UNDERSTANDING YOUNG CHILDREN'S MENTAL HEALTH

Introduction to the DC 0-5

Part Three

The Legacy House

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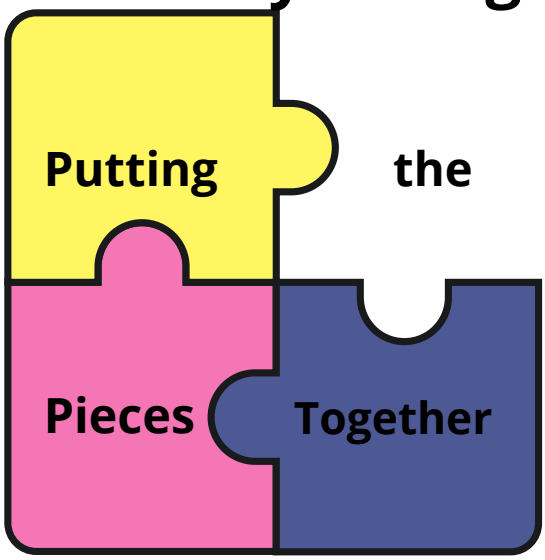
Diagnoses in Very Young Children



Approximately one out of every five children has a diagnosable mental illness. Since children are constantly developing mentally and physically, their behavior may be difficult to categorize.

Some behaviors such as anxiety, anger, and shyness can be a part of normal growth and developmental. It is usually the severity and impact of the child's life and the others around the child that indicate symptoms of a disorder.

Diagnosis usually begins with a medical doctor. The process should include a detailed history, physical exam and possibly even lab tests to test for side effects of medication, for allergies, or for other conditions that could produce symptoms.

The next step typically involves other professionals such as a psychologist, psychiatrist, therapist or counselor. Psychologists are trained to evaluate and diagnose mental illnesses. Psychiatrists are medical doctors who can diagnose mental illnesses and write prescriptions for medication. Therapists and counselors often work weekly or bi-weekly with the child sometimes for an extensive period of time and provide various kinds of therapy including play therapy.

Mental health disorders in children — or developmental disorders that are addressed by mental health professionals — may include the following:

Anxiety

Anxiety disorders in children are persistent fears, worries or anxiety that disrupt their ability to participate in play, school or typical age-appropriate social situations. Diagnoses include social anxiety, generalized anxiety and obsessive-compulsive disorders.

What do you already know about childhood anxiety? What does it look like in young children and how does a young child with anxiety behave? _____

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ADHD

Compared with most children of the same age, children with ADHD have difficulty with attention, impulsive behaviors, hyperactivity or some combination of these problems.

How have you experienced ADHD in young children? What else could be going on with a child who has symptoms of ADHD? _____

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Autism Spectrum Disorder

Autism spectrum disorder is a neurological condition that appears in early childhood — usually before age 3. Although the severity of ASD varies, a child with this disorder has difficulty communicating and interacting with others.

Have you had any children in your care that you suspect may have symptoms of autism?_____ How did you know?_____

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Eating Disorders

Eating disorders are defined as a preoccupation with an ideal body type, disordered thinking about weight and weight loss, and unsafe eating and dieting habits. Eating disorders — such as anorexia nervosa, bulimia nervosa and binge-eating disorder — can result in emotional and social dysfunction and life-threatening physical complications.

Have you had any children in your care that you suspect may have symptoms of autism?_____ How did you know?_____

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Depression

Depression is persistent feelings of sadness and loss of interest that disrupt a child's ability to function in school and interact with others. Bipolar disorder results in extreme mood swings between depression and extreme emotional or behavioral highs that may be unguarded, risky or unsafe.

What do you think is the difference between a young child and an adult who has depression? Think about behaviors, sleep, appetite, mood, etc. _____

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PTSD

PTSD is prolonged emotional distress, anxiety, distressing memories, nightmares and disruptive behaviors in response to violence, abuse, injury or other traumatic events.

