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EDITOR

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Psychiatric Disorders and Treatments: A Primer for Teachers

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Children who have social or emotional problems require understanding and support from teachers and family members and may occasionally require counseling to help the child deal with his or her feelings and explore ways of coping. Psychiatric disorders, on the other hand, are generally much more disabling, more difficult to diagnose correctly, and sometimes require very specific therapeutic or medical treatments, meaning treatment with psychopharmacology (medications used to help the child control his or her emotional or behavioral symptoms).

Child psychopharmacology is a controversial field that is often sensationalized in the popular media. Coverage in the media often suggests that large numbers of children are being prescribed medication for only minor problems. Studies suggest that only a small fraction of children with serious psychiatric disorders are actually receiving such medication (Jensen et al., 1999; Zito et al., 1998). In the hands of a competent pediatrician or child psychiatrist, moreover, these medications are not only effective but an essential component of an overall treatment program for many, if not most, children with psychiatric disorders.

Psychiatric disorders are likely to be prevalent in children or adolescents receiving special education.

Careful treatment with these medications has been shown not only to effect dramatic improvement in behavioral or emotional responses of these children, but also to improve their social and academic functioning. Specific behavioral and related therapies are also critical. These may be used alone, prior to, or concurrent with psychopharmacologic treatment; and combined behavioral and psychopharmacologic treatments are often better than either used alone (Forness & Kavale, 2001; Forness, Kavale, & Davanzo, 2002).

Psychiatric disorders are classified in the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM IV; 1994)*. *DSM IV* is used primarily by psychiatrists and psychologists to diagnose mental health problems in both children and adolescents. The diagnostic information contained here is taken directly from *DSM IV*, and treatment issues are referenced separately. All of these disorders were diagnosed only after a thorough evaluation that included

1. Screening for health, vision, or hearing problems.
2. Review of the child's developmental history.
3. Interviews with the parents and the child.

4. Review of information from teachers or school records.
5. Careful consideration of context and occurrence of symptoms.

Psychiatric disorders are likely to be prevalent in children or adolescents receiving special education (Garland et al., 2001). Educators working with these children should be familiar enough with such disorders so they can readily detect and refer children to mental health professionals and collaborate with these professionals in ongoing treatment. These disorders are discussed in the following paragraphs in terms of definition or diagnosis and therapeutic and psychopharmacologic treatment.

Oppositional Defiant and Conduct Disorders Diagnosis

Both oppositional defiant and conduct disorders involve disruptive behavior. Oppositional defiant disorder often seems developmentally to precede a later diagnosis of conduct disorder. Both disorders probably occur in at least 4% of children or adolescents (Forness, Kavale, & Walker, 1999). Children with oppositional defiant disorder are those who have persistent patterns of negativistic, hostile, or defiant behavior directed primarily toward adults. Children with conduct disorder show consistent patterns of behavior in which they violate the rights of others or transgress age-appropriate social norms.

In oppositional defiant disorder, symptoms may include

- Persistent temper tantrums.
- Arguing with adults.
- Refusing to comply with reasonable adult requests.
- Annoying others.
- Vindictiveness.

The symptoms of an oppositional defiant disorder bother adults but are not considered as troublesome as conduct disorder, in which symptoms usually cluster into more serious patterns of

- Overt aggression toward people or animals.
- Destruction of property.
- Deceitfulness or theft.
- Serious violations of rules such as staying out all night and truancy from school.

As is the case with all psychiatric disorders, oppositional defiant disorder and conduct disorder are diagnosed in *DSM IV* when the child meets a set number of symptoms from among a list of several symptoms

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typical of the disorder. Children must have 4 from a list of 8 symptoms to be diagnosed with oppositional defiant disorder and at least 3 from a list of 15 symptoms to be diagnosed with conduct disorder. These symptoms must also meet the criteria of causing significant impairment in social, academic, or related functioning. In conduct disorder, presence of only 3 symptoms is termed *mild conduct disorder*, whereas moderate and severe conduct disorder are characterized by increasing numbers of symptoms and increasingly greater harm to others.

The symptoms of an oppositional defiant disorder bother adults but are not considered as troublesome as conduct disorder.

Treatment

The primary treatment for both oppositional defiant disorder and conduct disorder is behavioral therapy (Kavale, Forness, & Walker, 1999). Usually this takes the form of a reward or a reinforcement system in which the child earns points for appropriate behavior and is ignored or even given time-outs for inappropriate behavior. Points are usually exchanged for privileges or tangible awards at home or school. A major part of such behavioral therapy is parent or teacher consultation, so that adults can learn how to praise or reward good behavior and ignore inappropriate behavior. Social skills training is also helpful for children who do not seem to know how to behave or interact appropriately.

