DSM-5 DIFFERENTIAL DIAGNOSIS TABLES AND KEY TERM DEFINITIONS

KEY FEATURES THAT DEFINE THE PSYCHOTIC DISORDERS	
Delusions	Fixed beliefs that are not amenable to change in light of conflicting evidence.
Persecutory	Belief that one is going to be harmed, harassed, and so forth by an individual, organization, or other group.
Referential	Belief that certain gestures, comments, environmental cues, and so forth are directed at oneself.
Grandiose	When an individual believes that he or she has exceptional abilities, wealth, or fame.
Erotomanic	When an individual believes falsely that another person is in love with him or her.
Nihilistic	Involves the conviction that a major catastrophe will occur.
Somatic	Focus on preoccupations regarding health and organ function.
Jealous	Central theme is that of an unfaithful partner.
Bizarre	Clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences.
Thought withdrawal	Belief that one's thoughts have been removed by some outside force.
Thought insertion	Foreign thoughts have been put into one's mind by some outside force.
Delusions of control	Body or actions are being acted on or manipulated by some outside force.
Hallucinations	Perception-like experiences that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control. They may occur in any sensory modality.
Auditory	Involving the perception of sound, most commonly of voices.
Gustatory	Involving the perception of taste (usually unpleasant).
Olfactory	Involving the perception of odor, such as of burning rubber or decaying fish.
Somatic	Involving the perception of physical experience localized within the body (e.g., a feeling of electricity).
Tactile	Involving the perception of being touched or of something being under one's skin (e.g., something creeping or crawling on or under the skin).
Visual	Involving sight, which may consist of formed images, such as of people, or of unformed images, such as flashes of light.
Disorganized Thinking/Speech (formal thought disorder)	A persistent underlying disturbance to conscious thought and is classified largely by its effects on speech and writing.
Derailment or loose associations	The individual may switch from one topic to another.
Tangentiality	Answers to questions may be obliquely related or completely unrelated.

Incoherence or word salad	Speech may be so severely disorganized that it is nearly incomprehensible and resembles receptive aphasia in its linguistic disorganization.
Grossly Disorganized or Abnormal Motor Behavior	May manifest itself in a variety of ways, ranging from childlike "silliness" to unpredictable agitation. Problems may be noted in any form of goal-directed behavior, leading to difficulties in performing activities of daily living.
Catatonia	Is a marked decrease in reactivity to the environment; resistance to instructions; maintaining a rigid, inappropriate or bizarre posture; complete lack of verbal and motor responses (mutism and stupor). It can also include purposeless and excessive motor activity without obvious cause (catatonic excitement). Other features are repeated stereotyped movements, staring, grimacing, mutism, and the echoing of speech.
Negative Symptoms	Reflect a diminution or loss of normal functions. Negative symptoms account for a substantial portion of the morbidity associated with schizophrenia but are less prominent in other psychotic disorders.
Affective flattening	Reductions in the expression of emotions in the face, eye contact, intonation of speech (prosody), and movements of the hand, head, and face that normally give an emotional emphasis to speech.
Avolition	Decreased self-initiated purposeful activities. When severe enough to be considered pathological, avolition is pervasive and prevents the person from completing many different types of activities (e.g., work, intellectual pursuits, or self-care).
Alogia	Diminished speech output. There may be brief and concrete replies to questions and restriction in the amount of spontaneous speech (poverty of speech). Sometimes the speech is adequate in amount but conveys little information because it is overconcrete, overabstract, repetitive, or stereotyped (poverty of content).
Asociality	Lack of interest in social interactions or a preference for solitary activities.
Anhedonia	Loss of interest or pleasure from activities usually found enjoyable (e.g. exercise, hobbies, music, sexual activities, or social interactions).

SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS DIFFERENTIAL DIAGNOSIS	
If the client…	*Then the diagnosis may be…*
Reports a pattern of social AND interpersonal deficits marked by acute discomfort with, AND reduced capacity for, close relationships as well as by cognitive or perceptual distortions AND eccentricities of behavior.	Schizotypal (Personality) Disorder
Reports the presence of 1 delusion with a duration of 1 month; AND HAS NEVER MANIFEST prominent hallucinations, disorganized speech, or negative symptoms; AND functioning is NOT markedly impaired; AND behavior is NOT grossly bizarre, odd, disorganized, or catatonic behavior.	Delusional Disorder
Reports the presence of delusions, hallucinations, or disorganized speech; WITH a duration of 1 day to 1 month; WITH eventual full return to premorbid level of functioning.	Brief Psychotic Disorder, without/ with marked stressors (brief reactive psychosis)
Reports the presence of delusions, hallucinations, or disorganized speech; WITH a duration of 1 day to 1 month; WITH grossly bizarre, odd, disorganized, or catatonic behavior; WITH eventual full return to premorbid level of functioning.	Brief Psychotic Disorder, with catatonia
Reports the presence of delusions, hallucinations, or disorganized speech; WITH onset during pregnancy or within 4 weeks postpartum; WITH a duration of 1 day to 1 month; WITH eventual full return to premorbid level of functioning.	Brief Psychotic Disorder, with peripartum onset
Reports the presence of delusions, and/or hallucinations, and/or disorganized speech for a SIGNIFICANT PORTION of time during 1 month BUT LESS than 6 months; AND equivocal or no major depressive or manic episodes have occurred concurrently with the active-phase symptoms; BUT DOES NOT report marked functional impairment.	Schizophreniform Disorder, with good prognostic features
Reports the presence of delusions, and/or hallucinations, and/or disorganized speech, AND negative grossly bizarre, odd, disorganized, or catatonic behavior; AND mild-moderate negative symptoms for a SIGNIFICANT PORTION of time during 1 month BUT LESS than 6 months; AND equivocal or no major depressive or manic episodes have occurred concurrently with the active-phase symptoms; • and/or manifests onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning; and/or confusion or perplexity; • and/or good premorbid social and occupational functioning; • and/or absence of blunted/flat affect.	Schizophreniform Disorder, without good prognostic features
Reports cognitive, emotional, and behavioral dysfunctions IN THE PRESENCE of delusions, and/or hallucinations, and/or disorganized speech; AND negative grossly bizarre, odd, disorganized, or catatonic behavior; AND moderate-severe negative symptoms for at least	Schizophrenia

