SELF-STUDY COURSE

Mental Health Disorders in Children and Adolescents: An Overview

Revised 8/07

3 Hours Credit

This self-study was developed utilizing materials from the following sources: Mental Health Training Curriculum: "Caring for Foster Children with Mental Health Issues.

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If you wish to receive training credit for reading this self-study, please fill out the "CHECK YOUR UNDERSTANDING" Questionnaire at the back of this course. Return the questionnaire to the Alaska Center for Resource Families for 3.0 hours of training credit. This course is yours to keep for further reference. Alaska Center for Resource Families, a project of Northwest Resource Associates, is funded through the State of Alaska Office of Children's Services to provide training and information to resource families statewide.

RETURN YOUR QUESTIONNAIRE TO:

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FOSTER PARENT COMPETENCIES

The foster parent will learn to collaborate with the foster child's therapist and understand the three phases of the counseling process including assessment, diagnosis and treatment.

LEARNING OBJECTIVES:

1: The foster parent will have a general understanding of children's mental health terms that will assist in navigating the mental health system.

2: The foster parent will know the many types of mental health professionals that may be involved in the foster child's assessment, diagnosis and treatment.

3: The foster parent will understand the phases of the counseling process including assessment, diagnosis and treatment.

4: The foster parent will learn how to advocate for mental health services by becoming an active participant in the treatment planning and counseling process.

Mental Health Disorders in Children and Adolescents:
Part One: An Introduction

Like adults, children can have mental health disorders which interfere with the way they think, feel and act. When untreated, or misunderstood, mental health disorders can lead to school failure, family conflicts, drug abuse, violence and even suicide.

Mental health is how people think, feel and act as they face life's situations, handle stress, relate to one another, and make decisions. Mental health influences the way people look at themselves, their lives and others in their lives. Like physical health, mental health is important in every stage of life.

Children and adolescents who have suffered child abuse are more likely to have some sort of mental health disorder. The causes are complicated and are due to both biology and environment.

Examples of biological causes are genetics, chemical imbalances in the body, or damage to the central nervous system, such as a head injury.

Many environmental factors also put young people at risk for developing mental health disorders. Examples include:

- Exposure to violence, such as witnessing or being the victim of physical or sexual abuse;
- Exposure to environmental toxins such as high levels of lead;
- Stress related to chronic poverty, natural disasters, or other serious hardships;
- Loss of important people through broken relationships such as placement in foster care, divorce, or death.

Signs Of Mental Health Disorders

Often foster or adoptive parents see a sign of mental health disorders before their social worker is aware of them. Children with these signs need help as soon as possible. A variety of signs may point to mental health disorders or serious emotional disturbances in children and adolescents.

Pay attention if a child or adolescent in your care has any of these warning signs:

A child is troubled by feeling:

- Sad or hopeless for no reason, and these feelings do not go away.
- Very angry most of the time, and crying a lot or over reacting to things.
- Worthless or guilty often.
- Anxious or worried often.
- Unable to get over loss of someone important after time passes.
- Extremely fearful or unexplained fears.

- Constantly concerned about physical problems or physical appearances. Frightened that his or her mind either is controlled or out of control.

A child or adolescent experiences big changes, such as:

- Showing declining performance in school.
- Losing interest in things they once enjoyed.
- Experiencing unexplained changes in sleeping or eating patterns.
- Avoiding friends or family and wanting to be alone.
- Day dreaming too much and not completing tasks.
- Feeling life is too hard to handle.
- Experiencing suicidal thoughts.

Other mental health warning signs may include:

- Using alcohol or drugs
- Eating large amounts of food and then purging
- Violating the rights of others
- Setting fires
- Killing animals

Remember, children who have been placed in foster care and away from their parents suffer loss. As a result of this loss, many children will act out in a variety of ways including having nightmares, loss of concentration, inability to follow directions and open defiance. These behaviors, among others, are to be expected. However, if your child has had a period of adjustment and is integrated into your family and you see any of the above symptoms, you should report them to your social worker. If you are an adoptive parent, then you should reschedule an appointment for a mental health consultation with a qualified provider near your home.

Statistics

- 1 in 5 children and adolescents may have a diagnosable disorder.
- 1 in 10 children and adolescents have a serious emotional disturbance.
- 1 in 33 children may have clinical depression.
- 3 in 1000 adolescents are diagnosed with schizophrenia.
- An estimated 2/3 of all young people with mental health problems are not getting the help they need!

Mental Health Disorders in Children and Adolescents:
Part Two: Mental Health Treatment

Early Diagnosis and Treatment

Early diagnosis and treatment are essential for a youth with mental health issues. If you suspect that a child in your care may have a mental, emotional, or behavioral problem, do not hesitate to get help. Accessing mental health services for your foster child may seem like an overwhelming task. Some of the questions that you may have of where to find help can be answered by your foster child's placement worker.

