

Diagnosis and Treatment Planning for Psychological and Emotional Disorders In Children and Adolescents

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Diagnosing Children and Adolescents

To diagnose or not to diagnose, that is the question?

Diagnosing psychopathology and emotional difficulties in children and adolescents has traditionally been controversial with some taking the position that it is inappropriate to pathologize what most often is immaturity, developmental lags, or differences in cultural or child rearing practices. Part of the difficulty is that behavior at one age may be very normal and acceptable, while the same behaviors at an earlier or later stage of development is clearly “abnormal.” The level and the pace of developmental changes that take place in children and adolescents make it difficult to determine if the behavior is “just a phase” or is indicative of an underlying psychological condition or disorder that requires treatment.

What is normal and what is abnormal?

One inherent problem is in defining what abnormal behavior in children and adolescents is. There are a variety of ways that behavior can be viewed and analyzed to determine its “abnormality.” Behaviors can be viewed from a statistical perspective as a part of the “normal curve,” with behaviors at either extreme being viewed as abnormal by the infrequency and rarity that they occur. On the continuum of the capacity to manage physical pain, both self-mutilation and passing out with a simple immunization reflect abnormal behavior at either end of the normal curve. These behaviors are statistically so rare that they must be considered “abnormal” and may be reflective of some underlying pathology that requires a diagnosis and treatment.

Another perspective from which one can consider “abnormality” is from a functional perspective. Does the behavior that the child is engaging in, no matter how bizarre and rare, actually allow them to function in an environment that is dysfunctional or out of control. Behaviors, no matter how “abnormal,” that allow the child to function at a high degree may be considered normal. Conversely normal behaviors that are exercised compulsively or are not appropriate to the environment or context may be “abnormal” because they do not allow the child to function effectively. Yelling and screaming uncontrollably in a child would most typically be viewed as abnormal; however, if a child is being threatened or attacked the same yelling and screaming may be seen as normal and appropriate. A seven year old who is lecturing people about quantum physics or the reason why dinosaurs became extinct may endear himself to adults and scholars, but that behavior will probably not allow him to function well on a school playground with other seven year olds and be considered quite “abnormal.”

An additional method for identifying “abnormal behavior” is to view the behavior in the context of and to its degree of compliance with group and societal norms. Norm violations, in either the form of breaking laws, violating manners and customs, or an inability to conform behavior to the stated expectations of others, are very often considered to be “abnormal.” A second grader who can’t follow the rules of the school and stay seated may be compulsively violating the norms, disregarding any consequences of his behavior to the point that his behavior will be considered “abnormal.” Some behaviors and norms are so well accepted, like not playing with one’s own feces or not soiling ones

clothes, that a child who chooses to not conform is displaying abnormal behavior and is reflecting some underlying pathology through his violation of the norm.

Some behaviors displayed by children may violate multiple standards and criteria of “abnormality.” A twelve year old who continues to soil himself would be considered abnormal statistically, functionally and as a violation of societal norms. Whatever standard or method might be applied, there is the recognition that some behaviors in children are clearly “abnormal” and may be indicative of underlying psychopathology or serious emotional difficulties. This identification of abnormality allows us to recognize and diagnose disordered behavior in children and to develop effective treatment plans for the abnormal behavior and any underlying pathology.

Advantages of Diagnosing

Developing a diagnosis, or defining the abnormality that is occurring, allows professionals and the general public to be able to communicate about the nature of the problem. Without the ability to diagnose and classify behaviors according to the type, level, and severity of the behavior or abnormality that is occurring, professionals across disciplines would not be able to effectively communicate with each other. If physicians had one way of describing abnormal behavior, nurses another, psychologist another, social workers another, and psychiatrists another, it is very doubtful that any effective treatment or intervention could take place. The *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition – Text Revision* provides a consistent vocabulary, description, and classification that cross all disciplines. It is the common language of behavioral, emotional, and mental disorders.

This commonality allows for the development of treatment approaches that are specific to certain types of disorders. This is the key to effectiveness based treatment that is based on demonstrable results of treatment approaches with specific diagnoses. Without the ability to classify and describe disorders common to children and adolescents, effective diagnostic based treatment could not be undertaken. Insuring that members of research studies are a homogenous group is essential to any meaningful research and to the advancement of specific treatment approaches that increase the likelihood of a positive treatment outcome.

In addition, there are some simple advantages to being able to simply name a phenomena or disorder. Many times in my practice, I have struggled with or been hesitant to “lay” a diagnosis on a child because of the implications that the diagnosis carries. There have been sessions where I dreaded having to tell parents that their child appears to be autistic, substance dependent, or suffering from post-traumatic stress. To my surprise, I have almost seen relief in parents’ eyes and heard statements like, “finally someone has put a name to what is wrong with my child.” At least, the diagnosis allows the some certainty and allows them to access information, ideas, and strategies that may be of benefit for their child.

Disadvantages of Diagnosing

Conversely, there are numerous disadvantages and legitimate reasons not to diagnose children. One of the most widely known arguments for not diagnosing is labeling theory. Labeling theory asserts

that in humans, once an individual has been labeled or categorized, they frequently begin to change their behavior to assume the label that is either self-imposed or externally imposed. I once had a child come into my office and announce “don’t expect me to sit still, I’m ADHD.” The mere fact of having a label or diagnosis often results in children being consciously or unconsciously responded to in a different fashion by parents, teachers, or other children. In many situations, we begin to attend to or selectively choose to notice behaviors that fit the “label” and overlook or ignore behaviors that do not fit with the categorization of the child.

Another legitimate drawback to diagnosing children is the limited number or paucity of diagnostic categories specific to children. While theoretically all diagnostic categories with a few exceptions can be used with children, the reality is that children and adolescents are qualitatively physically, intellectually, and emotionally different than adults. Many of the adult categories have typical age of onset in early or even late adulthood. There is only one chapter of the DSM-IV-TR that is devoted exclusively to disorders of childhood and adolescence and it contains only 36 or less than 10 percent of all DSM diagnostic categories. As a result of the scarcity of childhood specific categories, the clinician is often obliged to force a child into a category or use a “catch-all” or “garbage” diagnosis that really doesn’t adequately describe the phenomena or assist in treatment planning.

The fact that we are dealing with children or adolescents who are “works in progress” also complicates the diagnostic process. The major developmental shifts that occur may mean that while, at a particular time in her life, a child might meet diagnostic criteria, in several months her behavior may have changed radically as a result of normal maturation or advanced or slowed development. The child who is diagnosed as a conduct disordered child at 14 may have become a model citizen by the time he is 16 and has a job, a car, and a great deal of autonomy. One real danger is using diagnoses to explain situational variables. The same behavior that could be characterized as Oppositional Defiant Disorder may just as likely be the result of child abuse, poor parenting practices, or growing up in a substance abusing family.

Historical Background of the Diagnostic and Statistical Manual -IV

The first recorded attempt in the United States of a classification or categorization of individuals with mental disorders or emotional difficulties was in the 1840 Census. The Census had one category - idiocy/insanity. By 1880, the Census had expanded its classification to seven categories - mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy. The first real breakthrough in the classification and diagnosis of mental disorders occurred after World War II when the Veterans Administration was faced with the task of providing care to a huge number of veterans suffering from mental or emotional disorders. The VA nomenclature included 10 psychoses, 9 neuroses, and 7 disorders of character, behavior, and intelligence (the forerunner to Axis II and Personality Disorders).

Shortly after the VA established their system and nomenclature, the American Psychiatric Association published *Diagnostic and Statistical Manual: Mental Disorders (DSM-I)* in 1952 reflecting a psychobiological view and included the term *reaction*. The *DSM-II* was published in 1968 and was very similar to *DSM-I*, but eliminated the concept of *reaction*. The DSM I and II were psychoanalytic in theory and not particularly reflective of the emerging theories of the 60’s and 70’s in behavioral science.

Work began in 1974 that resulted in the publication of *DSM-III* in 1980. Major advances included the use of explicit diagnostic criteria, a multi-axial system, and a descriptive approach that was neutral to theories or etiology (eliminated terminology of neurosis and psychosis). As with any major paradigm shift, there was extreme controversy and criticism of the document almost immediately upon its publication. Inconsistencies and unclear criteria resulted in a revision of *DSM-III* the (*DSM-III-R*) being published in 1987. The *DSM-IV* was published in 1994 and expanded the diagnostic categories to 340 conditions, 120 more than contained in *DSM-III-R*. *DSM-IV-TR* published in 2001 made no changes to the number of diagnostic categories or the criteria for diagnosis, but provided updates on current research in each classification. Work on the *DSM-V* is in the committee process and publication is targeted for 2011.

Differences Between the DSM-III-R and the DSM-IV(DSM-IV-TR)

A number of significant changes related to the diagnosis and classification of children and adolescents occurred with the move to the *DSM-IV*. A number of the changes were of a more technical nature such as learning disorders being coded on Axis I rather than Axis II and Axis IV allowing for a listing of psychosocial and environmental problems rather than a numerical rating of the severity of those issues. In addition some older diagnoses were given newer more descriptive names such as Developmental Reading, Writing and Arithmetic disorders renamed as Reading, Writing, and Arithmetic Learning Disorders and Undifferentiated Attention Deficit being renamed Attention Deficit/Hyperactivity Disorder, Predominantly Inattentive Type. Bipolar Disorder was broken down into Bipolar I and Bipolar II. Simple Phobias became Specific Phobias, while the Overanxious Disorder of Childhood became Generalized Anxiety Disorder. In addition, several new classifications specific to children and adolescents were added i.e., Rett's Disorder, Asperger's Disorder, and Childhood Disintegrative Disorder.

DSM-IV Assumptions

It was the intention of the authors of the *DSM* to develop an atheoretical approach to classification and diagnosis, that is not based on particular theory of pathology, but that symptom clusters and measurable criteria for diagnosis apply to a variety of theoretical perspectives. Reliability (the ability to produce consistent diagnoses over time and between clinicians) and Validity (the assumption that *DSM* diagnostic categories are reflective of actual psychological issues and syndromes) were critical components of the *DSM* that are readily observed and understood. While the *DSM* is based on the Medical Model and the disease process involving symptoms, etiology, and course of disorder over time, it also recognizes that categories are on a continuum with few "sharp" boundaries either within or between disorders

The *DSM* does not pretend to be free from influence of culture and current political thinking. Most of the studies on which the *DSM* is based were conducted in US and Canada. Although widely used by North American and European clinicians, *DSM* is recognized to have some limitation with minorities and particularly South American Culture. The *DSM* is reflective of current times and culture and issues of homosexuality, premenstrual dysphoria, etc. have changed as the current thinking has evolved. *DSM-IV* is not envisioned as a cookbook to diagnosis, and guidelines must be filtered through clinical judgment, training, and experience. At the core of the *DSM* are the guiding principles of distress and disability. The

DSM proposes that all Mental Disorders are clinically significant behavioral or psychological patterns that create “distress” (a painful symptom) or “disability” (impairment in one or more areas of functioning) or increased risk. An expectable or identifiable response to a particular event should not be considered a Mental Disorder.