Name experiences that may impact a young child and contribute to the development of PTSD. _____

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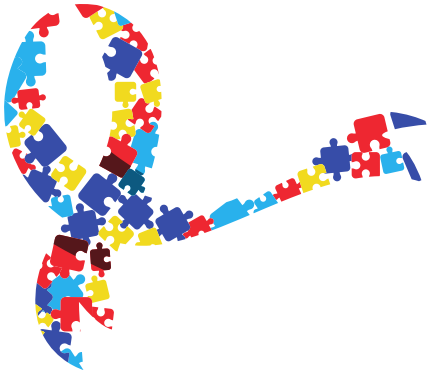
1. Neurodevelopmental Disorders

- Autism Spectrum Disorder
- Early Atypical Autism Spectrum Disorder
- Attention Deficit Hyperactivity Disorder
- Overactivity Disorder of Toddlerhood
- Global Developmental Delay
- Developmental Language Disorder
- Developmental Coordination Disorder
- Other



<u>Key Characteristics of Autism Spectrum Disorder</u>

1. Limited or atypical social–emotional responsivity, sustained social attention, or social reciprocity

2. Deficits in nonverbal social-communication behaviors

3. Peer interaction difficulties

Comparing the DC 0-5 to DSM Autism Spectrum Disorder

1. Limited or atypical social–emotional responsivity, sustained social attention, or social reciprocity	1.Deficits in social-emotional reciprocity, failure of normal back-and-forth conversation; reduced sharing of interests, emotions, failure to initiate or respond to social interactions.
2. Deficits in nonverbal social-communication behaviors	2.Deficits in nonverbal communicative behaviors.
3. Peer interaction difficulties	3. Deficits in developing, maintaining, and understanding relationships
4. Repetitive and restrictive behaviors	4.Restricted, repetitive patterns of behavior, interests, or activities.
5. The diagnosis should be made with caution in young children less than 18 months old	5. Symptoms must be present in the early developmental period
6.Symptoms cause clinically significant impairment in important areas of current functioning.	6. Symptoms cause clinically significant impairment in important areas of current functioning.

Key Characteristics of Overactivity Disorder of Toddlerhood (DC 0-5)

1. Frequently squirms or fidgets when expected to be still, even for short periods of time

2. Usually gets up or attempts to get up from seat during activities when sitting is expected

3. Often climbs on furniture or other inappropriate objects

4. Usually seems to make more noise than other young children and has difficulty playing quietly

5. Often shows excessive motor activity and nondirected energy (as if “driven by a motor”)

6. Usually talks too much

7. Often has a hard time taking turns in conversation or excessively interrupts others in conversations

8. Often has difficulty taking turns in activities or waiting for needs to be met

9. Is frequently intrusive in play, interactions, or other activities (e.g., takes over toys or activities from other young children, interrupts an established game)

Key Characteristics of ADHD

1. Inattention: Six (or more)
   a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities
   b. Often has difficulty sustaining attention in tasks or play activities
   c. Often does not seem to listen when spoken to directly
   d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace
   e. Often has difficulty organizing tasks and activities
   f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
   g. Often loses things necessary for tasks or activities
   h. Is often easily distracted by extraneous stimuli
   i. Is often forgetful in daily activities

2. Hyperactivity and impulsivity: Six (or more)
   a. Often fidgets with or taps hands or feet or squirms in seat.
   b. Often leaves seat in situations when remaining seated is expected
   c. Often runs about or climbs in situations where it is inappropriate.
   d. Often unable to play or engage in leisure activities quietly.
   e. Is often “on the go,”
   f. Often talks excessively.
   g. Often blurts out an answer before a question has been completed
   h. Often has difficulty waiting his or her turn
   i. Often interrupts or intrudes on others

DC:0-5 Crosswalk

Neurodevelopmental Disorders

DC: 0-5	DSM-5	ICD-10	ICD-10 Code
Autism Spectrum Disorder	Autism Spectrum Disorder	Childhood Autism	F84.0
Early Atypical Autism Spectrum Disorder	Other Specifies Neurodevelopmental Disorder	Pervasive Developmental Disorder, Unspecified	F84.9
Attention Deficit/ Hyperactivity Disorder	Attention Deficit/ Hyperactivity Disorder	Disterbances of Activity and Attention	F90.
Overactivity Disorder of Toddlerhood	Attention Deficit/ Hyperactivity Disorder, predominantly hyperactive-impulsive presentation	Disturbance of Activity and Attention	F90.1
Global Developmental Delay	Global Developmental Delay	Other Disorders of Psychological Development, Global Development Delay	F88
Developmental Language Disorder	Language Disorder	Developmental Disorder of Speech and Language, Unspecified	F80.9
Developmental Coordination Disorder	Developmental Coordination Disorder	Specific Developmental Disorder of Motor Function (Developmental Coordination Disorder)	F82
Other Neurodevelopmental Disorder	Unspecified Neurodevelopmental Disorder	Unspecified Disorder of Psychological Development	F89