A child or adolescent, who is exhibiting symptoms of a mental, emotional, or behavioral disorder, should be evaluated by a mental health professional or a physician that specializes in treating youth. The mental health professional will conduct an assessment, which should also include a physical health assessment, to determine if your foster child needs treatment. A good diagnostic evaluation will include a complete history of symptoms, i.e., when they started, how long they have lasted, how severe they are, whether the patient had them before, and if so, whether the symptoms were treated and what treatment was given. Further, a history should include questions about whether other family members have had a depressive illness and, if treated, what treatments they may have received and which were effective.

If treatment is recommended, a treatment plan is developed which can include such treatments as psychotherapy and drug therapy. You, the child's foster parent, may be asked to be involved in developing the treatment plan and should be an active participant in the treatment process. Treatment choice will depend on the outcome of the evaluation. There are a variety of medications and psychotherapies that can be used to treat mental health disorders. Some people with milder disorders, such as adjustment disorders, do well with psychotherapies treatment alone. People with moderate to severe symptoms may have greater benefit with medications. Many do well with combined treatments: medication to gain relatively quick symptom relief and psychotherapy to learn more effective ways to deal with life's problems.

Foster families should always consult the social worker prior to seeking mental health treatment or evaluation for their foster child. The social worker will recommend a therapist or counseling center and arrange for payment. If the therapist recommends medication management for the child's condition, the social worker must obtain parental approval for the medication. Parents maintain some rights which allow them to guide or be involved in their child's treatment, and consenting to medication is one of those rights. If the parent fails to consent, and the social worker/therapist feel strongly that the medication is vital, the social worker, through the OCS attorney would need to seek a court order to give the child medication. ***Foster parents may not give consent to any kind of anti-depressant or psychotropic medication for foster children in their care.***

The most important thing you can do as a foster parent of a child with a mental health disorder is to help the child get an appropriate diagnosis and treatment. This may involve encouraging the individual to stay in treatment until symptoms begin to abate or to seek different treatment if no improvement occurs. The second most important thing is to provide emotional support which involves understanding, listening and patience.

Mental Health Treatment Providers

Let's take a moment to look at the different kinds of mental health treatment providers.

Psychiatrist: A physician with a medical degree (M.D.). All psychiatrists have completed a bachelor's degree, medical school, and at least a three-year residency in psychiatry. Child psychiatrists have had specialized training with children and adolescents with mental disorders. Child psychiatrists usually have five years of specialized training and are able to prescribe medications as well as other forms of treatment for psychiatric disorders.

Psychiatric Nurse: A licensed, professional, registered nurse who has expertise in psychiatric and mental health nursing.

Psychologist: A mental health professional with a degree in psychology. Licensed psychologists are required to have a doctorate degree and two years of supervised work experience.

Licensed Clinical Social Worker: Social workers who provide mental health services generally have a master's degree (MSW), although some continue on to receive their doctorate in social work (DSW). To provide direct therapy, a social worker must be licensed as a clinical social worker (LCSW). In order to receive a license, social workers must complete their master's degree, all field placement requirements, practice under the supervision of a LCSW for a specified number of hours (established by the state), and complete a national licensing exam.

Licensed Professional Counselor: These professionals have master degrees in counseling or psychology and additional training with supervision, like social workers, to provide mental health counseling services. Most are licensed in the State of Alaska, and complete a national licensing examination. Typically, their credentials will be listed as: M.Ed., LCSW or MA, LCSW.

Marriage and Family Therapists: Like other mental health clinicians, marriage and family therapists hold advanced degrees. Higher education is usually a combined study of many fields including social work, psychology, family social science, child development, or psychiatry. The student is required to study under an approved marriage and family therapist and pass a national licensing exam. Their credentials typically state MSW, LMFT, MA, LMFT or M.Ed. LMFT.

The Counseling Process

The following is a brief overview of the components in the counseling process, so you can understand the underlying framework of most treatment programs. Counseling typically has three phases which include assessment, diagnosis and treatment.

THREE PHASES:

1) Assessment
   - Intake Interview
   - Psychological Testing
   - Supplemental Assessment
   - Strategies

2) Diagnosis
   - Multi-axial System

3) Treatment

- Treatment Goal
- Treatment Plans
- Treatment Teams

1) <u>Assessment:</u> The assessment process involves the initial building of rapport with the child as well as gathering information. As the primary caregiver for your foster child, you should be involved in the assessment process. An assessment usually consists of an ***"Intake interview"***, ***"psychological testing"***, and gathering of ***"supplemental information."***

<u>Intake Interview:</u> The assessment will usually begin with an intake interview. The intake interview consists of identification of the ***"presenting problem", "symptoms"***, and ***"effects of symptoms."*** Usually, the child and caregiver are interviewed separately in order to receive a "clear" picture of the presenting problem. Due to confidentiality reasons, be sure to share only information about the child since the child has entered your care. Any previous history including the child's previous behaviors, symptoms, and family information will need to be given by the child's caseworker.

