

What Is An Emotional or Behavioral Disorder?

Although childhood is generally regarded as a carefree time of life, many children and adolescents experience emotional difficulties growing up. Identifying an emotional or behavioral disorder is difficult for many reasons. For instance, it cannot be stated with certainty that something “goes wrong” in the brain, causing a child to act in a particular way. Contrary to early psychiatric theories, it is impossible to conclude that a mother or father did something wrong early in a child’s life, causing an emotional or behavioral disorder. The question of who or what is responsible for a child’s problems has given way to an understanding that the combinations of factors affecting development – biological, environmental, psychological - are almost limitless.

Children’s behaviors exist on a continuum, and there is no specific line that separates troubling behavior from a serious emotional problem. Rather, a problem can range from mild to serious. A child is said to have a specific “diagnosis” or “disorder” when his or her behaviors occur frequently and are severe. A diagnosis represents a “best guess” based on a child’s behaviors that he or she has a specific mental health disorder and not just a problem that all children might have from time to time. Research on the cause of emotional disorders has shown that the way the brain receives and processes information is different for children with some types of disorders than for those who do not have those problems. However, this is not true for all children with emotional disorders.

There have been many recent advances in understanding the emotional problems of children and adolescents. As technologies are developed to study the central nervous system and the relationships between brain chemistry and behavior, the research is providing new understanding of how and why some children develop emotional disorders. Still interviews with the child, parents or other family members remain one of the most important sources of information to help professionals arrive at a diagnosis.

A diagnosis of a mental health disorder will be based on one of several classification systems used in the United States. The most familiar system is the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Revised*. The DSM-IVR contains descriptions of specific behavioral characteristics that are used to determine whether a child or adult has an emotional or mental disorder. The criteria that establishes the presence of a mental health disorder are subject to interpretation that may vary from professional to professional. Cultural and subjective criteria such as race, socioeconomic status, or the behaviors of the child’s parents at the time of evaluation have an effect on professional opinion, as does the training of the professional and his or her years of experience.

A DSM-IVR diagnosis serves several purposes. First, it may establish the presence of a specific mental health problem which has an accepted treatment standard, such as the use of medication in treating depression. Second, a formal diagnosis may be required for insurance or Medicaid reimbursement. A diagnosis for a child may mean that insurance may cover the costs of services the child needs but would not be eligible for without the diagnosis.

Parents should bring up issues they believe may influence their child’s diagnosis during the evaluation. These influences must be considered by the evaluator in making a diagnosis. Generally, determining whether a child has a biologically based mental illness, a behavioral problem or an emotional disorder is not as important to a family as determining what interventions are the most useful to help support their child. What an evaluation *should* yield, regardless of whether a child’s problems result in a *diagnosed disorder* or something less definitive, is a set of recommendations for how to support him or her in developing necessary skills.

The question about whether a child needs help should not depend on whether he or she has a diagnosis. A problem does not disappear simply because it is not severe enough to meet the

criteria for a diagnosis. Parents should insist on a list of specific written recommendations for how to help their child as a result of any evaluation.

The DSM-IV-R, for instance, lists eighteen separate characteristics of behavior attributed to attention deficit hyperactivity disorder (ADHD). If a child shows six signs of inattention or six signs of hyperactivity and impulsivity, he or she may be given a clinical diagnosis of ADHD. This means that the mental health professional working with the child believes that the child has a medically-based problem and may recommend a specific therapy, such as medication. But the characteristics by which ADHD is diagnosed are also open to interpretation. What does it mean to say that a child is “often distracted by extraneous stimuli?” How often is often? What does distracted by mean? And what happens to the child who shows only five signs of inattention and therefore does not have ADHD, but is still failing in school and is unable to stay focused on his or her work?

Different professionals view emotional and behavioral disorders in different ways. Their outlook—and their treatment plan—is usually shaped by their training, their experience, and their philosophy about the origins of a child’s problems. Though the philosophical orientation or direction may not seem important to parents who are frantically seeking a way to locate help for their child, it is still recommended that parents discuss such beliefs with professionals they contact. Since the treatment program for a child will stem from the professional’s philosophy, parents should be sure they agree with “where the professional is coming from,” as well as with the methods used by the professional to help their child. Otherwise, their cooperation in the treatment process may be compromised. When seeking a treatment program for a child, parents may also want to seek a second opinion if they disagree with the approach suggested by the first mental health professional.