2. Sensory Processing Disorders

- Sensory Over-Responsivity Disorder
- Sensory Under-Responsivity Disorder
- Other Sensory Processing Disorder

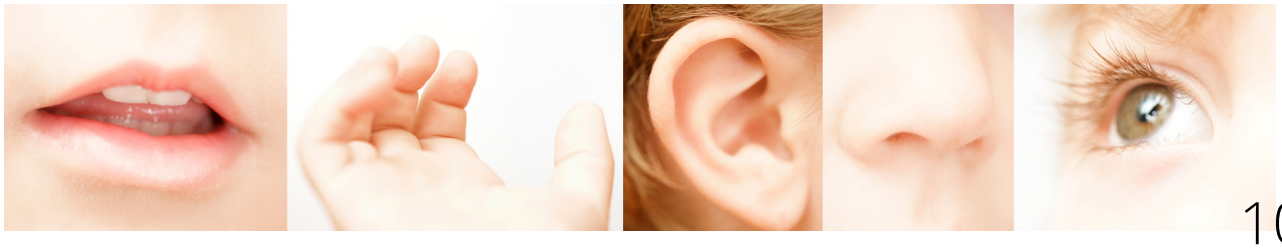
<u>Key Characteristics of Sensory Over/Under-Responsivity Disorder</u>

The infant/young child displays a persistent and pervasive pattern of sensory over/under-responsivity that involves

- intense, negative reactions to one or more types of routine sensory stimuli
- including tactile, visual, auditory, vestibular, olfactory, taste, proprioceptive, or interoceptive
- in more than one context (e.g., home, child care, playground) and with different caregivers (if the infant/young child has more than one caregiver).
- The intensity of reactivity or the duration of reactivity is disproportionate to the intensity of the stimulus.

AND

- The infant/young child shows intense emotional or behavioral responses when exposed to stimuli that evoke the sensation. OR
- The infant/young child predictably tries to avoid contact with routine sensory stimuli that are aversive to him or her.



DC:0-5 Crosswalk

Sensory Processing Disorders

DC: 0-5	DSM-5	ICD-10	ICD-10 Code
Sensory Over-Responsivity Disorder	Other Specified Neurodevelopmental Disorder	Other Disorders of Psychological Development	F88
Sensory Under-Responsivity Disorder	Other Specified Neurodevelopmental Disorder	Other Disorders of Psychological Development	F88
Other Sensory Processing Disorder	Other Specified Neurodevelopmental Disorder	Other Disorders of Psychological Development	F88

Anxiety Disorders

DC: 0-5	DSM-5	ICD-10	ICD-10 Code
Separation Anxiety Disorder	Separation Anxiety Disorder	Separation Anxiety Disorder of Childhood	F93.0
Social Anxiety Disorder (Social Phobia)	Social Anxiety Disorder	(Social Phobia) Social Anxiety Disorder of Childhood	F93.2
Generalized Anxiety Disorder	Generalized Anxiety Disorder	Generalized Anxiety Disorder	F41.1
Selective Mutism	Selective Mutism	Selective Mutism	F94.0
Inhibition to Novelty Disorder	Other Specified Anxiety Disorder	Other Specified Anxiety Disorder	F41.8
Other Anxiety Disorder of Infancy/ Early Childhood	Other Specified Anxiety Disorder	Other Specified Anxiety Disorder	F41.8

3. Anxiety Disorders

- Separation Anxiety Disorder
- Social Anxiety Disorder (Social Phobia)
- Generalized Anxiety Disorder
- Selective Mutism
- Inhibition to Novelty Disorder
- Other Anxiety Disorder of Infancy/Early Childhood

