Emotional and Behavioral Disorders

Hey, Lady, Can’t You Control Your Kid?

You are only a kid once—get in trouble while you can.
—Celeste, age 12

OUTLINE

Introduction
Emotional and Behavioral Disorders Diagnosed in Context
Distinguishing Mental Illness from Normal Development and Transient Reactions

Mental Illness in Children: When Behaviors Are Not Normal
Incidence
Risk Factors
Diagnostic Process

Specific Mental Health Disorders
Disorders of Attachment
Anxiety Disorders
Mood Disorders
Impulse Control Disorders
Eating Disorders

The Complexity of Childhood Mental Illness: Culture and Families
The Shifting Nature of Illness
Culture Contributes

Family and Community Contexts
Mental Illness Affects All Family Members
The Special Challenge of Parenting Children With Mental Illness

Occupational Therapy Interventions
Building Developmental Skills
Sensory Supports
Cognitive Interventions
Social Skills Training
Behavioral Interventions

Prevention: Creating Opportunities to Promote Mental Health

Summary

OBJECTIVES

1. Describe the differences between mental illness in children and normal developmental phases or reactions to developmental crises.

2. Define the main characteristics of mental illnesses commonly seen in children: attachment disorders, anxiety disorders (including phobias and obsessive-compulsive disorder), mood disorders, impulse control disorders (including oppositional defiant disorder and conduct disorder), and eating disorders (i.e., bingeing, anorexia nervosa, bulimia).

3. Describe sociocultural issues that contribute to the complexity of childhood mental illness.

4. Describe common occupational therapy approaches used in intervention with children who have mental illness, including sensory supports, cognitive approaches, and social stories.

5. Identify community-based programs that can promote mental health in children.
Introduction

Promoting mental health is essential to all occupational therapy practice areas. However, children experiencing, or at risk of, mental illness can particularly benefit from occupational therapy as a part of a team approach to promote participation in everyday life, support the development of healthy family and peer relationships, and minimize emotional distress. And while all that sounds logical, determining which children have mental illness and which are “going through a phase” can be extraordinarily difficult.

EMOTIONAL AND BEHAVIORAL DISORDERS DIAGNOSED IN CONTEXT

The terms “emotional disturbance,” “behavioral disorder,” “mental illness,” and “mental disorder” often are used interchangeably to describe atypical psychosocial development. Diagnosing such disorders can be difficult, perhaps because actions that would be described as “unusual” in adults are often displays of normal child development (e.g., temper tantrum in the supermarket). Further, emotional disturbance must be distinguished from an emotional reaction that is a transient response to a significant life event (e.g., the death of a parent). Although children and adolescents with problems secondary to a significant life event may benefit from psychological support, they are not routinely categorized as having an emotional disturbance unless the behavior persists for longer than 12 months.

Table 27-1 presents common signs of mental health problems in children by age group. In reviewing this table you will see that, in younger children, the manifestations of mental illness become both more diverse and more similar to those of adults.

Vignette 27-1  Sarah Tells Her Story

Sarah, age 17, commented: “When I was 4, my family decided that we needed to move. Mom, Dad, Grandma, four kids, and the family dog in a 3-bedroom house just wasn’t cutting it anymore. I distinctly remember being in the cab of the rental truck with my father and oldest brother and suddenly feeling overwhelmed, terrified, nauseous, and lightheaded for seemingly no reason. Once we reached our new home, the feelings subsided almost as quickly as they came.

I hated school and was very shy. I cried every morning at the school bus until I was in fourth grade. Going to restaurants, shopping, or participating in any event or activity where a crowd would gather became unbearable. My family and teachers labeled me as their “problem child,” “antisocial,” and “troubled.” On the surface, their accusations seemed valid. However, my unconventional behavior (i.e., truancy, lateness, confrontations) can all be attributed to my underlying anxiety.

Finally, at 15, I was diagnosed with agoraphobia with panic attacks, an anxiety disorder. I’m not “normal” now, but I understand myself better and am able to do more things for myself. Why did it take so long for me to find help?”

<table>
<thead>
<tr>
<th>TABLE 27-1</th>
<th>Common Signs of Mental Health Problems in Pediatric Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGES</td>
<td>COMMON SIGNS OF MENTAL HEALTH PROBLEMS</td>
</tr>
<tr>
<td>_______</td>
<td>____________________________________________________________</td>
</tr>
<tr>
<td>Preschool Children</td>
<td></td>
</tr>
<tr>
<td>Hyperactivity; fidgeting; constant movement (beyond regular playing)</td>
<td></td>
</tr>
<tr>
<td>Persistent nightmares</td>
<td></td>
</tr>
<tr>
<td>Frequent, unexplainable temper tantrums</td>
<td></td>
</tr>
<tr>
<td>Regression in developmental skills</td>
<td></td>
</tr>
<tr>
<td>Narrow or impoverished play skills</td>
<td></td>
</tr>
<tr>
<td>Changes in appetite or sleep</td>
<td></td>
</tr>
<tr>
<td>Social withdrawal</td>
<td></td>
</tr>
<tr>
<td>Fearfulness</td>
<td></td>
</tr>
<tr>
<td>Self-destructive behavior such as head banging; tendency to have frequent injuries</td>
<td></td>
</tr>
<tr>
<td>School-Age Children</td>
<td></td>
</tr>
<tr>
<td>Marked change in school performance</td>
<td></td>
</tr>
<tr>
<td>Frequent, unexplainable temper tantrums</td>
<td></td>
</tr>
<tr>
<td>Severe worry or anxiety, as shown by regular refusal to go to school, go to sleep or take part in activities that are normal for the child’s age</td>
<td></td>
</tr>
</tbody>
</table>
Distinguishing Mental Illness from Normal Development and Transient Reactions

It is easy to understand how Sarah’s family might have mistaken her first anxiety attack for a “normal” 4-year-old’s reaction. Periods of intense sibling rivalry, imaginary playmates, and school refusal are other examples of normal developmental phases that would be considered aberrant if manifested in adulthood. Another important challenge in pediatric mental health practice is to distinguish transient developmental crises from problems that require intervention. To establish that behaviors stem from emotional disturbance, adults caring for a child need to determine that the problems are severe, persistent, affecting participation in desired daily activities, and limiting desired social roles. This analysis of a child’s behavior needs to be conducted within the child’s cultures and communities.

Behaviors that connote mental illness are seen commonly in the context of everyday routines and tasks. For example, a school day routine for most North American teenagers, from the point of waking up, might include a visit to the bathroom followed by a trip to the kitchen to prepare and eat breakfast. After breakfast, the teen may return to the bedroom to dress and collect materials needed for school. All of these actions are taken relatively independently and within a specified time frame so that the teen can leave the house and get to school on time.

