AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 00 May 2008

The Child and Adolescent Psychiatrist

The child and adolescent psychiatrist is a physician who specializes in the diagnosis and the treatment of disorders of thinking, feeling and/or behavior affecting children, adolescents, and their families. A child and adolescent psychiatrist offers families the advantages of a medical education, the medical traditions of professional ethics, and medical responsibility for providing comprehensive care.

Practice

The child and adolescent psychiatrist uses a knowledge of biological, psychological, and social factors in working with patients. Initially, a comprehensive diagnostic examination is performed to evaluate the current problem with attention to its physical, genetic, developmental, emotional, cognitive, educational, family, peer, and social components. The child and adolescent psychiatrist arrives at a diagnosis and diagnostic formulation which are shared with the patient and family. The child and adolescent psychiatrist then designs a treatment plan which considers all the components and discusses these recommendations with the child or adolescent and family.

An integrated approach may involve individual, group or family psychotherapy; medication; and/or consultation with other physicians or professionals from schools, juvenile courts, social agencies or other community organizations. In addition, the child psychiatrist is prepared and expected to act as an advocate for the best interests of children and adolescents. Child and adolescent psychiatrists perform consultations in a variety of settings (schools, juvenile courts, social agencies).

Training

Child and adolescent psychiatric training requires four years of medical school, at least three years of approved residency training in medicine, neurology, and general psychiatry with adults, and two years of additional specialized training in psychiatric work with children, adolescents, and their families in an accredited residency in child and adolescent psychiatry.

In the general psychiatry training years, the physician achieves competence in the fundamentals of the theory and practice of psychiatry. In the child and adolescent psychiatry training, the trainee acquires a thorough knowledge of normal child and family development, psychopathology, and treatment. Special importance is given to disorders that appear in childhood, such as pervasive developmental disorder, attention-deficit hyperactivity disorder (ADHD), learning disabilities, mental retardation, mood disorders, depressive and anxiety disorders, drug dependency and delinquency (conduct disorder). The child psychiatry trainee applies and develops psychiatric skills by treating children, adolescents and their families in a variety of settings.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Definition of a Child and Adolescent Psychiatrist, "Facts for Families," (5/08)
An experience in consultation to other physicians, mental health professionals, schools, and community agencies is an important part of training.

Certification and Continuing Education
Having completed the child and adolescent psychiatry residency and successfully passing the certification examination in general psychiatry given by the American Board of Psychiatry and Neurology (ABPN), the child and adolescent psychiatrist is eligible to take the additional certification examination in the subspecialty of child and adolescent psychiatry. Although the ABPN examinations are not required for practice, they are a further assurance that the child and adolescent psychiatrist with these certifications can be expected to diagnose and treat all psychiatric conditions in patients of any age competently.
The child and adolescent psychiatrist continues to study and learn about new advances by reading scientific literature and attending conferences. New knowledge is then applied to diagnostic, therapeutic, and consultative work.

Finding a Child and Adolescent Psychiatrist
Child and adolescent psychiatrists can be found through local medical and psychiatric societies, local mental health associations, local hospitals or medical centers, departments of psychiatry in medical schools, and national organizations like the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association. In addition, pediatricians, family physicians, school counselors, and Employee Assistance Programs (EAP) can be helpful in identifying child and adolescent psychiatrists.

See also: *Facts for Families:* #24 Know When to Seek Help for Your Child, #25 Know Where to Seek Help for Your Child, #52 Comprehensive Psychiatric Evaluation. *Your Child* (1998 Harper Collins)/*Your Adolescent* (1999 Harper Collins).

# # #

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

specific Facts sheets. For all questions please contact the AACAP Communications & Marketing Coordinator, ext. 154.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 01 March 2011

Children and Divorce

One out of every two marriages today ends in divorce and many divorcing families include children. Parents who are getting a divorce are frequently worried about the effect the divorce will have on their children. During this difficult period, parents may be preoccupied with their own problems, but continue to be the most important people in their children's lives.

While parents may be devastated or relieved by the divorce, children are invariably frightened and confused by the threat to their security. Some parents feel so hurt or overwhelmed by the divorce that they may turn to the child for comfort or direction. Divorce can be misinterpreted by children unless parents tell them what is happening, how they are involved and not involved, and what will happen to them.

Children often believe they have caused the conflict between their parents. Many children assume the responsibility for bringing their parents back together, sometimes by sacrificing themselves. Vulnerability to both physical and mental illnesses can originate in the traumatic loss of one or both parents through divorce. With care and attention, however, a family's strengths can be mobilized during a divorce, and children can be helped to deal constructively with the resolution of parental conflict.

Talking to children about a divorce is difficult. The following tips can help both the child and parents with the challenge and stress of these conversations:

- Do not keep it a secret or wait until the last minute.
- Tell your child together with your spouse.
- Keep things simple and straight-forward.
- Tell them the divorce is not their fault.
- Admit that this will be sad and upsetting for everyone.
- Reassure your child that you both still love them and will always be their parents.
- Do not discuss each other’s faults or problems with the child.

Parents should be alert to signs of distress in their child or children. Young children may react to divorce by becoming more aggressive and uncooperative or by withdrawing. Older children may feel deep sadness and loss. Their schoolwork may suffer and behavior problems are common. As teenagers and adults, children of divorce can have trouble with their own relationships and experience problems with self-esteem.

Children will do best if they know that their mother and father will still be their parents and remain involved with them even though the marriage is ending and the parents won't live together. Long custody disputes or pressure on a child to "choose" sides can be

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

particularly harmful for the youngster and can add to the damage of the divorce. Research shows that children do best when parents can cooperate on behalf of the child.

Parents' ongoing commitment to the child's well-being is vital. If a child shows signs of distress, the family doctor or pediatrician can refer the parents to a child and adolescent psychiatrist for evaluation and treatment. In addition, the child and adolescent psychiatrist can meet with the parents to help them learn how to make the strain of the divorce easier on the entire family. Psychotherapy for the children of a divorce, and the divorcing parents, can be helpful.

For additional information see ***Facts for Families***:
#8 Children and Grief
#34 Children's Sleep Problems
#4 The Depressed Child
#27 Stepfamily Problems
#52 Comprehensive Psychiatric Evaluation
#00 Definition of a Child and Adolescent Psychiatrist

# # #

If you find *Facts for Families*© helpful and would like to make good mental health a reality for all children, please consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute *Facts for Families*, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to ***Campaign for America's Kids***, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 02 August 2013

Teenagers with Eating Disorders

In the United States, as many as 10 in 100 young women suffer from an eating disorder. Overeating related to tension, poor nutritional habits and food fads are relatively common eating problems for youngsters. In addition, two psychiatric eating disorders, anorexia nervosa and bulimia, are on the increase among teenage girls and young women and often run in families. These two eating disorders also occur in boys, but less often.

Parents frequently wonder how to identify symptoms of anorexia nervosa and bulimia. These disorders are characterized by a preoccupation with food and a distortion of body image. Unfortunately, many teenagers hide these serious and sometimes fatal disorders from their families and friends.

Symptoms and warning signs of anorexia nervosa and bulimia include the following:

- A teenager with anorexia nervosa is typically a perfectionist and a high achiever in school. At the same time, she suffers from low self-esteem, irrationally believing she is fat regardless of how thin she becomes. Desperately needing a feeling of mastery over her life, the teenager with anorexia nervosa experiences a sense of control only when she says "no" to the normal food demands of her body. In a relentless pursuit to be thin, the girl starves herself. This often reaches the point of serious damage to the body, and in a small number of cases may lead to death.
- The symptoms of bulimia are usually different from those of anorexia nervosa. The patient binges on huge quantities of high-caloric food and/or purges her body of dreaded calories by self-induced vomiting and often by using laxatives. These binges may alternate with severe diets, resulting in dramatic weight fluctuations. Teenagers may try to hide the signs of throwing up by running water while spending long periods of time in the bathroom. The purging of bulimia presents a serious threat to the patient's physical health, including dehydration, hormonal imbalance, the depletion of important minerals, and damage to vital organs.
- Binge eating can also occur on its own without the purging of bulimia and can lead to eventual purging. Children with binge eating disorder also require treatment from a mental health professional.

With comprehensive treatment, most teenagers can be relieved of the symptoms or helped to control eating disorders. The child and adolescent psychiatrist is trained to evaluate, diagnose, and treat these psychiatric disorders. Treatment for eating disorders usually requires a team approach; including individual therapy, family therapy, working with a primary care physician, working with a nutritionist, and medication. Many adolescents also suffer from other problems; including depression, anxiety, and substance abuse. It is important to recognize and get appropriate treatment for these problems as well.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Definition of a Child and Adolescent Psychiatrist, "Facts for Families," (08/13)

Research shows that early identification and treatment leads to more favorable outcomes. Parents who notice symptoms of anorexia or bulimia in their teenagers should ask their family physician or pediatrician for a referral to a child and adolescent psychiatrist.

For additional information see Facts for Families:
#4 The Depressed Child
#79 Obesity in Children and Teens
#52 Comprehensive Psychiatric Evaluation
#60 Obsessive Compulsive Disorder

See also: Your Child (1998 Harper Collins) / Your Adolescent (1999 Harper Collins)

# # #

If you find *Facts for Families*© helpful and would like to make good mental health a reality for all children, please consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute *Facts for Families*, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to ***Campaign for America's Kids***, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 3 July 2013

Teens: Alcohol and Other Drugs

Experimentation with alcohol and drugs during adolescence is common. Unfortunately, teenagers often don't see the link between their actions today and the consequences tomorrow. They also have a tendency to feel indestructible and immune to the problems that others experience.

Using alcohol and tobacco at a young age has negative health effects. Some teens will experiment and stop, or continue to use occasionally, without significant problems. Others will develop a dependency, moving on to more dangerous drugs and causing significant harm to themselves and possibly others. It is difficult to know which teens will experiment and stop and which will develop serious problems. Teenagers at risk for developing serious alcohol and drug problems include those:

- with a family history of substance use disorders
- who are depressed
- who have low self-esteem, and
- who feel like they don't fit in or are out of the mainstream

Teenagers abuse a variety of drugs, both legal and illegal. Legally available drugs include alcohol, prescribed medications, inhalants (fumes from glues, aerosols, and solvents) and over-the-counter cough, cold, sleep, and diet medications. The most commonly used illegal drugs are marijuana (pot), stimulants (cocaine, crack, and speed), LSD, PCP, opiates, heroin, and designer drugs (Ecstasy). The use of illegal drugs is increasing, especially among young teens. The average age of first marijuana use is 14, and alcohol use can start before age 12. The use of marijuana and alcohol in high school has become common.

Drug use is associated with a variety of negative consequences, including increased risk of serious drug use later in life, school failure, and poor judgment which may put teens at risk for accidents, violence, unplanned and unsafe sex, and suicide.

Parents can prevent their children from using drugs by talking to them about drugs, open communication, role modeling, responsible behavior, and recognizing if problems are developing.

Warning signs of teenage alcohol and drug use may include:

Physical: Fatigue, repeated health complaints, red and glazed eyes, and a lasting cough.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Emotional: personality change, sudden mood changes, irritability, irresponsible behavior, low self-esteem, poor judgment, depression, and a general lack of interest.

Family: starting arguments, breaking rules, or withdrawing from the family.

School: decreased interest, negative attitude, drop in grades, many absences, truancy, and discipline problems.

Social problems: new friends who are less interested in standard home and school activities, problems with the law, and changes to less conventional styles in dress and music.

Some of the warning signs listed above can also be signs of other problems. Parents may recognize signs of trouble and possible use of alcohol and other drugs with their teenager. If you have concerns you may want to consult a physician to rule out physical causes of the warning signs. This should often be followed or accompanied by a comprehensive evaluation by a child and adolescent psychiatrist or mental health professional.

For additional information see ***Facts for Families:***
#4 The Depressed Child
#17 Children of Alcoholics
#33 Conduct Disorders
#00 Definition of a Child and Adolescent Psychiatrist

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 04 July 2013

The Depressed Child

Not only adults become depressed. Children and teenagers also may have depression, as well. The good news is that depression is a treatable illness. Depression is defined as an illness when the feelings of depression persist and interfere with a child or adolescent's ability to function.

About 5 percent of children and adolescents in the general population suffer from depression at any given point in time. Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. Depression also tends to run in families.

The behavior of depressed children and teenagers may differ from the behavior of depressed adults. Child and adolescent psychiatrists advise parents to be aware of signs of depression in their youngsters.

If one or more of these signs of depression persist, parents should seek help:

- Frequent sadness, tearfulness, crying
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Hopelessness
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self-esteem and guilt
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self-destructive behavior

A child who used to play often with friends may now spend most of the time alone and without interests. Things that were once fun now bring little joy to the depressed child. Children and adolescents who are depressed may say they want to be dead or may talk about suicide. Depressed children and adolescents are at increased risk for committing suicide. Depressed adolescents may abuse alcohol or other drugs as a way of trying to feel better.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

The Depressed Child, "Facts for Families," No. 4 (5/08)

Children and adolescents who cause trouble at home or at school may also be suffering from depression. Because the youngster may not always seem sad, parents and teachers may not realize that troublesome behavior is a sign of depression. When asked directly, these children can sometimes state they are unhappy or sad.

Early diagnosis and treatment are essential for depressed children. Depression is a real illness that requires professional help. Comprehensive treatment often includes both individual and family therapy. For example, cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT) are forms of individual therapy shown to be effective in treating depression. Treatment may also include the use of antidepressant medication. For help, parents should ask their physician to refer them to a qualified mental health professional, who can diagnose and treat depression in children and teenagers.

Also see the following Facts for Families:
#8 Children and Grief
#10 Teen Suicide
#21 Psychiatric Medication for Children
#38 Bipolar Disorder in Teens
#86 Psychotherapies for Children and Adolescents
#00 Definition of a Child and Adolescent Psychiatrist

# # #

If you find *Facts for Families*© helpful and would like to make good mental health a reality for all children, please consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute *Facts for Families*, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to ***Campaign for America's Kids***, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,000 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 5 March 2011

Child Abuse – The Hidden Bruises

The statistics on physical child abuse are alarming. It is estimated hundreds of thousands of children are physically abused each year by a parent or close relative. Thousands actually die as a result of the abuse. For those who survive, the emotional trauma remains long after the external bruises have healed. Communities and the courts recognize that these emotional "hidden bruises" can be treated. Early recognition and treatment is important to minimize the long term effect of physical abuse. Whenever a child says he or she has been abused, it must be taken seriously and immediately evaluated.

Children who have been abused may display:

- a poor self-image
- sexual acting out
- inability to trust or love others
- aggressive, disruptive, and sometimes illegal behavior
- anger and rage
- self-destructive or self-abusive behavior, suicidal thoughts
- passive, withdrawn or clingy behavior
- fear of entering into new relationships or activities
- anxiety and fears
- school problems or failure
- feelings of sadness or other symptoms of depression
- flashbacks, nightmares
- drug and alcohol abuse
- sleep problems

Often the severe emotional damage to abused children does not surface until adolescence or even later, when many abused children become abusing parents. An adult who was abused as a child often has trouble establishing lasting and stable personal relationships. These men and women may have trouble with physical closeness, touching, intimacy, and trust as adults. They are also at higher risk for anxiety, depression, substance abuse, medical illness, and problems at school or work.

Early identification and treatment is important to minimize the long-term consequences of abuse. Qualified mental health professionals should conduct a comprehensive evaluation and provide treatment for children who have been abused. Through treatment, the abused child begins to regain a sense of self-confidence and trust. The family can also be helped to learn new ways of support and communicating with one another. Parents may also benefit from support, parent training and anger management.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Physical abuse is not the only kind of child abuse. Many children are also victims of neglect, or sexual abuse, or emotional abuse. In all kinds of child abuse, the child and the family can benefit from evaluation and treatment from a qualified mental health professional.

See ***Facts for Families***:
#9 Child Sexual Abuse
#28 Responding to Child Sexual Abuse
#43 Discipline
#81 Fighting and Biting
#00 Definition of a Child and Adolescent Psychiatrist

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 06 July 2013

Children Who Can't Pay Attention/ Attention-Deficit/Hyperactivity Disorder

Parents are distressed when they receive a note from school saying that their child won't listen to the teacher or causes trouble in class. One possible reason for this kind of behavior is Attention Deficit/Hyperactivity Disorder (ADHD).
Video: What is ADHD?
(use your browser's back button to return to this page)

Even though the child with ADHD often wants to be a good student, the impulsive behavior and difficulty paying attention in class frequently interferes and causes problems. Teachers, parents, and friends know that the child is misbehaving or different but they may not be able to tell exactly what is wrong.

Any child may show inattention, distractibility, impulsivity, or hyperactivity at times, but the child with ADHD shows these symptoms and behaviors more frequently and severely than other children of the same age or developmental level. ADHD occurs in 3-5% of school age children. ADHD typically begin in childhood but can continue into adulthood. ADHD runs in families with about 25% of biological parents also having this medical condition.
Video: ADHD Risk Factors
(use your browser's back button to return to this page)

A child with ADHD often shows some of the following:

- trouble paying attention
- inattention to details and makes careless mistakes
- easily distracted
- loses school supplies, forgets to turn in homework
- trouble finishing class work and homework
- trouble listening
- trouble following multiple adult commands
- blurts out answers
- impatience
- fidgets or squirms
- leaves seat and runs about or climbs excessively
- seems "on the go"
- talks too much and has difficulty playing quietly
- interrupts or intrudes on others

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

There are three types of ADHD. Some people have only difficulty with attention and organization. This is also sometimes called Attention Deficit Disorder or ADD. This is ADHD inattentive subtype. Other people have only the hyperactive and impulsive symptoms. This is ADHD-hyperactive subtype. The Third, and most commonly identified group consists of those people who have difficulties with attention and hyperactivity, or the combined type.

A child presenting with ADHD symptoms should have a comprehensive evaluation. Parents should ask their pediatrician or family physician to refer them to a child and adolescent psychiatrist, who can diagnose and treat this medical condition. A child with ADHD may also have other psychiatric disorders such as conduct disorder, anxiety disorder, depressive disorder, or bipolar disorder. These children may also have learning disabilities.

Without proper treatment, the child may fall behind in schoolwork, and friendships may suffer. The child experiences more failure than success and is criticized by teachers and family who do not recognize a health problem.

Research clearly demonstrates that medication can help improve attention, focus, goal directed behavior, and organizational skills. Medications most likely to be helpful include the stimulants (various methylphenidate and amphetamine preparations) and the non-stimulant, atomoxetine. Other medications such as guanfacine, clonidine, and some antidepressants may also be helpful.

Other treatment approaches may include cognitive-behavioral therapy, social skills training, parent education, and modifications to the child's education program. Behavioral therapy can help a child control aggression, modulate social behavior, and be more productive. Cognitive therapy can help a child build self-esteem, reduce negative thoughts, and improve problem-solving skills. Parents can learn management skills such as issuing instructions one-step at a time rather than issuing multiple requests at once. Education modifications can address ADHD symptoms along with any coexisting learning disabilities.

For additional information see Facts for Families:
#16 Learning Disabilities
#21 Psychiatric Medication for Children
#29 Psychiatric Medication: Types of Medications
#33 Conduct Disorders
#38 Bipolar Disorder in Teens
#51 Questions to Ask about Psychiatric Medications for Children and Adolescents
#52 Comprehensive Psychiatric Evaluation
#00 Definition of a Child and Adolescent Psychiatrist

# # #

Children Who Can't Pay Attention/ADHD, "Facts for Families," No. 6 (5/08)

If you find *Facts for Families*© helpful and would like to make good mental health a reality for all children, please consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute *Facts for Families*, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to ***Campaign for America's Kids***, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 7 July 2013

Children Who Won't Go to School
(Separation Anxiety)

Going to school is usually an exciting and enjoyable event for young children. However, for some it can cause intense fear or panic. Parents should be concerned if their child regularly complains about feeling sick or often asks to stay home from school with minor physical complaints. Not wanting to go to school may occur at any time, but is most common in children 5-7 and 11-14, times when children are dealing with the new challenges of elementary and middle school. These children may suffer from a paralyzing fear of leaving the safety of their parents and home. The child's panic and refusal to go to school is very difficult for parents to cope with, but these fears and behavior can be treated successfully, with professional help.

