5 Common Mental Health Diagnoses

Trying to figure out exactly which illness is affecting your child is not easy and requires the expertise of a mental healthcare provider. If a child is experiencing certain symptoms, a mental healthcare provider can evaluate the child and figure out if he or she has a mental health issue. Sometimes the symptoms are just part of normal child development. Sometimes they are not and the child is diagnosed with a mental illness.

The following section explains some of the most common mental health diagnoses in children. It is not meant to be a comprehensive list, but rather an introduction to the common types of diagnoses. The diagnoses are listed in alphabetical order. Each diagnosis provides a definition of the illness, describes common signs and symptoms, explains how the illness is diagnosed, lists typical co-existing diagnoses, introduces possible treatment options, and provides a few resources specific to that illness.

If you think that your child may have one of these illnesses, it is important that you first contact your child's pediatrician. For more information, turn to **TALKING TO YOUR CHILD'S PEDIATRICIAN (p33)**. Your child's pediatrician can do an initial screening and refer you for an appropriate evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

Anxiety Disorders

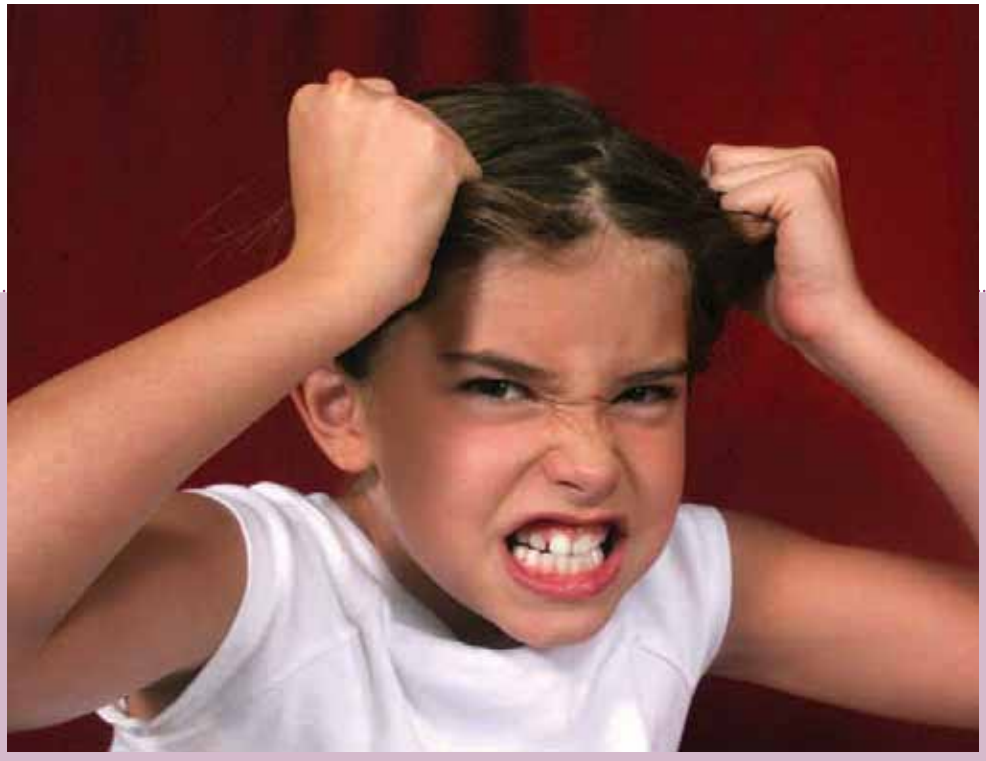
TIP

If your child has been diagnosed with a mental illness, it is important that you get as much information as you can. Check out the resources listed at the end of each diagnosis listing and investigate options for support and treatment.

Anxiety disorders are a group of mental illnesses that may cause anxiety—a state of distress, uneasiness, apprehension, or tension. Although it is common for children to be fearful or worried from time to time as they grow up, a child may have an anxiety disorder if he or she continually shows signs of extreme anxiety or fear.

Anxiety disorders can range from mild to severe. The different types of anxiety disorders in children include:

- **GENERALIZED ANXIETY DISORDER:** With this disorder, a child has a significant amount of worry and anxiety about a variety of situations. This anxiety is hard to control. Children with this disorder are often described as "worriers." They have physical symptoms of anxiety, such as easily tired, sleep problems, muscle tension, upset stomach, acting "edgy," and irritability. Their worrying interferes with their functioning in social and school settings or in other daily activities.
- **PANIC DISORDER:** With this disorder, a child has repeated periods of intense fear or discomfort, along with other symptoms, such as a racing heartbeat or shortness of breath. These periods are called "panic attacks" and can last anywhere from a few minutes to a few hours. Panic attacks often develop without a known cause or without warning and can interfere with your child's relationships, schoolwork, and development.
- **SEPARATION ANXIETY DISORDER:** With this disorder, a child worries excessively about his or her primary caregiver. This can lead to not wanting to go to school or socialize outside of the home, having nightmares and worrying about losing their primary caregiver, being unable to sleep alone, and having significant physical symptoms when separated or anticipating separation from their primary caregiver. Separation anxiety is a normal part of infancy and early toddlerhood. If it returns after this development stage, however, it is considered a disorder.
- **SOCIAL PHOBIA:** With this disorder, a child has a significant fear of social or performance situations, fearing that he or she will humiliate or embarrass himself or herself. For children, this leads to anxiety around other kids, not just around adults. The anxiety or fear leads to problems with functioning in social and



Diagnosing mental illnesses in children

For some mental illnesses, such as bipolar disorder or ADHD, your child has to show a certain number of signs and symptoms to be diagnosed. When talking to a mental healthcare provider about your child's illness, ask what the clinical criteria are for specific diagnoses. Usually mental healthcare providers diagnose a mental illness based on the criteria described in the DSM-IV. DSM-IV stands for Diagnostic and Statistical Manual, Version 4. It is a handbook about mental health illnesses that helps all doctors use a common language when talking about mental health. The handbook describes different diagnoses and lists the different symptoms for each one.

Mental illnesses can be difficult to diagnose in children for a many reasons, including:

- Mental illnesses can be diagnosed at different points in a child's development, depending on the nature and characteristics of the illness.
- Many illnesses have similar signs and symptoms, and it can take time to get a correct diagnosis.
- Many of the signs and symptoms of mental illnesses are also a part of normal child development. Distinguishing between a mental illness and normal child development can be hard when a child first starts to show signs and symptoms.
- Some mental illnesses happen together. A child has co-existing disorders when he or she has two or more mental illnesses at once.

In children, anxiety can appear in a variety of forms other than classic "worrying." Children can express anxiety through emotions like anger or sadness and behaviors like isolating themselves from others.

school settings or in other daily activities. Children with this disorder are often seen by others as "shy."

- **SPECIFIC PHOBIA:** With this disorder, a child excessively worries about a particular object or situation (for example, flying, spiders, or heights).

In addition, Obsessive Compulsive Disorder (OCD) (p80) and Post Traumatic Stress Disorder (PTSD) (p84) are also considered anxiety disorders.

SIGNS AND SYMPTOMS

Typical signs and symptoms of anxiety disorders include:

- Intense fear (a sense that something terrible is happening or going to happen)
- Racing or pounding heartbeat
- Dizziness or lightheadedness
- Shortness of breath or a feeling of being unable to breathe
- Trembling or shaking
- Feelings of disconnection and confusion about reality
- Fear of dying, losing control, or losing his or her mind

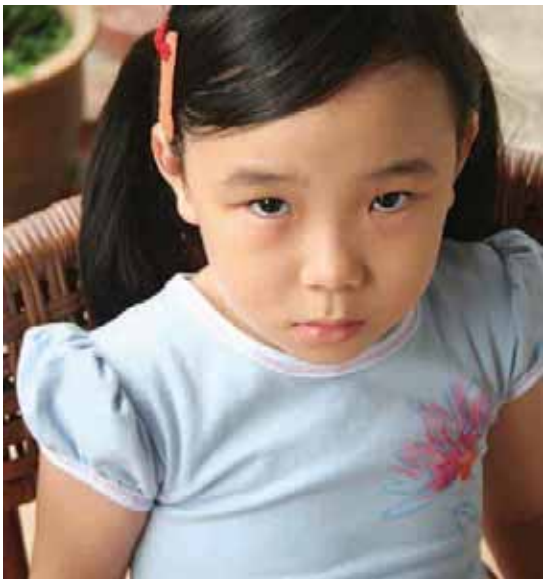
EVALUATION AND DIAGNOSIS

Anxiety disorders can lead to complications for your child if not recognized and treated appropriately. Anxiety disorders can be diagnosed anytime in childhood or adolescence. If you think your child has an anxiety disorder, your child may need a comprehensive psychiatric evaluation or psychotherapy evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

TYPICAL CO-EXISTING DIAGNOSES

Many children with one anxiety disorder will end up having more than one anxiety disorder. Common mental health diagnoses that co-exist with anxiety disorders include:

- Attention Deficit Hyperactivity Disorder (ADHD) (p52)
- Body Dysmorphic Disorder (BDD) (p62)
- Depression (p67)
- Learning Disorders (p75)



- Obsessive Compulsive Disorder (OCD) (p80)
- Oppositional Defiant Disorder (ODD) (p82)
- Post Traumatic Stress Disorder (PTSD) (p84)
- Speech and Language Disorders (p90)
- Substance Abuse and Dependence (p94)

TREATMENT

A psychotherapist or a child and adolescent psychiatrist can treat anxiety disorders. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

Several types of treatment are effective for anxiety disorders, including psychoeducation, psychotherapy (in particular, cognitive behavioral therapy), and anti-anxiety or anti-depressant medications (in particular, Serotonin Reuptake Inhibitors or SRIs). For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

If the anxiety disorder is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

RESOURCES

Helping Your Anxious Child: A Step-by-Step Guide for Parents (2000)
By Sue Spence, Vanessa Cobham, Ann Wignall and Ronald M. Rapee

If Your Adolescent Has an Anxiety Disorder: An Essential Resource for Parents (2006)
By Edna B. Foa and Linda Wasmer Andrews

Pediatric Anxiety Research Clinic
at Rhode Island Hospital
401-444-3003 or 401-444-2178
www.anxiouskids.org

Attention Deficit Hyperactivity Disorder

You may notice that your child is misbehaving or acting differently than other children, but you may not know exactly what is wrong. This is a common feeling among parents with children who are later diagnosed with ADHD.

Attention Deficit Hyperactivity Disorder (ADHD) causes children to have difficulty paying attention in school, have impulsive behavior, or have trouble staying focused when playing. While all children may show signs of inattention, distractibility, impulsivity, or hyperactivity at times, a child with ADHD shows these signs more frequently and severely than other children of the same age or developmental level.

SIGNS AND SYMPTOMS

Typical signs and symptoms of ADHD include:

- Trouble paying attention
- Making careless mistakes and not paying attention to details
- Easily distracted
- Losing school supplies and forgetting to turn in homework
- Trouble finishing class work and homework
- Trouble listening
- Trouble following multiple adult commands (directions or instructions)
- Blurting out answers
- Impatience
- Fidgeting or squirming
- Leaving seat and running about or climbing excessively
- Seeming "on the go"
- Talking too much and difficulty playing quietly
- Interrupting or intruding on others

EVALUATION AND DIAGNOSIS

Signs and symptoms of ADHD are often recognized by the school system because the child's behavior frequently interrupts and causes trouble in the classroom. ADHD usually begins and is diagnosed before age 7 and can continue to affect the child through to adulthood. If you think your child has ADHD, your child may need an ADHD evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

ADHD and ADD

These two diagnoses are often lumped together because they are very similar. ADD (Attention Deficit Disorder) is like ADHD, without the "H" which stands for Hyperactivity. Children diagnosed with ADD have symptoms of inattention and distractibility, without the impulsivity and hyperactivity that characterize children with ADHD. Children with ADD tend to be quieter. Their minds may be constantly "on the move", but they may not show it. Instead, they tend to daydream more. Because the child's behavior is oftentimes less disruptive, ADD is often a difficult diagnosis to make. ADD tends to be more common in girls.