6 months; AND equivocal or no major depressive or manic episodes have occurred concurrently with the active-phase symptoms; AND marked functional impairment.	
Reports an uninterrupted period of illness AND the presence of delusions, and/or hallucinations, and/or disorganized speech, and/or negative grossly bizarre, odd, disorganized, or catatonic behavior; and/or negative symptoms; AND delusions or hallucinations for 2 or more weeks IN THE ABSENCE of a major depressive episode BUT WITH a manic episode present for the majority of the total duration of the active and residual portions of the illness.	Schizoaffective Disorder, Bipolar Type
Reports an uninterrupted period of illness AND the presence of delusions, and/or hallucinations, and/or disorganized speech, and/or negative grossly bizarre, odd, disorganized, or catatonic behavior; and/or negative symptoms; AND delusions or hallucinations for 2 or more weeks IN THE ABSENCE of a manic episode BUT WITH a major depressive episode present for the majority of the total duration of the active and residual portions of the illness.	Schizoaffective Disorder, Depressive Type
Reports MANIC episode (3+ symptoms; 4 if the mood is only irritable) lasting at least 7 consecutive days AND present most of the day, nearly every day; AND delusions or hallucinations are present at any time in the episode.	Bipolar I Disorder, with psychotic features
Reports major depressive episode (5+ symptoms) lasting at least 14 consecutive days AND present most of the day, nearly every day; AND delusions or hallucinations are present at any time in the episode.	Major Depressive Disorder, with psychotic features
Reports INTRUSIVE hallucinations (visual or auditory) or NON-BIZARRE delusions (persecutory or nihilistic) IN THE CONTEXT of flashbacks AND/OR dissociative symptoms (depersonalization/ derealization) WITH a trauma-stressor theme IN THE PRESENCE OF intact reality testing.	Posttraumatic Stress Disorder, Acute Stress Disorder, Dissociative Identity Disorder, or Depersonalization/Derealization Disorder
Reports ONSET IN LATER LIFE of non-bizarre delusions (usually persecutory) or simple hallucinations (usually visual) WITHOUT disorganized speech and disorganized behavior IN THE CONTEXT of an acquired etiological syndrome (e.g., Alzheimer's disease or Parkinson's disease) RESULTING in a primary clinical deficit in cognitive function (e.g., complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) CAUSING decline from a previously attained level of functioning.	Major or Mild Neurocognitive Disorder, with behavioral disturbance
Reports TRANSIENT paranoid ideation MOST FREQUENTLY IN RESPONSE to real or imagined abandonment with the real or perceived return of the attachment figure RESULTING in symptom remission.	Borderline Personality Disorder

BIPOLAR AND RELATED DISORDERS DIFFERENTIAL DIAGNOSIS	
If the client…	*Then the diagnosis may be…*
Reports delusions or hallucinations for 2 or more weeks IN THE ABSENCE of a major mood episode (depressive or manic) during the lifetime duration of the illness.	Schizoaffective Disorder, Bipolar Type
Reports MANIC episode (3+ symptoms; 4 if the mood is only irritable) lasting at least 7 consecutive days AND present most of the day, nearly every day.	Bipolar I Disorder
Reports the mood disturbance IS sufficiently severe to cause marked IMPAIRMENT in social or occupational functioning, or to necessitate HOSPITALIZATION to prevent harm to self or others, or there are PSYCHOTIC features.	Bipolar I Disorder
Reports HYPOMANIC episode (3+ symptoms; 4 if the mood is only irritable), lasting at least 4 consecutive days and present most of the day, nearly every day.	Bipolar II Disorder
Reports the mood disturbance is NOT severe enough to cause marked IMPAIRMENT in social or occupational functioning, or to necessitate HOSPITALIZATION, or there is an absence of PSYCHOTIC features.	Bipolar II Disorder
Reports a mood episode that is associated with an UNEQUIVOCAL change in functioning that is UNCHARACTERISTIC of the individual when not symptomatic.	Bipolar II Disorder
Reports for at least 2 years (at least 1 years for children and adolescents) criteria for a major depressive episode (5+ symptoms), a manic episode (3+ symptoms), or hypomanic episode (3+ symptoms) have NEVER BEEN MET.	Cyclothymic Disorder

DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD) DIFFERENTIAL DIAGNOSIS	
If the client…	*Then the diagnosis may be…*
Reports non-severe/non-chronic irritability or mood elevation that is EPISODIC AND DISTINCTLY DIFFERENT from the 'normal' mood.	Bipolar Disorder I or II
Reports temper outbursts WITHOUT the presence of an irritable mood most of the day, every day.	Oppositional Defiant Disorder
Reports irritability EXCLUSIVELY during a major depressive episode or during persistent depressive disorder.	Major Depressive Disorder or Persistent Depressive Disorder
Reports irritability EXCLUSIVELY during the presence of an anxiety disorder.	Specific Anxiety Disorder (e.g., Generalized Anxiety Disorder)
Reports symptoms of Autism Spectrum Disorder and irritability or temper outbursts DUE TO their routine being disturbed or changed.	Autism Spectrum Disorder
Reports three behavioral outbursts, over 12 months, involving damage or destruction but DOES NOT report consistent irritable mood between behavioral outbursts.	Intermittent Explosive Disorder