For Sarah, this routine would likely involve much more parental interaction because she may refuse to get up, eat, and dress. She may dawdle so that she misses the bus or she may leave the house but skip school. In Sarah’s case, the responsibility for preparing for school will have to be assumed by a parent. Whereas more intense parental involvement may be common in other cultures, for a North American (or Australian) parent this need for parental oversight would cause concern and, likely, distress.

As with other types of childhood disorders, the earlier a mental health concern is identified and addressed, the greater is the potential for positive outcomes. However, a trend toward underidentifying mental health problems in childhood has been reported; often such problems are not diagnosed until they become severe (U.S. Department of Health and Human Services [HHS], 1999). Perhaps this is, in part, because children do not have the experience to articulate significant emotional distress. Even adolescents may not understand how different their experiences are than those of peers. And parents and other adults may be confused as to what is “just a phase.”

Here’s the Point

- The terms “emotional disturbance,” “behavioral disorder,” “mental illness,” and “mental disorder” often are used interchangeably to describe atypical psychosocial development.
- One challenge in child and adolescent mental health is to distinguish mental illness from normal developmental phases and transient psychosocial crises.

<table>
<thead>
<tr>
<th>Ages</th>
<th>Common Signs of Mental Health Problems—cont’d</th>
</tr>
</thead>
</table>
| Adolescents | • Marked change in school performance  
|           | • Inability to cope with problems and daily activities  
|           | • Marked changes in sleeping and/or eating habits  
|           | • Frequent physical complaints  
|           | • Sexual acting out  
|           | • Depression shown by sustained, prolonged negative mood and attitude  
|           | • Abuse of alcohol and/or drugs  
|           | • Persistent nightmares  
|           | • Threats to run away  
|           | • Self-injury or self-destructive behavior  
|           | • Opposition to authority, truancy, thefts, and/or vandalism  
|           | • Strange thoughts, beliefs, feelings, or unusual behaviors |
In younger children, the manifestations of mental health problems are vague and therefore difficult to identify. As the child matures toward adolescence, the signs of mental illness become both more diverse and more similar to those of adults.

 Serious disruptions to everyday routines may be an indicator of mental illness.

Mental Illness in Children: When Behaviors Are Not Normal

While some children do pass through difficult times, not all behavior problems can be explained as a phase. Some children have serious and persistent problems that stem from mental illness; they require specialized diagnosis and intervention. How many children? What factors predispose a child to mental illness? What is the diagnostic procedure like?

INCIDENCE

Because mental illness in children spans a wide variety of conditions and a range of severity, no one figure captures the overall incidence of these disorders. Table 27-2 provides an overview of the relative incidence of various mental health disorders in children and adolescents between 9 and 17 years of age (U.S. Department of Health & Human Services [HHS], 1999; http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml). However, incidence rates, like those shown in Table 27-2, can be misleading because they provide a static view of dynamic problems. Mental health disorders in young people may be transitory or they may evolve into different disorders over time. The incidence may differ from one culture to another.

As part of a larger study, Merikangas et al. (2010) followed children with a few mental health conditions. Because this study was cross-sectional, it reflects a snapshot in time. The much lower incidences reported here than by the U.S. Surgeon General in 1999 probably can be explained by the difference in the sample. The incidence of these conditions as described by Merikangas et al. can be summarized as follows:

- Anxiety disorders (a subset including general anxiety disorder and panic disorder); total incidence = 0.7%.
- Disruptive disorders (a subset including conduct disorder and ADHD); total incidence = 10.9%.
- Depression; incidence = 3.7%.

RISK FACTORS

Although the causes are often unknown, a number of intrinsic and extrinsic factors may contribute to mental illness in children (HHS, 1999). And, although they do not always result in mental illness, the following intrinsic factors pose risks: prenatal exposure to alcohol, illicit drugs, or tobacco; low birth weight; difficult temperament; and an inherited predisposition to a mental disorder (Fig. 27-1). For example, children of parents who are depressed are more than three times as likely as children of parents without depression to experience a depressive disorder (Birmaher et al., 1996). Parental depression also increases the risk of anxiety disorders, conduct disorder, and alcohol dependence in children and adolescents (Weissman, Warner, Wickramaratne, Moreau, & Olsson, 1997; Wickramaratne & Weissman, 1998).

<table>
<thead>
<tr>
<th>TABLE 27-2</th>
<th>Relative Incidence of Mental Disorders in Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>DISORDER</td>
<td>PERCENT</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>13.0</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>6.2</td>
</tr>
<tr>
<td>Disruptive disorders</td>
<td>10.3</td>
</tr>
</tbody>
</table>


FIGURE 27-1 Adolescents who also have a parent with depression are more than three times as likely as children of parents without depression to experience a depressive disorder. (Photograph © IAN HOOTON/Science Photo Library/Corbis.)
Extrinsic risk factors are those physical and social factors in the environment that can contribute to mental health disorders, particularly in children who also experience intrinsic factors. These include poverty, deprivation, abuse and neglect; unsatisfactory nurturing relationships; and exposure to traumatic events (HHS, 1999).

**DIAGNOSTIC PROCESS**

Children who have persistent problems suggestive of a mental health disorder should be referred to early intervention or a child and adolescent mental health service for evaluation and, if appropriate, diagnosis. Mental health diagnosis usually requires several hours for both the child and parents over one or more visits with the evaluator. In an attempt to tease out the nature of the problem, biological, psychological, and social evidence is gathered in the context of history, strengths, and demands for the child and family. Occupational therapists often contribute to the diagnostic process by providing assessments of the child’s functional performance and reports of observed behaviors in natural contexts.

**Specific Mental Health Disorders**

Evaluating a child for the presence of mental illness often yields a diagnostic label that, in turn, helps to suggest the best interventions. Of course, diagnosis is only one factor in intervention planning. The child’s developmental stage and other personal factors, the family’s circumstances, the desire and need for participation in everyday activities and routines, and the environments in which the child participates are other equally important contributors.

Several of the most common childhood disorders are described in some detail later. We have included those most commonly seen in occupational therapy: disorders of attachment, anxiety, mood, impulse control, and eating.

**DISORDERS OF ATTACHMENT**

Attachment is a lasting psychological bond between humans (Bowlby, 1969). The central theme of attachment theory is that mothers and caregivers who are available and responsive to the infant promote a sense of security and trust. The infant knows that the caregiver is dependable, which creates a secure base from which to explore the world. Attachment is thus reflected in behaviors that can be observed in infants and children in the context of their interactions with caregivers (e.g., Stayton & Ainsworth, 1973). Crittenden (2010) summarized the current, complex field of attachment and attachment research, stating that attachment reflects a complex interweaving of maturation, developmental processes, culture, context, and individual differences.

