Mental Health/Behavioral Health Resources
ACKNOWLEDGEMENTS

The basic content of this notebook has been edited and revised by Mission Children’s Family Support Network of WNC. This book was put together through a collaboration between Mission Children’s Family Support Network and Mission Children’s Child and Adolescent Psychiatric Units. This notebook was compiled and completed in 2016 and was updated in March 2020.
What Now?

Is your home safe?
✓ All sharp objects hidden
✓ All medications locked up

Do you have notes and medications needed?

Have appointments been made with therapist?
# Medication Management Form

**Childs Name:** ____________________  **Date of Birth:** ____________________  

**Pharmacy:** ____________________  **Pharmacy #:** ________________

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage/Time of Day</th>
<th>Reason for Medication</th>
<th>Current/Previous</th>
<th>Positive/Negative Outcomes</th>
<th>Physician</th>
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Mission Children’s Family Support Network of WNC
**Psych Services**

Psych Services could include therapy, behavior modification, psychiatric services, in-home services, and group therapies.

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<tr>
<th>Type of Service Received</th>
<th>Provider of Service</th>
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Transition back to school

✓ Have you met with the guidance counselor?

✓ Have you met with the teachers?

✓ Do you have a crisis plan in place?

✓ Have you met to change the IEP/504 plans?

As a parent, you have the right to not tell the school why your child was absent.
North Carolina’s Parent Center
Serving Families with Children Birth to 26 with Disabilities or Special Health Care Needs

ecac Offers:
- Individual Assistance with Educational Concerns
- Informational Resources & Materials
- Parent Training & Workshops
- Parent to Parent Support
- Specialized Support for Families & Children with Deaf-Blindness
- Professional Development & Training
- Referral Services
- Youth Leadership
- Family Engagement
- Parent Leadership
- Lending Library

All services are provided at no cost to NC Families!

Get in Touch With Us!

Help Line: (800) 962-6817
Main Office: (704) 892-1321
907 Barra Row, Suites 102/103
Davidson, NC 28036

www.ecac-parentcenter.org
exceptional children’s assistance center

El Centro de Asistencia para Padres de Niños con Necesidades Especiales ofrece los siguientes servicios:

1. Asistencia individual sobre los problemas relacionados con la educación.
2. Talleres (Workshops) educacionales sobre una variedad de temas.
   a. Leyes sobre la Educación Especial: Derechos y responsabilidades de los padres.
   b. Desarrollo efectivo del proceso IEP Programa de Educación Individualizada (Individual Education Program).
   c. Inclusión: El derecho de los niños con discapacidades para participar en la escuela y en eventos escolares con los niños sin discapacidades.
   d. Transición del nivel pre-escolar a la escuela.
   e. Planificación de la transición escolar a la madurez.
   f. Buen comportamiento.
   g. Como abogar por su hijo.
   h. Técnicas de comunicación efectiva.
   i. Planeación de Liderazgo para Padres.
   j. Otros tópicos sugeridos por los padres.
3. Información y referencia a otras agencias.
5. Servicio de biblioteca.
6. Apoyo entre los padres de familia (Parent to parent support).
7. Información y asistencia a grupos de padres (Parent groups).

¡Todos nuestros servicios se ofrecen gratuitamente a los padres y miembros de la familia!

Llame a ECAC para más información:
Oficina Principal: (704) 892 – 1321
Línea gratis de información para padres: 1-800-962-6817
Visite nuestra página en Internet:
www.ecac-parentcenter.org
A parent’s guide to creating a crisis prevention plan

Crisis Prevention Plans (CPP) are intended to help children/adolescents and their caregivers prevent minor problems from escalating into crisis events. CPPs provide an opportunity for the child/adolescent and the caregiver to logically think through situations by identifying the cause of distress, understanding and discussing options for minimizing difficult situations, and encouraging coping skills to help decrease the distress. Key components of a CPP include understanding triggers, identifying warning signs, and helping to facilitate interactions that will decrease the possibility of further difficulties. A thoughtful and carefully constructed CPP can help families make choices and take actions to diffuse difficult situations.

Steps for creating your own Crisis Prevention Plan:

• **Discuss triggers** — Triggers are things that cause distress for the child/adolescent. Common triggers include peer conflict, homework, chores, feeling sad or angry, and being told “no” or being unable to get their way. The child/adolescent and caregiver should be honest and explicit about the triggers for what is currently causing them the most difficulty.

• **Identify early warning signs** — Warning signs are physical clues the child/adolescent does (sometimes without their knowledge) that show others that they are upset or distressed. Common warning signs include blushing/flushed face, clenching fists, pacing, yelling, or withdrawing/becoming quiet.

• **List interventions the caregiver can do to help the child/adolescent calm down** — Discuss what the child/adolescent would want, and how the caregiver could provide that for them. Examples include giving the child/adolescent space to calm down, reminding them to use a coping skill, talking with them, or offering a hug.

• **List things the child/adolescent can do to help calm themselves** — This typically includes coping skills such as listening to music, talking a walk, doing deep breathing exercises, taking time to themselves (include a mention of how long to let the child/adolescent “cool off” before being expected to reengage with the family), writing, drawing/coloring, or other relaxation techniques.

• **Identify other supports if the above interventions aren’t helpful or are unavailable** — for instance, list three people the child/adolescent can contact, beside the caregiver, when distressed. Examples include peers who would have a positive influence, relatives, older siblings, therapists, or teachers/coaches. The child/adolescent and caregiver should agree who are a good resource. Also identify and list the crisis line where you live. A teen hotline such as Teen Link (1-866-833-6546 or [http://866teenlink.org](http://866teenlink.org)) is also helpful.

Christina Clark, MD
Crisis Prevention Plan

My triggers are:
1. .................................................................
2. .................................................................
3. .................................................................
4. .................................................................
5. .................................................................

My early warning signs are:
1. .................................................................
2. .................................................................
3. .................................................................
4. .................................................................
5. .................................................................

When my parents/caregivers notice my early warning signs, they can:
1. .................................................................
2. .................................................................
3. .................................................................
4. .................................................................
5. .................................................................

Things I can do when I notice my early warning signs:
1. .................................................................
2. .................................................................
3. .................................................................
4. .................................................................
5. .................................................................

If I am unable to help myself I can call:
1. .................................................................
2. .................................................................
3. .................................................................
4. .................................................................
5. .................................................................

• Your County Crisis Line Phone Number:  .................................................................
  (you can look it up here:  
  [link]

• Text HOME to 741741 or visit:  [link]

• Teen Link Hotline: 1-866-833-6546 or [link]

• The National Suicide Hotline: 1-800-784-2433

This Crisis Prevention Plan was created to give your family strategies you can use in your home to help calm your child during an escalation before they reach a crisis point. We do not advise using restraint, such as holding your child down, because you or your child could get hurt. Please call 911 if you or your child is in imminent danger.
General Home Safety Recommendations
After a Child Crisis Event

The following safety tips may help to keep things safe right now after an escalated crisis event, and help to reduce further escalations/crises:

1. In the home environment, maintain a “low-key” atmosphere while maintaining regular routines

2. Follow your typical house rules, but pick your battles appropriately, for example:
   • immediately intervene with aggressive or dangerous behaviors
   • if your child is just using oppositional words, it may be wise to ignore those behaviors

3. Provide appropriate supervision until the child’s crisis is resolved

4. Make a crisis prevention plan by identifying likely triggers for a crisis (such as an argument), and plan with your child what the preferred actions would be for the next time the triggers occur (such as calling a friend, engaging in a distracting activity or going to a personal space)

5. Encourage your child to attend school, unless otherwise directed by your provider

6. Make sure that you and your child attend the next scheduled appointment with their provider

7. Administer medications as directed by your child’s medical or psychiatric provider

8. Go into each day/evening with a plan for how time will be spent — this should help prevent boredom and arguments in the moment