MAJOR DEPRESSIVE DISORDER (MDD) DIFFERENTIAL DIAGNOSIS	
If the client…	*Then the diagnosis may be…*
Reports abnormally and persistently elevated/expansive mood AND abnormally and persistently increased activity or energy AND significant noticeable change from usual behavior.	Bipolar I or Bipolar II
Reports depressive symptoms which ONLY OCCUR as a direct consequence of a medical condition.	Depressive Disorder Due to Another Medical Condition
Reports depressive symptoms or changes in mood which ONLY OCCUR as a direct consequence of a substance such as alcohol or prescription or recreational drugs.	Substance/Medication-Induced depressive or bipolar disorder
Reports distractibility AND low frustration tolerance AND mood disturbance attributed PRIMARILY to irritability rather than sadness or loss of interest.	Attention-Deficit/Hyperactivity Disorder, Inattentive Presentation
Reports depressed mood SPECIFICALLY ATTRIBUTED to a psychosocial stressor (i.e. parents' divorce); however all criteria for MDD are not met.	Adjustment Disorder with Depressed Mood
Reports sadness or low mood; however all criteria for MDD or any other mental disorder is not met.	Sadness
Reports symptoms of MDD and symptoms of a co-existing personality disorder.	Both diagnosis are given

PERSISTENT DEPRESSIVE DISORDER (PDD) DIFFERENTIAL DIAGNOSIS	
If the client…	*Then the diagnosis may be…*
Has been diagnosed with PDD but reports symptoms that meet the full criteria for major depressive disorder but there have been periods of AT LEAST 8 WEEKS in at least the preceding 2 years with symptoms BELOW the threshold for a full major depressive episode.	Persistent Depressive Disorder with intermittent major depressive episodes, with current episode
Was diagnosed with PDD and reports symptoms that meet the full criteria for major depressive disorder that have persisted for at least 2 years.	Persistent Depressive Disorder with persistent major depressive episode
Is diagnosed with PDD and DOES NOT CURRENTLY report symptoms that meet the full criteria for major depressive disorder BUT has experienced a major depressive episode with the past 2 years.	Persistent Depressive Disorder with intermittent major depressive episodes, without current episode
Is diagnosed with PDD and HAS NOT reported symptoms that meet the full criteria for major depressive disorder over the past 2 years.	Persistent Depressive Disorder with pure dysthymic syndrome
Reports symptoms of PDD that occur ONLY during a psychotic episode.	Psychotic Disorder
Reports symptoms of PDD that can be directly connected to a time period in which the client can report experiencing the physiological effects of a specific and/or chronic illness (through self-report or physician or laboratory reports.	Depressive or Bipolar and Related Disorder Due to Another Medical Condition
Reports symptoms of PDD that were experienced during their use of a substance (i.e. prescription or recreational drugs, alcohol).	Substance/medication-induced depressive or bipolar disorder
Reports symptoms of PDD and symptoms of a co-existing personality disorder.	Both diagnosis are given

PREMENSTRUAL DYSPHORIC DISORDER (PMDD) DIFFERENTIAL DIAGNOSIS	
If the client…	*Then the diagnosis may be…*
Does not report at least five of the symptoms of PMDD. Does not report the affective symptoms of PMDD. Does report the physical and/or behavioral symptoms of PMDD.	Premenstrual Syndrome
Reports painful periods WITHOUT emotional changes Reports pain that only begins on the first day of their period.	Dysmenorrhea
Reports premenstrual symptoms AND are currently on hormonal treatments symptoms subside when hormonal treatment is discontinued.	Due to Hormonal Treatments

ANXIETY DISORDERS DIFFERENTIAL DIAGNOSIS	
If the client…	*Then the diagnosis may be…*
Reports excessive fear or anxiety (e.g., getting lost, being kidnapped, having an accident, acquiring an illness, being injured, or dying) concerning separation from HOME OR ATTACHMENT FIGURES is anticipated or occurs.	Separation Anxiety Disorder
Reports high social anxiety AND CONSISTENTLY DOES NOT SPEAK IN SPECIFIC SOCIAL SITUATIONS in which there is an expectation for speaking (e.g., at school) DESPITE SPEAKING IN OTHER SITUATIONS (e.g., in their home in the presence of immediate family members).	Selective Mutism
Reports marked fear or anxiety, nearly every time (NOT OCCASIONALLY), about a specific object (e.g., spiders, insects, dogs, heights, storms, water, needles, invasive medical procedures, airplanes, elevators, enclosed places, or costumed characters) or situation (e.g., choking, vomiting, or loud sounds).	Specific Phobia
Reports almost always having marked fear or anxiety about one or more social situations in which the individual is exposed to possible SCRUTINY BY OTHERS (e.g., having a conversation, meeting unfamiliar people, eating or drinking, or giving a speech.	Social Anxiety Disorder
Reports recurrent unexpected panic attacks (an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes) resulting in PHYSICAL AND COGNITIVE SYMPTOMS.	Panic Disorder
Reports persistent marked, or intense, fear or anxiety triggered by the real or anticipated exposure to a wide range of situations AND believes that ESCAPE from such situations might be difficult, or that HELP might be unavailable when panic-like symptoms, or other INCAPACITATING or embarrassing symptoms occur.	Agoraphobia
Reports excessive anxiety and worry (apprehensive expectation) about a NUMBER OF EVENTS OR ACTIVITIES (e.g., every day, routine life circumstances such as possible job responsibilities, health and finances, the health of family members, misfortune to children, doing household chores or being late for appointments).	Generalized Anxiety Disorder

