Serious Emotional Disturbances in Children, Youth, and Young Adults

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Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, SAMHSA.

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Abstract

Serious emotional disturbance (SED) in children, adolescents, and young adults is defined as a diagnosable mental, behavioral, or emotional disorder that substantially impairs a child's functioning in family, school, or community contexts. SED is estimated to affect roughly 5 to 10 percent of youth in the United States, translating to approximately 5 to 7 million children and adolescents. SED crosses demographic and socioeconomic groups, with exposure to trauma, family history of mental illness, poverty, and access to supportive resources on par with needs contributing to some of the risk. Comorbidities such as substance use disorders, suicidality, and intellectual and developmental disabilities are prevalent and complicate diagnosis and service eligibility. This paper provides an overview of SED, including the role of functional impairment in identifying youth with SED and the important developmental considerations. Best practices in assessment and treatment approaches are presented, including a discussion of the evidence-based service arrays needed to support youth with SED and the importance of long-term maintenance strategies and policy supports to sustain functioning gains. It includes briefs for various SED diagnostic categories, which outline the clinical presentation, prevalence, risk factors, comorbidities, treatments, and recommendations for state service systems. Finally, the paper calls for policies that ensure access to services and integrate wellness and prevention strategies, such as exercise, mindfulness, and nutrition, as part of a holistic approach to youth mental health.

Highlights

- The SED classification emerged formally in federal mental health legislation in the United States in 1992, and has served as the authorizing language for the systems of care initiative and for shaping national definitions and eligibility standards. This legal and regulatory framework underscores the importance of addressing functional impairment rather than relying solely on categorical diagnoses to determine service needs.
- The developmental context of SED across early childhood, school age, adolescence, and young adulthood is important, because symptom presentation, clinical needs, and functional expectations vary significantly by age.
- There is a need for developmentally appropriate, crosscutting assessment strategies, particularly given the high prevalence of overlapping symptoms (such as debilitating irritability or mood shifts) across diagnostic categories.
- Functional impairment plays an important role in identifying youth with SED, including its manifestations across settings, such as school disengagement, family conflict, peer difficulties, and justice system involvement. Aligning assessment methods with outcome monitoring frameworks is essential for evaluating both clinical progress and improvements in real-world functioning.
- Intensive care coordination, school- and community-based interventions, and peer and family support services are important parts of the service array to support youth with SED.

Recommendations

The following recommendations will help policymakers and providers enhance care for youth with SED:

1. **Emphasize functional impairment for eligibility criteria:** Given the complexity in youth diagnoses of mental illness and behavioral disorders and the crossover with developmental norms, it is important to emphasize functional impairment in eligibility criteria to ensure timely identification and early intervention.
2. **Ensure sustainability of services:** Recognize SED as often chronic, advocating for continuous support services beyond short-term interventions, and develop means to sustain appropriate supports as youth move into adulthood with different service systems.
3. **Promote access:** Use a data-informed approach to enhance service delivery and ensure affordability through comprehensive insurance coverage.[15]
4. **Strengthen workforce development:** Address workforce shortages through targeted incentives, specialized training, and inclusion of nontraditional mental healthcare roles such as peer support specialists.

Introduction

Nearly 20 million young people in the United States have a diagnosable mental health disorder.[1] Approximately 4.6 million of these individuals meet criteria for serious emotional disturbance (SED).[2] SED refers to diagnosable mental, behavioral, or emotional disorders in children and adolescents that significantly impair their ability to function effectively in family, school, or community settings.[3] The SED classification emerged formally in federal mental health legislation in the United States with the 1992 amendments to the Public Health Service Act, specifically outlined in the *Federal Register* in 1993, aiming to clearly identify and prioritize youth with substantial mental health needs for targeted services and support.[4] Since then, it has been adopted into state law, regulation, and policy. In many states, an SED designation is the gateway to accessing many Medicaid-funded home and community-based services.

SED is distinct from serious mental illness, a term designated for adults experiencing severe mental disorders that substantially interfere with or limit major life activities.[3] Although both SED and serious mental illness emphasize significant functional impairment, the separate SED designation for youth acknowledges that they have not fully evolved neurodevelopmentally and that their challenges exist within the context of family systems. Thus, a broader consideration of supports is needed to help them get on the best track possible. For example, differentiation by age groups recognizes the unique developmental contexts and intervention requirements of youth compared with adults. Notably, the systems of care framework legislation specifically recognizes not only youth diagnosed with SED but also those at risk for developing such disturbances.[5] Including "at-risk" populations underscores the importance of addressing functional impairments early, rather than relying solely on specific diagnoses, and establishes a foundation for preventive, developmentally appropriate interventions.

This paper is intended to reach a wide audience of people invested in understanding the needs of and improving the outcomes for children and young people with SED and their families. System leaders, builders, quality monitors, and payors may find the introduction and concluding sections most relevant to their work. They may also benefit from the examples in each of the diagnostic briefs, which illustrate related functional impairment and potential qualification for SED. Clinicians and other providers partnering with young people with SED and their families to provide treatment and support may find the most value in consulting the individual briefs to better understand a diagnostic category, including related evidence-based practices and supports.

DEVELOPMENTAL CONSIDERATIONS

Developmental considerations are central to accurately identifying and addressing SED across childhood and adolescence. In early childhood, mental health conditions often manifest through difficulties with self-regulation in interactions, emotions, and behavior, attachment disruptions, and developmental delays. School-age children with SED may present with disruptive behaviors, mood instability, or emerging anxiety and depressive symptoms that affect learning and peer interactions. Adolescents with SED typically exhibit more pronounced internalizing symptoms, risk behaviors, and substance use, while young adults with SED may face challenges transitioning to independent living and maintaining continuity of care. The 2013 fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) and its 2022 Text Revision (DSM-5-TR) have

contributed to improved developmental sensitivity in diagnosis by modifying criteria for some disorders (e.g., post-traumatic stress disorder [PTSD]) and adding new disorders (e.g., disruptive mood dysregulation disorder [DMDD]) aimed at improving diagnostic accuracy for youth.[6] Additionally, each new iteration of the DSM has moved toward assessing functioning, as it did with intellectual and developmental disabilities diagnoses.

The DSM-5-TR reflects significant progress in acknowledging developmental differences. The DSM classification system was originally designed for adult populations. This legacy presents challenges when applied to youth because the diagnostic criteria often reflect adult manifestations of mental disorders, which may differ significantly from how these disorders present in children and adolescents. Therefore, the text revisions are increasingly important, as they recognize that diagnostic symptoms in children can differ from those of adults. For example, children may exhibit irritability rather than depressed mood in cases of depression, or externalizing behaviors rather than anxiety in response to trauma. Additionally, for many childhood disorders, diagnostic clarity is complicated by crosscutting symptoms that span multiple diagnoses, such as irritability, sleep disturbances, or inattention. The variability in functional impairment within a single diagnosis also suggests that symptom presence alone may not capture the full impact on the child's daily life. These limitations underscore the importance of integrating functional assessments and context alongside symptomatology, and call for a greater emphasis on dimensional and developmentally informed approaches to understanding mental health conditions in youth.

Federal laws, regulations, and programs that impact children and youth with SED have different definitions and eligibility requirements. For example, the Individuals with Disabilities Education Act Part B ensures special education services for children and youth from ages 3 to 21 with emotional disturbances, while early intervention programs under Part C cover infants and toddlers. However, gaps persist in care transitions between childhood and adulthood, particularly for emerging adults with SED who typically lose access to child-serving systems when they cross an age threshold, even when their needs continue. Clinically, distinctions by age are critical in treatment planning. What constitutes impairment or risk in a toddler differs significantly from that of a 17-year-old. Providers must apply developmentally appropriate assessments and interventions to ensure accuracy and relevance.

A clear distinction must also be drawn between SED and intellectual and/or developmental disabilities (I/DD), although overlaps exist. I/DD involves impairments in intellectual functioning and adaptive behavior that begin during childhood, while SED focuses on emotional dysregulation and clinically significant behavioral symptoms that result in functional impairments. Children and youth may present with both conditions, complicating eligibility decisions and care planning. When youth have comorbid I/DD and SED, access to appropriate services may be further complicated by the bifurcation in systems that serve youth with I/DD versus those with SED; this requires families to navigate two siloed systems.[7] Moreover, when SED co-occurs with I/DD, these youth may be misclassified or denied access to necessary mental health services, highlighting the need for comprehensive, individualized assessments that consider the full scope of the child's functioning and developmental context. Bifurcated systems and misclassification can result in youth with SED being excluded from needed services or receiving inappropriate interventions. Improved assessment practices are needed that incorporate validated tools and cross-system collaboration to differentiate between

behavioral manifestations of I/DD and clinically significant emotional disturbances.[8] Emphasizing functional impairment, rather than diagnosis alone, is key to developing robust systems of care.

PREVALENCE, RISK FACTORS, AND CO-OCCURRING PROBLEMS

Estimates suggest that between 5 and 13 percent of children and adolescents in the United States meet criteria for SED at any given time, with rates varying based on population characteristics, diagnostic definitions, and access to services.[2,9,10] Prevalence tends to increase with age, as adolescents and young adults are more likely to experience the onset of mood disorders, anxiety, and substance use disorders (SUDs). Common diagnoses associated with SED include attention-deficit/hyperactivity disorder (ADHD), major depressive disorder (MDD), generalized anxiety disorder, PTSD, bipolar disorder, conduct disorder (CD), and DMDD. It is also common for youth to have multiple diagnoses (i.e., comorbidity) and for diagnoses to change or be added over time.[11] While these conditions vary in presentation and severity, they all have the potential to cause substantial functional impairment across multiple life domains. Additionally, SED is not limited to these diagnoses; any young person with significant impairment related to mental, behavioral, or emotional needs may qualify.

Numerous risk factors contribute to the development of SED, and many youth experience more than one. Exposure to trauma (including abuse, neglect, domestic violence, and community violence) is a well-documented risk factor, particularly when it occurs during early childhood.[12] Adverse childhood experiences (ACEs) increase the likelihood of developing mental health conditions characterized by emotional dysregulation and behavioral challenges, and predict worse outcomes into adulthood. Emerging research highlights the protective role of positive childhood experiences, such as supportive relationships and safe environments, which are linked to better mental health outcomes even in the presence of ACEs.[13,14] Genetic predispositions, including a family history of mental disorders, also elevate risk.[13] In addition, adverse social and economic conditions, such as poverty, food insecurity, housing instability, and chronic social stressors, have been consistently associated with poorer mental health outcomes across the life course.[15] Risk factors are not deterministic; while understanding correlated stressors clarifies how a broad range of factors may contribute to mental well-being, it should be noted that SED cuts across socioeconomic groups and occurs even in the absence of identified risk factors. As our understanding of the etiology of mental illness expands, evidence increasingly demonstrates a complex interplay of genetic, environmental, and social factors, underscoring the need for non-reductive approaches to prevention and intervention.[1,15]

Adverse childhood experiences (ACEs): potentially traumatic events that occur in childhood, including experiencing violence, abuse or neglect, witnessing violence in the home or community, and having a family member attempt or die by suicide or be incarcerated.

Positive childhood experiences (PCEs): positive interpersonal relationships between families, friends, in school, and in community that fosters a child's capacity to thrive.

Youth with SED frequently present with co-occurring problems, which complicate diagnosis and treatment and contribute to poorer functional outcomes. SUDs are common among adolescents

with SED, often emerging as maladaptive coping strategies in response to unaddressed emotional distress. National survey data indicate that nearly one in five adolescents have used illicit substances in the past year, with rates significantly higher among those with mental health concerns.[16] Co-occurring substance use and SED are associated with more severe psychiatric symptoms, earlier onset of substance use, and greater likelihood of polysubstance use.[17] These youth often experience fragmented care due to siloed mental health and substance use treatment systems, further compounding risk.[18] Co-occurrence of SED and substance use can result in increased hospitalization, school dropout, and justice involvement.[3]

Youth with SED are also at elevated risk for self-injurious behaviors and suicide, the second-leading cause of death among individuals ages 10 to 24 in the United States.[19] Self-injurious behavior and suicidality can exacerbate functional impairment through disruptions in family dynamics and repeated hospitalizations, and contribute to school disengagement.[20] Further, youth with SED are overrepresented in juvenile justice settings, where emotional and behavioral symptoms that are unrecognized or untreated often lead to delinquency, legal issues, and system involvement.[21] These patterns highlight the high risk and severe impacts that often distinguish SED from less disruptive mental health concerns and underscore the need for comprehensive, cross-setting assessment and intervention.

Clearly defining and accurately assessing for SED is essential to ensuring youth receive timely and appropriate services. While diagnosis is a critical component, the defining characteristic of SED is the presence of substantial functional impairment. Functional impairment refers to a child's inability to perform expected developmental tasks and roles in daily life, including challenges in school, home, or community settings. Relying solely on psychiatric diagnosis can overlook significant distress and dysfunction in youth whose symptoms may not meet full diagnostic criteria, but who nevertheless experience severe disruptions in functioning. This has important implications for eligibility decisions across systems, as services in education, mental health, and child welfare often hinge on meeting specific diagnostic thresholds. By integrating functional impairment assessments and diagnostic criteria, systems can expand access to care and target resources more effectively.

