**A 14-year-old with anxiety disorder avoids entering the school cafeteria despite wanting to join friends. Which therapy element in the table most directly targets the feared situation?**

A. Time-out
B. Cost response
C. Exposure
D. Parent ignoring
E. Activity scheduling

Original table 34.2 | Nelson printed p. 234 | PDF p. 279

**Table 34.2** Practice Elements in Interventions for Three Common Child and Adolescent Psychiatric Disorders

| | ANXIETY DISORDERS | DEPRESSION | DISRUPTIVE BEHAVIOR |
|---|---|---|---|
| Directed play | | | X |
| Limit setting | | | X |
| Time-out | | | X |
| Cost response | | | X |
| Activity scheduling | | X | |
| Maintenance | | X | X |
| Skill building | | X | |
| Social skills training | | X | X |
| Therapist praise/rewards | | | X |
| Natural and logical consequences | X | | X |
| Communication skills | X | | X |
| Assertiveness training | X | | |
| Parent monitoring | X | | X |
| Modeling | X | | |
| Ignoring | X | | X |
| Parent praise | X | | X |
| Problem solving | X | X | X |
| Parent coping | X | | X |
| Psychoeducation, parent | X | X | X |
| Relaxation | X | X | X |
| Tangible rewards | X | | X |
| Self-monitoring | X | X | X |
| Cognitive/coping | X | X | X |
| Psychoeducation, child | X | X | X |
| Exposure | X | | |

Adapted from Chorpita BF, Daleiden EL, Weisz JR. Identifying and selecting the common elements of evidence based interventions: a distillation and matching model. *Ment Health Serv Res.* 2005;7(1):5–20.



**Question selection and educational compilation: Dr. Manar Alshawabkeh**

## A family agrees to psychotherapy but misses the first two visits because of transportation and childcare problems. Which engagement element should the referring pediatrician use to identify these obstacles?

A. Assessment of treatment barriers
B. Homework assignment
C. Modeling
D. Self-monitoring
E. Competing response training

Original table 34.3 | Nelson printed p. 235 | PDF p. 280

**Table 34.3 Selected Psychotherapy Engagement Elements**

| ELEMENT | DEFINITION |
|---|---|
| Accessibility promotion | Any strategy used to make services convenient and accessible to proactively encourage and increase participation in treatment; e.g., hiring a co-located therapist or referring to a local community-based therapist with whom the practice has an ongoing collaborative relationship |
| Psychoeducation about services | Provision of information about services or the service delivery system; e.g., type of therapy being recommended, information about the therapist, session frequency and duration |
| Appointment reminders | Providing information about the day, time, and location of the therapy office for the initial appointment via mail, text, phone, email, etc., to increase session attendance |
| Assessment of treatment barriers | Discussion to elicit and identify barriers that hinder participation in treatment; e.g., transportation, scheduling, childcare, previous experiences with therapy, stigma |
| Assessment | Measurement of the patient's strengths/needs through a variety of methods; e.g., mental health screening instruments, interviews, recorded reviews during which the referring practitioner can motivate treatment engagement |
| Modeling | Demonstration of a desired behavior to promote imitation and performance of that behavior by client |
| Expectation setting | Instillation of hope regarding the efficacy of therapy and the patient's ability to participate successfully in treatment |
| Homework assignment | Therapeutic tasks given to the patient to complete outside the therapy session to reinforce or facilitate knowledge or skills that are consistent with the treatment plan |
| Goal setting | Selection of a therapeutic goal for the purpose of making a plan to achieve that goal |
| Rapport building | Strategies used to strengthen the relationship between therapist and patient |
| Cultural acknowledgment | Exploration of an individual's culture; e.g., race/ethnicity, age, sexual orientation, gender identity |

Adapted from Lindsey MA, Brandt NE, Becker KD, et al. Identifying the common elements of treatment engagement interventions in children's mental health services. *Clin Child Fam Psychol Rev.* 2014;17(3):283–298; Becker KD, Lee BR, Daleiden EL, Lindsey M, Brandt NE, Chorpita BF. The common elements of engagement in children's



Question selection and educational compilation: Dr. Manar Alshawabkeh

**A 13-year-old has persistent abdominal pain causing school absence for 8 months. Medical evaluation has found no dangerous disorder, and the patient spends hours each day fearing that the symptoms indicate serious disease. Which diagnosis best fits the listed criteria?**

A. Illness anxiety disorder
B. Somatic symptom disorder
C. Functional neurologic symptom disorder
D. Factitious disorder
E. Panic disorder

Original table 35.1 | Nelson printed p. 235 | PDF p. 280

## Table 35.1 DSM-5 Diagnostic Criteria for Somatic Symptom Disorder

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

Specify if:

**With predominant pain** (previously known as "pain disorder" in DSM IV-TR): for individuals whose somatic symptoms predominantly involve pain.

**Persistent:** A persistent course is characterized by severe symptoms, marked impairment, and long duration (>6 mo).

From the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. p 311.

**A 15-year-old develops leg weakness after a stressful event. Examination repeatedly demonstrates normal leg strength during spontaneous movements but marked weakness on formal testing; evaluation finds no explanatory neurologic disorder. Which finding supports functional neurologic symptom disorder?**

A. A family history of migraine
B. Positive evidence that examination findings are incompatible with a recognized neurologic disorder
C. A normal examination performed only once
D. The presence of any recent stressor by itself
E. Patient awareness of an external reward

Original table 35.2 | Nelson printed p. 236 | PDF p. 281

| Table 35.2 | DSM-5 Diagnostic Criteria for Conversion Disorder or Functional Neurologic Symptom Disorder |
|---|---|

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

Specify symptom type: weakness or paralysis, abnormal movements, swallowing symptoms, speech symptom, attacks/seizures, anesthesia/sensory loss, special sensory symptom (e.g., visual, olfactory, hearing), or mixed symptoms.

From the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. p 318. 

**A caregiver secretly contaminates a child's specimen, repeatedly presents the child for hospitalization, and gains no apparent material reward. Which diagnosis applies to the caregiver according to the table?**

A. Somatic symptom disorder in the child
B. Illness anxiety disorder in the child
C. Factitious disorder imposed on another
D. Conversion disorder in the child
E. Provisional tic disorder in the caregiver

Original table 35.3 | Nelson printed p. 236 | PDF p. 281

## Table 35.3 DSM-5 Diagnostic Criteria for Factitious Disorders

**FACTITIOUS DISORDER IMPOSED ON SELF**

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

Specify if: single episode or recurrent episodes.

**FACTITIOUS DISORDER IMPOSED ON ANOTHER (PREVIOUSLY "FACTITIOUS DISORDER BY PROXY")**

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

*Note:* The perpetrator, not the victim, receives this diagnosis.

Specify if: single episode or recurrent episodes.

From the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. p 324. Copyright 2013. American Psychiatric Association.

## A 12-year-old reports severe unilateral leg weakness but is observed walking normally when distracted. Which additional examination finding in the table gives positive support for a functional weakness pattern?

