The Classification of Child and Adolescent Mental Diagnoses in Primary Care (Diagnostic and Statistical Manual for Primary Care, Child and Adolescent Version- DSMPC)

1-800-433-9016
American Academy of Pediatrics
Box 927
Elk Grove Village, IL 60009

DEVELOPMENTAL VARIATION	COMMON DEVELOPMENTAL PRESENTATIONS
V65.49 Anxious Variation Fears and worries are experienced that are appropriate for developmental age and do not affect normal development. Transient anxious responses to stressful events occur in an otherwise healthy child and they do not affect normal development.	**Infancy** Normal fears of noises, heights, and loss of physical support are present at birth. Fear of separation from parent figures and fear of strangers are normal symptoms during the first years of life. The latter peaks at 8 to 9 months. Feeding or sleeping changes are possible in the first year. Transient developmental regressions occur after the first year. Scary dreams may occur. **Early Childhood** By age 3 years, children can separate temporarily from a parent with minimal crying or clinging behaviors. Children described as shy or slow to warm up to others may be anxious in new situations. Specific fears of thunder, medical settings, and animals are present. **Middle Childhood** In middle childhood, a child with anxious symptoms may present with motor responses (trembling voice, nail biting, thumb sucking) or physiologic responses (headache, recurrent abdominal pain, unexplained limb pain, vomiting, breathlessness). Normally these should be transient and associated with appropriate stressors. Transient fears may occur after frightening events, such as a scary movie. These should be relieved easily with reassurance. **Adolescence** Adolescents may be shy, avoid usual pursuits, fear separation from friends, and be reluctant to engage in new experiences. Risk-taking behaviors, such as experimentation with drugs or impulsive sexual behavior, may be seen.
	SPECIAL INFORMATION
	Clinicians should attempt to identify any potential stressful events that may have precipitated the anxiety symptoms (see Environmental Situations Defined, p 31). Difficulty falling asleep, frequent night awakenings, tantrums and aggressiveness, and excessive napping may reflect anxiety.

PROBLEM	COMMON DEVELOPMENTAL PRESENTATIONS
V40.2 Anxiety Problem An anxiety problem involves excessive worry or fearfulness that causes significant distress in the child. However, the behaviors are not sufficiently intense to qualify for an anxiety disorder or adjustment disorder with anxious mood.	**Infancy and Early Childhood** In infancy and early childhood, anxiety problems usually present with a more prolonged distress at separation or as sleep and feeding difficulties including anxious clinging when not separating. **Middle Childhood** In middle childhood, anxiety may be manifest as sleep problems, fears of animals, natural disasters, and medical care, worries about being the center of attention, sleep-overs, class trips, and the future (see Sadness and Related Symptoms cluster, p 153). Anxiety may involve some somatic symptoms such as tachycardia, shortness of breath, sweating, choking, nausea, dryness, and chest pain (see Pain/Somatic Complaints cluster, p 173). Environmental stress may be associated with regression (loss of developmental skills), social withdrawal, agitation/hyperactivity, or repetitive reenactment of a traumatic event through play. These symptoms should not be severe enough to warrant the diagnoses of a disorder and should resolve with the alleviation of the stressors. **Adolescence** In adolescence, anxiety may be manifest as sleep problems and fears of medical care and animals. Worries about class performance, participation in sports, and acceptance by peers may be present. Environmental stress may be associated with social withdrawal, boredom (see Sadness and Related Symptoms cluster, p 153), aggressiveness, or some risk-taking behavior (e.g., indiscriminate sexual behavior, drug use, or recklessness).
	SPECIAL INFORMATION
	Anxiety problems have a number of different clinical presentations *including* persistent worries about multiple areas in the child's life, excessive or unreasonable fear of a specific object or situation, fear of situations in which the child has to perform or be scrutinized by others, excessive worry about separation from parents, or anxiety following a significant, identifiable stressor. Separation difficulties may be prolonged if inadvertently rewarded by parents and can result in a separation anxiety disorder. Parental response to the child's distress or anxiety is a key factor in the assessment of anxiety problems. The extent of the child's anxiety may be difficult to assess and the primary care clinicians should err on the side of referral to a mental health clinician if there is uncertainty about the severity of the condition.