9. Secure and lock up all medications and objects your child could use to hurt him/herself and/or use to attempt suicide. When locking up items, ensure your child does not have knowledge of their location, the location of the key, or the combination to any padlock used to secure them. This includes:
   • Sharp objects like knives and razors
   • Materials that can be used for strangulation attempts, such as belts, cords, ropes and sheets
   • Firearms and ammunition (locked and kept in separate/different locations from each other)
   • All medications of all family members, including all over the counter medicines. If your child takes medication of any type, you should administer it for the time being (unless instructed to stop it by your care provider)

In the event of another crisis, please do the following:

• If you believe that you, your child, or another person is no longer safe as a result of your child’s behavior, call 911 to have your child transported to the emergency department closest to your home

• Consider calling your local county crisis hotline, which are listed at:

• Consider calling the national suicide hotline:
  1-800-784-2433

This resource page is now available in Spanish at www.seattlechildrens.org/pal
Parents can only give good advice or put them on the right paths, but the final forming of a person's character lies in their own hands. - Anne Frank

“Don’t worry about a thing. ‘Cause everything is gonna be alright.” – Bob Marley

“Courage does not always roar. Sometimes courage is the quite voice at the end of the day saying, ‘I will try again tomorrow.’” – Mary Anne Radmacher

“The strongest people are not those who show strength in front of us but those who win battles we know nothing about.” – Unknown

“Parenthood is about raising and celebrating the child you have, not the child you thought you’d have. It’s about understanding your child is exactly the person they are supposed to be. And, if you’re lucky, they might be the teacher who turns you into the person you’re supposed to be.” The Water Giver

“There’s something in you that the world needs.” – Unknown
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

Dedicated to all the professionals of trauma of the world.

Understanding ACEs

ACEs (Adverse Childhood Experiences) are serious childhood traumas that can result in toxic stress. Prolonged exposure to ACEs can create toxic stress, which can damage the developing brain and body of children and affect overall health. Toxic stress may prevent a child from learning or playing in a healthy way with other children, and can cause long-term health problems.

- Increases difficulty in making friends and maintaining relationships.
- Increases problems with learning and memory.
- Lowers tolerance for stress, which can result in behaviors such as fighting, checking out or defiance.
- Increases stress hormones which affect the body’s ability to fight infection.
- May cause lasting health problems.
- Reduces the ability to respond, learn, or figure things out, which can result in problems in school.

Exposure to childhood ACEs can increase the risk of:
- Adolescent pregnancy
- Alcohol and drug abuse
- Asthma
- Depression
- Heart disease
- Intimate partner violence
- Liver disease
- Sexually-transmitted disease
- Smoking
- Suicide

ACEs (Adverse Childhood Experiences) can include:

- Abuse: Emotional/physical/sexual
- Bullying/violence of/by another child, sibling, or adult
- Homelessness
- Household: Substance abuse/mental illness/domestic violence/incarceration/parental abandonment, divorce, loss
- Involvement in child welfare system
- Medical trauma
- Natural disasters and war
- Neglect: Emotional/physical
- Racism, sexism, or any other form of discrimination
- Violence in community

**SURVIVAL MODE RESPONSE**

Toxic stress increases a child's heart rate, blood pressure, breathing and muscle tension. Their thinking brain is knocked off-line. Self-protection is their priority.

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Parents and caregivers can help. Turn over to learn about resiliency.
What is resilience?
Research shows that if caregivers provide a safe environment for children and teach them how to be resilient, that helps reduce the effects of ACEs.

What does resilience look like?
Having resilient parents and caregivers who know how to solve problems, have healthy relationships with other adults, and build healthy relationships with children.

Building attachment and nurturing relationships:
Adults who listen and respond patiently to a child in a supportive way, and pay attention to a child’s physical and emotional needs.

Building social connections:
Having family, friends, neighbors, community members who support, help and listen to children.

Meeting basic needs:
Provide children with safe housing, nutritious food, appropriate clothing, and access to health care and good education, when possible. Make sure children get enough sleep, rest, and play.

Learning about parenting, caregiving and how children grow:
Understand how caregivers can help children grow in a healthy way, and what to expect from children as they grow.

Building social and emotional skills:
Help children interact in a healthy way with others, manage emotions, communicate their feelings and needs, and rebound after loss and pain.

Resources:
- ACEs Too High
- ACEs Connection
- Resource Center
- Parenting with ACEs

“Children with ACEs find ‘resilience’ because an adult provides a safe environment — in which they feel known, validated.”
Donna Jackson Nakazawa
Author of Childhood Disrupted: How Your Biography Becomes Your Biology & How You Can Heal

Special thanks to the Community & Family Services Division at the Spokane (WA) Regional Health District for developing and sharing the original parent hand-out.
ESTRÉS Y EL DESARROLLO TEMPRANO DEL CEREBRO
Entendiendo las experiencias adversas en la infancia (ACE)

¿Qué son las experiencias adversas en la infancia (ACE)?
Las experiencias adversas en la infancia son graves traumas de la niñez -- a continuación se muestra una lista -- que producen estrés tóxico que, a su vez, puede dañar el cerebro de un niño. Este estrés tóxico puede impedir que un niño aprenda, juegue de una manera sana con otros niños, y puede generar problemas de salud a largo plazo.

Las experiencias adversas en la infancia pueden incluir:
1. Abuso emocional
2. Abuso físico
3. Abuso sexual
4. El abandono emocional
5. El abandono físico
6. Madre tratada con violencia
7. Alcoholismo o drogadicción en el hogar
8. Enfermedad mental en el hogar
9. Separación o divorcio de los padres
10. Hay un miembro de la familia encarcelado
11. Intimidación (por otro niño o un adulto)
12. Ser testigo de violencia fuera del hogar
13. Ser testigo del abuso de un hermano o hermana
14. Racismo, sexismo o cualquier otra forma de discriminación
15. Encontrarse sin hogar
16. Desastres naturales y guerra

¿Cómo afectan la salud las experiencias adversas en la infancia?
Lo hacen a través del estrés. La exposición frecuente o prolongada a experiencias adversas en la infancia puede crear estrés tóxico que puede dañar al cerebro en desarrollo de un niño y afectar la salud en general.

La exposición a experiencias adversas en la infancia puede aumentar el riesgo de:
- Embarazos en la adolescencia
- Alcoholismo y el abuso del alcohol
- Depresión
- Consumo de drogas ilegales
- Enfermedades del corazón
- Enfermedades del hígado
- Múltiples parejas sexuales
- Violencia a manos de la pareja
- Enfermedades de transmisión sexual (enfermedades venéreas)
- Fumar
- Intentos de suicidio
- Embarazos no deseados

Una respuesta de modo de supervivencia al estrés tóxico aumenta la frecuencia cardíaca de un niño, la presión arterial, la respiración y la tensión muscular. Su cerebro racional se desconecta. La autoprotección es su prioridad. En otras palabras: “¡No te puedo escuchar! ¡No te puedo responder! ¡Sólo estoy tratando de mantenerte a salvo!”

Reduce la capacidad de responder, aprender o descifrar cosas, lo cual puede generar problemas en la escuela.
Reduce la tolerancia al estrés, lo cual puede resultar en conductas como pelearse, “ausentarse” o ser rebelde.

Aumenta la dificultad para hacer amigos y mantener relaciones.

Aumenta las hormonas del estrés, lo cual afecta la capacidad del cuerpo para combatir infecciones.

Aumenta los problemas del aprendizaje y la memoria, los cuales pueden ser permanentes.

