International Encyclopedia of Rehabilitation

Center for International Rehabilitation Research Information and Exchange (CIRRIE)
515 Kimball Tower
University at Buffalo, The State University of New York
Buffalo, NY 14214
E-mail: ub-cirrie@buffalo.edu
Web: http://cirrie.buffalo.edu

This publication of the Center for International Rehabilitation Research Information and Exchange is supported by funds received from the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education under grant number H133A050008. The opinions contained in this publication are those of the authors and do not necessarily reflect those of CIRRIE or the Department of Education.

Emotional Disorders (In Children and Adolescents)

Janet Shakuntala Walker, Ph.D.
Director of Research and Dissemination
Research and Training Center on Family Support and Children's Mental Health
Senior Research Associate
Regional Research Institute
Portland State University
Portland Oregon

Jonathan Kessler Melvin, QMHA
Research Assistant
Research and Training Center on Family Support and Children's Mental Health
Research Assistant
Regional Research Institute
Portland State University
Portland Oregon

Note: This article focuses on children and adolescents to age 18 though, for brevity, we sometimes use only the word "children."

The term *emotional disorder* is not a formal diagnosis, and thus there are no well-defined guidelines for its use. Most typically, when a child or adolescent is described as having an emotional disorder, this means that he or she has a diagnosed—or diagnosable—disorder of mood or anxiety. These kinds of disorders are characterized by feelings of intense internal and/or emotional distress that last, either continually or intermittently, for a period of months or years.

The broad categories of mood and anxiety disorders each include numerous specific diagnoses. There are two established systems for diagnosing mental disorders: the International Classification of Diseases (ICD-10), published by the World Health Organization (WHO 2004), and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), published by the American Psychiatric Association (APA 2000). These classification systems have converged over the years, so that most diagnoses are comparable. Each system includes a broad category of *mood disorders*, among which are the depressive and bipolar disorders. Each system also includes a broad category of *anxiety disorders*, which include Post-Traumatic Stress Disorder and Obsessive-Compulsive Disorder, as well as various specific phobias and anxieties. Mood and anxiety disorders can be diagnosed in children or adults; however, each of the two classification systems also includes a separate category of disorders that are typical of childhood and adolescence. Within this broad category—which includes a variety of types of disorders—each system lists a few emotional disorders that typically begin in childhood (e.g., Separation Anxiety Disorder).

Diagnosis

Formal diagnosis of an emotional disorder requires that a clinician decide whether or not a child or adolescent meets the criteria for the disorder as described in one of these classification systems. During the diagnostic process, the clinician typically observes and interacts with the child, and considers reports from adults who know the child well. Yet even with the use of these very detailed classification systems, diagnosing emotional disorders in children and adolescents can be extremely difficult. There are several reasons why this is the case. First, the criteria used to describe and distinguish most of these disorders in children are based on the criteria used for adults. However, the signs, symptoms, and course of a disorder in children may be very different from those in adults. Little systematic research has examined how well the diagnostic criteria actually apply to children. Diagnosis is further complicated by the fact that children often lack the verbal skills to describe their experiences, emotions or thought processes. Thus, clinicians often find themselves in the position of having to make diagnoses without key pieces of information. Diagnosis is also made difficult because children and adolescents undergo many changes as they grow and develop. Signs or symptoms such as angry outbursts, irritability, sadness, shyness, or fearfulness are key features of certain emotional disorders; however, they are also normal childhood behaviors under certain circumstances or at certain stages of development. In reaching diagnoses, clinicians are thus often required to make subtle distinctions, based on their assessment of the intensity and/or developmental appropriateness of behavior. Cultural factors can also impact the expression and interpretation of signs and symptoms (Westermeyer and Janca 1997). Finally, it is not uncommon for children to have multiple or *co-occurring* disorders. It can be difficult for clinicians to determine whether a set of symptoms is more consistent with a single diagnosis or with two or more diagnoses, particularly since one disorder—or the treatment for one disorder—can alter, conceal, and/or amplify the symptoms or signs of another disorder.

Uncertainties or disagreements about the appropriate diagnosis of emotional disorders are thus not uncommon, and can lead to controversy. This has been the case recently in the United States, where controversy has surrounded the rapid increase in use of the diagnosis of bipolar disorder in children and adolescents (Moreno et al. 2007). This increase appears to be unique to the United States, and this fact, coupled with the extreme rapidity of the rise, has led to questions about the accuracy of diagnosis, the suitability of diagnostic criteria, and possible external influences on the diagnostic process, such as changing cultural expectations for behavior and increased marketing of mood stabilizing medications by pharmaceutical companies (Harvard Medical School 2007; Mick et al. 2003).

Prevalence

From a public health standpoint, it is important to know how common emotional disorders are among children and adolescents, and whether prevalence rates are affected by the social, cultural and/or public policy contexts that surround children and families in the communities and countries where they live. While these are complex issues, recent

studies have provided initial information about the prevalence of emotional disorders and how prevalence rates vary internationally.

