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FUNDAMENTALS OF PSYCHOLOGICAL DISORDERS

CONTENTS

MODULE 16: DISORDERS OF CHILDHOOD OVERVIEW

3rd edition as of July 2023

Module Overview

In Module 16, we will provide an overview of disorders of childhood. Please note that a more comprehensive discussion can be found in our Behavioral Disorders of Childhood book (<https://opentext.wsu.edu/behavioral-disorders-childhood/>). Section 16.1 will cover the following disorders of infancy and early

childhood to include disinhibited social engagement disorder, reactive attachment disorder, pica, rumination disorder, and avoidant/restrictive food intake disorder, enuresis, and encopresis. In Section 16.2 we will discuss developmental and motor-related disorders to include intellectual developmental disorder (intellectual disability), specific learning disorder, autism spectrum disorder, social (pragmatic) communication disorder, stereotypic movement, and tic disorders.

In Section 16.3 we cover behavior-related disorders to include ADHD, oppositional defiant disorder, conduct disorder, and intermittent explosive disorder. Finally, Section 16.4 will cover select disorders not previously presented in this book in previous sections. These disorders include the anxiety disorders of selective mutism and separation anxiety disorder and the obsessive-compulsive and related disorders of trichotillomania, and excoriation disorder.

For all disorders we will cover their clinical presentation, prevalence, comorbidity. We will also cover differential diagnosis when relevant. For a discussion of etiology, assessment, and treatment options please see the **Behavioral Disorders of Childhood** book from which this content is derived (see link above and throughout this book). As the two books are written by the same authors and follow the same format, the content of this module is consistent with The Fundamentals of Psychological Disorders book you have been reading through Module 15. Also note that for disorders covered already in this book, the Behavioral Disorders of Childhood book will have more pertinent information related to childhood and adolescence. Our focus in this book has been on adulthood primarily.

Be sure you refer to Modules 1-3 for explanations of key terms (Module 1), an overview of the various models to explain psychopathology (Module 2), and descriptions of therapies (Module 3).

Module Outline

- 16.1. Disorders of Infancy and Early Childhood
- 16.2. Developmental and Motor-related Disorders
- 16.3. Behavior-related Disorders
- 16.4. Other Disorders

Module Learning Outcomes

- Describe disorders of infancy and early childhood to include their clinical presentation, prevalence, and comorbidity.
 - Describe developmental and motor-related disorders to include their clinical presentation, prevalence, and comorbidity.
 - Describe behavior-related disorders to include their clinical presentation, prevalence, and comorbidity.
 - Describe childhood-specific anxiety and obsessive-compulsive and related disorders to include their clinical presentation, prevalence, and comorbidity.
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16.1. DISORDERS OF INFANCY AND EARLY CHILDHOOD

Section Learning Objectives

- Describe the clinical presentation, prevalence, and comorbidity of disinhibited social engagement disorder.
- Describe the clinical presentation, prevalence, and comorbidity of reactive attachment disorder.
- Describe the clinical presentation, prevalence, and comorbidity of pica.
- Describe the clinical presentation, prevalence, and comorbidity of

rumination disorder.

- Describe the clinical presentation, prevalence, and comorbidity of avoidant/restrictive food intake disorder.
- Describe the clinical presentation, prevalence, and comorbidity of enuresis.
- Describe the clinical presentation, prevalence, and comorbidity of encopresis.

16.1.1. Disinhibited Social Engagement Disorder

16.1.1.1. Clinical Presentation. We will explore disinhibited social engagement disorder in terms of: (1) how the child presents and (2) the history of the child. Let's start with how the child presents. These children, unlike children with reactive attachment disorder described below, tend to be overly social and interact with complete strangers. The child may walk up to someone in a store they have never met and hug them or even walk away with them. They may do this without ever hesitating when separating from their caregiver and might not even look to check back with their caregiver.

In terms of the history of the child, these children often experience *impaired caregiving*, which means that the caregiver does not sufficiently care for the child on a consistent basis. This could result from a child simply not being attended by their caregivers. Perhaps the parent does not interact with them regularly, or the basic needs of the child are not appropriately cared for, such as food, hygiene, and shelter. The child may be in a setting in which there are not enough caregivers to care for them consistently (e.g., an orphanage in which there are only a few caretakers with several infants), or they may not have had one consistent caregiver (e.g., they moved from one foster care setting to another regularly). These situations interrupt the attachment and security of a developing child. It should be noted that the child will have a developmental age of at least 9 months.

Disinhibited social engagement disorder may co-occur with developmental delays such as cognitive and language delays, stereotypies, and other signs of severe neglect. Signs of the disorder often persist even after these other signs of neglect are absent. As such, it is not uncommon for children with disinhibited social engagement disorder to present with no current signs of neglect. The DSM adds that the condition can present in children who show no signs of disordered attachment. “Thus, disinhibited social engagement disorder may be seen in children with a history of neglect who lack attachments or whose attachments to their caregivers range from disturbed to secure” (APA, 2022, pg. 299).

The functional consequences of disinhibited social engagement disorder include impairment of a young child’s abilities to relate interpersonally to adults and peers. Social functioning and social competence may be impaired and there may be increased risk for peer conflicts and victimization.

16.1.1.2. Prevalence. The prevalence of disinhibited social engagement disorder is largely unknown (APA, 2022) and considered to be extremely rare. The DSM notes that prevalence is up to 2% in low-income community populations in the United Kingdom.

16.1.1.3. Comorbidity. Cognitive and language delays, autism spectrum disorder, as well as stereotypies are often comorbid with disinhibited social engagement disorder. ADHD and externalizing disorders are often comorbid in younger children and in middle childhood (APA, 2022).

16.1.2.4. Differential Diagnosis. Disinhibited social engagement disorder must be differentiated from ADHD. Unlike ADHD, children with disinhibited social engagement disorder do not show difficulties with either attention or hyperactivity (APA, 2022).

Additionally, the medical condition of Williams syndrome, caused by a partial chromosomal deletion, may mimic disinhibited social engagement disorder

symptoms (Zeanah, et al., 2016). These children struggle with social discrimination and tend to be overly approaching to strangers. However, they display this behavior despite not having a history of neglect/trauma symptoms (Zeanah, et. al, 2016). As such, if a child is socially disinhibited, but has no history of neglect, disinhibited social engagement disorder is not the likely diagnosis. In fact, it may be that the behavior is caused by a more medically-based etiology such as Williams syndrome.

16.1.2. Reactive Attachment Disorder

16.1.2.1. Clinical Presentation. We will discuss reactive attachment disorder in much the same way as disinhibited social engagement disorder starting with how the child presents. Children with this disorder typically present as detached from others or emotionally withdrawn. They do not seek comfort from caregivers or respond to physical touch when distressed. These children typically have low levels of expressed emotions, particularly positive emotions. They may experience unexplained irritability, sadness, and fearfulness.

In terms of the history of the child, similar to disinhibited social engagement disorder, the child will have experienced a pattern of extremes of insufficient care manifested as one of the following: social neglect or deprivation; repeated changes of primary caregivers that restrict their ability to form stable attachments, and/or rearing in unusual settings that do not allow for the formation of attachments. The clinical features of the disorder manifests between the ages of 9 months and 5 years.

Associated features include developmental delays, especially in cognition and language. Reactive attachment disorder impairs a young child's ability to relate interpersonally to adults or peers and causes functional impairment across many domains of early childhood.

16.1.2.2. Prevalence. The prevalence of reactive attachment disorder is largely unknown and considered extremely rare. Young children exposed to severe neglect often present with reactive attachment disorder before being placed in foster care or institutions. Despite this, the disorder is uncommon and occurs in less than 10% of neglected children, even when severe neglect has occurred (APA, 2022).

16.1.2.3. Comorbidity. Cognitive and language delays, severe malnutrition, as well as stereotypies are often comorbid with reactive attachment disorder. There may be a comorbidity with ADHD, though this is not clearly established.

16.1.2.4. Differential Diagnosis. Due to the significant deficit in emotional-social reciprocity, autism spectrum disorder must be differentiated from reactive attachment disorder. Whether or not a child was neglected, and the presence or absence of restricted or repetitive behaviors/interests, help differentiate the two disorders (APA, 2022). If a child has no history of severe neglect or abuse, the diagnosis of autism spectrum disorder is more likely than reactive attachment disorder. If the child does not have restricted/repetitive behaviors/interests, the child is not likely to be diagnosed with autism spectrum disorder, and as such, deficits in social/emotional reciprocity are more likely to be explained by reactive attachment disorder, particularly if there is a significant neglect/abuse history.

For more on disinhibited social engagement disorder and reactive attachment disorder please visit: <https://opentext.wsu.edu/behavioral-disorders-childhood/chapter/module-4-disinhibited-social-engagement-disorder-and-reactive-attachment/>

16.1.3. Pica

16.1.3.1. Clinical Presentation. Pica is the act of eating items that are not

food on a regular or recurring basis over a period of at least one month. These nonnutritive, nonfood substances could include grass, chalk, dirt, paper, hair, soap, wool, paint, gum, pebbles, coal, ash, or starch, to name a few. Pica can impair physical functioning but any impairment in social functioning usually occurs in conjunction with other disorders. The behavior is inappropriate to the developmental level of the child, so it should not be diagnosed before age 2 to exclude developmentally normal mouthing of objects leading to ingestion, typical of infants. Also, the behavior should not be part of a culturally supported or socially normative practice such as ingesting a particular grass for medicinal or spiritual purposes (APA, 2022). Pica is not often associated with specific biological abnormalities, though deficiencies in vitamins and minerals such as iron and zinc, have been reported.

