ACKNOWLEDGEMENTS

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Discharge Plan / Depart Summary

Do you have a list of new medications prescribed during this visit?

Do you have any follow-up appointments?

What are the key resource numbers you need to know?

*Make sure you have a copy of your child's depart summary for the next provider you visit.*
### Medication Management Form

<table>
<thead>
<tr>
<th>Side Effects</th>
<th>Physician</th>
<th>Outcomes Positive/Negative</th>
<th>Previous/Current Medication</th>
<th>Reason for Medication</th>
<th>Time of Day</th>
<th>Dose/Number</th>
<th>Name of Medicine</th>
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**Pharmacy:**

**Child's Name:**

**Date of Birth:**

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**Mission Children's Family Support Network of WNC**
<table>
<thead>
<tr>
<th>Outcome of Service</th>
<th>Provider of Service</th>
<th>Type of Service Received</th>
</tr>
</thead>
</table>

Psych Services could include therapy, behavior modification, psychiatric services, in-home services, and group therapies.
When transitioning back to school

Call your child’s school counselor and or social worker and set up an appointment to create a safety plan for your child.

When you go to the meeting bring the letter of discharge that will be provided to you by Copestone. Your child’s stay in the hospital will not count as absences.

**Remember:** As a parent you have the right to *not disclose* that your child has been hospitalized.
Behavior Intervention or Crisis Plans

Does your child with a disability also have behavioral or mental health challenges at school? If so, your child’s Individualized Education Program (IEP) can be used to address those needs. A positive behavior intervention plan is proactive or preventative in responding to your child’s behavior. A crisis plan is an action plan developed for how to respond to support a child at specific times when he or she may be at risk of harm to self or others related to mental health or behavioral health needs. The plans are distinctly different and important to consider when developing appropriate educational plans for children with emotional or behavioral disabilities.

What is a positive behavior intervention plan?

A positive behavior intervention plan is a written proactive plan that is part of a child’s IEP and includes strategies to help reduce or prevent the likelihood of challenging behaviors from occurring. For some students, simple interventions such as moving a desk in a classroom may make a difference. For others, a more formal plan may be needed to address the behavior.

When your child’s behavior is disruptive of his or her learning or that of others, the IEP team is required by federal law to consider the use of positive behavior interventions, strategies, and supports to address the problem. It is important for the team to consider ways to help your child learn positive behavioral skills as well as academic skills.

A positive behavior intervention plan is developed by the IEP team with information gathered from the:

- Student
- Parents
- Teachers
- Other staff who know the student well
- Updated evaluation information including a Functional Behavior Assessment (FBA), which determines the reason for a behavior through collecting, analyzing, and reviewing data and observations.

What should a positive behavior intervention plan include?

A positive behavior intervention plan should include specific steps to help your child learn new behavioral skills. It should include:

- Environmental changes to reduce or eliminate challenging behaviors
- Strategies for teaching new skills to replace challenging behaviors
- Skills training to increase student understanding of positive behavior strategies
- Support that will be provided to help the student practice the new strategies across different settings within the school

What is a crisis plan?

Many children have behavioral intervention plans in their IEPs; some children also benefit from a crisis plan as part of their IEP. A crisis plan is an action plan that is needed for times when a student may be at risk of harm to self or others. A child’s crisis plan should be developed by individuals knowledgeable about the child and
include someone trained in mental health crisis response. Crisis plans should be individualized and reviewed regularly by the IEP team. When developing a crisis plan, the IEP team should consider any school or district policies and procedures for responding to a student who is experiencing a crisis. In some cases, a child’s crisis behaviors may be viewed as violation of the school’s discipline policy. In these instances, the IEP team should plan on discussing whether the child’s crisis may trigger a school disciplinary action.

**What should a crisis plan include?**

A crisis plan defines what a child’s crisis looks like. It includes clear steps the school will take to support your child during a crisis including knowing who to contact for assistance, how to work together with the youth during the crisis, and how to know when the crisis is over. A crisis plan also identifies when parents should be notified.

A crisis plan:
- Is used when the student may be at risk of harm to self or others
- Focuses on **immediate response to the risk of the student’s harmful behaviors or actions**
- Can include support from a trained **mental health crisis response provider**
- Is more effective when developed using positive strategies and with the input and support of the student

The development of a positive behavior intervention plan or a crisis plan is an important addition to the IEP for students who experience mental health or behavior challenges at school. For additional information, parents can learn more by visiting:

**PACER Center**
8161 Normandale Boulevard
Minneapolis, MN 55437-1044
952-838-9000, voice
952-838-0199, fax

**PACER.org**

**Positive Behavior Interventions and Supports**
OSEP Technical Assistance Center
U.S. Office of Special Education Programs (OSEP)
U.S. Department of Education
400 Maryland Ave., SW
Washington, D.C. 20202-7100
202-245-7459

**PBIS.org**

**Minnesota Department of Education,**
Compliance – Restrictive Procedures
1500 Highway 36 West
Roseville MN 55113
651-582-8200
education.state.mn.us/MDE/dse/sped
School Safety Crisis Plan

When creating a safety/crisis plan for students remember to consider all domains of concern (home, school, community) where the harmful/dangerous behaviors may occur.

Definitions

Escalation Signals: Behaviors that occur right before the crisis, for example the student is unable to stop talking about an incident that has been previously resolved.

Escalation Strategies: Actions that help to prevent the crisis behavior (using what you know about triggers) and that divert/distract the student (re-directing student toward the situations in which the problem behavior does not occur).

Eruption Signals: Behaviors that occur during the crisis, for example the student is kicking/punching the walls, verbally threatening peers or staff.

Eruption Strategies: Identify distractions that will help to break the chain of behaviors that occur during a crisis. Identify safety concerns (Does the room need to be cleared; what staff is trained to assist with the Crisis Prevention Interventions?).

De-escalation Signals: Behaviors that occur right after the crisis, for example the student starts to cry and falls asleep.

De-escalation Strategies: Identify actions that will initiate and increase the rate of de-escalation. Identify ways for the student to obtain their needs without engaging in problem behaviors.

(Adapted) Milwaukee Public Schools, 5225 W. Vliet Street, Milwaukee, WI 53208
Crisis Management: Are procedures required to ensure safety in emergency situations for each phase of crisis? Yes ☐ No ☐

If yes, please describe behavior signals at each stage and procedures for staff response.

Escalation Signals:

Escalation Strategies:

Eruption Signals:

Eruption Strategies:

De-escalation Signals:

De-escalation Strategies:
1. Individual assistance with educational concerns.
2. Parent education workshops on a variety of topics:
   - Parents’ Rights and Education Laws (IDEA ‘04, NCLB, etc.)
   - Writing Effective IEPs (Individualized Education Programs)
   - Early Childhood Programs and Services (Birth to 3)
   - Transition to Preschool and Kindergarten
   - Becoming Your Child’s Best Advocate
   - Positive Behavior Supports
   - Transition to Adulthood
   - Effective Communication Skills
   - Inclusion: Everybody Belongs!
   - Assistive Technology...It’s NOT Rocket Science
   - Literacy for All!
   - Other topics as requested
3. Information Packets and referral services
4. Newsletter
5. Lending Library
6. IEP Partners
7. Parent to Parent Support
8. Information and assistance to parent groups

All services are provided to NC parents and families at no charge!

For More Information, contact **ecac:**
Main Office: (704) 892-1321 | Davidson, NC
Parent Information Line: 1-800-962-6817
(Parents only please on the toll-free number)

Raleigh Office: (866) 740-4135 – toll-free
Western Office: (866) 545-5299 – toll-free
Eastern Office: (800) 782-2094 – toll-free
Self-Awareness Worksheet for Kids

Prepare your child to self-advocate. Fill out this worksheet together to build awareness of strengths, weaknesses and how he prefers to ask for help.

I am strong in these areas:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I struggle with:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

My favorite thing about school is:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Here’s what the teachers I’m most comfortable with do to make that happen:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The most stressful part of my school day is:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I’d like some help with:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

When I need help, I’m comfortable asking for it in the following ways:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Understood
Remember
The kids who need the most love will ask for it in the most unloving ways.
—授课老师

"Trust yourself. You know more than you think you do." — Benjamin Spock

Successful mothers are not the ones that have never struggled. They are the ones that never give up, despite the struggles.
— Sharon Stone

Don't let yourself become so concerned with raising a good kid that you forget you already have one.
— [Attribution Missing]

Be the person you needed when you were younger.
— [Attribution Missing]
Family Mission Statement

If you want your family to be strong and successful, you have to create a working plan. You need to know what direction you would like to head and how you are going to get there. Sit down together and write your family mission statement. It will be a powerful first step on your family’s road to success.

Answer the following questions. On the next page, put your answers together in sentence format. Hang your mission statement in a common area where everyone in the family will see it often and refer to it frequently. For even more traction, have each family member memorize your mission statement. Then, family members can take it with them wherever they go.

1. We are at our best when...

2. We are at our worst when...

3. What does our family love doing together?

4. As a family, how can we better help one another?

5. As a family, what can we give to others and how can we help people outside of our family?

6. What do we need to change as a family?

7. On what principles do we want our family based?

8. What does each of us want to be in the future?
Preparing for your Family Session

Here are some things to consider:

1. What are some of your main concerns about your child coming home with you?
2. What do you want in your safety plan?
3. Do you truly understand the diagnosis your child has been given?

Notes:
“Self-Care is not about self-indulgence,
It's about self-preservation”
Audrey Lorde

As parents of children with mental health challenges we love to worry ourselves thinking about the what-if's. We are in a constant whirlwind trying to figure out the right treatment for our children, with little thought about ourselves. We have all heard, “it's hard to take care of others if you are not taking care of yourself” and we answer with a "yeah, but I have"..... As you read this I hope you find at least one thing you could start doing for yourself. Your child needs you, and they need you rested and ready, to support them in their journey!

**Tips of Self-Care**

- Move your body! Exercise is very important, for your mind, body and soul.
- Join a support group (there is a long list behind the resource and support tab).
- Take 15: Take time to regroup, and breathe.
- Educate yourself: Through educating yourself on mental health, you become empowered and a stronger support system for your child.
- Create something beautiful: Color, paint or sculpt something.
- Carve out time each week with your spouse, make sure you are communicating and supporting one another.
- Take a minute to notice the positive things in your life right now.
- After everyone is asleep, take a bubble bath or watch a funny movie or read a book.
- Create boundaries within your home, so you can say “mom/dad needs a break”

**Here are a few resources for you to continue your journey towards self-care!**


www.helpguide.org/

https://theselfcompassionproject.com

http://practicalparenting.ie/2015/05/15/4-self-care-tips-for-parents/

Attached you will find a plan to get you started on your journey to better self-care.
This Self-Care Wheel was inspired by and adapted from "Self-Care Assessment Worksheet" from Transforming the Pain: A Workbook on Vicarious Traumatization by Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996). Created by Olga Phoenix Project: Healing for Social Change (2013). Dedicated to all trauma professionals worldwide.

www.OlgaPhoenix.com
Create your own
SELF-CARE WHEEL

PHYSICAL

PSYCHOLOGICAL

LIFE

SELF-CARE WHEEL

BALANCE

PROFESSIONAL

EMOTIONAL

PERSONAL

SPIRITUAL

Created by Olga Plavsic Project: Healing for Social Change (2013) olgaphoenix.com
WHEN TO SEEK HELP FOR YOUR CHILD

Parents are usually the first to recognize that their child has a problem with emotions or behavior. Still, the decision to seek professional help can be difficult and painful for a parent. The first step is to gently try to talk to the child. An honest open talk about feelings can often help. Parents may choose to consult with the child's physicians, teachers, members of the clergy, or other adults who know the child well. These steps may resolve the problems for the child and family.

Following are a few signs which may indicate that a child and adolescent psychiatric evaluation will be useful.

YOUNGER CHILDREN

- Marked fall in school performance.
- Poor grades in school despite trying very hard.
- Severe worry or anxiety, as shown by regular refusal to go to school, go to sleep or take part in activities that are normal for the child's age.
- Hyperactivity; fidgeting; constant movement beyond regular playing.
- Persistent nightmares.
- Persistent disobedience or aggression (longer than six months) and provocative opposition to authority figures.
- Frequent, unexplainable temper tantrums.

PRE-ADOLESCENTS AND ADOLESCENTS

- Marked change in school performance.
- Inability to cope with problems and daily activities.
- Marked changes in sleeping and/or eating habits.
- Frequent physical complaints.
- Sexual acting out.
- Depression shown by sustained, prolonged negative mood and attitude, often accompanied by poor appetite, difficulty sleeping or thoughts of death.
- Abuse of alcohol and/or drugs.
- Intense fear of becoming obese with no relationship to actual body weight, purging food or restricting eating.
- Persistent nightmares.
When to Seek Help for Your Child, “Facts for Families,” No. 24 (7/04)

- Threats of self-harm or harm to others.
- Self-injury or self-destructive behavior.
- Frequent outbursts of anger, aggression.
- Threats to run away.
- Aggressive or non-aggressive consistent violation of rights of others; opposition to authority, truancy, thefts, or vandalism.
- Strange thoughts, beliefs, feelings, or unusual behaviors.