A major shift of the *DSM* is the inclusion of a multi-axial system of diagnosis. The *DSM* recognized that not all disorders are one-dimensional and while two individuals may have the same diagnosis, there are several other factors that are important to consider in developing an effective treatment approach. Two persons may both meet diagnostic criteria for a diagnosis of Paranoid Schizophrenia. Person A who has no underlying personality disorder, average intelligence, is free from major physical health issues, has no significant environmental stressors, and who was highly functional prior to the psychotic break is likely to require less treatment and more likely to recover than Person B, who in addition to meeting criteria for a diagnosis of Paranoid Schizophrenia, is also limited intellectually, has an underlying Schizoid Personality Disorder, has multiple physical health issues, is bankrupt, homeless, has pending legal charges, and who for the past 20 years has never been able to function completely on her own. While both are appropriately diagnosed as Paranoid Schizophrenics, the *DSM* multi-axial system gives us a great deal of information about the qualitative aspects of their disorders.

Axis I is reserved for the clinical syndrome or clinical disorder that is considered the most important and the immediate focus of treatment. It is certainly possible to meet diagnostic criteria for multiple Axis I Disorders, but the focus of treatment can be identified on Axis I. Axis II is reserved for those chronic conditions that are not easily modified such as Personality Disorders and Mental Retardation. Axis III and IV are utilized for general medical conditions and Psychosocial and Environmental Problems respectively. The Global Assessment of Functioning (GAF) or Axis V is an attempt to gauge the person’s current and past level of general functioning and is based on a scale of 1 to 100, with characteristic “benchmarks” of functioning

FACTORS TO CONSIDER WHEN MAKING A DIAGNOSIS WITH CHILDREN AND ADOLESCENTS

Diagnosis of Children and adolescents requires a subtlety of clinical judgment that is often not required with adults. Adults possess a greater capacity for self-reflection and self-reporting that can assist in developing an appropriate diagnosis. An adult is capable of being walked through a symptom list or diagnostic criteria listing and report (with varying degrees of accuracy) whether or not they judge that their behavior fits the criteria. Children do not possess some of the conceptual capacity to fully comprehend what is being asked or the memory acquisition skills to accurately report. In diagnosing children, it is extremely important to gather information beyond symptom checklists.

Perhaps one of psychology’s greatest contributions to date has been the study of normal development in humans. While still not necessarily understanding completely the processes of development, we now have a great deal of certainty about the timeframe and milestones of normal development. When a child or adolescent is not developing within normal limits, it is often a way of non-verbally expressing that “something is not right with my world.” That “something” may be a physical issue, a health concern, an emotional lag, or an environmental problem, such as abuse or neglect. Whatever the “something” it is

impeding the normal developmental processes to the point that parents, teachers, and other notice that the child is “different.” In many instances, failure to meet normal developmental milestones may be the child’s way of waving a red flag in hopes that someone will notice and help.

Several key developmental processes can be severely disrupted and are indicators of a diagnostic concern. The capacity to utilize language and communicate effectively with others is a key developmental task that can be impacted by emotional/psychological issues, physical issues or both. The ability to effectively fit in and be accepted by peers hinges largely on the capacity to effectively communicate. In addition, we can identify normal social interactions between children and types of play that are appropriate given the child’s developmental age. Any deviations from this sequence may be indicative of an underlying disorder. The lack of symbolic play that may be a key indicator of Autism Spectrum Disorders, is very appropriate for a child under two. However, the lack of symbolic play in a four year old may be a “red flag” in diagnosing a disorder that the child, and sometimes the parent, may not be aware of and cannot report.

Any “abnormal” behaviors such as motor or vocal tics, clumsiness, hyperactivity, inattention, tantrums, or poor impulse control may be key indicators that “something is wrong in my world.” Some abnormal behaviors may be a reflection or a symbolic representation of an emotional or psychological disorder. A four year old simulating oral sex on the playground is clearly “abnormal” and may be conveying a non-verbal message of the fact that the child has been sexually abused or exposed to inappropriate sexual materials or experiences. The regression of a child through enuresis or encopresis is clearly a non-verbal message of a disturbance in the child’s psychological equilibrium.

When attempting to arrive at a diagnosis with children and adolescents, it is important to gather a complete history of the child’s behavior, development, and recent changes. It is also critical to make distinctions between an adolescent’s behavior that is reflective of a recent crisis or trauma as opposed to a chronic behavior pattern. The behavior of a child who picks up a chair and throws it at someone may be very understandable if the child has just been admitted to a closed ward at a psychiatric hospital as opposed to a child who has been told that they can’t have ice cream for breakfast. We should probably expect “abnormal” behavior in a crisis situation. It is important to gather as much collateral information from other individuals, particularly teachers or child care professionals, to give a complete picture of the child absent parent-child dynamics. Collateral information may be more accurate than direct report, but may also have its own set of biases or agendas.

It is also important to insure that you have considered any possible cognitive or medical conditions that may mimic a psychological disorder. In many instances the symptoms of a physical disorder are identical to psychological conditions, such as mononucleosis and depression. Objective assessments such as checklists and psychological testing are also very helpful in clarifying what is going on with a child. But above all other information, a thorough and complete family psychological history can be the key to an accurate differential diagnosis. This involves more than simply asking the question “Does anyone in your family have a history of psychiatric disorders?” For most adolescents or parents that question will get a simple monosyllabic “NO.” Time must be spent talking in detail about parents own behavioral issues and the behaviors of grandparents. Finding out that Grandma had “heart palpitations” and occasional “spells” when she couldn’t leave the house may be a key directional signal toward an anxiety diagnosis. Finding out that Dad doesn’t have ADHD, “but spent the entire second through sixth grade sitting in the hall or in the principal’s office” may be a directional indicator toward an ADHD diagnosis

DIAGNOSTICALLY BASED TREATMENT PLANNING

Developing Treatment Goals and Objectives

Treatment for Specific Disorders of Childhood and Adolescence must be based on decisions and information arrived at during the assessment and diagnostic process. The process of diagnosis allows you to gather a great deal of information about symptoms, etiology, history, severity, level of dysfunction, and situations that exacerbate the undesired behaviors. The multi-axial system of diagnosis is the key to effectively developing a comprehensive treatment approach. Any treatment plan should describe outcomes you wish to achieve and the interventions you plan to use to reduce, relieve, ameliorate, or change the symptoms (distress) or impairment (loss of functioning). Establishing treatment goals and measurable objectives is the key to effective treatment.

Treatment goals can be developed by asking yourself “What” questions about the individual, paralleling the Multi-Axial Diagnostic System, (e.g. What is the most distressing aspect of the disorder? What physical factors may contribute to the situation or exacerbate the disorder? What stressors is the individual experiencing? etc.), The answers to the “what” questions determines the goals of the treatment. The most effective way of establishing treatment goals parallels the DSM-IV multi-axial system, and possibly adding in a sixth axis dealing with relationships and family and community support.

What Symptoms (distress) and Impairments (loss of functioning) is the individual experiencing (Axis I)?

What are the Underlying or Chronic Issues (Axis II)?

What are the Physical and Medical Aspects (Axis III)?

What are the Psychosocial Stressors (Axis IV)?

What are the Adaptive Behavior Deficits (Axis V)?

What are available Relationships and Support (Global Assessment of Relational Functioning)?

The objectives of the treatment plan specify “How” goals are to be addressed and the interventions that will be attempted (e.g. How will range of affect be expanded? How will self-esteem be increased? How will the client learn to express anger effectively? How will marital tension be reduced? How will family and teachers monitor change? Etc.) The answers to the “How” questions allow you to operationalize a plan and an approach for intervention. It is also very easy to then “quantify” these objectives by adding timelines, benchmarks, levels of improvement, amount or quality of symptom reduction, or ratings.

Sample Treatment Plan for a Child Diagnosed with Separation Anxiety

Diagnostic Impression:

Axis I: 309.21 Separation Anxiety, Early Onset

Axis II: V71.09

Axis III: Recurrent vomiting and headaches

Axis IV: Parental Conflict

Axis V: GAF 55

Goal I: Decrease Excessive Anxiety Concerning Separation

Objective A: Explore precipitating events such as losses, stressors, and changes through individual therapy by March 1.

Objective B: Deal with issues related to rational fears through problem solving and teaching coping skills by June 1.

Objective C: Confront irrational fears and beliefs through cognitive therapy.

Objective D: Minimize the psychological impact of anxiety by teaching relaxation training and self-talk strategies by March 1.

Goal II: Increase School Attendance and Achievement

Objective A: Increase school and parent consistency through conducting joint meeting with parents, school personnel, and child quarterly.

Objective B: Develop a system of “anxiety strategies” that can be deployed in the classroom to prevent withdrawal through access to support personnel or “worry time.”

Goal III: Explore Physical Symptoms

Objective A: Conduct a complete physical to rule out any organic basis for vomiting or headaches by February 1.

Goal IV: Reduce Parental Conflict

Objective A: Parents will participate in marital therapy to learn effective strategies for conflict resolution by June 30.

Objective B: Educate parents regarding age-appropriate emotional separation through parenting classes by September 1.

Goal V: Increase Overall Level of Functioning

Objective A: Increase, through systematic desensitization, the amount of time the child can tolerate being away from the parent by 15 percent.

Objective B: Develop a list of coping strategies that the client can employ to avoid feeling anxious when separated through a family brainstorming process by March 31.

Goal VI: Involve Other Family Members as Supports

Objective A: Increase anxiety free time away from parents by utilizing favorite Uncle to serve as a security object through monthly contact.

Objective B: Increase capacity to be away from parents through sleepovers at cousin’s house by 25 percent.

DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY CHILDHOOD OR ADOLESCENCE

LIMITATIONS OF INTELLECTUAL FUNCTIONING/MENTAL RETARDATION

Beginning before age 18, low intelligence causes significant functioning problems that also has behavioral and emotional sequelae. These are coded on Axis II. About one percent of the population meets the criteria and males outnumber females three to two. Eighty-five percent of those diagnosed with Limitations in Intellectual Functioning fall in the Mild Mental Retardation category and typically will attain sixth grade academic skills by the time they are adults. This diagnostic category also calls for deficits in adaptive functioning (i.e. conforming to and functioning within societal expectations) in two of the following areas: communication, self-care, home living, social interpersonal, self-direction, functional academics, work, leisure, health, and safety. Onset must be prior to age 18.

317.00 MILD MENTAL RETARDATION

- These individuals were formerly categorized as "educable." IQ is 50-55 to 70.

318.00 MODERATE MENTAL RETARDATION

- These individuals were formerly categorized as "trainable." IQ is 35-40 to 50-55.

318.10 SEVERE MENTAL RETARDATION

- These individuals normally acquire minimal speech and language skills and minimal self care skills. IQ is 20-25 to 35-40.

318.20 PROFOUND MENTAL RETARDATION

- Poor motor skills and little capacity for self-care. IQ is below 20-25.

319.00 UNSPECIFIED MENTAL RETARDATION

- Used when the diagnosis is assumed, but conditions make it impossible to administer standardized tests.

V62.89 BORDERLINE INTELLECTUAL FUNCTIONING

- These individuals function without typical problems in coping associated with Mental Retardation. IQ range is 71-84.

It is important to remember that even individually administered IQ tests will contain error measurement, typically, 5-7 points in either direction. In addition simply achieving a low IQ score is not sufficient to justify a diagnosis without also considering the level of adaptive functioning that is present. It may be advisable to consult with a psychologist who has completed extensive testing and measures of adaptive functioning before making the diagnosis. Like personality disorders, Mental Retardation is viewed as a lifelong condition that is coded on Axis II.