The **presenting problem** is the primary reason that prompts an individual to seek mental health services. Presenting problems can fall within three categories: acute, chronic, or a combination of both. Acute problems are problems that have arisen suddenly and can include failure at school, withdrawal, involvement with the law, fighting, and loss of appetite. Chronic problems are usually problems that are persistent and long-standing. Chronic problems can cover a wide range of issues including inability to develop healthy relationship/attachment, nervousness and anxiety, repetitive/compulsive behaviors, recurring thoughts that are difficult to push away, feelings of rage and anger, lack of self confidence, and poor self esteem. The presenting problem may also be a combination of acute and chronic problems: for example, a child's failure in school heightens intense feelings of low self-esteem.

Physical, emotional, and psychological symptoms tell us when there is a problem. Symptoms are measured by their frequency, duration, and their intensity. Any sudden, radical change is a symptom worth mentioning even if it doesn't appear to be related to the presenting problem. Sometimes, if any of the symptoms are physical in nature, the mental health professional may also request a physical examination.

<u>Definition:</u> A symptom is a radical change in thoughts, feelings, and behaviors.

<u>Examples:</u> Inability to concentrate, crying, nausea, lack of interest in everyday activities.

The therapist will assess how the **effect of current symptoms** affects your foster child's functioning. Some symptoms, if they are frequent and intense, may inhibit your child's ability to carry out everyday activities. The therapist may ask questions about the child's life prior to the onset of the presenting problem. This will assist the therapist in understanding how the current symptoms are related to the presenting problem.

<u>Symptoms:</u> Intensity, Frequency, Duration and Severity.

<u>Psychological Testing:</u> Sometimes, the mental health professional may request special psychological testing to assist in the assessment process. There are literally hundreds of tests that are designed to determine a wide range of psychological characteristics. It is not uncommon for a therapist to refer a child for testing. Most psychological tests fall into three main categories: 1) personality or quality of thinking, 2) type and quality of mood, 3) cognitive ability. Tests may include Behavior Rating Forms, Personality Assessments, Projective Testing, Achievement Testing, Intelligence Testing, and Neuropsychological Testing.

Supplemental Information: The therapist, through releases of information, may gather and examine supplemental information through school records, previous treatment records, assessments, and psychological testing. The therapist may also contact the child's OCS caseworker to discuss family history and previous mental health issues.

Due to confidentiality, the foster parent should not disclose any information related to the child's biological family and previous history. Inform the therapist that the child is in OCS custody and refer any family and past history questions to the child's caseworker. Any releases of information needed to gather records must be signed by the child's case worker. Typically, a psychological evaluation will provide a summary of impressions with a multi-axial diagnosis which tells professionals about the dimensions of the client and how they present on each axis. The following is a brief description of what the axis system describes.

2) Diagnosis: Multi-Axial System

Axis I: Clinical Conditions: A clinical condition is usually the principle reason that caregivers seek mental health services for their children. For example, if your child is experiencing anxiety, sleep disturbances, aggressive behaviors, low mood, agitation, and phobias, this information may be recorded on the first axis. Below are the classes of mental disorders that are recorded on the axis one.

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
Delirium, Dementia, and Amnesic and Other Cognitive Disorders
Mental Disorders Due to a Medical Condition
Substance-Related Disorders
Schizophrenia and Other Psychotic Disorders
Mood Disorders
Anxiety Disorders
Somatoform Disorders
Factitious Disorders
Dissociative Disorders
Sexual and Gender Identity Disorders
Eating Disorders
Sleep Disorders
Impulse-Control Disorders Not Elsewhere Classified
Adjustment Disorders

Axis II: Personality Disorders and Mental Retardation: Both personality disorders and mental retardation are recorded on axis two. A personality disorder may be described as an inflexible, ongoing pattern of behavior or perceptions that causes impairment or distress. Personality disorders usually become apparent in adolescence or early adulthood. IF the client does not have a personality disorder or mental retardation then the axial impression would state "none" or "n/a". Below are the classes of mental disorders that are recorded on axis two.

Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder
Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder
Avoidant Personality Disorder

Dependent Personality Disorder
Obsessive-Obsessive Personality Disorder
Mental Retardation

Axis III: Medical Conditions: Any medical problems, past and current, are recorded on axis three. Because medical conditions can affect mood, thought, and behavior, recording and considering any medical condition in treatment planning is crucial to providing a comprehensive approach to treatment. Medical conditions can include cancer, HIV, AIDS, cardiac disease, and diabetes. If the client is otherwise healthy medically, then the evaluator would indicate this on Axis III

Axis IV: Stressors (Psychosocial and Environmental): Foster children are usually under a huge amount of stress due to ever-changing circumstances in their lives. By noting environmental problems, therapists are better able to understand symptomology. Removal from the home, disruption of the family, sexual and physical abuse, neglect, inadequate discipline, are all psychosocial and environmental problems that are classified on the fourth axis.

Axis V: Overall Functioning: On this axis, the therapist records the Global Assessment of Functioning (GAF) score. This score is a rating on a scale from one to one hundred. The higher the score, the healthier the individual. The therapist may assign more than one GAF scores: the first score may represent functioning at the time of the assessment and the second score may represent the highest level of functioning within the past year or at discharge.

