UC DAVIS EXTENSION
CENTER FOR HUMAN SERVICES

NORTHERN CALIFORNIA TRAINING ACADEMY

ADVANCED ISSUES OF CHILD MENTAL HEALTH

PARTICIPANT GUIDE

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ADVANCED ISSUES OF ADULT AND CHILD MENTAL HEALTH

NORTHERN CALIFORNIA TRAINING ACADEMY

Pre-requisite: Participants must have attended Introduction to Mental Health: The DSM and Child Welfare Practice or The DSM 5 Update.

This two-day, advanced, clinically oriented course focuses on child and adult mental health diagnoses from a neurobiological viewpoint, including evidence-based therapeutic practices and psychopharmacological treatments.

After attending this training, participants will be able to:

- Understand the significant changes to and the controversies of the new DSM 5 diagnostic classification system
- Recognize the symptoms of commonly diagnosed disorders in children such as ADHD, autism spectrum, disruptive and conduct disorders and adjustment disorders
- Identify new diagnostic categories in children and adults, including trauma- and stressor-related disorders, and redesigned areas such as anxiety disorders, obsessive-compulsive disorders, and substance-related and addictive disorders
- Recognize medications prescribed for mental health disorders, review common side effects, and explore educational materials and resources for staff, clients and families

Successful participants will have a better understanding of mental health treatment issues and common promising practices of mental health partner providers. Further, participants can use this understanding to make better informed decisions when facilitating access to mental health services for adults, youth and children.

Course meets the qualifications for 12 hours of continuing education credit for MFTs or LCSWs as required by the California Board of Behavioral Sciences. BBS Provider Number PCE 577

Provider approved by the California Board of Registered Nursing, Provider Number 00046 for 12 contact hours.

INSTRUCTOR(S)

Margaret Cornish, LCSW
Renee Sievert, R.N., MFT

PROFESSIONAL CREDIT

1.2 CEUs, 12 BBS, 12 BRN

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About the Academy

Child welfare workers in public agencies serve some of the most vulnerable people in society—families and children in crisis. A consistently high-level of professional conduct in this work is essential for favorable outcomes, yet public agencies face substantial challenges in hiring and retaining professionally trained child welfare workers and supervisors.

The Northern California Training Academy' purpose is to aid counties by bringing to the region a training program designed to develop a uniformly high level of competence in services for families and children.

Professional Credit

CEU: Northern California Training Academy participants receive continuing education units (CEU) from the University of California, Davis. One CEU is awarded for each 10 hours of class time: 8.5 units for Core.

BBS: Core courses meet the qualification for the designated number of hours of continuing education credit for MFTs and/or LCSWs as required by the California Board of Behavioral Sciences, provider number PCE-577: 84.5 hours.

BRN: Core courses are approved by the California Board of Registered Nursing, provider number BRN00046. Students must enroll for credit and attend the entire course: 84.5 hours.

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About Your Instructors

Meg Cornish, LCSW has devoted over 30 years to working with children and families. A graduate of Smith College School for Social Work in 1988, she has focused on counseling for people with physical and emotional problems including cancer, diabetes, anxiety and depression. For the past 18 years, Meg has traveled throughout California providing training for Social Workers, Public Health Nurses, Case Managers, therapists and paraprofessionals. Her areas of training expertise include Interviewing skills, Attachment, Separation and Loss, Trauma Focused Practice, and DSM 5 and Advanced Mental Health Issues classes. Meg brings a creative, hands-on, solutions-focused approach to her live training sessions which are also integral parts of her online courses.

Renee Sievert, RN, MFT is an author, consultant, and master coach. She offers clinical training, leadership coaching, team building, strategic planning and experiential learning with horses (Equus Coaching). Renee has over 40 years of experience as a registered nurse with advanced certification in psychiatric and mental health nursing and HIV /AIDS. She has been a licensed therapist (MFT) in California for over 30 years and is certified in Gestalt Therapy, Domestic Violence Treatment and Addiction Treatment. She is a Certified Daring Way™ and Dare to Lead™ Facilitator, and a member of the International Motivational Interviewing Network of Trainers (MINT) and the International Coaching Federation. Renee was named *Mental Health Nurse of the Year* by the San Diego North County Civic Association in 2006 was honored at the *Tribute to Women in Industry (TWIN) Awards* in 2009.

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Northern California Training Academy

Advanced Issues of Child Mental Health

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Competencies

Safety 1

Children are, first and foremost, protected from abuse and neglect.

Permanency 1

Children have permanency and stability in their living situations without increasing reentry to foster care.

Well-being 1

Families have enhanced capacity to provide for their children's needs.

Well-being 2

Children receive services appropriate to their educational needs.

Well-being 3

Children receive services adequate to their physical, emotional, and mental health needs.

California Outcome 5F

Authorized for psychotropic medication

Learning Objectives

Knowledge:

K1. The participant will be able to recognize how commonly occurring mental disorders can affect a person's ability to parent safely.

K2. The participant will be able to recognize that there is a range of functioning among children, adolescents, and adults who experience mental and emotional disorders.

K3. The participant will be able to recognize that biological, psychological, cultural, environmental and behavioral (i.e. substance abuse) factors may influence the mental health functioning of family members.

K4. The participant will be able to describe the case management role of the child welfare worker working with health care and mental health professionals, including:

a) facilitating access to mental health services for adults, youth and children;
b) actively collaborating with mental health and medical professionals regarding mental health assessment; diagnostic testing; medication recommendations and management; and ongoing services for parents, youth and children;
c) ensuring ongoing court approval for use of psychotropic medication is in place for children and youth in placement;
d) Advocating on behalf of parents, youth and children regarding the mental health services they receive.

K5. The participant will be able to recognize common case plan interventions that are used by child welfare workers to engage and assist children, youth and adults who experience mental and emotional disorders.

Skills:

S1. Utilizing a case scenario, the participant will be able to identify possible symptoms, warning signs, and behaviors that could indicate a mental health concern.

S2. Utilizing a case example, the participant will be able to identify cultural factors that may influence behavior and articulate how such behavior may be misconstrued as symptomatic of a mental disorder.

S3. Utilizing a case example, the participant will be able to develop case plan objectives, client responsibilities and planned services that meet the individual mental health needs of adults and children.

Values:

V1. The participant will value the child welfare worker's role in educating families, collaterals, service providers, and colleagues about common misperceptions associated with certain mental disorders.

V2. The participant will value awareness of and sensitivity to cultural

differences and their implications when working with families with mental health issues.

V3. The participant will value seeking out clinical case consultations and thinking critically when working with children, youth and families regarding mental health concerns and diagnoses.

V4. The participant will value customizing mental health interventions to meet individual and family needs.

Related Title IV-E MSW Curriculum Competencies

CP 1.1.
Interact positively with clients, colleagues and supervisors and demonstrate skill in seeking out suitable client services and ensuring client access to those services.

CP 1.2.
Maintain professional demeanor and boundaries in practice situations, demonstrate skill in articulating professional knowledge and effective use of self, and utilize appropriate resources to ensure professional growth.

CF 6.b.
Demonstrate knowledge of how to consult and utilize research evidence to inform ongoing practice and policy at all levels.

CA 7.1.
Integrate knowledge and theory of human behavior and the social environment from diverse perspectives to conduct reliable and valid assessments, comprehensive service plans, effective interventions, and meaningful evaluations in child welfare.

CF 10(a).a.
Demonstrate the knowledge base and affective readiness to intervene constructively with individuals and groups.

CA 10(a).1.
Demonstrate the ability to develop relationships and manage power differentials

in routine and challenging client and partner situations, in a manner that reflects core social work values in child welfare practice.

CF 10(b).d.
Demonstrate ability to critically determine the most appropriate intervention strategies to implement a plan.

Action Plan

1. I need to learn_____about Child mental health disorders.

2. My current knowledge of the *DSM-5* is_____on a scale of 1-10.

3. _____ is a resource to study further in my professional growth.

4. _____ will support me in my further study of children's mental health.

5. Most common diagnoses in my work:

Factors Impacting Child Mental Health

List 3 factors that impact children's mental health for each category listed below.

- Developmental factors

- Assessment factors

- Family factors

- Unintended consequences of diagnosing children - negative stigma or labels

Classifying Mental Disorders

Why classify psychiatric diagnoses?

- Communication - between mental health professionals and with their patients
- Framework - for study of the outcome of mental illnesses
- Treatment - to predict the effects on the patient
- Research - into the causes of mental illness

Classification systems

DSM-5
American Psychiatric Association: Diagnostic and statistical manual of mental disorders, Fifth Edition.
Published by the American Psychiatric Association (APA)

- A comprehensive manual of mental disorders that will be used in this course.
- The DSM-5 is a guide, an aide to assist clinicians to help facilitate treatment.

Three major sections of the DSM-5

I. Introduction and clear information on how to use the DSM.
II. Provides information and categorical diagnoses.
III. Section III provides self-assessment tools, as well as categories that require more research.

New to the DSM-5

Throughout the entire manual, disorders are framed in age, gender, developmental characteristics.
Multi-axial system has been eliminated in the DSM-5.
GAF (Global Assessment of Functioning) has been eliminated and the use severity scales added.
DSM-5 removes artificial distinctions between medical and mental disorders.

In addition, the clinician can add the following to the diagnosis:

- Subtypes
- Specifiers and Severity Index
- Provisional Diagnoses
- V Codes

ICD 10

International Classification of Diseases, 10th edition, 1992 (ICD-10)
The International Classification of Diseases, Ninth Revision (ICD-9) has been used in the United States for over 30 years and is extremely limited in the level of specificity it can provide in clinical diagnoses within health care. On October 1, 2014, ICD-10 coding will allow for a greater level of detail with its seven (7) alphanumeric characters instead of the 5-digit ICD-9 code set. This massive overhaul of the national coding system, going from roughly 17,000 codes to about 140,000, will be the most significant change to health care in decades.

