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Psychotherapy present:

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**PSYCHOPATHOLOGY, DIFFERENTIAL  
DIAGNOSIS, AND THE DSM-5: A  
COMPREHENSIVE OVERVIEW**

**Module 3: Anxiety Disorders &  
Depressive Disorders**

# **Your Presenters**

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# Course Objectives

Upon completion of this program trainees will:

- 1. Comprehend the process of utilizing the DSM-5 for diagnosing Anxiety and Depressive Disorders**
- 2. Learn how to organize an assessment approach that aligns successfully with the DSM-5**
- 3. Comprehend the key changes and modifications from the DSM-IV-TR to the DSM-5 related to Anxiety and Depressive Disorders**
- 4. Understand the decision making process, assessments and best practices related to diagnosing Anxiety and Depressive Disorders**

# DSM-5 Differential Diagnosis, 6 Basic Steps

- 1) Ruling out Malingering & Factitious Disorder,
- 2) Ruling out a substance abuse,
- 3) Ruling out medical conditions,
- 4) Determining the specific primary disorder(s),
- 5) Differentiating Adjustment Disorder from the residual Other Specified and Unspecified conditions,
- 6) Establishing the boundary with no mental disorder.

# Mood Episode vs Mood Disorder

- *The mood disorder diagnoses are essentially defined as patterns of mood disturbances observed through time. Clinicians choose from among the various mood-related diagnoses on the basis of their observation of patients' **sequence of mood episodes**.*
- **A mood episode** last for several weeks or months and then give way to normal mood, or to another mood episode. Most people with mood disorders will have (or have already had) a history of multiple **mood episodes**.
- **Mood Episode**
  - Period of time when a patient feels abnormally happy or sad
  - Most patients will have one or more of these

# Mood Episodes

- **Major Depressive Episode**
  - **Duration** : At least **2** weeks
  - **Symptoms**: Patient feels depressed, can't enjoy life, problems with eating and sleeping, guilt feelings, low energy / fatigue
  - trouble concentrating, thoughts about death.
- **Manic Episode**
  - **Duration**: At least **1** week
  - **Symptom**: Patient feels elated (or only irritable), may be grandiose, talkative, hyperactive, and distractible. Poor judgement leads to social or work problems, often need hospitalization.
- **Hypomanic Episode**
  - **Duration**: **4** Consecutive days
  - **Symptom**: Much like manic episode but briefer and less severe, no hospitalization required.

# Mood Episode

- **Mixed Episode**
  - **Duration** 1 -week
  - **Symptoms** Mixed episodes are essentially a combination of manic and depressive episodes that become superimposed so that symptoms of both are present (at different times) during the same day. More specifically, the criteria are met both for a Manic Episode and for a Major Depressive Episode nearly every day.

# Mood Disorders

# (Depressive Disorders)

- **Major Depressive Disorder**
  - **Duration:** Recurrent or single episode
  - **Symptoms:** No manic or hypomanic episodes, but one or more major depressive episodes.
- **Persistent Depressive Disorder (Dysthymia)**
  - **Duration:** Last much longer than typical Major Depressive Disorder
  - **Symptoms:** No high's experienced and is not usually severe enough to be called an episode of major depression, (chronic major depression is included here.)
- **Disruptive Mood Dysregulation Disorder**
  - **Duration:** Can last for long periods of time.
  - **Symptoms:** The child's mood is persistently negative frequent and severe explosions of temper.



# Mood Disorders

# (Depressive Disorders)

- **Premenstrual Dysphoric Disorder**
  - **Duration:** Brief and a few days before a woman's menses.
  - **Symptoms:** Symptoms of depression and anxiety
- **Depressive Disorder Due to another Medical Condition**
  - **Duration:** Can vary greatly.
  - **Symptoms:** A wide range of medical and neurological conditions can produce depressive symptoms. These need not meet the criteria for any of the above.
- **Substance / Medication-Induced Depressive Disorder**
  - **Duration:** Single episode, occasionally or repeatedly
  - **Symptom:** Alcohol / substances (intoxication or withdrawal) can cause depressive symptoms. These need not meet the criteria for any of the above.

# **Mood Disorders                      (Depressive Disorders)**

- **Other Specified, or Unspecified, Depressive Disorder**
  - Use one of these when the patient has depressive symptoms that do not meet the criteria for the depressive diagnosis above or for any other diagnosis in which depression is a feature.

# Mood Disorders, Bipolar I & II and Related Disorders

Approximately 25% of patients with mood disorders experience manic or hypomanic episodes. Nearly all will have an episode of depression. The severity of the high's and lows will determine the bipolar disorder.

- **Bipolar I Disorder**
  - Requires at least **one manic episode** but most patients with bipolar I disorder have also had a **major depressive disorder**.
- **Bipolar II Disorder**
  - This diagnosis requires at least **one hypomanic episode plus at least one major depressive episode**.

# Mood Disorders      Bipolar and Related Disorders

- **Cyclothymic Disorder**

- These patients have repeated mood swings, but none are severe enough to be called major depressive episode or manic episode.

- **Substance / Medication –Induced Bipolar Disorder**

- Alcohol / substances (intoxication or withdrawal) can cause manic or hypomanic symptoms. These need not meet the criteria for any of the above.

- **Bipolar Disorder due to another Medical Condition**

- A wide range of medical and neurological conditions can produce manic or hypomanic symptoms. These need not meet the criteria for any of the above.

- **Other Specified, or Unspecified, Bipolar Disorder**

- Use one of these when the patient has bipolar symptoms that **do not meet the criteria for the bipolar diagnosis above.**

# Bipolar and Related Disorders

Diagnostic criteria and differential  
diagnosis

# Bipolar and Related Disorders

## Diagnostic Features

- The majority of those who meet the criteria for a full blown manic episode also will meet the criteria for full blown depressive episodes in their lifetime although Bipolar Disorder I does not require a psychosis nor does it require a life-long depression
- Bipolar Disorder II requires a lifetime experience of at least one episode of major depression and one manic episode although it is no longer considered a “milder” version of the disorder
- Cyclothymic Disorder is applied when an individual experiences at least two years (1 year for children) of both manic and depressive episodes without fulfilling the criteria for mania, hypomania or major depressive episode
- A large number of substances of abuse, some prescribed medications, and several medical conditions can be associated with manic-like phenomena. This fact is recognized in the diagnoses of substance/medication-induced bipolar and related disorder and bipolar and related disorder due to another medical condition

# Bipolar I and Related Disorders

Code	Disorder	Category
F31.11	Bipolar I Disorder, Most Recent Episode Manic, Mild	Bipolar and Related Disorders
F31.31	Bipolar I Disorder, Most Recent Episode Depressed, Mild	Bipolar and Related Disorders

Criteria:

## **Manic Episode**

- A. Defined period of abnormally and consistently elevated expansive, or irritable mood and abnormally and consistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, most every day (or any duration if hospitalization is necessary)

# Bipolar I and Related Disorders

## Bipolar I Disorder Criteria

Criteria:

B. During the period of mood disturbance and increased energy or activity, **three** (or more) of the following symptoms (four if the mood is only irritable) are present to a marked degree and represent a significant change from typical behavior:

1. Overly increased self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. Much more talkative than usual or intense pressure to keep talking.
4. Flight of ideas or subjective feeling that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to different or irrelevant external stimuli), as reported or observed.



# Bipolar I and Related Disorders

## Bipolar I Disorder Criteria

### Criteria:

6. Increased goal-directed activity (socially, at work, school, or sexually) or psychomotor agitation (i.e., purposeless, non-goal-directed activity).
  7. Excessive involvement in activities that have a high potential for negative consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- C. The mood disturbance is severe enough to cause significant impairment in social or occupational functioning or to require hospitalization to prevent harm to self or others, or there are psychotic features.
- D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, etc) or to another medical condition.

# Bipolar I and Related Disorders

## Bipolar I Disorder Criteria

Criteria:

Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

Note: Criteria A-D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

### **Hypomanic Episode**

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

# Bipolar I and Related Disorders

## Bipolar I Disorder Criteria

### Criteria:

- B. During the mood disturbance and increased energy/ activity, three (or more) of the following (four if the mood is only irritable) have persisted, represent a marked change from typical behavior, and have been present to a significant degree:
1. Inflated self-esteem or grandiosity.
  2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
  3. More talkative than usual or pressure to keep talking.
  4. Flight of ideas or subjective experience that thoughts are racing.
  5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
  6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
  7. Excessive involvement in activities with high potential for negative consequences (e.g., unrestrained buying sprees, sexual indiscretions, or unwise business investments).

# Bipolar I and Related Disorders

## Bipolar I Disorder Criteria

### Criteria:

- C. The episode is associated with an obvious change in functioning that is uncharacteristic of the individual's typical functioning.
- D. The disturbance in mood and the change in functioning are observable by others.
- E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
- F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, etc).

Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a full level beyond the physiological effect of that treatment is sufficient for a hypomanic diagnosis. However, caution is necessary so that one or two symptoms are not taken as sufficient for diagnosis of a hypomanic episode.

