

## Clinical Assessment Of Child Mental Health Issues In Child Abuse And Neglect

### Neglect

Committed to Excellence through Supervision

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## Child Mental Health Factors Associated with Placement Stability, Reunification, and Foster Care Re-entry

- Courtney (1994, 95) studies of California foster children
  - 1/3 under 4; 1/2 under 7, less than 4% had serious health problems including mental and emotional disabilities
  - Children with physical, mental and emotional problems are returned to parents at significantly lower rates and, once returned, are far more likely to re-enter foster care
  - Children with behavioral problems experienced significantly more foster care moves
  - Children who experienced more moves much more likely to have to re-enter foster care
- Zinn, et al (2006) study of Illinois foster children
  - 27% of foster parent requested moves are due to inability to tolerate children's behavioral or emotional problems

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## Important Things to Remember

10. Children's vocabularies may be limited or different and their perspectives more narrow
9. Gather information from multiple sources
8. In some cases, few data based studies, so diagnostic information will be changing

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## Important Things to Remember

7. Pathology in infants/toddlers is rarely fixed and is often dependent on context
6. Symptoms cut across diagnostic boundaries – look for a symptom picture and patterns
5. Symptoms in children differ when the diagnosis is the same used in an adult.

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## CHILD MENTAL HEALTH

4. Focus on the communication value of the behavior.
3. Know your biases and compensate for them.
2. Treatment for children should always be developmentally appropriate.

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## Important Things to Remember

1. It is essential to understand normal child development in order to properly identify problem behavior.

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## Common Child Diagnoses

- **Attention-Deficit and Disruptive Behavior Disorders**  
ADHD, ODD, Conduct Disorder
- **Reactive Attachment Disorder**
- **Mood Disorders**  
Major Depressive Disorder, Bipolar Disorder, Dysthymic Disorder

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## Common Child Diagnoses

- **Anxiety Disorders**  
GAD, OCD, Posttraumatic Stress Disorder
- **Pervasive Developmental Disorders**  
Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder NOS
- **Adjustment Disorder**

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## Attention-Deficit and Disruptive Behavior Disorders

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## Attention-Deficit / Hyperactivity Disorder

1. Hyperactivity & Impulsiveness
2. Inattention
3. Combined

- Symptoms prevalent before age 7
- Present 6 months
- **MUST** occur in more than 2 settings

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## 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

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## Effect On Relationships

- Why is this kid seeking so much negative attention? Why won't he leave me alone?
- Why won't he 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 loud, clumsy, space cadet, poor quality work, has to run the show.

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## Hoped For Effects

- Child is able to meet developmental goals
- Child approaches life with hope
- Child uses talents constructively
- Child is less susceptible to self-medication
- Child enjoys positive sense of self, confidence
- Child is viewed as unique, creative person

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## What Is Needed

- Proper screening
- Check for comorbidity, or co-occurring conditions
  - Learning Disorders, ODD, Conduct Disorder, Dysthymia, Depression, Anxiety
- Education re: treatment/options
- Eliminate blame for unintentional behavior
- Support

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## 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)

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## Questions For Workers:

- What is the early, developmental history (sometimes walking, talking are met early)
- Could anything else account for the behavior? Is there trauma history?
- Are parents open to screening? treatment?

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## Oppositional Defiant Disorder

- Defiant, hostile, negative behavior
- Teases, threatens, but does not deliberately intrude on rights of others
- Behavior occurs more than expected for age and developmental level & leads to problems in school/social functioning

Symptoms present 6 months  
Not part of another disorder (Mood)

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## 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

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## EFFECTS ON RELATIONSHIPS

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

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## 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

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## 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

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## CONDUCT DISORDER

Repeated, focused pattern of persistent violation of rules, age-appropriate norms or rights of others

1. Aggression against people or animals
  2. Property Destruction
  3. Lying or theft
  4. Serious rule violation
- Symptoms persist for 12 months in multiple settings
  - Early (Childhood) onset is before 10 years
  - Adolescent onset is after 10 years

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## HOW THE CHILD LOOKS

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

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## EFFECTS ON RELATIONSHIPS

1. Extreme stress, discord, feelings of helplessness
2. Child will come to the attention of community and authority
3. Earlier the onset, the worse the prognosis

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## 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
4. Individual and family therapy
5. Medication for comorbid conditions, ADHD, Depression

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## 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

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## REACTIVE ATTACHMENT DISORDER

1. Disturbed and developmentally inappropriate social relatedness associated with stress inhibited or disinhibited

Symptoms begin before age 5.