Refusal to go to school often begins following a period at home in which the child has become closer to the parent, such as a summer vacation, a holiday break, or a brief illness. It also may follow a stressful occurrence, such as the death of a pet or relative, a change in schools, or a move to a new neighborhood.

The child may complain of a headache, sore throat, or stomachache shortly before it is time to leave for school. The illness subsides after the child is allowed to stay home, only to reappear the next morning before school. In some cases the child may simply refuse to leave the house. Since the panic comes from leaving home rather than being in school, frequently the child is calm once in school.

Children with an unreasonable fear of school may:

- feel unsafe staying in a room by themselves
- display clinging behavior
- display excessive worry and fear about parents or about harm to themselves
- shadow the mother or father around the house
- have difficulty going to sleep
- have nightmares
- have exaggerated, unrealistic fears of animals, monster, burglars
- fear being alone in the dark, or
- have severe tantrums when forced to go to school

Such symptoms and behaviors are common among children with separation anxiety disorder. The potential long-term effects (anxiety and panic disorder as an adult) are serious for a child who has persistent separation anxiety and does not receive professional assistance. The child may also develop serious educational or social problems if their fears and anxiety keep them away from school and friends for an extended period of time.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

When fears persist the parents and child should consult with a qualified mental health professional, who will work with them to develop a plan to immediately return the child to school and other activities. Refusal to go to school in the older child or adolescent is generally a more serious illness, and often requires more intensive treatment.

Excessive fears and panic about leaving home/parents and going to school can be successfully treated.

For additional information see ***Facts for Families***:
#4 The Depressed Child
#8 Children and Grief
#47 The Anxious Child
#50 Panic Disorder in Children and Adolescents
Anxiety Disorders Resource Center

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 8 July 2013

Children and Grief

When a family member dies, children react differently from adults. Preschool children usually see death as temporary and reversible, a belief reinforced by cartoon characters who die and come to life again. Children between five and nine begin to think more like adults about death, yet they still believe it will never happen to them or anyone they know.

Adding to a child's shock and confusion at the death of a brother, sister, or parent is the unavailability of other family members, who may be so shaken by grief that they are not able to cope with the normal responsibility of childcare.

Parents should be aware of normal childhood responses to a death in the family, as well as signs when a child is having difficulty coping with grief. It is normal during the weeks following the death for some children to feel immediate grief or persist in the belief that the family member is still alive. However, long-term denial of the death or avoidance of grief can be emotionally unhealthy and can later lead to more severe problems.

A child who is frightened about attending a funeral should not be forced to go; however, honoring or remembering the person in some way, such as lighting a candle, saying a prayer, making a scrapbook, reviewing photographs, or telling a story may be helpful. Children should be allowed to express feelings about their loss and grief in their own way.

Once children accept the death, they are likely to display their feelings of sadness on and off over a long period of time, and often at unexpected moments. The surviving relatives should spend as much time as possible with the child, making it clear that the child has permission to show his or her feelings openly or freely.

The person who has died was essential to the stability of the child's world, and anger is a natural reaction. The anger may be revealed in boisterous play, nightmares, irritability, or a variety of other behaviors. Often the child will show anger towards the surviving family members.

After a parent dies, many children will act younger than they are. The child may temporarily become more infantile; demand food, attention and cuddling; and talk baby talk. Younger children frequently believe they are the cause of what happens around them. A young child may believe a parent, grandparent, brother, or sister died because he or she had once wished the person dead when they were angry. The child feels guilty or blames him or herself because the wish came true.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Children who are having serious problems with grief and loss may show one or more of these signs:

- an extended period of depression in which the child loses interest in daily activities and events
- inability to sleep, loss of appetite, prolonged fear of being alone
- acting much younger for an extended period
- excessively imitating the dead person
- repeated statements of wanting to join the dead person
- withdrawal from friends, or
- sharp drop in school performance or refusal to attend school

If these signs persist, professional help may be needed. A child and adolescent psychiatrist or other qualified mental health professional can help the child accept the death and assist the others in helping the child through the mourning process.

For more information, see Facts for Families:
#4 The Depressed Child
#7 Children Who Won't Go to School
#34 Children's Sleep Problems
#36 Helping Children After a Disaster
#78 When a Pet Dies

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 9 March 2011

Child Sexual Abuse

Child sexual abuse has been reported up to 80,000 times a year, but the number of unreported instances is far greater, because the children are afraid to tell anyone what has happened, and the legal procedure for validating an episode is difficult. The problem should be identified, the abuse stopped, and the child should receive professional help. The long-term emotional and psychological damage of sexual abuse can be devastating to the child.

Child sexual abuse can take place within the family, by a parent, step-parent, sibling or other relative; or outside the home, for example, by a friend, neighbor, child care person, teacher, or stranger. When sexual abuse has occurred, a child can develop a variety of distressing feelings, thoughts and behaviors.

No child is psychologically prepared to cope with repeated sexual stimulation. Even a two or three year old, who cannot know the sexual activity is wrong, will develop problems resulting from the inability to cope with the overstimulation.

The child of five or older who knows and cares for the abuser becomes trapped between affection or loyalty for the person, and the sense that the sexual activities are terribly wrong. If the child tries to break away from the sexual relationship, the abuser may threaten the child with violence or loss of love. When sexual abuse occurs within the family, the child may fear the anger, jealousy or shame of other family members, or be afraid the family will break up if the secret is told.

A child who is the victim of prolonged sexual abuse usually develops low self-esteem, a feeling of worthlessness and an abnormal or distorted view of sex. The child may become withdrawn and mistrustful of adults, and can become suicidal.

Some children who have been sexually abused have difficulty relating to others except on sexual terms. Some sexually abused children become child abusers or prostitutes, or have other serious problems when they reach adulthood.

Often there are no obvious external signs of child sexual abuse. Some signs can only be detected on physical exam by a physician.

Sexually abused children may also develop the following:

- unusual interest in or avoidance of all things of a sexual nature
- sleep problems or nightmares
- depression or withdrawal from friends or family

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- seductiveness
- statements that their bodies are dirty or damaged, or fear that there is something wrong with them in the genital area
- refusal to go to school
- delinquency/conduct problems
- secretiveness
- aspects of sexual molestation in drawings, games, fantasies
- unusual aggressiveness, or
- suicidal behavior

Child sexual abusers can make the child extremely fearful of telling, and only when a special effort has helped the child to feel safe, can the child talk freely. If a child says that he or she has been molested, parents should try to remain calm and reassure the child that what happened was not their fault. Parents should seek a medical examination and psychiatric consultation.

Parents can prevent or lessen the chance of sexual abuse by:

- Telling children that if someone tries to touch your body and do things that make you feel funny, say NO to that person and tell me right away
- Teaching children that respect does not mean blind obedience to adults and to authority, for example, don't tell children to, Always do everything the teacher or baby-sitter tells you to do
- Encouraging professional prevention programs in the local school system

Sexually abused children and their families need immediate professional evaluation and treatment. Child and adolescent psychiatrists can help abused children regain a sense of self-esteem, cope with feelings of guilt about the abuse, and begin the process of overcoming the trauma. Such treatment can help reduce the risk that the child will develop serious problems as an adult.

For additional information see ***Facts for Families***:
#4 The Depressed Child
#5 Child Abuse
#10 Teen Suicide
#28 Responding to Child Sexual Abuse
#62 Talking to Your Kids about Sex
#73 Self-Injury in Adolescents
#00 Definition of a Child and Adolescent Psychiatrist

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 10 July 2013

Teen Suicide

Suicides among young people continue to be a serious problem. Each year in the U.S., thousands of teenagers commit suicide. Suicide is the third leading cause of death for 15-to-24-year-olds, and the sixth leading cause of death for 5-to-14-year-olds.

Teenagers experience strong feelings of stress, confusion, self-doubt, pressure to succeed, financial uncertainty, and other fears while growing up. For some teenagers, divorce, the formation of a new family with step-parents and step-siblings, or moving to a new community can be very unsettling and can intensify self-doubts. For some teens, suicide may appear to be a solution to their problems and stress.

Depression and suicidal feelings are treatable mental disorders. The child or adolescent needs to have his or her illness recognized and diagnosed, and appropriate treatment plans developed. When parents are in doubt whether their child has a serious problem, a psychiatric examination can be very helpful.

Many of the signs and symptoms of suicidal feelings are similar to those of depression.

Parents should be aware of the following signs of adolescents who may try to kill themselves:

- change in eating and sleeping habits
- withdrawal from friends, family, and regular activities
- violent actions, rebellious behavior, or running away
- drug and alcohol use
- unusual neglect of personal appearance
- marked personality change
- persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- loss of interest in pleasurable activities
- not tolerating praise or rewards

A teenager who is planning to commit suicide may also:

- complain of being a bad person or feeling rotten inside
- give verbal hints with statements such as: I won't be a problem for you much longer, nothing matters, It's no use, and I won't see you again

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- put his or her affairs in order, for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
- become suddenly cheerful after a period of depression
- have signs of psychosis (hallucinations or bizarre thoughts)

If a child or adolescent says, I want to kill myself, or I'm going to commit suicide, always take the statement seriously and immediately seek assistance from a qualified mental health professional. People often feel uncomfortable talking about death. However, asking the child or adolescent whether he or she is depressed or thinking about suicide can be helpful. Rather than putting thoughts in the child's head, such a question will provide assurance that somebody cares and will give the young person the chance to talk about problems.

If one or more of these signs occurs, parents need to talk to their child about their concerns and seek professional help from a physician or a qualified mental health professional. With support from family and appropriate treatment, children and teenagers who are suicidal can heal and return to a more healthy path of development.

For more information, see Facts for Families:
#3 Teens: Alcohol and Other Drugs
#4 The Depressed Child
#37 Children and Firearms
#38 Bipolar Disorder in Children and Teens
#00 Definition of a Child and Adolescent Psychiatrist

# # #

If you find *Facts for Families*© helpful and would like to make good mental health a reality for all children, please consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute *Facts for Families*, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to ***Campaign for America's Kids***, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,000 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 11 May 2008

The Child with Autism

Most infants and young children are very social creatures who need and want contact with others to thrive and grow. They smile, cuddle, laugh, and respond eagerly to games like "peek-a-boo" or hide-and-seek. Occasionally, however, a child does not interact in this expected manner. Instead, the child seems to exist in his or her own world, a place characterized by repetitive routines, odd and peculiar behaviors, problems in communication, and a total lack of social awareness or interest in others. These are characteristics of a developmental disorder called autism.

Autism is usually identified by the time a child is 30 months old. It is often discovered when parents become concerned that their child may be deaf, is not yet talking, resists cuddling, and avoids interaction with others.

Some of the early signs and symptoms which suggest a young child may need further evaluation for autism include:

- no smiling by six months of age
- no back and forth sharing of sounds, smiles or facial expressions by nine months
- no babbling, pointing, reaching or waving by 12 months
- no single words by 16 months
- no two word phrases by 24 months
- regression in development
- any loss of speech, babbling or social skills

A preschool age child with "classic" autism is generally withdrawn, aloof, and fails to respond to other people. Many of these children will not even make eye contact. They may also engage in odd or ritualistic behaviors like rocking, hand flapping, or an obsessive need to maintain order.

Many children with autism do not speak at all. Those who do may speak in rhyme, have echolalia (repeating a person's words like an echo), refer to themselves as a "he" or "she," or use peculiar language.

The severity of autism varies widely, from mild to severe. Some children are very bright and do well in school, although they have problems with school adjustment. They may be able to live independently when they grow up. Other children with autism function at a much lower level. Mental retardation is commonly associated with autism.

Occasionally, a child with autism may display an extraordinary talent in art, music, or another specific area.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

The Child with Autism, "Facts for Families," No. 11 (5/08)

The cause of autism remains unknown, although current theories indicate a problem with the function or structure of the central nervous system. What we do know, however, is that parents do not cause autism.

Children with autism need a comprehensive evaluation and specialized behavioral and educational programs. Some children with autism may also benefit from treatment with medication. Child and adolescent psychiatrists are trained to diagnose autism, and to help families design and implement an appropriate treatment plan. They can also help families cope with the stress which may be associated with having a child with autism.

Although there is no cure for autism, appropriate specialized treatment provided early in life can have a positive impact on the child's development and produce an overall reduction in disruptive behaviors and symptoms.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 12 March 2011

Children Who Steal

When a child or teenager steals, parents are naturally concerned. They worry about what caused their child to steal, and they wonder whether their son or daughter is a "juvenile delinquent."

It is normal for a very young child to take something which excites his or her interest. This should not be regarded as stealing until the youngster is old enough, usually three to five years old, to understand that taking something which belongs to another person is wrong. Parents should actively teach their children about property rights and the consideration of others. Parents are also role models. If you come home with stationary or pens from the office or brag about a mistake at the supermarket checkout counter, your lessons about honesty will be a lot harder for your child to understand.

Although they have learned that theft is wrong, older children or teenagers steal for various reasons. A youngster may steal to make things equal if a brother or sister seems to be favored with affection or gifts. Sometimes, a child may steal as a show of bravery to friends, or to give presents to family or friends or to be more accepted by peers. Children may also steal out of a fear of dependency; they don't want to depend on anyone, so they take what they need.

Parents should consider whether the child has stolen out of a need for more attention. In these cases, the child may be expressing anger or trying to "get even" with his or her parents; the stolen object may become a substitute for love or affection. The parents should make an effort to give more recognition to the child as an important family member.

If parents take the proper measures, in most cases the stealing stops as the child grows older. Child and adolescent psychiatrists recommend that when parents find out their child has stolen, they:

- tell the child that stealing is wrong
- help the youngster to pay for or return the stolen object
- make sure that the child does not benefit from the theft in any way
- avoid lecturing, predicting future bad behavior, or saying that they now consider the child to be a thief or a bad person
- make clear that this behavior is totally unacceptable within the family tradition and the community

When the child has paid for or returned the stolen merchandise, the matter should not be brought up again by the parents, so that the child can begin again with a "clean slate."

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

If stealing is persistent or accompanied by other problem behaviors or symptoms, the stealing may be a sign of more serious problems in the child's emotional development or problems in the family. Children who repeatedly steal may also have difficulty trusting others and forming close relationships. Rather than feeling guilty, they may blame the behavior on others, arguing that, "Since they refuse to give me what I need, I will take it." These children would benefit from an evaluation by a child and adolescent psychiatrist.

In treating a child who steals persistently, a child and adolescent psychiatrist will evaluate the underlying reasons for the child's need to steal, and develop a plan of treatment. Important aspects of treatment are helping the child learn to establish trusting relationships and helping the family to support the child in changing to a more healthy path of development.

For additional information see ***Facts for Families***:
#1 Children and Divorce
#3 Teens: Alcohol and Other Drugs
#33 Conduct Disorder
#43 Discipline
#44 Children and Lying

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 13 March 2011

Children and TV Violence

American children watch an average of fours hours of television daily. Television can be a powerful influence in developing value systems and shaping behavior. Unfortunately, much of today's television programming is violent. Hundreds of studies of the effects of TV violence on children and teenagers have found that children may:

- become "immune" or numb to the horror of violence
- gradually accept violence as a way to solve problems
- imitate the violence they observe on television; and
- identify with certain characters, victims and/or victimizers

Extensive viewing of television violence by children causes greater aggressiveness. Sometimes, watching a single violent program can increase aggressiveness. Children who view shows in which violence is very realistic, frequently repeated or unpunished, are more likely to imitate what they see. Children with emotional, behavioral, learning or impulse control problems may be more easily influenced by TV violence. The impact of TV violence may be immediately evident in the child's behavior or may surface years later. Young people can even be affected when the family atmosphere shows no tendency toward violence.

While TV violence is not the only cause of aggressive or violent behavior, it is clearly a significant factor. Parents can protect children from excessive TV violence in the following ways:

- pay attention to the programs their children are watching and watch some with them
- set limits on the amount of time they spend with the television; consider removing the TV set from the child's bedroom
- point out that although the actor has not actually been hurt or killed, such violence in real life results in pain or death
- refuse to let the children see shows known to be violent, and change the channel or turn off the TV set when offensive material comes on, with an explanation of what is wrong with the program
- disapprove of the violent episodes in front of the children, stressing the belief that such behavior is not the best way to resolve a problem
- to offset peer pressure among friends and classmates, contact other parents and agree to enforce similar rules about the length of time and type of program the children may watch

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Parents can also use these measures to prevent harmful effects from television in other areas such as racial or sexual stereotyping. The amount of time children watch TV, regardless of content, should be moderated because it decreases time spent on more beneficial activities such as reading, playing with friends, and developing hobbies. If parents have serious difficulties setting limits, or have ongoing concerns about their child's behavior, they should contact a child and adolescent psychiatrist for consultation and assistance.

For additional information see ***Facts for Families:***
#40 Influence of Music and Rock Videos
#55 Understanding Violent Behavior in Children
#59 Children Online
#67 Children and the News
#00 Definition of a Child and Adolescent Psychiatrist

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 14 March 2011

Children and Family Moves

Moving to a new community may be one of the most stress-producing experiences a family faces. Frequent moves or even a single move can be especially hard on children and adolescents. Studies show children who move frequently are more likely to have problems at school. Moves are even more difficult if accompanied by other significant changes in the child's life, such as a death, divorce, loss of family income, or a need to change schools.

Moves interrupt friendships. To a new child at school, it may at first seem that everyone else has a best friend or is securely involved with a group of peers. The child must get used to a different schedule and curriculum, and may be ahead in certain subjects and behind in others. This situation may make the child stressed, anxious or bored.

Children in kindergarten or first grade may be particularly vulnerable to a family move because developmentally they are just in the process of separating from their parents and adjusting to new authority figures and social relationships. The relocation can interfere with that normal process of separation by causing them to return to a more dependent relationship with their parents.

In general, the older the child, the more difficulty he or she will have with the move because of the increasing importance of the peer group. Pre-teens and teenagers may repeatedly protest the move, or ask to stay in their hometown with a friend's family. Some youngsters may not talk about their distress, so parents should be aware of the warning signs of depression, including changes in appetite, social withdrawal, a drop in grades, irritability, sleep disturbances or other dramatic changes in behavior or mood.

Children who seem depressed by a move may be reacting more to the stress they are experiencing than to the relocation. Sometimes one parent may be against the move, and children will sense and react to this parental discord.

If the child shows persistent signs of depression or distress, parents can ask their family doctor, their pediatrician, or the local medical society to refer them to a child and adolescent psychiatrist. The child and adolescent psychiatrist can evaluate and treat the child's emotional problems which may be associated with stress and also help parents make the transition and new experience easier for the whole family.

To make the move easier on children, parents may take these steps:

- Explain clearly to the children why the move is necessary.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Familiarize the children as much as possible with the new area with maps, photographs or the daily newspaper.
- Describe advantages of the new location that the child might appreciate such as a lake, mountain or an amusement park.
- After the move, get involved with the children in activities of the local church or synagogue, PTA, scouts, YMCA, etc.
- If a son or daughter is a senior in high school, consider the possibility of letting him or her stay with a trusted family until the school year is over.
- Let children participate in designing or furnishing their room.
- Help children keep in touch with friends from the previous neighborhood through telephone, letters, e-mail, and personal visits.