Unlike most psychiatric disorders, medication is not usually used to control symptoms of oppositional defiant disorder or conduct disorder directly. Both disorders, however, are very likely to co-occur or be comorbid (more than one condition existing at the same time) with a wide range of other psychiatric disorders (Forness, Kavale, & Walker, 1999). Psychopharmacology for these disorders (such as attention deficit hyperactivity disorder, depression, or anxiety disorders) may often improve symptoms of oppositional defiant disorder or conduct disorder, as well.

Attention Deficit/Hyperactivity Disorder

Diagnosis

This disorder is found in 3%–5% of children or adolescents (Forness & Kavale, 2002). It is diagnosed when a child has persistent problems in inattentive or in hyperactive-impulsive behavior. At least some of these symptoms must have appeared prior to 7 years of age. The symptoms must also persist to a degree that markedly impairs the child's functioning in two or more settings, such as home and school.

Symptoms of inattention include

- Failing to give close attention to details in school work or related activities.
- Difficulty in sustaining attention.
- Seeming not to listen.
- Difficulty in organization.
- Distractibility.

Symptoms of hyperactivity or impulsivity include

- Excessive fidgeting.
- Inability to sit still in the classroom or other situations when this is expected.

- Running about or even climbing things excessively.
- Extreme restlessness or talkativeness.
- Difficulty waiting for turn.
- Interrupting conversations.

The child must usually meet criteria in *DSM IV* for six of nine symptoms in inattention or six of nine symptoms of hyperactivity-impulsivity. Children can thus be diagnosed with three subtypes of attention deficit/hyperactivity disorder (ADHD): predominantly inattentive, predominantly hyperactive-impulsive, or combined. It is usually important to rule out other psychiatric disorders (such as depression, anxiety disorder, schizophrenia, or autism) before diagnosing ADHD, since these diagnoses may be more serious and usually take precedence. In many cases, a child may have both ADHD and one or more of these other disorders.

Treatment

The most effective treatment for ADHD generally combines both psychopharmacologic and behavioral interventions (MTA Cooperative Group, 1999a, 1999b). Stimulant medications such as Ritalin, Adderall, or Dexedrine are usually the first medications considered. While it often seems paradoxical to treat an overactive child with stimulants, these drugs stimulate brain chemicals, called neurotransmitters, to work more effectively, thus allowing the child to slow down and concentrate. Children not responding to stimulant medications have sometimes been treated with other psychopharmacologic medications, such as antidepressants like Tofranil or Wellbutrin. There are other medications that can be used if the child does not respond to these drugs or when ADHD co-occurs or is comorbid with certain other psychiatric disorders.

Selecting the appropriate medication involves a process called titration (see box). Table 1 depicts some of the primary stimulants and the approximate length of time each drug lasts or has noticeable effects in the child being treated. Some of the primary side effects (see Table 1) may occur only during the titration phase of treatment and may disappear in all but a few children.

Children with ADHD may also respond to psychosocial or behavioral treatments (Forness & Kavale, 2002). Behavioral interventions include establishing predictable routines and expectations for children, both at home and at school, and reinforcing the child for meeting these expectations. By increasing goals gradually, the child does not have to be "perfect" at the outset but can accomplish small steps over a period of days or weeks. Parent education and teacher consultation can help adults in the child's life to set reasonable expectations, reinforce effective behavior, ignore hyperactive or distractible behavior, use time-out effectively, and collaborate by developing consistent expectations and reinforcers between home and school.

Research evidence on treatment of ADHDs comes both from a re-analysis of 115 recent medication studies (Forness, Kavale, Sweeney, & Crenshaw, 1999) and from a long-term nationwide study of nearly 600 children funded by the National Institute of Mental Health (NIMH; MTA Cooperative Group, 1999a, 1999b). This evidence suggests that psychopharmacologic treatment seems to be a critical factor in effective intervention for ADHD. The message from this research is also clear that best practice is a combination of medication and behavioral therapies (Swanson et al., 2001). In the NIMH study, combined treatment also tended to improve scores on reading tests and on ratings of social skills on long-term follow-up, if children remained on medication (Arnold et al., 2000).