LEARNING DISORDERS (Now coded on Axis I)

Learning disorders are characterized by inadequate development of academic skills that are not due to demonstrable physical or neurological disorders. By definition, a learning disorder represents a disorder where specific achievement in a given area is *SUBSTANTIALLY* below what would be expected given the

person's age, IQ, and educational level. One of the difficulties and ongoing debates is defining *substantially* and what that means. Current federal guidelines call for a two standard deviation between achievement and predicted scores. Some individuals may be significantly below grade level, struggling to perform, and possess inadequate achievement to allow them to function well, but are achieving at a level consistent with their ability. These individuals may have difficulty learning, but the severity of the problem, the discrepancy between ability and achievement, is not sufficient to meet criteria. Nevertheless, remediation and individualized instruction may be both needed and warranted. Estimates are that between 2 to 10 percent of the population meet the criteria for a diagnosis of a specific learning disability. Approximately 5 percent of students in public schools are identified as having a learning disorder.

315.00 READING DISORDER

- Predominantly a male disorder. A Reading Disorder must contain three elements: substantial discrepancy between achievement and ability, a significant interference in functioning, and is in excess of any sensory issues.

315.1 MATHEMATICS DISORDER

-Approximately one percent of school age children meet diagnostic criteria. While identifiable as early as kindergarten, it is not typically diagnosed until second or third grade. Mathematics Disorder must contain three elements: substantial discrepancy between achievement and ability, a significant interference in functioning, and is in excess of any sensory issues.

315.2 DISORDER OF WRITTEN EXPRESSION

-Writing skills (not handwriting) are significantly below the developmental expectation. It is generally reserved for a combination of difficulties in composing written text as seen in grammatical errors, punctuation, paragraph construction, spelling errors, and poor handwriting. It is not normally used for just poor handwriting or poor spelling. A Disorder of Written Expression must contain three elements: substantial discrepancy between achievement and ability, a significant interference in functioning, and is in excess of any sensory issues.

315.9 LEARNING DISORDER NOT OTHERWISE SPECIFIED

- Generally reserved for issues that do not meet specific criteria, but are of concern. Dysgraphia (inability to produce legible written text) and spelling difficulties would be included here.

MOTOR SKILL DISORDER (Now coded on Axis I)

Generally used where there is a significant impairment or delay in the development of motor coordination that is not explained by a general medical condition. Often referred to as the "clumsy child syndrome" or the "floppy child," it is seen in about six percent of children ages 5 - 11. A child with Motor Skills Disorder may be the child who literally falls out of the chair or desk for no apparent reason and is not attention seeking or oppositional.

315.4 DEVELOPMENTAL COORDINATION DISORDER

- Motor coordination is substantially below norm and significantly interferes with academics or daily living. It is disproportionate with physical difficulties or the degree of retardation.

COMMUNICATION DISORDERS (Now coded on Axis I)

These disorders are characterized by difficulty expressing or understanding verbal or sign language and difficulty articulating speech sounds, fluency, or rhythm. There is an assumption in these disorders that they are not solely the result of medical issues, pervasive developmental disorders, or mental retardation.

315.31 EXPRESSIVE LANGUAGE DISORDER

- Individuals may have small vocabularies or trouble producing grammatically correct sentences. This disorder is diagnosed in three to five percent of children. It is often recognizable by age three and approximately half the children "outgrow" it by adolescence. The Acquired Type of Expressive Language Disorder typically occurs after a major neurological event. Expressive Language abilities are substantially below intellectual ability and interfere with functioning. This is a disorder of expressive language and typically receptive language abilities are not impacted. Where both expressive and receptive language skills are deficient, Mixed Receptive-Expressive Disorder supersedes this diagnosis.

315.31 MIXED RECEPTIVE-EXPRESSIVE LANGUAGE DISORDER

- Individuals have problems producing and understanding language, words, or sentences. This disorder involves difficulty in either understanding words or signs (receptive language) and in using words or signs to communicate (expressive language). Onset is typically prior to age 4 and is seen in approximately three percent of children. A Mixed Receptive-Expressive Language Disorder is often a predictor of later learning disabilities.

315.39 PHONOLOGICAL DISORDER

- Speech develops slowly for the individual's age. This was formerly referred to as Developmental Articulation Disorder. The differential with Expressive Language Disorder is that the focus here is on sounds and speech sound production not utilization of language. Many children may be observed substituting one sound for another and/or omitting certain sounds entirely.

307.0 STUTTERING

- These individuals experience a frequent disruption in the normal fluency of speech characterized by repetitions or prolongation of sounds. Stuttering affects approximately one percent of pre-school children and the onset occurs between ages of two to seven, with peak onset at about age five. Recovery occurs in approximately 80 percent of individuals by age 18.

307.9 COMMUNICATION DISORDER NOT OTHERWISE SPECIFIED

- A residual category for communication difficulties.

PERVASIVE DEVELOPMENTAL DISORDERS (Now coded on Axis I)

These disorders are characterized by severe and pervasive impairment in several areas of development. Deficits are frequently observed in reciprocal social interaction, communication skills, and stereotypic behaviors, interests, and activities. These disorders are normally evident within the first two years and may be associated with some degree of retardation. The impact of these disorders on behavior and functioning can range from profound to idiosyncratic. In the past these may have been misdiagnosed as “childhood schizophrenia,” however, there is substantial evidence to indicate that Pervasive Developmental Disorders are distinct from schizophrenia.

299.00 AUTISTIC DISORDER

- These children are impaired in social interactions and communication, and develop stereotyped behaviors and interests. Onset typically occurs prior to age three and is seen in .0002 to .0005 of children. In Autism, the impairment in social interaction is gross and sustained and characterized by extreme social indifference and lack of responsiveness to human interaction and contact. Impairment in communication is also marked and sustained. There may be delays in development of language, inability to sustain a conversation, repetitive use of words, sounds, pitch, or rhythm, and a lack of make-believe or imitative play. Individuals with Autistic Disorder typically have restricted, repetitive, and stereotypical motor behaviors or non-functional rituals. Generally, only a small percentage of children are able to function independently as adults. About one-third achieve some degree of partial independence, but still show marked difficulty with social interaction and communication.

299.80 RETT'S DISORDER

- After six months of normal development, the child has abnormal development as indicated by slow head growth, delayed language, poor coordination, loss of purposeful hand movements, and limited social interests. Rett's Disorder is often associated with severe or profound retardation. This extremely rare disorder is seen almost exclusively in females.

299.10 CHILDHOOD DISINTEGRATIVE DISORDER

- Following two years of normal development, the child loses acquired skills in at least two of the following areas: expressive or receptive language, social skills, bowel or bladder control, play, or motor skills. Functional difficulties are seen in social interaction, communication, and stereotypical movements (as seen in Autistic Disorder). This extremely rare disorder has been referred to as Heller's Syndrome. It typically follows a continuous course and its duration is lifelong.

299.80 ASPERGER'S DISORDER

- This is a condition similar to Autism, except these individuals typically do not have delayed or impaired language. They generally meet the same criteria for Autistic Disorder in terms of social interaction impairment and stereotypical movement, but do not show the communication issues that are typically observed in Autism. These individuals also typically display intelligence in the normal to above average range. Onset is typically later than in Autism.

299.80 PERVASIVE DEVELOPMENTAL DISORDER NOT OTHERWISE SPECIFIED

ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS

Attention Deficit/Hyperactivity Disorder has had a variety of names and descriptions since it was first described in 1902 and is one of the most commonly diagnosed disorders of childhood. It is a composite disorder that includes two major symptoms: inattention and impulsivity/hyperactivity. It is especially difficult to establish this diagnosis in children younger than four, although symptoms can frequently be observed, as younger children typically experience fewer demands for sustained attention. Criteria call for symptoms to have occurred prior to age seven. Symptoms must also be observed in multiple settings and symptoms must be of sufficient magnitude to cause significant impairment in social, academic, or occupational functioning. Criteria must be met for six of the nine symptoms of Inattention to a degree that is maladaptive and inconsistent with development. Criteria also calls for meeting six of the nine symptoms of Hyperactivity/Impulsivity to a degree that is maladaptive and inconsistent with development

Mothers of children diagnosed with ADHD report observing their child with higher intrauterine activity, excessive crying, less sleep and increased irritability. For these youth, developmental milestones occur early and the child “hit the ground running from birth.” ADHD individuals appear to be “motor-driven” and often engage in dare-devil and risky activities. They perform poorly in school though IQ is typically in the normal range. In most individuals, symptoms lessen by adolescence, although many continue to experience symptoms into adulthood. There is a significant correlation between first-degree family members and individuals diagnosed with ADHD. A family history of mood disorders, learning disabilities, substance abuse, and anti-social behavior is also frequently reported.

ADHD is one of the most over diagnosed and under diagnosed disorders. This is especially true in adults. It is also extremely difficult to differentiate from anxiety disorders and Dysthymia due to similar symptom patterns. Consider the criteria carefully, especially age of onset and cross environment requirements.

314.01 ATTENTION-DEFICIT/HYPERACTIVITY DISORDER, COMBINED TYPE

- The criteria for both inattention and hyperactivity/impulsivity are met for six months. Onset is prior to age seven, is present in more than one setting, and significantly disrupts functioning. This disorder is diagnosed four to five times more often in boys.

314.00 ATTENTION-DEFICIT/HYPERACTIVITY DISORDER, PREDOMINANTLY INATTENTIVE TYPE

- The criteria for inattention but not hyperactivity/impulsivity are met for six months. Onset is prior to age seven, is present in more than one setting, and significantly disrupts functioning. This disorder is more frequently observed in girls than in boys.

314.01 ATTENTION-DEFICIT/HYPERACTIVITY DISORDER, PREDOMINANTLY HYPERACTIVE-IMPULSIVE TYPE

- The criteria for hyperactivity/impulsivity but not inattention are met for six months. Onset is prior to age seven, is present in more than one setting, and significantly disrupts functioning.

314.9 ATTENTION-DEFICIT/HYPERACTIVITY DISORDER NOT OTHERWISE SPECIFIED

- Residual category for children who do not meet part of the criteria

313.81 OPPOSITIONAL DEFIANT DISORDER

- Multiple examples of negativistic, defiant, disobedient, and hostile behavior that has been occurring for a period of more than six months. This can often be seen in very young children, but should be diagnosed with a recognition of normal developmental oppositionalism that may be age appropriate. Onset is typically gradual, occurring over the course of months or years, and is frequently observed in families with serious marital discord, substance abuse, and primary caretakers who struggle with depression.

312.8 CONDUCT DISORDER

- The child violates the rights of others, particularly as it relates to aggression, destruction of property, lying, stealing, and serious rules violations. Many view this as a precursor to Antisocial Personality Disorder (kid version of ASPD). Rates for males are estimated at 6% to 12% and for females, rates range from 2% to 9% and is one of the most frequently diagnosed conditions in inpatient and outpatient facilities for children. These youth must have met three or more of the criteria behavior for aggression to people and animals, destruction of property, deceitfulness or theft, and serious violations of rules within the past 12 months. The repetitive and persistent nature of the behavior distinguish it from an adjustment disorder.

Almost all cases which meet the criteria for Conduct Disorder would also meet criteria for Oppositional Defiant Disorder, however, the converse is not necessarily true. Convention assumes the severity of the Disorder and requires the use of Conduct Disorder when criteria is met. Developmentally, there is a fairly predictable progression from Oppositional Defiant Disorder to Conduct Disorder to Anti-Social Personality Disorder. Specifiers indicate both onset (Childhood or Adolescent) as well as severity.

