

An 8-year-old has been persistently argumentative and angry with adults at home and school for 8 months. He often defies rules and deliberately annoys others, but does not violate others' basic rights. Which diagnosis fits the criteria?

- A. Conduct disorder
- B. Oppositional defiant disorder
- C. Intermittent explosive disorder
- D. Bipolar I disorder
- E. Disruptive mood dysregulation disorder

Original table 42.1 | Nelson printed p. 278 | PDF p. 323

Table 42.1	DSM-5 Diagnostic Criteria for Oppositional Defiant Disorder
A. A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 mo as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling:	
ANGRY/IRRITABLE MOOD	
1. Often loses temper.	
2. Is often touchy or easily annoyed.	
3. Is often angry and resentful.	
ARGUMENTATIVE/DEFIANT BEHAVIOR	
4. Often argues with authority figures or, for children and adolescents, with adults.	
5. Often actively defies or refuses to comply with requests from authority figures or with rules.	
6. Often deliberately annoys others.	
7. Often blames others for his or her mistakes or misbehavior.	
VINDICTIVENESS	
8. Has been spiteful or vindictive at least twice within the past 6 mo.	
Note: The persistence and frequency of these behaviors should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic. For children younger than 5 yr, the behavior should occur on most days for a period of at least 6 mo unless otherwise noted (Criterion A8). For individuals 5 yr or older, the behavior should occur at least once per week for at least 6 mo, unless otherwise noted (Criterion A8). Although these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should be considered, such as whether the frequency and intensity of the behaviors are outside a range that is normative for the individual's developmental level, gender, and culture.	
B. The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.	
C. The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder.	

From the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. pp. 462–463. Copyright 2013. American Psychiatric Association.

A 15-year-old has recurrent impulsive aggressive outbursts grossly disproportionate to minor provocations. The attacks are not premeditated and occur without an external reward. Which diagnosis best fits?

- A. Intermittent explosive disorder
- B. Conduct disorder
- C. Tourette disorder
- D. Cyclothymia
- E. Social anxiety disorder

Original table 42.2 | Nelson printed p. 278 | PDF p. 323

Table 42.2	DSM-5 Diagnostic Criteria for Intermittent Explosive Disorder
A. Recurrent behavioral outbursts representing a failure to control aggressive impulses as manifested by either of the following: 1. Verbal aggression (e.g., temper tantrums, tirades, verbal arguments or fights) or physical aggression toward property, animals, or other individuals, occurring twice weekly, on average, for a period of 3 mo. The physical aggression does not result in damage or destruction of property and does not result in physical injury to animals or other individuals. 2. Three behavioral outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring with a 12 mo period.	
B. The magnitude of aggressiveness expressed during the recurrent outbursts is grossly out of proportion to the provocation or to any precipitating psychosocial stressors.	
C. The recurrent aggressive outbursts are not premeditated (i.e., they are impulsive and/or anger-based) and are not committed to achieve some tangible objective (e.g., money, power, intimidation).	
D. The recurrent aggressive outbursts cause either marked distress in the individual or impairment in occupational or interpersonal functioning, or as associated with financial or legal consequences.	
E. Chronologic age is at least 6 yr (or equivalent developmental level).	
F. The recurrent aggressive outbursts are not better explained by another mental disorder (e.g., major depressive disorder, bipolar disorder, disruptive mood dysregulation disorder, a psychotic disorder, antisocial personality disorder, borderline personality disorder) and are not attributable to another medical condition (e.g., head trauma, Alzheimer disease) or to the physiologic effects of a substance (e.g., a drug of abuse, a medication). For children ages 6-18 yr, aggressive behavior that occurs as part of an adjustment disorder should not be considered for this diagnosis.	
Note: This diagnosis can be made in addition to the diagnosis of attention-deficit/hyperactivity disorder, conduct disorder, oppositional defiant disorder, or autism spectrum disorder when recurrent impulsive aggressive outbursts are in excess of those usually seen in these disorders and warrant clinical attention.	

From the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. p. 466.
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A 14-year-old repeatedly steals while confronting victims, threatens classmates, and has been cruel to animals over the past year. Which diagnosis is most consistent?

- A. Oppositional defiant disorder
- B. Intermittent explosive disorder
- C. Conduct disorder
- D. Panic disorder
- E. Specific phobia

Original table 42.3 | Nelson printed p. 279 | PDF p. 324

Table 42.3	DSM-5 Diagnostic Criteria for Conduct Disorder
A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least 3 of the following 15 criteria in the past 12 mo from any of the following categories, with at least one criterion present in the past 6 mo:	
AGGRESSION TO PEOPLE AND ANIMALS	
1. Often bullies, threatens, or intimidates others.	
2. Often initiates physical fights.	
3. Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).	
4. Has been physically cruel to people.	
5. Has been physically cruel to animals.	
6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).	
7. Has forced someone into sexual activity.	
DESTRUCTION OF PROPERTY	
8. Has deliberately engaged in fire setting with the intention of causing serious damage.	
9. Has deliberately destroyed others' property (other than by fire setting).	
DECEITFULNESS OR THEFT	
10. Has broken into someone else's house, building, or car.	
11. Often lies to obtain good or favors or to avoid obligations (i.e., "cons" others).	
12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).	
SERIOUS VIOLATIONS OF RULES	
13. Often stays out at night despite parental prohibitions, beginning before age 13 yr.	
14. Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.	
15. Is often truant from school, beginning before age 13 yr.	
B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.	
C. If the individual is age 18 yr or older, criteria are not met for antisocial personality disorder.	
From the <i>Diagnostic and Statistical Manual of Mental Disorders</i> , 5th ed. pp. 469–471. Copyright 2013. American Psychiatric Association.	

A 16-year-old develops delusions and disorganized speech for 9 days after an otherwise healthy baseline, then fully returns to usual functioning. Medical and substance causes are excluded. Which psychotic disorder is most consistent?

- A. Schizophrenia
- B. Schizophreniform disorder
- C. Brief psychotic disorder
- D. Delirium
- E. Persistent delusional disorder

Original table 47.1 | Nelson printed p. 285 | PDF p. 331

Table 47.1	DSM-5 Diagnostic Criteria for Brief Psychotic Disorder
A. Presence of one (or more) of the following symptoms. At least one of these must be (1), (2), or (3): 1. Delusions 2. Hallucinations 3. Disorganized speech (e.g., frequent derailment or incoherence) 4. Grossly disorganized or catatonic behavior Note: Do not include a symptom if it is a culturally sanctioned response. B. Duration of an episode of the disturbance is at least 1 day but less than 1 mo, with eventual full return to premorbid level of functioning. C. The disturbance is not better explained by major depressive or bipolar disorder with psychotic features or another psychotic disorder such as schizophrenia or catatonia, and is not attributable to the physiologic effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. Specify if: With marked stressor(s) (brief reactive psychosis): If symptoms occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual’s culture. Without marked stressor(s): If the symptoms do not occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual’s culture. With postpartum onset: If onset is during pregnancy or within 4 wk postpartum.	
From the <i>Diagnostic and Statistical Manual of Mental Disorders</i>, 5th ed. p 94. Copyright	

An adolescent has delusions, auditory hallucinations, and disorganized speech for 10 weeks with no substance exposure or mood syndrome. Which duration-defined diagnosis currently fits?

- A. Brief psychotic disorder
- B. Schizophreniform disorder
- C. Schizophrenia
- D. Delirium
- E. Acute stress disorder

Original table 47.2 | Nelson printed p. 286 | PDF p. 332

Table 47.2	DSM-5 Diagnostic Criteria for Schizophreniform Disorder
A. Two (or more) of the following, each present for a significant portion of time during a 1 mo period (or less if successfully treated). At least one of these must be (1), (2), or (3): 1. Delusions 2. Hallucinations 3. Disorganized speech (e.g., frequent derailment or incoherence) 4. Grossly disorganized or catatonic behavior 5. Negative symptoms (i.e., diminished emotional expression or avolition) B. An episode of the disorder lasts at least 1 mo but less than 6 mo. When the diagnosis must be made without waiting for recovery, it should qualified as “provisional.” C. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either (1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms or (2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness. D. The disturbance is not attributable to the physiologic effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. Specify if: With good prognostic features: This specifier requires the presence of at least two of the following features: onset of prominent psychotic symptoms within 4 wk of the first noticeable change in usual behavior or functioning; confusion or perplexity; good premorbid social and occupational functioning; and absence of blunted or flat affect. Without good prognostic features: This specifier is applied if two or more of the previous features have not been present.	

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A 17-year-old has hallucinations, disorganized speech, and declining school and social function for 8 months, including at least a month of prominent active symptoms. Medical and substance causes are excluded. Which diagnosis best fits?

