

The Clinical-Behavioral Spectrum

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What is the meaning of a
“behavioral disorder”?

What underlies behavior?

Functional Behavior Analysis

Seeking attention
Gaining tangibles
Avoidance
Intrinsic Factors

What are “intrinsic factors”
(with internal causation)?

How do they relate to
psychiatric disorders?

3 Major Causes of Emotional and/or Behavioral Problems

1. Problems with adjustment to stress
2. Medical disorders, medication side effects, effects of toxins
3. Problems due to core psychiatric disorders that have biological bases

#2 and #3 are Intrinsic Factors,
with Internal Causation

The other end of the spectrum is “behavioral” reflecting learned behavior.

Visualize a scale,
with “learned behavior” on one
end and “internal causation”
(due to clinical factors) on the
other end

X

X

Learned
Behavior

Internal Causation

“Internal Causation”: e.g. severe psychosis with hallucinations, delusions, etc. Behavioral interventions are unlikely to be effective

Treatment is needed. If treatment is effective, the behavioral problems will resolve.

“Learned Behavior”

This individual needs behavioral interventions. No medication will be of help.

What is indicated is a behavioral plan with “a narrow path with high walls”.

Very few children and
adolescents are at
either extreme.

X

X

Learned
Behavior

Predominantly Learned

Mixed

Predominantly Internal

Internal Causation

What is “Predominately
Learned”?

This is a child or adolescent who happens to have a mental health disorder, but whose behavior problems are due to volitional planning, and not significantly related to the mental health disorder.

Example:
an antisocial
child/adolescent who
happens to also have
ADHD.

Medication will help him plan
his crimes better

This individual needs
behavioral interventions.
Medication treatment can be
helpful, but won't
significantly impact the
behavioral problem without
behavioral interventions.

What is “Predominately Internal”?

This is a child or adolescent whose problems are predominately due to a psychiatric disorder. There may be some tendencies towards power struggles or other behavioral problems, but these are minor compared to the psychiatric disorder.

Behavioral interventions are unlikely to be successful without treatment of the underlying disorder

Behavioral interventions need
to address the underlying
disorder in order to be effective

Identifying where a child or adolescent is on the continuum can be of help in identifying the most effective interventions.

If there are significant differences of opinion regarding where the child/adolescent is on the spectrum (e.g, a classroom teacher and a school social worker, or a probation officer and a therapist).....

This can be diagnostic of
systemic problems with
interventions, and can be a
starting point for reaching
common ground

This can be a good starting
point for discussion

What are the implications if various members of a team (Education, Corrections, Mental Health, etc.) have diametrically opposed viewpoints about where the child or adolescent is on the spectrum?

In a school setting: What if a functional behavioral assessment (FBA) is done on a child or adolescent whose problems are predominately due to the underlying psychiatric disorder?

It would be appropriate to have the FBA conclude that the behaviors are due to Internal Causative Factors

In Corrections, how should
the Juvenile Justice system
address a child or adolescent
who is at “Predominately
Learned” on the spectrum?
One who is at “Predominately
Internal”?

What if there is evidence of a mental health disorder, but no diagnosis has been made?

In a school setting, what are the implications of recommending a diagnostic evaluation? (Hint: the schools are the payers of last resort for what they recommend).

In this situation, e.g. a
Special Education
evaluation, if there is no
clear evidence of
antecedent factors, of
seeking attention, gaining
tangibles, and avoidance,
think “none of the above”
(internal factors).

What should a mental health therapist do when medications aren't working, psychotherapy (non-behavioral) isn't resulting in positive effects, and antisocial behavior appears to be volitional?

Which is worse?

Blaming a child or adolescent
for behaviors that are due to an
underlying mental health
disorder?

Accommodating for behaviors
as if they are due to
disabilities when they are
actually due to volitional,
planned behaviors?

Being wrong in either
direction can have adverse
consequences.

Assuming that behaviors that stem from mental health disorders are volitional leads to the child/adolescent feeling frustrated and powerless, and can lead to power struggles (and eventually, ironically, a diagnosis of Oppositional Defiant Disorder)

Assuming that volitional behavior is due to a disability, and accommodating for it rather than holding the child or adolescent accountable, results in enabling the behaviors to continue (and gives an excuse that can be used in litigation)

Often parents, teachers,
therapists, probation officers,
etc. just don't know

Hint: If Learned Behavior or
Predominately Learned on the
Clinical Behavioral Spectrum, err
on the side of accountability

If Internal Causation or
Predominately Internal on the
Clinical Behavioral Spectrum,
err on the side of
Accommodations

Internal Causation? Learned
Behavior?

Actually, the two are generally
intertwined

Clinical disorders that are initially purely internal can eventually transform to significant behavioral components

Example:

an individual who has Panic Disorder that goes untreated will, through “operant conditioning” begin to avoid more and more activities. This leads to agoraphobia, and even being house-bound.

When the Panic Disorder is eventually treated with medication, the panic attacks remit, but the agoraphobia continues. The agoraphobia may actually be a more severe problem, and will not respond to medication treatment. Behavioral interventions (e.g., systematic desensitization) are indicated.

Another example is an individual who has untreated depression for several years. This affects their self-esteem, social activities, etc. When depression is finally treated, the individual needs behavioral interventions to address these problems.

A purely internal disorder
may ultimately require
behavioral interventions for
treatment to be effective

The key is to understand the
nature of the underlying
disorder

And to have behavioral interventions focus on the underlying disorder, rather than on the external manifestations of their behaviors

Case Examples using the Clinical-Behavioral Spectrum

Internal Causation

John, a 16 year old student who has childhood schizophrenia, with no history of antisocial behavior prior to the onset of his illness three years ago.