OBSESSIVE-COMPULSIVE AND RELATED DISORDERS DIFFERENTIAL DIAGNOSIS	
If the client…	*Then the diagnosis may be…*
Reports intrusive, unwanted, recurrent, and persistent THOUGHTS, URGES, OR IMAGES typically related to CLEANING, SYMMETRY, FORBIDDEN OR TABOO THOUGHTS, AND HARM; AND engages in REPETITIVE BEHAVIORS OR MENTAL ACTS intended to reduce the distress triggered by obsessions or to prevent a feared event.	Obsessive-Compulsive Disorder
Reports difficulty controlling excessive anxiety and worry ABOUT A NUMBER OF EVENTS OR ACTIVITIES and finds it difficult to control the worry and to keep WORRISOME THOUGHTS from interfering with attention to tasks at hand.	Generalized Anxiety Disorder
Reports preoccupation WITH DEFECTS OR FLAWS IN PHYSICAL APPEARANCE and performs repetitive behaviors or mental acts in response to the appearance concerns.	Body Dysmorphic Disorder
Reports persistent difficulty and distress DISCARDING OR PARTING WITH POSSESSIONS because of a perceived need to save the items.	Hoarding Disorder
Reports recurrent HAIR PULLING resulting in loss and repeated attempts to decrease or stop hair pulling.	Trichotillomania (Hair-Pulling Disorder)
Reports recurrent SKIN PICKING resulting in skin lesions and repeated attempts to decrease or stop skin picking.	Excoriation (Skin-Picking) Disorder
Reports stereotypies—repetitive, seemingly driven, and apparently PURPOSELESS MOTOR BEHAVIOR (e.g., hand shaking or waving, body rocking, head banging, self-biting, hitting own body).	Stereotypic Movement Disorder
Reports preoccupation with THOUGHTS OF FOOD, BODY SHAPE, OR WEIGHT resulting in persistent and ritualized behavior that interferes with weight gain.	Anorexia Nervosa
Reports preoccupation with having or acquiring a SERIOUS ILLNESS, has a high level of ANXIETY ABOUT PERSONAL HEALTH STATUS, and performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness).	Illness Anxiety Disorder
Reports urges to use substances or preoccupation with gambling and recurrent substance use or repetitive gambling behaviors.	Substance-Related and Addictive Disorders
Reports recurrent and intense SEXUAL URGES, OR SEXUAL FANTASIES, OR SEXUAL BEHAVIORS that either violate the autonomy of another individual, psychologically or physically harm another individual, violate major social norms, or cause significant personal distress (e.g., anxiety, obsessions, and guilt or shame about the sexual impulses).	Paraphilic Disorders
Reports tension, affective arousal, and recurrent failure to resist AGGRESSIVE impulses that VIOLATE THE RIGHTS OF OTHERS or that bring the individual into significant CONFLICT	Pyromania or Kleptomania

WITH SOCIETAL NORMS or authority figures—and results in PLEASURE, GRATIFICATION, OR RELIEF.	
Reports guilty preoccupations or ruminations OVER MINOR PAST FAILINGS—that can be delusional or near-delusional; but are usually mood-congruent and NOT necessarily experienced as INTRUSIVE and are NOT associated with COMPULSIONS.	Major Depressive Disorder
Reports THOUGHT INSERTION AND DOES NOT manifest prominent obsessions, compulsions, preoccupations with appearance or body odor, hoarding, or body-focused repetitive behaviors.	Schizophrenia Spectrum and Other Psychotic Disorders
Reports restricted patterns of behavior, interests, or activities characterized by STEREOTYPED or repetitive motor movements, insistence on sameness, inflexible adherence to routines, or ritualized patterns of behavior (e.g., rigid thinking patterns, greeting rituals, need to take same route or eat same food every day) AND PERSISTENT DEFICITS IN SOCIAL COMMUNICATION AND SOCIAL INTERACTION across multiple contexts.	Autism Spectrum Disorder

REACTIVE ATTACHMENT DISORDER AND DISINHIBITED SOCIAL ENGAGEMENT DISORDER DIFFERENTIAL DIAGNOSIS		
	RAD	**DSED**
PROFILE	*Inhibited* - a pattern of markedly disturbed and developmentally inappropriate behavior, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection, and nurturance.	*Disinhibited* - a pattern of markedly disturbed and developmentally inappropriate behavior, in which the child displays overly familiar attachment that actively violates the social and cultural boundaries with relative strangers.
EXPRESSION	*Internalizing* disorder with depressive symptoms and withdrawn/avoidant behavior.	*Externalizing* disorder with impulsive symptoms and approaching/attention-seeking behavior.
ETIOLOGY	Persistent social neglect—a pattern of extremes of insufficient care or deprivation by caregiving adults.	Persistent social neglect—a pattern of extremes of insufficient care or deprivation by caregiving adults.
ONSET	> age 9 months and < age 5 years	> age 9 months
DEVELOPMENTAL DELAYS	Cognition and language.	Cognition and language.
ASSOCIATED FEATURES	• Stereotypies and other signs of severe neglect (e.g., malnutrition or signs of poor care).	• Stereotypies and other signs of severe neglect (e.g., malnutrition or signs of poor care).
EMOTIONAL ABERRANCE	• Diminished or absent expression of positive emotions. • Emotion regulation capacity is compromised; display episodes of negative emotions of fear, sadness, or irritability that are not readily explained.	• None.
DISTURBED BEHAVIOR	Threshold: 2 of 2 • Rarely or minimally *seeks* comfort when distressed. • Rarely or minimally *responds* to comfort when distressed.	Threshold: 2 of 4 • Reduced or absent reticence in approaching and interacting with unfamiliar adults. • Overly familiar verbal or physical behavior. • Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings. • Willingness to go off with an unfamiliar adult with minimal or no hesitation.
SOCIAL AND EMOTIONAL DISTURBANCE	Threshold: 2 of 3 • Minimal social and emotional responsiveness to others. • Limited positive affect.	None.

	• Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.	
CHRONICITY	Evident in young children; may persist for several years – yet rarely evident in older children.	Early childhood through adolescence; has not been described in adults.
DIAGNOSTIC CRITERIA	7 (with 5 of 8 symptoms minimum).	5 (with 3 of 7 symptoms minimum).
MUTUAL EXCLUSIVITY	Autism spectrum disorder.	None. Cautiously co-diagnose attention-deficit/hyperactivity disorder.