If problems persist over an extended period of time and especially if others involved in the child's life are concerned, consultation with a child and adolescent psychiatrist or other clinician specifically trained to work with children may be helpful.

See other Facts for Families:

#25 Where to Seek Help for Your Child
#29 Children's Major Psychiatric Disorders
#52 Comprehensive Psychiatric Evaluation
#22 Normality
#57 Normal Adolescent Development, Middle School, and Early High School Years and
#58 Normal Adolescent Development, Late High School Year and Beyond.

Facts For Families Main Menu
See also Facts for Families Translations:
[Deutsch] [French] [Polish] [Spanish]

###

If you find Facts for Families helpful and would like to make good mental health a reality for all children, please consider donating to the Campaign for America’s Kids. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to Campaign for America’s Kids, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 7,000 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

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Parenting a Child with Mental Health Challenges

Parenting a child with mental health challenges can be frustrating but there is hope. There are things you can do to help your child & family function better on a daily bases.

Parenting a child with a Mental Health Challenge requires:

- Patience and the ability to control the anxiety brought about by having a child with unique needs,
- A keen sense of organization paired with flexibility-and the ability to model this for your child
- A willingness to ask for and an ability to coordinate support and services, including that provided by teachers, therapist and physicians
- An ability to provide routine/structure to your child’s daily life with a positive behavior support plan in place for home & school
- A willingness to be educated about your child’s illness, but also to challenge the negativity that is often associated with the illness
- A sense of humor and ways to relieve your own stress

It is also helpful for parents to remember:

- That your child’s behavior is related to a disorder and is not generally intentional
- That your child has a unique set of abilities and characteristics that are valuable
- That your child has the ability to learn and succeed
- To focus on how to help you child change inappropriate behaviors
- To be your child’s advocate until your child can self-advocate
- To believe in and support your child

Most importantly, parents must be able to master a combination of compassion and consistency. Living in a home that provides both love and structure is the best thing for a child who is learning to manage a mental health disorder.

Types of Behavioral Approaches:

Behavioral training for parents and teachers to learn how to manage the child’s behavior

A systematic program of contingency management, such as learning to use positive reinforcement

Clinical behavioral therapy, such as training in problem-solving and social skills

Cognitive-behavioral treatment, such as self-monitoring

Dialectical Behavior Therapy, skills based therapy

With each type of approach, parents learn exactly what they need to do at home to manage their child’s illness. Parents must work to implement and follow through on the approach in the home on a regular and consistent basis.
Specific strategies:

- Focus on discrete rewards and consequences for appropriate and inappropriate behavior:
- Take the child away from situations that foster behavior
- Don’t say yes just because it is easier
- Spell out rules in advance
- Keep instructions and reminders short and simple
- Pick your battles
- Maintain a positive attitude about your child
- Catch your child being good
- Set a daily routine and stick to it
- Remember that all transitions will cause some behavior especially if unexpected
- Help your child to be organized
- Have tangible reminders: Picture schedules, Charts for chores
- Build in breaks for all activities
- Teach your child relaxation techniques
- Provide social coaching

Finally, but most importantly you must take care of yourself!

The challenges and difficulties that you have on a daily basis raising your child with a mental health challenges will take a total on you and your family.

Think about the big picture.
Family support encourages us to believe in ourselves and to rely on the resources we have in our community to help us during these times. Believing in yourself means listening to your feelings and paying attention to your own needs. It means keeping the “big picture” in focus.

Talk to others – Don’t keep secrets.
Talking with others and reducing your isolation is a very important coping technique. Develop a network of support people whom you are able to talk with regularly and who might be reliable in a crisis. Talking with other families who have had similar experiences—such as the families of Family Support Network and other local support groups in our state—can provide support and insight into how to deal with specific issues. These groups often offer groups for specific family members like siblings. Studies have shown that support groups work in helping families stay together.

Make time for yourself.
Although it may be the last thing you imagine you could do, taking time for yourself might be the most important. Without a break from the stresses of caring for your child, you will find it hard to muster your own coping skills.
Take each day as it comes.
When you concentrate on just getting through the day, this smaller focus will make it easier to cope with problems that arise.

The challenges and difficulties that you have on a daily basis raising your child with a mental health challenges will take a toll on you and your family. Build your support system and try to enjoy the ride. The rewards are great in the end.


For more information contact:

Mission Children's Hospital
Family Support Network of WNC
missionchildrens.org/family-support-network.php
828-213-0033
Glossary of Terms
Child and Adolescent Mental Health

This glossary contains terms frequently used when referring to the mental health needs of children and adolescents. The list is alphabetical. Words in italics are defined separately within the glossary. Since the words service and services are used frequently throughout the glossary, it may be helpful to begin by reading the definition for service.

The terms in this glossary describe ideal services. These services may not be available in all communities. The Comprehensive Community Mental Health Services Program for Children and Their Families, administered by the Center for Mental Health Services (CMHS), has grantees in communities across the country that are demonstrating these services. For more information about children's mental health issues or services, call SAMHSA's National Mental Health Information Center at 1-800-789-2647.

Accessible services:
Services that are affordable, located nearby, and open during evenings and weekends. Staff is sensitive to and incorporates individual and cultural values. Staff is also sensitive to barriers that may keep a person from getting help. For example, an adolescent may be more willing to attend a support group meeting in a church or club near home than to travel to a mental health center. An accessible service can handle consumer demand without placing people on a long waiting list.

Appropriate services:
Designed to meet the specific needs of each individual child and family. For example, one family may need day treatment, while another may need home-based services. Appropriate services for one child and family may not be appropriate for another. Appropriate services usually are provided in the child's community.

Assessment:
A professional review of child and family needs that is done when services are first sought from a caregiver. The assessment of the child includes a review of physical and mental health, intelligence, school performance, family situation, and behavior in the community. The assessment identifies the strengths of the child and family. Together, the caregiver and family decide what kind of treatment and supports, if any, are needed.

Caregiver:
A person who has special training to help people with mental health problems. Examples include social workers, teachers, psychologists, psychiatrists, and mentors.

Case manager:
An individual who organizes and coordinates services and supports for children with mental health problems and their families. (Alternate terms: service coordinator, advocate, and facilitator.)

Case management:
A service that helps people arrange for appropriate services and supports. A case manager coordinates mental health, social work, educational, health, vocational, transportation, advocacy, respite care, and recreational services, as needed. The case manager makes sure that the changing needs of the child and family are met. (This definition does not apply to managed care.)

Child protective services:
Designed to safeguard the child when abuse, neglect, or abandonment is suspected, or when there is no family to take care of the child. Examples of help delivered in the home include financial assistance, vocational training, homemaker services, and daycare. If in-home supports are insufficient, the child may be removed from the home on a temporary or permanent basis. Ideally, the goal is to keep the child with the family whenever possible.
Children and adolescents at risk for mental health problems:
Children are at greater risk for developing mental health problems when certain factors occur in their lives or environments. Factors include physical abuse, emotional abuse or neglect, harmful stress, discrimination, poverty, loss of a loved one, frequent relocation, alcohol and other drug use, trauma, and exposure to violence.

Continuum of care:
A term that implies a progression of services that a child moves through, usually one service at a time. More recently, it has come to mean comprehensive services. Also see system of care and wraparound services.

Coordinated services:
Child-serving organizations talk with the family and agree upon a plan of care that meets the child's needs. These organizations can include mental health, education, juvenile justice, and child welfare. Case management is necessary to coordinate services. Also see family-centered services and wraparound services.

Crisis residential treatment services:
Short-term, round-the-clock help provided in a nonhospital setting during a crisis. For example, when a child becomes aggressive and uncontrollable, despite in-home supports, a parent can temporarily place the child in a crisis residential treatment service. The purposes of this care are to avoid inpatient hospitalization, help stabilize the child, and determine the next appropriate step.

Cultural competence:
Help that is sensitive and responsive to cultural differences. Caregivers are aware of the impact of culture and possess skills to help provide services that respond appropriately to a person's unique cultural differences, including race and ethnicity, national origin, religion, age, gender, sexual orientation, or physical disability. They also adapt their skills to fit a family's values and customs.

Day treatment:
Day treatment includes special education, counseling, parent training, vocational training, skill building, crisis intervention, and recreational therapy. It lasts at least 4 hours a day. Day treatment programs work in conjunction with mental health, recreation, and education organizations and may even be provided by them.

DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition):
An official manual of mental health problems developed by the American Psychiatric Association. Psychiatrists, psychologists, social workers, and other health and mental health care providers use this reference book to understand and diagnose mental health problems. Insurance companies and health care providers also use the terms and explanations in this book when discussing mental health problems.

Early intervention:
A process used to recognize warning signs for mental health problems and to take early action against factors that put individuals at risk. Early intervention can help children get better in less time and can prevent problems from becoming worse.

Emergency and crisis services:
A group of services that is available 24 hours a day, 7 days a week, to help during a mental health emergency. Examples include telephone crisis hotlines, suicide hotlines, crisis counseling, crisis residential treatment services, crisis outreach teams, and crisis respite care.

Family-centered services:
Help designed to meet the specific needs of each individual child and family. Children and families should not be expected to fit into services that do not meet their needs. Also see appropriate services, coordinated services, wraparound services, and cultural competence.

Family support services:
Help designed to keep the family together, while coping with mental health problems that affect them. These services may include consumer information workshops, in-home supports, family therapy, parenting training, crisis services, and respite care.

**Home-based services:**
Help provided in a family's home either for a defined period of time or for as long as it takes to deal with a mental health problem. Examples include parent training, counseling, and working with family members to identify, find, or provide other necessary help. The goal is to prevent the child from being placed outside of the home. (Alternate term: in-home supports.)

**Independent living services:**
Support for a young person living on his or her own. These services include therapeutic group homes, supervised apartment living, and job placement. Services teach youth how to handle financial, medical, housing, transportation, and other daily living needs, as well as how to get along with others.

**Individualized services:**
Services designed to meet the unique needs of each child and family. Services are individualized when the caregivers pay attention to the needs and strengths, ages, and stages of development of the child and individual family members. Also see appropriate services and family-centered services.

**Inpatient hospitalization:**
Mental health treatment provided in a hospital setting 24 hours a day. Inpatient hospitalization provides: (1) short-term treatment in cases where a child is in crisis and possibly a danger to his/herself or others, and (2) diagnosis and treatment when the patient cannot be evaluated or treated appropriately in an outpatient setting.

**Managed care:**
A way to supervise the delivery of health care services. Managed care may specify which caregivers the insured family can see and may also limit the number of visits and kinds of services that are covered by insurance.

**Mental health:**
How a person thinks, feels, and acts when faced with life's situations. Mental health is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore choices. This includes handling stress, relating to other people, and making decisions.

**Mental health problems:**
Mental health problems are real. They affect one's thoughts, body, feelings, and behavior. Mental health problems are not just a passing phase. They can be severe, seriously interfere with a person's life, and even cause a person to become disabled. Mental health problems include depression, bipolar disorder (manic-depressive illness), attention-deficit/hyperactivity disorder, anxiety disorders, eating disorders, schizophrenia, and conduct disorder.

**Mental disorders:**
Another term used for mental health problems.

**Mental illnesses:**
This term is usually used to refer to severe mental health problems in adults.

**Plan of care:**
A treatment plan especially designed for each child and family, based on individual strengths and needs. The caregiver(s) develop(s) the plan with input from the family. The plan establishes goals and details appropriate treatment and services to meet the special needs of the child and family.

**Residential treatment centers:**
Facilities that provide treatment 24 hours a day and can usually serve more than 12 young people at a time. Children with serious emotional disturbances receive constant supervision and care. Treatment may include individual, group, and family therapy; behavior therapy; special education;
recreation therapy; and medical services. Residential treatment is usually more long-term than inpatient hospitalization. Centers are also known as therapeutic group homes.

Respite care:
A service that provides a break for parents who have a child with a serious emotional disturbance. Trained parents or counselors take care of the child for a brief period of time to give families relief from the strain of caring for the child. This type of care can be provided in the home or in another location. Some parents may need this help every week.

Serious emotional disturbances:
Diagnosable disorders in children and adolescents that severely disrupt their daily functioning in the home, school, or community. Serious emotional disturbances affect one in 10 young people. These disorders include depression, attention-deficit/hyperactivity, anxiety disorders, conduct disorder, and eating disorders.