The term *high-acuity youth* is frequently used to describe children and adolescents experiencing severe levels of emotional or behavioral distress that result in elevated risk or crisis situations.[22] While high acuity and functional impairment often co-occur, they are not synonymous. High acuity may be transient or situational, whereas functional impairment reflects a more enduring disruption in developmentally appropriate functioning. Understanding this distinction is critical when designing service eligibility criteria and ensuring unbiased access to intensive supports.

ASSESSMENT OF FUNCTIONAL IMPAIRMENT

Best practices for assessing functional impairment include use of validated, structured tools and multi-informant reporting. Instruments such as the *Child and Adolescent Functional Assessment Scale*, the *Child and Adolescent Needs and Strengths* tool, the *Ohio Youth Problems, Functioning, and Satisfaction Scales*, the *Child and Adolescent Service Intensity Instrument*, the *Early Childhood Service Intensity Instrument,* and the *Columbia Impairment Scale* provide standardized approaches to quantifying functional impairment across key life domains.[23-28] When using standardized measures, it is important to gather information from multiple informants (i.e., incorporating perspectives from youth, caregivers, educators, pediatricians, and

behavioral healthcare clinicians), as there are well-documented differences in reporting of both symptoms and functioning across reporters.[29] Multi-informant assessment enhances the reliability of evaluations and provides a more comprehensive understanding of the youth's functioning across various contexts. Functional impairment should be measured not only at intake but also regularly over time to monitor treatment progress and guide service adjustments.

Assessing functional impairment is not only important for making SED determinations, but is also a core component of understanding service impacts and outcomes.[30] Many assessment tools focus on symptoms, either narrowly (e.g., *Children's Depression Inventory*) or more broadly (e.g., *Child Behavior Checklist*), but may not include an assessment of functional impairment.[31,32] It is important to distinguish between symptom monitoring and functional impairment, as symptom reduction alone may not translate into meaningful improvements in functioning. For example, a youth with reduced depressive symptoms may continue to struggle academically or socially. Effective outcome monitoring should assess both symptomatology and functional domains to evaluate the real-world impact of treatment. The choice of assessment tools significantly influences the quality of outcome monitoring. Tools that are sensitive to both clinical symptoms and day-to-day functioning provide a more holistic picture of youth progress and can inform person-centered care planning, system-level quality improvement, and resource allocation. **Table A1** in Appendix A provides examples of validated assessment instruments for mental health conditions, SUDs, and functional impairment.

INTERVENTIONS AND SUPPORTS

To reduce symptoms and improve functioning across domains, a robust and flexible service array is essential to meeting the varied needs of youth with SED and their families. Effective systems for care include a continuum of services ranging from outpatient therapy and school-based interventions to intensive home- and community-based services, mobile response and stabilization services, and residential treatment when necessary. Services should be evidence based, trauma informed, developmentally appropriate, and responsive. Given the high rates of co-occurring SUDs among youth with SED, comprehensive service arrays must also include access to developmentally appropriate substance use treatment and early intervention services. These should be integrated within mental healthcare systems to promote seamless care coordination, reduce stigma, and address the complex interplay between substance use and emotional dysregulation.

Care practices should also adopt a family systems approach that recognizes the interdependence of youth and their family environments, ensuring that supports extend beyond the identified child to address the needs of caregivers, siblings, and other family members who play a critical role in the youth's development and recovery.[33] In addition to clinical services, supports such as peer mentoring, respite care, case management, and family education are critical to improving outcomes and promoting sustained engagement. Coordinated, cross-system collaboration (particularly among mental health care, child welfare, education, and juvenile justice sectors) is vital for ensuring continuity and avoiding service fragmentation.[34] Finally, to ensure that they can continue to meet the needs of young people and their families, systems may consider leveraging emerging technologies, such as mobile apps, virtual care platforms, digital therapeutics, and artificial intelligence–enabled tools.[34,35]

Maintaining gains achieved through intervention requires recognizing the need for ongoing services. Youth with SED often experience episodic or chronic patterns of symptoms and functional impairment, necessitating flexible and sustained supports that adapt over time. Policies that limit service duration or impose rigid eligibility criteria can create service gaps and increase the risk of crisis recurrence. A public behavioral healthcare system that integrates maintenance services (e.g., step-down levels of care, continued care coordination, and access to peer and family support) can help prevent relapse and support youth in achieving lasting stability. Moreover, access to care must be a foundational principle, ensuring that services are available and effective for all populations. Efforts to reduce barriers (e.g., provider shortages, language access issues, and insurance limitations) are essential to fulfilling the promise of a comprehensive, unbiased behavioral healthcare system.

Clinical Briefs

The remainder of the paper is laid out in a series of briefs, with each focused on a specific diagnostic category:

- trauma-related disorders
- neurodevelopmental disorders
- anxiety disorders
- obsessive-compulsive and related disorders
- mood disorders
- disruptive, impulse control, and conduct disorders

Each diagnostic category brief contains the clinical presentation, prevalence, risk factors, comorbidities, treatments, and recommendations for state service systems.

This paper does not comprehensively address several common disorders and diagnostic categories for youth, including eating disorders, autism spectrum disorder (ASD), and SUDs.[36-38] Resources for readers interested in additional information in those areas include the following:

- eating disorders[39]
- intellectual and developmental disorders, including ASD[7]
- SUDs[40]

Trauma-Related Disorders

Table 1: Trauma-Related Disorders in Youth

Category	Summary
Common Disorders	Post-traumatic stress disorder (PTSD), acute stress disorder, adjustment disorder, reactive attachment disorder, disinhibited social engagement disorder, complex trauma
Prevalence	• 60 to 70% of youth experience a traumatic stressor by age 16. • Lifetime PTSD prevalence is ~4 to 8%, with higher rates in girls than boys.
Age of Onset	• Can begin in early childhood, particularly for reactive attachment disorder and disinhibited social engagement disorder. • PTSD may be diagnosed in children as young as 3 years old, but is most common in mid-adolescence.
Evidence-Based Treatments [a]	• Trauma-focused cognitive behavioral therapy • Child-parent psychotherapy • Parent-child interaction therapy • Eye movement desensitization and reprocessing • Cognitive processing therapy • Prolonged exposure for adolescents • Seeking safety • Cognitive behavioral intervention for trauma in schools

[a] A comprehensive list of treatments is available through The National Child Traumatic Stress Network.[41]

CLINICAL PRESENTATION AND EXAMPLES OF COMMON DISORDERS

Trauma-related disorders in youth (**Table 1**) include conditions that arise after experiencing or witnessing traumatic events. Diagnoses include PTSD, adjustment disorder, reactive attachment disorder, and disinhibited social engagement disorder. Trauma-related disorders must be distinguished from normal developmental fears and short-term stress reactions. Many children have temporary nightmares or anxiety after a scary experience, which is expected and often resolves with support. A trauma-related disorder involves severe, persistent symptoms that impair daily functioning.[42] Presentations vary by age; however, all these disorders share a link to an overwhelming event or context. Identifying that link is key to appropriately diagnosing and treating the child.

In children and adolescents, PTSD symptoms generally fall into four clusters: intrusive reexperiencing of the trauma, avoidance of reminders, negative mood/cognitive changes, and hyperarousal.[42] Young children often show these symptoms through behavior rather than words, meaning trauma can masquerade as many other psychiatric conditions. A notable feature of child-onset PTSD is trauma-related play or drawings that repetitively mimic aspects of the event. Tantrums, developmental regression (e.g., bed-wetting, baby talk), or physical complaints based on stress reactions may also signal general distress.[43] Clinicians differentiate such symptoms from normal transient reactions by their persistence (i.e., lasting more than 1 month post trauma) and the degree of impairment.[42]

Acute stress disorder resembles PTSD but occurs within the 1st month post trauma.[44] In children, transient stress reactions typically resolve without meeting criteria for a diagnosis or requiring treatment. Adjustment disorders involve significant emotional or behavioral reactions to stressors that do not meet the full criteria for PTSD.[44] Early childhood trauma (e.g., caregiver neglect or abuse, multiple foster placements) can lead to reactive attachment disorder or disinhibited social engagement disorder.[45] In reactive attachment disorder, the young child is withdrawn and does not seek comfort even when distressed; in disinhibited social engagement disorder, the child is overly friendly and indiscriminate with strangers.[45] Both reflect disturbances in forming healthy attachments due to early trauma.[45]

Additionally, the term *complex trauma* is used to describe children who have experienced chronic, multiple forms of interpersonal trauma, causing pervasive emotional and interpersonal impairments beyond standard PTSD.[46] Although complex PTSD is not a DSM diagnosis, it is included in the 11th revision of the *International Classification of Diseases*. Clinicians should understand the neurodevelopmental impacts of early and chronic trauma (also considered toxic stress), routinely screen for exposure, and provide trauma-informed care. The Center on the Developing Child at Harvard University offers resources on the disruption of brain development related to toxic stress and protective mitigating factors.[47]

PREVALENCE

Exposure to traumatic events is common in childhood, though most children will not develop long-term disorders. Epidemiological research indicates that over half of children will experience or witness at least one significant trauma by adolescence.[48] While PTSD occurs in young children, adolescents report higher rates, likely due to greater threat awareness and better symptom articulation in surveys.[43] By mid-adolescence (age 16), 60 to 70 percent have been

exposed to violence, abuse, disaster, or other traumatic stressors.[49] Lifetime prevalence of PTSD is around 4 to 8 percent in adolescence,[3] with higher PTSD rates in girls than boys (8 versus 2 percent, respectively).[43,50]

Adverse childhood experiences (ACEs) correlate with lifelong health risks and problematic behaviors.[51] Given the high prevalence reported in ACEs research, screening for ACEs and trauma-informed approaches should guide all evaluations and treatments, even for individuals without known risks for specific trauma disorders.[11,52] Importantly, recent advances in resilience science demonstrate that positive childhood experiences (PCEs), such as consistent emotional support and community safety, can significantly offset ACE-related risks[13]; children with robust PCEs maintain better mental health outcomes despite trauma exposure.[53] The positive and adverse childhood experiences framework that developed from this evidence expands trauma-informed care by equally valuing resilience factors during assessment.[54] Clinically, this means not just evaluating trauma history but also identifying and strengthening protective relationships and environments as part of intervention strategies.[55]

RISK FACTORS

Risk factors for developing a trauma disorder after traumatic exposure include the nature of the traumatic event(s), interpersonal dynamics, and family or environmental factors. Interpersonal violence (e.g., assault, sexual or physical abuse) leads to higher PTSD rates in youth than impersonal events like natural disasters.[46] Severity, duration, and cumulative exposure matter. Children facing multiple or prolonged traumas face greater psychological risks, and prior trauma increases vulnerability to PTSD after subsequent events.[48] Physical proximity to trauma and perceived life threat also elevate risk.[48]

Children with mental health conditions may be more susceptible to PTSD after trauma due to heightened stress responses and limited coping skills. Social support plays a key role, with strong caregiver and community support offering protection, while isolation increases risk.[48] Parental responses are particularly influential. Comforting, open discussions promote recovery, whereas distressed reactions can exacerbate the child's distress. When parents face mental health challenges, their reduced capacity to provide emotional support can further impact children.[48] Neighborhood disadvantages also contribute to risk through increased exposure to traumatic events and poverty-related stressors.[56,57] This underscores the importance of family-centered and multigenerational approaches to care, in which identification and treatment of parental mental health conditions and/or SUDs are prioritized alongside child- and youth-focused interventions to strengthen caregiver capacity and promote recovery.

CO-OCCURRING DISORDERS, RULE-OUTS, AND DIFFERENTIAL DIAGNOSIS

In the aftermath of a traumatic event, it is expected that children will experience some distress.[42] Many children recover naturally with support during that initial period. However, trauma can also drive persistent symptoms that mimic other disorders, exacerbating existing mental health challenges. This overlap makes careful clinical distinction essential. Trauma may both intensify symptoms of other conditions and trigger co-occurring disorders. When criteria are met for both trauma-related and other mental health conditions, dual diagnoses may be warranted. Using a trauma-informed care approach, clinicians are encouraged to ask, "What happened to you?" instead of "What's wrong with you?"

Identifying trauma as the source of symptoms is crucial for proper treatment. Mistaking trauma for ADHD may result in stimulants worsening anxiety or sleep issues. Viewing trauma responses as simple oppositional behavior could prompt ineffective punitive responses. A trauma-informed approach explores whether challenging behaviors stem from distress or self-protection. Equally, assuming all symptoms are trauma-related without thorough assessment may overlook co-occurring conditions like mood disorders that could benefit from different treatments.

Although trauma responses may resemble other conditions, the key distinction is their connection to a traumatic event. Notably, this can be challenging to elucidate from children, particularly when trauma occurs preverbally. PTSD is technically classified as a trauma-related disorder rather than an anxiety disorder, but its symptoms include anxiety and fear. Trauma can also trigger mood changes (e.g., sadness, loss of pleasure, pessimism) that may reflect PTSD's emotional effects or co-occurring depression. Behaviors resembling ADHD or oppositional defiant disorder (ODD) may emerge post trauma (e.g., distractibility, impulsivity), but unlike those disorders, trauma-related symptoms appear after the event and often fluctuate within context. For example, concentration difficulties or defiance may only surface in situations recalling the trauma, whereas ADHD and ODD symptoms typically begin earlier and persist across settings.

