out of proportion to the provocation or to any precipitating psychosocial stressors.

- C. The recurrent aggressive outbursts are not premeditated (i.e., they are impulsive and/or anger-based) and are not committed to achieve some tangible objective (e.g., money, power, intimidation).

Intermittent Explosive Disorder

- D. The recurrent aggressive outbursts cause either marked distress in the individual or impairment in occupational or interpersonal functioning or are associated with financial or legal consequences.
- E. Chronological age is at least 6 years (or equivalent developmental level)
- F. The recurrent aggressive outbursts are not better explained by another mental disorder (e.g., major depressive disorder, bipolar disorder, disruptive mood dysregulation disorder, a psychotic disorder, antisocial personality disorder, borderline personality disorder) and are not attributable to another medical condition (e.g., head trauma, Alzheimer's disease) or to the physiological effects of a substance (e.g., a drug of abuse, a medication). **For children ages 6-18 years, aggressive behavior that occurs as part of an adjustment disorder should not be considered for this diagnosis.**
- **Note:** This diagnosis can be made in addition to the diagnosis of ADHD, conduct disorder, ODD, or autism spectrum disorder when recurrent impulsive aggressive outbursts are in excess of those usually seen in these disorders and warrant independent clinical attention.

Conduct Disorder

- 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 at least three 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 six months:
  - **Aggression to people and animals**
    - 1. Often bullies, threatens, or intimidates others
    - 2. Often initiates physical fights
    - 3. Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
    - 4. Has been physically cruel to people
    - 5. Has been physically cruel to animals
    - 6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
    - 7. Has forced someone into sexual activity
  - **Destruction of property**
    - 8. Has deliberately engaged in fire setting with the intention of causing serious damage
    - 9. Has deliberately destroyed others' property (other than by fire setting)

Conduct Disorder

- Criterion A continued:
- 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 at least three 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 six months:
  - **Deceitfulness or Theft**
    - 10. Has broken into someone else's house, building, or car
    - 11. Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
    - 12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)
  - **Serious Violations of Rules**
    - 13. Often stays out at night despite parental prohibitions, beginning before age 13 years
    - 14. Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period
    - 15. Is often truant from school, beginning before age 13 years

Conduct Disorder

- B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.
- C. If the individual is age 18 years or older, criteria are not met for antisocial personality disorder.
- *Specify* whether:
  - Childhood-onset type
  - Adolescent-onset type
  - Unspecified onset
- *Specify* if:
  - With limited pro-social emotions – as evidenced by at least two of the following over at least 12 months and in multiple relationships and settings:
    - 1) Lack of remorse or guilt
    - 2) Callous-lack of empathy
    - 3) Unconcerned about performance, and/or
    - 4) Shallow or deficient affect
- *Specify* current severity:
  - Mild, Moderate, or Severe

Conduct Disorder

- Conduct disorder has a specifier - “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 settings:
  - Lack of remorse or guilt
  - Callous-lack of empathy
  - Unconcerned about performance
  - Shallow or deficient affect

Antisocial Personality Disorder

- A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
  - 1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest
  - 2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
  - 3. Impulsivity or failure to plan ahead
  - 4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults
  - 5. Reckless disregard for safety of self or others
  - 6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
  - 7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
- B. The individual is at least age 18 years.
- C. There is evidence of conduct disorder with onset before age 15 years.
- D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

Pyromania

- A. Deliberate and purposeful fire setting on more than one occasion
- B. Tension or affective arousal before the act
- C. Fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (e.g., paraphernalia, uses, consequences)
- D. Pleasure, gratification, or relief when setting fires or when witnessing or participating in their aftermath
- E. The fire setting is not done for monetary gain, as an expression of sociopolitical ideology, to conceal criminal activity, to express anger or vengeance, to improve one's living circumstances, in response to a delusion or hallucination, or as a result of impaired judgment (e.g., in major neurocognitive disorder, intellectual developmental disorder [intellectual disability], substance intoxication).
- F. The fire setting is not better explained by conduct disorder, a manic episode, or antisocial personality disorder.

