CHILDREN AND MENTAL HEALTH

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SEE THE CHILD

- No matter what the diagnosis or symptoms, there is a child behind all of the labels. See the child first, not the diagnosis
- No matter what label you give the behaviors, you still have to manage the child

WHAT IS MENTAL HEALTH?

- There is no such thing as perfect mental health
- It changes and evolves over our life span
- Children with mental health problems are still in an intense "growth spurt"
- There are significant cultural differences in how we assess, cope with and treat behaviors and symptoms

THE CULTURE OF MENTAL HEALTH

- The culture of diagnosis and DSM-IV
- One child's community may value the symptoms another community is trying to medicate away
- Know how problematic or accepted a behavior or symptom is in the child's community

JARGON

- **DSM-IV** – Diagnostic and Statistical Manual Revision 4. The book that is used to identify, organize and understand a group of behaviors and/or symptoms.
- **Diagnosis** – the name or label that fits or matches the list of symptoms. It is used on insurance forms for reimbursement.
- **DC-03** – Diagnostic Criteria for children zero to three years old.

MORE JARGON

- **Co-morbidity** – more than one problem or diagnosis
- **Prognosis** – what the outcome or end result might be
- **Onset** – when the symptoms develop, the start
- **Mental illness** – not the same as having a mental health problem

CHILD DEVELOPMENT

- Significant mental health problems can and do impact a child's ability to master their developmental tasks

- It is time to intervene when a child is struggling and feels distress about their inability to master age appropriate skills and tasks

IMPACT OF NEGLECT/ABUSE

- Children who have been neglected or abused will go through the developmental milestones differently at almost every stage
- Each child will address these past hurts differently
- They are hard-wired differently
- Many of them have mental health concerns

DIAGNOSING YOUNG CHILDREN

- A new protocol, DC-03
- Very young children suffer from living in bad situations
- Assessing children early gives us a way to intervene sooner
- Mental health disorders look different at various ages/stages

IT'S NOT ABOUT YOU!

- It seems as though they are purposefully trying to make life difficult!
- They are often are very limited in their ability to make good choices
- They have diminished capacity

POTPOURRI

- Autism Spectrum - **ASD**
- Depression/Anxiety
- Post Traumatic Stress Disorder - **PTSD**
- Attention Deficit Disorder – **ADD/H**
- Oppositional Defiant Disorder - **ODD**
- Reactive Attachment Disorder - **RAD**
- Fetal Alcohol Spectrum Disorder - **FASD**

WHAT ABOUT DUAL DIAGNOSIS?

There is almost always more than one thing going on in the mental health arena of the children we provide care for

AUTISM
ASD - UNCLEAR ORIGINS

- Most researchers believe that it is caused by a combination of genetic vulnerabilities and environmental triggers
- It can be inherited. Some families seem to be especially vulnerable, with several children with ASD
- It is a neurologically based disorder of development

AUTISM SYMPTOMS

- Tactile defensiveness
- Easily over stimulated
- Perseveration – repetitive behaviors
- Spinning, head banging, rocking
- Difficulty communicating, can't explain
- Difficulty with transitions
- Impaired motor skills - clumsy

AUTISM CLINICAL CHARACTERISTICS

- Deviations or abnormalities in three broad domains:
  - Social relatedness and social skills
  - Use of language for communication
  - Stylistic and repetitive, perseverative behavior with an **intense and narrow range of interest**

AUTISM INTERVENTIONS

- Identify the child's strengths and interests and use what motivates them
- Create opportunities for choice making and the need for a break
- Try to honor refusals when possible
- **Don't ask them to earn the thing they need to regulate themselves**

SLOW DOWN

1. Allow time to process
2. Have an intentional plan
3. Be clear on what the next step is
4. Allow more time for transitions
5. Speak slowly, speak less
6. Take time to read the child's cues, signals and provide support

AUTISM TREATMENT

- The physical environment matters a great deal
- Break tasks down into manageable steps
- Follow a routine with predictable structure
- Have realistic expectations
- Don't assume they feel, think, desire and care less than typical children

AUTISM MEDICATION

- Many children with ASD use medication to sleep, for anxiety, for improved focus
- Sometimes symptoms can be alleviated with medication