312.9 DISRUPTIVE BEHAVIOR DISORDER NOT OTHERWISE SPECIFIED

- Residual category for behavioral/conduct disorders that do not meet criteria, but cause significant impairment in functioning.

FEEDING AND EATING DISORDERS OF INFANCY AND EARLY CHILDHOOD

These disorders are characterized by disturbances in eating.

307.52 PICA

- The individual repeatedly eats materials that are not food for a period of at least one month. This pattern of eating is not appropriate with the child's development and is not culturally accepted.

307.53 RUMINATION DISORDER

- The individual persistently regurgitates and rechews food already eaten. Onset is between ages 3 to 12 months. These children display a characteristic pattern of straining, arching their back, and holding their head back to force food back into the oral cavity.

307.59 FEEDING DISORDERS OF INFANCY AND EARLY CHILDHOOD

- A child fails to eat sufficiently which leads to weight loss or failure to gain weight. Onset occurs before age of six.

PRIMARY EATING DISORDERS OF ADOLESCENCE

Each of the primary eating disorders is defined by abnormal eating behaviors and a number of other common features. Individuals in both groups may binge and purge through laxatives, vomiting, or exercising excessively. Both disorders are encountered primarily (though not exclusively) in girls and young women. Onset typically occurs in the teens. Anorexia is more common than Bulimia, but overall prevalence is increasing. Eating disorders are also increasing in male adolescents.

307.1 ANOREXIA NERVOSA

- Despite the fact that these individuals are severely underweight (less than 85 percent of typical weight), they see themselves as fat and refuse to maintain body weight. There is a significant disturbance in the shape or size of his/her body. Presence of amenorrhea (absence of three consecutive menstrual cycles in postmenarcheal women) is also frequently observed. Note subtypes: Restricting Type or Binge-Eating Purging Type. Many anorexics also purge. The mean age of onset is 17 with bimodal peaks at 14 and 18. All individuals with Anorexia or Bulimia should be closely questioned about mood disorders as there is a high degree of comorbidity and overlapping symptom patterns. Also sexual abuse is reported by many individuals with anorexia and in approximately 25 percent of Bulimics.

307.51 BULIMIA NERVOSA

- These individuals eat in binges, then prevent weight gain by self-induced vomiting, purging, and exercise. Although appearance is important to their self-evaluations, they are fairly realistic about their size and body and these individuals do not have the body image distortion characteristic of Anorexia Nervosa. Symptoms must occur, on average, at least twice a week for three months. Note Subtypes: Purging Type and Non-purging Type.

307.50 EATING DISORDER NOT OTHERWISE SPECIFIED

- Use this category for eating difficulties that do not meet the criteria for Anorexia Nervosa or Bulimia Nervosa.

ELIMINATION DISORDERS (ENCOPRESIS AND ENURESIS)

After age four, the child passes feces into clothing or onto the floor at least once a month for three months. Primary encopresis occurs in individuals who have never achieved fecal continence. Secondary encopresis occurs in individuals who have achieved fecal continence for a period of time and is associated with regression, anxiety, Oppositional Defiant Disorder or Conduct Disorder.

787.6 ENCOPRESIS WITH CONSTIPATION AND OVERFLOW INCONTINENCE

307.7 ENCOPRESIS WITHOUT CONSTIPATION AND OVERFLOW INCONTINENCE

- After the age of four, at least once a month for three consecutive months, the child repeatedly passes feces into inappropriate places whether voluntary or involuntary.

307.6 ENURESIS

- After age five, there is repeated voiding of urine (voluntary or involuntary) into clothing or bedding at least twice a week for three months.

TIC DISORDERS

Tic disorders are characterized by involuntary, sudden, rapid, non-rhythmic and stereotyped movements or vocalizations. Tics must be distinguished from abnormal movements caused by substances, medication, or neurological diseases. They are experienced as irresistible, but can be suppressed for certain lengths of time with great effort. The tics are exacerbated by stress and lessened when the individual is engaged in demanding activities.

307.23 TOURETTE'S DISORDER

- Multiple vocal and motor tics occur frequently throughout the day with onset prior to age 18 and there has never been a tic-free period of more than three months. Motor tics typically involve the head, but may also include other parts of the body, particularly the torso and upper limbs. The location and severity of the motor tics may change with time. Vocal tics include various sounds such as grunts, yelps, coughs, or words. Coprolalia, the involuntary uttering of obscenities, is present 30% of the time. While the motor and vocal tics are described as involuntary, many individuals can suppress them for some period of time with enormous effort. This is an extremely rare condition occurring in approximately .0004 percent of the population. Males are two to three times more likely to have the disorder. There is often a family history of tics and Obsessive-Compulsive Disorder. Average age of onset is seven and most patients have become symptomatic by early teens. Duration of the disorder is lifelong, though there may be periods of remission.

307.22 CHRONIC MOTOR OR VOCAL TIC DISORDER

- An individual experiences either motor or vocal tics, but not both as observed in Tourette's. Symptoms must begin before age 18, and for a period of one year, tics have occurred almost daily, and the patient has never gone for more than three months without the tics.

307.21 TRANSIENT TIC DISORDER

- Motor and/or vocal tics occur for at least four weeks but less than one year.

307.20 TIC DISORDER NOT OTHERWISE SPECIFIED

- Residual category for atypical motor or vocal tic disorders.

OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE

309.21 SEPARATION ANXIETY DISORDER

- Prior to age 18, the individual becomes excessively anxious when separated from parents or home even for brief periods of time. Symptoms persist for a period of at least 4 weeks. During this time the child displays excessive worries, fears, distress, nightmares, and obsessive thinking about being separated from home or primary caregivers. The reaction is excessive in view of the circumstances and age and even the anticipated separation may include somatic complaints. Onset occurs normally during preschool years and occurs in approximately 4% of all children. The disorder is more common among first-degree relatives and in children whose primary caretaker has a history of Panic Disorder.

313.23 SELECTIVE MUTISM

- Consistent failure to speak in certain social settings for at least one month despite the ability to speak in other situations. Failure to speak is not due to lack of knowledge or familiarity with language.

313.89 REACTIVE ATTACHMENT DISORDER OF INFANCY OR EARLY CHILDHOOD

- Beginning before age five, the child does not relate appropriately to others as a result of pathogenic care that the child has received from caretakers. The presumed cause is pathogenic care through disregard of the child's emotional needs, physical needs, or repeated change of primary caregiver. Inhibited Type children do not interact in a developmentally appropriate way as seen by responses that are excessively inhibited, hypervigilant, ambivalent, or contradictory. The child may respond to caregivers with frozen watchfulness, approach-avoidance conflict, or resistance to conforming. Disinhibited Type Children have diffuse, indiscriminant, or non-selective attachments. The child may be overly familiar with strangers or lack selectivity in choosing attachment figures.

307.3 STEREOTYPIC MOVEMENT DISORDER

- The child repeatedly, for a four week period, rocks, bang their head, bites themselves, or picks at their skin or body.

313.9 DISORDER OF INFANCY, CHILDHOOD, OR ADOLESCENCE NOT OTHERWISE SPECIFIED

- The ultimate catch-all category. Used for any disorder that does not fit a criteria.

V61.20 PARENT-CHILD RELATIONAL PROBLEM

- The V code is used when there is no mental disorder, but a child and parents have difficulty getting along. The problematic interaction pattern may include faulty communication, ineffective discipline, or overprotection.

V61.8 SIBLING RELATIONAL PROBLEM

- The V code is used for difficulties among siblings that impair individual or family functioning.

V61.21 PHYSICAL/SEXUAL ABUSE OR NEGLECT OF A CHILD

- The V codes covers difficulties arising from abuse or neglect. Use a V-Code if the focus of treatment is on the perpetrator or the relational unit in which the abuse occurred. If the focus of treatment is the victim, code as 995.5

DOMINANT SYMPTOM

Intellectual Functioning

Learning Impairment

Motor Skill Impairment

**Socially Inappropriate or
Self Injurious Behavior**

Impairment in the Ability to Communicate

RULE OUT/IN

**Mild Mental Retardation
Moderate Mental Retardation
Severe Mental Retardation
Profound Mental Retardation
Unspecified Mental Retardation
Borderline Intellectual Function**

**Reading Disorder
Mathematics Disorder
Disorder of Written Expression
Learning Disorder NOS**

**Developmental Coordination Disorder
Tourette's Disorder
Chronic Motor or Vocal Tic Disorder
Transient Tic Disorder
Tic Disorder NOS
Stereotypic Movement Disorder**

**Pica
Rumination Disorder
Feeding Disorder of Infancy/Childhood
Anorexia Nervosa
Bulimia Nervosa
Encopresis with Constipation/Overflow
Encopresis w/o Constipation/Overflow
Enuresis
Separation Anxiety Disorder
Oppositional Defiant Disorder
Conduct Disorder
Reactive Attachment Disorder
Attention Deficit/Hyperactivity Disorder**

**Autistic Disorder
Pervasive Developmental Disorder
Expressive Language Disorder
Mixed Receptive-Expressive Language
Phonological Disorder
Stuttering
Selective Mutism**

CASE STUDY #1

Stephen Sandstone

Stephen was referred to a local Family Services agency by his pediatrician as a result of a history of over activity, behavior problems in school, and poor social relationships. His mother indicated that Steven was particularly active as an infant and a toddler. Stephen's teachers found him difficult to control and they see him as being extremely impulsive and distractible, moving from one activity to the next. At age 8, he currently knows his alphabet and has a sight vocabulary of approximately 20 words. He cannot read a full sentence and his math skills are also minimal. Because of these learning difficulties Stephen is in a small, self-contained class for learning disabled children. He often fails to give close attention to details and makes careless mistakes in schoolwork. His teachers report that he does not seem to listen even when spoken to directly and has difficulty organizing tasks and losing things necessary to complete tasks. He often talks excessively and is reported to be constantly on "the go." His teacher reports that he is immature and restless, responds best in a structured one-on-one situation, and is considered the class "pest" as he is constantly annoying other children. He frequently blurts out answers before the questions are asked and interrupts the work of other students

Since the start of the school year, he has soiled his pants two to three times per week. He does not have any friends and has been reported by the bus driver for fighting with other children. His mother reports that Stephen responds well to discipline, but lately he has started talking back and swearing at her. He frequently throws temper tantrums, especially if she asks him to do something or denies a request. His constant whining is irritating for her, especially since her husband has been in the hospital for the past six months. Because of his illness, his father has been minimally involved with Stephen's discipline for the last two years.

Treatment plan for a case study No. 1 – Steven Sandstone

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

CASE STUDY # 2

James Red

James is a five-year-old who shows significant delays in social and self-help skills. He makes a variety of sounds but has yet to form them into intelligible words. At times he uses peculiar finger movements and flaps his hands when he is either very happy or very angry. His parents report that sometimes he is very affectionate, but does not play appropriately with other children very well. A variety of inappropriate behaviors make him a difficult child to manage and he often has temper tantrums and screams without cause. He does not react to spankings and when injured does not cry.

