

## LECTURE 3: BEHAVIORAL SYMPTOMS & MENTAL HEALTH DIAGNOSES

**Focus:** *What to expect when a child has a mental health disorder, fundamentals of special education eligibility, and common psychiatric diagnoses.* [SLIDE 4]

This lecture will provide an overview of some emotional or behavioral characteristics that are required for special education services due to a mental health disorder, and what characteristics might lead to a formal psychiatric diagnosis. We will review the differences in terminology and eligibility between the school, social service, and medical systems. The bulk of this class meeting should be spent on small-group presentations of the 15 most common child and adolescent mental health disorders, how students with these disorders might respond in the classroom, and some recommended accommodations. The PowerPoint slides and the textbook or fact sheets are required for this lecture.

This lecture will focus on the behavioral characteristics teachers might see when their classroom includes a child with a specific mental health diagnosis. It is not meant to be a diagnostic guide, although it can be useful in helping teachers decide where to seek further information and whether to suggest diagnostic testing. Information for this lecture is summarized from the MACMH publication *A Teacher's Guide to Children's Mental Health* (MACMH, 2002).

[SLIDE 5] A psychiatric diagnosis is made by a licensed mental health professional (see Background Brief D), usually using criteria described in the DSM-IV (Diagnostic & Statistical Manual, 4th Ed., APA, 1994). Many disorders show similar symptoms, and a child may have a combination of disorders — for example, attention-deficit/hyperactivity disorder (AD/HD) and depression. These are then called “co-existing” or “comorbid” disorders. It may take years for a family to get an accurate diagnosis. Sometimes a physician’s evaluation report will include the whole succession of earlier diagnostic hypotheses, rather than replacing an old diagnosis with a newer one. Do not assume that a long string of technical names means a child is more severely disordered.

[SLIDE 6] Please note that *the criteria used to establish special education eligibility and the criteria for a psychiatric diagnosis are not the same.* It is also important to stress that neither set of criteria determines which educational supports will best serve a child’s need. Some children with a psychiatric diagnosis will be classified as having an emotional or behavioral disorder (EBD); some will be classified as students with other health disorders (OHD); some will not qualify for special education but be assisted by means of a 504 Plan; and some will need no educational assistance at all. Remember that special education is a service, not a classroom. Adding to the confusion, many

### PLEASE NOTE:

Slides for this lecture can be downloaded at no charge from [www.macmh.org](http://www.macmh.org).

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children classified as EBD and using special education services never receive a full psychiatric evaluation and diagnosis. (See Background Brief E for information on Special Education, IEPs [Individualized Education Program] and Section 504 of the Rehabilitation Act of 1973.)

**[SLIDES 7-10]** Revisions in Minnesota's EBD criteria made in 2004 were designed to clarify that inappropriate behavior is *not* the only factor used to determine whether or not a child has an emotional or behavioral disorder. Again, it is important to stress that meeting one or another set of criteria does not determine what classroom a student will be in or what services he or she will receive; these are team decisions made based on evaluation data including teacher and family input.

**[SLIDE 11]** Section 504 is the civil rights legislation that provides every student with the right to "equal access" to learning opportunities. This requires a school to offer accommodations to a student who has a functional deficit in one or more areas when compared to typical peers.

### "Developmental" Brain Disorders

This lecture also covers brain disorders such as pervasive developmental disorders (autism, Asperger's syndrome) and fetal alcohol spectrum disorders. These are sometimes called developmental disorders because they reveal themselves in early childhood, often as delays in normal development. Materials are included here because children with these disorders may be classified as EBD because they often exhibit symptoms and behaviors that are similar to those of children with other mental health disorders. These children need many of the same accommodations to help them succeed in school and to prevent secondary symptoms from occurring.

Another reason for including these disorders is the long and difficult road often traveled before an accurate diagnosis is recorded. Several preliminary diagnoses may be used. Sometimes a diagnosis will change completely, or clinicians may later discover that an underlying developmental difficulty, such as Asperger's, may co-exist with disorders such as bipolar disorder or learning disabilities.