DC: 0-3R

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (Diagnostic Classification: 0-3R)
Developmentally-based system for diagnosing mental health and developmental disorders in infants and toddlers
Categories reflected the consensus of a multidisciplinary group of experts in early childhood development and mental health.
Focuses on developmental issues, relationship with caregivers and patterns of the child using a separate axes system from the DSM-I V:
Axis I: Primary Classification
Axis II: Relationship Classification
Axis III: Physical, Neurological, Developmental and Mental Health Disorders or Conditions
Axis IV: Psychosocial Stress
Axis V: Functional Emotional Developmental Level
The current revised edition of the DC 0-3 draws upon empirical research and clinical practice in the field that have occurred worldwide since 1994

Relevant Diagnoses for Child Welfare

- **Autism Spectrum**
- **ADHD**
- **Depressive Disorders**
- **Anxiety Disorders**
- **Trauma and stressor- related disorders**
- **Conduct and ODD**

Culture and Mental Health in Children

Culture - a shared set of beliefs, norms and values

Interaction between culture and mental health

- Culture impacts which symptoms are reported and how the information is communicated
- Culture impacts how families seek help for mental issues
- Culture impacts how clients react to the stigma of mental issues
- Racism and discrimination are stressors on the family and may lead to an increase in depression and anxiety
- Cultural bias is inherent in diagnostic systems in mental health
- Basic emotional states are universal throughout cultures; however, there are unique interpretations of emotional states

Considerations for treatment of children

- Best interest of the child
- Cultural environment
- Developmental issues
- Time and cost considerations
- Family considerations
- Two Parents / Single Parent / Foster Parent
- Siblings

Goals of assessment

- Differentiate between normal and abnormal development
- Identify strengths and deficits
- Predict the course of the disorder
- Classify the problem
- Provide guidelines for intervention

Barriers to treatment

- Lack of access to care
- Lack of accurate diagnosis
- Time lag between onset of illness and treatment
- Not taking prescribed medications (if applicable)
- Chaotic, stressful or inflexible home / school environment
- The co-occurrence of other diagnoses
- Use of substances such as illegal drugs and alcohol

Modalities of Treatment with Children

Play and art therapy

- Children use play, stories, puppets and art to express feelings
- Allows children to transform their frightening feelings into feelings of mastery and control

Interventions in play therapy

- Use of puppets allows the child to project internal conflicts onto an external object.
- Storytelling can distance the child from a problem and recreate a healthier ending to the tale.
- Art therapy stimulates fantasy and creativity to resolve problems through self-reflection

Play therapy techniques

- Five feelings: sad, happy, mad, scared, lonely
- Five faces technique
- Story telling
- Play therapy
- Art therapy
- Puppets
- Feelings Games

Cognitive behavioral therapy (CBT)

- Maladaptive behavior is the result of maladaptive thinking patterns
- Must be adapted to the developmental stage of the child
- Thoughts drive behaviors

*See Advanced Adult Mental Health class for additional information on CB

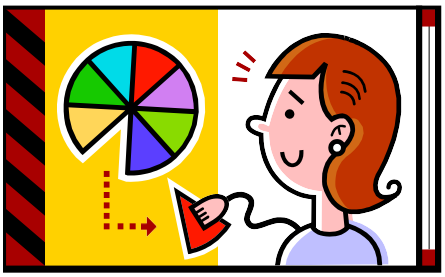
Dialectical Behavioral Therapy

- Validation of child's emotions
- Mindfulness tools
- Emotional regulation
- Distress tolerance
- Interpersonal effectiveness skills
- Parents learn these same tools

Behavior modification

- A specific set of procedures that target problem behaviors
- Operationalize the problem
- Identify antecedents
- Identify consequences
- Remove antecedents or use negative reinforcement
- Can be combined with CBT

Behavior modification techniques



- Token economies
- Behavior charts
- Reward systems

Social skills groups

- Learning to cope with bullying and teasing
- Anger management
- Friendship skills
- Reducing isolation
- Learning to cooperate in groups

Anger management groups

ABC approach

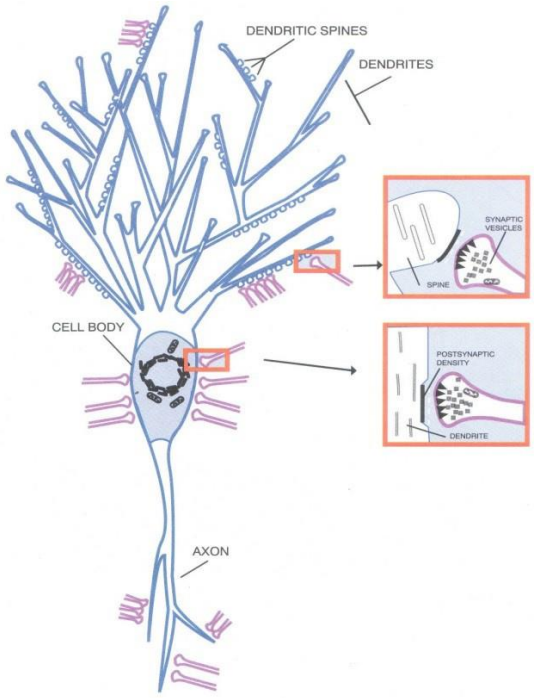
A: Trigger

B: Response

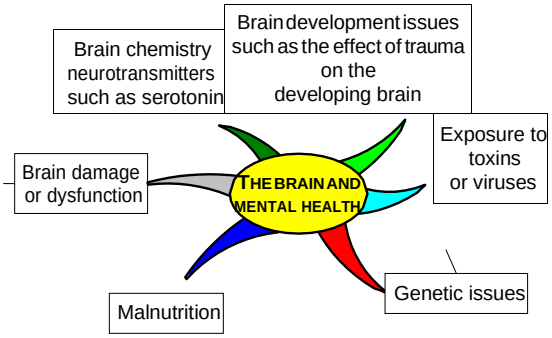
C: Consequence

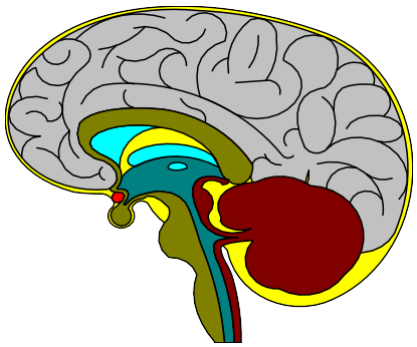
Neurobiological Components of Mental Illness

Neuronal development



Etiology

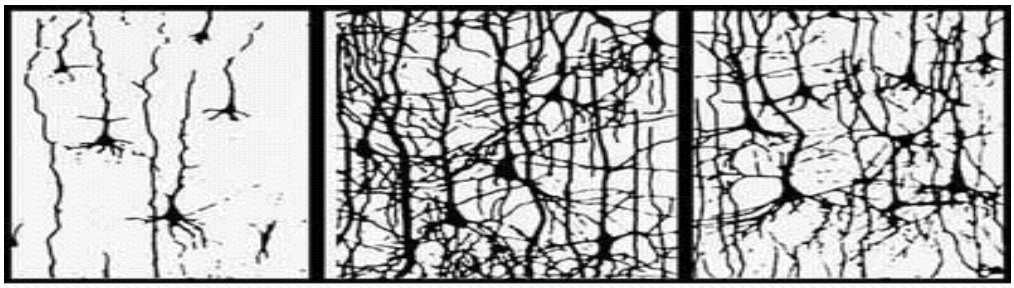




The brain: a complex system of 100 billion interconnected neurons

Synaptic density

- Infant born with 100 million neurons; before age one, brain develops more rapidly and extensively than previously thought
- Significant influence of environment & experience
- Pruning: "Use it or lose it"

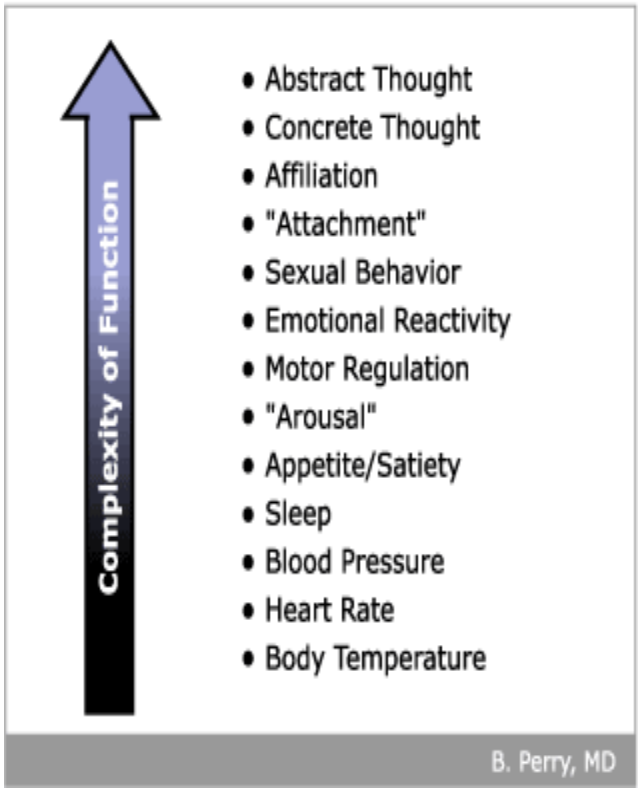


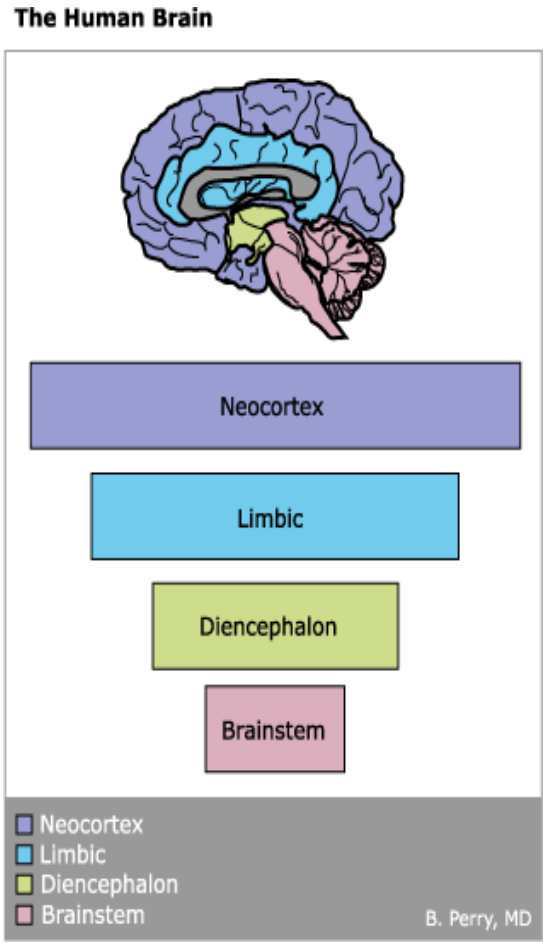
Birth **Six years old** **14 years old**

Source: Bruce Perry www.ChildTrauma.org

Principles of Brain Development

- Genetics provide blueprint; environment shapes expression of genes
- Sequential development is use-dependent
- Healthy growth needs specific repetitive patterns of activity
- Experience during critical periods of childhood organizes the brain

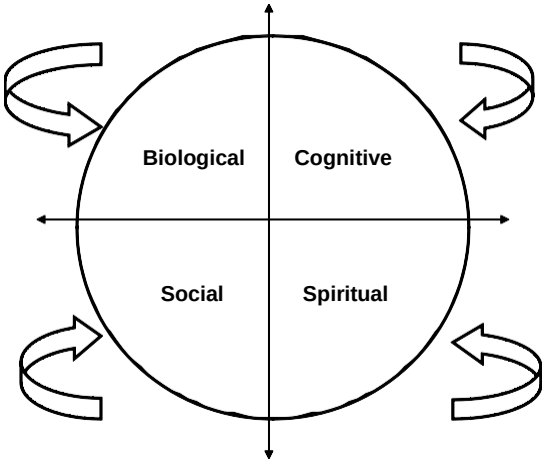




Source: Bruce Perry www.ChildTrauma.org

Principles of Brain Development

- Brain develops in a use-dependent way
- Sets down the templates for how the world is & how to interact with it
- Sets down the template for how we make decisions and make sense out of the way things happen



Source: Damluji, Sievert, Downey *Feeling Terrific, Four Strategies for Overcoming Depression Using Mood Regulation Therapy, iUniverse Publishing, 2005*

Psychopharmacology Principles

- Accurate assessment and diagnosis
- Choice of a therapeutic agent based on
  - ✓ Presenting Symptoms
  - ✓ History of previous treatment
  - ✓ Family history of treatment
  - ✓ Medical history and current status
- Desired effect, duration of action
- Maximize improvement in function
- Minimize negative side effects while taking advantage of positive