A. A fixed sensory level matching a spinal cord segment
B. A positive Hoover sign
C. A unilateral extensor plantar response
D. Persistent hyperreflexia with clonus
E. Progressive muscle atrophy

Original table 35.7 | Nelson printed p. 238 | PDF p. 283

**Table 35.7 Key Elements to Consider in the Psychiatric Assessment of Somatic Symptoms and Related Disorders in Children and Adolescents**

MEDICAL FINDINGS SUGGESTIVE OF SSRDS
- Absence of findings despite thorough medical workup
  - Lack of electrical evidence on video-electroencephalographic monitoring
- Inconsistent findings on examination
  - Sensory changes inconsistent with anatomic distribution (e.g., splitting at the midline, loss of sensation of entire face but not scalp, discrepancy between pain and temperature sensation, absence of Romberg sign)
  - Absence of functional impairment despite claims of profound weakness (e.g., impairment of fine motor function on testing, yet able to dress and undress)
  - Face-hand test (deflecting falling arm from face)
  - Hoover sign (patient pushes down with "paretic" leg when attempting to raise unaffected leg and fails to press down with unaffected leg when raising "paretic" leg)
  - Astasia-abasia (staggering gait, momentarily balancing, but never actually falling)
  - Dragging a "weak" leg as though it were a totally lifeless object instead of circumduction of the leg
  - Psychogenic deafness responding to unexpected words or noises
  - Tunnel vision
  - Movement disorder with normal concurrent electroencephalogram
  - Symptoms suggestive of conversion seizures (see Table 634.3).
  - Increased symptoms in the presence of family or medical staff
  - Periods of normal function when distracted
- Temporal relationship between onset of symptom and psychosocial stressor

PSYCHIATRIC FINDINGS SUGGESTIVE OF SSRDS
- Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns
- Co-occurring psychiatric disorder
- Learning difficulties and academic failure
- Stressful life events (including childhood trauma and bullying)
- Symptom model(s)

FAMILY BELIEFS REGARDING SOMATIC SYMPTOMS
- Belief in a single undiagnosed primary medical cause
  - Investment in further medical workup
  - Fear about serious medical illness
- Belief in the role of environmental triggers
- Belief in the role of psychologic factors
- Beliefs regarding symptom management
  - Awareness of nonpharmacologic approaches
  - Belief that the child should rest and be excused from usual responsibilities

FAMILY MEDICAL HISTORY
- Family history of unexplained somatic symptoms
- Pattern of reinforcement of illness behavior in the family

IMPACT OF SOMATIC SYMPTOMS
- Emotional (e.g., depression/anxiety vs la belle indifférence)
- Family (e.g., disruption of work schedule, impact on marital relationship, impact on distraction from family conflict)
- Social and peer relationships
- Academic (e.g., absenteeism, placement in home teaching)

REINFORCEMENT OF SOMATIC SYMPTOMS
- Reinforcement by parents
  - Medical journals and diaries of symptoms kept by parents
  - Parent home from work
- Increased attention from family/friends
- Increased attention from medical providers
- Avoidance of school, social, or athletic stressor

SSRD, Somatic symptoms and related disorder.
From Shaw RJ, DeMaso DR. *Clinical Manual of Pediatric Consultation-Liaison Psychiatry.* American Psychiatric Press; 2020:250–252.

**A teenager with disabling episodic weakness and palpitations is being assessed for a possible somatic symptom disorder. Which condition from the table should remain in the medical differential?**

A. Periodic paralysis
B. Conduct disorder
C. Selective mutism
D. Oppositional defiant disorder
E. Persistent tic disorder

Original table 35.8 | Nelson printed p. 238 | PDF p. 283

**Table 35.8** Selected Medical Conditions to Consider in the Differential Diagnosis of Youth Presenting with Disabling Somatic Symptoms

| | |
|---|---|
| AIDS | Hyperparathyroidism |
| Acquired myopathies | Hyperthyroidism |
| Acute intermittent porphyria | Juvenile idiopathic arthritis |
| Angina | Lyme disease |
| Autoinflammatory (recurrent fever) syndromes | Migraine headaches |
| Basal ganglia disease | Mitochondrial disorders |
| Brain tumors | Multiple sclerosis |
| Cardiac arrhythmias | Myasthenia gravis |
| Chronic systemic infections | Narcolepsy |
| Ehlers-Danlos syndrome | Optic neuritis |
| Fabry disease | Periodic paralysis |
| Gaucher disease | Postural orthostatic hypertension syndrome |
| Guillain-Barré syndrome | Polymyositis |
| Hereditary neuropathies | Seizure disorders |
| Hereditary angioedema | Small fiber neuropathy |
| | Superior mesenteric artery syndrome |
| | Systemic lupus erythematosus |

Modified from Shaw RJ, DeMaso DR. *Clinical Manual of Pediatric Consultation-Liaison Psychiatry.* American Psychiatric Press; 2020:248.

**A 16-year-old spends months fearing that a serious illness will develop, despite having no substantial physical complaint or abnormal findings. Which condition best matches the distinguishing features table?**

A. Somatic symptom disorder
B. Illness anxiety disorder
C. Functional neurologic symptom disorder
D. Bulimia nervosa
E. Factitious disorder

Original table 35.9 | Nelson printed p. 239 | PDF p. 284

**Table 35.9** Features of Conditions Characterized by Patient's Physical Complaints

| | ILLNESS ANXIETY DISORDER | SOMATIC SYMPTOM DISORDER | CONVERSION DISORDER FUNCTIONAL NEUROLOGIC DISORDER |
|---|---|---|---|
| Presenting complaint | Primary concern is the development of a serious illness—does not require specific symptoms | Primary concern is a specific symptom; generally presents with a more specific physical complaint<br>There are no objective physical findings other than those related to deconditioning | Presents with new-onset neurologic or physical symptom; patient may or may not be concerned about this new symptom |
| Medical correlation to complaint | Generally present with more vague complaints than a specific symptom; not usually explained by medical workup<br>In the presence of a known disease, the complaint does not correlate to the natural history of the disorder in severity, duration, or dysfunction | Patient can have a medical explanation for their symptom; however, the worry about the seriousness of the symptom is disproportionate or excessive | Physical and neurologic findings do not correlate with patient's presentation<br>Neurologic manifestations involve aspects of CNS where voluntary control is exercised |
| Course of disease | Often associated with other anxiety disorders; can be chronic | Chronic; rarely remits | Generally acute onset; can recur with same or different presenting symptom(s) |

CNS, Central nervous system
Modified from Byrne R, Elsner G, Beattie A. Emotional and behavioral symptoms. In: Kliegman RM, Toth H, Bordini BJ, Basel D, eds. *Nelson Pediatric Symptom-Based Diagnosis: Common Diseases and their Mimics*. 2nd ed. Elsevier; 2023:Table 31.14, p. 530.



**Question selection and educational compilation: Dr. Manar Alshawabkeh**

**A 10-year-old has had repeated eye blinking and intermittent throat-clearing for 16 months. Both tics began before age 18, and there is no medication or medical cause. Which diagnosis best fits the table?**

A. Provisional tic disorder
B. Persistent motor tic disorder
C. Tourette disorder
D. Stereotypic movement disorder
E. Functional movement disorder

Original table 37.1 | Nelson printed p. 242 | PDF p. 287

**Table 37.1 DSM-5 Diagnostic Criteria for Tic Disorders**

| |
|---|
| **TOURETTE DISORDER** |
| A. Both multiple motor and one or more vocal tics have been present at some time during the illness, although not necessarily concurrently.<br>B. The tics may wax and wane in frequency but have persisted for >1 year since first tic onset.<br>C. Onset is before age 18 years.<br>D. The disturbance is not attributable to the physiologic effects of a substance (e.g., cocaine) or another medical condition (e.g., Huntington disease, postviral encephalitis). |
| **PERSISTENT (CHRONIC) MOTOR OR VOCAL TIC DISORDER** |
| A. Single or multiple motor or vocal tics have been present during the illness, but not both motor and vocal.<br>B. The tics may wax and wane in frequency but have persisted for >1 year since first tic onset.<br>C. Onset is before age 18 years.<br>D. The disturbance is not attributable to the physiologic effects of a substance (e.g., cocaine) or another medical condition (e.g., Huntington disease, postviral encephalitis).<br>E. Criteria have never been met for Tourette disorder.<br>Specify if:<br>With motor tics only<br>With vocal tics only |
| **PROVISIONAL TIC DISORDER** |
| A. Single or multiple motor and/or vocal tics.<br>B. The tics have been present for <1 year since first tic onset.<br>C. Onset is before age 18 years.<br>D. The disturbance is not attributable to the physiologic effects of a substance (e.g., cocaine) or another medical condition (e.g., Huntington disease, postviral encephalitis).<br>E. Criteria have never been met for Tourette disorder or persistent (chronic) motor or vocal tic disorder. |

*Note*: A tic is a sudden, rapid, recurrent, nonrhythmic motor movement or vocalization.




**Question selection and educational compilation: Dr. Manar Alshawabkeh**

## A child has recurrent slow twisting movements that produce sustained abnormal postures rather than brief repetitive tics. Which movement type best matches the table?