The prevalence of emotional disorders among children and adolescents can be assessed in different ways, making it difficult to compare findings from different studies. For example, some studies report prevalence during a particular period of time, while others estimate a cumulative prevalence (i.e., the percentage of children who will experience a disorder before they reach a certain age). Furthermore, different studies report on different age ranges, and use very different methods to gather data. In sum, differences in method and analysis produce very different estimates for the prevalence of emotional disorders (Roberts et al. 1998). One systematic review of prevalence studies from around the world found median prevalence rates for all psychiatric disorders of 8.3% for preschoolers, 12.2% for preadolescents and 15.0% for adolescents (Roberts et al. 1998). Typically, about half or just under half of the children and adolescents in these kinds of studies have emotional disorders (Angold et al. 2002; Canino et al. 2004; Fombonne 1994; Meltzer et al. 2003; Waddell and Shepherd 2002).

A review of prevalence studies that used similar methodologies (Boyd et al. 2000) found that prevalence rates for anxiety and depression were similar in the North American and Western European countries (though Italy was somewhat lower than the other countries in this group), as well as Australia, Hong Kong, and China. Rates in Eastern European countries were higher. The authors for the study point out that these comparisons should not be considered definitive; particularly since it is difficult to know whether the self-report assessments used in the various studies were meaningful or valid when translated into different languages and across cultures.

In general, emotional disorders are about as common among children and adolescents as *behavioral disorders* (or *disruptive behavioral disorders*), the other major category of psychiatric disorders, which includes attention-deficit hyperactivity disorder (ADHD) and conduct disorder. However, the prevalence of emotional disorders among girls is typically found to be higher than boys (while the prevalence of behavioral disorders is higher among boys than girls). The prevalence of emotional disorders tends to increase among girls as they move through childhood and adolescence. The prevalence for boys does not tend to change in this manner. Many children with emotional disorders have more than one specific disorder, with the combination of anxiety and depressive disorders particularly common. It is also not uncommon for a child to experience both an emotional and a behavioral disorder.

Treatment

Emotional disorders are typically treated with psychosocial interventions (e.g., cognitive-behavioral therapy, family psychoeducation, social skills training, interpersonal psychotherapy, relaxation training, etc.) and medications, alone or in combination. Because there are so many specific disorders within the broad category of emotional disorders, there are also many different approaches to treatment. Many of these treatment approaches have been formally studied and the results published in peer reviewed journals. In recent years, efforts have been made to synthesize the findings from these

numerous studies, in order to provide clearer guidance about what treatments work best for which specific types of problems or disorders, and for which specific populations of children and/or adolescents (e.g., boys versus girls, or older versus younger children). A number of these research syntheses are available online, and are continually updated as new studies become available. Two prominent examples of online research syntheses that provide information about treatments for children and adolescents with emotional disorders are the National Registry of Evidence-based Programs and Practices (SAMHSA 2008) and the Cochrane Collaboration Reviews (Cochrane Collaboration 2008).

While these syntheses rigorously assess available research, they cannot provide definitive information about exactly what treatment will work best for a particular child. Research is expensive and takes time, so not all treatments have been formally studied. For such treatments, there may be no evidence that they are effective, yet there is also no evidence that they are *not* effective. Other treatments have been shown to be effective, but the studies were conducted among certain populations of children (e.g., adolescents or middle-class children or English-speaking children), so there is no guarantee that they will work with other populations (e.g. younger children, children from economically struggling families or children whose first language is Spanish). Additionally, the findings from research on treatments usually show that the treatment works on average. For some children it works well, and for others, not so well. Thus even a treatment with proven effectiveness may not work well for a particular child.

Medications that are used to treat emotional disorders in children and adolescents are particularly unstudied. Most of these medications have been tested on adults, but are not formally approved for use with children. Additionally, even in the studies that are done on adults, it appears that studies that show greater effectiveness are more likely to be published and/or disseminated than studies that show lesser (or no) effectiveness. This selective reporting and dissemination of results appears to inflate estimates of the effectiveness of some of the medications commonly used to treat emotional disorders (Liberati and Magrini 2003; Turner et al. 2008). Reviews of studies that focus on the effectiveness of medications for the treatment of depression in children and adolescents have had ambiguous results. In general, these medications appear to be substantially less effective in children than adults (Hetrick et al. 2007; Michael and Crowley 2002).

In sum, research can often provide good guidance about what sorts of treatment approaches may work best for a particular child or adolescent with an emotional disorder. However, children and their families should work with providers and clinicians to monitor whether or not a chosen treatment is having the desired effect, and, if not, to select another treatment approach. If a child or adolescent has a very serious disorder or co-occurring disorders, a coordinated approach that includes several treatments and/or specialized treatments may be needed.

Other Usage

As mentioned at the outset, *emotional disorder* is not a formal diagnosis. While the term is typically used to refer to any anxiety or mood disorder, it is used in other ways as well. Sometimes, popular media use the term to refer to any psychiatric difficulty. In some

instances, it seems that the usage is more specific, and intended to create a contrast with physical disabilities.