While secure attachment has a positive impact on emotional development, insecure attachment, related to neglect, abuse, or exposure to violence, poses a risk to emotional development that lasts into adulthood (Anda, 2006; Green & Goldwyn, 2002). Specifically studies have related insecure attachment to the development of anxiety disorders, depressive symptoms, and disruptive behavior disorders (Roelofs, Meesters, & Muris, 2008). In their extreme form, attachment disorders result in a person who lacks the ability to care for, or be affectionate with, other people (Corbin, 2007). Persons with severe attachment disorders may not develop a social conscience and may not respect cultural mores or values. Table 27-3 presents indicators of attachment disorders in infants and children.

<table>
<thead>
<tr>
<th>TABLE 27-3</th>
<th>Behavioral Manifestations of Attachment Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AGE</strong></td>
<td><strong>BEHAVIORS</strong></td>
</tr>
<tr>
<td>Infant</td>
<td>• Weak crying or constant whining</td>
</tr>
<tr>
<td></td>
<td>• Aversive reactions to touch or physical handling</td>
</tr>
<tr>
<td></td>
<td>• Resistance to cuddling</td>
</tr>
<tr>
<td></td>
<td>• Poor sucking response or other feeding disorders</td>
</tr>
<tr>
<td></td>
<td>• Little eye contact</td>
</tr>
<tr>
<td></td>
<td>• Lack of a reciprocal smile response</td>
</tr>
<tr>
<td></td>
<td>• Indifference to others, including lack of recognition of primary caregiver</td>
</tr>
<tr>
<td></td>
<td>• Delayed developmental milestones</td>
</tr>
<tr>
<td></td>
<td>• Lack of comfort seeking when distressed</td>
</tr>
<tr>
<td></td>
<td>• Inhibition/hesitancy in social interactions</td>
</tr>
<tr>
<td>Child</td>
<td>• Indiscriminately affectionate with strangers</td>
</tr>
<tr>
<td></td>
<td>• Destructive to both self and things</td>
</tr>
<tr>
<td></td>
<td>• Resistant to cuddling</td>
</tr>
<tr>
<td></td>
<td>• Cruel to siblings and animals</td>
</tr>
<tr>
<td></td>
<td>• Lack of eye contact</td>
</tr>
<tr>
<td></td>
<td>• Poor peer relationships</td>
</tr>
<tr>
<td></td>
<td>• Inappropriately demanding or clinging</td>
</tr>
<tr>
<td></td>
<td>• Delayed development</td>
</tr>
<tr>
<td></td>
<td>• Engages in lying and stealing</td>
</tr>
<tr>
<td></td>
<td>• Preoccupied or defiant behavior</td>
</tr>
</tbody>
</table>
**Protective Factors**

Attachment behaviors and the consequences of poor attachment provide a clear illustration of how critical the interaction is between the child and the child’s caregivers. Without early caregiver attachment, the incidence of mental health problems skyrocket, but even in these cases there are some “protective factors.” In their study of a small number of children raised in orphanages, Perry, Sigal, Boucher, and Pare (2006) identified factors that affect psychosocial adaptation: self-protectiveness, temperament, quality of care in the orphanage, post-orphanage environment, and experiences in late adolescence and adulthood.

Increasing numbers of children from economically depressed areas of the world are now adopted by families in more affluent countries. These families attempt to utilize protective factors to reverse the potentially negative effects experienced by infants born into poverty. Many of those children will have spent time in orphanages where large numbers of children mean that each child is likely to receive little individual attention from caregivers (Fisher, Ames, Chisholm, & Savoie, 1997; Lin, Cermak, Coster, & Miller, 2005). While attachment disorders are relatively rare in the general population, reactive attachment disorders are fairly common in institutionalized and post-institutionalized children (Fisher et al., 1997). In the definition provided in the *DSM-IV-TR* (APA, 2000), reactive attachment disorder (RAD) appears prior to the age of 5 years and is associated with “grossly pathological care.” Typically, infants and children with this disorder have had severe problems or disruptions at least in early relationships (Zeanah, 2001). Perry (2002) has indicated that severe neglect and abuse in the first 3 years of life lead to devastating and long-lasting effects because of the neurological vulnerability of this age group.

Adoptive parents who seek help to reverse the impact of early deprivation often turn to early intervention services in the United States or to Child and Adolescent Mental Health Services (CAMHS) in the United Kingdom, New Zealand, and Australia. Children in those settings are very likely to receive services from an occupational therapist.

**ANXIETY DISORDERS**

Feelings of fear warn of impending danger and allow a child to escape from or avoid a particular situation. Thus, fear is a normal and adaptive reaction. Fear may arise from traumatic events, like natural disaster, that are outside of human control. Such fear is normal when the child’s reaction decreases with time. Anxiety, however, results from threats that are perceived to be uncontrollable or unavoidable but that are not real. To qualify as an anxiety disorder, a pattern of persistent and excessive distress, fear, or worry must last for at least 4 weeks and significantly impair participation in daily activities (APA, 2000). An anxious child can experience sweating, racing heart, stomach ache, dizziness, crying, tantrums, freezing, and avoidance or intense dread of feared situations or objects.

When severe, anxiety disorders affect thinking and perceptions, decision-making, learning, and concentration.

**Anxiety disorders** are the most common mental health disorder (Kessler et al., 2005); they manifest in a number of ways. Selective mutism, the most common anxiety manifestation in very young children, is nearly twice as common as autism (Bergman, Piacentini, & McCracken, 2002). The anxiety disorders most common in children are generalized anxiety disorder, obsessive-compulsive disorder (OCD), specific phobias (e.g., social phobias, agoraphobia), and separation anxiety disorder (APA, 2000).

In children, the most common precursors to anxiety disorders are genetics, maladaptive learning, and parenting style (Hughes, LaGrea, & Conoley, 2001). Unlike in adults, there are no clear patterns of incidence of anxiety related to race or gender (Hughes et al., 2001). Occupational therapists, however, also have suggested a link between the emotional distress associated with sensory processing disorders in some people and anxiety disorders. See the Prove It! box.

Children may manifest anxiety differently as they mature. Sarah’s story at the beginning of the chapter is a good example. A young child may have a generalized anxiety problem and be described by family and friends as a “worrier.” As young children typically stay near parents and home, their stress related to leaving the home could be considered normal. However, the social anxiety Sarah described during her school years culminating in a diagnosis of agoraphobia reflect the evolution of her seemingly normal fears to a pathological level of anxiety. The major forms of anxiety disorders seen in children are presented in Table 27-4.