Evidence suggests that the presence of co-occurring or comorbid psychiatric disorders in children with ADHD may influence treatment outcome (Jensen et al., 2001). Children with ADHD and no other disorders tend to respond best, sometimes with only medication. Children

Titration

The process of determining the right dose of medication, called titration, requires close collaboration between child, parents, and teachers (Wilens, 2001). The goal of titration is to use the lowest effective dose of medication while avoiding unwanted side effects.

Side effects occur because these medications, while very helpful, are still imperfect. Although stimulants target certain areas of the brain, they sometimes also spill over into other areas for which they were not intended, thus causing side effects such as loss of appetite, insomnia, dizziness, or irritability. These side effects may occur only at higher doses for some children or may occur with some children for some stimulants and not for others. At other times, these side effects may diminish as time goes by or as the child gets used to the drug. For some children, they may persist to the point where another medication or treatment must be tried instead.

In recent medication studies, researchers present side effects that occur on the drug as well as side effects that occur on placebo pills that contain no active medication. Interestingly, many children with ADHD seemed to show problems with irritability, insomnia, and poor appetite even when not on medication. Medication side effects are usually only slightly more frequent than problems that, upon careful observation, existed previously in these children before they were placed on medication.

Titration is somewhat easier with stimulants because these medications usually act within an hour or so and generally wash out of the body within a few hours or by the end of the day. The process of finding the right dose or switching to another medication may be accomplished within a few days or weeks.

Antidepressant medications, on the other hand, may take at least 3 or more weeks to obtain a full therapeutic effect.

Other medications such as antipsychotics or neuroleptics for schizophrenia or other treatment-resistant disorders may take weeks to establish the most effective regimen. Thus, effective titration for these medications may commonly take weeks or even months. The side effects of these medications are also likely to be more debilitating and may also include

- Sedation.
- Dizziness.
- Problems in heart rhythms, especially in children with a family history of heart disease.
- Tremors.
- Significant weight gain.

Prescribing physicians should warn patients and their families about what to look for in terms of both therapeutic effects and adverse side effects. Physicians should also schedule regular follow-up visits to assess and monitor both the effects and the side effects of each medication. Competent physicians do careful patient and family education to prepare the child and his or her family for the titration process. During titration, they will usually provide the family and the child's teachers with checklists of symptoms and side effects so that significant adults in the child's environment can also monitor and provide regular feedback to the physician on how the medication is working.

Certain medications require more careful screening and monitoring of health status or drug effects through blood work, electrocardiograms, and the like. Physicians should give families careful instructions for regular administration of these medications, as well as numbers to call in case of unexpected emergencies.

with ADHD and comorbid anxiety disorders seem to respond almost as well, either to medication or to behavioral therapy. Children with ADHD and comorbid oppositional defiant disorder or conduct disorder also respond relatively well but only if combined psychopharmacologic and behavioral treatments are used.

Table 1 Stimulants

Generic (and Trade) Name	Duration
Methylphenidate or MPH (Ritalin)	3-4 hours
Dextroamphetamine (Dexedrine)	6-8 hours
Amphetamine (Adderall)	7-10 hours
Sustained MPH (Concerta)	10-12 hours

Side effects: appetite loss, stomachache, headache, insomnia

Depression or Other Mood Disorders

Diagnosis

Although childhood onset of depressive or other mood disorders does not occur as frequently as ADHD, it is not uncommon and may affect more than 2% of children and at least twice that number of adolescents (Birmaher & Brent, 1998). There are essentially three major types of mood disorders: depression, dysthymia, and bipolar or manic depressive disorder. Depression is diagnosed in *DSM IV* when the child has a depressed or irritable mood or loss of interest or pleasure in most activities. Other symptoms may include

- Unexplained fluctuations in weight.
- Insomnia.
- Loss of energy.
- Diminished ability to think or concentrate.
- Feelings of excessive guilt or worthlessness.

Of nine different symptoms, at least five must occur nearly every day during a 2-week period for depression to be diagnosed.

Dysthymia is diagnosed by a depressed or irritable mood on most days for at least a year and must also be accompanied by at least two of six other symptoms. Including

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- Insomnia.
- Low energy or fatigue.
- Low self-esteem.
- Poor concentration.
- Feelings of hopelessness.

The diagnosis of bipolar or manic depressive disorder depends on fluctuations in mood, from depressed episodes, as noted previously, to manic episodes. Manic episodes are characterized by distinct periods in which the child or adolescent has an abnormal and persistently elevated or expansive mood and in which three of seven other symptoms are present, such as

- Decreased need for sleep.
- Excessive talkativeness.
- Distractibility.
- Psychomotor agitation.

