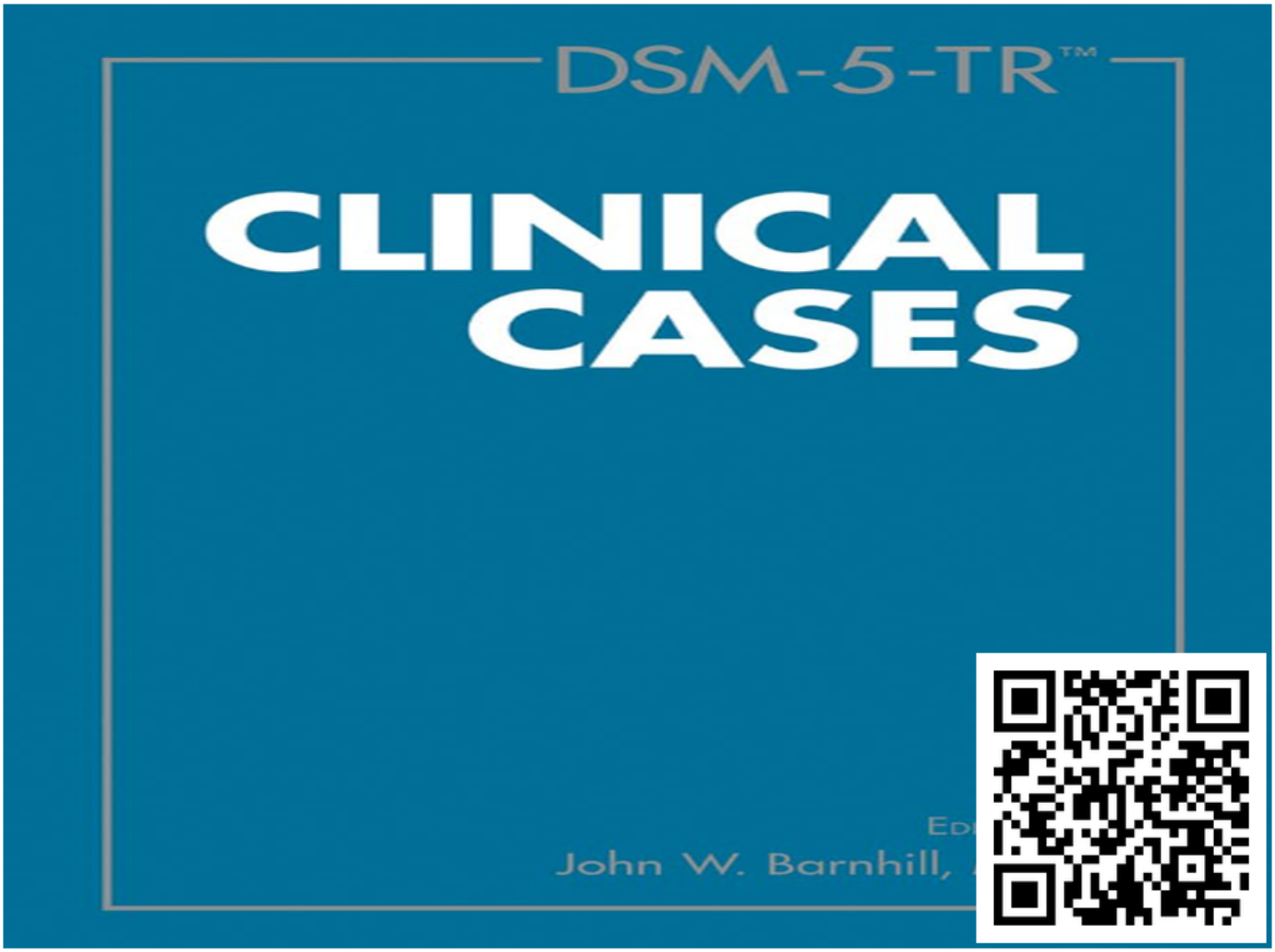

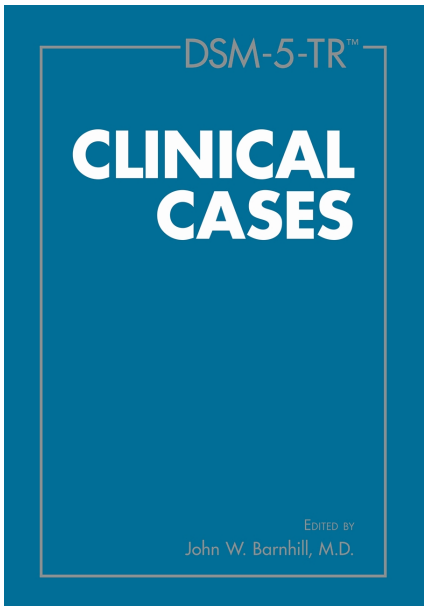

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Back to table of contents

Next Chapter

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First Edition

Manufactured in the United States of America on acid-free paper 27 26 25 24 23 5 4 3 2 1 ISBN 978-1-61537-361-1 (print), 978-1-61537-362-8 (ebook)

American Psychiatric Association Publishing 800 Maine Avenue SW, Suite 900 -2812

Library of Congress Cataloging-in-Publication Data Names: Barnhill, John W. (John Warren), 1959– editor. | American Psychiatric Association Publishing, issuing body. Title: DSM-5-TR clinical cases / edited by John W. Barnhill. Description: First edition. | Washington : American Psychiatric Association Publishing, [2023] | Includes bibliographical references and index. Identifiers: LCCN 2022049312 (print) | LCCN 2022049313 (ebook) | ISBN 9781615373611 (paperback) | ISBN 9781615373628 (ebook) Subjects: MESH: Diagnostic and statistical manual of mental disorders. ‡s 5th ed | Mental Disorders–diagnosis | Case Reports Classification: LCC RC473.D54 (print) | LCC RC473.D54 (ebook) | NLM WM 40 | DDC 616.89/075–dc23/eng/20230113 LC record available at https://lccn.loc.gov/2022049312 LC ebook record available at https://lccn.loc.gov/2022049313

British Library Cataloguing in Publication Data A CIP record is available from the British Library.

Back to table of contents Previous Chapter Next Chapter

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(books), Lippincott Williams & Wilkins (Editor-in-Chief of *Journal of Clinical Psychopharmacology*), University of Massachusetts Medical School (Rothschild Scale for Antidepressant Tachyphylaxis [RSAT®]), and Wolters Kluwer Health (UpToDate®).

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Jennifer J. Thomas, Ph.D.—*Royalties:* Cambridge University Press and Oxford University Press.