A. Chorea
B. Myoclonus
C. Akathisia
D. Dystonia
E. Compulsion

Original table 37.2 | Nelson printed p. 243 | PDF p. 288

**Table 37.2** Repetitive Movements of Childhood

| MOVEMENT | DESCRIPTION | TYPICAL DISORDERS WHERE PRESENT |
|---|---|---|
| Tics | Sudden rapid, recurrent, nonrhythmic, stereotyped, vocalization or motor movement | Transient tics, Tourette disorder, persistent tic disorder |
| Dystonia | Involuntary, sustained, or intermittent muscle contractions that cause twisting and repetitive movements, abnormal postures, or both | *DYT1* gene, Wilson disease, myoclonic dystonia, extra-pyramidal symptoms caused by dopamine-blocking agents |
| Chorea | Involuntary, random, quick, jerking movements, most often of the proximal extremities, that flow from joint to joint. Movements are abrupt, nonrepetitive, and arrhythmic and have variable frequency and intensity | Sydenham chorea, Huntington chorea |
| Stereotypies | Stereotyped, rhythmic, repetitive movements or patterns of speech, with lack of variation over time | Autism, stereotypic movement disorder, intellectual disability |
| Compulsions | A repetitive, excessive, meaningless activity or mental exercise that a person performs in an attempt to avoid distress or worry | Obsessive-compulsive disorder, anorexia, body dysmorphic disorder, trichotillomania, excoriation disorder |
| Myoclonus | Shocklike involuntary muscle jerk that may affect a single body region, one side of the body, or the entire body; may occur as a single jerk or repetitive jerks | Hiccups, hypnic jerks, Lennox-Gastaut syndrome, juvenile myoclonic epilepsy, mitochondrial encephalopathies, metabolic disorders |
| Akathisia | Unpleasant sensations of "inner" restlessness, often prompting movements in an effort to reduce the sensations | Extrapyramidal adverse effects from dopamine-blocking agents; anxiety |
| Volitional behaviors | Behavior that may be impulsive or caused by boredom, such as tapping peers or making sounds (animal noises) | Attention-deficit/hyperactivity disorder, oppositional defiant disorder, sensory integration disorders |

Adapted from Murphy TK, Lewin AB, Storch EA, Stock S. American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter for the assessment and treatment of children and adolescents with tic disorders. *J Am Acad Child Adolesc Psychiatry. 2013;52(12):1341–1359.*

**An adolescent develops new repetitive movements after starting a dopamine receptor-blocking medication. In the table's classification, which category best explains this trigger?**

A. Sporadic primary tic disorder
B. Inherited primary tic disorder
C. Secondary drug-associated cause
D. Chromosomal cause
E. Normal volitional behavior

Original table 37.3 | Nelson printed p. 244 | PDF p. 289

**Table 37.3 Etiology of Tics**

| |
|---|
| PRIMARY CAUSES |
| *Sporadic* |
| Transient motor or phonic (<1 year), chronic motor or phonic tics (>1 year), adult-onset recurrent) tics, Tourette disorder, primary dystonia |
| *Inherited* |
| Tourette disorder, Huntington disease, primary dystonia, neuroacanthocytosis syndromes, neurodegeneration with brain iron accumulation (type 1) (pantothenate kinase associated neurodegeneration), tuberous sclerosis, Wilson disease, Duchenne muscular dystrophy |
| SECONDARY CAUSES |
| *Infections* |
| Encephalitis, Creutzfeldt-Jakob disease, neurosyphilis, Sydenham chorea, PANS |
| *Drugs* |
| Amphetamines, methylphenidate, levodopa, cocaine, carbamazepine, phenytoin, phenobarbital, lamotrigine, antipsychotics, and other dopamine receptor-blocking drugs |
| *Toxins* |
| Carbon monoxide, wasp venom |
| *Developmental* |
| Static encephalopathy, intellectual disability syndromes, chromosomal abnormalities, autistic spectrum disorders |
| *Chromosomal Disorders* |
| Down syndrome, Klinefelter syndrome, XYY karyotype, fragile X, triple X, and 9p mosaicism, partial trisomy 16, 9p monosomy, citrullinemia, Beckwith-Wiedemann syndrome |
| *Other Causes* |
| Head trauma, stroke, cardiopulmonary bypass with hypothermia, neurocutaneous syndromes, schizophrenia, neurodegenerative diseases |
| RELATED DISORDERS |
| • Stereotypies/habits/mannerisms<br>• Self-injurious behaviors<br>• Motor restlessness<br>• Akathisia<br>• Compulsions<br>• Hyperekplexia<br>• Jumping Frenchman (startle response) |

PANS, Pediatric acute neuropsychiatric syndrome.
Modified from Jankovic J. Differential diagnosis and etiology of tics. In: Cohen DJ, Goetz, CG, Jankovic J, eds. Tourette Syndrome. Lippincott Williams & Wilkins, 2001:Table 2.2, p. 18.



**Question selection and educational compilation: Dr. Manar Alshawabkeh**

**A child in habit reversal training recognizes the urge preceding a vocal tic. Which next action is the competing response described for vocal tics in the table?**

A. Immediately leave the classroom
B. Practice deep relaxed breathing with a slight exhale before speaking
C. Ask family members to ignore all tics
D. Avoid all words that trigger a tic
E. Repeat the vocal tic until the urge fades

Original table 37.4 | Nelson printed p. 246 | PDF p. 291

| Table 37.4 | Components of Habit Reversal Training |
|---|---|
| **INCREASE INDIVIDUAL'S AWARENESS OF HABIT** | |
| Response description—have individual describe behavior to therapist in detail while reenacting the behavior and looking in a mirror. | |
| Response detection—inform individual of each occurrence of the behavior until each occurrence is detected without assistance. | |
| Early warning—have individual practice identifying earliest signs of the target behavior. | |
| Situation awareness—have individual describe all situations in which the target behavior is likely to occur. | |
| **TEACH COMPETING RESPONSE TO HABIT** | |
| The competing response must result in isometric contraction of muscles involved in the habit, be capable of being maintained for 3 min, and be socially inconspicuous and compatible with normal ongoing activities but incompatible with the habit (e.g., clenching one's fist, grasping and clenching an object). For vocal tics and stuttering, deep relaxed breathing with a slight exhale before speech has been used as the competing response. | |
| **SUSTAIN COMPLIANCE** | |
| Habit inconvenience review—have individual review in detail all problems associated with target behavior. | |
| Social support procedure—family members and friends provide high levels of praise when a habit-free period is noted. | |
| Public display—individual demonstrates to others that he or she can control the target behavior in situations in which the behavior occurred in the past. | |
| **FACILITATE GENERALIZATION—SYMBOLIC REHEARSAL PROCEDURE** | |
| For each situation identified in situation awareness procedure, individual imagines himself or herself beginning the target behavior but stopping and engaging in the competing response. | |

From Carey WB, Crocker AC, Coleman WL, et al., eds. *Developmental-Behavioral Pediatrics*. 4th ed. Philadelphia: Saunders; 2009:639.


**Question selection and educational compilation: Dr. Manar Alshawabkeh**

**A teenager presents with severe anxiety, insomnia, and racing thoughts but also has discrete periods of elevated energy and markedly reduced need for sleep. Which comorbidity in the table particularly changes the medication strategy?**