DISORDER	COMMON DEVELOPMENTAL PRESENTATIONS
300.02 Generalized Anxiety Disorder This disorder is characterized by at least 6 months of persistent and excessive anxiety and worry. Excessive and persistent worry occurs across a multitude of domains or situations, such as school work, sports, or social performance, and is associated with impaired functioning. The disorder is often associated with somatic and subjective/behavioral symptoms of anxiety (see Special Information). (see *DSM-IV* Criteria Appendix, p 329) **300.23 Social Phobia** This phobia involves a marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The person recognizes the fear is excessive or unreasonable. Avoidance of the situation leads to impaired functioning. (see *DSM-IV* Criteria Appendix, p 345) **300.29 Specific Phobia** Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation. Exposure to the phobic stimulus provokes an immediate anxiety response. In individuals under 18 years, the duration is at least 6 months. The anxiety associated with the object/situation is not better accounted for by another mental disorder.	**Infancy** Rarely diagnosed in infancy. During the second year of life, fears and distress occurring in situations not ordinarily associated with expected anxiety that is not amenable to traditional soothing and has an irrational quality about it may suggest a disorder. The fears are, for example, intense or phobic reactions to cartoons or clowns, or excessive fear concerning parts of the house (e.g., attic or basement). **Early Childhood** Rarely diagnosed in this age group. In children, these disorders may be expressed by crying, tantrums, freezing, or clinging, or staying close to a familiar person. Young children may appear excessively timid in unfamiliar social settings, shrink from contact with others, refuse to participate in group play, typically stay on the periphery of social activities, and attempt to remain close to familiar adults to the extent that family life is disrupted. **Middle Childhood and Adolescence** Symptoms in middle childhood and adolescence generally include the physiologic symptoms associated with anxiety (restlessness, sweating, tension) (see Pain/Somatic Complaints cluster, p 173) and avoidance behaviors such as refusal to attend school and lack of participation in school, decline in classroom performance or social functions. In addition, an increase in worries and sleep disturbances are present. **SPECIAL INFORMATION** Generalized anxiety disorder has subsumed the *DSM-III-R* diagnosis of overanxious disorder. Severe apprehension about performance may lead to refusal to attend school. This must be distinguished from other causes of refusal, including realistically aversive conditions at school (e.g., the child is threatened or harassed), learning disabilities (see Academic Skills cluster, p 69), separation anxiety disorder (see below), truancy (the child is not anxious about performance or separation), and depression (see Sadness and Related Symptoms cluster, p 153). To make these diagnoses in children, there must be evidence of capacity for social relationships with adults. Because of the early onset and chronic course of the disorder, impairment in children tends to take the form of failure to achieve an expected level of functioning rather than a decline from optimal functioning. Children with generalized anxiety disorder may be overly conforming, perfectionistic, and unsure of themselves and tend to redo tasks because of being zealous in seeking approval and requiring excessive reassurance about their performance and other worries.