AUTISM PROGNOSIS

- There is no (known) cure
- New research supports the possibility of dramatically improved understanding of this disorder
- It is typically a **lifelong** disorder, with the need for adaptive strategies throughout the lifespan

WHAT CAREGIVERS REPORT

- Finding good services and competent professional helpers is as stressful as the disorder itself
- Siblings in the home have many losses
- The family defines itself based on ASD

ASD CO-OCCURRING DISORDERS

- They look highly anxious = they are!!!
- They qualify for non-verbal learning disorder diagnosis
- They can and are frequently oppositional and defiant
- Treatment approaches for autism take precedence. As a diagnosis, autism would be considered primary

DEPRESSION-ORIGINS

- Major depression is a brain-based illness
- There is no singular cause
- It is not necessarily related to a major life event or stressor, but many times it is
- One in five teens in the US have this disorder

DEPRESSION CONTRIBUTING FACTORS

- Genetics – a family history of mood disorders
- Alcohol abuse/use and other drugs
- Major loss or changes in life
- Chronic stress

DEPRESSION SYMPTOMS

- Changes in sleep
- Changes in appetite
- Impaired concentration, short-term memory, lack of focus and decision making
- Loss of energy
- **Loss of interest**
- Feelings of hopelessness

DEPRESSION CHARACTERISTICS

- These kids are volatile
- They appear defiant in their stance and often are passive aggressive or aggressive as a way to manage
- They have VERY low self esteem
- They have no insight into why they behave the way they do
- They are often self-defeating with a "negative" worldview

DEPRESSION TREATMENT

- A combination of medication and supportive therapy is effective
- Most people have more than one episode of major depression
- 80% of brain-based episodes of depression respond favorably to treatment

THREATS OF SUICIDE

- Know who to call for help
- Know how to intervene
- Always take it seriously
- Seek professional help
- Always let others know the child is making these threats

SELF HARM OR SELF DESTRUCTIVE?

- Does the child have confidentiality when they do self harm? Does the caregiver?
- Self injurious behaviors (SIB) are destructive but typically not an indication of suicide
- Pay attention to a child who hurts their body They need interventions and support

DEPRESSION INTERVENTIONS

- Group work is great for school age children
- Family therapy is many times more useful than individual therapy
- Naming the problem as one of chemical imbalance rather than "bad choices" or negative attitude is useful
- Find small things a child can be successful at
- Tell the child it is not their "fault"

DEPRESSION PROGNOSIS

- Children with depression can recover and move to the next stage of development with no symptoms
- Reoccurrence may happen at different times
- Families learn how to "take into stride" the problems the child has and so does the child
- Ongoing services such as medication is usually good, as needed

DEPRESSION CO-MORBIDITY

- Depression presents along with
  - Anxiety
  - PTSD
  - RAD
  - ADHD
  - FASD
  - Or, all by itself!

ANXIETY

- Almost one in five children are born with anxiety
- Their brain is hard-wired differently (Dr. David Walsh)
- Many of the symptoms can be mistaken for depression
- It is environmental and neurologically based

ANXIETY CHARACTERISTICS

- Moody
- Irritable
- Sullen, withdrawn
- Lack of ability to regulate emotions
- Frequent crying/tantrums
- Loss of friends and lack of pleasure
- Intense anger/rage

ANXIETY SYMPTOMS

- They will not ask for help
- They may often refuse help
- Their rejection is often a test of your commitment
- They are deeply discouraged
- They believe they can't succeed and become dependent

ANXIETY TREATMENT

- Most effectively treated with medication and therapy
- Accurate and early diagnosis
- Therapy
  - Cognitive/behavioral
  - Interpersonal psychotherapy to focus on emotional and relationship disturbance
  - Support services within the community

ANXIETY INTERVENTIONS

- Practice doing the hard stuff
- Have a buddy or companion to tackle times that produce anxiety
- Don't push or punish when a child is afraid
- Offer rewards for success attempts
- Desensitization therapy can be helpful
- Biofeedback and relaxation to enhance feeling in control

ANXIETY MEDICATIONS

- Both anxiety and depressive disorders typically respond well to medications
- It may take some time to find the right dosage, and the right medication
- What may work for a time, may gradually decrease in effectiveness