Kleptomania

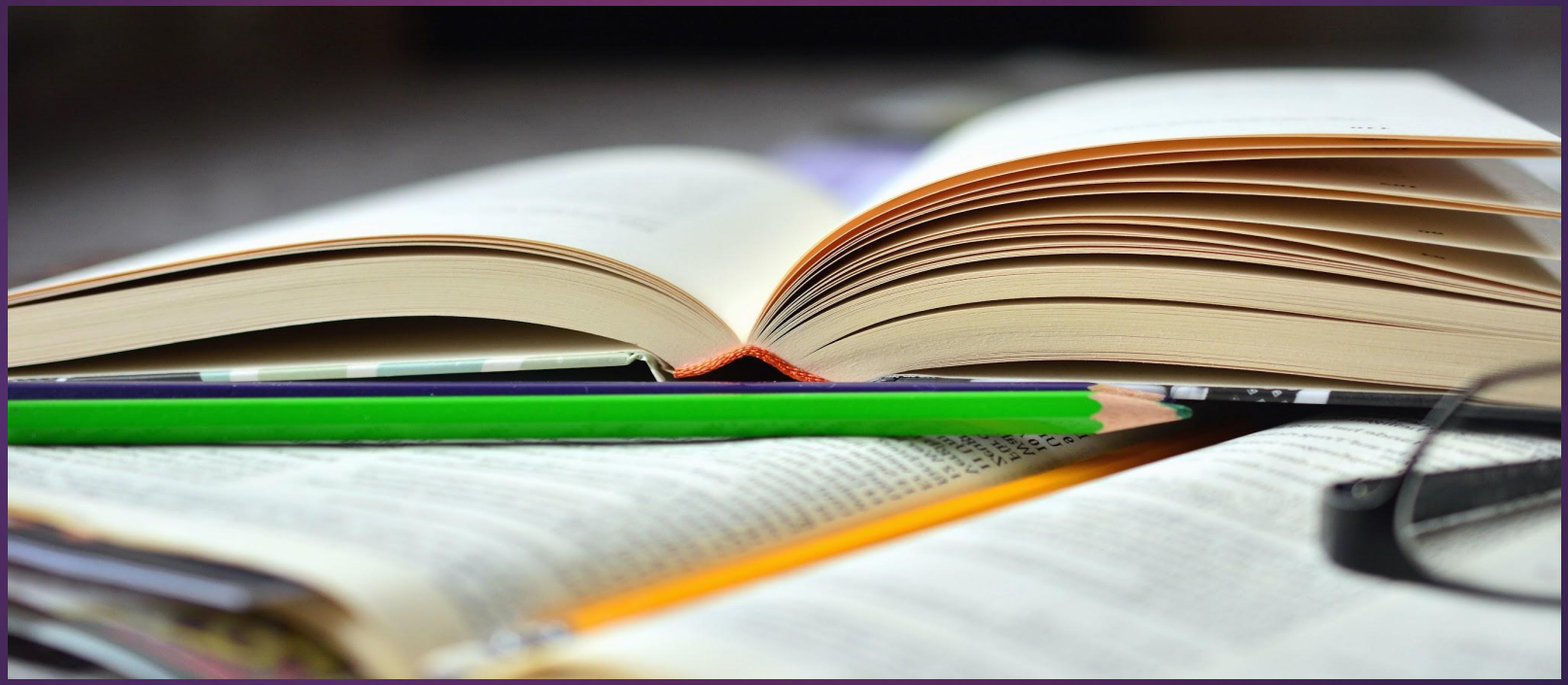
- A. Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value
- B. Increasing sense of tension immediately before committing the theft
- C. Pleasure, gratification, or relief at the time of committing the theft
- D. The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination.
- E. The stealing is not better explained by conduct disorder, a manic episode, or antisocial personality disorder.

Other Specified and Unspecified Disruptive, Impulse-Control, and Conduct Disorder

- The other specified disruptive, impulse-control, and conduct disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the full criteria for any of the disorders in the disruptive, impulse-control, and conduct disorder diagnostic class.
  - This is done by recording "other specified disruptive, impulse-control, and conduct disorder" followed by the specific reason (e.g., "recurrent behavioral outbursts of insufficient frequency").
- The unspecified disruptive, impulse-control, and conduct disorder category is used in situations in which the clinician chooses ***not*** to specify the reason that the criteria are not met for a specific disruptive, impulse-control, and conduct disorder and includes presentations in which there is insufficient information to make a more specific diagnosis. A common setting in which this occurs is a hospital emergency department.

Questions

Case # 4



Case # 4 Answers

- **Diagnosis:**
  - Conduct disorder (CD), childhood-onset type, severe, with limited prosocial emotions
  - Attention-deficit/hyperactivity disorder (by history)

- Kyle has exhibited **six** of the 15 behaviors for CD (3 + are required):
  - Bullying, fighting, stealing (with and without confrontation), break-ins, lying, and truancy
  - Onset prior to age 10 –> Childhood onset
  - Lack of empathy, lack of concern about performance, and lack of remorse or guilt –> Limited prosocial emotions

Other Conditions That May Be a Focus of Clinical Attention

Note: These conditions are not mental disorders.