Pica may occur more frequently in disorders such as autism spectrum disorder (or other mental health disorders); however, a clinician must be careful to ensure that the act of eating nonfood items is to a higher degree than would be expected if another disorder is present. For example, if a child regularly attempts to eat grass because they like the oral stimulation of it, and are diagnosed with autism spectrum disorder, a clinician must determine if the individual is attempting to ingest a nonfood item, or if they are trying to orally stimulate. If the individual is only trying to orally stimulate, they would not be diagnosed with pica.

16.1.3.2. Prevalence. Limited data suggests that the prevalence of pica is around 5% of school-age children and a third of pregnant women engage in pica, especially if they have food insecurity (APA, 2022; Murray, Thomas, Hinz, Munsch, & Hilbert, 2018). Some studies indicate that pica is more common in males than females (El-Nemer, Alian, Salah-Eldin, Khalil; 2014) whereas others do not show a significant difference between genders (APA, 2022; Murray et al., 2018). A worldwide meta-analysis showed a prevalence of 28% during pregnancy and/or the postpartum period (APA, 2022).

16.1.3.3. Comorbidity. Autism spectrum disorder and intellectual

developmental disorder (intellectual disability) are the two most common comorbid diagnoses. Less common are schizophrenia and OCD. Pica may also be comorbid with trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder, and avoidant/restrictive food intake disorder.

16.1.4. Rumination Disorder

16.1.4.1. Clinical Presentation. **Rumination disorder** is the frequent act of regurgitating food over a period of at least 1 month with no medical explanation such as gastroesophageal reflux and in the absence of a body-image/weight-related reason such as anorexia, bulimia, and binge-eating disorder. An individual may rechew and then eject the food from the mouth or re-swallow (APA, 2022).

Functional consequences of rumination disorder include growth delay due to malnutrition secondary to repeated regurgitation. Though the onset of the disorder can occur at any time during life, when it begins in infancy, the age at onset is between ages 3 and 12 months, and it can be fatal.

16.1.4.2. Prevalence. Limited European data suggests a prevalence of 1% to 2% of grade-school-age children.

16.1.4.3. Comorbidity. Rumination disorder also occurs more frequently in individuals with an intellectual disability (Olden, 2001). It can occur in the context of a concurrent medical condition or another mental disorder such as generalized anxiety disorder.

16.1.5. Avoidant/Restrictive Food Intake Disorder

16.1.5.1. Clinical Presentation. Avoidant/restrictive food intake disorder is a new disorder to the DSM 5 (APA, 2013) and replaces and extends the DSM-IV diagnosis of feeding disorder of infancy or early childhood (Norris & Katzman, 2015). It is an eating or feeding disturbance associated with at least one of the following: 1) significant weight loss, 2) significant nutritional deficiency, 3) dependence on enteral feeding or oral nutrition supplements, and 4) marked interference with psychosocial functioning. The disturbance is not better explained due to a lack of available food or a culturally sanctioned practice.

The food avoidance or restriction may occur due to the sensory characteristics of qualities of food such as its appearance, color, smell, texture, taste, or temperature. It may occur due to a conditioned negative response associated with food intake following, or in anticipation of, an aversive event such as choking, repeated vomiting, or a traumatic procedure. And for some, the food avoidance or restriction occurs due to a lack of interest in eating or food.

16.1.5.2. Prevalence. Prevalence rates are largely unknown. A study in Australia reported a frequency of 0.3% among individuals aged 15 years and up. Avoidant/restrictive food intake disorder is more common in children with autism spectrum disorder and when so, has a male predominance. This is possibly due to sensory concerns and rigidity that leads to children having very specific preferences for foods. Children may actively refuse to eat many foods due to texture aversions. When autism spectrum disorder is not comorbid, the disorder occurs about equally between males and females.

16.1.5.3. Comorbidity. As mentioned, autism spectrum disorder is a common comorbid disorder. Other neurodevelopmental disorders may be highly comorbid such as ADHD, intellectual development disorder (intellectual disability), anxiety disorders, and OCD (APA, 2022).

For more on pica, rumination disorder, and avoidant/restrictive food

16.1.6. Enuresis

16.1.6.1. Clinical Presentation. Enuresis is the repeated voiding of urine into bed or clothes and can be involuntary or intentional. It has occurred at least two times per week for the past three consecutive months. The child must also be at least five years of age. Mental health professionals can specify whether the enuresis is nocturnal only (i.e., urinary incontinence only while sleeping), diurnal only (i.e., urinary incontinence only while awake), or nocturnal and diurnal (i.e., both while asleep and awake; APA, 2022). The nocturnal only type is most common and occurs during the first one-third of the night. Diurnal enuresis most commonly occurs in the early afternoon on school days or after coming home from school. The degree of impairment is a function of, “...the limitation on the child’s social activities (e.g., ineligibility for sleep-away camp) or its effect on the child’s self-esteem, the degree of social ostracism by peers, and the anger, punishment, and rejection on the part of caregivers” (APA, 2022, pg. 401).

16.1.6.2. Prevalence. Daytime incontinence has a prevalence between 3.2% and 9.0% in children aged 7 years, from 1.1.% to 4.2% in youth ages 11-13 years, and from 1.2% to 3.0% in adolescents ages 15-17 years of age. Nocturnal enuresis is more common in males than females.

16.1.6.3. Comorbidity. Most children with enuresis do not have a comorbid mental disorder. That said, the prevalence of comorbid behavioral and developmental symptoms does appear to be higher in children with both diurnal and nocturnal enuresis than those without incontinence.

16.1.7. Encopresis

16.1.7.1. Clinical Presentation. **Encopresis** is defined as the repeated passage of feces into inappropriate places such as clothing or onto the floor, whether involuntary or intentional. There has been at least one such event each month for the past three months, and the individual must be at least four years of age. Mental health professionals will specify whether encopresis is with or without constipation and overflow incontinence (APA, 2022). The child often feels ashamed and may wish to avoid situations, such as going to camp, that might lead to embarrassment. Encopresis is associated with, “a significant decrease in health-related quality of life and family functioning, particularly in older children” (APA, 2022, pg. 404). When the incontinence is clearly deliberate, oppositional defiant disorder or conduct disorder may also be present.

16.1.7.2. Prevalence. Most children older than four years of age diagnosed with encopresis have the subtype “with constipation and overflow incontinence.” The disorder affects 1% to 4% of children in high-income countries, while in some Asian countries a prevalence rate of 2% to 8% has been reported. It also affects children aged 4-6 years more than children aged 10-12 years. Encopresis is also higher among children who were low-income youth or were abused or neglected early. The gender ratio appears to be about equal in children younger than 5 years but is more common in boys than in girls among older children.

16.1.7.3. Comorbidity. Enuresis is often reported in children with encopresis, especially in children not presenting with constipation and overflow incontinence.

For more on enuresis and encopresis please visit:

<https://opentext.wsu.edu/behavioral-disorders-childhood/chapter/module->

Key Takeaways

You should have learned the following in this section:

- A child with disinhibited social engagement disorder tends to be overly social and interact with complete strangers and have experienced *impaired caregiving*, which means that the caregiver does not sufficiently care for the child on a consistent basis.
- A child with reactive attachment disorder do not seek comfort from caregivers or respond to physical touch when distressed and has experienced a pattern of extremes of insufficient care.
- Pica is the act of eating items that are not food on a regular or recurring basis and over a period of at least one month.
- Rumination disorder is the frequent act of regurgitating food over a period of at least 1 month with no medical explanation such as gastroesophageal reflux and in the absence of a body-image/weight-related reason.
- Avoidant/restrictive food intake disorder is associated with at least one of the following: 1) significant weight loss, 2) significant nutritional deficiency, 3) dependence on enteral feeding or oral nutrition supplements, and 4) marked interference with psychosocial functioning.
- Enuresis is the repeated voiding of urine into bed or clothes and can be involuntary or intentional. It has occurred at least two times a week for the past three consecutive months and the child must be at least 5 years of age.
- Encopresis is defined as the repeated passage of feces into inappropriate places such as clothing or onto the floor, whether involuntary or intentional. There has been at least one such event

each month for the past three months and the individual must be at least four years of age.

Section 16.1 Review Questions

1. In what ways are disinhibited social engagement disorder and reactive attachment disorder similar and different from one another?
2. What is pica?
3. What is rumination disorder?
4. What is avoidant/restrictive food intake disorder? How does food avoidance or restriction manifest?
5. What is enuresis?
6. What is encopresis?

16.2. DEVELOPMENTAL AND MOTOR-RELATED DISORDERS

Section Learning Objectives

- Describe the clinical presentation, prevalence, and comorbidity of intellectual development disorder (intellectual disability).
- Describe the clinical presentation, prevalence, and comorbidity of specific learning disorder.
- Describe the clinical presentation, prevalence, and comorbidity of autism spectrum disorder (ASD).
- Describe the clinical presentation of social (pragmatic) communication disorder.
- Describe the clinical presentation, prevalence, and comorbidity of stereotypic movement disorder.
- Describe the clinical presentation, prevalence, and comorbidity of tic

disorders.

16.2.1. Intellectual Developmental Disorder (Intellectual Disability)

16.2.1.1. Clinical Presentation. At the core of an intellectual disability is a deficit in cognitive or intellectual functioning. Historically, we labeled individuals with this presentation of deficits as having mental retardation, but this term was changed to intellectual disability with the passage of Public Law 111-256, also called Rosa's law, to combat stigmatization and misuse of the term. While the terms intellectual disability and intellectual developmental disorder are considered interchangeable, we will use intellectual developmental disorder in this book.

When considering intellectual developmental disorder there are two primary areas of major deficits – intellectual functioning (Criterion A) and adaptive functioning (Criterion B; APA, 2022).

