Children’s Disorders Identified In School

Posted on October 9, 2019

Introduction

Schools are often the first institutions to notice that a child is struggling with attention, learning, behavior, mood, relationships, or attendance. This visibility can support early help, but it also creates a serious responsibility: teachers and school teams should identify educational needs and concerning patterns without diagnosing children from observation alone. The original essay assumes that “most children” in the assessed school have emotional disorders and treats quietness, poor concentration, unhappiness, and limited socialization as proof of emotional behavioral disorder. Those conclusions are too broad. Similar signs may be associated with anxiety, depression, attention-deficit/hyperactivity disorder, learning disability, trauma, sleep problems, bullying, sensory impairment, language barriers, family stress, physical illness, or ordinary short-term reactions. A responsible school process moves from observation to support, family consultation, evidence-based intervention, multidisciplinary evaluation, and referral when clinical assessment is needed. The aim is not to attach a label quickly but to understand what prevents the student from participating and learning. (Ogundele, 2018)

What Schools Can and Cannot Identify

Teachers can document classroom behavior, academic progress, peer interaction, attendance, work completion, and response to instruction. School psychologists and multidisciplinary teams can evaluate educational functioning and determine eligibility for services under applicable disability law. Healthcare professionals may diagnose psychiatric or medical conditions within their scope. These roles overlap but are not interchangeable. A teacher may observe that a student frequently leaves their seat and misses instructions, but cannot conclude from that observation alone that the student has ADHD. The CDC emphasizes that ADHD diagnosis involves several steps and that sleep disorders, anxiety, depression, and learning disabilities can produce similar symptoms. School evidence is valuable because it shows functioning in one important setting; it becomes stronger when combined with information from home, prior records, health assessment, and standardized measures. (Centers for Disease Control & Prevention, 2026; National Association of School Psychologists, 2020)

Begin With Specific, Neutral Observation

Concerns should be recorded in descriptive rather than judgmental language. “During four mathematics lessons, Jordan completed two of ten problems and looked away from the page after approximately one minute” is more useful than “Jordan is lazy and does not care.” Neutral

observation identifies frequency, duration, setting, antecedents, consequences, and variation. The team should ask when the behavior does not occur, because exceptions reveal strengths and environmental factors. A student may concentrate during hands-on science but struggle during long verbal instruction, suggesting that task design and prior knowledge require review. Documentation should also separate a child's behavior from the observer's interpretation. This practice reduces bias and provides a baseline against which support can be evaluated.

Academic Difficulty and Learning Disabilities

Persistent difficulty with reading, writing, mathematics, memory, or processing may indicate a learning disability, but poor performance can also result from interrupted schooling, ineffective instruction, limited language access, absenteeism, or unmet sensory and health needs. Schools should first ensure that the student has received appropriate, evidence-based teaching and accessible materials. Screening can identify risk, while a comprehensive evaluation examines achievement, cognitive and processing information where appropriate, developmental history, classroom performance, and response to intervention. A learning disability is not low intelligence or lack of motivation. Students may possess strong reasoning, creativity, or oral language while needing explicit instruction and accommodations in a particular academic domain.

Attention and Executive Function

Attention problems may appear as distractibility, incomplete work, forgetfulness, impulsive behavior, or difficulty beginning tasks. These behaviors can be associated with ADHD, but they can also reflect anxiety, sleep deprivation, hunger, trauma, unclear instruction, or a task that is too difficult. Evaluation should examine whether the pattern appears across settings, has persisted over time, began during development, and causes meaningful impairment. School support does not need to wait for a diagnosis. Teachers can provide clear routines, chunked directions, visual schedules, movement opportunities, reduced distraction, organizational coaching, and frequent feedback. If concerns remain significant, caregivers should be encouraged to consult a qualified healthcare provider, while the school continues its educational evaluation and support responsibilities.

Anxiety in the School Setting

Anxiety may present through avoidance, perfectionism, repeated reassurance seeking, physical complaints, irritability, freezing during tests, school refusal, or fear of speaking. A quiet and compliant student can be highly distressed without disrupting the classroom. Teachers should not force public disclosure or interpret avoidance as defiance automatically. Support may include predictable routines, gradual participation, access to a trusted adult, coping instruction, reduced humiliation, and collaboration with school mental-health personnel. Severe or persistent anxiety requires professional

assessment, especially when it interferes with attendance, eating, sleep, or daily functioning. Immediate safety procedures are required if the student expresses self-harm or suicidal thoughts.

