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

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.

Caution

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

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

Source: Hart, Pate, & Brock (2013)
The Classification of Mental Illness in the United States

<table>
<thead>
<tr>
<th>Source</th>
<th>Sets of Criteria</th>
<th>Document Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>1840 US Census</td>
<td>2</td>
<td>2 sentences</td>
</tr>
<tr>
<td>1888 US Census</td>
<td>7</td>
<td>4 sentences</td>
</tr>
</tbody>
</table>

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


The Classification of Mental Illness in the United States

<table>
<thead>
<tr>
<th>Source</th>
<th>Sets of Criteria</th>
<th>Document Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>1918 APA</td>
<td>63</td>
<td>40 pages</td>
</tr>
<tr>
<td>1938 AMA</td>
<td>98</td>
<td>7 pages</td>
</tr>
</tbody>
</table>

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

The Classification of Mental Illness in the United States

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1952 DSM</td>
<td>117</td>
<td>144 pages</td>
</tr>
<tr>
<td>1968 DSM-II</td>
<td>156</td>
<td>135 pages</td>
</tr>
<tr>
<td>1980 DSM-III</td>
<td>210</td>
<td>505 pages</td>
</tr>
<tr>
<td>1987 DSM-III-R</td>
<td>235</td>
<td>582 pages</td>
</tr>
<tr>
<td>1994 DSM-IV</td>
<td>322</td>
<td>914 pages</td>
</tr>
<tr>
<td>2000 DSM-IV-TR</td>
<td>324</td>
<td>980 pages</td>
</tr>
</tbody>
</table>

- 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

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<tr>
<td>2013 DSM-5</td>
<td>392</td>
<td>1009 pages</td>
</tr>
</tbody>
</table>

- 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 (2013a, October)

The Classification of Mental Illness in the United States

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- 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 PDs 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)
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
  - 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 was been given much attention by the popular press
  - Referred to 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

- 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

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.”

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-II; APA, 1980) to sign an open letter to Psychiatric News (the APA version of the Communiqué) complaining about DSM-5 task force secrecy
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

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

An interpretation of DSM-5’s conceptualization of mental illness

Genetic Vulnerability Interacts w/ Environmental Stress

Cause

Genetics

Cause/Effect

Biology

Psychology/Behavior

Environment

Effect

Cause

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.”

Neurodevelopmental Disorders

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

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
### 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).
- PI 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

### 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

### Alternative Diagnosis

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

### Intellectual Disabilities: DSM-5 v IDEA

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

### Social (Pragmatic) Communication Disorder

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

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

- **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 (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 criterions 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

• 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); Trie (2014)

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
    4. Associated with another neurodevelopmental, mental, or
    5. Associated with “catatonia”

Source: APA (2013b, p. 54); Brock & Hart (2013a, October)

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

Source: Brock & Hart (2013a, October)

Attention-Deficit/Hyperactivity Disorder

• Definition
  – A neurodevelopmental disorder that begins in
  – 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 neurological 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

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

Attention-Deficit/Hyperactivity Disorder

Changes from DSM-IV-TR (continued)
- 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

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

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

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.
Attention-Deficit/Hyperactivity Disorder

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

Source: Franch (2012a)

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

Source: APA (2013b); Lockwood (2015)
### Specific Learning Disorder

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

### Specific Learning Disorder: 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:

1. When standardized tests are considered to be valid for a specific pupil, the discrepancy shall be measured by alternative means as specified on the assessment plan.
2. 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.
3. 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

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

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

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.
   viii. Mathematics problem solving, 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

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

- 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 disorganized/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)

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

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

Source: Frances (2013a)

Bipolar II

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

Source: Frances (2013b)

Cyclothymic Disorder

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

Source: Frances (2013a)

Depressive Disorders

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

Source: APA (2013b)

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.

Source: APA (2013b), Hart (2014)
### Major Depressive Disorder

**Definition**

- 5 of 9 criteria (one must be #3 or #4)
  1. Depressed mood most of the day, nearly everyday (children: irritable)
  2. Diminished interest or pleasure in almost all activities
  3. Significant weight loss or gain or decreased/ increased appetite (children: failure to gain weight)
  4. Insomnia or hypersomnia
  5. Psychomotor retardation or agitation
  6. Fatigue, loss of energy
  7. Feelings of worthlessness or excessive 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

- Specifications: Anxious distress, mixed features, melancholic features, atypical features, mood-congruent psychotic features, mood-incongruent psychotic features, catatonia, peripartum onset, seasonal pattern