Service:
A type of support or clinical intervention designed to address the specific mental health needs of a child and his or her family. A service could be provided only one time or repeated over a course of time, as determined by the child, family, and service provider.

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.

For free information about child and adolescent mental health, including publications, references, and referrals to local and national resources and organizations, contact SAMHSA's National Mental Health Information Center at 1-800-789-2647 (toll-free), 866-889-2647 (TDD), 240-747-5470 (fax), or http://mentalhealth.samhsa.gov/child.
This sheet lists a selection of websites and online information sheets that have suicide prevention resources for parents, guardians, and other family members. The resources provide guidance on talking with your child if you think he or she may be at risk for suicide and on coping with a suicide attempt or death. A few of the resources also discuss how you can take action at the school and community levels to prevent suicide.

Websites

Jason Foundation Parent Resource Program

This website contains basic information about suicide and how you as a parent or guardian can help prevent youth suicide. It also has a video of a parent and community seminar that includes basic information on suicide and provides awareness and suicide prevention strategies for parents and other adults.

Maine Youth Suicide Prevention Program
http://www.maine.gov/suicide/parents/index.htm
(Look at both the center of the webpage and the links in the left sidebar.)

This website includes a parent-specific section with a number of information sheets that cover basic information on suicide prevention, common reactions to youth suicide, talking with your child, and coping after a suicide attempt or death.

Society for the Prevention of Teen Suicide
Parent Section: http://www.sptsusa.org/parents/

This website’s parent section provides information to help you talk with your teens about suicide or the death of a friend by suicide. It includes a link to the video Not My Kid: What Every Parent Should Know, which features eight parents from culturally diverse backgrounds asking two experts common questions about youth suicide.

Youth Suicide Prevention Program
http://www.ypp.org

This website has a lot of information for parents including basic information on depression, suicide, suicide prevention; how to talk with your child about suicide; and how to cope after a suicide attempt or death.

National Suicide Prevention Lifeline
1-800-273-TALK (8255)

The Lifeline is a 24-hour toll-free phone line for people in suicidal crisis or emotional distress. An online chat option is available at http://www.suicidepreventionlifeline.org/GetHelp/LifelineChat.aspx
Some materials are specifically for helping LGBTQ youth. The site also contains a list of other resources and links as well as a toolkit to help you take action in your community to prevent youth suicide.

**Information Sheets**

Cómo pueden los padres OBSERVAR ESCUCHAR AYUDAR (How Parents Can LOOK LISTEN AND HELP: Youth Suicide Is Preventable)

**Oregon Youth Suicide Prevention Program**
https://public.health.oregon.gov/PreventionWellness/SafeLiving/SuicidePrevention/Pages/espllh.aspx

This Spanish-language webpage discusses your role as a parent in recognizing changes in your child’s behavior that may indicate he or she is at risk of depression or suicide. It also outlines how you can intervene to prevent a crisis and obtain help. This information can be downloaded as a brochure, and an English-language version can be ordered by e-mail.

**National Association of School Psychologists**

Preventing Youth Suicide—Tips for Parents and Educators

This webpage describes the risk and resiliency factors related to suicide, warning signs of suicide, ways to respond, and the role of the school in suicide prevention.

**Preventing Suicidal Behavior among Youth in Foster Care**

This information sheet provides basic information about suicide prevention related to youth in foster care, including warning signs, and risk and protective factors. Suggestions are included specifically for foster parents and caregivers on how to help prevent suicide.

**Suicide Prevention: Facts for Parents**

This information sheet focuses on suicide among high school students and how parents and high schools can help prevent it.

For information on suicide prevention activities in your state, see SPRC’s list of state contacts at http://www.sprc.org/states/all/contacts.
Supporting vs Enabling

How to tell what’s helping and what’s not when a child has emotional or learning challenges

Julia Johnson Attaway

Why do parents spoon-feed babies, but expect healthy fourth graders to feed themselves? Because babies aren’t able to do the task alone, but older kids can. One of the basic ways we distinguish support from coddling is by assessing what children are capable of doing. The normal progression moves from complete support to coaching or teaching to self-reliance.

Yet what is relatively clear with a typical kid becomes murkier when a child struggles with learning disabilities or mental health issues. It’s not always easy to figure out what counts as supportive and what is enabling when a child’s mood, anxiety, distractability, and behavior vary from day to day. How do you know if you are being considerate of your child’s difficulties... or limiting his growth by taking on tasks he can do himself?

What is support?

“Life will throw all kinds of challenges at kids,” says Dr. David Anderson, a psychologist and director of the Behavior Disorders Center at the Child Mind Institute, “And the goal of support is to build up resilience and develop coping strategies.”

So let’s start with a rule of thumb: support should always empower your child to move forward toward greater stability and more independence. Support will acknowledge difficulties yet not eliminate them. It’s about working with your child as he learns to overcome obstacles, manage his fears, and build confidence for the future.

Thus it is always supportive to:

- Learn about your child’s disorder and treatment, so you are clear about what is helpful for healing and what is not
- Acknowledge your child’s feelings, validating how hard it is to be scared, sad, uncomfortable, embarrassed, or struggling
- Provide simple human comforts – snuggles, hot chocolate, a shoulder rub, sensory tools, anything that brings the stress down — and practical assistance that helps her push through strong emotions
- Model healthy coping skills for handling frustration, disappointment, anger and anxiety (or model perseverance if you are still learning how to do this)
- Provide structure at home in the form of appropriate rules, schedules, and positive consequences so your child can experience success with his behavior
- Notice and comment upon small steps forward, praising effort and perseverance in addition to results
- Discuss house rules and consequences in calm times, so you don’t find yourself inventing them on the fly
- Coach your child through problems she cannot handle without assistance
- Set clear boundaries for the personal health and safety of all members of the family (including yourself)
- Advocate for your child at his school, so he has accommodations for his disability that level the playing field
- Seek professional help for any member of your family who is struggling

If your child is already working with a therapist, you can support the work done in session by asking for “homework” that reinforces skills being worked on. The therapist may also provide guidance on strategies you can use in handling specific problems.

How enabling is different

To enable is to inadvertently reinforce an undesired behavior. All parents do this to some degree, because it’s only natural to want to shield our children from pain, fear, failure, difficulty and embarrassment.

Research suggests it’s best to delay exposure to the big risks like drugs, sex, and alcohol as long as possible, but as Dr. Anderson notes, children shouldn’t be protected from all risk-taking. Smaller risks are where kids build coping skills and confidence. As parents we have to learn to tolerate our own discomfort at seeing kids struggle if we are going to help them grow.

Enabling undesirable behavior also occurs when we give in to complaints or demands because we desperately want to avoid conflict. This avoidance is generally a short-term fix that’s at odds with helping the child make long-term progress.

It is usually enabling to:

- Allow your child to avoid all uncomfortable situations
- Cover up for things your child did, forgot to do, or did poorly
- Speak up on her behalf instead of letting her learn to express her own thoughts and feelings
- Enforce house rules inconsistently because you feel bad about your child’s struggles or are afraid he won’t like you
- Overly react to non-violent tantrums by engaging in long lectures or emotional fireworks of your own
- Intervene with other adults to prevent your child from experiencing disappointment, rather than helping her work through her feelings
- Protect him from the natural consequences of his actions

When matters are not clear-cut
Unfortunately, mental health symptoms vary from day to day, so what's possible for a kid to do one day may be impossible the next. A depressed teen may, for example, muster the energy to do homework on Tuesday, then climb into bed overwhelmed by sadness on Wednesday. An anxious kid might make it through the school day but then explode in the safety of home. This shifting ground between ability and disability can make it difficult for parents to know what constitutes support and what enables mental health challenges to retain their grip.

Gauging what your child can and can't do will always be a matter of observation, parental judgment, and trial and error. However, your accuracy in predicting success will improve if you keep track of the circumstances surrounding when success occurs. Often the good days are a function of basics, such as:

- Did your child have a solid night's sleep?
- Did he eat enough food and drink enough fluid?
- What else happened this week? (bullying at school, change of routine, family strife, etc.)
- What's on the horizon? (upcoming exams, unpleasant anniversaries, stressful situations)
- Has medication been taken regularly, or has there been a recent change in medication?
- How calmly have you been able to respond to your child's anger or distress?
- How consistent have you (and your partner) been in sticking to house rules?
- Is there any physical issue going on? (hormonal cycle, headache, incipient stomach bug, or other)

As you build your database of insight, you will get better at assessing whether your expectations are impossible, difficult-but-possible-with-help, difficult-but-possible-with-time, or not a problem.

Drama vs. reality

Kids with emotional challenges are refreshingly like every other kid on the planet when it comes to trying to get what they want... and avoid doing what they dislike. Sometimes the strategies they use involve capitalizing on a nugget of truth, like exaggerating a legitimate emotion. This is normal. Like most of us, kids tend to plead being overwhelmed when they simply fear being overwhelmed, and think "I can't!" when they really mean "I don't want to!"

Any parent who has logged hours of worry over their kid is likely to find this incredibly provoking. The prospect of heading into (yet another) downward spiral is anxiety inducing. This can make determining how much of your child's protest is due to inability and how much is an overlay of drama extra tricky.

Try to avoid falling into the either/or, can-she-or-can't-she trap. Almost all situations fall somewhere between can and can't, and the way to find the sweet spot is to validate your child's feeling and move things forward from there. For example, you might say:

- "I know you don't feel up to it, but I'd like you to come anyway. If you're still too exhausted once we get there, we don't have to go in."
• “Yes, this will be challenging, and yet I’m pretty sure we can find ways to help you manage it.”
• “Aww, I can see you’re tired! That often happens when you haven’t had enough fluids. Let me get you a cup of juice and see if that helps perk you up.”
• “It’s normal to be nervous about something like this. What’s one thing you can do to pull your anxiety down to a more manageable level?”
• “Hmmm. I can see it seems intimidating, yet I’m pretty sure it’s not entirely What could we do to make it merely very difficult?”

What you’re looking for is the middle ground, the wiggle room, the tiny step of progress. If you succeed – great! If you don’t, the information you gather in the process will equip you for the next round. Talk to your child’s therapist, collaborate on strategies, report back on progress… and move forward. With patience and insight, time and wisdom, professional help and at-home parental support, your child will make progress.

Julia Johnson Attaway is a freelance writer and mother of five.

GENERAL INQUIRIES CALL +1 (212) 308-3118445 PARK AVENUE (AT 56TH STREET), NEW YORK, NY 10022

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https://childmind.org
Suggested Reading:

The following reading list includes resources to aid you in helping your relationships with your family. Some of these are simple Do’s and Don’t’s some are more general, and some are specific to certain problems.

The Parallel Process - Krissy Pozatek; This book is a guide specifically for parents who have a child in treatment.

Codependent No More: How to Stop Controlling Others and Start Caring for Yourself – Melody Beattie

Boundaries with Kids: When to say Yes, When to say No, To help your children gain control of their lives – Dr. Henry Cloud

How To Talk to Kids so Kids Will Listen and Listen so Kids Will Talk and How to Talk So Teens Will Listen and

Listen So Teens Will Talk – Faber and Mazlish

Parent Effectiveness Training (PET): The Proven Program for Raising Responsible Children – Thomas Gordon

Nonviolent Communication: A Language of Life – Marshall B. Rosenberg

Healing the Shame that Binds You – John Bradshaw

Whale Done – The Power of Positive Relationships – Kenneth H. Blanchard, Chuck Tompkins, Jim Ballard

Changes that Heal – Dr. Henry Cloud; This book utilizes examples from The Bible as a basis for where our emotional pain comes from in broken relationships and how to heal and form healthier bonds.

For issues of Abandonment, Divorce, Adoption, and/or Reactive Attachment Disorder (RAD):

Parenting Teens with Love and Logic – Jim Faye and Foster Cline

Hope for Healing: A parent’s guide to trauma and attachment. Available through the website: www.ATTACH.org

Parenting the Hurt Child – Greg Keck and Regina Kupeckney

Attachment Parenting – Becker Weideman – Available at www.Center4attachment.org
FAMILY SUPPORT NETWORK OF WNC
MISSION CHILDREN’S HOSPITAL

MISSION: To enhance the lives of children in WNC with or at risk of different abilities by providing support, information and education to families who care for them and by encouraging parent-professional collaboration in the design and delivery of services for these families.

PARENT TO PARENT SUPPORT: Training to parents who want to be a mentor for another parent or family is provided throughout the year.

FAMILY GROUP NIGHT: Allows each family member to attend a group that addresses their needs. Groups are designed for the child with special needs and their siblings to connect with peers in their community. Parents have the opportunity to network with other families and guest speakers. Provided twice monthly 5:30-7:30. RSVP to (828) 213-0047. REGISTRATION IS REQUIRED for these events. Dinner is provided.

INPATIENT SERVICES: Provides resources and educational materials to families located within all units where children receive care.