His family tolerates his minor daily rituals, but interruptions cause them considerable distress. His father feels that he is “babied and catered to,” but his mother feels that she must do everything possible, and that sometimes “she can’t ignore him.” His mother does not feel supported by her husband and feels that she is “in this by herself.” At this point, James does not yet dress himself and wears diapers day and night. He is very attached to a stuffed bear, but easily separates from his mother. Often he will engross himself for long periods of time twisting tissues or blades of grass in front of his face. His parents are concerned that he is oblivious to danger and may cause harm to himself unless he is constantly supervised. They report that he rarely complies with commands or expected tasks.

When James was 18 months old his parents began to suspect that he was different. He seemed “too good” and, at the same time, not responsive enough. A hearing evaluation was normal. Intellectual functioning cannot be accurately assessed, but the examiner felt that there are some impairments.

On a recent clinic visit James continued to display poor social relations. He easily took the interviewer’s hand, but did not discriminate between his mother and other strangers in the waiting room. An occasional grimace momentarily altered his somewhat otherwise bland expression. He appears to tune out and be disinterested in most things about him. The background noise in the clinic agitated him, and he frequently put his fingers in his ears. When upset, he butted his head against his mother and resisted tactile contact.

Treatment plan for a case study No. 2 – James Red

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

CASE STUDY # 3

Dante Purple

Dante, an eleven-year-old child, was brought to the clinic by his mother (at the request of his school) because of continued fighting and bullying. His mother claims that Dante has always been a “handful,” but now feels that he gets out of line too often and that she can no longer control him. She recently found numerous items in his room that she believes to be stolen, and she has received several reports from the neighbors about property damage. He lies constantly, even when caught and confronted. He was recently suspended from school along with two friends for having set up a blockade to get younger kids on their way home from school. They then made demands for money, but Dante claimed that they intended no harm. There was, however, an incident in which a younger girl was pushed off her bike.

Dante has repeated both first and second grades. His teachers report that he is easily frustrated, and is failing most subjects. He is constantly out of his seat creating a disruption. He usually looks unhappy and upset. His behavior is viewed as attention seeking. He works much better in a small resource class to which he is assigned two hours a day for help in reading. Most of the rest of the day is spent in the principal’s office.

Dante is the second oldest of four children in a single parent home. His natural father left over two years ago and his mother works two part-time jobs to make ends meet. This means that the children are left unsupervised a good part of the day with Dante’s older sister taking most of the responsibility. Dante does not get along with his sister and will hit and bite her if she tries to manage him. During the interview Dante said little and looked miserable. When asked, he denied feeling “blue” but complained that his sister is “mean” to him. He stated that his sister once hit him with a bat, but she got a “whooping” for it. Prior testing showed that Verbal IQ equals 57, Performance IQ equals 78, and Full Scale IQ equals 66.

Treatment plan for a case study No. 3 – Dante Purple

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

CASE STUDY # 4

Susan Yellow

Six-year-old Susan was brought to the clinic by her parents who stated that their child was ruining their marriage. The father feels that the mother spoils the child with inconsistent discipline. The mother feels that she tries her best without success and that the father is extremely harsh and critical. Mother reports that their marriage was “rocky” from the very beginning and has just gotten worse with Susan’s disruptive behavior. Mother acknowledges that she has been diagnosed with major depression and wonders if she passed this on to Susan.

For the past three years Susan has been “extremely difficult.” She is willful and the “terrible twos” were never outgrown. Susan often spoils family events by her misbehavior. At the private school she attends the teachers often have her play quietly by herself because she irritates and annoys the other children. In turn, the other children who attempt to respond to her are met with aggression such as throwing things or slapping them. She lisps, has difficulty sounding out “d’s,” and talks baby talk, but this has improved somewhat in the past year. Developmental milestones have been reached within normal limits. She is considered quite bright in school but her behavior makes learning difficult.

During the clinic interview, Susan seemed to enjoy the individual attention shown her, but was demanding and destructive of the toys in the room. At the end of the interview, she tried to keep the toys even though she was told she couldn’t. She refused to help clean up at the end of the session stating she “just don’t feel like it.” Both parents appear to be substantially invested in their child, but are finding her violent temper tantrums more and more difficult to handle.

Treatment plan for a case study No. 4 – Susan Yellow

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

CASE STUDY # 5

Betty Blue

Betty is a 15-year-old girl who lives with her parents and is seeking therapy because of binge eating and vomiting. Her weight has ranged from 160 pounds at age 14 to the current low of 125. She has a tendency to be slightly heavy and is only five feet two inches tall. At age 12, she started bingeing and vomiting. She's an excellent athlete, jogs 6 miles a day, and plays competitive basketball on her high school team.

There are periods when she feels depressed, mainly because of friction at home between her parents. She is more likely to binge during these times, eating in secret, usually junk food, but it can be any food that is available. She has been known to eat an entire chicken at one setting, only to later purge through self-induced vomiting. She then becomes depressed about how fat she looks and refuses dates because of her embarrassment. She may binge several times a week for months and then resumes periods of normal eating. She reports having a "stash" of junk hidden in her closet that her father does not know anything about. She is afraid that if he discovers the "stash" he'll constantly pull room checks and increase his anger at her daily "weigh ins." She feels a great deal of pressure from her father to win an athletic scholarship.

She is a good student and is curious about the psychological basis for bingeing. She says she now understands how an alcoholic must feel because she knows that bingeing is bad for her but she simply can't stop when she starts to eat. She has kept her bingeing a secret from her parents and only one of her friends knows about her habits.

Treatment plan for a case study No. 5 – Betty Blue

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

CASE STUDY # 6

Jerry Brown

The product of a full-term pregnancy and uncomplicated delivery, Jerry had developed normally until he was eight half. That was when his mother noticed his first tic. He developed a habit of, every few seconds, blinking his eyes, squeezing them shut, and then opening them wide. “She asked me what was wrong and wondered if I was having a convulsion.” He suddenly interrupted his story to yell, “Shit-fuck, shit-fuck.” As he bellowed out each expletive, he twisted his head sharply to the right and shook it violently.

Unconcerned at this sudden outburst, Jerry continued his story. Throughout the rest of his childhood, he gradually accumulated an assortment of facial tics and other abrupt movements of his head and upper body. Each new motor tic earned renewed taunts from his classmates, but these were mild compared to the abuse he suffered once the vocal tics began.

Not long after he turned 13, Jerry noticed a certain tension would seem to accumulate in the back of his throat. He couldn’t describe it. It didn’t tickle and didn’t have a taste. It was not something he could swallow down. Sometimes a cough would temporarily relieve it, but more often it seemed to require some form of vocalization. A bark or yelp worked just fine. When it was most intense, only an obscenity would do. “Shit-fuck, shit fuck” he yelled again. Then he shook his head and hooted.

Halfway through his junior year in high school, the vocal tics became so bad that Jerry was placed on “permanent suspension” until he could keep quiet in the classroom. The third psychiatrist his parents took him to prescribed haloperidol. However after reading an article about tardive dyskinesia, he has begun to worry about the side effects and is looking for another option. He denies using alcohol or street drugs.

Treatment plan for a case study No. 6 – Jerry Brown

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

CASE STUDY # 7

Helen Black

Helen, a three-year old was referred by her caseworker before placement in foster care. She was in the 15th percentile for weight, although height was normal. The caseworker was struck by Helen's sad expression and lack of interest in toys or visitors.

Her existence had been chaotic since birth. Having been born to a chronic paranoid schizophrenic mother, who has now been institutionalized, Helen had minimal care from her mother. Her father is unknown. A landlady who took an interest in Helen provided some level of care as her mother's illness deteriorated. Her mother had been hallucinating and delusional since Helen's birth, and it was doubtful whether she would ever be able to provide adequate care.

During the interview Helen was apathetic and disinterested in the examiner. She made no sounds. Motor development appears to be normal. Attempts by staff to provide comfort were met with a frozen watchfulness. Helen appeared to be hypervigilant, constantly scanning the room and reacting to sudden changes in noise or light. She often would recoil at the touch of another person and avoided any contact with other children in the waiting room. When she was offered a stuffed animal to play with, she refused and sat in the corner playing with her fingers in a repetitive fashion.

Treatment plan for a case study No. 7 – Helen Black

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

CASE STUDY # 8

Laura Lemon

Laura, age 9 was brought to the clinic for excessive shyness, difficulty going to sleep, and an inability to be alone in the house. In addition, she had begun to brood that the family dog might get sick and die. She looked very sad and her affect was generally very flat. Her mother had just returned home following three months of psychiatric hospitalization for severe depression. The mother's illness had followed her husband separation from the family in order to live with a younger woman whom he intends to marry.

Laura had been reluctant to attend school when in kindergarten and first grade, but the school had handled this by setting limits about school attendance. At home, she often attempted to sleep in her parents' bed. In the past two years, the problems had worsened considerably. Frequently, Laura would fake illness on school days, and she had begun to do poorly academically. Recent testing had revealed reading difficulties that were thought to be long-standing, and tutoring had been initiated. This academic year she was repeating third grade. Laura has taken this poorly and has no friends in her current class.

During the interview, Laura spoke with reluctance and appeared sad. She seemed preoccupied with her dog, named Mandy, and feared that the dog might fall ill. When asked directly, she said she did not sleep well unless she was in the same bed as her mother. Although she admitted that she could not stay in her house alone for even 10 minutes, she claimed this was almost never a problem as long as her older sister, a neighbor, or a baby sitter was with her, which was almost all the time. She admitted she wanted to have more friends but was reluctant to spend much time in their houses except for a girl who lived next door, from whose house she could see her own.

Treatment plan for a case study No. 8 – Laura Lemon

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

Diagnostic Categories Normally Used with Adults But Which Are Also Appropriate for Children and Adolescents

SUBSTANCE DEPENDENCE

The user has taken the substance enough to produce clinically significant distress or impaired functioning, as well as certain behavioral characteristics. There may be an increased tolerance, larger quantities are required to produce the same effect, larger quantities are used than intended, withdrawal symptoms, or the use of the substance to control withdrawal. Role functioning is significantly affected and drug usage or drug seeking activities increase at the expense of social responsibilities. Two additional facets are also present: physiological dependence (tolerance/withdrawal) and compulsive use. Modifiers allow distinction between early vs. sustained remission.

SUBSTANCE ABUSE

This is a residual category (i.e. a diagnosis of last resort) for patients whose substance use produces problems, but does not meet the criteria for Substance Dependence. It may also include recurrent use (bingeing) or where the individual places themselves at great risk (drunk driving). It is conceptualized in DSM-IV as maladaptive pattern leading to *adverse consequences* (impaired role functioning, legal or interpersonal problems, or use when clearly dangerous).

SUBSTANCE INTOXICATION

This is an acute clinical condition that results from recent overuse of a substance. This is the only category that applies to someone who has used the substance only once. Each drug has a specific syndrome of intoxication.

SUBSTANCE WITHDRAWAL

Substance Withdrawal is a collection of symptoms, specific for the class of substance being used, which develop when the person who has frequently used a substance discontinues or markedly reduces the amount used. All substances except caffeine, cannabis, PCP, hallucinogens, and inhalants have a specific withdrawal syndrome.

ANXIETY DISORDERS

PANIC ATTACKS

Panic attacks involve a brief episode where the individual feels intense dread accompanied by a variety of physical symptoms. The panic attack begins suddenly and peaks rapidly. The onset of attacks and the presence of “triggers” is important in distinguishing treatment. Three subtypes: Unexpected (e.g. Panic Disorder), Situationally Bound (e.g. Phobias), or Situationally-Predisposed (e.g. PTSD). *Panic disorders are rarely seen in children until late adolescence*, but other anxiety disorders are more common than has been thought previously. Onset of panic disorder typically occurs in the 30’s and may be accompanied with agoraphobia. In Greek, *agoraphobia* literally translates as “fear of the marketplace.” DSM-IV usage reflects more a fear of situations or places where escape seems difficult or embarrassing or help is unavailable. These situations are then avoided, restricted, or endured with marked discomfort.