A. Specific learning disorder
B. Bipolar disorder
C. Selective mutism
D. Simple phobia
E. Enuresis

Original table 38.1 | Nelson printed p. 247 | PDF p. 292

**Table 38.1** Mental and Somatic Disorders that are Frequently Comorbid or Difficult to Distinguish in Anxiety Disorder

| | EXAMPLES OF OVERLAPPING SYMPTOMS | KEY CLINICAL INSIGHTS TO RECOGNIZE |
|---|---|---|
| MENTAL DISORDERS | | |
| Major depressive disorder | Fatigue, anxiety, worry, or agitation | Major depressive disorder is the highest comorbidity in anxiety disorder and associated with higher severity, suicidality, disability and chronicity; clinicians must comprehensively assess because major depressive disorder comorbidity requires more intensive pharmacologic treatment and a different form of psychotherapy treatment (e.g., cognitive-behavioral therapy for depression rather than for anxiety disorder) |
| Bipolar disorder | Agitation, irritability, or racing thoughts | Anxiety is often present in bipolar disorder and is associated with rapid cycling; targeting anxiety could aid in mood stabilization; bipolar disorder requires focus on mood stabilization and considerate use of medication, which could induce mania (especially antidepressants) |
| Obsessive-compulsive disorder* | Extreme worry or inability to relax | People who have obsessive-compulsive disorder engage in ritualistic, repetitive behavior to deal with their fears, which is absent in anxiety disorder; these people often realize that their behavior is irrational and inappropriate |
| Posttraumatic stress disorder* | Avoidance, hyperarousal, or anxiety-laden intrusive memories | The intense experience of anxiety in posttraumatic stress disorder is specifically in response to a psychologic trauma (e.g., abuse, war, or accident); specific psychotherapies focused on the trauma associated with the posttraumatic stress disorder should be used |
| Health anxiety* (hypochondriasis) | Anxiety or worry from bodily responses | Anxiety is specifically related to preoccupation with having or acquiring a serious, undiagnosed medical illness |
| Substance use (e.g., illicit drugs, alcohol, or benzodiazepines) disorder | Tremor, sweating, palpitations, or panic attacks (during withdrawal or in some cases intoxication) | When suspected, clinicians should conduct a psychiatric interview of substance use disorders, with potential breath, urine, or plasma drug screening; comorbidity of alcohol or benzodiazepine abuse with anxiety disorder is considerable |
| SOMATIC DISORDERS | | |
| Cardiac disease | Chest pain or palpitations (which is also common in panic disorder) | Clinical evaluation, including electrocardiogram, assessment of plasma troponin concentration, or Holter monitoring |
| Thyroid disease (e.g., hyperthyroidism) | Palpitations, tremor, panic attacks, or persistent anxiety | Laboratory assessment of plasma thyroid-stimulating hormone |
| Respiratory disease (e.g., asthma) | Shortness of breath | Clinical evaluation with a pulmonary function test |
| Pheochromocytoma or other disorders that result in sudden blood pressure increase | Panic attacks or bodily sensations | Blood pressure monitoring over 24 hr or hormone assessment (e.g., in blood or urine) |
| Epilepsy | Anxiety symptoms as part of aura or start of seizure | Clinical evaluation or neurologic referral when the causes of symptoms are unclear |

*In previous classifications of the *Diagnostic and Statistical Manual of Mental Disorders and International Classification of Diseases*, these disorders were included in the classification of anxiety disorders. In current classifications (e.g., the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* and the 11th edition of the *International Classification of Diseases*), they are integrated in different classifications.

From Penninx BWJH, Pine DS, Holmes EA, Reif A. Anxiety disorders. Lancet. 2021;397:914–926;Table 2, p. 917.



Question selection and educational compilation: Dr. Manar Alshawabkeh

## A 12-year-old repeatedly washes both hands for more than 2 hours daily to neutralize intrusive contamination thoughts and misses classes as a result. Which diagnosis best matches the table?

A. Generalized anxiety disorder
B. Obsessive-compulsive disorder
C. Specific phobia
D. Tic disorder
E. Illness anxiety disorder

Original table 38.3 | Nelson printed p. 248 | PDF p. 293

| Table 38.3 | DSM-5 Diagnostic Criteria for Obsessive-Compulsive Disorder |
|---|---|

A. Presence of obsessions, compulsions, or both:
Obsessions are defined by (1) and (2):
1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):
1. Repetitive behaviors (e.g., handwashing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hr/day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The obsessive-compulsive symptoms are not attributable to the physiologic effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating disorder, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).

Specify if:
**With good or fair insight:** The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.
**With poor insight:** The individual thinks obsessive-compulsive disorder beliefs are probably true.
**With absent insight/delusional beliefs:** The individual is completely convinced that obsessive-compulsive disorder beliefs are true.
Specify if:
**Tic-related:** The individual has a current or past history of a tic disorder.

From the *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed. p 237. Copyright 2013. American Psychiatric Association.


Question selection and educational compilation: Dr. Manar Alshawabkeh

**An 11-year-old has had difficult-to-control worry about several school and family matters most days for 8 months, with persistent sleep disturbance and impaired school functioning. Which diagnosis fits the age-specific criteria?**

A. Panic disorder
B. Generalized anxiety disorder
C. Specific phobia
D. Obsessive-compulsive disorder
E. Separation anxiety disorder

Original table 38.5 | Nelson printed p. 249 | PDF p. 294

**Table 38.5** DSM-5 Diagnostic Criteria for Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 mo, about a number of events or activities (such as work or school performance).
B. The individual finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 mo):

*Note:* Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

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

From the *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed. p 222. 



**Question selection and educational compilation: Dr. Manar Alshawabkeh**

## A 7-year-old speaks normally at home but consistently does not speak at school, despite adequate language skills; classroom participation is impaired. Which anxiety-related diagnosis best fits the comparison table?

A. Selective mutism
B. Panic disorder
C. Generalized anxiety disorder
D. Specific phobia
E. Agoraphobia

Original table 38.9 | Nelson printed p. 252 | PDF p. 297

**Table 38.9** Core Diagnostic Features and Characteristics for Anxiety Disorders

| | SELECTIVE MUTISM | SEPARATION ANXIETY | SPECIFIC PHOBIA | SOCIAL ANXIETY DISORDER | AGORAPHOBIA | PANIC DISORDER | GENERALIZED ANXIETY DISORDER |
|---|---|---|---|---|---|---|---|
| Core emotions or cognitions | Consistent failure to speak in situations for which there is an expectation to speak, despite language competence | Unrealistic, persistent fear or anxiety about separation from, or loss of, attachment figure, or adverse events occurring to them | Marked, excessive, and unreasonable fear or anxiety of circumscribed objects or situations (e.g., animals, natural forces, blood injection, or places) | Marked, excessive, and unreasonable fear or anxiety of scrutiny or negative judgement by other people | Marked, excessive, and concerning fear of leaving home, entering closed or open public places, crowds, or transportation | Recurrent, unexpected panic attacks with sustained mental (e.g., fear, fear of losing control, or feeling of alienation) manifestations | Marked, uncontrollable, and anxious worry and fears about everyday events and problems |
| Physical symptoms | No physical symptoms | Nightmares and symptoms of distress | No physical symptoms | Blushing, fear of vomiting, urgency or fear of micturition or defecation | No physical symptoms | Multiple symptoms (e.g., palpitations, dyspnea, diaphoresis, chest pain, dizziness, paresthesia, or nausea) | Restlessness, fatigue, irritability, difficulty concentrating, muscle tension, sleep disturbance, or autonomic arousal |
| Behavior | Disturbance interferes with (educational) achievement or social communication | Reluctance to leave attachment figure; disturbance impairs social, school, or other functioning | Avoidance of circumscribed objects or situations; disturbance impairs social, school, work, or other functioning | Avoidance of social interactions and situations; disturbance impairs social, school, work, or other functioning | Avoidance of fear-inducing situations; disturbance impairs social, school, work, or other functioning | Changed behavior in maladaptive ways related to the attacks; disturbance impairs social, school, work or other functioning | Disturbance impairs social, school, work, or other functioning |
| Required symptom duration | >1 month (beyond first school month) | >1 mo (childhood; 4-18 yr); >6 months (adulthood; 18 yr or older) | >6 mo | >6 mo | >6 mo | >1 mo | >6 mo |
| Median age of onset | Childhood (<5 yr) | Childhood (around 6 yr) | Childhood (around 8 yr) | Early adolescence (around 13 yr) | Late adolescence (around 20 yr) | Adulthood (around 25 yr) | Adulthood (around 30 yr) |

For OCD see Table 38.3; for PTSD see Table 38.8.
Characteristics and features for anxiety disorders were based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) *and International Classification of Diseases* (11th Edition).


**Question selection and educational compilation: Dr. Manar Alshawabkeh**

## A 13-year-old presents with new tremor, palpitations, and anxious restlessness. Which medication class listed in the differential should be reviewed before diagnosing primary anxiety?