DISORDER	COMMON DEVELOPMENTAL PRESENTATIONS
309.21 Separation Anxiety Disorder Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached. (see *DSM-IV* Criteria Appendix, p 341)	**Infancy** Not relevant at disorder level. **Early and Middle Childhood** When separated from attachment figures, children may exhibit social withdrawal, apathy, sadness, difficulty concentrating on work or play. They may have fears of animals, monsters, the dark, muggers, kidnappers, burglars, car accidents; concerns about death and dying are common. When alone, young children may report unusual perceptual experiences (e.g., seeing people peering into their room). **Adolescence** Adolescents with this disorder may deny feeling anxiety about separation; however, it may be reflected in their limited independent activity and reluctance to leave home.
300.01 Panic Disorder This disorder involves recurrent unexpected (uncued) panic attacks. Apprehension and anxiety about the attacks or a significant change in behavior related to the attack persists for at least 1 month. A panic attack is a discrete episode of intense fear or discomfort with sudden onset combining the following psychological symptoms — a sense of impending doom, fear of going crazy, and feelings of unreality — with somatic symptoms such as shortness of breath/dyspnea, palpitations/tachycardia, sweating, choking, chest pain, nausea, dizziness, paresthesia. (see *DSM-IV* Criteria Appendix, p 336)	**Infancy** Not relevant at disorder level. **Early Childhood** In children, these disorders may be expressed by crying, tantrums, freezing, clinging, or staying close to a familiar person during a panic attack. **Middle Childhood** Panic attacks may be manifested by symptoms such as tachycardia, shortness of breath, spreading chest pain, and extreme tension. **Adolescence** The symptoms are similar to those seen in an adult, such as the sense of impending doom, fear of going crazy, feelings of unreality and somatic symptoms such as shortness of breath, palpitations, sweating, choking, and chest pain.
	SPECIAL INFORMATION
	Separation anxiety disorder must be beyond what is expected for the child's developmental level to be coded as a disorder. In infancy, consider a developmental variation or anxiety problem rather than separation anxiety disorder. Worry about separation may take the form of worry about the health and safety of self or parents. Separation anxiety disorder may begin as early as preschool age and may occur at any time before age 18 years, but onset as late as adolescence is uncommon. Use early onset specifier if the onset of disorder is before 6 years. Children with separation anxiety disorder are often described as demanding, intrusive, and in need of constant attention, which may lead to parental frustration. Separation anxiety disorder is a common cause of refusal to attend school. Parental difficulty in separating from the child may contribute to the clinical problem (see Mental disorder of parent, p 46). A breakdown in the marital relationship (marital discord) and one parent's overinvolvement with the child is often seen (see p 44). Children with serious current or past medical problems (see Chronic and acute health conditions, pp 52 and 53) may be overprotected by parents and at greater risk for separation anxiety disorder. Parental illness and death may also increase risk.

SPECIAL INFORMATION, CONTINUED	
	Although panic attacks can be overwhelming, the social impairment in panic disorders is the result of secondary avoidance, rather than the attacks themselves. Panic attacks or panic symptoms can occur in a variety of anxiety problems or disorders, including specific phobia, social phobia, separation anxiety disorder, and posttraumatic stress disorder. Panic attacks in these disorders, however, are situationally bound, or cued; that is, they are triggered by specific contexts or environmental stimuli. Unexpected or uncued panic attacks must occur for a diagnosis of panic disorder. Major depressive disorder frequently (50% to 65%) occurs in individuals with panic disorder.

DISORDER	COMMON DEVELOPMENTAL PRESENTATIONS
309.81 Posttraumatic Stress Disorder (PTSD) PTSD occurs following exposure to an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. The child or adolescent has symptoms in each of the following three areas for more than 1 month, causing significant distress or impairment of functioning: (1) persistent reexperiencing of the trauma, (2) avoidance of stimuli associated with the trauma and diminished general responsiveness, and (3) increased arousal or hypervigilance. In infancy, a numbing of responsiveness may also occur. (see *DSM-IV* Criteria Appendix, p 339) **308.3 Acute Stress Disorder** (see *DSM-IV* Criteria Appendix, p 311)	**Infancy** Rarely diagnosed but may take the form of extra fears or aggressive behaviors in response to stress. **Early Childhood, Middle Childhood, Adolescence** In children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others. Reliving of the trauma may occur through repetitive play. Children may also exhibit various physical symptoms, such as stomachaches and headaches. **SPECIAL INFORMATION** PTSD follows exposure to acute or chronic stressors that involve actual or threatened death or serious injury to the child or others. The child must have reacted with intense fear, disorganized or agitated behavior, or helplessness. Stressors may be acute or chronic, single or multiple. PTSD may be chronic and associated with significant morbidity. Symptoms of repetitive trauma re-enacting play and a sense of a foreshortened future may persist after distress is no longer present. PTSD must be distinguished from normal bereavement. Bereavement is characterized by sadness and recurrent thoughts, but not by persistent impairment of functioning (see Sadness and Related Symptoms cluster, p 153). Consider sexual abuse/rape (p 45). Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents and teachers. In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult.