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Introduction

DSM-5-TR Clinical Cases is intended to accompany DSM-5-TR. Each of this book's 104 cases begins with a clinical vignette followed by a case discussion. The cases are organized to fit into one of the 19 core DSM-5-TR chapters. In other words, a case that features borderline personality disorder will be found in the chapter on personality disorders. In cases that feature co-occurring disorders, the case will be found in the chapter on what is considered to be the primary psychiatric disorder (although it is often true that each of the co-occurring disorders should also be the subject of clinical attention).

Each of the 133 discussants was asked to act like "an expert on the shoulder," outlining the thought process that might go into a diagnostic understanding of the patient. The limit of about 1,000 words for the combined case and discussion means that neither is exhaustive, but this same brevity allows the book to highlight the ways in which experienced clinicians efficiently convert complex clinical data into a differential diagnosis. It also allows the reader to obtain a focused learning experience in one sitting. Throughout, the reader is encouraged to actively consider the tentative diagnoses that conclude each discussion. Would you agree, disagree? Would you want more information? What sorts of co-occurring disorders might be considered? What is likely to develop in the patient during the ensuing months and years?

DSM-5-TR Clinical Cases is updated from the book of clinical cases that accompanied DSM-5. The authors, cases, and discussions are largely the same, although the book has been revised to include changes in DSM-5-TR as well as to expand its consideration of ethnicity, race, and other demographic factors.

Translated into a dozen languages, *DSM-5 Clinical Cases* was read by a variety of mental health clinicians, trainees, and students, as well as by nonprofessionals. We hope that readers will find this updated edition to be even more interesting and useful.

Back to table of contents Previous Chapter Next Chapter

Chapter 1. Neurodevelopmental Disorders

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https://doi.org/10.1176/appi.books.9781615375295.jb01

Introduction

Robert Haskell, M.D.

In its approach to mental illness across the lifetime of a patient, DSM-5 naturally begins with the neurodevelopmental disorders. As a group, these disorders are usually first diagnosed in infancy, childhood, or adolescence. Individually, these disorders have undergone a mix of pruning, reorganization, and clarification, including one of DSM-5's most controversial changes—to the definition of and diagnostic criteria for autism.

In DSM-5-TR, autism spectrum disorder describes patients previously divided among autistic disorder, Asperger's disorder, childhood disintegrative disorder, Rett's disorder, and pervasive developmental disorder not otherwise specified. These are no longer considered to be separate clinical entities. The new criteria include 1) persistent and pervasive deficits in social communication and social interaction and 2) restricted, repetitive patterns of behavior, interests, and activities. As now defined, autism spectrum disorder (ASD) can be subcategorized by the presence or absence of intellectual impairment and/or an associated medical condition. In addition, the

identification of three severity levels helps clarify the need for additional social or occupational services. For example, a patient requiring “very substantial support” might display extreme behavioral inflexibility or might possess only 20 words of intelligible speech.

Attention-deficit/hyperactivity disorder (ADHD) continues to be subdivided into two symptom dimensions (inattention and hyperactivity/impulsivity), with a core requirement being the presence of at least six symptoms from either or both of the two dimensions. For example, inattention might be noted by the presence of such behaviors as making careless mistakes, failing to follow through with homework, and losing books. Criteria for hyperactivity/impulsivity include fidgetiness, impatience, and garrulousness. The diagnosis of ADHD is generally incomplete without inclusion of dimensional specifiers (predominantly inattentive, predominantly hyperactive/impulsive, or combined). Several of these symptoms must have been present prior to age 12, a change from DSM-IV’s requirement that symptoms causing impairment be present prior to age 7. Another change is a reduction in the number of symptomatic criteria for adults from six to five within a particular dimension. These latter two changes reflect evidence that “loosening” criteria allows for identification of people who have symptoms, distress, and dysfunction that are very similar to those of people already diagnosed with ADHD and who can potentially benefit from clinical attention. As is true throughout DSM-5, it is up to the clinician to diagnose only those people who meet symptomatic criteria and whose distress and dysfunction reach a relevant clinical threshold.

DSM-5 had replaced the DSM-IV term *mental retardation* with the name *intellectual disability (intellectual developmental disorder)*, and in DSM-5-TR, the order of the two names in the diagnosis has been reversed to *intellectual developmental disorder (intellectual disability)* to indicate that the first-named term is preferred. The three core criteria for this diagnosis are unchanged: deficits in intellectual function and in adaptation (in areas such as communication, work, or leisure), as well as an early age at onset. The diagnosis does not depend on formal intelligence testing; instead, DSM-5-TR invites the clinician to make an aggregate assessment of severity, from mild to profound, according to three important life domains: conceptual, social, and practical. For example, a person with severe intellectual developmental disorder might have little understanding of concepts such as time or money, might use language to communicate

but not to explain, and would likely require support for all activities of daily living.

Disorders of communication first observed in childhood include language disorder (formerly divided into expressive and receptive language disorders); speech sound disorder, in which the patient displays an impaired ability to produce the phonological building blocks of words but has no congenital or acquired medical condition that explains the impairment; childhood-onset fluency disorder (stuttering); and a new diagnosis, social (pragmatic) communication disorder, in which the patient displays persistent difficulties in the social use of verbal and nonverbal communication—very likely a diagnostic home for some of the individuals who have traits of ASD but do not meet full criteria.

Specific learning disorder is a new umbrella diagnosis within DSM-5. Specifiers for reading, written expression, and mathematics are designed to help teachers and parents shine a more focused light on a child's academic needs.

The chapter on neurodevelopmental disorders culminates with the motor disorders, including developmental coordination disorder, stereotypic movement disorder, and the tic disorders. A tic is a nonrhythmic movement of short duration and sudden onset. Such movements can be divided into motor tics, such as shoulder shrugs and eyeblinks, and vocal tics, including sniffs, snorts, and the spontaneous production of a word or phrase. Tourette's disorder is the most complex of the tic disorders, describing patients who exhibit both multiple motor and at least one vocal tic for more than 1 year that cannot be explained by a medical condition or by the physiological effects of a substance such as cocaine.

Inevitably, the neurodevelopmental disorders share symptoms with a broad range of psychiatric illnesses, and clinicians must sort through the differential diagnosis with an understanding that that differential is much broader for children age 12 and under. Sometimes the neurodevelopmental disorders contribute to the emergence of other disorders; for example, a learning disorder may cause anxiety, and untreated ADHD may make a patient vulnerable to substance abuse. The cases that follow attempt to pull apart some of these diagnostic entanglements and explore the comorbidities that make the treatment of neurodevelopmental disorders among the most challenging tasks in

psychiatry.