<u>Key Characteristics of Selective Mutism</u>

- Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at preschool) despite being able to speak in other situations.
- Reluctance to speak is not explained by unfamiliarity with the spoken language

3. Anxiety Disorders

Key Characteristics of Inhibition to Novelty Disorder

- The infant/young child exhibits fearful symptoms in the presence of novel/ unfamiliar objects (e.g., toys), people, and situations. The infant/young child almost always does the following:
  - Freezes or withdraws (e.g., stops vocalizing, avoids eye contact) and attempts to distance him- or herself from the novel object, person, or experience by hiding or seeking the caregiver.
  - Displays marked, persistent, and pervasive negative affect.
- The inhibited behavior is not better explained as a trauma or stress-related symptom as in Posttraumatic Stress Disorder or Adjustment Disorder and is not simply a phobic reaction to specific stimuli.

4. Mood Disorders

- Depressive Disorder of Early Childhood
- Disorder of Dysregulated Anger and Aggression of Early Childhood
- Other Mood Disorder of Infancy/Early Childhood

<u>Key Characteristics of Disorder of Dysregulation Anger and Aggression of Early Childhood</u>

The young child demonstrates a pervasive and persistent pattern of mood and behavioral dysregulation as evidenced by at least three symptoms from any of the four clusters:

1. Substantial anger and temper dysregulation demonstrated by:
    a. Has difficulty calming down when angry more days than not.
    b. Angers easily and is irritable more days than not.
    c. Shows intense or extreme temper outbursts or anger reactions more days than not.
    d. Is verbally or physically aggressive toward self or others in response to frustration or limit setting.

4. Mood Disorders

2. Noncompliance and rule breaking demonstrated by:
    a. Arguing with adults more days than not.
    b. Actively defying adults more days than not.
    c. Not following routine directions that the young child has the capacity to comply with, even with repeated prompts, more days than not.
    d. Breaking rules when an adult is watching at least daily.
    e. Taking things from other people or stores when it is forbidden.

3. Reactive aggression (i.e., substantial aggression when angry, upset, or scared/under threat) demonstrated by:
    a. Hits, bites, kicks, or throws things or attempts to do so at caregivers more than once a week.
    b. Hits, bites, kicks, or throws things at young children other than siblings at least once a week.
    (Note: For young children with limited interaction with other young children, this behavior occurs more often than not.)
    c. Breaks things on purpose at least once a week.

4. Mood Disorders

4. Proactive aggression demonstrated by:
    a. Often (at least once a week) is coercive and controlling in play with peers (e.g., excluding peers from play).
    b. Often (at least once a week) says things or does things that hurt other people's feelings.
    (Note: Only endorse if young child demonstrates understanding.)
    c. Physically or verbally frightens others. d. Starts physical fights. e. Uses or threatens to use an object to harm others. DC:0–5™ 72

Symptoms must be present in more than one setting or in more than one relationship.

DC:0-5 Crosswalk

Mood Disorders

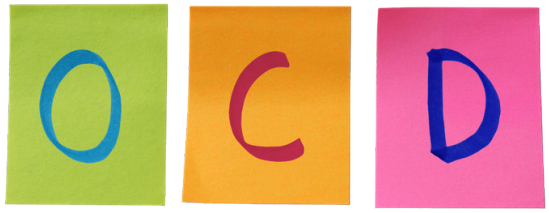
DC: 0-5	DSM-5	ICD-10	ICD-10 Code
Depressive Disorder of Early Childhood	Major Depressive Disorder	Depressive Episode	F32
Disorder of Dysregulated Anger and Aggression of Early Childhood	Disruptive Mood Dysregulation Disorder	Other Persistent Mood Disorders	F34.8
Other Mood Disorder of Early Childhood	Unspecified Depressive Disorder	Unspecified Mood Disorder	F39