ASD and reactive attachment disorder also have significant symptom overlap, such as difficulties with social relationships, emotional dysregulation, and inflexibility.[58] A key requirement for a diagnosis of reactive attachment disorder requires a history of insufficient care, whereas ASD has no such requirement and typically shows other features (i.e., stereotyped behaviors, restricted interests) that are not explained by trauma. Childhood schizophrenia is rare; trauma-related dissociation or flashbacks are more likely explanations for quasi-psychotic symptoms in traumatized children.[59] Nevertheless, persistent hallucinations warrant psychiatric consultation to rule out neuropsychiatric conditions. Most often, trauma treatment alleviates these symptoms.

In evaluating a child to elucidate a differential diagnosis, clinicians should use standardized trauma screenings and assess for medical explanations. The American Academy of Pediatrics recommends that pediatricians and mental health professionals routinely ask about trauma history in evaluations.[46] Tools like the *UCLA PTSD Reaction Index* or *Childhood Trauma Questionnaire* help systematically identify trauma exposure and symptom patterns.[46,60,61] Ultimately, diagnosing a trauma-related disorder in a child often means peeling back layers. A thorough, trauma-informed differential diagnostic process ensures the child receives the appropriate treatment. It also validates the child's experience, recognizing that their "symptoms" are how some people react to trauma, not character flaws or random illness, which can be an important part of healing.

EVIDENCE-BASED TREATMENTS AND PROMISING PRACTICES

Protective factors like positive self-esteem, strong coping skills, and supportive relationships (with family, peers, or mentors) can mitigate the impact of trauma. Some children show natural resilience due to innate qualities of temperament, executive functioning, or environmental supports. Early intervention serves as a protective factor, with prompt counseling frequently preventing full PTSD onset.

For pediatric trauma-related needs, trauma-focused psychotherapy is the first-line treatment modality.[62] Several evidence-based treatments that have been cataloged elsewhere (i.e., The National Traumatic Stress Network and The California Evidence-Based Clearinghouse) can effectively treat pediatric trauma.[63,64] Trauma-focused cognitive behavioral therapy (known as TF-CBT) is a short-term treatment (typically 12 to 20 sessions) that has been extensively tested in over 20 randomized trials, showing robust efficacy in reducing PTSD and related symptoms in children and adolescents.[46] Approximately 80 percent of youth show significant improvement, often no longer meeting PTSD criteria, with benefits extending to daily functioning.[65] Another well-supported therapy is child-parent psychotherapy, especially for young children (infants, toddlers, preschoolers) who have experienced trauma, such as maltreatment or witnessing violence. Multiple trials of child-parent psychotherapy have demonstrated reduced child PTSD symptoms and behavior issues and improved caregiver-child relationships.[42,66] Child-parent psychotherapy typically is longer-term (up to a year) and addresses the trauma in the context of developmental guidance and enhancing the caregiver's response. Research has also found that eye movement desensitization and reprocessing therapy reduces PTSD symptoms in children and youth, showing results comparable with those of cognitive behavioral therapy.[46] The World Health Organization has recognized eye movement desensitization and reprocessing as evidence-based treatment. The approach requires specialized training and often incorporates play therapy for younger children.[67]

For adolescents, cognitive processing therapy and prolonged exposure therapy for adolescents effectively treat trauma-related needs. Cognitive processing therapy is a structured cognitive approach that helps individuals challenge and modify unhelpful beliefs related to the trauma, while prolonged exposure therapy for adolescents guides youth to process trauma through repeated retelling of memories (imaginal exposure) and gradual exposure to avoided but safe real-life situations (in vivo exposure).[68] Both methods emphasize active participation and strong therapeutic relationships. Group approaches, like the school-based Cognitive Behavioral Intervention for Trauma in Schools program, reduce symptoms through peer support.[69] The Seeking Safety program, originally designed for trauma and substance use, is another group approach that focuses on developing healthy coping strategies without requiring deep trauma processing.[70] Family interventions prove particularly valuable after shared traumatic events (like a natural disaster or a community violence event), with caregiver treatment often essential to child recovery.

Pharmacotherapy in pediatric trauma cases is usually considered adjunctive. There are no medications specifically approved by the U.S. Food and Drug Administration (FDA) to treat pediatric PTSD. However, if a child's symptoms are severe or if there are comorbid conditions, clinicians may use medications to target certain symptoms, such as panic attacks, nightmares, or sleep disturbances.[62] Importantly, medication is never the stand-alone treatment for trauma; it is always combined with therapy.

Developmentally sensitive care means adjusting both the content and delivery of treatment to the child's age and stage. Younger children respond best to shorter, play-based methods with caregiver involvement, while adolescents benefit from collaborative approaches addressing identity and relationships. Evidence shows that timely and effective trauma treatment not only alleviates symptoms but also enhances overall functioning, highlighting the need for prompt referral when trauma is identified. To accommodate real-world barriers, trauma treatment is increasingly delivered in children's natural environments (schools, clinics, and homes), improving access and reducing stigma without compromising care quality. Across modalities, establishing safety, engaging caregivers, and building skills remain central.[46] With proper support, many children and youth recover and thrive, transforming their life course and reducing the multigenerational impact of trauma.[65]

FUNCTIONAL IMPAIRMENT RELATED TO TRAUMA DISORDERS

Trauma-related disorders in children and adolescents can lead to significant disruptions across developmental domains. Although many youth exposed to trauma demonstrate resilience, some experience severe symptoms meeting criteria for SED, particularly without early intervention.[71,72] These impairments often persist across educational, social, familial, and community functioning without timely trauma-sensitive care.

In educational settings, trauma symptoms often manifest as concentration difficulties, emotional dysregulation, and memory problems, leading to academic struggles and absenteeism.[73,74] Hypervigilance and avoidance behaviors may further disrupt learning, especially for youth with co-occurring attention or mood challenges.[75]

Interpersonal relationships frequently suffer, with children showing attachment difficulties, social withdrawal, or peer conflicts.[76] In younger children, attachment disturbances and difficulty trusting adults may manifest as clinginess, avoidance, or oppositional behavior, while adolescents may engage in risk-taking behaviors, including substance use, sexual risk-taking, or aggressive acting out, depending on the specific trauma they experienced.[77] Youth with complex trauma histories may particularly struggle with impulse control and emotional regulation, increasing vulnerability to disciplinary issues and juvenile justice involvement.[72,74]

There is also a well-documented association between trauma exposure and suicidality, with substantially elevated risk during adolescence, particularly when symptoms remain unaddressed.[75,78] Trauma-related disorders are also associated with chronic health conditions, such as sleep disturbances, headaches, and gastrointestinal issues, which further compound daily impairment and reduce quality of life.[73]

These findings underscore that trauma disorders can profoundly disrupt youth functioning and developmental trajectories. When symptoms severely impair school engagement, relationships, or self-regulation, they reach the level of SED and necessitate intensive, trauma-informed services. Without appropriate intervention, the long-term effects of trauma exposure can persist into adulthood, increasing the risk for psychiatric disorders, medical conditions, and social adversity. Therefore, early identification, responsive care, and system-wide coordination are essential components of supporting youth with trauma-related disorders.

Neurodevelopmental Disorders

Table 2: Neurodevelopmental Disorders

Category	Summary
Common Disorders	Primarily attention-deficit/hyperactivity disorder (ADHD); autism spectrum disorder (ASD) and intellectual developmental disorder (IDD) are recognized, but typically fall under developmental disability services, not behavioral health care.
Prevalence	• ADHD affects approximately 9.8% of U.S. children ages 3–17. • Boys are nearly twice as likely to be diagnosed as girls.
Age of Onset	• Symptoms typically emerge before age 12, with earlier onset often linked to more severe outcomes.
Evidence-Based Treatments	• Behavioral parent training • School-based interventions • Organizational skills training • Multimodal approaches including medication management • Promising telehealth, digital therapeutics, and mindfulness-based interventions

CLINICAL PRESENTATION AND EXAMPLES OF COMMON DISORDERS

Neurodevelopmental disorders (**Table 2**) comprise a group of conditions emerging in early childhood that are characterized by impaired personal, social, academic, or occupational functioning.[79] Attention-deficit/hyperactivity disorder (ADHD) is the most commonly diagnosed neurodevelopmental disorder among youth receiving services within public behavioral healthcare systems. Other diagnoses within neurodevelopmental disorders include autism spectrum disorder (ASD) and intellectual developmental disorder (IDD); however, services for these diagnoses typically fall under developmental disabilities services and are outside the scope of this report. For comprehensive information on ASD and IDD, readers are referred to the Centers for Disease Control and Prevention's (CDC's) Autism and Developmental Disabilities Monitoring Network and related resources.[80]

ADHD is a neurodevelopmental disorder marked by pervasive patterns of inattention and/or hyperactivity-impulsivity that interfere with functioning or development. The DSM-5 identifies three primary subtypes: predominantly inattentive, predominantly hyperactive/impulsive, and combined presentation.[79] Inattentive symptoms include frequent forgetfulness, distractibility, difficulty sustaining attention, and poor organizational skills. Hyperactive/impulsive symptoms often manifest as excessive fidgeting, restlessness, verbal interruptions, and difficulty with self-regulation. ADHD can manifest differently across developmental stages, and the symptoms can mimic other childhood disorders (e.g., inattention can also be a symptom of anxiety, depression, and trauma). Preschooler ADHD typically manifests with pronounced hyperactivity, while school-age children demonstrate increasing academic and behavioral challenges. Adolescents often show persistent inattention, while hyperactivity may diminish or become internalized (e.g., feeling restless rather than acting out). Diagnostic criteria require symptom onset before age 12, presence across multiple environments (i.e., home and school), and clinically significant functional impairment.[79]

PREVALENCE

ADHD is one of the most prevalent mental health diagnoses among children and adolescents in the United States. According to data from the CDC, approximately 9.8 percent of U.S. children ages 3–17 years (equivalent to over 6 million youth) have received an ADHD diagnosis at some point in their lives.[81,82] Notably, boys are diagnosed at nearly twice the rate of girls—a disparity reflecting both biological differences in symptom presentation and differences in identification, because inattentiveness, which is easier to miss, is more prominent in girls than is hyperactivity/impulsivity.[83,84]

Prevalence rates demonstrate significant variation across socioeconomic and demographic groups. Children from low-income households, and those enrolled in Medicaid show higher diagnosis rates compared with those enrolled in private insurance.[85] This pattern likely results from both elevated environmental risk factors (including prenatal exposure to substances, early trauma, or chronic stress), as well as increased detection through school-based referral systems in publicly funded programs. Within the United States, diagnosis rates have risen steadily over the past two decades, possibly due to improved awareness and screening practices, broader diagnostic criteria, and shifting educational demands that highlight attention and behavioral regulation difficulties.

RISK FACTORS

The etiology of ADHD involves complex interactions among genetic, neurobiological, environmental, and psychosocial factors. Research indicates no singular cause but rather cumulative risk pathways that disrupt typical neurodevelopment.

Genetic predisposition represents the most robust risk factor, with twin studies demonstrating 70 to 80 percent heritability.[86] Individuals with first-degree relatives (e.g., parent or sibling) diagnosed with ADHD face substantially increased risk. Genome-wide association studies have identified specific gene variants associated with dopamine transmission, including DRD4 and DAT1, which may contribute to the attentional and behavioral regulation deficits characteristic of ADHD.[87] Neuroimaging studies further support the biological basis of ADHD, revealing structural

and functional differences in brain regions involved in executive function, particularly the prefrontal cortex, basal ganglia, and cerebellum.[88]

Prenatal and perinatal adversities significantly elevate risk. Maternal substance use (including tobacco and alcohol exposure), premature birth, low birth weight, and delivery complications are well-documented contributors.[89,90] Emerging evidence suggests maternal stress, infection, micronutrient deficiencies, and exposure to neurotoxicants (e.g., lead or organophosphate pesticides) may alter developmental trajectories, particularly in genetically susceptible individuals.[91]

Adverse childhood experiences (ACEs) and chronic stressors in early development compound biological vulnerability, while positive childhood experiences (PCEs) such as structured routines, consistent caregiver responsiveness, and school-based supports, can buffer genetic and environmental risks by strengthening self-regulation and executive function networks.[92,93] Children exposed to maltreatment, violence, family instability, or parental mental health challenges demonstrate higher ADHD symptom severity.[94,95] Children who experience multiple ACEs have an increased likelihood of exhibiting impulsivity, emotional dysregulation, and attentional deficits. Chaotic home environments and inconsistent caregiving may amplify symptom expression while delaying accurate identification; however, PCEs can help mitigate symptoms even for those with genetic vulnerability to ADHD.[90,92] Increasing social supports and improving family climate can decrease ADHD symptoms over time.

Critically, while psychosocial stressors do not cause ADHD, they influence phenotypic presentation and clinical outcomes. Children from low-resource environments often experience diagnostic delays due to overlapping trauma symptoms and limited healthcare access.[96]

This cumulative risk framework highlights critical developmental periods when genetic susceptibility interacts with environmental factors to shape outcomes. Understanding these dynamic pathways informs both prevention strategies and targeted interventions tailored to individual risk profiles. Integrating screening for known risk factors, particularly in high-risk populations, can support earlier detection, accurate diagnosis, and timely access to supports that mitigate long-term functional impairment.

CO-OCCURRING DISORDERS, RULE-OUTS, AND DIFFERENTIAL DIAGNOSIS

Children with ADHD frequently present with co-occurring neurodevelopmental and mental health conditions that complicate clinical assessment and management. Approximately two-thirds of youth with ADHD meet criteria for at least one additional disorder, and nearly half meet criteria for two or more co-occurring conditions.[97,98] These include learning disabilities, speech and language delays, anxiety, depression, oppositional defiant disorder (ODD), and ASD.[99] This high comorbidity necessitates careful differential diagnosis to ensure accurate identification and appropriate intervention.