16.2.1.1.1. Intellectual functioning (Criterion A). Intellectual or cognitive functioning refers to our ability to problem solve, understand and analyze complex material, think abstractly, absorb information from our environment, learn from experience, plan, judge, and reason. Critical components include working memory, verbal comprehension, quantitative reasoning, cognitive efficacy, and perceptual reasoning. An individual with intellectual developmental disorder has a significant deficit in this area as confirmed by clinical assessment and individualized, standardized, culturally appropriate intelligence testing. The DSM-5-TR states that those with intellectual developmental disorder have scores approximately two standard deviations or more below the population mean. If a test has a standard deviation of 15 and a mean of 100, their scores will fall in the 65-75 range (70 ± 5 ; APA, 2022).

16.2.1.1.2. Adaptive functioning (Criterion B). Adaptive skills are those

that help us successfully navigate our daily lives. Our ability to understand safety signs in our environment, make appointments, interact with others, complete hygiene routines, etc. are examples of adaptive functioning. These are the skills one needs to live independently and be socially responsible. Individuals with intellectual developmental disorder typically have adaptive skills that are far below what is expected given their chronological age.

According to the DSM-5-TR (APA, 2022) adaptive functioning involves adaptive reasoning in three main domains: conceptual, social, and practical. First, the *conceptual domain* (also called the academic domain) involves competence in memory, language, math reasoning, problem-solving, etc. Second, the *social domain* involves being aware of the thoughts and feelings of other people, showing empathy, interpersonal communication skills, and social judgment, for example. Finally, the *practical domain* involves learning and self-management across life settings such as job responsibilities, personal care, and recreation.

16.2.1.1.3. Onset of intellectual developmental disorder (Criterion C). It should be noted that a third criterion must also be met– the onset of deficits described in criteria A and B must be present early in the neurodevelopmental period. As such, it is most frequently diagnosed in children. Intellectual developmental disorder is not something one would “acquire” in adulthood. If an individual experiences cognitive and adaptive function decline in later years, this is not considered intellectual developmental disorder (a neurodevelopmental disorder) but is more likely a neurocognitive disorder that may be due to a number of things such as traumatic brain injury or dementia. As such, although an individual can go undiagnosed until adulthood, and then as an adult be diagnosed with intellectual developmental disorder, there must be significant and undoubtable evidence of cognitive delay and adaptive functioning delay in the early developmental period. Otherwise, an adult would not be diagnosed with intellectual developmental disorder.

16.2.1.1.4. Severity specifiers. Rather than IQ scores, intellectual developmental disorder is assigned a severity specifier based on the level of

delays related to adaptive functioning. Essentially, the more support someone needs, the more severe the intellectual disability. Severity ranges from Mild (least severe), to Moderate, to Severe, and Profound (most severe; APA, 2022). Severity is considered in relation to the three domains of conceptual, social, and practical. For instance, a specifier of severe would result the child having little understanding of written language or concepts involving numbers, quantity, and money (conceptual domain), speech and communication being focused on the here and now within everyday events (social domain), and not being able to make responsible decisions regarding the well-being of self or others, necessitating supervision at all times (practical domain).

16.2.1.1.5. Associated features. Individuals with intellectual developmental disorder have difficulties with social judgment, assessing risk, emotions, are gullible, and lack awareness. This can lead to increased rates of accidental injury, being exploited by others, possible victimization or physical and sexual abuse, and unintentional criminal involvement. They may also become distressed about their intellectual limitations (APA, 2022).

16.2.1.1.6. Clarification on nomenclature. The DSM-5-TR uses the term *intellectual development disorder* to clarify its relationship with the ICD-11 classification system which uses the term *Disorders of Intellectual Development*. The equivalent term of *intellectual disability* is placed in parentheses for continued use. It should be noted that both terms (i.e., intellectual developmental disorder and intellectual disability) are used in the medical and research literature, while the term intellectual disability is more commonly used by educators, advocacy groups, and the lay public.

16.2.1.2. Prevalence. Intellectual development disorder occurs in approximately 1% of the overall general population while the global prevalence varies by country and level of development. Prevalence is 16 per 1,000 in middle-income countries but 9 per 1,000 in high-income countries (APA, 2022). Intellectual development disorder is more common in males than females, although sex ratios are inconsistent in the literature (APA, 2022; Einfeld &

Emerson, 2008). It is hypothesized that the reason there is a higher occurrence of intellectual development disorder in males is due to general genetic vulnerability, often linked to X chromosome issues that males experience (Harris, 2006). Prevalence is higher in youth than in adults and there are no significant differences between ethnoracial groups.

16.2.1.3. Comorbidity. Intellectual development disorder is often comorbid with other medical and physical conditions as well as other neurodevelopmental conditions including autism and ADHD. Moreover, depression, bipolar, and anxiety disorders are often comorbid with intellectual development disorder. Impulse-control disorders, major neurocognitive disorder, and stereotypic movement disorder are frequently comorbid (APA, 2022).

16.2.1.4. Onset. Onset of intellectual development disorder is in the developmental period, though etiology and severity of brain dysfunction affect exact age and characteristic features at onset. For individuals with more severe intellectual development disorder, delayed motor, language, and social milestones are typical within the first 2 years of life. For individuals with mild intellectual development disorder, impairments may not be identifiable until school age when problems with academic learning are evident.

16.2.2. Specific Learning Disorder

16.2.2.1. Clinical Presentation. A specific learning disorder is characterized by persistent difficulties learning critical academic skills during the years of formal schooling such as reading of single words accurately and fluently or arithmetic calculation; performance of the affected academic skills being well below expected for age; learning difficulties being apparent in the early school years for most individuals, and that the learning difficulties are considered “specific” for four reasons. First, the learning difficulties are not better

explained by intellectual developmental disorder, global developmental delay, hearing or vision disorders, or neurological or motor disorders. Second, they cannot be attributed to more general external factors such as economic or environmental disadvantage. Third, they cannot be attributed to neurological disorders such as a pediatric stroke, motor disorders, or to vision or hearing disorders. Fourth, a learning difficulty can be restricted to one academic skill or domain.

Historically, learning disorders were diagnosed when there was a significant discrepancy between an individual's intellectual/cognitive ability (as measured by an intelligence test) and their academic achievement (as measured by a standardized achievement test) as this was required by DSM-IV-TR criteria. This method is referred to as the *discrepancy model*. While many still use this model, and nothing in the DSM-5-TR disallows it, the DSM-5 criteria were rewritten to allow more flexibility. Ultimately, a discrepancy between one's IQ and academic achievement is no longer required; however, there must be specific data indicating an individual is performing significantly below what would be expected given their chronological age.

In addition to significant academic deficits, there must be evidence that efforts (e.g., tutoring, increased and specialized instruction) to improve abilities within the specific area have been made before diagnosing a specific learning disorder. This is to ensure that an individual has had full access to educational material and supports before a professional assigns a learning disorder diagnosis to them. In school systems, this is where tiered interventions have come into play (more on this in Section 7.5).

16.2.2.1.1. Domain/subskill specific specifiers. Once an individual has been diagnosed with a learning disorder, all academic domains and subskills that have been impaired should be noted as follows:

- **With impairment in reading** – The individual has trouble comprehending material, reading fluently and quickly, or reading words accurately.

- **With impairment in mathematics** – The individual has trouble with number sense, memorization of arithmetic facts, math reasoning, and calculation.
- **With impairment in written expression** – The individual has trouble with accurately spelling words, using correct punctuation and grammar, or with writing clearly and organized.

16.2.2.1.2. Matters of dyslexia and dyscalculia. Technically, dyslexia and dyscalculia are not diagnoses in the DSM-5-TR, but are alternative terms used to describe learning disorders in reading (dyslexia) and math (dyscalculia).

Dyslexia refers to a pattern of learning difficulties characterized by problems with accurate or fluent word recognition, decoding, and spelling (APA, 2022).

Dyscalculia refers to a pattern of learning difficulties characterized by “problems processing numerical information, learning arithmetic facts, and performing accurate or fluent calculations” (APA, 2022, pg. 78).

Although these two terms are used very frequently in school systems and by professionals such as Speech/Language Pathologists, they are not diagnoses and are considered alternative terms in the DSM-5-TR. Instead, a mental health professional will diagnose a *specific learning disorder with impairment in reading* (for dyslexia) and a *specific learning disorder with impairment in mathematics* (for dyscalculia). This is an excellent example of how professionals will sometimes discuss the same phenomenon but use different terminology.

Differences and Similarities between the Disorders

Although intellectual developmental disorder and specific learning disorder may seem very similar, it is important not to confuse the two, as they are different. When thinking about both disorders, we have three distinct core areas to consider: adaptive functioning, cognitive/intellectual ability (IQ), and academic achievement. A rudimentarily way to think about this is with intellectual developmental disorder we are concerned with adaptive functioning and IQ, and with specific learning disorder we are concerned with IQ (sort of) and academic achievement. Although IQ matters (sort of) in

both disorders, the reason it is important varies slightly. Because IQ is considered in both disorders, people often intertwine and confuse the two.

Let's take a minute and think about this: IQ is what we are cognitively able to do – what we *can* do. Adaptive skills and academic achievement refer to what we *are* doing.

Intellectual developmental disorder. If we *cannot* perform in the average range on an IQ test and we *are not* performing daily living tasks appropriately (for our chronological age –we would not expect a 7-year-old to make their own doctor's appointment but would expect them to know to dial 911 in an emergency), then this is indicative of intellectual developmental disorder (intellectual disability).