A. Topical emollients
B. Bronchodilators
C. Oral iron
D. Saline nasal drops
E. Vitamin D supplements

Original table 38.10 | Nelson printed p. 253 | PDF p. 298

**Table 38.10** Differential Diagnosis of Anxiety Disorders

| GENERAL | PSYCHIATRIC | MEDICAL |
|---|---|---|
| Shyness | Substance use (including caffeine)<br>Substance use withdrawal<br>Body dysmorphic disorder<br>ADHD (distractibility, restlessness)<br>ASD (social withdrawal, social skills deficits, distractibility)<br>MDD (distractibility, insomnia, somatic symptoms)<br>Bipolar disorder<br>Delusional disorder<br>Learning disorders (worry about school performance)<br>ODD (refusal to do activity) | Antihistamines<br>Bronchodilators<br>Nasal decongestants<br>Steroids<br>Dietary supplements<br>Stimulants<br>Hyperthyroidism<br>Allergic reactions<br>Asthma<br>Cardiac conditions<br>Autoimmune encephalitis<br>Chronic pain<br>Headaches<br>CNS disease<br>Diabetes<br>Dysmenorrhea<br>Lead intoxication<br>Hypoglycemia<br>Hypoxia<br>Pheochromocytoma<br>Mast cell disorders<br>Carcinoid syndrome<br>Hereditary angioedema<br>Systemic lupus erythematosus |

All of the SSRIs carry a "black box" warning for suicidal thinking and



Question selection and educational compilation: Dr. Manar Alshawabkeh

**An 8-year-old abruptly develops severe obsessive rituals, urinary frequency, and marked deterioration in school performance. Which further step is required by the listed criteria before attributing this syndrome to PANS?**

A. Confirm streptococcal infection in every case
B. Evaluate for neurologic or medical disorders that better explain the symptoms
C. Require the symptoms to persist for at least 12 months
D. Require a first-degree relative with Tourette disorder
E. Demonstrate an elevated antinuclear antibody titer

Original table 38.12 | Nelson printed p. 254 | PDF p. 299

**Table 38.12** Diagnostic Criteria for Pediatric Acute-Onset Neuropsychiatric Syndrome

| |
|---|
| **CRITERION 1**<br>Abrupt, dramatic onset of obsessive-compulsive disorder or severely restricted food intake. |
| **CRITERION 2**<br>Concurrent presence of additional neuropsychiatric symptoms with similarly severe and acute onset from at least two of the following seven categories:<br>1. Anxiety.<br>2. Emotional lability or depression.<br>3. Irritability, aggression, or severely oppositional behaviors.<br>4. Behavioral (developmental) regression.<br>5. Deterioration in school performance.<br>6. Sensory or motor abnormalities.<br>7. Somatic signs and symptoms, including sleep disturbances, enuresis, or urinary frequency. |
| **CRITERION 3**<br>Symptoms are not better explained by a known neurologic or medical disorder, such as Sydenham chorea, systemic lupus erythematosus, Tourette disorder, autoimmune encephalitis, or others. The diagnostic workup of patients with suspected PANS must be comprehensive enough to rule out these and other relevant disorders. The nature of the co-occurring symptoms will dictate the necessary assessments, which may include MRI scans, lumbar puncture, electroencephalograms, or other diagnostic tests. |

PANS, Pediatric acute-onset neuropsychiatric syndrome.
Modified from Johnson M, Fernell E, Preda I, et al. Paediatric acute-onset neuropsychiatric syndrome in children and adolescents: an observational cohort study. *Lancet Child Adolesc Health.* 2019;3(3):175–180.

## A 14-year-old has 2 weeks of irritability, loss of interest, insomnia, poor concentration, guilt, and fatigue, with clear decline in functioning. Which feature in the table allows the mood criterion to be met in an adolescent?

A. Irritability can substitute for depressed mood

B. Symptoms must have lasted 1 year

C. Anhedonia cannot count as a core symptom

D. A manic episode must precede the illness

E. Weight loss is obligatory

Original table 39.1 | Nelson printed p. 255 | PDF p. 300

**Table 39.1** DSM-5 Diagnostic Criteria for Major Depressive Episode

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

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

*Note:* In children and adolescents, can be irritable mood.

1. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
2. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

*Note:* In children, consider failure to make expected weight gain.

1. Insomnia or hypersomnia nearly every day.
2. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
3. Fatigue or loss of energy nearly every day.
4. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
5. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
6. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiologic effects of a substance or to another medical condition.

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

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

From the *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed. pp. 125–126. Copyright 2013. American Psychiatric Association.

**An 8-year-old has severe temper outbursts at least three times weekly for 14 months and is persistently irritable between episodes at home and at school. There has never been a distinct episode of elevated mood. Which diagnosis best fits the table?**

A. Bipolar I disorder
B. Disruptive mood dysregulation disorder
C. Intermittent explosive disorder
D. Provisional tic disorder
E. Panic disorder

Original table 39.3 | Nelson printed p. 257 | PDF p. 302

**Table 39.3** DSM-5 Diagnostic Criteria for Disruptive Mood Dysregulation Disorder

A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
B. The temper outbursts are inconsistent with developmental level.
C. The temper outbursts occur, on average, three or more times per week.
D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).
E. Criteria A-D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A-D.
F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.
G. The diagnosis should not be made for the first time before age 6 yr or after age 18 yr.
H. By history or observation, the age at onset of Criteria A-E is before 10 yr.
I. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.

*Note:* Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.

J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]).

*Note:* The diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, attention-deficit/hyperactivity disorder, conduct disorder, and substance use disorders. Individuals whose symptoms meet criteria for both disruptive mood dysregulation disorder and oppositional defiant disorder should only be given the diagnosis of disruptive mood dysregulation disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.

K. The symptoms are not attributable to the physiologic effects of a substance or to another medical or neurologic condition.

From the *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed. p. 156. 

**A 12-year-old becomes sad whenever reminded of a deceased parent, particularly around birthdays, but maintains enjoyment at other times and has no pervasive daily anhedonia. Which category in the comparison table most closely fits this pattern?**

A. Major depressive disorder
B. Persistent depressive disorder
C. Disruptive mood dysregulation disorder
D. Grief
E. Cyclothymia

Original table 39.4 | Nelson printed p. 258 | PDF p. 303

**Table 39.4** A Comparison of Features of Depression, Persistent Depressive Disorder, Disruptive Mood Dysregulation Disorder, and Grief in Children with Developmental Considerations

| | MAJOR DEPRESSIVE DISORDER | PERSISTENT DEPRESSIVE DISORDER | DISRUPTIVE MOOD DYSREGULATION DISORDER | GRIEF |
|---|---|---|---|---|
| Core feature(s) | Sadness, irritability, anhedonia | Sadness, irritability, anhedonia | Irritability and anger with behavioral outbursts (verbal, physical) | Sadness in response to the loss/death of a loved one |
| Duration | 2 weeks with symptoms nearly every day | 1 year with symptoms more days than not | 1 year with outbursts at least three times/week | Ongoing, can continue/recur indefinitely (e.g., around anniversaries, birthdays, holidays) |
| Associated symptoms | Changes in appetite, sleep, energy and activity level; impaired concentration; hopelessness, worthlessness and guilt; suicidal ideations/actions | Changes in appetite, sleep, energy and activity level; impaired concentration; hopelessness, worthlessness and guilt; suicidal ideations/actions | Persistent irritability between episodes | Anger; guilt; regret; anxiety; intrusive images; overwhelmed; lonely |
| Age considerations | Younger children may be irritable and complain of somatic symptoms | | Cannot be diagnosed before age 6 or after age 18 | Developmental level and understanding of death can influence grief symptoms |


Question selection and educational compilation: Dr. Manar Alshawabkeh

**A 16-year-old has 8 days of distinctly elevated mood, little need for sleep, grandiose claims, pressured speech, and high-risk spending, with severe school and family impairment. Which episode best fits the table?**

A. Hypomanic episode
B. Manic episode
C. Persistent depressive disorder
D. Panic attack
E. Disruptive mood dysregulation disorder

Original table 39.6 | Nelson printed p. 260 | PDF p. 305

**Table 39.6 DSM-5 Diagnostic Criteria for a Manic Episode**

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

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

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hr of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non–goal-directed activity).
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiologic effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.

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

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

From the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. p. 124. Copyright 2013. American Psychiatric Association.