RESOURCE CENTER: Services include our COMMUNITY RESOURCE GUIDE, assistance in navigating services, information packets to assist with GUARDIANSHIP, SSI AND TRANSITION TO ADULTHOOD. Visual schedules are made during your visit. Appointments are recommended. All services free of charge.

TRIPLE P- Positive Parenting Program:
Triple P - Positive Parenting Program and Stepping Stones Parenting Class. Families are offered useful ideas to help meet the challenges of raising a child with a disability. In addition to classes we are able to provide one to one sessions and tip sheets for specific behaviors. Sessions are provided through one to one appointments with staff members.
What Families say...........

Initially we came to FSN for education. We needed to understand Autism, IEP's, Therapies etc. The FSN staff are nurturing, compassionate, professional and wise. We attended many trainings and support groups. It was such an important part of our grieving and healing process. We learned from the experience of other families and found a community of people that we could really identify with, that understood the many heartaches and triumphs of raising a child with special needs.

- Anne J.

FSN has been a very important part of my life throughout my journey of parenting a special needs child who has multiple health and behavioral issues. From those early NICU days to present day of parenting a teenager, FSN has guided me and supported me through multiple medical events my son has endured. The FSN staff have been a source of education, support and encouragement to me. These ladies understand the struggles and emotions, as they are also parents of children with different abilities. They have lived through these challenges themselves. Family Support Network has become one of my “Community’s of friends.” They have laughed with me, cried with me and on those extra challenging days encouraged me. They have given me hope when I felt hopeless.

I am so thankful for the staff at FSN and I am grateful for ALL they do to provide support, resources, understanding and most of all compassion to families like mine!

- Sharon B.

FAMILY SUPPORT NETWORK OF WNC
MISSION CHILDREN’S HOSPITAL
11 Vanderbilt Park Drive, Asheville, NC 28803
828-213-0033 | Fax: (828) 213-0040
missionchildrens.org/familysupportnetwork
# Western Regional Support Group Options for Families (updated 3/2018)

<table>
<thead>
<tr>
<th>Name of Group</th>
<th>When</th>
<th>Where</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asheville Stay at Home Moms</td>
<td>Social get together</td>
<td>Various locations</td>
<td><a href="http://www.meetup.com/AspergersAdultsunited">www.meetup.com/AspergersAdultsunited</a></td>
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<tr>
<td>Brandy Lewis Coordinator</td>
<td></td>
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<td><a href="http://www.facebook.com/groups/AspergersAdultsunited">www.facebook.com/groups/AspergersAdultsunited</a></td>
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<tr>
<td>Buncombe County Chapter Autism Society of NC</td>
<td>3rd Thursday 6:30pm-8:00pm</td>
<td>First Baptist Church of Asheville, 5 Oak St. Avl</td>
<td><a href="mailto:buncombechapter@autismsociety-nc.org">buncombechapter@autismsociety-nc.org</a></td>
</tr>
<tr>
<td>Brain Injury Support Group for Teens/Young Adults</td>
<td>4th Tuesday 6-7:30 p.m.</td>
<td>Foster 7th Day Adv. Church 375 Hendersonville Rd.</td>
<td>828-277-4868 Karen Keating <a href="http://www.bianc.net">http://www.bianc.net</a> or <a href="mailto:wncbraininjurynetwork@gmail.com">wncbraininjurynetwork@gmail.com</a></td>
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<tr>
<td>Caring for Children with Food Allergies</td>
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<td><a href="mailto:cocoain-asheville@yahoo.com">cocoain-asheville@yahoo.com</a></td>
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<tr>
<td>Care Partners</td>
<td>Various Bereavement Gp's Available</td>
<td>68 Sweeten Creek Rd.</td>
<td>828-251-0126</td>
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<tr>
<td>Mission Family Support Network Family Group Nights</td>
<td>Choose One to Attend a Month</td>
<td>Mission Children's Outpatient Center 11 Vanderbilt Park Drive, Asheville</td>
<td>RSVP required 828-213-0047, <a href="mailto:kerri.eaker@msj.org">kerri.eaker@msj.org</a> Dinner and Childcare provided</td>
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<tr>
<td>WNC DOWN SYNDROME Alliance</td>
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<td><a href="https://www.facebook.com/WNCDSA">https://www.facebook.com/WNCDSA</a></td>
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<tr>
<td>Down Syndrome Baby Love Group</td>
<td>Monthly get-togethers</td>
<td>Various fun locations</td>
<td>Lacey Theede <a href="mailto:asevilledownsyrondembabylove@gmail.com">asevilledownsyrondembabylove@gmail.com</a></td>
</tr>
<tr>
<td>Ehlers-Danlos (EDS) MCAD/s, POTS</td>
<td>4th Saturday 10:00 am</td>
<td>Mission's My Care Plus Community Room/Biltmore. Pk</td>
<td><a href="mailto:ashnceds@gmail.com">ashnceds@gmail.com</a></td>
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<tr>
<td>F.I.R.S.T. Hispanic Family Support Group</td>
<td>1st &amp; 3rd Monday 5:00-8:00</td>
<td>West Avl Community Ctr.</td>
<td><a href="#">Referral base only</a>, Call Theresa 828-545-4190</td>
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<tr>
<td>Mended Little Hearts of Asheville</td>
<td>Monthly support groups</td>
<td><a href="http://www.namiwnc.org">www.namiwnc.org</a></td>
<td>Paulette Heck 828-505-7353</td>
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<td>NAMI</td>
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<tr>
<td>Arms Around ASD Parents of Children over 16 Support Group</td>
<td>1st Thursday 6:00-7:30pm</td>
<td>191 Charlotte Street</td>
<td>Miluska Kusz 228-369-2798 or Melissa Zenz 419-392-7370</td>
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<tr>
<td>Youth Outright (LGBT community)</td>
<td>Weekly support Groups</td>
<td><a href="http://www.youthoutright.org">www.youthoutright.org</a></td>
<td>866-881-3721</td>
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<td>Western Regional Support Group Options for Families (updated 3/2018)</td>
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<tr>
<td><strong>FSN/HOPE</strong> Vickie Dieter (828)256-5202  <a href="mailto:vickiefsnhope@gmail.com">vickiefsnhope@gmail.com</a></td>
<td>Serving Alexander, Burke, Caldwell, Catawba, Lenoir and McDowell Counties</td>
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<tr>
<td>Alexander Chapter Autism Society of NC</td>
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<td>Burke/Catawba Chapter Autism Society of NC</td>
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<tr>
<td>Caldwell Chapter Autism Society of NC</td>
<td>Third Thursday of the month, 6-7:30 p.m.</td>
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<tr>
<td>Whitnel Elementary School Media Center, 1425 Berkley St. SW, Lenoir</td>
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<td><strong>HENDERSON COUNTY</strong></td>
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<tr>
<td>Four Season's Hospice</td>
<td>Individual and group Bereavement sessions &quot;Heart Songs&quot; group for children</td>
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<td>Flat Rock</td>
<td>571 So. Allen Rd.</td>
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<tr>
<td>Henderson County Chapter Autism Society of NC</td>
<td>Last Tuesday of each month from 6pm- 7:30pm</td>
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<tr>
<td>Hendersonville Prebyterian Church</td>
<td>699 N. Grove St. Hendersonville, NC 28792</td>
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<tr>
<td>St. Gerard House</td>
<td>Monthly, 2nd Monday 5:30-7:30 p.m.</td>
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<tr>
<td>620 Oakland Street</td>
<td>Hendersonville</td>
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<tr>
<td><strong>FSN/HIGH COUNTRY</strong> Kaaren Hayes (828)262-6089  <a href="mailto:hayeskl@appstate.edu">hayeskl@appstate.edu</a></td>
<td>Serving Alleghany, Ashe, Avery, Mitchell, Watauga, Wilkes and Yancey</td>
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<tr>
<td>High Country Chapter Autism Society of NC</td>
<td>Second Monday of the month, 5:30-6:45 p.m.,</td>
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<td>Wilkes County Library, 215 Tenth St., North Wilkesboro</td>
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<tr>
<td>Not So Typical Circle Of Parents Wilkes Co.</td>
<td>Weekly 5:30-7:30</td>
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<td>Watauga Support Group</td>
<td>Monthly 2nd Friday 6-8</td>
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<td>Boone Unitarian Fellowship Church (No summer mtg's)</td>
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<tr>
<td>Mitchell/Yancey Family Events</td>
<td>Local Church's</td>
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<td><strong>MADISON COUNTY</strong></td>
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<tr>
<td>F.I.R.S.T: Grandparents raising their grandchildren with Disabilities</td>
<td>Wednesday 10:00am-12:00</td>
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<tr>
<td>Mars Hill University Nash Building-Room 108</td>
<td>F.I.R.S.T.  828-277-1315 (open 9-1)</td>
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<td>Madison County Parent Support Group</td>
<td>3rd Tuesday monthly 5:30pm-7:30pm</td>
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<tr>
<td>New Spring Church 7394 NC-213 Mars Hill</td>
<td>Sherry Holder 828-747-1529</td>
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<td><strong>RUTHERFORDTON &amp; POLK COUNTY</strong></td>
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<tr>
<td>Rutherford County Chapter Autism Society of NC</td>
<td>Last Monday of each Month 6:00 - 7:30 p.m.</td>
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<tr>
<td>Ellenbo Family Support Group 813 Piney Mountain Church Rd Ellenboro</td>
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</tbody>
</table>

**Contact Information**

- **Alexander Chapter Autism Society of NC**
  - Alexander Chapter Autism Society of NC
  - alexanderchapter@autismsociety-nc.org
  - www.facebook.com/groups/asnc.alexander

- **Burke/Catawba Chapter Autism Society of NC**
  - catawbavalleychapter@autismsociety-nc.org
  - www.facebook.com/groups/asnc.catawbavalley

- **Caldwell Chapter Autism Society of NC**
  - Third Thursday of the month, 6-7:30 p.m.
  - Caldwell Chapter Autism Society of NC
  - caldwellchapter@autismsociety-nc.org
  - www.facebook.com/groups/asnc.caldwell

- **Henderson County**
  - Four Season's Hospice
  - Henderson County Chapter Autism Society of NC
  - Hendersonville Prebyterian Church
  - hendersonchaper@autismsociety-nc.org
  - www.facebook.com/groups/asnc.henderson/

- **Henderson County Chapter Autism Society**
  - Last Tuesday of each month from 6pm- 7:30pm
  - Hendersonville Prebyterian Church
  - hendersonchaper@autismsociety-nc.org
  - www.facebook.com/groups/asnc.henderson/

- **St. Gerard House**
  - Monthly, 2nd Monday 5:30-7:30 p.m.
  - St. Gerard House
  - caldwellchapter@autismsociety-nc.org
  - www.facebook.com/groups/asnc.caldwell

- **High Country Chapter Autism Society of NC**
  - Second Monday of the month, 5:30-6:45 p.m.,
  - Wilkes County Library, 215 Tenth St., North Wilkesboro
  - highcountrychapter@autismsociety-nc.org
  - www.facebook.com/groups/asnc.highcountry

- **Not So Typical Circle Of Parents Wilkes Co.**
  - Second Monday of the month, 5:30-6:45 p.m.,
  - Wilkes County Library, 215 Tenth St., North Wilkesboro
  - highcountrychapter@autismsociety-nc.org
  - www.facebook.com/groups/asnc.highcountry

- **Watauga Support Group**
  - Monthly 2nd Friday 6-8
  - Boone Unitarian Fellowship Church (No summer mtg's)
  - Kaaren Hayes: 828-262-6089  Must RSVP
  - hayeskl@appstate.edu
  - dinner and childcare provided

- **Mitchell/Yancey Family Events**
  - Monthly 2nd Friday 6-8
  - Boone Unitarian Fellowship Church (No summer mtg's)
  - Kaaren Hayes: 828-262-6089  Must RSVP
  - hayeskl@appstate.edu
  - dinner and childcare provided

- **Madison County Parent Support Group**
  - 3rd Tuesday monthly 5:30pm-7:30pm
  - New Spring Church 7394 NC-213 Mars Hill
  - Madison County Parent Support Group
  - Sherry Holder 828-747-1529
  - www.facebook.com/groups/asnc.rutherford/
  - rutherfordchapter@autismsociety-nc.org
Western Regional Support Group Options for Families (updated 3/2018)