Obsessive Compulsive Disorders

DC: 0-5	DSM-5	ICD-10	ICD-10 Code
Obsessive-Compulsive Disorder	Obsessive- Compulsive Disorder	Separation Anxiety Disorder of Childhood	F93.0
Tourette's Disorder	Tourette's Disorder	(Social Phobia) Social Anxiety Disorder of Childhood	F93.2
Motor or Vocal Tic Disorder	Persistent (Chronic) Motor or Vocal Tic Disorder	Generalized Anxiety Disorder	F41.1
Trichotillomania	Trichotillomania	Selective Mutism	F94.0
Skin Picking Disorder of Infancy/Early Childhood	Excoriation (Skin-Picking) Disorder	Other Specified Anxiety Disorder	F41.8
Other Obsessive Compulsive and Related Disorders	Unspecified Obsessive-Compulsive and Related Disorder	Other Specified Anxiety Disorder	F41.8

5. Obsessive Compulsive Disorders

- Obsessive Compulsive Disorder
- Tourette's Disorder
- Motor or Vocal Tic Disorder
- Trichotillomania
- Skin Picking Disorder of Infancy/Early Childhood
- Other Obsessive Compulsive and Related Disorder



Comparing the

DC 0-5 to DSM

Obsessive Compulsive Disorder

Presence of obsessions, compulsions, or both:

1. Obsessions are evidenced by:
   a. Persistent uncontrollable preoccupation with thoughts or images that manifest as recurrent verbalizations.

Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Comparing the DC 0-5 to DSM Obsessive Compulsive Disorder

2. Compulsions are defined by:
   a. Repetitive behaviors (e.g., play enacted in a particular order, hand washing, ordering, checking, counting, repeating words silently) that the young child appears driven to perform according to rigid rules or insists that the parent perform.

   b. The young child vigorously resists or becomes markedly anxious or distressed in response to attempts to interfere with the behavior.

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applie19rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive. (Note: Young children may not be able to articulate the aims of these behaviors or mental acts.)

The obsessions are time-consuming

6. Sleep, Eating, and Crying Disorders

- Sleep Disorders
  - Sleep Onset Disorder
  - Night Waking Disorder
  - Partial Arousal Sleep Disorder
  - Nightmare Disorder of Early Childhood

- Eating Disorders of Infancy/Early Childhood
  - Overeating Disorder
  - Undereating Disorder
  - Atypical Eating Disorder

- Crying Disorder of Infancy/Early Childhood
  - Excessive Crying Disorder
  - Other Sleep, Eating, and Excessive Crying Disorder of Infancy/Early

6. Sleep, Eating, and Crying Disorders

- Sleep Disorders
  - Sleep Onset Disorder
  - Night Waking Disorder
  - Partial Arousal Sleep Disorder
  - Nightmare Disorder of Early Childhood

- Eating Disorders of Infancy/Early Childhood
  - Overeating Disorder
  - Undereating Disorder
  - Atypical Eating Disorder

- Crying Disorder of Infancy/Early Childhood
  - Excessive Crying Disorder
  - Other Sleep, Eating, and Excessive Crying Disorder of Infancy/Early

<u>Key Characteristics of Atypical Eating Disorder</u>

The infant/young child exhibits abnormal eating symptoms that include at least one of the following:

1. Hoarding—the infant/young child hides food in unusual places (e.g., in the bed, in a desk drawer).
2. Pica—habitual eating of nonnutritive substances.
3. Rumination—a pattern of regurgitating and reswallowing food.

DC:0-5 Crosswalk

Sleep Disorders

DC: 0-5	DSM-5	ICD-10	ICD-10 Code
Sleep Onset Disorder	Insomnia Disorder	Nonorganic Insomnia	F51.0
Night Waking Disorder	Insomnia Disorder	Nonorganic Insomnia	F51.0
Partial Arousal Sleep Disorder	Non-Rapid Eye Movement Sleep Arousal Disorders- Sleep terror type	Sleep Terrors	F51.4
Nightmare Disorder of Early Childhood	Nightmare Disorder	Nightmares	F51.5

Eating Disorders of Infancy/ Early Childhood

DC: 0-5	DSM-5	ICD-10	ICD-10 Code
Overeating Disorder	Unspecified Feeding or Eating Disorder	Overeating Associated with Other Psychological Disturbances	F50.4
Undereating Disorder	Unspecified Feeding or Eating Disorder	Other Eating Disorders	F50.8
Pica	Pica	Pica of Infancy and Childhood	F98.3
Rumination	Rumination Disorder	Feeding Disorders of Infancy and Early Childhood/ Rumination Disorder of Infancy	F98.21
Hoarding	Other Specified Feeding and Eating Disorder	Feeding Disorders of Infancy and Early Childhood	F98.2