The most effective treatment for attention deficit hyperactivity disorder generally combines both psychopharmacologic and behavioral interventions.

All of these disorders must cause significant distress or functional impairment and require that certain other disorders, such as schizophrenia or substance abuse, be ruled out before making the diagnosis. Bipolar disorders in children are relatively rare and may be difficult to diagnose because of less distinct patterns of cycling than occur in adults; however, they become more common during adolescence and early adulthood.

Treatment

Treatment for depression usually involves cognitive behavioral therapies and psychopharmacologic treatment. Psychopharmacology for dysthymia is less predictable because symptoms may not always be consistently present, but it may be used depending on the child's or adolescent's age and presentation of symptoms (Wagner & Ambrosini, 2001).

In medicating for depression, physicians usually begin with one of the drugs known as selective serotonin reuptake inhibitors (SSRIs), such as Zoloft, Prozac, or Paxil. If the child or adolescent fails to respond to two or more of these medications, tricyclic antidepressants such as Tofranil or atypical antidepressants, such as Wellbutrin, may be tried.

In bipolar or manic depressive disorder, physicians may begin with lithium and, in some cases, attempt a trial of other mood stabilizers such as Depakote. Examples of these medications in each classification are provided in Table 2, along with the approximate time it may take to obtain a full therapeutic effect. Table 2 also lists some of the most frequently occurring side effects.

Psychopharmacologic treatment in each of these disorders, however, can be quite complex because large numbers of children or adolescents may not respond favorably enough to continue treatment or may suffer from side effects that tend to lead to discontinuation of the drug. In a significant number of cases, more than one medication may be required for effective treatment. Pediatricians usually do not have sufficient training to manage such treatment effectively, so most children with these disorders should be referred to board certified child or adolescent psychiatrists for the best outcome.

Table 2 Antidepressants/Mood Stabilizers

Class (Examples)	Full Effects
SSRI (Zoloft, Paxil, Luvox, Prozac)	2 to 4 weeks
Tricyclics (Tofranil, Elavil)	2 to 4 weeks
Atypicals (Wellbutrin, Effexor, Serzone)	2 to 4 weeks
Stabilizers (Lithium, Depakote)	7 to 10 days

Side effects: stomachache, agitation, headache, dry mouth, dizziness.

Cognitive behavioral therapies may also be effective for treatment of depressive disorders (Asarnow, Jaycox, & Tompson, 2001). Such treatment focuses on the child or adolescent monitoring his or her mood, involvement in activities, stress, or other symptomatic behaviors and is then taught to coach himself or herself through "self talk," which is designed to give a sense of control over the symptoms and negate feelings of despair, low self-esteem, helplessness, and the like. Supportive therapy and education about the nature of the child's particular disorder can help and may assist in better outcomes for psychopharmacologic treatment, if warranted.

Monitoring suicidal symptoms is especially critical in children or adolescents with these disorders. These disorders also sometimes tend to have a diagnostic progression, with dysthymia putting a child at higher risk for depression and depression putting a child at higher risk for bipolar or manic depressive disorder. Early detection and treatment is therefore very critical.

Anxiety Disorders

Diagnosis

Anxiety disorders occur in approximately 4% of children and in a slightly larger percentage of adolescents (Bernstein & Shaw, 1997). *DSM IV* lists several types of anxiety disorders, including obsessive-compulsive disorder, generalized anxiety disorder, separation anxiety disorder, and posttraumatic stress disorder. Obsessive-compulsive disorder is marked by obsessions or compulsions that cause marked distress, are excessively time consuming, or significantly interfere with the child's or adolescent's functioning or social relationships. Obsessions are recurrent and persistent thoughts or impulses that seem to have no relationship to real-life problems or that the child or adolescent seems unable to ignore or suppress, despite the fact that he or she recognizes these as merely a product of his or her own mind.

Compulsions are repetitive behaviors (such as hand washing, ordering of objects, checking on things) or mental acts (such as counting objects or repeating words silently) that, according to rigid rules, the child or adolescent feels driven to perform and are aimed at preventing or reducing some imagined distress. These behaviors or mental acts do not seem to be connected in a realistic way to this distress or are clearly excessive.

Children or adolescents may be diagnosed with generalized anxiety disorder when they demonstrate excessive worry about events or activities (such as social functioning or school performance) and find it difficult to control these responses. Worrying must cause clinically significant impairment in social or academic functioning and also be associated with at least three of six anxiety symptoms:

- Restlessness.
- Fatigue.