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### PLEASE NOTE:

PowerPoint slides 7-10 summarize the latest criteria used by the Minnesota Department of Education for "Emotional or Behavioral Disorders and Other Health Disorders."

**ABOUT MENTAL HEALTH DIAGNOSES**

[SLIDE 12] To summarize this material in a useful way, we will review the diagnoses in categories based on similarities between their symptoms or underlying factors. These are DSM-IV medical categories used by mental health professionals to provide a useful way of thinking about the relationships between disorders. Often, behaviors will overlap within the categories, and the same accommodations may be useful across the range of a category as well.

**Disorders First Diagnosed in Infancy, Childhood, or Adolescence****Pervasive Developmental Disorders**

- Pervasive Developmental Disorder — Not Otherwise Specified (NOS)
- Autism
- Asperger's Syndrome

**Attention-Deficit and Disruptive Behavior Disorders**

- Attention Deficit Hyperactivity Disorder (ADHD)
- Attention Deficit Disorder without Hyperactivity (ADD)
- Oppositional Defiant Disorder
- Conduct Disorder

**Tic Disorders**

- Tourette's Disorder (also known as Tourette Syndrome)

**Other Disorders of Infancy, Childhood, or Adolescence**

- Reactive Attachment Disorder

**Fetal Alcohol Syndrome and Effects (FAS/FAE)**

(Not yet a DSM-IV diagnosis; also known as Fetal Alcohol Spectrum Disorder)

**Schizophrenia and other Psychotic Disorders****Mood Disorders**

- Depressive Disorders, Depression
- Bipolar Disorder (Manic Depressive Illness)

**Anxiety Disorders**

- Generalized Anxiety Disorder
- Phobias
- Social Phobia
- Panic Disorder
- Obsessive-Compulsive Disorder (OCD)
- Post Traumatic Stress Disorder (PTSD)

**Eating Disorders**

- Anorexia Nervosa
- Bulimia Nervosa

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### Critical Incident

#### [SLIDES 13-28]

**Small group activity:** Each group review the information in a specific disorder fact sheet (see Note at bottom of this page) and report back to the class. The report can be prepared during class time (allow at least 20 minutes), or groups can receive their assignment beforehand and come to class ready to present. Here are some suggested questions for groups to discuss:

- Do you think this is a malfunction located in the basal ganglia, in the frontal lobe, or elsewhere in the brain? Why?
- Would you expect a student with this disorder to require modifications of class content, a different presentation style, behavioral support, or accommodations in all three areas?
- What else would be helpful for you to know about the behavior of a student with this disorder?
- How would you explain the disorder to the student's classmates in simple terms to help them understand, to stop teasing or harassment, and to build a supportive classroom climate?

The next class meeting will consider specific classroom techniques that can lessen disruptive behaviors and eliminate other barriers to learning and success. You may wish to present the diagnoses by category, or use the alphabetical arrangement used in the *Teacher's Guide*.

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#### PLEASE NOTE:

This small group activity *requires* the use of the Children's Mental Health Fact Sheets for the Classroom, which are included in the recommended text. The fact sheets can also be downloaded for free at [www.macmh.org](http://www.macmh.org).

### Critical Incident

Conduct two or three of the following simulations and encourage discussion of the class's reactions. The goal is to experience some typical symptoms of specific disorders and to develop understanding and respect for the challenges faced by students with mental health disorders.

- **Selective Attention and Over-stimulation (AD/HD, Asperger's Syndrome, Tourette's Disorder, Autism, FAS/E, Bipolar Disorder)**

Fold "caps" or "ear muffs" of tin foil, prepare CD player or radio by turning the bass all the way up and treble all the way down with volume very high. With music playing and ear muffs on, ask students to read the following paragraph while you are blinking the room lights on/off or dim/bright.

*"The brain must sift through thousands of incoming messages per second, attending to the important signals and muffling the less urgent. A student with an impaired sensory integration system may have no way to sort out the flood of information which assaults him or her at all times."*

Allow discussion of the reactions. You might also want to ask how long the exercise lasted; to most people, it seems to last much longer than it actually does.