# Bipolar and Related Disorders

## Bipolar I Disorder Criteria

Criteria:

### **Major Depressive Episode**

- A. Five (or more) of the following symptoms present during the same 2-week period and are a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. Note: Do not include symptoms that are attributable to a medical condition.
1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)

# Bipolar I and Related Disorders

## Bipolar I Disorder Criteria

### Criteria:

2. Significantly diminished interest or pleasure in all, or almost all, activities most of the day, almost every day (either subjective account or observation).
3. Significant weight change (e.g., a change of more than 5% of body weight in a month when not dieting), or decrease or increase in appetite nearly every day. (Note: In children, failure to make expected weight gain.)
4. Change in sleep or amount of desire to sleep nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others; not simply feelings of restlessness).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive guilt nearly every day

# Bipolar I and Related Disorders

## Bipolar I Disorder Criteria

### Criteria:

8. Reduced ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
  9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The episode is not attributable to the physiological effects of a substance or another medical condition.

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

# Bipolar I and Related Disorders

## Bipolar I Disorder Criteria

Criteria:

### **Bipolar I Disorder**

- A. Criteria have been met for at least one manic episode (Criteria A-D under “Manic Episode” above).
- B. The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder



# DSM-5 Diagnostic Codes for Bipolar Disorder

Current or most recent episode:	<u>manic</u>	hypomanic	depressed
Mild	F31.11	NA	F31.31
Moderate	F31.12	NA	F31.32
Severe	F31.13	NA	F31.4
With psychotic features	F31.2	NA	F31.5
In partial remission	F31.73	F31.71	F31.75
In full remission	F31.74	F31.72	F31.76
Unspecified	F31.9	F31.9	F31.9

# Bipolar II and Related Disorders

Code	Disorder	Category
F31.81	Bipolar II Disorder, Most Recent Episode Hypomanic	Bipolar and Related Disorders
F31.81	Bipolar II Disorder, Current Episode Hypomanic	Bipolar and Related Disorders

Criteria:

## **Hypomanic Episode**

- A. A definite period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, almost every day.

# Bipolar II and Related Disorders

## Bipolar II Disorder Criteria

### Criteria:

- B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and are present to a significant degree:
1. Increased self-esteem or grandiosity.
  2. Decreased need for sleep (e.g., feel rested after only 3 hours of sleep).
  3. More talkative than usual or pressured to keep talking.
  4. Flight of ideas or subjective experience that thoughts are racing.
  5. Distractibility (i.e., attention too easily drawn to external stimuli).
  6. Increase in activity (socially, at work, school, or sexually) or psychomotor agitation.
  7. Involvement in activities that have potential for negative consequences (e.g., unrestrained buying sprees, sexual indiscretions, or poor business investments).

# Bipolar II and Related Disorders

## Bipolar II Disorder Criteria

### Criteria:

- C. The episode is associated with an obvious change in functioning that is nontypical of the individual when not symptomatic.
- D. The disturbance in mood and the change in functioning are noticed by others.
- E. The episode is not severe enough to cause significant issues in functioning or to require hospitalization.
- F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment).

Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a full level beyond the physiological effect of that treatment is sufficient for a hypomanic diagnosis. However, caution is warranted so that one or two symptoms are not seen as sufficient for diagnosis of a hypomanic episode.

# Bipolar II and Related Disorders

## Bipolar II Disorder Criteria

Criteria:

### **Major Depressive Episode**

- A. Five (or more) of the following symptoms are present during the same 2-week period and represent a change in functioning; at least one of the symptoms is either (1 ) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are attributable to a medical condition.

1. Depressed mood most of the day, most every day, as indicated by subjective report (e.g., feels sad or hopeless) or observation by others.
2. Marked decline in pleasure in activities most of the day most every day.
3. Significant change in weight when not dieting (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, failure to make expected weight gain.)

# Bipolar II and Related Disorders

## Bipolar II Disorder Criteria

### Criteria:

4. Change in sleep or desire to sleep nearly every day.
  5. Psychomotor agitation or retardation nearly every day (observable; not merely subjective feelings of restlessness or being slowed down).
  6. Persistent fatigue or loss of energy.
  7. Feelings of worthlessness or excessive guilt nearly every day.
  8. Diminished ability to concentrate or indecisiveness, nearly every day.
  9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, a suicide attempt, or a specific plan for committing suicide
- B. Experience clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The episode is not attributable to the physiological effects of a substance or another medical condition.

# Bipolar II and Related Disorders

## Bipolar II Disorder Criteria

### Criteria:

Note: Criteria A-C above constitute a major depressive episode.

Note: Responses to a significant loss may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of that loss.

# Bipolar II and Related Disorders

## Bipolar II Disorder Criteria

Criteria:

### **Bipolar II Disorder**

- A. Criteria have been met for at least one hypomanic episode (Criteria A-F under “Hypomanic Episode” above) and at least one major depressive episode (Criteria A-C under “Major Depressive Episode” above).
- B. There has never been a manic episode.
- C. The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
- D. The symptoms of depression or the unpredictability caused by frequent alternation between times of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.



# Bipolar II and Related Disorders

## Bipolar II Disorder Differential Diagnosis

- **Major depressive disorder.** A challenging differential diagnosis to consider is major depressive disorder, which may be accompanied by hypomanic or manic symptoms that do not meet full criteria (either fewer symptoms or shorter duration than required for a hypomanic episode).
- **Cyclothymic disorder.** In cyclothymic disorder, there are numerous periods of hypomanic symptoms and numerous periods of depressive symptoms that do not meet symptom or duration criteria for a major depressive episode. Bipolar II disorder is distinguished by the presence of one or more major depressive episodes. If a major depressive episode occurs after the first 2 years of cyclothymic disorder, the additional diagnosis of bipolar II disorder is given.

# Bipolar II and Related Disorders

## Bipolar II Disorder Differential Diagnosis

- **Schizophrenia spectrum and other related psychotic disorders.** Bipolar II disorder must be distinguished from psychotic disorders. Schizophrenia, schizoaffective disorder, and delusional disorder are all characterized by periods of psychotic symptoms that occur in the absence of prominent mood symptoms. Other helpful considerations include the accompanying symptoms, previous course, and family history.
- **Panic disorder or other anxiety disorders.** Anxiety disorders need to be considered in the differential diagnosis and may frequently be present as co-occurring disorders.
- **Substance use disorders.** Substance use disorders are included in the differential diagnosis.

# Bipolar II and Related Disorders

## Bipolar II Disorder Differential Diagnosis

- **Attention-deficit/hyperactivity disorder.** Attention-deficit/hyperactivity disorder (ADHD) may be misdiagnosed as bipolar II disorder, especially in adolescents and children. Many symptoms, such as rapid speech, racing thoughts, distractibility, and less need for sleep, overlap with the symptoms of hypomania. The double counting of symptoms toward both can be avoided if the clinician clarifies whether the symptoms represent a distinct episode and if the noticeable increase over baseline required for the diagnosis of bipolar II disorder is present.
- **Personality disorders.** The same convention also applies when evaluating an individual for a personality disorder since mood lability and impulsivity are common in both personality disorders and bipolar II disorder. Symptoms must represent a distinct episode, and the noticeable increase over baseline required for the diagnosis of bipolar II disorder must be present. A diagnosis of a personality disorder should not be made during an untreated mood episode unless the lifetime history supports the presence of a personality disorder.

# Bipolar II and Related Disorders

## Bipolar II Disorder Differential Diagnosis

- **Other bipolar disorders.** Diagnosis of bipolar II disorder should be differentiated from bipolar I disorder by carefully considering whether there have been any past episodes of mania and from other specified and unspecified bipolar and related disorders by confirming the presence of fully syndromal hypomania and depression

# Bipolar II and Related Disorders

Code	Disorder	Category
F34.0	Cyclothymic Disorder	Bipolar and Related Disorders

## Criteria:

- A. For at least 2 years (1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.
- B. During the above 2-year period (1 year in children and adolescents), the hypomanic and depressive periods have been present at least half the time and the individual has not been without the symptoms more than 2 months at a time.

# Bipolar II and Related Disorders

## Cyclothymic Disorder Criteria

### Criteria:

- C. Criteria for a major depressive, manic, or hypomanic episode have never been met.
- D. The symptoms in Criterion A are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
- E. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse or a medication) or another medical condition.
- F. The symptoms cause clinically significant impairment in social, occupational, or other important areas of functioning.  
Specify if: With anxious distress

# Bipolar II and Related Disorders

## Cyclothymic Disorder Differential Diagnosis

- **Bipolar and related disorder due to another medical condition and depressive disorder due to another medical condition.** The diagnosis of bipolar and related disorder due to another medical condition or depressive disorder due to another medical condition is made when the mood disturbance is judged to be attributable to the physiological effect of a specific, usually chronic medical condition. If it is judged that the hypomanic and depressive symptoms are not the physiological consequence of the medical condition, then the primary mental disorder (i.e., cyclothymic disorder) and the medical condition are coded. For example, this would be the case if the mood symptoms are considered to be the psychological (not the physiological) consequence of having a chronic medical condition, or if there is no etiological relationship between the hypomanic and depressive symptoms and the medical condition.