**Obsessive-Compulsive Disorder**

**Obsessive-Compulsive disorder** (OCD) is an anxiety disorder characterized by intrusive thoughts (obsessions) that produce anxiety, by repetitive behaviors aimed at reducing anxiety (compulsions), or by a combination of such thoughts and behaviors (American Psychiatric Association, 2000).

Children with OCD are usually referred to occupational therapy because their rituals are time consuming.
<table>
<thead>
<tr>
<th>TABLE 27-4  Common Forms of Anxiety Disorders Seen in Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERALIZED ANXIETY DISORDER</strong></td>
</tr>
<tr>
<td>Description</td>
</tr>
<tr>
<td>Onset</td>
</tr>
<tr>
<td>Features specific to childhood onset</td>
</tr>
<tr>
<td>Performance impacts</td>
</tr>
<tr>
<td>Social impacts</td>
</tr>
</tbody>
</table>
and interfere with the everyday functioning of the family. However, they do not respond to coaching in time management. In fact, a focus on specific skill development may play into the child’s need for perfection (Poe, personal communication, August 8, 2010). For this reason an occupational therapist who suspects this condition in a client should refer the child for formal evaluation. Any intervention plan for a child with OCD should be developed in collaboration with the child’s primary mental health-care provider.

**Social Phobias**

Social phobias most typically develop in adolescence (APA, 2000). Children and adolescents with social phobia avoid situations that could lead to embarrassment or looking foolish; this can prevent them from engaging in common activities including speaking, eating, or writing in front of others (Semel Institute, 2009). Not surprisingly, they appear as extremely shy and self-conscious with peers and with adults. Some individuals with social phobia seem to lack good social or interactional skills, which may contribute to their anxiety about social situations. Extreme social anxiety sometimes results in failure to speak when away from home. Avoidance of situations that involve social interactions significantly interferes with school performance and attendance, as well as the ability to socialize with peers and develop and maintain relationships. The lives of family members also are affected as social events that a family might do together (e.g., family reunions, church events) often must be avoided.

**Agoraphobia**

Reflecting the tendency for anxiety to take different forms as a child matures, agoraphobia, as described by Sarah in Vignette 27-1, may emerge as a separation anxiety disorder or a school phobia in childhood. Treatment for children with anxiety disorders always occurs under the care of a mental health expert. Occupational therapy may be involved as a support at home or in school where the occupational therapist may build a relationship with a child that might then serve as a bridge to other social relationships. Consider Aisha’s story in Vignette 27-2.

### Vignette 27-2 Aisha: School Can Be Very Hard

Aisha, age 6, waited for her mother in the school nurse’s office. She was agitated and had soiled herself in class. Aisha does not speak to anyone at school. She is afraid to raise her hand and does not ask to leave her seat to use the toilet. Aisha has made no friends at school and seems quite fearful of the school environment. Aisha’s parents report that she does speak at home and tells them: “I hate school! The other kids all think I’m weird and no one wants to be my buddy in class projects.” Aisha is able to do all the school reading and writing assignments, but does not participate verbally at school or in playground activities.

Aisha saw a child psychiatrist. She also worked with a school occupational therapist. The occupational therapist befriended Aisha and then began spending time on the playground during recess. She always brought along activities that interest 6-year-old girls: a jump rope or some chalk, for example. She would begin playing with Aisha but before long some other children invariably showed up. The occupational therapist was Aisha’s “special buddy.” She knew exactly how to facilitate the play. Before long, she could move away from the game—a few feet away and then farther.

**Childhood Separation Anxiety Disorder**

Childhood separation anxiety disorder, which affects approximately 4% of children, is characterized by significant (often extreme) distress when a child is separated from his or her loved ones. The extreme emotional distress at partings, even anticipated partings, may include headaches, nausea, vomiting; the distress limits independence in everyday life. The child may withdraw, worry excessively about losing the subject of attachment, or have difficulty concentrating when separated from attachment figures (Williams & Pearman, 2010).

**MOOD DISORDERS**

Mood disorders are rare in preschoolers but are found in 2% to 3% of school-age children and 5% to 6% of adolescents (Kaplan & Sadock, 2002). There are two large classifications for mood disorders: depression and bipolar disorder. These mood disorders are presented in Table 27-5.
TABLE 27-5  Mood Disorders Common to Childhood and Adolescence

<table>
<thead>
<tr>
<th>Major Depressive Disorder</th>
<th>Mood Disorder Due to a General Medical Condition</th>
<th>Substance-Induced Mood Disorder</th>
<th>Dysthymic Disorder</th>
<th>Bipolar Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Illnesses (including cancer and chronic medical conditions) can trigger symptoms of depression.</td>
<td>Symptoms of depression secondary to the effects of medication or other forms of medical treatment, drug abuse, or exposure to toxins.</td>
<td>A chronic, low-grade, depressed or irritable mood for at least 1 year. The child may have been depressed for so long that he or she does not complain of feeling depressed.</td>
<td>Recurrent episodes of depression, mania, and/or mixed symptom states that interfere with daily occupations. Mood swings are rapid, often several a day.</td>
</tr>
<tr>
<td>Onset</td>
<td>Children may have anxiety and somatic symptoms with their depression. Depressed children are rarely psychotic.</td>
<td>When manic, children and adolescents may be irritable and prone to destructive outbursts.</td>
<td>May appear hyperactive, inattentive, fidgety, easily frustrated and prone to tantrums. The child may have difficulty making transitions.</td>
<td>May be bossy and overbearing resulting in social isolation, poor communication, and extreme sensitivity to rejection or failure.</td>
</tr>
<tr>
<td>Performance</td>
<td>A loss of interest in usual activities or activities once enjoyed. Sleep disturbances and daytime irritability are common. The child may have difficulty concentrating and have difficulty making decisions. Sudden decrease in school performance is often seen.</td>
<td>May involve hyperactivity, distractibility, and aggression.</td>
<td>May involve hyperactivity, distractibility, and aggression.</td>
<td>May involve hyperactivity, distractibility, and aggression.</td>
</tr>
<tr>
<td>Social Impact</td>
<td>Children with depressed mood are often very self-conscious and hypersensitivity to failure or rejection. Adolescence with mood disorders may leave old friendships and choose new friends mirroring their negative affect.</td>
<td>May involve hyperactivity, distractibility, and aggression.</td>
<td>May involve hyperactivity, distractibility, and aggression.</td>
<td>May involve hyperactivity, distractibility, and aggression.</td>
</tr>
</tbody>
</table>

Self-mutilation. The following excerpt creates a poignant picture of depression in adolescence and the social isolation associated with it. (See [http://www.depressedchild.org](http://www.depressedchild.org) for many additional “diary entries” describing the everyday experiences of children with depression.)