Puede causar problemas de salud duraderos.
¿Qué es la resistencia?
La resistencia es la capacidad de recuperar la buena salud y volver a sentir esperanza después de que hayan sucedido cosas malas. Las investigaciones muestran que si los padres ofrecen un ambiente seguro a sus hijos y les enseñan a cómo ser resistentes, eso ayuda a disminuir los efectos de las experiencias adversas en la infancia.

¡La resistencia triunfa sobre las experiencias adversas en la infancia!
Los padres, maestros y personas al cuidado de los niños pueden ayudarlos al:
· Adquirir un entendimiento de las experiencias adversas en la infancia
· Ayudar a los niños a identificar sentimientos y manejar emociones
· Crear ambientes seguros tanto física como emocionalmente en el hogar, la escuela y en los vecindarios

¿Qué apariencia tiene la resistencia?
1. Tener padres resistentes
 Padres que saben cómo resolver problemas, que tienen relaciones sanas con otros adultos y que crean relaciones sanas con sus hijos.

2. Desarrollar apego y relaciones enriquecedoras
Adultos que escuchan y responden pacientemente a un niño, de una manera que lo apoye, y que prestan atención a las necesidades físicas y emocionales del niño.

3. Crear conexiones sociales
Tener familiares, amigos o vecinos que brinden apoyo, ayuden y escuchen a los niños.

4. Satisfacer las necesidades básicas
Brindar a los niños una vivienda segura, alimentos nutritivos, ropa adecuada y acceso a atención médica y una buena educación.

5. Aprender sobre la crianza de los niños y cómo crecen los niños
Entender cómo los padres pueden ayudar a que sus hijos crezcan de una manera sana, y qué esperar de los niños a medida que van creciendo.

6. Desarrollar habilidades sociales y emocionales
Ayudar a los niños a interactuar de una manera sana los unos con los otros, manejar sus emociones y comunicar sus sentimientos y necesidades.

Recursos:
ACES 101 (Información básica sobre las experiencias adversas en la infancia, en inglés)
http://acestoohigh.com/aces-101/

Triple-P Parenting (Información sobre la crianza de los hijos, en inglés) www.triplep-parenting.net/glo-en/home/

Resilience Trumps ACEs (Resistencia Triunfa sobre las ACE, en inglés)
www.resiliencetrumpsACES.com

Estudio de los CDC y Kaiser sobre las experiencias adversas en la infancia (ACE) [en inglés]
www.cdc.gov/violenceprevention/acesstudy/

Guías para padres, de “Zero to Three”

Muchas gracias a las personas de la División de Servicios a la Familia y la Comunidad (Community & Family Services Division) en el Distrito Sanitario Regional (Regional Health District) de Spokane (WA) por crear este folleto para los padres de familia en el estado de Washington, y compartirlo con otras personas alrededor del mundo.
Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   **or**
   Act in a way that made you afraid that you might be physically hurt?
   Yes   No   If yes enter 1   ________

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   **or**
   **Ever** hit you so hard that you had marks or were injured?
   Yes   No   If yes enter 1   ________

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   **or**
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes   No   If yes enter 1   ________

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   **or**
   Your family didn’t look out for each other, feel close to each other, or support each other?
   Yes   No   If yes enter 1   ________

5. Did you **often** feel that …
   You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?
   **or**
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes   No   If yes enter 1   ________

6. Were your parents **ever** separated or divorced?
   Yes   No   If yes enter 1   ________

7. Was your mother or stepmother:
   **Often** pushed, grabbed, slapped, or had something thrown at her?
   **or**
   **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard?
   **or**
   **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes   No   If yes enter 1   ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes   No   If yes enter 1   ________

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes   No   If yes enter 1   ________

10. Did a household member go to prison?
    Yes   No   If yes enter 1   ________

    **Now add up your “Yes” answers:   ________  This is your ACE Score**
Parenting to prevent and heal ACEs (Adverse Childhood Experiences)

Donna Jackson Nakazawa, *Childhood Disrupted: How Your Biography Becomes Your Biology & How You Can Heal*

“The main point is this: No matter how old you are — or how old your child may be, there are scientifically supported and relatively simple steps that you can take to reboot the brain, create new pathways that promote healing, and come back to who it is you were meant to be.”

**NURTURE & PROTECT KIDS AS MUCH AS POSSIBLE**

Be a source of safety and support.

**MAKE EYE CONTACT**

Look at kids (babies, too). It says, “I see you. I value you. You matter. You’re not alone.”

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**GIVE 20-SECOND HUGS**

There’s a reason we hug when things are hard. Safe touch is healing. Longer hugs are most helpful.

**HUNT FOR THE GOOD**

When there’s pain or trauma, we look for danger. We can practice looking for joy and good stuff, too.

**HELP KIDS TO EXPRESS MAD, SAD & HARD FEELINGS**

Hard stuff happens. But helping kids find ways to share, talk, and process helps. Our kids learn from us.

**SLOW DOWN OR STOP**

Rest. Take breaks. Take a walk or a few moments to reset or relax.

**BE THERE FOR KIDS**

It’s hard to see our kids in pain. We can feel helpless. Simply being present with our kids is doing something. It shows them we are in their corner.

**KEEP LEARNING**

Understand how ACEs impact you and your parenting.

More tips & resources for parents on back.

**MOVE AND PLAY**

Drum. Stretch. Throw a ball. Dance. Move inside or outside for fun, togetherness and to ease stress.

**SAY, “SORRY”**

We all lose our patience and make mistakes. Acknowledge it, apologize, and repair relationships. It’s up to us to show kids we’re responsible for our moods and mistakes.

**MAKE EYE CONTACT**

Look at kids (babies, too). It says, “I see you. I value you. You matter. You’re not alone.”

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**KEEP LEARNING**

Understand how ACEs impact you and your parenting.

More tips & resources for parents on back.
Support for parents with ACEs

“The best thing we can do for the children we care for is to manage our own stuff. Adults who've resolved their own trauma help kids feel safe.”

–Donna Jackson Nakazawa

There are many paths to healing. Learn more about these well-researched supports in Childhood Disrupted.

“Learning about ACEs is a start but sometimes we need more. Many people with ACEs have never had their pain validated. Understanding that there exists a biological connection between what they experienced in childhood, and the physical and mental health issues they face now, can help set them on a healing path, where they begin to find new ways to take care of themselves, and begin new healing modalities.”

–Donna Jackson Nakazawa

Thanks to Donna Jackson Nakazawa for allowing ACEs Connection to paraphrase her research. Please add your logo on the front and share freely.
Resources
Family Group Night

Family Group Night allow each family member to attend a group that addresses their needs! The design of the program is to support the child with special healthcare/behavioral needs and their siblings to connect with peers in their community. We offer social skills building activities provided by our Childcare Provider Team. Parent support is addressed by providing information related to raising a child with special healthcare/behavioral needs.

Please RSVP! Signing up helps insure enough food for dinner and volunteers for groups.

