


## What School Psychologists Need to Know about DSM-5

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## Seminar Objectives


Participants will understand:

- the history and development of DSM
- the relevance of the DSM-5 to school-employed mental health professionals
- DSM-5 and IDEA eligibility determinations, and how they are different



## Caution


- DSM-5 should direct our attention.
- DSM-5 should not dictate any IEP team action.



## Introduction

- What is *DSM* and How is it Used?
  - Descriptions, symptoms, and other criteria for diagnosing mental disorders
    - Strives to ensure diagnoses are accurate and consistent
    - Identifies prevalence rates for mental health service planning
    - Linked to ICD codes to report diagnoses to insurers for reimbursement and used by public health authorities for causes of illness/death classifications.
    - Does not provide treatment recommendations.


From APA (2012)



## Introduction


- How is it Used by Schools?
  - May direct the attention of school psychologists, but NEVER (in an of itself) dictates the actions of IEP/504 teams
  - Can help inform interventions in the schools/counseling framework
  - **Handout 1** provides a listing of *DSM-5* diagnoses that may be associated with IDEA eligibility, as well as those that are typically not associated with special education eligibility

Source: Hart, Pate, & Brock (2013)



## Seminar Outline

- The Classification of Mental Illness in the United States
- Controversies associated with *DSM-5*
- The DSM-5 Specific Criteria




### The Classification of Mental Illness in the United States

Source	Sets of Criteria	Document Length
1840 US Census	2	2 sentences
1888 US Census	7	4 sentences

By the 1880s different categories of insanity were established.

1. Mania
2. Melancholia
3. Paresis (motor weakness or partial paralysis)
4. Dipsomania (craving alcohol)
5. Dementia
6. Monomania (single pathological preoccupation, otherwise sound mind)
7. Epilepsy


Sources: Douglas & Yates (1981), Wines (1988)



### The Classification of Mental Illness in the United States

Source	Sets of Criteria	Document Length
1918 APA	63	40 pages
1938 AMA	98	7 pages

Sources: Committee on Statistics (1918), National Conference on Nomenclature (1938)




### The Classification of Mental Illness in the United States

Source	Sets of Criteria	Document Length
1952 DSM	117	144 pages
1968 DSM-II	156	135 pages
1980 DSM-III	210	505 pages
1987 DSM-III-R	235	582 pages
1994 DSM-IV	322	914 pages
2000 DSM-IV-TR	324	980 pages

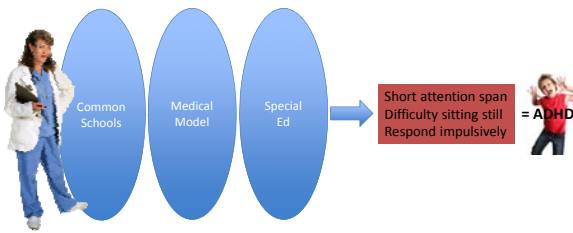
- What does the title Diagnostic & "Statistical" Manual imply?
- What is a primary use of the DSM?

Source: Brock & Hart (2013b, October)




### The Classification of Mental Illness in the United States

*Social Constructionism Example*



Discussion: Can you identify how DSM has been influenced by society and culture?




### The Classification of Mental Illness in the United States

Source	Sets of Criteria	Document Length
2013 DSM-5	392	1009 pages

- Diagnostic Inflation?
  - In the 61 years since DSM was first published 275 new diagnoses have been added
    - M = 4.5 new Diagnoses per year
  - In the 38 years since IDEA was first regulated 3 new disability categories have been added
    - M = 0.08 new categories per year

Source: Brock & Hart (2013b, October)




### The Classification of Mental Illness in the United States

Source	Sets of Criteria	Document Length
2013 DSM-5	392	1009 pages


- Diagnostic Inflation?
  - However, DSM-5 has actually reduced the number of different sets of specific diagnostic criteria
    - Sets of criteria in DSM-IV-TR; n = 243
    - Sets of criteria in DSM-5; n = 228
      - For example, the 5 PDDs are now 1 ASD; the 3 specific learning disorders are now 1 diagnosis with three separate codes for reading, written expression, and mathematic impairments.

Source: Brock & Hart (2013b, October)



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### Controversies Associated with *DSM-5*

- 51 mental health organizations suggested to APA that an independent scientific review is needed.
- Field testing cancelled due to deadlines
- Many changes viewed as loosening Dx criteria
- Two primary sources of controversy
  1. NIMH statements on *DSM-5*
  2. Allen Frances, MD (*DSM-IV* Task Force Chair)


Source: Brock & Hart (2013, September)



### Controversies Associated with *DSM-5*

- NIMH statements on *DSM-5*
  - Director, Dr. Thomas Insel called *DSM-5* less a bible of mental health and more a flawed dictionary of diagnostic terms
  - Moved NIMH’s research agenda away from *DSM* categories and toward its Research Domain Criteria (RDoC)
    - A classification system based on genetics, biomarkers, neural circuitry
    - Aims to better understand the biological components of mental illness


Source: Brock & Hart (2013, September)



### Controversies Associated with *DSM-5*

- NIMH statements on *DSM-5*
  - RDoC is a matrix of constructs
    - Functional dimensions of behavior and classes or units of analysis used to study the constructs
      - 5 domains of behavior (Negative Valence, Positive Valence, Cognitive, Social Processes, and Arousal/Regulatory Systems)
      - 7 classes (genes, molecules, cells, neural circuits, physiology, behaviors, and self-reports)
  - Dr. Insel has indicated that NIMH funding decisions will be based on researchers utilizing RDoC versus diagnosis-specific projects


Source: Brock & Hart (2013, September)



### Controversies Associated with *DSM-5*

- NIMH statements on *DSM-5*
  - From the high rates of comorbidity with most Dx categories + recurrence of particular symptoms across categories = frequent overlap in *DSM*’s boundaries
  - RDoC framework attempts to make this overlap of Sx less important in research
  - Encourages researchers to cut across categories to develop a system based on the domains of behavior, and not constricted by the of *DSM* categories


Source: Brock & Hart (2013, September)



### Controversies Associated with *DSM-5*

- NIMH statements on *DSM-5*
  - Dr. Insel’s post were been given much attention by the popular press
  - Referred to a as a “humiliating blow,” a “bombshell,” and a “potentially seismic move”
  - This NIMH paradigm shift has been associated with the release of *DSM-5*

Source: Brock & Hart (2013, September)



## Controversies Associated with *DSM-5*

- NIMH statements on *DSM-5*
  - However, the funding changes Insel discussed have been part of the NIMH strategic plan **since 2008**.
  - Insel never stated that the RDoC should supplant *DSM-5*
    - He acknowledged, that the *DSM* as it currently stands is an imperfect system, and we need to do better for those dealing with mental health challenges.
  - The RDoC is an attempt to provide researchers the resources needed to uncover that better system of classification
    - It is **not currently** an alternative to *DSM-5*

Source: Brock & Hart (2013, September)



## Controversies Associated with *DSM-5*

- Allen Frances, MD (*DSM-IV* Task Force Chair)
  - Professor Emeritus at Duke University
  - Chair of the *DSM-IV* Task force
  - Author of 2 books critical of *DSM-5*
    - *Essentials of Psychiatric Diagnosis*: (2013a)
    - *Saving Normal* (2013b)
  - Was initially reluctant to come out of a decade-long retirement and comment publicly on *DSM-5*.
  - Initially declined an invitation from Dr. Robert Spitzer (lead Ed. of *DSM-III*; APA, 1980) to sign an open letter to *Psychiatric News* (the APA version of the *Communiqué*) complaining about *DSM-5* task force secrecy

Source: Brock & Hart (2013, September)



## Controversies Associated with *DSM-5*

- Allen Frances, MD (*DSM-IV* Task Force Chair)
  - A conversation with Dr. William Carpenter during the 2009 APA convention lead Dr. Frances to change his mind
  - Carpenter's Psychotic Disorders *DSM-5* workgroup was considering a new previously unrecognized diagnosis.
  - Frances' concerns about this proposed new diagnosis got him into the *DSM-5* fray

Source: Brock & Hart (2013, September); Frances (2013b)



## Controversies Associated with *DSM-5*

- Allen Frances, MD (*DSM-IV* Task Force Chair)
  - Frances' concerns about Psychosis Risk Syndrome lead to his highly publicized comments about diagnostic inflation.
    - “... boundaries of psychiatry are easily expanded because no bright line separates patients who are simply worried from those with mild mental disorders.”
  - His frustration over this issue is clearly revealed in his December 2010 *Wired Magazine* interview wherein he was quoted:
    - “there is no definition of a mental disorder. It's bullshit. I mean, you just can't define it.”