Suggested Readings

Brown TE (ed): ADHD Comorbidities. Washington, DC, American Psychiatric Publishing, 2009

Cepeda C, Gotanco L: Psychiatric Interview of Children and Adolescents. Washington, DC, American Psychiatric Association Publishing, 2019

Hansen RL, Rogers SJ (eds): Autism and Other Neurodevelopmental Disorders. Washington, DC, American Psychiatric Publishing, 2013

Case 1.1 A Second Opinion on Autism

Catherine Lord, Ph.D.

Ashley, age 17, was referred for a diagnostic reevaluation after having carried diagnoses of autism and intellectual disability for almost all of her life. She was recently found to have Kleefstra syndrome, and the family wanted to reconfirm the earlier diagnoses and assess the genetic risk to the future children of her older sisters.

At the time of the reevaluation, Ashley was attending a special school with a focus on functional skills. She was able to dress herself, but she was not able to shower independently or be left alone in the house. She was able to decode (e.g., read words) and spell at a second-grade level but understood little of what she read. Changes to her schedule and heightened functional expectations tended to make her irritable. When upset, Ashley would often hurt herself (e.g., biting her wrist) and others (e.g., pinching and hair pulling).

In formal testing done at the time of the reevaluation, Ashley had a nonverbal IQ of 39 and a verbal IQ of 23, with a full scale IQ of 31. Her adaptive scores were somewhat higher, with an overall score of 42 (with 100 as average).

By history, Ashley first received services at age 9 months after her parents noticed significant motor delays. She walked at 20 months and was toilet trained at 5 years. She

spoke her first word at age 6. She received a diagnosis of developmental delay at age 3 and of autism, obesity, and static encephalopathy at age 4. An early evaluation noted possible facial dysmorphology; genetic tests at that time were noncontributory.

Her parents indicated that Ashley knew hundreds of single words and many simple phrases. She had long been very interested in license plates and would draw them for hours. Her strongest skill was memory, and she could draw precise representations of license plates from different states. Ashley had always been very attached to her parents and sisters, and although affectionate toward babies, she showed minimal interest in other teenagers.

Ashley's family history was pertinent for a father with dyslexia, a paternal uncle with epilepsy, and a maternal male cousin with possible "Asperger's syndrome." Her siblings, both sisters, were in college and doing well.

On examination, Ashley was an overweight young woman who made inconsistent eye contact but often peered out the corner of her eye. She had a beautiful smile and would sometimes laugh to herself, but most of the time her facial expressions were subdued. She did not initiate joint attention by trying to catch another person's eyes. She frequently ignored what others would say to her. To request a preferred object (e.g., a shiny magazine), Ashley would rock from foot to foot and point. When offered an object (e.g., a small decorated box), she brought it to her nose and lips for inspection. Ashley spoke in a high-pitched voice with unusual intonation. During the interview, she used multiple words and a few short phrases that were somewhat rote but communicative, such as "I want to clean up," and "Do you have a van?"

In the months prior to the evaluation, Ashley's parents noticed that she had become increasingly apathetic. A medical evaluation concluded that urinary tract infections were the most likely cause for her symptoms, but antibiotics seemed only to make her more listless. Further medical evaluation led to more extensive genetic testing, and Ashley was diagnosed with Kleefstra syndrome, a rare genetic defect associated with multiple medical problems, including intellectual developmental disorder. The parents said they were also tested and found to "be negative."

The parents specifically wanted to know whether the genetic testing results affected

Ashley's long-standing diagnoses and access to future services. Furthermore, they wanted to know whether their other two daughters should get tested for their risk of carrying genes for autism, intellectual disability, and/or Kleefstra syndrome.

Discussion

In regard to diagnosis, Ashley's cognitive testing and limited everyday adaptive skills are consistent with intellectual developmental disorder, a term in DSM-5-TR that is equivalent to "intellectual disability," which had previously been the preferred term. In addition, Ashley manifests two symptom clusters that are core to the diagnosis of autism spectrum disorder (ASD): 1) deficits in social communication and 2) restricted, repetitive patterns of behavior, interests, or activities. Ashley also fulfills the DSM-5-TR ASD requirement of having had symptoms in the early developmental period and a history of significant impairment. A fifth requirement for ASD is that the disturbances are not better explained by intellectual developmental disorder, which is a more complicated question in Ashley's case.

For many years, clinicians and researchers have debated the boundary between ASD and intellectual developmental disorders. As IQ decreases, the proportion of children and adults who meet criteria for ASD increases. Most individuals with IQs below 30 have ASD as well as intellectual developmental disorder.

For Ashley to meet DSM-5-TR criteria for both ASD and intellectual developmental disorder, the specific deficits and behaviors associated with ASD must be greater than what would ordinarily be seen in people with her overall intellectual development. In other words, if her deficits were due solely to limited intellectual abilities, she would be expected to have the social and play skills of a typical 3- to 4-year-old child. Ashley's social interaction is not at all like that of a typical preschooler, however, and never has been. She has limited facial expressions, poor eye contact, and minimal interest in peers. In comparison with her "mental age," Ashley demonstrates significant restriction in both her range of interests and her understanding of basic human emotions. Furthermore, she manifests behaviors that are not seen commonly at any age.

The heterogeneity of autism has led to significant conflict. Some argue, for example, that children with very severe intellectual developmental disorder should be excluded from

the diagnosis of ASD. Others argue that more intellectually able children with ASD should be placed into their own category, Asperger syndrome. Research does not support either of these distinctions. For example, studies indicate that children with ASD symptoms and severe intellectual developmental disorder often have siblings with ASD and stronger intellectual abilities. Much remains to be known about ASD, but IQ does not appear to be the key distinguishing factor.

From a pragmatic perspective, the critical factor is whether an ASD diagnosis offers information that helps guide treatment and the availability of services. For Ashley, the ASD diagnosis encourages a focus on helping to support her in social skills and less structured environments. It calls attention to differences in her motivation and in her need for structure. The ASD diagnosis also underlines the importance of looking carefully for Ashley's cognitive strengths (e.g., rote memory and visual representation) and weaknesses (e.g., comprehension, social interaction, and an ability to adapt to change). All of these may play a large role in her efforts to live as independently as possible.

Ashley's parents are also concerned about the impact of the recent genetic testing results on Ashley's treatment and on her sisters' family planning. Hundreds of individual genes may play a role in the complex neurological issues involved in autism, but most cases of ASD lack a clear cause. Ashley's genetic condition, Kleefstra syndrome, is reliably associated with both intellectual developmental disorder and ASD symptoms. When a genetic or medical condition or environmental factor appears to be implicated, it is listed as a specifier, but the ASD diagnosis is not otherwise affected.