CASE EXAMPLE: CHARLIE

Charlie, age 16, has, for the past year, been experiencing obsessive and suicidal thoughts and has been unable to function in the foster home or school. Recently, Charlie attempted suicide with an intent to kill himself, has very poor personal hygiene, and is actively suicidal. The therapist assigns the following global assessment of function score. ***GAF10/50***

3) Treatment: The final phase of the counseling process is treatment. Once a diagnosis has been assigned, the therapist needs to decide how to improve the child's functioning. Two major steps in the treatment phase include deciding on treatment goals and design a treatment plan.

Treatment goals are linked to the diagnosis. The goals and the diagnosis provide a context for the treatment. The purpose of the treatment goals is to identify methods of changing problems which inhibit the child's functioning. Treatment goals should be specific and realistic.

When treatment goals are identified, the therapist develops a treatment plan. The plan outlines the specific interventions that will allow the child to achieve the treatment goals. The treatment plan will address the most urgent needs first. A comprehensive treatment plan specifies the form/s of therapy, provides direction, teaches new skills, and results in improved functioning.

Many times, a child having multiple mental health issues will have a treatment team. This team is comprised of professionals, sometimes from various agencies, that are providing

services to the child. When a child is receiving services from more than one agency, this is referred to as "wraparound services."

Who's on the Treatment Team? Members of a treatment team can include any of the following:

Psychiatrists	**Psychiatric Nurses**	**Psychologists**
Social Workers	**Marriage and Family Therapists**	
Occupational Therapists	**Recreational Therapists**	
Special Education Teachers	**Tribal Social Service Workers**	

ADVOCATE

There are several different ways a resource family can advocate for the foster child. Just remember…

Access "the system"

Determine appropriate services

Voice your opinion

Organize records and *document*

Call, call, call

Ask for help and support

Team approach

Evaluate progress and make changes

Mental Health Disorders in Children and Adolescents:

Part Three: Children's Mental Health Terms and Definitions

Accessing and navigating the mental health system may seem overwhelming. There are many types of mental health services available for children and youth. Many times, mental health professionals talk in a language that is difficult to understand. The following is a glossary of common children's mental health terms that will make the system much less complicated.

Assessment: A professional review of the child and/or family's needs that is done during when they seek mental health services. The assessment is an information-gathering tool, which covers many areas of the child's life including physical and mental health, school performance, intelligence, family interaction, and behavior in the community.

Case Manager: An individual who coordinates services such as mental health, social work, education, vocational, health, transportation, advocacy, respite, support, and recreation services for families and children with mental health issues.

Case Management: The case manager assures that the child's and family's needs are being met. Case management services assist the family in the arranging of appropriate and available services and supports.

Child Protective Services: When there is suspicion of abuse, neglect, or abandonment, or where there is no family to take care of the child, Child Protective Services (CPS) may become involved. When necessary, CPS may have to remove a child from the home. If the child is not in immediate danger, in-home services may be provided to the family. The goal is to keep the child with his or her family whenever possible.

Children and Adolescents At-Risk for Mental Health Problems: Children are at higher risk for developing mental health problems when certain factors occur in their lives or environment. Some of these factors are abuse, neglect, stress, poverty, loss of loved one, frequent moving, alcohol and other drug use, trauma, and exposure to violence.

Continuum of Care: A term that implies a progression of services that a child would move through.

Coordinated Services: Agencies and the family agree on a plan of care that meet's the child's needs. Agencies may include mental health, education, juvenile justice, and child welfare.

Crisis Residential Treatment Services: Short-term, twenty-four hour care in a non-hospital setting during a crisis. CRTS avoid inpatient hospitalization, help to stabilize the child, and determine the next appropriate step.

Cultural Competence: Help that is responsive to cultural differences. Agencies are aware of the impact of their own culture and possess skills that help them provide services that respect cultural differences such as race and ethnicity, national origin, religion, age, gender, sexual orientation, physical disability.

Day Treatment: Includes special education, counseling, crisis intervention, parent training, skill building, recreational therapy, and vocational training. Treatment usually lasts at least four hours per day.

DSM-IV (Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition): A manual of mental health problems developed by the American Psychiatric Association. This book is used by psychiatrists, psychologists, social workers, and other health and mental health care providers to understand and diagnose a mental health problem.

Early Intervention: A process for recognizing warning signs that individuals are at risk for mental health problems and taking early action against factors that put them at risk. Early intervention can prevent problems from becoming worse.

Emergency and Crisis Services: Services that are available 24 hours a day, seven days a week, to help during a mental health emergency. When a child is thinking about suicide, these services can provide intervention that could save the child's live. ***Examples:*** telephone crisis hotlines, crisis counseling, crisis residential treatment services, crisis respite care.

Family-Centered Services: Services designed for the specific needs of each individual child that include his/her family.

Family Support Services: Services designed to keep the family together and to cope with mental health problems that affect them.

Home-Based Services: Services provided in a family's home for either a defined period of time or for as long as needed to deal with a mental health problem. Examples include parent training, counseling, and working with family members to identify, find, or provide other help they may need. The goal is to prevent the break-up of the family.