The following examples of emotional and behavioral disorders are from the DSM-IV-R diagnostic criteria. This list is not comprehensive, but is included to give parents examples of emotional disorders affecting children and youth.

Adjustment Disorders describe emotional or behavioral symptoms that children may exhibit when they are unable, for a time, to appropriately adapt to stressful events or changes in their lives. The symptoms, which must occur within three months of a stressful event or change, and last no more than six months after the stressor ends, are: marked distress, in excess of what would be expected from exposure to the event(s), or an impairment in social or school functioning. There are many kinds of behaviors associated with different types of adjustment

disorders, ranging from fear or anxiety to truancy, vandalism, or fighting. Adjustment disorders are relatively common, ranging from 5% to 20%.

Anxiety Disorders are a large family of disorders (school phobia, posttraumatic stress disorder, avoidant disorder, obsessive-compulsive disorder, panic disorder, panic attack, etc.) where the main feature is exaggerated anxiety. Anxiety disorders may be expressed as physical symptoms, (headaches or stomach aches), as disorders in conduct (work refusal, etc.) or as inappropriate emotional responses, such as giggling or crying. Anxiety occurs in all children as a temporary reaction to stressful experiences at home or in school. When anxiety is intense and persistent, interfering with the child’s functioning, it may become deemed as an Anxiety Disorder.

Obsessive-Compulsive Disorder (OCD) which occurs at a rate of 2.5%, means a child has recurrent and persistent obsessions or compulsions that are time consuming or cause marked distress or significant impairment. Obsessions are persistent thoughts, impulses, or images that are intrusive and inappropriate (repeated doubts, requirements to have things in a specific order, aggressive impulses, etc.). Compulsions are repeated behaviors or mental acts (hand washing, checking, praying, counting, repeating words silently, etc.) that have the intent of reducing stress or anxiety. Many children with OCD may know that their behaviors are extreme or unnecessary, but are so driven to complete their routines that they are unable to stop.

Post-Traumatic Stress Disorder (PTSD) can develop following exposure to an extremely traumatic event or series of events in a child’s life, or witnessing or learning about a death or injury to someone close to the child. The symptoms must occur within one month after exposure to the stressful event. Responses in children include intense fear, helplessness, difficulty falling asleep, nightmares, persistent re-experiencing of the event, numbing of general responsiveness, or increased arousal. Young children with PTSD may repeat their experience in daily play activities, or may lose recently acquired skills, such as toilet training or expressive language skills.

Selective Mutism (formerly called Elective-Mutism) occurs when a child or adolescent persistently fails to speak in specific social situations such as at school or with playmates, where speaking is expected. Selective mutism interferes with a child’s educational achievement and social communication. Onset of Selective Mutism usually occurs before the age of five, but may not be evaluated until a child enters school for the first time. The disorder is regarded as relatively rare, and usually lasts for

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a period of a few months, although a few children have been known not to speak in school during their entire school career.

Attention Deficit/Hyperactivity Disorder is a condition, affecting 3%-5% of children, where the child shows symptoms of inattention that are not consistent with his or her developmental level. The essential feature of Attention Deficit Hyperactivity Disorder is “a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development.” A few doctors have written articles on ADHD in early childhood, and some suggest that signs of the disorder can be detected in infancy. Most physicians prefer to wait until a clear pattern of inattentive behaviors emerge that affect school or home performance before attempting to diagnose ADHD. Medications, such as Ritalin or Dexedrine, or a combination of these and other medicines have been very successful in treating ADHD.

Oppositional Defiant Disorder. The central feature of oppositional defiant disorder (ODD), which occurs at rates of 2 to 16%, is “a recurrent pattern of negativistic, defiant, disobedient and hostile behaviors towards authority figures, lasting for at least six months ...” The disruptive behaviors of a child or adolescent with ODD are of a less severe nature than those with Conduct Disorder, and typically do not include aggression toward people or animals, destruction of property, or a pattern of theft or deceit. Typical behaviors include arguing with adults, defying or refusing to follow adult directions, deliberately annoying people, blaming others, or being spiteful or vindictive.