Knowledge of the genetic cause for Ashley's intellectual developmental disorder and ASD is important for several reasons. It reminds her physicians to look for medical comorbidities that are common in Kleefstra syndrome, such as problems with the heart and kidneys (possibly leading, for example, to her recurrent urinary tract infections). Knowledge of the genetic cause also expands informational resources by connecting Ashley's family to other families that are affected by this rare syndrome.

A particularly important aspect of this new genetic diagnosis is its effect on Ashley's sisters. In almost all reported cases, Kleefstra syndrome has occurred de novo, meaning

that there is an extremely low likelihood that anyone else in her family has any abnormality in the affected gene region. On rare occasions, an unaffected parent has a chromosomal translocation or mosaicism that leads to the syndrome, but the fact that Ashley's parents were found to "be negative" implies they are not genetic carriers. Although this is not necessarily true for situations involving other autism-related genetic disorders, this particular genetic diagnosis in Ashley likely indicates that her sisters are not at greatly increased risk for having children with ASD, although they are not protected from ordinary risk. Such information can be very reassuring and useful to Ashley's sisters. The fact remains that although genetics undoubtedly plays a large role in ASD and intellectual developmental disorders, most cases cannot be reliably predicted, and diagnosis is made through ongoing, longitudinal observation during childhood.

Diagnoses

- Intellectual developmental disorder (intellectual disability), severe
- Autism spectrum disorder, with accompanying intellectual and language impairments, associated with Kleefstra syndrome

Suggested Readings

Kleefstra T, Nillesen WM, Yntema HG: Kleefstra syndrome. GeneReviews October 5, 2010

Lord C, Pickles A: Language level and nonverbal social-communicative behaviors in autistic and language-delayed children. J Am Acad Child Adolesc Psychiatry 35(11):1542–1550, 1996

Muhle RA, Reed, HE, Stratigos K, et al: The emerging clinical neuroscience of autism spectrum disorder: a review. JAMA Psychiatry 75(5):514–523, 2018

Willemsen MH, Vulto-van Silfhout AT, Nillesen WM, et al: Update on Kleefstra syndrome. Mol Syndromol 2(3–5):202–212, 2012

Case 1.2 Temper Tantrums

The authors would like to thank Arshya Vahabzadeh, M.D., for his contributions to an earlier edition of this case.

Robyn Thom, M.D.

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Christopher McDougle, M.D.

Brandon was a 12-year-old boy brought in by his mother for psychiatric evaluation for temper tantrums that seemed to be contributing to declining school performance. The mother became emotional as she reported that things had always been difficult but had become worse after Brandon entered middle school. Shortly after starting middle school, Brandon had started complaining of stomachaches on school-day mornings and was often reluctant to go to school.

Brandon's sixth-grade teachers reported that he was academically capable but that he had little ability to make friends. He seemed to mistrust the intentions of classmates who tried to be nice to him but attempted to befriend others who laughingly feigned interest in the toy cars and trucks that he brought to school. The teachers noted that he often cried and rarely spoke in class. In recent months, multiple teachers had heard him screaming at other boys, generally in the hallway but sometimes in the middle of class. The teachers had not identified a cause but generally had not disciplined Brandon because they assumed he was responding to provocation. He was embarrassed about these outbursts and did not want to go to swim practice because he did not want his swim friends to ask why he'd had an outburst at school.

When interviewed alone, Brandon responded with nonspontaneous mumbles when asked questions about school, classmates, and his family. When the examiner asked if he was interested in toy cars, however, Brandon lit up. He pulled several cars, trucks, and airplanes from his backpack and, while not making good eye contact, did talk at length about vehicles, using their apparently accurate names (e.g., front-end loader, B-52, Jaguar). When asked again about school, Brandon pulled out his cell phone and showed a string of text messages: "dumbo!!!!" "mr stutter"; "LoSeR"; "freak!"; "EVERYBODY

HATES YOU." While the examiner read the long string of texts that Brandon had saved but apparently not previously revealed, Brandon added that other boys would whisper "bad words" to him in class and then scream in his ears in the hall. "And I hate loud noises." He also told the examiner that he sometimes wished that he had never been born.

Developmentally, Brandon spoke his first word at age 11 months and began to use short sentences by age 3. He had always been very focused on trucks, cars, and trains. According to his mother, he had always been "very shy" and had never had a best friend. As he has gotten older, it has become more apparent that he struggles with jokes and typical young adolescent banter because "he takes things so literally." Brandon's mother had long seen this behavior as "a little odd" but added that it was not much different from that of Brandon's father, a successful attorney, who had similarly focused interests. Both of them were "sticklers for routine" who "lacked a sense of humor." Brandon's mother noted that he made efforts to conceal his interest in trucks, cars, and trains outside of the home but would eagerly speak about them when encouraged. Brandon has shared with his mother that he tries to appear "normal" when interacting with peers at school, which is exhausting. He often feels nervous around peers and generally tries to avoid socializing.

On examination, Brandon was shy and generally nonspontaneous. He made below-average eye contact. His speech was coherent and goal directed. At times, Brandon stumbled over his words, paused excessively, and sometimes rapidly repeated words or parts of words. Brandon said he felt okay but added that he was scared of school, particularly when around other children. He appeared sad, brightening only when discussing his toy cars. He denied current suicidal thoughts or plans as well as homicidality. He denied psychotic symptoms. He was cognitively intact.

Discussion

Brandon presents with symptoms consistent with autism spectrum disorder (ASD). DSM-5 ASD incorporates several previously separate disorders, namely DSM-IV autistic disorder (autism), Asperger's disorder, and pervasive developmental disorder not otherwise specified. ASD is characterized by two main symptom domains: social

communication deficits and a fixated set of interests and repetitive behaviors.

It is evident that Brandon has considerable difficulty in his peer social interactions. He is unable to form friendships, does not engage in interactive play, and struggles with reading social cues. People with ASD typically find it challenging to correctly interpret the relevance of facial expressions, body language, and other nonverbal behaviors. He is humorless and “takes things so literally.” These symptoms meet the ASD criteria for social communication deficits.

In regard to the second ASD symptom domain, Brandon has fixated interests and repetitive behaviors that cause significant distress. He seems interested in cars and trains, has little interest in anything else, and has limited insight that other children might not share his enthusiasms. He requires “sameness,” with distress arising if his routine is altered. Brandon meets both of the primary symptomatic criteria, therefore, for DSM-5 ASD.

Brandon also stumbles over words, pauses excessively, and repeats words or parts of words. These symptoms are consistent with stuttering, which is classified as one of the DSM-5 communication disorders, namely childhood-onset fluency disorder. Typically persistent and characterized by frequent repetitions or prolongations of sounds, broken words, pauses in speech, and circumlocutions, childhood-onset fluency disorder may result in significant social, academic, and occupational dysfunction.