Disruptive disorders demonstrate particularly strong associations with ADHD. Recent meta-analytic evidence indicates that ODD and other disruptive behavior problems are among the most prevalent psychiatric comorbidities in children and youth with ADHD; conduct disorder also occurs at elevated rates compared with the general population, particularly among those with

prominent hyperactivity-impulsivity symptoms and other externalizing features.[100] These comorbidities substantially increase risks for academic failure, aggression, and juvenile justice system involvement.

Internalizing disorders also show significant overlap with ADHD. Approximately 25 to 30 percent of children with ADHD meet criteria for depressive disorders, while a similar proportion experience clinically significant anxiety.[101,102] The symptomatic overlap between conditions, including shared features like restlessness and concentration difficulties, requires careful clinical discernment to avoid misattribution. Adolescents with ADHD face elevated risks for SUDs, demonstrating two to three times higher rates of early nicotine, alcohol, and marijuana use compared with neurotypical peers, often reflecting attempts to self-medicate or consequences of impulsivity.[103,104]

Learning disorders, particularly reading and math disabilities, co-occur in 20 to 30 percent of children with ADHD.[105] These academic challenges frequently compound existing difficulties with task persistence and organization. Speech and language disorders are also disproportionately common, particularly in younger children.

Differential diagnosis must carefully distinguish ADHD from other neurodevelopmental conditions, particularly ASD and IDD. Although these conditions share some behavioral features, ASD is characterized by core social communication deficits, restricted interests, and sensory sensitivities, whereas IDD involves global cognitive and adaptive functioning impairments.[80,106] Medical conditions (including thyroid dysfunction, seizure disorders, sleep apnea, traumatic brain injuries, and lead poisoning) can also mimic or exacerbate ADHD symptoms and warrant systematic screening. Children with unrecognized vision or hearing problems may also present with apparent inattention or hyperactivity. Comprehensive screening should include developmental, medical, and neurological history.

Environmental factors further complicate diagnostic clarity. Children exposed to chronic trauma, inconsistent caregiving, or psychosocial adversity may exhibit attention and behavioral dysregulation resembling ADHD.[90] In such cases, symptoms may better reflect trauma responses or adjustment disorders, rather than primary neurodevelopmental etiology, particularly if symptoms are only manifest in one setting, such as home.

Diagnostic accuracy requires multimodal assessment incorporating caregiver and teacher reports, standardized rating scales, clinical interviews, and neuropsychological testing when indicated. Given the substantial overlap of ADHD symptoms with other conditions, best practices call for longitudinal observation and the reassessment of symptoms over time, especially when functional impairment is severe or treatment response proves inadequate.

EVIDENCE-BASED TREATMENTS AND PROMISING PRACTICES

Wellness behaviors have shown modest evidence for improving symptoms related to ADHD. Regular aerobic exercise correlates with improved attention and behavioral regulation,[107] while omega-3 supplementation may benefit children with nutritional deficiencies.[108] Mindfulness-based interventions have also shown early evidence for improving attention, emotion regulation, and executive functioning in youth with ADHD.[109] These strategies may help mitigate the impact of ADHD symptoms; however, when ADHD symptoms begin to impair functioning, effective

management of ADHD often includes multimodal interventions addressing core symptoms and functional impairments across home, school, and social environments. Decades of research support three primary treatment modalities: behavioral interventions, pharmacotherapy, and combined approaches, with emerging promise from novel technologies.

Behavioral interventions constitute first-line treatment, particularly for young children.[110] Behavioral parent training programs demonstrate robust efficacy, with meta-analyses showing medium to large effect sizes for improving child compliance and family functioning.[111,112] School-based interventions incorporating daily behavior monitoring, contingency management, and positive reinforcement systems prove equally valuable when implemented with teacher training and coaching.[113] Organizational skills training is another evidence-based intervention, especially for youth with prominent inattention and executive function deficits. Organizational skills training programs and Ohio University's Challenging Horizons Program have demonstrated improved task management, homework completion, and academic engagement.[114]

Pharmacotherapy remains central for moderate to severe presentations. Stimulant medications show short-term beneficial effects on several behavioral or neuropsychiatric outcomes (i.e., injuries, motor vehicle accidents, education, SUDs), with estimates suggesting relative risk reduction of 9 to 58 percent for these outcomes.[115] The available evidence from pharmacoepidemiology studies on long-term effects of ADHD medication (such as improved academic outcomes) is less clear.[116,117] Nonstimulant options offer alternatives for children who do not respond well to stimulants or have contraindications. Although their effect sizes are generally smaller than those of stimulants, non-stimulants can be effective for reducing symptoms and improving functioning, particularly in youth with co-occurring anxiety, tics, or sleep disturbances.[118]

The Multimodal Treatment Study of Children With ADHD established combined behavioral and medication management as the gold standard for comprehensive care, yielding superior outcomes to either modality alone.[119] This approach proves especially critical for children facing socioeconomic adversity or significant academic impairment. School accommodations that include preferential seating, extended time, and organizational supports represent essential components of treatment planning.[120]

Innovative delivery models show particular promise for improving access. Telehealth platforms effectively disseminate parent training to communities,[121] while digital therapeutics like the EndeavorRx video game (FDA approved for ages 8 to 12) demonstrate preliminary efficacy for improved attention and cognitive control.[122] Additionally, school mental healthcare partnerships that embed behavioral specialists in educational settings improve early identification and service coordination.[123] Computerized cognitive training programs, such as working memory training, have shown modest effects on executive functioning, though generalizability to real-world outcomes is debated.[124]

The evolving treatment landscape reflects growing recognition of ADHD as a chronic condition requiring sustained, developmentally informed support. Optimal care integrates evidence-based interventions with emerging innovations, prioritizing functional outcomes and quality of life across the lifespan.

FUNCTIONAL IMPAIRMENT RELATED TO ADHD

The functional impairments associated with ADHD are profound, impacting educational achievement, family relationships, peer interactions, and self-perception. Children with untreated ADHD are at increased risk for school dropout, substance use, risky behaviors, and involvement with juvenile justice systems. Although many children and adolescents may display inattentiveness or hyperactivity at times, those with neurodevelopmental disorders experience persistent functional impairments across critical developmental domains. The disorder's impact extends beyond core symptoms, often meeting federal criteria for SED when symptoms prove severe, persistent, and unresponsive to early interventions.[125]

Academic functioning represents one of the most significantly affected areas. Students with ADHD demonstrate markedly lower academic achievement, with higher rates of grade retention, disciplinary actions, and school dropout compared with neurotypical peers.[113,126] Organizational difficulties impair assignment completion, while impulsivity disrupts classroom participation. Social functioning is equally compromised. Peer relationships are frequently strained by impulsive behaviors, emotional dysregulation, and difficulty interpreting social cues, which can lead to social rejection, isolation, and conflict. Children with ADHD are more likely to experience fewer close friendships, more negative peer interactions, and higher rates of bullying victimization and perpetration.[127,128] During adolescence, these social challenges may escalate into risky peer associations, increasing vulnerability to delinquent behaviors and substance use initiation.[104]

Family systems bear significant stress from ADHD symptoms. Caregivers report elevated stress levels and disrupted household routines, while sibling relationships often suffer from conflict and unequal parental attention.[129] Daily living skills are routinely impaired, with particular deficits in time management, personal organization, and sleep regulation, which can contribute to conflict with caregivers. Youth with ADHD are more likely to struggle with time management, forgetfulness, and poor planning, which can hinder their ability to navigate increasing expectations in adolescence and adulthood. These dynamics frequently create cyclical patterns, where caregiver stress reduces treatment adherence, thereby exacerbating child symptoms and further intensifying family distress.[130]

Safety risks emerge prominently during adolescence. The combination of impulsivity and sensation seeking elevates risks for accidental injuries, motor vehicle accidents, and legal system involvement.[131] Longitudinal data indicate that youth with ADHD face threefold greater odds of juvenile justice contact compared with peers.[132] Mental health comorbidities amplify these functional consequences. Children with ADHD and co-occurring conditions demonstrate substantially higher risks for SUDs, self-harm behaviors, and suicidality.[111,133] Emerging research highlights concerning associations between ADHD symptom severity and suicidal ideation, particularly among youth with comorbid emotional dysregulation.[103,104] These findings underscore the importance of suicide risk screening and crisis safety planning as part of comprehensive care for youth with ADHD.

When these multidimensional impairments persist despite intervention, they meet criteria for SED, reflecting the disorder's profound developmental impact. This recognition underscores ADHD as a neurodevelopmental condition with potentially life-altering consequences, requiring intensive, coordinated, and sustained support. Effective management must address not only core symptoms but also their functional repercussions across academic, social, familial, and safety domains.

Anxiety Disorders

Table 3: Anxiety Disorders

Category	Summary
Common Disorders	Separation anxiety disorder, specific phobias, social anxiety disorder, generalized anxiety disorder, panic disorder
Age of Onset	• Median onset is age 6 for separation anxiety and specific phobia. • Social anxiety typically emerges around age 13. • Generalized anxiety disorder and panic disorder often emerge in mid-adolescence.
Prevalence	• 10% of U.S. children (ages 3–17) currently have an anxiety disorder. • Lifetime prevalence by age 18 is approximately 32%. • Girls are more affected than boys (38 versus 26%, respectively) by mid-adolescence.
Evidence-Based Treatments	• Cognitive behavioral therapy (CBT) is the gold standard, with sustained effects. • Pharmacotherapy with selective serotonin reuptake inhibitors (SSRIs) is effective for moderate to severe cases. • Combination treatment (CBT + medication) showed the highest response rate (80%) in the Child/Adolescent Anxiety Multimodal Study. • Mindfulness, physical activity, and diet are promising adjunctive wellness interventions.

CLINICAL PRESENTATION AND EXAMPLES OF COMMON DISORDERS

Anxiety disorders in youth (**Table 3**) include a variety of diagnoses, all of which share features of excessive fear or worry that are difficult to control, developmentally inappropriate, and that impair the young person's functioning at home, in school, or in the community. An anxiety disorder presents when fear or worry is out of proportion to the situation, persistent (at least 4 weeks or more), and disrupts the child's normal routines and development.[79] The most commonly diagnosed anxiety disorders in youth include separation anxiety disorder, specific phobias, social anxiety disorder, generalized anxiety disorder, and panic disorder.[79] However, the clinical presentation and prevalence of these disorders vary by developmental stage. Younger children often cannot articulate their worries and instead show physical symptoms

(headaches, stomachaches) or behavioral distress (tantrums, clinginess) when anxious.[134] For example, a preschooler with severe separation anxiety may cry and refuse to leave a parent, disrupting their availability to work, whereas a youth with social anxiety might skip social events due to an intense fear of embarrassment. Children may appear "on edge," irritable, or restless, and even exhibit oppositional behavior as a manifestation of anxiety. Importantly, clinicians should distinguish these disorders from developmentally appropriate fears (e.g., transient stranger anxiety in toddlers) by evaluating the duration, intensity, and impairment caused by the symptoms.[134]

PREVALENCE

Anxiety disorders are among the most common mental health conditions in youth. Recent data from the CDC indicate that approximately 10 percent of children ages 3–17 in the United States have a current, diagnosed anxiety disorder.[135] Prevalence increases with age and peaks by adolescence. About 1 in 3 youth (31.9 percent) experience an anxiety disorder by age 18, and roughly 8 percent of youth have anxiety that causes severe impairment.[50] Notably, anxiety in early childhood is often under-detected, with one longitudinal study finding nearly 10 percent of children had an anxiety disorder between ages 4 and 14 when systematically assessed.[136] That study also observed developmental shifts in the common types of anxiety. Specific phobias predominated in younger children, while generalized anxiety disorder was found to be the most prevalent by age 14.[136] Overall, specific phobias (e.g., fear of the dark, animals) and separation anxiety are more common in early childhood, while social anxiety and panic attacks typically emerge in adolescence.[136] Studies also report sex-based differences, with a higher prevalence of anxiety disorders in females by mid-adolescence (e.g., 38 percent in girls versus 26 percent in boys in lifetime estimates).[50,137] In general, adolescence is a vulnerable period; surveys in 2021 to 2022 found that about 21 percent of youth in the United States reported clinically significant anxiety symptoms in the past 2 weeks. Note that these rates were higher due to the impact of the COVID-19 pandemic and associated public health interventions, including school closures and limits on social gatherings.[135] Longitudinal studies show that pediatric anxiety disorders often persist into adulthood if not effectively treated and are associated with increased risk of developing depression, SUDs, and suicidal behavior later in life.[138] Because of these far-reaching impacts, early identification and intervention are critical. National guidelines now recommend routine anxiety screening starting at age 8 in primary care to detect problems early and reduce downstream impairment.[134]

RISK FACTORS

Research has identified a multitude of risk factors that contribute to the development of anxiety disorders in children and youth. Key risk factors include family history and genetic predispositions, temperament, environmental stressors and trauma, cognitive and developmental factors, and biological and health factors. Having a parent with an anxiety disorder or depression increases a child's risk of anxiety, due to both genetic vulnerability and modeling of anxious behaviors.[134] Children with anxious or overprotective parents may receive messages (intentional or not) that the world is unsafe, reinforcing avoidant coping. Temperamentally, infants and toddlers who display behavioral inhibition have a higher likelihood of developing anxiety disorders later in childhood.[139] Adverse experiences, including chronic

socioeconomic stress, exposure to violence or abuse, bullying, peer victimization, and parental divorce, can precipitate or exacerbate anxiety. In particular, the COVID-19 pandemic was a broad environmental stressor; studies documented increased rates of anxiety and depression among children and youth during the pandemic years.[140] Children who tend to interpret situations as threatening or who have an attentional bias toward negative information are more likely to develop anxiety. Such cognitive patterns can be both a cause and a consequence of anxiety. Emerging research points to certain biological factors, such as disturbances in fear-processing brain circuitry[141] and environmental toxins. For example, some studies have linked prenatal or early childhood exposure to air pollution with a higher anxiety risk.[139] While more research is needed on these factors, it underscores that anxiety etiology is multifaceted, involving a complex interplay of genetics, brain development, and environment.