To Register Call 828-213-0047 or email kerri.eaker@msj.org

NEW in 2019

1st Tuesday of each month

Mission Children’s Reuter Outpatient Center
11 Vanderbilt Park Drive
Asheville, NC

5:30pm to 6:00pm Supper
6:00pm-7:30pm Group Time

Model Me Kids®

Videos for Modeling Social Skills

Is a research based Social Skills program that uses Kids on DVD's modeling the use of social skills in everyday scenarios. While following up with positive interactive activities for reinforcement of the skill being taught. New in 2019 our Childcare Provider Team will be implementing this program during our Family Group Nights with the Children and Youth Groups. Parents will receive a handout to follow up working on the skill at home.
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 help 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 2 ½ 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 trained 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
Resources for Caregivers
(Substance Use)

**Red Oak Recovery**
Adolescent Program for young men
Admissions: 866-457-7426

**NA/Al-ALON/AA meetings**

www.crna.org (NA)
https://al-anon.org/al-anon-meetings/find-an-al-anon-meeting/ (Al-Anon)
http://ashevilleaa.org/ (AA)

**NC Partnership for Substance Free Youth**
https://www.substancefreeyouth.com/

**Insight Human Services, Swain Recovery Center**
932 Old US 70, 2nd Floor, Moore II
Black Mountain, NC 28711
Phone: 828.669.4161

Residential substance abuse programs for adults and adolescents
# Western Regional Support Group Options for Families (updated 9/2019)

<table>
<thead>
<tr>
<th>Name of Group</th>
<th>When</th>
<th>Where</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSN of WNC-Mission Children’s Outpatient Center</td>
<td>(828) 213-0047  <a href="mailto:kerri.eaker@hcahealthcare.com">kerri.eaker@hcahealthcare.com</a>  (828) 213-9740  <a href="mailto:suzan.muldowney@hcahealthcare.com">suzan.muldowney@hcahealthcare.com</a>  (828) 213-9787  <a href="mailto:jessica.edwards@hcahealthcare.com">jessica.edwards@hcahealthcare.com</a>  (828) 652-3686  <a href="mailto:samantha.parrow@hcahealthcare.com">samantha.parrow@hcahealthcare.com</a></td>
<td></td>
<td></td>
</tr>
<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@autismsoociety-nc.org">buncombechapter@autismsoociety-nc.org</a>  <a href="http://www.facebook.com/groups/asnc.buncombe">www.facebook.com/groups/asnc.buncombe</a></td>
</tr>
<tr>
<td>Brain Injury Support Group For Teens/Young Adults Asheville</td>
<td>4th Tuesday 6pm-7:30pm</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>
</tr>
<tr>
<td>Caring for Children with Food Allergies</td>
<td></td>
<td></td>
<td><a href="mailto:Cocoa-in-asheville@yahoo.com">Cocoa-in-asheville@yahoo.com</a></td>
</tr>
<tr>
<td>Care Partners</td>
<td>Various Bereavement Gp’s Available</td>
<td>68 Sweeten Creek Rd.</td>
<td>828-251-0126</td>
</tr>
<tr>
<td>Mission Family Support Network-Family Group Nights</td>
<td>1st Tuesday Monthly 5:30pm-6pm-Deinner 6-7:30pm Groups</td>
<td>Mission Children’s Outpatient Center</td>
<td>RSVP required 828-213-0047,  <a href="mailto:kerri.eaker@msj.org">kerri.eaker@msj.org</a>  Dinner and Childcare provided</td>
</tr>
<tr>
<td>WNC Down Syndrome Alliance</td>
<td></td>
<td></td>
<td><a href="https://www.facebook.com/WNCDSA">https://www.facebook.com/WNCDSA</a></td>
</tr>
<tr>
<td>Down Syndrome Baby Love Group</td>
<td>Monthly get-togethers</td>
<td>Various Fun Locations</td>
<td>Lacey Theede  <a href="mailto:ashevilledowndysdromebabylove@gmail.com">ashevilledowndysdromebabylove@gmail.com</a></td>
</tr>
<tr>
<td>Ehlers-Danlos (EDS) MCAD/s,POTS</td>
<td>4th Saturday 10:00am</td>
<td>Mission’s My Care Plus Community Room/BiltmorePark</td>
<td><a href="mailto:ashnceds@gmail.com">ashnceds@gmail.com</a></td>
</tr>
<tr>
<td>FIRST Hispanic Family Support Group</td>
<td></td>
<td></td>
<td>Referral base only. Call Amy Moose 230-7721</td>
</tr>
<tr>
<td>NAMI</td>
<td>Monthly Support Groups</td>
<td><a href="http://www.namiwnc.org">www.namiwnc.org</a></td>
<td>Paulette Heack 828-505-7353</td>
</tr>
<tr>
<td>Arms Around ASD Parents of Children</td>
<td>Monthly Support Groups</td>
<td></td>
<td><a href="https://www.armsaroundasd.org/services/">https://www.armsaroundasd.org/services/</a></td>
</tr>
<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>
</tr>
</tbody>
</table>
### Western Regional Support Group Options for Families (updated 9/2019)

<table>
<thead>
<tr>
<th>FSN/HOPE  Vickie Dieter</th>
<th>(828)256-5202</th>
<th><a href="mailto:vickiefsnhope@gmail.com">vickiefsnhope@gmail.com</a></th>
</tr>
</thead>
</table>
| Alexander Chapter Autism Society of NC | Serving Alexander, Burke, Caldwell, Catawba, Lenoir and McDowell Counties | 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.catawba.valley  |
| McDowell Allergy Awareness | | mcdowellallergyawareness@gmail.com |
| Caldwell Chapter Autism Society of NC | Third Thursday of the month, 6-7:30 p.m. | Whitnel Elementary School Media Center, 1425 Berkley St. SW, Lenoir | caldwellchapter@autismsociety-nc.org  
www.facebook.com/groups/asnc.caldwell  |
| **HENDERSON COUNTY** | | |
| Four Season’s Hospice | Individual and group Bereavement sessions “Heart Songs” group for children | 571 So. Allen Rd. Flat Rock | 828-692-6178  
https://www.facebook.com/groups/fourseasonsгrief  |
| Henderson County Chapter Autism Society of NC | Last Tuesday of each month from 6pm- 7:30pm | Hendersonville Presbyterian Church  
699 N. Grove St. Hendersonville, NC 28792 | 828-693-4223- Caroline Long, Exec. Director  
Dinner and Childcare provided with registration |
| St. Gerard House Family Support Group | Monthly, 2nd Monday 5:30-7:30 p.m. | 620 Oakland Street, Hendersonville |  |
| **FSN/HIGH COUNTRY Kaaren Hayes (828)262-6089 hayeskl@appstate.edu** | | |
| 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. | Weekly 5:30-7:30 | | Norma Bouchard- 866-812-3122 Dinner and Childcare Provided |
| 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 | | Local Church’s | Teresa Emory: 828-682-4772  
Toll Free Parent Line: 866-448-5781 emorytd@appstate.edu |
| **MADISON COUNTY** | | |
| Madison County Chapter Autism Society of NC | First Tuesday of each month, 4-5:30 p.m. | Madison Middle School, 95 Upper Brush Creek Road, Marshall |  |
| **RUTHERFORDTON & POLK COUNTY** | |  |
| Rutherford County Chapter Autism Society of NC | Last Monday of each Month 6:00 - 7:30 p.m. | Ellenboro Elementary School  
813 Piney Mountain Church Rd Ellenboro |  |

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The above information is subject to change. Please contact the respective groups for the most up-to-date information.
# Western Regional Support Group Options for Families (updated 9/2019)

<table>
<thead>
<tr>
<th>Region</th>
<th>Contact Information</th>
<th>Meeting Details</th>
<th>Location/Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FSN of REGION A</strong></td>
<td><a href="mailto:jmillerr@rapc.org">jmillerr@rapc.org</a></td>
<td>Serving Jackson, Cherokee, Swain, Haywood, Clay, Graham, and Macon Counties</td>
<td></td>
</tr>
<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 <a href="https://www.facebook.com/FamilySupportNetworkofRegionA/">Link</a></td>
</tr>
<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 <a href="https://www.facebook.com/FamilySupportNetworkofRegionA/">Link</a></td>
</tr>
<tr>
<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 <a href="https://www.facebook.com/FamilySupportNetworkofRegionA/">Link</a></td>
</tr>
<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 <a href="https://www.facebook.com/FamilySupportNetworkofRegionA/">Link</a></td>
</tr>
<tr>
<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 <a href="https://www.facebook.com/FamilySupportNetworkofRegionA/">Link</a></td>
</tr>
<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="https://www.facebook.com/groups/asnc.jackson.swain.qb">Link</a></td>
</tr>
<tr>
<td>Cherokee County Chapter Autism Society of NC (Murphy)</td>
<td>2nd Tuesday of each month 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/cherokeechapter@autismsociety-nc.org">Link</a></td>
</tr>
<tr>
<td>Macon County Chapter Autism Society of NC (Franklin)</td>
<td>1st Sunday of each month 6pm-7:30pm</td>
<td>Bethel United Methodist Church 81 Bethel Church Rd. Franklin</td>
<td><a href="https://www.facebook.com/groups/asnc.macon/maconchapter@autismsociety-nc.org">Link</a></td>
</tr>
</tbody>
</table>