The more frequently a family moves, the more important is the need for internal stability. With the proper attention from parents, and professional help if necessary, moving can be a positive growth experience for children, leading to increased self-confidence and interpersonal skills.

For additional information see ***Facts for Families***:
#4 The Depressed Child
#7 Children Who Won't Go to School
#8 Children and Grief
#47 The Anxious Child

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 15 March 2011

The Adopted Child

Approximately 120,000 children are adopted each year in the United States. Children with physical, developmental, or emotional handicaps who were once considered unadoptable are now being adopted ("special needs adoptions"). Adoption helps many of these children to grow up in permanent families rather than in foster homes or institutions.

Parents with an adopted child wonder whether, when, and how to tell their child that he or she is adopted. They also want to know if adopted children face special problems or challenges.

Child and adolescent psychiatrists recommend that the child be told about the adoption by the adoptive parents. Children should be told about their adoption in a way that they can understand.

There are two different views on when a child should be told they are adopted. Many experts believe the child should be told at the youngest possible age. This approach provides the child an early opportunity to accept and integrate the concept of being "adopted." Other experts believe that telling a child too early may confuse the young child who can't really understand the information. These experts advise waiting until the child is older.

In either case, children should learn of their adoption from the adoptive parents. This helps give the message that adoption is good and that the child can trust the parents. If the child first learns about the adoption intentionally or accidentally from someone other than parents, the child may feel anger and mistrust towards the parents, and may view the adoption as bad or shameful because it was kept a secret.

Adopted children will want to talk about their adoption and parents should encourage this process. Several excellent children's story books are available in bookstores and libraries which can help parents tell the child about being adopted. Children have a variety of responses to the knowledge that they are adopted. Their feelings and responses depend on their age and level of maturity. The child may deny the adoption or create fantasies about it. Frequently, adopted children hold onto beliefs that they were given away for being bad or may believe that they were kidnapped. If the parents talk openly about the adoption and present it in a positive manner, these worries are less likely to develop.

All adolescents go through a stage of struggling with their identity, wondering how they fit in with their family, their peers, and the rest of the world. This struggle may be even more intense for children adopted from other countries or cultures. In adolescence, the

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

adopted child is likely to have an increased interest in his or her birth parents. This open curiosity is not unusual and does not mean that he or she is rejecting the adoptive parents. Some adolescents may wish to learn the identity of their birth parents. Adoptive parents can respond by letting the adolescent know it is okay to have such interest and questions, and when asked should give what information they have about the birth family with sensitivity and support.

Adoptive parents often have questions about how to deal with the circumstances of adoption. These parents need support from mental health and health professionals.

Some adopted children may develop emotional or behavioral problems. The problems may or may not result from insecurities or issues related to being adopted. If parents are concerned, they should seek professional assistance. Children who are preoccupied with their adoption should also be evaluated. A child and adolescent psychiatrist can help the child and adoptive parents determine whether or not help is needed.

For additional information see ***Facts for Families:***
#4 The Depressed Child
#5 Child Abuse - The Hidden Bruises
#8 Children and Grief
#24 Know When to Seek Help for Your Child
#52 Comprehensive Psychiatric Evaluation
#64 Foster Care
#85 Reactive Attachment Disorder

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 16 August 2013

Children with Learning Disorders

Parents are often worried when their child has learning problems in school. There are many reasons for school failure, but a common one is a specific learning disorder. Children with learning disorders can have intelligence in the normal range but the specific learning disorder may make teachers and parents concerned about their general intelligence. Often, these children may try very hard to follow instructions, concentrate, and "be good" at home and in school. Yet, despite this effort, he or she is not mastering school tasks and falls behind. Learning disorders affect at least 1 in 10 schoolchildren.

It is believed that learning disorders are caused by a difficulty with the nervous system that affects receiving, processing, or communicating information. They may also run in families. Some children with learning disorders are also hyperactive; unable to sit still, easily distracted, and have a short attention span.

Child and adolescent psychiatrists are aware that some of the long range consequences of learning disorders can be lessened with early intervention. However, If not detected and treated, they can have a "snowballing" effect. For instance, a child who does not learn addition in elementary school cannot understand algebra in high school. The child, trying very hard to learn, becomes more and more frustrated, and develops emotional problems such as low self-esteem in the face of repeated failure. Some children with learning disorders misbehave in school because they would rather be seen as "bad" than "stupid."
Frequent signals of learning disorders that parents should watch for in their child include the following:

- difficulty understanding and following instructions.
- trouble remembering what someone just told him or her.
- fails to master reading, spelling, writing, and/or math skills, and thus fails
- difficulty distinguishing right from left; difficulty identifying words or a tendency to reverse letters, words, or numbers; (for example, confusing 25 with 52, "b" with "d," or "on" with "no").
- lacks coordination in walking, sports, or small activities such as holding a pencil or tying a shoelace.
- easily loses or misplaces homework, schoolbooks, or other items.
- difficulty understanding the concept of time; is confused by "yesterday, today, tomorrow."

Generally, an important first step is to understand the child's learning difficulties and consider how they will affect their communication, self-help skill, willingness to accept discipline, impact on play and capacity for independence. Such problems deserve a

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

comprehensive evaluation by an expert who can assess all of the different issues affecting the child. A child and adolescent psychiatrist can help coordinate the evaluation, and work with school professionals and others to have the evaluation and educational testing done to clarify if a learning disorder exists. This includes talking with the child and family, evaluating their situation, reviewing the educational testing, and consulting with the school. The child and adolescent psychiatrist will then make recommendations on appropriate school placement, the need for special help such as special educational services or speech-language therapy and help parents assist their child in maximizing his or her learning potential. Sometimes individual or family psychotherapy will be recommended. Medication may be prescribed for hyperactivity or distractibility Parents need to consider the delicate balance between providing too much or too little assistance to their child to help them meet their educational goals. It is important to strengthen the child's self-confidence, which is vital for healthy development, and also help parents and other family members better understand and cope with the realities of living with a child with learning disorders.

For additional information see Facts for Families:

#6 Children Who Can't Pay Attention
#7 Children Who Won't Go to School
#33 Conduct Disorder

See also: Your Child (1998 Harper Collins) / Your Adolescent (1999 Harper Collins)

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 17 December 2011

Children of Alcoholics

One in five adult Americans have lived with an alcoholic relative while growing up. These children are in general at greater risk for having emotional problems than children whose parents are not alcoholics. Alcoholism runs in families, and children of alcoholics are four times more likely than other children to become alcoholics themselves. Compounding the psychological impact of being raised by a parent who is suffereing from alcohol abuse is the fact that most children of alcoholics have experienced some form of neglect or abuse.

A child being raised by a parent or caregiver who is suffering from alcohol abuse may have a variety of conflicting emotions that need to be addressed in order to avoid future problems. They are in a difficult position because they cannot go to their own parents for support. Some of the feelings can include the following:

- Guilt. The child may see himself or herself as the main cause of the mother's or father's drinking.
- Anxiety. The child may worry constantly about the situation at home. He or she may fear the alcoholic parent will become sick or injured, and may also fear fights and violence between the parents.
- Embarrassment. Parents may give the child the message that there is a terrible secret at home. The ashamed child does not invite friends home and is afraid to ask anyone for help.
- Inability to have close relationships. Because the child has been disappointed by the drinking parent many times, he or she often does not trust others.
- Confusion. The alcoholic parent will change suddenly from being loving to angry, regardless of the child's behavior. A regular daily schedule, which is very important for a child, does not exist because bedtimes and mealtimes are constantly changing.
- Anger. The child feels anger at the alcoholic parent for drinking, and may be angry at the non-alcoholic parent for lack of support and protection.
- Depression. The child feels lonely and helpless to change the situation.

Although the child tries to keep the alcoholism a secret, teachers, relatives, other adults, or friends may sense that something is wrong. Teachers and caregivers should be aware that the following behaviors may signal a drinking or other problem at home:

- Failure in school; truancy
- Lack of friends; withdrawal from classmates
- Delinquent behavior, such as stealing or violence
- Frequent physical complaints, such as headaches or stomachaches

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Abuse of drugs or alcohol; or
- Aggression towards other children
- Risk taking behaviors
- Depression or suicidal thoughts or behavior

Some children of alcoholics may cope by taking the role of responsible "parents" within the family and among friends. They may become controlled, successful "overachievers" throughout school, and at the same time be emotionally isolated from other children and teachers. Their emotional problems may show only when they become adults.

It is important for relatives, teachers and caregivers to realize that whether or not the parents are receiving treatment for alcoholism, these children and adolescents can benefit from educational programs and mutual-help groups such as programs for children of alcoholics, Al-Anon, and Alateen. Early professional help is also important in preventing more serious problems for the child, including reducing risk for future alcoholism. Child and adolescent psychiatrists can diagnose and treat problems in children of alcoholics. They can also help the child to understand they are not responsible for the drinking problems of their parents and that the child can be helped even if the parent is in denial and refusing to seek help.

The treatment program may include group therapy with other youngsters, which reduces the isolation of being a child of an alcoholic. The child and adolescent psychiatrist will often work with the entire family, particularly when the alcoholic parent has stopped drinking, to help them develop healthier ways of relating to one another.

For additional information see Facts for Families:

#5 Child Abuse
#4 The Depressed Child
#3 Teens: Alcohol And Other Drugs
#68 Tobacco And Kids
#33 Conduct Disorder
Al-Anon Family Group (800) 356-9996

See also: Your Child (1998 Harper Collins) / Your Adolescent (1999 Harper Collins)

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 18 December 2011

Bedwetting

Many parents are concerned when their child continues to wet their bed at night past the age of 3 years old. Since most children begin to stay dry through the night around three years of age their concerns are valid However, child and adolescent psychiatrists stress that enuresis is a fairly common symptom and not a disease. Occasional accidents may occur, often when the child is ill. Parents need to be understanding particularly if the child has been able to have a majority of dry nights. Some facts parents should know about bedwetting:

- Approximately 15 percent of children wet the bed after the age of three
- Many more boys than girls wet their beds
- Bedwetting runs in families
- Usually bedwetting stops by puberty
- Most bedwetters do not have emotional problems

Persistent bedwetting beyond the age of three or four rarely signals a kidney or bladder problem. Bedwetting may sometimes be related to a sleep disorder. In most cases, it is due to the development of the child's bladder control being slower than normal. Bedwetting may also be the result of the child's tensions and emotions that require attention.

There are a variety of emotional reasons for bedwetting. For example, when a young child begins bedwetting after several months or years of dryness during the night (secondary enuresis), this may reflect new fears or insecurities. Often, this may follow changes or events which make the child feel insecure such as moving to a new home, parents' divorce, losing a family member or loved one, or the arrival of a new baby or child in the home.

Parents should remember that children rarely wet on purpose, and usually feel ashamed about the incident. Rather than make the child feel ashamed, parents need to encourage the child and express confidence that he or she will soon be able to stay dry at night. Parents may help children who wet the bed by:

- Limiting liquids before bedtime
- Encouraging the child to go to the bathroom before bedtime
- Praising the child on dry mornings
- Avoiding punishments
- Waking the child during the night to empty their bladder

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Treatment for bedwetting in children usually includes behavioral conditioning devices (pad/buzzer) and/or medications if behavioral interventions are unsuccessful. In rare instances, the problem of bedwetting cannot be resolved by the parents, the family physician or the pediatrician. Sometimes the child may also show symptoms of emotional problems--such as persistent sadness or irritability, or a change in eating or sleeping habits. In these cases, parents may want to talk with a child and adolescent psychiatrist, who will evaluate physical and emotional problems that may be causing the bedwetting, and will work with the child and parents to resolve these problems. Early supportive intervention will help minimize the potential emotional impact of persistent bedwetting on the child.

For additional information see Facts for Families:

#48 Problems with Soiling and Bowel Control
#34 Children's Sleep Problems

See also: Your Child (1998 Harper Collins) / Your Adolescent (1999 Harper Collins)

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 19 December 2011

The Child with a Long-Term Illness

The child who is diagnosed with a serious and chronic medical illness is at greater risk for developing emotional problems. Unlike a child who has a temporary medical condition such as the flu, the child with a chronic illness must cope with knowing that the disease is permanent, incurable and may even get worse with time.

The young child, unable to understand why the sickness has occurred, may assume it is a punishment for being "bad." He or she may become angry with parents and doctors for not being able to cure the illness. The youngster may react strongly against pampering, teasing, or other attention because they highlight his or her differences from other healthy children. Uncomfortable medical treatments and restrictions in diet and activity may make the child unhappy and withdrawn. Parents often wish to be supportive of their children and withhold information because they don't want their children to worry unnecessarily. However, it is important for parents to understand that they can best help by providing age appropriate information about the disease, prognosis and the importance of compliance to treatments to minimize advancement of the disease or to control the symptoms.

A teenager with a long-term illness may feel pulled in opposite directions. On the one hand, he or she must take care of the physical problem, requiring dependence on parents and doctors. On the other hand, the adolescent wants to become independent and join his or her friends in various activities. When a teenager with a long-term illness tries to decrease or stop taking the prescribed medication without consulting his or her physician, this may reflect a normal adolescent desire to control one's own body.

Chronic illness entails frequent physician visits and medical leaves requiring the child or adolescent to miss classes and school activities. The lack of continuity in school attendance may cause problems, including avoidance or refusal to attend school. This can increase the child's loneliness and feeling of being different from other youngsters. It is important for parents to help a child maintain as normal a routine as possible. They should respond not only to the child's illness, but to the child's strengths. Child and adolescent psychiatrists know that if isolated or overprotected, the child may not learn to socialize or may have difficulty separating from parents when it is time to be involved in school or other activities outside the home. How can parents help? The following is a list of suggestions to consider for the child struggling with chronic physical illness:

- Help your child to be in contact with others who have successfully adjusted to living with a chronic illness.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- In their prolonged periods of hospitalization and/or rest at home, children may develop excellence in a hobby or a special talent such as art, model airplanes, or a foreign language.

- Help your child learn as much about their illness as possible. Such activities are emotionally healthy and should be encouraged.

Children with long-term illnesses are often treated by a team of medical specialists. This team often includes a child and adolescent psychiatrist, who can help the child and family identify and overcome problems resulting from the burden of chronic medical illness. The psychiatrist can help families and their children understand the impact on the family of coping with multiple life changes imposed by the illness and develop emotionally healthy ways of living with the disease and its effects.

For additional information see ***Facts for Families***:
#8 Children and Grief
#7 Children Who Won't Go to School
#30 Children and AIDS

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 20 December 2011

Making Day Care a Good Experience

Child and adolescent psychiatrists recognize that the ideal environment for raising a small child is in the home with parents and family. Some experts recommend a minimum of six or more months leave for parents after a child is born to promote bonding. Intimate daily parental caretaking of infants for the first several months of life is particularly important. Since the ideal environment often is not possible if parents have to return to work, the role of day care has to be considered. Experts agree that when day care is used in the first years of a child's life, the quantity and quality of the day care have significant impact on the child's emotional and physical development.

Before choosing a day care environment, parents should be familiar with the state licensure regulations for child care. They should also check references from other parents and observe the potential caregivers with the child.

Parents sometimes take their young child to the home of a person who is caring for one or more other children. Infants and children under the age of two-and-one-half need:

- More adults per child than older children require
- A lot of individual attention
- The same caregiver(s) over a long period of time
- A caregiver who will play and talk with them, smile with them, praise them for their achievements, and enjoy them

Parents should seek a caregiver who is warm, caring, self-confident, attentive, and responsive to the children. The caregiver should be able to encourage social skills and positive behavior, and set limits on negative ones. Parents should consider the caregiver's ability to relate to children of different ages. Some individuals can work well only with children at a specific stage of development.

It is wise for parents to find out how long the individual plans to work in this day care job. High turnover of individuals, several turnovers, or any turnover at critical points of development, can distress the child. If parents think or feel the day care they have chosen is unsatisfactory, they should change caregivers. All parents have the right to drop in during the day and make an unannounced visit.

Many children, particularly after the age of three, benefit from good, group day care, where they can have fun and learn how to interact with others. Child and adolescent psychiatrists suggest that parents seek day care services that have:

- trained, experienced teachers who enjoy, understand and can lead children

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- appropriate number of teachers and assistants, ideally, at least one for every five children, small rather than large groups if possible. (Studies have shown that five children with one caregiver is better than 20 children with four caregivers)
- staff that has been there for a long period of time
- opportunities for creative work, imaginative play, and physical activity
- space to move indoors and out
- lots of drawing and coloring materials and toys, as well as equipment for physical activity such as swings, wagons, jungle gyms, etc.

If the child seems afraid to go to day care, parents should introduce the new environment gradually: at first, the mother or father can go along, staying nearby while the child plays. The parent and child can stay for a longer period each day until the child wants to become part of the group. If the child shows unusual or persistent terror about leaving home, parents should consider consulting a child and adolescent psychiatrist to discuss their concerns and develop strategies to help the child to talk about his or her fears. Parents can help make day care more positive and less stressful for their child by being actively involved with the day care staff and proactively talking to their child about daily activities in daycare.

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 21 July 2004

Psychiatric Medication for Children and Adolescents Part 1- How Medications Are Used

Medication can be an effective part of the treatment for several psychiatric disorders of childhood and adolescence. A doctor's recommendation to use medication often raises many concerns and questions in both the parents and the youngster. The physician who recommends medication should be experienced in treating psychiatric illnesses in children and adolescents. He or she should fully explain the reasons for medication use, what benefits the medication should provide, as well as possible risks and side effects and other treatment alternatives.

Psychiatric medication should not be used alone. The use of medication should be based on a comprehensive psychiatric evaluation and be one part of a comprehensive treatment plan.

Before recommending any medication, the child and adolescent psychiatrist interviews the youngster and makes a thorough diagnostic evaluation. In some cases, the evaluation may include a physical exam, psychological testing, laboratory tests, other medical tests such as an electrocardiogram (EKG) or electroencephalogram (EEG) , and consultation with other medical specialists.

Medications which have beneficial effects may also have side effects, ranging from just annoying to very serious. As each youngster is different and may have individual reactions to medication, close contact with the treating physician is recommended. Do not stop or change a medication without speaking to the doctor. Psychiatric medication should be used as part of a comprehensive plan of treatment, with ongoing medical assessment and, in most cases, individual and/or family psychotherapy. **When prescribed appropriately by a psychiatrist (preferably a child and adolescent psychiatrist), and taken as prescribed, medication may reduce or eliminate troubling symptoms and improve the daily functioning of children and adolescents with psychiatric disorders.**

Medication may be prescribed for psychiatric symptoms and disorders, including, but not limited to:

1. **Bedwetting**-if it persists regularly after age 5 and causes serious problems in low self-esteem and social interaction.
2. **Anxiety** (school refusal, phobias, separation or social fears, generalized anxiety, or posttraumatic stress disorders)-if it keeps the youngster from normal daily activities.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

3. **Attention deficit hyperactivity disorder (ADHD)** -marked by a short attention span, trouble concentrating and restlessness. The child is easily upset and frustrated, often has problems getting along with family and friends, and usually has trouble in school.
4. **Obsessive-compulsive disorder (OCD)** -recurring obsessions (troublesome and intrusive thoughts) and/or compulsions (repetitive behaviors or rituals such as handwashing, counting, checking to see if doors are locked) which are often seen as senseless but which interfere with a youngster's daily functioning.
5. **Depression**-lasting feelings of sadness, helplessness, hopelessness, unworthiness and guilt, inability to feel pleasure, a decline in school work and changes in sleeping and eating habits.
6. **Eating disorder**-either self-starvation (anorexia nervosa) or binge eating and vomiting (bulimia), or a combination of the two.
7. **Bipolar (manic-depressive) disorder**-periods of depression alternating with manic periods, which may include irritability, "high" or happy mood, excessive energy, behavior problems, staying up late at night, and grand plans.
8. **Psychosis**-symptoms include irrational beliefs, paranoia, hallucinations (seeing things or hearing sounds that don't exist) social withdrawal, clinging, strange behavior, extreme stubbornness, persistent rituals, and deterioration of personal habits. May be seen in developmental disorders, severe depression, schizoaffective disorder, schizophrenia, and some forms of substance abuse.
9. **Autism**-(or other pervasive developmental disorder such as Asperger's Syndrome)-characterized by severe deficits in social interactions, language, and/or thinking or ability to learn, and usually diagnosed in early childhood.
10. **Severe aggression**-which may include assaultiveness, excessive property damage, or prolonged self-abuse, such as head-banging or cutting.
11. **Sleep problems**-symptoms can include insomnia, night terrors, sleep walking, fear of separation, anxiety.