CO-OCCURRING DISORDERS, RULE-OUTS, AND DIFFERENTIAL DIAGNOSIS

Serious childhood anxiety has a high rate of comorbidity with other mental health diagnoses, with depression being the most frequent co-occurring condition.[142] Other anxiety disorders also commonly co-occur, and it is typical for youth in clinical populations to have two or more anxiety diagnoses.[143] Development considerations are also warranted, including developmentally appropriate fears. Clinicians should only diagnose a disorder when the anxiety is excessive relative to developmental expectations and causes significant functional impairment.[134]

Differential diagnosis for anxiety disorders includes ruling out other explanations for the symptoms, including other psychiatric conditions that may mimic symptoms of anxiety disorders. A thorough medical evaluation may be warranted for sudden or unusual anxiety presentations. For instance, thyroid dysfunction, certain seizures, cardiac arrhythmia, medication side effects, or substance exposures can produce anxiety-like symptoms. These medical causes need to be ruled out and, if found to be present, treated according to physical health guidelines. In addition, several psychiatric conditions can mimic or overlap with anxiety symptoms, or may be comorbid with anxiety, including ASD, ADHD, oppositional behavior, trauma- and stress-related disorders, or obsessive-compulsive disorder. Accurate diagnosis guides appropriate intervention. The high rate of co-occurrence underscores the importance of comprehensive assessment, given that more than one-third of children with any mental health condition have two or more diagnoses.[135] Effective treatment planning for SED must address all co-occurring problems in an integrated way.

EVIDENCE-BASED TREATMENTS AND PROMISING PRACTICES

Pediatric anxiety disorders are highly treatable, with decades of research and multiple evidence-based interventions demonstrating efficacy.[134] Additionally, emerging research demonstrates that wellness behaviors, such as regular physical activity, adequate sleep, nutritious eating, and mindfulness practices, contribute to overall mental health and can serve as protective or adjunctive strategies for managing anxiety.[144-146] Mindfulness-based interventions have gained attention for their ability to reduce anxiety symptoms in youth. Mindfulness is a state of active, open attention to the present, observing one's thoughts and feelings without judging them.[144,147] As such, systems of care and clinicians are encouraged to promote integrating wellness

behaviors into treatment planning, prevention strategies, and psychoeducation as part of a comprehensive, developmentally appropriate approach to managing pediatric anxiety.

Despite the preventive benefits of these wellness behaviors, pediatric anxiety may reach a threshold of distress and functional impairment that requires treatment. The backbone of treatment is psychotherapy, with cognitive behavioral therapy (CBT) as the gold standard. Randomized controlled trials show that approximately 60 percent of treated children no longer met the diagnostic criteria post treatment, with sustained benefits over time.[138] While over 50 percent of treated youth experience meaningful symptom reduction, only one-third achieve full remission,[138] underscoring the need for advanced interventions or periodic "booster" therapy sessions. Technology and telehealth delivery methods, including therapist-guided digital CBT platforms, show promise in improving accessibility while maintaining therapeutic integrity. Given this robust evidence, clinical practice guidelines, such as the 2020 American Academy of Child and Adolescent Psychiatry's *Assessment and Treatment of Children and Adolescents With Anxiety Disorders*, recommend CBT as a first-line treatment for anxiety disorders in children and youth.[134] Overall, the consensus in the field is that early, intensive, multimodal intervention yields optimal outcomes, particularly for youth with anxiety symptoms that lead to significant functional impairments that reach the SED level.

Medication serves as a critical intervention for moderate to severe pediatric anxiety, being particularly relevant when significant functional impairment is present. Selective serotonin reuptake inhibitors (SSRIs), in conjunction with CBT, are the first-line pharmacological treatment. Serotonin norepinephrine reuptake inhibitors (known as SNRIs) may be considered as an alternative to SSRIs.[148] The robust evidence base for medication efficacy includes the Child/Adolescent Anxiety Multimodal Study,[149] as well as a Cochrane systematic review of 22 randomized trials demonstrating significantly higher response rates for medications compared with placebo (58 percent versus 31 percent).[150] Additionally, combination treatment (therapy plus medication) is optimal for youth with moderate to severe anxiety. The Child/Adolescent Anxiety Multimodal Study demonstrated 80 percent response rates with combined treatment, a significant improvement over CBT alone (60 percent) or medication alone (55 percent).[134] Although medications can reduce symptoms, they do not teach the skills needed to manage symptoms over the life course, which are core elements of CBT. Therefore, medication should never be used in isolation from evidence-based psychosocial interventions. When implemented as part of a multimodal treatment approach with careful dosing, monitoring, and family involvement, pharmacotherapy can significantly enhance outcomes for youth with anxiety disorders, particularly those meeting SED criteria.

Overall, the consensus in the field is that early, intensive, multimodal intervention yields optimal outcomes, particularly for youth with anxiety symptoms that lead to significant functional impairments that reach the SED level.

FUNCTIONAL IMPAIRMENT RELATED TO ANXIETY DISORDERS

Anxiety disorders in children and youth can cause profound functional impairment when symptoms are severe.[151,152] In such cases, the disturbance substantially interferes with the

young person's daily life, meeting the criteria for an SED determination as defined by U.S. federal guidelines.[153]

Anxiety disorder symptoms often manifest in behaviors that create impairments demonstrating this level of disturbance. For example, school avoidance and refusal are well-documented outcomes of severe anxiety.[154] School refusal can set off a cycle of escalating problems. As the student stays home, academic performance declines and social isolation increases, causing greater functional impairment. Significant defiance or irritability is also associated with anxiety disorders, which may present as oppositional or angry.[155] This defiance and irritability, when misattributed, can lead to increased familial conflict.[156] In addition, some youth with severe anxiety engage in high-risk behaviors as maladaptive coping mechanisms. They may experiment with alcohol or drugs in an attempt to self-medicate their distress, which heightens the risk of developing substance use problems. Severe anxiety has also been correlated with suicidality in youth, with chronic feelings of worry and fear contributing to a high psychological burden, making some youth more prone to suicidal ideation and even attempts.[157] These findings demonstrate that anxiety disorders in children and youth can lead to pervasive disruptions of school engagement, family life, and safety. When anxiety disorders are associated with these types of functional impairments, it unequivocally qualifies as an SED-level condition requiring a supportive system of care that both addresses the mental disorders and focuses on improving functioning across these multiple domains.

Obsessive-Compulsive and Related Disorders

Table 4: Obsessive-Compulsive and Related Disorders

Category	Summary
Common Disorders	Obsessive-compulsive disorder (OCD), body dysmorphic disorder (BDD), hoarding disorder, trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder
Prevalence	• Obsessive-compulsive and related disorders (OCRDs) affect approximately 2 to 5% of youth, • OCD affects 1 to 3%, • BDD affects ~1%, • Trichotillomania and excoriation disorder each affect ~1 to 2%, • Hoarding affects ~2%.
Age of Onset	• OCD symptoms typically onset in late childhood. • BDD onset is more common in adolescence. • Trichotillomania typically begins around puberty. • Hoarding symptoms may appear in adolescence, often persisting into adulthood.
Evidence-Based Treatments	• Cognitive behavioral therapy (CBT) with exposure and response prevention for OCD and BDD • Habit reversal training for trichotillomania and excoriation • Skills-based CBT for hoarding • Pharmacotherapy combined with psychotherapy for moderate to severe OCD • Acceptance and commitment therapy and family-based interventions

CLINICAL PRESENTATION AND EXAMPLES OF COMMON DISORDERS

Obsessive-compulsive and related disorders (OCRDs) in youth (**Table 4**) encompass conditions characterized by intrusive thoughts and/or repetitive behaviors. Obsessive-compulsive disorder (OCD) is defined by persistent, intrusive thoughts or urges (i.e., obsessions), and repetitive behaviors or mental acts performed to reduce distress (i.e., compulsions).[79] In children and adolescents, common OCD symptoms include fears of contamination, excessive doubt leading to checking rituals, symmetry and ordering needs, or distressing aggressive or taboo thoughts. Young people with OCD often recognize their obsessions are irrational to some degree, yet feel driven to perform compulsions; younger children, however, may have limited insight. These symptoms cause significant anxiety and disrupt daily activities.[158] Pediatric OCD symptoms frequently create a cyclical pattern of family dysfunction, with children persistently seeking validation or requiring family engagement in ritualized behaviors.[159] Although accommodation behaviors temporarily reduce distress, symptom severity can heighten over time.[160-162]

Several related disorders share features with OCD. Body dysmorphic disorder (BDD) involves a preoccupation with perceived defects in appearance that are not observable or appear slight to others.[163] Youth with BDD engage in repetitive behaviors like mirror checking, excessive grooming, or seeking reassurance, leading to significant distress.[164] Importantly, these appearance concerns extend beyond typical adolescent self-consciousness; they are persistent, intrusive, and drive compulsive behaviors that significantly impair daily functioning.

Hoarding disorder is characterized by a persistent difficulty with discarding possessions, regardless of value.[165] In children, differentiating developmentally normal collecting behaviors from pathological hoarding is crucial. Pathological hoarding results in extreme emotional attachment to possessions, severe anxiety when attempting to discard items, and progressively cluttered living spaces that compromise functionality and safety.[165]

Trichotillomania (hair-pulling disorder) involves recurrent, impulsive pulling of one's hair (scalp, brows, lashes) to relieve tension.[166] The urge-relief cycle drives the behavior, often leading to patchy bald spots or thinning hair.[167] Unlike OCD, it functions as maladaptive emotion regulation, managing anxiety or boredom without obsessive thoughts.[167] Excoriation (skin-picking) disorder involves recurrent skin picking, resulting in skin lesions.[79] Although classified with OCD-related disorders due to their repetitive character, trichotillomania and excoriation disorder are fundamentally impulse-control disorders, distinguished by their non-obsessional etiology and driven by sensory urges that establish tension-relief cycles to manage distress.[166]

PREVALENCE

OCRDs affect approximately 2 to 5 percent of children and adolescents, with OCD alone estimated to impact 1 to 3 percent.[168,169] These estimates may underrepresent the prevalence of the disorders. OCD that starts in childhood affects more boys than girls, with male-to-female ratio of approximately 3:2. Boys often develop symptoms earlier, with onset typically in late childhood.[170] By adolescence, this gap closes, with OCD prevalence becoming comparable or slightly more common in girls.[170] BDD is more prevalent during adolescence, with estimated point prevalence at roughly 1 percent during adolescence with higher rates among females.[171] Research suggests that about 2 percent of adolescents may meet criteria for clinically significant hoarding symptoms, with a significantly higher prevalence in girls than in boys.[172]

Trichotillomania shows a female predominance in clinical settings, with onset typically around puberty.[173] Trichotillomania and excoriation disorder each affect roughly 1 to 2 percent of youth.[166,174]

OCRDs collectively impact a meaningful proportion of youth, with heightened risk during adolescence and notable differences by sex in some conditions (e.g., BDD, hoarding). Left untreated, these disorders frequently persist into adulthood, creating substantial burdens across multiple domains. Integrating mental health screenings into routine pediatric care could address this challenge by improving early detection and intervention. These critical steps can mitigate functional impairments, reduce long-term costs, and alleviate strain on medical, educational, and family systems.

RISK FACTORS

A range of genetic, neurobiological, and environmental risk factors contribute to OCRDs. Family and twin studies have shown strong genetic heritability for OCRDs, including shared genetic vulnerability across OCRDs (i.e., a family member with OCD increases risk for BDD).[175-177] Neurobiological factors include abnormalities in brain circuits, particularly cortico-striato-thalamo-cortical pathways, and neurotransmitter dysfunction.[178] In some children, OCD symptoms can appear suddenly following a streptococcal infection, a phenomenon known as pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections.[179] A similar condition, pediatric acute-onset neuropsychiatric syndrome, involves the sudden appearance of OCD symptoms of unknown medical etiology, often triggered by infections, metabolic disturbances, or inflammatory responses.[180] This abrupt onset is thought to occur when the immune system mistakenly targets brain tissue during infection.[181]

Temperamental traits and environmental factors also influence risk. Children with high perfectionism, harm avoidance, or anxiety are more prone to developing OCD or BDD under stress.[182] For BDD, risk factors include appearance-related teasing, low self-esteem, or perfectionism about body image.[171] Many adolescents with BDD report past criticism about their looks, reinforcing obsessive concerns.