TYPICAL CO-EXISTING DIAGNOSES

Common mental health diagnoses that co-exist with ADHD include:

- Anxiety Disorders (p48)
- Bipolar Disorder (p59)
- Conduct Disorder (p64)
- Depression (p67)
- Learning Disorders (p75)
- Oppositional Defiant Disorder (ODD) (p82)
- Substance Abuse and Dependence (p94)

TREATMENT

ADHD can be treated by a pediatrician, a developmental behavioral pediatrician, a neurologist, or a child and adolescent psychiatrist. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

A child who is diagnosed with ADHD and receives appropriate treatment can live a productive and successful life. Some of the treatment options for children with ADHD include ADHD medication, parent management training, and psychoeducation. When children also have a co-existing diagnosis, they may need psychotherapy, as well. For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

If ADHD is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

Roughly 5 out of 100 school-age children have ADHD, but fewer than that have been diagnosed and treated.

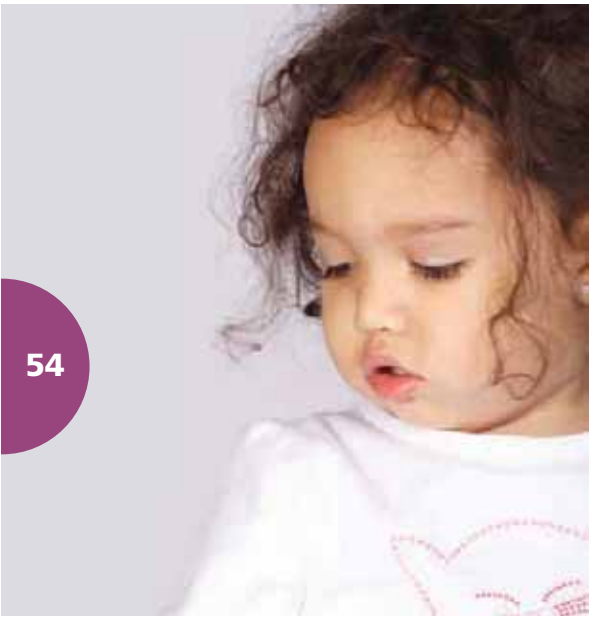
RESOURCES

CHADD (Children and Adults with Attention Deficit Disorder)
800-233-4050
www.chadd.org

CHADD of Rhode Island
401-943-9399

Driven To Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood Through Adulthood (1995)
By Edward M. Hallowell and John J. Ratey

Autism Spectrum Disorders



Autism Spectrum Disorders (ASDs) are also known as Pervasive Developmental Disorders. ASDs are neurological disorders, which means that they affect how the brain works. Although every child will go through development stages at his or her own pace, a child who has significant delays may have ASD. The different types of ASDs include:

- **ASPERGER'S DISORDER:** Asperger's Disorder is a relatively new diagnosis that affects boys more than girls. Most children with Asperger's Disorder have average or above average intelligence and early language development. However, they have severely impaired social skills and are unable to use their language skills to communicate effectively with others. Many children with this disorder have poor coordination, repetitive speech, problems with reading, math or written skills, odd behaviors or mannerisms, obsession with specific topics, and a lack of common sense.
- **AUTISTIC DISORDER:** Children with this disorder have trouble forming normal social relationships and communicating with others. They may also have a limited range of activity and interests. Autistic Disorder is also sometimes referred to as early infantile autism, childhood autism, classic autism, or Kanner's autism. Autistic Disorder affects boys more often than girls.
- **PERVASIVE DEVELOPMENTAL DISORDER – NOT OTHERWISE SPECIFIED (PDD-NOS):** PDD-NOS is also called atypical autism or mild autism. Children with PDD-NOS usually have severe impairment in several areas of development, including social interaction and communication skills. It is diagnosed when a child has many features of autistic disorder, but does not meet the full criteria. Within the diagnosis of PDD-NOS, there are also two specific conditions:
  - » **CHILDHOOD DISINTEGRATIVE DISORDER:** Childhood Disintegrative Disorder is a condition that occurs in children, ages 3 to 4. The child's thinking, social, and language skills get worse over the course of several months. This rare condition is also known as disintegrative psychosis or Heller's Syndrome.

» **RETT'S DISORDER:** Rett's Disorder is a genetic disorder seen mostly in girls. It starts in children, ages 6 to 18 months. It is characterized by wringing of hands, slowed brain and head growth, walking abnormalities, seizures, and mental retardation. A genetic test is now available to confirm a diagnosis of Rett's Disorder.

SIGNS AND SYMPTOMS

ASDs affect each child in different degrees. Two children with the same disorder can act very differently and can have very different skills. However, all children with ASDs share difficulties in 3 skill areas: social interaction, social communication, and repetitive behaviors.

Typical signs and symptoms related to social interaction problems include:

- Spending more time alone rather than with others
- Showing little interest in making friends
- Being less responsive to social or physical interactions, such as making eye contact, hugging, smiling, imitating, or being aware of other's feelings

Typical signs and symptoms related to social communication problems include:

- Losing or not developing speech or another method of communicating, such as pointing or gesturing. For example, a child may not have typical speaking skills for his or her age, not respond to his or her name or to parents' questions, or appear not to understand simple requests.

Typical signs and symptoms related to repetitive behaviors include:

- Being very focused on one interest or topic
- Lacking imaginative play
- Not imitating other's actions
- Not beginning or playing along in pretend games
- Becoming too attached to objects or toys
- Playing with toys in unusual ways, such as lining them up
- Not liking changes in routine or the location of objects
- Having unusual body movements, such as spinning or hand flapping

TIP

Help your child learn about his or her condition. Use different materials such as books, brochures, and the Internet. Make sure that the materials are age appropriate. Answer your child's questions but do not overload him or her with more details than he or she needs.

Sensory integration

Every day a child uses his or her senses to guide behavior and interact with the world. These senses include the five common senses (sight, hearing, touch, taste, and smell), as well as sensory systems, such as balance and movement and muscle and joint sense. Just like the brain sends messages to the body about smell or taste, the brain also sends messages to the body about balance, movement, and how to use muscles and joints. For example, balance and movement senses help a child come down a slide or use a swing in a playground. Muscle and joint senses help a child lift a spoon without spilling. The senses are working all the time in order for the body to perform daily functions. Sensory integration is when all of the senses work together well to perform these daily activities.

When one or more senses is not working and the brain cannot tell the body how to behave, it is called Sensory Integrative Disorder. Sensory Integrative Disorder can reveal itself in many ways. On one hand, a child may be overly sensitive to touch, movements, sounds, or sights. He or she may withdraw from touch, avoid certain textures in clothes of food, or be very sensitive to loud noises. On the other hand, a child may be under-reactive to stimulation. He or she may seek out intense sensory experiences, such as whirling around, falling, and crashing into objects, or appear oblivious to pain or body positioning. Children with Sensory Integrative Disorder may also have the following signs and symptoms:

- Unexpected reactions to sensory inputs (for example, aggression or fearfulness in new situations)
- A high or low activity level compared to other children
- Coordination problems (for example, poor balance, difficulty with new tasks, or awkward, stiff, or clumsy behavior)
- Academic or motor development delays (for example, tying shoes or zipping a coat)
- Difficulty following directions
- Lacking in the ability to plan tasks or anticipate outcomes
- Appearing distracted, bored, lazy, or unmotivated
- Avoiding tasks and appearing stubborn or troublesome

An occupational therapist who is trained in sensory integration can evaluate and treat Sensory Integration Disorder. The therapist creates an environment where a child can play in an organized manner. A balance of structured and free play teaches the child to use his or her senses effectively. In addition, treatment also includes developing a predictable schedule and daily routine for the child. Doing this limits the amount of disruption and disorganization in the child's environment. The therapist can also work with a parent to help the child at home.

RESOURCES

Rehab New England, Inc.
401-941-9111

Sargent Rehabilitation Center
401-886-6600

Senseabilities: Understanding Sensory Integration (1993)
By Maryann Colby Trott, MA, Marci K. Laurel, MA, CCC-SLP, and Susan L. Windeck, MS, OTR/L

In addition, a child's senses (sight, hearing, touch, smell, or taste) may be overactive or underactive. A child may:

- Cover his or her ears
- Become stiff when held
- Remove clothes often
- Refuse to eat certain foods
- Smell objects frequently
- Become either overly quiet or hyperactive in noisy or bright environments

EVALUATION AND DIAGNOSIS

Most children with an ASD show signs of a disorder in infancy. ASDs are usually diagnosed in children, ages 18 to 24 months, with the exception of Asperger's Disorder, which begins later on. To make a diagnosis, providers must see clear signs and symptoms of an ASD before age 3. If you think your child has ASD, your child may need a developmental evaluation or a comprehensive psychiatric evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**. Before using these evaluations, providers may first use several medical tests to rule out other problems, such as hearing loss or mental retardation.

TYPICAL CO-EXISTING DIAGNOSES

Common mental health diagnoses that co-exist with ASDs include:

- Anxiety Disorders (p48)
- Attention Deficit Hyperactivity Disorder (ADHD) (p52)
- Bipolar Disorder (p59)
- Depression (p67)
- Learning Disorders (p75)
- Tic Disorders (p97)

Families are often the first to notice that their child is not reaching developmental milestones and to observe worrisome behaviors. As a parent, it is important to keep track of your child's development and to note changes or signs of difficulty in these areas. For more information on early child development, turn to page 10 in SIGNS AND SYMPTOMS OF MENTAL HEALTH ISSUES.

TREATMENT FACILITIES

Center for Autism and Developmental Disabilities at Bradley Hospital
401-432-1189
www.bradleyhospital.org

Groden Center
401-274-6310
www.grodencenter.org

Sargent Rehabilitation Center
401-886-6600

TREATMENT

Treatment facilities exist specifically to treat ASDs. ASDs can be treated by a developmental behavioral pediatrician, a neurologist, a child and adolescent psychiatrist, a psychotherapist, a speech-language pathologist, and/or other professionals who specialize in early intervention. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

Treatments for ASDs work to different degrees for different children. Treatment must be tailored to the needs and strengths of your child. Factors to consider when choosing treatments include: your child's age, level of skills, type of learner (for example, whether they learn better by seeing or hearing things), behaviors, and previous treatments.

Many treatments have been developed to address a range of social, language, sensory, and behavioral challenges that children with ASDs may have. These treatments include parent management training and medications for particular behaviors. For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

If the ASD is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

RESOURCES

Autism Project of Rhode Island
401-785-2666
www.theautismproject.org

Autism Society of America, Rhode Island Chapter
401-595-3241
www.autism-society.org

Rhode Island Department of Health's *Resource Guide for Families of Children with Autism Spectrum Disorders* (2006),
800-942-7434
www.health.ri.gov/family/specialneeds/autismguide.pdf

Bipolar Disorder

Children with Bipolar Disorder go back and forth between two emotional states: mania and depression. Although Bipolar Disorder is usually diagnosed in adults, the disorder can begin in childhood. All children have "mood swings" from time to time, but children with Bipolar Disorder constantly switch between manic and depressed moods. The frequency of these mood changes can vary among children.

SIGNS AND SYMPTOMS

Typical manic signs and symptoms of Bipolar Disorder include:

- Severe changes in mood—either unusually happy or silly or very irritable, angry, agitated, or aggressive
- Unrealistically high self-esteem
- Significant increases in energy and the ability to go with little or no sleep for days without feeling tired
- Increase in talking—the child talks too much or too fast, changes topics too quickly, and cannot be interrupted
- Distractibility—the child's attention moves constantly from one thing to the next
- Repeated high risk-taking behavior, such as abusing alcohol and drugs, reckless driving, or sexual promiscuity

Typical depressive signs and symptoms of Bipolar Disorder include:

- Irritability, depressed mood, persistent sadness, or frequent crying
- Thoughts of death or suicide
- Loss of enjoyment in favorite activities
- Frequent complaints of physical illnesses, such as headaches or stomachaches
- Low energy level, fatigue, poor concentration, or complaints of boredom
- Major changes in eating or sleeping patterns, such as overeating or oversleeping

EVALUATION AND DIAGNOSIS

Bipolar Disorder can be a very dangerous condition in children, with both the manic and depressive symptoms having an impact on all aspects of their lives. Unfortunately, diagnosing Bipolar Disorder is complex. Bipolar Disorder can be diagnosed at any point in childhood, but it tends to be more common in adolescence. If you think your child has Bipolar Disorder, your child may need a comprehensive psychiatric evaluation. For more information, turn to MENTAL HEALTH EVALUATIONS (p39).