No one knows about this, it’s my “secret.” No one knows that this is what I go through every day of my life no matter where I am or who I am with. No one knows that I am scared. Everyone thinks that I am the happiest girl alive and not scared of anything and that I have no problems. Well, they are wrong. Wait until they see me after I did what I do—after I take away the pain.

I move the blade closer to my ankle. “Why do I have to live like this? Why can’t I live like everyone else and be happy?” So many questions and thoughts race through my mind. The tears are building up. I try to control them. I try not to cry, but I can’t hold it in. I have to let it out. I have to cry ... Every day I am in pain.

In Vignette 27-3, a mother describes her child who has depression and ADHD.
IMPULSE CONTROL DISORDERS

Impulse control disorders include attention-deficit/hyperactive disorder (ADHD), oppositional-defiant disorder (ODD), and conduct disorder (CD). ODD and CD are described further here. More information on ADHD appears in Chapter 28: Learning Disabilities. Collectively, ODD and CD are considered as antisocial behaviors rather than as coherent patterns of mental dysfunction (HHS, 1999). Perhaps unsurprisingly, children and adolescents with ODD and CD are more distressing or troubling to others than they are distressed or troubled by their own behavior. Openly uncooperative and hostile behavior becomes a serious concern when it is so frequent and consistent that it impairs the child’s and family’s participation in everyday life.

Some sources describe ODD and CD as variable manifestations of the same dysfunction (APA, 2000). Generally, ODD is considered the milder impairment and is sometimes the precursor to CD. These impulse control disorders are specific to children and adolescents with an age of onset prior to 13 years of age. Table 27-6 provides a comparison of these disruptive behaviors.

An evidence-based approach to treatment of children and adolescents with ODD or CD is Multisystemic Therapy (MST), a goal-oriented family-centered intervention targeting aspects of the young person’s social network (e.g., persons, places) that contribute to antisocial behavior (MST Institute, 2010). MST often includes family education to improve caregiver discipline practices, enhance family recreational and shared leisure activities; improve school participation and performance; and assist in developing a support network of extended family, neighbors, and friends to help both the parents and youth.

Typically MST services are delivered by a coordinated interdisciplinary team in the natural environment (e.g., home, school, community) (MST Services, 2010). A major focus is on improving school performance and developing support networks at school. Occupational therapy intervention in this approach is often school-based and focused on positive peer relationships, academic enhancement, and the development of positive, prosocial leisure and recreational patterns.

The MST Institute provides evidence from 3 decades of research that confirms MST reduces criminal activity and out-of-home placements for violent and chronic offenders. Among the positive results that have been documented are that long-term rearrest rates reduced by 25% to 70%, there is decreased substance use, and fewer identified mental health problems for serious juvenile offenders (MST Institute, 2010).

EATING DISORDERS

Human cultures tend to build routines and celebrations around the sharing of food, making it important not only physically but also culturally (Schuck & Bucy, 1997; Segal, 2004). When infants, children, or adolescents refuse to eat a healthy amount and variety of foods, they are considered to have an eating disorder. Families that have been coping with significant, life-threatening health problems with their children often have been exposed to significant medical pressure to increase their child’s food intake. When parents become emotionally invested in their child’s meals, the child is able to gain extra attention by becoming picky or highly selective about what they will eat. For these reasons, eating and mealtime occupations are a fundamental performance domain that should be addressed by occupational therapists both as a physical and a socioemotional skill arena. Treatment for children and adolescents with eating disorders typically involves medical interventions in hospital or community settings. In cases in which an adolescent is hospitalized, occupational therapy may be involved early in the recovery process.

### Table 27-6 Comparison of Impulse Control Disorders

<table>
<thead>
<tr>
<th>Description</th>
<th>An ongoing pattern of uncooperative, defiant, and hostile behavior toward authority figures like parents and teachers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Features</td>
<td>Child has frequent temper tantrums, arguing with adults, active defiance and refusal to comply with adult rules. The child may make deliberate attempts to annoy or upset people, blaming others for his or her mistakes.</td>
</tr>
<tr>
<td>Performance Impacts</td>
<td>Refusing to obey rules at home and school leads to poor performance in all everyday occupations.</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>An enduring pattern of negative behavioral and emotional problems that evolve over time.</td>
</tr>
<tr>
<td>Features</td>
<td>Child is aggressive and routinely violates the right of others. The aggression is to people and animals, and includes the destruction of property, deceitfulness or theft, and serious violations of rules. This condition may escalate as the child gets older.</td>
</tr>
<tr>
<td>Performance Impacts</td>
<td>Irresponsibility in daily routine and expectations paired with delinquent behaviors (such as truancy or running away), violating the rights of others (such as theft), and/or physical aggression toward others (such as assault or rape).</td>
</tr>
</tbody>
</table>
Anorexia, Bulimia, and Binge Eating

In the United States, approximately 3% of adolescent girls have one of the three main eating disorders: anorexia nervosa, bulimia nervosa, and binge-eating disorder (Becker, Grinspoon, Klibanski, & Herzog, 1999). These disorders are characterized by a preoccupation with food and a distortion of body image. Binge-eating disorder involves episodic, uncontrolled consumption, without compensatory activities, such as vomiting or laxative abuse, to avert weight gain (Devlin, 1996). Bulimia is marked by both binge eating and by compensatory activities. Anorexia nervosa is characterized by low body weight (less than 85% of expected weight), intense fear of weight gain, and an inaccurate perception of body weight or shape.

Infantile Anorexia

Infantile anorexia arises in the first 3 years of life (Chatoor, Surles, Ganiban, Beker, Paez, & Kerzner, 2004). However, it is often called “idiopathic failure to thrive.” Infants with failure to thrive fail to communicate signals of hunger, while showing a strong interest in exploration, play, and/or interaction with their caregivers. They tend to share a distinctive temperament, which includes high levels of irregularity, negativity, dependence, and persistence (Chatoor, Ganiban, Hirsch, Borman-Spurrell, & Mrazeck, 2000). Children with infantile anorexia elaborate and extend social contact with caregivers through extreme food refusal.

Here’s the Point

➤ Secure attachment has a positive impact on emotional development; insecure attachment, caused by neglect, abuse, or exposure to violence, poses a risk to emotional development.
➤ Anxiety disorders are the most common type of mental health disorder in children, affecting more than that of virtually all other mental disorders of childhood and adolescence; there are a number of types of anxiety disorders.
➤ OCD is characterized by intrusive thoughts that produce anxiety (obsessions), by repetitive behaviors aimed at reducing anxiety (compulsions), or by a combination of thoughts and behaviors.
➤ Social phobia is anxiety attached to social situations.