Specific learning disorder. To differentiate between a specific learning disorder and intellectual developmental disorder, it is useful to consider the discrepancy between what is expected of an individual (what they *can* do) and what they *are* doing. If an individual cannot perform averagely because their IQ is substantially below average, we could not expect them to perform at an average level on academic tasks. For example, if a person's IQ is 70 and they cannot function typically on cognitive tasks, we would not expect them to achieve an academic score of 100, a 30-point jump from what they can do to what they are doing. If an individual has an IQ of 70, we would expect their academic score to be around 70, which would not necessarily indicate a specific learning disorder, even though the score is low. In this case, they would be performing as expected, so the low score achievement score would reflect low cognitive abilities resulting from intellectual development disorder. However, if there is a large discrepancy between what a person can do and what they are doing, for example, someone with an IQ of 100 scoring only a 70 in an academic achievement task, this could indicate a specific learning disorder.

16.2.2.2. Prevalence. Specific learning disorder occurs in approximately 5 to 15% of school-age children in Brazil, Northern Ireland, and the United States. It is more common in males than females and suicidal thoughts and behavior were found in U.S. adolescents aged 15 years in public school presenting with poor reading ability (APA, 2022).

16.2.2.3. Comorbidity. The different types of specific learning disorder are comorbid with one another (i.e., impairment in mathematics with reading), other neurodevelopmental disorders (e.g., ADHD, ASD, developmental coordination disorder, and communication disorders), anxiety disorders, behavioral problems, and depressive disorders.

16.2.2.4. Onset. Onset, recognition, and diagnosis of specific learning disorder typically occur during the elementary school years as this is when children are required to read, spell, write, and learn mathematics. During early childhood and before the child starts school, there may be warning signs to include delays or deficits in language, problems with rhyming or counting, and issues related to fine motor skills needed for writing. Specific learning disorder is lifelong, though an individual may experience a persistent shifting array of learning difficulties across the lifespan. According to APA (2022), negative functional consequences occur across the lifespan and can include, “...lower academic attainment, higher rates of high school dropout, lower rates of postsecondary education, high levels of psychological distress and poorer overall mental health, higher rates of unemployment and underemployment, and lower incomes” (DSM-5-TR, pg. 84).

Specific learning disorder in the cognitively delayed and in the cognitively gifted

Individuals with extreme cognitive functioning abilities are often overlooked. For example, children that are gifted, but have a reading disorder, often go undiagnosed because their deficits look like average abilities to others. Here

is an example to illustrate this:

A 2nd grader with a high cognitive ability earns all As. She excels in math and writing. In fact, she is far past her peers in these areas. She has long learned her multiplication and division facts and is even working on some basic geometry skills. She can write and has been drafting paragraphs with ease and has even started learning to write essays. She loves math and writing, but she dislikes reading. When in class, she reads just like her peers, no more advanced, but right on 2nd grade level expectations. She finds reading to be more difficult, though, and it doesn't come nearly as easy as math and writing. However, because she is on track compared to her peers, her teachers and parents do not recognize any issues – her grades are fine and her school standardized testing is not a problem.

What if you learned that her standardized math and writing scores matched her intellectual ability (meaning her *can do* and *is doing* matched) but her reading score (*is doing*), although average, is well below what would be expected given her IQ (*can do*) and is much lower than her math and writing scores, despite still being an acceptable score? Would you say she may have a reading disorder? If you said yes, you are right. If you said no, you may be right too. The fact is, this is a gray area. Previous versions of the DSM would have made it easy to diagnose this child with a learning disorder in reading. The DSM-5-TR makes it a bit tougher. If this reading deficit, compared to her own abilities, caused apparent impairment (internal distress, preventing her from advancing in math and writing because her reading abilities were lagging behind her other abilities), one would be inclined to diagnose her with a specific learning disorder in reading. However, one can see how this child could be overlooked and undiagnosed for years.

Now let's reverse the scenario. A 2nd grade girl has a diagnosis of an intellectual developmental disorder (intellectual disability). She struggles in all areas of academics. However, her math abilities are even more behind than her reading and writing. Do you think one could make a case for a specific learning disorder in math? Theoretically, they could. But it takes a lot of careful documentation of intervention attempts (see RTI discussion) and

standardized testing that makes it undoubtedly clear that this is true (similar to the above example).

When an individual has an IQ that lands in an extreme (low or high), their weaknesses are often missed. As such, providers and educators must be careful not overlook potential specific learning disorders in these individuals.

For more on intellectual developmental and specific learning disorders please visit: <https://opentext.wsu.edu/behavioral-disorders-childhood/chapter/module-7-intellectual-disability-intellectual-developmental-disorder-ididd-learning-disorders/>

16.2.3. Autism Spectrum Disorder

16.2.3.1. Clinical Presentation. The essential features of ASD are twofold and include persistent impairment in reciprocal social communication and social interaction (Criterion A) and restricted, repetitive patterns of behavior, interests, or activities (Criterion B). It is described as a spectrum because of the varying manifestations of the disorder due to severity of the autistic condition, developmental level, chronological level, and gender (APA, 2022).

16.2.3.1.1. Criterion A: Social communication and social interaction. The child must present with all of the following symptoms. These include behaviors such as poor eye contact, dominating a conversation/or lacking ability to maintain conversation due to absent or limited **reciprocity** (i.e., “to and fro” conversation in the exchange of information), trouble with integrating verbal communication with nonverbal communication (e.g., for example using

gestures, body language, or visual guiding), and struggles with maintaining friendships or relationships in general. Individuals with these difficulties have trouble understanding others' perspectives, reading emotions, and inferring minor and subtle social cues.

16.2.3.1.2. Criterion B: Restricted and repetitive behaviors, interests, or activities. The child must present with at least two of the following. First, they engage in stereotyped movement, frequently called **stereotypy**, such as hand flapping, spinning, or any repetitive movement that does not have an obvious function. They might display **restricted or repetitive play** such as lining up toys or fixating on a part of a toy or button. Individuals may have excessive and **restricted interests** such as being overly interested in history, dinosaurs, robotics, etc. Their interests may be so intense that, if discussing their interests, it is difficult to get them to move on to a new topic, or it may be the only thing about which they will engage in a conversation.

Restricted behaviors might include strict adherence to routines or schedules. Individuals may become very dysregulated if there is a new routine introduced or their routine is changed in any way. Moreover, **sensory concerns** may be of particular relevance. Some individuals may seek out sensory stimulation (sensory seeking behavior which is often referred to as “*stimming*”) as a soothing method. In fact, many repetitive movements can be seen as sensory stimulating. Examples, although not an exhaustive list, of “stimming” may include rubbing hands on a rough material repetitively (tactile), putting objects on their mouth/lips (oral), grunting or making nonfunctional vocalizations (vocal), or looking at lights or visual lines in odd ways (visual). Others may avoid certain sensory input which is known as a *sensory aversion*. For example, being very averse to certain textures, heightened sensitivity to pitch or volume of noise, or bright lights.

16.2.3.2. Diagnosing ASD. Individuals must exhibit both social communication concerns *and* restricted/repetitive behaviors/interests/activities to be diagnosed with ASD. Furthermore, these symptoms must have been

present very early in development (APA, 2022).

Although language delays are common in children with ASD, they are not necessarily required. Moreover, there is often a misconception that if a child has severe ASD, they are nonverbal, meaning they do not have language. This is not accurate. Children with ASD present very differently from each other. Regarding ASD, Dr. Stephen Shore said, “If you’ve met one person with autism, you’ve met one person with autism.” In other words, one child with ASD may have symptoms that present very differently from another child with ASD, but both children have ASD.

16.2.3.3. Specifiers for ASD. ASD is diagnosed within the context of *language development and intellectual development* given that these factors may indicate prognosis. As such, clinicians will assign specifiers that identify if there is any evidence of language impairment or intellectual impairment. For intellectual impairment, separate estimates of verbal and nonverbal skill are necessary. For language impairment, the clinician should consider receptive and expressive language skills separately since receptive may lag behind expressive language development in ASD.

Moreover, ASD is diagnosed in the context of current *severity* for both social communication impairments and restricted, repetitive patterns of behavior, interests, or activities. The clinician will assign a severity level to each of the two main criteria indicating how much support the individual needs. Level 3 indicates “Requiring very substantial support,” Level 2 means “Requiring substantial support, and Level 1 states, “Requiring support.”

16.2.3.4. Associated features. Intellectual and/or language impairment is common in many individuals with ASD. They may have difficulty seeing the world from another person’s perspective, called a *theory-of-mind deficit*. Motor deficits are also present and can include odd gait, being clumsy, and walking on tiptoes. Self-injury such as banging one’s head or biting one’s wrist are also common.

16.2.3.5. Development and course. The behavioral features of ASD first become noticeable in early childhood as some children will present with a lack of interest in social interaction during their first year of life. For children in which skills have been lost, parents and other caregivers may provide a history showing gradual or relatively rapid deterioration in social behaviors or language skills occurring between 12 and 24 months.

In terms of symptoms, the first symptoms of ASD typically involve delayed language development, often accompanied by lack of social interest or unusual social interactions, odd play patterns such as carrying a toy around but never playing with it, and unusual communication patterns such as knowing the alphabet but not responding when their name is said. During the second year, odd and repetitive behaviors, and the absence of typical play become more apparent (APA, 2022).

16.2.3.6. Prevalence. ASD has been reported in 1% to 2% of the U.S. population. Prevalence is lower among African American (1.1%) and Latinx (0.8%) children compared to Caucasian children (1.3%). In non-U.S. countries prevalence has approached 1% of the population. The male:female ratio globally is 3:1. Individuals with ASD are at greater risk for suicide death and children with ASD who had impaired social communication had a higher risk for self-harm with suicidal intent, suicidal thoughts, and suicide plans by age 16 compared to those without the impaired social communication (APA, 2022).