- A. Brief psychotic disorder
- B. Schizophreniform disorder
- C. Schizophrenia
- D. Panic disorder
- E. Adjustment disorder

Original table 47.3 | Nelson printed p. 286 | PDF p. 332

Table 47.3	DSM-5 Diagnostic Criteria for Schizophrenia
A. Two (or more) of the following, each present for a significant portion of time during a 1 mo period (or less if successfully treated). At least one of these must be (1), (2), or (3): 1. Delusions 2. Hallucinations 3. Disorganized speech (e.g., frequent derailment or incoherence) 4. Grossly disorganized or catatonic behavior 5. Negative symptoms (i.e., diminished emotional expression or avolition) B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved before the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning). C. Continuous signs of the disturbance persist for at least 6 mo. This 6 mo period must include at least 1 mo of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences). D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either (1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms or (2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness. E. The disturbance is not attributable to the physiologic effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least a month (or less if successfully treated).	

From the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. pp 99–100. Copyright 2013. American Psychiatric Association.

A previously well adolescent develops rapidly progressive psychosis and new seizures. Which listed secondary etiology should be specifically investigated?

- A. Autoimmune encephalitis
- B. Isolated academic stress
- C. Habitual snoring
- D. Developmental dyslexia
- E. Primary nocturnal enuresis

Original table 47.4 | Nelson printed p. 287 | PDF p. 333

Table 47.4 Possible Causes of Secondary Psychosis		
EXAMPLES		INVESTIGATIONS
Trauma	Traumatic head injury	CT, MRI
Autoimmune disorders	Systemic lupus erythematosus, NMDA receptor encephalitis and others	Autoantibody titers
Cytogenetic/congenital disorders	Velocardiofacial syndrome, agenesis of corpus callosum	Karyotyping, MRI
Toxic/substance-induced disorders	PCP, MDMA, LSD, cannabis, alcohol, cocaine, synthetic cannabinoids (bath salts) Lead, mercury or arsenic poisoning, ginseng, St. John's Wort, ma huang	Careful medication history; urine screen for drugs, heavy metal screen; trial off the offending agent
Iatrogenic disorders	Antimalarials, steroids, isoniazid	Careful medication history; trial off the offending agent
Cerebrovascular disorders	Stroke, subdural hematomas	CT, MRI
Space-occupying disorders	Cerebral tumors	CT, MRI
Metabolic disorders	Pheochromocytoma, metachromatic leukodystrophy, Wilson disease, adult Tay-Sachs disease, acute intermittent porphyria	Urinary catecholamines; arylsulfatase-A levels, copper and ceruloplasmin levels
Dietary disorders	Pellagra, B ₁₂ deficiency; thiamine deficiency	B ₁₂ , folate, thiamine levels
Sepsis/infectious disorders	Neurosyphilis, toxoplasmosis, HIV disease, encephalitis	RPR to rule out syphilis; HIV antibody titers; glucose, protein in CSF
Unknown cause/degenerative/demyelinating disorders	Lewy body dementia, Parkinson disease, Huntington disease, multiple sclerosis, Friedreich ataxia	MRI, CT, EEG, evoked potentials
Seizure disorders	Partial complex seizures, temporal lobe epilepsy	EEG, including sleep deprivation; telemetric EEG as indicated
Endocrine disorders	Hyperthyroidism, hypothyroidism, hyperparathyroidism	Serum calcium, thyroid/parathyroid hormone levels

CSF, Cerebrospinal fluid; EEG, electroencephalography; LSD, lysergic acid diethylamide; MDMA, 3,4-methylenedioxy-N-methylamphetamine; NMDA, N-methyl-D-aspartate; PCP, phencyclidine; RPR, rapid plasma reagin.
Modified from Keshavan MS, Kaneko Y. Secondary psychoses: An update. *World Psychiatry*. 2013;12(1):4–15:Table 1, p 5.

An adolescent with first-episode psychosis also has fluctuating consciousness, abnormal movements, and a recent febrile illness. Which interpretation best follows the red-flag table?

- A. Typical uncomplicated primary psychosis
- B. Features concerning for a secondary medical etiology
- C. Diagnostic evidence of conduct disorder
- D. Findings that exclude encephalitis
- E. Evidence of isolated social anxiety

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Table 47.5	Red Flags and Features Suggesting Secondary Etiologies of Psychosis
ATYPICAL FEATURES • Normal before event • Very early (≤ 13 yr) age of onset • Acute or subacute onset (days, ≤ 1 mo) • Catatonia • Dyskinesias • Isolated misidentification delusion (Capgras syndrome) • Depressed level of consciousness; disorientation; somnolence • Cognitive and recent memory decline • Poor orientation • Intractability despite adequate therapy • Rapidly progressive and/or fluctuating (polymorphic) symptoms • Multimodal hallucinations: visual, auditory, olfactory, gustatory • Poor response to antipsychotics HISTORY • Infectious prodrome (fever) • New or worsening headache; change in headache pattern • Paresthesias • Past, current substance misuse • Recent onset incontinence • Anorexia/weight loss • Risk factors for cerebrovascular disease or central nervous system infections • Malignancy • Immunocompromised status • Head trauma • Seizures • Hepatobiliary disorders • Systemic lupus erythematosus/other autoimmune diseases • Biologic relatives with similar medical complaints • Aphasia, mutism, dysarthria PHYSICAL EXAMINATION • Autonomic hyperactivity: tachycardia, hypertension, mydriasis, sleep disturbance • Incoordination, or gait difficulty; nystagmus • Toxidrome • Abnormal neurologic exam: upper and lower motor neuron focal findings • Movement disorder • Neuroendocrine changes DIAGNOSTIC ABNORMALITIES • Abnormal electroencephalogram (extreme delta brush, diffuse slowing) • Abnormal cerebrospinal fluid (pleocytosis: greater than 5 lymphocytes) • Positive urine toxicology • Screening laboratory tests including N-methyl-D-aspartate receptor and other antibodies • Abnormal neuroimaging studies (unilateral or bilateral hippocampal/medial temporal lobe hyperdensities: limbic encephalitis) • Hyponatremia	
Modified from Kliegman RM, Toth H, Bordini BJ, Basel D, eds. <i>Nelson Pediatric Symptom-Based Diagnosis</i> . 2nd ed. Elsevier, 2023: Table 31.9, p 526	

A previously healthy teen develops psychosis over 3 weeks together with new seizures and abnormal movements. Which additional diagnostic category is raised by the proposed criteria?

- A. Possible autoimmune psychosis
- B. Persistent tic disorder
- C. Uncomplicated adjustment disorder
- D. Somatic symptom disorder
- E. Specific learning disorder

Original table 47.6 | Nelson printed p. 288 | PDF p. 334

Table 47.6	Proposed Diagnostic Criteria for Autoimmune Psychosis
For a diagnosis of possible autoimmune psychosis: The patient must have current psychotic symptoms of abrupt onset (rapid progression of <3 months) with at least one of the following: • Currently or recently diagnosed with a tumor • Movement disorder (catatonia or dyskinesia) • Adverse response to antipsychotics, raising suspicion of neuroleptic malignant syndrome (rigidity, hyperthermia, or raised creatine kinase) • Severe or disproportionate cognitive dysfunction • A decreased level of consciousness • The occurrence of seizures that are not explained by a previously known seizure disorder • A clinically significant autonomic dysfunction (abnormal or unexpectedly fluctuant blood pressure, temperature, or heart rate) If a patient has possible autoimmune psychosis, they should be investigated as per section 5 (“Consensus multimodal approach to the systematic investigation of patients with suspected autoimmune psychosis”), including electroencephalography, MRI, serum autoantibodies, and CSF analysis (including CSF autoantibodies). The results should lead to a diagnosis of non-autoimmune psychosis or probable/definite autoimmune psychosis. For a diagnosis of probable autoimmune psychosis: The patient must have current psychotic symptoms of abrupt onset (rapid progression of <3 mo) with at least one of the seven clinical criteria listed previously for possible autoimmune psychosis and at least one of the following: • CSF pleocytosis of >5 white blood cells/μL • Bilateral brain abnormalities on T2 weighted fluid-attenuated inversion recovery MRI highly restricted to the medial temporal lobes Or two of the following: • Electroencephalogram encephalopathic changes (i.e., spikes, spike-wave activity, or rhythmic slowing [intermittent rhythmic delta or theta activity] focal changes, or extreme delta brush • CSF oligoclonal bands or increased IgG index • The presence of a serum antineuronal antibody detected by cell-based assay After exclusion of alternative diagnoses. For a diagnosis of definite autoimmune psychosis: The patient must meet the criteria for probable autoimmune psychosis with IgG class antineuronal antibodies in CSF. Note that these criteria do not exclude a diagnosis being made in a patient with an acute onset (<3 mo) of psychosis, even if that patient has had a previous psychotic, other psychiatric, or encephalopathic episode that resolved.	