Conduct Disorder, which affects between 6% and 16% of boys and 2% to 9% of girls, has as the essential feature “a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate social norms or rules are violated.” Children with Conduct Disorder often have a pattern of staying out late despite parental objections, running away from home, or being truant from school. Children with Conduct Disorder may bully or threaten others or may be physically cruel to animal and people. Conduct Disorder is often associated with an early onset of sexual behavior, drinking, smoking, and reckless and risk-taking acts.

Anorexia Nervosa can be thought of as a “distorted body image” disorder, since many adolescents who have Anorexia see themselves as overweight and unattractive. In Anorexia Nervosa, the individual refuses to maintain a minimally normal body weight, is intensely afraid of gaining weight, and has no realistic idea of the shape and size of his or her body. Signs of anorexia nervosa include extremely low body weight, dry skin, hair loss, depressive symptoms, constipation, low blood pressure, and bizarre behaviors, such as hiding food or binge eating.

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Bulimia Nervosa is characterized by episodes of “binge and purge” behaviors, where the person will eat enormous amounts of food, then induce vomiting, abuse laxatives, fast, or follow an austere diet to balance the effects of dramatic overeating. Essential features are binge eating and compensatory methods to prevent weight gain. Bulimia Nervosa symptoms include the loss of menstruation, fatigue or muscle weakness, gastrointestinal problems or intolerance of cold weather. Depressive symptoms may follow a binge and purge episode.

Bipolar Disorder (Manic Depressive Disorder) has symptoms that include an alternating pattern of emotional highs and emotional lows or depression. The essential feature of Bipolar 1 Disorder is “a clinical course that is characterized by the occurrence of one or more Manic Episodes (a distinct period during which there is an abnormally and persistently elevated, expansive or irritable mood), or Mixed Episodes (a period of time lasting at least one week in which the criteria are met both for a Manic Episode and a Depressive Episode nearly every day).” There are six different types of Bipolar 1 Disorder, reflecting variations in manic and depressive symptoms.

Major Depressive Disorder occurs when a child has a series of two or more major depressive episodes, with at least a two-month interval between them. Depression may be manifested in continuing irritability or inability to get along with others, and not just in the depressed affect. In Dysthymic Disorder, the depressed mood must be present for more days than not over a period of at least two years. Dysthymic Disorder and Major Depressive Disorder are differentiated based on severity, chronicity, and persistence. Usually, Major Depressive Disorder can be distinguished from the person’s usual functioning, whereas Dysthymic Disorder is characterized by chronic, less severe depressive symptoms that have been present for many years.

Autistic Disorder is a Pervasive Developmental Disorder, characterized by the presence of markedly abnormal or impaired development in social interaction and communication, and a markedly restricted level of activities or interests. Children with Autism may fail to develop relationships with peers of the same age, and may have no interest in establishing friendships. The impairment in communication (both verbal and nonverbal) is severe for some children with this disorder.

Schizophrenia is a serious emotional disorder characterized by loss of contact with environment and personality changes. Hallucinations and delusions, disorganized speech, or catatonic behavior often exist as symptoms of this disorder, which is frequently manifest in young adulthood. The symptoms may also occur in younger children. There are a number of subtypes of schizophrenia, including Paranoid Type, Disorganized Type, Catatonic Type, Residual Type, and Undifferentiated Type. The lifetime prevalence of Schizophrenia is estimated at between 0.5% and 1%.

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Tourette's Disorder occurs in approximately 4-5 individuals per 10,000. The disorder includes both multiple motor tics and one or more vocal tics, which occur many times per day, nearly every day, or intermittently throughout a period of more than one year. During this period, there is never a tic-free period of more than 3 consecutive months. Chronic Motor or Vocal Tic Disorder includes either motor tics or vocal tics, but not both as in Tourette's Disorder. Transient Tic Disorder includes either single or multiple motor tics many times a day for at least four weeks, but for no longer than 12 months. This can occur as either a single episode or as recurrent episodes over time.

Seriously Emotionally Disturbed, or SED, is not a DSM-IVR medical diagnosis, but a label that public schools may use when children, due to their behaviors, are in need of special education services. School professionals may or may not use diagnostic classification systems as part of this determination. The school's responsibility is to provide services for students with emotional or behavioral disorders or mental illnesses under the special education category of SED (many states have chosen to use a "different" label such as Emotional or Behavioral Disorder (EBD), to describe this special education service category), when their emotional or behavioral problems are so severe that they cannot succeed without help.