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

Module 5: Somatic Symptom and Related Disorder: Neurodevelopmental, Feeding and Eating Disorders, Elimination Disorders
Your Presenters

Linda Paulk Buchanan, PhD
Linda Paulk Buchanan, PhD, is a Clinical Director and the founder of the Atlanta Center for Eating Disorders (ACE). Dr. Buchanan is a licensed psychologist who has been treating individuals with eating disorders since 1983. Dr. Buchanan has developed and published a model for the treatment of eating disorders. She has conducted various research projects, including the diagnosis of eating disorders, personality variables and coping resources of individuals with eating disorders. Dr. Buchanan has been active in training other psychologists and mental health professionals in the treatment of eating and anxiety disorders.
Your Presenters

Sheryl K. Pruitt, M.Ed., ET/P
Ms. Pruitt is the Clinical Director of Parkaire Consultants, a clinic she founded to serve neurologically impaired individuals. Prior to the founding of Parkaire Consultants, Ms. Pruitt conducted a State of Georgia exemplary Model Learning Disability Program and taught behavior-disordered students in a psychoeducational setting. Ms. Pruitt has co-authored several books including Teaching the Tiger, Tigers Too, and Challenging Kids, Challenged Teachers. She is also a contributor to the Tourette Foundation of Canada’s Handbook For Educators: Understanding Tourette Syndrome. Ms. Pruitt is an author and speaker who educates children, adolescents and adults about neurological disorders and the coping skills needed to remediate deficit areas caused by these disorders. She speaks locally, nationally, and internationally on neurological disorders.
Your Presenters

Wayne Hulon, MDiv, LPC, AAPB
Pres., CEO, American College of Psychotherapy
Psychotherapy & Neuroscience

Ken Scroggs, LPC, LCSW, LMFT, CEAP, DCC
EAP Works and TMH Professionals
Course Objectives

Upon completion of this program trainees will:

- Learn the etiology of somatic symptom and related disorders based on current research
- Comprehend the complexities of diagnosis for this disorder
- Grasp appropriate assessment processes for determining somatic symptom and related disorders, role clarification and differentiation for master’s level clinicians, and appropriate referrals to other professionals in establishing obsessive-compulsive and related disorders diagnoses
- Comprehend differential diagnosis from other disorders with similar presentations
- Apply common specifiers for somatic symptom and related disorders
- Learn appropriate treatment strategies based upon diagnosis
- Grasp etiology of neurodevelopmental disorders based on current research, and complexities of diagnosis for these disorders
Course Objectives

Upon completion of this program trainees will:

- Know appropriate assessment processes for determining neurodevelopmental disorders, distinguishing these disorders from disorders with similar presentations, role clarification and differentiation for master’s level clinicians, and appropriate referrals to other professionals in establishing neurodevelopmental disorder diagnoses
- Differential diagnosis from other disorders with similar presentations
- Apply common specifiers for neurodevelopmental disorders
- Learn appropriate treatment strategies based upon diagnosis
- Learn the etiology of elimination disorders based on current research
- Comprehend the complexities of diagnosis for this disorder
- Grasp appropriate assessment processes for determining elimination disorders, role clarification and differentiation for master’s level clinicians, and appropriate referrals to other professionals in establishing elimination disorders diagnoses
Course Objectives

Upon completion of this program trainees will:

- Comprehend differential diagnosis with other disorders with similar presentations
- Apply common specifiers for elimination disorders
- Learn appropriate treatment strategies based upon diagnosis
- Learn the etiology of feeding and eating disorders based on current research
- Comprehend the complexities of diagnosis for this disorder
- Grasp appropriate assessment processes for determining feeding and eating disorders, role clarification and differentiation for master’s level clinicians, and appropriate referrals to other professionals in establishing feeding and eating disorders diagnoses
- Comprehend differential diagnosis with other disorders with similar presentations
- Apply common specifiers for feeding and eating disorders
- Learn appropriate treatment strategies based upon diagnosis
Feeding and Eating Disorders

Diagnostic criteria and differential diagnosis
Feeding and Eating Disorders
Diagnostic Features

• Feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning.

• Some individuals with these disorders report eating-related symptoms resembling those typically endorsed by individuals with substance use disorders, such as craving and patterns of compulsive use. This resemblance may reflect the involvement of the same neural systems, including those implicated in regulatory self-control and reward, in both groups of disorders. However, the relative contributions of shared and distinct factors in the development and perpetuation of eating and substance use disorders remain insufficiently understood.
Understanding and Treating Eating Disorders

Linda Buchanan, Ph.D.
Founder
Senior Director of Clinical Services

Atlanta Center for Eating Disorders/
A Walden Behavioral Care Company

www.eatingdisorders.cc
Differential Diagnosis in the DSM-5

- Pica, Rumination Disorder
  - Children F98.3
  - Adults F50.8
- Avoidant/Restrictive Food Intake Disorder F50.8
- Anorexia Nervosa
  - Restricting type F70
  - Binge-eating/purging type F71
- Bulimia Nervosa F50.2
- Binge Eating Disorder F50.8
- Other Specified Feeding or Eating Disorder
- Unspecified Feeding or Eating Disorder F50.9
- Rumination Disorder F98.21
Anorexia Nervosa

1. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health (no longer give a specific weight criteria).

2. Intense fear of gaining weight or becoming fat, even though underweight.

3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

Note no longer require loss of menses

Prevalence: 1% females, .02% are males
Bulimia Nervosa

- Recurrent episodes of binge eating characterized by BOTH of the following:
  - Eating in a discrete amount of time (within a 2 hour period) large amounts of food.
  - Sense of lack of control over eating during an episode.