300.01 PANIC DISORDER WITHOUT AGORAPHOBIA

- These individuals experience repeated panic attacks with worry about experiencing additional attacks and symptoms that accompany them for a period of one month or more. There is an absence of or not fully meeting criteria for agoraphobia (no real changes in lifestyle or cognitions).

300.21 PANIC DISORDER WITH AGORAPHOBIA

- These individuals experience repeated panic attacks with worry about experiencing additional attacks and symptoms that accompany them for a period of one month or more. Criteria for Agoraphobia is met and accompanied by changes in lifestyle and cognition.

300.22 AGORAPHOBIA WITHOUT HISTORY OF PANIC DISORDER

- Agoraphobia and accompanying restriction of activities develops as a result of fear of developing symptoms of anxiety. This category is used in situations where the criteria for Panic Disorder are not met. This typically involves avoidance associated with a medical condition or a specific stressor in excess of what is normal.

300.29 SPECIFIC PHOBIA (formerly Simple Phobia)

- Individuals have excessive fear of specific objects or situations (e.g. animals, storms, closed spaces). The person recognizes that the fear is unreasonable and avoids the specific stimuli, or endures it with intense distress. For children it must be of at least six months duration and they may not recognize their fear as excessive and may not be able to report it, but it may be expressed non-verbally through crying, tantrums, freezing, or clinging. School phobia is frequently observed, but a differential must be made between specific phobia, social phobia, and separation anxiety. Childhood fears are developmentally appropriate and a distinction must be made based on functioning and the level of severity of the anxiety.

300.23 SOCIAL PHOBIA (Social Anxiety Disorder)

- These individuals fear embarrassment or humiliation in social or performance situations. The individual recognizes that the fear is excessive and that it interferes with normal functioning. For

children it must have been present for six months, there must be evidence of the capacity for age-appropriate social relationships, and the anxiety must occur in peer settings, not just with adults. Children do not always recognize that their fear is excessive and the anxiety may be expressed non-verbally through crying, tantrums, and freezing or shrinking from unfamiliar people. Social Phobia is typically motivated out of a fear of embarrassment or humiliation; whereas, agoraphobia is motivated from a fear of having a panic attack.

300.3 OBSESSIVE COMPULSIVE DISORDER

- These individuals are bothered by repeated thoughts or behaviors that may seem senseless, even to them, but somehow makes them feel less anxious and more comfortable, although this recognition of the excessiveness or unreasonableness does not always occur with younger children. While the obsessions (thoughts or images) cause distress, the compulsions (thoughts or actions) prevent, reduce, or relieve anxiety. The disorder may take the form of *either* obsessions or compulsions, but normally both are present. Washing, checking, and ordering rituals are particularly common with children, and do not necessarily cause loss of functioning.

309.81 POSTTRAUMATIC STRESS DISORDER

- The person has experienced, witnessed, or been confronted with an event that involves threat of death, serious injury, or loss of physical integrity (sexual abuse). The person's response involved fear, helplessness, or horror which is re-experienced in the absence of the original stimuli. In children, it is often expressed by disorganized or agitated behavior. The individual re-experiences the trauma, avoids stimuli (or is unresponsive to stimuli) associated with the trauma, and experiences a level of increased arousal. In children, repetitive play with themes or aspects of the trauma are expressed; there may be frightening dreams without recognizable content; and trauma specific reenactment may occur. The disturbance last for more than one month and significantly interferes with functioning. Delayed onset modifier has been used in recovered memory cases of sexual abuse and is quite controversial. Many therapists dispute the fact that symptoms can begin months or years after the trauma (recovered memory), while others find it acceptable.

308.3 ACUTE STRESS DISORDER

- This disorder is very similar to PTSD, except that it begins during or immediately after the event and lasts for a minimum of two days, but less than one month. It is highly predictive of later development of PTSD.

300.02 GENERALIZED ANXIETY DISORDER (Overanxious Disorder of Childhood)

- Although these individuals do not experience episodes of acute panic, they feel tense or anxious most of the time and find it difficult to control the worry. These individuals typically experience a variety of psychosomatic symptoms including restlessness, fatigue, irritability, memory problems, muscle tension, and sleep difficulties. The disorder includes what had formerly been called Overanxious Disorder of Childhood. For children and adolescents anxieties typically involve competence, performance, catastrophic events, perfectionism, and lack of approval. The anxiety is not focused as with some other Axis I disorders, but is marked by the experience of vaguer bodily symptoms.

298.9 ANXIETY DISORDER NOT OTHERWISE SPECIFIED

AFFECTIVE DISORDERS

MOOD EPISODES

A Mood Episode refers to a period of time when a person feels abnormally happy or sad, or when affect is not appropriate for the time or circumstance. Mood episodes are the “building blocks” for identifying a specific disorder. There are four types of mood episodes: Major Depressive, Manic, Mixed, and Hypomanic. In children, a number of other disorders, such as, ADHD, Conduct Disorders, Anxiety Disorders, and Developmental Disorders are known to frequently and regularly produce at least some mood symptoms. It is important to determine if the affective disturbance is primary and not secondary to another disorder. When a mood disturbance is mild, and appears to stem from some acute psychosocial stressor, a diagnosis of Adjustment Disorder may be more appropriate.

MAJOR DEPRESSIVE EPISODE

For a period of two weeks the individual feels depressed, cannot enjoy life, has problems with eating and sleeping, guilt, loss of energy, trouble concentrating, and thoughts of death. In children, a major depressive episode is more likely to occur in conjunction with other disorders than in isolation (Oppositional Defiant, Conduct Disorder, ADHD, and Anxiety Disorders). The Major Depressive Episode produces significant impairment in functioning and the symptoms are not a part of the normal grieving process (normal sadness associated with death, divorce, or moving). A Major Depressive Episode is less common in children than in adults, particularly prepubertal children, but has generally been under diagnosed in children. In children, mood may be less “depressed” and more irritable. In many children it is an “agitated depression” rather than depressed mood or loss of interest in activities. For children, failure to gain weight at an expected rate is the equivalent of significant weight loss.

MANIC EPISODE

For a period of one week, the individual feels elated (or excessively irritable) and may be grandiose, talkative, hyperactive, and distractible. Bad judgment often leads to social or occupational impairment. A full blown manic episode is rarely seen in children and only occasionally in adolescents, primarily as a result of the time criteria. Adolescents may have a long history of behavior problems that precede their first manic episode. A manic episode is a physiologically out of control behavior that often results in arrest or hospitalization.

MIXED EPISODE

For a period of one week, nearly every day, the individual has met criteria for both major depressive episode and manic episode. This involves a significant loss of functioning.

HYPOMANIC EPISODE

For a period of at least four days, the individual feels elated, grandiose, talkative, hyperactive, and distractible. Loss of functioning is much less severe or noticeable than in a Manic Episode. In many cases the hypomanic episode is seen by the individual as a positive due to the increased energy and productivity. In adolescents it may be associated with other behavioral issues or substance abuse.

MOOD DISORDERS

Nearly every individual who has a mood disorder experiences depression, but may also experience “highs.” Most mood disorders are diagnosed on the basis of a mood episode and fit into one of the codeable categories listed below:

DEPRESSIVE DISORDERS

There are two possible mistakes when evaluating clients with depressive symptoms. The first mistake is to focus exclusively on the individual’s anxiety, substance abuse, relational issues, or psychotic symptoms and ignore underlying depression or Dysthymia. *Always* consider a mood disorder even if the complaint is something else. The second error is in diagnosing depression and failing to notice anxiety, alcoholism, or another disorder. *Never* assume that a mood disorder is the individual’s only Axis I issue. A good model to use for accurately diagnosing depression would follow the following steps:

1. Identify current and past mood episodes: Major Depressive, Manic, Mixed or Hypomanic. If symptoms do not meet criteria for mood episode, consider Dysthymia, Substance-Induced, or a medical condition.
2. Choose the appropriate type of mood disorder: Depressive or Bipolar. If Bipolar II or Cyclothymic you are done.
3. Select the appropriate fourth digit for Major Depression or Bipolar I
4. Assign the fifth digit severity code.
5. Add specifiers as appropriate.
6. If criteria are not fully met, consider Depressive Disorder NOS, Bipolar Disorder NOS, Mood Disorder NOS, or Adjustment Disorder with Depressed Mood

296.2x MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE

- The presence of a *single* major depressive episode and no manic, hypomanic, or mixed episodes.

296.3x MAJOR DEPRESSIVE DISORDER, RECURRENT

- The presence of *two or more* major depressive episodes and no manic, hypomanic, or mixed episodes.

300.4 DYSTHYMIC DISORDER

- This type of depression is not severe enough to be called a major depressive episode, but last much longer than a major depression (at least two years) and there are no manic or hypomanic phases. In children, mood may be irritable, “agitated depression”, and the duration is only for one year. Use the early onset modifier for children. An individual who has Dysthymia and then develops a Major Depression can be given both diagnoses on Axis I. These situations are called “double depression.”

311.0 DEPRESSIVE DISORDER NOT OTHERWISE SPECIFIED

- The individual has depressive symptoms that do not meet the criteria (PMS, brief depression, and postpsychotic depression)

BIPOLAR DISORDERS

296.0x BIPOLAR I DISORDER, SINGLE MANIC EPISODE

- The disorder involves the presence of only one Manic Episode and no past Major Depressive Episodes.

296.40 BIPOLAR I DISORDER, MOST RECENT EPISODE HYPOMANIC

- The individual is currently, or most recently, in a Hypomanic Episode and has previously had at least one Manic Episode or Mixed Episode.

296.4 BIPOLAR I DISORDER, MOST RECENT EPISODE MANIC

- The individual is currently, or most recently, in a Manic Episode and has previously had at least one Major Depressive Episode, Manic Episode, or Mixed Episode.

296.6x BIPOLAR I DISORDER, MOST RECENT EPISODE MIXED

- The individual is currently, or most recently, in a Mixed Episode and has previously had at least one Major Depressive Episode, Manic Episode, or Mixed Episode

296.5x BIPOLAR I DISORDER, MOST RECENT EPISODE DEPRESSED

- The individual is currently, or most recently, in a Major Depressive Episode and has previously had at least one Manic Episode or Mixed Episode.

296.7 BIPOLAR I DISORDER, MOST RECENT EPISODE UNSPECIFIED

- Criteria, except for duration, are currently, or most recently met for Major Depressive Episode, Manic Episode, Hypomanic Episode, or Mixed Episode. There has previously been at least one Manic Episode or Mixed Episode.

296.89 BIPOLAR II DISORDER

- Characterized by recurrent major depressive episodes with intermittent hypomanic episodes, but never a manic episode. Loss of functioning is much less severe or noticeable than in Bipolar I.

301.13 CYCLOTHYMIC DISORDER

- For at least two years (one year for children and adolescents), there have been repeated mood swings, but not of sufficient magnitude to be classified as a Major Depression. Cyclothymic disorder usually begins in adolescence, but may be recognizable in small children as a basic temperamental predisposition to Mood Disorders.