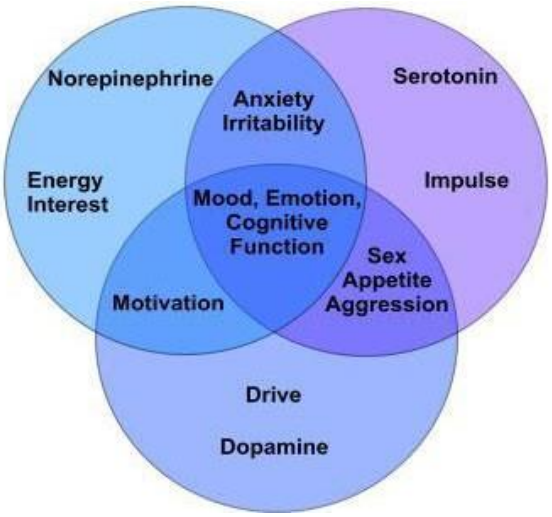
secondary effects
- Minimize burden of medication administration
- Monitor compliance, side effects, response

- FDA Approval of Medications
    - "Off Label" use

Neurotransmitters

- *Dopamine* (DA)
- *Serotonin* (5HT)
- *Norepinephrine* (NE)
- *Acetylcholine* (AcH)
- *Glutamate* (Glu)

Neurotransmitters and the brain



From: Medscape.com

Mechanisms of Action of Psychotropic Medications

Agonist

- Activates or facilitates Neurotransmitter

Antagonist

- Blocks action of Neurotransmitter at receptor site

Inhibitor

- Inhibits production or activity of regulatory enzymes thereby influencing amount of neurotransmitter

Neurodevelopmental Disorders
Autistic Spectrum Disorders (ASD)

New insights into the autistic world

Understanding old behaviors in new ways:

Chandima Rajapatirana, an autistic writer from Maryland, offers this account: **"Helplessly I sit while Mom calls me to come. I know what I must do, but often I can't get up until she says STAND UP….. The knack of knowing where my body is does not come easy for me…. I do not know if I am sitting or standing. I am not aware of my body unless it is touching something… Your hand on mine lets me know where my hand is…"**

Such insights shed light on some behaviors that may seem self-destructive (biting, scratching, spinning, head banging).

ASD now encompasses the previous DSM-IV autistic disorder (autism), Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified.
ASD is characterized by 1) deficits in social communication and social interaction and 2) restricted repetitive behaviors, interests, and activities (RRBs). Because both components are required for diagnosis of ASD, social communication disorder is diagnosed if no RRBs are present.

People with ASD tend to have communication deficits, such as responding inappropriately in conversations, misreading nonverbal interactions, or having difficulty building friendships appropriate to their age. In addition, people with ASD may be overly dependent on routines, highly sensitive to changes in their environment, or intensely focused on inappropriate items. Again, the symptoms of people with ASD will fall on a continuum, with some individuals showing mild symptoms and others having much more severe symptoms. This spectrum will allow clinicians to account for the variations in symptoms and behaviors from person to person.

Under the DSM-5 criteria, individuals with ASD must show symptoms from

early childhood, even if those symptoms are not recognized until later. This criteria change encourages earlier diagnosis of ASD but also allows people whose symptoms may not be fully recognized until social demands exceed their capacity to receive the diagnosis. It is an important change from DSM-IV criteria, which was geared toward identifying school-aged children with autism-related disorders, but not as useful in diagnosing younger children.

Causes and risk factors

We do not know all of the causes of ASDs. However, we have learned that there are likely many causes for multiple types of ASDs. There may be many different factors that make a child more likely to have an ASD, including environmental, biologic and genetic factors.

- Most scientists agree that genes are one of the risk factors that can make a person more likely to develop an ASD.
- Children who have a sibling or parent with an ASD are at a higher risk of also having an ASD.
- ASDs tend to occur more often in people who have certain other medical conditions. About 10% of children with an ASD have an identifiable genetic disorder, such as Fragile X syndrome, tuberous sclerosis, Down syndrome and other chromosomal disorders.
- Some harmful drugs taken during pregnancy have been linked with a higher risk of ASDs, for example, the prescription drugs thalidomide and valproic acid.
- We know that the once common belief that poor parenting practices cause ASDs is not true.
- There is some evidence that the critical period for developing ASDs occurs before birth. However, concerns about vaccines and infections have led researchers to consider risk factors before and after birth.
- Many of the classic symptoms (spinning head banging, repetition of phrases) appear to be coping mechanisms rather than "hard-wired" behaviors.

Autism spectrum disorder

DSM-5 criteria

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative paly or in making friends; to absence of interest in peers.

Specify current severity:
Severity is based on social communication impairments and restricted repetitive patterns of behavior).

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g, strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
4. Hyper- or hypo-reactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:
Severity is based on social communication impairments and restricted, repetitive patterns of behavior.

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.
Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify if:
With or without accompanying intellectual impairment
with or without accompanying language impairment
Associated with a known medical or genetic condition or environmental factor (Coding note: Use additional code to identify the associated medical or genetic condition.)
Associated with another neurodevelopmental, mental, or behavioral disorder (Coding note: Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder[s].)

With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119-120, for definition) (Coding note: Use additional code 293.89 [F06.1] catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)

Severity levels for autism spectrum disorder

Severity level	Social communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interferes with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.

Level 1 "Requiring support"	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to-and-from conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

From: http://www.autismspeaks.org/what-autism/diagnosis/dsm-5-diagnostic-criteria

Autism Warning Signs

- Child has not. . .
  - Babbled or cooed by one year
  - Gestured, pointed or waved by one year
  - Spoken a single word by 16 months
  - Spoken a two-word phrase by two years

Additional warning signs

- Experiences any loss of any language skills at any age
- Does not respond to his or her name
- Cannot tell or describe what he or she wants
- Experience any language delays
- Does not follow directions at all
- Appear at times to have a hearing impairment
- Does not know how to play with toys
- Has poor eye contact
- Appears to be in his or her own world
- Does not smile socially
- Has odd movement patterns
- Has unusual attachment to toys or other objects
- Regularly lines up toys or other items

Treatment of autism spectrum disorders

- Parent Education
- School intervention
- Social skills groups
- Sensory skills training
- Behavior modification

Attention-Deficit/Hyperactivity Disorder (AD/HD)

The diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD) in DSM-5 are similar to those in DSM-IV. The same 18 symptoms are used as in DSM-IV, and continue to be divided into two symptom domains (inattention and hyperactivity/impulsivity), of which at least six symptoms in one domain are required for diagnosis. However, several changes have been made in DSM-5: 1) examples have been added to the criterion items to facilitate application across the life span; 2) the cross-situational requirement has been strengthened to "several" symptoms in each setting; 3) the onset criterion has been changed from "symptoms that caused impairment were present before age 7 years" to "several inattentive or hyperactive-impulsive symptoms were present prior to age 12"; 4) subtypes have been replaced with presentation specifiers that map directly to the prior subtypes; 5) a comorbid diagnosis with autism spectrum disorder is now allowed; and 6) a symptom threshold change has been made for adults, to reflect their substantial evidence of clinically significant ADHD impairment, with the cutoff for ADHD of five symptoms, instead of six required for younger persons, both for inattention and for hyperactivity and impulsivity. Finally, ADHD was placed in the neurodevelopmental disorders chapter to reflect brain developmental correlates with ADHD and the DSM-5 decision to eliminate the DSM-IV chapter that includes all diagnoses usually first made in infancy, childhood, or adolescence.

Attention deficit hyperactivity disorder (ADHD) has been modified in the DSM-5 to emphasize that this disorder can continue into adulthood. An adult can be diagnosed with ADHD as an adult if they meet one less symptom than in the child. While that weakens the criteria marginally for adults, the criteria are also strengthened at the same time. For instance, the cross-situational requirement has been strengthened to "several" symptoms in each setting (ADHD cannot be diagnosed if it only happens in one setting, such as at work).

The criteria were changed to read that the symptoms appeared before age 12, instead of before age 7.

From: Highlights of Changes from DSM-IV-TR to DSM-5 APA 2013

Prevalence

- ADHD is the most commonly diagnosed neurobehavioral disorder of childhood
- ADHD may affect as many as 9-10% of the population in the United States
- Boys (13.2%) were more likely than girls (5.6%) to have ever been diagnosed with ADHD.
- The occurrence of ADHD is reported worldwide; statistical variations may be due to cultural perceptions of behavior

DSM-5 criteria

Persistent pattern of inattention and/or hyperactivity/impulsivity that interferes with functioning or development.

Inattention

6 or more symptoms for at least 6 months

Note: Not solely due to oppositional, defiance or hostility.

Older adolescents require only 5 symptoms
Fails to give close attention
Difficulty sustaining attention
Does not seem to listen
Does not follow through on instructions
Difficulty organizing tasks and activities
Avoids tasks that require sustained mental effort
Often loses things
Easily distracted by extraneous stimuli
Often forgetful in daily activities

Hyperactivity and Impulsivity

6 or more of the following symptoms

Note: Not solely due to oppositional, defiance or hostility.

Older adolescents require only 5 symptoms
Often fidgets, taps hand or feet or squirms
Often leaves seat when at work or in classroom
Often runs about or climbs in inappropriate settings
Often unable to play quietly
Acts as if "driven by a motor"
Often talks excessively
Often blurts out answers
Has difficulty waiting his or her turn
Interrupts or intrudes on others

Must begin before age 12 and cause significant impairment in at least two types of settings. The criteria also specifically require that the symptoms have persisted for at least six months to a degree that is inconsistent with the developmental level of the child and negatively impacts directly on social and academic/occupational activities.

Rule out

Schizophrenia
Psychotic disorder
Other mental disorder

Specifiers

- Predominantly Inattentive
- Predominantly Hyperactive/impulsive
- Combined presentation
- In partial remission

Severity

- Mild
- Moderate
- Severe

Presentation in School Setting

- Misses directions
- Misunderstands directions
- Organizational problems
- Variable performance
- Working slowly
- Distracted by irrelevant details
- Eliciting negative attention
- Gaps in knowledge
- Immature social skills
- Trouble with transitions
- Trouble sustaining effort
- Decreased motivation due to lack of successes
- Inattentive
- Trouble learning new ground rules
- Trouble with tedious or boring tasks

Developmental features of AD/HD

Early childhood

There is less readiness for school and social skill development due to problems with attentiveness and persistence when other children are acquiring these skills. At home, the child has difficulty following through on tasks such as self-care activities.

Middle childhood

Difficulties with academic performance and competencies in the social arena become more pronounced. Problems with following through on family roles and functioning create negativity in the home environment.

Adolescence

Impulsivity and difficulty with self-regulation can interfere with the independence required in this age group. Teens with AD/HD can become quite defiant and impulsive toward all authorities, including parents.

Assessment of AD/HD

- Assessment of cognitive and behavioral components is key
- Behavioral assessment
- Structured interviews
- Parent and teacher questionnaires
- Direct observations

ADHD can exist concurrently in children with autism

- Often undiagnosed under treated
- A study of 2,000 children treated at autism treatment centers across the US found that more than half of them had symptoms of inactivity and hyperactivity. However, only 11% of the children were being treated for ADHD.