- **Visual Motor and Distractibility (AD/HD, Tourette's Disorder, OCD)**

Have students copy the "Pledge of Allegiance" from a board in the front of the classroom, directing them to start over each time they look from their paper and up to the board. (Coordination of visual input and motor activity is a common problem for students with mental health disorders, and simply copying from the blackboard or from a textbook can be overwhelming.)

- **Tics and Obsessions (Tourette's Disorder, OCD)**

Direct students to write the "Pledge of Allegiance" under the following conditions; have students keep a running count of the number of times they write the letter "e" (do not count afterward); if they lose count, they must begin again. As they are writing rap on the table at random intervals, and have the students jerk their head sharply to the side, each time they hear the rapping.

(Counting is among the most common obsessions and is usually an internal process. Students whose work is disrupted this way may never explain their compulsion and may have no idea that everyone does not do the same thing. Physical tics are distracting, time-consuming, and often painful.)

These symptoms make routine classroom tasks arduous and exhausting. For children with these types of disorders, it is a challenge to make it through the day. They have to struggle enormously to complete schoolwork, let alone excel. By experiencing a semblance of the distractions and problems these children face, teachers can learn to understand that students "can't" rather than believing that they "won't." This is the basis of active classroom management based on support and prevention. Such active management is more effective than reactive classroom management based on rewards and consequences.

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### Critical Incident

### Quiz

### LECTURE 3: QUIZ OR DISCUSSION

1. Tourette's syndrome, AD/HD, and OCD often co-occur. Does this surprise you? Why or why not?
2. Have you seen a media portrayal of a person with mental health disorders, for example in a news story, movie, or TV show? Do media images reflect the diagnostic criteria that have been discussed in class? What affect could a mismatch between the media and reality have on a teacher's relationship with a student? On relationships between peers?
3. Children with bipolar disorder are often first diagnosed as having AD/HD. Why does this make sense?
4. What other Special Education category(ies) may include children with emotional or behavioral disorders?

### REFERENCES

American Psychiatric Association (APA). (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC.

Lepicello, Mitch. (2003). "Disorders first diagnosed in infancy, childhood, or adolescence." Available from Minnesota Association for Children's Mental Health (MACMH).

Minnesota Association for Children's Mental Health (MACMH). (2002). *A teacher's guide to children's mental health*. St. Paul, MN: Author.

**LECTURE 3: ANSWER GUIDELINES**

**Quiz or Discussion**

1. The control of movement, inattention, and over-attention (perseverance) are all mediated by the neurotransmitters in the basal ganglia region of the brain.
2. *Monk*, *The Practice*, and *Allie McBeal* are TV shows that have featured characters with mental health disorders. *David and Lisa*, *Rainman*, and *As Good as It Gets* are just a few movies portraying characters with mental health disorders. Even the best attempts usually portray only one individual and, too often, the public is left with the impression that every person with that disorder is going to behave like that one person. In addition, news and media coverage tend to focus on persons with violent and uncontrollable behavior, increasing the stigma that affects children and families dealing with such a disorder.
3. The symptoms of early-onset bipolar disorder differ from those seen in adults, and doctors are just beginning to recognize this diagnosis in young children. The manic phases may well be mistaken for hyperactivity, and may occur as often as several times a day. Depressive phases are usually revealed in extreme irritability or an outbreak of wildly angry and aggressive behavior, and it, too, can be mistaken for hyperactivity or oppositional defiant disorder.
4. OHD (other health disorders), autism spectrum, Specific Learning Disabilities (SLD).

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### **BACKGROUND BRIEF C** **WORKING AS A TEAM**

Students with brain disorders may need special help “learning how to learn,” how to resolve problems, even how to play. Many lack the organizational, study, and social skills that enable them to function competently in the school community. Some do not even understand the basic vocabulary of classroom instructions. These lectures address some of the assistance a teacher can provide. However, teachers also need to know that there is a team of allies standing by to help if they are asked.

A teacher’s first and best ally is always the student’s family. They should be considered the true experts on a student’s strengths and his behaviors. Solicit family input during all planning, and inform families of student progress on a regular basis. Too often, families are asked to participate only when their children are having difficulties. Sharing successes and celebrating together establishes a deeper and more productive relationship (CECP, 2000).