Sources: Brock & Hart (2013, September); Frances (2013, May); Greenberg (2010)



## Controversies Associated with *DSM-5*

- Allen Frances, MD (*DSM-IV* Task Force Chair)
  - Argues *DSM-5* will result in mislabeling everyday problems as a mental illness
  - Acknowledges problems generated by his work on *DSM-IV*, and asserts that *DSM-5* will make matters worse
  - Fears drug companies will use “loose DSM definitions” and promote ...
    - “the misleading idea that everyday life problems are actually undiagnosed psychiatric illness caused by a chemical imbalance and requiring a solution in pill form.”

Source: Frances (2013, May)



## Controversies Associated with *DSM-5*

- Allen Frances, MD (*DSM-IV* Task Force Chair)
  - “With *DSM-5*, patients worried about having a medical illness will often be diagnosed with somatic symptom disorder, normal grief will be misidentified as major depressive disorder, the forgetfulness of old age will be confused with mild neurocognitive disorder, temper tantrums will be labeled disruptive mood dysregulation disorder, overeating will become binge eating disorder, and the already overused diagnosis of attention-deficit disorder will be even easier to apply to adults thanks to criteria that have been loosed further.”

Source: Frances (2013, May, p. 1)



### Controversies Associated with *DSM-5*

- Discussion:
  - What are some of the “concerns” you have heard (or have questions about) regarding APA’s (2013) *DSM-5*

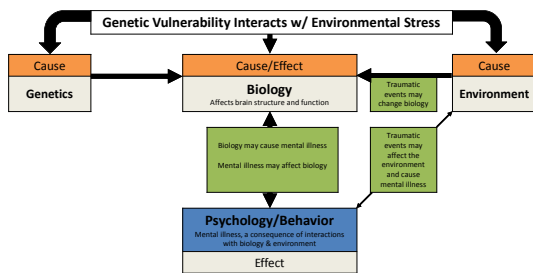


### Seminar Outline

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An interpretation of *DMS-5*’s conceptualization of mental illness



### Neurodevelopmental Disorders



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

Source: APA (2013b)



### Intellectual Disabilities

- DSM-5 Definition
  - “... a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.”
- IDEA 2004 Definition
  - “... means significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects a child’s educational performance.”

Source: APA (2013b, p. 33); IDEA (2004)



### Intellectual Disabilities: DSM-5

- Changes from *DSM-IV-TR*
  - Name change
    - No longer referred to as Mental Retardation
    - “Intellectual Development Disorder” in ICD-11
  - Severity determined by adaptive functioning
    - No longer determined by IQ scores (no specific IQ score specified)
    - Severity level specifiers “mild,” “moderate,” “severe,” “profound” (see pp. 34-36)
  - Defines adaptive functioning in 3 domains (vs. 11 areas)
  - Requires BOTH standardized testing and clinical assessment
  - “Global Developmental Delay” used for children under age 5 years & unable to be tested.
  - “Unspecified Intellectual Delay” use for children over age 5 when testing is difficult or impossible


Sources: APA (2013b), Morera (2014)



### Intellectual Disabilities: DSM-5

- Rationale for *DSM-5* Changes
  - Intellectual disabilities is now the more common (preferred) term
    - MR had become pejorative (as had “mental deficiency” when DSM-II was published in 1968).
  - PL 111-256, Rosa’s Law
    - ID is quite literally PC
  - Criteria encourage a more comprehensive assessment
    - Emphasizes clinical assessment AND standardized cognitive testing
    - It is not the test that identifies ID, rather it is the mental health professionals clinical judgment that does so


Sources: APA (2013b), Morera (2014)



### Intellectual Disabilities: DSM-5

- Consequences of *DSM-5* Changes
  - Less stigmatizing
    - But with the passage of time ID may also become pejorative
  - Less reliance on the IQ score
    - Ensures IQ tests are not over emphasized
    - Requires a more comprehensive assessment
  - Greater emphasis on adaptive functioning
    - Severity levels (mild, moderate, severe, profound) based on conceptual, social, and practical behaviors
  - Elimination of multi-axial format (was Axis II) may mean comorbid conditions are overlooked

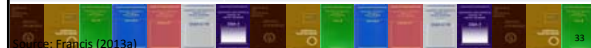
Sources: APA (2013b); Morera (2014)



### Intellectual Disabilities: DSM-5

Alternative Diagnosis	Differential Consideration
Borderline Intellectual Functioning	IQ above 70
Autism Spectrum Disorder	Significant deficits in social interaction and stereotypical behaviors not accounted for by IQ
Learning Disorder	Problem specific to learning, not generalized to all intellectual functions
Major Neurocognitive Disorder (Dementia)	Onset is after age 18
Malingering	Person seeks to avoid legal or other responsibilities by feigning intellectual incapacity
Other mental disorders	Depressive Disorder, Anxiety Disorders, and others may interfere with intellectual functioning


Source: Morera (2014)



### Intellectual Disabilities: DSM-5

- Implications for School Psychologists
  - Same terminology as IDEA
  - A neurocognitive disorder may also be appropriate for students in the TBI category
  - Can be more certain that clinical assessments have given adequate consideration to adaptive behavior
  - Not the same as IDEA’s ID
    - Which adds a 4<sup>th</sup> criteria (adverse impact on educational functioning)


Source: Morera (2014)



### Intellectual Disabilities: DSM-5 v IDEA

DSM-5	IDEA 2004
1. Includes intellectual deficits	1. Significantly subaverage general intellectual functioning
2. Includes adaptive functioning deficits (determines severity if the ID) in conceptual, social, and practical domains	2. Concurrent deficits in adaptive behavior
3. Onset during the developmental period	3. Manifest during the developmental period
	4. Adversely affects educational performance


Source: APA (2013b), pp. 47-48



### Social (Pragmatic) Communication Disorder

- Definition
  - Difficulty with verbal and nonverbal communication that cannot be explained by cognitive ability
  - Characterized primarily by poor pragmatics

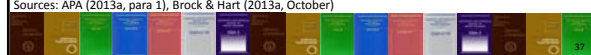
Source: APA (2013b), pp. 47-48



### Social (Pragmatic) Communication Disorder

- Rationale for inclusion in *DSM-5*
  - Need to recognize individuals who have problems using language for social purposes
  - Brings "... social and communication defects out of the shadows of a "not otherwise specified" label to help them get the services and treatment they need"


Sources: APA (2013a, para 1), Brock & Hart (2013a, October)



### Social (Pragmatic) Communication Disorder

- Possible Consequences of inclusion in *DSM-5*
  - A new diagnoses for some individuals who were previously identified as PDD-NOS


Sources: APA (2013a), Brock & Hart (2013a, October)



### Social (Pragmatic) Communication Disorder

- Implications for School Psychologists
  - Would most likely direct IEP team attention to "Speech or Language Impaired" criteria
  - May make it less likely that "Autism" criteria is used for some students


Source: Brock & Hart (2013a, October)



### Autism Spectrum Disorder (ASD)

- Definition
  - Impaired reciprocal social communication; and restricted, repetitive patterns of behaviors, interests or activities (RRB).

Sources: APA (2013b, p. 53)

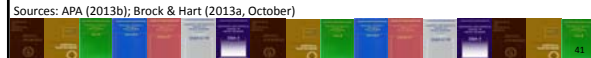


### Autism Spectrum Disorder

- Changes from *DSM-IV-TR*
  - Drops the 5 different PDDs, in favor of a single unifying ASD diagnosis.
  - Three symptoms groups becomes two.

<i>DSM-IV-TR</i>	<i>DSM-5</i>
Autistic Disorder Asperger's Disorder Rett's Disorder Childhood Disintegrative Disorder PDD Not Otherwise Specified	Autism Spectrum Disorder Social Communication Disorder

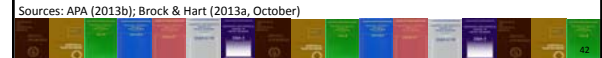
Sources: APA (2013b); Brock & Hart (2013a, October)



### Autism Spectrum Disorder

- Changes from *DSM-IV-TR* (continued)
  - Criteria do not specify a specific number of social communication and interaction symptoms.
  - Criteria specify that 2 of 4 symptoms of RRB must be present
  - For both criteria A & B, clinicians are directed to specify the severity level
  - Symptoms may be displayed currently or that there may be a history of such dating back to early childhood.