From Pollak TA, Lennox BR, Müller S, et al. Autoimmune psychosis: an international consensus on an approach to the diagnosis and management of psychosis of suspected autoimmune origin [published correction appears in *Lancet Psychiatry*. 2019

An adolescent develops hallucinations soon after starting a medication known to cause psychotic symptoms. Symptoms are absent during periods without exposure, and there is no delirium. Which diagnosis best fits the table?

- A. Schizophrenia
- B. Brief psychotic disorder
- C. Substance/medication-induced psychotic disorder
- D. Catatonia
- E. Major depressive disorder

Original table 47.7 | Nelson printed p. 291 | PDF p. 337

Table 47.7	DSM-5 Diagnostic Criteria for Substance/Medication Induced Psychotic Disorder
A. Presence of one or both of the following symptoms: 1. Delusions 2. Hallucinations B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2): 1. The symptoms of Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication. 2. The involved substance/medication is capable of producing the symptoms in Criterion A. C. The disturbance is not better explained by a psychotic disorder that is not substance/medication induced. D. The disturbance does not occur exclusively during the course of a delirium. E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if: With onset during intoxication: If the criteria are met for intoxication with the substance and the symptoms develop during intoxication. With onset during withdrawal: If the criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal.	
From the <i>Diagnostic and Statistical Manual of Mental Disorders</i>, 5th ed. pp 110–115. Copyright 2013. American Psychiatric Association. .	

A child develops persistent hallucinations during an established neurologic illness. Evaluation shows the hallucinations are a direct pathophysiologic consequence of the disease, and attention remains intact. Which diagnosis best fits?

- A. Psychotic disorder due to another medical condition
- B. Substance-induced psychotic disorder
- C. Delirium
- D. Brief psychotic disorder
- E. Oppositional defiant disorder

Original table 47.8 | Nelson printed p. 291 | PDF p. 337

Table 47.8	DSM-5 Diagnostic Criteria for Psychotic Disorder Due to Another Medical Condition
A. Prominent hallucinations or delusions. B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiologic consequence of another medical condition. C. The disturbance is not better explained by another mental disorder. D. The disturbance does not occur exclusively during the course of a delirium. E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify whether: With delusions: If delusions are the predominant symptom. With hallucinations: If hallucinations are the predominant symptom.	
From the <i>Diagnostic and Statistical Manual of Mental Disorders</i>, 5th ed. pp 115–116. Copyright 2013. American Psychiatric Association. .	

An adolescent abruptly remains motionless with a fixed gaze, gives almost no verbal responses, and holds an imposed posture. Which syndrome is described by these combined signs?

- A. Hyperkinetic tic disorder
- B. Catatonia
- C. Panic attack
- D. Selective mutism alone
- E. Attention-deficit/hyperactivity disorder

Original table 47.9 | Nelson printed p. 292 | PDF p. 338

Table 47.9	Catatonia
Excitement: Extreme hyperactivity; constant motor unrest, which is apparently nonpurposeful	
Immobility/stupor: Extreme hypoactivity, immobility; minimally responsive to stimuli	
Mutism: Verbally unresponsive or minimally responsive	
Staring: Fixed gaze, little or no visual scanning of environment, decreased blinking	
Posturing/catalepsy: Maintains posture(s), including mundane (e.g., sitting or standing for hours without reacting)	
Grimacing: Maintenance of odd facial expressions	
Echopraxia/echolalia: Mimics of examiner’s movements/speech	
Stereotypy: Repetitive, non–goal-directed motor activity (e.g., finger play; repeatedly touching, patting, or rubbing self)	
Mannerisms: Odd, purposeful movements (hopping or walking tiptoe, saluting passersby, exaggerated caricatures of mundane movements)	
Verbigeration: Repetition of phrases or sentences	
Rigidity: Maintenance of a rigid posture despite efforts to be moved	
Negativism: Apparently motiveless resistance to instructions or to attempts to move/examine the patient; contrary behavior does the opposite of the instruction	
Waxy flexibility: During reposturing of the patient, offers initial resistance before allowing themselves to be repositioned (similar to that of bending a warm candle)	
Withdrawal: Refusal to eat, drink, or make eye contact	
Impulsivity: Suddenly engaging in inappropriate behavior (e.g., runs down the hallway, starts screaming, or takes off clothes) without provocation; afterward, cannot explain	
Automatic obedience: Exaggerated cooperation with examiner’s request, or repeated movements that are requested once	
Passive obedience (<i>mitgehen</i>): Raising arm in response to light pressure of finger, despite instructions to the contrary	
Negativism (<i>gegenhalten</i>): Resistance to passive movement that is proportional to strength of the stimulus; response seems automatic rather than willful	
Ambitendency: Appears stuck in indecisive, hesitant motor movements	
Grasp reflex: Striking the patient’s open palm with two extended fingers of the examiner’s hand results in automatic closure of the patient’s hand	
Perseveration: Repeatedly returns to the same topic or persists with the same movements	
Combateness: Belligerence or aggression, usually in an undirected manner, without explanation	
Autonomic abnormality: Abnormality of body temperature (fever), blood pressure, pulse rate, respiratory rate, inappropriate sweating	

From Dhossche DM, Wachtel LE. Catatonia is hidden in plain sight among different pediatric disorders: A review article. *Pediatr Neurol*. 2010;43:307–315.

A child with suspected catatonia has new seizures and cognitive change. Which listed category of associated conditions warrants active consideration?

- A. Neurologic illness including autoimmune encephalitis
- B. Uncomplicated myopia
- C. Primary dental caries
- D. Seasonal allergic rhinitis alone
- E. Lactose intolerance

Original table 47.10 | Nelson printed p. 292 | PDF p. 338

Table 47.10	Conditions Associated with Catatonia
Psychotic Disorders - Paranoid schizophrenia, catatonic schizophrenia, psychosis, autism, Prader-Willi syndrome, intellectual impairment Mood Disorders - Bipolar disorder: manic or mixed episodes Major Depressive Disorder Medical Conditions - Hyper-hypothyroidism, euthyroid autoimmune thyroiditis, Addison disease, infections, electrolyte imbalances, pathogenic variants in <i>SCN2A</i> gene, systemic lupus erythematosus Neurologic Conditions - Epilepsy, strokes, traumatic brain injury, multiple sclerosis, infectious and autoimmune encephalitis, acute disseminated encephalomyelitis, neuromyelitis optica spectrum Drugs - Withdrawal: benzodiazepines, L-dopa, gabapentin - Overdose: LSD, PCP, cocaine, MDMA (Ecstasy), disulfiram, levetiracetam	
LSD, Lysergic acid; MDMA, 3,4-methylenedioxy-N-methylamphetamine; PCP, phencyclidine.	

A hospitalized teenager with a medical illness has stupor, mutism, and waxy flexibility, in the absence of delirium. Which statement best matches the listed catatonia criteria?

- A. One motor sign is sufficient
- B. Three or more characteristic signs support catatonia due to a medical condition
- C. A hallucination is required
- D. Symptoms must begin before age 10 years
- E. A confirmed mood disorder is required

Original table 47.11 | Nelson printed p. 292 | PDF p. 338

Table 47.11	DSM-5 Criteria for Catatonia Due to Another Medical Condition
A. The clinical picture is dominated by three (or more) of the following symptoms: 1. Stupor (i.e., no psychomotor activity; not actively relating to environment). 2. Catalepsy (i.e., passive induction of a posture held against gravity). 3. Waxy flexibility (i.e., slight, even resistance to positioning by examiner). 4. Mutism (i.e., no, or very little, verbal response [Note: not applicable if there is an established aphasia]). 5. Negativism (i.e., opposing or not responding to instructions or external stimuli). 6. Posturing (i.e., spontaneous and active maintenance of a posture against gravity). 7. Mannerism (i.e., odd, circumstantial caricature of normal actions). 8. Stereotypy (i.e., repetitive, abnormally frequent, non-goal-directed movements). 9. Agitation, not influenced by external stimuli. 10. Grimacing. 11. Echolalia (i.e., mimicking another’s speech). 12. Echopraxia (i.e., mimicking another’s movements). B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiologic consequence of another medical condition. C. The disturbance is not better explained by another mental disorder (e.g., a manic episode). D. The disturbance does not occur exclusively during the course of a delirium. E. The disturbance causes clinically significant distress or impairment in social, occupational, or other areas of functioning. <i>Coding note:</i> Include the name of the medical condition in the name of the mental disorder (e.g., F06.1 catatonic disorder due to hepatic encephalopathy). The other medical condition should be coded and listed separately immediately before the catatonic disorder due to the medical condition (e.g., K71.90 hepatic encephalopathy; F06.1 catatonic disorder due to hepatic encephalopathy)	

Adapted from Weder ND, Muralee S, Penland H, Tampi RR. Catatonia: A review. *Ann Clin Psychiatry*. 2008;20(2):97–107:Table 2.