## TRANSYLVANIA COUNTY

<table>
<thead>
<tr>
<th>Group Name</th>
<th>Meeting Details</th>
<th>Location/Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassionate Friends of Brevard. For parents grieving the loss of a child</td>
<td>Monthly 2nd Monday 6-7:30 pm</td>
<td>Lutheran Church of the Good Sheppard, 22 Fisher Rd. Bvd</td>
</tr>
<tr>
<td>Transylvania County Chapter Autism Society of NC</td>
<td>3rd Monday of each month 6:00 - 7:30 pm</td>
<td>Transylvania County Library, 212 S Gaston St, Brevard, NC. 28712</td>
</tr>
<tr>
<td>Hearing Loss Assoc. of America</td>
<td>Monthly 2nd Saturday 1:00 p.m.</td>
<td>Transylvania Hospital</td>
</tr>
</tbody>
</table>
# Western Regional Support Group Options for Families (updated 9/2019)

## OTHER SUPPORTS

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<tr>
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<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 <a href="mailto:noelle.moore@thefinleyproject.org">noelle.moore@thefinleyproject.org</a> <a href="https://www.thefinleyproject.org/">https://www.thefinleyproject.org/</a></td>
<td></td>
</tr>
<tr>
<td>The Quirkies of Asheville</td>
<td>Secret Facebook Group-By Invitation Only</td>
<td>Rochelle Hylton <a href="mailto:rochelle.guy@gmail.com">rochelle.guy@gmail.com</a> Jennifer Allen Haines <a href="mailto:jenuofroc@aol.com">jenuofroc@aol.com</a></td>
<td></td>
</tr>
<tr>
<td>Middle School Autism Group</td>
<td>Brenda Logan <a href="mailto:sbalogan@gmail.com">sbalogan@gmail.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Arc of NC Self-Advocacy Group</td>
<td>Beth Weegar 828-702-5059</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asheville City Therapeutic Recreation Program</td>
<td>TR staff at (828) 232-4529 <a href="mailto:trprogram@ashevillenc.gov">trprogram@ashevillenc.gov</a></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Mental Health Resources
North Carolina

NAMI North Carolina Young Families
www.naminc.org

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

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

NC Disability Rights
www.disabilityrightsnc.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

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
Imagine Project
www.theimagineproject.org
Mental Health
www.mentalhealth.gov
Adolescent Health
www.adolescenthealth.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/edi/pcp/

For more information, contact Mission Children’s Family Support Network
828-213-0033
www.missionchildrens.org/family-support-network.php
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
Common Diagnoses
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.

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
- blurs 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 (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.

A child who is diagnosed with ADHD and treated appropriately can have a productive and successful life.
Anxiety and Children

No. 47; Updated October 2017

All children experience some anxiety. Anxiety in children is expected and normal at specific times in development. For example, from approximately age 8 months through the preschool years, healthy youngsters may show intense distress (anxiety) at times of separation from their parents or other people with whom they are close. Young children may have short-lived fears, such as fear of the dark, storms, animals, or a fear of strangers.

Anxious children are often overly tense or uptight. Some may seek a lot of reassurance, and their worries may interfere with activities. Parents should not dismiss their child's fears. Because anxious children may also be quiet, compliant, and eager to please, their difficulties may be missed. Parents should be alert to the signs of severe anxiety so they can intervene early to prevent complications.

There are quite a few different types of anxiety in children.

**Symptoms of separation anxiety include:**

- Constant thoughts and intense fears about the safety of parents and caretakers
- Refusing to go to school
- Frequent stomachaches and other physical complaints
- Extreme worries about sleeping away from home
- Being overly clingy
- Panic or tantrums at times of separation from parents
- Trouble sleeping or nightmares

**Symptoms of phobia include:**

- Extreme fear about a specific thing or situation (ex. dogs, insects, or needles)
- Fears causing significant distress and interfering with usual activities

**Symptoms of social anxiety include:**

- Fears of meeting or talking to people
- Avoidance of social situations
- Few friends outside the family

**Other symptoms of anxious children include:**

- Many worries about things before they happen
• Constant worries or concerns about family, school, friends, or activities
• Repetitive, unwanted thoughts (obsessions) or actions (compulsions)
• Fears of embarrassment or making mistakes
• Low self esteem and lack of self-confidence

Severe anxiety problems in children can be treated. Early treatment can prevent future difficulties, such as loss of friendships, failure to reach social and academic potential, and feelings of low self-esteem. Treatments may include a combination of the following: individual psychotherapy, family therapy, medications, behavioral treatments, and consultation to the school.

If anxieties become severe and begin to interfere with the child's usual activities (for example separating from parents, attending school, and making friends), parents should consider seeking an evaluation from a qualified mental health professional or a child and adolescent psychiatrist.

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Attachment Disorders

Attachment Disorders are psychiatric illnesses that can develop in young children who have problems in emotional attachments to others. Parents, caregivers, or physicians may notice that a child has problems with emotional attachment as early as their first birthday. Often, a parent brings an infant or very young child to the doctor with one or more of the following concerns:

- severe colic and/or feeding difficulties
- failure to gain weight
- detached and unresponsive behavior
- difficulty being comforted
- preoccupied and/or defiant behavior
- inhibition or hesitancy in social interactions
- being too close with strangers

Most children with attachment disorders have had severe problems or difficulties in their early relationships. They may have been physically or emotionally abused or neglected. Some have experienced inadequate care in an institutional setting or other out-of-home placement. Examples of out-of-home placements include residential programs, foster care or orphanage. Others have had multiple traumatic losses or changes in their primary caregiver. The exact cause of attachment disorders is not known, but research suggests that inadequate care-giving is a possible cause. The physical, emotional and social problems associated with attachment disorders may persist as the child grows older.

Children who have attachment issues can develop two possible types of disorders: Reactive Attachment Disorder and Disinhibited Social Engagement Disorder.

**Reactive Attachment Disorder (RAD)**

Children with RAD are less likely to interact with other people because of negative experiences with adults in their early years. They have difficulty calming down when stressed and do not look for comfort from their caregivers when they are upset. These children may seem to have little to no emotions when interacting with others. They may appear unhappy, irritable, sad, or scared while having normal activities with their caretaker. The diagnosis of RAD is made if symptoms become chronic.

**Disinhibited Social Engagement Disorder (DSED)**
Children with DSED do not appear fearful when meeting someone for the first time. They may be overly friendly, walk up to strangers to talk or even hug them. Younger children may allow strangers to pick them up, feed them, or give them toys to play with. When these children are put in a stranger situation, they do not check with their parents or caregivers, and will often go with someone they do not know.

Treatment

Children who exhibit signs of RAD or DSED need a comprehensive psychiatric assessment and individualized treatment plan. Treatment involves both the child and the family. Therapists focus on understanding and strengthening the relationship between a child and his or her primary caregivers. Without treatment, these conditions can affect a child's social and emotional development. Treatments such as "rebirthing" strategies are potentially dangerous and should be avoided.