Sources: APA (2013b); Brock & Hart (2013a, October)



## Autism Spectrum Disorder

- Changes from *DSM-IV-TR* (continued)
  - Added 5 specifiers
    1. Intellectual impairment
    2. Language impairment, whether the ASD diagnosis is a
    3. Associated with a “known medical or genetic condition or environmental factor”
    4. Associated with another neurodevelopmental, mental, or behavioral disorder”
    5. Associated with “catatonia”


Sources: APA (2013b, p. 51); Brock & Hart (2013a, October)



## Autism Spectrum Disorder

- Rationale for *DSM-5* Changes
  - Autism symptoms are better thought of as existing on a continuum
  - Evidence does not robustly support a distinction between Asperger’s and autistic disorder
  - The differentiation is not reliably made in practice
  - Genetic studies indicate more commonalities between Asperger’s and autism than differences
  - Diagnostic conversion between these disorders may be common

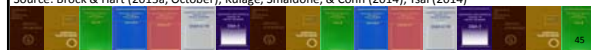
Source: Brock & Hart (2013a, October)



## Autism Spectrum Disorder

- Possible Consequences of *DSM-5* Changes
  - A more homogeneous ASD population
    - 2,037 Sx combinations to 11 (to 77) Sx combinations
  - Recognition of sensory issues will facilitate program planning
  - Specifiers for ID and symptom severity will facilitate program planning
  - Appears to have affected the epidemiology of ASD


Source: Brock & Hart (2013a, October); Kulage, Smaldone, & Cohn (2014); Tsai (2014)



## Autism Spectrum Disorder

- Implications for School Psychologists
  - Educational placements use education codes and regulations, and are more restrictive than are *DSM*
    - While approximately 20 out of every 1,000 school age youth have ASD, only about 6 out of every 1,000 students are eligible for special education using autism criteria
    - *DSM-5*’s use of severity level and specifiers will help IEP teams determine the likelihood of a given student with ASD meeting IDEA autism eligibility criteria
  - Remains to be seen how new “labeling” will impact parents accessibility to community services, but should not affect IDEA numbers

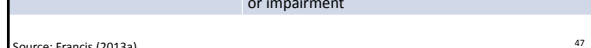
Sources: Brock & Hart (2013a, October)



## Autism Spectrum Disorder

Alternative Diagnosis	Differential Consideration
Intellectual Disabilities	Low IQ score without social disconnectedness and ritualistic behaviors
Learning Disorder	Academic deficits without the characteristic autistic behaviors
OCD	Strange RRB-like rituals, but OCD usually has later onset, normal attachment, & intact language
Social Anxiety Disorder (Social Phobia)	Socially awkward, but not the other social, speech, and RRBs
Schizophrenia	Much later onset, with delusions or hallucinations
Schizotypal Personality Disorder	Later onset, but there is considerable overlap
Normal eccentricity	Behaviors don’t cause clinically significant distress or impairment


Source: Francis (2013a)



## Attention-Deficit/Hyperactivity Disorder

- Definition
  - A neurodevelopmental disorder that begins in childhood
  - Characterized by significant inattention and/or hyperactivity-impulsivity that impact functioning or development

Source: APA (2013b)






### Attention-Deficit/Hyperactivity Disorder

- Changes from *DSM-IV-TR*
  - Re-categorized within Neurodevelopmental Disorders
    - Differentiates it from other impulse-related and behavioral disorders (e.g., Conduct Disorder), and the emphasis is on the neurobiological nature of the disorder.
      - Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence category eliminated
  - Examples added to differentiate between ADHD in children vs. older adolescents/adults
  - Persons 17+ required to demonstrate only 5 symptoms for both inattention and hyperactivity/impulsivity
    - Children still required to demonstrate a persistent pattern of at least 6 symptoms for each


Sources: APA (2000; 2013b); Gibbons (2013)



### Attention-Deficit/Hyperactivity Disorder

- Changes from *DSM-IV-TR* (continued)
  - Age of onset criterion changed
    - *DSM-IV-TR* required that some symptoms of inattention and/or hyperactivity/impulsivity have been present and caused significant impairment by age 7, *DSM-5* requires that symptoms were present before age 12
  - Specifiers are now included
    - Mild, Moderate, or Severe; and Partial Remission
      - Aid in describing the course and prognosis of the disorder
    - Shift from subtypes to presentation specifiers in *DSM-5*
      - Combined Presentation, Predominantly Inattentive Presentation, Predominantly Hyperactive/Impulsive Presentation


Sources: APA (2000; 2013b); Gibbons (2013)



### Attention-Deficit/Hyperactivity Disorder

- Changes from *DSM-IV-TR* (continued)
  - Impairment criteria wording changes
    - *DSM-IV-TR* required *some impairment* be present in at least 2 settings
    - *DSM-5* requires that *several symptoms* be present in 2 or more settings
  - *DSM-IV-TR* prohibited a comorbid diagnosis of ADHD in those with a Pervasive Developmental Disorder
  - *DSM-5* allows for comorbid diagnosis of ADHD and Autism Spectrum Disorder


Sources: APA (2000; 2013b); Gibbons (2013)



### Attention-Deficit/Hyperactivity Disorder

- Rationale for *DSM-5* Changes
  - ADHD viewed as a lifespan disorder
  - Onset criterion in *DSM-IV-TR* acknowledged as having been arbitrary
  - Use of subtypes not supported by empirical data
  - Specifiers improve clinical utility of diagnosis
  - ASD and ADHD can co-occur


Source: APA (2013b); Gibbons (2013)



### Attention-Deficit/Hyperactivity Disorder

- Possible Consequences of *DSM-5* Changes
  - Reliable diagnosis (Kappa Coefficient of .61)
  - Facilitate diagnosis in adolescents and adults
    - May increase prevalence
  - Being viewed as a neurodevelopmental (vs. disruptive behavior) disorder may reduce stigma
  - With older children, symptoms could be related to other causes that get overlooked


Source: APA (2013b); Gibbons (2013); Frances (2013b)



### Attention-Deficit/Hyperactivity Disorder

- Implications for School Psychologists
  - May affect eligibility decisions and school psychologists may be called on to consider these criteria
  - May require school psychologists to alter assessment approaches
  - Severity specifiers result in the need to determine the impact of ADHD on student functioning.
  - Satisfying the requirement that several symptoms be present in two or more settings will be dependent upon observation and information from across multiple settings.

Source: Gibbons (2013)



### Attention-Deficit/Hyperactivity Disorder


Alternative Diagnosis	Differential Consideration
Normal Immaturity	Developmentally appropriate at 4 may be ADHD at 7
Oppositional Defiant Disorder (ODD)	Willful refusal to comply with structure or authority
Conduct Disorder	Pattern of severe violation of rules
Intellectual Developmental Disorder	Child seems inattentive or disorganized because can't keep up with work
Adjustment Disorder	Sx are response to chaotic environment, family stress, or life changes
Other mental disorders	Hyperactivity, impulsivity, and inattentiveness are common across many Dx (e.g., substance use, mania, dementia)
Malingering	Obtaining prescription for stimulant drugs for performance enhancement, recreation, or resale

Source: Francis (2013a) 55

### Specific Learning Disorder/Disability

- DSM-5 Definition
  - "... a neurodevelopmental disorder with a biological origin that is the basis for abnormalities at a cognitive level that are associated with the behavioral signs of the disorder. The biological origin includes an interaction of genetic, epigenetic, and environmental factors, which affect the brain's ability to perceive or process verbal or non-verbal information efficiently and accurately."
- IDEA 2004 Definition
  - "... means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may have manifested itself in the imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The basic psychological processes include attention, visual processing, auditory processing, sensory-motor skills, cognitive abilities including association, conceptualization and expression."

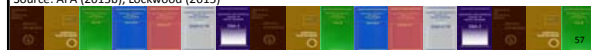
Source: APA (2013b, p. 68); IDEA, 2004



### Specific Learning Disorder: DSM-5

- Changes from *DSM-IV-TR*
  - Now a single overall diagnosis of deficits that impact academic achievement
  - Includes specifiers for "impairment in" reading, written expression, and mathematics.
  - Requires identification of impaired subskills
    - Reading subskills: word reading accuracy, reading rate or fluency, reading comprehension
    - Written expression subskills: spelling accuracy, grammar and punctuation accuracy, clarity or organization of written expression
    - Mathematics subskills: number sense, memorization of arithmetic facts, accurate or fluent calculation, accurate math reasoning


Source: APA (2013b); Lockwood (2015)



### Specific Learning Disorder: DSM-5

- Rationale for *DSM-5* Changes
  - Increase diagnostic accuracy
  - Effectively target care


Source: APA (2013b); Lockwood (2015)



### Specific Learning Disorder: DSM-5


- Possible Consequences of *DSM-5* Changes
  - Clinical diagnoses may more accurately direct the attention of IEP teams
  - Will be easier to identify – could increase prevalence of diagnosis!