A resident uses the Bush-Francis Catatonia Screening Instrument in a child with suspected catatonia. When uncertain whether a finding was present during the examination, how should that item be scored according to the table?

- A. Score it as definitely present
- B. Score it zero
- C. Double the score of a related item
- D. Omit the entire assessment
- E. Assign the maximum possible score

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Table 47.12	Standard Examination of Catatonia
The method described here is used to complete the 23-item Bush-Francis Catatonia Rating Scale (BFCRS) and the 14-item Bush-Francis Catatonia Screening Instrument (BFCSI). Item definitions on the two scales are the same. The BFCSI measures only the presence or absence of the first 14 signs. Ratings are based solely on observed behaviors during the examination, with the exception of completing the items for “withdrawal” and “autonomic abnormality,” which may be based on directly observed behavior or chart documentation. As a general rule, only items that are clearly present should be rated. If the examiner is uncertain as to the presence of an item, rate the item as “0.” PROCEDURE 1. Observe the patient while trying to engage in a conversation. 2. The examiner should scratch his or her head in an exaggerated manner. 3. The arm should be examined for cogwheeling. Attempt to reposture and instruct the patient to “keep your arm loose.” Move the arm with alternating lighter and heavier force. 4. Ask the patient to extend his or her arm. Place one finger beneath his or her hand and try to raise it slowly after stating, “Do not let me raise your arm.” 5. Extend the hand stating, “Do not shake my hand.” 6. Reach into your pocket and state, “Stick out your tongue. I want to stick a pin in it.” 7. Check for grasp reflex. 8. Check the chart for reports from the previous 24-hour period. Check for oral intake, vital signs, and any incidents. 9. Observe the patient indirectly, at least for a brief period each day, regarding the following: • Activity level • Abnormal movements • Abnormal speech • Echopraxia • Rigidity • Negativism • Waxy flexibility • Gegenhalten • Mitgehen • Ambitendency • Automatic obedience • Grasp reflex	

Gegenhalten, Resistance to movements that is equal and opposite to the pressure exerted by examiner; *mitgehen*, extreme mitmachen where even slightest pressure moves limb; *mitmachen*, passive movement of extremity despite instruction not to move

A hospitalized 12-year-old develops acute fluctuating confusion over 2 days, cannot sustain attention, and has new disorientation. Which syndrome meets the table's core clinical features?

- A. Primary schizophrenia
- B. Delirium
- C. Persistent depressive disorder
- D. Specific learning disorder
- E. Selective mutism

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Table 48.1	DSM-5 Diagnostic Criteria for Delirium
A. A disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment).	
B. The disturbance develops over a short period of time (usually hours to a few days), represents a change from baseline attention and awareness, and tends to fluctuate in severity during the course of a day.	
C. An additional disturbance in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception).	
D. The disturbances in Criteria A and C are not explained by another preexisting, established, or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal, such as coma.	
E. There is evidence from the history, physical examination, or laboratory findings that the disturbance is a direct physiologic consequence of another medical condition, substance intoxication or withdrawal (i.e., due to a drug of abuse or to a medication), or exposure to a toxin, or is due to multiple etiologies.	

From the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. p. 596. Copyright 2013. American Psychiatric Association.

A child in the ICU becomes quiet, withdrawn, slow to respond, and intermittently confused after a previously alert baseline. Which delirium motor subtype best fits?

- A. Hyperactive delirium
- B. Hypoactive delirium
- C. Catatonia by definition
- D. Compulsion
- E. Provisional tic disorder

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Table 48.2	DSM-5 Delirium Subtypes
Hyperactive delirium	Increased psychomotor activity and mood lability • Confusion • Psychosis • Disorientation • Agitation • Hypervigilance • Hyper-alertness • Combativeness • Loud, pressured speech • Behavioral dysregulation • Pulling at lines/catheters
Hypoactive delirium	Decreased psychomotor activity • Sluggishness • Lethargy • Stupor • Confusion • Apathy
Mixed delirium	Normal level of psychomotor activity • Poor attention • Decreased awareness • Rapid fluctuation of activity level

Adapted from Meagher D, Moran M, Raju B, et al. A new data-based motor subtype schema for delirium. *J Neuropsychiatry Clin Neurosci.* 2008;20(2):185–193:Fig 1.

A mechanically ventilated child develops fluctuating inattention while receiving prolonged sedation. Which potentially reversible contributor appears in the delirium mnemonic table?

- A. Medication/sedation exposure
- B. Primary dyslexia
- C. Normal tooth eruption
- D. Familial tall stature
- E. Speech articulation delay

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Table 48.3	Etiologies of Pediatric Delirium (CRITICAL CARE mnemonic)
Cardiovascular	Anemia, shock, vasculitis, hypertensive encephalopathy
Respiratory	Respiratory insufficiency, respiratory failure, pneumothorax
Infection	Sepsis, encephalitis, urinary tract infection, meningitis, fever, pneumonia, tracheitis, cellulitis, surgical site infection, COVID-19
Toxins	Polypharmacy, heavy metals, drug:drug interactions
Inflammatory process	Autoimmune and rheumatologic disease
CNS pathology	Stroke, seizure, head trauma, intracranial bleed, tumor, anoxic brain injury
Abuse, withdrawal, sedation	Alcohol, benzodiazepines, opioids, barbiturates, prolonged/excessive sedation
Liver	Liver insufficiency, hepatic failure, hyperammonemia
Catheters, central line infections	Invasive device or procedure complications
Alimentation	Electrolyte imbalance, nutritional deficiencies, dehydration
Renal	Renal insufficiency or failure
Endocrinopathies	Glycemic disturbance, thyroid disease, parathyroid disease, adrenal disease

Adapted from Malas N, Brahmbhatt K, McDermott C, Smith A, Ortiz-Aguayo R, Turkel S. Pediatric delirium: Evaluation, management, and special considerations. *Curr Psychiatry Rep*. 2017;19(9):45

A 13-year-old has new visual hallucinations, severe inattention, and a waxing and waning course over hours. Which diagnosis is favored over primary psychosis in the comparison table?

- A. Delirium
- B. Schizophrenia
- C. Specific phobia
- D. Persistent depressive disorder
- E. Oppositional defiant disorder

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Table 48.4 Differential Diagnosis of Delirium				
CLINICAL FEATURE	DELIRIUM	PSYCHOSIS	DEPRESSION	CATATONIA
Course	Acute onset, hours, days or more	Insidious onset over many months, prodrome	Insidious onset, at least 2 wk, often over months	Onset variable
Attention	Markedly impaired attention and arousal	Normal to mild impairment	Mild impairment	Variable difficulty with attention and arousal
Fluctuation	Characterized by a waxing and waning course; disturbed day/night cycle	Absent	Absent	Less likely to fluctuate, motor signs may show more fluctuation
Perception	Misperceptions; hallucinations (visual, fleeting); paramnesia	Hallucinations, auditory with personal reference	May have mood-congruent hallucinations	May have hallucinations, especially if secondary to primary psychosis
Speech and language	Abnormal clarity, speed and coherence; disjointed and dysarthric; misnaming; characteristic dysgraphia	Disorganized with bizarre theme	Decreased amount of speech	Mutism; echolalia
Other cognition	Disorientation to time, place; recent memory and visuospatial abnormalities	Disorientation to person; concrete interpretations	Mental slowing; indecisiveness; memory retrieval difficulty	Global disorientation
Behavior	Lethargy; nonsystematized delusions; emotional lability	Systematized delusions; paranoia; bizarre behavior	Depressed mood; anhedonia; lack of energy; sleep and appetite disturbance	Stupor; catalepsy; negativism; posturing; stereotypy; agitation not influenced by external stimuli; grimacing; echopraxia
Electroencephalogram	Diffuse slowing; low voltage fast activity; specific patterns	Normal	Normal	Normal, focal abnormalities or generalized slowing

A disoriented ICU patient sleeps poorly during the day and becomes more agitated overnight. Which nonpharmacologic intervention is listed?

- A. Keep the room brightly illuminated overnight
- B. Provide a visible clock and orienting calendar while maintaining daytime light cues
- C. Rotate different unfamiliar caregivers at every contact
- D. Remove prescribed hearing aids
- E. Increase overnight noise to maintain alertness

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Table 48.5	Nonpharmacologic Management of Delirium
Environmental modifications	• Maintain lighting consistent with the time of day • Minimize noise • Familiar objects • Visible clock, calendar
Sensory modifications	• Have appropriate sensory aides available (glasses, hearing aids) • Soft, calming music • Minimize lines, catheters, restraints • Maintain comfortable position and body alignment
Caregiver interventions	• Frequent reorientation • Fewer care team providers/different faces • Cluster cares to minimize interruptions • Promote normal sleep/wake schedule • Presence of familiar caregivers

A student can start homework but repeatedly forgets the second and third steps of multistep directions. Which executive-function domain in the table is most affected?