Creating school success may require teaming with school support staff and non-school professionals in a student’s life. A range of professionals may be working with the student, and they will fill your requests for information provided that the student’s right to privacy is maintained (See Background Brief I). Working in this collaborative manner ensures consistency throughout the settings in the child’s life, contributing to the chance of successful outcomes. Following is a list of some of the professionals you may interact with.

#### **School Personnel**

**Case manager:** responsible for organizing IEP team meetings, maintaining records, and informing regular education teachers of accommodations needed by a specific student. A case manager may be a special education teacher or another school professional.

**School psychologist:** organizes evaluations and conducts some testing.

**School social worker:** helps with family/school relationships; sometimes organizes student support groups on topics like divorce, social skills, etc.

**Counselor:** has duties similar to that of a school social worker; helps with transition to post-secondary education or school-to-work.

**Occupational therapist:** makes sensory integration recommendations; works with student on fine motor skills such as handwriting and activities of daily living.

**Speech-language therapist:** works with students on speech and language development; as well as social language (pragmatics), nonverbal language, following directions, and memory skills.

**Paraprofessional or teacher aide:** non-licensed staff member who assists with accommodations needed in the classroom. May be a general aide or assigned one-on-one to a single student with considerable needs.

**Cultural liaison:** knowledgeable member of a student’s cultural community who can advise the team as needed. May be a licensed school professional or unlicensed community advocate.

## BACKGROUND BRIEF C, continued

### Licensed Mental Health Professionals

**Child and adolescent psychiatrists:** medical doctors with specialization in psychiatry and advanced training in working with youth. Services may include evaluation, diagnosis, prescribing and monitoring medications, and a range of other options including direct therapy sessions.

**Neurologists:** licensed medical doctor with specialty training in the brain and nervous system. Children with a “developmental” disorder such as FAS or autism, with AD/HD, with Tourette syndrome, or with seizures may be diagnosed and followed by a neurologist.

**Psychologist:** a licensed psychologist (LP) in Minnesota must have a doctoral degree with a major in psychology. Psychologists licensed before that requirement may have an MA/MS and be “licensed by waiver.” A student may see a psychologist for evaluation as well as diagnosis and treatment, which may include individual, group, or family therapy. Psychologists cannot prescribe medication.

**Psychology practitioner:** individual with an MA or MS in psychology; practitioners have supervised practical experience.

**Clinical social worker:** licensed independent clinical social worker (LICSW) must have a graduate degree in clinical social work and can provide mental health therapy.

**Marriage and family therapist:** licensed professional with a graduate degree who specializes in family-related issues.

**Chemical dependency counselors:** licensed and unlicensed counselors trained and experienced in chemical dependency; staff titles and requirements vary widely and many have little training in mental health disorders.

**Psychiatric Nurse:** registered psychiatric nurse (RPN) has advanced training in mental health treatment. RPNs may recommend but cannot prescribe medication.

### Unlicensed Practitioners

Training varies widely and some of these practitioners are quite experienced and skilled. By law, they are not allowed to refer to themselves as psychologists or by any other licensed title, and they cannot prescribe medication. Some of the titles you may see include:

- Professional counselor
- Mental health counselor or practitioner
- Holistic therapist
- Psychotherapist
- Pastoral counselor
- Personal care assistant (PCA)
- Mental health behavioral aide (MHBA)

### **BACKGROUND BRIEF C, continued**

#### **Other Systems and Professionals**

- **County Social Service Systems and Children's Mental Health Collaboratives:** may fund and coordinate services and provide informal community supports for children and their families.
- **Public systems professionals:** may include social workers, case managers, collaborative coordinators, family team facilitators, and corrections officers. Any of these may also be a licensed or unlicensed practitioner.
- **Juvenile justice professionals:** may include a community/school liaison officer, truant officer, diversionary program director, or probation officer.
- **Community team members:** other persons who may be involved in the life of a child or his family and are invited to attend team meetings. These might include family friends, members of the extended family, professional or informal advocates, respite providers, school and in-home aides, church or community group mentors, and others important in the life of the student. Like the parents, these "informal support people" may have unique and valuable insight into a student's strengths, skills, and needs. Team members may also be able to provide informal supports such as job shadowing, respite, mentoring, or tutoring.