Prove It!

Anorexia and CBT

Pike, Walsh, Vitousek, Wilson, and Bauer (2003) conducted an evaluation of cognitive behavior therapy as a post-hospitalization treatment for anorexia nervosa. In this study 33 patients with anorexia nervosa were randomly assigned to 1 year of outpatient cognitive behavior therapy or nutritional counseling. It was found that cognitive behavior therapy was more effective than nutritional counseling in improving outcome and preventing relapse.

➤ Mood disorders are associated with suicide and suicidal behavior; therefore, their diagnosis and treatment are of utmost importance.
➤ Impulse control disorders include ADHD, ODD, and CD. Collectively, they are considered as antisocial behaviors rather than as coherent patterns of mental dysfunction.
➤ When infants, children, or adolescents refuse to eat a healthy amount and variety of foods, they are considered to have an eating disorder.

The Complexity of Childhood Mental Illness: Culture and Families

Several factors contribute to the difficulty of understanding, diagnosing, and describing childhood mental illness. For example, the nature of the disorders may change as a child matures. Further, differences in cultural norms also contribute to the complexity.

THE SHIFTING NATURE OF ILLNESS

While some diagnostic labels (e.g., disorders of impulse control and attachment disorder) are applied only to children, there is emerging evidence that mental illness changes over time, manifesting differently at different points of development. For instance, attachment disorders have been linked to personality disorders such that a very young child with a disorganized attachment disorder could later develop symptoms of borderline personality disorder (Miti & Chiaia, 2003). A similar developmental pathway of disruptive behavior disorders also has been proposed such that a young child with oppositional defiant disorder may later be diagnosed with conduct disorder and, as an adult with an antisocial personality disorder (Washburn et al., 2007).

To add to the diagnostic complexity, some disorders once thought to occur only in adults are now known to have an onset in childhood. The National Institute of Mental Health (NIMH) (2005) reported: “Not long ago, it was thought that many brain disorders such as anxiety disorders, depression, and bipolar disorder began only after childhood. We now know they can begin in early childhood.” The Methodology for Epidemiology of Mental Disorders in Children and Adolescents (MECA) Study estimated that almost 21% of U.S. children ages 9 to 17 had a diagnosable mental or addictive disorder associated with at least minimum impairment (NIMH, 2005).

CULTURE CONtributes

As Weisner and Lowe (2004) noted, culture is the most important tool that children use for adaptation to life. Perhaps that explains regional and cultural differences in
the incidence of some types of mental illness. For example, the incidence of anorexia nervosa is much higher in the affluent societies of the world (Hoek, van Hoeken, & Katzman, 2003), presumably reflecting the standards for beauty and achievement promoted through the popular media. In contrast, Hoek et al. reported that the incidence of anorexia nervosa among the black population of the island nation of Curacao is nil. These authors speculated that being overweight is socially acceptable in the African Caribbean population of Curacao. The norms about body size may have enhanced resiliency to the emphasis on thinness in the media and this might have served to protect young black women. Interestingly, the incidence among the minority mixed and white population in Curacao is similar to that of the United States.

**Family and Community Contexts**

Diagnostic labels such as “behavioral disorder” and “mental illness” can be misleading because they focus on the child or adolescent who carries the diagnosis while seemingly ignoring the family and community. The anxiety Sarah experienced associated with leaving the house will increase her parents’ needs for vigilance and could even cause legal problems for the family if her truancy is severe. The extended influence of mental illness is crucial to understanding the problem.

**MENTAL ILLNESS AFFECTS ALL FAMILY MEMBERS**

Because of the dependence of children on their families, the family context is one of the most significant to children with mental illness. When a child has a mental illness, the typical roles and daily occupations of all of the family members are challenged (Cara & MacRae, 2005). In the case of children with mental illness, particularly those with intense behavioral demands, parents commonly become very involved with that child. A disproportionate allocation of parental time and energy impacts the entire family. Parents have less time for themselves, each other, and for other children in the family. These other children may have to take on “adult” roles to assist with caregiving. As Jordan’s mother commented, “[Even now that he is 17], everything I do revolves around him. ... Like somebody wanted me to go to a really neat thing on Tuesday night, and it’s “No,” because I have to be home to get him in bed. Everything revolves around making sure his life is structured” (Cronin, 1995).

Cara and MacRae (2005) noted that, “While those with a mental illness are no more violent than the normal population, the family is often the target of their anger” (p. 13). This means that, not only is the child taking a disproportionate amount of the family’s physical, economic, and emotional resources, but the child may act in a hurtful way to the family members who are already providing extraordinary care. Understandably, other family members may react negatively, setting up a vicious cycle. Thus, problems in a family can never be ascribed exclusively to “deficits” or abnormalities of one member.

In addition to resource drain and the dysfunctional behavior of a child, families may experience censure from the community because of their child’s behavior and the things they must do to compensate for, or try to control, that behavior. Families deal differently with community pressures to conform, but strain can be debilitating. As one mother of a child with ODD commented during an interview:

**INTERVIEWER:** How do you think people perceive your special child?

**MOTHER:** They think he’s a bad influence, probably. This is my child I’m talking about. It’s horrible to think about how he is.

**INTERVIEWER:** When you meet people socially with your child, do you usually tell them about the problem?

**MOTHER:** I enjoy telling people. Because I don’t want people to say, “Look at that mother, she can’t handle her child.” I don’t enjoy it. That’s not the right word to say. But I want people to know that he has a problem, it’s not just that he’s bad. Because he’s not bad. You know, I don’t want them to think he’s bad, like everybody does. I want them to know there’s a reason for it. I mean, I don’t walk around and tell everybody, but the people I’m close to. Put a banner on the house (Cronin, 1995, p. 82).