<table>
<thead>
<tr>
<th>FSN of REGION A</th>
<th>Jody Miller (828)506-6111</th>
<th><a href="mailto:jody@regionakids.org">jody@regionakids.org</a></th>
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<tbody>
<tr>
<td>Serving Jackson, Cherokee, Swain, Haywood, Clay, Graham and Macon Counties</td>
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<tr>
<th>Macon County Chapter Autism Society of NC</th>
<th>1st Sunday of each month 5:00pm - 6:30pm</th>
<th>Bethel UM Church, 81 Bethel Church Rd, Franklin, NC 28734</th>
<th><a href="mailto:maconchapter@autismsociety-nc.org">maconchapter@autismsociety-nc.org</a></th>
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<td><a href="mailto:mzen@autismsociety-nc.org">mzen@autismsociety-nc.org</a></td>
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<tr>
<td>Cherokee County Caregivers</td>
<td>1st Thursday of each month 6:00pm</td>
<td>Region A Partnership 141 Peachtree St. # 5, Murphy</td>
<td>828-631-3900 ext.126</td>
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<td><a href="mailto:jody@regionakids.org">jody@regionakids.org</a></td>
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<tr>
<td>Haywood County Caregivers</td>
<td>2nd Saturday of each month 10am</td>
<td>Longs Chapel 133 Old Clyde Rd. Waynesville</td>
<td>828-631-3900</td>
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<td><a href="mailto:jody@regionakids.org">jody@regionakids.org</a></td>
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<td>Jackson County Caregivers</td>
<td>2nd Wednesday of each month 6pm</td>
<td>Children’s Developmental Services Agency 87 Bonnie Ln, Sylva, NC 28779</td>
<td>828-631-3900</td>
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<td><a href="mailto:jody@regionakids.org">jody@regionakids.org</a></td>
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<tr>
<td>Macon County Caregivers</td>
<td>Monthly 3rd Thursday 6pm</td>
<td>Macon Public Library 149 Siler Farm Road Franklin</td>
<td>828-631-3900</td>
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<td><a href="mailto:jody@regionakids.org">jody@regionakids.org</a></td>
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<td>Swain County Caregivers</td>
<td>Meets Sept-June w/Autism Society Monthly 2nd Tuesday 6:00pm</td>
<td>Swain East Elem. School 4747 Ela Road Bryson City</td>
<td>828-631-3900</td>
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<td><a href="mailto:jody@regionakids.org">jody@regionakids.org</a></td>
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<tr>
<td>Jackson/Swain/Qualla Boundary Chapter Autism Society of NC</td>
<td>2nd Thursday of the month 6-8 p.m.</td>
<td>Sweet Thoughts Respite Care 67 Bryson Ave Bryson City</td>
<td><a href="mailto:jacksonswainswainqbchapter@autismsociety-nc.org">jacksonswainswainqbchapter@autismsociety-nc.org</a></td>
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<tr>
<td>Cherokee County Chapter Autism Society of NC (Murphy)</td>
<td>2nd Tuesday of each month from 6pm-7:30pm</td>
<td>Kids in Stride, 2810 US Hwy 64, Ste 2, Murphy</td>
<td><a href="https://www.facebook.com/groups/asnc.cherokee/">https://www.facebook.com/groups/asnc.cherokee/</a></td>
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<td><a href="mailto:cherokeechapter@autismsociety-nc.org">cherokeechapter@autismsociety-nc.org</a></td>
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<tr>
<td>Macon County Chapter Autism Society of NC (Franklin)</td>
<td>1st Sunday of each month 5pm-7pm</td>
<td>Bethel United Methodist Church 81 Bethel Church Rd. Franklin</td>
<td><a href="https://www.facebook.com/groups/asnc.macon/">https://www.facebook.com/groups/asnc.macon/</a></td>
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<td><a href="mailto:maconchapter@autismsociety-nc.org">maconchapter@autismsociety-nc.org</a></td>
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**TRANSYLVANIA COUNTY**

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<tr>
<th>Compassionate Friends of Brevard. For parents grieving the loss of a child</th>
<th>Monthly 2nd Monday</th>
<th>Lutheran Church of the Good Sheppard, 22 Fisher Rd. Brvd</th>
<th>Bill: 828-890-8227</th>
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<tbody>
<tr>
<td>The Family Place of Transylvania</td>
<td>Various Support Groups</td>
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<td><a href="http://www.tcfofbrevardnc.org/tcf/home.htm">www.tcfofbrevardnc.org/tcf/home.htm</a></td>
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<tr>
<td>Hearing Loss Assoc. of America</td>
<td>Monthly 2nd Saturday 1:00 p.m.</td>
<td>Transylvania Hospital</td>
<td><a href="mailto:kborzell@gmail.com">kborzell@gmail.com</a></td>
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<td></td>
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<td><a href="http://www.nchearingloss.org/brevard.htm">www.nchearingloss.org/brevard.htm</a></td>
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**OTHER SUPPORTS**

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<tr>
<th>WNC Special Needs Homeschoolers</th>
<th>On-line support with social gatherings</th>
<th>Regional Participants</th>
<th>Lisa Pickering.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Finley Project: For loss of a birthed infant age 22 weeks through 2 years.</td>
<td>1:1 family matching and healing through a 7 part holistic approach</td>
<td>Noelle Moore, Exec. Director 407-463-7576</td>
<td><a href="mailto:noelle.moore@thefinleyproject.org">noelle.moore@thefinleyproject.org</a></td>
</tr>
</tbody>
</table>
STEPPING STONES TRIPLE P –
FOR PARENTS OF A CHILD WITH A DISABILITY

IS THIS YOU?
You have a child with an intellectual or physical disability, and life is incredibly tough. Your child may seem unwilling or unable to follow instructions or master new skills. Perhaps they have terrible tantrums or emotional meltdowns. Maybe they can’t make friends or play with their siblings.

As for you, stress is a constant. Holding down a job may be too difficult. You may feel isolated from your friends, your community – perhaps even from your partner or your other children. You possibly feel guilty and don’t know how to tackle your child’s problem behavior. If the pressure of raising a child with a special need is straining your family life, Stepping Stones Triple P may help.

WHAT IS STEPPING STONES TRIPLE P?
Stepping Stones is based on Triple P’s positive parenting strategies. It helps you manage problem behavior and developmental issues common in children with disability. It also helps encourage behavior you like, cope with stress, develop a close relationship with your child and teach your child new skills. You choose the type of Stepping Stones program based on your own needs. They range in intensity from light-touch seminars to ongoing courses.

STEPPING STONES TRIPLE P SEMINAR SERIES
Seminars tackle the most common issues for parents of children with a disability and bring together large groups of parents – often 20 or more. Each seminar takes just 90 minutes and you can do one, two or all three in the series. The topics in the series are: Positive Parenting for Children with a Disability; Helping your Child Reach their Potential; and Changing Problem Behavior into Positive Behavior.

LEVEL 3 INDIVIDUAL STEPPING STONES TRIPLE P
This is a brief, personal and tailored way to get your Stepping Stones support. You’ll meet with a provider for about four sessions of between 15 and 30 minutes each time, tackling one or two specific behaviors or issues that are particularly worrying you. You could target anything from your child’s fears and anxiety to mealtime dramas.

GROUP STEPPING STONES TRIPLE P
You’re either having significant problems with your child’s behavior or you simply want to know how to encourage your child’s development and potential. About a dozen parents come together for six sessions, which last 2½ hours each. Your Stepping Stones provider will also call you at home at pre-arranged times to offer support, feedback and ideas.

LEVEL 4 INDIVIDUAL STEPPING STONES TRIPLE P
This is more in-depth and is recommended for families with significant problems. There are eight to 10 private consultations with a provider who’ll help you develop a wide range of positive parenting skills. Each session lasts about an hour.

FOR MORE INFORMATION CONTACT
Kerri Eaker at 828-213-0047 or Kerri.Eaker@msj.org
Mental Health Resources
North Carolina

NAMI North Carolina Young Families
www.naminc.org

Mission Children’s Family Support Network
www.missionchildrens.org/family-support-networ.php

NC Division of Mental Health, Developmental Disabilities and Substance Use Services
www.dhh.state.nc.us/mhddsas

NC Disability Rights
www.disabilityrightsncc.org

Mental Health Association in North Carolina
www.mha-nc.org

NC Families United
www.ncfamiliesunited.org

National

American Academy of Child and Adolescent Psychiatry
www.aacap.org

Bring Change to Mind: A group that aims to combat the stigma of mental illness and provide easy access to support and resources.
www.bringchange2mind.org

Depression and Bipolar Support Alliance: A patient directed organization focusing on depression and bipolar disorder.
www.dbsalliance.org

Mental Health America: A non-profit dedicated to helping all people live with mental health, to live happier lives.
www.nmha.org

November 2016
**NARSAD:** The Brain and Behavior Research Fund: A charity dedicated to funding research on mental illness; including schizophrenia, depression, bipolar disorder, autism and anxiety.

www.narsad.org

**National Alliance for Mental Illness:** A non-partisan organization dedicated to improving the lives of individuals and families affected by mental illness.

www.nami.org

**National Institute of Mental Health**

www.nimh.nih.gov

**System of Care**

www.systemofcare.net

**Technical Assistance Partnership for Child and Family Mental Health**

www.tapartnership.org

**Other**

**Council of Parent Attorneys and Advocates:** A non-profit of attorneys, special education advocates and parents aiming to secure high quality educational services for children with disabilities.

www.copaa.net

**Center for Parent Information and Resources:** Provides information about programs and services around the country for children with disabilities.

www.parentcenterhub.org

**The Pearson-Centered Planning Education site:**

www.ilr.cornell.edu/edj/pcp/

For more information, contact Mission Children's Family Support Network

828-213-0033

www.missionchildrens.org/family-support-network.php
Young Adult Substance Use Group

An outpatient addiction recovery group, specific to teenagers, focused on providing education, coping skills, life skills, and support for substance use, recovery, and relapse prevention.

Who
Teens struggling with substance use

When
Tuesdays and Thursdays:
4:30pm to 6:00pm

Where
Family Preservation Services:
1314 D Patton Ave. Asheville, N.C.

How to be a part of the group or refer a participant:

Complete one of the following:

Call Buncombe Referrals: (828) 225-3100

Email: buncombereferalkl@pathways.com

Fax to 828-225-3604 attn: Buncombe Referrals
Introduction

If you have a brother or sister with a mental illness, this fact sheet is for you. One in four people will experience a mental illness at some point in their life (Beyond Blue 2010). These illnesses vary from the more common depression and anxiety, through to psychotic illnesses such as Schizophrenia.

The experience of having a brother or sister with a mental illness is different for everyone. It is a complex journey and you may experience a mix of reactions and feelings. You may be confused by what is happening in your family and feel unsure about what role you should play. While much attention needs to be focused on your brother or sister, you may face difficulties yourself. With so much going on you may not realise that you are experiencing stress and that this may affect your health. Stress can show up in a number of ways, including: sleeping troubles, change in appetite, headaches, difficulty concentrating, or withdrawing from family and friends.

This fact sheet outlines the common concerns of siblings and what you can do to ensure you gain the support you need. While siblings do speak about the challenges they face, many acknowledge the personal growth that is possible. Some siblings believe that the experience has made them more empathic and tolerant of others and has led to important changes in their own lives.

What Siblings Say

No one understands what I'm going through

I'm worried about my sister

My brother is so selfish
I feel like I have to walk on eggshells around him

My parents are so focused on my sister's mental health that they do not have any time or energy for me

I don't understand what my brother's diagnosis means

I'm embarrassed by her sometimes

Our family is secretive about my brother's mental health

Common Concerns

Your family relationships

The pressure put on families who are supporting someone with a mental illness can be immense. It can be difficult to talk to each other openly when there is so much stress and emotion. Families often have difficult decisions to make on behalf of the person with a mental illness. This can cause strain and conflict if individual family members have different opinions about what is in the best interests of the person with the mental illness.

Your feelings

Having a brother or sister with a mental illness can be an emotional experience. Siblings sometimes report feeling relieved when their brother or sister receives a diagnosis. Having a diagnosis can help to explain behaviour that had previously been considered to be deliberate or defiant. For others, however, gaining a diagnosis may be a very scary time. Feelings of grief and loss are common for siblings of people with a mental illness. There is the grief for the person with the illness, for your parents, for yourself as well as the change in relationship with your sibling.

Feelings of losing the sibling to the illness, or wishing for a 'normal' sibling are not uncommon. You may feel some resentment and then feel guilty about those feelings. You may love and care about your brother or sister but still feel angry about the situation. It's important to acknowledge your emotions and to give yourself permission to feel the way that you do. There is no 'right' way to respond.

Your social life

You may find that your social life is impacted. Your responsibilities to your brother or sister and family may take up a lot of your time. You may not spend as much time with friends due to stress, or you may feel obligated to socialise with your sibling if they are isolated. It can also be hard to talk to friends about your experience. You may feel that friends cannot understand your brother or sister's mental illness, or their behaviour and, as a result, you may feel uncomfortable having friends over to your house.

Signs of stress

With so much going on, you may not notice that you are becoming stressed. Ongoing stress may affect your health. It can show up in a number of ways, including:

• Sleeping troubles
• Change in appetite
• Headaches
• Difficulty concentrating
• Withdrawal from friends and family.