TRAUMA- AND STRESSOR-RELATED DISORDERS DIFFERENTIAL DIAGNOSIS				
	PTSD: < AGE 7	**PTSD: > AGE 6**	**ACUTE STRESS DISORDER**	**ADJUSTMENT DISORDERS**
PROFILE	Development of characteristic symptoms (e.g., fear-based re-experiencing, emotional, behavioral, anhedonic or dysphoric mood states, negative cognitions, arousal and reactive-externalizing, or dissociative) following exposure to one or more traumatic events.	Development of characteristic symptoms (e.g., fear-based re-experiencing, emotional, behavioral, anhedonic or dysphoric mood states, negative cognitions, arousal and reactive-externalizing, or dissociative) following exposure to one or more traumatic events.	Development of characteristic symptoms (e.g., reactive anxiety, dissociative or detached presentation, strong emotional or physiological reactivity, strong anger response/irritable or aggressive response).	Presence of marked emotional (e.g., depressed mood and/or anxiety) or behavioral symptoms (e.g., suicide attempts or disturbance of conduct) exceeding what would normally be expected in response to an identifiable stressor.
ONSET	Exposure to actual or threatened death, serious injury, or sexual violence.	Exposure to actual or threatened death, serious injury, or sexual violence.	Exposure to actual or threatened death, serious injury, or sexual *violation*.	Identifiable stressor.
SOURCES	• *Direct* recipient. • *Witnessing* to others, especially primary caregivers (excludes electronic media, television, movies, or pictures). • *Learning* of events to a parent or caregiving figure.	• *Direct* recipient. • *Witnessing* to others. • *Learning* of events, violent or accidental, to a family member or friend. • *Exposure*, repeated or extreme, to aversive details (excludes non work-related electronic media, television, movies, or pictures).	• *Direct* recipient. • *Witnessing* to others. • *Learning* of events, violent or accidental, to a family member or friend. • *Exposure*, repeated or extreme, to aversive details (excludes non work-related electronic media, television, movies, or pictures).	Identifiable stressor (e.g., single, multiple, recurrent, continuous, acute, or developmental).
INTRUSION SYMPTOMS	<u>Threshold: 1 of 4</u> • Psychological distress. • Distressing memories. • Distressing dreams. • Dissociative reactions. • Physiological reactions.	<u>Threshold: 1 of 4</u> • Psychological distress • Distressing memories (*repetitive play with traumatic themes*).	<u>Threshold: 0 of 4</u> • Psychological distress or physiological reactions • Distressing memories (*repetitive play with traumatic themes*).	None.

		• Distressing dreams *(may be frightening without recognizable content*). • Dissociative reactions (trauma-specific reenactment in play). • Physiological reactions (*…to internal or external cues that symbolize or resemble an aspect*…)	• Distressing dreams *(may be frightening without recognizable content*). • Dissociative reactions (trauma-specific reenactment in play). • Physiological reactions (*…to internal or external cues that symbolize or resemble an aspect*…)	
PERSISTENT AVOIDANCE	Threshold: 0 or 1 of 2 Activities, places, or physical reminders that arouse recollections of the traumatic event(s).	Threshold: 1 of 2 Memories, thoughts, or feelings about or closely associated with the traumatic event(s).	Threshold: 0 of 2 Memories, thoughts, or feelings about or closely associated with the traumatic event(s).	None.
ALTERATIONS IN COGNITIONS AND MOOD	Threshold: 0 or 1 of 4 • Significantly increased frequency of negative emotional states. • Socially withdrawn behavior. • Markedly diminished interest or participation in significant activities, *including constriction of play*. • Persistent reduction in expression of positive emotions.	Threshold: 2 of 7 • Persistent negative emotional state. • Feelings of detachment or estrangement from others. • Markedly diminished interest or participation in significant activities. • Persistent inability to experience positive emotions. • Inability to remember an important aspect of the traumatic event(s) • Persistent and exaggerated negative beliefs or expectations	Threshold: 0 of 1 • Persistent inability to experience positive emotions.	None.

		about oneself, others, or the world. • Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.		
ALTERATIONS IN AROUSAL AND REACTIVITY	Threshold: 2 of 5 • Hypervigilance. • Exaggerated startle response. • Problems with concentration. • Sleep disturbance. • Irritable behavior and angry outbursts (*including extreme temper tantrums*).	Threshold: 1 of 6 • Hypervigilance. • Exaggerated startle response. • Problems with concentration. • Sleep disturbance. • Irritable behavior and angry outbursts. • *Reckless or self-destructive behavior.*	Threshold: 0 of 5 • Hypervigilance. • Exaggerated startle response. • Problems with concentration. • Sleep disturbance. • Irritable behavior and angry outbursts.	None.
DISSOCIATIVE SYMPTOMS	None. Specify PTSD as depersonalization/ derealization.	None. Specify PTSD as depersonalization/ derealization.	Threshold: 0 of 2 • Altered sense of the reality of one's surroundings or oneself (depersonalization/ derealization). • Inability to remember an important aspect of the trauma (amnesia).	None.
DURATION	> 1 month after trauma exposure.	> 1 month after trauma exposure.	> 3 days and < 1 month after trauma exposure.	< 3 months of the stressor onset and < 6 months after the stressor cessation.

DISTRESS OR IMPAIRMENT	Relationships with parents, siblings, peers, or other caregivers or with school behavior.	Social, occupational, or other important areas of functioning.	Social, occupational, or other important areas of functioning.	Social, occupational, or other important areas of functioning.
DIAGNOSTIC CRITERIA	7 (with 3 symptom clusters requiring 4 of 18 symptoms minimum).	8 (with 4 symptom clusters requiring 6 of 20 symptoms minimum).	5 (with 5 symptom clusters requiring 9 of 14 symptoms minimum).	5 (with 1 of 2 symptoms minimum).
MUTUAL EXCLUSIVITY	Acute stress disorder, physiological effects of a substance, and another medical condition.	Acute stress disorder, physiological effects of a substance, and another medical condition.	Posttraumatic stress disorder, brief psychotic disorder, physiological effects of a substance, and another medical condition.	Normative stress reactions, another mental disorder, exacerbation of a preexisting mental disorder, and normal bereavement.