Hoarding disorder is associated with family history and personality traits (e.g., indecisiveness, perfectionism, difficulty organizing).[183] Stressful life events such as loss or instability may worsen hoarding behaviors, which serve as a coping mechanism. Neurodevelopmental factors are also relevant, as ADHD frequently co-occurs with pediatric hoarding, suggesting that executive dysfunction contributes to symptom persistence.[172] With trichotillomania, some youth report a triggering stress or anxiety preceding the start of hair-pulling, though many cases lack a clear precipitant. Trichotillomania may have a genetic component, as it often co-occurs with OCD or other repetitive behaviors in families, suggesting shared vulnerabilities in habit regulation. This multifaceted risk profile underscores the importance of early identification and tailored interventions.

CO-OCCURRING DISORDERS, RULE-OUTS, AND DIFFERENTIAL DIAGNOSIS

Co-occurring disorders affect up to 70 percent of pediatric OCD cases, often masking symptoms or delaying effective treatment.[168] Common comorbidities include anxiety disorders (in nearly 50 percent of cases) and depression, which frequently emerges as a secondary complication of

chronic OCD when persistent symptoms lead to social isolation or functional impairment.[167] For OCD, it is important to distinguish true obsessions and compulsions from other phenomena (e.g., generalized anxiety [realistic worries], ASD [routines without distress], and psychosis [fixed delusions]).

Approximately 70 percent of adolescents with BDD have at least one comorbid psychiatric disorder, often a mood or anxiety disorder.[171] BDD differs from social anxiety disorder in that the anxiety is specifically about appearance. Eating disorders commonly co-occur with BDD (particularly weight-focused cases), and substance use may develop in older youth to cope with their appearance-related distress.[184] Notably, BDD should be differentiated from normative appearance concerns.

Hoarding behaviors may co-occur with other conditions as well. For some youth, hoarding behaviors occur alongside depression and anxiety. These co-occurring challenges might stem from the stress of living in disorganized spaces, or they may reflect shared risk factors. ADHD aligns with the difficulties in organization and inhibition that characterize both disorders[172]; hoarding must be separated from typical collecting or disorganization due to ADHD.

Trichotillomania may present alongside anxiety or depressive disorders. Co-occurring conditions often exacerbate functional impairment and complicate treatment.[160] Trichotillomania should be distinguished from dermatological conditions, stereotypies in ASD, and compulsive behaviors associated with OCD. For example, if a child with OCD also pulls hair, careful assessment is needed to determine whether the hair-pulling is an uncontrolled habit (trichotillomania), or if it is a compulsion responding to an obsession, which would be treated as part of OCD.

Thorough assessment should include family history, onset pattern, level of insight, and motivation behind behaviors.[166] Accurate differential diagnosis is essential, as treatment approaches vary significantly across these disorders. Additionally, comorbid conditions often amplify functional impairment and require tailored treatment adaptations, highlighting the need for integrated, individualized care.

EVIDENCE-BASED TREATMENTS AND PROMISING PRACTICES

Prevention and early intervention efforts for OCRDs are critical to intercept the progression from mild symptoms to refractory pathology by modifying maladaptive neural pathways, protecting developmental milestones, and optimizing lifelong functioning. For young people at risk for OCRDs, promoting wellness behaviors, such as regular physical activity, adequate sleep, nutritious diets, and mindfulness practices, may buffer against the onset or worsening of obsessive-compulsive symptoms.[185] These lifestyle factors can help build resilience and lessen the impact of genetic or environmental risks to youth mental health.[186,187] Prevention efforts focus on identifying young people who may be at higher risk by screening for early signs (such as ritualized behaviors, avoidance patterns, or repetitive body-focused behaviors) and providing tailored support. For subclinical symptoms, psychoeducation and adaptive coping skills can mitigate progression, while family-based interventions reduce accommodation behaviors that reinforce symptoms.

The most effective treatment approach for OCRDs combines evidence-based interventions tailored to the child's developmental level and symptom profile. CBT with exposure and

response prevention serves as the cornerstone of psychotherapy.[188] Exposure and response prevention gradually exposes the child to feared situations or thoughts and helps them resist performing their usual compulsions, teaching them that anxiety will decrease over time and that feared outcomes rarely occur.[167] BDD treatment also involves CBT focused on distorted appearance beliefs and ritual prevention. Psychotropic medication may be incorporated for moderate to severe cases or when therapy alone proves insufficient.[189-191] Only four medications (clomipramine, fluoxetine, fluvoxamine, and sertraline) are approved by the FDA for use in children. Despite treatment with these medications and CBT, up to 50 percent of children and adolescents with OCD continue to experience significant, impairing symptoms. Transcranial magnetic stimulation is FDA approved for treatment-resistant OCD in adults and has demonstrated safety in pediatric populations; however, its efficacy in adolescents with OCD has not been carefully studied.[192]

For hoarding disorder in adolescents, research is less extensive, but interventions adapted from evidence-based adult strategies have demonstrated efficacy. Interventions include skills-based CBT that targets organization, decluttering, and decision-making, as well as exposure to discarding items with prevention of hoarding behaviors. Motivational techniques help individuals with hoarding behaviors connect change to their personal goals, fostering insight and positive action. Family involvement and in-home coaching are key, as structured parental limit-setting helps modify hoarding behaviors. Trichotillomania and excoriation disorder are treated primarily with habit reversal training, a behavioral approach that includes awareness training and competing response development.[193] In addition to habit reversal training, newer approaches like acceptance and commitment therapy have shown promise, often in combination with habit reversal training, to help individuals accept urges without acting on them.[166] Unlike OCD, pharmacologic treatments for body-focused repetitive behaviors often do not yield significant benefits.

With OCRDs, family involvement can help reduce accommodation behaviors and reinforce therapeutic strategies across settings. Environmental modifications in school and home contexts further support treatment gains by minimizing triggers and facilitating the practice of new coping skills. Notably, developmental considerations are critical. Treatment must be tailored to cognitive and emotional maturity. Younger children may require more parental involvement and concrete techniques, while adolescents may engage better with autonomy-supportive interventions. A well-informed support network optimizes recovery outcomes by delivering coordinated, evidence-based care through a flexible treatment framework that adapts to the youth's evolving needs and developmental stage.

FUNCTIONAL IMPAIRMENT RELATED TO OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

OCRDs can lead to significant and enduring impairments in functioning when symptoms become severe and persistent. For some youth, these disorders meet federal criteria for SED, as symptoms such as intrusive thoughts, ritualized behaviors, and preoccupations severely disrupt school, family, and social functioning.[6,194]

Functional impairment from OCRDs in children and adolescents often includes time-consuming rituals that significantly delay academic work or school attendance. Youth may spend hours engaged in compulsions, leading to missed instructional time, reduced academic performance,

and school refusal.[195] In severe cases, youth with OCD have difficulty completing basic daily activities (e.g., getting dressed, eating) due to rigid routines, often leading to caregiver burden, family conflict, and accommodation behaviors that further reinforce the disorder.[196,197]

Social functioning is impaired when youth avoid peers or public spaces due to fears of contamination, concerns about physical appearance, or distress around intrusive thoughts, limiting developmental opportunities and increasing risks of depression or anxiety.[171,198] Body-focused repetitive behavior disorders (e.g., trichotillomania, excoriation disorder) are also associated with avoidance, shame, and poor self-esteem, especially during adolescence when peer acceptance is critical.[199]

Youth with OCRDs are at increased risk for suicidality, particularly when accompanied by depressive symptoms or lack of treatment engagement.[200,201] Up to half of those diagnosed with OCD meet criteria for at least one comorbid psychiatric disorder, most commonly anxiety, depression, or tic disorders.[202] The chronic and intrusive nature of these symptoms, coupled with the resulting functional impairment, contributes to long-term psychosocial disability and increased use of emergency or inpatient mental health services.[203]

The functional impact of OCRDs on youth can be profound and enduring. These disorders necessitate early identification and intensive intervention. Without timely, evidence-based care, the impairments can persist into adulthood, underscoring the need for comprehensive, system-level responses to support affected youth and their families.

Mood Disorders: Depressive Disorders and Bipolar and Related Disorders

Table 5: Mood and Bipolar Disorders

Category	Summary
Common Disorders	Major depressive disorder (MDD), bipolar I disorder, bipolar II disorder, persistent depressive disorder (dysthymia), disruptive mood dysregulation disorder (DMDD)
Prevalence	• Mood disorders affect approximately 14% of adolescents by age 18. • MDD is the most prevalent mood disorder in youth, with an estimated 12-month prevalence of 12.9% among adolescents. • Bipolar disorders are less common, with prevalence estimates ranging from 1 to 3%.
Age of Onset	• MDD often emerges in adolescence, with a median age of onset around 14 years. • Bipolar disorder typically has an onset in mid- to late-adolescence, though symptoms can appear earlier.
Evidence-Based Treatments	• Cognitive behavioral therapy (CBT), interpersonal psychotherapy, and dialectical behavior therapy for depressive symptoms • Family-focused therapy, CBT, and psychoeducation for bipolar disorder • Combined treatment approaches (psychotherapy and medication) for moderate to severe mood disorders

CLINICAL PRESENTATION AND EXAMPLES OF COMMON DISORDERS

Mood disorders (**Table 5**) are mental health conditions characterized by significant changes in mood that cause functional impairment. Mood disorders in youth encompass depressive disorders, such as major depressive disorder (MDD), disruptive mood dysregulation disorder (DMDD), and persistent depressive disorder (dysthymia); and bipolar spectrum disorders, including bipolar I and II disorders, and cyclothymic disorder. These conditions involve disturbances in mood that are developmentally inappropriate in intensity and duration, causing significant impairment.

Depression in children often presents as irritability, loss of interest in activities, fatigue, and somatic complaints like headaches or stomachaches. Youth more commonly report sadness, hopelessness, changes in sleep and appetite, and suicidal ideation.[204] Bipolar disorders are characterized by mood episodes, typically with somewhat unpredictable episodes of mania or hypomania and depression. Mania may include elevated or irritable mood, decreased need for sleep, impulsivity, and grandiosity. Hypomania features similar but less severe symptoms. DMDD, a pediatric mental disorder added in the DSM-5,[79] is defined by chronic, severe irritability and frequent temper outbursts across multiple settings. The diagnosis was added for greater accuracy and in part to reduce the overdiagnosis of pediatric bipolar disorder, especially in children with non-episodic mood dysregulation (i.e., chronic irritability).[205]

Differentiating among these disorders is challenging due to overlapping symptoms (e.g., irritability, emotional lability) and the difficulty of separating typical developmental states from pathology (e.g., what does “grandiosity” look like in a child?). The episodic nature of bipolar disorders distinguishes them from persistent mood disturbances like DMDD or dysthymia. Evaluation should include input from multiple sources, including youth, caregivers, and schools, to capture the full scope of symptoms.

PREVALENCE

Depressive disorders are common among youth, with approximately 4 percent of youth (ages 3–17) diagnosed with depression in the United States.[135] Prevalence increases with age, with 20.1 percent of adolescents (ages 12–17) experiencing a major depressive episode in the past year, and 14.7 percent of adolescents experiencing a major depressive episode with severe impairment.[206] Rates are significantly higher among adolescent girls (29.2 percent) compared with boys (11.5 percent).[206] DMDD is estimated to affect 2 to 3 percent of children.[207] Bipolar disorders are less prevalent. Bipolar I disorder affects approximately 0.6 percent of youth, while broader bipolar spectrum disorders affect 3 to 4 percent of youth.[208] Importantly, mood disorders in youth often follow a recurrent or persistent course. An estimated 20 to 60 percent of adolescents experience a recurrence of MDD within 1 to 2 years after remission, and approximately 70 percent experience a recurrence within 5 years.[209] Early-onset bipolar disorder is associated with high rates of relapse and chronicity.[210] These findings underscore that early mood disturbances may portend lifelong challenges, highlighting the need for sustained intervention.

Early onset is a hallmark of many mental health conditions. According to the Substance Abuse and Mental Health Services Administration, a significant proportion of mental disorders begin by age 14, with half of all lifetime cases emerging by this age and 75 percent established by age 24.[211] This developmental trajectory emphasizes that mood disorders are, by definition, conditions that frequently originate in childhood, adolescence, or young adulthood. Research shows that earlier onset of MDD predicts lower remission rates and higher relapse risk, distinct from the neurobiological sensitization process seen in bipolar disorder.[212] Given that mood disorders can be developmental in nature (evolving as the youth grows),[213] failure to intervene early may lead to persistent illness that is less responsive to treatment. Therefore, early identification and intervention are critical. National guidelines recommend routine screening for depression in youth ages 12 and older in primary care settings for early identification and connecting youth to care.[214]

RISK FACTORS

Research has identified numerous risk factors that increase the likelihood of developing depression or bipolar disorder in children and youth. Risk factors across genetic, familial, psychosocial, and biological domains often interact in complex ways and are cumulative.[215] Family history of mood disorders represents one of the strongest known risk factors for developing these conditions.[216] Twin and family studies indicate substantial heritability for both depression and bipolar disorder.[213] Children of parents with depression are at elevated risk not only for depression but also for anxiety and other problems, due to genetic vulnerability and the impact of parental depression on the child's environment. Temperamental traits, such as behavioral inhibition, emotional reactivity, and poor emotion regulation, heighten vulnerability to subsequent mood problems. Early puberty has been associated with increased depression risk as well, potentially due to hormonal influences combined with social role changes.[217] Adverse childhood experiences and community-wide stressors can also play a role.[218] For instance, the COVID-19 pandemic created social isolation, school disruption, and family economic hardship—factors that have been linked to elevated rates of depression and anxiety in youth between 2020 and 2022.[219]

Underlying neurobiology plays a critical role in mood disorders. For instance, depressed youth often show atypical amygdala and prefrontal cortex activity, while bipolar disorder involves irregularities in reward and emotion regulation tasks.[220] Chronic illnesses (e.g., diabetes, cancer, migraines) and chronic pain in childhood increase depression risk through biological and psychosocial stress. Sleep deprivation, whether from poor sleep hygiene, insomnia, or conditions like sleep apnea, can worsen mood or induce mania. Emerging research has begun to examine environmental toxins (exposure to lead or air pollution) and inflammation in pediatric depression or anxiety, though these factors are less established than psychosocial risks.

