

# ATTENTION-DEFICIT / HYPERACTIVITY DISORDER

## HOW THE CHILD MAY LOOK

- 1) Fidgety, squirmy, cannot sit still, restless, difficulty engaging in quiet activities, talks a lot/ blurts, interrupts, cannot wait turn
- 2) Does not seem to listen, does not follow through, DESPITE understanding, has trouble organizing tasks, dislikes tasks requiring sustained mental effort, easily distracted, forgetful
- 3) Symptoms of both

## EFFECT ON RELATIONSHIPS

- Why is this kid seeking so much negative attention?
- Why won't he leave me alone?
- Why won't she do what I say? Listen? Respect others? Learn? Shape up?
- Why doesn't she do this for her grandparents? They think I'm mean.
- The other kids don't like him/her because he/she is loud, clumsy, poor quality work, has to run the show. . .

## WHAT IS NEEDED

- Proper screening
- Check for comorbidity, or co-occurring conditions
  - ADHD often occurs with Learning Disorders, ODD, Conduct Disorder, Dysthymia, Depression, Anxiety
- Education regarding treatment/options
- Eliminate blame for unintentional behavior
- Support for both child and family members

## QUESTIONS FOR WORKERS:

- Is parent frustration understandable?
- Does symptom picture suggest ADHD?
- In how many settings are symptoms seen?
- How long has child displayed symptoms?
- Is there history of ADHD in the family? (strong genetic link)
- What is the early developmental history (sometimes milestones are met early)
- Could anything else account for the behavior? Is there trauma history?
- Are parents open to screening? treatment?

## OPPOSITIONAL DEFIANT DISORDER (ODD)

### HOW THE CHILD MAY LOOK

- 1) A “brat” with an attitude
- 2) Disobedient, stubborn, resistant to authority
- 3) Unwilling to compromise
- 4) Argumentative
- 5) Blames others, not accountable

### EFFECT ON RELATIONSHIPS

- Stress – tiring for parents
- Discord about how to deal with problem behaviors – inconsistency
- May either become punitive or “give in”
- Discord with siblings, peers

### WHAT IS NEEDED

- Early intervention is important to help child accept limits & authority, as appropriate, so symptoms do not worsen.
- Treatment includes individual and family therapy, emphasis on consistency, effective limit setting.
- Check for comorbidity with ADHD.
- Check family history.

### QUESTIONS FOR WORKERS:

1. Are the behaviors more serious than is usually seen in a child of this age, but not delinquent, extreme, dangerous?
2. Are the behaviors interfering with the child’s friendships/school performance?
3. Is parental discipline appropriately flexible, consistent?
4. Are there ADHD symptoms, especially impulsivity?
5. Is there trauma history?
6. Are the parents disturbed by the behavior?
7. Are parents open to treatment?

# CONDUCT DISORDER

## HOW THE CHILD MAY LOOK

- 1) Engages in bullying, threatening, starts fights, uses weapon that might injure, physical cruelty to people or animals, theft with confrontation, forcing sex.
- 2) Set fire to cause damage, destroyed property of another.
- 3) Broken into another's home, car, lies or breaks promises for gain, stolen valuables.
- 4) Before 13 years, stays out at night against parent wishes, run away twice or more, frequent truancy

## EFFECT ON RELATIONSHIPS

1. Extreme stress, discord, feelings of helplessness.
2. Child will come to the attention of community and authority figures.
3. The earlier the onset, the worse the prognosis for children with this diagnosis.

## WHAT IS NEEDED

1. Comprehensive and immediate assessment/treatment with collaboration among child, family, child/adolescent psychiatrist, additional behavioral specialist, teachers.
2. Social skills, anger management skills, limit setting, behavior management.
3. Out of home placement a strong possibility.
4. Individual and family therapy.
5. Medication for comorbid conditions such as ADHD or Depression.