Diagnosis implies cause:  
pathological care that has disturbed the bonding process

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## RAD - Questions for Workers

1. Did the disturbed behavior begin Before or After the pathogenic care?
2. What is the persistent pathogenic care and can it be documented?
3. Is there history of frequent changes of PRIMARY caregivers?
4. To whom does this child appear attached? Who says?
5. Do the behaviors justify the diagnosis of RAD or are there apparent attachment problems (traits, features) that should be addressed?
6. Could anything else account for these behaviors?
7. How does the treatment plan affect the child's attachment needs?

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## MOOD DISORDERS

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## MOOD DISORDERS

1. Major Depressive Disorder
2. Dysthymic Disorder
3. Bipolar Disorder

Children can be depressed  
Child depression takes different forms  
Symptoms picture may differ from adults  
Symptoms represent a change

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## MOOD DISORDERS

### 1) Major depressive episode:

For at least 2 weeks, feels depressed or cannot enjoy life, has problems with eating/sleeping, guilt feelings, loss of energy, trouble concentrating, and thoughts about death

This represents a noticeable change from usual level of functioning (may be noticed by child or by others)



## MOOD DISORDERS

### 2) Manic episode:

For at least 1 week, feels elated or irritable, may be grandiose, talkative, hyperactive and distractible; bad judgment leads to social and work/school impairment

Manic episode will result in diagnosis of Bipolar Disorder

### 3) Mixed episode:

Child has symptoms of depression and mania, for between 4 and 7 days at a minimum

Will result in diagnosis of Bipolar Disorder



## HOW THE CHILD MAY LOOK

1. When manic, children are more likely to be irritable and prone to destructive outbursts than elated or euphoric
2. 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



## HOW THE CHILD MAY LOOK

3. Symptoms will be more episodic (in ADHD, more chronic) and will be more evidence of mood fluctuations
4. Most children with Bipolar are rapid cyclers, going back and forth between mood states several times/day.



## HOW THE CHILD MAY LOOK

5. Pattern may be:  
more difficult to rouse in morning with irritability, complaining, 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



## HOW THE CHILD MAY LOOK

6. School may be hard because the background noise irritates them
7. Problems become quite serious by 8 (same age as most ADHD referrals)

## Dysthymic Disorder

- “Low grade, chronic depression”
- Same symptoms as depression, including appetite, sleep disturbance, low energy, poor self image, reduced concentration
  - Symptoms last 1 year
  - Children may be irritable

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## HOW THE CHILD MAY LOOK

1. Somatic (physical) complaints, irritability and social withdrawal are common in children
2. Psychomotor retardation, hypersomnia and delusions are less common in prepuberty than in adolescence and adulthood
3. In prepuberty, Major Depressive episodes occur more frequently with Disruptive Behavior Disorders, ADHD and Anxiety Disorders than in isolation

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## HOW THE CHILD MAY LOOK

4. In adolescents, Major Depressive episodes often associated with these disorders, as well as Substance Related and Eating Disorders
5. Manic symptoms interfere with daily activities and may interfere with mastery of developmental tasks.

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## EFFECTS ON RELATIONSHIPS

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

1. Depressed, slowed child may frustrate or may not be noticed due to lack of acting out, confusion with other causes for behavior
2. Irritable, agitated child or child with mood fluctuations may anger
3. Child may be misunderstood (symptom overlap) and mistreated

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## EFFECTS ON RELATIONSHIPS

4. Improper environmental response and no treatment will aggravate the symptoms
5. Social loss and academic risks
6. Potential high risk behaviors either due to self medicating for depressive symptoms or behavior during high phase

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## WHAT IS NEEDED

1. Diagnostic assessment by mental health practitioner, including thorough evaluation of family history, possible physical exam and psychological testing.
2. Comprehensive treatment plan for alleviation of symptoms and allowing for coordination among providers. May include school intervention and education for child and family
3. Medication will be part of treatment
4. Medications trials will involve close monitoring by physician and family

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## WHAT IS NEEDED

5. Therapy – individual with family component
6. May include behavior, cognitive, interpersonal and play therapies for younger children
7. Behavior therapy will include identification of stressors, attention to reduction of/managing stressors to avoid relapse.
8. Attention to physical needs, including regular sleep pattern, exercise.