DIFFERENTIAL DIAGNOSIS	SPECIAL INFORMATION
General Medical Conditions Endocrine Hyperthyroidism Hypoglycemia Pheochromocytoma Others Mitral valve prolapse, especially when related to panic Acute bronchospasm	If a general medical condition is producing anxiety-like symptoms, the medical condition should be coded and **anxiety disorder due to a general medical condition** should be coded as **293.84.** If there is an overreaction to a medical condition consider adjustment disorder with anxious mood.
Substance-Related Anxiety Symptoms Stimulant medications ß-agonists Cocaine Phenylpropanolamine Withdrawal from central nervous system (CNS) depressants	Symptoms are produced by central nervous system stimulants and withdrawal from CNS depressants. If substance withdrawal is producing anxiety-like symptoms, the specific substance abuse problem should be coded, and substance-induced anxiety disorder should also be noted. If prescription medication (or withdrawal from medication) is causing anxiety symptoms, code substance-induced anxiety disorder and note the specific medication involved.
Mental Disorders **314.xx** Attention-deficit/hyperactivity disorder (ADHD) **300.3** Obsessive-compulsive disorder **296.xx** Major depressive disorder **300.4** Dysthymic disorder	Anxiety can be a manifestation of virtually every psychiatric syndrome. To be classified as an anxiety problem or disorder, anxiety must be the central feature of the disturbance.

COMMONLY COMORBID CONDITIONS	SPECIAL INFORMATION
Other Comorbid Mental Health Conditions Anxiety disorders are frequently comorbid with ADHD and depressive disorders.	If the child meets criteria for both an anxiety disorder and a depressive disorder or ADHD, both disorders should be coded. Multiple anxiety diagnoses are often present
Other General Medical Conditions Any serious medical condition may be associated with anxiety. Children may experience anxiety symptoms or reactive anxiety problems in relation to hospitalization and medical or surgical procedures. Mitral valve prolapse is associated with panic disorder.	Code medical diagnosis and anxiety symptoms or problem. Code mitral valve prolapse and panic disorder.

DEVELOPMENTAL VARIATION	COMMON DEVELOPMENTAL PRESENTATIONS
V65.49 Sadness Variation Transient depressive responses or mood changes to stress are normal in otherwise healthy populations. **V62.82 Bereavement** Sadness related to a major loss that typically persists for less than 2 months after the loss. However, the presence of certain symptoms that are not characteristic of a "normal" grief reaction may be helpful in differentiating bereavement from a major depressive disorder. These include guilt about things other than actions taken or not taken by the survivor at the time of death, thoughts of death, and morbid preoccupation with worthlessness.	**Infancy** The infant shows brief expressions of sadness, which normally first appear in the last quarter of the first year of life, manifest by crying, brief withdrawal, and transient anger. **Early Childhood** The child may have transient withdrawal and sad affect that may occur after losses and usually experiences bereavement due to the death of a parent or the loss of a pet or treasured object. **Middle Childhood** The child feels transient loss of self-esteem after experiencing failure and feels sadness with losses as in early childhood. **Adolescence** The adolescent's developmental presentations are similar to those of middle childhood but may also include fleeting thoughts of death. Bereavement includes loss of a boyfriend or girlfriend, friend, or best friend.
	SPECIAL INFORMATION
	A normal process of bereavement occurs when a child experiences the death of or separation from someone (person or pet) loved by the child. There are normal age-specific responses as well as responses related to culture, temperament, the nature of the relationship between the child and the one the child is grieving, and the child's history of loss. While a child may manifest his or her grief response for a period of weeks to a couple of months, it is important to understand that the loss does not necessarily go away within that time frame. Most children will need to revisit the sadness at intervals (months or years) to continue to interpret the meaning of the loss to their life and to examine the usefulness of the coping mechanisms used to work through the sadness. A healthy mourning process requires that the child has a sense of reality about the death and access to incorporating this reality in an ongoing process of life. Unacknowledged, invalidated grief usually results in an unresolving process and leads to harmful behaviors toward self or others. Symptoms reflecting grief reaction may appear to be mild or transient, but care must be taken to observe subtle ways that unexpressed sadness may be exhibited. Children in hospitals or institutions often experience some of the fears that accompany a death or separation. These fears may be demonstrated in actions that mimic normal grief responses.