16.2.3.7. Comorbidity. Comorbid disorders are very common for children with autism. Specifically, 70% of children with autism have a comorbid diagnosis. Further, 40% of children with autism have two or more additional disorders. ASD is comorbid with intellectual developmental disorder and language disorder, specific learning difficulties, anxiety disorders, depression, ADHD, and avoidant/restrictive food intake disorder.

16.2.4. Social (Pragmatic) Communication Disorder

16.2.4.1. Clinical Presentation. Social (pragmatic) communication disorder is similar to autism spectrum disorder in that social communication, whether verbal or nonverbal, is impacted. Pragmatics refers to the social use of language and communication. To receive a diagnosis, all of the following must be present: 1) problems with using communication for social purposes such as greeting or exchanging information, 2) difficulty with changing communication to match context or needs of the listener such as recognizing that one speaks softer in a classroom but louder at a football game, 3) difficulty following the rules for conversation or storytelling such as understanding that individuals engaged in a conversation take turns speaking, and 4) problems understanding what is not explicitly stated and nonliteral or ambiguous meanings of language such as idioms, humor, or metaphors.

Although, in many ways this may seem very similar to ASD, one of the biggest differences is that restricted or repetitive behaviors/interests are not present. It should be noted that, as individuals with ASD age, restricted/repetitive behaviors tend to decline. If this occurs, but the individual had a history of the restricted/repetitive behaviors, they are still diagnosed with ASD, even if those behaviors are not currently present, rather than social (pragmatic) communication disorder.

16.2.4.2. Development and course. Social (pragmatic) communication disorder is not typically diagnosed in children under four years of age. By age 4 or 5 years, most children have obtained adequate speech and language capabilities to allow for the identification of specific deficits in social communication, though milder forms of the disorder may go undetected until early adolescence, when language and social interactions become more complex.

Making Sense of the Disorders

- Autism spectrum disorder is distinguished from social (pragmatic) communication disorder by the presence in ASD of restricted/repetitive patterns of behavior, interests, or activities

.....

- and their absence in social (pragmatic) communication disorder.

Note to the Reader: Social (pragmatic) communication disorder was presented in this module only so that it can be distinguished from ASD in terms of a differential diagnosis. It will not be discussed going further, and to be candid, the DSM does not really have much more to say about it either.

For more on autism spectrum disorder and **social (pragmatic) communication disorder** please visit:

<https://opentext.wsu.edu/behavioral-disorders-childhood/chapter/module-8-autism-spectrum-disorder/>

16.2.5. Stereotypic Movement Disorder

16.2.5.1. Clinical Presentation. Stereotypic movement disorder involves “repetitive, seemingly driven, and apparently purposeless motor behavior” such as hand flapping, body rocking, or hitting one’s own body (APA, 2022, pg. 89). Whether efforts to stop such movements are successful is questionable. For children that are developing typically, directing attention to the movements, or

distracting them from performing the movements, are successful. For children with neurodevelopmental disorders, such efforts are less successful. The behavior displayed varies, but each child has their own signature or individually patterned behavior. Duration of the behavior is a few seconds to several minutes or longer, while the frequency can vary from many occurrences during a single day, to several weeks between episodes. The behaviors can occur during moments of boredom, excitement, stress, fatigue, or when the child is engrossed in other activities.

The stereotypic movements cause impairment in social, academic, or other activities and can result in self-injury. In fact, the mental health professional should specify if stereotypic movement disorder is with or without self-injurious behavior and whether the severity of the disorder is mild, moderate, or severe. A mild presentation is one in which the stereotypic movement is easily suppressed by a sensory stimulus or distraction. Severe presentation would be characterized by continuous movements that interfere with daily living. The onset of the disorder is during the early developmental period, typically within the first three years of life (APA, 2022).

16.2.5.2. Prevalence. Stereotypic movement disorder is relatively rare, occurring in only about 3 to 4% of the general population. However, in individuals with intellectual developmental disorder (intellectual disability), the prevalence rate is higher and occurs in about 4 to 16% of individuals. The risk is greater in individuals with severe intellectual developmental disorder.

16.2.5.3. Comorbidity. Stereotypic movement disorder is often comorbid with other genetic and biologically based disorders such as fragile X syndrome, Rett syndrome, Lesch-Nyhan syndrome, as well as other related conditions (Oliver, Petty, Ruddick, & Bacarese-Hamilton, 2012). Additionally, the disorder is comorbid with ADHD, motor coordination problems, tics/Tourette's disorder, and anxiety (APA, 2022).

16.2.5.4. Differential diagnosis: Autism spectrum disorder. Although the

repetitive movements of stereotypic movement disorder may be reminiscent of behaviors seen in children with autism and may develop in the same developmental timeframe (e.g., around or before age 3) as autism spectrum disorder, children with stereotypic movement disorder do not display social communication and reciprocity deficits. Moreover, they do not have circumscribed interests, difficulty with transitions, delayed speech, etc. The only displayed symptom related to autism spectrum disorder is the stereotypy related to behavior. As the DSM says, “When autism spectrum disorder is present, stereotypic movement disorder is diagnosed only when there is self-injury or when the stereotypic behaviors are sufficiently severe to become a focus of treatment” (APA, 2022, pg. 91).

16.2.5.5. Differential diagnosis: Tic disorders. It may seem that distinguishing between a tic and stereotyped movement would be difficult. However, there are a few factors that help differentiate the two. For example, tics tend to be variable, meaning they change over time. Stereotyped movements, although they may change, tend to be more fixed and consistent. Moreover, stereotyped movements related to stereotypic movement disorder tend to present earlier in development (before age 3) than tics related to tic disorders do (mean age at onset 4-6 years). Finally, tics are typically quick, brief, and fleeting, whereas stereotypic movements tend to be more prolonged and repetitive (APA, 2022).

16.2.5.6. Differential diagnosis: OCD. The absence of obsessions in stereotypic movement disorder distinguishes it from obsessive-compulsive disorder. As the DSM says, “In OCD the individual feels driven to perform repetitive behaviors in response to an obsession or according to rules that must be applied rigidly, whereas in stereotypic movement disorder the behaviors are seemingly driven but apparently purposeless” (APA, 2022, pg. 92).

OCD-related disorders of trichotillomania (e.g., pulling hair) and excoriation (e.g., picking at skin) may also seem difficult to differentiate from stereotypic movement disorder. However, in trichotillomania and excoriation, there tends

to be a purpose for the behavior (e.g., extreme anxiety) and the behavior is not typically patterned or displayed in a rhythmic way. Whereas, in stereotypic movement disorder, the behaviors are more patterned or rhythmic. Stereotypic movement disorder has an earlier onset than OCD-related disorders, which tends to be around puberty or later (APA, 2022).

16.2.6. Tic Disorders

16.2.6.1. Clinical Presentation. Tic disorders consist of three separate diagnoses. The most commonly known of the three is Tourette's disorder. The second diagnosis is persistent (chronic) motor or vocal tic disorder. The third is provisional tic disorder. We will start by discussing the tic disorders generally and then move to specifics of each.

16.2.6.1.1. General symptoms. These disorders present before adulthood (i.e., 18 years old). Typically speaking, the time in which they present is between the ages of 4 and 6 and are most severe in symptomology between the ages of 10 and 12.

For all three disorders, tics are present. The DSM defines a tic as, “a sudden, rapid, recurrent, nonrhythmic motor movement or vocalization (APA, 2022, pg. 93). Tics can be either *motor movements* (motor) or *vocalizations* (vocal). These can be *simple*, meaning they only involve one movement or vocalization, or they can be *complex*, meaning they involve multiple movements, vocalizations, or a combination of movements and vocalizations within the same tic. Tics are largely considered to be involuntary. It is common for tics to increase in severity for a period of time and then resolve or drastically reduce for a period of time (APA, 2022).

16.2.6.1.2. Tourette's disorder. Tourette's disorder occurs when *both* motor and vocal tics are present. More than one motor tic must be present and

at least one vocal tic must occur (APA, 2022) to be classified as Tourette's disorder. The tics do not have to occur together and do not have to be complex tics. Though tics may increase and decrease in frequency, they will have persisted for more than one year since the first tic onset.

16.2.6.1.3. Persistent (chronic) motor or vocal tic disorder. This is when *either* one or more motor tic *or* one or more vocal tic is present. However, vocal and motor tics are *not* both present (APA, 2022). These again can be simple or complex and only the presence of one tic is required. To receive this diagnosis, the individual must never have been diagnosed with Tourette's disorder. The mental health professional will specify whether the disorder presents with motor tics only or with vocal tics only, and though tics may increase and decrease in frequency, they will have persisted for more than one year since first tic onset.

16.2.6.1.4. Provisional tic disorder. This diagnosis is used if there are single or multiple motor and/or vocal tics, but they have been present for less than one year since first tic onset. The criteria for Tourette's disorder or persistent (chronic) motor or vocal tic disorder will never have been met.

Making Sense of the Disorders

In relation to motor disorders, note the following:

- Diagnose **Tourette's disorder** if there are more than one motor and at least one vocal tic (both types are present) and this condition has persisted for more than one year.
- Diagnose **persistent (chronic) motor or vocal tic disorder** if one or more motor or vocal tics are present (only one type is present) and this condition has persisted for more than one year.
- Diagnose **provisional tic disorder** if there is a single or multiple motor and/or vocal tic(s) (some type of tic is present) but the

condition has been present for less than one year.