Related Terms

Among adults, the term *mental illness* is often used to refer to any diagnosis within the spectrum of psychiatric disorders. This makes it possible to talk about "people with mental illness" as a group. However, this term is not usually applied to children, and several alternatives are often used. One of these is *emotional and behavioral disorders,* and variants that are only slightly different, for example, *emotional and behavioral difficulties* (sometimes preferred because it includes children who do not have a formal diagnosis) or *emotional, behavioral, and mental disorders* (which may or may not include mental retardation and learning disorders).

A related term is *emotional disturbance*. This term has special importance for children and adolescents in the United States, because it is the term used in the Individuals with Disabilities Education Act (IDEA), the federal law that ensures that children with disabilities receive a free and appropriate education.

Many parents and other caregivers—as well as children and adolescents themselves—find the term *emotional disturbance* stigmatizing. Some prefer *emotional and behavioral disorders* or *emotional, behavioral and mental disorders*, because including the word *disorder* highlights the fact that these conditions are bio-physically based, and not the fault of parents or the children themselves. Others do not like the use of *disorder* and consider that stigmatizing because it implies that there is something essentially wrong or "other" about a child or adolescent. Youth and their families often prefer alternative words and phrases that, rather than focusing on disorder, disability or deficit, focus on mental health and thriving.

References

American Psychiatric Association. 2000. Diagnostic and statistical manual of mental disorders: DSM-IV-TR. 4th ed., text rev. Washington (DC): American Psychiatric Press. 943 p.

Angold A, Costello EJ, Erkanli A, Farmer EMZ, Fairbank JA, Burns BJ, Keeler G. 2002. Psychiatric disorder, impairment, and service use in rural African American and White youth. Archives of General Psychiatry 59:893-901.

Boyd CP, Kostanski M, Gullone E, Ollendick TH, Shek DTL. 2000. Prevalence of anxiety and depression in Australian adolescents: Comparisons with worldwide data. Journal of Genetic Psychology 161(4):479-492.

Canino G, Shrout PE, Rubio-Stipec M, Bird HR, Bravo M, Ramirez R, Chavez L, Alegria M, Bauermeister JJ, Hohmann A, et al. 2004. The DSM-IV rates of child and adolescent disorders in Puerto Rico: Prevalence, correlates, service use, and the effects of impairment. Archives of General Psychiatry 61:85-93.

Cochrane Collaboration. 2008. Cochrane reviews; [cited 2008 Jan 26]. Available from: http://www.cochrane.org/reviews

Fombonne E. 1994. The Chartres Study: I. Prevalence of psychiatric disorders among French school-aged children. British Journal of Psychiatry 164:69-79.

Harvard Medical School. 2007 May. Bipolar disorder in children. Harvard Mental Health Letter.

Hetrick SE, Merry S, McKenzie J, Sindahl P, Proctor M. 2007. Selective serotonin reuptake inhibitors (SSRIs) for depressive disorders in children and adolescents. Cochrane Database of Systematic Reviews. [cited 2008 Jan 26]. Available from: http://www.cochrane.org/reviews/en/ab004851.html

Liberati A, Magrini N. 2003. Information from drug companies and opinion leaders. British Medical Journal 326:1156-1157.

Meltzer H, Gatward R, Goodman R, Ford T. 2003. Mental health of children and adolescents in Great Britain. International Review of Psychiatry 15:185–187.

Michael KD, Crowley SL. 2002. How effective are treatments for child and adolescent depression? A meta-analytic review. Clinical Psychology Review 22:247–269.

Mick E, Biederman J, Pandina G, Faraone SV. 2003. A preliminary meta-analysis of the child behavior checklist in pediatric bipolar disorder. Biological Psychiatry 53:1021–1027.

Moreno C, Laje G, Blanco C, Jiang H, Schmidt AB, Olfson M. 2007. National trends in the outpatient diagnosis and treatment of bipolar disorder in youth. Archives of General Psychiatry 64(9):1032-1039.

Roberts RE, Attkisson CC, Rosenblatt A. 1998. Prevalence of psychopathology among children and adolescents. American Journal of Psychiatry 155:715–725.

Substance Abuse and Mental Health Services Administration. [Internet]. [updated 2008 Jan 3]. The National Registry Of Evidence-based Programs & Practices. [cited 2008 Jan 25]. Available from: http://nrepp.samhsa.gov

Turner EH, Matthews AM, Linardatos E, Tell RA, Rosenthal R. 2008. Selective publication of antidepressant trials and its influence on apparent efficacy. New England Journal of Medicine 358:252-260.

Waddell C, Shepherd C. 2002. Prevalence of mental disorders in children and youth. Vancouver (BC): Mental Health Evaluation & Community Consultation Unit, University of British Columbia.

Westermeyer J, Janca A. 1997. Language, culture and psychopathology: Conceptual and methodological issues. Transcultural Psychiatry 34:291-311.

World Health Organization. 2004. ICD-10: International statistical classification of diseases and related health problems. 10th rev 2nd ed. Geneva: WHO. 1208 p.