#### **RESOURCES**

Center for Effective Collaboration and Practice (CECP), American Institutes for Research. (March 2000). *Working together with families, educational strategies for children with emotional and behavioral problems.*

Minnesota Association for Children's Mental Health. (2003). *A survival manual for parents of children with emotional and behavioral disorders and mental health needs.*

**BACKGROUND BRIEF D**  
**SPECIAL SERVICES IN THE SCHOOLS**

**IDEA:** The Individuals with Disabilities Education Act (IDEA) states that all children with a disability (including mental health disorders), as defined by the law or by state criteria, are entitled to a Free, Appropriate Public Education (FAPE). It also mandates that their education must be in a regular classroom as much as possible — the Least Restrictive Environment (LRE).

Parents or school staff may request an initial evaluation for special education services. The evaluation should include intelligence, personality, speech, language, and academic achievement, plus other areas depending on the individual student. It should also include observations by teachers and other staff members and input from the parents (and the student himself if possible).

This evaluation, if the child proves eligible, provides the basis for an Individualized Education Program (IEP). This is written by the entire team, including parents, and it spells out the services to be provided based on measurable goals and objectives. A regular education teacher should always be part of the IEP team so the student's goals can be coordinated with the regular education curriculum as appropriate.

**504 Plans:** Students who don't qualify for special education but who do have a disability, may qualify for a 504 Plan that modifies the regular school program. 504 plans are not provided by or carried out by special education personnel; they apply only to general education. These plans are derived from Section 504 of the Rehabilitation Act of 1973, which requires federally funded programs to be accessible to all persons with disabilities. Section 504 is designed to protect individuals whose physical or mental impairments "substantially limit" major life activities such as self-care, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working. Again, a team determines modifications under the plan; modifications might include shortened assignments, special allowances for fidgety or inattentive behaviors, or help with organizational skills.

*Contact school or district administration for more information about these programs. Many advocacy groups provide workshops for parents and teachers on the fundamentals of special education laws.*

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### **BACKGROUND BRIEF E** **DEFINITIONS OF ED AND SED**

**Emotional disturbance (ED)** means an organic disorder of the brain or a clinically significant disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

1. Is listed in the specific code ranges of the International Classification for Diseases (ICD-9), current edition, or in the American Psychiatric Association's Diagnostic and Statistical Manual or Mental Disorders (DSM-MD), current edition; and
2. Seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

**Severe emotional disturbance (SED)** means having an emotional disturbance (see above) and meeting one of the following criteria:

1. Has been admitted within the last three years (this is included in an effort to provide on-going coordination to children who have been removed from their home), or is at risk of being admitted to an inpatient or residential treatment program for emotional disturbance.
2. Is a Minnesota resident receiving treatment for emotional disturbance through the Interstate Compact.
3. Is a child with one of the following as determined by a mental health professional:
  - a. psychosis or clinical depression
  - b. risk of harming self or other as a result of an emotional disturbance
  - c. psychopathological symptoms as a result of being a victim of physical or sexual abuse or psychic trauma within the past year.
4. Is a child who, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year, or, in the written opinion of a mental health professional, presents substantial risk of lasting one year.

**BACKGROUND BRIEF F  
SERVICE ELIGIBILITY**



**All Minnesota Children:**

- Education and prevention services
- Early identification and intervention services
- Emergency services

**Emotional Disturbance** — the services listed above **and:**

- Outpatient services
- Case management services
- Family community support services
- Day treatment services

**Severe Emotional Disturbance** — the services listed above **and:**

- Therapeutic foster care
- Benefits assistance
- Residential treatment services
- Acute care hospitalization

**Severe Emotional Disturbance and at risk of out-of-home placement or returning from out-of-home placement** — the services listed above **and:**

- Professional home-based family treatment

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