## QUESTIONS FOR WORKERS

- Does child display extremely depressed mood, fatigue, irritability, other symptoms for more than two weeks, especially without identifiable cause?
- 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)
- Is there unusual irritability, grandiose, fluctuations or excessive behavior?
- Is there a family history of mood problems, due to strong genetic link
- Is there substance use
- Is there any other way to consider the behavior of the child that credibly accounts for the symptoms

## ANXIETY DISORDERS

## ANXIETY DISORDERS

Anxiety Disorders are prevalent in children  
Anxiety is subjective experience of worry, tension, unease that involves thoughts, feelings and behaviors.

Most common disorders are:

- Generalized Anxiety Disorder (GAD)
- Obsessive Compulsive Disorder (OCD)
- Posttraumatic Stress Disorder (PTSD)

## GENERALIZED ANXIETY DISORDER

1. Overall sense of being worried about everything.
2. Unfounded or out of proportion to the situation
3. Child cannot control the worry
  - Occurs for at least 6 months, most days
  - Worry not caused by any other physical or mental condition

## HOW THE CHILD MAY LOOK

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

## HOW THE CHILD MAY LOOK

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

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## 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

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## WHAT IS NEEDED

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

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## QUESTIONS FOR WORKERS

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"

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## OBSESSIVE-COMPULSIVE DISORDER (OCD)

1. Child has obsessions (thoughts) compulsions (acts) OR both.
2. Child at some point realizes that these are unreasonable or excessive.
3. The obsessions or compulsions lead to distress or time consuming thoughts/behaviors (ONE HOUR/DAY), significantly impair functioning
4. Not caused by anything else

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## Obsessions:

1. repeated thoughts, impulses or mental images that are intrusive, inappropriate & cause distress;
2. not excessive worries about real-life problems,
3. Child tries to ignore/suppress or neutralize with another thought/behavior
4. Recognition that these are produce of own mind

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## Compulsions

1. Repeated behaviors OR mental acts performed in response to obsession (thought) or in response to rigid rules



## HOW THE CHILD MAY LOOK

1. Tense, worried
2. Washing/cleaning
3. Checking
4. Repeating
5. Ordering in the "right" place
6. Hoarding



## HOW THE CHILD MAY LOOK

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



## 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



## WHAT IS NEEDED

1. A professional diagnosis
2. Psycho-education (obtaining information about OCD, risks and benefits of therapy, specifics of treatment plan)
3. Therapy that will probably include CBT and Exposure/Ritual Prevention
4. Relapse prevention plan
5. Often medication
6. Knowledgeable and supportive family/friends and school



## QUESTIONS FOR WORKERS

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)

By definition:

1. An event that is potentially traumatic (CAUSE)
  2. A experience of being overwhelmed
  3. Re-experiencing of the event
  4. Avoidance of anything associated with the event as well as emotional numbing
  5. Persistent signs of increased arousal
- Symptoms last more than 1 month
  - Symptoms cause serious impairment
  - Symptoms vary in onset & chronicity

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## POSTTRAUMATIC STRESS DISORDER

Higher risk associated with:

- Firsthand experience (vs. witnessing or hearing about) traumatic event
- More intense the trauma, the greater likelihood of developing PTSD AND the more severe the symptoms
- Long-lasting, repeated trauma (eg, violence in the home) especially likely to lead to long term difficulties
- Intentional infliction of harm by another (vs. natural disaster)
- Genetic, biological, environmental factors

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## 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

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## HOW THE CHILD MAY LOOK

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

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## 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

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## QUESTIONS FOR WORKERS

1. Is the response from family and friends appropriate
2. Does family know how to access information, help and will it access?
3. Is there accurate information re: event, response, supportive larger environment
4. In event of 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

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## EFFECTS 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


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## EFFECTS ON RELATIONSHIPS


- Depression, which might be magnified by avoiding activities that are fun, might help
- 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.