PROBLEM	COMMON DEVELOPMENTAL PRESENTATIONS
V40.3 Sadness Problem Sadness or irritability that begins to include some symptoms of major depressive disorders in mild form. • depressed/irritable mood • diminished interest or pleasure • weight loss/gain, or failure to make expected weight gains • insomnia/hypersomnia • psychomotor agitation/retardation • fatigue or energy loss • feelings of worthlessness or excessive or inappropriate guilt • diminished ability to think/concentrate However, the behaviors are not sufficiently intense to qualify for a depressive disorder. These symptoms should be more than transient and have a mild impact on the child's functioning. Bereavement that continues beyond 2 months may also be a problem.	**Infancy** The infant may experience some developmental regressions, fearfulness, anorexia, failure to thrive, sleep disturbances, social withdrawal, irritability, and increased dependency, which are responsive to extra efforts at soothing and engagement by primary caretakers. **Early Childhood** The child may experience similar symptoms as in infancy, but sad affect may be more apparent. In addition, temper tantrums may increase in number and severity, and physical symptoms such as constipation, secondary enuresis (see Day/Nighttime Wetting Problems cluster, p 215), encopresis (see Soiling Problems cluster, p 209), and nightmares may be present. **Middle Childhood** The child may experience some sadness that results in brief suicidal ideation with no clear plan of suicide, some apathy, boredom, low self-esteem, and unexplained physical symptoms such as headaches and abdominal pain (see Pain/Somatic Complaints cluster, p 173). **Adolescence** Some disinterest in school work, decrease in motivation, and daydreaming in class may begin to lead to deterioration of school work. Hesitancy in attending school, apathy, and boredom may occur. **SPECIAL INFORMATION** Sadness is experienced by some children beyond the level of a normal developmental variation when the emotional or physiologic symptoms begin to interfere with effective social interactions, family functioning, or school performance. These periods of sadness may be brief or prolonged depending on the precipitating event and temperament of the child. Reassurance and monitoring is often needed at this level. If the sad behaviors are more severe, consider major depressive disorders. The potential for suicide in grieving children is higher. Evaluation of suicidal risk should be part of a grief workup for all patients expressing profound sadness or confusion or demonstrating destructive behaviors toward themselves or others. Behavioral symptoms resulting from bereavement that persist beyond 2 months after the loss require evaluation and intervention. Depressed parents or a strong family history of depression or alcoholism (see Mental disorder of parent, p 46) puts youth at very high risk for depressive problems and disorders. Family and marital discord, p 44, exacerbates risk. Suicidal ideation should be assessed (see Suicidal Thoughts or Behaviors cluster, p 165). Lying, stealing, suicidal thoughts (see Suicidal Thoughts or Behaviors cluster, p 165), and promiscuity may be present. Physical symptoms may include recurrent headaches, chronic fatigue, and abdominal pain (see Pain/Somatic Complaints cluster, p 173).

DISORDER	COMMON DEVELOPMENTAL PRESENTATIONS
296.2x, 296.3x Major Depressive Disorder Significant distress or impairment is manifested by five of the nine criteria listed below, occurring nearly every day for 2 weeks. These symptoms must represent a change from previous functioning and that either depressed or irritable mood or diminished interest or pleasure must be present to make the diagnosis. • depressed/irritable • diminished interest or pleasure • weight loss/gain • insomnia/hypersomnia • psychomotor agitation/retardation • fatigue or energy loss • feelings of worthlessness • diminished ability to think/concentrate • recurrent thoughts of death and suicidal ideation (see *DSM-IV* Criteria Appendix, p 332)	**Infancy** True major depressive disorders are difficult to diagnose in infancy. However, the reaction of some infants in response to the environmental cause is characterized by persistent apathy, despondency (often associated with the loss of a caregiver or an unavailable [e.g., severely depressed] caregiver), nonorganic failure-to-thrive (often associated with apathy, excessive withdrawal), and sleep difficulties. These reactions, in contrast to the "problem" level, require significant interventions. **Early Childhood** This situation in early childhood is similar to infancy. **Middle Childhood** The child frequently experiences chronic fatigue, irritability, depressed mood, guilt, somatic complaints, and is socially withdrawn (see Pain/Somatic Complaints cluster, p 173). Psychotic symptoms (hallucinations or delusions) may be present. **Adolescence** The adolescent may display psychomotor retardation or have hypersomnia. Delusions or hallucinations are not uncommon (but not part of the specific symptoms of the disorder). **SPECIAL INFORMATION** Depressed parents or a strong family history of depression or alcoholism puts youth at very high risk for depressive disorder (see Mental disorder of parent, p 46). Risk is increased by family and marital discord, p 44), substance abuse by the patient (see Substance Use/Abuse cluster, p 135), and a history of depressive episodes. Suicidal ideation should be routinely assessed. Sex distribution of the disorder is equivalent until adolescence, when females are twice as likely as males to have a depressive disorder. Culture can influence the experience and communication of symptoms of depression, (e.g., in some cultures, depression tends to be expressed largely in somatic terms rather than with sadness or guilt). Complaints of "nerves" and headaches (in Latino and Mediterranean cultures), of weakness, tiredness, or "imbalance" (in Chinese and Asian cultures), of problems of the "heart" (in Middle Eastern cultures), or of being "heartbroken" (among Hopis) may express the depressive experience. Subsequent depressive episodes are common. Bereavement typically improves steadily without specific treatment. If significant impairment or distress is still present after 2 months following the acute loss or death of a loved one, or if certain symptoms that are not characteristic of a "normal" grief reaction are present (e.g., marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation), consider diagnosis and treatment of major depressive disorder.