CO-OCCURRING DISORDERS, RULE-OUTS, AND DIFFERENTIAL DIAGNOSIS

Mood disorders in youth frequently co-occur with other psychiatric conditions. Anxiety disorders are the most common co-occurring condition, with 30 to 75 percent of young people with depression and 40 to 50 percent with bipolar disorder also having an anxiety disorder diagnosis.[221,222] Other common co-occurring disorders include ADHD and disruptive, impulse-control, and conduct disorders,[223] SUDs,[224] eating disorders,[225] autism spectrum disorder,[226] and trauma-related disorders.[227] Accurate diagnosis of pediatric mood disorders also requires distinguishing them from normal development and overlapping conditions. In children and young people, developmentally typical brief mood fluctuations (e.g., school-related sadness, teen irritability) without functional impairment are expected. Mood disorders require persistent symptoms (e.g., 2 or more weeks of depression, 2 or more days of mania), causing clear functional impairment.[79]

Although comorbidity of mood disorders and other mental disorders is common, thorough assessment and considered discernment are needed to avoid assignment of multiple diagnoses where one would suffice. For example, children who meet the criteria for DMDD will usually also meet the criteria for oppositional defiant disorder, but the reverse is not the case; therefore, only

a diagnosis of DMDD should be made in those youth with only one condition. Other important differential diagnosis considerations include determining whether the change in mood is better attributed to a fixed or time-limited event, such as bereavement or a response to a specific stressor, indicating the presence of an adjustment disorder. A thorough medical examination may be warranted to rule out medical conditions linked with changes in mood, such as hypothyroidism (depression), hyperthyroidism (mania), medication side effects, or substance exposure. Assessment should include medical screening, family and developmental history, and evaluation of symptom onset, duration, and context. Misdiagnosis risks inappropriate treatment, and complex cases may benefit from specialist consultation.

EVIDENCE-BASED TREATMENTS AND PROMISING PRACTICES

Wellness behaviors play a vital role in promoting mental health and may buffer against the development of mood disorders in children. Adequate nutrition supports neurodevelopment and sleep quality impacts emotional regulation.[145,228] Regular physical activity contributes to mood stabilization through physiological mechanisms, including increased endorphin release and neuroplasticity, and is inversely associated with depressive symptoms.[229] Social connectedness through family, peers, or school engagement provides emotional support and fosters resilience, while social isolation is a known risk factor for the onset and persistence of mood disorders.[230] Mindfulness practices, including breathing and meditation exercises, have shown promise in reducing depressive symptoms and improving emotional regulation in school-age children, particularly when integrated into school-based programs.[231] Collectively, these lifestyle factors represent protective mechanisms that may reduce vulnerability to mood disorders and should be integrated into prevention and early intervention strategies for youth.

When treatment for a mood disorder is indicated, psychotherapy forms the cornerstone of treatment, with CBT as the gold standard for depression.[232] Research indicates CBT produces meaningful improvement for 60 to 70 percent of youth with depression when delivered properly over 12 to 16 weeks.[233] Interpersonal psychotherapy for adolescents is another well-established treatment that targets interpersonal stressors contributing to depressive episodes and has been shown to improve functioning and symptom severity.[234] Youth with suicidal ideation or self-harm behaviors may particularly benefit from dialectical behavior therapy, which provides concrete skills for emotion regulation and safety planning.[235] Family involvement enhances outcomes across modalities, with family-focused therapy showing particular promise for bipolar disorder by educating families about early warning signs and improving household communication patterns.[236,237] For youth with chronic irritability or DMDD, behavioral therapy approaches are often employed to target emotional and behavioral dysregulation. *The Modular Approach to Therapy for Children With Anxiety, Depression, Trauma, or Conduct Problems* is a flexible, modular treatment manual that integrates CBT and behavioral therapy approaches. Research has shown that the model is effective for reducing symptoms of depression, anxiety, and behavioral problems.[238]

When symptoms reach moderate to severe levels and cause significant functional impairment, combining psychotherapy with medication often yields optimal results.[239] Numerous randomized controlled trials and meta-analyses have demonstrated that medication, when used as part of a comprehensive treatment plan, can significantly reduce depressive and manic symptoms,

improve functioning, and enhance treatment response in youth with mood disorders.[240,241] The landmark Treatment for Adolescents With Depression Study demonstrated that CBT paired with medication achieves higher response rates (71 percent) than either treatment alone for adolescent depression.[242] This combined approach also provides protective benefits against potential medication side effects. While pharmacotherapy may alleviate acute symptoms, it does not impart the coping and emotional regulation skills essential for long-term recovery—skills that are central to psychotherapeutic approaches such as CBT, interpersonal psychotherapy, and dialectical behavior therapy. Given the potential for mood disorders to be recurrent or to become chronic, learning skills to manage the condition may allow the youth to navigate a future independent of having to restart medication. The most effective treatment plans consider the whole person: their developmental stage, family context, co-occurring conditions, and personal strengths. Regular monitoring and adjustment of treatment strategies remain essential throughout the recovery process.

FUNCTIONAL IMPAIRMENT RELATED TO MOOD DISORDERS

It is important to note that depressive symptoms are relatively common in adolescence, and these do not necessarily equate to having a mood disorder. In other words, for a subset of youth who experience debilitating levels of mood disturbance, there will be a resultant level of functional impairment that rises to a level consistent with the federal criteria for SED.[232,243,244] When symptoms are severe and persistent, mood disorders can lead to profound impairments in functioning across major life domains (e.g., school, social relationships, family functioning, activities of daily living).

Functional impairments associated with pediatric mood disorders often manifest as school disengagement, difficulty maintaining peer relationships, and withdrawal from family activities. School-related challenges may include declining grades, chronic absenteeism, or disciplinary actions stemming from irritability and behavioral outbursts.[245,246] In some cases, irritability or defiance may be misattributed to conduct problems rather than underlying mood dysregulation, delaying access to appropriate care. Social withdrawal, a hallmark of depression, may limit peer support and further exacerbate feelings of isolation and hopelessness.[247] Youth with bipolar disorder are at even greater risk for severe functional impairment due to alternating episodes of mania or hypomania and depression, which may disrupt sleep, impair judgment, and contribute to high-risk behaviors.[248]

Additionally, mood disorders are strongly associated with suicidality in youth. Depression is the most common psychiatric disorder among adolescents who attempt suicide, and mood instability significantly increases the likelihood of suicidal ideation, self-harm, and suicide attempts.[249] In 2023, 40 percent of high school students in the United States reported persistent feelings of sadness or hopelessness, and 9 percent had attempted suicide in the past year.[250] Alarmingly, suicide is a leading cause of death among youth, commonly linked to untreated depression or bipolar disorder.[251] Some youth may also turn to substances as a form of self-medication to alleviate emotional pain, placing them at elevated risk for developing co-occurring SUDs.[252]

Taken together, these impairments underscore the seriousness of pediatric mood disorders. When mood disorders result in disruptions across multiple domains, they rise to the level of SED and require coordinated, intensive mental health services designed to support functional recovery in addition to symptom reduction. Given the rising rates of depression and suicide, some experts have advocated for depression screening in schools, and the U.S. Preventive Services Task Force recommends screening for depression and suicide risk.[214] All public and many private/commercial insurance plans (including all those that are part of the Health Insurance Marketplace) cover behavioral healthcare assessments for all children and depression screening for children age 12 and older without requiring co-payments or coinsurance.[253] Mood disorders in youth are common and often severe, with wide-ranging impacts that justify a coordinated public health and systems-based response.

Disruptive, Impulse-Control, and Conduct Disorders

Table 6: Disruptive, Impulse-Control, and Conduct Disorders

Category	Summary
Common Disorders	Oppositional defiant disorder (ODD), conduct disorder (CD), intermittent explosive disorder (IED)
Age of Onset	• Typically emerges in early to middle childhood. • Symptoms of ODD may appear as early as preschool, with CD often developing later. • IED tends to emerge in late childhood or adolescence.
Prevalence	• ODD: approximately 3.3% of youth • CD: approximately 2.5 to 4.0% of youth • IED: lifetime prevalence estimated as 3 to 4% in adolescents
Evidence-Based Treatments	• Parent management training • Multisystemic therapy • Functional family therapy • Cognitive behavioral therapy (CBT) • School-based behavioral supports

CLINICAL PRESENTATION AND EXAMPLES OF COMMON DISORDERS

Disruptive, impulse-control, and conduct disorders (**Table 6**) are characterized by persistent patterns of defiance, aggression, and rule-breaking behavior that violate social norms or the rights of others. While some aggression, defiance, and rule-breaking are developmentally typical during childhood and adolescence, these disorders are marked by behaviors that are chronic, developmentally unexpected, and impair functioning.[254] The most common disorders in this category are oppositional defiant disorder (ODD), conduct disorder (CD), and intermittent explosive disorder (IED); less commonly diagnosed are pyromania and kleptomania.[79]

It is critical to distinguish these disorders from antisocial personality disorder (ASPD), which is only diagnosed in adults age 18 years or older. This diagnostic boundary reflects the dynamic nature of adolescent development. Behavioral patterns often shift significantly with maturation, and many youth who exhibit disruptive behaviors do not persist into adulthood with ASPD.

However, when symptoms are severe, persistent, and impairing, they meet diagnostic thresholds for conditions classified as SED.

ODD often begins in early childhood and is defined by an angry or irritable mood, argumentative or defiant behavior, and vindictiveness, especially toward authority figures. These behaviors persist for at least 6 months and often emerge in familiar settings like home or school.[79] CD involves more severe behavior, including aggression toward people or animals, destruction of property, deceitfulness, theft, and serious rule violations.[255] It typically arises later than ODD and may include a specifier for limited prosocial emotions, such as a lack of empathy or lack of guilt.[256] While a CD diagnosis before age 15 is a diagnostic criterion for ASPD in adulthood, the progression is not inevitable. Behavioral patterns and personality development often shift during late adolescence and early adulthood, meaning many youth with CD do not develop ASPD. IED is marked by impulsive, explosive outbursts of aggression that are disproportionate to the situation.[257] The aggression is not premeditated and is followed by remorse. Pyromania and kleptomania are rare in youth and involve recurring impulses to set fires or steal, respectively, without clear external incentives.[258]

PREVALENCE

Disruptive disorders are among the most common serious mental health conditions in youth. National data indicate that approximately 7 percent of children ages 3–17 had a current behavioral or conduct disorder at the time of the survey, and approximately 9 percent had a diagnosis of behavior problems at some point.[259] Prevalence rates for specific disruptive disorders have varied across studies, but lifetime estimates by late adolescence are 3 to 5 percent for ODD[260] and 2 to 10 percent for CD.[261] Estimated lifetime prevalence rates for IED range from 5 to 7 percent.[262] Boys are more frequently diagnosed with disruptive disorders, particularly with CD.[259] However, girls with disruptive behaviors may exhibit relational aggression (e.g., social exclusion, gossip) more prominently than overt defiance, potentially contributing to underdiagnosis.[263,264]

Oppositional defiant disorder is a strong risk factor for later CD, with about half of the genetic influences shared between the two conditions.[263] However, the prevalence of ODD naturally decreases with age, and most affected youth will not continue to meet the diagnostic criteria in adulthood.[265]

RISK FACTORS

The development of disruptive disorders is understood to be multifactorial, arising from an interplay of child, family, and environmental factors. Genetic and biological factors, including family history of antisocial behavior, substance use, or mood disorders, increase a child's risk of developing ODD/CD through predispositions and environmental interactions.[255] Twin and adoption studies find moderate heritability for aggressive and defiant behavior.[266] Children may also inherit difficult temperamental traits; for example, poor frustration tolerance or a high emotional reactivity can predispose a child to oppositional behavior.[258] Starting from an early age, toddlers who are unusually headstrong, impulsive, or insensitive to punishment signals are at higher risk. Low physiological arousal (e.g., low resting heart rate) has been consistently associated with behavior in youth that violates social norms, suggesting an under-reactive stress response that may promote sensation seeking or fearless aggression.[267,268]

Neuropsychological factors such as executive functioning deficits and language delays have also been implicated as risk factors, supporting the need for a careful assessment to rule out other underlying causes that could be responsive to early intervention.[269]

Family and parenting factors are among the strongest and most well-established contributors to disruptive disorders. Harsh, inconsistent, or neglectful parenting significantly increases risk.[270] Children who experience physical abuse, severe punishment, or witness domestic violence are more likely to develop aggressive, oppositional behavior.[255] Socioeconomic stress amplifies these issues, as poverty frequently co-occurs with key risk factors. Specifically, parenting difficulties, single-parent households, and parental mental illness represent a cluster of indicators for heightened developmental risk.[255]

Environmental and social factors extending beyond the family unit significantly influence behavioral development.[271,272] Particularly during adolescence, peer dynamics emerge as a critical determinant.[273] Early rejection by prosocial peers and affiliation with deviant peers can accelerate conduct problems.[274,275] School-related factors further compound risk, as poor academic performance and punitive or unsupportive school climates may perpetuate negative self-perceptions.[276,277] Similarly, adverse childhood experiences (such as community violence, chronic trauma exposure, household dysfunction, collective trauma) can socialize youth to view aggression as normative, fostering a hostile worldview and perpetuating defiant and conduct difficulties.[278,279]

Taken together, the convergence of cumulative risk factors across biological, psychological, and social domains typically precedes the onset of disruptive, impulsive, and conduct disorders. A child with a strong genetic predisposition toward impulsivity, combined with inconsistent parental discipline and affiliation with deviant peers, represents a high-risk profile. Conversely, the presence of protective factors, such as a stable, supportive relationship with at least one caregiver, good social support, positive school experiences, healthy peer relationships, or individual strengths in skills, can mitigate risks and prevent serious behavioral issues, even for children with underlying vulnerabilities.[280]

CO-OCCURRING DISORDERS, RULE-OUTS, AND DIFFERENTIAL DIAGNOSIS

Disruptive disorders demonstrate significant psychiatric comorbidity, with affected youth frequently presenting with concurrent mental health conditions. Clinically, this diagnostic complexity carries important implications, as co-occurring disorders typically amplify functional impairment and symptom severity.