**THE SPECIAL CHALLENGE OF PARENTING CHILDREN WITH MENTAL ILLNESS**

Many parents of children identified with a mental illness are attentive and supportive (such as Sarah’s parents described in Vignette 27-1 and Jordan’s parents described in Vignette 27-3). The parents are not to blame for their child’s illness or challenging behaviors. Nevertheless, both Sarah and Jordan have intrinsic challenges that made parenting them difficult. The “cost” to parents of a child’s mental illness varies greatly. Some parents feel guilt or denial. The mother in the interview above was anxious that people in the community knew that her child had a mental health diagnosis and that her child’s unacceptable behavior was not the result of something she had done or not done. Weisman and Lowe (2004) described well-being as the capacity “for engaged participation in the activities that a cultural community deems desirable, and the psychological experiences that go along with that participation” (p. 11). Clearly, the well-being of both children with mental illness and their families is at risk.
Processing, communicative intent, state control and arousal, to be based in one or more of four factors: sensory pro-
total Disorders of Infancy and Early Childhood, Revised
Diagnostic Classification of Mental Health and Developmen-
tory disorder appears in both the
ficult to console. In fact, the diagnosis of sensory regula-
tions to teach developmentally appropriate skills often
to exacerbate or cause emotional distress. Thus, interven-
tventions and consultation, important forms that inter-
ferred to Chapters 20: Direct Intervention through 22:
Programs. What follows are descriptions of the subject
matter for common interventions. Readers also are re-
ferred to Chapters 20: Direct Intervention through 22:
Consultation which describe direct and indirect inter-
ventions and consultation, important forms that inter-
vention can take with children who have mental health

ders showed no signs of another disorder.
moderate regulatory disorders had delays in develop-
ment or difficulties with parent–child relations. More
were documented during infancy and characterized as
mild, moderate, or severe. DeGangi et al. (2000) also
followed a group of children without RD. Children were
retested at 36 months with regard to development,
behavior, and play. At 36 months, 95% of infants with
moderate regulatory disorders had delays in develop-
ment or difficulties with parent–child relations. More
than half (60%) of children with mild regulatory disor-
ders showed no signs of another disorder.

The nature of occupational therapy intervention
depends in part on the setting. Different systems pull for
different approaches. Readers are referred to Chapters 4:
Early Intervention through 7: Transitioning to Adult-
hood, which describe common settings for intervention:
early intervention, preschool, school, and transition
programs. What follows are descriptions of the subject
matter for common interventions. Readers also are re-
ferred to Chapters 20: Direct Intervention through 22:
Consultation which describe direct and indirect inter-
ventions and consultation, important forms that inter-
vention can take with children who have mental health

tional Developmental Skills
Developmental asynchronies and skill deficits are likely
to exacerbate or cause emotional distress. Thus, interven-
tions to teach developmentally appropriate skills often
are used with children who have mental health diagnoses.

Sensory Supports
The term “regulatory disorder” is used to describe babies
who cry very often, have difficulty sleeping, and are dif-
ficult to console. In fact, the diagnosis of sensory regula-
tory disorder appears in both the Diagnostic Manual for
Infancy and Early Childhood (Interdisciplinary Council on
Developmental and Learning Disorders, 2005) and the
Diagnostic Classification of Mental Health and Developmen-
tal Disorders of Infancy and Early Childhood, Revised (Zero
to Three, 2005).

Disorders of regulation seen in infancy are thought
to be based in one or more of four factors: sensory pro-
cessing, communicative intent, state control and arousal,
and modulation of emotions (DeGangi, Breinbauer,
Roosevelt, Porges, & Greenspan, 2000). Careful assess-
ment followed by guided sensory enrichment in natural
environments can reduce distress in babies and promote
improved parent–child relationships.

Sensory processing interventions also are often used
with older children with mental health conditions, per-
haps because so many of these children appear to have
sensory processing or self-regulation disorders (Barnes
et al., 2003; Shultz, 1992). Growing support in the field
of psychiatry suggests that sensory interventions, as part
of an overall environmental enrichment program, may
be effective in reducing impairments in some children
(Raine, Mellingen, Liu, Venables, & Mednick, 2003). See
also Chapter 20: Direct Intervention for details on sen-
sory integration as an approach in direct intervention.

Here’s the Point
- Diagnostic labels such as “behavioral disorder” and
  “mental illness” can be misleading; they focus on the child
  or adolescent who carries the diagnosis while seemingly
  ignoring the family and community.
- When a child has a mental illness, the typical roles
  and daily occupations of all of the family members are
  challenged.
- In addition to resource drain and the dysfunctional
  behavior of a child, families may experience censure from
  the community because of their child’s behavior and the
  things they must do to compensate for, or try to control,
  that behavior.
- The “cost” to parents of a child’s mental illness varies
greatly.

Occupational Therapy Interventions

The objective of a study by DeGangi, Breinbauer,
Roosevelt, Porges, and Greenspan (2000) was to deter-
mine if symptoms of regulatory disorder (RD) during
infancy predicted the child’s functional status at
3 years. Problems with self-regulation, including sleep,
feeding, state control, self-calming, sensory reactivity,
mood regulation, and emotional and behavioral control,
were documented during infancy and characterized as
mild, moderate, or severe. DeGangi et al. (2000) also
followed a group of children without RD. Children were
retested at 36 months with regard to development,
behavior, and play. At 36 months, 95% of infants with
moderate regulatory disorders had delays in develop-
ment or difficulties with parent–child relations. More
than half (60%) of children with mild regulatory disor-
ders showed no signs of another disorder.

Prove It!

Regulatory Disorder

Establishing Rapport

Children and adolescents with mental health disorders
are particularly vulnerable; by definition they often lack
the required resources for dealing with everyday life
challenges. This vulnerability often manifests in the dif-
ficulty they have in relating to people or specific con-
texts. For this reason it is imperative for any mental
health professional working with children and adoles-
cents to be aware of this vulnerability and have particu-
larly well-developed skills in establishing rapport with
this client group. By specializing in play and using activ-
ities to engage children, the occupational therapist is
well equipped to establish rapport. Moreover, a main role
of the occupational therapist often is to act as an advo-
cate for children who are misunderstood by people in the
community.
COGNITIVE INTERVENTIONS

A number of cognitive approaches are used commonly with children who have disorders of mental health. Collectively, these interventions can be said to help children think differently about some aspect of their beliefs or functioning.

Cognitive-behavioral therapy, the most common of the cognitive approaches, and the Alert Program, a cognitive approach developed by occupational therapists, are described next. Other cognitive approaches used by occupational therapists include relaxation training and visualization and guided imagery. Reif (1997) commented that, “The ability to visualize with colorful, vivid images, rich imagination and detailed action are natural skills of childhood.” Imagery is helpful in developing focus and concentration; calming; coping with stress/anxiety; and increasing positive study skills, social skills, and creative expression.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) is a term used to describe a group of psychotherapeutic interventions that aim to reduce psychological distress and maladaptive behavior by altering cognitive processes (Kaplan, Thompson, & Searson, 2005). Metacognitive skills (e.g., planning and selecting strategies, monitoring learning, correcting errors, analyzing the effectiveness of strategies) are required for children and adolescents to engage in CBT (Ridley, Schutz, Glanz, & Weinstein, 1992). Although metacognition develops throughout childhood, specific training to support the development of problem-solving skills and self-reflection can be important to children with mental health impairments.