# Bipolar II and Related Disorders

## Cyclothymic Disorder Differential Diagnosis

- **Substance/medication-induced bipolar and related disorder and substance/medication-induced depressive disorder.** These are distinguished from cyclothymic disorder by the judgment that a substance/medication (especially stimulants) is etiologically related to the mood disturbance. The frequent mood swings that are suggestive of cyclothymic disorder usually resolve following cessation of substance/medication use.
- **Bipolar I disorder, with rapid cycling, and bipolar II disorder, with rapid cycling.** Both may resemble cyclothymic disorder by virtue of the frequent marked shifts in mood. By definition, in cyclothymic disorder the criteria for a major depressive, manic, or hypomanic episode has never been met, whereas the bipolar I disorder and bipolar II disorder specifier "with rapid cycling" requires that full mood episodes be present.
- **Borderline personality disorder** is associated with marked shifts in mood that may suggest cyclothymic disorder. If the criteria are met for both disorders, both borderline personality disorder and cyclothymic disorder may be diagnosed.



# Depressive Mood Disorders

Diagnostic criteria and differential  
diagnosis

# Depressive Disorders

- The common feature of all of these disorders is the presence of sad, empty, or irritable mood
- somatic and cognitive changes that significantly affect the individual's capacity to function
- What differs among them are issues of duration, timing, or presumed etiology
- Children with this symptom pattern typically develop unipolar depressive disorders or anxiety disorders, rather than bipolar disorders, as they mature into adolescence and adulthood

# Depressive Mood Disorders

Code	Disorder	Category
F32.9	Major Depressive Disorder, Single Episode, Unspecified	Mood Disorders
F33.9	Major Depressive Disorder, Recurrent, Unspecified	Mood Disorders

## Criteria:

A. Five or more of the following symptoms present during the same 2-week period and are a change from previous functioning:

at least one of the symptoms is either

(1) depressed mood or

(2) loss of interest or pleasure.

Note: Do not include symptoms that are attributable to medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad) or observation made by others.

# Depressive Mood Disorders

Code	Disorder	Category
F32.9	Major Depressive Disorder, Single Episode, Unspecified	Mood Disorders

## Criteria:

2. Markedly diminished interest or pleasure in activities most of the day, nearly every day (indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (as observed by others, not merely subjective feelings of restlessness or being slowed down).

# Depressive Mood Disorders

Code	Disorder	Category
F32.9	Major Depressive Disorder, Single Episode, Unspecified	Mood Disorders

## Criteria:

6. Fatigue or regular loss of energy.
7. Feelings of worthlessness or excessive guilt nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either subjective account or observed by others).
9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

# Depressive Mood Disorders

Code	Disorder	Category
F32.9	Major Depressive Disorder, Single Episode, Unspecified	Mood Disorders

## Criteria:

- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A-C represent a major depressive episode.

# Depressive Mood Disorders

Code	Disorder	Category
F32.9	Major Depressive Disorder, Single Episode, Unspecified	Mood Disorders

## Criteria:

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include feelings of intense sadness, rumination, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision requires the clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of that loss.

# Depressive Mood Disorders

Code	Disorder	Category
F32.9	Major Depressive Disorder, Single Episode, Unspecified	Mood Disorders

## Note:

In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the primary affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness. The dysphoria in grief is likely to decrease in intensity over days to weeks and primarily occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of MDE.



# Depressive Mood Disorders

Code	Disorder	Category
F32.9	Major Depressive Disorder, Single Episode, Unspecified	Mood Disorders

## Note:

The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical and pessimistic ruminations seen in MDE. In grief, self-esteem is generally preserved, whereas in MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings toward the deceased (not visiting frequently enough, not telling the deceased how much he or she was loved, etc.). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in MDE such thoughts are focused on ending one's own life because of feeling worthless or unable to cope with the pain of depression.

# Depressive Mood Disorders

Code	Disorder	Category
F32.9	Major Depressive Disorder, Single Episode, Unspecified	Mood Disorders

## Criteria:

- D. The major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- E. There has never been a manic episode or a hypomanic episode.  
Note: This exclusion does not apply if all of the manic-like or hypomanic--like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

# Depressive Mood Disorders

Code	Disorder	Category
F32.0	Major Depressive Disorder, Single Episode, Mild	Mood Disorders
F33.0	Major Depressive Disorder, Recurrent, Mild	Mood Disorders

## Criteria:

**Mild-** Few, if any, symptoms beyond those required to make the diagnosis are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning.

# Depressive Mood Disorders

Code	Disorder	Category
F32.1	Major Depressive Disorder, Single Episode, Moderate	Mood Disorders
F33.1	Major Depressive Disorder, Recurrent, Moderate	Mood Disorders

Criteria:

**Moderate**-The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for “mild” and “severe.”

# Depressive Mood Disorders

Code	Disorder	Category
F32.3	Major Depressive Disorder, Single Episode, Severe Without Psychotic Features	Mood Disorders
F33.3	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features	Mood Disorders

## Criteria:

**Severe-** The number of symptoms is substantially in excess of that required to make the diagnosis, the intensity is seriously distressing and unmanageable, and the symptoms severely interfere with social and occupational functioning.

# Depressive Mood Disorders

Code	Disorder	Category
F32.3	Major Depressive Disorder, Single Episode, Severe (F32.2) With Psychotic Features (F32.3)	Mood Disorders
F33.3	Major Depressive Disorder, Recurrent (F32.2) , Severe With Psychotic Features (F32.3)	Mood Disorders

## Criteria:

Delusions and/or hallucinations are present.

Mood-congruent psychotic features:

The content of all delusions and hallucinations is consistent with the typical depressive themes of personal inadequacy, guilt, disease, death, or deserved punishment.

# Depressive Mood Disorders

Code	Disorder	Category
F32.3	Major Depressive Disorder, Single Episode, Severe With Psychotic Features	Mood Disorders
F33.3	Major Depressive Disorder, Recurrent, Severe With Psychotic Features	Mood Disorders

## Criteria:

Mood-incongruent psychotic features:

The content of the delusions or hallucinations does not involve typical depressive themes of personal inadequacy, guilt, disease, death, or deserved punishment, or the content is a mixture of mood-incongruent and mood-congruent themes

# Depressive Mood Disorders

Code	Disorder	Category
F32.4	Major Depressive Disorder, Single Episode, In Partial Remission	Mood Disorders
F33.41	Major Depressive Disorder, Recurrent, In Partial Remission	Mood Disorders

## Criteria:

In partial remission: Symptoms of the immediately previous major depressive episode are present, but full criteria are not met, or there is a period lasting less than 2 months without any significant symptoms of a major depressive episode following the end of such an episode



# Depressive Mood Disorders

Code	Disorder	Category
F32.5	Major Depressive Disorder, Single Episode, In Full Remission	Mood Disorders
F33.42	Major Depressive Disorder, Recurrent, In Full Remission	Mood Disorders

## Criteria:

In full remission: During the past 2 months, no significant signs or symptoms of the disturbance were present

# Anxiety Disorders

Diagnostic criteria and differential  
diagnosis

# Anxiety Disorders

- **Fear** is the emotional response to real or perceived imminent threat
- **Anxiety** is anticipation of future threat
- **Fear** is more often associated with surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger and escape behaviors
- **Anxiety** is more often associated with muscle tension and vigilance in preparation for future danger and cautious or avoidant behaviors

# Anxiety Disorders

Code	Disorder	Category
F41.9	Unspecified Anxiety Disorder (Anxiety Disorder NOS)	Anxiety Disorders

## Description:

This category applies when symptoms of an anxiety disorder causing clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet full criteria for any of the disorders in the anxiety disorders diagnostic class. The unspecified anxiety disorder category is used when the clinician chooses not to specify the reason that the criteria are not met for a specific anxiety disorder, and includes presentations when there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

# Anxiety Disorders

Code	Disorder	Category
F06.4	Anxiety Disorder Due to Medical Condition	Anxiety Disorders

## Criteria:

- A. Panic attacks or anxiety is prominent in the clinical picture
- B. There is evidence from the histories, physical exams, or lab findings that the disturbances are the direct pathophysiological consequences of other medical conditions
- C. The disturbance is not better explained by another mental disorder
- D. The disturbance does not occur exclusively during the course of a delirium
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

Note: Include the name of the other medical condition within the name of the mental disorder (e.g., 293.84 [F06.4] anxiety disorder due to pheochromocytoma). The other medical condition should be coded and listed separately immediately before the anxiety disorder due to the medical condition (e.g., 227.0 [D35.00] pheochromocytoma; 293.84 [F06.4] anxiety disorder due to pheochromocytoma)

# Anxiety Disorders

Code	Disorder	Category
F06.4	Anxiety Disorder Due to Medical Condition	Anxiety Disorders

## Differential Diagnosis

**Delirium.** A separate diagnosis of anxiety disorder due to another medical condition is not given if the anxiety disturbance occurs exclusively during the course of a delirium. However, a diagnosis of anxiety disorder due to another medical condition may be given in addition to a diagnosis of major neurocognitive disorder (dementia) if the etiology of anxiety is judged to be a physiological consequence of the pathological process causing the neurocognitive disorder and if anxiety is a prominent part of the clinical presentation.