Source: APA (2013b); Lockwood (2015)



### Specific Learning Disorder: DSM-5

- Implications for School Psychologists
  - Identifies Dyslexia and Dyscalculia as alternative terms
  - Specifically identifies "school reports," and "psychoeducational assessment" as bases for documenting diagnostic criteria
  - Evaluations done outside school setting may find SLD easier to identify due to broad criteria



### Specific Learning Disorder

Alternative Diagnosis	Differential Consideration
Intellectual Disabilities	Learning problems no greater than what would be expected given IQ.
Autism Spectrum Disorder	This is the primary cause of poor functioning. Both diagnoses can be given if a specific academic area is disproportionately impaired.
Sensory Deficit	Accounts for learning problems.
ADHD	Causes poor test taking. Both diagnoses can be given when appropriate.

Source: Francis (2013a)

### Specific Learning Disorder/Disability: DSM-5 v IDEA

DSM-5 (Disorder)	IDEA 2004 (Disability)
1. Neurodevelopmental disorder affects brain's ability to perceive/process verbal/non-verbal information	1. Disorder in one or more basic psychological processes
2. Abnormalities at the cognitive level	2. Psychological processes include attention, visual/auditory processing, sensory-motor skills, cognitive abilities
3. Behavioral signs	3. Manifest in the imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia
4. Biological origin (interaction of genetic, epigenetic, & environmental factors)	

### Specific Learning Disability: IDEA

a) Specific learning disabilities **do not include** learning problems that are primarily the result of visual, hearing, or motor disabilities, of intellectual disability, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

b) In determining whether a pupil has a specific learning disability, the public agency may consider whether a pupil has a **severe discrepancy** between intellectual ability and achievement in oral expression, listening comprehension, written expression, basic reading skill, reading comprehension, mathematical calculation, or mathematical reasoning. The decision as to whether or not a severe discrepancy exists shall take into account all relevant material which is available on the pupil. No single score or product of scores, test or procedure shall be used as the sole criterion for the decisions of the IEP team as to the pupil's eligibility for special education. In determining the existence of a severe discrepancy, the IEP team shall use the following procedures:

### Specific Learning Disability: IDEA

1. **When standardized tests are considered to be valid** for a specific pupil, a severe discrepancy is demonstrated by: first, converting into common standard scores, using a mean of 100 and standard deviation of 15, the achievement test score and the intellectual ability test score to be compared; second, computing the difference between these common standard scores; and third, comparing this computed difference to the standard criterion which is the product of 1.5 multiplied by the standard deviation of the distribution of computed differences of students taking these achievement and ability tests. A computed difference which equals or exceeds this standard criterion, adjusted by one standard error of measurement, the adjustment not to exceed 4 common standard score points, indicates a severe discrepancy when such discrepancy is corroborated by other assessment data which may include other tests, scales, instruments, observations and work samples, as appropriate.

### Specific Learning Disability: IDEA

2. **When standardized tests are considered to be invalid** for a specific pupil, the discrepancy shall be measured by alternative means as specified on the assessment plan.


3. **If the standardized tests do not reveal a severe discrepancy as defined in subdivisions 1. or 2. above, the IEP team may find that a severe discrepancy does exist**, provided that the team documents in a written report that the severe discrepancy between ability and achievement exists as a result of a disorder in one or more of the basic psychological processes. The report shall include a statement of the area, the degree, and the basis and method used in determining the discrepancy.

### Specific Learning Disability: IDEA

4. A severe discrepancy shall not be primarily the result of limited school experience or poor school attendance.


### Specific Learning Disability: IDEA

c) Whether or not a pupil exhibits a severe discrepancy as described in subdivision (b)(10)(B) above, a pupil may be determined to have a specific learning disability if:




### Specific Learning Disability: IDEA

1. The pupil does not achieve adequately for the pupil's age or to meet State-approved grade-level standards in one or more of the following areas, when provided with learning experiences and instruction appropriate for the pupil's age or State-approved grade-level standards:
  - i. Oral expression.
  - ii. Listening comprehension.
  - iii. Written expression.
  - iv. Basic reading skill.
  - v. Reading fluency skills.
  - vi. Reading comprehension.
  - vii. Mathematics calculation.
  - viii. Mathematics problem solving, **and ...**




### Specific Learning Disability: IDEA

2. (i) The pupil does not make sufficient progress to meet age or State-approved grade-level standards in one or more of the areas identified in subdivision (b)(10)(C)(1) of this section when using a process based on the pupil's **response to scientific, research-based intervention**;
- or -
- (ii) The pupil exhibits a **pattern of strengths and weaknesses** in performance, achievement, or both, relative to age, State-approved grade-level standards, or intellectual development, that is determined by the group to be relevant to the identification of a specific learning disability, using appropriate assessments, consistent with 34 C.F.R. sections 300.304 and 300.305; **and**




### Specific Learning Disability: IDEA

3. The findings under subdivisions (b)(10)(C)(1) and (2) of this section are not primarily the result of:
  - i. A visual, hearing, or motor disability;
  - ii. Intellectual disability;
  - iii. Emotional disturbance;
  - iv. Cultural factors;
  - v. Environmental or economic disadvantage; or
  - vi. Limited English proficiency.




### Specific Learning Disability: IDEA

4. To ensure that underachievement in a pupil suspected of having a specific learning disability is not due to lack of appropriate instruction in reading or math, the group making the decision must consider:
  - i. Data that demonstrate that prior to, or as a part of, the referral process, the pupil was provided appropriate instruction in regular education settings, delivered by qualified personnel; and
  - ii. Data-based documentation of repeated assessments of achievement at reasonable intervals, reflecting formal assessment of student progress during instruction, which was provided to the pupil's parents.




### Specific Learning Disability: IDEA

5. In determining whether a pupil has a specific learning disability, the public agency must ensure that the pupil is observed in the pupil's learning environment in accordance with 34 C.F.R. section 300.310. In the case of a child of less than school age or out of school, a qualified professional must observe the child in an environment appropriate for a child of that age. The eligibility determination must be documented in accordance with 34 C.F.R. section 300.311.



## Schizophrenia Spectrum and Other Psychotic Disorders



- Delusional Disorder
- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizophrenia
- Schizoaffective Disorder
- Catatonia

Source: APA (2013b)

## Schizophrenia Spectrum

- Definition
  - Includes disorders defined by one or more of the following:
    - delusions
    - hallucinations
    - disorganized thinking
    - grossly disorganize/abnormal motor behavior,
    - negative symptoms (diminished emotional expression or avolition)

Source: APA (2013b)

## Schizophrenia Spectrum

- Implications for School Psychologists
  - Hard to distinguish schizophrenia from other mental disorders that have psychotic symptoms -
    - Looking for presence of psychosis, disorganization, and negative symptoms along with absence of other etiologies (e.g., bipolar)
  - Attenuated Psychosis Syndrome
    - A Section III “Condition for Further Study”
    - Psychosis-like, but below diagnostic threshold for a psychotic disorder
    - Onset is usually in mid to late adolescence or early adulthood.
      - Appears to best apply to person aged 15- to 35-years.
    - 18% meet diagnostic criteria for a psychotic disorder within 1 years of identification
    - 32% meet diagnostic criteria for a psychotic disorder within 3 years of identification


Source: Francis (2013a)

## Schizophrenia Spectrum

Alternative Diagnosis	Differential Consideration
Schizoaffective Disorder	Mood Sx are prominent in presentation, but psychotic symptoms persist even absent mood episodes
Major Depressive Disorder, severe with psychotic features	Psychotic symptoms restricted to depressive episodes
Bipolar I, Severe with Psychotic Features	Psychotic symptoms restricted to manic or depressive episodes
Schizotypal Personality Disorder	No psychotic symptoms
Schizophreniform Disorder	Same Sx as schizophrenia, but last for >1 month and <6 months
Brief Psychotic Disorder	Same Sx as schizophrenia, but last for <1 month
Delusional Disorder	Only delusions – no hallucinations, disorganization, or negative symptoms
Autism Spectrum Disorder	No prominent delusions or hallucinations
Malingering	Is something to be gained by “faking crazy?”
Political or Religious Zealotry	Bizarre beliefs shared by others

Source: Francis (2013a)