Behavioral interventions for John would be ineffective in addressing the underlying cause of his difficulties. A behavioral model of intervention would be inappropriate. John needs a clinical model of intervention.

Learned Behavior

In contrast, Alan is a 17 year old student who has a long history of delinquent behaviors dating back to age 9. He has no evidence of any psychiatric illness, and all of his behaviors are planned and volitional.

Alan grew up in a home where he was exposed to antisocial behaviors of both parents and two older siblings. He was finally placed in foster care at the age of 16, and has been receiving structure, nurturance, consistency and stability since then.

Also, Alan would not benefit from insight oriented psychotherapeutic approaches. Alan needs “a narrow path with high walls”- clear behavioral consequences, and a behavior plan that will hopefully extinguish his antisocial behaviors, and replace them with pro-social behaviors.

Predominately Internal

Susan is a 16 year old student who has a history of oppositional and defiant behaviors since early childhood. She grew up in a home where she received inconsistent parenting, and subsequently tested limits in all settings, including school.

She has a family history of Bipolar Mood Disorder, and began to develop symptoms of this disorder at age 15. Within the last six months, she has been agitated, hyperactive, irritable, engaging in risky behaviors, and demonstrating severe mood swings.

Her baseline of mild to moderate oppositional behaviors remain, but are overshadowed by her new behavioral difficulties.

Susan will require behavioral interventions, but, since her severe behaviors directly stem from her psychiatric disorder, the predominate intervention needs to be clinical. Otherwise, she is unlikely to improve.

Predominately Learned

Jared is a 9 year old boy who has been stealing, lying, cruel to animals, setting fires, skipping school and aggressively bullying other children. He also has ADHD, and was recently diagnosed with this disorder.

His antisocial behaviors are planned and volitional, and are not related to the impulsivity of ADHD.

Medication for ADHD is likely to “help him plan his crimes better”.

Although Jared has a mental health disorder, the predominate intervention for addressing his behavior problems will need to be behavioral.

Mixed

Karen is a 16 year old who has spent most of her life in a home with catastrophic stresses. She has fetal alcohol and drug spectrum disorder, ADHD, Post Traumatic Stress Disorder secondary to being molested at age 10, and clinical depression.

Karen also has a long history of antisocial behaviors, dating back to kindergarten. She has assaulted teachers and other students, shoplifted from stores and vandalized the neighborhood. She is noted to be able to charm others, and to be able to be in control of her behaviors to suit her desires.

Karen is a very high risk individual,
at risk of involvement in the
Corrections and Social Service
systems, and of dropping out of
school. She has a mixture of severe
mental illness and of severe
antisocial behaviors.

Some of her behavior problems stem from her psychiatric disorders, whereas others have clear environmental antecedents. Effective interventions will require equally intensive therapeutic and behavioral approaches.

The Clinical-Behavioral
Spectrum bridges the
conceptual gap
between behavioral and
clinical models.

It addresses the bias of educators who tend to overly rely on behavioral concepts to explain students' difficulties. This overreliance results in failed behavioral interventions, frustrated teachers and parents, and demoralized students.

It also addresses the bias of clinicians who may overly rely on a medical model of diagnosis and clinical treatment, without recognizing that many students require a major focus on behavioral interventions.

Although behavioral interventions are not excluded from clinical treatment, they do differ from medical models of “chemical imbalance”, medication interventions, talk therapy, etc.

Thus, the severity of the clinical or behavioral problem may be more pertinent than the relative percentage of the problem.

For example:

an individual who has entrenched severe antisocial behaviors, who then has a traumatic brain injury that limits his level of functioning, and who continues to be severely antisocial would be in the Learned or Predominately Learned category, despite the extent of the brain injury.

How to Assign a Spectrum Location

High Likelihood of Accurate Placement

Medium Likelihood of Accurate
Placement

Low Likelihood of Accurate Placement

High Likelihood of
Accurate Placement
for Internal Causation

- Diagnosis has been made
- Behaviors seen are the criteria of the diagnosis
- Problems disappear with treatment
- Problems re-occur when treatment stops
- No evidence of volitional planning
- Does not fit social responsiveness patterns or functions of avoidance, attention-seeking or gaining tangibles

High Likelihood of Accurate
Placement

for Learned Behavior

- No diagnosis has been made
- Mental health screening yields no evidence of diagnosis other than Conduct Disorder or Oppositional Defiant Disorder
- Clear evidence of function to behaviors
- Behavior is planned and volitional
- No remorse

High Likelihood of Accurate
Placement

for Mixed

Clear evidence of both clinical disorder symptoms contributing to behavioral difficulties and of functional behavioral contributors as well

Medium Likelihood of
Accurate Placement

When all of the “High Likelihood” factors are not present, but there is compelling evidence for the placement.

E.g., No diagnosis has been made, but screening provides strong evidence of depression, ADHD, etc., with symptoms that match the behaviors in question

Low Likelihood of Accurate Placement

When there is no clear information to clarify whether the individual has evidence of mental health disorders or of functional behavioral difficulties.

Summary:

The Clinical-Behavioral Spectrum
isn't a diagnostic tool.

It is a “hypothesis generator” that
raises awareness that clinical and
behavioral issues are often not
“either-or” but “both-and”

It can be used to “diagnose” a system, when there is strong disagreement among professionals regarding an individual’s position on the spectrum.

It can be the basis of discussion
when educational plans or
treatment plans are not working
well.

It can defuse highly charged emotional discussions regarding a student's behaviors.

(E.g., parents who say, “My child has a psychiatric disorder and therefore should have no consequences for his/her behavior”)

Or, conversely, a situation where a teacher tells parents, “I know that he can pay attention when he wants to- I don’t believe that he has any disorder, just an attitude problem”.

It can also be used in generating hypotheses about the best course of action, if the source of behavior is not fully understood.

Give it a try.