Other DSM-5 communication disorders include difficulties in speech production (speech sound disorder), difficulty in use of spoken and written language (language disorder), and difficulty in the social uses of verbal and nonverbal communication (social [pragmatic] communication disorder). Although these difficulties are not noted in the case report, Brandon should be evaluated for each of these, because language impairments are so commonly part of ASD that they are listed as specifiers of ASD rather than as separate, comorbid diagnoses.

Many individuals with ASD have comorbid anxiety symptoms. The most common anxiety disorders in ASD are specific phobia, social anxiety disorder, and agoraphobia. In Brandon’s case, signs that suggest he should be further evaluated for an anxiety disorder include his stomachaches, avoidance of social activities, and frequent feelings of

embarrassment in social situations. The 25-item Parent-Rated Anxiety Scale for ASD (PRAS-ASD) is a reliable and valid scale for measuring anxiety in youth with ASD.

Prior to DSM-5, Brandon would have met criteria for Asperger's disorder, which identified a cluster of individuals with core autism features (social deficits and fixated interests) and normal intelligence. Perhaps because he shared autism spectrum symptoms with his own father, however, Brandon was viewed as "a little odd" but without problems that merited specific clinical attention. The lack of a diagnosis contributed to Brandon's having become the defenseless target of malicious bullying, a not uncommon finding in people with ASD.

Brandon has experienced passive suicidal thoughts. Individuals with ASD are at elevated risk for suicidal thoughts and completed suicide, and it will be important for Brandon to periodically receive careful safety assessments in the future. Without appropriate interventions for both his core ASD symptoms and his stuttering, Brandon is at serious risk for ongoing psychological trauma and academic derailment.

Brandon's ongoing passion for a single subject (in his case, trucks, cars, and trains) is typical for children with ASD. Brandon is sensitive to the fact that his peers no longer share his passion (if they ever did), so he hides his interest. Similarly, he wants to skip swim practice because of his earlier outburst at school. In both cases, his embarrassment is painful, but there are positives as well: Brandon is aware that his behaviors are unusual, and he wants to have friends; his insight and desire to socialize are positive prognostic factors and suggest that appropriate treatment interventions may be beneficial.

Diagnosis

- Autism spectrum disorder requiring support for deficits in social communication and for restricted, repetitive behaviors without accompanying intellectual impairment, with accompanying language impairment—childhood-onset fluency disorder (stuttering)

Suggested Readings

Matthias C, LaVelle JM, Johnson DR, et al: Exploring predictors of bullying and victimization of students with autism spectrum disorder (ASD): findings from NLTS 2012. J Autism Dev Disord 51(12):4632–4643, 2021

Scahill L, Lecavalier L, Schultz RT, et al: Development of the parent-rated anxiety scale for youth with autism spectrum disorder. J Am Acad Child Adolesc Psychiatry 58(9):887–896, 2019

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Toth K, King BH: Asperger's syndrome: diagnosis and treatment. Am J Psychiatry 165(8):958–963, 2008

Case 1.3 Academic Difficulties

Stewart Adelson, M.D.

Rosemary Tannock, Ph.D.

Carlos was a 19-year-old Hispanic college student in his freshman year at a public university in a large city. He was referred by his guidance counselor to the hospital's outpatient psychiatric clinic for help with academic difficulties. Since starting college 6 months earlier, he had done poorly on tests and been unable to manage his study schedule. His worries that he was going to flunk out of college were leading to anxiety, insomnia, poor concentration, and a general sense of hopelessness. After a particularly tough week, he told his family that he thought he should quit. His mother accompanied him to the clinic that had previously helped both Carlos and his younger brother. The mother specifically wondered whether Carlos's "ADHD" might be causing his problems, or whether he had outgrown it.

Carlos had been seen at the same clinic when he was age 9, at which time he had been diagnosed with attention-deficit/hyperactivity disorder (ADHD), predominantly

combined type. Notes from that clinical evaluation indicated that Carlos had been in trouble at school for not following instructions, not completing homework, getting out of his seat, losing things, not waiting his turn, and not listening. He had trouble concentrating except in regard to video games, which he "could play for hours." Carlos had apparently been slow to talk, but his birth and developmental histories were otherwise normal. He repeated first grade because of behavioral immaturity and difficulty learning to read. The ease with which Carlos learned English, his second language, was not noted. His family had emigrated to the United States from the Dominican Republic when he was 5 years old. The family was Catholic and attended church every Sunday. Both of his parents worked in maintenance and housekeeping at a local municipal hospital.

During the evaluation when Carlos was age 9, a psychoeducational assessment by a clinical psychologist confirmed reading problems (particularly problems in reading fluency and comprehension). Carlos did not, however, meet the school board criteria for a learning disability, which required evidence of a 20-point discrepancy between IQ and achievement scores. Thus, he was not eligible for special education services. The evaluator had noted Carlos to be eager to do well and anxious about underperforming. His anxiety was thought to be a reaction to his school difficulties and his challenges in meeting the academic expectations of his family. Carlos's pediatrician had recommended pharmacotherapy, but his parents did not want to pursue medication. They cited negative experiences with local youth who used diverted controlled substances and hung out "on the street." Instead, his mother reported taking on an extra job to pay for tutors to help her son "with concentration and reading." The eldest of four siblings, Carlos had done well with this intervention and was now the first member of his family to attend college.

The psychiatry trainee carefully reviewed Carlos's academic history; his symptoms, including the course and severity of sadness, anxiety, insomnia, and hopelessness; and his social and developmental history. She obtained collateral history from his family and school records. She used the revised DSM-5-TR Core Cultural Formulation Interview for assistance in obtaining a better understanding of Carlos's acculturation experiences, the family's past feelings about the clinic's recommendations, and what treatment interventions would be relevant and acceptable to Carlos and his family.

The psychiatry trainee learned that Carlos had a childhood history of "nervousness" identified by a neighborhood *curandera* (traditional healer) as *ataque de nervios*. The family had addressed this problem with supportive prayer and a traditional herbal tea. They had apparently not revealed this to the psychiatrist at the time, thinking he would find it irrelevant and not wishing to seem disrespectful of his authority. During these unrevealed episodes of acute anxiety, Carlos would experience trembling and agitation, palpitations, shortness of breath, dread of harm, and fear of separation from caregivers. Workup by the pediatrician had revealed no physiological cause.