ANXIETY PROGNOSIS

- The "anxious child" will probably always have a tendency to be a worried person with some fearfulness
- It does not have to rule or dictate a child's life as they get older
- More social supports and encouragement will be required at every stage of development
- It can cease to be a significant problem

ANXIETY CO-MORBIDITY

- Anxiety appears with many other diagnoses
  - Depression
  - PTSD
  - RAD
  - ASD
  - FASD
  - Bipolar

POST-TRAUMATIC STRESS DISORDER

- PTSD is an increasingly common diagnosis, but overall, is rare
- By virtue of losing their families, they have endured extreme distress and prolonged lack of security and safety

ONSET OF PTSD SYMPTOMS

- Symptoms can occur directly after the event or much later, for no obvious reason
- They can last from a few months to years
- The victim re-experiences the event in a way that makes them relive the trauma

PTSD ORIGINS

- It is an anxiety disorder that occurs after a person experiences or witnesses a traumatic event that they perceive as life threatening to self or others
- Most of the children that we see have extreme or layered trauma; that is, one trauma after another

PTSD CONTRIBUTING FACTORS

- Seriousness of trauma
- Repeated trauma or single episode
- Child's proximity to the trauma
- Child's relationship to the victim
- Child's relationship to the perpetrator
- Parental reaction
- Hyper vigilance

IMAGINE THE UNIMAGINABLE

- When the worst possible thing happens
- **Then it happens again**
- A child develops coping skills that look like "symptoms" when they come to your home

PTSD CLINICAL CHARACTERISTICS

- Intense fear, sleeplessness, intrusive thoughts, memories or pictures in the mind
- Dreams related to the event
- Anxiety
- Hyper vigilance, exaggerated startle response, often seem hyperactive
- Frequent physical complaints
- Reenactment of the event in play or work

PTSD SYMPTOMS

- Confusion, disorganized thoughts, difficulties concentrating
- Anger and irritability
- Freezing, dissociation (fight or flight)
- Night terrors, trouble falling, staying asleep
- Regression
- Auditory learning problems

PTSD OR ODD? FIGHT OR FLIGHT?

- Is the child defiant or frozen
- The child can act as though they had no conscience
- The child will dissociate – seems like they are not "there" with you.
- The child will have trouble learning in school

TANTRUM OR FLASHBACK?

- You may not always know what the child is reacting to
- Punishing these children may be pointless
- They need to know they won't always feel and act the way they do now

PTSD INTERVENTIONS

- **Early intervention** is important
- **Support** from parents, school and peers is important
- Child needs to believe they are **safe**
- Rituals to reestablish feeling a sense of control are helpful
- **Therapy**, individual, family, group

PTSD PRE-TEACHING

- What will you do next time, options?
- That was then, this is now, you are bigger, stronger, have more help.
- How did you feel and was your response helpful?

PTSD ACTION PLAN

- Stay calm
- Find the time
- Have a plan for the meltdown
- Get some history, if possible
- Encourage the child to have a buddy
- Know what comforts the child

PTSD TREATMENT

- Allows the child a safe way to discuss, show, express their trauma story
- Does **not** expect the child to tell their story repeatedly to a variety of people
- Does not assume a child will use words or language to express trauma
- Can retraumatize the child

PTSD MEDICATION

- Many children use a sleep aid to help them relax at night
- Sometimes an anti anxiety or anti depressant is useful
- They mimic the symptoms of ADHD but using a stimulant medication to treat PTSD is not a good idea. These kids are over stimulated already

PTSD PROGNOSIS

This is a disorder that can be treated and managed but will always be a part of the child's story

PTSD CO-MORBIDITY

PTSD shows up with several other diagnoses:

- RAD
- FASD
- Depression
- Anxiety/depression

ATTENTION DEFICIT HYPERACTIVE DISORDER - DIAGNOSING

- Frequently misdiagnosed
- Needs to be observed in several life domains – school, home, community
- Collateral information from parents and teachers is essential
- Use of the Connors Behavioral Checklist (CBCL) is standard
- Often "runs in the family"

ATTENTION SUB TYPES

- Attention deficit – ADD, they are not focused
- Impulsivity – act or talk before they think
- Hyperactivity – this is the "H", high energy
- These can occur distinctly or be combined

ADHD CLINICAL CHARACTERISTICS

- Can be observed in all major life domains
- Becomes more problematic during middle school years
- Child experiences failure and frustration in spite of efforts and desire to improve
- Teachers and parents view child as choosing to fail or not paying attention