For additional information about psychiatric medications see Facts for Families:
#29 Psychiatric Medication for Children and Adolescents: Part II-Types of Medications
#51 Psychiatric Medications for Children and Adolescents: Part III-Questions to Ask.

For additional information see Facts for Families:
#00 Definition of a Child and Adolescent Psychiatrist
#25 Know Where to Seek Help for Your Child
#52 Comprehensive Psychiatric Evaluation

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 22 March 2011

Normality

Parents are naturally concerned about the health and welfare of their children. Many parents correctly and comfortably see their youngster as normal. However, some parents worry whether their infant, child, or teenager has a problem. These worries can include questions about:

- how the child is developing
- the emotional well-being of the child
- what the child says, thinks, and feels
- how the child acts, for example, eating and sleeping patterns, behavior at school, getting along with family and friends, or coping with stress

Child and adolescent psychiatrists can help parents and families answer these questions about what's normal and what's not. They usually interview the child and ask the parents about the child's previous health and behavior. They may also ask about how the family gets along together. It is likely that infants, children, and teenagers are normal when, at the appropriate age, they fully participate in and enjoy their:

- learning, school, and/or work
- relationships within the family
- relationships with friends; and
- play

Many parents first discuss their concerns about their child's normality with a family member or friend, or with the child's physician, school counselor or member of the clergy--who may then refer the family to a child and adolescent psychiatrist. He or she listens carefully to the parents and child and sorts out:

- the long-term factors that tend to lead to--or protect against-the child's developing problems
- the short-term factors that set off the child's problem
- the factors causing these problems to persist
- the possible roles of other medical conditions; and
- the contribution of school learning, social and emotional growth to the child's functioning.

Based on the evaluation, the child and adolescent psychiatrist may:

- reassure the parents, explaining how they can enhance normal development;

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- suggest an activity or an educational program for the child, and/or education for parents, which will support normal development and effective parenting;
- provide or arrange for brief counseling to help the child and parents with minor developmental problems, stressful life situations or difficulties due to the child's temperament

If the evaluation reveals a psychiatric disorder, the child and adolescent psychiatrist will recommend a specific treatment program.

Parents, better than anyone else, know their child and know what is usual behavior for their child. If you feel your child has a problem, seek professional help. It is a very important first step in knowing for sure whether there is a problem, and if so, what measures will best help your child.

For additional/related information see other ***Facts for Families***:
#24 When to Seek Help for Your Child
#25 Where to Seek Help for Your Child
#52 Comprehensive Psychiatric Evaluation
#66 Helping Teenagers with Stress

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 23 July 2004

Children Who Are Mentally Retarded

The term "intellectual disability" is often misunderstood and seen as derogatory. Some think that retardation is diagnosed only on the basis of below-normal intelligence (IQ), and that persons with intellectual disabilities are unable to learn or to care for themselves. Actually, in order to be diagnosed as a person with intellectual disabilities, the person has to have both significantly low IQ and considerable problems in everyday functioning. Most children with intellectual disabilities can learn a great deal, and as adults can lead at least partially independent lives. Most individuals with intellectual disabilities have only a mild level. Intellectual disabilities may be complicated by several different physical and emotional problems. The child may also have difficulty with hearing, sight or speech.

In the past, parents were often advised to institutionalize a child with significant intellectual disabilities. Today, the goal is to help the child with intellectual disabilities stay in the family and take part in community life. In most states, the law guarantees them educational and other services at public expense.

It is very important that the child has a comprehensive evaluation to find out about his or her strengths and needs. Since no specialist has all the necessary skills, many professionals might be involved. General medical tests as well as tests in areas such as neurology (the nervous system), psychology, psychiatry, special education, hearing, speech and vision, and physical therapy are useful. A pediatrician or a child and adolescent psychiatrist often coordinates these tests.

These physicians refer the child for the necessary tests and consultations, put together the results, and jointly with the family and the school develop a comprehensive treatment and education plan.

Emotional and behavioral disorders may be associated with intellectual disabilities, and they may interfere with the child's progress. Most children with intellectual disabilities recognize that they are behind others of their own age. Some may become frustrated, withdrawn or anxious, or act "bad" to get the attention of other youngsters and adults. Adolescents and young adults with intellectual disabilities may become depressed. These persons might not have enough language skills to talk about their feelings, and their depression may be shown by new problems, for instance in their behavior, eating and sleeping.

Early diagnosis of psychiatric disorders in children with intellectual disabilities leads to early treatment. Medications can be helpful as one part of overall treatment and management of children with intellectual disabilities.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Children Who Are Mentally Retarded, "Facts for Families," No. 23 (7/04)

Periodic consultation with a child and adolescent psychiatrist may help the family in setting appropriate expectations, limits, opportunities to succeed, and other measures which will help their child with intellectual disabilities handle the stresses of growing up.

For additional information see Facts for Families:
#69 Asperger's Disorder
#21 Psychiatric Medications for Children
#45 Lead Exposure in Children Affects Brain and Behavior
#11 The Child With Autism
#16 Children with Learning Disabilities

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 24 March 2011

When to Seek Help for Your Child

Parents are usually the first to recognize that their child has a problem with emotions or behavior. Still, the decision to seek professional help can be difficult and painful for a parent. The first step is to gently try to talk to the child. An honest open talk about feelings can often help. Parents may choose to consult with the child's physicians, teachers, members of the clergy, or other adults who know the child well. These steps may resolve the problems for the child and family.

Following are a few signs which may indicate that a child and adolescent psychiatric evaluation will be useful.

YOUNGER CHILDREN

- Marked fall in school performance
- Poor grades in school despite trying very hard
- Severe worry or anxiety, as shown by regular refusal to go to school, go to sleep or take part in activities that are normal for the child's age
- Frequent physical complaints
- Hyperactivity; fidgeting; constant movement beyond regular playing with or without difficulty paying attention
- Persistent nightmares
- Persistent disobedience or aggression (longer than 6 months) and provocative opposition to authority figures
- Frequent, unexplainable temper tantrums
- Threatens to harm or kill oneself

PRE-ADOLESCENTS AND ADOLESCENTS

- Marked decline in school performance
- Inability to cope with problems and daily activities
- Marked changes in sleeping and/or eating habits
- Extreme difficulties in concentrating that get in the way at school or at home
- Sexual acting out
- Depression shown by sustained, prolonged negative mood and attitude, often accompanied by poor appetite, difficulty sleeping or thoughts of death
- Severe mood swings
- Strong worries or anxieties that get in the way of daily life, such as at school or socializing
- Repeated use of alcohol and/or drugs

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Intense fear of becoming obese with no relationship to actual body weight, excessive dieting, throwing up or using laxatives to loose weight
- Persistent nightmares
- Threats of self-harm or harm to others
- Self-injury or self destructive behavior
- Frequent outbursts of anger, aggression
- Repeated threats to run away
- Aggressive or non-aggressive consistent violation of rights of others; opposition to authority, truancy, thefts, or vandalism
- Strange thoughts, beliefs, feelings, or unusual behaviors

If problems persist over an extended period of time or if others involved in the child's life are concerned, consider speaking with your seeking a consultation with a child and adolescent psychiatrist or a trained mental health professional.

See other ***Facts for Families:***
#25 Where to Seek Help for Your Child
#52 Comprehensive Psychiatric Evaluation
#22 Normality
#57 Normal Adolescent Development, Middle School, and Early High School Years
#58 Normal Adolescent Development, Late High School Year and Beyond
#00 Definition of a Child and Adolescent Psychiatrist

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 25 March 2011

Where to Find Help for Your Child

Parents are often concerned about their child's emotional health or behavior but they don't know where to start to get help. The mental health system can sometimes be complicated and difficult for parents to understand. A child's emotional distress often causes disruption to both the parent's and the child's world. Parents may have difficulty being objective. They may blame themselves or worry that others such as teachers or family members will blame them.

If you are worried about your child's emotions or behavior, you can start by talking to friends, family members, your spiritual counselor, your child's school counselor, or your child's pediatrician or family physician about your concerns. If you think your child needs help, you should get as much information as possible about where to find help for your child. Parents should be cautious about using Yellow Pages phone directories as their only source of information and referral. Other sources of information include:

- Employee Assistance Program through your employer
- Local medical society, local psychiatric society
- Local mental health association
- County mental health department
- Local hospitals or medical centers with psychiatric services
- Department of Psychiatry in nearby medical school
- National Advocacy Organizations (National Alliance for the Mentally Ill, Federation of Families for Children's Mental Health, National Mental Health Association)
- National professional organizations (American Academy of Child and Adolescent Psychiatry, American Psychiatric Association)

The variety of mental health practitioners can be confusing. There are psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, counselors, pastoral counselors and people who call themselves therapists. Few states regulate the practice of psychotherapy, so almost anyone can call herself or himself a “psychotherapist” or a “therapist.”

Child and Adolescent Psychiatrist — A child and adolescent psychiatrist is a licensed physician (M.D. or D.O.) who is a fully trained psychiatrist and who has two additional years of advanced training beyond general psychiatry with children, adolescents and families. Child and adolescent psychiatrists who pass the national examination administered by the American Board of Psychiatry and Neurology become board certified in child and adolescent psychiatry. Child and adolescent psychiatrists provide medical/psychiatric evaluation and a full range of treatment interventions for emotional

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

and behavioral problems and psychiatric disorders. As physicians, child and adolescent psychiatrists can prescribe and monitor medications.

Psychiatrist — A psychiatrist is a physician, a medical doctor, whose education includes a medical degree (M.D. or D.O.) and at least four additional years of study and training. Psychiatrists are licensed by the states as physicians. Psychiatrists who pass the national examination administered by the American Board of Psychiatry and Neurology become board certified in psychiatry. Psychiatrists provide medical/psychiatric evaluation and treatment for emotional and behavioral problems and psychiatric disorders. As physicians, psychiatrists can prescribe and monitor medications.

Psychologist — Some psychologists possess a master's degree (M.S.) in psychology while others have a doctoral degree (Ph.D., Psy.D, or Ed.D) in clinical, educational, counseling, developmental or research psychology. Psychologists are licensed by most states. Psychologists can also provide psychological evaluation and treatment for emotional and behavioral problems and disorders. Psychologists can also provide psychological testing and assessments.

Social Worker — Some social workers have a bachelor's degree (B.A., B.S.W., or B.S.), however most social workers have earned a master's degree (M.S. or M.S.W.). In most states social workers can take an examination to be licensed as clinical social workers. Social workers provide different forms of psychotherapy.

Parents should try to find a mental health professional who has advanced training and experience with the evaluation and treatment of children, adolescents, and families. Parents should always ask about the professionals training and experience. However, it is also very important to find a comfortable match between your child, your family, and the mental health professional.

For additional information see ***Facts for Families:***
#00 Definition of a Child and Adolescent Psychiatrist
#24 When to Seek Help
#26 Understanding Your Mental Health Insurance
#52 Comprehensive Psychiatric Evaluations

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 26 March 2011

Understanding Your Mental Health Insurance

Insurance benefits for mental health services have changed a lot in recent years. These changes are consistent with the nationwide trend to control the expense of health care. It is important to understand your mental health care coverage so that you can be an active advocate for your child's needs within the guidelines of your particular plan. Here are some useful questions to ask when evaluating the mental health benefits of an insurance plan or HMO:

- Do I have to get a referral from my child's primary care physician or employee assistance program to receive mental health services?
- Is there a "preferred list of providers" or "network" that you must see? Are child psychiatrists included? What happens if I want my child to see someone outside the network?
- Is there an annual deductible that I pay before the plan pays? What will I actually pay for services? What services are paid for by the plan: office visits, medication, respite care, day hospital, inpatient?
- Are there limits on the number of visits? Will my provider have to send reports to the managed care company?
- What can I do if I am unhappy with either the provider of the care or the recommendations of the "utilization review" process?
- What hospitals can be used under the plan?
- Does the plan exclude certain diagnoses or pre-existing conditions?
- Is there a "lifetime dollar limit" or an "annual limit" for mental health coverage, and what is it?
- Does the plan have a track record in your area?

The following section explains terms and procedures commonly used in health plan. Managed care refers to the process of someone reviewing and monitoring the need for and use of services. Your insurance company may do its own review and monitoring or may hire a "managed care company" to do the reviewing. The actual review of care is commonly known as "utilization review" and is done by professionals, mostly social workers and nurses, known as "utilization reviewers" or "case managers." The child psychiatrist treating your child may have to discuss the treatment with a reviewer in order for the care to be authorized and paid for by your insurance. The reviewers are trained to use the guidelines developed by your health care plan. A review by a child and adolescent psychiatrist reviewer usually must be specially requested.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

The review process often takes place over the telephone. Written treatment plans may also be required. Some plans may require that the entire medical record be copied and sent for review. Reviewers usually authorize payment for a limited number of outpatient sessions or a few days of inpatient care. In order for additional treatment to be authorized, the psychiatrist must call the reviewer back to discuss the child's progress and existing problems. Managed care emphasizes short term treatment with a focus on changing specific behaviors.

Preferred providers are groups of doctors, social workers, or psychologists which your insurer has agreed to pay. If you choose to see doctors outside of this list, (out of network caregivers), your insurer may not pay for the services. You will still be responsible for the bill. Similarly, care given in hospitals designated as "in network" is paid for by your insurance, while care given in hospitals "out of network" is usually not paid by your insurance and becomes your responsibility. Even when using preferred providers and in network hospitals, utilization reviewers still closely monitor treatment.

Another change is the variety of services and diagnosis paid for by different plans. In the past, only inpatient care and outpatient care was covered by insurance. Now, depending upon your particular plan, other services such as day hospital, home-based care, and respite care may also be covered. These lower cost services may offer advantages to inpatient hospitalization.

A limiting feature of some mental health care plans is a low lifetime maximum or a low annual dollar amount that can be used for mental health care. (i.e. Once this amount is used, plan coverage ends.) You, as parent or guardian, are responsible for paying the non-covered bill. If your child/adolescent needs continued care, you may need to seek help from your state public mental health system. This usually means changing doctors which may disrupt your child's care.

It is important to understand as much as possible about your particular insurance plan. Understanding your coverage will put you in a better position to help your child. Sometimes you may need to advocate for services that are not a part of your plan, but which you and your child's psychiatrist feel are necessary. Advocacy groups may provide you with important information about local services. The support of other parents is also useful and important when engaged in advocacy efforts.

Additional/related ***Facts for Families***:
#00 Definition of a Child and Adolescent Psychiatrist
#24 When to Seek Help for Your Child
#25 Where to Seek Help for Your Child
#52 Comprehensive Psychiatric Evaluation
#75 Advocating for Your Child

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 27 March 2011

Stepfamily Problems

With the high incidence of divorce and changing patterns of families in the United States, there are increasing numbers of stepfamilies. New stepfamilies face many challenges. As with any achievement, developing good stepfamily relationships requires a lot of effort. Stepfamily members have each experienced losses and face complicated adjustments to the new family situation.

When a stepfamily is formed, the members have no shared family histories or shared ways of doing things, and they may have very different beliefs. In addition, a child may feel torn between the parent they live with most (more) of the time and their other parent who they visit (e.g. lives somewhere else). Also, newly married couples may not have had much time together to adjust to their new relationship.

The members of the new blended family need to build strong bonds among themselves through:

- acknowledging and mourning their losses
- developing new skills in making decisions as a family
- fostering and strengthening new relationships between: parents, stepparent and stepchild, and stepsiblings
- supporting one another; and
- maintaining and nurturing original parent-child relationships

While facing these issues may be difficult, most stepfamilies do work out their problems. Stepfamilies often use grandparents (or other family), clergy, support groups, and other community-based programs to help with the adjustments.

Parents should consider a psychiatric evaluation for their child when they exhibit strong feelings of being:

- alone dealing with the losses
- torn between two parents or two households
- excluded
- isolated by feelings of guilt and anger
- unsure about what is right
- very uncomfortable with any member of the original family or stepfamily

In addition, if parents observe that the following signs are lasting or persistent, then they should consider a psychiatric evaluation for the child/family:

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- child vents/directs anger upon a particular family member or openly resents a stepparent or parent
- one of the parents suffers from great stress and is unable to help with the child's increased need
- a stepparent or parent openly favors one of the children
- discipline of a child is only left to the parent rather than involving both the stepparent and parent
- frequent crying or withdrawal by the child; or
- members of the family derive no enjoyment from usual pleasurable activities (i.e. learning, going to school, working, playing or being with friends and family)

Child and adolescent psychiatrists are trained and skilled at providing comprehensive psychiatric evaluations of both the child and family if serious problems develop.

Most stepfamilies, when given the necessary time to work on developing their own traditions and to form new relationships, can provide emotionally rich and lasting relationships for the adults, and help the children develop the self-esteem and strength to enjoy the challenges of life.

For additional information see ***Facts for Families***:
#24 When to Seek Help for Your Child
#1 Children and Divorce
#52 Comprehensive Psychiatric Evaluation
#8 Children and Grief
#66 Teens with Stress

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 28 March 2011

Responding to Child Sexual Abuse

When a child tells an adult that he or she has been sexually abused, the adult may feel uncomfortable and may not know what to say or do. The following guidelines should be used when responding to children who say they have been sexually abused:

What to Say

If a child even hints in a vague way that sexual abuse has occurred, encourage him or her to talk freely. Don't make judgmental comments.

- Show that you understand and take seriously what the child is saying. Child and adolescent psychiatrists have found that children who are listened to and understood do much better than those who are not. The response to the disclosure of sexual abuse is critical to the child's ability to resolve and heal the trauma of sexual abuse.
- Assure the child that they did the right thing in telling. A child who is close to the abuser may feel guilty about revealing the secret. The child may feel frightened if the abuser has threatened to harm the child or other family members as punishment for telling the secret.
- Tell the child that he or she is not to blame for the sexual abuse. Most children in attempting to make sense out of the abuse will believe that somehow they caused it or may even view it as a form of punishment for imagined or real wrongdoings.
- Finally, offer the child protection, and promise that you will promptly take steps to see that the abuse stops.

What to Do

Report any suspicion of child abuse. If the abuse is within the family, report it to the local Child Protection Agency. If the abuse is outside of the family, report it to the police or district attorney's office. Individuals reporting in good faith are immune from prosecution. The agency receiving the report will conduct an evaluation and will take action to protect the child.

Parents should consult with their pediatrician or family physician, who may refer them to a physician who specializes in evaluating and treating sexual abuse. The examining doctor will evaluate the child's condition and treat any physical problem related to the abuse, gather evidence to help protect the child, and reassure the child that he or she is all right.

Children who have been sexually abused should have an evaluation by a child and adolescent psychiatrist or other qualified mental health professional to find out how the sexual abuse has affected them, and to determine whether ongoing professional help is

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

necessary for the child to deal with the trauma of the abuse. The child and adolescent psychiatrist can also provide support to other family members who may be upset by the abuse.

While most allegations of sexual abuse made by children are true, some false accusations may arise in custody disputes and in other situations. Occasionally, the court will ask a child and adolescent psychiatrist to help determine whether the child is telling the truth, or whether it will hurt the child to speak in court about the abuse.