Since starting college, Carlos reported that he had frequently been unable to remain focused while reading and listening to lectures. He was easily sidetracked and therefore had difficulty handing in his written assignments on time. He complained of feeling restless, agitated, and worried. He described difficulty falling asleep, poor energy, and an inability to "have fun" like his peers. He reported that the depressive symptoms went "up and down" over the course of the week and possibly influenced his problems with concentration; it was hard for him to be certain. He denied substance use.

Carlos said that he'd had some great teachers in high school who had understood him, helped him get the meaning of what he read, and allowed him to audiotape lectures and use other formats (e.g., videos, wikis, visual presentations) for final assignments. Without this support at college, he said he felt "lonely, stupid, a failure—unable to cope."

Although advised by his high school teacher to do so, Carlos had not registered with the university's student disability services office. He preferred not to be seen as different from his peers and thought he should be able to get through college by himself.

Carlos's family history was positive for ADHD in a younger brother. A cousin was reported to have had "dyslexia" and had dropped out of a local community college after one semester. His social and developmental history revealed that he had been well liked by his cluster of friends throughout school. His group consisted of boys and girls and tended to consist of kids more interested in school than in sports. Carlos denied ever having dated or been sexually active, and he also denied having any significant interest in pursuing either of these activities.

On examination, Carlos was well-groomed, polite, and soft-spoken. He wore clean jeans,

a T-shirt, and a hoodie that he kept pulling down over his face. He sat quietly and hunched over. He sighed a lot and rarely made eye contact with the clinician. He often tapped his fingers and shuffled in his seat but responded appropriately to questions. His command of English appeared strong, but he spoke with a slight Spanish accent. He often mumbled and mispronounced some multisyllabic words (e.g., he said "literalchure" instead of "literature" and "intimate" when he clearly meant "intimidate"). He denied any suicidal thoughts. He appeared motivated to do better. On a follow-up interview with the psychiatry trainee, Carlos asked whether the conversations were confidential. When informed that they were, he hesitantly admitted that he felt overwhelmed by new relationships with college peers. He indicated that "in my neighborhood growing up, everybody was Dominican, but in college, I'm the only Dominican." He also quietly said that he thought he might "like guys rather than girls." He revealed two recent episodes of panic "like when I was a kid" that had occurred during social situations. He declined to go into further detail.

After these two initial sessions, the psychiatrist suggested extending the evaluation so that they could optimize a treatment strategy. She told Carlos that she wanted to better understand his mood and anxiety symptoms, as well as how he felt about being the first in his family to go to college (i.e., role transitions), and to talk a little more about his concerns about his sexual orientation. She also referred Carlos for updated psychoeducational testing. This psychoeducational reassessment confirmed that Carlos's reading and writing abilities were substantially and quantifiably below those expected for his age. That report also concluded that these learning difficulties were not attributable to intellectual developmental disorder, uncorrected visual or auditory acuity, psychosocial adversity, or lack of proficiency in the language of academic instruction. The report concluded that Carlos had specific difficulties with reading fluency and comprehension as well as spelling and written expression.

Discussion

Carlos presents with a history of ADHD that was diagnosed in childhood. He also appears to have anxiety and panic attacks that recurred in college. His earlier anxiety/panic had not been previously identified by his pediatrician (although it had been diagnosed as *ataque de nervios* and treated by a traditional healer in their community).

He also appears to have a new-onset major depressive episode, mild severity, in the context of stressors surrounding acculturation, transition to college, and uncertainty about his sexual orientation.

When Carlos was first evaluated at age 9, DSM-IV criteria for ADHD required six of the nine symptoms listed in either of the two categories: inattention or hyperactivity-impulsivity (as well as an onset before age 12). He had been diagnosed as having the combined type of ADHD, indicating the specialty clinic had found at least six symptoms in each of these spheres.

Carlos now presents at age 19, and the case report indicates that he may have five different inattentive symptoms and two symptoms related to hyperactivity-impulsivity. This seems to indicate a symptomatic improvement. Partial remission of ADHD is common with age, especially in regard to hyperactivity symptoms. Under DSM-IV, Carlos's ADHD would be said to have remitted. DSM-5 has a lower threshold of five symptoms in either category, rather than six, so Carlos would continue to meet the symptomatic criteria for ADHD.

Carlos's anxiety and depression might actually be causing his inattention, however, and ADHD should not be diagnosed if an alternative explanation is more likely. Carlos does appear to have had ADHD as a child, but that earlier evaluation did not uncover the symptoms that were identified by a traditional healer as *ataque de nervios*.

In addition to trying to clarify the cause of his inattention (and whether he actually has ADHD), the ongoing assessment might also explore Carlos's perspective on being the first in his family to attend college and on his identity as "the only Dominican on campus." It would also be useful to tactfully explore issues related to sexual orientation. This might include his sexual feelings and fantasies, the triggers for his recent panic attacks, and his (and his family's) views on homosexual behavior. The case report mentions that members of Carlos's family are observant Catholics and that they sought out a traditional healer for Carlos's *ataque de nervios*. It would be useful to better understand how Carlos and his family merge aspects of their Catholicism and traditional Afro-Caribbean religions; such an understanding might inform Carlos's perspective on all of his concerns, including the anxiety, depression, and his "liking guys."

Carlos may well have mood and anxiety disorders in addition to ADHD. Academic problems are common in ADHD even in the absence of a specific learning disorder (SLD), although SLDs are also commonly comorbid with ADHD. Even before his repeat psychological testing, Carlos appeared to have multiple historical issues that increase the likelihood of an SLD. His speech was delayed in his first language, Spanish; his reading was slow in both Spanish and English; and he received (and thrived with) educational accommodations in high school. All of these suggest an SLD, as does his positive family history for learning disability.

Carlos's previous psychoeducational assessment failed to confirm a learning disorder because he did not meet the required discrepancy between IQ and achievement for diagnosis with an SLD. Based on an additional decade of evidence, DSM-5 eliminated this discrepancy criterion for SLD. This change has made it reasonable to refer older adolescent patients for reevaluation.

The repeat psychological testing indicates a moderately severe SLD. Because Carlos's learning difficulties began when he was school age and continue to cause academic impairment, he meets the DSM-5 diagnostic criteria for SLD. Documentation of both ADHD and SLD will enable Carlos to access academic accommodations that should allow him to more robustly pursue his college studies.

Diagnoses

- Major depressive disorder, mild, single episode
- History of panic disorder; rule out current
- History of attention-deficit/hyperactivity disorder, with predominantly inattentive presentation, of mild to moderate severity; rule out current
- Specific learning disorder affecting the domains of reading (both fluency and comprehension) and written expression (spelling and organization of written expression), all currently of moderate severity

Suggested Readings

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Case 1.4 School Problems

Arden D. Dingle, M.D.