## QUESTIONS FOR WORKERS:

1. Can anything else account for serious behaviors?
2. Is there a trauma history?
3. Have behaviors occurred for 12 months?
4. Has child been thoroughly evaluated for co-existing disorders such as ADHD, Depression, evidence of PTSD symptoms?
5. Has there been psychological/educational testing?
6. Is there substance use, sexual activity?

**MOOD DISORDERS:  
MAJOR DEPRESSIVE DISORDER; DYSTHYMIC DISORDER  
BIPOLAR DISORDER**

**HOW THE CHILD MAY LOOK**

1. Manic symptoms interfere with daily activities and may interfere with mastery of developmental tasks.
2. When manic, children are more likely to be irritable and prone to destructive outbursts than elated or euphoric
3. When depressed, may see complaints of headaches, stomach aches, tiredness, poor school performance, poor communication (regardless of intelligence), and extreme sensitivity to rejection or failure.
4. Symptoms will be more episodic (in ADHD, more chronic) and will be more evidence of mood fluctuations.
5. Most children with Bipolar are rapid cyclers, going back and forth between mood states several times/day.
6. Typical bipolar pattern may be:
  - more difficult to rouse in morning with irritability, griping, sullen, withdrawn
  - by midday, may enjoy clearer focus
  - by 3:00 or 4:00 PM, may become wired, euphoric, giddy, wild, aggressive in play – may make up stories or believe they have superhuman abilities
  - this may continue until night, which accounts for difficulty sleeping
7. School may be hard because the background noise irritates them
8. Problems become quite serious by 8 (same age as most ADHD referrals)
9. Somatic (physical) complaints, irritability and social withdrawal are common.
10. Psychomotor retardation, hypersomnia and delusions are less common in pre-puberty than in adolescence and adulthood.
11. In pre-puberty, Major Depressive episodes occur more frequently with Disruptive Behavior Disorders, ADHD and Anxiety Disorders than in isolation
12. In adolescents, Major Depressive episodes often associated with these disorders, as well as Substance Related and Eating Disorders.

**EFFECT ON RELATIONSHIPS**

Effects may depend on the symptom presentation as well as family functioning

- Depressed, slowed child may frustrate or may not be noticed due to lack of acting out, confusion with other causes for behavior
- Irritable, agitated child or child with mood fluctuations may anger
- Child may be misunderstood (symptom overlap) and mistreated
- Improper environmental response and no treatment will aggravate the symptoms
- Social loss and academic risks
- Potential high risk behaviors either due to self medicating for depressive symptoms or behavior during high phase

## WHAT IS NEEDED

- Diagnostic assessment by mental health practitioner, including thorough evaluation of family history, recent physical exam and psychological testing.
- Comprehensive treatment plan for alleviation of symptoms and allowing for coordination among providers. May include school intervention and education for child and family.
- Medication will be part of treatment.
- Medications trials will involve close monitoring by physician and family.
- Therapy – individual with family component.
- May include behavior, cognitive, interpersonal and play therapies for younger children.
- Behavior therapy will include identification of stressors, attention to reduction of/managing stressors to avoid relapse.
- Attention to physical needs, including regular sleep pattern, exercise.

## QUESTIONS FOR WORKERS:

- 1) Does child display extremely depressed mood, fatigue, irritability, other symptoms for more than two weeks, especially without identifiable cause?
- 2) Is there a marked change in social interest, personal care, or other interests related to loss of concentration or energy? (Dysthymia may worsen into depression)
- 3) Is there unusual irritability, grandiose, fluctuations or excessive behavior?
- 4) Is there a family history of mood problems, due to strong genetic link?
- 5) Is there substance use?
- 6) Is there any other way to consider the behavior of the child that credibly accounts for the symptoms?