- Concentration problems.
- Irritability.
- Muscle tension.
- Sleep disturbance.

Separation anxiety disorder is diagnosed when a child has developmentally inappropriate and excessive anxiety concerning separation from home or family. This must cause clinically significant distress or impairment and be accompanied by at least three of eight symptoms, such as

- Excessive worrying about injury or loss of a major family member.
- Anxiety about separation from family through being kidnapped or getting lost.
- Persistent refusal or reluctance to attend school because of fear of separation.
- Sleep disturbance.
- Complaints of physical symptoms whenever separation from a major family member occurs or is anticipated.

The diagnosis of posttraumatic stress disorder is made when a child or adolescent has experienced or witnessed a traumatic event that involved intense fear, helplessness, or horror. Subsequently, following that actual event, other symptoms have to occur. The traumatic event has to be persistently re-experienced in terms of at least one of the following:

- Intrusive recollections.
- Recurrent dreams.
- Feeling that the event is actually recurring.
- Intense distress upon exposure to cues that remind the child of the event or a physiologic reaction to such cues, like shaking or sweating.

There must also be persistent avoidance of at least three things that remind the child or adolescent of the traumatic event, such as

- Avoiding thoughts or situations.
- Inability to recall important details of the trauma.
- Feeling detached from others.
- Restriction of emotional range.

Finally, the child must demonstrate at least two of five symptoms of increased arousal, such as

- Sleep disturbance.
- Irritability.
- Difficulty concentrating.
- Hypervigilance.
- Exaggerated startle response.

Community agencies and regional centers often provide education for parents in using behavioral approaches to further develop social and functional skills at home.

Treatment

Treatment for each of these anxiety disorders varies, depending on the specific diagnosis, but generally involves cognitive or behavioral therapies and possible psychopharmacologic treatment (Ollendick & King, 1998). The cognitive therapies generally focus on providing the

child both with ways to monitor his or her own internal anxieties and with a sense of control through "self talk." For example, a young child with an obsessive-compulsive disorder may be taught to pretend that his or her obsessions or compulsions are like a "little monster" trying to trick him or her into performing these rituals. The child is then shown ways to make the monster less threatening or powerful.

Other cognitive or behavioral approaches focus, in similar ways, on the unreality of the anxiety and how to anticipate responding in a more adaptive way. Reinforcement schemes may also be employed to assist or motivate the child in establishing a sense of control and participating more gradually over a period of time in anxiety-provoking events.

Psychopharmacologic treatment may involve anxiolytic or antidepressant medications (Green, 2001). The anxiolytic or anxiety-breaking medications are drugs such as Klonopin, Ativan, or Buspar. These medications are relatively fast-acting and must often be taken two or three times per day. Their major side effects include sedation or drowsiness and, in a few children, may cause a sudden onset of agitation, silliness, talkativeness, or even increased anxiety, a response that usually wears off within a couple of hours.

Stopping these drugs abruptly may also lead to increased agitation or anxiety, so their use should be withdrawn gradually, as is the case with most other psychopharmacologic medications discussed. Usually anxiolytics are used in children on a short-term basis only. The antidepressants that have been found most helpful for anxiety disorders are SSRI medications (such as Paxil or Luvox) or atypical antidepressants (such as Effexor). For children and younger adolescents, SSRIs and atypical antidepressants have become the first choice for treatment of most anxiety disorders.

Schizophrenic or Other Psychotic Disorders

Diagnosis

These disorders are exceedingly rare, especially in children—the rate is probably less than a tenth of a percent (McClellan & Werry, 2000). *DSM IV* diagnoses children or adolescents with schizophrenia when at least two of the following symptoms are present:

- Delusions (such as thinking one has special powers or feeling that people are out to do one harm).
- Hallucinations (such as hearing voices or seeing things that no one else experiences).
- Disorganized speech.
- Grossly disorganized behavior.
- Certain symptoms of social withdrawal.

These symptoms must generally be present over a period of at least 6 months and must markedly affect one or more areas of functioning, like school or interpersonal relationships. Separate diagnoses exist for brief or atypical psychotic disorders, which last less than a month or do not meet full criteria.