TYPICAL CO-EXISTING DIAGNOSES

Common mental health diagnoses that co-exist with Bipolar Disorder include:

- Anxiety Disorders (p48)
- Attention Deficit Hyperactivity Disorder (ADHD) (p52)
- Conduct Disorder (p64)
- Substance Abuse and Dependence (p94)

TREATMENT

Treatment of Bipolar Disorder usually requires a team-based approach. The team should include a psychotherapist and a child and adolescent psychiatrist. For more information on mental health specialists, turn to page 106 in MENTAL HEALTH SUPPORT. The team could also include a care manager to help coordinate a child's treatment. For more information on health insurance care managers, turn to page 144 in MENTAL HEALTH SUPPORT.

The treatment should address school, work, social, and family functioning. Treatment may include psychoeducation, psychotherapy, and mood stabilizing medications. For more information, turn to MENTAL HEALTH TREATMENT (p147). A family support group can also be helpful.

If Bipolar Disorder is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in MENTAL HEALTH SUPPORT.

RESOURCES

Child and Adolescent
Bipolar Foundation
www.cabf.org

Depression and
Bipolar Support Alliance
800-826-3632
www.ndmda.org

New Hope for Children and Teens with Bipolar Disorder: Your Friendly, Authoritative Guide to the Latest in Traditional and Complementary Solutions (2004)
By Boris Birmaher

Diagnosing Bipolar Disorder

HOW COMMON IS BIPOLAR DISORDER?

At the moment, it is hard to say. Psychiatrists have not agreed upon a common definition of Bipolar Disorder in children. Some professionals have a more limited and narrow definition, and some have a more broad and general definition. Also, there is a lack of long-term research on this disorder in children. It is thought that about 1% of children have Bipolar Disorder, which is similar to the number of adults with the disorder. About 59% of adults with Bipolar Disorder report that their symptoms started in childhood.

IF MY CHILD IS DEPRESSED, WHAT ARE THE RISK FACTORS FOR DEVELOPING BIPOLAR DISORDER?

Risk factors for developing Bipolar Disorder include:

- A family history of Bipolar Disorder
- Medication-induced mania or hypomania
- Sudden onset of symptoms
- Delusions (fixed false beliefs)
- Moving very slowly (psychomotor retardation)
- Significant increase in need for sleep

WHAT DOES MANIA OR HYPOMANIA LOOK LIKE IN A CHILD?

Mania is a period of extreme irritability that lasts for about a week (or less if hospitalization is necessary). During this time, the child would have three or more of the following symptoms:

- Significantly increased self-esteem (for example, feels like a superhero)
- Decreased need for sleep (for example, sleeps 3–4 hours and feels fully rested in the morning)
- Very talkative, difficult to interrupt, and uses rapid speech
- Racing thoughts (difficult to follow a linear path in his or her thoughts)
- Easily distracted
- Increase in goal-directed activity (normal activities done in large amounts)
- Engaging in pleasurable behaviors that are dangerous (for example, sexual talk or actions, or extremely wild driving)

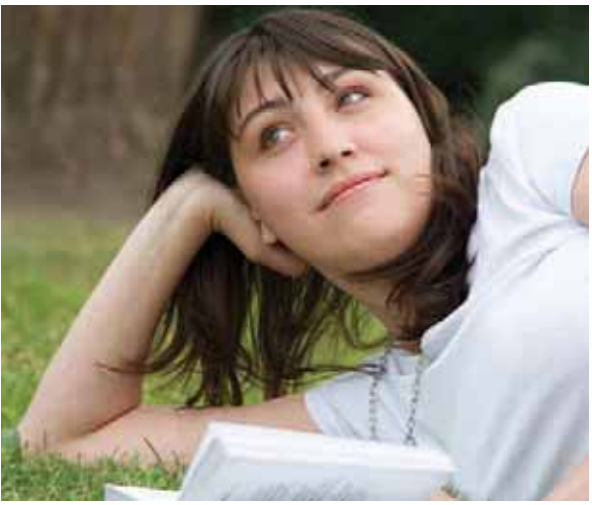
Hypomania is a milder form of mania that does not last as long (4 days rather than 7 days) and is not severe enough to require hospitalization.

HOW DO I KNOW IF IT IS ADHD OR BIPOLAR DISORDER?

Psychiatrists are working hard to answer this question. Hyperactivity is a common symptom in both ADHD and Bipolar Disorder—90% of bipolar cases have this symptom. Children who respond inconsistently to psychostimulants (medications that raise the mood or energy level) may have Bipolar Disorder, rather than ADHD. Also, children with ADHD have symptoms that are chronic, whereas mania occurs in episodes and reflects a change in functioning. A decreased need for sleep and increase in goal-directed activities are two distinguishing features of Bipolar Disorder. Children with ADHD can be irritable or feel a loss of pleasure or interest in usual activities due to decreased self-esteem and associated depression. Even more confusing is that some children may have both Bipolar Disorder and ADHD.

Body Dysmorphic Disorder

It may be hard to notice some of the signs and symptoms of BDD. However, noticing a significant change in grades, a decrease in social activities, or a desire to not want to leave the house may provide some clues about your child's underlying mental health issue.



Body Dysmorphic Disorder (BDD) occurs when a child is extremely preoccupied with a perceived flaw in his or her appearance. Children with BDD are obsessed with the belief that something is wrong with the way they look. They may describe themselves as looking ugly, unattractive, "not right," deformed—or even "hideous" or "monstrous." Although this preoccupation frequently focuses on the face or head, children with BDD can dislike any part of their body. The preoccupations can be very difficult to control.

It is normal for children to be occasionally concerned with their appearance. However, it is also important to note that not all appearance concerns in adolescents are normal or a passing phase. If your child has an extreme preoccupation or obsession with his or her appearance, then he or she may have BDD.

Typical signs and symptoms of BDD include:

- Often scrutinizing the appearance of others and comparing his or her appearance with others
- Often checking his or her appearance
- Hiding the flaw with clothing, makeup, his or her hand, or posture
- Seeking surgery, dermatological treatment, or other medical treatment, when doctors or other people have said the flaw is minimal and treatment is not needed
- Often asking others about the flaw or trying to convince others of its ugliness
- Excessive grooming (for example, combing hair, shaving, removing or cutting hair, or applying makeup)
- Avoiding mirrors
- Often touching the disliked body part to check its shape, size, or other characteristics
- Picking his or her skin to try to improve its appearance
- Measuring the disliked body part
- Excessively reading about the flaw and how to make it look better
- Exercising or dieting excessively
- Using drugs (for example, anabolic steroids) to become more muscular or lose fat
- Changing his or her clothes often to try to find something that makes him or her look better
- Avoiding social situations in which the flaw might be exposed
- Feeling very anxious and self-conscious around other people because of the flaw

EVALUATION AND DIAGNOSIS

In addition to its effects on everyday functioning, BDD can cause serious emotional problems that may have long-term effects on a child's academic progress, job performance, or social life (for example, poor grades, dropping out of school, withdrawing from family and friends, becoming housebound, and even trying to kill himself or herself). BDD often begins as early as adolescence. If you think your child has BDD, your child may need a comprehensive psychiatric evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

TYPICAL CO-EXISTING DIAGNOSES

Common mental health diagnoses that co-exist with BDD include:

- Anxiety Disorders (p48)
- Depression (p67)
- Obsessive Compulsive Disorder (OCD) (p80)
- Substance Abuse and Dependence (p94)

TREATMENT

Treatment options for BDD can help to lower the impact that the disorder has on a child's life. Treatment may reduce appearance preoccupations and compulsive behaviors, lessen emotional distress, and improve depression. It may also help children feel better about how they look, function better, and lead a happier and more productive life.

A psychotherapist or a child and adolescent psychiatrist can treat BDD. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

Common treatment approaches include anti-anxiety or anti-depressant medications (in particular, Serotonin Reuptake Inhibitors or SRIs) and psychotherapy (in particular, cognitive behavioral therapy). For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

If BDD is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

RESOURCES

The Body Image Program
at Butler Hospital
401-455-6466
www.butler.org

The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder (2005)
By Katharine A. Phillips, MD

Learning to Live With Body Dysmorphic Disorder
By Katharine A. Phillips, MD, Barbara Livingstone Van Noppen, MSW, and Leslie Shapiro, MSW
Available from the Obsessive Compulsive Foundation
www.ocfoundation.org

Conduct Disorder

TIP

Insist on the best. Find out who in your community has the most experience and expertise in evaluating and treating your child's mental illness. Talk to mental health specialists, school professionals, and other parents.

Conduct Disorder is a group of behavioral and emotional problems in children. These general behavioral and emotional problems usually result in the child having difficulty following rules and behaving in a socially acceptable way. As a result, many children with Conduct Disorder are viewed by others as "bad" or delinquent, rather than as having a mental illness. Most children will test their parents' rules at some point during their development. However, when a child "goes to the extreme" in breaking these rules, then he or she may have Conduct Disorder.

SIGNS AND SYMPTOMS

Typical signs and symptoms of Conduct Disorder include aggression, rule violation, and property destruction. Some examples of potential behaviors include:

- Bullying, threatening, or intimidating others
- Initiating physical fights with others
- Using a weapon that could cause serious physical harm to others (for example, a bat, brick, broken bottle, knife, or gun)
- Being physically cruel to others
- Stealing from someone while confronting him or her (for example, assault)
- Forcing someone into sexual activity
- Staying out at night often despite parental objections
- Running away from home
- Skipping school often
- Breaking into someone else's building, house, or car
- Lying to obtain goods or favors or to avoid obligations
- Stealing from someone without confronting him or her (for example, shoplifting without breaking and entering)
- Setting fire to property or objects

EVALUATION AND DIAGNOSIS

It is crucial for Conduct Disorder to be diagnosed early to reduce the risk of the child getting hurt or hurting others, as well as reduce the risk of the child getting involved with the judicial system. Conduct Disorder can be diagnosed at any time in childhood or adolescence. It is especially important to address Conduct

Disorder in young children, as this disorder tends to be more problematic when it starts at a young age. If you think your child has Conduct Disorder, your child may need a comprehensive psychiatric evaluation or psychotherapy evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

TYPICAL CO-EXISTING DIAGNOSES

Most children with Conduct Disorder have other mental health diagnoses. Common mental health diagnoses that co-exist with Conduct Disorder include:

- Anxiety Disorders (p48)
- Attention Deficit Hyperactivity Disorder (ADHD) (p52)
- Depression (p67)
- Learning Disorders (p75)
- Oppositional Defiant Disorder (ODD) (p82)
- Post Traumatic Stress Disorder (PTSD) (p84)
- Substance Abuse and Dependence (p94)

TREATMENT

Early treatment of Conduct Disorder is important and can help a child develop into a healthy adult. However, treatment is complex and depends on the severity of a child's case. In many cases a comprehensive and team-based approach to treatment is used. The team should include family, school professionals, and other professionals who can hold the child responsible for his or her behavior and help the child avoid problems with the law. In addition to the child's pediatrician, the team could include a child and adolescent psychiatrist, a psychotherapist, and an advanced practice registered nurse. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**. A care manager can also help coordinate a child's treatment. For more information on health insurance care managers, turn to page 144 in **MENTAL HEALTH SUPPORT**.

Caring for a child with Conduct Disorder

It can be very difficult to care for a child with Conduct Disorder and get him or her the services that he or she needs. If your child has Conduct Disorder, you may need someone to step in and help.

If your child has a mental health issue in addition to Conduct Disorder, you may want to file a voluntary petition. This petition is a request for services that your insurance may not pay for. If approved, the Rhode Island Department of Children, Youth, and Families (DCYF) would step in and pay for these services. These services include residential facilities or special schools for your child.

If your child has Conduct Disorder without another co-existing mental illness and you are having trouble managing him or her, you may want to file a wayward petition. This petition is a request for the judicial system to take over the care of your child. This is often a "last resort" for parents. Your child will get the services he or she needs, but you will have to hand over the care of your child to the courts.

A Diversionary Program is a program designed to divert children from the most restrictive settings in either the mental health or juvenile justice system. These programs can help children who have begun to have problems with the law. The programs focus on positive behaviors and help children avoid future law-breaking activities and prosecution.