Daphne, a 13-year-old in the ninth grade, was brought for a psychiatric evaluation because of academic and behavioral struggles. She had particular difficulty starting and completing schoolwork and following instructions, and she had received failing grades in math. When prompted to complete tasks, Daphne became argumentative and irritable. She had become increasingly resistant to attending school, asking to stay home with her mother. These difficulties had been evident since early childhood but had worsened significantly this year. Because Daphne had become increasingly distressed, her parents have been less insistent on making her do any activity that upsets her.

Psychological testing indicated that Daphne had above-average intelligence, age-appropriate achievement in all subjects except math, and some difficulties in visuospatial skills. The test results were shared with the school, which offered additional tutoring. Daphne attended only a few sessions, stating that they were not helpful. Her parents talked to the school counselors and Daphne's teachers, asking for more services. They were told repeatedly that Daphne needed to be more assertive and ask for help. Several teachers commented that Daphne should be more motivated and try harder. Several years earlier, her pediatrician had diagnosed ADHD and prescribed a stimulant.

She took the medication for a week, but her parents stopped giving it to her because she seemed agitated.

At home, Daphne's parents' close supervision of her homework often led to arguments with crying and screaming. Her behavior and attitude were noticeably better when she was out of school. She had two long-standing friends but had made no new close friends for several years. In groups with other children, she preferred to play with those younger than she. When her friends chose the activity or did not follow her rules, she tended to withdraw. She was generally quiet in groups and in school but more interactive with family members and individuals she knew well.

Since early childhood, Daphne has had difficulty falling asleep, requiring a nightlight and parental reassurance. Recognizing that Daphne was easily upset by change, her parents rarely forced her into new activities. She did well during the summer, which she spent with her grandparents. Her parents reported no particular traumas, stressors, or developmental or medical problems. Daphne had started her menses about 2 months prior to the evaluation. Her family history was pertinent for multiple first- and second-degree relatives with mood, anxiety, or learning disorders.

At first meeting, Daphne was shy and tense. Her eye contact was poor, and she had difficulty talking about anything other than her plastic horse collection. Within 15 minutes, she became more comfortable, revealing that she disliked school because the work was too hard. She thought that other children did not seem to like her because she was stupid and was not into clothes and dating. Sometimes they made fun of her and would start laughing whenever the teacher called on her. There were several peers who had similar interests in animals and seemed okay. She has been eating lunch with them but found it hard to relax and to believe that they really wanted to be friends. Daphne was always afraid of making mistakes, getting bad grades, and disappointing everyone. Often, she was so preoccupied with what to say or do next that she did not pay attention to her peers or teachers. She frequently was unable to make a decision for fear of not being right. Daphne was unable to identify any personal strengths or any aspect of her life that was going well. She wished she had more friends and that she was smarter. As long as she could remember, she had always felt this way. These difficulties made her sad, but she denied persistent depressive feelings or suicidal thoughts. She appeared

anxious but brightened when discussing her horse figurine collection, her longtime friends, and her family.

Discussion

Daphne has symptoms of inattention, anxiety, academic difficulties, limited peer relationships, and poor self-esteem that are causing distress and impaired functioning. Biologically, Daphne is experiencing the hormonal changes of puberty against the backdrop of a family history of mood, anxiety, and learning disorders. Psychologically, Daphne is living with the belief that she is inadequate, probably connected with her ongoing academic and social difficulties. Developmentally, Daphne's emotional and social functioning appears to be somewhat delayed, with younger-than-expected interests and coping strategies. Socially, Daphne has a supportive family environment that has emphasized protecting her, possibly interfering with the acquisition of skills related to independence and autonomy. Meanwhile, the educational system has not provided the necessary support for Daphne to succeed.

Daphne's academic problems can be explained in part by a specific learning disorder in mathematics. She has persistent difficulties with math, supported by testing that showed her performance to be below her intellectual level and chronological age. Her achievement in other academic subjects and her level of adaptive functioning generally appear to be age appropriate, indicating that her global intelligence and adaptive functioning are normal and that she does not have an intellectual developmental disorder.

It can be difficult to distinguish between anxiety and mood disorders in children Daphne's age. In this case, an anxiety disorder is more likely because Daphne's symptoms have been chronic and persistent rather than episodic, which depressive symptoms often are. Daphne's sadness is related to her sense of failure and worry about her competence. With the exception of a sleep disturbance, she does not have neurovegetative symptoms. Her difficulty with falling asleep appears anxiety based, as do her social ineptitude, reluctance to comply with school demands, and overreaction when faced with unwelcome tasks. In addition to her anxiety about her capabilities, Daphne appears to have concerns about security, which may explain her tense

appearance. Daphne manages her anxieties by avoiding or controlling activities. Although some of her concerns are consistent with other anxiety disorders, such as social anxiety disorder or separation anxiety disorder, Daphne's worries extend beyond those domains. Given the pervasiveness of her anxiety, the most appropriate diagnosis is generalized anxiety disorder (GAD).

GAD is characterized by persistent, excessive anxiety and worry. Symptom criteria include restlessness, poor concentration, irritability, muscle tension, sleep disturbance, and being easily fatigued. Although three of six criteria are required for adults, a GAD diagnosis can be made in children with only one symptom in addition to the excessive anxiety and worry.

Social difficulties are common among children and adolescents, particularly those with psychiatric disorders. Daphne's issues are related to her anxiety about being competent and likable. Her academic struggles and anxiety have impeded her development, making her emotionally and socially immature.

Her immaturity might suggest an autism spectrum disorder. She does have difficulty initiating social interactions and engaging in reciprocity with peers (with poor eye contact notable on examination), but Daphne does not have the communication difficulties, rigidity, or stereotyped behaviors associated with autism. Her behavior improves with familiarity, and she expresses interest in her peers.

Daphne's language, speech, and communication skills seem developmentally appropriate, making disorders in these areas unlikely.

Oppositional defiant disorder might also be considered because Daphne is resistant and uncooperative in school and at home when it comes to her academic work. However, this attitude and behavior do not carry over to other situations, and her behaviors do not meet oppositional defiant disorder's requirements for symptom level and frequency. They are better conceptualized as a manifestation of anxiety and an attempt at its management.

Inattention is a symptom that occurs in a variety of diagnoses. Individuals with ADHD have problems with attention, impulsivity, and/or hyperactivity that occur in multiple

settings prior to age 12 and cause significant impairment. Although Daphne has several symptoms consistent with inattention, these seem confined to school settings. She also does not appear to have significant problems with behaviors related to impulsivity or activity regulation. ADHD should remain a diagnostic possibility, but other diagnoses better account for Daphne's difficulties.