Depression and Persistent Unhappiness

A prolonged mood of sadness or irritability, loss of interest, fatigue, withdrawal, hopelessness, declining performance, or changes in sleep and appetite can warrant concern. These signs should not be dismissed as ordinary adolescence, but neither should one difficult week be converted into a diagnosis. Staff should document changes from the student's usual functioning and ask supportive, direct questions within their role. Statements about death, worthlessness, or self-harm require prompt risk assessment by trained personnel and communication according to safeguarding procedures. Schools can provide connection, predictable expectations, academic flexibility during treatment, and coordination with caregivers and clinicians. Discipline alone is inappropriate when behavior is a signal of distress.

Trauma and Stress Responses

Children exposed to violence, loss, displacement, abuse, family separation, or chronic instability may show hypervigilance, aggression, dissociation, avoidance, concentration difficulty, or emotional shutdown. Similar behavior can arise for other reasons, so staff should not attempt to reconstruct a traumatic history through leading questions. Trauma-informed practice assumes that behavior may serve a protective function and asks what support would increase safety and regulation. It does not remove boundaries or excuse harm to others. Teachers can use calm routines, advance notice of changes, private correction, opportunities for regulation, and referral to qualified support. Mandatory reporting laws must be followed when abuse or neglect is suspected.

Emotional Disturbance Under IDEA

In the United States, the Individuals with Disabilities Education Act includes an eligibility category called "emotional disturbance." The federal definition requires one or more specified characteristics to be present over a long period, to a marked degree, and to adversely affect educational performance. These characteristics include an inability to learn not explained by intellectual, sensory, or health factors; difficulty building or maintaining satisfactory relationships; inappropriate behavior or feelings under normal circumstances; a pervasive mood of unhappiness or depression; or physical symptoms and fears connected with personal or school problems. Eligibility is an educational determination made through evaluation, not a casual synonym for any challenging behavior. States may use different terminology, and a clinical diagnosis does not automatically establish or exclude special-education eligibility. (Individuals with Disabilities Education Act, 20 U.S.C, n.d.; Individuals with Disabilities Education Act Regulations, 34 C.F.R, n.d.)

Behavior Is Communication, but It Also Has Consequences

A functional behavior assessment can help determine what happens before and after a behavior and what the student may gain or avoid through it. A student might leave work because the task is inaccessible, seek peer attention through disruption, or react defensively to perceived threat. Understanding function allows the team to teach a replacement skill and adjust the environment. This approach does not imply that every behavior is acceptable. Aggression, harassment, or serious disruption requires protection and accountability. The response should include safety, repair, instruction, and examination of causes rather than punishment that removes the student repeatedly without changing the pattern.

Multi-Tiered Systems of Support

A multi-tiered system of support organizes increasingly intensive academic and behavioral assistance. Universal supports at Tier 1 include effective instruction, predictable classroom expectations, social-emotional learning, screening, and positive school climate. Tier 2 provides targeted small-group or short-term intervention for students needing more support. Tier 3 uses individualized and intensive planning. Movement among tiers should depend on data, not on a student's reputation. Intervention must not be used to delay a legally required disability evaluation when a disability is suspected. Under IDEA's child-find duties, school systems must identify and evaluate children who may require special education.

Classroom Design and Differentiated Instruction

Teachers can reduce unnecessary barriers by clarifying objectives, varying representation, offering structured choices, and providing several ways to participate. Seating close to the teacher may help one student and feel stigmatizing or distracting to another, so placement should be individualized. Directions can be brief, written and spoken, followed by a check for understanding. Tasks may be divided into manageable stages, with feedback at each stage. Visual schedules, calm spaces, assistive technology, peer supports, and planned movement can improve access. Differentiation should preserve meaningful learning goals rather than assigning permanently easier work. The student's response should be monitored so that support can be adjusted.

Positive Behavioral Support

Recognition and reinforcement can strengthen expected behavior when they are specific, fair, and connected with skills. "You began the task after the first direction and completed the first section"

teaches more than general praise. Rewards should not become public comparisons or systems that punish students whose disability makes compliance harder. Positive behavior support includes teaching expectations, practicing routines, preventing predictable triggers, and responding consistently. It also includes opportunities for students to repair harm and regain standing after mistakes. A school climate based only on control may produce temporary silence without emotional safety or genuine self-regulation.