Independent Living Services: Services designed to assist a young person to live on his own including how to handle financial, medical, housing, transportation, and other daily living needs, as well as how to get along with other.

Individualized Services: Services that are designed to meet the unique needs of each child and family. Services are individualized when the agencies pay attention to the child's and family's needs and strengths.

Inpatient Hospitalization: Mental health treatment in a hospital setting twenty-four hours a day. The purpose of the hospitalization is: 1) short-term treatment in cases where a child is in crisis and possibly a danger to self or others, and 2) diagnosis and treatment when the patient cannot be evaluated or treated appropriately in an outpatient setting.

Managed Care: A way to supervise the delivery of health care services. Managed care may specify the mental health agencies that the insured family can see, the kinds of services that will be covered, and the number of visits allowed.

Mental Health: Mental health refers to how a person thinks, feels, and acts when faced with life's situations. It is how people look at themselves, their lives, and the other people in their lives; evaluate the challenges and the problems, and explore choices.

Mental Health Problems: Mental Health Problems are real. These problems affect one's thoughts, body, feelings, and behavior. They can be severe, persistent, and can interfere with a person's life. Mental health problems are often not a passing phase and can cause a person to be disabled.

Mental Disorder: Another term for mental health problems.

Mental Illness: This term is usually used to refer to sever mental health problems in adults.

Plan of Care: A treatment plan designed for each child or family. The mental health professional develops the plan with the family that identifies the child's and family's strengths and needs. It establishes goals and details appropriate treatment and services to meet his or her special needs.

Residential Treatment Centers: Facilities that provide treatment twenty-fours hours a day and can usually serve more than twelve people at a time. Treatment at residential facilities may include individual, group, and family therapy; behavior therapy; special education; recreation therapy; and medical services. Usually more long-term than inpatient hospitalization.

Respite Care: A service that provides a break either in the home or in another location for caregivers who have a child with a serious emotional disturbance. Some parents may need this help regularly to receive relief from the strain of taking care of a child with a serious emotional disturbance.

Serious Emotional Disturbance (S.E.D.): A person under age of 21 who has a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV that has resulted in at least moderate functional impairment which substantially interferes with or limits the child's functioning in the family, school or community and that has been present for at least six months.

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

System of Care: A method of delivering mental health services that helps children and adolescents with mental health problems and their families get the full range of services in or near their homes and communities. The services will be designed to meet the child's physical, emotional, social, and educational needs.

Therapeutic Foster Care: A home where a child with a serious emotional disturbance that lives with trained foster parents who have access to services and supports. These foster parents receive special support from organizations that provide crisis intervention, psychiatric, psychological, and social work services. The intended length of this care is usually from six to twelve months.

Therapeutic Group Homes: Community-based, home-like settings that provide intensive treatment services to a small number of young people (usually five to ten persons) who require twenty-four hour supervision due to serious behavioral issues.

Transitional Services: Services that help children leave the system that provide help for children and move into adulthood and the adult service system. Help includes mental health care, independent living services, supported housing, vocational services, and other support services.

Wraparound Services: A comprehensive service approach to developing help that meets the mental health need of individual children and their families. Children and families may need a range of community support services to fully benefit from traditional mental health services such as family therapy and special education.

DEFINITIONS OF THE MAJOR MENTAL HEALTH DISORDERS SEEN IN CHILDREN AND ADOLESCENTS

The following is a list of the most common types of major mental health disorders that are seen in children and adolescents. The purpose of providing you with this information is so you can become familiar with the kinds of presenting problems and features a client would present with for a qualified professional to make a diagnosis. As a foster parent, it would be important for you to observe the child's behaviors and problems and report those to the social worker and treating clinician; however, it would not be appropriate for foster parents to use this information and make their own diagnosis of children.

Serious Emotional Disturbance (SED)

Definition: A person under the age of 21 who has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV that has resulted in at least moderate functional impairment which substantially interferes with or limits the child's functioning in family, school or community and that has been present for at least six months.

Mental, Emotional, and Behavioral Disorders**

********The following section does not cover all mental, emotional, and behavioral disorders. The purpose of this introduction is to provide information on disorders that are more common and usually first diagnosed during infancy, childhood, and adolescence.*

1. PERVASIVE DEVELOPMENTAL DISORDERS:

The DSM-IV describes persuasive developmental disorders as being characterized by severe and pervasive impairment in several areas of development including diminished interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities.