- Recurrent inappropriate compensatory behavior in order to prevent weight gain (purging).

- The binge eating and compensatory behaviors both occur, on average, at least once a week for three months.

- Self-evaluation is unduly influenced by body shape and weight.

- The disturbance does not occur exclusively during episodes of anorexia nervosa

Prevalence: 2-3%, 10% of college age, males about 1/10 of the number of females.
Binge Eating Disorder

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - eating, in a discrete period of time (for example, within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances
  - a sense of lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating)
- The binge-eating episodes are associated with three (or more) of the following:
  - eating much more rapidly than normal
  - eating until feeling uncomfortably full
  - eating large amounts of food when not feeling physically hungry
  - eating alone because of feeling embarrassed by how much one is eating
  - feeling disgusted with oneself, depressed, or very guilty afterwards
- Marked distress regarding binge eating is present.
- The binge eating occurs, on average, at least once a week for three months.
- The binge eating is not associated with the recurrent use of inappropriate compensatory behavior (for example, purging) and does not occur exclusively during the course Anorexia Nervosa, Bulimia Nervosa, or Avoidant/Restrictive Food Intake Disorder.

Prevalence: 3%
Other Specific Eating Disorders

For individuals who have an eating disorder but it doesn’t fit the criteria for any one diagnosis. Examples include:

- Atypical anorexia nervosa: All of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range.

- Bulimia nervosa (of low frequency and/or limited duration): All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.

- Binge-eating disorder (of low frequency and/or limited duration): All of the criteria for binge-eating disorder are met, except the binge eating occurs, on average, less than once a week and/or for less than 3 months.

- Purging Disorder: Recurrent purging behavior to influence weight or shape (e.g., self-induced vomiting, misuse of laxatives, diuretics, or other medications) in the absence of binge eating.

- Night eating syndrome: Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better explained by external influences such as changes in the individual's sleep-wake cycle or by local social norms. The night eating causes significant distress and/or impairment in functioning. The disordered pattern of eating is not better explained by binge-eating disorder or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.
Statistics

- At least 30 million people of all ages and genders suffer from an eating disorder in the U.S. \(^1\), \(^2\)
- Every 62 minutes at least one person dies as a direct result from an eating disorder.\(^3\)
- Eating disorders have the highest mortality rate of any mental illness.\(^4\)
- 13% of women over 50 engage in eating disorder behaviors.\(^5\)
- In a large national study of college students, 3.5% sexual minority women and 2.1% of sexual minority men reported having an eating disorder.\(^6\)
- 16% of transgender college students reported having an eating disorder.\(^6\)
- In a study following active duty military personnel over time, 5.5% of women and 4% of men had an eating disorder at the beginning of the study, and within just a few years of continued service, 3.3% more women and 2.6% more men developed an eating disorder.\(^7\)
- Eating disorders affect all races and ethnic groups.\(^8\)
- Genetics, environmental factors, and personality traits all combine to create risk for an eating disorder.\(^9\)
Factors and Myths Related to Developing an Eating Disorder

Myths:

• People with eating disorders are vain and could get over it:
  • Highly Sensitive Personality
  • Serotonin, HPA, Glucocorticoid production,
• Due to Family Problems
• Will struggle their entire life
• Mainly a rich, white girl disease
• People with eating disorders are selfish

The truth about eating disorders:

• In summary, people who develop eating disorders are born with differences in their brain chemistry which increase their sensitivity to stimuli. This sensitivity develops into a heightened awareness of their own and other’s reactions which generally leads to harm avoidant strategies such as perfectionism, obsessive-compulsive behaviors, social avoidance, shyness and ultimately eating disorders. These strategies are faulty attempts to control the level of distress they may experience.

• Treatment involves recognizing that their sensitivity is both a blessing and a burden and learning more effective tools for coping.

sources

• http://www.umm.edu/patiented/articles/what-causes-eating-disorders_000049_3.htm
• http://www.anred.com/causes.html
• http://comp.uark.edu/~nlwill/polivy02.pdf
• http://www.actforyouth.net/resources/rt/rt_eatingdisorders_1106.pdf
Comparison of Prevalence and NIH Funding

<table>
<thead>
<tr>
<th>Illness</th>
<th>Prevalence</th>
<th>NIH Research Funds (2011)</th>
<th>Person/Year</th>
<th>Mortality/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s Disease</td>
<td>5.1 Million</td>
<td>$450 M</td>
<td>$88.24</td>
<td>-</td>
</tr>
<tr>
<td>Autism</td>
<td>3.6 Million</td>
<td>$160 M</td>
<td>$44.44</td>
<td>-</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>3.4 Million</td>
<td>$276 M</td>
<td>$81.18</td>
<td>-</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>30.0 Million</td>
<td>$28 M</td>
<td>$0.93</td>
<td>300,000</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>3.0 Million</td>
<td>$872 M</td>
<td>$290.67</td>
<td>40,000</td>
</tr>
</tbody>
</table>

**SOURCE:** NIH 2012, CDC 2012
Comparison of Mortality and NIH Funding per Disease

Comparison of Prevalance and NIH Funding Per Disease, 2014

- Alcoholism
- Breast Cancer
- Depression
- Smoking

Mortality Compared to NIH Funding
NIH 2014, CDC 2014,
Comparison of Mortality and NIH Funding per Disease with Eating Disorders Added