Cognitive Behavioral and Clinical Interventions

Cognitive behavioral therapy can help children and adolescents with several conditions, including anxiety and depression, when delivered by appropriately trained professionals and adapted to age and need. It should not be described as a classroom technique that teachers independently use to "cure" emotional disorder. School counselors, psychologists, social workers, or external clinicians may provide or coordinate evidence-based treatment. Teachers can reinforce coping skills such as structured problem-solving, emotion labeling, and gradual practice, but clinical decisions belong within qualified care. Medication decisions likewise require healthcare assessment and informed discussion with caregivers; schools may observe effects but should not diagnose or prescribe.

Family Partnership

Families hold information about development, health, behavior across settings, language, culture, strengths, and recent changes. Initial contact should describe observations and invite perspective rather than announce a diagnosis. A statement such as "We have noticed that Sam has stopped joining group work and has visited the nurse four times before presentations" encourages collaboration. Families may have experienced stigma or discrimination and may reasonably distrust institutions. Schools should provide interpretation, explain evaluation rights, and avoid blaming parenting. When caregivers disagree with the school, the team should return to evidence, listen to concerns, and use formal procedural safeguards rather than treating disagreement as noncooperation.

Student Voice

Children should participate in decisions at a developmentally appropriate level. They can explain what feels difficult, which adults feel safe, what strategies help, and what goals matter. Adults should not ask a student to choose a diagnosis or carry the burden of resolving conflict among professionals. Student voice is especially important because behavior may be interpreted differently from the inside. A learner described as oppositional may report that directions are confusing or that peers provoke them privately. Listening does not mean accepting every account without review; it means treating the student as a source of evidence and a participant in the plan.

Bias and Disproportionality

Race, gender, disability, language, poverty, and cultural expectations can influence which behaviors adults notice and how they interpret them. Black students and students with disabilities may experience disproportionate discipline, while girls or quiet students with attention difficulties may be overlooked. Cultural communication differences can be mistaken for disrespect or withdrawal. Teams should review referral, evaluation, placement, restraint, suspension, and achievement data across groups. Individual decisions require individualized evidence, but system-level patterns can reveal bias that no single case makes visible. Training should include implicit bias, culturally responsive assessment, and alternatives to exclusionary discipline.

Confidentiality and Ethical Communication

Student information should be shared only with people who need it for education, safety, or legally authorized care. Staff should not discuss a child's suspected diagnosis in public areas or with other parents. Records should distinguish fact, source, and professional interpretation. Confidentiality has limits when there is risk of harm, abuse, or a legal reporting duty; these limits should be explained honestly. Ethical language avoids labels such as "crazy," "manipulative," or "bad child." Even a correct diagnosis does not define the student's identity, future, or danger to others.

A Step-by-Step School Response

A responsible pathway begins with specific observation and review of instruction, attendance, health, and context. The teacher consults the appropriate school team and communicates with caregivers. Low-risk supports are introduced and measured while urgent safety or child-protection concerns are escalated immediately. If the pattern persists or a disability is suspected, the school initiates a comprehensive evaluation under applicable procedures rather than delaying indefinitely through intervention tiers. The multidisciplinary team integrates academic, behavioral, developmental, family, and health information. It then develops an educational plan, referral, or both, with clear goals and progress monitoring. Reassessment determines whether support is effective and whether the original explanation remains plausible.

Conclusion

Schools are well positioned to identify patterns that may signal learning, attention, emotional, behavioral, or health needs, but they must not convert classroom observation into unsupported diagnosis. Poor concentration, withdrawal, irritability, sadness, social difficulty, and low achievement can have many causes. The correct response is a structured pathway combining neutral documentation, strong instruction, family and student voice, tiered support, multidisciplinary

evaluation, clinical referral where needed, and protection of rights and confidentiality. Emotional disturbance under IDEA is an educational eligibility category with defined criteria, not a general label for difficult behavior. Effective intervention is individualized and measured, and serious safety concerns receive prompt professional attention. The goal is not to make every child behave identically. It is to identify barriers accurately and provide the educational, psychological, social, and health support each student needs to participate with dignity.

References

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