**Mixed presentation of symptoms** (e.g., mood and anxiety). If the presentation includes a mix of different types of symptoms, the specific mental disorder due to another medical condition depends on which symptoms predominate in the clinical picture.

**Substance/medication-induced anxiety disorder.** If there is evidence of recent or prolonged substance use (including medications with psychoactive effects), withdrawal from a substance, or exposure to a toxin, a substance/medication-induced anxiety disorder should be considered. Certain medications are known to increase anxiety (e.g., corticosteroids, estrogens, metoclopramide), and when this is the case, the medication may be the most likely etiology, although it may be difficult to distinguish whether the anxiety is attributable to the medications or to the medical illness itself.

# Anxiety Disorders

Code	Disorder	Category
F06.4	Anxiety Disorder Due to Medical Condition	Anxiety Disorders

## Differential Diagnosis

**Anxiety disorder** (not due to a known medical condition). Anxiety disorder due to another medical condition should be distinguished from other anxiety disorders (especially panic disorder and generalized anxiety disorder). In other anxiety disorders, no specific and direct causative physiological mechanisms associated with another medical condition can be demonstrated. Late age at onset, atypical symptoms, and the absence of a personal or family history of anxiety disorders suggest the need for a thorough assessment to rule out the diagnosis of anxiety disorder due to another medical condition. Anxiety disorders can exacerbate or pose increased risk for medical conditions such as cardiovascular events and myocardial infarction and should not be diagnosed as anxiety disorder due to another medical condition in these cases.

**Illness anxiety disorder.** Anxiety disorder due to another medical condition should be distinguished from illness anxiety disorder. Illness anxiety disorder is characterized by worry about illness, concern about pain, and bodily preoccupations. In the case of illness anxiety disorder, individuals may or may not have diagnosed medical conditions. Although an individual with illness anxiety disorder and a diagnosed medical condition is likely to experience anxiety about the medical condition, the medical condition is not physiologically related to the anxiety symptoms.

# Anxiety Disorders

Code	Disorder	Category
F06.4	Anxiety Disorder Due to Medical Condition	Anxiety Disorders

## Differential Diagnosis

**Adjustment disorders.** Anxiety disorder due to another medical condition should be distinguished from adjustment disorders, with anxiety, or with anxiety and depressed mood. Adjustment disorder is warranted when individuals experience a maladaptive response to the stress of having another medical condition. The reaction to stress usually concerns the meaning or consequences of the stress, as compared with the experience of anxiety or mood symptoms that occur as a physiological consequence of the other medical condition. In adjustment disorder, the anxiety symptoms are typically related to coping with the stress of having a general medical condition, whereas in anxiety disorder due to another medical condition, individuals are more likely to have prominent physical symptoms and to be focused on issues other than the stress of the illness itself.

**Associated feature of another mental disorder.** Anxiety symptoms may be an associated feature of another mental disorder (e.g., schizophrenia, anorexia nervosa).

**Other specified or unspecified anxiety disorder.** This diagnosis is given if it cannot be determined whether the anxiety symptoms are primary, substance-induced, or associated with another medical condition.



# Anxiety Disorders

Code	Disorder	Category
F41.1	Generalized Anxiety Disorder	Anxiety Disorders

## Criteria:

- A. Excessive anxiety/worry, more days than not for at least 6 months, about events or activities (such as work or school).
- B. The individual finds it difficult to control the worry.
- C. The anxiety/ worry associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months): Note: Only one item required in children.
  1. Restlessness, feeling keyed up or on edge.
  2. Being easily fatigued.
  3. Difficulty concentrating or mind going blank.
  4. Irritability.
  5. Muscle tension.
  6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)

# Anxiety Disorders

Code	Disorder	Category
F41.1	Generalized Anxiety Disorder	Anxiety Disorders

Criteria:

- D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
- F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

# Anxiety Disorders

Code	Disorder	Category
F41.1	Generalized Anxiety Disorder	Anxiety Disorders

## Differential Diagnosis:

- A. **Anxiety due to medical condition**--The diagnosis of anxiety disorder associated with another medical condition should be made if the individual's anxiety and worry are determined, based on history, laboratory findings, or physical examination, to be a physiological effect of another specific medical condition
- B. **Substance/medication-induced anxiety**-- A substance/medication-induced anxiety disorder is distinguished from generalized anxiety disorder by the fact that a substance or medication (e.g., a drug of abuse, exposure to a toxin) is considered related to the anxiety. For example, severe anxiety that occurs only following heavy coffee consumption

# Anxiety Disorders

Code	Disorder	Category
F41.1	Generalized Anxiety Disorder	Anxiety Disorders

## Differential Diagnosis:

- C. **Social Anxiety**-- Individuals with social anxiety disorder often have anticipatory anxiety focused on upcoming situations in which they must perform or be evaluated by others, where individuals with generalized anxiety disorder worry, whether or not they are being evaluated.
- E. **OCD**-- In generalized anxiety disorder the focus of worry is about forthcoming problems, and the excessiveness of worry about future events that is abnormal. In obsessive-compulsive disorder, the obsessions are inappropriate ideas that take the form of intrusive and unwanted thoughts, urges, or images.

# Anxiety Disorders

Code	Disorder	Category
F41.1	Generalized Anxiety Disorder	Anxiety Disorders

## Differential Diagnosis:

**E. PTSD, Adjustment D/O--** Anxiety is inevitably present in posttraumatic stress disorder. Generalized anxiety disorder is not diagnosed if the anxiety and worry are better explained by symptoms of posttraumatic stress disorder. Anxiety may also be present in adjustment disorder, but this category should be used only when the criteria are not met for any other disorder (including generalized anxiety disorder). Additionally, in adjustment disorders, the anxiety occurs due to an identifiable stressor within 3 months of the onset of the stressor and does not persist more than 6 months after the termination of the stressor or its consequences.

# Anxiety Disorders

Code	Disorder	Category
F41.1	Generalized Anxiety Disorder	Anxiety Disorders

Differential Diagnosis:

**F. Depressive, Bipolar, Psychotic disorders**– Generalized anxiety/worry is a common component of depressive, bipolar, and psychotic disorders and should not be diagnosed separately if the excessive worry occurs only during the course of these conditions

# Anxiety Disorders

Code	Disorder	Category
F40.10	Social Phobia (Social Anxiety Disorder)	Anxiety Disorders

## Criteria:

- A. Significant fear or anxiety about social situations in which the individual is exposed to potential scrutiny by others. Examples are social interactions (e.g., a conversation or meeting new people), being watched (e.g., eating or drinking), or performing in front of others (e.g., giving a speech). Note: In children, the anxiety must occur in peer settings and not only during interactions with adults.
- B. The individual fears he or she will act in a way or show anxiety that will be negatively judged (i.e., will be humiliating or embarrassing: will lead to rejection or offend others).

# Anxiety Disorders

Code	Disorder	Category
F40.10	Social Phobia (Social Anxiety Disorder)	Anxiety Disorders

## Criteria:

- C. Social situations almost always provoke fear or anxiety. In children, the fear or anxiety may be expressed by crying, tantrums, clinging, shrinking, or failing to speak in social situations.
- D. Social situations are consistently avoided or endured with a great deal of fear or anxiety.
- E. The level of or intensity of fear or anxiety is out of proportion to the actual threat presented by the social situation.
- F. The fear, anxiety, or avoidance is persistent and usually lasts 6 months or longer.



# Anxiety Disorders

Code	Disorder	Category
F40.10	Social Phobia (Social Anxiety Disorder)	Anxiety Disorders

Criteria:

- G. The fear, anxiety, or avoidance results in clinically significant behavior or impairment in social, occupational, or other important areas of life.
- H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a recreational drug, a medication) or another medical condition.
- I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.
- J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive beyond that condition.

# Anxiety Disorders

Code	Disorder	Category
F40.10	Social Phobia (Social Anxiety Disorder)	Anxiety Disorders

## Differential Diagnosis:

- A. Normative shyness.** Shyness (i.e., social reticence) is a common personality trait and is not pathological in and of itself. However, when there is a significant negative impact on several important areas of functioning, a diagnosis of social anxiety disorder should be considered, and when full diagnostic criteria are met, the disorder should be diagnosed. Only a minority of self-identified shy individuals have symptoms that meet diagnostic criteria for social anxiety disorder.
- B. Agoraphobia.** Individuals with agoraphobia may fear and avoid social situations because escape might be difficult or help might not be available in the event of incapacitation or panic-like symptoms, whereas individuals with social anxiety disorder are most fearful of scrutiny by others. Moreover, individuals with social anxiety disorder are likely to be calm when left entirely alone, which is often not the case in agoraphobia.

# Anxiety Disorders

Code	Disorder	Category
F40.10	Social Phobia (Social Anxiety Disorder)	Anxiety Disorders

Differential Diagnosis:

- C. **Panic disorder.** Individuals with social anxiety disorder may have panic attacks, but the concern is about fear of negative evaluation, whereas in panic disorder the concern is about the panic attacks themselves.
- D. **Generalized anxiety disorder.** Social worries are common in generalized anxiety disorder, but the focus is more on the nature of ongoing relationships rather than on fear of negative evaluation. Individuals with generalized anxiety disorder, especially children, may have significant worries about the quality of their social performance, but these worries also pertain to nonsocial performance and when the individual is not being evaluated by others. In social anxiety disorder, the worries focus on social performance and others' evaluation.