Comparison of Prevalance and NIH Funding Per Disease, 2014

- Eating Disorders
- Breast Cancer
- Depression
- Smoking
- Alcoholism

Mortality Compared to NIH Funding
NIH 2014, CDC 2013, ANAD, Archives of General Psychiatry, 68(7), 724-731. 2011
Prevalence, Mortality, and NIH Funding per Disease

Comparison of Prevalence and NIH Funding Per Disease, 2012

Prevalence Compared to NIH Funding
NIH 2012, CDC 2012, NAMI 2012,
Warning Signs

- **General Signs:** Makes excuses to skip meals and eats alone
- Preoccupation with food-related subjects in conversations
- Has difficulty admitting to problems and expressing feelings
- Makes self-critical statements about body and other aspects of self
- Worries excessively about other’s opinions
- Begins to isolate
- Becomes increasingly perfectionistic of self and others

- **Anorexia Nervosa:** Significant weight loss
- Focus on "good" foods and "bad" foods
- Drastically reduces fat in diet
- Makes statements indicating the perception of being overweight (though thin)
- Verbally denies being hungry
- Skips meals and may also purge food
- Engages in food rituals such as cutting food into small pieces, leaving food on plate, eating very slowly
- Engages in excessive exercise
- Develops other rituals such as having difficulty changing pen colors when note-taking, rigid schedule
Warning Signs Continued

- **Bulimia Nervosa**: Goes to restroom after meals
- Eats large quantities of food without gaining weight
- Eats rapidly
- Unexplained disappearance of food
- Has mood swings
- Appearance of laxative or diuretic wrapper in trash
- Swelling around the jaw, blood shot eyes, dental problems

- **Binge Eating Disorder**: Weight gain (though not always)
- Frequently eats large amounts of food rapidly
- Eats to the point of being overly full
- May eat only in isolation
Hans Solo Action Figures

1977

2010
Luke Skywalker 1977
Physiological Effects of Hunger: Deer Metaphor

- Increased production of adrenaline
- Difficulties sleeping
- Selective attention
- Obsessiveness
- Decrease in social interest
- Bingeing
The Vicious Binge-Purge Cycle

Use the diagram to:
Increase the understanding of the way each behavior maintains the cycle
Understand the role that under eating plays in maintaining the cycle, use of the deer metaphor
Brain storm ways to divert from the cycle at any point

Source: Bulimarexia, 1983
Family Based Treatment
The Maudsley Method

Basics of Family Based Treatment for adolescent Anorexia and Bulimia

Source:

- Agnostic view of etiology
- Alternative to inpatient hospitalization
- Evidence Based
- Empowers parents as primary vehicle to reefed their child
- Therapist is in an “expert witness” role

Completed in 3 phases:
- Phase 1: Re-feeding: parents take control of nutrition and engage in efforts to reefed their child while working with therapist to separate their child from the ED
- Phase 2: Return control: Once weight is restored, gradually return control of feeding back to child in developmentally appropriate way
- Phase 3: Return adolescent and family to normal, developmentally appropriate functioning: assist patient in getting back to normal without using the ED as a coping tool, address any non-ED related family issues.
Window of Opportunity (WOO) Journaling

- Goal 15 minutes prior to symptom use but can start small
- Journaling can take many forms
- Questions to contemplate
  - What am I feeling, where in my body?
  - What has happened to make me feel this way?
  - Do I feel this way often, does it go back to childhood?
  - What does a person who is feeling this way really need?
  - How will I feel if I do or don’t use symptom?
  - Is there anything else that I could do that would help even a little?

Source: Linda Buchanan, Ph.D.
Using Family Based Treatment

• How do you know when “classic” Family Based treatment will be a good fit?

• Appropriate age range (8-15 ideal)

• Family ego Strength:
  – Are parents/caregivers free of active eating disorders, addictions, mental illnesses?
  – Are parents in full understanding of their role and willing to make the commitment to home-based treatment?
Meal Groups: Using Grounding Statements and other Mindfulness Strategies

• Check in with hunger level (1-10), anxiety level (1-10) and grounding statements
  – It’s okay to enjoy food,
  – My body needs this,
  – This is on my meal plan
  – I’m eating enough to take me to my next planned eating experience
  – I’m not depriving myself
  – I can stop when I’m full

• Chaining as a mindfulness strategy

• Check out with hunger level, anxiety level and grounding statements
  – I didn’t eat too much
  – It’s okay to feel full
  – It’s okay to need food
  – This food will give me energy for my day
  – I am satisfied and can now focus my attention on other things

• Source: ACE and others
My Vision of The Good Life

• **PURPOSE:**
  To help patients clarify their image of the life lived well, a life in recovery, one consistent with their true values. This exercise helps identify treatment goals, to form a collaborative therapeutic relationship, to enable patients to own their recovery. The Vision is a tool to motivate patients with relevant goals to move towards.

• **DESCRIPTION:**
  “I am going to be your scribe. I would like you to tell me your vision of the life worth living, the good life. Think out loud about the aspects of your life you want to keep, the aspects you used to do and want to reclaim, and the parts you have never put into place but would like to.” Paraphrase what you hear in present tense, positive form. Phrase unrealized goals as, “I am moving toward” or “open to…”. If they state an “ego goal”, ask them for the meaning behind that goal…Ex: ”And if you were skinny, what would that mean?”…”Then no one would ever tease me.”…becomes “I use my voice to assert myself and surround myself with supportive people”. Offer them a copy to look at frequently. Review as treatment progresses.