## Bipolar and Related Disorders



- Bipolar I
- Bipolar II
- Cyclothymic

Source: APA (2013b)

## Bipolar and Related Disorders

### Definition

- Distinct mood phases ranging from mania or hypomania to depression.
  - Bipolar I Disorder
    - Criteria have been met for at least 1 manic episode
      - May have been preceded by and followed by hypomanic OR major depressive episodes
  - Bipolar II Disorder
    - Criteria have been met for a current or past hypomanic episode AND a past major depressive episode
      - There has never been a manic episode
  - Cyclothymic
    - Alternating hypomanic and depressive symptoms but not severe enough for Bipolar I or Bipolar II

Source: APA (2013b); Francis (2013a)

## Bipolar and Related Disorders

- Implications for School Psychologists
  - Children who experience bipolar-like phenomena that do not meet criteria for bipolar I, bipolar II, or cyclothymic disorder would be diagnosed “other specified bipolar and related disorder”
  - If they have explosive tendencies may be (mis)diagnosed with Disruptive Mood Dysregulation Disorder
    - focus too much on externalizing behaviors and ignore possible underlying depressive symptoms

### Bipolar I

Alternative Diagnosis	Differential Consideration
Major Depressive Disorder	Person with depressive Sx never had Manic/Hypomanic episodes
Bipolar II	Hypomanic episodes, w/o a full Manic episode
Cyclothymic Disorder	Lesser mood swings of alternating depression - hypomania (never meeting depressive or manic criteria) cause clinically significant distress/impairment
Normal Mood Swings	Alternating periods of sadness and elevated mood, without clinically significant distress/impairment
Schizoaffective Disorder	Sx resemble Bipolar I, severe with psychotic features but psychotic Sx occur absent mood Sx
Schizophrenia or Delusional Disorder	Psychotic symptoms dominate. Occur without prominent mood episodes
Substance Induced Bipolar Disorder	Stimulant drugs can produce bipolar Sx

Source: Francis (2013a) 80

### Bipolar II

Alternative Diagnosis	Differential Consideration
Major Depressive Disorder	No Hx of hypomanic (or manic) episodes
Bipolar I	At least 1 manic episode
Cyclothymic Disorder	Mood swings (hypomania to mild depression) cause clinically significant distress/impairment; no history of any Major Depressive Episode
Normal Mood Swings	Alternately feels a bit high and a bit low, but with no clinically significant distress/impairment
Substance Induced Bipolar Disorder	Hypomanic episode caused by antidepressant medication or cocaine
ADHD	Common Sx presentation, but ADHD onset is in early childhood. Course chronic rather than episodic. Does not include features of elevated mood.

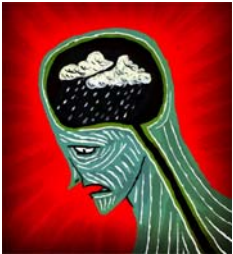
Source: Francis (2013b) 81

### Cyclothymic Disorder

Alternative Diagnosis	Differential Consideration
Normal Mood Swings	Ups & downs without clinically significant distress/impairment
Major Depressive Disorder	Had a major depressive episode
Bipolar I	At least one Manic episode
Bipolar II	At least one clear Major Depressive episode
Substance Induced Bipolar Disorder	Mood swings caused by antidepressant medication or cocaine. Stimulant drugs can produce bipolar symptoms

Source: Francis (2013a) 82

## Depressive Disorders



- Disruptive Mood Dysregulation Disorder
- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)

Source: APA (2013b) 83

## Disruptive Mood Dysregulation Disorder


- Definition
  - Characterized by chronic, severe and persistent irritability and generally, was introduced in the hopes of helping to address challenges and disagreements regarding the diagnosis of bipolar disorder in youth.

Sources: APA (2013b), Hart (2014) 84

### Disruptive Mood Dysregulation Disorder

- Implications for School Psychologists
  - It will be intriguing to see how quickly the assignment of DMDD “catches on.”
    - There will likely be a lag in community-based clinicians becoming aware of, accepting, and diagnosing this disorder
    - It might be up to knowledgeable school-employed mental health practitioners to bring awareness of these children to clinical entities.
  - While it may direct our attention toward students who might require support, diagnostic labels do not automatically result in special education eligibility or services.

Source: Hart (2014)




### Major Depressive Disorder

**Definition**

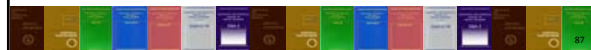
- 5 of 9 criteria (one must be #1 or #2)
  1. depressed mood most of the day, early everyday (children: irritable)
  2. diminished interest or pleasure in almost all activities
  3. significant weight loss/gain or decreased/increased appetite (children: failure weight gain)
  4. insomnia or hypersomnia
  5. psychomotor retardation or agitation
  6. fatigue, loss of energy
  7. feelings of worthlessness or excessive/inappropriate guilt
  8. Diminished ability to think/concentrate or indecisiveness
  9. Recurrent thoughts of death, recurrent suicide ideation, plan and/or attempt
- The feelings are pervasive and symptoms are intense.
- Marked impairment in occupational functioning or in usual social activities or relationships
- Not due to bereavement, substance use, medical condition
- **Specifiers:** anxious distress, mixed features, melancholic features, atypical features, mood-congruent psychotic features, mood incongruent psychotic features, catatonia, peripartum onset, seasonal pattern

APA (2013b)



### Major Depressive Disorder

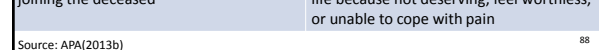
- Implications for School Psychologists
  - Easy to miss and easy to overdiagnose
  - If person experiences a loss, reserve diagnosis for those had previously experiences major depressive episodes and/or are now having server and prolonged symptoms



### Major Depressive Disorder

Grief	Major Depressive Episode
Feelings of emptiness and loss	Persistent depressed mood; inability to anticipate happiness or pleasure
Dysphoria likely decreases in intensity and over days/weeks (associated with thoughts/reminders of loss)	Depressed mood is more persistent and not tied to specific thoughts or preoccupations
Pain accompanied by positive emotions/humor	Pervasive unhappiness and misery
Preoccupation with thoughts and memories of loss	Self-critical or pessimistic ruminations
Self-esteem preserved	Feeling worthless and self-loathing
Perceived failings connected to deceased	Perceived failing in many situations
Thoughts of death (if present) focused on joining the deceased	Thoughts of death focused on ending own life because not deserving, feel worthless, or unable to cope with pain


Source: APA(2013b)



### Major Depressive Disorder

Alternative Diagnosis	Differential Consideration
Bipolar Disorders	Current or previous Sx of mania or hypomania
Uncomplicated Bereavement	Depressive Sx better understood as expectable manifestation of normal grief
Substance-Induced Mood Disorder	Sx are caused by drug abuse or medications
Chronic Depressive Disorder (Dysthymic Disorder)	Depressive Sx milder and persist for years
Schizophrenia, Schizoaffective Disorder, or Delusional Disorder	Delusions & hallucinations occur during periods absent of mood Sx
Brief Psychotic Disorder	Sx occur without an episode of depression, resolve quickly, and sometimes arise in response to stress

Source: Francis (2013a)




### Persistent Depressive Disorder (Dysthymia)

- A. A depressed mood for most of the day, for more days than not...for at least 2 years (at least one year in children and can be irritable)
- B. Depression is accompanied by at least two:
  - A. Poor appetite or overeating, insomnia or hyperinsomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, feelings of hopelessness
- C. During the course of 2 years (1 year children), there has not been symptom relief of A and B for more than 2 months
- D. Major Depressive Disorder can be continuously present for 2 years. Etc....

- **Specifiers:** anxious distress, mixed features, melancholic features, atypical features, mood-congruent psychotic features, mood incongruent psychotic features, peripartum onset, seasonal pattern; partial or full remission, early or late onset...