# Anxiety Disorders

Code	Disorder	Category
F40.10	Social Phobia (Social Anxiety Disorder)	Anxiety Disorders

Differential Diagnosis:

- E. **Separation anxiety disorder.** Individuals with separation anxiety disorder may avoid social settings (including school refusal) due to concerns about being separated from attachment figures or about requiring the presence of a parent when it is not developmentally appropriate. Individuals with separation anxiety disorder are usually comfortable in social settings when their attachment figure is present or when they are at home, but those with social anxiety disorder may be uncomfortable when social situations occur at home or in the presence of attachment figures.

# Anxiety Disorders

Code	Disorder	Category
F40.10	Social Phobia (Social Anxiety Disorder)	Anxiety Disorders

## Differential Diagnosis:

- F. Specific phobias.** Individuals with specific phobias may fear embarrassment or humiliation but they do not usually fear negative evaluation in other social situations.
- G. Selective mutism.** Individuals with selective mutism may fail to speak because of fear of negative evaluation, but do not fear negative evaluation in social situations when no speaking is required
- H. Major depressive disorder.** Individuals with major depressive disorder may be concerned about being negatively evaluated by others because they feel they are bad or not worthy of being liked. Individuals with social anxiety disorder, however, are worried about being negatively evaluated because of certain social behaviors or physical symptoms.
- I. Body dysmorphic disorder.** Individuals with body dysmorphic disorder are preoccupied with one or more perceived defects or flaws in their physical appearance that are not observable or appear slight to others; this preoccupation often causes social anxiety and avoidance. If their social fears and avoidance are caused only by their beliefs about their appearance, a separate diagnosis of social anxiety disorder is not warranted.

# Anxiety Disorders

Code	Disorder	Category
F40.10	Social Phobia (Social Anxiety Disorder)	Anxiety Disorders

Differential Diagnosis:

- J. Delusional disorder.** Individuals with delusional disorder may have delusions and/or hallucinations that focus on being rejected by or offending others. Although the extent of insight into beliefs about social situations may vary, many individuals with social anxiety disorder have good insight that their beliefs are out of proportion to the actual threat posed by the social situation.
- K. Autism spectrum disorder.** Social anxiety and social communication deficits are hallmarks of autism spectrum disorder. Individuals with social anxiety disorder typically have adequate age-appropriate social relationships and social communication capacity, although they may appear to have impairment in these areas when first interacting with unfamiliar individuals.

# Anxiety Disorders

Code	Disorder	Category
F40.10	Social Phobia (Social Anxiety Disorder)	Anxiety Disorders

Differential Diagnosis:

- L. Personality disorders.** Social anxiety disorder may resemble a personality disorder. The most apparent overlap is with avoidant personality disorder. Individuals with avoidant personality disorder have a broader avoidance pattern than those with social anxiety disorder. Nonetheless, social anxiety disorder is typically more comorbid with avoidant personality disorder than with other personality disorders, and avoidant personality disorder is more comorbid with social anxiety disorder than with other anxiety disorders.
- M. Other mental disorders.** Social fears and discomfort can occur as part of schizophrenia, but other evidence for psychotic symptoms is usually present. In individuals with an eating disorder, it is important to determine that fear of negative evaluation about eating disorder symptoms or behaviors (e.g., purging and vomiting) is not the sole source of social anxiety. Similarly, obsessive compulsive disorder may be associated with social anxiety, but the additional diagnosis of social anxiety disorder is used only when social fears and avoidance are independent of the foci of the obsessions and compulsions.

# Anxiety Disorders

Code	Disorder	Category
F40.10	Social Phobia (Social Anxiety Disorder)	Anxiety Disorders

Differential Diagnosis:

- N. **Other medical conditions.** Medical conditions may produce symptoms that may be embarrassing (e.g. trembling in Parkinson's disease). When the fear of judgment due to other medical conditions is excessive, a diagnosis of social anxiety disorder should be considered.
- O. **Oppositional defiant disorder.** Refusal to speak due to opposition to authority figures should be differentiated from failure to speak due to fear of negative evaluation.



# Assessment

***Assessment*** is defined as the process of:

**“gathering, analyzing, and synthesizing salient data into a formulation that encompasses the following vital dimensions: (1) the *nature* of the patients’ problems, including special attention to the roles that patients and significant others play in the difficulties, (2) the *functioning* (strengths, limitations, personality assets, and deficiencies) of patients and significant others, (3) the *motivation* of the patient to work on the problems, (4) the relevant *environmental* factors that contribute to the problems, and (5) the *resources* that are available or are needed to ameliorate the patients’ difficulties”**

**(Hepworth & Larsen, 1990)**

# **Who Makes the Diagnosis?**

**Diagnosis by history**

**Diagnosis by observation**

**Diagnosis by psychometric tools**

# Assessment

**Assessment is two-fold:**

- 1) collecting patient data
- 2) monitoring case progress

# Assessment

- 1) Is the assessment empirically-based – meaning ***based on research and statistics***?
- 2) Has the assessment been made from ***both a systems and an ecological perspective***, capturing the full picture of the client and his/her functioning within the environment(s) in which he/she exists: biological, familial, social, cultural, societal?
- 3) Has the assessment been able to accurately ***measure the essential factors that shape a fully formed understanding of the case***?

# Assessment

- 4) Have the practitioners engaged in a conscientious process of ***evaluating their practice***, and determined that their assessment processes are sufficiently well-designed to capture the right data concerning the client?
- 5) Are the practitioners ***sufficiently knowledgeable about the development and use of a wide variety of assessment methods***, so that the clinician may direct the process towards the use of the assessment tools and methods that produce the most precise and essential information necessary to understand the case?
- 6) Are the practitioners willing to ***refer the client(s) to additional parties for further assessment*** when the assessment needs fall outside of the practitioner's area of competence?

# **Assessing Anxiety & Depression:**

## **Step in Diagnosing Anxiety & Depression**

# Ethics in Tools and Assessment

- What are the legal and ethical boundaries for Master's level clinicians?
- How do we differentiate, ethically and legally, the diagnostic criteria in assessment?

# Ethics in Tools and Assessment

- When do we refer for further testing and diagnostics?
- To whom do we refer for further assessment?



# Ethics in Tools and Assessment

GA Composite Board states:

Rule 135-7-.05. Assessment Instruments

(1) When using assessment instruments or techniques, the licensee shall make every effort to promote the welfare and the best interests of the client....(see handout)

# Ethics in Tools and Assessment

- (2) Unprofessional conduct, includes but is not limited to the following:
  - (a) Failing to provide the client with an orientation to the purpose of testing or the proposed use of the test results prior to administration or assessment instruments or techniques;
  - (b) Failing to consider the specific validity, reliability, and appropriateness of test measures for use in a given situation or with a particular client;

# Ethics in Tools and Assessment

(c) Using unsupervised or inadequately supervised test-taking techniques with clients, such as testing through the mail, unless the test is specifically self-administered or self-scored.

(d) Administering test instruments either beyond the licensee's competence for scoring and interpretation or outside of the licensee's scope of practice, as defined by law;

# Ethics in Tools and Assessment

...and

(d) Failing to make available to the client, upon request, copies of documents in the possession of the licensee which have been prepared for and paid for by the client.

# From the Social Work Code of Ethics

**Value:** *Competence*

**Ethical Principle:** *Social workers practice within their areas of competence and develop and enhance their professional expertise.*

Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

# **From the Social Work Code of Ethics**

## **1.04 Competence**

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

# Psychological Testing by Law

**O.C.G.A. 377 states:**

**“‘Psychological testing’ means the use of assessment instruments to both:**

- (A) Measure mental abilities, personality characteristics, or neuropsychological functioning; and**
- (B) Diagnose, evaluate, classify, or render opinions regarding mental and nervous disorders and illnesses, including, but not limited to, organic brain disorders, brain damage, and other neuropsychological conditions.”**

- Example of Assessment Training in Master's Program:  
CACREP requirements for Professional Counseling  
Identity

#### 7. Assessment and Testing:

- a) Historical perspectives concerning the nature and meaning of assessment and testing in counseling
- b) Methods of effectively preparing for and conducting initial assessment meetings
- c) Procedures for assessing risk of aggression or danger to others, self-inflicted harm, or suicide
- d) Procedures for identifying trauma and abuse and for reporting abuse
- e) Use of assessments for diagnostic and intervention planning purposes



- f) Basic concepts of standardized and non-standardized testing, norm referenced and criterion-referenced assessments, and group and individual assessments
- g) Statistical concepts, including scales of measurement, measures of central tendency, indices of variability, shapes and types of distributions, and correlations.
- h) Reliability and validity in the use of assessments
  - i) Use of assessments relevant to academic/educational, career, personal, and social development
  - j) Use of environmental assessments and systematic behavioral observations
  - k) Use of symptom checklists, and personality and psychological testing

- l) Use of assessment results to diagnose developmental, behavioral and mental disorders
- m) Ethical and culturally relevant strategies for selecting, administering, and interpreting assessment and test results