• **SOURCE:** Rick Kilmer, PhD, adapted from a Harville Hendrix, PhD couples exercise.
<table>
<thead>
<tr>
<th>Belief</th>
<th>I’m not important</th>
<th>People always leave</th>
<th>I must be perfect to be accepted</th>
<th>People are more important than I am</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action</td>
<td>Say very little</td>
<td>Stay guarded in relationships</td>
<td>Never admit a mistake</td>
<td>Never ask for any kind of help or favor</td>
</tr>
<tr>
<td>Self-fulfilling prophesy</td>
<td>People don’t know me thus I feel unimportant</td>
<td>People leave because they don’t feel close to me</td>
<td>People are intimidated so don’t want to be close-still unaccepted</td>
<td>Others expect me to give so I continue to feel unimportant</td>
</tr>
<tr>
<td>Alternative Action</td>
<td>Talk about an interest of mine</td>
<td>Choose who to risk being open with</td>
<td>Admit to mistakes and allow others to see imperfections</td>
<td>Express a preference or need.</td>
</tr>
</tbody>
</table>
Miracle Day Exercise

- **TECHNIQUE:** Miracle Day Exercise

- **PURPOSE:**
  To help a client clarify his/her desired changes, envision life in recovery and increase motivation to change.

- **DESCRIPTION:**
  “Suppose tonight, while you are asleep, a miracle happens and you awake completely recovered. How will you be able to tell that a miracle has happened? What will you see, hear, think, feel and do that is different than your usual days? How would the other people in your life see, hear, and notice that is different about you? How would you and others describe the behaviors, attitudes and values in your new life?”

- **SOURCE:** Solution Focused Therapy.

- Contributed by: Rick Kilmer, PhD
Destroy The Scale

- **PURPOSE:**
  To end obsessive weighing and defining oneself by a machine that measures gravity.

- **DESCRIPTION:**
  Determine a satisfying manner in which to physically destroy your scale. Methods used have included heaving the scale from a high place, breaking with a hammer or ax, shooting scale with buckshot, etc. Some people write affirmations of independence prior to destruction on the scale and invite friends/family/group members to witness or participate in the ritual.

- **SOURCE:** ACE
Mindful Eating Exercise: Mindfulness of Mind Scale

- **PURPOSE:**
  For teaching mindful eating - either in individual nutrition counseling, meal group, or one on one meal coaching

- **DESCRIPTION:**
  10: Mindlessly unaware eating. I am zoned out and multitasking while I eat, unaware of portion sizes (eating out of the bag, standing in front of the refrigerator picking at food, grazing and grabbing handfuls, picking at the breadbasket).
  9: Taking big bites, eating very rapidly, finishing everything on my plate despite fullness. Having scattered thoughts. Eating while studying, reading, watching TV, or driving. Being unaware.
  8: Very inattentive to each bite. Just eating without checking in with self. Not really tasting the food.
  7: Moderately unaware of the process of eating. Eating with little awareness.
  6: Occasionally noticing taste, texture, and smell. Fleeting acknowledgment of sensations.
  5: Aware of portion size. Momentary acknowledgement of taste and attention to food and body cues.
  4: Briefly noticing taste and food sensations. Stopping to place and redirect attention when it wanders.
  3: Moderately present in the moment and attentive to eating process.
  2: Very alert. Diligently noticing flavors and temperature. Almost all attention is directed to eating.
  1: Mindfully aware eating. Completely present in the moment. Aware of every bite. Tasting each grain of salt and smoothness of yogurt. Noticing lifting the fork. Listening to the sound of chewing. Following sensations of food as it travels down my throat. Eating bite by bite.

- **SOURCE:** Adapted from Eat Drink and Be Mindful, Susan Albers, Psy.D....
The Basic Mindfulness Bite

• **PURPOSE:**
  For teaching mindful eating - either in individual nutrition counseling, meal group, or one on one meal coaching

• **DESCRIPTION:**
  The simplest technique of mindful eating is the Basic Mindfulness Bite. You can use this technique with any solid food.
  1. As you bring food to your mouth, slow down and become aware of your movements.
  2. Once the food is in your mouth, clear your hands. Put silverware or remaining food down.
  3. Chew this bite with your mind in laser-sharp focus on the process. Concentrate on the taste of the food and the act of eating. Do not do anything else while you are chewing. Simply chew and pay attention.
  4. Keep chewing until the food is uniformly smooth. Use this consistency of the food as a signal to swallow.
  5. After you swallow, but before you bring more food to your mouth, rest for a few seconds, thereby inserting a pause into your eating.

No matter what other technique or strategy you may use with mindful eating, this Basic Mindfulness Bite can serve you as the best starting point.

• **SOURCE:**
  Adapted from Discover Mindful Eating, Burggraf, M.Ed., Megrette Hammond RD, CDE
Medical Complications from Restrictive Eating Practices

Anorexia affects your whole body

- **Brain and Nerves**
  - can’t think right, fear of gaining weight, sad, moody, irritable, bad memory, fainting, changes in brain chemistry

- **Hair**
  - hair thins and gets brittle

- **Heart**
  - low blood pressure, slow heart rate, fluttering of the heart (palpitations), heart failure

- **Blood**
  - anemia and other blood problems

- **Muscles, Joints, and Bones**
  - weak muscles, swollen joints, bone loss, fractures, osteoporosis

- **Kidneys**
  - kidney stones, kidney failure

- **Body Fluids**
  - low potassium, magnesium, and sodium

- **Intestines**
  - constipation, bloating

- **Hormones**
  - periods stop, problems growing, trouble getting pregnant. If pregnant, higher risk for miscarriage, having a C-section, baby with low birthweight, and post partum depression.