It is important to be able to identify signs of stress and to manage your stress.
Strategies

Even though your brother or sister may need lots of support, your needs are important too. Here are some ideas to help you look after yourself.

Self care
- Eating well
- Exercise
- Relaxation

This might seem obvious, but eating well and getting regular exercise are really important. A balanced diet ensures that you are getting the nourishment you need and can improve your overall wellbeing. Regular exercise helps to reduce stress by releasing tension stored in your muscles.

Taking time out to relax is really important too. People choose to do this in different ways. Maintaining hobbies, taking time out to socialise with friends and making time for yourself, all help to keep things in perspective. Yoga, meditation, or listening to music may be helpful.

Information
Try to learn as much as you can about your brother or sister’s diagnosis, and the treatment process. The mental health team who are involved with your brother or sister may include you in discussions about what treatment is planned and what role you can play in that process. There may be some things that they cannot discuss with you due to confidentiality.

Talking with your family
Try to talk with your family about what is happening. Although it can be difficult to talk about emotional issues, many families become closer through sharing their thoughts and feelings. Try to understand other family members’ perspectives; you will all be affected in different ways, and experience a range of feelings. Sometimes the mental health team will be able to help you work through these together.

Your role
It can be difficult working out how involved you would like to be in supporting your brother or sister. You may want to have a significant caring role, but it is important to set clear boundaries about what is ok for you. Try to recognise the difference between things that are within your control (e.g., going along to appointments with your brother or sister) and things that are not (your brother or sister’s symptoms). Sometimes, being just a brother or sister, and focussing on sharing some fun activities, can be of more benefit than taking on a ‘carer’ role.

Seeking help
You may be very concerned about your brother or sister, but it is ok for you to ask for help for yourself too. Seeking help and support from others is an important part of looking after yourself. This can mean spending time with close friends and family, or seeking professional help. It can be useful to talk to a professional about how you are feeling. If you wish to talk to a mental health professional about your own concerns you can seek a referral from your GP. If you are a student, your school or university counsellor may be able to help. Sometimes it can help to have contact with other siblings or to read books by, or for, siblings. The Siblings Australia website has a number of resources.

Responding in a crisis
It can really help if your family has a plan in place for a crisis. If your brother or sister is involved with a mental health team, or a mental health clinician, they will be able to provide you with a safety plan. It is important to familiarise yourself with the Mental Health Triage number (in SA it is 131465), or to call 000 if the situation is life-threatening.

For further information please contact Centacare’s Navigate program on 8159 1400 or Siblings Australia

Helpful Contacts

| Kids Helpline | 1800 551 800 |
| Lifeline | 13 11 14 |
| Beyond Blue | www.beyondblue.org.au |
| Black Dog | www.blackdoginstitute.org.au |
| Mental Illness Fellowship of Australia (MIFA) | www.mifa.org.au |
| Reachout! | http://au.reachout.com |
| Early Psychosis Prevention and Intervention Centre (EPPIC) | www.eppic.org.au |
| It’s all right (SANE) | itsallright.org |

Statement regarding the traditional owners of the land.

For thousands of years Aboriginal people have walked on this land, in their country. Their relationship with the land is at the centre of their lives. We acknowledge the Aboriginal people and their stewardship and spiritual connection with their lands.
Why am I struggling with my loved one's mental illness?

If you find it difficult to come to terms with the challenges presented by your sibling’s or parent’s mental illness, you are not alone. Most people find that mental illness in a brother, sister or parent is a tragic event that changes everyone’s life in many fundamental ways. Strange, unpredictable behaviors in a loved one can be devastating, and your own personal anxiety may increase as you struggle with each illness episode and worry about the future. It seems impossible at first, but most siblings and adult children find that over time they do gain the knowledge and skills to cope with the challenges effectively.

What can I do to better understand and cope with the situation?

The best starting place for learning to cope is to educate yourself; find out as much information as possible about mental illness by reading and by talking with others experiencing similar difficulties. NAMI has a variety of resources available for you: books, pamphlets, fact sheets and tapes available about different illnesses, treatments and issues you may have to deal with. The NAMI Family-to-Family Education Program is a 12-session course that teaches families about the illnesses, skills needed to navigate challenges and how to find support for the future. NAMI also provides support groups for family members of individuals living with mental illness. For information on support groups and classes contact your NAMI State Organization or NAMI Affiliate or call the NAMI HelpLine at (800) 950-6264.

Do you have any coping tips?

The following are some things to consider as you learn to live with mental illness:

1. Basic Principles
   - You cannot cure a mental disorder for someone you love.
   - No one is to blame for the one you love developing the disorder.
   - Mental disorders affect more than the person who is ill; they affect everyone.
   - Despite your best efforts, your loved one's symptoms will change for the better or sometimes for the worse; it is out of your control.
   - It is important to learn to separate the disorder from the person you love.
   - If you feel anger and resentment, direct that negative energy toward the illness, not the person that you love.
   - Remember that it is quite often difficult for the person you love to accept their disorder. This is a process you too may contend with. Acceptance of the disorder by all concerned may be helpful, but it is not necessary.

2. Strategies and Realities
Coping Tips for Siblings and Adult Children

- Hallucinations and delusions have little or nothing to do with reality. It is not helpful to discuss them with your family member or attempt “talk them out of” such a belief.
- It is not realistic to think that it is possible to “fix” a biological disorder such as diabetes or depression with talk. However, addressing social complications is helpful.
- People you encounter will have a varying ability to discuss this with you. Unlike medical conditions which typically bring out sympathy, the community will likely be mixed in how they provide support for you and your loved one.
- Acknowledge the remarkable courage and strengths your loved one may show when dealing with a mental disorder.
- Grief issues for siblings are often common and powerful. Dealing with family responsibilities is another challenge to get support and advice on.
- After denial, sadness and anger over learning about your loved one’s mental disorder comes acceptance. Acceptance and understanding of the disorder itself yields compassion for the person you love.
- The symptoms presented by the disorder may change over time and circumstance. This can make expectations of your loved one a challenge – stay flexible.
- With your loved one’s permission, you may request information from their mental health treatment team to deepen your understanding of their condition.
- If your loved one isn’t getting what they need, assess your ability to engage their mental health provider to see how a case manager or other professional can help.
- It’s not personal, unusual or uncharacteristic behavior is a symptom of the disorder.
- Don’t be afraid to ask your sibling or parent if he or she is thinking about hurting him or herself. The possibility of suicide is a real concern, and asking about it will not give them the idea. See if they have a safety plan to address these concerns.

3. Self-Care and Balancing Your Needs with Those of Your Loved One

- Prioritize your own self-care. Good nutrition, rest, support groups, relationships, spiritual or religious support, exercise and hobbies are avenues to support self-care.
- You are not a paid professional. You are a sibling or child, not a parent or caseworker.
- The needs of the ill person do not have to come first; it’s not always possible.
- It is important to establish boundaries and to set clear limits for you.
- It is natural for you to experience a variety of emotions. You, not the person with the disorder, are responsible for your own feelings. Getting psychotherapy support can often be quite helpful for these experiences.
- You are not alone. Sharing your thoughts and feelings in a support group has been helpful and enlightening for many. NAMI has thousands of support groups across the nation. The shared experience found in support groups reduces isolation and stress.

Reviewed by Ken Duckworth, M.D., Darcy Gruttadaro and Teri Brister, May 2013
Gay, Lesbian and Bisexual Adolescents

Growing up is a demanding and challenging task for every adolescent. One important aspect is forming one's sexual identity. All children explore and experiment sexually as part of normal development. This sexual behavior may be with members of the same or opposite sex. For many adolescents, thinking about and/or experimenting with people of the same sex may cause concerns and anxiety regarding their sexual orientation. For others, even thoughts or fantasies may cause anxiety. These feelings and behavior do not necessarily mean an individual is homosexual or bisexual.

Homosexuality is the persistent sexual and emotional attraction to someone of the same sex. It is part of the range of sexual expression. Homosexuality has existed throughout history and across cultures. Many gay, lesbian and bisexual individuals first become aware of and experience their sexual thoughts and feelings during childhood and adolescence. Recent changes in society's attitude toward sexuality have helped gay, lesbian, and bisexual teens feel more comfortable with their sexual orientation. In other aspects of their development, they are similar to heterosexual youngsters. They experience the same kinds of stress, struggles, and tasks during adolescence.

Parents need to clearly understand that sexual orientation is not a mental disorder. The cause(s) of homosexuality or bisexuality are not fully understood. However, a person's sexual orientation is not a matter of choice. In other words, individuals have no more choice about being homosexual or bisexual than heterosexual. All teenagers do have a choice about their expression of sexual behaviors and lifestyle, regardless of their sexual orientation.

Despite increased knowledge and information, gay, lesbian and bisexual teens still have many concerns. These include:

- feeling different from peers
- feeling guilty about their sexual orientation
- worrying about the response from their families and loved ones
- being teased and ridiculed by their peers
- worrying about AIDS, HIV infection, and other sexually transmitted diseases
- fearing discrimination when joining clubs, sports, seeking admission to college, and finding employment
- being rejected and harassed by others

Gay, lesbian, and bisexual teens can become socially isolated, withdraw from activities and friends, have trouble concentrating, and develop low self-esteem. Some may develop depression and think about suicide or attempt it. Parents and others need to be alert to these signs of distress because recent studies show that gay, lesbian and bisexual youth account for a significant number of deaths by suicide during adolescence.

It is important for parents to understand their teen's sexual orientation and to provide emotional support. Parents may have difficulty accepting their teen's sexuality for some
of the same reasons that the youngster wants to keep it secret. Gay, lesbian or bisexual adolescents should be allowed to decide when and to whom to disclose their homosexuality. Telling a person's sexuality before they are ready is called " outing" and can be traumatic. Parents and other family members may gain understanding and support from organizations such as Parents, Families and Friends of Lesbians and Gays (PFLAG).

Counseling may be helpful for teens who are uncomfortable with their sexual orientation or uncertain about how to express it. They may benefit from support and the opportunity to clarify their feelings. Therapy may also help the teen adjust to personal, family, and school-related issues or conflicts that emerge. Therapy directed specifically at changing sexual orientation is not recommended and may be harmful for an unwilling teen. It may create more confusion and anxiety by reinforcing the negative thoughts and emotions with which the youngster is already struggling.

For additional information about Parents, Families and Friends of Lesbians and Gays (PFLAG) visit PFLAG's website www.pflag.org or contact: PFLAG, 1726 M Street, NW Suite 400 Washington, DC 20036: (202) 467.8180; (202) 467.8194 FAX

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BIPOLAR DISORDER IN CHILDREN AND TEENS

Children and teenagers with Bipolar Disorder have manic and/or depressive symptoms. Some may have mostly depression and others a combination of manic and depressive symptoms. Highs may alternate with lows.

**Manic symptoms include:**

- severe changes in mood—either unusually happy or silly, or very irritable, angry, agitated or aggressive
- unrealistic highs in self-esteem - for example, a teenager who feels all powerful or like a superhero with special powers
- great increase in energy and the ability to go with little or no sleep for days without feeling tired
- increase in talking - the adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted
- distractibility - the teen'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

**Depressive symptoms include:**

- irritability, depressed mood, persistent sadness, frequent crying
- thoughts of death or suicide
- lack of enjoyment in favorite activities
- frequent complaints of physical illnesses such as headaches or stomach aches
- low energy level, fatigue, poor concentration, complaints of boredom
- major change in eating or sleeping patterns, such as oversleeping or overeating

Some of these signs are similar to those that occur in teenagers with other problems such as drug abuse, delinquency, attention-deficit hyperactivity disorder, or even schizophrenia.

Research has improved the ability to diagnose Bipolar Disorder in children and teens. Bipolar Disorder can begin in childhood and during the teenage years, although it is usually diagnosed in adult life. The illness can affect anyone. However, if one or both parents have Bipolar Disorder, the chances are greater that their children may develop the disorder. Family history of drug or alcohol abuse also may be associated with greater risk for Bipolar Disorder.
Teenagers with Bipolar Disorder can be effectively treated. Treatment for Bipolar Disorder usually includes education of the patient and the family about the illness, mood stabilizing medications such as lithium, valproic acid, or “atypical antipsychotic,” and psychotherapy. Mood stabilizing medications often reduce the number and severity of manic episodes, and also help to prevent depression. Psychotherapy helps the child understand himself or herself, adapt to stresses, rebuild self-esteem and improve relationships.

The diagnosis of Bipolar Disorder in children and teens is complex and involves careful observation over an extended period of time. A thorough evaluation by a child and adolescent psychiatrist identify Bipolar Disorder and start treatment.