When a child is asked as to testify, special considerations--such as videotaping, frequent breaks, exclusion of spectators, and the option not to look at the accused--make the experience much less stressful.

Adults, because of their maturity and knowledge, are always the ones to blame when they abuse children. The abused children should never be blamed.

When a child tells someone about sexual abuse, a supportive, caring response is the first step in getting help for the child and reestablishing their trust in adults.

Additional/related ***Facts for Families***,
#5 Child Abuse: The Hidden Bruises
#24 When to Seek Help for Your Child
#9 Child Sexual Abuse
#70 Posttraumatic Stress Disorder (PTSD)
#52 Comprehensive Psychiatric Evaluation

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 29 May 2012

Psychiatric Medication for Children and Adolescent Part II – Types of Medications

Psychiatric medications can be an effective part of the treatment for psychiatric disorders of childhood and adolescence. In recent years there have been an increasing number of new and different psychiatric medications used with children and adolescents. Research studies are underway to establish more clearly which medications are most helpful for specific disorders and presenting problems. Clinical practice and experience, as well as research studies, help physicians determine which medications are most effective for a particular child. Before recommending any medication, the prescriber should conduct a comprehensive psychiatric diagnostic evaluation of the child or adolescent. Parents should be informed about known risks and/or Food and Drug Administration (FDA) warnings before a child starts any psychiatric medication as well as whether the medication is being prescribed on-label or off-label (whether the medication has been approved for children and adolescents for the condition for which it is being prescribed). When prescribed appropriately by an experienced psychiatrist (preferably a child and adolescent psychiatrist) and taken as directed, medication may reduce or eliminate troubling symptoms and improve daily functioning of children and adolescents with psychiatric disorders.

ADHD Medications: Stimulant and non-stimulant medications may be helpful as part of the treatment for attention deficit hyperactive disorder (ADHD). They come in several different forms, such as pills, patches, and liquid forms. Examples of stimulants include: Dextroamphetamine (*Dexedrine, Adderal, Vyanse, Procentra*) and Methylphenidate (*Ritalin, Metadate, Concerta, Daytrana, Focalin*). Non-stimulant medications include Atomoxetine (*Strattera*), Guanfacine (*Tenex, Intuniv*) and Clonidine (*Kapvay*).

Antidepressant Medications: Antidepressant medications may be helpful in the treatment of depression, school phobias, panic attacks, and other anxiety disorders, bedwetting, eating disorders, obsessive-compulsive disorder, posttraumatic stress disorder, and attention deficit hyperactive disorder. There are several types of antidepressant medications.
Examples of **serotonin reuptake inhibitors** (SRI's) include: Fluoxetine (*Prozac*), Sertraline (*Zoloft*), Paroxetine (*Paxil*), Fluvoxamine (*Luvox*), Venlafaxine (*Effexor*), Desvenlafaxine (*Pristiq*), Citalopram (*Celexa*) and Escitalopram (*Lexapro*). Examples of **serotonin norepinephrine reuptake inhibitors** (SNRIs) include Venlafaxine (*Effexor, Pristiq*), and Duloxetine (*Cymbalta*). Examples of **atypical antidepressants** include: Bupropion (*Wellbutrin*), Nefazodone (*Serzone*), Trazodone (*Desyrel*), and Mirtazapine (*Remeron*). Examples of **tricyclic antidepressants** (TCA's) include: Amitriptyline (*Elavil*), Clomipramine (*Anafranil*), Imipramine (*Tofranil*), and Nortriptyline (*Pamelor*).

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

PSYCHIATRIC MEDICATION FOR CHILDREN AND ADOLESCENTS: PART II - TYPES OF MEDICATIONS, "Facts for Families," No. 29 (5/12)

Examples of **monoamine oxidase inhibitors** (MAOI's) include: Phenelzine (*Nardil*), and Tranylcypromine (*Parnate*).

Antipsychotic Medications: These medications can be helpful in controlling psychotic symptoms (delusions, hallucinations) or disorganized thinking. These medications may also help muscle twitches ("tics") or verbal outbursts as seen in Tourette's Syndrome. They are occasionally used to treat severe anxiety and may help in reducing very aggressive behavior. Examples of **first generation antipsychotic medications** include: Chlorpromazine (*Thorazine*), Thioridazine (*Mellaril*), Fluphenazine (*Prolixin*), Trifluoperazine (*Stelazine*), Thiothixene (*Navane*), and Haloperidol (*Haldol*). **Second generation antipsychotic medications** (also known as atypical or novel) include: Clozapine (*Clozaril*), Risperidone (*Risperdal*), Paliperidon (*Invega*), Quetiapine (*Seroquel*), Olanzapine (*Zyprexa*), Ziprasidone (*Geodon*) and Aripiprazole (*Abilify*) Iloperidone (*Fanapt*), Lurasidon (*Latuda*), and Asenapine (*Saphris*).

Mood Stabilizers and Anticonvulsant Medications: These medications may be helpful in treating bipolar disorder, severe mood symptoms and mood swings (manic and depressive), aggressive behavior and impulse control disorders. Examples include: Lithium (lithium carbonate, *Eskalith*), Valproic Acid (*Depakote, Depakene*), Carbamazepine (*Tegretol*), Lamotrigine (*Lamictil*), and Oxcarbazepine (*Trileptal*).

Anti-anxiety Medications: Selective serotonin reuptake inhibitors (SSRIs) are used to treat anxiety in children and adolescents and are described above in the antidepressant section. There are also other medications used to treat anxiety in adults. These medications are rarely used in children and adolescents, but may be helpful for brief treatment of severe anxiety. These include: benzodiazepines; antihistamines; and atypicals. Examples of benzodiazepines include: Alprazolam (*Xanax*), lorazepam (*Ativan*), Diazepam (*Valium*), and Clonazepam (*Klonopin*). Examples of antihistamines include: Diphenhydramine (*Benadryl*), and Hydroxyzine (*Vistaril*). Examples of atypical anti-anxiety medications include: Buspirone (*BuSpar*), and Zolpidem (*Ambien*).

Sleep Medications: A variety of medications may be used for a short period to help with sleep problems. Examples include: Trazodone (*Desyrel*), Zolpidem (*Ambien*), Zaleplon (*Sonata*), Eszopiclone (*Lunesta*), and Diphenhydramine (*Benadryl*).

Miscellaneous Medications: Other medications are also being used to treat a variety of symptoms. For example: clonidine (*Catapres, Kapvay*) and guanfacine (*Tenex, Intuniv*) may be used to treat the severe impulsiveness in some children with ADHD.

Long-Acting Medications: Many newer medications are taken once a day. These medications have the designation SR (sustained release), ER or XR (extended release), CR (controlled release) or LA (long-acting)

PSYCHIATRIC MEDICATION FOR CHILDREN AND ADOLESCENTS: PART II - TYPES OF MEDICATIONS, "Facts for Families," No. 29 (5/12)

For additional information see: *Facts for Families:*
#21 Psychiatric Medication for Children and Adolescents: Part I - How Medications Are Used,
#51 Psychiatric Medication for Children and Adolescents: Part III - Questions to Ask.

See also: Anxiety Disorders Resource Center

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 30 May 2012

Children, Adolescents and HIV/AIDS

Today adolescents of both sexes face a serious risk of HIV infection, which is the cause of AIDS. AIDS is a chronic and often fatal disease. Despite growing understanding and awareness, HIV infection is a serious threat to both heterosexual and homosexual teens. When adolescents take certain risks, they are more likely to become infected with HIV and develop AIDS:

These are the most important facts about AIDS:

- AIDS is often fatal
- anyone can get AIDS - many teens (both boys and girls) have been infected
- condoms can reduce the risk of getting AIDS
- you can get AIDS from use of even one contaminated needle or one sexual act with a partner who has HIV/AIDS

Risk of AIDS is increased by:

- an increased number of sexual partners
- IV drug use
- anal intercourse
- any sex (oral, anal or vaginal) without condoms
- alcohol and other drug use (sex is more impulsive and use of condoms less likely if under the influence of alcohol or other drugs)
- tattoos and body piercing with contaminated (unsterile) needles or instruments

AIDS (Acquired Immune Deficiency Syndrome) is a chronic illness caused by infection with HIV (human immunodeficiency virus). Millions of Americans are infected with HIV. Some of them have AIDS, but most have no symptoms at all, and many do not know they are infected. Despite significant advances in available medical treatment for HIV, there are no definitive cures or vaccines that can prevent the disease. New treatments have enabled many people with AIDS to live longer, healthier lives. HIV infection and AIDS can be prevented by avoiding risk behaviors.

HIV is transmitted through exchange of certain bodily fluids such as blood, semen, vaginal secretions, and breast milk. To produce an infection, the virus must pass through the skin or mucous membranes into the body.

HIV infection is preventable. Knowledge about HIV is an important aspect of prevention. Parents should educate their children and also work closely with schools, churches, youth

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

organizations, and health care professionals to ensure that children and teens receive sex education and preventive drug abuse courses which include material on HIV.

The HIV virus dies quickly when it is outside the human body. It cannot be transmitted by day-to-day or even through close social contacts. Family members of an individual infected with HIV will not catch the virus if they share drinking glasses with the person. There is no known instance in which a child infected with HIV has passed the virus to another child in the course of school activities.

HIV infection occurs in all age groups. Twenty-five percent of the babies born to untreated mothers infected with HIV develop HIV infection themselves. Babies born infected with HIV may die in the first few years or live for many years and will suffer delays in development and many infections. Mothers-to-be with HIV must get special treatment to try to prevent transmission of the virus to their fetuses. New treatments for pregnant women may reduce the transmission of the virus to less than one in ten babies of HIV-positive mothers.

Drug and/or alcohol abuse, premature and/or promiscuous sexual activity are serious risk behaviors. Evaluation by a child and adolescent psychiatrist can be an important first step in helping a family respond effectively to high risk behaviors in their children and adolescents.

Additional/related ***Facts for Families***,
#52 Comprehensive Psychiatric Evaluation
#3 Teens: Alcohol and other Drugs
#9 Child Sexual Abuse
#57 Normal Adolescent Development
#63 Gay and Lesbian Adolescents
#62 Talking to Your Kids about Sex

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 31 May 2012

When Children Have Children

Babies born in the U.S. to teenage mothers are at risk for long-term problems in many major areas of life, including school failure, poverty, and physical or mental illness. The teenage mothers themselves are also at risk for these problems.

Teenage pregnancy is usually a crisis for the pregnant girl and her family. Common reactions include anger, guilt, and denial. If the father is young and involved, similar reactions can occur in his family.

Adolescents who become pregnant may not seek proper medical care during their pregnancy, leading to an increased risk for medical complications. Pregnant teenagers require special understanding, medical care, and education--particularly about nutrition, infections, substance abuse, and complications of pregnancy. They also need to learn that using tobacco, alcohol, and other drugs, can damage the developing fetus. All pregnant teenagers should have medical care beginning early in their pregnancy.

Pregnant teens can have many different emotional reactions:

- some may not want their babies
- others may view the creation of a child as an achievement and not recognize the serious responsibilities
- some may keep a child to please another family member
- some may want a baby to have someone to love, but not understand the amount of care the baby needs
- depression is also common among pregnant teens
- many do not realize that their adorable baby can also be demanding and sometimes irritating
- some become overwhelmed by guilt, anxiety, and fears about the future

Babies born to teenagers are at risk for neglect and abuse because their young mothers are uncertain about their roles and may be frustrated by the constant demands of caretaking. Parents of teenagers can help prevent teenage pregnancy through open communication and by providing guidance to their children about sexuality, contraception, and the risks and responsibilities of sexual relationships and pregnancy. Some teenage girls drop out of school to have their babies and don't return. In this way, pregnant teens lose the opportunity to learn skills necessary for employment and self-survival as adults. School classes in family life and sexual education, as well as clinics providing reproductive information and birth control to young people, can also help to prevent an unwanted pregnancy.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

If pregnancy occurs, teenagers and their families deserve honest and sensitive counseling about options available to them, from abortion to adoption. Special support systems, including consultation with a child and adolescent psychiatrist when needed, should be available to help the teenager throughout the pregnancy, the birth, and the decision about whether to keep the infant or give it up for adoption. There may be times when the pregnant teenager's emotional reactions and mental state will require referral to a qualified mental health professional.

For additional information see Facts for Families:
#62 Talking to Your Kids About Sex
#4 The Depressed Child
#5 Child Abuse: The Hidden Bruises
#15 The Adopted Child
#66 Helping Teenagers with Stress
#30 Children and AIDS
#77 Grandparents Raising Grandchildren

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 32 May 2012

11 Questions To Ask Before Psychiatric Hospitalization of Your Child or Adolescent

Hospitalization in a psychiatric facility is one of a range of available treatment options when a child or adolescent is mentally ill. Parents are naturally concerned and may be frightened and confused when inpatient treatment is recommended for their child. By asking the following questions, parents will gain a better understanding of the care proposed by admission to an inpatient facility:

1. Why is psychiatric inpatient treatment being recommended for our child, and how will it help our child?
2. What are the other treatment alternatives to hospital treatment, and how do they compare?
3. Is a child and adolescent psychiatrist admitting our child to the hospital?
4. What does the inpatient treatment include, and how will our child be able to keep up with school work?
5. What are the responsibilities of the child and adolescent psychiatrist and other people on the treatment team?
6. How long will our child be in the hospital, how much will it cost, and how do we pay for these services?
7. What will happen if we can no longer afford to keep our child in this hospital or if the insurance company denies coverage and inpatient treatment is still necessary?
8. Will our child be on a unit specifically designed for the treatment of children and adolescents and is this hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a treatment facility for youngsters of our child's age?
9. How will we as parents be involved in our child's hospital treatment, including the decision for discharge and after-care treatment?
10. How will the decision be made to discharge our child from the hospital?
11. Once our child is discharged, what are the plans for continuing or follow-up treatment?

Hospital treatment is a serious matter for parents, children and adolescents. Parents should raise these questions before their child or adolescent is admitted to the hospital. Parents who are informed and included as part of their child's hospital treatment are important contributors and partners in the treatment process. If after asking the above questions, parents still have serious questions or doubts, they

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

should feel free to ask for a second opinion. For additional information see *Facts for Families*:

#24 When to Seek Help for Your Child
#25 Where to Seek Help for Your Child
#26 Understanding Your Mental Health Insurance
#41 Making Decisions About Substance Abuse Treatment
#42 The Continuum of Care
#74 Advocating for Your Child
#52 Comprehensive Psychiatric Evaluation
#86 Psychotherapies for Children and Adolescents

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 33 August 2013

Conduct Disorder

"Conduct disorder" refers to a group of behavioral and emotional problems in youngsters. Children and adolescents with this disorder have great difficulty following rules and behaving in a socially acceptable way. They are often viewed by other children, adults and social agencies as "bad" or delinquent, rather than mentally ill. Many factors may contribute to a child developing conduct disorder, including brain damage, child abuse, genetic vulnerability, school failure, and traumatic life experiences.
Children or adolescents with conduct disorder may exhibit some of the following behaviors:

Aggression to people and animals

- bullies, threatens or intimidates others
- often initiates physical fights
- has used a weapon that could cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife or gun)
- is physically cruel to people or animals
- steals from a victim while confronting them (e.g. assault)
- forces someone into sexual activity

Destruction of Property

- deliberately engaged in fire setting with the intention to cause damage
- deliberately destroys other's property

Deceitfulness, lying, or stealing

- has broken into someone else's building, house, or car
- lies to obtain goods, or favors or to avoid obligations
- steals items without confronting a victim (e.g. shoplifting, but without breaking and entering)

Serious violations of rules

- often stays out at night despite parental objections
- runs away from home
- often truant from school

Children who exhibit these behaviors should receive a comprehensive evaluation. Many children with a conduct disorder may have coexisting conditions such as mood disorders,

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

anxiety, PTSD, substance abuse, ADHD, learning problems, or thought disorders which can also be treated. Research shows that youngsters with conduct disorder are likely to have ongoing problems if they and their families do not receive early and comprehensive treatment. Without treatment, many youngsters with conduct disorder are unable to adapt to the demands of adulthood and continue to have problems with relationships and holding a job. They often break laws or behave in an antisocial manner.

Treatment of children with conduct disorder can be complex and challenging. Treatment can be provided in a variety of different settings depending on the severity of the behaviors. Adding to the challenge of treatment are the child's uncooperative attitude, fear and distrust of adults. In developing a comprehensive treatment plan, a child and adolescent psychiatrist may use information from the child, family, teachers, and other medical specialties to understand the causes of the disorder.

Behavior therapy and psychotherapy are usually necessary to help the child appropriately express and control anger. Special education may be needed for youngsters with learning disabilities. Parents often need expert assistance in devising and carrying out special management and educational programs in the home and at school. Treatment may also include medication in some youngsters, such as those with difficulty paying attention, impulse problems, or those with depression.

Treatment is rarely brief since establishing new attitudes and behavior patterns takes time. However, early treatment offers a child a better chance for considerable improvement and hope for a more successful future.

For additional information see Facts for Families:
#3 Teens: Alcohol and Other Drugs
#55 Understanding Violent Behavior in Children and Adolescents
#72 Children with Oppositional Defiant Disorder
#6 Children Who Can't Pay Attention
#12 Children Who Steal
#38 Bipolar Disorder in Children and Teens
#80 Bullying
81 Fighting and Biting
#00 Definition of a Child and Adolescent Psychiatrist

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

Conduct Disorder, "Facts for Families," No. 33 (8/13)

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 34 August 2013

Children's Sleep Problems

Many children have sleep problems. Examples include:

- Frequent awakening during the night
- Talking during sleep
- Difficulty falling asleep
- Waking up crying
- Feeling sleepy during the day
- Having nightmares
- Bedwetting
- Teeth grinding and clenching
- Waking early

Many childhood sleep problems are related to poor sleep habits or to anxiety about going to bed and falling asleep. Persistent sleep problems may also be symptoms of emotional difficulties. "Separation anxiety" is a developmental landmark for young children. For all young children, bedtime is a time of separation. Some children will do all they can to prevent separation at bedtime. However, to help minimize common sleep problems, a parent should develop consistent, regular bedtime sleep routines for children. Parents often find that feeding and rocking help an infant to get to sleep. However, as the child leaves infancy, parents should encourage the child to sleep without feeding and rocking. Otherwise, the child will have a hard time going to sleep alone. Bedtime routines such as reading stories and teeth-brushing help the child understand it is time for bed.

Nightmares are relatively common during childhood. The child often remembers nightmares, which usually involve major threats to the child's well-being. Nightmares, which begin at a variety of ages, affect girls more often than boys. For some children nightmares are serious, frequent, and interfere with restful sleep.

Sleep terrors (night terrors), sleepwalking, and sleep talking constitute a relatively rare group of sleep disorders, called "parasomnias." Sleep terrors are different from nightmares. The child with sleep terrors will scream uncontrollably and appear to be awake, but is confused and can't communicate. The child usually has no memory of the sleep terror in the morning. Sleep terrors usually begin between ages 4 and 12. Children who sleepwalk may appear to be awake as they move around, but are actually asleep and in danger of hurting themselves. Sleepwalking usually begins between ages 6 and 12. Both sleep terrors and sleepwalking run in families and affect boys more often than girls. Most often, children with these sleep disorders have single or occasional episodes of the disorder. However, when episodes occur several times a night, or nightly for weeks at a

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

time, or interfere with the child's daytime behavior, treatment by a child and adolescent psychiatrist may be necessary. A range of treatments is available for sleep disorders.

Sleep wake reversal may occur in some teens and cause problems with daily life. Sleep can also be disturbed by mood disorders, PTSD, substance abuse, ADHD, and anxiety.