Severity: mild, moderate, severe (DSM 5, p. 188)

APA (2013b)






## Persistent Depressive Disorder (Dysthymia)

Alternative Diagnosis	Differential Consideration
Normal Existential Sadness	Persistent sadness can be normal, especially in people who cope with chronic stress/disappointment
Bipolar Disorders	Have been manic or hypomanic episodes
Chronic Major Depressive Disorder	Sx are severe
Depressive Disorder Due to Another Medical Condition	Physiological aspects of an illness cause long-term depressive Sx
Substance-Induced Mood Disorder	Substance use is also chronic
Chronic Psychotic Disorders	Chronic depression is an associated feature, but not diagnosed separately

Source: Francis (2013a) 91

## Anxiety Disorders



- Separation Anxiety Disorders
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder (Social Phobia)
- Panic Disorder
- Agoraphobia
- Generalized Anxiety Disorder

Source: APA (2013b) 92

## Anxiety Disorders

- Definition
  - Include features of excessive fear and anxiety and related behavioral disturbances.
  - *Generalized Anxiety Disorder* has greater emphasis on “worry” (difficult to control, apprehensive expectation...) in addition to the anxiety
  - *Social Anxiety Disorder* – more emphasis on the fear of being negatively evaluated
    - Purposeful avoidance of social situations
    - Fear must occur also in peer settings
  - *Selective Mutism* – recognizes anxiety underlying fear of speaking in some situations
  - *Agoraphobia* - endorsement of fears from two or more agoraphobia situations is now required

Source: APA (2013b, p. 189) 93

## Anxiety Disorders

- Implications for School Psychologists
  - More clearly defines various anxiety disorders
  - Selective Mutism acknowledged
    - hopefully lead to better research and professional agreement
  - Not having to be able to recognize phobia is irrational allows us better identify given age groups we work with
  - May be an element of OHI and ED eligibility determinations

Source: Kravnak & Hart (2014) 94

## Anxiety Disorders (Agoraphobia)

Alternative Diagnosis	Differential Consideration
Social Anxiety Disorder (Social Phobia)	Only specific situations are avoided
Specific Phobia	Only a specific situation/object is avoided
PTSD or Acute Stress Disorder	Avoids reminders of the traumatic event
Separation Anxiety Disorder	Avoidance motivated by fear of separation from caregiver
OCD	Avoidance focused on things that trigger compulsive rituals
Major Depressive Disorder	Withdrawal caused by loss of interest, pleasure, & energy rather than fears
Psychotic Disorder	Fears motivating avoidance are delusional
Substance Dependence	Intoxication and lack of motivation make person housebound

Source: Francis (2013a) 95

## Anxiety Disorders (Social Anxiety Disorder)

Alternative Diagnosis	Differential Consideration
Normal Shyness	Fears is going to a party where don't know anyone
Agoraphobia	Avoidance generalized, not restricted to social situations
Specific Phobia	A specific object/nonsocial situation is avoided
PTSD or Acute Stress Disorder	Avoids reminders of the traumatic event
Separation Anxiety Disorder	Avoidance motivated by fear of caregiver separation
OCD	Avoidance focused compulsive rituals triggers
Autism Spectrum Disorder or Schizotypal, or Schizoid Personality Disorder	Lacks interest others
Avoidance Personality Disorder	Avoidance of social situations has early onset, long-standing, and a pervasive pattern of behavior
Major Depressive Disorder	Social withdrawal caused by loss of interest, pleasure, & energy
Psychotic Disorder	Fears motivating avoidance are delusional
Substance Dependence	Intoxication & lack of motivation cause social avoidance
Medical Illness	Avoids embarrassment of showing illness

Source: Francis (2013a) 96




### Anxiety Disorders (Generalized Anxiety Disorder)

Alternative Diagnosis	Differential Consideration
Realistic Worries	Require no diagnosis
Adjustment Disorder	Worries are exaggerated/impairing, but usually transient and related to a specific realistic stress
Panic Disorder	Worry is focused on having a panic attack
Social Anxiety Disorder	Worry is confined to embarrassment in social situations
OCD	Worry is about an obsession
Separation Anxiety Disorder	Worry is about separation from caregivers
Anorexia Nervosa	Worry is about gaining weight
Body Dysmorphic Disorder	Worry is about perceived defect in physical appearance
Somatic Symptom Disorder	Worried are focused on bodily symptoms
PTSD and Acute Distress	Worry is focused on reminders of a traumatic event
Major Depressive Disorder	Worry has a desperate theme
Psychotic Disorders	Worries that are not reality-tests become delusional
Substance-Induced Anxiety Disorder	Anxiety comes from substance intoxication or withdrawal

Source: Francis (2013a) 97

### Obsessive-Compulsive and Related Disorders



- Obsessive Compulsive Disorder
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania
- Excoriation Disorder (Skin-Picking)

Source: APA (2013b) 98

### Obsessive-Compulsive and Related Disorders

- Definition
  - OCD: Obsessions, Compulsions – has not changed from *DSM-IV*
    - Particular obsessions tend to be paired with particular compulsions
  - Body Dysphoric Disorder: disproportionate concerns about real or imagined flaw in way they look
  - Hoarding Disorder: persistent difficulty discarding or parting with possessions, regardless of value
  - Trichotillomania: pull out hair – sense of relief accompanied by anxiety – largely unchanged
  - Excoriation Disorder (Skin-Picking): skin picking results in lesions
  - Substance/Medication-Induced OCD

Source: APA (2013b) 99

### Obsessive-Compulsive and Related Disorders

- Implications for School Psychologists
  - Some symptoms can overlap with developmental disorders (e.g. Autism)
  - Treatment can be very complex and difficult for a school setting

Source: APA (2013b) 100

### Obsessive-Compulsive and Related Disorders

Alternative Diagnosis	Differential Consideration
Major Depressive Disorder	Depressive occupations
Body Dysmorphic Disorder	Intrusive thoughts of a body part that is horribly ugly
Generalized Anxiety Disorder	Excessive but realistic worries about everyday things
PTSD or Acute Stress Disorder	Repetitive memories of the terrible event
Anorexia Nervosa	Preoccupations with being fat
Delusional Disorder	Obsessions that have turned into delusions (i.e. I will die because of the contamination)
Schizotypal Personality Disorder	Odd, eccentric thoughts, but not experienced as externally driven and intrusive
Somatic Symptom Disorder	Intrusive worries about having a serious illness

Source: Francis (2013a) 101

### Trauma- and Stressor-Related Disorders




- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorders

Source: APA (2013b) 102

### Reactive Attachment Disorder

- Definition
  - Pattern of inhibited, emotionally withdrawn behavior
  - Persistent social and emotional disturbance
  - Patterns of extreme insufficient care
  - Lack of care is presumed to be responsible for emotionally withdrawn behavior
  - Evident before age 5
  - Has developmental age of at least nine months
  - Specifier: Persistent= present more than 12 months  
Severe = high levels of all symptoms


Source: APA (2013b)



### Reactive Attachment Disorder

- Implications for School Psychologists
  - Developmental history is critical
  - Use caution if diagnosis is made after the age of 5
  - Can see functional impairment in all areas of schools


Source: Leveille (2014)



### Disinhibited Social Engagement Disorder

- Definition
  - A pattern of behavior wherein a child actively approaches and interacts with unfamiliar adults (2 of following)
    - Reduced/absent reticence in approach
    - Overly familiar behavior
    - Diminished/absent checking back in with caregiver
    - Willingness to with unfamiliar adult with little/no hesitation
  - Patterns of extremes of insufficient care
  - Present for more than 12 months


Sources: APA (2013b), Leveille (2014)



### Disinhibited Social Engagement Disorder

- Implications for School Psychologists
  - Preschool:
    - Attention seeking behaviors due to indiscriminant social behaviors
  - Middle Childhood:
    - Verbal and physical overfamiliarity; inauthentic expression of emotions (especially with adults)
  - Adolescents:
    - Indiscriminate behavior and conflicts
  - Neglect begins before age 2 – dev hx is critical!


Source: Leveille (2014)



### Posttraumatic Stress Disorder

- Definition
  - Exposure
    - Indirect exposure is limited to close relatives, friends, or violent or accidental death (exposure via social networking or death by natural cause does not count)
  - Intrusion symptoms
  - Avoidance of stimuli
  - Negative alterations in cognitions and mood
  - Marked alterations in arousal and reactivity
  - Duration longer than a month
  - Clinical distress
  - Specifier: with dissociative symptoms
    - Depersonalization
    - Derealization


Source: APA (2013b)



### Posttraumatic Stress Disorder

- Implications for School Psychologists
  - Still no clear definition of a traumatic event
  - Still using adult criteria for elementary and secondary age students
  - Really should be reserved for those with traumatic memories and avoidance many months after
  - Can provide validation for reactions to adversity/traumatic event
  - Has led to school-based interventions that help minimize PTSD symptomology (e.g., CBITs)
  - For preschoolers has allowed for more age and developmentally sensitive diagnostic criteria
  - Need to be well-informed of proven therapies to help if a referral is needed

Source: Paris (2013)



### Posttraumatic Stress Disorder

Alternative Diagnosis	Differential Consideration
PTSD Sx w/out PTSD	Typical PTSD Sx are present, but not at a level to cause clinically significant distress/impairment
Acute Stress Disorder	Sx confined to the first month after trauma exposure
Adjustment Disorder	Reaction to stress. but symptomatic reaction is subthreshold
Other causes of flashbacks	Perceptual distortions come from substance use, head injury, Bipolar or Depressive Disorder, or Psychotic Disorder
Malingering	When stressor is marginal and/or there is financial or other gain from having diagnosis of PTSD

Source: Francis (2013a) 109

### Acute Stress Disorder

**Definition**

- Exposure
  - Indirect exposure is limited to close relatives, friends, or violent or accidental death (exposure via social networking, media, or death by natural cause does not count unless part of your job)
- Intrusion symptoms
- Negative Mood
- Dissociative Symptoms
- Avoidance symptoms
- Arousal symptoms
- Duration: 3 days to one month
- Clinical distress

Source: APA (2013b) 110

### Acute Stress Disorder

- Implications for School Psychologists
  - Understand the difference between ASD and PTSD
  - Need to be well-informed of proven therapies to help if a referral is needed
  - Does ASD develop into PTSD?