**Question selection and educational compilation: Dr. Manar Alshawabkeh**

**An adolescent has had a hypomanic episode and a separate major depressive episode but has never had a manic episode. Which category in the comparison table best fits?**

A. Bipolar I disorder
B. Bipolar II disorder
C. Cyclothymia
D. Major depressive disorder only
E. Disruptive mood dysregulation disorder

Original table 39.8 | Nelson printed p. 261 | PDF p. 306

**Table 39.8** A Comparison of Bipolar I and II and Cyclothymia in Children and Adolescents

| | BIPOLAR I | BIPOLAR II | CYCLOTHYMIA |
|---|---|---|---|
| Core feature(s) | One manic episode | One hypomanic episode AND one major depressive episode | Symptoms of hypomania and depression, without meeting full criteria for a manic, hypomanic or depressive episode |
| Duration | Mania: 7 days | Hypomania: 4 days<br>Depressive episode: 14 days | 1 year |
| Associated symptoms | Depressive episodes, hypomanic episodes, psychosis | | Chronic disruption in mood patterns |


**Question selection and educational compilation: Dr. Manar Alshawabkeh**

**A 15-year-old seen after a recent suicide attempt is newly agitated and has just been discharged from psychiatric hospitalization. Which listed change is a dynamic suicide risk factor relevant to current assessment?**

A. Biologic sex
B. Past family history of suicide
C. Recent discharge from psychiatric hospitalization
D. Age at first school entry
E. Chromosomal sex

Original table 40.1 | Nelson printed p. 265 | PDF p. 310

**Table 40.1 Dynamic and Static Risk Factors for Suicide in Children and Adolescents**

| | |
|---|---|
| **DYNAMIC RISK FACTORS** | |
| Psychiatric symptoms | Anhedonia<br>Feelings of hopelessness, helplessness, or worthlessness<br>Impulsivity<br>Insomnia<br>Command hallucinations<br>Agitation<br>Anxiety or panic<br>Poor coping |
| Changes in psychiatric treatment | Recent discharge from a psychiatric hospital<br>Change in treatment plan<br>Change in treatment team |
| Psychosocial stressors or precipitants | Events that can cause humiliation, shame, or despair (e.g., loss of a relationship, death of a loved one, housing insecurity, academic problems, newly diagnosed medical condition)<br>Ongoing medical illness<br>Substance intoxication<br>Family turmoil/chaos/conflict<br>Social isolation<br>Bullying or being bullied<br>Pending legal situation<br>Suicide in the community (contagion) |
| **STATIC RISK FACTORS** | |
| Demographics | Age: 14-25<br>Sex: male<br>Race: White, Indigenous American, and Native Alaskan<br>LGBTQ+ identification |
| Preexisting and/or current psychiatric illness | Mood disorder<br>Psychotic disorder<br>Substance abuse disorder<br>ADHD<br>Eating disorder<br>Posttraumatic stress disorder<br>Cluster B personality traits/disorders<br>Conduct disorder or behaviors (antisocial behavior, aggression)<br>History of trauma, abuse, or neglect |
| Past suicidal and parasuicidal behavior | Previous suicide attempts<br>Aborted or interrupted suicide attempts<br>Nonsuicidal self-injury (self-harm) thoughts and/or action |
| Family history | Psychiatric illness<br>Psychiatric hospitalization<br>Suicide attempts and completions |

ADHD, Attention-deficit/hyperactivity disorder.


Question selection and educational compilation: Dr. Manar Alshawabkeh

**A pediatrician asks a distressed adolescent about trusted adults who can be contacted during a safety crisis. Which listed protective factor is the clinician identifying?**

A. Social supports and positive mentoring relationships
B. History of previous attempts
C. Recent psychiatric discharge
D. Ongoing substance intoxication
E. Access to lethal means

Original table 40.2 | Nelson printed p. 266 | PDF p. 311

**Table 40.2** Protective Factors Against Suicide in Children and Adolescents

| PROTECTIVE FACTORS | |
|---|---|
| Internal protective factors | Positive coping skills<br>Frustration tolerance<br>Religious faith<br>Fear of consequences of an attempt (e.g., disfigurement, hospitalization, effects on family/friends)<br>Future oriented thinking<br>Fear of lost opportunities |
| External protective factors | Responsibilities for others (e.g., other children in the home, pets)<br>Positive therapeutic or mentoring relationships (e.g., physician, therapist, teacher, coach)<br>Social supports<br>Living with others |


**Question selection and educational compilation: Dr. Manar Alshawabkeh**

**A 15-year-old with marked weight loss restricts food because of a persistent fear of weight gain and perceives themself as overweight despite significantly low weight. Which diagnosis best matches the table?**

A. Avoidant/restrictive food intake disorder
B. Anorexia nervosa
C. Bulimia nervosa
D. Somatic symptom disorder
E. Illness anxiety disorder

Original table 41.1 | Nelson printed p. 269 | PDF p. 314

| Table 41.1 | DSM-5 Diagnostic Criteria for Anorexia Nervosa |
|---|---|
| A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected. | |
| B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight. | |
| C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight. | |
| Specify whether: | |
| **Restricting type** (ICD-10-CM code F50.01): During the last 3 mo, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise. | |
| **Binge-eating/purging type** (ICD-10-CM code F50.02): During the last 3 mo, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). | |
| Specify if: | |
| **In partial remission**: After full criteria for anorexia nervosa were previously met, Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met. | |
| **In full remission**: After full criteria for anorexia nervosa were previously met, none of the criteria has been met for a sustained period of time. | |
| Specify current severity: | |
| The minimum level of severity is based, for adults, on current BMI (see the following) or, for children and adolescents, on BMI percentile. **The ranges below are derived from World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used.** The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision. | |
| **Mild**: BMI ≥17 kg/$m^2$<br>**Moderate**: BMI 16-16.99 kg/$m^2$<br>**Severe**: BMI 15-15.99 kg/$m^2$<br>**Extreme**: BMI <15 kg/$m^2$ | |

From the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. pp. 338–339.



Question selection and educational compilation: Dr. Manar Alshawabkeh

**A 16-year-old reports objectively large episodes of uncontrolled eating followed by self-induced vomiting twice weekly for 4 months. Weight is not significantly low, and body shape dominates self-evaluation. Which diagnosis best fits the table?**

A. Bulimia nervosa
B. Anorexia nervosa, restricting type
C. Avoidant/restrictive food intake disorder
D. Illness anxiety disorder
E. Specific phobia

Original table 41.2 | Nelson printed p. 269 | PDF p. 314

| Table 41.2 | DSM-5 Diagnostic Criteria for Bulimia Nervosa |
|---|---|
| A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:<br>1. Eating, in a discrete period of time (e.g., within any 2 hr period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.<br>2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating). | |
| B. Recurrent inappropriate compensatory behaviors to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise. | |
| C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 mo. | |
| D. Self-evaluation is unduly influenced by body shape and weight. | |
| E. The disturbance does not occur exclusively during episodes of anorexia nervosa. | |
| Specify if: | |
| **In partial remission**: After full criteria for bulimia nervosa were previously met, some, but not all, of the criteria have been met for a sustained period of time. | |
| **In full remission**: After full criteria for bulimia nervosa were previously met, none of the criteria has been met for a sustained period of time. | |
| Specify current severity: | |
| The minimum level of severity is based on the frequency of inappropriate compensatory behaviors (see the following). The level of severity may be increased to reflect other symptoms and the degree of functional disability. | |
| **Mild**: An average of 1-3 episodes of inappropriate compensatory behaviors per week. | |
| **Moderate**: An average of 4-7 episodes of inappropriate compensatory behaviors per week. | |
| **Severe**: An average of 8-13 episodes of inappropriate compensatory behaviors per week. | |
| **Extreme**: An average of 14 or more episodes of inappropriate compensatory behaviors per week. | |

From the *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed. p. 345.