Fortunately, as they mature, children usually get over common sleep problems as well as the more serious sleep disorders (parasomnias). However, parents with ongoing concerns should contact their pediatrician, a sleep specialist or a trained child mental health professional for a comprehensive evaluation.

For additional information see ***Facts for Families***:
#7 Children Who Won't Go to School
#18 Bedwetting
52 Comprehensive Psychiatric Evaluation
#66 Helping Teenagers with Stress
#70 Post Traumatic Stress Disorder
#4 The Depressed Child

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 35 May 2012

Tic Disorders

A tic is a problem in which a part of the body moves repeatedly, quickly, suddenly and uncontrollably. Tics can occur in any body part, such as the face, shoulders, hands or legs. They can be stopped voluntarily for brief periods. Sounds that are made involuntarily (such as throat clearing, sniffing) are called vocal tics. Most tics are mild and hardly noticeable. However, in some cases they are frequent and severe, and can affect many areas of a child's life.

The most common tic disorder is called "transient tic disorder" and may affect up to 10 percent of children during the early school years. Teachers or others may notice the tics and wonder if the child is under stress or "nervous." Transient tics go away by themselves. Some may get worse with anxiety, tiredness, and some medications.

Some tics do not go away. Tics which last one year or more are called "chronic tics." Chronic tics affect less than one percent of children and may be related to a special, more unusual tic disorder called Tourette's Disorder.

Children with Tourette's Disorder have both body and vocal tics (throat clearing). Some tics disappear by early adulthood, and some continue. Children with Tourette's Disorder may also have problems with attention, and learning disabilities. They may act impulsively, and/or develop obsessions and compulsions.

Sometimes people with Tourette's Disorder may blurt out obscene words, insult others, or make obscene gestures or movements. They cannot control these sounds and movements and should not be blamed for them. Punishment by parents, teasing by classmates, and scolding by teachers will not help the child to control the tics but will hurt the child's self-esteem and increase their distress.

Through a comprehensive evaluation, often involving pediatric and/or neurologic consultation, a child and adolescent psychiatrist can determine whether a youngster has Tourette's Disorder or another tic disorder. Treatment for the child with a tic disorder may include medication to help control the symptoms and habit reversal training; a behavioral therapy. The child and adolescent psychiatrist can also advise the family about how to provide emotional support and the appropriate educational environment for the youngster.

Further information about Tourette's Disorder is available from
The Tourette Syndrome Association, Inc.
42-40 Bell Boulevard
Bayside, NY 11361-2861

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

http://www.tsa-usa.org/
718.224.2999

For additional information see *Facts for Families*:
#6 Children Who Can't Pay Attention
#21 Psychiatric Medication for Children
#52 Comprehensive Psychiatric Evaluation
#47 The Anxious Child
#60 Obsessive Compulsive Disorder in Children and Adolescents
#66 Helping Teenagers With Stress

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 36 December 2008

Helping Children after a Disaster

A catastrophe such as an earthquake, hurricane, tornado, fire, flood, or violent acts is frightening to children and adults alike. Talking about the event with children can decrease their fear. It is important to explain the event in words the child can understand, and at a level of detail that will not overwhelm them.

Several factors affect a child's response to a disaster. The way children see and understand their parents' responses are very important. Children are aware of their parents' worries most of the time, but they are particularly sensitive during a crisis. Parents should admit their concerns to their children, and also stress their abilities to cope with the disaster. Falsely minimizing the danger will not end a child's concerns.

A child's reaction also depends on how much destruction and/or death he or she sees during and after the disaster. If a friend or family member has been killed or seriously injured, or if the child's school or home has been severely damaged, there is a greater chance that the child will experience difficulties.

A child's age affects how the child will respond to the disaster. For example, six-year-olds may show their worries by refusing to attend school, whereas adolescents may minimize their concerns, but argue more with parents and show a decline in school performance.

Following a disaster, people may develop Posttraumatic Stress Disorder (PTSD), which is a set of symptoms that can result from experiencing, witnessing, or participating in an overwhelmingly traumatic (frightening) event. Children with this disorder have repeated episodes in which they re-experience the traumatic event. Children often relive the trauma through repetitive play. In young children, upsetting dreams of the traumatic event may change into nightmares of monsters, of rescuing others, or of threats to self or others. PTSD rarely appears during the trauma itself. Though its symptoms can occur soon after the event, the disorder often surfaces several months or even years later.

<u>After a disaster, parents should be alert to these changes in a child's behavior:</u>

- Refusal to return to school and "clinging" behavior, including shadowing the mother or father around the house
- Persistent fears related to the catastrophe (such as fears about being permanently separated from parents)
- Sleep disturbances such as nightmares, screaming during sleep and bedwetting, persisting more than several days after the event
- Loss of concentration and irritability

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Jumpiness or being startled easily
- Behavior problems, for example, misbehaving in school or at home in ways that are not typical for the child
- Physical complaints (stomachaches, headaches, dizziness) for which a physical cause cannot be found
- Withdrawal from family and friends, sadness, listlessness, decreased activity, and preoccupation with the events of the disaster

Professional advice or treatment for children affected by a disaster--especially those who have witnessed destruction, injury or death--can help prevent or minimize PTSD. Parents who are concerned about their children can ask their pediatrician or family doctor to refer them to a child and adolescent psychiatrist for an evaluation.

For more information see ***Facts for Families***:
#4 The Depressed Child
#8 Children and Grief
#34 Children's Sleep Problems
#66 Helping Teenagers with Stress
#70 Posttraumatic Stress Disorder
#87 Talking to Children About Terrorism and War

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 37 December 2008

Children and Firearms

Parents, professionals and many others are concerned about the large numbers of children and adolescents killed by firearms. In order to prevent further deaths, it is important to remember the following:

1) We cannot gun-proof our children and adolescents. Children are playful and active. Adolescents are curious and impulsive. Such healthy traits when mixed with guns can cause death.

2) The best way to protect children against gun violence is to remove all guns from the home. If guns are kept in the home, there will always be dangers.

The following actions are crucial to lessen the dangers:

- Store all firearms unloaded and uncocked in a securely locked container. Only the parents should know where the container is located
- Store the guns and ammunition in separate locked locations
- For a revolver, place a padlock around the top strap of the weapon to prevent the cylinder from closing, or use a trigger lock; for a pistol, use a trigger lock
- When handling or cleaning a gun, never leave it unattended, even for a moment; it should be in your view at all times

Even if parents don't own a gun, they should check with parents at other places where their children play, to make sure safety precautions are followed. Research shows that a large percentage of accidentally shootings occur in the homes of friends and relatives. The tragedies take place most often when children are left unsupervised.

When youngsters use alcohol and also have a gun available, the risk for violence rapidly increases. Research reveals that youth suicide victims who used firearms were about five times more likely to have been drinking than those who used other means. Additionally, with regard to firearm-associated murders among family members, almost 90% of the offenders and victims had used alcohol or drugs before the killings.

The average American child witnesses many acts of violence each day on TV, in movies, and through computer games. Most involve firearms. Children often imitate what they see, and are more aggressive after extensive viewing of violence on TV, in movies and videos, and/or playing violent computer video or arcade games. Parents should help protect their children from the effects of gun violence portrayed in the media. For example, they can watch TV, movies, and videos with children; ration TV; and

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

disapprove of the violent episodes in front of the children, stressing the belief that such behavior is not the best way to resolve a problem.

Children and adolescents with emotional or behavioral problems may be more likely than other children to use guns, against themselves or others. Parents who are concerned that their child is too aggressive or might have an emotional disorder may wish to seek an evaluation by a child and adolescent psychiatrist or other qualified mental health professional.

More information about gun safety issues and guidelines is available from the:
The Brady Center to Prevent Handgun Violence
1225 I Street, N.W., Suite 1100
Washington, D.C. 20005
or at their website www.bradycenter.org

For more information see Facts for Families:
#10 Teen Suicide
#13 Children and TV Violence
#40 The Influence of Music and Music Videos
#55 Understanding Violent Behavior in Children
#65 Children's Threats: When Are They Serious

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 38 December 2008

Bipolar Disorder in Children and Teens

Children and teenagers with Bipolar Disorder have manic and/or depressive symptoms. Some may have mostly depression and others a combination of manic and depressive symptoms. Highs may alternate with lows.

Manic symptoms include:

- severe changes in mood-either unusually happy or silly, or very irritable, angry, agitated or aggressive
- unrealistic highs in self-esteem - for example, a teenager who feels all powerful or like a superhero with special powers
- great increase in energy and the ability to go with little or no sleep for days without feeling tired
- increase in talking - the adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted
- distractibility - the teen's attention moves constantly from one thing to the next
- repeated high risk-taking behavior; such as, abusing alcohol and drugs, reckless driving, or sexual promiscuity

Depressive symptoms include:

- irritability, depressed mood, persistent sadness, frequent crying
- thoughts of death or suicide
- loss of enjoyment in favorite activities
- frequent complaints of physical illnesses such as headaches or stomach aches
- low energy level, fatigue, poor concentration, complaints of boredom
- major change in eating or sleeping patterns, such as oversleeping or overeating

Some of these signs are similar to those that occur in teenagers with other problems such as drug abuse, delinquency, attention-deficit hyperactivity disorder, or even schizophrenia.

Research has improved the ability to diagnose Bipolar Disorder in children and teens. Bipolar Disorder can begin in childhood and during the teenage years, although it is usually diagnosed in adult life. The illness can affect anyone. However, if one or both parents have Bipolar Disorder, the chances are greater that their children may develop the disorder. Family history of drug or alcohol abuse also may be associated with greater risk for Bipolar Disorder.

Teenagers with Bipolar Disorder can be effectively treated. Treatment for Bipolar

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Disorder usually includes education of the patient and the family about the illness, mood stabilizing medications such as lithium, valproic acid, or " atypical antipsychotic", and psychotherapy. Mood stabilizing medications often reduce the number and severity of manic episodes, and also help to prevent depression. Psychotherapy helps the child understand himself or herself, adapt to stresses, rebuild self-esteem and improve relationships.

The diagnosis of Bipolar Disorder in children and teens is complex and involves careful observation over an extended period of time. A thorough evaluation by a child and adolescent psychiatrist identify Bipolar Disorder and start treatment.

For additional information see *Facts for Families*:
#3 Teens: Alcohol and Other Drugs
#4 The Depressed Child
#6 Children Who Can't Pay Attention (ADHD)
#33 Conduct Disorder
#52 Comprehensive Psychiatric Evaluation
#55 Understanding Violent Behavior in Children
#72 Oppositional Defiant Disorder
#00 Definition of a Child and Adolescent Psychiatrist

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 39 December 2008

Children of Parents with Mental Illness

Mental illnesses in parents represent a risk for children in the family. These children have a higher risk for developing mental illnesses than other children. When both parents are mentally ill, the chance is even greater that the child might become mentally ill.

The risk is particularly strong when a parent has one or more of the following: Bipolar Disorder, an anxiety disorder, ADHD, schizophrenia, alcoholism or other drug abuse, or depression. Risk can be inherited from parents, through the genes.

An inconsistent, unpredictable family environment also contributes to psychiatric illness in children. Mental illness of a parent can put stress on the marriage and affect the parenting abilities of the couple, which in turn can harm the child.

Some protective factors that can decrease the risk to children include:

- Knowledge that their parent(s) is ill and that they are not to blame
- Help and support from family members
- A stable home environment
- Psychotherapy for the child and the parent(s)
- A sense of being loved by the ill parent
- A naturally stable personality in the child
- Positive self esteem
- Inner strength and good coping skills in the child
- A strong relationship with a healthy adult
- Friendships, positive peer relationships
- Interest in and success at school
- Healthy interests outside the home for the child
- Help from outside the family to improve the family environment (for example, marital psychotherapy or parenting classes)

Medical, mental health or social service professionals working with mentally ill adults need to inquire about the children and adolescents, especially about their mental health and emotional development. If there are serious concerns or questions about a child, it may be helpful to have an evaluation by a qualified mental health professional.

Individual or family psychiatric treatment can help a child toward healthy development, despite the presence of parental psychiatric illness. The child and adolescent psychiatrist can help the family work with the positive elements in the home and the natural strengths of the child. With treatment, the family can learn ways to lessen the effects of the parent's mental illness on the child.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Unfortunately, families, professionals, and society often pay most attention to the mentally ill parent, and ignore the children in the family. Providing more attention and support to the children of a psychiatrically ill parent is an important consideration when treating the parent.

For more information see *Facts for Families*:
#24 When to Seek Help for Your Child,
#25 Where to Seek Help for Your Child
#52 Comprehensive Psychiatric Evaluation

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 40 September 2008

The Influence of Music and Music Videos

Singing and music have always played an important role in learning and the communication of culture. Children learn from what their role models do and say. For many years, some children's television very effectively used the combination of words, music and fast-paced animation to achieve learning.

Most parents are concerned about what their young children see and hear, but as children grow older, parents pay less attention to the music and videos that capture and hold their children's interest.

Sharing music between generations in a family can be a pleasurable experience. Music also is often a major part of a teenager's separate world. It is quite common for teenagers to get pleasure from keeping adults out, which causes adults some distress.

A concern to many interested in the development and growth of teenagers is the negative and destructive themes of some kinds of music (rock, heavy metal, hip-hop, etc.), including best-selling albums promoted by major recording companies. The following themes, which are featured prominently in some lyrics, can be particularly troublesome:

- Drugs and alcohol abuse that is glamorized
- Suicide as an "alternative" or "solution"
- Graphic violence
- Sex which focuses on control, sadism, masochism, incest, children devaluing women, and violence toward women

Parents can help their teenagers by paying attention to their teenager's purchasing, downloading, listening and viewing patterns, and by helping them identify music that may be destructive. An open discussion without criticism may be helpful.

Music is not usually a danger for a teenager whose life is balanced and healthy. But if a teenager is persistently preoccupied with music that has seriously destructive themes, and there are changes in behavior such as isolation, depression, alcohol or other drug abuse, evaluation by a qualified mental health professional should be considered.

For additional information see *Facts for Families*:
#3 Teens: Alcohol and Other Drugs
#10 Teen Suicide
#13 Children and TV Violence
#55 Understanding Violent Behavior in Children
65 Children's Threats: When Are They Serious

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

The Influence of Music and Music Videos, "Facts for Families," No. 40 (09/08)

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 41 July 2013

Substance Abuse Treatment for Children and Adolescents: Questions to Ask

Many children and adolescents use alcohol and other drugs. Some develop serious problems which require professional treatment. Examples of treatment include inpatient units, outpatient clinics, twelve step programs, and dual diagnosis units for individuals with emotional and substance use problems.

The decision to get treatment for a child or adolescent is difficult, and parents are encouraged to seek consultation from a child and adolescent psychiatrist when making decisions about substance use treatment. Other psychiatric disorders often co-exist with substance use problems and need assessment and treatment.

When substance use treatment is recommended, parents can obtain the information they need by asking the following questions from professionals:

1. Why do you believe this treatment in this program is indicated for my child? How does it compare to other programs or services which are available?
2. What are the credentials and experience of the members of the treatment team, and will the team include a child and adolescent psychiatrist with knowledge and skills in substance use treatment?
3. What treatment approaches does this program use regarding chemical dependency; detoxification; abstinence; individual, family, and group therapy; use of medications; a twelve-step program; mutual-help groups; relapse prevention; and a continuing recovery process?
4. Based on your evaluation, does my child have other psychiatric problems in addition to the substance use problem? If so, will these be addressed in the treatment process?
5. How will our family be involved in our child's substance use treatment -- including the decision for discharge and the after-care?
6. What will treatment cost? Are the costs covered by my insurance or health plan?
7. How will my child continue education while in treatment?
8. If this treatment is provided in a hospital or residential program, is it approved by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)? Is this substance use treatment program a separate unit accredited for youngsters of our child's age?
9. How will the issue of confidentiality be handled during and after treatment?
10. How long will this phase of the treatment process continue? Will we reach our insurance limit before treatment in this phase is completed?

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Substance Abuse Treatment for Children and Adolescents: Questions to Ask "Facts for Families," No. 41 (7/13)

11. When my child is discharged from this phase of treatment, how will it be decided what types of ongoing treatment will be necessary, how often, and for how long?
12. As my child's problem improves, does this program provide less intensive/step-down treatment services?

Severe substance use in adolescence may be a chronic and relapsing disorder. Parents should ask what treatment services are available for continued or future treatment. If questions or doubts persist about either admission to a substance use treatment

program or about a denial of treatment, a second opinion may be helpful.

For additional information see *Facts for Families*
#3 Teens: Alcohol and Other Drugs,
#26 Understanding Your Mental Health Insurance
#42 The Continuum of Care
#68 Tobacco and Kids

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 42 September 2008

The Continuum of Care

Communities provide different types of treatment programs and services for children and adolescents with mental illnesses. The complete range of programs and services is referred to as the continuum of care. Not every community has every type of service or program on the continuum. Some psychiatric hospitals and other organized systems of care now provide many of the services on the continuum. When several of the services are provided, the organization may be called a health care system.

The beginning point for parents concerned about their child's behavior or emotions should be an evaluation by a qualified mental health professional such as a child and adolescent psychiatrist. At the conclusion of the evaluation, the professional will recommend a certain type of service(s) or program(s) from the continuum available locally. The professional then usually is required to obtain approval from the insurance company or organization managing mental health benefits (e.g. managed care organization). In the case of programs funded publicly, a specific state agency must authorize the recommended program(s) or service(s). If the program or service is not authorized, it will not be paid. Many of the programs on the continuum offer a variety of different treatments, such as individual psychotherapy, family therapy, group therapy, and medications.

A brief description of the different services or programs in a continuum of care follows:

Office or outpatient clinic	Visits are usually 30-60 minutes. The number of visits per month depends on the youngster's needs.
Intensive case management	Specially trained individuals coordinate or provide psychiatric, financial, legal, and medical services to help the child or adolescent live successfully at home and in the community.
Home-based treatment services	A team of specially trained staff go into a home and develop a treatment program to help the child and family.
Family support services	Services to help families care for their child such as parent training, parent support group, etc.
Day treatment program	This intensive treatment program provides psychiatric

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

	treatment with special education. The child usually attends five days per week.
Partial hospitalization (day hospital)	This provides all the treatment services of a psychiatric hospital, but the patients go home each evening.
Emergency/crisis services	24-hour-per-day services for emergencies (for example, hospital emergency room, mobile crisis team).
Respite care services	A patient stays briefly away from home with specially trained individuals.
Therapeutic group home or community residence	This therapeutic program usually includes 6 to 10 children or adolescents per home, and may be linked with a day treatment program or specialized educational program.
Crisis residence	This setting provides short-term (usually fewer than 15 days) crisis intervention and treatment. Patients receive 24-hour-per-day supervision
Residential treatment facility	Seriously disturbed patients receive intensive and comprehensive psychiatric treatment in a campus-like setting on a longer-term basis.
Hospital treatment	Patients receive comprehensive psychiatric treatment in a hospital. Treatment programs should be specifically designed for either children or adolescents. Length of treatment depends on different variables.

Parents should always ask questions when a professional recommends psychiatric treatment for their child or adolescent. For instance, which types of treatment are provided, and by whom? Over what length of time? What is the cost? How much of the cost is covered by insurance or public funding? What are the advantages and disadvantages of the recommended service or program? Parents should always feel free to obtain a second opinion about the best type of program for their child or adolescent.

Related *Facts for Families*:
#25 - Where to Find Help for Your Child
#26 - Understanding Your Mental Health Insurance
#32 - 11 Questions to Ask Before Psychiatric Hospital Treatment of Children and Adolescents
#41 - Making Decisions About Substance Abuse Treatment

The Continuum of Care for Children and Adolescents, "Facts for Families," No. 42 (9/08)

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 43 September 2008

Discipline

Children do not always do what parents want. When a child misbehaves, the parent must decide how to respond. All children need rules and expectations to help them learn appropriate behavior. How does a parent teach a child the rules and, when those rules are broken, what should parents do?