Comprehensive treatment for Conduct Disorder needs to occur over a long period of time. Treatment needs to individually address each of the causes for the child's behaviors. Depending of the particular situation, different treatments, including medication, may be needed. Parent management training is an essential part of treatment for Conduct Disorder. In addition, psychotherapy (particularly, cognitive behavioral therapy) may also be very helpful. For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

It is important to note that some types of treatment do not work. For example, group psychotherapy is not a recommended form of treatment for children with Conduct Disorder. In addition, inoculation approaches are not effective. Inoculation approaches are "scared straight" methods that try to prevent the behavior by scaring the child with the consequences of the behavior. Examples of these approaches include putting a child in jail for a few days or sending him or her to boot camp.

If Conduct Disorder is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

A child with Conduct Disorder may also benefit from a diversionary program that would address the child's risk for entering the legal system.

RESOURCES

The Explosive Child: A New Approach for Understanding and Parenting Easily Frustrated, Chronically Inflexible Children (2005)
By Ross Greene
www.explosivechild.com

Foundation For Children with Behavioral Challenges
www.fcbcsupport.org

It's Nobody's Fault: New Hope and Help For Difficult Children (1997)
By Harold Koplewicz

Depression

Although all children may be sad at one time or another, depression is characterized by periods of sadness or feeling "down" that last for a longer period of time (more than 2 weeks) and interfere with a child's ability to function on a daily basis.

Unlike adults, children who have depression may not appear sad, tearful, or melancholy. Children express their depression in a variety of ways.

SIGNS AND SYMPTOMS

Typical signs and symptoms of depression include:

- Frequent sadness, tearfulness, or crying
- Hopelessness
- Decreased interest in activities or inability to enjoy previously favorite activities
- Persistent boredom
- Little energy
- Social isolation or poor communication
- Low self-esteem
- Feeling guilty
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses, such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- Major changes in eating or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self-injurious behaviors

EVALUATION AND DIAGNOSIS

Depression affects all aspects of a child's life and in some unfortunate cases can be fatal. For this reason, it is essential that depression be diagnosed quickly. Depression is not difficult to diagnose once a parent, teacher, or other caregiver recognizes it. If you aren't sure, be cautious and bring your child in for an evaluation. Depression can be diagnosed anytime in childhood or adolescence. If you think your child has depression, your child may need a comprehensive psychiatric evaluation or psychotherapy evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

About 5 out of 100 children suffer from depression at some point in their childhood or adolescence.

TYPICAL CO-EXISTING DIAGNOSES

Common mental health diagnoses that co-exist with depression include:

- Anxiety Disorders (p48)
- Attention Deficit Hyperactivity Disorder (ADHD) (p52)
- Oppositional Defiant Disorder (ODD) (p82)
- Substance Abuse and Dependence (p94)

TREATMENT

Depression is treatable and is best treated when diagnosed early. A variety of different types of mental health specialists can treat your child, including child and adolescent psychiatrists, advanced practice registered nurses, and psychotherapists. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

Suggested treatment options include individual psychotherapy (particularly, cognitive behavioral therapy and interpersonal psychotherapy), family psychotherapy, psychoeducation, and anti-depressant medications (in particular, Serotonin Reuptake Inhibitors or SRIs). For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

If depression is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**. Treatment is most successful when ongoing support is provided to the child, family, and school.

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RESOURCES

Depression and Bipolar Support Alliance
800-826-3632
www.ndmda.org

DepressedTeens.com
www.depressedteens.com

Help Me, I'm Sad: Recognizing, Treating, and Preventing Childhood and Adolescent Depression (1998)
By David G. Fassler and Lynne Dumas

Suicide

Many children feel strong emotions as they grow up, including stress, self-doubt, confusion, and a number of pressures related to success and their future. For some children, these pressures lead them to believe that suicide is their only way out.

A child at risk for suicide typically shows the signs and symptoms of depression. Typical signs and symptoms include:

- Change in eating and sleeping habits
- Withdrawal from friends, family, and regular activities
- Violent or rebellious behavior
- Running away
- Excessive drug and alcohol use
- Neglect of his or her personal appearance
- Change in his or her normal personality
- Persistent boredom
- Difficulty concentrating
- Decline in the quality of schoolwork
- Frequent complaints about physical symptoms, such as stomachaches, headaches, or fatigue
- Loss of interest in activities he or she used to enjoy
- Not accepting of praise or rewards

In addition, a child who is planning to commit suicide may:

- Complain that he or she is a bad person or feels rotten inside
- Begin to give verbal hints of committing suicide by saying things like:
  - » I won't be a problem for you much longer
  - » Nothing matters
  - » It's no use
  - » I won't see you again
- Put his or her affairs in order (for example, give away favorite possessions, clean his or her room, or throw away important belongings)
- Become suddenly cheerful after a period of depression
- Show signs of psychosis

Recognizing the warning signs of suicide is critical to prevention. If you are concerned that your child may be suicidal, seek help immediately even if you do not think he or she will act on his or her feelings. Turn to CRISIS SITUATIONS (p213) at the end of the guide.

If your child is at risk of committing suicide, the first step in treatment is to develop a plan to keep your child safe. A mental health specialist will work with you and your child to develop a safety plan. Once the threat of suicide is reduced, the next phase of treatment focuses on addressing any underlying mental illness. Children can return to a healthy life after having suicidal thoughts. The support and encouragement from family members and professionals is critical to recovery.

RESOURCES

National Suicide Prevention Hotline
800-273-TALK (8255)
www.suicidepreventionlifeline.org

Night Falls Fast: Understanding Suicide (2001)
By Kay Redfield Jamison

Samaritans of Rhode Island
401-272-4044 (Providence)
800-365-4044 (Statewide)
www.samaritansri.org

Eating Disorders

Eating disorders often run in families. They are also becoming more common. As many as 1 in 10 young women suffer from an eating disorder.

Eating disorders are characterized by a preoccupation with food and a distorted body image (a child thinks he or she is fat when he or she is really underweight or of normal weight). Although it is normal for children to be occasionally concerned with their appearance, weight, and the type of food they eat, a child who is obsessed with food and his or her shape or weight may have an eating disorder. The level of preoccupation relates to the seriousness of the condition.

Anorexia Nervosa (also called Anorexia) and Bulimia are the two most common eating disorders. They occur mostly in teenage girls and young women and less often in teenage boys and young men. A child with Anorexia often refuses to eat, eats very little, or exercises more often than necessary. A child with Bulimia often eats large amounts of high calorie or high fat foods and then tries to counteract this by vomiting, overexercising, or using laxatives.

SIGNS AND SYMPTOMS

Identifying symptoms of Anorexia or Bulimia in your child may be very difficult. Often, children hide these illnesses from their families and friends. In fact, one common sign of an eating disorder is pulling away from friends and spending more time alone.

Typical signs and symptoms of eating disorders include:

- Perfectionism and an excessive drive for high achievement in school
- Low self-esteem
- Believing he or she is fat regardless of how thin he or she becomes
- The need to feel control over his or her life
- Dramatic weight fluctuations

EVALUATION AND DIAGNOSIS

Eating disorders can lead to serious medical problems. Early detection and intervention is important. However, eating disorders can be difficult to recognize and diagnose because children will often go to great lengths to hide their behaviors. Although an eating disorder can be diagnosed at any point in childhood, it is more typical in adolescence. If you think your child has an eating

disorder, your child may need a comprehensive psychiatric evaluation or psychotherapy evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

TYPICAL CO-EXISTING DIAGNOSES

Common mental health diagnoses that co-exist with eating disorders include:

- Anxiety Disorders (p48)
- Body Dysmorphic Disorder (BDD) (p62)
- Depression (p67)
- Substance Abuse and Dependence (p94)

Your child may also have a medical problem that is causing his or her symptoms. Talk to your child's pediatrician about your child's symptoms.

TREATMENT

Treating an eating disorder can take time. Treatment is usually most effective when a team approach is used. The team should consist of a psychiatrist, a psychotherapist, and a nutritionist, as well as the child's pediatrician and parents. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

Most likely, the team will suggest a number of treatment strategies, including individual and family psychotherapy and anti-depressant or anti-anxiety medications. For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

If the eating disorder is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

For both evaluation and treatment of an eating disorder, it is important to find a mental healthcare provider who specializes in eating disorders.

RESOURCES

Life Without Ed: How One Woman Declared Independence from Her Eating Disorder and How You Can Too (2003)
By Jenni Schaefer and Thom Rutledge

National Eating Disorders Association
800-931-2237
www.edap.org

Wise Girl: What I've Learned About Life, Love, and Loss (2002)
By Jamie-Lynn Sigler and Sheryl Berk

Feeding Disorders

A temporary decrease in the amount of food a child will eat is very common when a child has a cold, experiences a change in his or her daily routine, or is trying a new food. However, your child may have a feeding disorder if he or she refuses to eat for an extended period of time and your child's weight is not in line with other children his or her age.

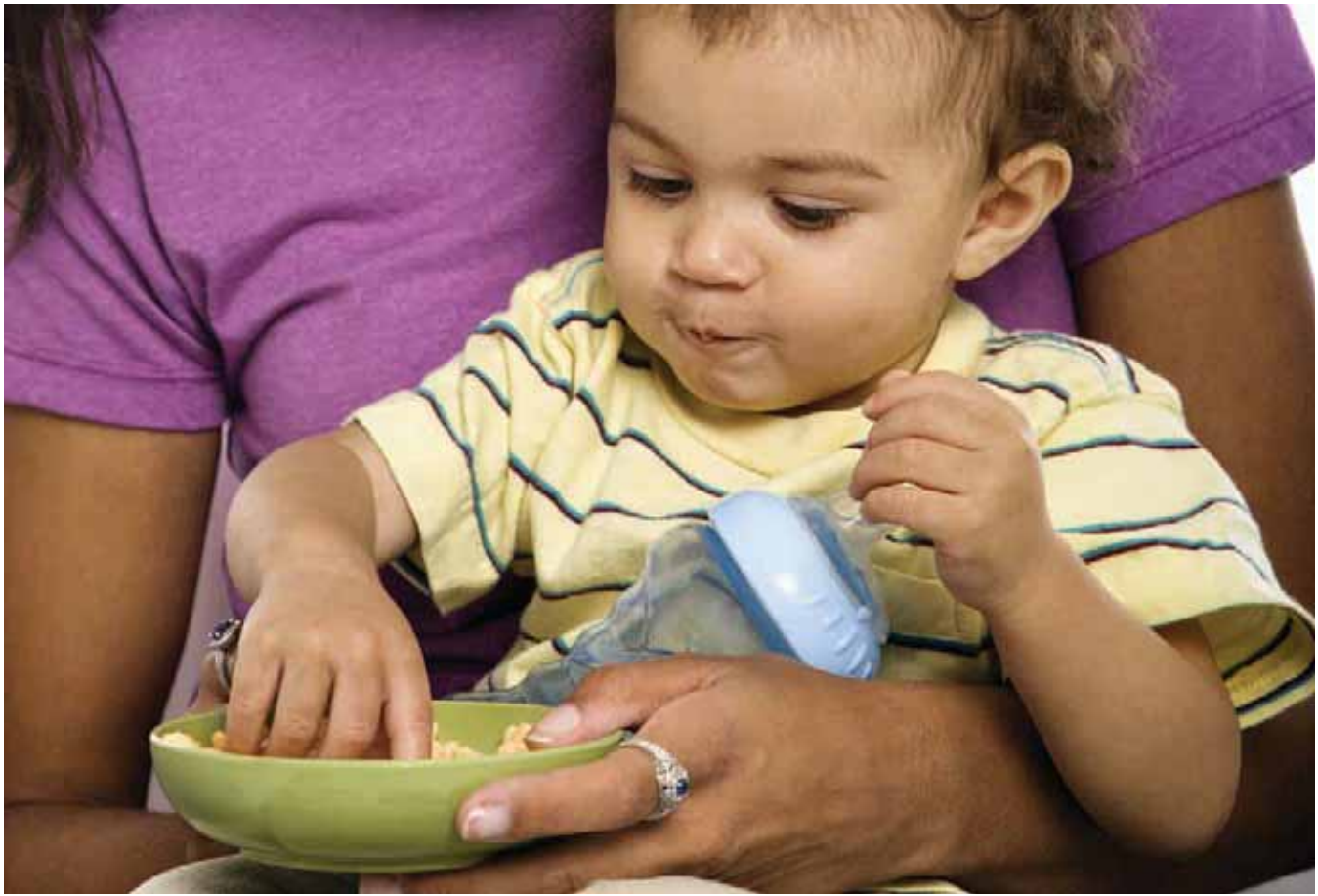
SIGNS AND SYMPTOMS

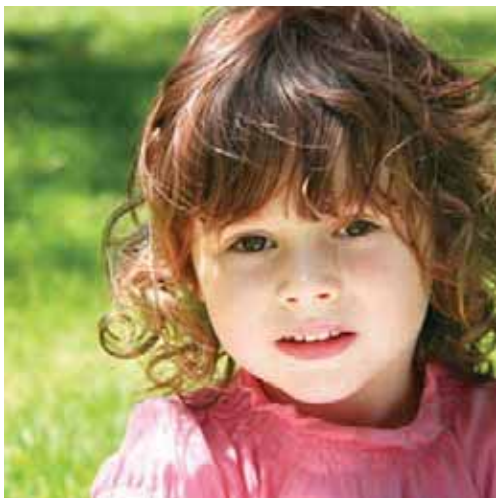
Typical signs and symptoms of feeding disorders include:

- Failure to eat that is not explained by a medical condition or by lack of available food
- Too little weight gain or a significant weight loss

EVALUATION AND DIAGNOSIS

It is essential to diagnose feeding disorders early, because children will not grow and develop without appropriate nutrition. In addition, feeding disorders can also make it difficult for parents to





bond with their children. Diagnosis of a feeding disorder can be complicated because it requires both a medical and a mental health evaluation. A provider will look at medical, social, and behavioral factors to find out the cause of the feeding problem. A feeding disorder is typically diagnosed early in infancy, within the first 6 to 12 months. If you think your child has a feeding disorder, your child may need a feeding evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

TYPICAL CO-EXISTING DIAGNOSES

Common mental health diagnoses that co-exist with feeding disorders include:

- Anxiety Disorders (p48)
- Depression (p67)
- Reactive Attachment Disorder (RAD) (p86)
- Speech and Language Disorders (p90)

Your child may also have a medical problem that is causing his or her symptoms. Talk to your child's pediatrician about your child's symptoms.