16.2.6.2. Prevalence. Tic disorders are relatively rare. The CDC estimates that approximately 0.3% of children are diagnosed with Tourette's disorder (CDC, 2018) while the DSM reports an estimated 3 per 1,000 for the prevalence of clinically identified cases (APA, 2022). Tic disorders are more common in males, and there are lower rates in African American and Latinx individuals.

16.2.6.3. Comorbidity. Comorbid disorders are common, with 86% of individuals with Tourette's disorder also having another psychological disorder (CDC, 2018, October). ADHD, disruptive behavior, and OCD are commonly comorbid with tic disorders (APA, 2022) with about two-thirds of individuals with Tourette's disorder also having ADHD and one-third having OCD (CDC, 2018, October).

16.2.6.4. Differential Diagnosis. In terms of differential diagnosis, tic disorders must be distinguished from OCD and related disorders. The compulsions of OCD attempt to prevent or reduce anxiety or distress and are usually performed in response to an obsession, while individuals with a tic disorder feel the need to perform the action in a particular fashion, equally on both sides of the body a specific number of times, or until a "just right" feeling is achieved. As for body-focused repetitive behavior disorders, they tend to be more goal-directed and complex than tics (APA, 2022).

For more on stereotypic movement and tic disorders please visit:
<https://opentext.wsu.edu/behavioral-disorders-childhood/chapter/module-9-motor-related-disorders/>

Key Takeaways

You should have learned the following in this section:

- Intellectual developmental disorder is characterized by intellectual functioning (Criterion A) and adaptive functioning (Criterion B) deficits and they must occur during the developmental period.
- A specific learning disorder is characterized by persistent difficulties learning critical academic skills during the years of formal schooling such as reading of single words accurately and fluently or arithmetic calculation; performance of the affected academic skills being well below expected for age; learning difficulties being apparent in the early school years for most individuals, and that the learning difficulties are considered “specific” (for four reasons).
- The essential features of ASD are twofold and include persistent impairment in reciprocal social communication and social interaction (Criterion A) and restricted, repetitive patterns of behavior, interests, or activities (Criterion B).
- Social (pragmatic) communication disorder is characterized by difficulty with pragmatics or the social use of language and communication.
- Stereotypic movement disorder involves repetitive, seemingly driven, and apparently purposeless motor behavior such as hand flapping, body rocking, or hitting one’s own body.
- According to the DSM, a tic is “a sudden, rapid, recurrent, nonrhythmic motor movement or vocalization.” Tics can be either *motor movements* (motor) or *vocalizations* (vocal) and can be simple or complex.

Section 16.2 Review Questions

1. How does intellectual development disorder present and what specifiers are used?
2. How does specific learning disorder present and what specifiers are used?
3. What distinguishes ASD and social (pragmatic) communication disorder?
4. What is stereotypic movement disorder? What specifiers are used with it?
5. What is a tic?
6. What are the three tic disorders and what makes them different from one another?

16.3. BEHAVIOR-RELATED DISORDERS

Section Learning Objectives

- Describe the clinical presentation, prevalence, and comorbidity of ADHD.
- Describe the clinical presentation, prevalence, and comorbidity of oppositional defiant disorder.
- Describe the clinical presentation, prevalence, and comorbidity of conduct disorder.
- Describe the clinical presentation, prevalence, and comorbidity of intermittent explosive disorder.

16.3.1. Attention Deficit/Hyperactivity Disorder (ADHD)

16.3.1.1. Clinical Presentation. ADHD is a disorder in which individuals have difficulty with **executive functioning**, an individual's decision-making ability, which involves working memory, inhibition of inappropriate or unhelpful responses, and the ability to focus on relevant information while dismissing unimportant or irrelevant information (Barkley, 2015). Essentially, an individual's ability to regulate their cognitions, emotions, and behaviors, are impaired. Individuals may lose things frequently, talk excessively, forget assignments/appointments, fidget frequently, move constantly, get distracted, and struggle with organization. Symptoms also are required to be present in more than one setting. For example, if symptoms are only present at school, an individual would not be diagnosed with ADHD.

Symptoms are generally organized into two main categories: hyperactivity and impulsivity symptoms and inattention symptoms. An individual receives a diagnosis of ADHD with the needed specifier if there are: 1) at least six symptoms of inattention for this specifier, 2) at least six symptoms of hyperactivity and impulsivity for this specifier, or 3) six of each of the preceding two for the combined specifier (APA, 2022). The exact symptoms an individual may experience are described below.

16.3.1.1.1. Inattentive symptoms (A1). Children who are inattentive tend to lose things necessary for tasks or activities, do not listen when spoken to directly, do not follow through on instructions and fail to finish tasks, do not give close attention to details or make careless mistakes, and are easily distracted by extraneous stimuli. They also are forgetful in daily activities; avoids, dislikes, or are reluctant to partake of activities requiring sustained mental effort; fail to sustain attention in tasks or play activities; and have problems organizing tasks and activities. Of these 9 symptoms, 6 or more must be displayed to receive the specifier and should have occurred for the past six months (APA, 2022).

16.3.1.1.2. Hyperactivity and impulsivity symptoms (A2). These symptoms are related to excessive energy and movement as well as impulsivity. Individuals with these symptoms are often described as high energy or “on the go,” talkative, and fidgety. These children may have a hard time waiting their turn, standing still, remaining in their seat, or engaging in leisure activities quietly. They blurt out answers before the question has been completed and often interrupt or intrude on others. Of these 9 symptoms, 6 or more must be displayed to receive the specifier and should have occurred for the past six months (APA, 2022).

16.3.1.1.3. Combined presentation. To receive the combined presentation specifier, an individual must display at least six inattention symptoms and six hyperactivity and impulsivity symptoms for the past six months (APA, 2022).

16.3.1.2. Associated features. Individuals with ADHD (any specifier) display emotional dysregulation or emotional impulsivity, are often quick to anger, easily frustrated, and overreact emotionally. They may exhibit neurocognitive deficits and often show delays in language, motor, or social development.

16.3.1.3. Development and course. Excessive motor activity is often observed by parents when the child is a toddler but, “...symptoms are difficult to distinguish from highly variable normative behavior before age 4 years” (APA, 2022, pg. 71). In preschool, hyperactivity is most common. ADHD is most often identified during the elementary school years as the inattention becomes more prominent and impairing. Hyperactivity becomes less prominent during adolescence and is confined to being fidgety, restless, or impatient. In adulthood, impulsivity, inattention, and restlessness may remain problematic, even if hyperactivity has diminished.

16.3.1.4. Prevalence. ADHD occurs in about 7.2% of children worldwide, with cross-national prevalence rates ranging from 0.1% to 10.2% of children and adolescents and higher prevalence rates occurring in special populations, such as foster children and correctional settings. ADHD is more often diagnosed

in males than in females. Females are more likely to present primarily with inattentive features. Because predominantly inattentive symptoms are not as disruptive and noticeable as hyperactive/impulsive symptoms, predominantly inattentive presentations of ADHD may go undiagnosed or be diagnosed much later than ADHD predominantly hyperactive/impulsive or combined presentations. Finally, ADHD is a risk factor for suicidal ideation and behavior in children (APA, 2022).

16.3.1.5. Comorbidity. According to the CDC, approximately 60% of children with ADHD have another comorbid disorder (CDC, 2018a, September). About 50% of children with ADHD combined presentation, and about 25% of children with ADHD predominantly inattentive presentation, are also diagnosed with Oppositional Defiant Disorder (ODD). Conduct Disorder is also highly comorbid with ADHD (i.e., about 25% of youth with ADHD combined presentation) and most children and adolescents with disruptive mood dysregulation disorder have symptoms that also meet the criteria for ADHD (APA, 2022).

Learning disorders are also commonly comorbid with ADHD. However, differentiating if a learning disorder is present, in addition to ADHD, requires thorough evaluation (see differential discussion below).

Mood and anxiety disorders, as well as OCD and intermittent explosive disorder, are less likely to be comorbid than other behavioral disorders (CDC, 2018a, September). However, they do occur at a higher rate in children with ADHD compared to children without ADHD (APA, 2022). Many individuals with ADHD report daytime sleepiness that could meet criteria for hypersomnolence disorder.

16.3.1.6. Differential Diagnosis. ADHD should be distinguished from the following disorders:

16.3.1.6.1. ODD. Because inattention and impulsivity can lead to noncompliance with rules, psychologists need to carefully assess behaviors and

differentiate between ADHD and ODD. For example, a child may be told to clean their room. A child with ADHD may (1) not hear or fully attend to the instruction and then not comply or (2) may hear the instruction, begin to clean their room, get distracted mid-way, and start playing with a toy they found, perhaps impulsively, while they are supposed to be cleaning. Although *noncompliant* with the command, they are not actively being *defiant*. A child with ODD may be told to clean their room, and rather than comply, may actively defy the command. Because symptoms of ADHD can lead to a higher risk of noncompliance, we must be careful to not misperceive noncompliance with defiance. However, both can occur together (see comorbidity section above), and as such, when both are present, both will be diagnosed.

16.3.1.6.2. Anxiety. Anxiety can lead to difficulty with concentration, fidgeting, and distractibility, which overlap with some symptoms of ADHD. It is not uncommon for a child to be referred for concerns related to ADHD, especially ADHD predominantly inattentive presentation, but may, in fact, be experiencing anxiety instead. Bear in mind that the inattention in anxiety disorders may be attributable to worry and rumination. Differential diagnosis of anxiety versus ADHD is important because treatment for the two disorders is different.

16.3.1.6.3. Learning disorders. Because symptoms of ADHD can impair school performance and learning, psychologists must differentiate between (1) general impairment in learning due to inattentive, impulsiveness, etc. or (2) a specific impairment in an identified learning area (i.e., math, reading, written expression).