Autistic Disorder in Infants:

- Failure to cuddle
- Indifference or aversion to affection or physical contact
- Lack of eye contact, facial responsiveness, or socially directed smiles
- Failure to respond to their caregiver's voices

Autistic Disorder In Children and Adolescents:

- Hyperactivity
- Short attention span
- Impulsivity
- Aggressiveness
- Self-injurious behaviors such as finger, hand, or wrist biting and/or head banging
- High threshold for pain
- Oversensitivity to sounds or to being touched

- Exaggerated reactions to light or odors
- Fascination with certain stimuli
- Temper tantrums
- Limiting diet to a few foods
- Recurrent awakening at night with rocking
- Giggling or weeping for no apparent reason

2. ATTENTION DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS:

Attention-Deficit/Hyperactivity Disorder: *characterized by the following behaviors:*

- often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- often has difficulty sustaining attention in tasks or play activities
- often does not seem to listen when spoken to directly
- often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- often has difficulty organizing tasks and activities
- often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort such as schoolwork or homework
- often loses things necessary for tasks or activities
- is often distracted by extraneous stimuli
- often forgetful in daily activities
- often fidgets with hands or feet or squirms in seat
- often leaves seat in classroom or in other situations in which remaining seated is expected
- often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- often has difficulty playing or engaging in leisure activities quietly
- is often “on the go” or often acts as if “driven by a motor”
- often talks excessively
- often blurts out answers before questions have been completed often has difficulty awaiting turn often interrupts or intrudes on others

Conduct Disorder: *characterized by the following categories:*

Aggression to people and animals

- often bullies, threatens, or intimidates others
- often initiates physical fights
- has used a weapon that can cause serious physical harm to others
- has been physically cruel to people

- has been physically cruel to animals
- has stolen while confronting a victim
- has forced someone into sexual activity

Destruction of property

- has deliberately engaged in fire setting with the intention of causing serious damage
- has deliberately destroyed others' property
- has broken into someone else's house building or car

Deceitfulness or theft

- often lies to obtain goods or favors or to avoid obligations
- has stolen items of nontrivial value without confronting a victim
- often stays out at night despite parental prohibitions, beginning before age 13

Serious violations of rules

- has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
- is often truant from school beginning before age 13

Oppositional Defiant Disorder: *characterized by the following behaviors:*

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults' requests or rules
- often deliberately annoys people
- often blames others for his or her mistakes or misbehavior
- is often touchy or easily annoyed by others
- is often angry and resentful
- is often spiteful or vindictive

Elimination Disorders:

Encopresis: Repeated passage of feces into inappropriate places whether involuntary or intentional (child must be at least four years of age)

Enuresis: Repeated voiding of urine into bed or clothes (child must be at least five years of age)

3. OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE:

Separation Anxiety Disorder: *Separation Anxiety Disorder is characterized by the following symptoms:*

- recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
- persistent and excessive worry about losing, or about possible harm to major attachment

figures

- persistent and excessive worry that an untoward event will lead to separation from a major attachment figure
- persistent reluctance or refusal to go to sleep without being near a major attachment figures at home or without significant adults in other settings
- persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
- repeated nightmares involving the theme of separation
- repeated complaints of physical symptoms when separation from major attachment figures occurs or is anticipated

Reactive Attachment Disorder: *Requires current or previous "pathogenic care" including:*

- persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection
- persistent disregard of the child's basic physical needs repeated changes of primary caregiver that prevent formation of stable attachments

Behaviors include:

- persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hyper-vigilant, or highly ambivalent and contradictory responses diffuse attachments as indicated by indiscriminate sociability with marked inability to exhibit appropriate selective attachments

4. SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS:

The term "psychotic" has varied definitions. Psychosis refers to disorganized speech, disorganized or catatonic behavior, and/or delusions or hallucinations that are not accompanied by insight. It is often difficult to diagnose a child with schizophrenia or other psychotic disorders as a child's delusions and/or hallucinations are usually less sophisticated than adults.

Two common symptoms observed in children are *disorganized behavior* and *disorganized speech*. Although these symptoms may fall into a classification of a Psychotic Disorder, they can also fall into other classifications. Professionals usually consider the more common disorders of childhood unless the child or adolescent has symptoms that meet the criteria for a specific Psychotic Disorder.

Psychotic disorders and Schizophrenia may have onset during adolescence. Onset prior to adolescence is rare although there have been reported cases of Schizophrenia at ages five and six.

5. ANXIETY DISORDERS:

Panic Disorder without Agoraphobia: This disorder is characterized by recurrent unexpected panic attacks about which there is persistent concern. Children and adolescents with Separation Anxiety Disorder may have panic attacks stemming from separation concerns.

Specific Phobia: This disorder is characterized by an anxiety that is provoked by exposure to a specific feared object or situation, often leading to trying to avoid the object or situation. Types of Specific Phobias that may have childhood onset include the animal type (fear of animals or insects), natural environment type (fear of storms, heights, or water), or situational type (fear of a specific situation such as bridges, elevators, flying, driving). A diagnosis of Specific Phobia will not be assigned unless the fears lead to clinically significant impairment.

Social Phobia: This disorder is characterized by an anxiety that is provoked by exposure to certain types of social or performance situation, often leading to trying to avoid the behavior. Symptoms can include crying, tantrums, freezing, and clinging or staying close to a familiar person. Young children may appear excessively timid in unfamiliar social settings, shrink from contact with others, refuse to participate in group play, typically stay on the periphery of social activities, and attempt to remain close to familiar adults. Unlike adults, children with Social Phobia usually do not have the option of avoiding feared situations altogether and may be unable to identify the nature of their anxiety.