TREATMENT

Treatment may include different types of psychotherapy and training, as well as medical monitoring. The goal of treatment of a feeding disorder is to make meal time a more positive experience for the parent and the child. This will help the parent meet the nutritional, physical, and developmental needs of the child. Specific treatments may focus on improving mealtime structure, schedule, and limits; teaching parents successful eating approaches; making sure that parents are providing good food choices and variety; and helping to improve parent-child interaction patterns. For more serious cases, treatment should be team-based and could include the following providers: the child's pediatrician, a gastroenterologist, a psychiatrist, a psychotherapist, a nutritionist or dietician, a speech-language pathologist, and occupational and physical therapists. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

RESOURCES

How to Get Your Kid to Eat: But Not Too Much (1987)
By Ellyn Satter
www.ellynsatter.com

Just Two More Bites!: Helping Picky Eaters Say Yes to Food (2006)
By Linda Piette

Pediatric Gastroenterology Clinic
at Hasbro Children's Hospital
401-444-8306
www.lifespan.org/hch/services/gi

Finding quality information on the Internet

The Internet can be a great place to find information about children's mental health issues, but it can also be difficult to find quality information. The following information and tips are meant to help you decide what online information you can trust and what information could be false or misleading. Remember, no website should take the place of your child's pediatrician or mental health specialists! You should always discuss the information you find on the Internet with your child's mental healthcare providers.

Start your search for information using a reputable health information site. For a list of local and national websites, turn to page 198 in **ADDITIONAL RESOURCES**.

If these sites don't provide the information that you are looking for, you can use a commercial search engine. A commercial search engine is a website like google.com or yahoo.com. These websites can be a great place to look for information. However, commercial search engines will also list websites that may provide incorrect information.

HELPFUL TIPS:

1. If the site has an "About Us" section, click on it and read about the organization. This information will give you a better understanding of the people who are providing the information and what the purpose or mission of the organization is. If the website is not clear about who operates it, then you should question the quality of the information.
2. Is there a way to contact the organization that is operating the website? If it is difficult to contact the organization, then it may mean that the organization is not as credible as others.
3. When was the site last updated? This information is usually found at the bottom of the homepage. Sites that are a part of a large organization are updated frequently and should have a recent date listed on the page.
4. Does the organization mention where it gets the information on the site? A credible website should tell you the sources of the information.
5. There should not be ads posted on the website. The main purpose of a health information site should not be to sell you something. If there are ads, it means that the site is receiving money for advertising, which could bias the information.
6. You should not have to enter personal information to visit a site. If you are asked to—don't!

Learning Disorders

Learning disorders (or disabilities) are considered to be disorders of basic brain processes. There are several types of learning disorders, including mathematics, reading, written and oral expression, and listening comprehension. A child may have a learning disorder in a single area of functioning, such as reading, or may have multiple, overlapping learning disorders. Although many children have trouble learning in school from time to time, a child who is consistently having trouble with an academic subject or subjects at school may have a learning disorder.

Learning disorders affect children from all racial, economic, and cultural backgrounds.

MATHEMATICS

A mathematics learning disorder can occur in either math calculation or math reasoning. Problems with math calculation include difficulty learning basic math facts and performing basic math operations, such as addition, subtraction, multiplication, and division. A problem with math reasoning includes difficulty solving math problems that is not simply the result of difficulties with math calculation. The two types of mathematics learning disorders can also occur together.

Typical signs and symptoms of a mathematics learning disorder include difficulty:

- Mastering numbers, such as counting or understanding quantities
- Learning and memorizing basic addition, subtraction, and multiplication facts, leading to slow and cumbersome calculating strategies
- Counting by 2's, 5's, 10's, or 100's
- Estimating
- Lining up numbers, resulting in calculation errors
- Comparing numbers (greater than or less than)
- Telling time
- Learning multiplication tables or formulas
- Interpreting graphs and charts
- Visualizing mathematics concepts, such as geometric shapes, numerical quantities, or rotation in space
- Holding mathematical information in his or her head long enough to complete a calculation

Once diagnosed with a learning disorder, a child is provided with services and or protections through the Individuals with Disabilities Education Act (IDEA) and/or Section 504 of the Rehabilitation Act (otherwise known as a 504 Plan). They may also be provided protections through the Americans with Disabilities Act. Depending on the nature of the disorder, certain protections and services may continue into adulthood.

- Understanding the language aspects of mathematics, such as understanding word problems
- Moving from concrete mathematical representations (for example, counting objects) to abstract representations (for example, using symbols and numbers to perform calculations)

READING

A reading learning disorder can occur in one of three areas: basic reading, reading comprehension, or reading fluency. Basic reading refers to the ability to decode words. Reading comprehension is the ability to make sense of and understand written information. Reading fluency refers to the ability to read quickly and fluidly. The three types of reading disorders may, and often do, occur together.

Typical signs and symptoms of a reading learning disorder include:

- Difficulty recognizing and remembering sight words (words that good readers should instantly recognize without having to "figure them out")
- Frequently losing his or her place while reading
- Confusing similar-looking letters, numbers, or words (for example, beard and bread)
- Reversing letter order in words (for example, saw and was)
- Poor memory for printed words and new vocabulary
- Poor understanding of what has been read
- Significant trouble naming letters and learning to read
- Problems associating letters and sounds, understanding the difference between sounds in words, blending sounds into words
- Guessing at unfamiliar words rather than using word analysis skills (sounding them out)
- Reading very slowly
- Substituting or leaving out words while reading
- Disliking and avoiding reading or reading "reluctantly"

WRITTEN EXPRESSION

Children with this disorder have problems with their writing skills. This disorder often occurs with an oral expression learning disorder.

Typical signs and symptoms of a written expression learning disorder include:

- Difficulty formulating ideas into a logical, coherent sentences or paragraphs
- Consistent difficulty learning and applying grammatical concepts in written sentences (for example, capitalization, punctuation, conjugation, or noun-verb agreement)
- Poor spelling ability
- Poor handwriting ability
- Slow and labored writing (not due to motor disability)

ORAL EXPRESSION

Children with this disorder have problems expressing themselves verbally (by speaking).

Typical signs and symptoms of an oral expression learning disorder include:

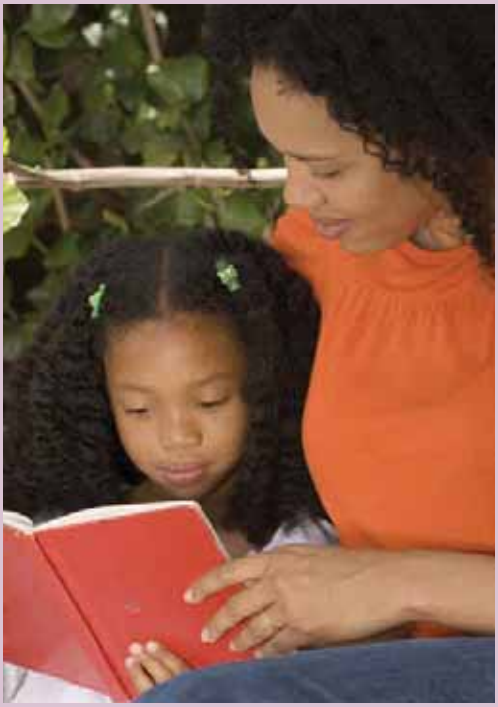
- Consistent difficulty answering developmentally appropriate questions, often shown by a long pause between the time a question is asked and when the child answers
- Consistent difficulty formatting thoughts into speech (ideas are jumbled or confused and the meaning is often lost)
- Difficulty with word finding (cannot find the word to say, even though they know what they want to say)
- Difficulty giving directions or telling stories

Dyslexia

Although not a formal mental health diagnosis, dyslexia is a common term used for a type of reading learning disorder. Dyslexia generally affects a child's ability to decode and spell words. Dyslexia can occur in children of all different intelligence levels.

Typical signs and symptoms of dyslexia include having difficulty:

- Learning to speak
- Organizing language (for example, a child may reverse letters or words)
- Learning letters and their sounds
- Spelling
- Reading
- Learning a foreign language
- Calculating math equations
- Memorizing math facts

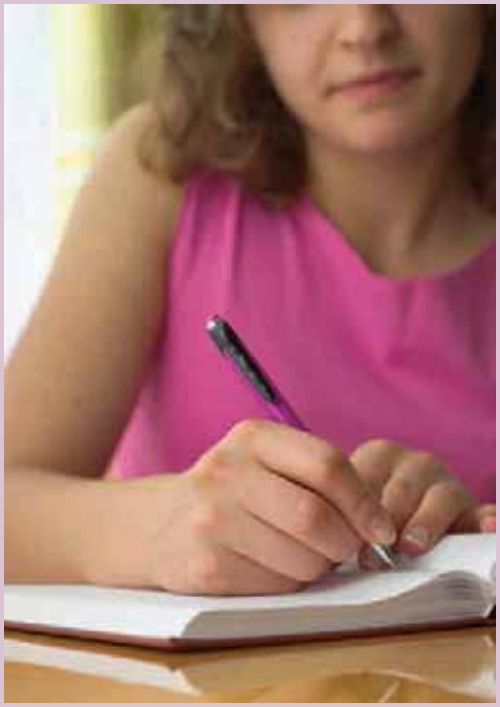


Bypass strategies

Bypass strategies are a way of "going around" a child's learning disorder. An example of a bypass strategy is providing a child who has a mathematics calculation disability with a calculator. Another example would be providing books on tape to a child who has a disability of basic reading skills.

Depending on a child's specific disorder and age, bypass strategies may be taught to children to help them learn what they can at a better pace. Bypass strategies can help them keep up with classroom instruction and continue to benefit from instruction at his or her level or ability.

Bypass strategies should not replace appropriate instruction in the area of the learning disorder. This is particularly true when children are still young and are more likely to accept help.



LISTENING COMPREHENSION

Children with this disorder have difficulty listening to and understanding what others say.