Treatment of AD/HD

- Parent training and education
- School based behavior modification
- Self-monitoring and self-talk
- Problem solving
- Relaxation training
- Biofeedback
- Medications

AD/HD pharmacotherapy

- 60-80% of youth and adults with ADHD gain significant relief from stimulant medications
- Some require other medications to treat ADHD symptoms
- Rationale for non-stimulant medication
  - When stimulants do not relieve symptoms.
  - When stimulants cause intolerable side effects.
  - When medical problems make stimulant use difficult.
  - Co-occurring psychiatric disorder along with AD/HD (must treat both)
- Options
  - Stop the stimulant & substitute another medication
  - Add a second agent to the stimulant regimen

Stimulant drugs (first line treatment)

NRIs (Norepinephrine Reuptake inhibitors)

SSRIs (Serotonin Reuptake Inhibitors)

May be helpful for accompanying irritability, anxiety or depression

Tricyclic antidepressants

Have been shown to effectively treat AD/HD
Blood tests and EKG are sometimes required

Mood stabilizers

May be useful to help modulate irritability and rapid mood shifts in ADHD
Blood tests and EKG are sometimes required

Potential drug interactions of stimulants

Decongestants	Can increase effect of both drugs
Antihistamines	May inhibit effectiveness of stimulant medication
Tricyclic antidepressants	May increase effect of both medications
Anticonvulsant	Can increase or decrease anticonvulsant level
SSRI antidepressants	No typical interaction
Antibiotics	No typical interaction
Antipsychotics	No typical interaction
Antianxiety	No typical interaction

AD/HD treatment (non-pharmacotherapy options)

- Voucher, Token or Point System
  - Helps children with ADD/ADHD, & oppositional behaviors
  - Kids work at correcting behavior because they know the choices they make will determine their rewards and consequences
  - Control over actions and accountability increases dramatically
  - With the structure they learn to be more creative, overcome obstacles, attain goals, and improve behaviors
  - Hard to manipulate, and does not provoke anger as many other methods of discipline can
  - Because nothing is taken away from the child, power struggles and retaliation can be prevented
  - Tailored to fit each child individually
  - Even the compliant child can benefit (use with sibs also)
  - Parents often comment that sibling rivalry and fighting between siblings is greatly reduced or eliminated as children learn to control angry outbursts and other unacceptable behaviors

Depressive Disorders

Disruptive Mood Dysregulation Disorder (DMDD)

New diagnosis in DSM-5

This diagnosis is seen as the new childhood Bipolar Disorder and was intended to address issues of over-diagnosis and over-treatment of bipolar disorder in children. DMDD can be diagnosed in children up to age 18 years who exhibit persistent irritability and frequent episodes of extreme out of control behavior.

Far beyond temper tantrums, DMDD is characterized by severe and recurrent temper outbursts that are grossly out of proportion in intensity or duration to the situation. These occur, on average, three or more times each week for one year or more. Between outbursts, children with DMDD display a persistently irritable or angry mood, most of the day and nearly every day, that is observable by parents, teachers, or peers. A diagnosis requires the above symptoms to be present in at least two of three settings (at home, at school, or with peers) for 12 or more months, and symptoms must be severe in at least one of these settings. During this period, the child must not have gone three or more consecutive months without symptoms.

The onset of symptoms must be before age 10, and a DMDD diagnosis should not be made for the first time before age 6 or after age 18.
The onset of the disorder generally begins at age 12 or younger. Abnormal mood is present at least half of the day on most days and is noticeable to people around the child. The symptoms should impair at least one setting in the child's life.

Hyper arousal must be prevalent and is defined by agitation, insomnia, intrusiveness, pressured speech, racing thoughts, and flight of ideas. The child exhibits increased reactivity to negative emotional stimuli that come out verbally or behaviorally.
From: Highlights of Changes from DSM-IV-TR to DSM-5 APA 2013

DSM-5 criteria

- Severe recurrent temper outbursts manifested verbally and/or behaviorally that are grossly out of proportion
- The outbursts are inconsistent with developmental level
- The outbursts occur 3 or more times per week
- The mood in between outbursts is irritable or angry and observable by others
- 12 or more months in duration
- Occurs in at least 2 or 3 settings
- Age 6-18

Rule out:
ODD
Bipolar Disorder

Co-occuring conditions can include:
Depression
ADHD
Conduct Disorder

Etiology

No current consensus as to the causes of DMDD.

One theory for developing DMDD includes a history of early psychological trauma and abuse. Some causes identified include family structure (recent death in the family, divorce, relocation); poor diet (lack of nutrition or vitamin deficiencies, underlying medical conditions); and a neurological disability that causes poor behavior, such as migraine headaches. If any of these problems are occurring, they should be addressed before a diagnosis is made.

Treatment and Prevention

There is no set way to treat DMDD; however, studies have found certain treatments to be effective at lessening the outbursts and decreasing the effects.

These include:

- Behavior Modification Therapy
- Behavioral Psychotherapy
- Dialectical Behavioral Therapy for Children
    - Mindfulness tools
    - Emotional regulation
- Educating family and teachers about DMDD and how to deal with the outbursts instead of punishment
- Observing the children for their individual triggers
- Timeout strategies
- Preventative measures, such as assigning children a safe place to alleviate their outbursts
- Giving children a person they can confide in when on the verge of an outburst
- Giving children breaks to alleviate the tension they are experiencing
- Counseling from school psychologists
- Classroom support
- Modified time allotted for tests and homework
- Addressing family dysfunction
- Modifying the child's diet

Pharmacological Treatment

- Medication can be prescribed when therapy and parent training are not available, or not effective alone.
- Stimulant medication, which helps kids rein in impulses, and an antidepressant with mild side effects, like SSRIs, are usually a first step when medication seems necessary
- If that combination doesn't work, or if there's an urgency to the situation, a low dose of an atypical antipsychotic such as Risperdal can be prescribed.

Major Depressive Disorder

Development and Course

"Major depressive disorder may first appear at any age, but the likelihood of onset increases markedly with puberty. In the United States, incidence appears to peak in the 20's, however, first onset in late life is not uncommon.

Developmental Features in Depression

- Age 1-2
  - Delay in development, nightmares and night terrors, self-stimulating behaviors, clinginess, excessive fears, and decrease in play behaviors
- Age 3-5
  - Sadness, tiredness, anger, apathy, illness, irritability, social withdrawal, weight loss
- Age 6-12
  - Symptoms more closely resemble that of an adult with depression: Anhedonia, apathy, and low self-esteem, moodiness, lack of motivation, suicidal ideation, and decline in school performance, anger, delinquency, and somatization.
- Age 12-18
  - Volatile mood, rage, low self-esteem, sexual acting out, substance abuse, oversleeping, overeating, social withdrawal, suicidal ideation

Pharmacotherapy for Major Depression in Children and Adolescents

- For mild depression, CBT or interpersonal psychotherapy is recommended first
- For pharmacologic therapy, SSRIs are the first-line choice
- If there is no response to the SSRI, switch to a second SSRI

Anxiety Disorders

Definition

- Anxiety can result when a combination of increased internal and external stresses overwhelm ones normal coping abilities or when one's ability to cope normally is lessened for some reason.

Anxiety: state of dread, unease, worry, or apprehension about an upcoming situation

Anxiety disorders in children

Anxiety disorders in the DSM-5 include:

Separation Anxiety Disorder
Selective Mutism
Specific Phobia
Social Anxiety Disorder (Social Phobia)
Panic Disorder
Panic Attack (Specifier)
Agoraphobia
Generalized Anxiety Disorder
Substance/Medication-Induced Anxiety Disorder
Anxiety Disorder Due to Another Medical Condition
Other Specified Anxiety Disorder
Unspecified Anxiety Disorder

Obsessive compulsive disorder and Post traumatic stress disorders are moved to separate categories in the DSM-5. Somatic Symptom and Related Disorders now includes an Illness Anxiety Disorder category. However, the sequential order of these chapters in DSM-5 reflects the close relationships among them.

Prevalence

- According to the most recent data, the lifetime prevalence for anxiety disorders as a whole in adults is about 25%
- Prevalence in children is unknown
- Anxiety disorders in children often are overlooked or misjudged
- Consensus that many "adult" psychiatric disorders likely have their first (although perhaps subtle or ignored) manifestations in childhood
- If left untreated these anxiety disorders in children likely progress to adult versions

Components

- Physiological: "fight/flight" response, experience of bodily tension
- Cognitive: beliefs, thoughts, interpretations of the negative feeling
- Behavioral: trying to physically avoid or escape the feeling or situation

Etiology of anxiety disorders

Genetic

- Studies shows 50% of patients with Panic Disorder have at least one relative affected with an anxiety disorder. There is a higher chance of an anxiety disorder in the parents, children, and siblings of a person with an anxiety disorder than in the relatives of someone without an anxiety disorder. Twin studies demonstrate varying but important degrees of genetic contribution to the development of anxiety disorders

Physiological

- Evidence exists that supports the involvement of norepinephrine, serotonin, and GABA. In some cases there appears to be a dysregulation of the noradrenergic and serotonergic neural systems, two systems that are complexly interrelated in the brain

Symptoms of anxiety

- Many worries about things before they happen
- Constant worries or concern about school performance, friends, or sports
- Repetitive thoughts or actions (obsessions)
- Fears of embarrassment or making mistakes
- Low self esteem

- Phobias
  - Afraid of specific things such as dogs, insects, or needles and these fears cause significant distress
  - Afraid to meet or talk to new people
  - May have few friends outside the family

- Anxious children may be overly tense or uptight
- Some may seek a lot of reassurance, and their worries may interfere with activities
- Some children may be quiet, compliant and eager to please, so their difficulties may be missed

Focus of fears and anxieties in children

Age	Focus of Fear or Anxiety
0-6 months	Loss of primary caregiver Loud noises, intense stimuli
6-9 months	Strangers or unexpected stimuli
1 year	Separation from caretaker, injury, toilet, strangers
2 years	Animals, dark, separation from caretakers, loud noises such as thunder
3 years	Animals, masks, being alone, separation from caretaker
4 years	Darkness, animals, noises
5 years	Animals, bad people, darkness, separation from caretaker
6 years	Sleeping alone, going to school (separation from caretaker), monsters, ghosts, bodily injury
7-8 years	Monsters, ghosts, extraordinary traumatic events (9/11), injury, staying alone
9-12 years	Tests, oral reports, school performance, bullying, teasing or rejection by peers
13-18 years	Social alienation, embarrassment, failure in school, death, natural or manmade disasters

Treatment of anxiety disorders

- Family therapy
- Cognitive behavioral therapy
- Exposure, desensitization, flooding and relaxation
- Behavior modification
- Play therapy
- Psychodynamic psychotherapy
- Parent education

Pharmacotherapy in Anxiety Disorder

- Medications are used to treat anxiety disorders when symptoms are causing significant subjective distress for the child and/or are contributing to persistent functional impairment e.g. difficulties at school, with peers, and/or at home
- Severity of symptoms will determine whether medications are started at the beginning of treatment at the same time as psychotherapy, or added later if symptoms do not improve with psychotherapy alone
- Some clinicians have argued that medications should only be used after children with an anxiety disorder fail to respond to psychotherapy
    - While this is a reasonable position, opinions remain mixed on this view
    - Many children with severe anxiety will not even begin to initiate the tasks that must be completed for psychotherapy to be successful
    - Others will simply refuse to talk with a therapist at all
- For these children, it is reasonable to initiate treatment with a medication before a course of psychotherapy has been attempted
- The selective serotonin reuptake inhibitors (SSRIs) are currently the medications of choice for the treatment of both childhood and adult anxiety disorders
- Tricyclic antidepressants are less commonly used in the treatment of childhood anxiety disorders

Pharmacotherapy: Duration of treatment

- Current recommendations suggest that initial treatment of childhood anxiety disorders with an SSRI should be continued for approximately one year
    - Medication may be recommended beyond this period if symptoms persist or reoccur
- Symptoms and treatment response should be reassessed at regular intervals by the child's doctor
- Starting a child on an SSRI does not mean that he/she will be on the

medication for life
- Many children may not need more than one course of medication treatment.