- A. Inhibitory control
- B. Working memory
- C. Cognitive shifting
- D. Self-monitoring
- E. Response initiation

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Table 49.1 Symptom Expression of Executive Dysfunction	
EXECUTIVE FUNCTION DEFICIT	SYMPTOM EXPRESSION
Inhibitory control	Impulsivity/poor behavioral regulation Interrupts “Blurts things out”
Shifting	Problems with transitioning from one task/activity to another Unable to adjust to unexpected change Repeats unsuccessful problem-solving approaches
Initiation	Difficulty independently beginning tasks/activities Lacks initiative Difficulty developing ideas or making decisions
Working memory	Challenges following multistep instruction (e.g., only completes one of three steps) Forgetfulness
Organization and planning	Fails to plan ahead Work is often disorganized Procrastinates and does not complete tasks “Messy” child
Self-monitoring	Fails to recognize errors and check work Does not appreciate impact of actions on others Poor self-awareness
Emotional control	Experiences behavioral and emotional outbursts (e.g., tantrums) Easily upset/frustrated Frequent mood changes

A child has persistent difficulty reading unfamiliar words and manipulating individual speech sounds. Which neurodevelopmental domain in the academic-disorder table is most relevant?

- A. Phonologic language processing
- B. Gross motor endurance
- C. Olfactory recognition
- D. Cardiac conduction
- E. Color perception

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Table 49.2	Neurodevelopmental Dysfunction Underlying Academic Disorders*
ACADEMIC DISORDER	POTENTIAL UNDERLYING NEURODEVELOPMENTAL DYSFUNCTION
Reading	Language • Phonologic processing • Verbal fluency • Syntactic and semantic skills Memory • Working memory SequencingVisual-spatialAttention
Written expression, spelling	Language • Phonologic processing • Syntactic and semantic skills GraphomotorVisual-spatialMemory • Working memory SequencingAttention
Mathematics	Visual-spatialMemory • Working memory LanguageSequencingGraphomotorAttention

*Isolated neurodevelopmental dysfunction can lead to a specific academic disorder, but more often there is a combination of factors underlying weak academic performance.

A child repeatedly forgets a three-step classroom instruction. Which real-world intervention in the table best targets the suspected executive-function deficit?

- A. Repeat concise instructions and provide a concrete visual reference
- B. Give longer verbal instructions without cues
- C. Punish each missed step
- D. Require immediate unsupervised multitasking
- E. Remove all classroom structure

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Table 49.3 Executive Function Categories: Presenting Symptoms, Suggested Dysfunction, and Potential Interventions		
SYMPTOM/PRESENTING COMPLAINT	SUSPECTED AREA OF DYSFUNCTION	POSSIBLE “REAL-WORLD” INTERVENTIONS
Acts before thinking Interrupts Poor behavioral and/or emotional control	Inhibitory control	Increase structure in environment to set limits for inhibition problems. Make behavior and work expectations clear and explicit; review with child. Post rules in view; point to them when child breaks rule. Teach response-delay techniques (e.g., counting to 10 before acting).
Cannot follow multistep instructions Forgetful	Working memory	Repeat instructions as needed. Keep instructions clear and concise. Provide concrete references.
Struggles starting assignments/tasks Lacks initiative/motivation Has trouble developing ideas/strategies	Initiation	Increase structure of tasks. Establish and rely on routine. Break tasks into smaller, manageable steps. Place child with partner or group for modeling and cueing from peers.
Does not plan ahead Uses trial-and-error approach	Planning	Practice with tasks with only a few steps first. Teach simple flow charting as a planning tool. Practice with planning tasks (e.g., mazes). Ask child to verbalize plan before beginning work. Ask child to verbalize second plan if first does not work. Ask child to verbalize possible consequences of actions before beginning. Review incidents of poor planning/anticipation with child.
Work/belongings is/are “messy” Random/haphazard problem solving Procrastinates/does not complete tasks	Organization	Increase organization of classroom and activities to serve as model, and help child grasp structure of new information. Present framework of new information to be learned at the outset, and review again at the end of a lesson. Begin with tasks with only a few steps and increase gradually.
Gets “stuck” Trouble transitioning Does not adapt to change	Flexibility/shifting	Increase routine to the day. Make schedule clear and public. Forewarn of any changes in schedule. Give “2-minute warning” of time to change. Make changes from one task to the next or one topic to the next, clear and explicit. Shifting may be a problem of inhibiting, so apply strategies for inhibition problems.

A 9-year-old has persistent inattention and impulsivity at home and school for 9 months with clear academic impairment. Which additional feature of the listed ADHD criteria must be established?

- A. Symptoms began before age 12 years
- B. Only one symptom is required
- C. Symptoms occur exclusively during psychosis
- D. Symptoms must first emerge after age 15
- E. A normal academic record is required

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Table 50.1 DSM-5 Diagnostic Criteria for ADHD	
A. A persistent pattern of inattention and/or hyperactivity/impulsivity that interferes with functioning or development, as characterized by (1) and/or (2): 1. Inattention: Six (or more) of the following symptoms of inattention have persisted for ≥6 mo to a degree that is inconsistent with development level and that negatively affects directly on social and academic/occupational activities: a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate). b. Often has difficulty sustaining attention in tasks or play activities. c. Often does not seem to listen when spoken to directly. d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not the result of oppositional behavior or failure to understand instructions). e. Often has difficulty organizing tasks and activities. f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork, homework). g. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, tools). h. Is often easily distracted by extraneous stimuli. i. Is often forgetful in daily activities. 2. Hyperactivity/impulsivity: Six (or more) of the following symptoms of inattention have persisted for ≥6 mo to a degree that is inconsistent with development level and that negatively affects directly on social and academic/occupational activities. a. Often fidgets with hands or feet or squirms in seat. b. Often leaves seat in classroom or in other situations in which remaining seated is expected. c. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness). d. Often has difficulty playing or engaging in leisure activities quietly. e. Is often “on the go” or often acts as if “driven by a motor.”	f. Often talks excessively. Impulsivity. g. Often blurts out answers before questions have been completed. h. Often has difficulty awaiting turn. i. Often interrupts or intrudes on others (e.g., butts into conversations or games). B. Several inattentive or hyperactive/impulsive symptoms were present before 12 yr of age. C. Several inattentive or hyperactive/impulsive symptoms are present in two or more settings (e.g., at school [or work] or at home) and are documented independently. D. There is clear evidence of clinically significant impairment in social, academic, or occupational functioning. E. Symptoms do not occur exclusively during the course of schizophrenia, or another psychotic disorder, and are not better accounted for by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal). CODE BASED ON TYPE 314.01 Attention-deficit/hyperactivity disorder, combined presentation: if both Criteria A1 and A2 are met for the past 6 mo. 314.00 Attention-deficit/hyperactivity disorder, predominantly inattentive presentation: if Criterion A1 is met but Criterion A2 is not met for the past 6 mo. 314.01 Attention-deficit/hyperactivity disorder, predominantly hyperactive-impulsive presentation: if Criterion A2 is met but Criterion A1 is not met for the past 6 mo. Specify if: Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and if the symptoms result in no more than minor impairments in social and occupational functioning. Moderate: Symptoms or functional impairment between “mild” and “severe” are present. Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

From American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed, Text Revision, Washington, DC: American Psychiatric Association; 2000, and *Fifth Edition* (Copyright 2013 American Psychiatric Association.)

An adolescent has clinically significant inattentive symptoms without the minimum hyperactive/impulsive symptoms. Which comparison in the table explains why DSM-5 ADHD may still be diagnosed whereas older ICD-10 hyperkinetic disorder criteria might not be met?