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## PERVASIVE DEVELOPMENTAL DISORDERS


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## PERVASIVE DEVELOPMENTAL DISORDERS

1. A pervasive condition that affects all areas of life.
2. Children fail to develop normally in
  - Ability to interact socially
  - To communicate verbally and non-verbally
  - To use their imaginations
3. Most common are
  - Autism,
  - Asperger's Syndrome
  - Pervasive Developmental Disorder

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## AUTISM

1. Impaired social interaction
2. Impaired communication
3. Restricted behaviors, activities, interests or repetitive, stereotyped behavior

Delayed or abnormal functioning apparent before age 3 years

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## WHAT CHILD MAY LOOK LIKE

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

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## WHAT CHILD MAY LOOK LIKE

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% and seizure disorder

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## EFFECTS OF RELATIONSHIPS

1. Sadness, sense of failure due to child's lack of expected response, often from the beginning
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

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## ASPERGER'S SYNDROME

Used to be called "High functioning Autism"  
Similar to Autistic Disorder without delayed or impaired language

1. Impaired non-verbal contact, eye contact, facial expression, posture, gestures; peer relationships; absence of sharing pleasures with others
2. Some restriction or abnormality in interests, behavior and activities
3. Child can care for self, adapt to environment (not socially) and be curious about environment
4. Impaired social, occupational, personal functioning
5. Schizophrenia is ruled out

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## WHAT CHILD MAY LOOK LIKE

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

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## EFFECTS ON RELATIONSHIPS

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

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## PERVASIVE DEVELOPMENTAL DISORDER

A "residual category" for disorders that do not meet specific criteria for Autistic Disorder due:  
later age of onset  
too few symptoms  
atypical symptoms

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## 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

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## 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?

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## QUESTIONS FOR WORKERS

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?

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## ADJUSTMENT DISORDER

Within 3 months of a stressor (cause), the person (child) develops emotional or behavioral problems

1. Distress exceeds what is normally expected as a reaction to the stressor
2. there is impaired functioning (social, academic, work)
3. Symptoms do not last longer than 6 months after the stressor (or its consequences) ends \*(Usually)
4. Symptoms involve depression, anxiety, problems with behavior, some combination or it may not be clear

Used with adults and children

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## ADJUSTMENT DISORDER QUESTIONS FOR WORKERS

(Note that child can look as though he has almost any problem or mental health diagnosis)

1. Is there anything else that could account for these symptoms (depression, anxiety, ADHD, trauma, learning problems, substance use)
2. Is there family history of mental disorder?
3. Does this diagnosis represent uncertainty?
4. Is there any more information that will help understand/treat the child effectively?
5. Has appropriate screening/testing been done?

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## PROFESSIONAL CONDUCT

Attend to language, especially clinical use of language. Use specific, behavioral, concrete terminology.

A "bad hair day" is not "traumatic"  
A perfectionist is not necessarily "compulsive"  
Grief is not necessarily "major depression"  
Even a physical tantrum is not necessarily ODD

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## PROFESSIONAL CONDUCT

Attend to symptoms, including duration, how they present themselves and in how many settings.

DSM uses time requirements for many diagnoses to differentiate from normal ups and downs of life or to differentiate among diagnoses

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## PROFESSIONAL CONDUCT

Develop knowledge and understanding of normal child behavior, range of usual responses to stress and major mental health disorders in children

Some Resources:

DSM-IV

Training/Cultural Competence

Formal supervision, internet

Mental health practitioners, especially social workers

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## PROFESSIONAL CONDUCT

Work with therapists closely

1. Questions or concerns about service delivery, method of treatment, (expected) length of treatment, lack of response will be welcomed.

2. Identify therapist based on area of expertise and availability to team members, family, school

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## PROFESSIONAL CONDUCT

Work with families of children closely

1. Service to children should include individually developed, culturally competent treatment planning

2. Ask questions, keep families informed

3. Communication is intentional, appropriate and guided by respect for confidentiality

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## Conclusion

Workers attend to serious, even life & death concerns:

Value of understanding child development/mental health issues is to advance professional development and critical thinking skills.

1. Normal development varies
2. Children have mental health needs/problems
3. Even unusual behavioral disturbance may be expected or straightforward adjustment struggles
4. Not all behavioral problems are trauma based
5. Not all problems are caused by deliberate abuse or neglect
6. Not all interactional problems are RAD
7. Proper assessment and individualized, appropriate treatment are essential.

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