**Question selection and educational compilation: Dr. Manar Alshawabkeh**

**A 9-year-old with severe food-texture aversion has growth faltering and needs oral nutritional supplements. The child has no concerns about body size or weight. Which diagnosis best fits?**

A. Anorexia nervosa
B. Bulimia nervosa
C. Avoidant/restrictive food intake disorder
D. Illness anxiety disorder
E. Body dysmorphic disorder

Original table 41.3 | Nelson printed p. 270 | PDF p. 315

| Table 41.3 | DSM-5 Diagnostic Criteria for Avoidant/Restrictive Food Intake Disorder |
|---|---|
| A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:<br>1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).<br>2. Significant nutritional deficiency.<br>3. Dependence on enteral feeding or oral nutritional supplements.<br>4. Marked interference with psychosocial functioning. | |
| B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice. | |
| C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced. | |
| D. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention. | |
| Specify if: | |
| **In remission**: After full criteria for avoidant/restrictive food intake disorder were previously met, the criteria have not been met for a sustained period of time. | |

From the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. p. 334. Copyright 2013. American Psychiatric Association.



Question selection and educational compilation: Dr. Manar Alshawabkeh

## An adolescent presents with progressive food restriction. Meals are rigidly planned around foods labeled as healthy, with very low caloric density despite apparently large volumes. Which table pattern is most consistent?

A. Typical intake pattern of anorexia nervosa
B. Typical intake pattern of bulimia nervosa
C. Normal appetite in a growth spurt
D. Habit pattern specific to panic disorder
E. Compensatory behavior in tic disorder

Original table 41.4 | Nelson printed p. 271 | PDF p. 316

**Table 41.4** Eating and Weight Control Habits Commonly Found in Children and Adolescents with an Eating Disorder (ED)

| | PROMINENT FEATURE | | CLINICAL COMMENTS REGARDING ED HABITS | |
|---|---|---|---|---|
| HABIT | ANOREXIA NERVOSA | BULIMIA NERVOSA | ANOREXIA NERVOSA | BULIMIA NERVOSA |
| Overall intake | Inadequate energy (calories), although volume of food and beverages may be high because of very low caloric density of intake as a result of "diet" and nonfat choices | Variable, but calories normal to high; intake in binges is often "forbidden" food or drink that differs from intake at meals | Consistent inadequate caloric intake leading to wasting of the body is an essential feature of diagnosis | Inconsistent balance of intake, exercise, and vomiting, but severe caloric restriction is short-lived |
| Food | Counts and limits calories, especially from fat; emphasis on "healthy food choices" with reduced caloric density<br>Monotonous, limited "good" food choices, often leading to vegetarian or vegan diet<br>Strong feelings of guilt after eating more than planned leads to exercise and renewed dieting | Aware of calories and fat, but less regimented in avoidance than AN<br>Frequent dieting interspersed with overeating, often triggered by depression, isolation, or anger | Obsessive-compulsive attention to nutritional data on food labels and may have "logical" reasons for food choices in highly regimented pattern, such as sports participation or family history of lipid disorder | Choices less structured, with more frequent diets |
| Beverages | Water or other low- or no-calorie drinks; nonfat milk | Variable, diet soda common; may drink alcohol to excess | Fluids often restricted to avoid weight gain | Fluids ingested to aid vomiting or replace losses |
| Meals | Consistent schedule and structure to meal plan<br>Reduced or eliminated caloric content, often starting with breakfast, then lunch, then dinner<br>Volume can increase with fresh fruits, vegetables, and salads as primary food sources | Meals less regimented and planned than in AN; more likely impulsive and unregulated, often eliminated following a binge-purge episode | Rigid adherence to "rules" governing eating leads to sense of control, confidence, and mastery | Elimination of a meal following a binge-purge only reinforces the drive for binge later in the day |
| Snacks | Reduced or eliminated from meal plan | Often avoided in meal plans, but then impulsively eaten | Snack foods removed early because "unhealthy" | Snack "comfort foods" can trigger a binge |
| Dieting | Initial habit that becomes progressively restrictive, although often appearing superficially "healthy"<br>Beliefs and "rules" about the patient's idiosyncratic nutritional requirements and response to foods are strongly held | Initial dieting gives way to chaotic eating, often interpreted by the patient as evidence of being "weak" or "lazy" | Distinguishing between healthy meal planning with reduced calories and dieting in ED may be difficult | Dieting tends to be impulsive and short-lived, with "diets" often resulting in unintended weight gain |
| Binge eating | None in restrictive subtype, but an essential feature in binge-purge subtype | Essential feature, often secretive<br>Shame and guilt prominent afterward | Often "subjective" (more than planned but not large) | Relieves emotional distress, may be planned |
| Exercise | Characteristically obsessive-compulsive, ritualistic, and progressive<br>May excel in dance, long-distance running | Less predictable<br>May be athletic, or may avoid exercise entirely | May be difficult to distinguish active thin vs ED | Males often use exercise as means of "purging" |
| Vomiting | Characteristic of binge-purge subtype<br>May chew, then spit out, rather than swallow, food as a variant | Most common habit intended to reduce effects of overeating<br>Can occur after meal as well as a binge | Physiologic and emotional instability prominent | Strongly "addictive" and self-punishing, but does not eliminate calories ingested—many still absorbed |
| Laxatives | If used, generally to relieve constipation in restrictive subtype, but as a cathartic in binge-purge subtype | Second most common habit used to reduce or avoid weight gain, often used in increasing doses for cathartic effect | Physiologic and emotional instability prominent | Strongly "addictive," self-punishing, but ineffective means to reduce weight (calories are absorbed in small intestine, but laxatives work in colon) |
| Diet pills | Very rare, if used; more common in binge-purge subtype | Used to either reduce appetite or increase metabolism | Use of diet pills implies inability to control eating | Control over eating may be sought by any means |

AN, Anorexia nervosa; BN, bulimia nervosa.



**Question selection and educational compilation: Dr. Manar Alshawabkeh**

**A 16-year-old with a restrictive eating disorder has symptomatic bradycardia, dehydration, and hypophosphatemia. Which disposition is supported by the medical-instability categories in the table?**

A. Routine annual follow-up
B. Medical evaluation for inpatient stabilization
C. Only an outpatient diet handout
D. Delay assessment until weight falls below an arbitrary cutoff
E. Exercise clearance without further evaluation

Original table 41.7 | Nelson printed p. 275 | PDF p. 320

**Table 41.7 Potential Indications for Inpatient Medical Hospitalization of Patients with Anorexia Nervosa**

| |
|---|
| **PHYSICAL AND LABORATORY** |
| Heart rate <50 beats/min |
| Other cardiac rhythm disturbances |
| Blood pressure <80/50 mm Hg |
| Postural hypotension resulting in >10 mm Hg decrease or >25 beats/min increase |
| Hypokalemia |
| Hypophosphatemia |
| Hypoglycemia |
| Dehydration |
| Body temperature <36.1°C (97°F) |
| <80% healthy body weight |
| Hepatic, cardiac, or renal compromise |
| **PSYCHIATRIC** |
| Suicidal intent and plan |
| Very poor motivation to recover (in family and patient) |
| Preoccupation with ego-syntonic thoughts |
| Coexisting psychiatric disorders |
| **MISCELLANEOUS** |
| Requires supervision after meals and while using the restroom |
| Failed day treatment |


**Question selection and educational compilation: Dr. Manar Alshawabkeh**

# Answer key and teaching notes

**01. C | Table 34.2 | printed p. 234, PDF p. 279**

Why: Exposure is listed as an intervention element for anxiety disorders and directly addresses avoidance of feared situations.
Closest distractor: Activity scheduling is an element for depression and does not directly target the specific avoidance.

**02. A | Table 34.3 | printed p. 235, PDF p. 280**

Why: Assessment of treatment barriers specifically elicits transportation, scheduling, and childcare obstacles to participation.
Closest distractor: Appointment reminders address forgetting an appointment but do not identify the stated barriers.

**03. B | Table 35.1 | printed p. 235, PDF p. 280**

Why: Persistent distressing somatic symptoms together with excessive illness-related thoughts and behavior fit somatic symptom disorder.
Closest distractor: Illness anxiety disorder centers on fear of disease when somatic symptoms are absent or mild.

**04. B | Table 35.2 | printed p. 236, PDF p. 281**

Why: The conversion disorder criteria require clinical evidence that the altered motor or sensory symptom is incompatible with recognized neurologic conditions.
Closest distractor: A recent stressor may be relevant, but its presence alone is not the positive examination evidence required here.