- **Skin**
  - bruise easily, dry skin, growth of fine hair all over body, get cold easily, yellow skin, nails get brittle
Medical Criteria for Hospitalization

• Anorexia Nervosa
  – <75% ideal body weight
  – Refusal to eat, ongoing weight loss despite intensive outpatient therapy
  – Heart rate <50 beats per minute daytime, <45 beats per minute nighttime
  – Systolic blood pressure <90
  – Orthostatic changes in pulse (>20 beats per minute) or blood pressure (>10 mm Hg)
  – Hypothermia (body temperature <96 degrees F)
  – Arrhythmia
  – Electrolyte abnormalities

• Bulimia Nervosa
  – Syncope
  – Electrolyte disturbances:
    • Serum potassium < 3.2 mmol/L
    • Serum chloride < 88 mmol/L
  – Esophageal tears
  – Cardiac arrhythmias including prolonged QTc
  – Hypothermia
  – Intractable vomiting
  – Hematemesis

• Any Patient
  – Suicidality (ideation, plan, attempt)
  – Failure to respond to outpatient treatment

From Clinical Guideline for the Evaluation and management of patients with eating disorders, 2014
Anna B. Tanner, MD, FAAP, FSAHM
Common forms of Ambivalence

- Power Struggles
- Manipulation
- Splitting
- Avoidance
- Denial
- Therapist Error

JUST THINK OF ME AS AN AGENT OF CHANGE.
When to Refer for Intensive Outpatient

- No behavior change after one month of traditional outpatient therapy (individual, family, nutrition, psychiatry)

- Severity of symptoms suggesting direct referral to Intensive Outpatient treatment
  - Weight less than 85% of expected weight give height and weight and pt’s growth chart
  - Binging and/or purging weekly
  - Milder symptoms persisting more than two months.

- Power of Group Therapy and Milieu
Feeding and Eating Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Disorder</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>F98.3</td>
<td>Pica</td>
<td>Feeding and Eating Disorders</td>
</tr>
</tbody>
</table>

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).
Feeding and Eating Disorders

Pica

F98.3 in children
F50.8 in adults

Criteria:

A. Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.

B. The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.

C. The eating behavior is not part of a culturally supported or socially normative practice.

D. If the eating behavior occurs in the context of another mental disorder or medical condition, it is sufficiently severe to warrant additional clinical attention.

Specify if: In remission: After full criteria for pica were previously met, the criteria have not been met for a sustained period of time.
Neurodevelopmental Disorders

May 6, 2017
Sheryl K. Pruitt, M.Ed., ET/P
Parkaire Consultants
Regulatory Disorders

- Tourette’s Disorder
- Obsessive Compulsive Disorder
- Other Anxiety Disorders
- Mood Disorders
- Autistic Spectrum
- Stuttering
- Sleep Disorders
- Sensory Defensiveness
- Attention Deficit Hyperactivity Disorder
- © Sheryl K. Pruitt, M.Ed., 1999
Non-Regulatory Disorders

- Intellectual Developmental Disorder
- Learning Disabilities
- Executive Dysfunction
- Memory Disorders
- Speech Disorders
- Language Disorders
- Social Engagement Disorder
- Visual-Motor Disability
- Slow Processing Speed
Intellectual Developmental Disorder

- Must have standardized intelligence testing.
- Must have deficient adaptive living skills which include communication, daily living self-care skills and social skills.
Screening for Intellectual Developmental Disorder

- Consistently low scores on IQ tests including subtests on intelligence testing.
- Has difficulty making and keeping friends.
- Is not good at higher level communications, e.g. inferences and cause and effect.
Autism Spectrum Disorder

- Poor social communication and reciprocity
- Restricted, repetitive patterns of behavior
- Inflexible
- Communication deficits
- Motor skills deficits
- Does not have Theory of Mind

They walk away from me when I start talking about trains.”
Lacking Theory of Mind

• Cannot understand how my mind works

• Cannot understand how your mind is different than my mind

• Can exist as a problem outside of Autism

• Refer for speech and language evaluation, e.g., deficits in cause and effect and abstract language.

• Refer for an occupational therapy evaluation with someone who specializes in autism and sensory defensiveness.

• Screen for co-morbid and associated disorders.
• See if single or limited interest.
• Can be very literal.
• Has repetitive behaviors.

“They walk away from me when I start talking about trains.”
Who turned out the Lights?! 

This is what your brain looks like “ON” ADHD.

**Hallmarks of ADHD**

- Dysregulation of attention
- Distractibility
- Impulsivity
- Hyperactivity (optional)
- Arousal difficulties in the frontal lobes.
Tips for Screening ADHD

Use an ADHD checklist such as the Connors or Vanderbilt.

• Take a history of the impact of ADHD on the person’s life.

• See if there is history in the family of similar behaviors.

• Are they hyperactive (optional), distractible, inattentive and impulsive

“What did I do wrong this time?!”
Information Processing

- Learning Disabilities
- Speech/Language Problems
- Visual Processing Problems
Speech

Oral Mechanism
- Tongue
- Lips
- Teeth
- Palate and uvula
- Nose and throat
- Breathing
- Mechanism

Articulation
- Omissions
- Substitutions
- Distortions

Voice
- Pitch
- Volume
- Resonance
- Quality
- Vocal
- Abuse

Fluency
- Rate
- Rhythm
- Prosody
Communication Disorders

Difficulty with:
- Hearing
- Speech
  - Articulation
  - Oral Motor
- Language
  - Receptive
  - Expressive
- Social Skills
  - Pragmatic Language
The ability to be an effective communicator. An effective communicator is one who is able to process and express language in both social and educational settings. Processing means ability to sequence, recall, retrieve, organize and express information effectively and in a timely manner.
Auditory Processing

Auditory Perception
Auditory Discrimination
Memory
Sequencing
Analysis
Synthesis
Closure
Figure Ground

Receptive Vocabulary
Expressive Language

• The ability to say or write what you want and have it understood.