DISSOCIATIVE IDENTITY DISORDER DIFFERENTIAL DIAGNOSIS	
If the client…	*Then the diagnosis may be…*
Reports the presence of chronic or recurrent mixed dissociative symptoms that DO NOT meet Criterion A for dissociative identity disorder or ARE NOT accompanied by recurrent amnesia.	Other Specified Dissociative Disorder
Reports the depressed mood and cognitions FLUCTUATE because they are experienced in some identity states but not others.	Other Specified Depressive Disorder
DOES NOT report relatively RAPID SHIFTS in mood—typically within minutes or hours.	Bipolar Disorders
Reports amnesia for some aspects of trauma, dissociative flashbacks (i.e., reliving of the trauma, with reduced awareness of one's current orientation), and symptoms of intrusion and avoidance, negative alterations in cognition and mood, and hyper arousal that are focused around the traumatic event.	Posttraumatic Stress Disorder
DOES report chaotic identity change and acute intrusions that disrupt thought processes, BUT DOES NOT report predominance of dissociative symptoms and amnesia for the episode.	Psychotic Disorders
DOES NOT report longitudinal variability in personality style (due to inconsistency among identities), BUT DOES report pervasive and persistent dysfunction in affect management and interpersonal relationships.	Personality Disorders
Reports the ABSENCE OF AN IDENTITY DISRUPTION characterized by two or more distinct personality states or an experience of possession.	Conversion Disorder (Functional Neurological Symptom Disorder)
DOES NOT obtain very high dissociation scores.	Seizure Disorders
DOES NOT report the subtle symptoms of intrusion and depression, BUT DOES over report dissociative amnesia, is relatively undisturbed by or may even seem to enjoy "having" identity disruption characterized by two or more distinct personality states or an experience of possession, or has stereotyped alternate identities, with feigned amnesia, related to the events for which gain is sought.	Factitious Disorder and Malingering

DISSOCIATIVE AMNESIA TERMINOLOGY	
Generalized amnesia	Complete loss of memory for one's life history (personal identity)—more common among combat veterans, sexual assault victims, individuals experiencing extreme emotional stress or conflict.
Localized amnesia	Failure to recall events during a circumscribed period of time—most common form of dissociative amnesia.
Selective amnesia	Recall some, but not all, of the events during a circumscribed period of time.
Systematized amnesia	Loses memory for a specific category of information.
Continuous amnesia	Forgets each new event as it occurs.

DISSOCIATIVE AMNESIA DIFFERENTIAL DIAGNOSIS	
If the client…	*Then the diagnosis may be…*
Reports pervasive discontinuities in sense of self and agency, ACCOMPANIED BY amnesia for everyday events, finding of unexplained possessions, sudden fluctuations in skills and knowledge, major gaps in recall of life history, and brief amnesic gaps in interpersonal interactions.	Dissociative Identity Disorder
DOES NOT report amnesia extending beyond the immediate time of the trauma.	Posttraumatic Stress Disorder
Reports memory loss for personal information that is usually embedded in cognitive, linguistic, affective, attentional, and behavioral disturbances; AND INTELLECTUAL AND COGNITIVE DECLINE.	Neurocognitive Disorders
Reports episodes of "black outs" or periods of no memory that OCCUR ONLY in the context of intoxication and do not occur in other situations.	Substance-Related Disorders
Reports difficulties in the domains of complex attention, executive function, learning and memory, AS WELL as slowed speed of information processing, AND disturbances in social cognition.	Posttraumatic Amnesia Due To Brain Injury
DOES NOT display behavior that is PURPOSEFUL, COMPLEX, AND GOAL-DIRECTED lasting for days, weeks, or longer.	Seizure Disorders
Reports acute, florid dissociative amnesia; FINANCIAL, SEXUAL, OR LEGAL PROBLEMS; or a wish to escape stressful circumstances.	Factitious Disorder and Malingering
DOES NOT report memory decrements associated with stressful events, and that are more specific, extensive, and/or complex.	Normal and Age-Related Changes in Memory

DEPERSONALIZATION/DEREALIZATION DISORDER DIFFERENTIAL DIAGNOSIS	
If the client…	*Then the diagnosis may be…*
Reports vague somatic complaints as well as fears of permanent brain damage, but DOES NOT report a constellation of typical depersonalization/derealization symptoms.	Illness Anxiety Disorder
DOES NOT report that depersonalization/derealization clearly precedes the onset of a major depressive episode or clearly continues after its resolution.	Major Depressive Disorder
Reports the symptoms OCCUR ONLY during panic attacks that are part of panic disorder, social anxiety disorder, or specific phobia; OR symptoms are very prominent from the start, clearly exceeding in duration and intensity of the manifest anxiety.	Anxiety Disorders
DOES NOT display the presence of intact reality testing (e.g., attention, perception, memory, and judgment).	Psychotic Disorders
Reports symptoms during acute INTOXICATION OR WITHDRAWAL of marijuana, hallucinogens, ketamine, ecstasy, and salvia.	Substance/Medication-Induced Disorders
Reports symptom onset after age 40 years or the presence of ATYPICAL SYMPTOMS AND COURSE.	Mental Disorders Due to Another Medical Condition

FEEDING AND EATING DISORDERS DIFFERENTIAL DIAGNOSIS				
	AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER	**ANOREXIA NERVOSA**	**BULIMIA NERVOSA**	**BINGE-EATING DISORDER**
PROFILE	An eating or feeding disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs.	Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health.	Occurrence of excessive food consumption accompanied by a sense of lack of control and inappropriate compensatory behaviors in normal-weight and overweight individuals.	Occurrence of excessive food consumption accompanied by a sense of lack of control and inappropriate compensatory behaviors in normal-weight, overweight, and *obese* individuals.
ONSET	Commonly develops in infancy or early childhood.	Commonly begins during adolescence or young adulthood; rarely begins before puberty or after age 40.	Commonly begins during adolescence or young adulthood; rarely begins before puberty or after age 40.	Typically begins in adolescence or young adulthood but can begin in later adulthood.
EATING BEHAVIORS	Avoidance or restriction.	Persistent restriction; may include recurrent episodes of binge eating.	Recurrent episodes of binge eating characterized by a sense of lack of control over eating during the episodes.	• Recurrent episodes of binge eating characterized by a sense of lack of control over eating during the episodes. Threshold: 3 of 5 • Marked distress from binge-eating more rapidly than normal, feeling uncomfortably full, not feeling physically hungry, feeling embarrassed, or feeling disgusted with oneself, depressed, or very guilty afterward.