Source: APA (2013b) 111

### Adjustment Disorders

- Definition
  - Response to an identifiable stressor occurring within 3 months of onset
  - Marked distress out of proportion
  - Significant impairment
  - Specifiers- with:
    - Depressed mood
    - Anxiety
    - Mixed anxiety and depressed
    - Disturbance of conduct
    - Mixed disturbance of emotions and conduct
    - Unspecified

Source: APA (2013b) 112


### Dissociative Disorders



- Dissociative Identity Disorder
- Dissociative Amnesia
- Depersonalization-Derealization Disorder

Source: APA (2013b) 113

### Somatic Symptom and Related Disorders




- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Conversion Disorder
- Factitious Disorder

Source: APA (2013b)  
NOTE: Dx should be made with caution in individuals whose cultural beliefs sanction such thinking

Source: APA (2013b) 114


### Feeding and Eating Disorders



- Pica\*
- Rumination Disorder\*
- Avoidant/Restrictive Food Intake Disorder\*
- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder\*

Source: APA (2013b) NOTE: \* = New to this classification


### Elimination Disorders



- Enuresis
- Encopresis

Source: APA (2013b) NOTE: No significant changes made

### Sleep-Wake Disorders




- Insomnia Disorder
- Hypersomnolence Disorder
- Narcolepsy
- Breathing-Related Sleep Disorders
- Circadian Rhythm Sleep-Wake Disorders
- Parasomnias

Source: APA (2013b)

### Sexual Dysfunctions

Overview not necessarily needed for school-age population

### Gender Disorder Dysphoria



- Gender Dysphoria
- in Children
- in Adolescents and Adults

Sources: APA (2013b), Dickey, Fedewa, Hirsch (2014)

### Disruptive, Impulse-Control, and Conduct Disorders



- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Antisocial Personality Disorder
- Pyromania
- Kleptomania

Source: APA (2013b)

## Oppositional Defiant Disorder

**Definition**

- A persistent pattern of angry and irritable mood along with defiant and vindictive behavior as evidenced by four (or more) of the following symptoms

**Angry/Irritable Mood**

- Loses temper
- Is touchy or easily annoyed by others.
- Is angry and resentful


**Defiant/Headstrong Behavior**

- Argues with adults
- Actively defies or refuses to comply with adults' request or rules
- Deliberately annoys people
- Blames others for his or her mistakes or misbehavior

**Vindictiveness**

- Has been spiteful or vindictive at least twice within the past six months


Sources: APA (2013b), Twyford (in press)



## Oppositional Defiant Disorder

- Implications for School Psychology**
  - Possible that a student whose learning is adversely impacted and has ODD symptoms would qualify for special education eligibility criteria under the Emotional Disturbance (ED) category.
  - Additions of frequency guidelines, specifiers, and three facets of symptoms will aid IEP teams to determine special education ED eligibility
  - Organizing ODD symptoms by different facets will assist school psychologists and researchers to clearly identify the appropriate prognosis and probabilities for co-morbid conditions, such as internalizing problems (e.g., depression, anxiety), attention-deficit/hyperactivity disorder (ADHD), substance abuse, and CD.


Source: Twyford (in press)



## Oppositional Defiant Disorder

Alternative Diagnosis	Differential Consideration
Developmentally normal willfulness	Part of growing up is establishing independence and separate identity
Parent-Child Relational Problem	Not considered a mental disorder
Adjustment Disorder	Defiance is in reaction to a life stressor (e.g. divorce, birth of sibling)
Conduct Disorder	Misbehavior is more severe and pervasive
ADHD	Also has hyperactivity, impulsivity, and/or inattentiveness
Bipolar or Depressive	Irritability arises from clear depressive or manic symptoms
Separation Anxiety Disorder	Opposition is focused on resisting separations


Source: Francis (2013a)



## Intermittent Explosive Disorder

Alternative Diagnosis	Differential Consideration
Another mental condition	Intermittent Explosive Disorder is only a residual category; it is not meant to be used if the aggressive behavior is an associated feature of any other mental disorder diagnosis
A Neurological Disorder	Refer the patient for evaluation and testing
Simple Criminal Behavior	Unrelated to medical or psychiatric disorder
Purposeful Aggression	Person is motivated by revenge or honor killing
Normal anger of everyday life	Outbursts do not cause clinically significant distress or impairment
Malingering	Person is trying to avoid facing the consequences of his/her actions


Source: Francis (2013a)



## Conduct Disorder

**Definition**


- Repetitive and persistent pattern in which basic rights of others or age-appropriate societal norms or rules are violated
- Need 3 of 15 criteria in past 12 months, with at least one in past 6 months
- 4 areas:
  - Aggression to people and animals
  - Destruction or property
  - Deceitfulness or theft
  - Serious violation of rules
- Childhood, Adolescent, or unspecified onset
- Severity: Mild, Moderate or Severe
- Specifier: with limited prosocial emotions
  - lack of remorse or guilt; callous – lack of empathy; unconcerned about performance, shallow or deficient effect



## Conduct Disorder

**Implications for School Psychologists**

- Clearer criteria
- Time frames allow for better consistency with diagnosis
- Specifiers and severity ratings better reflect behavior on a continuum
- Better reflects underlying emotional issues
- Hopefully will lead to better research and treatment options




### Conduct Disorder

Alternative Diagnosis	Differential Consideration
No mental disorder	Misbehaviors are not severe & don't cause clinically significant impairment
Adjustment Disorder	Bad conduct doesn't exceed environmental cultural norms or he/she is responding to chaotic/abusive situation
Oppositional Defiant Disorder	Has pattern of defiance to authority, but without severe/pervasive lack of respect for law and others rights
Substance Use Disorders	Misbehaviors occur only in relation to Intoxication/Dependence
ADHD	Causes behavioral scrapes, but not the same magnitude/pervasiveness
Bipolar or Depressive	Misbehavior occurs in the context of clear depressive/manic symptoms
Child or Adolescent Antisocial Behavior	One isolated act of misbehavior, however severe, does not constitute a mental disorder

Source: Francis (2013a) 127


### Substance-Related and Addictive Disorders



- Substance Related Disorders
  - Alcohol-Related Disorders
  - Caffeine-Related Disorders
  - Cannabis-Related Disorders
  - Hallucinogen-Related Disorders
  - Inhalant-Related Disorders
  - Opioid-Related Disorders
  - Sedative-, Hypnotic-, Anxiolytic- Related Disorders
  - Stimulant-Related Disorders
  - Tobacco-Related Disorders
  - Other (or Unknown) Substance-Related Disorders
- Non-Substance-Related Disorders
  - Gambling Disorder

Source: APA (2013b) 128


### Neurocognitive Disorders



- Overview not necessarily needed for school-age population
- Controversy around Mild Neurocognitive Disorder
  - Over dx of dementia like sx
  - May be normal aging
  - Pathologizing typical decline
  - No treatment for this
  - May cause mislabeling and panic

Source: APA (2013b) 129

### Personality Disorders



- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder

Source: APA (2013b) 130

### Paraphilic Disorders

Overview not necessarily needed for school-age population

Source: APA (2013b) 131

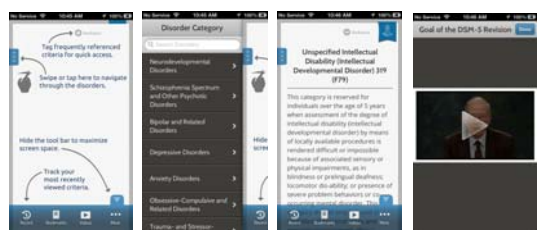
### Other Conditions That May Be a Focus of Clinical Attention

- Not mental disorders, just to draw attention to other factors that may be involved
  - Problems Related to Family Upbringing
  - Other Problems Related to Primary Support Group
  - Child Maltreatment and Neglect Problems
  - Child Sexual Abuse
  - Child Neglect
  - Child Psychological Abuse
  - Educational Problems
  - Housing Problems
  - Economic Problems

Source: APA (2013b) 132



### DSM-5 Mobile (APA, 2013)



<http://www.appi.org/Pages/DSM5Mobile.aspx>

### References

American Psychiatric Association. (1952). *Diagnostic and statistical manual: Mental Disorders*. Washington, DC: Author. Retrieved from <http://www.turkpsikiyatri.org/arsiv/dsm-1952.pdf>

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2<sup>nd</sup> ed., DSM-II). Washington, DC: Author. Retrieved from <http://www.scribd.com/doc/14532307/dsmii>

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3<sup>rd</sup> ed., DSM-III). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3<sup>rd</sup> ed., Rev., DSM-III-R). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed., DSM-IV). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed., Text Rev., DSM-IV-TR). Washington, DC: Author.