DC:0-5 Crosswalk

Crying Disorders

DC: 0-5	DSM-5	ICD-10	ICD-10 Code
Excessive Crying Disorder	None listed	Nonspecific-Symptoms Peculiar to Infancy (Excessive Crying in Infants)	R68.1

Other Eating, Sleeping, and Crying Disorders

DC: 0-5	DSM-5	ICD-10	ICD-10 Code
Other Sleep, Eating, and Excessive Crying Disorder of Infancy/ Early Childhood	Other Specified Feeding or Eating Disorder	Other Eating Disorder	F50.8
	Other Specified Sleep-Wake Disorder	Other Nonorganic Sleep Disorder	F51.8
		Nonspecific Symptoms Peculiar to Infancy (Excessive Crying in Infants)	R68.11

Trauma, Stress, and Deprivation Disorders

DC: 0-5	DSM-5	ICD-10	ICD-10 Code
Posttraumatic Stress Disorder	Posttraumatic Stress Disorder for Children 6 Years and Younger	Posttraumatic Stress Disorder	F43.10
Adjustment Disorder	Adjustment Disorder, Unspecified	Adjustment Disorder-Unspecified	F43.20
Complicated Grief Disorder	Other Specified Trauma- and Stressor-Related Disorder (Persistent Complex Bereavement Disorder)	Other Reactions to Severe Stress	F43.8

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DC:0-5 Crosswalk

Trauma, Stress, and Deprivation Disorders - continued from previous page

DC: 0-5	DSM-5	ICD-10	ICD-10 Code
Reactive Attachment Disorder	Reactive Attachment Disorder	Reactive Attachment Disorder	F94.1
Disinhibited Social Engagement Disorder	Disinhibited Social Engagement Disorder	Disinhibited Attachment Disorder of Childhood	F94.2
Other Trauma, Stress, and Deprivation Disorder	Unspecified Trauma- and Stressor- Related Disorder	Reaction to Severe Stress, Unspecified	F43.9

Relationship Disorder

DC: 0-5	DSM-5	ICD-10	ICD-10 Code
Relationship Specific Disorder of Infancy/ Early Childhood	Parent-Child Relational Problem	Other Specified Problems Related to Upbringing	F93.9

7. Trauma, Stress and Deprivation Disorders

- Posttraumatic Stress Disorder
- Adjustment Disorder

- Complicated Grief Disorder of Infancy/Early Childhood
- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Other Trauma, Stress, and Deprivation Disorder of Infancy/Early Disorder of Infancy/Early

Comparing the DC 0-5 to DSM PTSD

A. The infant/young child was exposed to significant threat of or actual serious injury, accident, illness, medical trauma, significant loss, disaster, violence

1. Directly experiencing the traumatic event.
2. Hearing or seeing, in person, the event as it occurred to others.
3. Learning that the traumatic event occurred to a significant person in the infant's/young child's life.

B. The infant/young child shows evidence of re-experiencing the traumatic event(s).

C. The infant/young child persistently attempts to avoid trauma-related stimuli through efforts to avoid people, places, activities, conversations, or interpersonal situations that are reminders of the trauma(s).

A. Exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.
3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.

B. Presence of one or more of the following intrusion symptoms associated with the traumatic event(s).

C. One or more of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s), or negative alterations in cognitions and mood associated with the traumatic event.

Comparing the DC 0-5 to DSM PTSD

D. The infant/young child experiences a dampening of positive emotional responsiveness that appears or intensifies after the trauma(s).

E. After a traumatic event, an infant/young child may exhibit onset or intensification of signs of increased arousal.

D. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidence by two (or more) of the following:

- Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).
- Problems with concentration.
- Hyper-vigilance.
- Exaggerated startle response.