Typical signs and symptoms of a listening comprehension learning disorder include:

- Difficulty following verbal instructions, particularly those with multiple steps
- Difficulty following along with class discussions
- Difficulty understanding vocabulary words
- Long pauses before answering questions
- Becoming confused or frustrated when information is presented verbally, but not when information is presented visually
- Becoming tired quickly when listening to stories or lectures
- Easily distracted in class

EVALUATION AND DIAGNOSIS

Early diagnosis (and treatment) of a learning disorder is extremely important. Early diagnosis can reduce the potential negative effects of having a learning disorder, such as low self-esteem, depression, and lack of success in school. As many children learn ways to compensate for their learning disorder, a learning disorder is typically diagnosed when a child's ability to "hide" the disorder reaches its limit. If you think your child has a learning disorder, your child may need an educational evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

TYPICAL CO-EXISTING DIAGNOSES

Common mental health diagnoses that co-exist with learning disorders include:

- Anxiety Disorders (p48)
- Attention Deficit Hyperactivity Disorder (ADHD) (p52)
- Autism Spectrum Disorders (Pervasive Developmental Disorders) (p54)
- Depression (p67)
- Oppositional Defiant Disorder (ODD) (p82)
- Speech and Language Disorders (p90)

TREATMENT

All learning disorders are life-long conditions that do not go away. The treatment of a learning disorder varies by the specific diagnosis, as well as the child's age, development level, and strengths and weaknesses. A psychologist or a speech-language pathologist, depending on the specific disorder, can provide treatment. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

Some children with learning disorders may benefit from psychotherapy to address their social, behavioral, and emotional symptoms. This psychotherapy should be tailored to the child's language and cognitive abilities. Treatment may also include parent supports, including parent management training. For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

Children with learning disorders may also need adjustments made to their education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

Specialized reading programs, such as those that use the Orton-Gillingham approach or the Wilson Reading System, can be very effective for children with reading learning disorders. For more information about these programs, visit www.ncld.org.

Most children with learning disorders have average or above average intelligence. Because of their learning disorder, however, these children have difficulty acquiring the skills essential for school and work success.

RESOURCES

All Kinds of Minds: A Young Student's Book About Learning Abilities and Learning Disorders (1992)
By Melvin D. Levine

Learning Disabilities Association of America
www.ldaamerica.org

National Center for Learning Disabilities
888-575-7373
www.ncld.org

Obsessive Compulsive Disorder

TIP

Recognize that most mental health issues are not caused by poor parenting, but by genes or brain chemistry.

Obsessive Compulsive Disorder (OCD) is a type of anxiety disorder (p48). OCD usually affects older children and adolescents, but can begin earlier. OCD occurs when a child develops intense obsessions or compulsions that interfere with day-to-day functioning. It is normal for all children to have some level of focus on certain items or activities, particularly young children who "obsess" as part of how they learn. However, when these obsessions cause significant anxiety or distress, take up more than one hour a day, or interfere with a child's normal routine (school, social activities or relationships), then he or she may have OCD.

SIGNS AND SYMPTOMS

Typical signs and symptoms of OCD include:

- **COMPULSIONS:** Repetitive behaviors or rituals (for example, hand washing, hoarding, keeping things in order, or checking something over and over) or mental acts (for example, counting or repeating words silently). For example, a child may check the locks on all the doors in the house after his or her parents have gone to sleep. The child may then fear that he or she accidentally unlocked a door while checking them and will then check the locks all over again.
- **OBSESSIONS:** Recurrent and persistent thoughts, impulses, or images that are unwanted and cause significant anxiety or distress. Frequently, they are unrealistic or irrational. For example, a child may have constant thoughts that a family member will be harmed.

EVALUATION AND DIAGNOSIS

In addition to causing distress and interfering with normal life, OCD can lead to depression and social isolation in some cases if not evaluated and treated. OCD can be diagnosed anytime in childhood or adolescence. If you think your child has OCD, your child may need a comprehensive psychiatric evaluation or psychotherapy evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

TYPICAL CO-EXISTING DIAGNOSES

Common mental health diagnoses that co-exist with OCD include:

- Anxiety Disorders (p48)
- Attention Deficit Hyperactivity Disorder (ADHD) (p52)
- Body Dismorphic Disorder (BDD) (p62)
- Depression (p67)
- Tic Disorders (p97)

TREATMENT

A psychotherapist or a child and adolescent psychiatrist can treat OCD. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

OCD is usually treated with a combination of cognitive behavioral therapy and anti-anxiety or anti-depressant medications (in particular, Serotonin Reuptake Inhibitors or SRIs). Children often feel shame and embarrassment about their OCD. Many children fear it means they are "crazy" and are hesitant to talk about their thoughts and behaviors. As a result, treatment may include family psychotherapy and psychoeducation to help the entire family understand OCD and to increase communication about the disorder between the parent and child. For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

If OCD is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

RESOURCES

The Boy Who Couldn't Stop Washing: The Experience and Treatment of Obsessive-Compulsive Disorder (1991)
By Judith L. Rapoport

Obsessive Compulsive Foundation
www.ocfoundation.org

Talking Back to OCD: The Program That Helps Kids and Teens Say "No Way"—and Parents Say "Way to Go" (2006)
By John S. March

Oppositional Defiant Disorder

Oppositional Defiant Disorder (ODD) is characterized by an ongoing pattern of uncooperative, defiant, and hostile behavior toward authority figures that has serious effects on a child's day-to-day functioning. At some point during child development, most children express some form of oppositional behavior. When children are tired, hungry, stressed, or upset they are likely to argue, talk back, disobey, and defy parents, teachers, or other adults. However, if this type of behavior becomes frequent and affects a child's social, family, and school life, then his or her behavior may be caused by ODD.

SIGNS AND SYMPTOMS

Typical signs and symptoms of ODD include:

- Frequent temper tantrums
- Excessive arguing with adults
- Active defiance and refusal to comply with adult requests and rules
- Deliberate attempts to annoy or upset people
- Blaming others for his or her mistakes or misbehavior
- Often being irritable or easily annoyed by others
- Frequent anger and resentment
- Talking in a mean and hateful way when upset
- Seeking revenge

Parenting a child with a disruptive behavior disorder

Parenting a child with a disruptive behavior disorder, such as ODD or Conduct Disorder, can be very challenging.

Here are some tips to help:

- Think positive! Praise your child when he or she shows flexibility or cooperation.
- Time-outs are not only for children. If you feel you may react to a conflict with your child that would make it worse, take a break. Your child needs a role model to show him or her appropriate behavior.
- Pick your battles. Since a child with a disruptive behavior disorder has trouble avoiding power struggles, prioritize the things you want your child to do. If you give him or her a time-out in his or her room for misbehavior, don't add time for arguing.
- Set up reasonable, age-appropriate limits with consequences that can be enforced the same way each time.
- Take care of yourself. Try to work with and obtain support from the other adults (for example, spouse, teachers, and coaches) who know your child.

EVALUATION AND DIAGNOSIS

A child with ODD hears a lot of negative comments about him or herself. If ODD is not diagnosed, these negative comments can end up impacting a child's self-esteem and this can lead to a variety of other mental health issues. ODD is usually diagnosed in early childhood. If your child is oppositional, his or her behavior will be seen at home and in other settings, such as school, daycare, or other activities. If you think your child has ODD, your child may need a comprehensive psychiatric evaluation or psychotherapy evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

TYPICAL CO-EXISTING DIAGNOSES

Most children with ODD have other mental health diagnoses. Common mental heath diagnoses that co-exist with ODD include:

- Anxiety Disorders (p48)
- Attention Deficit Hyperactivity Disorder (ADHD) (p52)
- Conduct Disorder (p64)
- Depression (p67)
- Learning Disorders (p75)
- Post Traumatic Stress Disorder (PTSD) (p84)
- Substance Abuse and Dependence (p94)

TREATMENT

A psychotherapist can treat ODD. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

Comprehensive treatment for ODD needs to occur over a long period of time. Treatment needs to individually address each of the causes for the child's behaviors. Depending of the particular situation, different treatments may be needed. Treatment of ODD may include parent management training and medications. For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

It is important to note that inoculation approaches are not effective. Inoculation approaches are "scared straight" methods that try to prevent the behavior by scaring the child with the consequences of the behavior. Examples of these approaches include putting a child in jail for a few days or sending him or her to boot camp.

If ODD is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

RESOURCES

1-2-3 Magic: Effective Discipline for Children 2–12 (2004)
By Thomas W. Phelan

The Explosive Child: A New Approach for Understanding and Parenting Easily Frustrated, Chronically Inflexible Children (2005)
By Ross Greene
www.explosivechild.com

Your Defiant Child: Eight Steps to Better Behavior (1998)
By Russell A. Barkley and Christine M. Benton

Post Traumatic Stress Disorder

A child's risk of developing PTSD is related to the seriousness of the trauma, whether the trauma is repeated, how close the child was to the trauma, and the child's relationship to the victim or victims of the trauma.

Post Traumatic Stress Disorder (PTSD) is a type of anxiety disorder (p48). PTSD is a prolonged emotional and physical reaction to a traumatic event. Throughout development, all children experience stressful events that can have an emotional or physical affect on them. These experiences are usually short lived. If a child develops ongoing difficulties after a traumatic event, he or she may have PTSD.

SIGNS AND SYMPTOMS

Typical signs and symptoms of PTSD include:

- Easily agitated immediately following the event
- Intense fear, helplessness, anger, sadness, horror, or denial
- Avoidance of situations or places that may trigger memories of the event
- Frequent memories of the event
- Repetition of events from the trauma over and over while playing
- Nightmares or general problems falling and staying asleep
- Withdrawn and less emotionally responsive
- Detachment from feelings
- Physical or emotional symptoms that continually arise with a reminder of the event
- Worries about dying at an early age
- Loss of interest in activities he or she once enjoyed
- Complaints of headaches and stomachaches
- Problems concentrating on tasks
- Starts acting younger than his or her age. Some examples of behaviors include bed-wetting, clingy behavior, thumb-sucking, and sharing a bed with a parent.

EVALUATION AND DIAGNOSIS

PTSD affects a child's ability to function, and therefore, it is essential to address the issue. PTSD can only be diagnosed a month or more after the exposure to the trauma. If you think your child has PTSD, your child may need a comprehensive psychiatric evaluation or psychotherapy evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

For some children PTSD may last only a few months. For others, the effects may last years.

TYPICAL CO-EXISTING DIAGNOSES

Common mental health diagnoses that co-exist with PTSD include:

- Anxiety Disorders (p48)
- Attention Deficit Hyperactivity Disorder (ADHD) (p52)
- Conduct Disorder (p64)
- Depression (p67)
- Oppositional Defiant Disorder (ODD) (p82)
- Substance Abuse and Dependence (p94)

TREATMENT

A psychotherapist or a child and adolescent psychiatrist can treat PTSD. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

Treatment of PTSD becomes more effective based on the level of support from parents, the school, and peers. This support is important because the child needs to be constantly reassured of his or her safety. Treatment should start with a direct discussion of the traumatic event. After that, common treatment approaches include psychotherapy (in particular, cognitive behavior therapy), relaxation skills training, and anti-anxiety or anti-depressant medication (in particular, Serotonin Reuptake Inhibitors or SRIs). For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

If PTSD is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

RESOURCES

National Child Advocacy Center
www.nationalcac.org

National Child Traumatic Stress Network
www.nctsnet.org

New York University Child Study Center
www.aboutourkids.org

Reactive Attachment Disorder

RAD is the result of situations such as consistent physical abuse or neglect, inconsistent caregiving, or repeated moves—all of which do not allow the child to create close attachments with caregivers.

Children with Reactive Attachment Disorder (RAD) have problems with emotional attachment. They tend to be unresponsive to parents, caregivers, or other adults when they are upset and may not seek out nurturing or comfort from caregivers. Healthy attachments are formed when a child is able to "ask" for care from adults in the form of crying, talking, or other communication and when adults are able to provide care for a child. If a child is missing either of these components (lacks the ability to "ask" for care or adults are not providing appropriate care), the child may not be able to form healthy attachments and may have RAD.

There are two types of RAD:

- **EMOTIONALLY WITHDRAWN / INHIBITED TYPE:** A child has extremely emotionally inhibited behavior in social interactions with others. When distressed or upset, these children do not try to obtain comfort or nurturing and may resist offers of comfort.
- **INDISCRIMINATE / UNINHIBITED TYPE:** Children are very unselective when they choose caregivers or others to provide them comfort. They tend to lack a preference for primary caregivers and to lack an appropriate wariness of strangers. These children may wander from caregivers without checking back and often approach or seek nurturing from total strangers rather than from caregivers they know.

SIGNS AND SYMPTOMS

Typical signs and symptoms of RAD include:

- Severe colic or feeding difficulties
- Failure to gain weight
- Detached and unresponsive behavior
- Difficult to comfort him or her
- Defiant behavior
- Appearing distracted
- Lack of response in social interactions
- History of physical or emotional abuse or neglect, repeated moves, or a traumatic event

EVALUATION AND DIAGNOSIS

The emotional and social problems associated with RAD can continue to have an impact throughout childhood. RAD is usually diagnosed before age 5. If you think your child has RAD, your child may need a comprehensive psychiatric evaluation or psychotherapy evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**. Diagnosis of RAD is based on an evaluation of both the caregiver and the child, as well as the interaction between the two.