Treatment

Treatment is usually a combination of behavioral training (including social skills training) and psychopharmacology (Vitiello, Bhatara, & Jensen, 1999). Medications for schizophrenia are currently the new or atypical neuroleptic or antipsychotic drugs such as Risperdal, Zyprexa, and Seroquel. These medications may diminish agitation almost immediately but take days to diminish hallucinations. After several weeks, these medications will improve disorganized thinking and social withdrawal. Side effects, however, can be severe, including sedation or even abnormal facial or motor movements.

These side effects tend to limit their use especially in children but, in rare cases, are seen as unavoidable or preferable in the face of full-blown psychosis, which can be devastatingly frightening to children or adolescents with the disorder and to those around them. In some instances, these newer neuroleptic drugs are also being used for treatment resistant depression and anxiety disorders.

Autistic Spectrum Disorders

Diagnosis

These disorders also occur quite infrequently but may not be as rare as childhood-onset schizophrenia (Volkmar, Cook, Pomeroy, Realmuto, & Tanguay, 1999). Autistic spectrum disorder is diagnosed by at least six symptoms across three areas:

1. Social impairment, such as
 - Lack of eye contact.
 - Failure to develop peer relationships.
 - Lack of sharing enjoyment or interests with others.
 - Lack of social or emotional give and take.
2. Communicative impairment, such as
 - Delays in spoken language.
 - Inability to initiate or sustain conversations.
 - Repetitive or odd use of phrases.
 - Lack of make-believe or social-imitative play.
3. Restrictive or repetitive behavior, such as
 - Intense preoccupations with restricted patterns of interest.
 - Inflexible routines or rituals.
 - Repetitive motor mannerisms such as hand- or finger-flapping.
 - Preoccupation only with parts of objects.

At least some of these symptoms must have occurred prior to 3 years of age. About three of every four children with autism may also have severe cognitive delays as well.

Asperger's disorder is diagnosed if at least three symptoms are present from the social impairment and restricted or repetitive behavior lists above but there are no significant delays in language or cognitive development. Pervasive developmental disorder may be diagnosed if it is not clear that symptoms were present prior to 3 years of age or if sufficient symptoms are not clearly present.

Treatment for children with autistic spectrum disorders relies primarily on developing basic language and social skills using behavioral strategies and reinforcement systems. Academic skills are taught according to the child's cognitive or intellectual levels. Community agencies and regional centers often provide education for parents in using behavioral approaches to further develop social and functional skills at home. There are as yet no recognized psychopharmacologic medications to treat autism directly. Some children with autism may also be at risk for other psychiatric disorders or symptoms, however, and they might be responsive to psychopharmacologic medications for such disorders (Sweeney, Forness, & Levitt, 1998).

Other Diagnoses in DSM IV

DSM-IV includes learning disorders, mental retardation, and communication disorders. Although they are not strictly considered mental health disorders, they are sometimes closely associated with certain psychiatric disorders. Children with these disorders are also at significantly higher risk for comorbid or co-occurring psychiatric disorders

(Beichtman, Cantwell, Forness, Kavale, & Kauffman, 1998; King, DeAntonio, McCracken, Forness, & Ackerman, 1994). Eating disorders such as anorexia nervosa are listed as psychiatric disorders in DSM IV and involve refusal to maintain normal weight for height and age (usually defined as less than 85% of expected weight), coupled with an intense fear of gaining weight and a disturbance of body image related to weight. This disorder affects primarily adolescent girls who are often apt to focus obsessively on academic achievement, in addition to their obsession with weight or diet (Lewis, 2002).

Tourettes disorder is also listed in DSM IV and involves chronic motor and sometimes vocal tics occurring many times a day, usually in bouts. This disorder is often treated by SSRI or antihypertensive medications such as Clonidine (Sweeney et al., 1998).

Substance-related disorders, such as alcohol or drug abuse are listed in DSM IV as psychiatric disorders and involve recurrent substance use that results in poor work or school performance, hazardous behavior such as impaired driving, or recurrent social or personal problems.

Final Thoughts

This is neither an exhaustive list nor a comprehensive description of childhood psychiatric disorders but, rather, an introduction for teachers and other school professionals to some of the major diagnoses that can impair school learning or classroom behavior. Detection and treatment of these disorders may sometimes greatly improve academic progress and social adjustment of children with more serious school learning or behavior problems. A behavioral checklist for teachers and parents has therefore been developed that is based on DSM IV and provides both primary and possible comorbid psychiatric diagnoses (Gadow & Sprafkin, 1994). Introductory materials to further educate teachers and parents about psychopharmacology have also been developed for those interested in particular medications (Konopasek, 2002; Wilens, 2001).

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