Parents should begin by talking to each other about how they want to handle discipline and establish the rules. It is important to view discipline as teaching not punishment. Learning to follow rules keeps a child safe and helps him or her learn the difference between right and wrong.

Once rules have been established, parents should explain to the child that broken rules carry consequences. For example, Here are the rules. When you follow the rules, this will happen and if you break a rule, this is what will happen. Parents and the child should decide together what the rewards and consequences will be. Parents should always acknowledge and offer positive reinforcement and support when their child follows the rules. Parents must also follow through with an appropriate consequence when the child breaks a rule. Consistency and predictability are the cornerstones of discipline and praise is the most powerful reinforcer of learning.

Children learn from experience. Having logical consequences for misbehavior helps them learn that they are accountable for their actions, without damaging their self-esteem. For example, if children are fighting over the television, computer or a video game, turn it off. If a child spills milk at the dinner table while fooling around, have the child clean it up. Some behaviors have natural consequences. For example, a teenager who stays up too late may suffer the natural consequences of being tired the next day. Another type of consequence that can be effective is the suspension or delay of a privilege. For example, if a child breaks the rule about where they can go on their bike, take away the bike for a few days. When a child does not do chores, he or she cannot do something special like spend the night with a friend or rent a movie.

There are different styles and approaches to parenting. Research shows that effective parents raise well-adjusted children who are more self-reliant, self-controlled, and positively curious than children raised by parents who are punitive, overly strict (authoritarian), or permissive. Effective parents operate on the belief that both the child and the parent have certain rights and that the needs of both are important. Effective parents don't need to use physical force to discipline the child, but are more likely to set clear rules and explain why these rules are important. Effective parents reason with their children and consider the youngsters' points of views even though they may not agree with them.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

The following are tips for effective discipline:

- Trust your child to do the right thing within the limits of your child's age and stage of development.
- Make sure what you ask for is reasonable.
- Speak to your child as you would want to be spoken to if someone were reprimanding you. Don't resort to name-calling, yelling, or disrespect.
- Be clear about what you mean. Be firm and specific.
- Model positive behavior. "Do as I say, not as I do" seldom works.
- Allow for negotiation and flexibility, which can help build your child's social skills.
- Let your child experience the consequences of his behavior.
- Whenever possible, consequences should be delivered immediately, should relate to the rule broken, and be short enough in duration that you can move on again to emphasize the positives.
- Consequences should be fair and appropriate to the situation and the child's age.

Parenting classes and coaching can be helpful in learning to be an effective parent. If parents have serious concerns about continuing problems with their child's behavior, consultation with a child and adolescent psychiatrist or other qualified mental health professional may be helpful.

For additional information see the ***Facts for Families***:
#22 Normality
#24 When to Seek Help for Your Child
#25 Where to Seek Help for Your Child
#33 Conduct Disorder
#44 Lying
#52 Comprehensive Psychiatric Evaluation
#72 Children with Oppositional Defiant Disorder
#80 Bullying

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

website (www.aacap.org). ***Facts*** sheets may not be reproduced, duplicated or posted on any other website without written consent from AACAP. Organizations are permitted to create links to AACAP's website and specific ***Facts*** sheets. For all questions please contact the AACAP Communications & Marketing Coordinator, ext. 154.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 44 November 2004

Children and Lying

Honesty and dishonesty are learned in the home. Parents are often concerned when their child or adolescent lies.

Lying that is probably not a serious problem:
Young children (ages 4-5) often make up stories and tell tall tales. This is normal activity because they enjoy hearing stories and making up stories for fun. These young children may blur the distinction between reality and fantasy.

An older child or adolescent may tell a lie to be self-serving (e.g. avoid doing something or deny responsibility for their actions). Parents should respond to isolated instances of lying by talking with the youngster about the importance of truthfulness, honesty and trust.

Some adolescents discover that lying may be considered acceptable in certain situations such as not telling a boyfriend or girlfriend the real reasons for breaking up because they don't want to hurt their feelings. Other adolescents may lie to protect their privacy or to help them feel psychologically separate and independent from their parents (e.g. denying they sneaked out late at night with friends).

Lying that may indicate emotional problems:
Some children, who know the difference between truthfulness and lying, tell elaborate stories which appear believable. Children or adolescents usually relate these stories with enthusiasm because they receive a lot of attention as they tell the lie.

Other children or adolescents, who otherwise seem responsible, fall into a pattern of repetitive lying. They often feel that lying is the easiest way to deal with the demands of parents, teachers and friends. These children are usually not trying to be bad or malicious but the repetitive pattern of lying becomes a bad habit.

There are also some children and adolescents who are not bothered by lying or taking advantage of others. Other adolescents may frequently use lying to cover up another serious problem. For example, an adolescent with a serious drug or alcohol problem will lie repeatedly to hide the truth about where they have been, who they were with, what they were doing, and where the money went.

What to do if a Child or Adolescent lies:
Parents are the most important role models for their children. When a child or adolescent lies, parents should take some time to have a serious talk and discuss:

- the difference between make believe and reality, lying and telling the truth,

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- the importance of honesty at home and in the community, and
- alternatives to lying.
-

If a child or adolescent develops a pattern of lying which is serious and repetitive, then professional help may be indicated. Evaluation by a child and adolescent psychiatrist would help the child and parents understand the lying behavior and would also provide recommendations for the future.

For additional information see ***Facts for Families:***
#3 Teens: Alcohol and Other Drugs
#12 Children Who Steal
#33 Conduct Disorder
#43 Discipline
#52 Comprehensive Psychiatric Evaluations
#65 Children's Threats: When Are They Serious
#72 Children with Oppositional Defiant Disorder

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 45 November 2004

Lead Exposure in Children Affects Brain and Behavior

Lead exposure is one of the most common preventable poisonings of childhood. Data from the Center for Disease Control (CDC) shows that 6% of all children ages 1-2 years and 11% of black (non-Hispanic) children ages 1-5 years have blood lead levels in the toxic range. Lead is a potent poison that can affect individuals at any age. Children with developing bodies are especially vulnerable because their rapidly developing nervous systems are particularly sensitive to the effects of lead.

Almost all children in the United States are exposed to lead. Common sources include lead paint and lead contained in water and soil. Housing built before 1950 has the greatest risks of containing lead-based paint. Some children may eat or swallow chips of paint (pica) which increases their risk of exposure to lead.

Exposure to lead can have a wide range of effects on a child's development and behavior. Even when exposed to small amounts of lead levels, children may appear inattentive, hyperactive and irritable. Children with greater lead levels may also have problems with learning and reading, delayed growth and hearing loss. At high levels, lead can cause permanent brain damage and even death.

Parents should make sure that their homes are free of lead paint and that the lead level in their drinking water is acceptably low. The Center for Disease Control (CDC) recommends that all children be screened for exposure to lead. A simple and inexpensive blood test all can determine whether or not a child has a dangerous level of lead in his or her body. The test can be obtained through a physician, or public health agency.

Early identification and treatment of lead poisoning reduces the risk that children will suffer permanent damage. Treatment begins with removal of the child from the sources of the lead. Medications can remove lead from the body.

For additional information about lead poisoning, contact your physician, county or state Department of Health, or the

Alliance for Healthy Homes
227 Massachusetts Avenue, NE, Suite 200
Washington, DC 20002,
202-543-1147, www.aeclp.org

See also: ***Facts for Families***:
#6 Children Who Can't pay Attention/ADHD
#16 Children with Learning Disabilities
#23 Mental Retardation
#52 Comprehensive Psychiatric Evaluation

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 46 November 2004

Home Alone Children

Every day thousands of children arrive home from school to an empty house. Every week thousands of parents make decisions to leave children home alone while they go to work, run errands, or for social engagements. It is estimated over 40% of children are left home at some time, though rarely overnight. In more extreme situations, some children spend so much time without their parent(s) that these children are labeled "latch key children", referring to the house or apartment key strung visibly around their neck.

The movie "Home Alone", and its sequel, have portrayed a child's survival skills in a very humorous, but unrealistic manner. The realities facing children who find themselves home alone are very different. There are many issues and potential risks and dangers that parent(s) should consider before a child is placed in this situation. Parent(s) should consider the following:

- Age readiness
- Definition of parental "rules and expectations"
- How to access parent(s) or other adults (e.g. phone numbers)
- Potentially unsafe situations (e.g. medical emergencies, fire, alcohol, drugs, strangers, guns, etc.)
- When and how to answer the phone or doorbell
- Use of phone, 911 for emergencies
- Use of computer (internet)
- Friends and visitors coming to the house
- Responsibilities for siblings
- Use of unstructured time (e.g. watch TV, videos, etc.);
- Access to "adult" cable TV; internet chat rooms and adult web sites

It is not possible to make a general statement about when a child can be left home. Many states have laws which hold parents responsible for the supervision of their children. Older adolescents are usually responsible enough to manage alone for limited periods of time. Parent(s) must consider the child's level of maturity and past evidence of responsible behavior and good judgment. When a child is ready to be left alone, a graduated approach should be used starting with a very short period of time (e.g.1 hour).

Parent(s) should talk with their youngsters to prepare them for each of the issues or potential problems listed above. In addition, parent(s) should strive to make their home as safe as possible from obvious dangers and hazards and rehearse the developed "emergency plan" with their children. Parents should also teach their child important safety precautions (i.e. locking the door, dealing with strangers or visitors who come to the house, use of the stove, etc.)

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Home Alone Children, "Facts for Families," No. 46 (11/04)

Being home alone can be a frightening and potentially dangerous situation for many children and adolescents. Parents should strive to limit the times when children are home alone. Parents should prepare their children in advance for how to deal with situations that may arise.

For additional information see Facts for Families:
#59 Children Online
#37 Children and Firearms
#54 Children and Watching TV

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 47 November 2004

The Anxious Child

All children experience anxiety. Anxiety in children is expected and normal at specific times in development. For example, from approximately age 8 months through the preschool years, healthy youngsters may show intense distress (anxiety) at times of separation from their parents or other persons with whom they are close. Young children may have short-lived fears, (such as fear of the dark, storms, animals, or strangers). Anxious children are often overly tense or uptight. Some may seek a lot of reassurance, and their worries may interfere with activities. Parents should not discount a child's fears. Because anxious children may also be quiet, compliant and eager to please, their difficulties may be missed. Parents should be alert to the signs of severe anxiety so they can intervene early to prevent complications. There are different types of anxiety in children.

Symptoms of separation anxiety include:

- constant thoughts and intense fears about the safety of parents and caretakers
- refusing to go to school
- frequent stomachaches and other physical complaints
- extreme worries about sleeping away from home
- being overly clingy
- panic or tantrums at times of separation from parents
- trouble sleeping or nightmares

Symptoms of phobia include:

- extreme fear about a specific thing or situation (ex. dogs, insects, or needles)
- the fears cause significant distress and interfere with usual activities

Symptoms of social anxiety include:

- fears of meeting or talking to people
- avoidance of social situations
- few friends outside the family

Other symptoms of anxious children include:

- many worries about things before they happen
- constant worries or concerns about family, school, friends, or activities
- repetitive, unwanted thoughts (obsessions) or actions (compulsions)
- fears of embarrassment or making mistakes

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- low self esteem and lack of self-confidence

Severe anxiety problems in children can be treated. Early treatment can prevent future difficulties, such as loss of friendships, failure to reach social and academic potential, and feelings of low self-esteem. Treatments may include a combination of the following: individual psychotherapy, family therapy, medications, behavioral treatments, and consultation to the school.

If anxieties become severe and begin to interfere with the child's usual activities, (for example separating from parents, attending school and making friends) parents should consider seeking an evaluation from a qualified mental health professional or a child and adolescent psychiatrist.

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 48 November 2004

Problems with Soiling and Bowel Control

Most children can control their bowels and are toilet trained by the time they are four years of age. Problems controlling bowel movements can cause soiling which leads to frustration and anger on part of the child, parents, teachers and other people important in the child's life. In addition, social difficulties with this problem can be severe -- the child is often made fun of by friends and avoided by adults. These problems can cause children to feel badly about themselves.

Some of the reasons for soiling are:

- problems during toilet training,
- physical disabilities, which make it hard for the child to clean him/herself,
- physical condition, for example chronic constipation, Hirschprung's Disease,
- family or emotional problems.

Soiling which is not caused by a physical illness or disability is called **encopresis**. Children with encopresis may have other problems, such as short attention span, low frustration tolerance, hyperactivity and poor coordination. Occasionally, this problem with soiling starts with a stressful change in the child's life, such as the birth of a sibling, separation/divorce of parents, family problems, or a move to a new home or school. Encopresis is more common in boys than in girls.

Although most children with soiling do not have a physical condition, they should have a complete physical evaluation by a family physician or pediatrician. If no physical causes are found, or if problems continue, the next step is an evaluation by a child and adolescent psychiatrist. The child and adolescent psychiatrist will review the results of the physical evaluation and then decide whether emotional problems are contributing to the encopresis.

Encopresis can be treated with a combination of educational, psychological and behavioral methods. Most children with encopresis can be helped, but progress can be slow and extended treatment may be necessary. Early treatment of a soiling or bowel control problem can help prevent and reduce social and emotional suffering and pain for the child and family.

For additional information see *Facts for Families:*
#18 Bedwetting
#52 Comprehensive Psychiatric Evaluation
#72 Children with Oppositional Defiant Disorder

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Problems with Soiling and Bowel Control, "Facts for Families," No. 48 (11/04)

#82 Starting School
#86 Psychotherapies for Children and Adolescents

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 49 July 2013

Schizophrenia in Children

Schizophrenia is a serious psychiatric illness that causes strange thinking, strange feelings, and unusual behavior. It is uncommon in children and is hard to recognize in its early phases. The cause of schizophrenia is not known. Current research suggests a combination of brain changes, bio-chemical, genetic and environmental factors may be involved. Early diagnosis and medical treatment are important. Schizophrenia is a life-long disease that can be controlled but not cured.

The symptoms and behavior of children and adolescents with schizophrenia may differ from that of adults with this illness. The following symptoms and behaviors can occur in children or adolescents with schizophrenia:

- seeing things and hearing voices which are not real (hallucinations),
- odd and eccentric behavior, and/or speech,
- unusual or bizarre thoughts and ideas,
- confusing television and dreams from reality,
- confused thinking,
- extreme moodiness,
- ideas that people are out to get them or talking about them, (paranoia)
- severe anxiety and fearfulness,
- difficulty relating to peers, and keeping friends.
- withdrawn and increased isolation,
- decline in personal hygiene

The behavior of children with schizophrenia may change slowly over time. For example, children who used to enjoy relationships with others may start to become more shy or withdrawn and seem to be in their own world. Sometimes youngsters will begin talking about strange fears and ideas. They may start to cling to parents or say things which do not make sense. These early symptoms and problems may first be noticed by the child's school teachers.

Children with schizophrenia must have a complete evaluation. Parents should ask their family physician or pediatrician to refer them to a psychiatrist, preferably a child and adolescent psychiatrist, who is specifically trained and skilled at evaluating, diagnosing, and treating children with schizophrenia. Children with schizophrenia need a comprehensive treatment plan. A combination of medication, individual therapy, family therapy, and specialized programs (school, activities, etc.) is often necessary. Psychiatric medication can be helpful for many of the symptoms and problems identified. These medications require careful monitoring by a psychiatrist (preferably a child and adolescent psychiatrist.)

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

For more information see **Facts For Families:**
#11 The Child With Autism
#21 Psychiatric Medication for Children
#29 Psychiatric Medication Part II: Types
#38 Bipolar Disorder in Teens
#69 Asperger's Disorder
#85 Reactive Attachment Disorder
#52 Comprehensive Psychiatric Evaluation

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 50 July 2013

Panic Disorder in Children and Adolesents

Panic disorder is a common and treatable disorder. Children and adolescents with panic disorder have unexpected and repeated periods of intense fear or discomfort, along with other symptoms such as a racing heartbeat or feeling short of breath. These periods are called "panic attacks" and last minutes to hours. Panic attacks frequently develop without warning.

Symptoms of a panic attack include:

- Intense fearfulness (a sense that something terrible is happening)
- Racing or pounding heartbeat
- Dizziness or lightheadedness
- Shortness of breath or a feeling of being smothered
- Trembling or shaking
- Sense of unreality
- Fear of dying, losing control, or losing your mind

More than 3 million Americans will experience panic disorder during their lifetime. Panic disorder often begins during adolescence, although it may start during childhood, and sometimes runs in families.

If not recognized and treated, panic disorder and its complications can be devastating. Panic attacks can interfere with a child's or adolescent's relationships, schoolwork, and normal development. Attacks can lead to not just severe anxiety, but can also affect other parts of a child's mood or functioning. Children and adolescents with panic disorder may begin to feel anxious most of the time, even when they are not having panic attacks. Some begin to avoid situations where they fear a panic attack may occur, or situations where help may not be available. For example, a child may be reluctant to go to school or be separated from his or her parents. In severe cases, the child or adolescent may be afraid to leave home. As with other anxiety disorders, this pattern of avoiding certain places or situations is called "agoraphobia." Some children and adolescents with panic disorder can develop severe depression and may be at risk of suicidal behavior. As an attempt to decrease anxiety, some adolescents with panic disorder will use alcohol or drugs.

Panic disorder in children can be difficult to diagnose. This can lead to many visits to physicians and multiple medical tests that are expensive and potentially painful. When properly evaluated and diagnosed, panic disorder usually responds well to treatment. Children and adolescents with symptoms of panic attacks should first be evaluated by their family physician or pediatrician. If no other physical illness or condition is found as

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

a cause for the symptoms, a comprehensive evaluation by a child and adolescent psychiatrist should be obtained.

Several types of treatment are effective. Specific medications may stop panic attacks. Psychotherapy may also help the child and family learn ways to reduce stress or conflict that could otherwise cause a panic attack. With techniques taught in "cognitive behavioral therapy," the child may also learn new ways to control anxiety or panic attacks when they occur. Many children and adolescents with panic disorder respond well to the combination of medication and psychotherapy. With treatment, the panic attacks can usually be stopped. Early treatment can prevent the complications of panic disorder such as agoraphobia, depression and substance abuse.

For more information about panic disorder, visit the National Institute of Mental Health's website at www.nimh.nih.gov or call 1-800-64-PANIC.

See also: The Freedom from Fear's website www.freedomfromfear.org or ***Facts for Families:***
#4 The Depressed Child
#7 Children Who Won't Go to School
#10 Teen Suicide
#47 The Anxious Child
#60 Obsessive Compulsive Disorder in Children and Adolescents
#66 Helping Teenagers with Stress
#70 Posttraumatic Stress Disorder

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 51 November 2004

Psychiatric Medications for Children and Adolescents Part III: Questions to Ask

Medication can be an important part of treatment for some psychiatric disorders in children and adolescents. Psychiatric medication should only be used as one part of a comprehensive treatment plan. Ongoing evaluation and monitoring by a physician is essential. Parents and guardians should be provided with complete information when psychiatric medication is recommended as part of their child's treatment plan. Children and adolescents should be included in the discussion about medications, using words they understand. By asking the following questions, children, adolescents, and their parents will gain a better understanding of psychiatric medications:

1. What is the name of the medication? Is it known by other names?
2. What is known about its helpfulness with other children who have a similar condition to my child?
3. How will the medication help my child? How long before I see improvement? When will it work?
4. What are the side effects which commonly occur with this medication?
5. Is this medication addictive? Can it be abused?
6. What is the recommended dosage? How often will the medication be taken?
7. Are there any laboratory tests (e.g. heart tests, blood test, etc.) which need to be done before my child begins taking the medication? Will any tests need to be done while my child is taking the medication?
8. Will a child and adolescent psychiatrist be monitoring my child's response to medication and make dosage changes if necessary? How often will progress be checked and by whom?
9. Are there any other medications or foods which my child should avoid while taking the medication?
10. Are there interactions between this medication and other medications (prescription and/or over-the-counter) my child is taking?
11. Are there any activities that my child should avoid while taking the medication? Are any precautions recommended for other activities?
12. How long will my child need to take this medication? How will the decision be made to stop this medication?
13. What do I do if a problem develops (e.g. if my child becomes ill, doses are missed, or side effects develop)?
14. What is the cost of the medication (generic vs. brand name)?
15. Does my child's school nurse need to be informed about this medication?