Parents should be very careful when researching information on RAD and considering providers and treatment options. There is a large amount of incorrect information on RAD on the Internet.

TYPICAL CO-EXISTING DIAGNOSES

Children with RAD are at greater risk for delays in development. Pediatricians should evaluate them regularly for appropriate development. Common mental health diagnoses that co-exist with RAD include:

- Post Traumatic Stress Disorder (PTSD) (p84)
- Speech and Language Disorders (p90)

TREATMENT

A psychotherapist can treat RAD. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

A key component of treatment of RAD includes making sure the child has safe, consistent, and familiar caregivers. Treatment focuses on creating appropriate and secure attachments with caregivers by working with the child and caregivers individually and as a group. Treatment options include parent–child interaction psychotherapy and skill building. For more information, turn to **MENTAL HEALTH TREATMENT (p147)**. If the child has been traumatized, this may also be something that needs to be addressed in treatment.

There are quite a few potentially dangerous RAD treatments that should be avoided. These include treatments that are designed to enhance attachment through physical restraint, coercion, or "reworking" of the trauma. These also include treatments that promote regression for reattachment. Although the names of the these treatments can vary, some names to watch out for include: Attachment Therapy, Holding Therapy, Rage Reduction Therapy, Re-Attachment Therapy, and Rebirthing Therapy. There is no scientific evidence that these treatments work. And worse, these treatments can be dangerous—they have been associated with deaths on multiple occasions. For appropriate treatment, talk to your child's pediatrician and get a referral for a mental health specialist.

If RAD is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

RESOURCES

Casey Family Services
Post Adoption Program
401-781-3669,
www.caseyfamilyservices.org
(Offers support, social skills, and discussion groups for adoptive parents and children. These groups are not specifically for RAD, but program providers are aware of RAD and can work with families and refer them for treatment.)

Handbook for Treatment of Attachment - Trauma Problems in Children (1994)
By Beverly James

New York University
Child Study Center
www.aboutourkids.org

Schizophrenia

The symptoms of Schizophrenia are sometimes mistaken as moodiness or "teenage rebellion." In young people, hearing voices is not necessarily a sign of Schizophrenia, but may be due to anxiety, stress, or depression.

Schizophrenia is very rare in children. Schizophrenia can cause unusual behavior and abnormal thinking. Children normally go through a stage where they cannot tell the difference between what is real and what is pretend. However, after this stage of development, if a child continues to see and hear things that do not exist, he or she may have Schizophrenia.

SIGNS AND SYMPTOMS

Typical signs and symptoms of Schizophrenia include:

- Trouble discerning dreams from reality
- Seeing things and hearing voices that are not real
- Confused thinking
- Vivid and bizarre thoughts and ideas
- Extreme moodiness
- Peculiar behavior
- Believing that people are "out to get them"
- Severe anxiety and fearfulness
- Confusing television or movies with reality
- Severe problems in making and keeping friends
- Start acting younger than his or her age. Some examples of behaviors include bed-wetting, clingy behavior, thumb-sucking, and sharing a bed with a parent.

Misdiagnosis

If your child is receiving treatment for a mental health illness and he or she is not getting better, this may mean that you need to change your child's treatment plan. It also may be a sign that you should take a look at your child's diagnosis. Your child may not have the correct diagnosis or may have an additional diagnosis that has not been considered yet.

EVALUATION AND DIAGNOSIS

Schizophrenia is a serious psychiatric disorder that needs to be diagnosed and treated as soon as possible. The longer it goes without treatment, the more harmful it can be for the child. Schizophrenia is more commonly diagnosed in adolescence. If you think your child has Schizophrenia, your child may need a comprehensive psychiatric evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

TYPICAL CO-EXISTING DIAGNOSES

Common mental health diagnoses that co-exist with Schizophrenia include:

- Anxiety Disorders (p48)
- Attention Deficit Hyperactivity Disorder (ADHD) (p52)
- Autism Spectrum Disorders (Pervasive Developmental Disorders) (p54)
- Depression (p67)
- Oppositional Defiant Disorder (ODD) (p82)
- Speech and Language Disorders (p90)

TREATMENT

A psychotherapist or a child and adolescent psychiatrist can treat Schizophrenia. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

Treatment for Schizophrenia may include psychoeducation, psychotherapy (in particular, cognitive behavior therapy), family and groups psychotherapy, coping skills training, and anti-psychotic medication. For more information, turn to **MENTAL HEALTH TREATMENT (p147)**. Your child may also need inpatient care in a mental health hospital.

In addition, educational and vocational training may be helpful to support the child in school, work, and community settings. If Schizophrenia is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

RESOURCES

National Schizophrenia Foundation
www.nsfoundation.org

The Quiet Room: A Journey Out of the Torment of Madness (1996)
By Lori Schiller and Amanda Bennett

Surviving Schizophrenia: A Manual for Families, Patients, and Providers (2006)
By E. Fuller Torrey

Speech and Language Disorders

Speech and language disorders is a general category that covers the following diagnoses:

- **ARTICULATION DISORDER:** Articulation disorders include difficulties making sounds. Sounds can be substituted, left off, added, or changed. These errors may make it hard for other people to understand the child.
- **COMMUNICATION DISORDER:** Communication disorders include difficulties giving or receiving non-verbal, verbal, written, or gestural messages (for example, reaching, pointing, or shaking hands). These problems can be related to speech, language, or hearing.
- **FLUENCY DISORDER:** Fluency disorders include problems such as stuttering, the condition in which the flow of speech is interrupted by abnormal stops, repetitions (st-st-stuttering), or prolonging sounds and syllables (ssssstuttering).
- **LANGUAGE DISORDER:** Language disorders can be either receptive or expressive. Receptive disorders refer to difficulties understanding or processing language. Expressive disorders include difficulty putting words together, limited use of vocabulary, or inability to use language in a socially appropriate way.
- **RESONANCE OR VOICE DISORDER:** Resonance or voice disorders include problems with the pitch, volume, or quality of a child's voice that distract listeners from what is being said. These disorders may also cause pain or discomfort for the child when speaking.
- **SOCIAL COMMUNICATION DISORDER:** Social communication disorders include difficulties using words, pictures, facial expressions, body language, eye gaze, and gestures to start and continue interactions with others. These problems include difficulty participating in conversations, knowing how close to stand to others, and being able to vary what one says based on whether the other person is a teacher, acquaintance, friend, or family member.

TIP

Parent involvement is crucial to treating speech and language disorders. A speech-language pathologist may recommend parent counseling and education. Ask your child's speech-language pathologist for suggestions on how you can help your child, such as emphasizing important words when you read together.

SIGNS AND SYMPTOMS

Typical signs and symptoms of speech and language disorders include when a child has a hard time:

- Talking clearly enough to be understood outside the family
- Understanding others
- Following directions
- Reading or writing
- Answering questions
- Expressing his or her thoughts and ideas in a clear manner using appropriate vocabulary and grammar
- Using language in a variety of social situations

EVALUATION AND DIAGNOSIS

If untreated, children with speech and language disorders may not be able to fully engage in daily conversations with their parents, family members, or other children. They also may not be able to follow directions—not because they do not want to listen, but because they do not understand. In school, a child with speech and language problems may fall behind, shut down, or act up. A speech-language pathologist can evaluate your child for speech and language disorders and help avoid behavioral consequences that can come along with having trouble in school. This is true even in cases where the problem may be more subtle, such as in older children. If you think your child has a speech and language disorder, your child may need a speech-language evaluation. For more information, turn to MENTAL HEALTH EVALUATIONS (p39).

TYPICAL CO-EXISTING DIAGNOSES

Common mental health diagnoses that co-exist with speech and language disorders include:

- Attention Deficit Hyperactivity Disorder (ADHD) (p52)
- Autism Spectrum Disorders (Pervasive Developmental Disorders) (p54)
- Learning Disorders (p75)

TREATMENT

A speech-language pathologist can treat speech and language disorders. For more information on mental health specialists, turn to page 106 in MENTAL HEALTH SUPPORT.

TREATMENT FACILITIES

University of Rhode Island
Speech and Hearing Centers
401-874-5969

RESOURCES

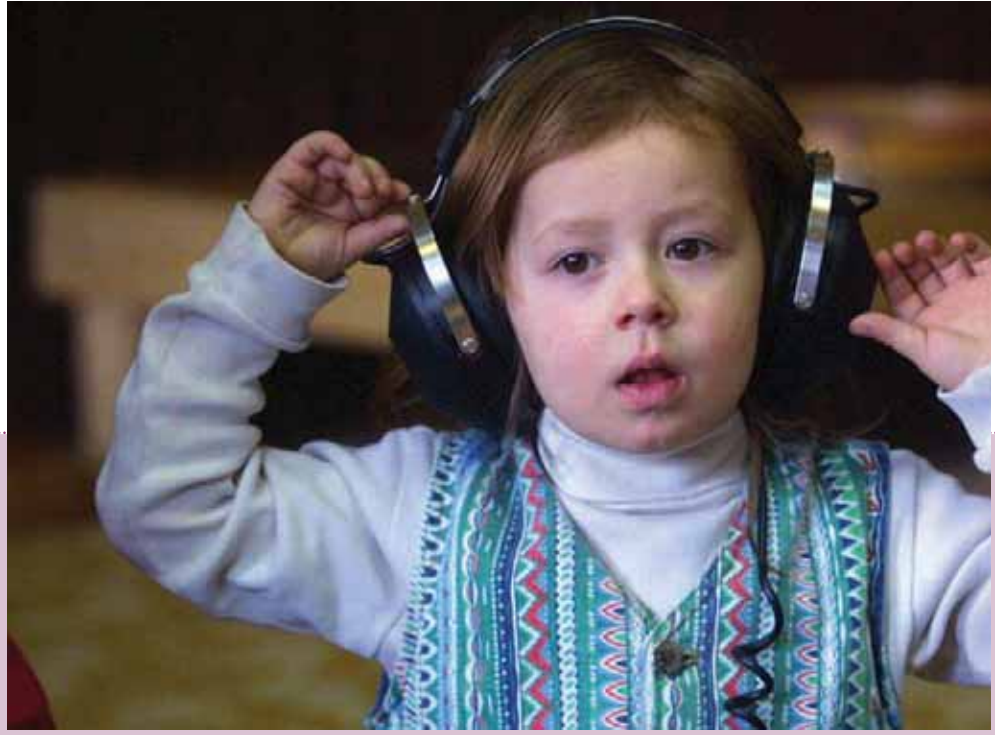
American Speech-Language Hearing Association
800-638-8255
www.asha.org

Therapy should begin as soon as possible. Children who begin therapy early in their development tend to do better than children who begin therapy later. This does not mean that older children and adolescents cannot make progress in therapy. However, when a problem goes unrecognized, it can interfere with a child's family interactions, social relationships, and schoolwork. When a problem is identified, a speech-language pathologist can work with the child, parents, and teachers to enhance the child's speech and language development and reduce the impact of the any problems on a child's family, social, and school life.

Treatment may include clinic or home-based coaching, individual or group therapy, school-based individual or group therapy in a classroom, and other school-based interventions. Speech-language therapy may include:

- **ARTICULATION THERAPY:** In this treatment, a speech-language pathologist models correct sounds and syllables for a child during play activities. A speech-language pathologist helps the child learn how the sounds are formed with the lips, tongue, and teeth (for example, moving the tongue to the back of the mouth to say "car" instead of "tar").
- **LANGUAGE INTERVENTION ACTIVITIES:** In this treatment, a speech-language pathologist talks to a child and uses pictures, books, objects, structured play, or actual events, such as cooking. The speech-language pathologist may model certain words or types of sentences and ask the child to imitate. Together, these activities work to improve vocabulary, sentence structure, and language use. The level of play is age appropriate and related to the child's specific needs. For older children, the speech-language pathologist tries to improve a child's ability to understand others, like his or her teachers. A speech-language pathologist may teach the child to ask questions when he or she does not understand something in class or may explain the vocabulary used in daily school assignments.

If the speech and language disorder is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.