# **ANXIETY DISORDERS**

## **GENERALIZED ANXIETY DISORDER (GAD); OBSESSIVE COMPULSIVE DISORDER (OCD)**

### HOW THE CHILD MAY LOOK

#### GENERALIZED ANXIETY DISORDER

1. May “sneak up” on the child, gradually
2. May not look too different, or as if there is a problem
3. May be a worrywart, worry about certain things, all things or nothing in particular, just feel overall worry
4. May suffer from frequent pains, aches, have deeper breathing, develop tics
5. May seem mature beyond their years due to adult preoccupations
6. May be perfectionistic, critical of self
7. Adolescents may worry about past as well as future and not recall time they felt at ease

#### GAD Red Flags:

- Worries about all sorts of events/activities
- Keyed up or on edge a lot/all the time
- More tired than usual
- Distracted, “out of it”
- Sleep difficulties
- Awakens tired after full night’s sleep
- Unreasonable standards for self/perfectionistic
- Minor setbacks viewed as catastrophes
- Unexplained headaches, nausea, diarrhea
- Profuse sweat, cold/clammy hands
- No physical cause or other condition causes these problem

#### OBSESSIVE COMPULSIVE DISORDER

1. Tense, worried
2. Washing/cleaning
3. Checking
4. Repeating
5. Ordering in the “right” place
6. Hoarders
7. Mental ritualizers (the rituals are entirely in the mind)
8. Some (minority) only have obsessive thoughts, i.e., disturbing images to hurt loved one, shameful images that child cannot stop
9. Teens more likely to tell you about obsessions; children may not know
10. Tics in up to 30 % of those with OCD

### OCD Red flags:

- Upsetting thoughts keep returning
- Unusually worried about dirtiness or sinfulness
- Doing things over and over
- Increasing preoccupation with minor details
- Washing, showering, cleaning excessively
- Checking door, window locks repeatedly
- Inflexible about arranging things
- Doing things a certain number of times
- Hoarding, collecting
- Taking too long to do simple task
- Acting as if daily life is a struggle
- Seeking repeated assurance about safety
- Secretive about symptoms

### EFFECT ON RELATIONSHIPS

Disorders can lead to low self-esteem, interrupted school attendance, clinging, problematic interpersonal skills

Problems due to:

- school refusal, especially in GAD and Separation Anxiety. This has academic and social repercussions.
- social isolation, depriving child of much needed emotional and practical support.
- Depression, which might be magnified by avoiding activities that are fun, and might help child.
- Substance use, as a misguided effort to relieve emotional stress.
- Physical illness. Can coexist with thyroid problems, hypoglycemia, etc. Illness may increase anxiety or, in turn, be worsened by it.

### WHAT IS NEEDED

GAD:

- Physical exam to rule out medical condition
- Consult mental health practitioner if no medical cause determined
- Regular sleep pattern
- Treatment will be individualized, based on the child's needs, including primary symptoms, presence of coexisting conditions. May include family and other therapies
- Therapy will include Cognitive Behavioral Therapy (CBT) to teach child how to put their interpretations "to the test."
- Therapy may include medication, including antidepressants

OCD:

- A physical exam to rule out medical condition
- A professional diagnosis
- Psycho-education (obtaining information about OCD, risks and benefits of therapy, specifics of treatment plan)
- Therapy that will probably include CBT and Exposure/Ritual Prevention
- Relapse prevention plan
- Often medication
- Knowledgeable and supportive family/friends and school

QUESTIONS FOR WORKERS:

GAD:

1. Does child seem to worry or fuss a lot?
2. Can child “shut it off,” “let it go,” or take comfort from parent, appropriate adult?
3. How does parent describe the child’s behavior? Does it represent a change?
4. Has child always seemed kind of sensitive?
5. What has worsened the worry?
6. Is there family history of anxiety “worry”

OCD:

1. Are there related problems, including family history of anxiety, tics, hair pulling, hypochondria?
2. Is there depression?
3. Are there learning disabilities, especially with handwriting, math or expressive language?