ADHD SYMPTOMS

- Lack of attention, inability to stay focused on activities that are not novel or interesting
- Makes careless mistakes
- Seems tuned out or easily distracted
- Poor organization
- Impulsive/can't sit still, fidgets
- Poor social skills – can be volatile

ADHD SYMPTOMS

- They can't get organized
- They lack a sense of being good at things
- Transitions will be hard, they need time
- The child becomes easily frustrated and feels "dumb"

ADHD TREATMENT

- ADHD children perform better with familiar, consistent, structured routines with positive reinforcements
- Structure and routine are very helpful. Plan ahead and learn to anticipate. (Adaptive strategies)

ADHD TREATMENT

- Medication
- Cognitive/Behavioral therapy to develop coping strategies. Teaches the child how to "think" and plan
- Support and education with child and parents to develop routines and skills
- Adaptive strategies

ADHD INTERVENTIONS

- Reduce stimulation
- Limit their options and choices
- Touch, look at, show the child. Be with them. They are not good listeners
- Give them extra time
- Communication with the school is essential
- They need things broken down into small steps

WHAT ARE ADAPTIVE STRATEGIES?

- Lists
- A learning buddy
- Pictures instead of words
- Routines for key parts of the day
- Good relationships with the school
- Places to put things every day such as bins, boxes, drawers etc…

ADHD MEDICATION

- Medication is the single most effective method of treatment. These include stimulants and non stimulants. MUST BE CONSISTENT!!!
- Adderall, Strattera, Ritalin
- With social skills training only, the disorder is significantly harder to treat

ADHD PROGNOSIS

- With effective treatment, this is a highly manageable disorder
- Child can achieve success with adaptive strategies, good support and medication

ADHD CHALLENGES

- Know that the child is probably not intentionally being disrespectful
- Give them feedback AFTER the event
- Punitive consequences will fail to shape their behavior
- They are smarter than they "behave"

ADHD CO-MORBIDITY

- ADHD is often misdiagnosed and symptoms of PTSD are overlooked
- ADD is often overlooked
- It is often over diagnosed
- It goes hand in hand with several other disorders:
  - PTSD, ODD, Anxiety, ASD

OPPOSITIONAL DEFIANT DISORDER

- This is a recurring pattern of negative, hostile, disobedient and defiant behavior in a child or adolescent, lasting for at least six months without serious violation of the basic rights of others
- These children rate high on the "PITB scale"

ODD SYMPTOMS

- Spiteful, vindictive
- Persistently stubborn
- Won't negotiate. Their way is the only way
- Tests limits
- Ignores orders, requests
- Will not accept blame
- Loves to argue
- Deliberately annoying, swears, aggressive language

ODD CLINICAL CHARACTERISTICS

- Low self esteem
- Distressed peer relationships
- High value on being in control
- Lack of success in school settings
- Compliance is seen as giving in

ODD TREATMENT

- Individual, group and/or family therapy
- For child, a peer group that focuses on role play, friendship development, problem solving, anger control, relaxation and self talk
- For parents, it is stress management and providing structure and positive limits

ODD INTERVENTIONS

- The ODD child requires a caregiver/teacher with:
  - -A good support system
  - -Personal self control
  - -Effective communication
  - -Patience!!!

ODD INTERVENTIONS

- Use of positive, tangible rewards
- Identify the target behavior
- Set up rewards and consequences
- Have fair reinforcers that are meaningful
- Understand how fear and anxiety may be underlying causes of opposition

ODD PROGNOSIS

- Child often outgrows this behavior
- Left unaddressed, the behavior may become increasingly aggressive and more problematic (conduct disorder)
- Developmentally, many of the behaviors and symptoms are culturally normed for our society, relative to adolescent development

THE CONTEXT OF THE CHILD

- Our children are looking for ways to be in charge
- Adolescents often feel things are out of control
- Our society values and rewards those who appear to have power
- We do not know how to give power to children in safe or healthy ways

REACTIVE ATTACHMENT DISORDER

- The most extreme form of attachment disorder
- Attachment disorder occurs on a continuum, with RAD, or disorganized attachment disorder being the most severe, and rare
- The only label that DSM –IV recognizes for attachment problems is RAD

WHAT IS ATTACHMENT?