296.80 BIPOLAR DISORDER NOT OTHERWISE SPECIFIED

- A residual for individuals with Bipolar features who do not meet diagnostic criteria. This may include rapidly cycling moods, hypomanic episodes without depression, a Manic/Mixed imposed on a psychotic disorder, or Bipolar symptoms from medical conditions or substance abuse.

ADJUSTMENT DISORDERS

ADJUSTMENT DISORDERS

In the past, Adjustment Disorders served as a diagnosis that said nothing, but allowed for third-party reimbursement. The label was so innocuous that practitioners who had concerns about stigmatization could be comfortable they were divulging little or nothing. In DSM-IV, specific criteria have been developed that clarify the nature of an adjustment disorder and establish specific diagnostic criteria.

Use of the diagnosis of Adjustment Disorder is appropriate when an *identifiable* stressor leads to *impaired* relationships, work performance, social interactions, or when the symptoms seem *excessive* for the degree of stress that is present. Adjustment Disorder individuals may be responding to one stressor or to a combination of many stressors. The stressor may have been a one time occurrence (tornado, fire, death, divorce separation) or a chronic condition (parental conflict, alcoholism in the family, job dissatisfaction, and chronic illness). Whatever the nature of the stressor, the individual feels overwhelmed by the environment.

The criteria for Adjustment Disorder describes the course (relatively brief); the onset of symptoms (within three months of the stressor); and persistence (no longer than six months after stressor is removed). There must be functional impairment and symptoms in excess of the normal response to similar stressors. The symptoms are not the result of normal bereavement. The nature of the stressor is coded on Axis IV.

309.0 ADJUSTMENT DISORDER WITH DEPRESSED MOOD

- The individual is tearful, sad, and hopeless as a result of an identifiable stressor.

309.24 ADJUSTMENT DISORDER WITH ANXIETY

- The individual is nervous, fearful, and worried as a result of an identifiable stressor.

309.28 ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD

- The individual displays a combination of anxiety and depressive symptoms as a result of an identifiable stressor.

309.3 ADJUSTMENT DISORDER WITH DISTURBANCE OF CONDUCT

-The individual acts out and violates rules and rights of others.

309.4 ADJUSTMENT DISORDER WITH MIXED DISTURBANCE OF EMOTIONS AND CONDUCT

- The individual's predominant manifestations are both emotional symptoms and a disturbance in conduct as a result of an identifiable stressor.

309.9 UNSPECIFIED

- The individual displays maladaptive reactions as a result of an identifiable stressor.

CASE STUDY # 9

Paula Pear

Paula is a nine-year-old female who currently lives in a foster home. She had been in foster care on several prior occasions as a result of physical and emotional abuse. Recently she had been reunited with her biological mother and her father, who had been diagnosed as a paranoid schizophrenic. Four months ago, she witnessed her father shoot her mother and then threaten to kill Paula before finally turning the gun on himself and making her watch as he pulled the trigger.

Since that time she has had repeated nightmares where she re-experiences the evening again. She repeatedly talks about the experience and seems unable to talk about other subjects. Her father's brother has made inquiries about adopting her, however, whenever he visits she cries continually. He is threatening to make her live with them and has hired an attorney to fight the State for custody. She refuses to go back to her hometown even for short visit with her former classmates and neighbors.

Paula has become increasingly irritable, has difficulty falling asleep, and has difficulty concentrating in school. She has become excessively afraid of blood and has been known to pass out at school if one of her classmates is injured in a minor fashion. Her grades have gone from straight A's to D's and F's. At school she does not participate in class and tends to isolate herself on the playground. She refuses to be left alone in a room, and follows her foster mother from room to room.

Treatment plan for a case study No. 9 – Paula Pear

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

CASE STUDY # 10

Adam Apple

Adam is a well-groomed 16-year-old male whose hands are badly chapped and the color of dusty bricks. He states that, “whenever I go to the bathroom I get this feeling that there could be some semen on my hands and it might get some girl pregnant even if I only shook hands with her. I get this urge to wash my hands, but then after I have washed them I’m afraid to turn off the water because I touched the handle with my “dirty” hands. At times I am afraid to come out of the bathroom because I may have touched the door, on my way in and “it may have semen on it.”

Adam was extremely bright and a good student, however, recently his grades had been slipping. Adam attributed this to his hand washing rituals. Whenever he thought he might have accidentally contaminated his hands with semen, he felt compelled to scrub them thoroughly. A year earlier, this had only meant three or four minutes with a bar of soap and water as hot as hot as he could stand it. Now he carries surgical soap with him and may wash for 15 minutes at a time. “I know it seems crazy, but if I don’t wash, the pressure just won’t let up and builds until I *have* to wash them. Washing is the only thing that relieves the pressure.” Adam denied being depressed, although he was visibly saddened and upset about his behavior. His sleep and appetite had been normal; he denies hallucinations or delusions; and he did not feel guilty or suicidal. He did acknowledge that his father was a minister, and it would “absolutely kill him” if he got a girl pregnant even by accident.

Treatment plan for a case study No. 10 – Adam Apple

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

CASE STUDY # 11

Rick Red

For the past three months, nine-year-old Rick has expressed fearfulness about attending an after school program. In spite of being an excellent student, he becomes upset at the prospect of spending time in after school care. He reports a mixture of worries about failure and complains of stomachaches and headaches. Primarily, he feels sad, and for the past few weeks he has been unable to enjoy his usual school activities. Going to sleep is problematic also, because he is worried about doing poorly in school and he is frequently awakened several times during the night. At the same time, his school performance has begun to decline, because of missing school and difficulty in concentrating. He has become very blue and on several occasions he has burst into tears for no apparent reason.

His mother has had three Major Depressive Episodes. During their 20 years of marriage, his parents have had continuing marital problems. Rick and his two brothers have often been at the center of their disputes. Although shy, he is a likable child and has always been a good student. In the past, he has attended summer camp, and, though he was somewhat home sick, he seemed to enjoy the activities. He has stayed overnight several times with friends who live nearby, but does appear to be somewhat tied to his mother.

During the interview, Rick suddenly began to sob and said that he felt terrible all the time. He said that at times he felt he would be better off if he were dead. Although he denied any specific suicidal plan, he indicated that he just didn't want to wake-up in the morning. He feels guilty that he is a problem to his parents and feels responsible for many of their marital difficulties.

Treatment plan for a case study No. 11 – Rick Red

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

CASE STUDY # 12

Charles Cabbage

Charles, a 14 year old whose parents had been divorced since he was 8, was evaluated because in the past two months he had been breaking a variety of school rules. He had consistently been getting into fights with other children, which was quite unlike his previous behavior. This appeared to start after his return from summer vacation. Charles had always had difficulty with reading and is in a special reading program for junior high school.

Charles had been in California with his father for the summer. The previous summers had been very enjoyable for Charles and his father. This year a girlfriend, who the father plans to marry, had monopolized his father's time. She resented Charles and had arranged his schedule to be a series of day camps so she could spend time with his father alone. Charles' mother was upset because his father was trying to reduce child support in connection with his upcoming marriage.

When interviewed, Charles was friendly towards the examiner, but brash in criticizing the school and pointing out what "dopes" his friends were. His boast of being "a bad ass" is out of proportion to any of his offenses. He said he didn't think that he wanted to continue at that school, but was very receptive to the interest and concern about his future. Psychological testing indicates bright normal intelligence, but reading is approximately two years below grade level.

Treatment plan for a case study No. 12 – Cabbage

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

Bibliography

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Division, American Psychiatric Association, 2001.

Fauman, M..*Study Guide to DSM-IV*. American Psychiatric Press, 1994.

First, M. and Francers, A.. *DSM-IV Handbook for Differential Diagnosis*. American Psychiatric Press, 1995.

Frances, A., First, M., and Pincus, H..*DSM-IV Guidebook*. American Psychiatric Press, 1995.

Hibbs, E. and Jensen, P. *Psychosocial Treatments for Child and Adolescent Disorders*. American Psychological Association Press. Washington, D.C., 1996.

Johnson, S. *Therapists Guide to Clinical Intervention: The 1-2-3 of Treatment Planning*. Academic Press, Orlando, FL. 1997.

Morrison, J. *DSM-IV Made Easy*. Guilford Press, New York, NY.,1995.

Rapoport, J. and Ismond, D.. *DSM-IV Training Guide for Diagnosis of Childhood Disorders*. Bruner/Mazell, New York, NY. 1996.

Treatment plan for case study No. 1 – Sandstone

Diagnostic impression

*AXIS I 314.01 Attention Deficit Hyperactivity Disorder, Combined Type
307.7 Encopresis w/o Constipation 315.9 Learning Disorder NOS*

AXIS II *V71.09 No Diagnosis*_____

AXIS III *None Reported*_____

AXIS IV *Father's Illness, Parent-Child Relationship*_____

AXIS V (GAF) *45*_____

Goal I Decrease Hyperactive-Impulsive Behaviors

Objective A *Refer for ADHD evaluation*_____

Objective B *Obtain medication evaluation from Pediatrician*_____

Objective C *Institute behavior modification program at home and school*

Goal II Reduce Educational Delays and Deficits

Objective A *Obtain psychoeducational evaluation*_____

Objective B *Conduct ARC meeting*_____

Objective C *Determine educational accommodations/placements*_____

Goal III Decrease Encopretic Episodes

Objective A *Refer for physical examination*_____

Objective B *Institute behavior modification program*_____

Objective C _____

Goal IV Improve Parent-Child Functioning

Objective A *Institute family counseling*_____

Objective B *Parents to attend parent training*_____

Objective C *Participate in ADHD support group*_____

Treatment plan for case study No. 2 – James Red
Diagnostic impression

AXIS I 299.00 Autistic Disorder

AXIS II 317.00 Mild Mental Retardation (Provisional)