[www.cacrep.org](http://www.cacrep.org)

# Qualifications for Ordering Tests

- Qualification Level A: There are no special qualifications to purchase these products
- Qualification Level B: Tests may be purchased by individuals with:
  - A master's degree in psychology, education, occupational therapy, social work, counseling, or in a field closely related to the use of the assessment, and formal training in the ethical administration, scoring and interpretation of clinical assessments

([www.pearsonclinical.com](http://www.pearsonclinical.com))

# Psychological Tests and Screening Tools

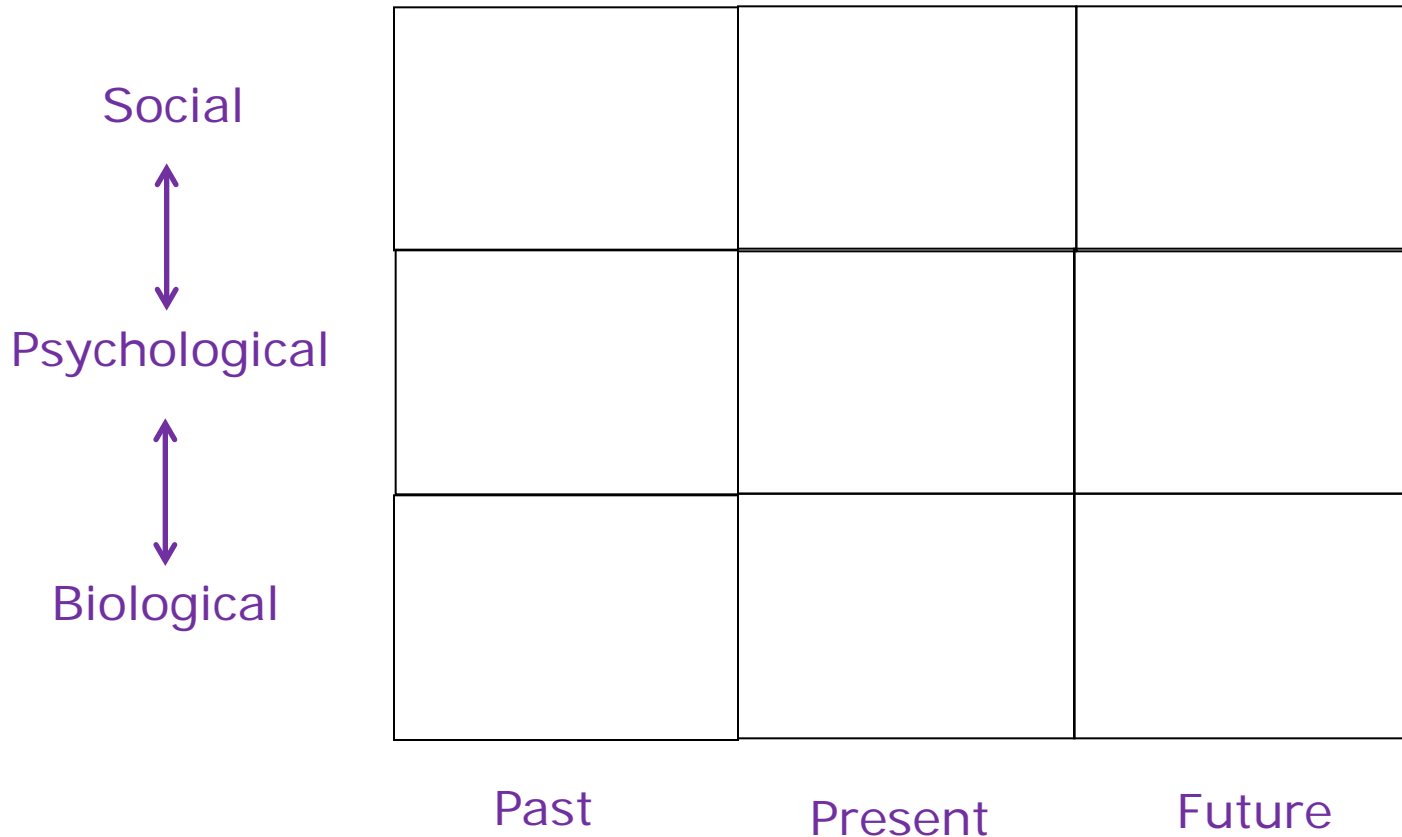
**The following web site contains a substantially complete list of current psychological tests and screening tools for a wide range of mental health concerns.**

**<http://www.scalesandmeasures.net/search.php>**

**Proficiency in Diagnosis:**

**The Biopsychosocial Assessment**

# The Biopsychosocial Perspective



Source: Ross, DE  
A Method for  
Developing a  
Biopsychosocial  
Formulation

# **Components of Assessment:** **Biological, Psychological, Social**

- **Gather a history of past and current problems, signs and symptoms, and challenges**
- **Gather a history of past and current strengths and resources: skill based, relationship based, socially based**
- **Gather medical history, including surgeries, major injuries, medications past and present**
- **Gather mental health history, including current and prior counseling or psychiatric care**
- **Gather a wellness history: sleep, exercise, nutrition including supplements, self-care**
- **Gather a history of religious or spiritual life and its importance and relevance for the well-being of the client**

# **Components of Assessment:** **Biological, Psychological, Social**

- **Conduct a comprehensive mental status check**
- **Conduct a substance use assessment**
- **Gather a history of past and current suicidal and homicidal thoughts and actions**
- **Gather a history of past and current domestic violence and physical, emotional and/or sexual abuse**
- **Establish client goals for treatment and their vision for outcomes**



# **Proficiency in DSM-5 Diagnosis:**

**There has been a significant expansion in**

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

**Z-codes and T-codes  
(formerly V-codes)**

# **Components of Assessment:** **Methods of Gathering Information**

- **Patient self-report and self-monitoring**
- **Self-anchored and rating scales**
- **Questionnaires**
- **Direct behavioral observation**
- **Role play and analogue situations**
- **Behavioral by-products**
- **Psycho-physiological measures**
- **Goal attainment scaling**

# Mental Status Checklist

**Symptom Inventory / Mental Status** (0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme )

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Generalized Anxiety     | <input type="checkbox"/> Weight change                | <input type="checkbox"/> Suspiciousness                     |
| <input type="checkbox"/> Phobias                 | <input type="checkbox"/> Impaired memory              | <input type="checkbox"/> Paranoid ideation                  |
| <input type="checkbox"/> Panic Attacks           | <input type="checkbox"/> Irritability                 | <input type="checkbox"/> Bizarre Behaviors                  |
| <input type="checkbox"/> Depersonalization       | <input type="checkbox"/> Anger control problems       | <input type="checkbox"/> Tangential/Circumstantial thinking |
| <input type="checkbox"/> Obsessions/Compulsions  | <input type="checkbox"/> Aggressiveness               | <input type="checkbox"/> Confusion                          |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Impulsiveness                | <input type="checkbox"/> Delusions                          |
| <input type="checkbox"/> Psychomotor retardation | <input type="checkbox"/> Focus/concentration problems | <input type="checkbox"/> Agitation                          |
| <input type="checkbox"/> Low energy              | <input type="checkbox"/> Distractibility              | <input type="checkbox"/> Dissociation                       |
| <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Negative Self Image          | <input type="checkbox"/> Hallucinations                     |
| <input type="checkbox"/> Withdrawal              | <input type="checkbox"/> Disorientation               | <input type="checkbox"/> Loose Associations                 |
| <input type="checkbox"/> Hopelessness            | <input type="checkbox"/> Mania/Hypomania              | <input type="checkbox"/> Flight of Ideas                    |
| <input type="checkbox"/> Sleep disturbance       | <input type="checkbox"/> Tremors                      | <input type="checkbox"/> Intrusive thoughts                 |

# Mental Status Checklist

**Symptom Inventory / Mental Status** (0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme )

**Mood:** \_\_ Normal \_\_Anxious \_\_Depressed \_\_Irritable \_\_Euphoric \_\_Expansive \_\_Dysphoric \_\_Calm

**Affect:** \_\_Normal \_\_Unconstrained \_\_Blunted/Restricted \_\_Inappropriate \_\_Labile \_\_Flat

**Behavior:** \_\_Normal \_\_Aggressive \_\_Impulsive \_\_Angry \_\_Oppositional \_\_Agitated \_\_Explosive

**Social Relating / Executive Functioning** (0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme)

**Eye Contact:** \_\_Normal \_\_Fleeting \_\_Avoidant \_\_Staring \_\_Other: \_\_\_\_\_

**Facial Expression:** \_\_Responsive \_\_Flat \_\_Tense \_\_Anxious \_\_Sad \_\_Angry

**Attitude Toward Clinician:** \_\_Normal/Cooperative \_\_Uninterested \_\_Passive \_\_Guarded \_\_Dramatic  
\_\_Manipulative \_\_Suspicious \_\_Rigid \_\_Sarcastic \_\_Resistant \_\_Critical \_\_Irritable \_\_Hostile \_\_Threatening