For additional information see Facts for Families:
#3 Teens: Alcohol and Other Drugs,
#4 The Depressed Child,
#6 Children Who Can’t Pay Attention (ADHD),
#33 Conduct Disorder,
#52 Comprehensive Psychiatric Evaluation,
#55 Understanding Violent Behavior in Children,
#72 Oppositional Defiant Disorder, and
#00 Definition of a Child and Adolescent Psychiatrist.


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CHILDREN WITH OPPOSITIONAL DEFIANT DISORDER

All children are oppositional from time to time, particularly when tired, hungry, stressed or upset. They may argue, talk back, disobey, and defy parents, teachers, and other adults. Oppositional behavior is often a normal part of development for two to three year olds and early adolescents. However, openly uncooperative and hostile behavior becomes a serious concern when it is so frequent and consistent that it stands out when compared with other children of the same age and developmental level and when it affects the child's social, family and academic life.

In children with Oppositional Defiant Disorder (ODD), there is an ongoing pattern of uncooperative, defiant, and hostile behavior toward authority figures that seriously interferes with the youngster's day to day functioning. Symptoms of ODD may include:

- Frequent temper tantrums
- Excessive arguing with adults
- Often questioning rules
- 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 touchy or easily annoyed by others
- Frequent anger and resentment
- Mean and hateful talking when upset
- Spiteful attitude and revenge seeking

The symptoms are usually seen in multiple settings, but may be more noticeable at home or at school. One to sixteen percent of all school-age children and adolescents have ODD. The causes of ODD are unknown, but many parents report that their child with ODD was more rigid and demanding that the child's siblings from an early age. Biological, psychological and social factors may have a role.

A child presenting with ODD symptoms should have a comprehensive evaluation. It is important to look for other disorders which may be present; such as, attention-deficit hyperactivity disorder (ADHD), learning disabilities, mood disorders (depression, bipolar disorder) and anxiety disorders. It may be difficult to improve the symptoms of ODD without treating the coexisting disorder. Some children with ODD may go on to develop conduct disorder.

Treatment of ODD may include: Parent Management Training Programs to help parents and others manage the child's behavior. Individual Psychotherapy to develop more effective anger management. Family Psychotherapy to improve communication and mutual understanding. Cognitive Problem-Solving Skills Training and Therapies to assist with problem solving and decrease negativity. Social Skills Training to increase flexibility and improve social skills and frustration tolerance with peers.

Medication may be helpful in controlling some of the more distressing symptoms of ODD as well as the symptoms related to coexistent conditions such as ADHD, anxiety and mood disorders.
A child with ODD can be very difficult for parents. These parents need support and understanding. Parents can help their child with ODD in the following ways:

- Always build on the positives, give the child praise and positive reinforcement when he shows flexibility or cooperation.
- Take a time-out or break if you are about to make the conflict with your child worse, not better. This is good modeling for your child. Support your child if he decides to take a time-out to prevent overreacting.
- Pick your battles. Since the child with ODD has trouble avoiding power struggles, prioritize the things you want your child to do. If you give your child a time-out in his room for misbehavior, don’t add time for arguing. Say “your time will start when you go to your room.”
- Set up reasonable, age appropriate limits with consequences that can be enforced consistently.
- Maintain interests other than your child with ODD, so that managing your child doesn’t take all your time and energy. Try to work with and obtain support from the other adults (teachers, coaches, and spouse) dealing with your child.
- Manage your own stress with healthy life choices such as exercise and relaxation. Use respite care and other breaks as needed.

Many children with ODD will respond to the positive parenting techniques. Parents may ask their pediatrician or family physician to refer them to a child and adolescent psychiatrist or qualified mental health professional who can diagnose and treat ODD and any coexisting psychiatric condition.

See also: cAACAP Oppositional Defiant Disorder Resource Center. This resource center offers a definition of the disorder, answers to frequently asked questions, and information on getting help.

For additional information see other Facts for Families: #6 Children Who Can’t Pay Attention/ADHD, #16 Learning Disabilities, #4 The Depressed Child, #38 Manic-Depressive Illness in Teens, #52 Comprehensive Psychiatric Evaluation, #33 Conduct Disorder, #65 Children’s Threats, #66 Helping Teenagers with Stress, and #00 Definition of a Child and Adolescent Psychiatrist. See also: Your Child (1998 Harper Collins)/Your Adolescent (1999 Harper Collins).

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CONDUCT DISORDER

“Conduct disorder” refers to a group of behavioral and emotional problems in youngsters. Children and adolescents with this disorder have great difficulty following rules and behaving in a socially acceptable way. They are often viewed by other children, adults and social agencies as “bad” or delinquent, rather than mentally ill. Many factors may contribute to a child developing conduct disorder, including brain damage, child abuse, genetic vulnerability, school failure, and traumatic life experiences.

Children or adolescents with conduct disorder may exhibit some of the following behaviors:

Aggression to people and animals

- bullies, threatens or intimidates others
- often initiates physical fights
- has used a weapon that could cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife or gun)
- is physically cruel to people or animals
- steals from a victim while confronting them (e.g. assault)
- forces someone into sexual activity

Destruction of Property

- deliberately engaged in fire setting with the intention to cause damage
- deliberately destroys other’s property

Deceitfulness, lying, or stealing

- has broken into someone else’s building, house, or car
- lies to obtain goods, or favors or to avoid obligations
- steals items without confronting a victim (e.g. shoplifting, but without breaking and entering)

Serious violations of rules

- often stays out at night despite parental objections
- runs away from home
- often truant from school

Children who exhibit these behaviors should receive a comprehensive evaluation. Many children with a conduct disorder may have coexisting conditions such as mood disorders, anxiety, PTSD, substance abuse, ADHD, learning problems, or thought disorders which can also be treated. Research shows that youngsters with conduct disorder are likely to have ongoing problems if they and their families do not receive early and comprehensive treatment. Without treatment, many youngsters with conduct disorder are unable to adapt to the demands of adulthood and continue to
have problems with relationships and holding a job. They often break laws or behave in an antisocial manner.

Treatment of children with conduct disorder can be complex and challenging. Treatment can be provided in a variety of different settings depending on the severity of the behaviors. Adding to the challenge of treatment are the child's uncooperative attitude, fear and distrust of adults. In developing a comprehensive treatment plan, a child and adolescent psychiatrist may use information from the child, family, teachers, and other medical specialties to understand the causes of the disorder.

Behavior therapy and psychotherapy are usually necessary to help the child appropriately express and control anger. Special education may be needed for youngsters with learning disabilities. Parents often need expert assistance in devising and carrying out special management and educational programs in the home and at school. Treatment may also include medication in some youngsters, such as those with difficulty paying attention, impulse problems, or those with depression.

Treatment is rarely brief since establishing new attitudes and behavior patterns takes time. However, early treatment offers a child a better chance for considerable improvement and hope for a more successful future.

For additional information see Facts for Families:
#3 Teens: Alcohol and Other Drugs
#55 Understanding Violent Behavior in Children and Adolescents
#72 Children with Oppositional Defiant Disorder
#6 Children Who Can't Pay Attention
#12 Children Who Steal
#38 Bipolar Disorder in Children and Teens
#80 Bullying
#81 Fighting and Biting

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NOT only adults become depressed. Children and teenagers also may have depression as well. The good news is that depression is a treatable illness.

Depression is defined as an illness when the feelings of depression persist and interfere with a child or adolescent’s ability to function.

About five percent of children and adolescents in the general population suffer from depression at any given point in time. Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. Depression also tends to run in families.

The behavior of depressed children and teenagers may differ from the behavior of depressed adults. Child and adolescent psychiatrists advise parents to be aware of signs of depression in their youngsters.

If one or more of these signs of depression persist, parents should seek help:

- Frequent sadness, tearfulness, crying
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Hopelessness
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self esteem and guilt
- 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
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self destructive behavior

A child who used to play often with friends may now spend most of the time alone and without interests. Things that were once fun now bring little joy to the depressed child. Children and adolescents who are depressed may say they want to be dead or may talk about suicide. Depressed children and adolescents are at increased risk for committing suicide. Depressed adolescents may abuse alcohol or other drugs as a way of trying to feel better.
Children and adolescents who cause trouble at home or at school may also be suffering from depression. Because the youngster may not always seem sad, parents and teachers may not realize that troublesome behavior is a sign of depression. When asked directly, these children can sometimes state they are unhappy or sad.

Early diagnosis and treatment are essential for depressed children. Depression is a real illness that requires professional help. Comprehensive treatment often includes both individual and family therapy. For example, cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT) are forms of individual therapy shown to be effective in treating depression. Treatment may also include the use of antidepressant medication. For help, parents should ask their physician to refer them to a qualified mental health professional, who can diagnose and treat depression in children and teenagers.

Also see the following Facts for Families:
#8 Children and Grief
#10 Teen Suicide
#21 Psychiatric Medication for Children
#38 Bipolar Disorder in Teens, and
#86 Psychotherapies for Children and Adolescents.


For more information about medications used to treat childhood and adolescent depression, see: www.parentsmedguide.org.

AACAP wishes to thank the Klingenstein Third Generation Foundation for support.

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Attention-Deficit Hyperactivity Disorder (ADHD)

Supported by a grant from The Klingenstein Third Generation Foundation.

Parents are distressed when they receive a note from school saying that their child won't listen to the teacher or causes trouble in class. One possible reason for this kind of behavior is Attention Deficit/Hyperactivity Disorder (ADHD).

Even though the child with ADHD often wants to be a good student, the impulsive behavior and difficulty paying attention in class frequently interferes and causes problems. Teachers, parents, and friends know that the child is misbehaving or different but they may not be able to tell exactly what is wrong.

Any child may show inattention, distractibility, impulsivity, or hyperactivity at times, but the child with ADHD shows these symptoms and behaviors more frequently and severely than other children of the same age or developmental level. ADHD occurs in 3-5% of school age children. ADHD typically begin in childhood but can continue into adulthood. ADHD runs in families with about 25% of biological parents also having this medical condition.

(use your browser's back button to return to this page)

A child with ADHD often shows some of the following:

- trouble paying attention
- inattention to details and makes careless mistakes
- easily distracted
- loses school supplies, forgets to turn in homework
- trouble finishing class work and homework
- trouble listening
- trouble following multiple adult commands
- blurts out answers
- impatience
- fidgets or squirms
- leaves seat and runs about or climbs excessively
- seems "on the go"
• talks too much and has difficulty playing quietly
• interrupts or intrudes on others

There are three types of ADHD. Some people have only difficulty with attention and organization. This is also sometimes called Attention Deficit Disorder or ADD. This is ADHD inattentive subtype. Other people have only the hyperactive and impulsive symptoms. This is ADHD-hyperactive subtype. The Third, and most commonly identified group consists of those people who have difficulties with attention and hyperactivity, or the combined type.

A child presenting with ADHD symptoms should have a comprehensive evaluation. Parents should ask their pediatrician or family physician to refer them to a child and adolescent psychiatrist, who can diagnose and treat this medical condition. A child with ADHD may also have other psychiatric disorders such as conduct disorder, anxiety disorder, depressive disorder, or bipolar disorder. These children may also have learning disabilities.

Without proper treatment, the child may fall behind in schoolwork, and friendships may suffer. The child experiences more failure than success and is criticized by teachers and family who do not recognize a health problem.

Research clearly demonstrates that medication can help improve attention, focus, goal directed behavior, and organizational skills. Medications most likely to be helpful include the stimulants (various methylphenidate and amphetamine preparations) and the non-stimulant, atomoxetine. Other medications such as guanfacine, clonidine, and some antidepressants may also be helpful.

Other treatment approaches may include cognitive-behavioral therapy, social skills training, parent education, and modifications to the child’s education program. Behavioral therapy can help a child control aggression, modulate social behavior, and be more productive. Cognitive therapy can help a child build self-esteem, reduce negative thoughts, and improve problem-solving skills. Parents can learn management skills such as issuing instructions one-step at a time rather than issuing multiple requests at once. Education modifications can address ADHD symptoms along with any coexisting learning disabilities.

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Anxiety Disorders

Everyone experiences anxiety. However, when feelings of intense fear and distress are overwhelming and prevent us from doing everyday things, an anxiety disorder may be the cause. Anxiety disorders are the most common mental health concern in the United States. An estimated 40 million adults in the U.S., or 18%, have an anxiety disorder. Approximately 8% of children and teenagers experience the negative impact of an anxiety disorder at school and at home.