Parent education

- There is no evidence that the SSRIs are addictive
- If medications are discontinued abruptly, symptoms such as dizziness, nausea, headache, and behavioral changes may occur
- Medication dosages should not be changed, and medications should not be discontinued unless directed by the child's physician
- Keep the physician informed of any side effects, missed dosages, change in child's behavior/affect and functioning

Separation Anxiety Disorder (SAD)

About 4% of children are extremely anxious about leaving their parents. Symptoms may develop at any time during childhood, but often arise following an event that, for the child, is traumatic

DSM-5 Criteria

- Developmentally inappropriate and excessive anxiety concerning separation as evidenced by three (or more) of the following:
  - Recurrent excessive distress when anticipating separation from major attachment figures
  - Excessive worry about losing major attachment figures or possible harm to them
  - Persistent worry about experiencing an untoward event that causes separation from major attachment figure.
  - Persistent reluctance or refusal to go to school or elsewhere
  - Persistently & excessively fearful/reluctant to be alone
  - Persistent reluctance / refusal to go to sleep without being near a major attachment figure
  - Repeated nightmares involving the theme of separation
  - Repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting)
- The duration of the disturbance is at least 4 weeks in children and adolescents and typically 6 months or more in adults.
- The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- The disturbance is not better explained by another mental disorder such as Autism spectrum disorder, psychotic disorders, agoraphobia, generalized anxiety or illness anxiety disorder.

Treatment of separation anxiety

- The most common treatments for Separation Anxiety Disorder are often used in combination with each other:
  - Play therapy
  - Cognitive Behavioral Therapy
  - Systematic Desensitization (gradual introduction of the separation, measured by time and distance)
  - Relaxation techniques
- Bibliotherapy (using books and stories to model healthy separation behavior)
- Family therapy (including the parents and even siblings) - this reduces the sense of "it's your problem," addresses the reality that one child's problems affect everyone else in the family, and also accounts for the probability that something in the parents' lives or parenting style may be contributing to the problem in the first place

Pharmacotherapy

- When symptoms do not improve significantly with psychotherapy alone, children may benefit from medications
- The FDA has not approved specific medications for the treatment of separation anxiety disorder in children and adolescents
- Medications approved by the FDA for other uses and age groups are prescribed for young people with separation anxiety disorder
  - SSRIs
  - Tricyclics

Panic Disorder and Panic Attacks

Etiology

Panic disorder sometimes runs in families, but no one knows for sure why some people have it while others don't. Researchers have found that several parts of the brain are involved in fear and anxiety. By learning more about fear and anxiety in the brain, scientists may be able to create better treatments. Researchers are also looking for ways in which stress and environmental factors may play a role. *(National Institute of Mental Health: www.nimh.nih.gov)*

Panic attacks in children

- Up to 12% of ninth graders have had a panic attack. About 1-2% of all adults have multiple panic attacks. If you look at adults with panic disorder, 20% had their first panic attack before age 10
    - In children and teenagers, panic attacks can take on many different disguises classic (SOB, Chest Pain, Red Face, Palpitations)
    - The nausea disguise
    - The anger disguise
    - "Family doctor's new child" (fear of being ill)

Panic disorder in children

- Panic disorder in children is not common, but can be a very disabling condition
- It will often
    - affect school performance
    - impair them socially

- Approximately 10% of children will have a panic attack
- Approximately 1-2% will develop Panic disorder.
- Of those that do develop Panic disorder
    - 10-35% will recover and remain well the rest of their lives

- At least 50% will be mildly affected years later
- The rest will have chronic Panic disorder for years

Panic Disorder
DSM-5 criteria

Recurrent unexpected panic attacks

Definition: an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time, 4 or more of the following symptoms occur.

Palpitations
Sweating
Trembling or shaking
Sensations of shortness of breath or smothering
Feelings of choking
Chest pain or discomfort
Nausea or abdominal distress
Feeling dizzy, unsteady, lightheaded or faint
Chills or heat sensations
Numbness or tingling
Feelings of unreality or being detached from oneself
Fear of losing control or "going crazy"
Fear of dying

Note:
Culture specific symptoms may be present and do not count toward the 4 required symptoms.

At least one of the attacks has been followed by 1 month or more of both of the following:

- Persistent concern or worry about having additional panic attacks or their consequences
- Significant maladaptive change in behavior related to the attacks to avoid having panic attacks.

Not attributable to effects of a substance or a medical condition.

Rule Out:

- Social anxiety disorder
- Phobias
- Obsessive Compulsive disorder
- Effects of trauma or PTSD
- Separation anxiety disorder

Panic and co-occurring disorders

- Many children with panic disorder also had agoraphobia
- The children with panic or agoraphobia had a high rate of co-morbid depression, and other anxiety disorders
- They also had a high incidence of disruptive behavior disorders such as Conduct Disorder and ADHD
- The course of the panic disorder and agoraphobia appeared to be chronic.

(Biederman, J et al., 1997)

Long term outcomes

- If you follow-up children with panic disorder, about 25% will still have it years later
- Of those who continue to have Panic disorder as they go into adulthood, many will develop other psychiatric difficulties
  - About 50% will develop agoraphobia
  - 20% will make suicide attempts
  - 27% will develop alcohol abuse
  - 60% will develop depression
  - 35% will believe they are unhealthy
  - 27% will not be financially independent
  - 28% will make frequent outpatients visits
  - 50% will be show significant social impairment

Treatment of panic disorder

- Regular meals, adequate sleep, regular exercise and a supportive environment.
- Deep abdominal breathing and other relaxation techniques
- CBT: Exposure, desensitization, flooding and relaxation
- If agoraphobia is present, the child should make up a hierarchy of fear-inducing situations. Assist the child to move up the hierarchy of feared situations
- If therapy is only partially effective, medication may be added
- In children with severe anxiety or with co-morbid disorders, one might

start therapy and medications simultaneously.

Pharmacoptherapy of panic disorder

- SSRIs

- Children and adolescents with panic disorder often respond to much lower doses of SSRIs, and may not do as well if started off with higher doses
- Other medications
  - Beta blockers
  - Tricyclics
  - benzodiazepines

Trauma and Stressor-Related Disorders

The DSM-5 emphasizes Trauma related disorders and the impact of trauma across the lifespan. Exposure to trauma or a stressful event is part of the diagnostic criteria for these disorders. Children in the Child Welfare system are vulnerable to trauma and stressful events so these diagnoses are particularly important.

Trauma and Stressor-Related Disorders in the DSM-5 include:

Reactive Attachment Disorder
Disinhibited Social Engagement Disorder
Posttraumatic Stress Disorder (DSM-5 now distinguishes between Adult and Child 6 years and younger versions of the disorder)
Acute Stress Disorder
Adjustment Disorders

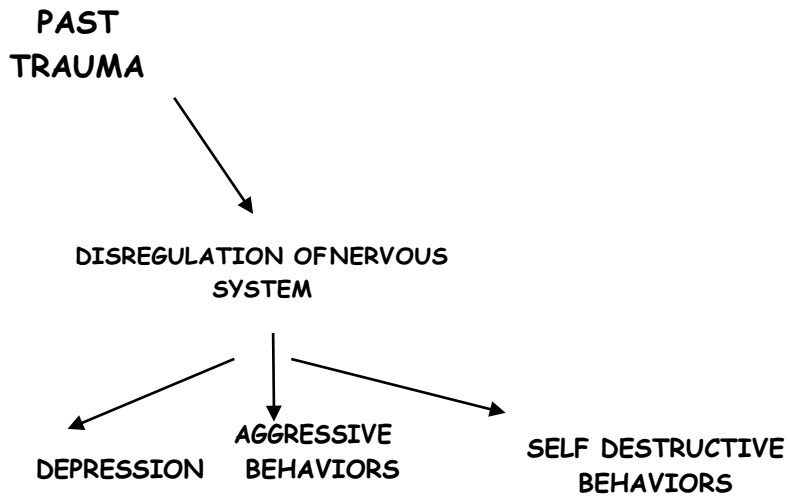
Attachment Problems

Defining attachment and attachment problems is crucial in determining whether children meet the criteria for a disorder.

What is attachment?

> "An enduring affective bond characterized by a tendency to seek and maintain proximity to a specific person, particularly when under stress."
>
> Attachment: learned behavior defined as a deep and enduring connection which develops over the first three years of life
>
> Bonding: not a learned behavior, develops without conscious intent

Attachment problems affect the brain much like trauma.



Children with attachment problems

- Templates based on experiences (neglect, violence, fear, inconsistency, etc.)
- Developmental Delays
- Health issues – eating, nutrition, somatic
- "Bizarre" (adaptive, soothing) behavior
- Emotional problems → attachment problems
- Inappropriate Modeling → aggressive / abusive / victim

Attachment Disordrers: Etiology

Societal causes

- Alcohol/drug abuse
- Inadequate childcare
- Teen pregnancy
- Breakdown of family
- Unprepared foster/adoptive families

Familial causes

- Abuse/neglect
- Generational patterns
- Poor parenting skills
- Parental depression
- Mental health issues in family

Biological causes

- In-utero drug exposure
- Maternal ambivalence to the pregnancy
- Innate disposition
- Medical problems at birth
- Developing brain

Reactive Attachment Disorder

Reactive Attachment disorder is now listed under Trauma and Stressor-Related Disorders in the DSM-5.

The DSM-IV childhood diagnosis reactive attachment disorder had two subtypes: emotionally withdrawn/inhibited and indiscriminately social/disinhibited. In DSM-5, these subtypes are defined as distinct disorders: reactive attachment disorder and disinhibited social engagement disorder. Both of these disorders are the result of social neglect or other situations that limit a young child's opportunity to form selective attachments. Although sharing this etiological pathway, the two disorders differ in important ways. Because of dampened positive affect, reactive attachment disorder more closely resembles internalizing disorders; it is essentially equivalent to a lack of or incompletely formed preferred attachments to caregiving adults. In contrast, disinhibited social engagement disorder more closely resembles ADHD; it may occur in children who do not necessarily lack attachments and may have established or even secure attachments. The two disorders differ in other important ways, including correlates, course, and response to intervention, and for these reasons are considered separate disorders.