16.3.1.6.4. Intermittent explosive disorder. Both disorders share high levels of impulsive behavior, but serious aggression toward others is common with intermittent explosive disorder and not ADHD. As well, those with intermittent explosive disorder do not experience issues with sustaining attention, characteristic of ADHD.

For more on ADHD please visit: <https://opentext.wsu.edu/behavioral-disorders-childhood/chapter/module-10-attention-deficit-hyperactivity-disorder/>

16.3.2. Oppositional Defiant Disorder

16.3.2.1. Clinical Presentation. Oppositional defiant disorder is characterized by a child that is defiant/argumentative, angry/irritable, and vindictive, and has shown this pattern of behavior for at least six months. Of the eight possible symptoms, the child must present with at least four of them. In terms of angry/irritable mood, they may lose their temper often, are easily annoyed or touchy, and are often angry and resentful. In terms of argumentative/defiant behavior the child argues with authority figures, actively defies or refuses to comply, deliberately annoys others, or blames others for their mistakes. Finally, they must have acted spiteful or vindictive at least twice within the past six months. Distress occurs in the child's immediate social context or affects social, occupational, educational, or other important areas of functioning. Functional consequences of these behaviors include frequent conflicts with parents, teachers, supervisors, peers, and romantic partners (APA, 2022). The disorder typically appears during the preschool years and rarely later than early adolescence.

16.3.2.2. Prevalence. According to the DSM-5-TR, the cross-national prevalence of oppositional defiant disorder ranges from 1% to 11% with an average prevalence estimate of around 3.3%. The disorder is more common in boys than girls prior to adolescence (APA, 2022).

16.3.2.3. Comorbidity. Oppositional defiant disorder occurs more often in children, adolescents, and adults also diagnosed with ADHD and often precedes

conduct disorder. Other comorbid disorders are anxiety disorders and major depressive disorder. Rates of substance use disorders are higher in adolescents and adults diagnosed with oppositional defiant disorder.

16.3.2.4. Differential diagnosis. Oppositional defiant disorder should be distinguished from *conduct disorder*. Both disorders bring the individual in conflict with adults and authority figures, but the behaviors of oppositional defiant disorder are usually less severe than conduct disorder and do not include aggression toward people or animals, destruction of property, or a pattern of theft or deceit. However, the impairment associated with oppositional defiant disorder may be equivalent or greater than that of conduct disorder. Finally, oppositional defiant disorder includes problems of emotional dysregulation which are absent from conduct disorder.

Oppositional defiant disorder shares with *intermittent explosive disorder* high rates of anger. However, those with intermittent explosive disorder often show serious aggression toward others that is not characteristic of oppositional defiant disorder.

Finally, stressors may lead to emotional dysregulation, which can present as tantrums and oppositional behavior in children, or aggressive behaviors in adolescents. The DSM says, “Temporal association with a stressor and symptom duration of less than 6 months after the resolution of the stressor may help distinguish *adjustment disorder* from oppositional defiant disorder” (APA, 2022).

16.3.3. Conduct Disorder

16.3.3.1. Clinical Presentation. **Conduct disorder** is a more severe behavioral disorder in which an individual displays a disregard, not only for rules and authority, but also the rights and conditions of humans and/or animals. Behaviors that may be exhibited are stealing, fighting, cruelty to

people or animals, fire-setting, running away from home, bullying or threatening others, using a weapon that can cause harm, committing a mugging or armed robbery, forcing someone into sexual activity, deliberately destroying another person's property, lying to obtain goods or favors, stealing items of nontrivial value without confronting the victim, staying out at night in clear violation of parental rules, and being truant from school. The preceding represents 15 symptoms of which the person must present with at least three in the past 12 months, with at least one criterion present in the past 6 months.

There are three subtypes of conduct disorder focused on the age of onset. The *childhood-onset type* occurs prior to age 10 while the *adolescence-onset type* occurs after age 10. The *unspecified onset subtype* is used when age of onset is unknown. Males usually receive the childhood-onset subtype and have disturbed peer relationships, likely were diagnosed with oppositional defiant disorder in early childhood, and typically have symptoms that meet full criteria for conduct disorder before puberty.

Conduct disorder is often associated with limited prosocial emotions. To qualify for this specifier, at least two of the following characteristics must have been displayed persistently over the past 12 months and in multiple relationships and settings. These include: a lack of remorse or guilt, a lack of concern for the feelings of others (callous – lack of empathy), being unconcerned about performance, and having shallow or deficient affect.

Functional consequences of these behaviors include being suspended or expelled from school, problems in work adjustment, legal problems, sexually transmitted diseases, physical injury from accidents or fights, and unplanned pregnancy. It is also associated with early onset of sexual behavior; alcohol, tobacco, and illegal substances use; and reckless and risk-taking behaviors.

The onset of conduct disorder occurs as early as the preschool years, but it is during middle childhood through middle adolescence that the first significant symptoms usually emerge. The DSM states, “Physically aggressive symptoms are

more common than nonaggressive symptoms during childhood, but nonaggressive symptoms become more common than aggressive symptoms during adolescence” (APA, 2022, pg. 534).

16.3.3.2. Prevalence. In the United States and other largely high-income countries, one-year population prevalence estimates range from 2% to more than 10%, with a median of 4%. In the United States, the lifetime prevalence was 12% among men and 7.1% among women. For those with conduct disorder, suicidal thoughts, suicidal attempts, and suicide occur at a higher-than-expected rate.

In relation to sex and gender-related diagnostic issues, girls and women diagnosed with conduct disorder are more likely to display lying, truancy, running away, and prostitution while boys and men with the disorder exhibit fighting, stealing, vandalism, and school discipline problems. Both boys and men and girls and women display relational aggression, however, girls and women show less physical aggression than boys and men (APA, 2022).

16.3.3.3. Comorbidity. Conduct disorder has been found to be comorbid with ADHD and oppositional defiant disorder, and this comorbid presentation predicts the poorest outcomes. Other comorbid disorders include specific learning disorder, anxiety disorders, depressive or bipolar disorders, and substance-related disorders.

16.3.3.4. Differential diagnosis. Conduct disorder and intermittent explosive disorder share the feature of high rates of aggression, but the aggression in intermittent explosive disorder is limited to impulsive aggression that is not premeditated and does not seek to accomplish an aim such as money, power, or intimidation. Additionally, nonaggressive symptoms of conduct disorder are not present in intermittent explosive disorder.

16.3.4. Intermittent Explosive Disorder

16.3.4.1. Clinical Presentation. Intermittent explosive disorder is characterized by recurrent behavioral outbursts which represent a failure to control aggressive impulses. It is manifested by one of the following: 1) verbal or physical aggression toward property, animals, or other individuals which occur twice a week on average, for up to three months; and 2) “...three behavioral outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring within a 12-month period” (APA, 2022). The level of aggressiveness displayed by the individual is out of proportion with the experienced provocation or stressors and is not for the purpose of achieving a tangible objective such as money, power, or intimidation. The disorder should not be diagnosed in individuals younger than 6 years.

Functional consequences of these behaviors include loss of friends, relatives, or marital instability in the social domain, demotion or loss of employment in the occupational domain, or civil suits due to the aggressive behavior against person or property in the legal domain. There could also be criminal charges and financial loss due to the destruction of objects.

16.3.4.2. Prevalence. The 1-year prevalence in the United States is about 2.6% with a lifetime prevalence of 4.0%. When intermittent explosive disorder is comorbid with PTSD, the rate of lifetime suicide attempts increases (41%; APA, 2022).

16.3.2.3. Comorbidity. Disorders comorbid with intermittent explosive disorder include depressive disorders, anxiety disorders, PTSD, bulimia, binge-eating disorder, and substance use disorders. Additionally, antisocial personality disorder, borderline personality disorder, ADHD, conduct disorder, and oppositional defiant disorder are comorbid.

16.3.2.4. Differential diagnosis. Both intermittent explosive disorder and

ADHD share high levels of impulsive behavior, but serious aggression toward others is common with intermittent explosive disorder and not ADHD. As well, those with intermittent explosive disorder do not experience issues with sustaining attention, characteristic of ADHD.

Antisocial and borderline personality disorders share the feature of recurrent, problematic impulsive aggressive outbursts but the level of impulsive aggression is higher with intermittent explosive disorder.

For more on oppositional defiant disorder, conduct disorder, and intermittent explosive disorder please visit:
<https://opentext.wsu.edu/behavioral-disorders-childhood/chapter/module-11-oppositional-and-conduct-disorder/>

Key Takeaways

You should have learned the following in this section:

- Symptoms of ADHD are generally organized into two main categories: hyperactivity and impulsivity symptoms and inattention symptoms.
- Oppositional defiant disorder is characterized by a child that is defiant/argumentative, angry/irritable, and vindictive and has shown this pattern of behavior for at least six months. At least 4 of 8 symptoms must be present.
- Conduct disorder is a more severe behavioral disorder in which an individual displays a disregard not only for rules and authority, but also the rights and conditions of humans and/or animals. The individual must display at least 3 of the 15 symptoms.

- Conduct disorder is often associated with limited prosocial emotions.
- Intermittent explosive disorder is characterized by recurrent behavioral outbursts which represent a failure to control aggressive impulses.

Section 16.3 Review Questions

1. What symptoms are included in the inattention category?
2. What symptoms are included in the hyperactive and impulsive category?
3. When is ADHD most often identified and diagnosed and why?
4. Which of the disorders discussed in this section is the most severe?
5. Which of the disorders is associated with limited prosocial emotions?
6. Which of the disorders is not diagnosed in children under 6 years of age?
7. Which disorder is characterized by being irritable, argumentative, and vindictive?