7. Trauma, Stress and Deprivation Disorders

Key Characteristics of Reactive Attachment Disorder

Lack of attachment to any caregiving adult that manifests as:

1. A pattern of emotionally withdrawn, inhibited behavior with adult caregivers that is characterized by at least two of the following:

a. Absent or significantly reduced interest in engaging socially with others.
b. Absent or significantly reduced developmentally appropriate comfort seeking when distressed.
c. Absent or significantly reduced responses to comfort when offered.
d. Absent or significantly reduced social reciprocity with adult caregivers.

2. A pattern of emotion regulation difficulties characterized by reduced or absent positive affect and episodes of excessive or unexplained fearfulness or irritability/anger with caregivers.

The lack of an attachment figure results from the infant/young child experiencing insufficient care (social and emotional neglect) or repeated changes in caregivers.

8. Relationship Disorders, Stress and Deprivation Disorders

- Relationship Specific Disorder of Infancy/Early Childhood

<u>Key Characteristics of Relationship Specific Disorder</u>
The infant/young child exhibits a persistent emotional or behavioral disturbance in the context of one particular relationship with a caregiver.

Examples include (but are not limited to) the following:
1. Oppositional behavior.
2. Aggression.
3. Fearfulness.
4. Self-endangering behavior.
5. Food refusal.
6. Sleep refusal.
7. Role-inappropriate behavior with solicitous or controlling behavior).

The symptomatology in criterion A is expressed exclusively in one caregiving relationship.

Learn more Do more Share more

Develop a plan to address concerns about a child.

Name of Child_____ **Date**_____

For each area, write your overall impression or concerns regarding the child.

Axis II: Relational Context:_____

_____

_____

_____

Axis III: Psychosocial Stressors:_____

_____

_____

_____

Axis IV: Physical Health:_____

_____

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Axis V: Developmental Competence:_____

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Axis I: Clinical Disorders:_____

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https://www.psychologytoday.com/us/blog/the-many-faces-addiction/201105/your-lifes-baggage-part-1-what-are-you-carrying

Develop a plan to address concerns about a child.

For each listed area, list the name and contact information for an organization or individual that you that could help if you have a concern.

Health/Medical
Name:_____
Contact Information:_____
_____

Developmental/Speech/Hearing/Vision/Dental
Name:_____
Contact Information:_____
_____

Mental Health/Behavior
Name:_____
Contact Information:_____
_____

Abuse/Neglect
Name:_____
Contact Information:_____
_____

Financial/Home/Benefits
Name:_____
Contact Information:_____
_____

https://www.psychologytoday.com/us/blog/the-many-faces-addiction/201105/your-lifes-baggage-part-1-what-are-you-carrying

Before you call, consider:

What are you concerned about?_____

_____

_____

_____

When you have identified a behavior as needing further evaluation, be prepared to address the following factors:

Intensity:

Is the intensity of the child's behavior grossly out of proportion to the situation? Throwing a tantrum to avoid the first day of kindergarten may be typical; doing it every day for weeks on end is not. In addition, although all children get upset or frustrated at times, repeatedly throwing objects or breaking things as a result may signal a problem. Other overly intense reactions may include panic attacks and severe clinging or crying in response to relatively unthreatening situations, staying in bed all day in response to a mildly sad event, or violent outbursts in response to perceived slights or intrusions into his or her personal space.

Duration:

Does the behavior usually continue after the situation has been resolved? Separation difficulties on school mornings typically get better within a couple of weeks of the start of school. Similarly, feeling upset or angry about losing a soccer match or not being able to have a sleepover at a friend's house should usually resolve within a day or two.

https://www.psychologytoday.com/us/blog/the-many-faces-addiction/201105/your-lifes-baggage-part-1-what-are-you-carrying

Developmental Level:

Is the child's behavior inappropriate for his/her age or developmental level?It's pretty normal for a six year old to whine in a boring situation, cry over a minor frustration, or refuse to sleep alone, but much less so for a teenager to do the same. Similarly, it is not uncommon for a young child to shy away when asked to say "hi" when mom and dad's friends come over or when asked to order for him or herself in a restaurant. When a teenager does these same things or is repeatedly unwilling to answer the phone or doorbell that may be a sign of excessive anxiety.