Obsessive-Compulsive Disorder: This disorder is characterized by obsessions that cause marked anxiety or distress and/or by compulsions that serve to neutralize anxiety. Although Obsessive-Compulsive Disorder usually begins in adolescence or early adulthood, it may begin in childhood. Presentations of Obsessive-Compulsive Disorder in children are generally similar to those in adulthood. Washing, checking, and ordering rituals are particularly common in children. Gradual declines in schoolwork secondary to impaired ability to concentrate have been reported. Children generally do not request help and are more likely to engage in rituals at home rather than in front of peers, teacher, or strangers. More often than not, parents or primary caregivers identify the problem.

Post Traumatic Stress Disorder: This disorder is characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma. Post Traumatic Stress Disorder can occur at any age, including childhood. In younger children, distressing dreams of the event can change into generalized nightmares of monsters, of rescuing others, or of threat to self or others. Young children usually do not have the sense that they are reliving the past. They may instead relive the trauma through repetitive play. Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents or caregivers, teachers, and other observers. In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult. Children may also exhibit various physical symptoms such as stomachaches and headaches.

Generalized Anxiety Disorder: This disorder is characterized by at least six months of persistent and excessive anxiety and worry. In children and adolescents with Generalized Anxiety Disorder, the anxieties and worries often concern the quality of their performance or competence at school or in sporting events, even when their performance in not being evaluated by others. There may be excessive concerns about punctuality and/or catastrophic events such as earthquakes or nuclear war. Children with the disorder may be overly conforming, perfectionist, and unsure of themselves and tend to redo tasks because of zealous in seeking approval and require excessive reassurance about their performance and their other worries.

6. DISSOCIATIVE DISORDERS:

Dissociative Amnesia: This disorder is characterized by an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness. Dissociative Amnesia can be present in any age group, from young children to adults however, it is especially difficult to assess in preadolescent children as it may be confused with inattention, anxiety, oppositional behavior, Learning Disorders, psychotic disturbances, and developmentally appropriate childhood amnesia.

Dissociative Identity Disorder (formerly Multiple Personality Disorder): This disorder is characterized by the presence of two or more distinct identities or personality states that recurrently take control of the individual's behavior accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. The manifestations of this disorder may be more distinctive in adolescents and adults than in preadolescent children.

7. EATING DISORDERS:

Eating Disorders are characterized by severe disturbances in eating behavior as provided in two specific diagnoses, Anorexia Nervosa and Bulimia Nervosa. Both of these disorders commonly have onset in late adolescence and are more often found in females than males. Two other eating-related difficulties not found in the DSM-IV that may be observed in foster children include overeating and hoarding of food.

Anorexia Nervosa: The common features of Anorexia Nervosa include refusal to maintain a minimally normal body weight, fear of gaining weight, and an altered perception of the shape or size of one's body. Anorexia Nervosa rarely begins before puberty, with the mean age for onset at seventeen years of age.

Bulimia Nervosa: The common features of Bulimia Nervosa are binge eating ("binging") and inappropriate measures to prevent weight gain ("purging"). Bulimia Nervosa usually begins in late adolescence or early adult life.

8. SLEEP DISORDERS:

Nightmare Disorder: This disorder is characterized by the repeated occurrence of frightening dreams that lead to awakenings from sleep and results in significant distress or social or occupational dysfunction. Nightmares often begin between three and six years of age is most likely to appear in children exposed to severe psychosocial stressors. Most children who develop a nightmare problem outgrow it.

Sleep Terror Disorder: The essential features of Sleep Terror Disorder is the repeated occurrence of abrupt awakenings from sleep usually beginning with a panicky scream or cry in which the individual is difficult to awaken or comfort. Often times, the individual will not recall the dream and will have amnesia for the event the following morning. Sleep Terror Disorder usually begins in children between four and twelve years of age and resolves spontaneously during adolescence. Older children and adults provide a more detailed recollection of fearful images associated with sleep terrors than do younger children, who are more likely to have complete amnesia or report only a vague sense of fear.

Sleepwalking Disorder: This disorder is characterized by repeated episodes of complex motor behavior during sleep including rising from bed and walking about. Sleepwalking can occur at any time after a child is able to walk, but episodes most commonly occur for the first

time between four and eight years of age. Sleepwalking in childhood usually disappears spontaneously during early adolescence, typically by fifteen years of age.

9. IMPULSE-CONTROL DISORDERS:

Intermittent Explosive Disorder: This disorder is characterized by discrete episodes of failure to resist aggressive impulses resulting in serious assaults or destruction of property. Due to the seriousness of the aggressive behavior, this disorder may result in school suspension, accidents, hospitalization, or involvement with the law. There is limited data on the age of onset for Intermittent Explosive Disorder, but it appears to be from late adolescence to the third decade of life.