Helping a child with a speech and language disorder

HERE ARE A FEW TIPS YOU CAN TRY AT HOME:

- When talking to your child, talk just a "notch above" what they do. If your child uses single words like "doggie," then you can use a phrase like "nice doggie."
- When interacting with your child, give him or her time to listen and learn. Pause after you talk, so your child has a chance to talk or gesture to answer you.
- Be patient. Your child may not repeat words you say right away, but these words may "pop out" later.
- Ask helpful questions (rather than test questions) and acknowledge your child's responses, even when they're hard to understand. If your child says "bamma" and you think he or she means to say "grandma," ask your child "Are you talking about grandma" (helpful question) rather than "What's her name?" (test question).
- Show your child that it is okay for him or her to ask questions when he or she does not understand what you are saying. If your child looks puzzled or does not follow a direction correctly, consider changing what you say and see if it helps him or her.
- If your child is having trouble expressing himself or herself, focus on what he or she means, rather than how he or she says it.
- If your child is having trouble understanding what you are saying, use gestures, objects, or pictures to help him or her understand what you are talking about. Older children can benefit from drawings, simple lists, and outlines.
- Keep in mind that even older children may not understand abstract expressions, such as "Those people live in a zoo." When giving directions or just talking, say what you mean. For example, instead of saying "Put down your dukes" say "Put your hands down."

Substance Abuse and Dependence

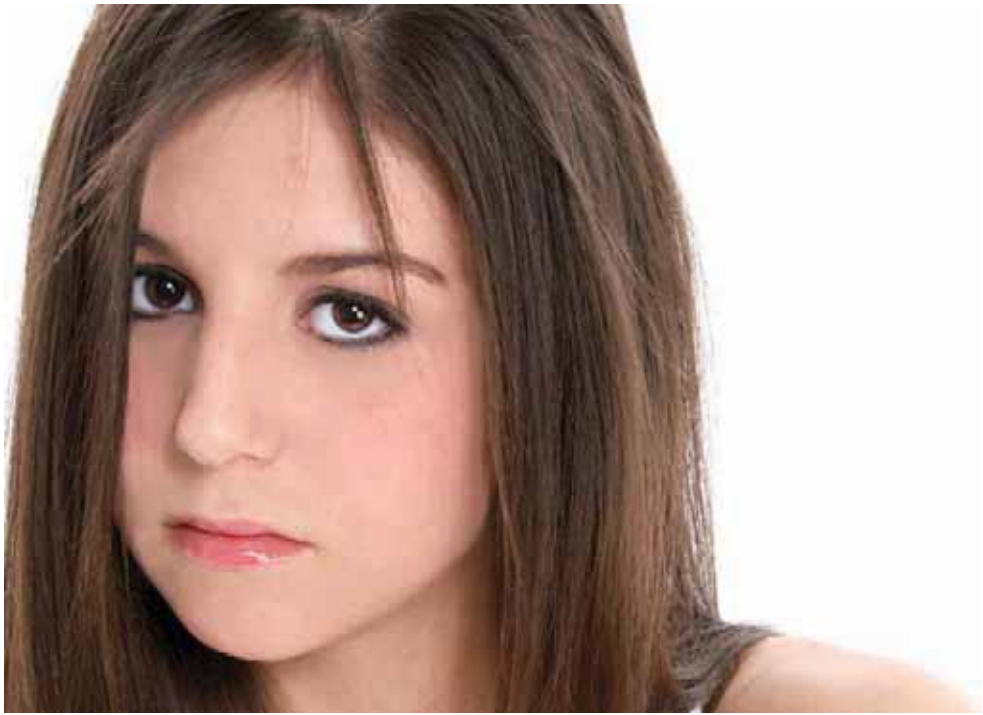
There are a number of risk factors that can increase the likelihood that a child may develop a substance abuse and dependence problem. These risk factors include depression, anxiety, low self-esteem, the child not feeling like they fit in or belong in their community, and a family history of substance abuse or addiction.

For some children, continued use of alcohol, drugs, or other substances (for example, over-the-counter medications like cough syrup or household products like inhalants) may begin to interfere with their activities and health and develop into a substance abuse problem. If children take the substances often enough, their body or mind may become dependent on them (in other words, they need the substances to function). The child will have negative physical and emotional reactions to not having the alcohol or drugs. Children can also develop a tolerance for the substance. The alcohol or drug will no longer make them feel drunk or high the way it did at first, and they need more of it to feel that way.

SIGNS AND SYMPTOMS

Typical signs and symptoms of substance abuse and dependence include:

- Fatigue or red and glazed eyes
- A lasting cough
- Sudden mood changes or irritability
- Irresponsible behavior
- Withdrawal from the family
- Decreased interest in school or a negative attitude toward school
- A drop in grades
- Discipline problems at school or problems with the law



EVALUATION AND DIAGNOSIS

Substance abuse can affect every aspect of a child's life and can lead to problems in school, with relationships, and even with law enforcement. Continued substance abuse can lead to medical problems, as well. For these reasons, it is important that it is diagnosed as early as possible. Unfortunately, substance abuse is also an issue that can be easily hidden. Substance abuse and dependence is typically diagnosed in adolescence, but it can occur in younger children.

For both evaluation and treatment of a substance abuse and dependence problem, it is important to find a mental healthcare provider who specializes in substance abuse.

If you think your child has a substance abuse and dependence problem, your child may need a comprehensive psychiatric evaluation or psychotherapy evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**. In addition to an evaluation, a provider will usually do a toxicology screening to determine what types of substances are in your child's system. Sometimes a child may not know exactly what he or she has ingested, so it is important to establish exactly what types of chemicals are present.

TYPICAL CO-EXISTING DIAGNOSES

Substance abuse is often a sign of other mental illnesses. A child may use alcohol or other drugs as a way to feel better and reduce the symptoms of a mental illness. For example, a child who is depressed may use drugs as a way to feel happier, or a child with anxiety may use alcohol to help him or her relax. If your child is abusing substances, it is important to both seek treatment for the substance abuse and have him or her evaluated and possibly treated for other mental illnesses.

Common mental health diagnoses that co-exist with substance abuse and dependence include:

- Anxiety Disorders (p48)
- Attention Deficit Hyperactivity Disorder (ADHD) (p52)
- Bipolar Disorder (p59)
- Conduct Disorder (p64)
- Depression (p67)
- Eating Disorders (p70)
- Learning Disorders (p75)

TREATMENT FACILITIES

Caritas, Inc.
401-722-4644
www.caritasri.org

CODAC Cranston
401-461-5056
www.codacinc.org

Stanley Street Treatment
and Resources
800-747-6237
www.sstar.org

RESOURCES

Al-Anon and Alateen
888-4AL-ANON or 888-425-2666
www.al-anon.alateen.org

Alcoholics Anonymous
in Rhode Island
401-438-8860
www.rhodeisland-aa.org
www.alcoholics-anonymous.org

New England Region
of Narcotics Anonymous
866-624-3578
www.newenglandna.org
www.na.org

TREATMENT

Substance abuse and dependence can be treated by a licensed mental health counselor, a psychotherapist, or a child and adolescent psychiatrist. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

There are many successful treatments for substance abuse and dependence. Treatment includes drug or alcohol rehabilitation, which allows the child's body to get over any physical dependence to the substance. In addition, individual and family psychotherapy are suggested forms of treatment. Medication may be used to reduce emotional or psychological dependence on a substance. Treatment of any existing mental illnesses can also help in treating substance abuse. For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

Many treatment facilities exist specifically to treat substance abuse and dependence and provide comprehensive programs for children with substance abuse problems. Treatment programs can include twelve step programs and peer support from friends who do not use substances. In particular, treatment programs usually address how the child is spending his or her time and figure out a way to keep the child busy through recreational or vocational services. As children with substance abuse problems may have trouble in other areas, comprehensive programs also usually include legal, family, and medical services.

If substance abuse and dependence is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

Tic Disorders

A tic is when a part of the body moves repeatedly, quickly, suddenly, or uncontrollably. Tics can occur in any part of the body, but are most common in the face, shoulders, hands, or legs. In addition, some tics can be vocal. A vocal tic is when a child makes sounds or speaks involuntarily.

Tics can range from mild to severe. Most tics are mild and hardly noticeable. However, in some cases, they are frequent and severe and can affect a child's ability to function in many different areas, including at home, school, and work.

The different types of tic disorders in children include:

- **CHRONIC TIC DISORDER:** With this disorder, a child has either one or more motor or vocal tics that last for more than a year. This type of tic disorder is rare. In some cases, chronic tics may be a sign of Tourette's Disorder (p98).
- **TRANSIENT TIC DISORDER:** A child with this disorder has multiple motor and/or vocal tics that last for at least a month, but not more than a year. Tics are usually mild and hard to notice, but may increase in frequency when a child is tired, nervous, or stressed. Transient Tic Disorder is the most common type of tic disorder in children. This disorder goes away on its own and does not require treatment.

Up to 10% of children may have transient tics during their early school years.

EVALUATION AND DIAGNOSIS

Tic disorders can be very stressful for children, especially due to the other children's reactions to the tics. Tic disorders can be diagnosed at any time in childhood. If you think that your child has a tic disorder, your child may need a comprehensive psychiatric evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

TREATMENT

If your child has Transient Tic Disorder, the tics will go away on their own, and your child does not require treatment. If your child has Chronic Tic Disorder or another type of tic disorder, treatment depends on the type of tics, but may include medication to control the symptoms and psychoeducation. For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

Tourette's Disorder

Children with Tourette's Disorder cannot control their sounds and movements and should not be blamed for them.

Tourette's Disorder is a type of tic disorder (p97). Tourette's is a rare disorder that affects less than one percent of children. Tourette's Disorder is characterized by chronic tics, which persist for a year or more. A child with Tourette's Disorder usually has both body and vocal tics that are frequent and severe, making it hard for the child to function normally.

SIGNS AND SYMPTOMS

Common signs and symptoms of Tourette's Disorder include:

- Acting impulsively
- Developing obsessions and compulsions
- Blurting out obscene words
- Insulting others
- Making obscene gestures or movements

EVALUATION AND DIAGNOSIS

Tourette's Disorder can be distressing for children, particularly because of peer reactions to the tics. Tourette's Disorder is usually diagnosed in children, around ages 8 to 10. However, symptoms can come and go. If you think your child has Tourette's Disorder, your child may need a comprehensive psychiatric evaluation. For more information, turn to **MENTAL HEALTH EVALUATIONS (p39)**.

TYPICAL CO-EXISTING DIAGNOSES

Common mental health diagnoses that co-exist with Tourette's Disorder include:

- Anxiety Disorders (p48)
- Attention Deficit Hyperactivity Disorder (ADHD) (p52)
- Autism Spectrum Disorders (Pervasive Developmental Disorders) (p54)
- Learning Disorders (p75)
- Obsessive Compulsive Disorder (OCD) (p80)

TREATMENT

Tourette's Disorder can be treated by a developmental behavioral pediatrician, a neurologist, a child and adolescent psychiatrist, or a psychotherapist. For more information on mental health specialists, turn to page 106 in **MENTAL HEALTH SUPPORT**.

Treatment for the child with Tourette's Disorder may include individual psychotherapy and medications. The types of medications that may be used include anti-anxiety or anti-depressant medications (in particular, Serotonin Reuptake Inhibitors or SRIs), anti-psychotic medications, or other medications (in particular, clonidine guanfacine). Family psychotherapy can also help families provide emotional support and the appropriate educational environment for the child. For more information, turn to **MENTAL HEALTH TREATMENT (p147)**.

If Tourette's Disorder is affecting the child's ability to learn, adjustments may need to be made in his or her education program. For more information on the school system, turn to page 118 in **MENTAL HEALTH SUPPORT**.

RESOURCES

Teaching the Tiger: A Handbook for Individuals Involved in the Education of Students with Attention Deficit Disorders, Tourette Syndrome or Obsessive-Compulsive Disorder (1995)
By Marilyn P. Dornbush, PhD and Sheryl K. Pruitt

The Tourette Syndrome Association,
Rhode Island Chapter
401-301-9980
www.ri.net/tsari or www.tsa-usa.org

PANDAS

PANDAS stands for Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infection. This means that certain kinds of bacterial streptococcal infections (for example, strep throat) may be related to tic disorders (including Tourette's Disorder), as well as Obsessive Compulsive Disorder (OCD). A pediatrician, child and adolescent psychiatrist, neurologist, or developmental behavioral pediatrician can check to see if your child's symptoms are related to a strep infection.