From: Highlights of Changes from DSM-IV-TR to DSM-5 APA 2013

DSM-5 criteria

- Consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers manifested by both:
    - Rarely seeks comfort when distressed
    - Rarely responds to comfort when distressed
- Persistent social and emotional disturbance characterized by at least 2 of the following:
    - Minimal social and emotional responsiveness to others
    - Limited positive affect
    - Episodes of unexplained irritability, sadness or fearfulness even during nonthreatening interactions with caregivers
- Child has experienced extremes of insufficient care as evidenced by at

least 1 of the following:
    - Social neglect or deprivation in the form of lack of comfort, stimulation, affection by caregivers
    - Repeated changes in primary caregivers
    - Rearing in unusual settings that limit selective attachments (institutions)
- Begins before age 5
- Rule out Autistic Spectrum disorder

Specifiers

- Persistent: if the disorder is present for more than 12 months
- Severity:
- Note Severe if all symptoms are present at high levels

Disinhibited Social Engagement Disorder

DSM-5 criteria

- A pattern of behavior in which a child approaches and interacts with adults exhibiting at least 2 of the following criteria:
    - Reduced or absent reticence in approaching unfamiliar adults
    - Overly familiar verbal or physical behaviors (with culture in mind)
    - Diminished or absent checking back with adult caregiver
    - Willingness to go off with unfamiliar adult

  Not due to impulsivity as in ADHD

  Child must have developmental level of at least 9 months
- Child has experienced extremes of insufficient care as evidenced by at least 1 of the following:
    - Social neglect or deprivation in the form of lack of comfort, stimulation, affection by caregivers
    - Repeated changes in primary caregivers
    - Rearing in unusual settings that limit selective attachments (institutions)
- **Specifiers**

- Persistent: if the disorder is present for more than 12 months
- Severity:
- Note Severe if all symptoms are present at high levels

Treatment issues

Interventions

- Medical evaluation/hospitalization
- Behavioral interventions
- Parent-child Interaction therapy
- "Theraplay"

Long term goals of attachment therapy

Child

- Learn to function mutually in relationships
- Understand and take responsibility
- Learn productive means of identifying and dealing with emotions and stress
- Welcome emotional intimacy
- Develop the ability to love and enjoy life, themselves and others

Parents

- Learn healthy parenting skills and coping skills
- Establish specific, well-enforced structure
- Learn to hope again as they acquire new skills for helping their child with his/her behavior

Posttraumatic Stress Disorder

The DSM-5 introduced a preschool subtype of PTSD for children ages 6 years and younger.

Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition.

Two specifications are noted including delayed expression and a dissociative subtype of PTSD, the latter of which is new to DSM-5. In both specifications, the full diagnostic criteria for PTSD must be met for application to be warranted.

PTSD now includes four primary major symptom clusters:

- Re-experiencing
- Arousal
- Avoidance
- Persistent negative alterations in cognitions and mood

- Diagnostic thresholds have been lowered for children and adolescents.
- Separate criteria have been added for children age 6 years or younger with this disorder.

Prevalence

- 15 to 43% of girls and 14 to 43% of boys have experienced at least one traumatic event in their lifetime
- Of those children and adolescents who have experienced a trauma
    - 3 to 15% of girls and 1 to 6% of boys could be diagnosed with PTSD
- Research findings regarding development of PTSD
    - 100% of children who witness a parental homicide or sexual assault

develop PTSD

- 90% of sexually abused children
- 77% of children exposed to a school shooting
- 35% of urban youth exposed to community violence

Trauma vs. Neglect: Brain Development

- Neglect means that there was an absence of appropriate stimulation at the right time of development
- Trauma means that there was an over stimulation at the wrong time and perhaps for a prolonged period of time
- Trauma results from the over-activation of the stress network
- Repeated activation of traumatic experiences increases the severity of traumatic effects and makes them less amenable to treatment

Stress response and brain development

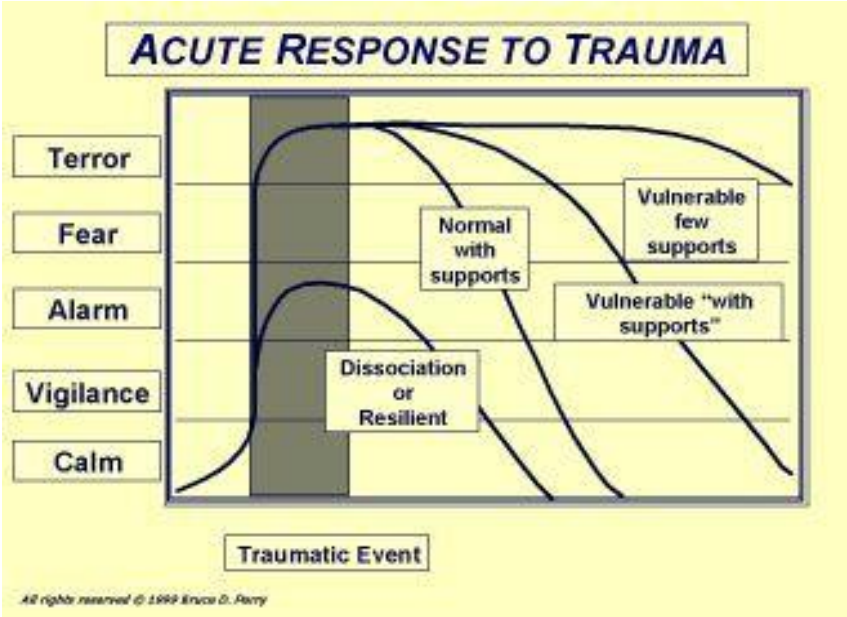
- Threat results in total-body mobilization
- Survival strategies involve more primitive brain functions
- Fight, flight, or surrender (dissociate)
- Primary adaptive responses in the brain to threat exist on two

continuums:

- Hyper arousal
- Dissociative

- Different people may have different responses to the same trauma

Fear Response



Posttraumatic Stress Disorder

for children 6 years and younger

Young children are exposed to many types of traumatic experiences, placing them at risk for PTSD. These include:

- abuse
- witnessing interpersonal violence
- motor vehicle accidents
- experiences of natural disasters
- conditions of war
- dog bites
- invasive medical procedures

PTSD
DSM-5 criteria include*:*

In children 6 years and younger exposure to actual threatened death, serious injury or sexual violence in one or more of the following ways:

- Directly experiencing the traumatic events
- Witnessing the events in person as it occurred to others, especially primary caregivers (note that this does not include watching TV, movies, etc.)

Presence of one or more of the following **intrusive** symptoms

- Recurrent, involuntary and intrusive distressing memories of the traumatic event (could be reenacted in play and not necessarily appear distressing)
- Recurrent distressing dreams related to the event
- Dissociative reactions (flashbacks)
- Intense or prolonged distress at exposure to cues about the event
- Marked physiological reactions to reminders

Presence of one or more of the following **avoidance** symptoms

- Avoidance or efforts to avoid activities, places, or physical reminders about the event
- Avoidance of people, conversations, or interpersonal situations that arouse recollections about the event

Negative alterations in Cognitions

- Increased frequency of negative emotional states such as fear, guilt, sadness, shame, confusion
- Diminished interest or participation in significant activities including play
- Socially withdrawn
- Reduction in positive emotions

Alteration in arousal and reactivity

- Irritable behaviors and angry outbursts
- Hyper vigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance

Duration of the disturbance is more than one month

Causes clinically significant distress or impairment

Specifiers

With dissociative symptoms: depersonalization or derealization
With Delayed expression

Assessment of preschool PTSD

Standardized screening and assessment instruments have been developed for caregivers of this age group, with both self-administered checklists and diagnostic interviews.

Treatments

Cognitive behavioral therapy
Relationally based treatments
Play therapy
Eye movement desensitization and reprocessing (EMDR)
Modalities may be effective if the traumatic memories can be engaged in developmentally-appropriate methods.

Adjustment Disorders

In DSM-5, adjustment disorders are re-conceptualized as a varied array of stress-response syndromes that occur after exposure to a distressing (traumatic or non-traumatic) event, rather than as a residual category for individuals who exhibit clinically significant distress without meeting criteria for a more discrete disorder (as in DSM-IV). DSM-IV subtypes marked by depressed mood, anxious symptoms, or disturbances in conduct are unchanged.

Children's reactions to grief, crisis and loss

- Bodily Distress
  - Somatic bodily symptoms such as tightness in throat, can't breathe, nightmares, can't go to school
- Hostile Reactions
  - Resentment projected outward in order to relieve guilt by making someone else responsible for the death
- Idealization
  - In an attempt to fight off unhappy thoughts, becomes obsessed with deceased person's good qualities

Adjustment disorders - Prevalence

- Adjustment disorder is very common in the United States
- More than five percent (5%) of all persons seen in clinical, outpatient mental health settings have some type of adjustment disorder

Adjustment disorders
DSM-5 criteria

- The development of emotional or behavioral symptoms in response to an identifiable stressor occurring within 3 months of the onset of the stressor(s)
  - ➢ marked distress that is in excess of what would be expected from exposure to the stressor (note culture and external context)
  - ➢ significant impairment in social or occupational (academic) functioning
- Rule out other mental disorders
- Not due to normal bereavement
- Symptoms do not persist for more than an additional 6 months if the stressor is terminated.

Specifiers

- With Depressed mood
- With Anxiety
- With Mixed Anxiety and Depressed Mood
- With Disturbance of Conduct
- With Mixed Disturbance of Emotions and Conduct
- Unspecified

Adjustment disorders treatment

- Psychotherapy (CBT, Play/Art)
  - Can be helpful to lessen or alleviate ongoing symptoms of adjustment disorder before they become disabling.
- Group therapy
- Use of prescription medications may ease depression or the anxiety

Disruptive, Impulse-Control and Conduct Disorders

Oppositional Defiant Disorder

Four refinements have been made to the criteria for oppositional defiant disorder:

1. Symptoms are now grouped into three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness. This change highlights that the disorder reflects both emotional and behavioral symptomatology.
2. The exclusion criterion for conduct disorder has been removed.
3. Given that many behaviors associated with symptoms of oppositional defiant disorder occur commonly in normally developing children and adolescents, a note has been added to the criteria to provide guidance on the frequency typically needed for a behavior to be considered symptomatic of the disorder.
4. A severity rating has been added to the criteria to reflect research showing that the degree of pervasiveness of symptoms across settings is an important indicator of severity.

Conduct Disorder

The criteria for conduct disorder are largely unchanged from DSM-IV. A descriptive features Specifier has been added for individuals who meet full criteria for the disorder but also present with limited prosocial emotions. This specifier applies to those with conduct disorder who show a callous and unemotional interpersonal style across multiple settings and relationships. The specifier is based on research showing that individuals with conduct disorder who meet criteria for the specifier tend to have a relatively more severe form of the disorder and a different treatment response.

Prevalence

Oppositional Defiant Disorder

- Evidence suggests that between 1 and 16 percent of children and adolescents have ODD
  - There is not very much information on the prevalence of ODD in preschool children, and estimates cannot be made
- ODD usually appears in late preschool or early school-aged children.
  - In younger children, ODD is more common in boys than girls
  - However, in school-age children and adolescents the condition occurs about equally in boys and girls
- Although the disorder seems to occur more often in lower socioeconomic groups, ODD affects families of all backgrounds

Conduct Disorder

- In the United States, prevalence rates for conduct disorder (CD) are estimated at 2-9%, and are complicated by relatively high rates of co-occurrence or comorbidity with other disorders

Etiology

Biological factors

- A parent with a history of attention-deficit/ hyperactivity disorder (ADHD), ODD, or CD
- A parent with a mood disorder (such as depression or bipolar disorder)
- A parent who has a problem with drinking or substance abuse
- Impairment in the part of the brain responsible for reasoning, judgment, and impulse control
- A brain-chemical imbalance
- A mother who smoked during pregnancy
- Exposure to toxins
- Poor nutrition

Psychological factors

- A poor relationship with one or more parent

- A neglectful or absent parent
- A difficulty or inability to form social
- relationships or process social cues

Social factors

- Poverty
- Chaotic environment
- Abuse
- Neglect
- Lack of supervision
- Uninvolved parents
- Inconsistent discipline
- Family instability (such as divorce or frequent moves)

Children with either may experience. . .