Parents of a young child who shows signs or symptoms of RAD or DSED should:

- seek a comprehensive psychiatric evaluation by a qualified mental health professional prior to the initiation of any treatment
- make sure they understand the risks as well as the potential benefits of any intervention
- feel free to seek a second opinion if they have questions or concerns about the diagnosis and/or treatment plan

Reactive Attachment Disorder and Disinhibited Social Engagement Disorder are serious clinical conditions. However, close and ongoing collaboration between the child's family and the treatment team will increase the likelihood of a successful outcome.

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Bipolar disorder (formerly called manic depressive illness) is an illness of the brain that causes extreme changes in a person’s mood, energy, thinking, and behavior. Children with bipolar disorder have periods (or episodes) of mania and depression.

**Manic Episodes:** An episode of mania includes a period where someone’s mood has changed and it is elevated (overly happy), expansive, or very irritable and the person also has increased energy at the same time.

Other manic symptoms may include:

- Unrealistic highs in self-esteem - for example, a child or adolescent who feels all-powerful or like a superhero with special powers
- Great increase in energy
- Decreased need for sleep such as being able to go with little or no sleep for days without feeling tired
- Increase in talking - when the child or adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted
- Distractibility - the child's attention moves constantly from one thing to the next
- Thinking more quickly - for example, thoughts are on “fast forward”
- Repeated high risk-taking behavior, such as abusing alcohol and drugs, reckless driving, or sexual promiscuity

**Depressive Episodes:** People who have bipolar disorder may also experience periods of depression. An episode of depression includes low, depressed, or irritable mood.

Other symptoms of a depressive episode may include:

- Decreased enjoyment in favorite activities
- Low energy level or fatigue
- Major changes in sleeping patterns, such as oversleeping or difficulty falling asleep
- Poor concentration
- Complaints of boredom
- Major change in eating habits such as decreased appetite, failure to gain weight or overeating
- Frequent complaints of physical illnesses such as headaches or stomach aches
- Thoughts of death or suicide
Some of these signs are similar to those that occur in children and adolescents with other problems such as drug abuse, attention-deficit hyperactivity disorder, major depressive disorder, disruptive mood dysregulation disorder, or even schizophrenia.

Bipolar disorder can begin in childhood or during the teenage years. 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.

The diagnosis of bipolar disorder in children and teens is complex and involves careful observation over an extended period of time. A comprehensive evaluation by a child and adolescent psychiatrist or trained mental health professional can help identify bipolar disorder and is the first step to starting treatment. Children and 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, or atypical antipsychotics, and psychotherapy. Medications often reduce the number and severity of manic episodes, and may also help to prevent depression. Psychotherapy helps the child understand himself or herself, adapt to stresses, rebuild self-esteem, and improve relationships.

Visit Bipolar Med Guide.

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"Conduct disorder" refers to a group of repetitive and persistent behavioral and emotional problems in youngsters. Children and adolescents with this disorder have great difficulty following rules, respecting the rights of others, showing empathy, 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 lead to a child developing conduct disorder, including brain damage, child abuse or neglect, 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
- delights in being cruel and mean to others
- starts 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 hurting them
- forces someone into sexual activity
- shows no genuine remorse after an aggressive episode

**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 stays away from

Children who exhibit these behaviors should receive a comprehensive evaluation by an experience mental health professional. 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.

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, community (including the legal system) 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 help to develop and carry out special management and educational programs in the home and at school. Home-based treatment programs such as Multisystemic Therapy (MST) are effective for helping both the child and family.

Treatment may also include medication in some youngsters who may have difficulty paying attention, impulse problems, or 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.

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Depression in Children and Teens

No. 4; Updated October 2018

Many children have times when they are sad or down. Occasional sadness is a normal part of growing up. However, if children are sad, irritable, or no longer enjoy things, and this occurs day after day, it may be a sign that they are suffering from major depressive disorder, commonly known as depression. Some people think that only adults become depressed. In fact, children and adolescents can experience depression, and studies show that it is on the rise. More than one in seven teens experience depression each year.

Common symptoms of depression in children and adolescents include:

- Feeling or appearing depressed, sad, tearful, or irritable
- Not enjoying things as much as they used to
- Spending less time with friends or in after school activities
- Changes in appetite and/or weight
- Sleeping more or less than usual
- Feeling tired or having less energy
- Feeling like everything is their fault or they are not good at anything
- Having more trouble concentrating
- Caring less about school or not doing as well in school
- Having thoughts of suicide or wanting to die

Children also may have more physical complaints, such as frequent headaches or stomach aches. Depressed adolescents may use alcohol or other drugs as a way of trying to feel better.

We don't always know the cause of depression. Sometimes it seems to come out of nowhere. Other times, it happens when children are under stress or after losing someone close to them. Bullying and spending a lot of time using social media may be associated with depression. Depression can run in families. Having another condition such as attentional problems, learning issues, conduct or anxiety disorders also puts children at higher risk for depression.

Sometimes parents are not sure if their child is depressed. If you suspect your child has depression, try asking them how they are feeling and if there is anything bothering them. When asked directly, some children will say that are unhappy or sad, while others will say they want to hurt themselves, be dead, or even that they want to kill themselves. These statements should be taken very seriously because depressed children and adolescents are at increased risk of self harm. Another way of identifying depression is through "screening" by your child's pediatrician, who may ask your child questions about their mood or ask them to fill out a brief survey.
If you think your child or teenager might be depressed, it is important to seek help. A pediatrician, school counselor, or qualified mental health professional can help by referring your child to someone who can conduct a comprehensive assessment, diagnose depression, and identify the right treatments.

The good news is that there are several effective treatments for depression. Treatment may include psychotherapy (or "talk therapy"), meetings with your family, and, with your permission, discussions with your child's school. Cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT) are forms of psychotherapy shown to be effective in treating depression. Treatment may also include the use of antidepressant medication. The potential risks and benefits of any medicine should be carefully discussed. Learn more about medications used to treat depression in children and adolescents.

AACAP wishes to thank the Klingenstein Third Generation Foundation for supporting production of the depression in Children and Teens and Suicide in Children and Teens Facts for Families.

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Disruptive Mood Dysregulation Disorder (DMDD) is a relatively new diagnosis in the field of mental health. Children with DMDD have severe and frequent temper tantrums that interfere with their ability to function at home, in school or with their friends. Some of these children were previously diagnosed with bipolar disorder, even though they often did not have all the signs and symptoms. Research has also demonstrated that children with DMDD usually do not go on to have bipolar disorder in adulthood. They are more likely to develop problems with depression or anxiety.

Many children are irritable, upset or moody from time to time. Occasional temper tantrums are also a normal part of growing up. However, when children are usually irritable or angry or when temper tantrums are frequent, intense and ongoing, it may be signs of a mood disorder such as DMDD.

**Symptoms of DMDD**

The symptoms of DMDD include:

- Severe temper outbursts at least three times a week
- Sad, irritable or angry mood almost every day
- Reaction is bigger than expected
- Child must be at least six years old
- Symptoms begin before age ten
- Symptoms are present for at least a year
- Child has trouble functioning in more than one place (e.g., home, school and/or with friends)

Some of the symptoms associated with DMDD are also present in other child psychiatric disorders, such as depression, bipolar disorder and oppositional defiant disorder. Some children with DMDD also have a second disorder, such as problems with attention or anxiety. This is why it is particularly important to get a comprehensive evaluation by a trained and qualified mental health professional.

**What To Do**

The treatment for DMDD will be individualized to the needs of the particular child and his or her family. It may include individual therapy, as well as work with the child's family and/or school. It may also include the use of medication to help address specific symptoms.

Parents of children with DMDD should learn as much as they can about the disorder. They should ask lots of questions about the risks and benefits of specific treatment options before deciding what
is best for their child. If they have questions or concerns about the diagnosis or treatment alternatives, they should always feel free to get a second opinion.