16.4. OTHER DISORDERS

Section Learning Objectives

- Describe the clinical presentation, prevalence, and comorbidity of selective mutism.
- Describe the clinical presentation, prevalence, and comorbidity of separation anxiety disorder.

- Describe the clinical presentation, prevalence, and comorbidity of trichotillomania.
- Describe the clinical presentation, prevalence, and comorbidity of excoriation.

16.4.1. Anxiety Disorders – Selective Mutism

16.4.1.1. Clinical Presentation. Selective mutism is characterized by an absence of speech in particular social situations in which a person is expected to speak, such as at school or work, despite speaking in other situations. This lack of speech is not due to a communication disorder; does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder; or due to a lack of knowledge of, or comfort with, the spoken language required in a specific social situation (APA, 2022). For example, a child with selective mutism may speak fluently and freely with a trusted caregiver in the privacy of their home (providing evidence that the child does not have a speech, language, or communication disorder) but produces no speech at school with peers or a teacher. The disturbance must have lasted for at least one month and is often marked by high social anxiety. According to the DSM, associated features include, “excessive shyness, fear of social embarrassment, social isolation and withdrawal, clinging, compulsive traits, negativism, temper tantrums, or mild oppositional behavior” (APA, 2022, pg. 222). The onset of the disorder is usually before 5 years but may not become apparent until entry into school.

16.4.1.2. Prevalence. Selective mutism is relatively rare, occurring in only 0.03% to 1.9% of the population and is more common in young children than adolescents and adults. There is conflicting evidence about gender, with some studies/samples showing equal distribution and others showing a higher prevalence in girls. Prevalence does not vary by race/ethnicity.

16.4.1.3. Comorbidity. Selective mutism is highly comorbid with other anxiety disorders, particularly social anxiety disorder followed by separation anxiety disorder and specific phobia. Communication disorders or delays also appear in some children with selective mutism (APA, 2022).

16.4.2. Anxiety Disorders – Separation Anxiety Disorder

16.4.2.1. Clinical Presentation. Separation anxiety disorder is characterized by excessive fear or anxiety concerning being separated from those to whom the individual is attached. A child may worry about the caregiver becoming seriously ill, dying, or being permanently separated from them, and show persistent and excessive fear of or reluctance about being alone or without this figure at home or other settings. They may refuse to go to school or other places and worry about experiencing an untoward event such as getting lost or being kidnapped that causes separation from a major attachment figure. They may refuse to sleep in their own bed or have recurring nightmares that involve separation from their attachment figure. These children may also have several physical manifestations of the anxiety including headaches and stomachaches when they are separated from, or anticipate separation from, the major attachment figure. This fear, anxiety, or avoidance is persistent and has lasted for at least four weeks in children and adolescents. For adults, it must last 6 months or more.

Adults or children with the disorder may exhibit social withdrawal, apathy, difficult concentrating or playing, and sadness and for children, the school refusal can lead to academic difficulties and social isolation. Children may also display anger and act aggressively toward the person forcing separation from their attachment figure and can become homesick. Children diagnosed with separation anxiety disorder are seen as demanding, intrusive, and in need of constant attention (APA, 2022).

16.4.2.2. Prevalence. Separation anxiety disorder occurs in approximately 4% of children and decreases in prevalence from childhood through adolescence and adulthood. For instance, only 1.6% of adolescents in the United States have the disorder and for adults, 12-month prevalence ranges from 0.9% to 1.9%. In toddlers, separation anxiety disorder occurs about equally between girls and boys but in school-aged children, it is more prevalent for girls than boys.

16.4.2.3. Comorbidity. Separation anxiety disorder is highly comorbid with other anxiety disorders, such as generalized anxiety disorder and specific phobia (APA, 2022).

For more on separation anxiety disorder and selective mutism please visit: <https://opentext.wsu.edu/behavioral-disorders-childhood/chapter/module-13-anxiety-disorders/>

16.4.3. Obsessive Compulsive and Related Disorders – Trichotillomania

16.4.3.1. Clinical Presentation. Trichotillomania (Hair-Pulling) disorder is characterized by an individual recurrently pulling their hair out and results in hair loss. Despite attempts to cease the behavior, the individual continues with it. These behaviors cause distress and impairment and may also lead to other dermatological/medical conditions (APA, 2022).

Hair pulling may be accompanied by a range of behaviors or rituals such as searching for a particular kind of hair to pull such as those with a specific texture or color, pulling out hair in a specific way so that the root comes out intact, or visually examining or tactilely or orally manipulating the hair after it is pulled out such as pulling the strand between the teeth. Pain does not

routinely accompany hair pulling.

It can be triggered by feelings of anxiety, boredom, and/or an increasing sense of tension, and may lead to gratification, pleasure, or a sense of relief once the hair is pulled out. It has been noted that for some, an “itch-like” or tingling sensation occurs and is alleviated once the hair has been pulled out. The act of hair pulling does not usually occur in the presence of other people with the exception of immediate family members. Some even have the urge to pull hair from other people or from pets, dolls, and other fibrous materials (APA, 2022).

Hair pulling can occur in infancy and will typically resolve during early development. Onset, though, most commonly coincides with, or follows, the onset of puberty. The usual course of trichotillomania is chronic with waxing and waning of symptoms being typical if untreated. The disorder manifests similarly across cultures and ethnic groups though there is not much data from non-Western regions.

16.4.3.2. Prevalence. Trichotillomania occurs in 1% to 2% of adults and adolescents. Females are more often diagnosed with this disorder than males, in adulthood. However, in childhood, males and females are equally impacted.

16.4.3.3. Comorbidity. The most common comorbid disorders are MDD and excoriation disorder. Other repetitive body-focused symptoms such as nail-biting occur in most individuals with trichotillomania and may warrant an additional diagnosis of other specified obsessive-compulsive and related disorder (APA, 2022).

16.4.4. Obsessive Compulsive and Related Disorders – Excoriation

16.4.4.1. Clinical Presentation. Excoriation (Skin-Picking) disorder is similar to trichotillomania, except it involves skin-picking which results in skin

lesions. Despite attempts to cease the behavior, the individual continues with it. The skin picking causes impairment and may also lead to other medical consequences (APA, 2022).

Skin picking can be triggered by feelings of anxiety, boredom, and/or an increasing sense of tension, and may lead to gratification, pleasure, or a sense of relief once the skin or scab has been picked. It involves behaviors such as searching for a particular kind of scab to pull and examining, playing with, or swallowing the skin after it has been pulled. The act of skin picking usually does not occur in the presence of other people, except immediate family members, and some individuals report picking the skin of others. Pain is not typically associated with skin picking (APA, 2022).

Excoriation disorder usually begins during adolescence, commonly with or following the onset of puberty, and begins with a dermatological condition such as acne. The course is chronic with some waxing and waning if untreated. It appears clinical features are similar across cultures, though there is limited data currently.

16.4.4.2. Prevalence. In terms of excoriation disorder, an online survey of over 10,000 adults between the ages of 18-69 and gender-matched to the U.S. population found that 2.1% self-identified as having current excoriation disorder while 3.1% reported lifetime excoriation disorder. Community samples show that 75% or more of individuals diagnosed with the disorder are women.

16.4.4.3. Comorbidity. OCD, trichotillomania, and MDD are comorbid with excoriation disorder, with depression comorbidity being more common in women. Other repetitive body-focused symptoms such as nail-biting occur in most individuals with excoriation disorder and may warrant an additional diagnosis of other specified obsessive-compulsive and related disorder (APA, 2022).

For more on trichotillomania and excoriation disorder please visit:
<https://opentext.wsu.edu/behavioral-disorders-childhood/chapter/module-14-obsessive-compulsive-and-related-disorders/>

Key Takeaways

You should have learned the following in this section:

- Separation anxiety disorder is characterized by excessive fear or anxiety concerning being separated from those to whom the individual is attached.
- Selective mutism is characterized by an absence of speech in particular social situations in which a person is expected to speak, such as at school or work, despite speaking in other situations.
- Trichotillomania (Hair-Pulling) disorder is characterized by an individual recurrently pulling their hair out and results in hair loss.
- Excoriation (Skin Picking) disorder involves skin picking which results in skin lesions.

Section 16.4 Review Questions

1. What is separation anxiety disorder?
2. What is selective mutism and how does it differ from social anxiety disorder?
3. What is the difference between trichotillomania disorder from excoriation disorder? How much pain do both involve for the afflicted?

Module Recap

The purpose of Module 16 was to provide an overview, not exhaustive coverage, of disorders present in childhood and adolescence. This included a discussion of the clinical presentation, prevalence, comorbidity, and differential diagnosis (when relevant) for these disorders. For a more comprehensive discussion, to include a discussion of etiology, assessment, and treatment options, please see our Behavioral Disorders of Childhood book (<https://opentext.wsu.edu/behavioral-disorders-childhood/>).

In this module, we covered:

- Disorders of infancy and early childhood to include disinhibited social engagement disorder, reactive attachment disorder, pica, rumination disorder, and avoidant/restrictive food intake disorder, enuresis, and encopresis.
- Developmental and motor-related disorders to include intellectual developmental disorder (intellectual disability), specific learning disorder, autism spectrum disorder, social (pragmatic) communication disorder, stereotypic movement, and tic disorders.
- Behavior-related disorders to include ADHD, oppositional defiant disorder, conduct disorder, and intermittent explosive disorder.
- Anxiety disorders of selective mutism and separation anxiety disorder
- Obsessive-compulsive and related disorders of trichotillomania, and excoriation disorder.

We hope this overview was helpful as we recognize many universities do not have a class specialized in mental disorders present during these critical developmental periods (i.e., childhood and adolescence).

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