- Higher rates of depression, suicidal thoughts, suicide attempts, and suicide;
- Academic difficulties;
- Poor relationships with peers or adults;
- Sexually transmitted diseases;
- Difficulty staying in adoptive, foster, or group homes; and
- Higher rates of injuries, school expulsions, and problems with the law.

Oppositional Defiant Disorder (ODD)

DSM-5 criteria

A pattern of angry/irritable mood, argumentative/defiant behavior or vindictiveness lasting at least 6 months with at least 4 symptoms from any of the categories outlined. (Behavior must be exhibited with at least one non-sibling).

Angry/Irritable Mood

Loses temper
Touchy or easily annoyed
Angry and resentful

Argumentative/Defiant

Argues with adults and authorities

Defies or refuses to comply with rules
Blames others for own mistakes
Annoys people on purpose

Vindictiveness

Spiteful and vindictive

Note:

- Look at normal behaviors in teenagers to distinguish between a disorder and normal teen behaviors.
- The behaviors cause distress in the individual or others in the immediate social context.
- Rule out psychotic, substance use, depressive or bipolar disorder. Also, the criterion are not met for DMDD.

Specifiers

Mild
Moderate
Severe

Conduct disorder - DSM-5 criteria

Symptoms include a repetitive and persistent pattern of violating the basic rights of others for the past 12 months. At least one of the following symptoms must occur in the past six months:

Aggression to people and animals

Bullying, threatening, or intimidating
Physical fighting
Use of weapon
Physically cruel to people
Physically cruel to animals
Has stolen while confronting a victim
Forced sexual activity

Destruction of property

Fire setting

Other deliberate destruction

Deceitfulness or theft
Breaks and enters,
Lies to obtain goods
Steals items of nontrivial value

Serious violation of rules
Often stays out all night beginning before age 13
Has run away from home overnight while living in the parental home
Truancy from school before age 13

Specifiers

Childhood-onset type
Adolescent-onset type
Unspecified onset
With limited prosocial emotions

- Lack of remorse or guilt
- Callous lack of empathy
- Unconcerned about performance
- Shallow or deficient affect

Severity

Mild
Moderate
severe

Treatment of ODD / CD

- Treatment includes a combination of
  - Training for parents on how to handle child or adolescent behavior
  - Family therapy to improve communication / trust
  - Training in problem solving skills for children or adolescents
  - Individual Therapy to develop more effective anger management
  - Cognitive-Behavioral Therapy to assist problem solving and decrease negativity

- Social Skills Training to increase flexibility and improve frustration tolerance with peers
- Community-based services that focus on the young person within the context of family and community influences
- Residential care may be needed

Treatment of CD

- Conduct disorder is one of the most difficult behavior disorders to treat
- The earlier the conduct disorder is identified and treated, the better the chance for success
- It's never too late to start a Voucher, Token or Point System
    - Teaches teens the skills they will need to function in the real world (money management, cooperation, time management, and responsible behavior)
    - Enhances self-discipline and responsibility while building self-esteem, self-respect, and respect of others
    - Relationships and overall communication with parents improves as the system creates more time for positive interactions, and less time nagging about every day annoyances.

Other Conditions That May Be a Focus of Clinical Attention

These conditions are presented with their corresponding codes from ICD-9-CM (usually V codes) and ICD-10-CM (usually Z codes).

A condition or problem in this chapter may be coded if it is a reason for the current visit or helps to explain the need for a test, procedure, or treatment. Conditions and problems in this chapter may also be included in the medical record as useful information on circumstances that may affect the patient's care, regardless of their relevance to the current visit.

Glossary of Terms

Anhedonia - loss of pleasure in activities

Comorbidity - the co-occurrence of two or more disorders

Disorder - a syndrome consisting of particular signs and symptoms contained within a diagnostic classification system such as the *DSM-IV*

Incidence: The term 'incidence' refers to the annual diagnosis rate, or the number of new cases of a given disorder

Lability - rapid mood swings or moodiness

Mood congruent - thoughts are of the same theme as the mood

Mood incongruent - thoughts are of a different theme than the mood

Neurotransmitter - chemical messengers that are the communication link between nerve cells

Prevalence: The term usually refers to the estimated population of people who are managing an illness or disorder at any given time.

Symptom - refers to a subjective experience; indicated by the patient of a condition

Syndrome - a group of symptoms and signs occurring together which may indicate an underlying cause or process

Prefixes and suffixes used in medical terminology

The following are common prefixes and suffixes used by health care providers to describe body conditions and procedures.

Prefixes (Pertaining to the body)

brach	**arm**
cardi	heart
chole	gall
cyst	bladder
derma	skin
entero	intestines
glosso	tongue
gastro	stomach
hemo	blood
hepat	liver
laparo	abdomen
myo	muscle
nephro	kidney
neuro	nerve
oculo, ophthalm	eye
odont	tooth
oto	ear
osteo	bone
oral	mouth
pharyn	throat
phleb	vein
pneumo	lung
procto	rectum
rhino	nose
thorac	chest

Suffixes/Prefixes (Pertaining to procedures)

-ectomy	removal of
-plasty	to form or build up
-(o)rrhaphy	repair of
-(o)stomy	creation of an opening
-(o)tomy	cutting into
-manometer	used to measure pressure
-meter	used to measure
-scope,-scopy	used to examine by looking into or by hearing
dys	difficult, painful
endo	within
hemi	half
hydro	water
hyper	above, increase
hypo	below, under
mal	faulty, poor
neo	new
oligi	scanty, few
ortho	straight
peri	around
poly	many, much
pyo	pus
pyro	heat, temperature

Suffixes (Pertaining to body conditions)

-algia	pain
-cele	tumor, hernia
-emia	blood
-esthesia	sensation
-iasis (osis)	condition of
-itis	inflammation
-lith	stone, calculus
-oma	growth, tumor
-opia	vision
-osis (iasis)	condition of
-pathy	disease
-phobia	fear or dread
-plegia	paralysis
-pnea	breathing
-ptosis	drooping, falling
-rrhea	flow, discharge
-therapy	treatment
-thermy	heat
-tropic	nutrition, growth
-trophy	nutrition, growth
-uric, uria	urine

References and Further Reading

American Psychiatric Association: Diagnostic and statistical manual of mental disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

American Psychiatric Association: Desk Reference to the Diagnostic Criteria From DSM-5. Arlington, VA, American Psychiatric Association, 2013.

Paris, J. The Intelligent Clinician's Guide to the DSM-5. Oxford University Press: 2013

Paris, J. and Phillips, J. (eds.) Making the DSM-5 2013 Concepts and Controversies. Springer Science + Business Media New York 2013

Nussbaum, A. Pocket guide to the Diagnostic and statistical Manual of mental disorders-5 diagnostic exam 1st ed. Arlington, VA American Psychiatric Publishing, 2013.

Wilens, T. (2008). Straight talk about psychiatric medication for kids, Third edition. NewYork: Guilford Press.

Zero to Three (2005). DC: 0-3R, Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (Revised Edition), Washington DC: ZERO TO THREE.

Web Sites and Resources

American Academy of Child and Adolescent Psychiatry (AACAP)
www.aacap.org

The AACAP has produced the *Facts for Families* in English and Spanish. Other translations available on the internet, while perhaps based on the original, were created independently and without benefit of AACAP review.

They are available in English, Spanish, Chinese, Malaysian, Polish, Icelandic, Arabic, Urdu and Hebrew.

Child Mind Institute
www.childmind.org

Child Trauma
www.childtrauma.org

National Mental Health Association (NMHA)
www.nmha.org

National Institute of Mental Health NIMH)
www.nimh.nih.gov

American Psychiatric Association
For patients and families:
www.psychiatry.org/patients-families

Evidence-Based Practice
www.samhsa.gov/ebp-resource-center
www.nimh.nih.gov

DSM5
www.dsm5.org

Zero to Three
Zerotothree.org

Depression
Wings of Madness
www.wingofmadness.com/articles/children.htm

Balanced Mind Foundation
www.thebalancedmind.org

National Alliance on Mental Illness
www.nami.org

NAMI Youth
https://nami.org/Find-Support/Teens-and-Young-Adults

Mental Health America
www.mentalhealthamerica.net

American Psychiatric Association
www.psychiatry.org

International Association for Child and Adolescent Psychiatry and Allied Professions' (IACAPAP)
Textbook of Child and Adolescent Mental Health
http://iacapap.org/iacapap-textbook-of-child-and-adolescent-mental-health

Mental Health America
www.mhanational.org/self-help-tools

ADHD
The Attention Deficit Information Support Network, Inc.
www.addinfonetwork.com

Attention Deficit Disorder Association
www.add.org

Children and Adults with Attention Deficit Hyperactivity Disorder (CHADD)
www.chadd.org

Online Assessment Measures
www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Depression and Bipolar Support Alliance
www.dbsalliance.org/site/PageServer?pagename=home

Teen depression
www.erikaslighthouse.org

Teen suicide prevention
www.morethansad.org

American foundation for Suicide Prevention
www.afsp.org/

Autism www.autismspeaks.org

Reading list from AACAP:

The material in some books may not be appropriate for every reader. The clinician should review the material and use clinical judgment before recommending books to specific patients.

Category	Audience	Title	Author
ADHD	Adolescents, Young adults	A Bird's-Eye View of Life with ADD and ADHD: Advice from Young Survivors	Chris A. Zeigler Dendy and Alex Zeigler
ADHD	Young adults	ADHD and Me: Forty Years in a Fog	Ken Patterson
Anxiety	Young adolescents, Adolescents, Adults	What You Must Think of Me: A First Hand Account of One Teenager's Experience with Social Anxiety Disorder	Emily Ford
Autism	Adolescents, Adults	Look Me in the Eye	John Elder Robinson
Autism	All	I Am Utterly Unique	Elaine Marie Larson
Autism	All	Little Rainman	Karen L. Simmons
Autism	Healthcare practitioners	Nobody Nowhere	Donna William
Autism	Parents of children with Autism	A Special Book About Me	Josie Santomauro
Autism	All	What it is to be me! An Asperger Kid Book	Angela Wine
Autism	Young adolescents, Adolescents, Adults	Freaks, Geeks and Asperger Syndrome: A user guide to Adolescense	Luke Jackson

Bipolar Disorder	Adolescents, Adults	An Unquiet Mind: A Memoir of Moods and Madness	Kay Redfield Jamison
Bipolar Disorder	Young adults, Adults	Sugar and Salt	Jane Thompson
Borderline Personality Disorder	Young adults, Adults	Get Me Out of Here: My Recovery from Borderline Personality Disorder	Rachel Reiland
Borderline Personality Disorder	Young adults, Adults	Girl, Interrupted	Susanna Kaysen
Cutting	Young adults, Adults	Skin Game: A Memoir	Caroline Kettlewell
Schizophrenia	Young adults, Adults	Divided Minds	Pamela Spiro Wagner and Carolyn S. Spiro, M.D.
Schizophrenia	Young adults, Adults	The Quiet Room	Lori Schiller and Amanda Bennett
Schizophrenia	Young adults, Adults	Welcome to My Country	Lauren Slater
Suicide	Adolescents, Adults	Eight Stories Up: An Adolescent Chooses Hope over Suicide	Dequincy A. Lezine, Ph.D., with David Brent, M.D.
Suicide	Adolescents, Young adults, Adults	In Her Wake: A Child Psychiatrist Explores the Mystery of Her Mother's Suicide	Nancy Rappaport, M.D.
Trauma	Adolescents, Young adults, Adults	Lucky	Alice Sebold