AXIS III None Reported

AXIS IV Marital Conflict

AXIS V (GAF) 25

Goal I Increase Social Interaction

Objective A Increase eye contact

Objective B Provide opportunities for peer contact

Objective C Increase reciprocal play

Goal II Improve Language Skills

Objective A Behavior modification to increase verbalization

Objective B Implement facilitative language program

Objective C _____

Goal III Increase Parental Support and Cooperation

Objective A Parents will participate in autism support group

Objective B Parents to enrolling marital therapy

Objective C Investigate sources of possible respite care

Goal IV _____

Objective A _____

Objective B _____

Treatment plan for case study No. 3 – Dante Purple
Diagnostic impression

AXIS I 312.81 Conduct Disorder, Childhood Onset, Moderate

AXIS II 317.00 Mild Mental Retardation

AXIS III None Reported

AXIS IV Family difficulties, sibling relation problems

AXIS V (GAF) 35

Goal I Decrease Aggressive Behaviors

Objective A Participate in anger management group

Objective B Implement behavior modification program

Objective C _____

Goal II Reduce Rule Violations

Objective A Implement behavior modification program

Objective B Increase adult supervision

Objective C Monitor stealing behavior

Goal III Improve Family Functioning

Objective A Reduce older sibling's parental role

Objective B Obtain after school care for Dante

Objective C Initiate family counseling

Goal IV Insure Intellectual/Academic Development

Objective A Conduct ARC meeting

Objective B Obtain psychoeducational evaluation

Objective C _____

Treatment plan for case study No. 4 – Susan Yellow
Diagnostic impression

AXIS I 313.81 Oppositional Defiant Disorder 315.39 Phonological Disorder

AXIS II V71.09 No Diagnosis

AXIS III None Reported

AXIS IV Marital conflict, parent-child conflict, mother's depression

AXIS V (GAF) 65

Goal I Reduce Opportunities for Oppositional Behavior

Objective A Chart frequency, intensity, circumstances of oppositional behavior

Objective B Establish reward/consequence contingencies

Objective C Implement behavior modification program

Goal II Reduce Parent Child Conflict

Objective A Parents will attend Parenting Classes

Objective B Begin family counseling

Objective C Implement strategies to avoid power struggles

Goal III Resolve Speech Difficulties

Objective A Obtain speech/language evaluation

Objective B Implement recommendation of speech/language evaluation

Objective C _____

Goal IV Reduce Family Dysfunction

Objective A Institute marital therapy

Objective B Obtain treatment for mother's depression

Objective C Explore parental respite opportunities

Treatment plan for case study No. 5 – Betty Blue
Diagnostic impression

AXIS I 307.51 Bulimia Nervosa, Purging Type

AXIS II V71.09 No Diagnosis

AXIS III None Reported

AXIS IV Parental Conflict

AXIS V (GAF) 65

Goal I Reduce Binging Episodes

Objective A Chart frequency and circumstances of binging behavior

Objective B Develop Options to reduce tension other than binging

Objective C Increase understanding of the role binging behavior plays

Goal II Obtain Medical Support

Objective A Schedule physical examination

Objective B Consult with dietician

Objective C _____

Goal III Improve Family Functioning

Objective A Establish boundaries between father and daughter

Objective B Family counseling to reduce friction at home

Objective C Explore feelings of depression

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

Treatment plan for case study No. 6 – Jerry Brown
Diagnostic impression

AXIS I 307.23 Tourette's Disorder

AXIS II V71.09 No Diagnosis

AXIS III None Reported

AXIS IV Medical concerns, educational issues

AXIS V (GAF) 55

Goal I Resolve Medical Concerns

Objective A Consult physician regarding tardive dyskinesia

Objective B Monitor response to medication

Objective C _____

Goal II Reduce Anxiety and Regulate Tic Behaviors

Objective A Chart frequency of tics and situational factors

Objective B Provide information on visual imaging

Objective C Learn progressive relaxation

Goal III Obtain Appropriate Educational Services

Objective A Request an IEP meeting

Objective B Review educational accommodations

Objective C Review educational options

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

Treatment plan for case study No. 7 – Helen Black
Diagnostic impression

AXIS I 313.89 Reactive Attachment Disorder, Inhibited Type

AXIS II V71.09 No Diagnosis

AXIS III None Reported

AXIS IV Parent's mental illness, neglect and inconsistent care

AXIS V (GAF) 50

Goal I Provide Consistent Quality Care

Objective A Explore relative placement options

Objective B Develop permanency plan

Objective C Provide opportunities for emotional needs to be addressed

Goal II Improve Capacity to Bond

Objective A Identify and define roles for permanent figures in her life

Objective B Increase time that she spends with permanent figures

Objective C Stabilize mother's role in her life

Goal III Improve Social Skills

Objective A Provide consistent daycare/socialization opportunities

Objective B Provide models for appropriate social behaviors

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

Treatment plan for case study No. 8 – Laura Lemon
Diagnostic impression

AXIS I 309.21 Separation Anxiety Disorder R/O 296.23 Major Depression, Single Episode

AXIS II V71.09 No Diagnosis

AXIS III None Reported

AXIS IV parent's separation, mother's depression

AXIS V (GAF) 55

Goal I Decrease Excessive Anxiety

Objective A Explore recent and anticipated losses in individual therapy

Objective B Minimize rational fears with coping strategies

Objective C Develop capacity for positive self-talk

Goal II Increase Autonomous Behaviors

Objective A Gradually require her to sleep in her own bed

Objective B Increase time and frequency of separation from parents

Objective C Desensitize her to being alone in the house

Goal III Reduce Parental Conflict

Objective A Family therapy to minimize impact of divorce

Objective B Divorce support group

Objective C _____

Goal IV Minimize Impact of Mother's Depression

Objective A Psychoeducation for child about the nature of depression

Objective B Individual therapy with mother to focus on impact of disorder on her daughter

Treatment plan for case study No. 9 – Paula Pear
Diagnostic impression

AXIS I 309.81 Post Traumatic Stress Disorder

AXIS II V71.09 No Diagnosis

AXIS III None Reported

AXIS IV custody issue, academic failure

AXIS V (GAF) 45

Goal I Reduce Negative Impact of Trauma

Objective A Identify and rank aspects of traumatic event

Objective B Implement stress reduction techniques

Objective C Explore EMDR techniques

Goal II Develop Coping Skills for Threatening Situations

Objective A Identify how symptoms are affecting functioning

Objective B Instruct client in “Self-talk” techniques

Objective C Systematic desensitization of traumatic stimuli

Goal III Resolve Custody Issue and Develop Permanency Plan

Objective A Mediate custody dispute with Uncle

Objective B Develop permanency plan

Objective C _____

Goal IV Improve Academic Performance

Objective A Obtain psychoeducational evaluation

Objective B Conference with school personnel

Treatment plan for case study No. 10 – Adam Apple
Diagnostic impression

AXIS I 300.3 Obsessive Compulsive Disorder

AXIS II V71.09 Diagnosis

AXIS III None Reported

AXIS IV parental expectations, academic difficulties

AXIS V (GAF) 55

Goal I Identify the Source of Anxiety

Objective A Clarify fearful consequences of not performing rituals

Objective B Refer for psychological evaluation

Objective C Confront irrational thinking patterns

Goal II Resolve Key Life Conflicts That Fuel Obsession/Compulsions

Objective A Verbalize and clarify feelings around conflicts

Objective B Explore Parent Child relationship

Objective C Explore religious value system

Goal III Reduce The Level of Interference From Compulsions

Objective A Chart frequency, severity, and situations of compulsions

Objective B Decrease time allotted for rituals

Objective C Develop rituals that interrupt current pattern

Goal IV Utilize Medications to Augment Treatment

Objective A Refer to psychiatrist for medication evaluation

Objective B Achieve compliance with medication regimen

Treatment plan for case study No. 11 – Rick Red
Diagnostic impression

AXIS I 296.21 Major Depression, Single Episode, Mild 309.21 Separation Anxiety Dis.

AXIS II V71.09 No Diagnosis

AXIS III None Reported

AXIS IV school performance, parental conflict

AXIS V (GAF) 60

Goal I Alleviate Depressed Mood and Other Symptoms of Depression

Objective A Identify and verbalize source of depressed mood

Objective B Encourage expression of repressed anger, hurt, and loss

Objective C Identify and counter “depressed thinking” patterns

Goal II Develop Contract for Safety

Objective A Inform parents of passive suicidal ideation

Objective B Psychoeducation with parents around suicide issues and risk signs

Objective C Establish access to “sources of safety” outside the family

Goal III Decrease Anxiety Around Separation Issues

Objective A Confront irrational fears through cognitive therapy

Objective B Instruct client on relaxation techniques

Objective C Teach positive “self talk” strategies

Goal IV Reduce Parental Conflict

Objective A Refer parents for marriage therapy

Objective B Encourage differentiation between client and parents

Objective C Conduct psychoeducational efforts with parents

Treatment plan for case study No. 12 – Charles Cabbage
Diagnostic impression

AXIS I 309.30 Adjustment Disorder with Conduct Disturbance 315.00 Reading Dis.

AXIS II V71.09 No Diagnosis

AXIS III None Reported

AXIS IV father's new relationship, parental conflict

AXIS V (GAF) 65

Goal I Reduce Emotional Stress Around Father's Marriage

Objective A Participate in divorce support group

Objective B Resolve unanswered questions about impact of father's marriage

Objective C Gradually increase exposure to new stepmother

Goal II Improve Coping and Problem Solving Skills

Objective A Discuss other options of expressing unhappiness

Objective B Develop increased interest outside of the family

Objective C Increase sense of autonomy and self-sufficiency

Goal III Reduce Impact of Reading Difficulties

Objective A Obtain psychoeducational evaluation

Objective B Conduct IEP meeting

Objective C Determine necessary educational accommodations

Goal IV Reduce Unacceptable Behavior

Objective A Develop behavioral contract and contingencies

Objective B Obtain commitment from both parents to behavior contract

Objective C Implement behavior modification program

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**Diagnosis and Treatment Planning For Psychological & Emotional Disorders in
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Post Test for Diagnosis and Treatment Planning for Psychological and Emotional Disorders in Children and Adolescents

1. T F There are a number of perspectives from which an individual's behavior can be viewed to determine normality or abnormality.
2. T F Potential dangers of diagnosing children and adolescents would include labeling, the relatively limited number of diagnoses for children, and the fact of a child's potential to go through rapid periods of development.
3. T F The *Diagnostic and Statistical Manual of Mental Disorders* was the first attempt to identify and classify Mental Disorders
4. T F It is essential that clinicians use the *DSM-IV-TR* rather than the *DSM-IV* since numerous changes were made in diagnostic criteria between the *DSM-IV-TR* and the *DSM-IV*.
5. T F Rett's Disorder, Asperger's Disorder, and Childhood Disintegrative Disorder were not in the *DSM-III-R*, but were added to *DSM-IV*.
6. T F When a child or adolescent is not developing within normal limits, it is often a way of non-verbally expressing that "something is not right with my world."
7. T F The goals of a treatment plan are often identified by asking the question "how can we change this behavior?"
8. T F It is easy to "quantify" treatment plan objectives by adding timelines, benchmarks, levels of improvement, amount or quality of symptom reduction, or ratings.
9. T F Learning disorders are characterized by inadequate development of academic skills that are not easily changed and therefore are coded on Axis II.
10. T F By age 18, most children who stuttered at an earlier age are still stuttering.
11. T F Children diagnosed with Asperger's Disorder generally meet the same criteria for Autistic Disorder in terms of social interaction impairment and stereotypical movement, but do not show the communication issues that are typically observed in Autism.

12. T F It is especially difficult to establish a diagnosis of ADHD in children younger than four, although symptoms can frequently be observed, as younger children typically experience few demands for sustained attention.

13. T F Adolescents diagnosed with anorexia do not binge and purge like those diagnosed with bulimia.

14. T F Coprolalia, the involuntary uttering of obscenities, is present 80% of the time in individuals diagnosed with Tourette's Disorder.

15. T F The presumed cause of Reactive Attachment Disorder is pathogenic care through disregard of the child's emotional needs, physical needs, or repeated change of primary caregiver.

16. T F Panic Attacks are frequently observed in children, even very young children.

17. T F Individuals diagnosed with Obsessive-Compulsive Disorder are bothered by repeated thoughts or behaviors that may seem senseless, even to them, but some how make them feel less anxious and more comfortable, although this recognition of the excessiveness or unreasonableness does not always occur with younger children.

18. T F In a Hypomanic Episode, loss of functioning is much less severe or noticeable than in a Manic Episode.

19. T F Cyclothymic disorder usually begins in adolescence, but may be recognizable in small children as a basic temperamental predisposition to Mood Disorders.

20. T F The criteria for Adjustment Disorder describes the course (relatively brief); the onset of symptoms (within three months of the stressor); and persistence (no longer than six months after stressor is removed).

I, _____ (name of participant) affirm that I am the person who completed this home study and am responsible for this post test.

Signature: _____