DISORDER	COMMON DEVELOPMENTAL PRESENTATIONS
300.4 Dysthymic Disorder The symptoms of dysthymic disorder are less severe or disabling than those of major depressive disorder but more persistent. Depressed/irritable mood for most of the day, for more days than not (either by subjective account or observations of others) for at least 1 year. Also the presence, while depressed/irritable, of two (or more) of the following: • poor appetite/overeating • insomnia/hypersomnia • low energy or fatigue • poor concentration/difficulty making decisions • feelings of hopelessness (see *DSM-IV* Criteria Appendix, p 326) **309.0 Adjustment Disorder With Depressed Mood** (see *DSM-IV* Criteria Appendix, p 312) **311 Depressive Disorder, Not Otherwise Specified**	**Infancy** Not diagnosed. **Early Childhood** Rarely diagnosed. **Middle Childhood and Adolescence** Commonly experience feelings of inadequacy, loss of interest/pleasure, social withdrawal, guilt/brooding, irritability or excessive anger, decreased activity/productivity. May experience sleep/appetite/weight changes and psychomotor symptoms. Low self-esteem is common. **SPECIAL INFORMATION** Because of the chronic nature of the disorder, the child may not develop adequate social skills. The child is at risk for episodes of major depression.

DIFFERENTIAL DIAGNOSIS	SPECIAL INFORMATION
General Medical Conditions — Examples include: Endocrine abnormalities, e.g., thyroid disorders Malignancies Malnutrition Mononucleosis Chronic fatigue syndrome Neurologic disorders Autoimmune disorders Metabolic disorders	Almost any medical condition can cause fatigue, loss of energy, insomnia, changes in appetite, and other symptoms of depression. If a general medical condition is producing mood disturbance problems, the medical condition should be coded, and mood disorder due to a general medical condition should be coded as **293.83.**
Substances — Examples include: Alcohol abuse Drug abuse Prescription drug side effects (reserpine, glucocorticoids, anabolic steroids) Over-the-counter drugs containing synthetic narcotics	Code substance-induced mood disorder.
Mental Disorders **309.0** Adjustment disorder with depressed mood **314.xx** Attention-deficit/hyperactivity disorder **300.82** Somatization disorder **293.83** Mood disorders due to a general medical condition	

COMMONLY COMORBID CONDITIONS	SPECIAL INFORMATION
Other Comorbid Mental Health Conditions — Examples include: **300.3** Obsessive-compulsive disorder **307.80** Panic disorders **312.81** Conduct disorder childhood onset **312.82** Conduct disorder adolescent onset **313.81** Oppositional defiant disorder **305** Substance abuse disorder **314.xx** Attention-deficit/hyperactivity disorder **295.** Schizophrenia **299.00** Autistic disorder **307.1** Anorexia nervosa **307.51** Bulimia nervosa **300.02** Generalized anxiety disorder **309.81** Posttraumatic stress disorder **309.21** Separation anxiety disorder	In children, major depressive disorders occur more frequently in conjunction with other mental disorders (especially disruptive behavior and anxiety disorders, and attention-deficit/hyperactivity disorder).
Other General Medical Conditions that are acute, chronic, or disabling.	Especially prevalent in chronic conditions that significantly affect appearance or ability to engage in age-appropriate activities (e.g., diabetes, cystic fibrosis). If this occurs, code both conditions.