Symptoms
Just like with any mental illness, people with anxiety disorders experience symptoms differently. But for most people, anxiety changes how they function day-to-day. People can experience one or more of the following symptoms:

Emotional symptoms:
- Feelings of apprehension or dread
- Feeling tense and jumpy
- Restlessness or irritability
- Anticipating the worst and being watchful for signs of danger

Physical symptoms:
- Pounding or racing heart and shortness of breath
- Upset stomach
- Sweating, tremors and twitches
- Headaches, fatigue and insomnia
- Upset stomach, frequent urination or diarrhea

Types of Anxiety Disorders
Different anxiety disorders have various symptoms. This also means that each type of anxiety disorder has its own treatment plan. The most common anxiety disorders include:

- **Panic Disorder.** Characterized by panic attacks—sudden feelings of terror—sometimes striking repeatedly and without warning. Often mistaken for a heart attack, a panic attack causes powerful, physical symptoms including chest pain, heart palpitations, dizziness, shortness of breath and stomach upset.

- **Phobias.** Most people with specific phobias have several triggers. To avoid panicking, someone with specific phobias will work hard to avoid their triggers. Depending on the type and number of triggers, this fear and the attempt to control it can seem to take over a person’s life.

- **Generalized Anxiety Disorder (GAD).** GAD produces chronic, exaggerated worrying about everyday life. This can consume hours each day, making it hard to concentrate or finish routine daily tasks. A person with GAD may become exhausted by worry and experience headaches, tension or nausea.

- **Social Anxiety Disorder.** Unlike shyness, this disorder causes intense fear, often driven by irrational worries about social humiliation—“saying something stupid,” or “not knowing what to say.” Someone with social anxiety disorder may not
participate in conversations, contribute to class discussions, or offer their ideas, and may become isolated. Panic attack symptoms are a common reaction.

**Causes**

Scientists believe that many factors combine to cause anxiety disorders:

- **Genetics.** Some families will have a higher than average numbers of members experiencing anxiety issues, and studies support the evidence that anxiety disorders run in families. This can be a factor in someone developing an anxiety disorder.

- **Stress.** A stressful or traumatic situation such as abuse, death of a loved one, violence or prolonged illness is often linked to the development of an anxiety disorder.

**Diagnosis**

The physical symptoms of an anxiety disorder can be easily confused with other medical conditions like heart disease or hyperthyroidism. Therefore, a doctor will likely perform a carefully evaluate involving a physical examination, an interview and ordering lab tests. After ruling out a medical illness, the doctor may recommend a person see a mental health professional to make a diagnosis.

**Treatment**

As each anxiety disorder has a different set of symptoms, the types of treatment that a mental health professional may suggest also can vary. But there are common types of treatment that are used:

- Psychotherapy, including cognitive behavioral therapy (CBT)
- Medications, including anti-anxiety medications and antidepressants
- Complementary health approaches, including stress and relaxation techniques.

See more at: [http://www.nami.org/Learn-More/Mental-Health-Conditions/Anxiety-Disorders](http://www.nami.org/Learn-More/Mental-Health-Conditions/Anxiety-Disorders)

*Updated March 2015*
Posttraumatic Stress Disorder (PTSD)

No. 70; Updated October 2013

All children and adolescents experience stressful events which can affect them both emotionally and physically. Their reactions to stress are usually brief, and they recover without further problems. A child or adolescent who experiences a catastrophic event may develop ongoing difficulties known as posttraumatic stress disorder (PTSD). The stressful or traumatic event involves a situation where someone’s life has been threatened or severe injury has occurred (ex. they may be the victim or a witness of physical abuse, sexual abuse, violence in the home or in the community, automobile accidents, natural disasters (such as flood, fire, earthquakes), and being diagnosed with a life threatening illness). A child’s risk of developing PTSD is related to the seriousness of the trauma, whether the trauma is repeated, the child’s proximity to the trauma, and his/her relationship to the victim(s).

Following the trauma, children may initially show agitated or confused behavior. They also may show intense fear, helplessness, anger, sadness, horror or denial. Children who experience repeated trauma may develop a kind of emotional numbing to deaden or block the pain and trauma. This is called dissociation. Children with PTSD avoid situations or places that remind them of the trauma. They may also become less responsive emotionally, depressed, withdrawn, and more detached from their feelings.

A child with PTSD may also re-experience the traumatic event by:

- having frequent memories of the event, or in young children, play in which some or all of the trauma is repeated over and over
- having upsetting and frightening dreams
- acting or feeling like the experience is happening again
- developing repeated physical or emotional symptoms when the child is reminded of the event

Children with PTSD may also show the following symptoms:

- worry about dying at an early age
- losing interest in activities
- having physical symptoms such as headaches and stomachaches
- showing more sudden and extreme emotional reactions
- having problems falling or staying asleep
- showing irritability or angry outbursts
- having problems concentrating
- acting younger than their age (for example, clingy or whiny behavior, thumbsucking)
- showing increased alertness to the environment
- repeating behavior that reminds them of the trauma

The symptoms of PTSD may last from several months to many years. The best approach is prevention of the trauma. Once the trauma has occurred, however, early intervention is essential. Support from parents, school, and peers is important. Emphasis needs to be placed upon establishing a feeling of safety. Psychotherapy (individual, group, or family) which allows the child to speak, draw, play, or write about the event is helpful. Behavior modification techniques and cognitive therapy may help reduce fears and worries. Medication may also be useful to deal with agitation, anxiety, or depression.
Child and adolescent psychiatrists can be very helpful in diagnosing and treating children with PTSD. With the sensitivity and support of families and professionals, youngsters with PTSD can learn to cope with the memories of the trauma and go on to lead healthy and productive lives.

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Symptoms of Disruptive Mood Dysregulation Disorder

The defining characteristic of disruptive mood dysregulation disorder (DMDD) in children is a chronic, severe and persistent irritability. This irritability is often displayed by the child as a temper tantrum, or temper outburst, that occur frequently (3 or more times per week). When the child isn’t having a temper outburst, they appear to be in a persistently irritable or angry mood, present most of the day, nearly every day. As the DSM-5 Fact Sheet says, “Far beyond temper tantrums, DMDD is characterized by severe and recurrent temper outbursts that are grossly out of proportion in intensity or duration to the situation.”

This disorder, which was new to the DSM-5 in 2013, was created in an effort to replace the diagnosis of childhood bipolar disorder. The prevalence of this disorder is not yet known, but is expected to be within the 2 to 5 percent range for children.

The onset of symptoms must be before age 10, and a diagnosis should not be made for the first time before age 6 or after age 18.

Specific Symptoms of Disruptive Mood Dysregulation Disorder

1. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
2. The temper outbursts are inconsistent with developmental level (e.g., the child is older than you would expect to be having a temper tantrum).
3. The temper outbursts occur, on average, three or more times per week.
4. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, friends).
5. The above criteria have been present for 1 year or more, without a relief period of longer than 3 months. The above criteria must also be present in two or more settings (e.g., at home and school), and are severe in at least one of these settings.
6. The diagnosis should not be made for the first time before age 6 years or after age 18. Age of onset of these symptoms must be before 10 years old.
7. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.
8. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder.

As with all child mental disorders, the symptoms also cannot be attributable to the physiological effects of a substance or to another medical or neurological condition.

This diagnosis is new to the DSM-5. Code: 296.99 (F34.8)
Education for Pregnant and Parenting Students

The Board of Education will provide all pregnant and parenting students with the same educational instruction as other students or its equivalent. Pregnant and parenting students will not be discriminated against or excluded from school or from any program, class or extracurricular activity because they are pregnant or parenting students. School administrators shall provide assistance and support to encourage pregnant and parenting students to remain enrolled in school and graduate.

In accordance with state law, school system officials shall use, as needed, supplemental funds from the At-Risk Student Services allotment to support programs for pregnant and parenting students. Students who are pregnant or parenting will be given excused absences from school for pregnancy and related conditions for the length of time the students' physicians find medically necessary. These absences include those due to the illness or medical appointment during school hours of a child of whom the student is the custodial parent. Homework and make-up work will be made available to pregnant and parenting students to ensure that they have the opportunity to keep current with assignments and avoid losing course credit because of their absence from school, and, to the extent necessary, a homebound teacher will be assigned. For more information regarding homebound services, see Buncombe County Schools Special Services, Hospital/Homebound Program Guidelines.

In addition, school personnel shall annually provide all students in Grades 9 through 12 with information on the manner in which a parent may lawfully abandon a newborn baby with a responsible person in accordance with G.S. 7B-500.

According to G.S. 7B-500, the following individuals shall take into temporary custody an infant under seven (7) days of age that is voluntarily delivered to the individual by the infant's parent: (1) a health care provider who is on duty or at a hospital or at a local or district health department or at a nonprofit community health center; (2) a law enforcement officer who is on duty or at a police station or sheriff's department; (3) a social services worker who is on duty or at a local department of social services; or (4) a certified emergency medical service worker who is on duty or at a fire or emergency medical service station. Any adult may take into temporary custody an infant under seven (7) days of age that is voluntarily delivered to the adult by the infant's parent and the adult shall immediately notify the Department of Social Services or a local law enforcement agency.

Any individual identified above may inquire as to parents' identities and as to any relevant medical history, but the parent is not required to provide that information. The individual shall notify the parent that the parent is not required to provide that information.

Legal Reference: G.S. 7B-500; 115C -47(52), -375.5

Adopted: March 7, 2013
Adolescent Parenting Programs
State Fiscal Year 2016-2017

Alamance County
Family Center of Alamance
Mailing Address: 200 N. Main Street, Graham, NC 27253
Phone: 336-227-5601

Buncombe County
YWCA of Asheville
Mailing Address: 185 S. French Broad Ave., Asheville, NC 28801
Phone: 828-254-7206

Cabarrus County
Cabarrus Health Alliance
Mailing Address: 1207 South Cannon Blvd., Kannapolis, NC 28083
Phone: 704-920-1000

Caldwell County
Caldwell Council on Adolescent Health
Mailing Address: P.O. Box 575, Lenoir, NC 28645
Phone: 828-757-9020

Catawba County
Council on Adolescents of Catawba County
Mailing Address: 1120 Fairgrove Church Rd SE, Suite 22, Hickory, NC 28602
Phone: 828-322-4591

Cumberland County
Cumberland County Public Health Department
Mailing Address: 1235 Ramsey St, Fayetteville, NC 28301
Phone: 910-433-3600

Davidson County
Communities in Schools of Thomasville
Mailing Address: 400 Turner Street, Thomasville, NC 27360
Phone: 336-870-1627

Edgecombe County
Community Enrichment Organization
Mailing Address: 99 N Main St., Tarboro, NC 27886
Phone: 252-823-1733

Gaston County
Gaston County Health Department
Mailing Address: 991 West Hudson Blvd., Gastonia, NC 28052
Phone: 704-853-5013
Guilford County
YWCA of Greensboro
Mailing Address: 1807 Wendover Ave E, Greensboro, NC 27405
Phone: 336-273-3461

Guilford County
YWCA of High Point
Mailing Address: 112 Gatewood Avenue, High Point, NC 27262
Phone: 336-882-4126

Harnett County
NC Cooperative Extension Service
Mailing Address: 126 Alexander Dr., Lillington, NC 27546
Phone: 910-893-7530

Henderson County
Children and Family Resource Center
Mailing Address: P.O. Box 1105, Hendersonville, NC 28792
Phone: 828-698-0674

Lee County
Coalition for Families in Lee County
Mailing Address: PO Box 3873, Sanford, NC 27331
Phone: 919-774-8144

Mecklenburg County
Communities in Schools
Mailing Address: 601 E. 5th Street, Suite 300, Charlotte, NC 28202
Phone: 704-335-0601

New Hanover County
Planned Parenthood South Atlantic
Mailing Address: 1921 Tradd Court, Wilmington, NC 28401
Phone: 910-762-3497

Onslow County
Onslow County DSS
Mailing Address: 151 Chaney Avenue, Jacksonville, NC 28540
Phone: 910-938-5457

Orange County
Orange County DSS
Mailing Address: P.O. Box 8181, Hillsborough, NC 27278
Phone: 919-245-2850
Robeson County
Robeson County Health Department
Mailing Address: 460 Country Club Rd, Lumberton, NC 28360
Phone: 910-671-3200

Rockingham County
Rockingham Partnership for Children
Mailing Address: P.O. Box 325, Wentworth, NC 27375
Phone: 336-342-9676

Rowan County
Families First Rowan County
Mailing Address: P.O. Box 459, Rockwell, NC 28138
Phone: 704-630-0481

Scotland County
Scotland County Partnership for Children and Families
Mailing Address: P.O. Box 586, Laurinburg, NC 28253
Phone: 910-276-3333

Vance County
F.G. Vance Partnership for Children
Mailing Address: 125 Charles Rollins Drive, Henderson, NC 27536
Phone: 252-433-9110 ext. 232

Watauga County
Children’s Council of Watauga
Mailing Address: 225 Birch St, Suite 3, Boone, NC 28607
Phone: 828-262-5424

Wilson County
Wilson County DSS
Mailing Address: 100 Gold St NE, Wilson, NC 27893
Phone: 252-206-4000