- Neurobiological in nature
- Attachment patterns are formed in the first three years of life
- It is part of the normal developmental process for all children
- The child's brain becomes hard-wired in terms of how they view relationships

THE WHOLE CHILD

- Children with RAD have suffered harm in many ways which include:
  - Neurological
  - Psychological
  - Physiological
  - Social
  - Emotional

RAD ORIGINS

- Pathogenic care giving
- Prenatal exposure to violence/alcohol
- Caregiver depression or severe mental illness
- Severe neglect and/or abuse
- Early and chronic pain or hospitalizations

RAD CLINICAL CHARACTERISTICS

- Hyper-vigilance
- Poor physical/emotional boundaries
- Overly needy or overly self reliant
- Lacks ability to self regulate emotional states
- Distressed peer and family relationships
- Eating/sleeping/hoarding/stealing issues
- INABILITY TO TRUST

RAD SYMPTOMS ANXIOUS & COMPULSIVE BEHAVIORS

- Lying
- Stealing
- Hoarding
- Chatting non-stop
- Self harm and mutilation
- Addiction

RAD WHY PUNITIVE CONSEQUENCES WON'T WORK

- They are not linear thinkers
- They are not auditory learners
- They have already lost everything
- All they have is their pride, backing down is seen as loss of power, which scares them

RAD TREATMENT

- Therapy for this disorder is relationship based. Best practice includes the primary caregiver to develop a connection that is reciprocal and safe
- It is typically long term and family centered
- Multisensory (taste, touch, sight, smell, movement) approaches are most effective; it is about doing, not talking

RAD TREATMENT

- They are not motivated by the same things that typically developed children care about
- Constancy and continuity in caregiver
- Positive, compassionate parenting
- Attend to the emotions, not the behaviors (the core issue that gets in the way of trust)

NORMATIVE CRISIS FOR CAREGIVERS

- I don't like the child
- I can't help this child
- I am not very good at this
- This child would do better somewhere else
- There is something wrong with me

PROJECTION

- The caring/engaged adult will be treated as if:
  - They had been the abuser
  - They had abandoned the child
  - They had molested the child
  - They had lied to the child
  - They were responsible for all the pain the child feels
  - IT IS PERSONAL!!!

RAD IDEAS

- Be consistent
- Attention is all there is, not good or bad
- Look at the child, touch the child, be sad for the child when giving a consequence.
- Don't ask "*why*", use "how", "what"
- Use words to identify feelings – give them language skills

PARTS LANGUAGE

- Children have many parts to them
- Help the child identify the easy parts or the hard parts, the manageable parts from the unmanageable one
- The ones that love and the parts that get angry or cause hurt

RAD PROGNOSIS

- These children can and do get better
- It has everything to do with good care giving relationships that are available to support the child's healing. The child will not get better because they "choose" to get better

RAD CO-MORBIDITY

- Reactive Attachment as a diagnosis would almost always take a front seat in terms of how to treat and intervene
- You can treat symptoms of anxiety and depression or hyperactivity but in general, it is the lack of regulation, brain development and negative coping skills that are the source of the problems

FETAL ALCOHOL SPECTRUM DISORDER

- When mom drinks during pregnancy the forming brain can be severely impaired
- It is permanent
- It causes many problems for the child life long and for the child's family

WHEN FASD MEETS RAD

- These two disorders are often seen in tandem
- This is a very challenging condition to treat and to live with
- Most children with FASD have some level of difficulty in forming strong, reciprocal attachments
- Many RAD children have been prenatally exposed to AOD

FASD CLINICAL CHARACTERISTICS

- Short term memory problems
- Organization of time, events in space
- Auditory learning problems
- Learning lags and learning disabilities
- Smaller body, stunted growth
- Facial characteristics
- Impulsivity and lack of problem solving skills

FASD SYMPTOMS

- Quick to have a melt down
- Has trouble accepting responsibility
- Makes the same mistakes over and over
- Does not put sequences together
- Has very poor social and emotional boundaries.
- Lies, takes things, breaks the rules

FASD TREATMENT

- Support and educate the caregiver
- Find a specialist
- High structure, repetition, nurture and parenting for life is required
- Interventions are similar in nature to Autism, with managing the environment, consistency, life-long impairment