Trichotillomania: This disorder is characterized by recurrent pulling out of one's hair for pleasure, gratification, or relief of tension that result in noticeable hair loss. Children with this disorder will usually not engage in hair pulling in the presence of other people except immediate family members. Commonly, the individual will deny the hair pulling behavior and may try to conceal the areas of noticeable hair loss. Children may experience periods of hair pulling in early childhood that may be considered a benign "habit" due to its self-limited course. However, individuals who later develop chronic Trichotillomania report that the hair pulling behavior began in early childhood. Trichotillomania may have an onset of around five to eight years of age.

10. MOOD DISORDERS:

Mood Disorders include "depressive disorders" and "bipolar disorders" both of which simply mean that there is a disturbance in an individual's mood. Depressive Disorders include such disorders as Major Depressive Disorder and Dysthymic Disorder. Bipolar Disorders include Bipolar I Disorder, Bipolar II Disorder, and Cyclothymic Disorder. Children and adolescents may be diagnosed with any of these disorders if the criteria are met. Depressive and bipolar disorders are more easily understood in relation to their "episodes."

Depressive Disorders:

- Major Depressive Disorder
- Dysthymic Disorder

Bipolar Disorders:

- Bipolar I Disorder
- Bipolar II Disorder
- Cyclothymic Disorder

11. MOOD EPISODES

Major Depressive Episode: For children and adolescents, a Major Depressive Episode may include a depressed/ irritable mood or the loss of interest or pleasure in nearly all activities. There may also be changes in weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans or attempts. These symptoms, according to the DSM-IV, must be present for at least two consecutive weeks.

Persons in a Major Depressive Episode may describe their condition as being “down in the dumps,” feeling “blah,” and “not caring anymore.” Children may fail to make expected weight gains, lose interest in hobbies or favorite forms of play, exhibit decreased energy, tiredness, and fatigue, and/or have noticeable agitation or retardation of psychomotor activity (agitation could include inability to sit still, pulling or rubbing of skin, clothing, or other objects; retardation could include decrease in volume, rate, rhythm, inflection, etc. of speech)

Manic Episode: A Manic Episode is defined as a period of at least one week during which there is persistent and abnormal elevated, expansive, or irritable mood. The mood disturbance is also accompanied by inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, and excessive involvement in pleasurable activities with a high potential for painful consequences.

Manic episodes usually begin in early adulthood, but some cases start in adolescence. Attention-Deficit/Hyperactivity Disorder (ADHD) and a Manic Episode are both characterized by excessive activity, impulsive behavior, poor judgment, and denial of problems. ADHD is distinguished from a Manic Episode by its characteristic early onset (before seven years of age), chronic instead of episodic course, lack of relatively clear onsets and offsets, and the absence of abnormally expansive or elevated mood or psychotic features.

Mixed Episode: A Mixed Episode is characterized by a period of time lasting at least one week in which the criteria are met both for a Manic Episode and for a Major Depressive Episode nearly every day. The child or adolescent will exhibit rapidly alternating moods. Symptoms may include agitation, insomnia, irregular appetite, psychotic features, and suicidal thinking. Mixed Episodes appear to be more common in younger individuals.

Hypomanic Episode: A Hypomanic Episode is defined as a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood that lasts at least four days. This period of abnormal mood is also accompanied by inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in pleasurable activities that have a high potential for painful consequences. In adolescents, Hypomanic Episodes may be associated with school truancy, antisocial behavior, school failure, or substance use.

CASE EXAMPLE: JASON

Jason, age five, has been "in and out" of state custody. Recently, he reentered "the system" after being abandoned by his mother at the bus station. Jason has been in and out of foster homes, in fact, he has been placed in seven homes over a period of two years. Due to Jason's behaviors, he is considered "hard to place."

In his last foster home, Jason's foster mother asked for him to be removed from the home after a period of three months (one of his longest placements) due to his aggressive behaviors, repetitive smearing of feces on the wall, and lack of response to affection. The foster mother had tried very hard to provide a structured, loving home, but became "burn-out" due to lack of support.

Jason rarely speaks unless frustrated. As such, he usually yells and talks very fast using sentences that consist primarily of swear words. His play is impulsive and aggressive. Due to is tend to misbehave, he needs to be watched constantly. The only time Jason will sit still is when he is playing with the front wheels of his favorite car. He will study and spin the wheels for hours!

If given any sort of consequences or limits, Jason will throw tantrums. During these tantrums, he engages in self injurious behavior including hitting himself and banging his head. Jason also has sleep problems. He wakes frequently during the night and wanders around the house unless his door is shut. If his door is shut, he will curl up in a ball and sleep by the door. Sometimes, Jason can be affectionate however; the moments are brief and somewhat fake. When he smiles, it is as though he is forcing himself to be pleasant. Other times, Jason's smiles indicate that he is "up to something."

You are Jason's new foster parent. After a week of experiencing Jason's behaviors, you are almost to the end of your rope.

QUESTIONS TO ASK YOURSELF:

What concerns you about Jason's behavior?

What action would you take to get help?

What information would be important to share with the mental health provider?

TEST