MOTIVATION/ ANTECEDENTS	• Apparent lack of interest in eating or food. • Sensory characteristics of food. • Concern about aversive consequences of eating.	• Intense fear of gaining weight or of becoming fat. • Stressful life events.	• Negative affect. • Interpersonal stressors. • Dietary restraint. • Negative feelings related to body weight, body shape, and food. • Boredom.	• Negative affect. • Interpersonal stressors. • Dietary restraint. • Negative feelings related to body weight, body shape, and food. • Boredom.
PSYCHOLOGICAL DISTURBANCES	• Irritable mood. • Generalized emotional difficulties that do not meet diagnostic criteria for an anxiety, depressive, or bipolar disorder, sometimes called "food avoidance emotional disorder."	• Suicide risk. • Preoccupied with thoughts of food. • Depressed mood, social withdrawal, irritability, insomnia, and diminished interest in sex. • Concerns about eating in public, feelings of ineffectiveness, a strong desire to control one's environment, inflexible thinking, limited social spontaneity, and overly restrained emotional expression.	• Suicide risk. • Ashamed of eating problems. • Negative self-evaluation and dysphoria.	• Suicide risk. • Ashamed of eating problems. • Negative self-evaluation and dysphoria.
BODY WEIGHT OR SHAPE CONCERNS	• None.	• Disturbed experiences. • Unduly influences self-evaluation.	Excessive emphasis on body shape or weight in self-evaluation, and these factors are typically extremely important in determining self-esteem.	Individuals typically *do not* show marked or sustained dietary restriction designed to influence body weight and shape between binge-eating episodes.
WEIGHT LOSS	Significant, resulting in faltering growth.	• Significant, less than minimally normal or minimally expected.	None.	None.

		• Persistent lack of recognition of the seriousness of the current low body weight. • Often viewed as an impressive achievement and a sign of extraordinary self-discipline. • Accomplished primarily through dieting, fasting, and/or excessive exercise (*Restricting type*).		
WEIGHT GAIN	None.	• Perceived as an unacceptable failure of self-control. • Persistent behavior that interferes with. • May manipulate medication dosage to avoid.	• May take thyroid hormone in an attempt to avoid. • May fast for a day or more or exercise excessively in an attempt to prevent.	None.
NUTRITIONAL DEFICIENCY	Significant; assessed by dietary intake, physical examination, or laboratory testing.	Significant; assessed by dietary intake, physical examination, or laboratory testing.	Moderate; fluid and electrolyte disturbances.	None. Consume more calories.
PHYSIOLOGICAL DISTURBANCES	Hypothermia, bradycardia, or anemia.	Hypotension, hypothermia, bradycardia, amenorrhea, vital sign abnormalities, loss of bone mineral density, constipation, abdominal pain, cold intolerance, lethargy, or excess energy.	Menstrual irregularity or amenorrhea; gastrointestinal symptoms.	• Increased medical morbidity and mortality. • Associated increased health care utilization.

SUPPLEMENTARY FEEDING	• Nasogastric tube feeding. • Nutritionally complete supplements. • Gastrostomy tube feeding.	• Hospitalization may be required to restore weight and to address medical complications.	None.	None.
COMPENSATORY BEHAVIORS	None.	Self-induced vomiting or the misuse of laxatives, diuretics, or enemas (*Purging type*).	Recurrent self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.	None.
ASSOCIATED FEATURES	• Difficult to console during feeding, apathetic and withdrawn, or developmental lags. • Refusal to eat particular brands of foods or to tolerate the smell of food being eaten by others.	• Frequent weighing, obsessive measuring of body parts, and persistent use of a mirror to check for perceived areas of "fat." • Distress over the somatic and psychological sequelae of starvation. • Frequently either lack insight into or deny the problem.	• Usually occurs in secrecy or as inconspicuously as possible. • Typically are within the normal weight or overweight range.	• Usually occurs in secrecy or as inconspicuously as possible. • Greater functional impairment, lower quality of life, more subjective distress, and greater psychiatric comorbidity.
FUNCTIONAL IMPAIRMENT	Inability to participate in normal social activities, such as eating with others, or to sustain relationships.	• Significant social isolation and/or failure to fulfill academic or career potential. • Serious medical implications from malnourished state.	• Range of limitations associated with the disorder. • Severe role impairment, with the social-life domain.	• Social role adjustment problems. • Impaired health-related quality of life and life satisfaction.
DURATION	None.	3 months minimum.	1 episode per week/3 months minimum.	1 episode per week/3 months minimum.

CHRONICITY	May persist in adulthood.	Some individuals recover fully after a single episode, with some exhibiting a fluctuating pattern of weight gain followed by relapse, and others experiencing a chronic course over many years.	May be chronic or intermittent, with periods of remission alternating with recurrences of binge eating.	Common in adolescent and college-age samples; relatively persistent.
DIAGNOSTIC CRITERIA	4 (with 1 of 4 symptoms minimum).	3.	5 (with 2 of 2 symptoms minimum).	5 (with 3 of 5 symptoms minimum).
MUTUAL EXCLUSIVITY	Absence of an underlying medical condition; lack of availability of food or to cultural practices; rumination disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder.	Rumination disorder, avoidant/restrictive food intake disorder, bulimia nervosa, and binge-eating disorder.	Rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, and binge-eating disorder.	Rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, and bulimia nervosa.

GENDER DYSPHORIA-RELATED TERMINOLOGY		
LIFE-SPAN TRAJECTORY	*Disorder of sex development*	Refers to a congenital condition in which development of chromosomal, gonadal, or anatomical sex is atypical.
	Gender assignment/natal gender	Refers to the initial assignment as male or female usually at birth.
	Gender identity	Refers to an individual's identification as male, female, or, occasionally, some category other than male or female.
	Gender role	Refers to the public (and usually legally recognized) lived role as boy or girl, man or woman.
	Gender dysphoria	Refers to the affective/cognitive discontent/distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender.
	Gender-atypical/Gender-nonconforming	Refers to somatic features or behaviors that are not typical (in a statistical sense) of individuals with the same assigned gender in a given society and historical era.
	Transgender	Refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender.
	Sex reassignment/confirmation surgery	Refers to somatic transition by cross-sex hormone treatment and genital surgery.
	Transsexual	Refers to an individual who seeks, or has undergone, a social transition from male to female or female to male.