Other Conditions That May Be a Focus of Clinical Attention

- **Overview of Conditions:**
  - Suicidal Behavior and Non-Suicidal Self-Injury
  - Abuse and Neglect
  - Relational Problems
  - Educational Problems
  - Occupational Problems
  - Housing Problems
  - Economic Problems
  - Problems Related to the Social Environment
  - Problems Related to Interaction with the Legal System
  - Problems Related to Other Psychosocial, Personal, and Environmental Circumstances
  - Problems Related to Access to Medical and Other Health Care
  - Circumstances of Personal History
  - Other Health Service Encounters for Counseling and Medical Advice
  - Additional Conditions or Problems That May Be a Focus of Clinical Attention

Other Conditions That May Be a Focus of Clinical Attention

- **Suicidal Behavior and Non-suicidal Self-Injury (New!)**
  - **Suicidal Behavior**
    - This category may be used for individuals who have engaged in potentially self-injurious behavior with at least some intent to die as a result of the act.
      - If the individual is dissuaded by another person or changes his or her mind before initiating the behavior, this category does not apply.
  - **Non-suicidal Self-Injury**
    - This category may be used for individuals who have engaged in intentional self-inflicted damage to their body in the absence of suicidal intent.

Other Conditions That May Be a Focus of Clinical Attention

- **Abuse and Neglect**
  - **Child Maltreatment and Neglect Problems**
    - Child Physical Abuse
      - Confirmed, Suspected, or Other Circumstances Related to Child Physical Abuse
    - Child Sexual Abuse
      - Confirmed, Suspected, or Other Circumstances Related to Child Sexual Abuse
    - Child Neglect
      - Confirmed, Suspected, or Other Circumstances Related to Child Neglect
    - Child Psychological Abuse
      - Confirmed, Suspected, or Other Circumstances Related to Child Psychological Abuse

Other Conditions That May Be a Focus of Clinical Attention

- **Abuse and Neglect**
  - **Adult Maltreatment and Neglect Problems**
    - Spouse or Partner Violence, Physical
      - Confirmed, Suspected, or Other Circumstances Related to Spouse or Partner Violence, Physical
    - Spouse or Partner Violence, Sexual
      - Confirmed, Suspected, or Other Circumstances Related to Spouse or Partner Violence, Sexual
    - Spouse or Partner Neglect
      - Confirmed, Suspected, or Other Circumstances Related to Spouse or Partner Neglect
    - Spouse or Partner Abuse, Psychological
      - Confirmed, Suspected, or Other Circumstances Related to Spouse or Partner Abuse, Psychological

Other Conditions That May Be a Focus of Clinical Attention

- **Relational Problems**
  - Parent-Child Relational Problem
  - Sibling Relational Problem
  - Relationship Distress with Spouse or Intimate Partner
    - **Problems Related to the Family Environment**
    - Upbringing Away From Parents
    - Child Affected by Parental Relationship Distress
    - Disruption of Family by Separation or Divorce
    - High Expressed Emotion Level Within Family

Other Conditions That May Be a Focus of Clinical Attention

- **Educational Problems**
  - May be used when an academic or educational problem is the focus of clinical attention.
  - Problems to be considered include:
    - Illiteracy and Low-Level Literacy
    - Schooling Unavailable and Unattainable
    - Failed School Examinations
    - Underachievement in School
    - Educational Maladjustment and Discord with Teachers and Classmates
    - Problems Related to Inadequate Teaching
    - Other Problems Related to Education and Literacy

Other Conditions That May Be a Focus of Clinical Attention

- **Housing and Economic Problems**
  - **Housing Problems**
    - Sheltered Homelessness
    - Unsheltered Homelessness
    - Inadequate Housing
    - Discord with Neighbor, Lodger, or Landlord
    - Problem Related to Living in a Residential Institution
    - Other Housing Problem
  - **Economic Problems**
    - Food Insecurity
    - Lack of Safe Drinking Water
    - Extreme Poverty
    - Low Income
    - Insufficient Social or Health Insurance or Welfare Support
    - Other Economic Problem

Other Conditions That May Be a Focus of Clinical Attention

- **Additional Conditions or Problems That May Be a Focus of Clinical Attention**
  - Wandering Associated with a Mental Disorder
  - Uncomplicated Bereavement
  - Phase of Life Problem
  - Religious or Spiritual Problem
  - Adult Antisocial Behavior
  - Child or Adolescent Antisocial Behavior
  - Nonadherence to Medical Treatment
  - Overweight or Obesity
  - Malingering
  - Age-Related Cognitive Decline
  - Borderline Intellectual Functioning

Questions

★ Additional Resources ★

ICD-10-CM

DSM-5-TR Supplement

DSM-5-TR Resources

Psychiatry Online

American Psychiatric Association Publishing

American Academy of Child and Adolescent Psychiatry

National Institute of Mental Health

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