Having a child with DMDD can be a challenging experience. Appropriate treatment for your child is important. However, it is also important to make sure you have the information, support and assistance you need.

More information about children with DMDD and other challenging behaviors is available from:
The Balanced Mind Foundation at www.thebalancedmind.org
National Alliance on Mental Illness at www.nami.org
Mental Health America at www.mentalhealthamerica.net

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In the United States, as many as 10 in 100 young women suffer from an eating disorder. Disordered eating related to stress, poor nutritional habits, and food fads are relatively common problems for youth. In addition, two psychiatric eating disorders, anorexia nervosa and bulimia, are on the increase among teenage girls and young women and often run in families. These two eating disorders also occur in boys, but less often.

Parents frequently wonder how to identify symptoms of anorexia nervosa and bulimia. These disorders are characterized by a preoccupation with food and a distortion of body image. Unfortunately, many teenagers hide these serious and sometimes fatal disorders from their families and friends.

Symptoms and warning signs of anorexia nervosa and bulimia include the following:

- A teenager with anorexia nervosa is typically female, and a perfectionist and a high achiever in school. At the same time, she suffers from low self-esteem, irrationally believing she is fat regardless of how thin she becomes. Desperately needing a feeling of mastery over her life, the teenager with anorexia nervosa experiences a sense of control only when she says "no" to the normal food demands of her body. In a relentless pursuit to be thin, the girl starves herself. This often reaches the point of serious damage to the body, and in a small number of cases may lead to death.
- The symptoms of bulimia are usually different from those of anorexia nervosa. The patient binges on large quantities of high-caloric food and/or purges her body of dreaded calories by self-induced vomiting, extreme exercise, or laxatives. The binges may alternate with severe diets, resulting in dramatic weight fluctuations. Teenagers may try to hide the signs of throwing up by running water while spending long periods of time in the bathroom. Frequent vomiting can cause a serious threat to the patient's physical health, including dehydration, hormonal imbalance, the depletion of important minerals, and damage to vital organs.

Binge eating can also occur on its own without the purging of bulimia and can lead to eventual purging. Children with binge eating disorder also require treatment from a mental health professional.

Avoidant/Restrictive Food Intake Disorder (or ARFID) is another eating disorder which can occur in younger children or adolescents. It involves a disturbance in eating or feeding which includes substantial weight loss or a lack of expected weight gain, and nutritional deficiencies. ARFID can lead to dependence on a feeding tube or dietary supplements.

With comprehensive treatment, most children and teenagers can recover from disordered eating. The child and adolescent psychiatrist is trained to evaluate, diagnose, and treat these psychiatric disorders. Treatment for eating disorders usually requires a team approach, including individual therapy, family therapy, working with a primary care physician, working with a nutritionist, and medication. Many children and adolescents also suffer
from other problems including depression, anxiety, and substance abuse. It is important to recognize and get appropriate treatment for these problems as well.

Research shows that early identification and treatment leads to more favorable outcomes. Parents who notice symptoms of anorexia or bulimia in their teenagers should ask their family physician or pediatrician for a referral to a child and adolescent psychiatrist.

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Intellectual disability (ID) is a diagnosis given when an individual has problems both in intellectual functioning and the ability to function in everyday activities. An individual with ID may have problems with speaking, reading, eating, using a telephone, taking care of themselves, or interacting appropriately with others. In the past, we used to use the term "mental retardation," but we no longer use that term. Intellectual disability is diagnosed before the age of 18. Most children with intellectual disabilities can learn a great deal and as adults may have partially or even fully independent lives. Individuals with intellectual disabilities may also have different physical problems such as seizures, seeing, hearing, or speaking.

When intellectual disabilities are suspected, it is very important that the child has a comprehensive evaluation to find out the cause of the intellectual disability, and strengths and specific needs to support gaining new skills. Many professionals are involved in the evaluation. General medical tests as well as tests in areas such as neurology (the nervous system), psychology, psychiatry, special education, hearing, speech and vision, and physical therapy are part of the evaluation. A clinician, often a pediatrician or a child and adolescent psychiatrist, coordinates these tests.

When the evaluation is done, the evaluation team along with the family and the school develop a comprehensive treatment and education plan. When a child has intellectual disabilities, the goal is to help the child stay with the family and take part in community life. Each state offers a variety of educational and support services.

Emotional and behavioral disorders may be associated with intellectual disabilities, and they may interfere with the child's progress. Most children with intellectual disabilities recognize that they are behind others of their own age. Some may become frustrated, withdrawn or anxious, or act "bad" to get the attention of other youngsters and adults. Children and teens with intellectual disabilities may be victims of bullying in school and social settings. Adolescents and young adults with intellectual disabilities may become depressed and even suicidal. Youth, teens, and young adults may not have the language skills needed to talk about their feelings, and their depression may be shown by new problems in their behavior, eating, and sleeping. It is important to have your child with intellectual disabilities evaluated both medically and psychiatrically if you noticed sudden changes in the child's behaviors, including aggressive behaviors. The child may also be experiencing an underlying medical problem that they cannot tell you about.

Early diagnosis of psychiatric disorders in children with intellectual leads to early treatment. Medications can also be helpful as one part of overall treatment and management of children with intellectual disabilities.

Working with a child and adolescent psychiatrist over the course of childhood can help the family in
setting appropriate expectations, limits, opportunities to succeed, and other measures which will help their child with intellectual disabilities handle the stresses of growing up. In your state, you and your child may have a case manager to help make sure all of the services are being given to your child. There is hope; each child is different and may reach goals not felt possible when the diagnosis of intellectual disability was made.

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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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Obsessive-compulsive disorder (OCD) usually begins in adolescence or young adulthood and is seen in as many as 1 in 200 children and adolescents. OCD is characterized by recurrent intense obsessions and/or compulsions that cause severe discomfort and interfere with day-to-day functioning. Obsessions are recurrent and persistent thoughts, impulses, or images that are unwanted and cause marked anxiety or distress. Frequently, they are unrealistic or irrational. They are not simply excessive worries about real-life problems or preoccupations. Compulsions are repetitive behaviors or rituals (like hand washing, keeping things in order, checking something over and over) or mental acts (like counting, repeating words silently, avoiding). In OCD, the obsessions or compulsions must cause significant anxiety or distress, or interfere with the child's normal routine, academic functioning, social activities, or relationships.

The obsessive thoughts may vary with the age of the child and may change over time. A younger child with OCD may have persistent thoughts that harm will occur to himself or a family member, for example an intruder entering an unlocked door or window. The child may compulsively check all the doors and windows of his home after his parents are asleep in an attempt to relieve anxiety. The child may then fear that he may have accidentally unlocked a door or window while last checking and locking, and then must compulsively check over and over again.

An older child or a teenager with OCD may fear that he will become ill with germs, AIDS, or contaminated food. To cope with his/her feelings, a child may develop "rituals" (a behavior or activity that gets repeated). Sometimes the obsession and compulsion are linked; "I fear this bad thing will happen if I stop checking or hand washing, so I can't stop even if it doesn't make any sense."

Research shows that OCD is a brain disorder and tends to run in families, although this doesn't mean the child will definitely develop symptoms if a parent has the disorder. A child may also develop OCD with no previous family history.

Children and adolescents often feel shame and embarrassment about their OCD. Many fear it means they're crazy and are hesitant to talk about their thoughts and behaviors. Good communication between parents and children can increase understanding of the problem and help the parents appropriately support their child.