THE CAN'T/WON'T QUESTION

- **Don't expect them to do something they can't do**
- **Children want to be successful, but they are afraid**
- **FASD kids want to but CAN'T**

FASD PROGNOSIS

- It is life long
- Launching these children is not the typical process
- They will need some level of supportive services at all ages
- They can and do accomplish great things, get married, have healthy babies, and get jobs

FASD CO-MORBIDITY

- This diagnosis takes precedence over everything else
- All interventions must take into consideration how this child processes, remembers and uses information
- The attachment formations always need to be taken into account

IN SUMMARY

- **There is usually more than one thing going on for children with mental health problems**
- **Using a professional and informal support system is essential for caregivers**
- **These children often do overcome or learn to manage their disabilities**
- **It requires dedication and commitment and hard work by everyone**

CARE ABOUT THE CAREGIVER

- Grief continues to be the most common reaction from parents who are raising children with mental illness
- This response is largely unrecognized and untreated and commonly misinterpreted as parental pathology

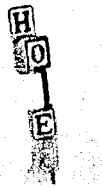
DIGNITY

- Too often we compromise a child's dignity as we discuss their challenges and our frustrations
- Reports are written, meetings are held, files are exchanged, secrets are shared, privacy is compromised, and the child loses a sense of dignity and privacy in the process
- This can be true for caregivers also

YOUR RESOURCES

- The school
- Social Services
- Children's mental health case management
- The police, doctor, personal care attendant
- Your mental health professional
- Informal supports such as parent groups and respite providers

REMAIN HOPEFUL



- *Believe* in the power of the human spirit
- *Believe* in the hopefulness of childhood
- *Believe* in yourself and what you bring to the process

TRAINING QUESTION?

Email your Children and Mental Health VPC training question to:

[redacted]

Please maintain confidentiality by not disclosing any identifying information regarding children in your care

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Children and Adolescents

DEPRESSION FACT SHEET

NAMI MINNESOTA
National Alliance on Mental Illness

DEPRESSION is an illness that affects the whole body–thoughts, feelings, behavior and physical health.

DEPRESSION affects 2% of children and 4% of adolescents.

DEPRESSION affects all areas of a child's life–home, work, school and social life.

CLINICAL SYMPTOMS	WHAT DOES A PARENT/CAREGIVER SEE?
Persistent sad or irritable mood →	Sadness, hopelessness or irritable, angry and aggressive.
Loss of interest in everyday activities →	Boredom, dropping activities, loss of interest in fun activities.
Significant change in appetite or weight →	Frequent unexplained physical complaints such as headaches, muscle aches and pains, stomach aches, change in weight, worries a lot.
Difficulty sleeping or oversleeping **Loss of energy** **Difficulty concentrating** →	Frequent absences from school, poor performance in school, unable to concentrate or stay focused, unfinished tests, consistently forgets homework, sleepy.
Agitation or slowing of behavior →	Restless, can't sit still or speech and behavior slowed, sluggish, feeling edgy.
Feeling worthless or guilty →	Talks of running away from home, overreacts to disappointment or failure, low self esteem.
Ongoing thoughts of death or suicide →	Fear or preoccupation with dying, talking about people who have died.

EVIDENCE-BASED PRACTICES

are treatments that have shown through clinical research to produce positive outcomes for children and their families.

The most effective treatments for DEPRESSION are:

- Psychoeducation
- Problem Solving
- Activity Scheduling
- Relaxation
- Skill building
- Social Skills
- Cognitive Therapy

Children and Adolescents

ADHD/ATTENTION-DEFICIT/HYPERACTIVITY DISORDER FACT SHEET

NAMI MINNESOTA
National Alliance on Mental Illness

ADHD is an illness characterized by inattention, hyperactivity, and impulsivity.

ADHD is the most commonly diagnosed behavior disorder in young persons.

ADHD affects an estimated three to five percent of school age children.

ADHD affects all areas of a child's life–home, work, school and social life.