- A. DSM-5 permits either inattentive or hyperactive/impulsive symptom domains
- B. DSM-5 always requires symptoms in only one classroom
- C. ICD-10 excludes all inattention
- D. DSM-5 requires a coexisting tic disorder
- E. ICD-10 has no symptom requirements

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Table 50.2 Differences Between U.S. and European Criteria for ADHD or HKD		
DSM-5 ADHD	ICD-10 HKD	ICD-11 ADHD*
SYMPTOMS		
<i>Either or both of the following:</i> - At least 6 of 9 inattentive symptoms - At least 6 of 9 hyperactive or impulsive symptoms	<i>All of the following:</i> - At least 6 of 8 inattentive symptoms - At least 3 of 5 hyperactive symptoms - At least 1 of 4 impulsive symptoms	<i>No minimum numbers of symptoms but must have:</i> Persistent pattern (≥6 mo) of inattention and/or hyperactivity-impulsivity that has a direct negative impact on academic, occupational, or social functioning
PERVASIVENESS		
Some impairment from symptoms is present in one or more settings	Criteria are met for one or more settings	Symptoms must be evident across multiple situations or settings but are likely to vary according to the structure and demands of the setting

*ICD-11 went into effect on January 1, 2022.
ADHD, Attention-deficit/hyperactivity disorder; HKD, hyperkinetic disorder; DSM-5, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; ICD-10, International Classification of Diseases, Tenth Edition.
Modified from Riederman, I. Faraone S. Attention-deficit hyperactivity disorder. *Lancet*. 2005;366:237–248

A school-aged child is referred for inattentiveness and restless behavior but also snores loudly every night and has daytime sleepiness. Which listed ADHD mimic should be assessed?

- A. Obstructive sleep apnea
- B. Familial tall stature
- C. Uncomplicated eczema
- D. Dental eruption
- E. Primary color blindness

Original table 50.3 | Nelson printed p. 313 | PDF p. 360

Table 50.3 Differential Diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD)	
GENERAL CATEGORY	SPECIFIC CONDITIONS, CAUSES
Developmental	Low developmental level/cognitive abilities Very high cognitive abilities Specific learning disabilities in reading, mathematics, or written expression Communication or language disorder Autism spectrum disorder Fetal alcohol syndrome
Psychiatric	Anxiety/depression Oppositional defiant disorder/conduct disorder Bipolar disorder/disruptive mood dysregulation disorder Substance use disorder Posttraumatic stress disorder/adjustment disorder
Medical	Sleep disorder, obstructive sleep apnea Hearing or vision impairment Specific medications, such as some antiepileptics or high-dose steroids Thyroid disorders Tic disorders Posttraumatic head injury or encephalitis Genetic conditions, such as fragile X, Klinefelter syndrome, Turner syndrome, tuberous sclerosis, and neurofibromatosis
Psychosocial	Response to abuse, neglect Response to distress in home, inappropriate expectations or parenting practices Response to inappropriate classroom setting

A child repeatedly scores below the 20th percentile on math progress monitoring and the teacher reports inability to advance to the next math concept. Which interpretation best follows the table?

- A. Findings raise concern for a mathematics learning disability and justify evaluation
- B. A family history is required before any evaluation
- C. The pattern proves a global intellectual disability
- D. Academic progress should be checked only in adulthood
- E. Concern is excluded because the child attends school

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Table 52.2	Risk Factors for a Specific Learning Disability Involving Mathematics
The child is at or below the 20th percentile in any math area, as reflected by standardized testing or ongoing measures of progress monitoring. The teacher expresses concerns about the child’s ability to “take the next step” in math. There is a positive family history for math learning disability (this alone will not initiate an intervention). Parents think they have to “reteach” math concepts to their child.	

A 10-year-old continues to make severe grammar and paragraph-organization errors after 7 months of targeted instruction; individually administered tests show achievement well below age expectations. Which diagnosis best fits?

- A. Specific learning disorder with impairment in written expression
- B. Oppositional defiant disorder
- C. Specific phobia
- D. Tourette disorder
- E. Transient developmental variation

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Table 52.3	DSM-5 Diagnostic Criteria for Specific Learning Disability with Impairment in Written Expression
A. Difficulties learning and using academic skills that have persisted for at least 6 months, despite the provision of interventions that target those difficulties. Difficulties with written expression (e.g., makes multiple grammatical or punctuation errors within sentences; employs poor paragraph organization; written expression of ideas lacks clarity). B. The affected academic skills are substantially and quantifiably below those expected for the individual’s chronologic age and cause significant interference with academic or occupational performance or with activities of daily living, as confirmed by individually administered standardized achievement measures and comprehensive clinical assessment. For individuals age 17 years and older, a documented history of impairing learning difficulties may be substituted for the standardized assessment. C. The learning difficulties begin during school-age years but may not become fully manifest until the demands for those affected academic skills exceed the individual’s limited capacities (e.g., as in timed tests, reading or writing lengthy complex reports for a tight deadline, excessively heavy academic loads). D. The learning difficulties are not better accounted for by intellectual disabilities, uncorrected visual or auditory acuity, other mental or neurologic disorders, psychosocial adversity, lack of proficiency in the language of academic instruction, or inadequate educational instruction. 315.2 (F81.81) With impairment in written expression: Spelling accuracy Grammar and punctuation accuracy Clarity or organization of written expression Specify current severity: Mild: Some difficulties learning skills in one or two academic domains, but of mild enough severity that the individual may be able to compensate or function well when provided with appropriate accommodations or support services, especially during the school years. Moderate: Marked difficulties learning skills in one or more academic domains, so that the individual is unlikely to become proficient without some intervals of intensive and specialized teaching during the school years. Some accommodations or supportive services at least part of the day at school, in the workplace, or at home may be needed to complete activities accurately and efficiently. Severe: Severe difficulties learning skills, affecting several academic domains, so that the individual is unlikely to learn those skills without ongoing intensive individualized and specialized teaching for most of the school years. Even with an array of appropriate accommodations or services at home, at school, or in the workplace, the individual may not be able to complete all activities efficiently.	

From the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. Washington, DC: American Psychiatric Association; 2013:66–67.

A child understands instructions and uses grammatically normal sentences but consistently misproduces speech sounds, making words hard to understand. Which domain is most directly impaired?

- A. Speech production
- B. Receptive language
- C. Pragmatic language
- D. Working memory
- E. Written language

Original table 53.1 | Nelson printed p. 325 | PDF p. 372

Table 53.1 Definitions of Basic Terms in Communication, Language, and Speech		
TERM	DEFINITION	EXAMPLES
Communication	Broad umbrella term that encompasses understanding and producing language, speech, nonverbal communicative gestures, and written language	- Humans share ideas using verbal or signed speech and language - Nonverbal communicative gestures include nodding one’s head up and down to convey “yes” in some cultures
Language	Verbal, signed, written, or other systems that use arbitrary but conventional, rule-governed symbols to communicate about objects, events, and ideas in the past, present, and future	- Verbal symbols include words (e.g., <i>apple</i> in English or <i>manzana</i> in Spanish, both of which represent a red, tasty fruit) - Signed symbols include the word <i>apple</i> in American Sign Language, produced by the twist of the knuckle of the index finger on the cheek
Speech	Perception of the meaningful units of sounds that comprise verbal language and production of these sounds by coordinating the mouth, tongue, airflow, and vibration of the vocal folds	- Speech sounds or phonemes make a difference in meaning (e.g., <i>b</i>, <i>p</i>, <i>a</i>, <i>i</i>, and <i>t</i> affect the meaning of <i>bat</i>, <i>bit</i>, <i>pat</i>, and <i>pit</i>) - Speech does not include all vocal sounds, such as coughs or throat clearing - Phonemes in sign language are based on spatial, temporal features, such as hand shape
Receptive language	Hearing and understanding verbal or sign language	- Recognizing own name - Following two-step directions
Expressive language	Speaking using verbal or sign language	- Speaking first words or signs in a sign language - Telling stories
Phonology	The system of relationships among speech sounds or phonemes that constitute a fundamental component of language	- Understanding <i>seetheredball</i> can be segmented into <i>see the red ball</i> - Babbling, consonant-vowel combinations that use phonemes
Lexicon	All of the words or vocabulary of a person or a language	The lexicon of the mathematician may vary from the lexicon of the lawyer
Morphology	Units of meaning that can be combined to form vocabulary	In English <i>dogs</i> is made of two morphemes, <i>dog</i> and the plural <i>-s</i>; <i>untie</i> is made of <i>un-</i> and <i>tie</i>
Syntax	Grammar and word order to make sentences	In English word order, <i>the dog chases the cat</i>, while in Hindi word order, <i>the cat the dog chases</i>
Pragmatics	- Verbal and nonverbal communication skills that govern how language and communication are used in context - Includes intonation, facial expression, and body language	- Use of eye contact and gestures to make a point forcefully - The timing and responsiveness between communication partners (e.g., engaging, responding, and maintaining reciprocal exchanges)
Nonliteral or figurative language skill	Meaning of a word or phrase that is not literal but understood in context	- Hints (e.g., a teacher saying, “<i>I think I hear children talking</i>”) - Idioms (e.g., “<i>Give me a hand</i>”) - Metaphor (e.g., “<i>You are my sunshine</i>”) - Hyperbole (e.g., “<i>That’s the biggest thing I’ve ever seen!</i>”)
Advanced language skills	Ability to listen, speak, read, write, and reason using language	- Academic language - Ability to debate and deliver speeches
Literacy skills	Skills required for reading and writing	- Reading an alphabetic language requires awareness of the sounds of language, print, and the relationship between letters and sounds - Spelling is a literacy skill
Bilingualism and multilingualism	Ability to speak and/or sign two or more languages	- Ability to communicate verbally in Chinese and English - Ability to communicate verbally in English and to use American Sign Language - Ability to use Chinese, English, and American Sign Language
Biliteracy and multiliteracy	Ability to read and write in two or more languages	Ability to read and write Chinese, Spanish, and English
Phonologic processes	Errors in speech production that affect more than a single sound and are based on violations of predictable, rule-based features	- Fronting, when a sound that should be made in the back of the mouth (cat) is made in the front of the mouth (tat) - Cluster reduction, when a consonant cluster (as in stop) is reduced to a single consonant (top)

At a well visit, a 12-month-old responds to a request such as “come here” and uses a first word. Which age band of communication development in the table is the closest match?