• Vocabulary
• Syntax
• Semantics
• Morphology
• Verbal/Written
Pragmatics

• Communicate Intent
• Stay on Topic
• Follow Turn Taking Routines
• Cue Listener to Topic Changes
• Use of Clarification Strategies When Misunderstood
• No Excessive Verbiage

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Disinhibited Social Engagement Disorder

One of the leading causes of teenage depression is social failure.

The impact of social failure can be deadly!

Cyberbullying is one of the leading causes of depression and suicidal ideation and execution!

“I do not know why they won’t be friends with me and it hurts my feelings.”
Tips for Screening Disinhibited Social Engagement Disorder

• Has trouble making and keeping friends.

• Cannot take the perspective of others.

• Has difficulty reading social cues.

• Cannot resolve conflicts with friends.

“I do not know why they won’t be friends with me and it hurts my feelings.”
LEARNING DISABILITIES

Difficulties with:

1. Oral Expression
2. Listening Comprehension
3. Basic Reading Skills
4. Reading Comprehension
5. Written Expression
6. Math Calculation
7. Math Reasoning
8. Spelling

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Dyslexia

• Has trouble sounding out letters, blending sounds and memorizing sight vocabulary.

• Struggles to write essays and term papers.

• Has difficulty spelling

• Has trouble with word problems.

• Has trouble with memory for sequences and facts.

• Has normal intelligence or is brighter than most people.

• Is a learning disability.
WRITTEN EXPRESSION
Learning Disability

Difficulties With:

- Handwriting
- Initiating
- Persisting
- Organization
- Editing
- Memory
- Retrieval
- Impulsivity
- Prioritizing

Look at work samples and grades in writing reports.

Learning Disorders

Can have math anxiety.

• Has trouble lining up problems.
• Struggles to memorize math facts.
• Cannot do the order of long division.
• Has great difficulty with word problems.
• Has struggled for a long time in math and has a history of low standardized math test scores.

"I can't learn like other kids and I feel stupid!"
Stereotypic Movement

- Self-injurious behaviors such as lip biting, head banging
- More males than females
- Sometimes caused by drugs such as amphetamines
- Can be the result of head injuries
Screening Stereotypic Movement Disorders

- Look for self-injurious behavior
- Body rocking
- Head banging
- Refer to a neurologist or psychiatrist

These behaviors can interfere with daily functioning.
Developmental Coordination Disorder

- Gross motor delays
- Fine motor delays
- Knowing position in space
- Motor planning deficits
- Maintaining a stable posture
- Difficulties with daily living skills
- Clumsy
Graphomotor Skills
Tips for Screening Developmental Coordination Disorder

Look for:

Handwriting difficulties.
A history of accidents.
Difficulty with sports such as cannot catch a ball.
Trouble skipping.
Problems dressing, e.g., buttoning, zipping.
Tourette’s Disorder

• Tics are brief, purposeless, repetitive, involuntary movements or sounds that usually occur in bouts.

• Tics may be simple or complex and are often confused with allergies, habits, or misbehavior.
Tips for Screening Tourette’s Disorder

• Check for a history of habits in the family history.

• See if Dad has a history of ADHD and Mom a history of anxiety or perfectionism.

• Eyeblinking and throat clearing are the most common motor and vocal

A history of being difficult to medicate can come with tic disorders.
Tourette’s Disorder with Obsessive-Compulsive Disorder

- Obsessions and compulsions are different when co-morbid with Tourette’s Disorder, e.g., “just right” and “the moral policeman.”

- Very few compulsions are observable if any co-morbid disorders such as ADHD, TD or mood disorders are also present.

- OCD and Tourette Disorder are related genes and screen all TD and siblings for anxiety disorders.
Tourette Disorder with Mood Disorders

- Look for chronic irritability
- Having both together makes it more difficult to medicate the mood disorder.
- Screen for Bipolar Disorder

“When I am depressed, I feel so blue!”
Sensory Integration

- Takes place from infancy through childhood. A child usually matures and is well integrated by 8-10 years of age, but sensory processing continues to be refined throughout life.

- Occurs on an unconscious level, whereas thinking and cognition are more conscious processes.

- Is developed and/or enhanced by sensory experiences.

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Screen Motor Components Essential for Learning

• **Bilateral Coordination**
  is the ability to coordinate the right and left sides of the body and to cross midline of the body.

• **Fine Motor Control**
  is the ability to precisely utilize one’s hands and fingers in skilled activity.

• **Praxis**
  is the ability of the brain to conceive of, organize and carry out a sequence of unfamiliar action.
Screening for Fine Motor/Coordination Difficulties

- Difficulty manipulating small objects
- Poor desk posture
- Difficulty drawing, coloring, copying, cutting, and avoidance of these activities
- Poor pencil grasp; drops pencil frequently
- Hand dominance not well established
- Difficulty in dressing, buttons, zippers, tying shoes
Screen for Sensory Defensiveness

- Smelling
- Seeing
- Tasting
- Hearing
- Touching
- Proprioceptive
- Vestibular

Photo Credit C. Wang

© 2011 Challenging Kids, Inc.
Sensory Defensiveness

- Refer to occupational therapy.
- See if the child does not like labels in shirts...cuts them out.
- Watch for sensory overload settings such as cafeteria, assemblies and playgrounds where behavior problems occur.
- See if child is a picky eater, e.g., will not eat raw tomatoes or eats a very restrictive diet.