Most children with OCD can be treated effectively with a combination of psychotherapy (especially cognitive and behavioral techniques) and certain medications, for example, serotonin reuptake inhibitors (SSRIs). Family support and education are also central to the success of treatment. Seeking help from a child and adolescent
psychiatrist is important both to better understand the complex issues created by OCD as well as to get treatment

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Posttraumatic Stress Disorder (PTSD)

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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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Schizophrenia In Children

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Schizophrenia is a serious psychiatric illness that causes changes in thinking, feelings, and unusual or strange behavior. It is uncommon in children and hard to recognize in its early phases. Symptoms that are more prominent may be noted in adolescents and young adults. The cause of schizophrenia is not known. Current research suggests a combination of brain changes, biochemical causes, genetic and environmental factors. Early diagnosis and medical treatment are important. Schizophrenia is a life-long disease that can be controlled but not cured.

The symptoms and behavior of children and adolescents with schizophrenia may be different from those of adults with this illness. The following symptoms and behaviors can occur in children or adolescents with schizophrenia:

- seeing things and hearing voices which are not real (hallucinations)
- odd and eccentric behavior and/or speech
- unusual or bizarre thoughts and ideas
- confusing television and dreams from reality
- confused thinking
- new academic problems
- extreme moodiness
- personality changes
- ideas that people are out to get them or talking about them (paranoia)
- severe anxiety and fearfulness
- difficulty relating to peers and/or keeping friends
- withdrawal and increased isolation
- worsening personal grooming

The behavior of children with schizophrenia may change slowly over time. For example, children who used to enjoy relationships with others may start to become more shy or withdrawn and seem to be in their own world. Sometimes youngsters will begin talking about strange fears and ideas. They may start to say things that do not make sense. These early symptoms and problems may first be noticed by the child's teachers. Children with these symptoms must have a complete evaluation. Parents should ask their family physician or pediatrician to refer them to a child and adolescent psychiatrist, who is specifically trained and skilled at evaluating, diagnosing, and treating children with schizophrenia. Treating children with schizophrenia can involve a combination of medication, individual therapy, and family therapy, and specialized programs (school, activities, etc.) are often necessary. Psychiatric medication can be helpful for many of the symptoms of the illness. These medications require careful monitoring by a psychiatrist (preferably a child and adolescent psychiatrist).
An experienced child and adolescent psychiatrist should be able to differentiate changes in thinking, feelings, and unusual behavior that could be due to a person’s or their families’ cultural belief system versus changes caused by a mental illness. Families should feel comfortable discussing these beliefs with their mental health providers; for example, some cultures believe they can communicate with deceased individuals, and so on. Please let your doctor know if these or other beliefs are part of your family’s belief and cultural structure.

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Self-injury is the act of deliberately harming body tissue, at times to change a way of feeling. Self-injury is seen differently by groups and cultures within society. The behavior has become more popular lately, especially in adolescents. The causes and severity of self-injury can vary. Some forms may include:

- Carving
- Scratching
- Branding
- Marking
- Picking and pulling skin and hair
- Burning/abrasions
- Cutting
- Biting
- Head banging
- Bruising
- Hitting
- Tattooing
- Excessive body piercing

Some adolescents may self-mutilate to take risks, rebel, reject their parents' values, state their individuality, or merely be accepted. Others may injure themselves out of desperation or anger to seek attention, to show their hopelessness and worthlessness, or because they have suicidal thoughts. These children may suffer from serious psychiatric problems such as depression, psychosis, posttraumatic stress disorder (PTSD), and bipolar disorder. Additionally, some adolescents who engage in self-injury may develop borderline personality disorder as adults. Some young children may resort to self-injurious acts from time to time but often grow out of it. Children with developmental delays and/or autism spectrum disorder as well as children who have been abused or abandoned may also show these behaviors.

**Why do adolescents self-injure?**

Self-injury is a complex behavior and symptom that results from a variety of factors. Adolescents who have difficulty talking about their feelings may show their emotional tension, physical discomfort, pain, and low self-esteem with self-injurious behaviors. Although some teenagers may feel like the steam in the pressure cooker has been released following the act of harming themselves, others may feel hurt, anger, fear, and hate. The effects of peer pressure and contagion can also influence adolescents to injure themselves. Even though fads come and go, most of the wounds on the adolescents' skin will be permanent. Occasionally, teenagers may hide their scars, burns, and bruises due to feeling embarrassed, rejected, or criticized about their physical appearance.
What can parents and teenagers do about self-injury?
Parents are encouraged to talk with their children about respecting and valuing their bodies. Parents should also serve as role models for their teenagers by not engaging in acts of self-harm. Some helpful ways for adolescents to avoid hurting themselves include learning to:

- Accept reality and find ways to make the present moment more tolerable
- Identify feelings and talk them out rather than act on them
- Distract themselves from feelings of self-harm (for example, counting to ten, waiting 15 minutes, saying "No!" or "Stop!," practicing breathing exercises, journaling, drawing, thinking about positive images, using ice and rubber bands)
- Stop, think, and evaluate the pros and cons of self-injury
- Soothe themselves in a positive, non-injurious way
- Practice positive stress management
- Develop better social skills

Evaluation by a mental health professional may assist in identifying and treating the underlying causes of self-injury. Feelings of wanting to die or kill themselves are reasons for adolescents to seek professional care immediately. A child and adolescent psychiatrist can also diagnose and treat the serious psychiatric disorders that may accompany self-injurious behavior.

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Experiments with alcohol and drugs during adolescence are common. Unfortunately, teenagers often don't see the link between their actions today and the consequences tomorrow. They also have a tendency to feel indestructible and immune to the problems that others experience.

Using alcohol and tobacco at a young age has negative health effects. Some teens will experiment and stop, or continue to use occasionally without significant problems. Others will develop a dependency, moving on to more dangerous drugs and causing significant harm to themselves and possibly others. It is difficult to know which teens will experiment and stop and which will develop serious problems. Teenagers at risk for developing serious alcohol and drug problems include those:

- with a family history of substance use disorders
- who are depressed
- who have low self-esteem, and
- who feel like they don't fit in or are out of the mainstream

Teenagers abuse a variety of drugs, both legal and illegal. Legally available drugs include alcohol, prescribed medications, inhalants (fumes from glues, aerosols, and solvents) and over-the-counter cough, cold, sleep, and diet medications. The most commonly used illegal drugs are marijuana (pot), stimulants (cocaine, crack, and speed), LSD, PCP, opiates or opioid pain killers, heroin, and designer drugs (Ecstasy). The use of illegal drugs is increasing, especially among young teens. The average age of first marijuana use is 14, and alcohol use can start before age 12. The use of marijuana and alcohol in high school has become common.

Often teenagers use other family members' or friends' medications to get high. Additionally, some adolescents misuse their friends' stimulant medications like Ritalin and Adderall.

Drug use is associated with a variety of negative consequences, including increased risk of serious drug use later in life, school failure, and poor judgment which may put teens at risk for accidents, violence, unplanned and unsafe sex, and suicide.

Parents can prevent their children from using drugs by talking to them about drugs, open communication, role modeling, responsible behavior, and recognizing if problems are developing. Prescription pain killers like opioids should be kept secure and closely monitored. Any prescription medications that are no longer being used should not remain in the home.

**Warning signs of teenage alcohol and drug use may include:**

**Physical:** Fatigue, repeated health complaints, red and glazed eyes, and a lasting cough.

**Emotional:** personality change, sudden mood changes, irritability, irresponsible behavior, low self-esteem, poor judgment, depression, and a general lack of interest.

**Family:** starting arguments, breaking rules, or withdrawing from the family.

**School:** decreased interest, negative attitude, drop in grades, many absences, truancy, and discipline problems.
Social problems: new friends who are less interested in standard home and school activities, problems with the law, and changes to less conventional styles in dress and music.

Some of the warning signs listed above can also be signs of other problems. Parents may recognize signs of trouble and possible use of alcohol and other drugs with their teenager. If you have concerns you may want to consult a physician to rule out physical causes of the warning signs. This should often be followed or accompanied by a comprehensive evaluation by a child and adolescent psychiatrist or mental health professional.

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