**Appearance:** \_\_Normal \_\_Disheveled \_\_Unclean \_\_Inappropriate \_\_Unhealthy looking

**Insight:** \_\_Good \_\_Impairments in insight **Decision Making:** \_\_Good \_\_Impairments in decision making

**Reality Testing:** \_\_Good \_\_Impairments in reality testing **Judgment:** \_\_Good \_\_Impairments in judgment

**Interpersonal Skills:** \_\_Normal \_\_Impaired **Intellect:** \_\_Average or above \_\_Impaired

# Example of Detailed Mental Status Checklist

(0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme )

## **Generalized Anxiety as manifested by:**

- Feelings of apprehension or dread
- Trouble concentrating
- Feeling tense and jumpy
- Anticipation of negative outcomes
- Heightened irritability
- Restlessness or unsettled feeling
- Vigilance for signs of danger
- Muscle fatigue associated with tenseness

# Alternative Detailed Mental Status Checklist

(0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme )

## Generalized Anxiety as manifested by:

Feelings of apprehension or dread	___By self-report	___By observation
Trouble concentrating	___By self-report	___By observation
Feeling tense and jumpy	___By self-report	___By observation
Anticipation of negative outcomes	___By self-report	___By observation
Heightened irritability	___By self-report	___By observation
Restlessness or unsettled feeling	___By self-report	___By observation
Vigilance for signs of danger	___By self-report	___By observation
___Muscle fatigue	___By self-report	___By observation
associated with tenseness		

# Example of Detailed Mental Status Checklist

**Panic Attack as manifested by episodes of anxiety in conjunction with:**

- Sweating
- Heart pounding
- Fear of death
- Shortness of breath
- Feeling of choking
- Shaking
- Chest pain
- Nausea or stomach ache
- Dizziness
- Fear of going crazy
- Chills or hot flashes
- Derealization

# Example of Detailed Mental Status Checklist

## Mania as manifested by:

- Irritability
- Pressured speech/ feel urge to talk or keep talking
- Decreased need for sleep
- Inflated self esteem or grandiosity
- Racing thoughts
- Distractibility
- Increased goal directed activity or psychomotor agitation
- Excessive involvement in pleasurable activities that have a high threshold for painful consequences.



# Example of Detailed Mental Status Checklist

## Depression as manifested by:

- Markedly decreased interest in activities
- Significant weight loss or gain (5% or more)
- Increased or decreased need for sleep
- Psychomotor agitation or retardation
- Loss of energy
- Feelings of worthlessness or guilt
- Inability to concentrate or think
- Recurrent thoughts of death or suicidal thoughts.

# Example of Detailed Substance Abuse Assessment

**Drug/ETOH Use (Please rate amount and frequency, present and past: e.g., 2B = moderate, infrequent)**

**(Amount of use ratings: 0=No use 1=Light or limited use 2=Moderate use 3=Heavy use 4=Extreme use)**

**(Frequency of use modifier: A=Almost never B=Infrequent / Occasional C=Regular, not constant D=Constant)**

	<b>Current use</b>	<b>Past use</b>
<b>Alcohol</b>	_____	_____
<b>Marijuana</b>	_____	_____
<b>Cocaine</b>	_____	_____
<b>Other (list):</b> _____	_____	_____
<b>Other (list):</b> _____	_____	_____
<b>Other (list):</b> _____	_____	_____
<b>Other (list):</b> _____	_____	_____

# Example of Detailed Substance Abuse Assessment

**Substance Use Problem Effects (0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme)**

**Current use Past use**

**Used alcohol/drugs more than intended**

\_\_\_\_\_

\_\_\_\_\_

**Spent more time using/drinking than intended**

\_\_\_\_\_

\_\_\_\_\_

**Neglected some usual responsibilities because of alcohol or drugs**

\_\_\_\_\_

\_\_\_\_\_

**Wanted or needed to cut down on drinking or drug use in past year**

\_\_\_\_\_

\_\_\_\_\_

**Someone has objected to client's drinking/drug use**

\_\_\_\_\_

\_\_\_\_\_

**Preoccupied with wanting to use alcohol or drugs**

\_\_\_\_\_

\_\_\_\_\_

**Used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom**

\_\_\_\_\_

\_\_\_\_\_

**Comments:**

# **Components of Assessment:** **Methods of Gathering Information**

- **Projective measures**
- **Standardized measures**
- **Coordination of care with medical, psychiatric, psychological, and other providers**

# **Complications in Diagnosis:**

**How Certain are You?**

**Provisional, Deferred and Rule Out  
Diagnoses**

## **When to use provisional diagnosis**

If the clinician is inclined to believe that the final diagnosis selected will in all likelihood be Major Depressive Disorder, Recurrent, Moderate (296.32), but there remains enough uncertainty to proceed cautiously, then the word “provisional” would simply be added to the end of the diagnosis, either separated by a comma, or placed in parentheses

## **When to use provisional diagnosis**

The specifier “provisional” may also be used when there are diagnoses where the criteria include a requirement for the symptoms to be present for a specified period of time that has not elapsed.

## **When to use diagnosis deferred**

Diagnosis deferred is utilized when there is still a substantial amount of uncertainty about any specific diagnosis, often when the assessment session has been interrupted or too brief to allow for the formation of a reasonable idea of the patient's likely diagnosis.

This is designed to be used as a temporary measure pending resumption of the assessment process when the client returns for additional sessions.

The code for diagnosis deferred is R69



## **When to use unspecified mental disorder**

- 1) when it is not expected that a more precise diagnosis will ultimately be reached either through gathering additional information or by the passage of more time.
- 2) when the treatment circumstances will not permit time for more clarifying assessment to occur.

## **No diagnosis**

If no diagnosis is present, the code for “No diagnosis” is Z99.

## Other Clarifying Specifiers

- “**Traits**—this person does not meet criteria, however, he or she presents with many of the features of the diagnosis (e.g., borderline traits or cluster B traits).
- **By history**—previous records (another provider or hospital) indicate this diagnosis; records can be inaccurate or outdated (e.g., alcohol dependence by history).
- **By self-report**—the client claims this as a diagnosis; it is currently unsubstantiated; these can be inaccurate (e.g., bipolar by self-report).”

## Other Clarifying Specifiers: Traits

“**Traits**—this person does not meet criteria, however, he or she presents with many of the features of the diagnosis (e.g., borderline traits or cluster B traits).

# **Complications in Diagnosis: Getting the Specifiers Right**

## Specifiers

With the implementation of ICD-10-CM, code will move from a format that allows up to five digits (e.g., 296.32, Major Depressive Disorder, Recurrent Episode, Moderate) to a format that allows for up to seven digits (e.g., F40.232, Specific Phobia, Fear of Medical Care).

The new codes, with up to seven digits, will allow for the recording of additional specifiers within the code numbers.

# Specifiers and Subtypes

The first, second and third number after the decimal point may indicate subtype of the disorder or specifiers for the disorder, including severity level:

e.g., F31.12 Bipolar Disorder, moderate, most recent episode manic    1=manic, 2= moderate

e.g., F17.209 Unspecified Tobacco-Related Disorder  
9=Unspecified

## Common Specifiers

- 1) Level of severity: Mild, moderate, severe
- 2) Onset: Early onset or late onset, with onset during intoxication, withdrawal or after medication use; with peripartum onset; with seasonal pattern
- 3) Remission status: In partial remission or full remission; in early remission or sustained remission
- 4) Duration: Lifelong or acquired; episodic, persistent, or recurrent
- 5) Pervasiveness: Generalized or situational
- 6) Prognostic features: With or without good prognostic features