Distress:

Is the behavior upsetting to the child or other family members?When everyone is tired or hungry, some behaviors may be irritating but understandable. When a child is never happy or content even with the most positive situations, this may be a red flag. Siblings who are constantly upset, embarrassed or angry about their brother or sister's behavior may also signal a problem with that child.

Interference:

Does the child's behavior interfere with his or her and/or family functioning? Some children seem to always be slow to get ready or late for things, which may be annoying but not significantly interfere with family activities. However, a child or teen who repeatedly causes the family to miss movies, birthday parties or baseball games or who repeatedly causes his or her siblings to be late for school is more concerning. Along these lines, child behaviors that repeatedly interfere with meals, bedtime routines or other family activities may indicate a problem.Context: Is the behavior inappropriate to the situation?Some anxiety prior to a big exam, giving a book report in class, or going to the doctor or dentist is normal. Fears of going to a close relative's house, to a restaurant, or shopping with mom are less typical. Arguing over who gets to use the computer at home or sit in the front seat of the car is also common, but regular fights among siblings in public places, like when shopping, eating out, or even at school, may suggest something is wrong.

https://www.psychologytoday.com/us/blog/the-many-faces-addiction/201105/your-lifes-baggage-part-1-what-are-you-carrying

Context:

Is the behavior inappropriate to the situation? Some anxiety prior to a big exam, giving a book report in class, or going to the doctor or dentist is normal. Fears of going to a close relative's house, to a restaurant, or shopping with mom are less typical. Arguing over who gets to use the computer at home or sit in the front seat of the car is also common, but regular fights among siblings in public places, like when shopping, eating out, or even at school, may suggest something is wrong.

Spontaneity:

Does the child's behavior occur out of the blue for no obvious reason? A child or teen who occasionally "sasses" is typical. A mild-mannered child who suddenly starts screaming, "I hate you" for no reason may signal an underlying problem. Repeated instances of crying, panicking, or hitting a parent or siblings for no reason may also indicate a problem.

Avoidance:

Does the behavior lead the child to try and avoid important social, school or family activities? Trying to avoid homework, chores, or 'boring' family activities like grocery shopping is common among children and teens. However, children who refuse to go to school, who avoid even "fun" activities such as going to a park or birthday party or even being with friends may have issues with mood or anxiety that need to be addressed.

All children are different, and even the most typical child or teen may engage in "problematic" behaviors from time to time, especially when they are tired, stressed or sick. However, if your child or teen repeatedly engages in inappropriate or unwanted behaviors similar to those described above, then it may be time to consider seeking consultation with a qualified child and adolescent mental health professional.

https://infoaboutkids.org/blog/when-should-i-be-worried-about-my-childs-behavior/

https://www.psychologytoday.com/us/blog/the-many-faces-addiction/201105/your-lifes-baggage-part-1-what-are-you-carrying

Conclusion

Thank you for your interest in the mental health of young children. I hope that this information will inspire you to

Learn more **Do more** **Share more.**

Resources

DC:0-5: Diagnostic Classification on Mental Health and Developmental Disorders of Infancy and Early Childhood. Zero to Three, 2016.

https://www.pacer.org/ec/early-development/when-parents-should-be-concerned-about-behavior.asp

https://www.nami.org/Support-Education/Mental-Health-Education/NAMI-Basics

https://www.verywellfamily.com/normal-and-abnormal-behavior-warning-signs-1094839

https://www.pacer.org/cmh/learning-center/does-my-child-have-an-emotional-or-behavioral-disorder.asp

Family Therapy for children with Behavioral Disorders (kidsmentalhealth.org)

https://www.rch.org.au/kidsinfo/fact_sheets/Mentalhealthinfantsandchildren/#signs-and-symptoms

Development regression in young kids - what it is and when to be concerned (babyology.com.au)

https://pathways.org/all-ages/checklists/

https://childdevelopment.com.au/areas-of-concern/what-is-child-development/#:~:text=Child%20development%20covers%20the%20full%20scope%20of%20skills,gross%20motor%20%28whole%20body%29%20skills%20More%20items...%20

https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/mental-illness-in-children/art-20046577

https://developingchild.harvard.edu/science/deep-dives/mental-health/

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