American Psychiatric Association. (2012). *DSM-5 overview: The future manual*. Retrieved from <http://www.dsm5.org/ABOUT/Pages/DSM5Overview.aspx>

American Psychiatric Association. (2013a). *Autism spectrum disorder*. Retrieved from <http://www.dsm5.org/Documents/Autism%20spectrum%20disorder%20Fact%20Sheet.pdf>

American Psychiatric Association. (2013b). *Diagnostic and statistical manual of mental disorders* (5<sup>th</sup> ed., DSM-5). Washington, DC: Author.

### References

American Psychiatric Association. (2013c) *Conduct disorder*. Retrieved from <http://www.dsm5.org/Documents/Conduct%20Disorder%20Fact%20Sheet.pdf>

American Psychiatric Association. (2013d) *Obsessive compulsive disorder*. Retrieved from <http://www.dsm5.org/Documents/Schizophrenia%20Disorders%20Fact%20Sheet.pdf>

American Psychiatric Association. (2013e). Schizophrenia. Retrieved from <http://www.dsm5.org/Documents/Schizophrenia%20Fact%20Sheet.pdf>

Brock, S. E., & Hart, S. R. (2013, September). DSM-5 and school psychology: Controversy surrounds release of DSM-5. *Communique: Newspaper of the National Association of School Psychologists*, 42(1), 1, 30-31. Retrieved from <http://www.nasponline.org/publications/ca/index-list.aspx>

Brock, S. E., & Hart, S. R. (2013a, October). 5 and school psychology: Changes to ASD diagnosis. *Communique: Newspaper of the National Association of School Psychologists*, 42(2), 1, 34-35. Retrieved from <http://www.nasponline.org/publications/ca/index-list.aspx>

Brock, S. E., & Hart, S. R. (2013b, September). Diagnostic inflation. *Communique: Newspaper of the National Association of School Psychologists*, 42(2), 1, 35. Retrieved from <http://www.nasponline.org/publications/ca/index-list.aspx>

Committee on Statistics of the American Medico-Psychological & Bureau of Statistics, National Committee for Mental Hygiene. (1918). *Statistical manual for the use of institutions for the insane*. New York, NY: Author. Retrieved from <http://archive.org/stream/statisticalmnu00assogooq/page/n10/mode/2up>

### References

Dickey, L. M., Fedewa, A., & Hirsch, A. (2014, May). DSM-5 and school Psychology. *Diagnostic changes: Gender dysphoria. Communique: Newspaper of the National Association of School Psychologists*, 42(7), 1, 16. Retrieved from <http://www.nasponline.org/publications/ca/index-list.aspx>

Douglas, M., & Yates, M. (1981, October) New York State census records, 1790-1925: Bibliography Bulletin 88. Albany, NY: The University of the State of New York, The State Education Department. Retrieved from <http://128.121.13.244/awweb/main.jsp?lag=browse&smid=1&awwid=1>

Francis, A. (2013a). *Essentials of psychiatric diagnosis: Responding to the challenge of DSM-5*. New York, NY: Guilford Press.

Francis, A. (2013b). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, Big Pharma, and the medicalization of ordinary life*. New York, NY: HarperCollins.

Francis, A. (2013, May 17). The new crisis in confidence in psychiatric diagnosis. *Annals of Internal Medicine* Advance online publication. doi:10.7326/0003-4819-159-3-201308060-00655

Gibbons, E. (2013, November). DSM-5 and school psychology: Changes to DSM-5 ADHD diagnosis. *Communique: Newspaper of the National Association of School Psychologists*, 42(3), 1, 30-31. Retrieved from <http://www.nasponline.org/publications/ca/index-list.aspx>

Greenberg, G. (2010, December 27). Inside the battle to define mental illness. *Wired Magazine*. Retrieved from [http://www.wired.com/magazine/2010/12/ff\\_dsmiv/](http://www.wired.com/magazine/2010/12/ff_dsmiv/)

Gibbons, E., & Hart, S. R. (in preparation). DSM-5 and school psychology: Disruptive mood dysregulation disorder. *Communique: Newspaper of the National Association of School Psychologists*.

### References

Gubi, A. A., McDonnell, C., & Bocanegra, J. O. (2014, December). DSM-5 and school Psychology: Changes to DSM-5 Schizophrenia diagnosis. *Communique: Newspaper of the National Association of School Psychologists*, 43(4), 1, 23. Retrieved from <http://www.nasponline.org/publications/ca/index-list.aspx>

Hart, S. R. (2014, September). DSM-5 and school Psychology: Disruptive mood dysregulation disorder. *Communique: Newspaper of the National Association of School Psychologists*, 43(1), 1, 20-22. Retrieved from <http://www.nasponline.org/publications/ca/index-list.aspx>

Hart, S. R., Pate, C. M., & Brock, S. E. (Ed.). (2013, January/February). Meet the new (and improved?) DSM-5. *Communique: Newspaper of the National Association of School Psychologists*, 41(5), 1, 15. Retrieved from <http://www.nasponline.org/publications/ca/index-list.aspx>

Kraynak, A. R., & Hart, S. R. (2014, March/April). DSM-5 and school Psychology: Changes to intellectual disability diagnosis. *Communique: Newspaper of the National Association of School Psychologists*, 42(6), 12-13. Retrieved from <http://www.nasponline.org/publications/ca/index-list.aspx>

Kulage, K. M., Smaldone, A. M., & Cohn, E. G. (2014). How will DSM-5 affect autism diagnosis? A systematic literature review and meta-analysis. *Journal Of Autism And Developmental Disorders*, 44(8), 1918-1932. doi:10.1007/s10803-014-2065-2

Leveille, M., A. R. (2014, June). DSM-5 and school Psychology: Reactive attachment disorder and disinhibited social engagement disorder. *Communique: Newspaper of the National Association of School Psychologists*, 42(8), 1, 21, 23. Retrieved from <http://www.nasponline.org/publications/ca/index-list.aspx>

### References

Morera, C. C. (2014, January/February). DSM-5 and school Psychology: Changes to DSM-5 anxiety disorder diagnosis. *Communique: Newspaper of the National Association of School Psychologists*, 42(5), 1, 14-15. Retrieved from <http://www.nasponline.org/publications/ca/index-list.aspx>

National Conference on Nomenclature of Disease, & Logie, H. B. (1938). *Standard classified nomenclature of disease*. Chicago, IL: American Medical Association. Retrieved from <http://babel.hathitrust.org/cgi/pt?id=uc1.b3958532;view=tup;seq=7>

Paris, J. (2013). *The intelligent clinician's guide to the DSM-5*. New York, NY: Oxford University Press.

Tsai, L. Y. (2014). Impact of DSM-5 on epidemiology of autism spectrum disorder. *Research In Autism Spectrum Disorders*, 8(11), 1454-1470. doi:10.1016/j.rasd.2014.07.016

Twyford, J. M. (in press). DSM-5 and school Psychology: Oppositional defiant disorder. *Communique: Newspaper of the National Association of School Psychologists*.

Wines, F. H. (1888). *Report on the defective, dependent, and delinquent classes of the population of the United States, as returned at the tenth census (June 1, 1880)*. Washington, DC: Government Printing Office. Retrieved from [http://www2.census.gov/prod2/decennial/documents/1880a\\_v21-01.pdf](http://www2.census.gov/prod2/decennial/documents/1880a_v21-01.pdf)