## Common Specifiers

7) Environment: In a controlled environment or on maintenance therapy

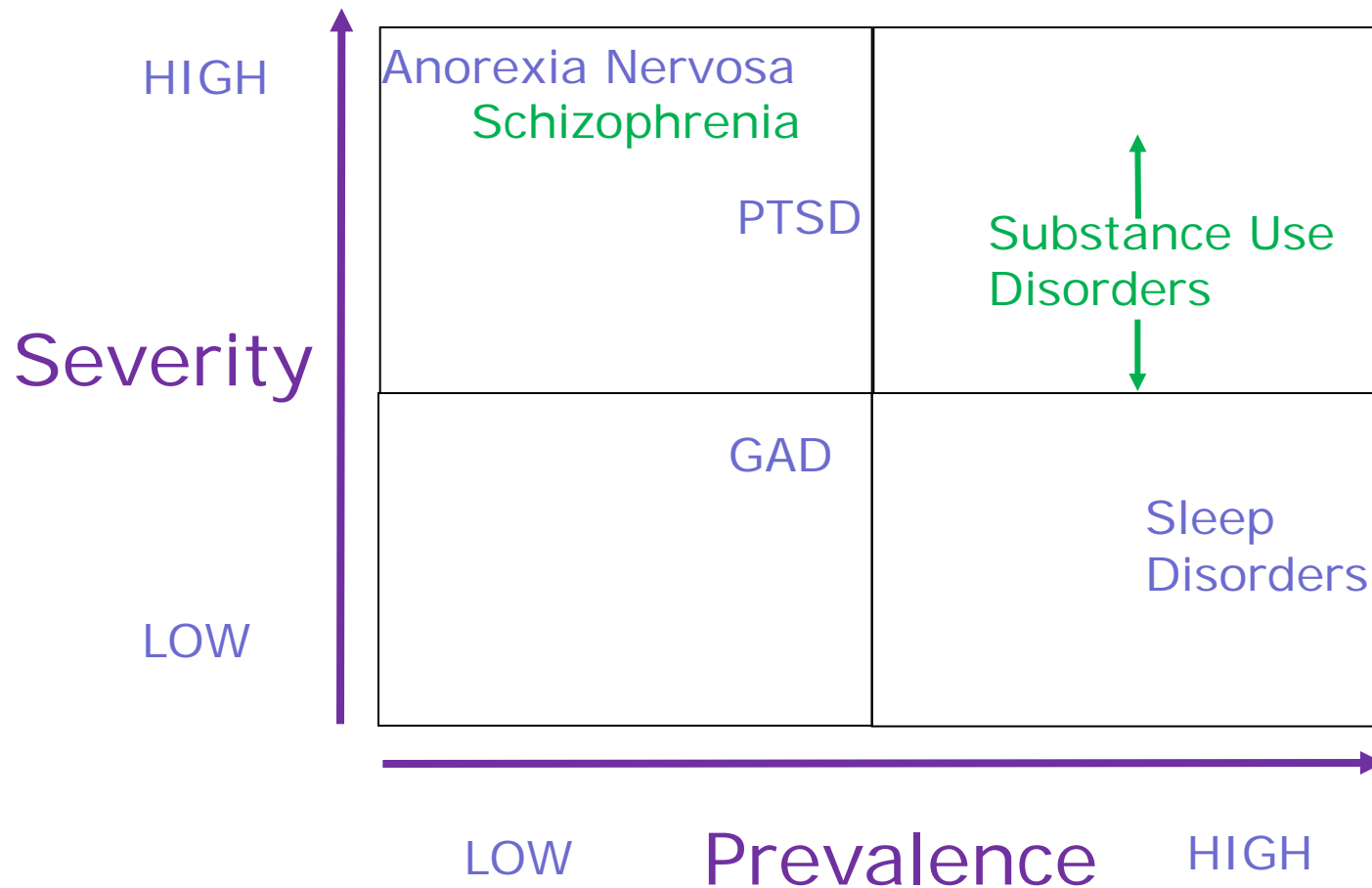
8a) Episode type: First, multiple, continuous, unspecified, mixed

8b) Episode type: Erotomanic, grandiose, jealous, persecutory, somatic

## Common Specifiers

- 9) With other symptoms: With:
  - a) medical condition
  - b) perceptual disturbances
  - c) anxious distress
  - d) mixed features
  - e) melancholic features
  - f) rapid cycling
  - g) atypical features
  - h) mood congruent psychotic features
  - i) mood incongruent psychotic features
  - j) catatonia
  - k) delusions
  - l) hallucinations

# Where Do We Focus



# **Notable Mental Health Problems**

**(NIMH as applied to 2004)**

## **1. Anxiety Disorders – 18.1% of adult Americans**

- Panic disorder: 2.7% of adults
- OCD – 1% of adults
- PTSD – 3.5% of adults
- GAD – 3.1% of adults
- Social phobia – 6.8% of adults

## **2. Mood Disorders – 9.5% of adult Americans**

- Major Depressive Disorder: 6.7% of adults
- Bipolar Disorder: 2.6% of adults
- Dysthymic Disorder: 1.5%

## **3. Personality Disorders – 9.1% of adult Americans**

- Avoidant Personality Disorder: 5.2% of adults
- Antisocial Personality Disorder: 1.0% of adults
- Borderline Personality Disorder: 1.6%

# **Substance Abuse Problems**

**(NIMH as applied to 2007)**

- 1. Alcohol abuse over lifetime – 17.8% of adult Americans  
Alcohol dependence over lifetime – 12.5%**
- 2. Drug abuse over lifetime – 7.7% of adult Americans  
Drug Dependence over lifetime – 2.6%**

# Sleep Problems

- 1. Insomnia Disorder – 10-15% of adult Americans meet criteria  
Signs and symptoms not meeting full criteria – 30%**
- 2. Obstructive sleep apnea – 3-7% of adult Americans  
This diagnosis is growing in numbers.**
- 3. 22-75% of alcohol use disorder in treatment report sleep disorders, 35-70% problems w/ sleep**

# **Complications in Diagnosis of Anxiety Disorders**

# GAD versus PTSD

- **History of identifiable traumatic episode**
  - The person experienced, witnessed, or was confronted with an event or actual events that threatened death or serious injury, or threat to physical integrity of self or others.
  - The person's response involved intense fear, helplessness, or horror.
  - The event is re-experienced with recurrent and intrusive recollections, or memories, of the event.



## **GAD versus PTSD**

**Both PTSD and GAD occur with alterations to HPA axis (hypothalamus-pituitary-adrenal) and stress related changes to the hippocampus, but the rate of change is faster and more pronounced with PTSD.**

# **Anxiety Disorder versus Attention Deficit Disorder**

# Anxiety Disorder versus ADHD

- **Significant symptom overlap**
  - A number of studies note high percentage of children referred for ADHD were diagnosed with anxiety disorder
  - Numerous children with ADHD also present with significant amounts of anxiety
  - Overall, up to 30% of cases have overlap and may be practically indistinguishable one from the other

# Anxiety Disorder versus ADHD

- **Differentiating features**

- ADHD tends to exhibit more externalization of behaviors
- ADHD tends to present with higher degrees of impulsiveness and distractibility
- Decreases in anxiety can lead to improvements in symptoms for children with anxiety disorders, but can lead to increases in symptoms in some children with ADHD
- ADHD distractibility often not tied to worries, but rather to causes the client cannot explain

# **PTSD versus Attention Deficit Disorder**

# Anxiety Disorder versus ADHD

- **Significant symptom overlap**
  - A number of symptoms similar in both PTSD and ADHD

# Anxiety Disorder versus ADHD

- **Key differentiating features**

- With PTSD symptoms, are more circumscribed and situational
- Defined traumatic source of PTSD development
- ADHD persistent and consistent from situation to situation

# **Complications in Diagnosis of Mood Disorders**



# **Bipolar Disorder versus Major Depression**

# Bipolar Disorder versus Major Depression

- **History of manic episode**

If a client has ever experienced a full manic episode, then the correct diagnosis would be Bipolar I Disorder even if the client currently presents with depression only.

# **Bipolar Disorder versus Thyroid Disease**

# Bipolar Disorders versus Thyroid Disease

- **Neurochemical versus endocrinological versus both**

There is a high rate of overlap between thyroid disorder and bipolar and a complex relationship and not yet fully understood relationship between the two

Lithium may interfere with thyroid functioning and predispose a client towards Hashimoto

Autoimmune thyroiditis may be related to bipolar disorder

Thyroid hormone is sometimes given as part of the treatment for bipolar disorder

# **Bipolar Disorders versus Thyroid Disease**

**Patients suspected of bipolar disorder or who are resistant to treatment, should be referred to their PCP for a simple thyroid test due to the degree of overlap between these two disorders.**

# **Bipolar Disorder versus Schizoaffective Disorder**

# Bipolar Disorders versus Schizoaffective

- **Major Mood disorder Plus Criterion A of Schizophrenia**
  - Delusions
  - Hallucinations
  - Disorganized speech
  - Grossly disorganized or catatonic behavior
  - Negative symptoms (explained below)
    - Diminished emotional expression
    - Avolition

# Bipolar Disorders versus Schizoaffective

- **Presence of a thought disorder with alterations in mood**

The main distinguishing features are which of these disorders has the most presence, the psychosis or the mood disturbance.

If the positive or negative symptoms only occur in the presence of the mood disturbance, the diagnosis of bipolar with psychotic features is most appropriate.



# **Bipolar Disorder versus Borderline Personality Disorder**

# Bipolar Disorders versus BPD

- **Key diagnostic symptoms of BPD**
  - Extreme efforts to avoid abandonment (real or imagined)
  - Intense and unstable relationships, and individual alternates between idealizing and devaluing others in relationships.
  - Sense of self is unstable showing an identity disturbance.
  - Impulsive in at least two areas of behavior that are harmful to self (overspending, overeating, inappropriate or unsafe sexual behavior, substance abuse, etc.). Does not include suicidal thoughts of self-mutilation covered in next criterion.

# Bipolar Disorders versus BPD

- **Key diagnostic symptoms of BPD**
  - Recurrent self-mutilating behavior or suicidal behaviors or threats.
  - Intense affective instability, lasting only a few hours possibly up to a few days.
  - Chronic feelings of emptiness
  - Intense, inappropriate expression of anger.
  - Transient paranoid or dissociative ideation, linked with stress.

# **Borderline Personality Disorder versus PTSD**

# BPD versus PTSD

- **Attachment security and PTSD**
  - Clients with diminished attachment security appear to be more likely to develop PTSD in the face of external trauma
  - Attachment security is a protective element for surviving traumatic incidents without developing PTSD
  - Treatment for PTSD involves the use of efforts to increase attachment security

# BPD versus PTSD

- **Key differentiating features**

-Symptoms of excessive emotional expressiveness pursuant to traumatic incident as opposed to durable expression of symptoms