The environmental contributions to Daphne's problems should not be minimized. Her central psychiatric diagnoses—a specific learning disorder in mathematics and GAD—do not appear to have been adequately addressed either at home or at school. With more adequate services, Daphne would likely feel less anxiety and emotional distress and be far more likely to succeed in her course work and to stay on track developmentally.

Although the case report indicates that Daphne's diagnosis and treatment were delayed, we do not know much about her demographic background. In general, we know that learning disorders in children often go unidentified, especially for children whose families are poor, members of historically marginalized groups, immigrants, or living in adverse circumstances. Daphne's parents tried to advocate for a more thorough diagnosis (and treatment), with little apparent success. Their efforts to shield Daphne from stress were well meaning but might have prevented her from gaining successful experiences and contributed to her sense of incompetence.

It would be useful to better understand Daphne's perspective on her anxiety, her academic performance, and anything else that she finds interesting or problematic. She has experienced negative, critical comments that might have escalated to bullying and harassment. An evaluation that looks specifically for these common experiences is likely not only to find additional problems but also to be felt as empathic by patients who might otherwise quietly hold on to private shames.

Diagnoses

- Specific learning disorder (mathematics)
- Generalized anxiety disorder

Suggested Readings

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Case 1.5 Fidgety and Distracted

Robert Haskell, M.D.

John T. Walkup, M.D.

Ethan, a 9-year-old boy, was referred to a psychiatric clinic by his teacher, who noticed that his attention was flagging. At that time, Ethan was a fourth grader at a private regular-education school for boys. The teacher told Ethan's parents that although Ethan had been among the best students in his class in the fall, his grades had slipped during the spring semester. He tended to get fidgety and distracted when the academic work became more challenging, and the teacher suggested the parents seek neuropsychiatric testing for him.

At home, Ethan's mother explained, he seemed more emotional of late: "He just looks weepy sometimes, which is unusual for him." She denied any difficulties at home, and she described her husband, son, 8-year-old daughter, and herself as a "happy family." She had noticed, however, that Ethan seemed uneasy about being left alone. He had

become “clingy,” often following his parents around the house, and he hated being in any room by himself. Ethan had also started climbing into bed with his parents in the middle of the night, something he had never done in the past. Although Ethan had a few good friends in the neighborhood and at school and was glad to have other kids come to his house, he refused to go on sleepovers.

Ethan’s mother agreed that he appeared more fidgety. She had noticed that he often seemed to be shrugging his shoulders, grimacing, and blinking, which she took to be a sign of anxiety. These movements worsened when he was tired or frustrated, and they diminished in frequency during calm, focused activities such as clarinet practice or homework, especially when she was helping him.

His mother also mentioned that Ethan had suddenly become “superstitious.” Whenever he stepped through a doorway, he would go back and forth until he touched both doorjambs with his hands simultaneously, twice in rapid succession. She hoped that Ethan’s more conspicuous habits would subside by summer, when the family took its annual vacation. She felt that it was the right year for Disneyland, but Ethan’s father had suggested taking him on a fishing trip (“just the boys”) while mother and daughter visited relatives in New York City.

Ethan’s mother recalled her son as an “easy child, but sensitive.” He was the product of a planned, uncomplicated pregnancy and met all his developmental milestones on time. He had no history of medical problems or recent infections, but his mother mentioned that he had begun to make frequent visits to the school nurse’s office complaining of stomachaches.

On examination, Ethan was a slightly built boy with fair, freckly skin and blond hair. He was somewhat fidgety, tugging at his pants and shifting in his seat. Hearing his mother talk about his new movements seemed to provoke them, and the examiner noted that Ethan also occasionally blinked tightly, rolled his eyes, and made throat-clearing noises. Ethan said that he sometimes worried about “bad things” happening to his parents. His concerns were vague, however, and he seemed to fear only that burglars might break into their house.

Discussion

Ethan presents with declining school performance, which his family seems to attribute to a cluster of anxiety symptoms that are of relatively recent onset. He is uneasy with solitude and reluctant to attend sleepovers, has fears that bad things will happen to his parents, and makes frequent trips to the school nurse. He appears to meet criteria for DSM-5 separation anxiety disorder, the symptoms of which need only persist for 1 month in children and adolescents.

Ethan's mother also points out that he has become more fidgety. She links his shoulder shrugging, grimacing, and blinking to this recent onset of separation anxiety. Neither the parents nor the teacher appears to recognize these movements as tics, which are nonrhythmic movements of short duration and sudden onset. Ethan appears to have a variety of tics, including those observed by the interviewer: some motor (blinks, shoulder rolls) and some vocal (chirps, grunts, throat clearing, sniffs, clicks). Tics can be simple, meaning that they last only milliseconds, or complex, which are of longer duration or consist of a chain or sequence of movements. Although tics may vary broadly throughout the course of a tic disorder, they tend to recur in a specific repertoire during any given period of the illness.

The specific tic disorder (if any) is determined by the type and duration of movements. In Tourette's disorder, both motor and vocal tics must be present, whereas in persistent (chronic) motor or vocal tic disorder, only motor or vocal tics are present. Ethan has a mixture of tics, but at this point they have been present for only about 6 months—not the minimum of 1 year required for either Tourette's disorder or persistent tic disorder. Therefore, Ethan is diagnosed with provisional tic disorder.

Tics occur in 15%–20% of children, and it appears that 0.6%–1.0% develop Tourette's disorder. On average, tics emerge between ages 4 and 6, reach peak severity by age 10–12, and generally decline in severity during adolescence. Tics first observed in adulthood were very likely present but unnoticed in childhood. Tics are typically worsened by anxiety, excitement, and exhaustion and abate during calm, focused activity—which is why that fishing trip with dad may be Ethan's best bet for a summer vacation.

Anxiety likely explains Ethan's inattention in the classroom. Although attention-deficit/hyperactivity disorder, inattentive subtype, cannot be ruled out, it seems more probable

that tics and anxiety have taken Ethan off task, as he has no early history of inattention or hyperactivity. His success in the fall semester all but rules out a learning disorder, so no testing is indicated. (As a rule, testing should always follow the treatment of a confounding problem such as anxiety.)

Ethan does manifest rituals in the doorway, which suggests OCD, which is an illness that often co-occurs with both anxiety and tic disorders. Although that possibility might be further explored, a diagnosis of OCD—like that of other psychiatric disorders—requires not only symptoms but also a clinical evaluation that finds the symptoms are distressing or impairing. Without additional information as to whether the rituals have an impact on him, Ethan would not meet criteria for OCD.

Diagnoses

- Provisional tic disorder
- Separation anxiety disorder

Suggested Readings

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