GENDER DYSPHORIA DIAGNOSTIC CRITERIA	
Early-onset: Children (ages 2-10~) – Requires 6 of 8 symptoms	*Late*-onset: Adolescents (ages ~11-17) and Adults (age 18+) – Requires 2 of 6 symptoms
Strong Desire… A.1. To be of the other gender. A.8. For the sex characteristics that match one's experienced gender. Strong Preference For… A.2. Cross-dressing/clothing. A.3. Cross-gender roles in play. A.4. Cross-gender activities. A.5. Cross-gender playmates. Strong Rejection Of… A.6. Stereotypical toys, games, and activities. Strong Dislike Of… A.7. One's sexual anatomy.	Marked Incongruence… A.1. Between gender and sex characteristics. Strong Desire… A.2. To be rid of one's sex characteristics. A.3. For sex characteristics of the other gender. A.4. To be of the other gender. A.5. To be treated as the other gender. Strong Conviction… A.6. That one has the typical feelings and reactions of the other gender.

DISRUPTIVE DISORDERS AND DEPRESSIVE DISORDERS DIFFERENTIAL DIAGNOSIS				
	DISRUPTIVE MOOD DYSREGULATION DISORDER	**PERSISTENT DEPRESSIVE DISORDER**	**OPPOSITIONAL DEFIANT DISORDER**	**INTERMITTENT EXPLOSIVE DISORDER**
PROFILE	Presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function.	Presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function.	Problems in the self-control of emotions and behaviors that violate the rights of others (e.g., aggression, destruction of property) and/or that bring the individual into significant conflict with societal norms or authority figures.	Problems in the self-control of emotions and behaviors that violate the rights of others (e.g., aggression, destruction of property) and/or that bring the individual into significant conflict with societal norms or authority figures.
ONSET	Prior age 10 years. Common among children presenting to pediatric mental health clinics.	Often early and insidious (i.e., in childhood, adolescence, or early adult life).	The first symptoms usually appear during the preschool years and rarely later than early adolescence.	Late childhood or adolescence and rarely begins for the first time after age 40 years.
AGE LIMITS	Restricted prior age 6 years and after age 18 years.	None.	None.	Restricted prior age 6 years.
IRRITABLE MOOD	Very severe persistent, chronic, non-episodic irritability and anger.	Persistent irritability.	Persistent irritability/anger (e.g., loses temper, is touchy or easily annoyed, and is angry and resentful). *However, common for individuals to show behavioral features without negative mood.*	None.
TEMPER OUTBURSTS	Severe recurrent behavioral temper outbursts that are grossly out of proportion and are inconsistent with developmental level.	None.	None.	Severe damage or destruction of property and/or physical assault involving physical injury against animals or other individuals.

VERBAL OUTBURSTS	Severe recurrent verbal outbursts that are grossly out of proportion and are inconsistent with developmental level.	None.	Argumentative/defiant behavior (e.g., argues with adults, actively defies or refuses to comply with requests from authority figures or with rules, deliberately annoys others, blames others for his or her mistakes or misbehavior).	Less severe verbal aggression (e.g., temper tantrums, tirades, verbal arguments or fights). Outbursts typically last for less than 30 minutes.
PHYSICAL AGGRESSION	Consistently against property, self, or others.	None.	None.	Impulsive/anger-based toward property, animals, or other individuals.
SETTINGS	2 minimum.	1 minimum.	1 minimum.	1 minimum.
FREQUENCY	• Irritable mood most of the day, nearly every day. • Temper outbursts three + times per week.	Irritable mood most of the day, for more days than not.	• Children < 5 years most days. • Children > 5 years once per week.	• Twice weekly for verbal aggression or non-damaging/non-destructive/non-injurious physical aggression. • Three damaging/ destructive/injurious behavioral outbursts within a 12-month period.
DURATION	12 months minimum.	12 months minimum.	6 months minimum.	• 3 months for either verbal aggression or non-damaging/non-destructive/non-injurious physical aggression. • 12 months for damaging/ destructive/injurious behavioral outbursts.
CHRONICITY	Characteristic of the child, being present most of the day, nearly every day, and	Symptoms have become a part of the individual's day-	Commonly show symptoms only at home and only with family members; often are	May be episodic or chronic and persistent over many years.

	noticeable by others in the child's environment. Approximately half of children continue to meet criteria for the condition 1 year later. Symptoms are likely to change as children mature (i.e., unipolar major depression w/comorbid anxiety).	to-day experience and have a chronic course.	part of a pattern of problematic interactions with others.	
DIAGNOSTIC CRITERIA	11 (with 0 of 0 symptoms minimum).	8 (with 2 of 6 symptoms minimum).	3 (with 4 of 8 symptoms minimum).	6 (with 1 of 2 symptoms minimum).
MUTUAL EXCLUSIVITY	Autism spectrum disorder, bipolar disorder, persistent depressive disorder (dysthymia), posttraumatic stress disorder, separation anxiety disorder, oppositional defiant disorder, intermittent explosive disorder.	Schizoaffective disorder, schizophrenia, delusional disorder, other specified or unspecified schizophrenia spectrum and other psychotic disorder, bipolar-related disorders.	Psychotic disorder, bipolar disorder, disruptive mood dysregulation disorder and other depressive disorders, substance use disorders.	Psychotic disorder, bipolar disorder, major depressive disorder, disruptive mood dysregulation disorder, antisocial personality disorder, borderline personality disorder; not attributable to another medical condition (e.g., head trauma, Alzheimer's disease) or to the physiological effects of a substance (e.g., a drug of abuse, a medication).