type may be related to social anxiety and a resulting reluctance to use the toilet, or it may be because the child becomes preoccupied with play or other activities.

Some children show a combination of both day and night enuresis.

For both encopresis and enuresis, there is a primary and secondary type:

- With the primary type, the child has never been toilet trained.
- In the secondary type, the disturbance develops after a period of using the toilet appropriately.

Of course, the problem is not diagnosed as a mental disorder unless the child has reached a chronological age at which elimination problems should not be apparent (at least age 4 for encopresis and age 5 for enuresis).

Predisposing factors for both disorders include inconsistent or lax toilet training, or psychosocial stressors such as entry to school or a sibling birth. In contrast to encopresis, about 75% of all children with enuresis have a parent or sibling who had the disorder (APA, 2000).

Both disorders are more common in boys, with prevalence rates for enuresis being higher (5% to 10% of 5-year-olds) than for encopresis (1% of all 5-year-olds) (APA, 2000). Neither disorder is typically chronic. Most children become continent by adolescence. The degree of immediate and long-term impairment depends to a great extent on the amount of resulting peer rejection, punishment and rejection by the caregiver, and a child’s overall self-esteem.

### OTHER IMPORTANT DISORDERS OF INFANCY OR CHILDHOOD

Two other disorders are typically diagnosed in childhood and rarely continue past childhood. Features or components of these disorders may have relevance for adult behaviors.

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**Selective Mutism**

Selective mutism is the persistent failure to speak in specific social situations, even though the child can speak in other situations. Of course, the failure to speak must not be the result of a lack of normal language skills or knowledge of a certain language. The child can be excessively shy, fearful of embarrassment, withdrawn, clunging, and negative; or you may observe temper tantrums or oppositional behavior, especially at home. Mutism is rare, but slightly more common in girls. Usually, the disturbance lasts for only a few months, but it can continue for several years.

**Stereotypic Movement Disorder**

Stereotypic movement disorder is a pattern of motor behavior that is repetitive and nonfunctional and one that the child appears driven to do. Examples of such movements are rocking, twirling objects, head banging, self-biting, picking at skin or body orifices, or hitting parts of one’s own body. The specific behaviors may change over time from one type to another. The disorder can result in self-injurious behavior (see Chapter 23) that causes tissue damage or is life threatening. The behavior is frequently associated with mental retardation; however, it may also occur in children with severe sensory deficits—blindness or deafness, for example—or in institutional environments in which there is insufficient stimulation.

Sometimes children try to restrain themselves from the behavior—for example, by putting their hands in their pockets—but if the restraint is interfered with, the behaviors resume. Onset of the disorder may follow a stressful event. See the DSM-IV-TR feature for diagnostic criteria related to this condition.

### TIC DISORDERS

There are three disorders classified as tics:

1. Tourette’s disorder
2. Chronic motor or vocal tics disorder
3. Transient tic disorder

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**DSM-IV-TR Diagnostic Criteria for Stereotypic Movement Disorder**

A. Repetitive, seemingly driven, and nonfunctional motor behavior (e.g., hands shaking or waving, body rocking, head banging, mouthing of objects, self-biting, picking at skin or bodily orifices, hitting own body).

B. The behavior markedly interferes with normal activities or results in self-inflicted bodily injury that requires medical treatment (or would result in injury if preventive measures were not used).

C. If Mental Retardation is present, the stereotypic or self-injurious behavior is of sufficient severity to become a focus of treatment.

D. The behavior is not better accounted for by a compulsion (as in Obsessive–Compulsive Disorder), a tic (as in Tic Disorder), a stereotype that is part of a Pervasive Developmental Disorder, or hair pulling (as in Trichotillomania).

E. The behavior is not due to the direct physiological effects of a substance or general medical condition.

F. The behavior persists for four weeks or longer.

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**USING DSM-IV-TR**

Health care providers often use language unfamiliar to clients and their families. Explain *nonfunctional motor behavior* in terms that a client and family members can easily understand.