**05. C | Table 35.3 | printed p. 236, PDF p. 281**

Why: Identified deception or induction of illness in another person, presented as ill without obvious external reward, is factitious disorder imposed on another; the caregiver receives the diagnosis.
Closest distractor: Somatic symptom disorder does not require deliberate falsification of another person's illness.

**06. B | Table 35.7 | printed p. 238, PDF p. 283**

Why: The table includes Hoover sign and normal function when distracted as findings that may support functional weakness.
Closest distractor: A fixed anatomic sensory level would prompt assessment of an organic neurologic lesion rather than provide this positive functional sign.

**07. A | Table 35.8 | printed p. 238, PDF p. 283**

Why: Periodic paralysis is explicitly included among medical conditions to consider before attributing disabling symptoms to a somatic disorder.
Closest distractor: Conduct disorder is not a medical explanation for episodic weakness and palpitations.

**08. B | Table 35.9 | printed p. 239, PDF p. 284**

Why: Illness anxiety disorder centers on preoccupation with having or acquiring serious illness without requiring a substantial specific symptom.
Closest distractor: Somatic symptom disorder centers on distressing specific somatic symptoms and an excessive response to them.

**09. C | Table 37.1 | printed p. 242, PDF p. 287**

Why: Tourette disorder requires both motor and vocal tics at some point, with tics present for more than 1 year since onset.
Closest distractor: Persistent motor tic disorder applies to motor tics without vocal tics.

**10. D | Table 37.2 | printed p. 243, PDF p. 288**

Why: Dystonia involves involuntary sustained or intermittent contractions producing twisting movements and abnormal postures.
Closest distractor: Chorea consists of brief, random, flowing, nonrepetitive jerks.

**11. C | Table 37.3 | printed p. 244, PDF p. 289**

Why: The table lists antipsychotics and other dopamine receptor blockers among secondary drug-associated causes of tic-like movements.
Closest distractor: Primary sporadic tic disorder would not account for a clear temporal medication trigger.

**12. B | Table 37.4 | printed p. 246, PDF p. 291**

Why: The table describes deep relaxed breathing with a slight exhale before speech as a competing response for vocal tics.
Closest distractor: Family praise is part of social support but is not the competing response itself.

**13. B | Table 38.1 | printed p. 247, PDF p. 292**

Why: The bipolar disorder row emphasizes mood stabilization and careful medication use because antidepressants may induce mania.
Closest distractor: A simple phobia does not account for episodic elevated energy with decreased need for sleep.

**14. B | Table 38.3 | printed p. 248, PDF p. 293**

Why: Intrusive unwanted thoughts, driven repetitive acts intended to reduce distress, and significant time burden/impairment fit obsessive-compulsive disorder.
Closest distractor: Generalized anxiety disorder involves broad worries without the characteristic ritual performed to neutralize an obsession.

**15. B | Table 38.5 | printed p. 249, PDF p. 294**

Why: The table specifies difficult-to-control worry about multiple matters for at least 6 months with impairment; only one associated symptom is required in children.
Closest distractor: Specific phobia is restricted to a circumscribed object or situation.

**16. A | Table 38.9 | printed p. 252, PDF p. 297**

Why: Selective mutism is consistent failure to speak where speaking is expected despite language competence, with impaired social or educational functioning.
Closest distractor: Social anxiety may involve fear of judgment but the table specifically distinguishes the failure to speak in this vignette.

## Answer key (continued)

**17. B | Table 38.10 | printed p. 253, PDF p. 298**

Why: Bronchodilators are included in the medical/medication differential for anxiety-like symptoms.
Closest distractor: Topical emollients are not listed as a cause of this symptom cluster.

**18. B | Table 38.12 | printed p. 254, PDF p. 299**

Why: The table requires exclusion of better neurologic or medical explanations; the stem already supplies abrupt OCD plus two other acute neuropsychiatric categories.
Closest distractor: Evidence of streptococcal infection is not required by the broader PANS criteria.

**19. A | Table 39.1 | printed p. 255, PDF p. 300**

Why: The table explicitly permits irritable rather than depressed mood in children and adolescents, provided the other episode criteria are satisfied.
Closest distractor: A 1-year minimum belongs to different chronic mood conditions; a major depressive episode can meet the 2-week criterion.

**20. B | Table 39.3 | printed p. 257, PDF p. 302**

Why: The chronic severe outbursts and persistent interepisode irritability for at least 12 months across settings fit disruptive mood dysregulation disorder.
Closest distractor: Bipolar I disorder requires a distinct manic episode rather than chronic nonepisodic irritability.

**21. D | Table 39.4 | printed p. 258, PDF p. 303**

Why: The grief column describes sadness related to the loss of a loved one that can recur around birthdays or anniversaries.
Closest distractor: Major depression is characterized by a sustained episode with pervasive mood or interest disturbance, rather than only reminder-linked sadness.

**22. B | Table 39.6 | printed p. 260, PDF p. 305**

Why: A distinct elevated mood/increased energy episode lasting at least 1 week with marked impairment and several listed associated features meets the manic-episode pattern.
Closest distractor: Hypomania is shorter and lacks the marked impairment characteristic of mania.

**23. B | Table 39.8 | printed p. 261, PDF p. 306**

Why: Bipolar II combines a hypomanic episode and a major depressive episode without a full manic episode.
Closest distractor: Bipolar I requires at least one full manic episode.

**24. C | Table 40.1 | printed p. 265, PDF p. 310**

Why: Recent discharge from psychiatric hospitalization is a dynamic risk factor listed in the table, alongside agitation.
Closest distractor: Family history is a static rather than a recent dynamic factor in this table.

**25. A | Table 40.2 | printed p. 266, PDF p. 311**

Why: External protective factors include social supports and positive therapeutic or mentoring relationships.
Closest distractor: Prior attempts are a risk factor and cannot serve as this protective factor; protective factors do not remove the need for assessment.

**26. B | Table 41.1 | printed p. 269, PDF p. 314**

Why: Significantly low weight from restriction together with fear of gain and body-image disturbance meets the core anorexia nervosa pattern.
Closest distractor: ARFID lacks the weight- or shape-based disturbance present in this vignette.

**27. A | Table 41.2 | printed p. 269, PDF p. 314**

Why: Binges with loss of control and compensatory vomiting at least weekly for 3 months, with weight/shape overvaluation, fit bulimia nervosa.
Closest distractor: Anorexia nervosa requires significantly low weight and does not account for the described presentation.

**28. C | Table 41.3 | printed p. 270, PDF p. 315**

Why: Sensory-based restriction causing growth faltering and nutritional supplement dependence without body-image disturbance fits ARFID.
Closest distractor: Anorexia nervosa involves fear of weight gain or distorted perception of weight, which is absent here.

**29. A | Table 41.4 | printed p. 271, PDF p. 316**

Why: The anorexia column describes inadequate calories despite high food volume due to rigid choices of low-density foods.
Closest distractor: The bulimia column more often describes variable intake with binge episodes rather than persistent structured caloric restriction.

**30. B | Table 41.7 | printed p. 275, PDF p. 320**

Why: Bradycardia, dehydration, and hypophosphatemia are listed as medical reasons to consider inpatient hospitalization.
Closest distractor: Waiting for a particular weight threshold ignores potentially serious medical instability. Updated SAHM 2022 criteria individualize assessment and use percent median BMI, physiologic instability, electrolyte disturbance, and other factors.

*Clinical update: The original table uses older numerical thresholds (including <80% healthy body weight). Review decisions against Society for Adolescent Health and Medicine, Medical Management of Restrictive Eating Disorders in Adolescents and Young Adults (2022), doi:10.1016/j.jadohealth.2022.08.006, which uses percent median BMI and physiologic criteria; original table reproduced unchanged.*

# Table selection log

Thirty single-page tables selected in book order. Printed folios and PDF page numbers are both shown.

Excluded in this span: continued Table 38.8 and lower-priority tables. Statistical/date-specific tables omitted.

Thirty selected after Table 34.1; resume after Table 41.7 (PDF p. 320). One table has an update note in its answer.