- A. Birth to 3 months
- B. 4 to 6 months
- C. 7 to 12 months
- D. 3 to 4 years
- E. 4 to 5 years

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Table 53.2 Speech, Language, and Communication Milestones from Birth to 5 Years, Based on Typically Developing Children Acquiring a Single Verbal Language	
HEARING AND UNDERSTANDING	SPEAKING
BIRTH TO 3 MO	
- Startles at loud sounds - Recognizes voices and quiets if crying - Turns head toward sounds - Watches faces - Quiets or smiles when spoken to	- Makes pleasure sounds (cooing, gooing) - Cries differently for different needs
4-6 MO	
- Moves eyes in direction of sounds - Responds to changes in tone of voice - Notices music and sounds - Recognizes familiar people and things at a distance	- Vocalizes differently to show excitement, being tired, or in pain - Makes sounds when alone and when playing - Makes babbling sounds that are speechlike and uses consonant sounds, such as <i>p</i>, <i>b</i>, and <i>m</i> - Reaches for toys or objects - Engages in turn-taking and protoconversations
7-12 MO	
- Listens when spoken to - Turns and looks in direction of sounds - Enjoys social games, such as peek-a-boo and pat-a-cake - Responds to own name - Recognizes words for common items, such as <i>cup</i>, <i>shoe</i>, and <i>juice</i> - Begins to respond to simple requests (<i>Come here</i>; <i>Want more?</i>) or <i>No</i> - Looks when an adult points at something	- Uses speech sounds or gestures to get and keep attention and to respond to others - Imitates different speech sounds and gestures - Babbles with long and short groups of sounds, such as <i>bababa upup bibi</i>, and mixes different syllables, such as <i>badadeda</i> - Says one or two words (<i>bye-bye</i>, <i>dada</i>, <i>mama</i>) - Points to or shows things to spontaneously share interest with familiar people - Uses gestures such as waving for <i>hi</i> and <i>bye</i> or shaking head for <i>no</i>
1-2 YR	
- Listens to simple stories, songs, and rhymes - Follows simple commands and understands simple questions (<i>Roll the ball</i>; <i>Kiss the baby</i>; <i>Where’s your shoe?</i>) - Points to things when asked or when named such as body parts and objects	- Learns to say more words every month - Uses some one- and two-word questions (<i>Where kitty?</i> <i>Go bye-bye?</i> <i>What’s that?</i>) - Combines two words in their own ways (<i>more cookie</i>, <i>no juice</i>, <i>mommy book</i>) - Uses consonant sounds such as <i>p</i>, <i>b</i>, <i>m</i>, <i>h</i>, and <i>w</i> in English
2-3 YR	
- Understands differences in meaning (e.g., go–stop, in–on, big–little, up–down) - Follows two-step requests (<i>Get the book and put it on the table.</i>)	- Often asks for or directs attention to objects by naming them - Has a word for almost everything - Uses prepositions like <i>in</i>, <i>on</i>, and <i>under</i> - Often uses two- to three-word “sentences” - Speech is mostly understood by familiar listeners - Uses consonant sounds such as <i>k</i>, <i>g</i>, <i>f</i>, <i>t</i>, <i>d</i>, and <i>n</i> in English
3-4 YR	
- Understands simple <i>who</i>, <i>what</i>, <i>where</i>, and <i>why</i> questions - Understands words for colors like <i>red</i>, <i>blue</i>, or <i>green</i> and shapes like <i>circle</i> or <i>square</i> - Responds when you call from another room	- Uses pronouns like <i>I</i>, <i>you</i>, <i>me</i>, <i>we</i>, and <i>they</i> - Uses sentences that have four or more words with more complex grammar such as negative (<i>I no want to</i>) and questions - Talks about activities outside the home - Usually understood by people outside the family
4-5 YR	
- Hears and understands most of what is said at home and in school - Pays attention to a short story and answers simple questions about it - Understands words for time like <i>yesterday</i>, <i>today</i>, and <i>tomorrow</i> - Understands words for order like <i>first</i>, <i>next</i>, and <i>last</i> - Follows longer directions such as (<i>Find an animal you like, draw a circle around it, and bring the paper to me</i>)	- Uses sentences that include details (<i>I like to read my books</i>) and different action words like <i>jump</i> or <i>play</i>; may still make some grammar mistakes (<i>I gots one game and he got three games</i>) - Tells simple stories using mostly full sentences - Communicates easily with other children and adults - Says most sounds correctly except a few that are harder to say, such as <i>l</i>, <i>s</i>, <i>r</i>, <i>v</i>, <i>z</i>, <i>ch</i>, <i>sh</i>, and <i>th</i> in English
Milestones may not apply to bilingual children, children exposed to sign languages, children learning a second language, and children with language and learning disorders For Spanish translations and more information, including activities for families: • American Speech-Language-Hearing Association: http://www.asha.org/public/speech/development/chart.htm	

Answer key and teaching notes

01. B | Table 42.1 | printed p. 278, PDF p. 323

Why: A pattern of angry/irritable and defiant behavior for at least 6 months involving someone other than a sibling supports ODD.

Closest distractor: Conduct disorder requires more serious violations of rights or societal norms.

02. A | Table 42.2 | printed p. 278, PDF p. 323

Why: Disproportionate, impulsive, nonpremeditated aggressive outbursts fit intermittent explosive disorder.

Closest distractor: Conduct disorder is a persistent pattern violating the rights of others, potentially including planned behavior.

03. C | Table 42.3 | printed p. 279, PDF p. 324

Why: Aggression, cruelty, and confrontational stealing are among the major violations listed under conduct disorder.

Closest distractor: ODD comprises defiance and irritability without this pattern of major rights violations.

04. C | Table 47.1 | printed p. 285, PDF p. 331

Why: Brief psychotic disorder lasts at least 1 day but less than 1 month, followed by full return to baseline.

Closest distractor: Schizophreniform disorder requires an episode lasting at least 1 month.

05. B | Table 47.2 | printed p. 286, PDF p. 332

Why: Schizophreniform disorder has psychotic features lasting at least 1 month but less than 6 months.

Closest distractor: Schizophrenia requires continuous signs of illness for at least 6 months.

06. C | Table 47.3 | printed p. 286, PDF p. 332

Why: The table requires characteristic active psychotic symptoms, functional decline, and continuous disturbance for at least 6 months.

Closest distractor: Schizophreniform disorder is limited to an illness lasting under 6 months.

07. A | Table 47.4 | printed p. 287, PDF p. 333

Why: The table lists autoimmune disorders including NMDA receptor encephalitis among secondary causes of psychosis.

Closest distractor: Academic stress alone does not explain new seizures with rapidly progressive psychosis.

08. B | Table 47.5 | printed p. 288, PDF p. 334

Why: Acute onset, fever, dyskinesias, and fluctuating consciousness are red flags for secondary psychosis.

Closest distractor: Primary psychosis alone does not readily explain fluctuating consciousness with new neurologic signs.

09. A | Table 47.6 | printed p. 288, PDF p. 334

Why: Rapidly progressive psychosis accompanied by unexplained seizures or movement disorder meets features raising possible autoimmune psychosis.

Closest distractor: A tic disorder cannot account for rapidly progressive psychosis and new seizures.

10. C | Table 47.7 | printed p. 291, PDF p. 337

Why: The table requires a temporal relation to exposure and a substance/medication capable of causing the psychotic symptoms.

Closest distractor: Schizophrenia is less fitting when onset tracks a causative medication exposure.

11. A | Table 47.8 | printed p. 291, PDF p. 337

Why: The criteria require prominent delusions or hallucinations with direct evidence of a medical pathophysiologic cause and exclusion of delirium.

Closest distractor: Delirium has a disturbance of attention and awareness, absent in this vignette.

12. B | Table 47.9 | printed p. 292, PDF p. 338

Why: Stupor, staring, mutism, and maintained posture are clinical signs of catatonia in the table.