CLINICAL SYMPTOMS	WHAT DOES A PARENT/CAREGIVER SEE?
Inattentiveness →	Appears not to be listening, needs instruction repeated, obeying rules and following instructions are difficult, disorganized, doesn't finish what is started, easily distracted by external surroundings, often seems to be daydreaming, careless, forgetful.
Impulsivity →	Acts before thinking, constantly pestering, cannot keep hands to him/her self, often clumsy and accident prone, interrupts or intrudes on other's conversations and games, talks too much, talks too often and loud, difficulty waiting for turn.
Hyperactivity →	Seems irritable, impatient, unable to tolerate delay or frustration, fidgety, makes noises or distracts others, squirms, taps feet, shakes legs, always on the go.
Combined hyperactive/impulsive →	Significant difficulty in home, social or school settings beginning before age seven, can not function in two or more settings, symptoms are not due to another illness.

EVIDENCE-BASED PRACTICES

are treatments that have shown through clinical research to produce positive outcomes for children and their families.

The most effective treatments for ADHD are:

- Parent Psycho-education
- Active Ignoring
- Commands
- Tangible Rewards
- Attending
- Time Out
- Praise

Children and Adolescents

ANXIETY DISORDERS
FACT SHEET

NAMI MINNESOTA
National Alliance on Mental Illness

ANXIETY is an illness characterized by excessive fear or worry that repeatedly interferes with a child's well being.

ANXIETY DISORDER is the most common mental illness among children and adolescents.

ANXIETY DISORDER affects all areas of a child's life–home, work, school and social life.

CLINICAL SYMPTOMS	WHAT DOES A PARENT/CAREGIVER SEE?
Separation Anxiety Disorder/ Panic Disdorder →	Intense anxiety about separation from parents, clinging, refusal to sleep alone or to go to school; pounding heart, sweating, shaking, nausea, dizziness, fear of dying.
Social Phobia →	Noticeable anxiety in social situations, extremely self conscious, fear of humiliation or embarrassment, avoids social interaction but has good relations with familiar people or in one-to-one situations, refuses to speak in front of others.
Generalized Anxiety Disorder →	Many worries about everyday experiences such as school, sports and appearance, worries about things before they happen, fear of doing things wrong even though work is excellent, headaches, stomach aches, frequent tears.
Post Traumatic Stress Disorder (PTSD) →	Symptoms following exposure to an event involving actual or threatened death or serious injury, or a threat to the physical safety of self or others. *Symptoms fall into three categories: persistent re-experiencing of the negative event, avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal.*

EVIDENCE-BASED PRACTICES

are treatments that have shown through clinical research to produce positive outcomes for children and their families.

The most effective treatments for ANXIETY DISORDERS are:

- Psycho-education
- Cognitive Therapy
- Relaxation
- Self-monitoring
- Attending
- Problem Solving
- Exposure

Children and Adolescents

ODD and CD: Disruptive Behavior Disorder

FACT SHEET

NAMI MINNESOTA
National Alliance on Mental Illness

OPPOSITIONAL DEFIANT DISORDER is hostile, inflexible behavior.

CONDUCT DISORDER is intentional, physically aggressive and cruel with people.

DISRUPTIVE BEHAVIOR DISORDER is an ongoing pattern of uncooperative, defiant, and hostile behavior toward authority figures that seriously interferes with the child's day to day functioning.

DISRUPTIVE BEHAVIOR DISORDER seriously affects all areas of a child's life–home, work, school and social life.

CLINICAL SYMPTOMS	WHAT DOES A PARENT/CAREGIVER SEE?
Anger, hostility →	Negative, hostile, defiant, excessive arguing with adults, will not comply with adult requests and rules, intense rigidity, touchy, easily annoyed.
Uncooperative, defiant →	Deliberate attempts to annoy or upset people, bullying, blaming others for his or her mistakes or misbehavior, lack of remorse, aggressive and cruel with people and animals, destructive, seeks revenge when things go badly, lying, stealing, conniving.
Interpersonal difficulties →	Frightens and alienates family and classmates, anti-social, reckless, sociopathic behaviors causing serious harm to others - physical abuse, intimidation, loners who feel they have nothing to lose by acting worse.

EVIDENCE-BASED PRACTICES

are treatments that have shown through clinical research to produce positive outcomes for children and their families.

The most effective treatments for DISRUPTIVE BEHAVIOR DISORDERS are:

- Parent Management Training
- Parent Psycho-education
- Attending
- Praise
- Differential Reinforcement
- Commands
- Tangible Rewards
- Time Out