DSM-5 Classification listing
(Diagnoses in ***bold italic*** covered in this Advanced Child Mental Health course)

Neurodevelopmental Disorders

Intellectual Disabilities
Intellectual Disability (Intellectual Developmental Disorder)
Global Developmental Delay
Unspecified Intellectual Disability (Intellectual Developmental Disorder)
Communication Disorders
Language Disorder
Speech Sound Disorder (previously Phonological Disorder)
Childhood-Onset Fluency Disorder (Stuttering)
Social (Pragmatic) Communication Disorder
Unspecified Communication Disorder
Autism Spectrum Disorder
Attention-Deficit/Hyperactivity Disorder
Other Specified Attention-Deficit/Hyperactivity Disorder
Unspecified Attention-Deficit/Hyperactivity Disorder
Specific Learning Disorder
Specific Learning Disorder
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
Other Neurodevelopmental Disorders
Other Specified Neurodevelopmental Disorder
Unspecified Neurodevelopmental Disorder

Schizophrenia Spectrum and Other Psychotic Disorders

Schizotypal (Personality) Disorder
Delusional Disorder
Brief Psychotic Disorder
Schizophreniform Disorder

Schizophrenia
Schizoaffective Disorder
Substance/Medication-Induced Psychotic Disorder
Psychotic Disorder Due to Another Medical Condition
Catatonia
Catatonia Associated With Another Mental Disorder (Catatonia Specifier)
Catatonic Disorder Due to Another Medical Condition
Unspecified Catatonia
Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Bipolar and Related Disorders

Bipolar I Disorder
Bipolar II Disorder
Cyclothymic Disorder
Substance/Medication-Induced Bipolar and Related Disorder
Bipolar and Related Disorder Due to Another Medical Condition
Other Specified Bipolar and Related Disorder
Unspecified Bipolar and Related Disorder

Depressive Disorders

Disruptive Mood Dysregulation Disorder
Major Depressive Disorder, Single and Recurrent Episodes
Persistent Depressive Disorder (Dysthymia)
Premenstrual Dysphoric Disorder
Substance/Medication-Induced Depressive Disorder
Depressive Disorder Due to Another Medical Condition
Other Specified Depressive Disorder
Unspecified Depressive Disorder

Anxiety Disorders

Separation Anxiety Disorder
Selective Mutism
Specific Phobia
Social Anxiety Disorder (Social Phobia)
Panic Disorder
Panic Attack (Specifier)
Agoraphobia
Generalized Anxiety Disorder
Substance/Medication-Induced Anxiety Disorder
Anxiety Disorder Due to Another Medical Condition

Other Specified Anxiety Disorder
Unspecified Anxiety Disorder

Obsessive-Compulsive and Related Disorders

Obsessive-Compulsive Disorder
Body Dysmorphic Disorder
Hoarding Disorder
Trichotillomania (Hair-Pulling Disorder)
Excoriation (Skin-Picking) Disorder
Substance/Medication-Induced Obsessive-Compulsive and Related Disorder
Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
Other Specified Obsessive-Compulsive and Related Disorder
Unspecified Obsessive-Compulsive and Related Disorder

Trauma- and Stressor-Related Disorders

Reactive Attachment Disorder
Disinhibited Social Engagement Disorder
Posttraumatic Stress Disorder
Acute Stress Disorder
Adjustment Disorders
Other Specified Trauma- and Stressor-Related Disorder
Unspecified Trauma- and Stressor-Related Disorder

Dissociative Disorders

Dissociative Identity Disorder
Dissociative Amnesia
Depersonalization/Derealization Disorder
Other Specified Dissociative Disorder
Unspecified Dissociative Disorder

Somatic Symptom and Related Disorders

Somatic Symptom Disorder
Illness Anxiety Disorder
Conversion Disorder (Functional Neurological Symptom Disorder)
Psychological Factors Affecting Other Medical Conditions
Factitious Disorder
Other Specified Somatic Symptom and Related Disorder
Unspecified Somatic Symptom and Related Disorder

Feeding and Eating Disorders

Pica

Rumination Disorder
Avoidant/Restrictive Food Intake Disorder
Anorexia Nervosa
Bulimia Nervosa
Binge-Eating Disorder
Other Specified Feeding or Eating Disorder
Unspecified Feeding or Eating Disorder

Elimination Disorders

Enuresis
Encopresis
Other Specified Elimination Disorder
Unspecified Elimination Disorder

Sleep-Wake Disorders

Insomnia Disorder
Hypersomnolence Disorder
Narcolepsy
Breathing-Related Sleep Disorders
Obstructive Sleep Apnea Hypopnea
Central Sleep Apnea
Sleep-Related Hypoventilation
Circadian Rhythm Sleep-Wake Disorders
Parasomnias
Non–Rapid Eye Movement Sleep Arousal Disorders
Sleepwalking
Sleep Terrors
Nightmare Disorder
Rapid Eye Movement Sleep Behavior Disorder
Restless Legs Syndrome
Substance/Medication-Induced Sleep Disorder
Other Specified Insomnia Disorder
Unspecified Insomnia Disorder
Other Specified Hypersomnolence Disorder
Unspecified Hypersomnolence Disorder
Other Specified Sleep-Wake Disorder
Unspecified Sleep-Wake Disorder

Sexual Dysfunctions

Delayed Ejaculation
Erectile Disorder

Female Orgasmic Disorder
Female Sexual Interest/Arousal Disorder
Genito-Pelvic Pain/Penetration Disorder
Male Hypoactive Sexual Desire Disorder
Premature (Early) Ejaculation
Substance/Medication-Induced Sexual Dysfunction
Other Specified Sexual Dysfunction
Unspecified Sexual Dysfunction
Gender Dysphoria
Gender Dysphoria
Other Specified Gender Dysphoria
Unspecified Gender Dysphoria

Disruptive, Impulse-Control, and Conduct Disorders

Oppositional Defiant Disorder
Intermittent Explosive Disorder
Conduct Disorder
Antisocial Personality Disorder
Pyromania
Kleptomania
Other Specified Disruptive, Impulse-Control, and Conduct Disorder
Unspecified Disruptive, Impulse-Control, and Conduct Disorder

Substance-Related and Addictive Disorders

Substance-Related Disorders
Substance Use Disorders
Substance-Induced Disorders
Substance Intoxication and Withdrawal
Substance/Medication-Induced Mental Disorders
Alcohol-Related Disorders
Alcohol Use Disorder
Alcohol Intoxication
Alcohol Withdrawal
Other Alcohol-Induced Disorders
Unspecified Alcohol-Related Disorder
Caffeine-Related Disorders
Caffeine Intoxication
Caffeine Withdrawal
Other Caffeine-Induced Disorders
Unspecified Caffeine-Related Disorder

Cannabis-Related Disorders
Cannabis Use Disorder
Cannabis Intoxication
Cannabis Withdrawal
Other Cannabis-Induced Disorders
Unspecified Cannabis-Related Disorder
Hallucinogen-Related Disorders
Phencyclidine Use Disorder
Other Hallucinogen Use Disorder
Phencyclidine Intoxication
Other Hallucinogen Intoxication
Hallucinogen Persisting Perception Disorder
Other Phencyclidine-Induced Disorders
Other Hallucinogen-Induced Disorders
Unspecified Phencyclidine-Related Disorder
Unspecified Hallucinogen-Related Disorder
Inhalant-Related Disorders
Inhalant Use Disorder
Inhalant Intoxication
Other Inhalant-Induced Disorders
Unspecified Inhalant-Related Disorder
Opioid-Related Disorders
Opioid Use Disorder
Opioid Intoxication
Opioid Withdrawal
Other Opioid-Induced Disorders
Unspecified Opioid-Related Disorder
Sedative-, Hypnotic-, or Anxiolytic-Related Disorders
Sedative, Hypnotic, or Anxiolytic Use Disorder
Sedative, Hypnotic, or Anxiolytic Intoxication
Sedative, Hypnotic, or Anxiolytic Withdrawal
Other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders
Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder
Stimulant-Related Disorders
Stimulant Use Disorder
Stimulant Intoxication
Stimulant Withdrawal
Other Stimulant-Induced Disorders

Unspecified Stimulant-Related Disorder
Tobacco-Related Disorders
Tobacco Use Disorder
Tobacco Withdrawal
Other Tobacco-Induced Disorders
Unspecified Tobacco-Related Disorder
Other (or Unknown) Substance–Related Disorders
Other (or Unknown) Substance Use Disorder
Other (or Unknown) Substance Intoxication
Other (or Unknown) Substance Withdrawal
Other (or Unknown) Substance–Induced Disorders
Unspecified Other (or Unknown) Substance–Related Disorder
Non-Substance-Related Disorders
Gambling Disorder

Neurocognitive Disorders

Delirium
Other Specified Delirium
Unspecified Delirium
Major and Mild Neurocognitive Disorders
Major Neurocognitive Disorder
Mild Neurocognitive Disorder
Major or Mild Neurocognitive Disorder Due to Alzheimer's Disease
Major or Mild Frontotemporal Neurocognitive Disorder
Major or Mild Neurocognitive Disorder With Lewy Bodies
Major or Mild Vascular Neurocognitive Disorder
Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury
Substance/Medication-Induced Major or Mild Neurocognitive Disorder
Major or Mild Neurocognitive Disorder Due to HIV Infection
Major or Mild Neurocognitive Disorder Due to Prion Disease
Major or Mild Neurocognitive Disorder Due to Parkinson's Disease
Major or Mild Neurocognitive Disorder Due to Huntington's Disease
Major or Mild Neurocognitive Disorder Due to Another Medical Condition
Major or Mild Neurocognitive Disorder Due to Multiple Etiologies
Unspecified Neurocognitive Disorder

Personality Disorders

General Personality Disorder
Cluster A Personality Disorders

Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder
Cluster B Personality Disorders
Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder
Cluster C Personality Disorders
Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder
Other Personality Disorders
Personality Change Due to Another Medical Condition
Other Specified Personality Disorder
Unspecified Personality Disorder

Paraphilic Disorders

Voyeuristic Disorder
Exhibitionistic Disorder
Frotteuristic Disorder
Sexual Masochism Disorder
Sexual Sadism Disorder
Pedophilic Disorder
Fetishistic Disorder
Transvestic Disorder
Other Specified Paraphilic Disorder
Unspecified Paraphilic Disorder

Other Mental Disorders

Other Specified Mental Disorder Due to Another Medical Condition
Unspecified Mental Disorder Due to Another Medical Condition
Other Specified Mental Disorder
Unspecified Mental Disorder
Medication-Induced Movement Disorders and Other Adverse Effects of Medication

Other Conditions That May Be a Focus of Clinical Attention

Section III: Emerging Measures and Models

Assessment Measures

Cross-Cutting Symptom Measures

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult
Parent/Guardian-Rated DSM-5 Level 1 Cross-Cutting Symptom Measure—Child Age 6–17
Clinician-Rated Dimensions of Psychosis Symptom Severity
World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)
Cultural Formulation
Cultural Formulation Interview (CFI)
Cultural Formulation Interview (CFI)—Informant Version

Alternative DSM-5 Model for Personality Disorders

Conditions for Further Study

Attenuated Psychosis Syndrome
Depressive Episodes With Short-Duration Hypomania
Persistent Complex Bereavement Disorder
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Caffeine Use Disorder
Internet Gaming Disorder
Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure
Suicidal Behavior Disorder
Nonsuicidal Self-Injury