Cognitive reframing is one of the strategies most widely used in CBT. This approach, originated by Beck (Seligman, 1996), is based on the idea that people need to cast aside their self-defeating, negative thoughts and substitute positive self-talk (i.e., cognitive restructuring or reframing). There are many approaches to cognitive re-framing. One example accessible to occupational therapists is teaching the child to talk about and rate fear. This approach is not intended to focus on the fear but to help children think differently about some aspect of their beliefs or functioning.

Alert Program

The Alert Program is a cognitive intervention developed by occupational therapists (Shellenberger & Williams, 1996) for children with sensory processing disorders. This program likens arousal levels to an engine running. It consists of a series of activities that teach children and caregivers (especially for very young children) to recognize the feel of various levels of arousal (i.e., far too low, optimal, far too high). Children and caregivers also explore methods for changing engine levels, allowing the child to function more frequently at an optimal level.

SOCIAL SKILLS TRAINING

Children with emotional and social behavioral disorders may benefit from specific support for school issues, including social interaction problems, peer issues/bullying, and poor classroom participation. Social skills training has an important cognitive component in that it helps children think differently about social situations. Social skills training should be individualized and be accompanied by supports in natural social environments.

Social Stories

A social skills training approach commonly used with young children is Gray’s (2003) Social Stories approach. In this approach, the therapist creates a story that includes many details specific to the child’s social and environmental context. The goal of Gray’s technique is to help children and adolescents rehearse and evaluate difficult or stressful situations in a safe and comfortable context. The therapist seeks to improve the child’s understanding of events and expectations that, in turn, may lead the child to use more effective behaviors. This approach is a cognitive approach because it teaches problem-solving and self-reflection.

To develop a social story, the therapist chooses a single event or issue that the child finds distressing and builds a series of factual statements or action strategies that the adult and the child rehearse together. When writing a social story, the perspective taken on the subject will vary, depending on the location of the child, the personal impact of the event, and the opinions of the adults in the child’s life (Hoekman, 2005). Box 27-1 includes an example of a social story designed for Aisha, the young girl with selective mutism described earlier in the chapter.

The social stories approach provides cognitive reframing and a structured training process that integrates aspect of cognitive behavioral intervention into a format that is flexible and effective in that child’s natural environments (Fig. 27-2). This approach is easily adapted for use within home, school, and community settings.
outcomes and minimizing problem behaviors (Crone & Horner, 2003; Crone, Horner, & Hawken, 2004). In a PBS approach, a child’s lack of skill as well as setting- and system-level constraints are analyzed and altered to reduce inappropriate behavior and teach more appropriate behavior, and provide contextual supports necessary for successful outcomes (Warger, 1999).

**BOX 27-1**

**EXAMPLE OF SOCIAL STORY**

**Being Worried Is Okay: People Want to Help Me**

It’s okay to feel worried sometimes. All people feel worried now and then. As children become older, they learn safe ways to handle their worries. This is very, very, very, very important. It makes it easier to learn and to make friends at school.

It’s important to keep thinking when I am afraid or worried. It is easy to forget to talk, or tell people when my worries are big. When I don’t talk, teachers and kids don’t know why I am doing things. I can make mistakes when I am worried. It is a good thing that as people get older they learn to make good choices EVEN WHILE THEY ARE WORRIED. This, of course, is a very mature and grown-up thing to do.

Even when children are very, very, worried, they can learn to keep thinking so that they make good choices and tell people important things. Knowing what to think is important. Here are three things that mature, intelligent children like me learn to think when they are angry:

1. Mr. Green, my teacher, wants me to be comfortable and safe at school. Even if I cannot talk to him, I can write notes or plan signals so Mr. Green will know that I need to leave the room.
2. There is a solution to this problem. Talking to others is really the only good way to find these solutions. I can talk to any adult in the school privately. My mom can help the adults know me so they can meet with me when I have a problem.
3. It’s possible to have a bad time during a good day. Sometimes children feel angry or sad for a short time, but they know the good day will return. This is especially true when children make good choices while worried.

When children get older, and they still are too worried to talk, people wonder why that child is deciding to do what usually only very young children do. By the time children are in third grade, they make very calm, intelligent, safe decisions when they are worried. They stay in control ALL of the time. I am learning to do this, too. More and more, I stay calm and keep thinking and working with others when I am angry. This is a very intelligent and mature thing to do!

**FIGURE 27-2** Social groups can serve many functions in the development and maintenance of mental health. Using such groups to develop social stories can provide a powerful intervention. (Photograph courtesy of Art Hsieh.)

**BEHAVIORAL INTERVENTIONS**

A number of behavioral approaches can be used with children who have mental health disorders to address problematic behaviors. These approaches are often used with children who have intellectual disability in addition to their behavioral problems. One such approach is positive behavioral support.

**Positive Behavioral Support**

Positive behavioral support (PBS) includes a range of long-term strategies for achieving social and learning outcomes and minimizing problem behaviors (Crone & Horner, 2003; Crone, Horner, & Hawken, 2004). In a PBS approach, a child’s lack of skill as well as setting- and system-level constraints are analyzed and altered to reduce inappropriate behavior, teach more appropriate behavior, and provide contextual supports necessary for successful outcomes (Warger, 1999).
Prevention: Creating Opportunities to Promote Mental Health

Community-based programs are ideally placed to prevent disorders of mental health in children and adolescents. Occupational therapists are well suited to run, or consult with, such programs. Exercise groups are one such supportive approach. Regular exercise groups have been found to result in improved mood and sense of well-being (Bartholomew, Morrison, & Ciccolo, 2005; Lane & Lovejoy, 2001).

Education of parents regarding all aspects of development and parenting represents another important prevention activity. Parenting behaviors can both prevent and exaggerate mental health problems in children. Through modeling positive interactions and providing appropriate child-specific information, the occupational therapist or other professional may reduce the caregivers’ tension when providing care.

An example of a potential system-level prevention service is “transition planning” that is legally mandated in the United States (but which is also practiced in many other countries) to help adolescents with disabilities transition out of school into the community. Occupational therapists in the schools are ideally prepared to support the prevention of emotional and social problems for these adolescents, but unfortunately few actually participate in the process (Kardos & White, 2005).

Summary

In this chapter we have described some of the main difficulties associated with diagnosing mental illness in children, including distinguishing illness from normal developmental phases and transient developmental reactions to crisis. Toward that end, we listed common manifestations of mental illness in infancy, childhood, and adolescence. As children become older and more is expected of them by their various cultural groups, the symptoms become less vague and more easily detected. We have described the incidence and characteristics of various common childhood conditions, risk factors that may predispose children to disorders, and the diagnostic process used to unravel the source of difficulties experienced by a child or adolescent. We have discussed common approaches to occupational therapy intervention and provided some thoughts on programs for promoting mental health.

References