ADHD co-occurs in 40 to 50 percent of cases of disruptive disorders and exacerbates impulsivity and aggression.[281,282] CD represents the strongest identifiable risk factor for adolescent SUDs, with affected youth initiating substance use 2 to 3 years earlier than peers and demonstrating a 4-fold greater likelihood of developing what would have previously been called “substance dependence” and is now more accurately referred to as a more symptomatic SUD.[283,284] Comorbid mood disorders, anxiety disorders, and learning disabilities are also common.[285,286] These comorbidities increase impairment and complicate treatment, highlighting the need for comprehensive assessment and coordinated intervention.

To distinguish pathological symptoms from developmentally expected behaviors, it is important to also rule out other psychiatric comorbidities. ADHD-related behaviors typically reflect impulsivity and poor inhibitory control rather than intentional oppositionality, whereas in autism spectrum disorder and intellectual disability, noncompliance often stems from communication difficulties rather than defiance. Mood disorders can present with irritability that resembles ODD, while manic episodes in bipolar disorder may mimic CD symptoms. Importantly, an ODD diagnosis should not be made if the behavioral issues only occur during active mood episodes. Similarly, anxiety and trauma-related disorders (including PTSD) can lead to defiant behavior rooted in fear as opposed to deliberate disobedience. Grief and trauma exposure may lead to conduct-like behaviors that reflect maladaptive responses, distinct from core conduct pathology.[287,288] A grief-informed and trauma-informed assessment helps isolate the triggers for these behaviors.[289] Consistent with best practices across child mental health assessments, accurate diagnosis requires multi-informant data collection and attention to developmental, contextual, and co-occurring factors.[290]

It is crucial to distinguish developmentally appropriate behavior from a disorder. The frequency, severity, and persistence of behaviors are the distinguishing factors. For example, a 2-year-old with occasional temper tantrums is expected, whereas a 4-year-old who has severe tantrums *daily* that include aggression and lead to preschool expulsion warrants an evaluation to consider an ODD diagnosis. Similarly, early adolescent "rebellion" (mild rule-breaking, arguing) can be normative, whereas consistent delinquent acts or physical aggression are not.

EVIDENCE-BASED TREATMENTS AND PROMISING PRACTICES

Prevention and early intervention approaches are critical in reducing the likelihood and impact of disruptive, impulse-control, and conduct disorders. A growing body of evidence highlights the role of wellness behaviors, such as regular physical activity, healthy nutrition, sufficient sleep, and mindfulness practice, in supporting behavioral regulation and reducing the risk of developing disruptive disorders. For example, consistent aerobic exercise has been shown to improve executive functioning and decrease impulsivity and aggression in children with externalizing problems.[291] Nutritional patterns rich in whole foods and low in processed sugars are associated with better emotional regulation and fewer behavioral issues.[292] Mindfulness-based interventions, including those implemented in school settings, have demonstrated reductions in aggression and improvements in prosocial behaviors.[293] Other preventive programs implemented in preschool and early elementary, such as the Good Behavior Game (a team-based classroom behavior management strategy), can reduce aggression and increase prosocial behavior, and have been shown to reduce the long-term risk of developing disruptive behaviors.[294] When embedded into daily routines, these wellness behaviors serve as protective factors by enhancing self-regulation, mood stability, and coping skills, thereby reducing the risk and severity of disruptive, impulse-control, and conduct disorders in at-risk youth.

When treatment is needed, psychosocial interventions are the first-line treatment for disruptive disorders. Among these, parent management training has demonstrated strong efficacy, emphasizing consistent discipline and positive reinforcement techniques.[295] Evidence-based programs, such as The Incredible Years, Triple P, and parent-child interaction therapy, are well supported by clinical research.[296] For children, CBT targets anger management and problem-

solving skill development. Adolescents with severe conduct problems often benefit from intensive interventions, such as multisystemic therapy and functional family therapy.[297] For youth who have multisystem involvement (i.e., behavioral healthcare, child welfare, juvenile justice, or special education)—a population in which disruptive, impulse-control, or conduct disorders are disproportionately prevalent—wraparound services provide comprehensive support by creating an integrated plan of care, coordinating services across systems, and developing natural and community supports, such as mentorship or after-school programs.[298,299]

Although medication is not the primary treatment for ODD or CD, it may serve a supportive role, especially when there are co-occurring conditions. For example, medication can improve self-regulation in youth with ADHD, and atypical antipsychotics may reduce severe aggression in some cases.[300] As emphasized throughout this report, medication should only be used as part of a comprehensive, multimodal treatment plan and requires ongoing monitoring for therapeutic response and potential adverse effects. A thorough evaluation of medication regimens, along with prioritizing evidence-based non-pharmacological interventions, are essential to ensure safe, effective, and individualized treatment for youth with complex behavioral needs.

Developmental considerations are key to effective treatment. Young children benefit from family-based interventions, while school-age children may respond well to combined parent- and child-focused therapies. Adolescents often require more intensive, coordinated interventions. For older youth, transition planning is crucial to support continued functioning into adulthood.

FUNCTIONAL IMPAIRMENT RELATED TO DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

Disruptive disorders can lead to substantial and often escalating functional impairment, particularly when symptoms are severe, chronic, and present across multiple settings. Affected functional domains may include difficulties forming and sustaining relationships, persistent disruptive or aggressive behavior, and substantial interference with academic progress. An SED designation is appropriate when symptoms are pervasive and persistent, and when they interfere with daily functioning despite appropriate supports.[301]

For families with multigenerational histories of trauma, poverty, or systemic marginalization, these impairments often intersect with child welfare involvement.[302,303] Parental mental health needs, untreated disruptive disorders, or prior juvenile justice system contact can perpetuate cycles of insecure attachment patterns and environmental instability, further complicating interventions.[304,305]

In the school setting, students with disruptive, impulse-control, and conduct disorders may exhibit chronic absenteeism, defiance toward teachers, and disruptive classroom behaviors that interfere with both their learning and that of their peers. These behaviors frequently result in disciplinary actions such as suspensions and expulsions, which further disengage the youth from education and reduce opportunities for positive peer relationships and adult mentorship. At home, parent-child conflict may be persistent and severe, often marked by arguments, threats, and verbal or physical aggression.[306] These patterns contribute to family stress and caregiver burnout, and they are associated with increased use of out-of-home placements or juvenile justice involvement for some youth.[261]

Beyond interfering with daily functioning, disruptive, impulse-control, and conduct disorders are strongly associated with high-risk actions, including substance use, suicidality, and impulsive risk-taking. Youth with CD, for example, are significantly more likely to initiate alcohol or drug use at an earlier age, and longitudinal studies suggest they are at increased risk of developing SUDs in adolescence and adulthood.[307] Suicidality is also alarmingly prevalent among youth with disruptive disorders. Although these disorders are often conceptualized as externalizing in nature, research shows that impulsive aggression and poor emotional regulation may increase the likelihood of suicide attempts. In one large national study, youth with CD and comorbid depression had among the highest rates of suicide attempts across diagnostic groups.[308] Similarly, youth with IED exhibit elevated rates of suicidal ideation and behavior, independent of other psychiatric comorbidities.[308]

Risk-taking behaviors are another key area of functional impairment. These may include reckless driving, unsafe sexual activity, and delinquent behavior, often beginning in early adolescence. The developmental trajectory of youth with untreated or undertreated disruptive disorders may involve early justice system involvement, school dropout, and chronic unemployment in adulthood. The social and economic costs of these outcomes underscore the need for early identification and intervention. These behaviors, when present alongside persistent emotional or behavioral symptoms, clearly demonstrate the level of impairment required for an SED designation and necessitate a systems-level response. Youth with SED-level disruptive disorders typically require coordination across multiple systems, including mental health care, education, child welfare, and juvenile justice. The SED designation facilitates access to intensive services, such as wraparound care coordination, designed to restore functioning and support improved long-term outcomes.

Conclusion

Effectively addressing SED demands a coordinated, integrated approach encompassing clear definitions, precise assessments, comprehensive service arrays, and collaborative multisystem interventions. Policymakers and practitioners must commit to sustained and accessible supports to significantly improve long-term outcomes for youth with SED.

INTERVENTION AND SERVICE RECOMMENDATIONS

Effective SED intervention requires evidence-based services tailored to specific developmental and contextual needs:

- **Continuum of care approaches** include preventive interventions, early identification programs, outpatient therapies, school-based mental health supports, intensive home-based interventions, crisis stabilization services, residential treatment, and transitional-age supports.
- **Family system approaches** ensure that care planning and delivery address the needs of the entire family, not just the identified child. This includes providing accessible and responsive supports for caregivers, integrating family voice in treatment and system-level decision-making, and promoting services that target sibling and caregiver well-being.

- **Evidence-based practices** prioritize practices such as multisystemic therapy, family-focused therapy, trauma-focused CBT, and wraparound care coordination.
- **Emerging technology methods** incorporate telehealth, digital therapeutics, mobile apps, and artificial intelligence–enabled tools to expand access to youth mental health services in the face of persistent workforce shortages and geographic disparities.
- **Family and youth-centered approaches** actively involve youth and families in planning and implementing care to enhance engagement, adherence, and outcomes.
- **Cross-system coordination** facilitates collaboration between mental health, educational, juvenile justice, and child welfare systems through joint planning, coordinated service delivery, and shared funding mechanisms.

POLICY RECOMMENDATIONS

The following recommendations will help policymakers and providers enhance care for youth with SED:

1. **Emphasize functional impairment in eligibility criteria:** Given the complexity in youth diagnoses of mental illness and behavioral disorders and the crossover with developmental norms, it is important to emphasize functional impairment in eligibility criteria to ensure timely identification and early intervention.
2. **Ensure sustainability of services:** Recognize SED as often chronic, advocating for continuous support services beyond short-term interventions, and develop means to sustain appropriate supports as youth move into adulthood with different service systems.
3. **Promote access:** Use a data-informed approach to enhance service delivery and ensure affordability through comprehensive insurance coverage.[15]
4. **Strengthen workforce development:** Address workforce shortages through targeted incentives, specialized training, and inclusion of nontraditional mental healthcare roles, such as peer support specialists.

APPENDIX A

Table A1: Examples of Validated Assessment Instruments for Mental and Behavioral Health Symptoms and Functional Impairment

Instrument Name	Brief Description	Reference Article for Psychometric Properties	Symptom Measure	Functional Impairment Measure	Reporter Forms
Child and Adolescent Functional Assessment Scale	Assesses youth functioning across multiple life domains to guide service planning.	Hodges[309]	N	Y	Clinician
Child and Adolescent Needs and Strengths	Evaluates youth's needs, strengths, and functioning across multiple domains.	Lyons[310]	Y	Y	Clinician
Ohio Youth Problems, Functioning, and Satisfaction Scales	Measures emotional/behavioral problems and functioning for youth receiving mental health services.	Ogles et al.[311]	Y	Y	Youth Parent Clinician
Child and Adolescent Service Intensity Instrument	Determines the appropriate level of service intensity based on functional status.	American Academy of Child and Adolescent Psychiatry [312]	N	Y	Clinician
Early Childhood Service Intensity Instrument	Service intensity assessment tool for children under age six.	American Academy of Child and Adolescent Psychiatry [313]	N	Y	Clinician
Columbia Impairment Scale	Brief scale assessing impairment in interpersonal, academic, and leisure functioning.	Bird et al.[314]	N	Y	Youth Parent

Instrument Name	Brief Description	Reference Article for Psychometric Properties	Symptom Measure	Functional Impairment Measure	Reporter Forms
Child Behavior Checklist	Assesses a wide range of behavioral and emotional problems in youth.	Achenbach & Rescorla[32]	Y	Y	Parent Teacher Youth
Strengths and Difficulties Questionnaire	Behavioral screening tool measuring emotional symptoms, conduct problems, and peer relationships.	Goodman[315]	Y	Y	Parent Teacher Youth

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Acknowledgments

Contributing Authors:

F. Tony Bonadio, PhD, Sarah Quinn, MSW, Jessica Lim, MSSW, and Michelle Zabel, MSS
Innovations Institute, University of Connecticut School of Social Work

Christopher Bellonci, MD
Harvard Medical School