“Make the firm alarm bell stop!”
The Executive Functions Are the Cuing of the Executive Skills!
The “Dreaded Book Bag Diagnostic Test”

Photo credit, Colleen Wang
“He is such a good boy. I just don’t know enough things to tell him not to do?”

-Ferrell Sams
EXECUTIVE FUNCTION SKILLS

- Set Goals
- Initiate
- Prioritize
- Pace
- Plan
- Sequence
- Organize

EXECUTIVE FUNCTION SKILLS

- Shift
- Use Feedback
- Inhibit
- Self-Monitor
- Problem Solve
- Execute
- Generalize
Now! Or Not Now!
Teach them to do it now - not later! Later is a lie!
Executive Dysfunction

- Client is “clueless” in spite of being very smart.
- Screen for organizational problems.
- Screen for social problems due to missing social cues.
- Check on the ability to write a document.
- Check to see if gets roles of family members.
Memory Functioning

Spared Memory

Short-Term Memory
Immediate Memory
Long-Term Memory
Declarative Memory
Semantic Memory
Episodic Memory

Memory Functioning

Impaired Memory

Short-Term Memory
Working Memory
Long-Term Memory
Procedural Memory
Prospective Memory
Metamemory
Strategic Memory
Tips for Screening Memory Problems

- Cannot follow multiple oral directions, like a shortage of RAM.
- Cannot remember sequences.
- Has an inability to remember the future.
- Cannot visualize when reading.
- Does not hold on to what was taught this year when next year comes.
Slow processing speed is reported by researchers to exist in one-fourth to one-half of students with ADHD-Inattentive Type.

Processing Speed Influences:
- Sustained Attention
- Executive Functions
- Memory
- Academic Achievement
- Behavior
- Social Competence

Tips for Screening for Slow Processing Speed

• Look for ADHD-Inattentive Type

• Responds more slowly in conversation.

• See if completes classwork and tests on time.

• Requires extra time for everything!

• The Fast ForWord® Program

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©Tigers, Too, 2009
PANS, PITANDS, and PANDAS, Oh My!

Title: Raymond A. Cattaneo, 2011

© modified from L.E. Packer, 1999 by Sheryl K Pruitt, MEd, ET/P, 2012
Hey, you forgot Oppositional Defiant Disorder!!

Did Not!!!!
Pathways to “Storms” or “Fight-or-Flight” Behavior

- Depression/ Bipolar Disorder
- Attention Deficit Hyperactivity Disorder
- Obsessive-Compulsive Disorder
- Executive Dysfunction
- Sleep Disorders or Fatigue
- Learning Disabilities
- Nonverbal Learning Disability
- Social Impairments
- Anxiety Disorders
- Autistic Spectrum Disorders
- Sensory Defensiveness
- Complex Partial Seizures
- Traumatic Brain Injury
- Language Processing Deficits
- Medication Side Effects
Curiosity vs Judgment!
Just Try Harder!

© Leslie E. Packer, Ph.D., 1999
Tigers, Too

Tigers, Too
Supplements

1. Checklists and Objectives for the Classroom

and

2. Assessment

www.parkairepress.com
Challenging Kids, Challenged Teachers

www.parkaireconsultants.com
Tourette Syndrome

© Edited by James F. Leckman, MD and Davide Martino, MD, 2013
Credits....

Thanks go to Leslie Packer, Ph. D. for her constant support and contributions for several of the power point slides used here today.

Thanks also to Marilyn Dornbush, Ph.D. and Warren Walter, Ph.D. for their contributions and support to several power point slides today.

Thanks especially to my husband, Daniel G. Pruitt, PCC, SCAC, who has been my supporter, partner in our clinic, my publisher, and a contributor to this presentation.

Dedication

This program is cheerfully dedicated to the author's family, who have cleverly managed to have almost every problem described. Any problem my husband and I did not have I gave birth to. They are my first, and best, teachers.
Elimination Disorders

Diagnostic criteria and differential diagnosis
Elimination Disorders
Diagnostic Features

• Elimination disorders involve the inappropriate elimination of urine or feces and are usually first diagnosed in childhood or adolescence. This group of disorders includes enuresis, the repeated voiding of urine into inappropriate places, and encopresis, the repeated passage of feces into inappropriate places. Subtypes are provided to differentiate nocturnal from diurnal (i.e., during waking hours) voiding for enuresis and the presence or absence of constipation and overflow incontinence for encopresis. Although there are minimum age requirements for diagnosis of both disorders, these are based on developmental age and not solely on chronological age. Both disorders may be voluntary or involuntary. Although these disorders typically occur separately, co-occurrence may also be observed.
Elimination Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Disorder</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>F98.0</td>
<td>Enuresis</td>
<td>Elimination Disorders</td>
</tr>
</tbody>
</table>

Criteria:

A. Repeated voiding of urine into bed or clothes, whether involuntary or intentional.
B. The behavior is clinically significant as manifested by either a frequency of at least twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in functioning.
C. Chronological age is at least 5 years
D. The behavior is not attributable to the physiological effects of a substance or another medical condition.

Specify whether:
Nocturnal only: Passage of urine only during nighttime sleep.
Diurnal only: Passage of urine during waking hours.
Nocturnal and diurnal: A combination of the two subtypes above.
Elimination Disorders

<table>
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<tr>
<th>Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>F98.1</td>
<td>Encopresis</td>
<td>Elimination Disorders</td>
</tr>
</tbody>
</table>

Criteria:

A. Repeated passage of feces into inappropriate places (e.g., clothing, floor), whether involuntary or intentional.
B. At least one such event occurs each month for at least 3 months.
C. Chronological age is at least 4 years
D. The behavior is not attributable to the physiological effects of a substance or another medical condition except through a mechanism involving constipation.