Closest distractor: Selective mutism concerns speech in particular social settings and does not explain stupor and posturing.

13. A | Table 47.10 | printed p. 292, PDF p. 338

Why: Autoimmune and infectious encephalitis and epilepsy are among neurologic conditions associated with catatonia.

Closest distractor: Seasonal allergic rhinitis alone does not explain the new neurologic findings.

14. B | Table 47.11 | printed p. 292, PDF p. 338

Why: The criteria call for at least three characteristic catatonic signs; the stem names stupor, mutism, and waxy flexibility.

Closest distractor: A single isolated motor sign does not meet the three-sign criterion.

15. B | Table 47.12 | printed p. 293, PDF p. 339

Why: The examination instructions say to rate an uncertain finding as zero and score only clearly present signs.

Closest distractor: Assigning maximum points to uncertain signs would inflate the screening result.

16. B | Table 48.1 | printed p. 295, PDF p. 341

Why: Delirium combines acute fluctuating disturbances in attention and awareness with an additional cognitive disturbance.

Closest distractor: Primary schizophrenia usually does not present with this acute waxing and waning attentional disturbance.

17. B | Table 48.2 | printed p. 295, PDF p. 341

Why: Hypoactive delirium involves decreased psychomotor activity, lethargy, sluggishness, and confusion.

Closest distractor: Hyperactive delirium more typically includes agitation and increased activity.

Answer key (continued)

18. A | Table 48.3 | printed p. 297, PDF p. 343

Why: The table includes prolonged or excessive sedation and medication-related toxic effects as delirium contributors.
Closest distractor: A developmental learning difficulty does not explain sudden ICU inattention.

19. A | Table 48.4 | printed p. 297, PDF p. 343

Why: Fluctuating attention and acute onset with visual perceptual disturbances are characteristic of delirium in the table.
Closest distractor: Primary psychosis tends to have more sustained attention and a less acutely fluctuating course.

20. B | Table 48.5 | printed p. 298, PDF p. 344

Why: Environmental modification includes a visible clock/calendar, daytime-consistent lighting, and caregiver reorientation.
Closest distractor: Bright overnight lighting disrupts day-night cues and is the opposite of the listed approach.

21. B | Table 49.1 | printed p. 302, PDF p. 348

Why: Working-memory difficulty is illustrated by completing only part of a multistep instruction.
Closest distractor: Initiation impairment mainly affects beginning a task independently.

22. A | Table 49.2 | printed p. 304, PDF p. 350

Why: Phonologic processing is listed under language functions relevant to reading difficulties.
Closest distractor: Gross motor endurance is not among the proposed cognitive pathways for reading disability in this table.

23. A | Table 49.3 | printed p. 308, PDF p. 354

Why: The working-memory row recommends repeating concise instructions and providing concrete references.
Closest distractor: Longer uncued directions raise the memory load and do not implement the listed strategy.

24. A | Table 50.1 | printed p. 310, PDF p. 357

Why: The DSM-5 ADHD table requires several symptoms present before age 12 and interference in more than one setting.
Closest distractor: A single isolated symptom does not satisfy the persistent multi-symptom criteria.

25. A | Table 50.2 | printed p. 311, PDF p. 358

Why: The DSM-5 column allows either symptom domain, whereas the ICD-10 HKD column requires inattentive, hyperactive, and impulsive criteria.
Closest distractor: The ICD-10 criteria include substantial inattention requirements rather than excluding them.

26. A | Table 50.3 | printed p. 313, PDF p. 360

Why: A sleep disorder, including obstructive sleep apnea, is listed in the ADHD differential and fits snoring with daytime impairment.
Closest distractor: Eczema does not explain habitual snoring with sleepiness.

27. A | Table 52.2 | printed p. 321, PDF p. 368

Why: Low math performance and teacher concern about taking the next step are listed risk indicators for math-specific learning disability.
Closest distractor: Family history alone is not required and the table says it would not by itself initiate intervention.

28. A | Table 52.3 | printed p. 321, PDF p. 368

Why: Persistent written-expression difficulty despite targeted intervention and documented academic impairment fit the listed criteria.
Closest distractor: A transient variation does not explain persistence despite intervention and objectively low achievement.

29. A | Table 53.1 | printed p. 325, PDF p. 372

Why: Speech refers to the production of spoken sounds; preserved comprehension and sentence structure point away from broad language impairment.
Closest distractor: Receptive language impairment would affect understanding of instructions.

30. C | Table 53.2 | printed p. 326, PDF p. 373

Why: The 7-to-12-month entries include responsiveness to simple words/requests and emerging spoken words.
Closest distractor: The 4-to-6-month band emphasizes babbling and response to sound rather than a first word with comprehension.

Table selection log

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

Excluded in this span: low-value rating scales and resource lists; continued tables omitted.

Thirty selected after Table 41.7; resume after Table 53.2 (PDF p. 373).

01. **Table 42.1 | PDF 323 | printed 278 | Completed**
Table 42.1 DSM-5 Diagnostic Criteria for Oppositional Defiant Disorder
02. **Table 42.2 | PDF 323 | printed 278 | Completed**
Table 42.2 DSM-5 Diagnostic Criteria for Intermittent Explosive Disorder
03. **Table 42.3 | PDF 324 | printed 279 | Completed**
Table 42.3 DSM-5 Diagnostic Criteria for Conduct Disorder
04. **Table 47.1 | PDF 331 | printed 285 | Completed**
Table 47.1 DSM-5 Diagnostic Criteria for Brief Psychotic Disorder
05. **Table 47.2 | PDF 332 | printed 286 | Completed**
Table 47.2 DSM-5 Diagnostic Criteria for Schizophreniform Disorder
06. **Table 47.3 | PDF 332 | printed 286 | Completed**
Table 47.3 DSM-5 Diagnostic Criteria for Schizophrenia
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Table 47.4 Possible Causes of Secondary Psychosis
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Table 47.5 Red Flags and Features Suggesting Secondary Etiologies of Psychosis
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Table 47.6 Proposed Diagnostic Criteria for Autoimmune Psychosis
10. **Table 47.7 | PDF 337 | printed 291 | Completed**
Table 47.7 DSM-5 Diagnostic Criteria for Substance/Medication-Induced Psychotic Disorder
11. **Table 47.8 | PDF 337 | printed 291 | Completed**
Table 47.8 DSM-5 Diagnostic Criteria for Psychotic Disorder Due to Another Medical Condition
12. **Table 47.9 | PDF 338 | printed 292 | Completed**
Table 47.9 Catatonia
13. **Table 47.10 | PDF 338 | printed 292 | Completed**
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Table 47.12 Standard Examination of Catatonia
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Table 48.1 DSM-5 Diagnostic Criteria for Delirium
17. **Table 48.2 | PDF 341 | printed 295 | Completed**
Table 48.2 DSM-5 Delirium Subtypes
18. **Table 48.3 | PDF 343 | printed 297 | Completed**
Table 48.3 Etiologies of Pediatric Delirium (CRITICAL CARE mnemonic)
19. **Table 48.4 | PDF 343 | printed 297 | Completed**
Table 48.4 Differential Diagnosis of Delirium
20. **Table 48.5 | PDF 344 | printed 298 | Completed**
Table 48.5 Nonpharmacologic Management of Delirium
21. **Table 49.1 | PDF 348 | printed 302 | Completed**
Table 49.1 Symptom Expression of Executive Dysfunction
22. **Table 49.2 | PDF 350 | printed 304 | Completed**
Table 49.2 Neurodevelopmental Dysfunction Underlying Academic Disorders
23. **Table 49.3 | PDF 354 | printed 308 | Completed**
Table 49.3 Executive Function Categories: Presenting Symptoms, Suggested Dysfunction, and Potential Interventions
24. **Table 50.1 | PDF 357 | printed 310 | Completed**
Table 50.1 DSM-5 Diagnostic Criteria for ADHD
25. **Table 50.2 | PDF 358 | printed 311 | Completed**
Table 50.2 Differences Between U.S. and European Criteria for ADHD or HKD
26. **Table 50.3 | PDF 360 | printed 313 | Completed**
Table 50.3 Differential Diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD)
27. **Table 52.2 | PDF 368 | printed 321 | Completed**
Table 52.2 Risk Factors for a Specific Learning Disability
28. **Table 52.3 | PDF 368 | printed 321 | Completed**
Table 52.3 DSM-5 Diagnostic Criteria for Specific Learning Disability with Impairment in Written Expression
29. **Table 53.1 | PDF 372 | printed 325 | Completed**
Table 53.1 Definitions of Basic Terms in Communication, Language, and Speech
30. **Table 53.2 | PDF 373 | printed 326 | Completed**
Table 53.2 Speech, Language, and Communication Milestones from Birth to 5 Years, Based on Typically Developing Children