### Alternative Diagnoses

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

Source: American Psychiatric Association (2013b)

### 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:
  - Poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, feelings of hopelessness
- C. During the 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...
  - Specifications: 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)

Source: American Psychiatric Association (2013b)
### 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

### Anxiety Disorders (Agoraphobia)

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

### Anxiety Disorders (Social Anxiety Disorder)

<table>
<thead>
<tr>
<th>Alternative Diagnosis</th>
<th>Differential Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal Shyness</td>
<td>Fears is going to a party where don't know anyone</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>Avoidance generalized, not restricted to social situations</td>
</tr>
<tr>
<td>Specific Phobia</td>
<td>A specific object/non-social situation is avoided</td>
</tr>
<tr>
<td>PTSD or Acute Stress Disorder</td>
<td>Avoids reminders of the traumatic event</td>
</tr>
<tr>
<td>Separation Anxiety Disorder</td>
<td>Avoidance motivated by fear of caregiver separation</td>
</tr>
<tr>
<td>OCD</td>
<td>Avoidance focused compulsive rituals triggers</td>
</tr>
<tr>
<td>Autism Spectrum Disorder or</td>
<td>Lacks interest others</td>
</tr>
<tr>
<td>Schizophrenia, or School</td>
<td></td>
</tr>
<tr>
<td>Personality Disorder</td>
<td></td>
</tr>
<tr>
<td>Avoidance Personality Disorder</td>
<td></td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>Social withdrawal caused by loss of interest, pleasure, &amp; energy</td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td>Fears motivating avoidance are delusional</td>
</tr>
<tr>
<td>Substance Dependence</td>
<td>Intoxication &amp; lack of motivation cause social avoidance</td>
</tr>
<tr>
<td>Medical Illness</td>
<td>Avoids embarrassment of showing illness</td>
</tr>
</tbody>
</table>

### Anxiety Disorders

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

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**Source:**
- Anxiety Disorders: APA (2013b), p. 189
- Anxiety Disorders (Agoraphobia): Francis (2013a)
- Anxiety Disorders (Social Anxiety Disorder): Francis (2013a)

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**Source:**
- Anxiety Disorders: APA (2013b)
- Anxiety Disorders (Agoraphobia): Francis (2013a)
- Anxiety Disorders (Social Anxiety Disorder): Francis (2013a)
Anxiety Disorders (Generalized Anxiety Disorder)

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

Source: APA (2013a)

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/Medications-Induced OCD

Source: APA (2013b)

Trauma- and Stressor-Related Disorders

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

Source: APA (2013b)
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)

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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 to with unfamiliar adult with little/no hesitation
  - Patterns of extremes of insufficient care
  - Present for more than 12 months

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

---

Posttraumatic Stress Disorder

- **Definition**
  - Exposure
    - 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)

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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)

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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)

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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., CBT/TS)
  - 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: Frances (2013a)

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)

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)

Dissociative Disorders

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

Source: APA (2013b)

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.
### 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
- Hypersomnia 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


### 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
1. Loses temper
2. Is touchy or easily annoyed by others.
3. Is angry and resentful

Defiant/Headstrong Behavior
4. Argues with adults
5. Actively defies or refuses to comply with adults’ request or rules
6. Deliberately annoys people
7. Blames others for his or her mistakes or misbehavior

Vindictiveness
8. 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

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

Source: Francis (2013a)

Intermittent Explosive Disorder

<table>
<thead>
<tr>
<th>Alternative Diagnosis</th>
<th>Differential Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Another mental condition</td>
<td>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</td>
</tr>
<tr>
<td>A Neurological Disorder</td>
<td>Refer the patient for evaluation and testing</td>
</tr>
<tr>
<td>Simple Criminal Behavior</td>
<td>Unrelated to medical or psychiatric disorder</td>
</tr>
<tr>
<td>Purposeful Aggression</td>
<td>Person is motivated by revenge or honor killing</td>
</tr>
<tr>
<td>Normal anger of everyday life</td>
<td>Outbursts do not cause clinically significant distress or impairment</td>
</tr>
<tr>
<td>Malingering</td>
<td>Person is trying to avoid facing the consequences of his/her actions</td>
</tr>
</tbody>
</table>

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 or 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

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

Source: Francis (2013a)
Conduct Disorder

Alternative Diagnosis
- 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

Substance-Related and Addictive Disorders

- Substance Related Disorders
- Alcohol-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

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

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

Paraphilic Disorders

Overview not necessarily needed for school-age population

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