Specify whether:

With constipation and overflow incontinence: There is evidence of constipation on physical examination or by history.
Without constipation and overflow incontinence: There is no evidence of constipation on physical examination or by history.
Somatic Symptom and Related Disorders

Diagnostic criteria and differential diagnosis
Somatic Symptom and Related Disorders
Diagnostic Features

• A distinctive characteristic of many individuals with somatic symptom disorder is not the somatic symptoms per se, but instead the way they present and interpret them. Incorporating affective, cognitive, and behavioral components into the criteria for somatic symptom disorder provides a more comprehensive and accurate reflection of the true clinical picture than can be achieved by assessing the somatic complaints alone.

• A number of factors may contribute to somatic symptom and related disorders. These include genetic and biological vulnerability, learning, as well as cultural/social norms that devalue and stigmatize psychological suffering as compared with physical suffering. Differences in medical care across cultures affect the presentation, recognition, and management of these somatic presentations. Variations in symptom presentation are likely the result of the interaction of multiple factors within cultural contexts that affect how individuals identify and classify bodily sensations, perceive illness, and seek medical attention for them. Thus, somatic presentations can be viewed as expressions of personal suffering inserted in a cultural and social context.
## Somatic Symptom and Related Disorders

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>F45.1</td>
<td>Somatic Symptom Disorder</td>
<td>Somatic Symptom and Related Disorders</td>
</tr>
</tbody>
</table>

Criteria:
A. One or more somatic symptoms that are distressing or result in disruption of daily life.
B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or health concerns as manifested by at least one of the following:
   1. Disproportionate and persistent thoughts about the seriousness of one’s symptoms.
   2. High level of anxiety about health or symptoms.
   3. Excessive time and energy devoted to these symptoms or health concerns.
C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

**Specify if:** With predominant pain: This specifier is for individuals whose somatic symptoms predominantly involve pain.

**Specify if:** Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).

**Specify current severity:** Mild: Only one of the symptoms specified in Criterion B is fulfilled.
   Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.
   Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).
Somatic Symptom and Related Disorders

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</tr>
</thead>
<tbody>
<tr>
<td>F45.21</td>
<td>Illness Anxiety Disorder</td>
<td>Somatic Symptom and Related Disorders</td>
</tr>
</tbody>
</table>

Criteria:
A. Preoccupation with having or acquiring a serious illness.
B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history), the preoccupation is clearly excessive or disproportionate.
C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
D. The individual performs excessive health-related behaviors or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).
E. Preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

Specify whether: Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used.  
Care-avoidant type: Medical care is rarely used.
Somatic Symptom and Related Disorders
Conversion Disorder (Functional Neurological Symptom Disorder)

Criteria:

A. One or more symptoms of altered voluntary motor or sensory function.
B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.
C. The symptom or deficit is not better explained by another medical or mental disorder.
D. The symptom or deficit causes clinically significant impairment in functioning or warrants medical evaluation.

Specify Symptom Type:

- F44.4- With weakness or paralysis
- F44.4- With abnormal movement (e.g., tremor, dystonic movement, gait disorder)
- F44.4- With swallowing symptoms
- F44.4- With speech symptom (e.g., dysphonia, slurred speech)
- F44.5- With attacks or seizures
- F44.6- With anesthesia or sensory loss
- F44.6- With special sensory symptom (e.g., visual, olfactory, or hearing disturbance)
- F44.7 With mixed symptoms
Somatic Symptom and Related Disorders
Conversion Disorder (Functional Neurological Symptom Disorder)

• Specify if: Acute episode- Symptoms present for less than 6 months.
  Persistent- Symptoms occurring for 6 months or more.

• Specify if: With psychological stressor (specify stressor)
  Without psychological stressor
Somatic Symptom and Related Disorders

Criteria:

A. A medical symptom or condition (other than a mental disorder) is present.
B. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:
   1. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
   2. The factors interfere with the treatment of the medical condition
   3. The factors constitute additional well-established health risks for the individual.
   4. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.
C. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder

Specify current severity:
Mild: Increases medical risk (e.g., inconsistent adherence with antihypertension treatment). Moderate: Aggravates underlying medical condition (e.g., anxiety aggravating asthma).
Severe: Results in medical hospitalization or emergency room visit. Extreme: Results in severe, life-threatening risk (e.g., ignoring heart attack symptoms).
Somatic Symptom and Related Disorders

<table>
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</thead>
<tbody>
<tr>
<td>F68.10</td>
<td>Factitious Disorder</td>
<td>Somatic Symptom and Related Disorders</td>
</tr>
</tbody>
</table>

Criteria:

Factitious Disorder Imposed on Self
A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.
B. The individual presents himself or herself to others as ill, impaired, or injured.
C. The deceptive behavior is evident even in the absence of obvious external rewards.
D. The behavior is not better explained by another mental disorder

Specify: Single episode/ Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

Factitious Disorder Imposed on Another (Previously Factitious Disorder by Proxy)
A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
B. The individual presents another individual (victim) to others as ill, impaired, or injured.
C. The deceptive behavior is evident even in the absence of obvious external rewards.
D. The behavior is not better explained by another mental disorder

Note: The perpetrator, not the victim, receives this diagnosis. Specify: Single episode/ Recurrent episodes (two or more events of falsification of illness and/or induction of injury)