## POSTTRAUMATIC STRESS DISORDER (PTSD)

### HOW THE CHILD MAY LOOK

1. May be agitated or disorganized
2. May relive through repetitive play, re-enacting, nightmares without recognizable content
3. Child may look okay initially, develop symptoms gradually or later
4. Increased memories of event
5. Act like it is happening again
6. Avoiding anything associated with event
7. Physical/emotional symptoms when reminded of event
8. Unable to recall important aspects of event
9. Worried about dying at young age
10. Emotionally detached from others
11. Startling more easily
12. Trouble sleeping or with nightmares
13. Teens may be more aggressive or impulsive than children

### WHAT IS NEEDED

1. Positive (believing, accepting) response from friends and family and school – negative (blaming, lack of listening, sympathy -response increases symptom severity
2. Professional assessment for diagnosis, severity, risks, involvement in treatment planning if symptoms persist
3. Therapy, as needed and appropriate to individual.
4. Medication may be used for symptom relief

### QUESTIONS FOR WORKERS:

1. Is the response from family and friends appropriate?
2. Does family know how to access information and help and is family willing to access help?
3. Is there accurate information re: event, response, supportive larger environment?
4. At the onset of behaviors, check for trauma history because onset can be delayed.
5. Are there signs of depression, self-harm, suicidal ideation or action?
6. Is there use of/increase in substance use?

**PERVASIVE DEVELOPMENTAL DISORDERS**  
**AUTISM; ASPERGER'S SYNDROME;**  
**PERVASIVE DEVELOPMENTAL DISORDER**

HOW THE CHILD MAY LOOK

**AUTISM:**

Different presentations:

1. Social impairment in reciprocity/sharing attention "they don't give back."
2. Parents sometimes suspect child is deaf.
3. Do not use language as others do  
delay, impairment or lack of language  
lack of spontaneous, make believe play  
stereotyped language (echolalia)
4. Stereotyped behavior  
restricted interests, may be fascination with items  
repetitive motor mannerisms, may rock, flap hands  
inflexible adherence to routines
5. Sensory disturbance often seen  
hypersensitivity and hyposensitivity may co-exist  
certain noises may upset, while others may be tolerated easily  
child may need to identify boundaries (tight clothing, beginning and end, tray  
holding the food, etc.
6. Might look like they have ADHD (impulsive, distracted) or ODD (non-compliant), or psychotic.
7. Autism coexists with mental retardation in 75% of children

**ASPERGER'S SYNDROME:**

1. May be quite imaginative.
2. Does not understand social cues but may scrutinize face of other to determine what to do.
3. May not be recognized until later in life, although typically between 2 and 6.
4. Likes "non-functional" routines like walking the same route to school.
5. Preoccupation with specific topics.
6. May seem awkward or clumsy, especially in pre-school.
7. Fails to develop peer relationships or may relate better to adult.
8. May present as depressed, especially with higher functioning.

EFFECT ON RELATIONSHIPS

**AUTISM:**

1. Sadness, sense of failure due to child's lack of expected response, from the beginning often.
2. Parents sometimes suspect child is deaf.
3. Anger, if child is non-compliant yet does not have clear signs of disorder. May be understood as hostility.

## EFFECT ON RELATIONSHIPS

### ASPERGER'S SYNDROME:

1. May be sadness or apprehension that something is not quite right.
2. May be minimizing or denial, especially if the peak skills are strong.
3. May be frustrated, because it can be hard to diagnose .

## WHAT IS NEEDED

1. Thorough assessment with a therapist/mental health provider familiar with autism.
2. Individualized treatment planning to make necessary accommodations for child (often not therapy).
3. Coordination among parents, school, providers.
4. Possible medication to treat specific symptoms, usually of anxiety, depression, impulse control or aggression.
5. Knowledgeable and supportive family/friends and school.

## QUESTIONS FOR WORKERS:

1. At what age were child behaviors concerning?
2. Did you ever suspect your child was deaf? Too sensitive to sound?
3. Does your child have unusual interests?
4. How does your child react to cold and heat?
5. Did your child like to be held? Did she cuddle back? Stiff?
6. Does your child make good eye contact? Stare? Look past you?
7. Does your child like to share toys, include you in play?
8. At what age did your child begin to speak?
9. Can other children understand your child? Do you need to "interpret" meaning for others?
10. Is your child interested in playing with other children? Is he more interested in items or the child(ren)?
11. Has your child had any seizures or taking medication for that?