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Psychiatric Medication Part III, "Facts for Families," No. 51 (11/04)

Treatment with psychiatric medications is a serious matter for parents, children and adolescents. Parents should ask these questions **before** their child or adolescent starts taking psychiatric medications. Parents and children/adolescents need to be fully informed about medications. If, after asking these questions, parents still have serious questions or doubts about medication treatment, they should feel free to ask for a second opinion by a child and adolescent psychiatrist.

For additional information see *Facts for Families*:
#21 Psychiatric Medication for Children and Adolescents Part I-How Medications Are Used
#29 Psychiatric Medication for Children and Adolescents Part II- Types of Medications
#52 Comprehensive Psychiatric Evaluation

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

Facts for Families© information sheets are developed, owned and distributed by AACAP. Hard copies of ***Facts*** sheets may be reproduced for personal or educational use without written permission, but cannot be included in material presented for sale or profit. All ***Facts*** can be viewed and printed from the AACAP website (www.aacap.org). ***Facts*** sheets may not be reproduced, duplicated or posted on any other website without written consent from AACAP. Organizations are permitted to create links to AACAP's website and specific ***Facts*** sheets. For all questions please contact the AACAP Communications & Marketing Coordinator, ext. 154.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 52 February 2005

Comprehensive Psychiatric Evaluation

Evaluation by a child and adolescent psychiatrist is appropriate for any child or adolescent with emotional and/or behavioral problems. Most children and adolescents with serious emotional and behavioral problems need a comprehensive psychiatric evaluation.

Comprehensive psychiatric evaluations usually require several hours over one or more office visits for the child and parents. With the parents' permission, other significant people (such as the family physician, school personnel or other relatives) may be contacted for additional information.

The comprehensive evaluation frequently includes the following:

- Description of present problems and symptoms
- Information about health, illness and treatment (both physical and psychiatric), including current medications
- Parent and family health and psychiatric histories
- Information about the child's development
- Information about school and friends
- Information about family relationships
- Interview of the child or adolescent
- Interview of parents/guardians
- If needed, laboratory studies such as blood tests, x-rays, or special assessments (for example, psychological, educational, speech and language evaluation)

The child and adolescent psychiatrist then develops a formulation. The formulation describes the child's problems and explains them in terms that the parents and child can understand. The formulation combines biological, psychological and social parts of the problem with developmental needs, history and strengths of the child, adolescent and family.

Time is made available to answer the parents' and child's questions. Parents often come to such evaluations with many concerns, including:

- Is my child normal? Am I normal? Am I to blame?
- Am I silly to worry?
- Can you help us? Can you help my child?
- What is wrong? What is the diagnosis?
- Does my child need additional assessment and/or testing (medical, psychological etc.)?

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- What are your recommendations? How can the family help?
- Does my child need treatment? Do I need treatment?
- What will treatment cost, and how long will it take?

Parents are often worried about how they will be viewed during the evaluation. Child and adolescent psychiatrists are there to support families and to be a partner, not to judge or blame. They listen to concerns, and help the child or adolescent and his/her family define the goals of the evaluation. Parents should always ask for explanations of words or terms they do not understand.

When a treatable problem is identified, recommendations are provided and a specific treatment plan is developed. Child and adolescent psychiatrists are specifically trained and skilled in conducting comprehensive psychiatric evaluations with children, adolescents and families.

For additional information see *Facts for Families*:
#24 When to Seek Help for Your Child
#25 Where to Seek Help for Your Child
#26 Your Health Insurance Benefits
#42 The Continuum of Care
#00 Definition of a Child and Adolescent Psychiatrist

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 53 February 2005

What is Psychotherapy for Children and Adolescents

Psychotherapy refers to a variety of techniques and methods used to help children and adolescents who are experiencing difficulties with their emotions or behavior. Although there are different types of psychotherapy, each relies on communications as the basic tool for bringing about change in a person's feelings and behaviors. Psychotherapy may involve an individual child, a group of children, a family, or multiple families. In children and adolescents, playing, drawing, building, and pretending, as well as talking, are important ways of sharing feelings and resolving problems.

As part of the initial assessment, a qualified mental health professional or child and adolescent psychiatrist will determine the need for psychotherapy. This decision will be based on such things as the child's current problems, history, level of development, ability to cooperate with treatment, and what interventions are most likely to help with the presenting concerns. Psychotherapy is often used in combination with other treatments (medication, behavior management, or work with the school). The relationship that develops between the therapist and the patient is very important. The child or adolescent must feel comfortable, safe and understood. This type of trusting environment makes it much easier for the child to express his/her thoughts and feelings and to use the therapy in a helpful way.

Psychotherapy helps children and adolescents in a variety of ways. They receive emotional support, resolve conflicts with people, understand feelings and problems, and try out new solutions to old problems. Goals for therapy may be specific (change in behavior, improved relations with friends or family), or more general (less anxiety, better self-esteem). The length of psychotherapy depends on the complexity and severity of problems.

Parents should ask the following questions about psychotherapy:

- Why is psychotherapy being recommended?
- What results can I expect?
- How long will my child be involved in therapy?
- How frequently will the doctor see my child?
- Will the doctor be meeting with just my child or with the entire family?
- How much do psychotherapy sessions cost?
- How will we (the parents) be informed about our child's progress and how can we help?
- How soon can we expect to see some changes?

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

What is Psychotherapy for Children and Adolescents, "Facts for Families," No. 53 (02/05)

A child and adolescent psychiatrist will be able to provide you with answers to your questions and concerns. Child and adolescent psychiatrists and other child mental health professionals are specifically trained and skilled to provide psychotherapy to children and adolescents.

For additional information see *Facts for Families*:
#25 Where to Seek Help for Your Child
#26 Know Your Health Insurance Benefits
#52 Comprehensive Psychiatric Evaluation

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 54 December 2011

Children and Watching TV

Television viewing is a major activity and influence on children and adolescents. Children in the United States watch an average of three to four hours of television a day. By the time of high school graduation, they will have spent more time watching television than they have in the classroom. While television can entertain, inform, and keep our children company, it may also influence them in undesirable ways.

Time spent watching television takes away from important activities such as reading, school work, playing, exercise, family interaction, and social development. Children also learn information from television that may be inappropriate or incorrect. They often can not tell the difference between the fantasy presented on television versus reality. They are influenced by the thousands of commercials seen each year, many of which are for alcohol, junk food, fast foods, and toys.

Children who watch a lot of television are likely to:

- Have lower grades in school
- Read fewer books
- Exercise less
- Be overweight

Violence, sexuality, race and gender stereotypes, drug and alcohol abuse are common themes of television programs. Young children are impressionable and may assume that what they see on television is typical, safe, and acceptable. As a result, television also exposes children to behaviors and attitudes that may be overwhelming and difficult to understand.

Active parenting can ensure that children have a positive experience with television. Parents can help by:

- Viewing programs with your children
- Selecting developmentally appropriate shows
- Placing limits on the amount of television viewing (per day and per week)
- Turning off the TV during family meals and study time
- Turning off shows you don't feel are appropriate for your child

In addition, parents can help by doing the following: don't allow children to watch long blocks of TV, but help them select individual programs. Choose shows that meet the developmental needs of your child. Children's shows on public TV are appropriate, but soap operas, adult sitcoms, and adult talk shows are not. Set certain periods when the

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

television will be off. Study times are for learning, not for sitting in front of the TV doing homework. Meal times are a good time for family members to talk with each other, not for watching television.

Encourage discussions with your children about what they are seeing as you watch shows with them. Point out positive behavior, such as cooperation, friendship, and concern for others. While watching, make connections to history, books, places of interest, and personal events. Talk about your personal and family values as they relate to the show. Ask children to compare what they are watching with real events. Talk about the realistic consequences of violence. Discuss the role of advertising and its influence on buying. Encourage your child to be involved in hobbies, sports, and peers. With proper guidance, your child can learn to use television in a healthy and positive way.

MAKE TV VIEWING AN ACTIVE PROCESS FOR CHILD AND PARENT!

For additional information see *Facts for Families***:**
#13 Children and TV Violence
#40 Influence of Music and Music Videos
#67 Children and the News
#79 Obesity in Children and Teens

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 55 December 2011

Understanding Violent Behavior in Children and Adolescents

There is a great concern about the incidence of violent behavior among children and adolescents. This complex and troubling issue needs to be carefully understood by parents, teachers, and other adults.

Children as young as preschoolers can show violent behavior. Parents and other adults who witness the behavior may be concerned, however, they often hope that the young child will "grow out of it." Violent behavior in a child at any age always needs to be taken seriously. It should not be quickly dismissed as "just a phase they're going through!"

Range of Violent Behavior

Violent behavior in children and adolescents can include a wide range of behaviors: explosive temper tantrums, physical aggression, fighting, threats or attempts to hurt others (including homicidal thoughts), use of weapons, cruelty toward animals, fire setting, intentional destruction of property and vandalism.

Factors Which Increase Risk of Violent Behavior

Numerous research studies have concluded that a complex interaction or combination of factors leads to an increased risk of violent behavior in children and adolescents. These factors include:

- Previous aggressive or violent behavior
- Being the victim of physical abuse and/or sexual abuse
- Exposure to violence in the home and/or community
- Genetic (family heredity) factors
- Exposure to violence in media (TV, movies, etc.)
- Use of drugs and/or alcohol
- Presence of firearms in home
- Combination of stressful family socioeconomic factors (poverty, severe deprivation, marital breakup, single parenting, unemployment, loss of support from extended family)
- Brain damage from head injury

What are the "warning signs" for violent behavior in children?

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Children who have **several risk factors and show the following behaviors** should be carefully evaluated:

- Intense anger
- Frequent loss of temper or blow-ups
- Extreme irritability
- Extreme impulsiveness
- Becoming easily frustrated

Parents and teachers should be careful not to minimize these behaviors in children.

What can be done if a child shows violent behavior?

Whenever a parent or other adult is concerned, they should immediately arrange for a comprehensive evaluation by a qualified mental health professional. Early treatment by a professional can often help. The goals of treatment typically focus on helping the child to: learn how to control his/her anger; express anger and frustrations in appropriate ways; be responsible for his/her actions; and accept consequences. In addition, family conflicts, school problems, and community issues must be addressed.

Can anything prevent violent behavior in children?

Research studies have shown that much violent behavior can be decreased or even prevented if the above risk factors are significantly reduced or eliminated. Most importantly, efforts should be directed at dramatically decreasing the exposure of children and adolescents to violence in the home, community, and through the media. Clearly, violence leads to violence.

In addition, the following strategies can lessen or prevent violent behavior:

- Prevention of child abuse (use of programs such as parent training, family support programs, etc.)
- Sex education and parenting programs for adolescents
- Early intervention programs for violent youngsters
- Monitoring child's viewing of violence on TV/videos/movies

For additional information see ***Facts for Families***:
#33 Conduct Disorder
#37 Children and Firearms
#13 Children and TV Violence
#5 Child Abuse
#9 Child Sexual Abuse

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 56 December 2011

Parenting: Preparing for Adolescence

Parenting can be the most rewarding work of adult life. Nothing brings more joy and pride than a happy, productive, and loving child. Each age and stage of a child's development has specific goals and tasks. For infants, it is to eat, sleep, and explore their world. For adolescents, it is to become their own person with their own group of friends. Adolescents need many skills in order to successfully achieve their goal of increased independence. Some adolescents do not make this transition smoothly. Their movement toward independence can cause stress and grief for parents. Some aspects of this rough transition are normal and, while stressful, should not alarm parents.

Starting early is the best way for parents to prepare for their child's adolescence. The following are ways that parents can prepare themselves and their child for a smoother transition and greater success in achieving the tasks of adolescent development:

- Providing a safe and loving home environment
- Creating an atmosphere of honesty, mutual trust, and respect
- Allowing age appropriate independence and assertiveness
- Developing a relationship that encourages your child to talk to you
- Teaching responsibility for their belongings and yours
- Teaching basic responsibility for household chores
- Teaching the importance of accepting limits
- Teaching the importance of thinking before acting

These are complex processes which occur gradually and start during infancy. A teenager's adolescent years will be less stressful when parents and child have worked together on these tasks throughout the child's earlier development.

The ability to talk openly about problems is one of the most important aspects of the parent and child relationship. Developing this relationship and open communication takes time, persistence, and understanding. The relationship develops gradually by spending time with the child. Meal times, story telling, reading, playing games, outings, vacations, and celebrations are important opportunities for parents to spend time with their child. Parents should also try to spend some individual time with each child, particularly when talking about difficult or upsetting things. This relationship creates the foundation for talking with the child when struggles and conflicts emerge during adolescence.

A parent-child relationship which is very stressful or troubled during the preadolescent years can be a strong signal that professional help may be needed. Parents= investment

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

of time and energy in the child's early years can prevent small problems of childhood from becoming larger problems of adolescence.

For additional information see ***Facts for Families***:
#24 Know When To Seek Help
#43 Discipline
#57 Normal Adolescence: Part I
#58 Normal Adolescence: Part II

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 57 December 2011

Normal Adolescent Development Part I

Middle School and Early High School Years

Parents are often worried or confused by changes in their teenagers. The following information should help parents understand this phase of development. Each teenager is an individual with a unique personality and special interests, likes and dislikes. However, there are also numerous developmental issues that everyone faces during the adolescent years. The normal feelings and behaviors of the middle school and early high school adolescent are described below.

Movement Towards Independence

- Struggle with sense of identity
- Feeling awkward or strange about one's self and one's body
- Focus on self, alternating between high expectations and poor self-esteem
- Interests and clothing style influenced by peer group
- Moodiness
- Improved ability to use speech to express one's self
- Realization that parents are not perfect; identification of their faults
- Less overt affection shown to parents, with occasional rudeness
- Complaints that parents interfere with independence
- Tendency to return to childish behavior, particularly when stressed

Future Interests and Cognitive Changes

- Mostly interested in present, with limited thoughts of the future
- Intellectual interests expand and gain in importance
- Greater ability to do work (physical, mental, emotional)

Sexuality

- Display shyness, blushing, and modesty
- Girls develop physically sooner than boys
- Increased interest in sex
- Movement toward heterosexuality with fears of homosexuality
- Concerns regarding physical and sexual attractiveness to others
- Frequently changing relationships
- Worries about being normal

Morals, Values, and Self-Direction

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Rule and limit testing
- Capacity for abstract thought
- Development of ideals and selection of role models
- More consistent evidence of conscience
- Experimentation with sex and drugs (cigarettes, alcohol, and marijuana)

Young teenagers do vary slightly from the above descriptions, but the feelings and behaviors are, in general, considered normal for each stage of adolescence.

For additional information see Facts for Families:
#24 Know When to Seek Help For Your Child
#62 Talking to Your Kids About Sex
#63 Gay and Lesbian Adolescents

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 58 December 2011

Normal Adolescent Development Part II

Late High School Years and Beyond

Parents are often worried or confused by changes in their teenagers. The following information should help parents understand this phase of development. Each teenager is an individual with a unique personality and special interests, likes and dislikes. However, there are also numerous developmental issues that everyone faces during the adolescent years. The normal feelings and behaviors of the late high school adolescent are described below.

Movement towards Independence

- Increased independent functioning
- Firmer and more cohesive sense of identity
- Examination of inner experiences
- Ability to think ideas through
- Conflict with parents begins to decrease
- Increased ability for delayed gratification and compromise
- Increased emotional stability
- Increased concern for others
- Increased self-reliance
- Peer relationships remain important and take an appropriate place among other interests

Future Interests and Cognitive Changes

- Work habits become more defined
- Increased concern for the future
- More importance is placed on one's role in life

Sexuality

- Feelings of love and passion
- Development of more serious relationships
- Firmer sense of sexual identity
- Increased capacity for tender and sensual love

Morals, Values, and Self-Direction

- Greater capacity for setting goals

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Interest in moral reasoning
- Capacity to use insight
- Increased emphasis on personal dignity and self-esteem
- Social and cultural traditions regain some of their previous importance

Older teenagers do vary slightly from the above descriptions, but the feelings and behaviors are, in general, considered normal for each stage of adolescence.

For additional information see ***Facts for Families***:
#24 Know When to Seek Help For Your Child
#03 Teens Alcohol and Other Drugs
#63 Gay and Lesbian Adolescents
#65 Children's Threats: When Are They Serious?

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 59 December 2011

Children Online

Computers have traditionally been trusted by both children and adults as reliable and accurate sources of information. The rapid growth of online services and internet access has added a new dimension to modern computing. Through the internet children now have access to an almost endless supply of information and opportunity for interaction. However, there can be real risks and dangers for an unsupervised child.

Most online services give children resources such as encyclopedias, current events coverage, and access to libraries and other valuable material. They can also play games and communicate with friends on social media platforms like Facebook. The ability to "click" from one area to another appeals to a child's natural impulsivity and curiosity and needs for immediate gratification or feedback.

Most parents teach their children not to talk with strangers, not to open the door if they are home alone, and not to give out information on the telephone to unknown callers. Most parents also monitor where their children go, who they play with, and what TV shows, books, or magazines they are exposed to. However, many parents don't realize that **the same level of guidance and supervision must be provided for a child's online experience.**

Parents cannot assume that their child will be protected by the supervision or regulation provided by the online services. Most "chat rooms" and social media sites are completely unsupervised. Because of the anonymous nature of the "screen name," children who communicate with others in these areas will not know if they are "talking" with another child or a child predator pretending to be a child or teen. Unlike the mail and visitors that a parent sees a child receive at home, e-mail or "chat room" activity is not seen by parents. Unfortunately, there can be serious consequences to children who have been persuaded to give personal information, (e.g. name, passwords, phone number, email or home address) or have agreed to meet someone in person.

Some of the other risks or problems include:

- accessing areas that are inappropriate or overwhelming
- being exposed to online information that promotes hate, violence, and pornography
- being misled and bombarded with intense advertising
- being invited to register for prizes or to join a club when they are providing personal or household information to an unknown source
- losing time from developing real social skills and from physical activity and exercise

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- revealing too much personal information on social media sites
- being bullied on social media sites

In order to make a child's online experience more safe and educational, parents should:

- limit the amount of time a child spends online and "surfing the web"
- teach a child that talking to "screen names" in a "chat room" is the same as talking with strangers
- teach a child never to give out any personal identifying information to another individual or website online
- teach a child to never agree to actually meet someone they have met online
- never give a child credit card numbers or passwords that will enable online purchases or access to inappropriate services or sites
- remind a child that not everything they see or read online is true
- make use of the parental control features offered with your online service, or obtaining commercially available software programs, to restrict access to "chat lines," news groups, and inappropriate websites
- provide for an individual e-mail address only if a child is mature enough to manage it, and plan to periodically monitor the child's e-mail and online activity
- monitor the content of a child's personal webpage and screen name profile information
- teach a child to use the same courtesy in communicating with others online as they would if speaking in person -- i.e. no vulgar or profane language, no name calling, etc.
- insist that a child follow the same guidelines at other computers that they might have access to, such as those at school, libraries, or friends' homes

Parents should remember that communicating online does not prepare children for real interpersonal relationships. Spending time with a child initially exploring an online service and periodically participating with a child in the online experience gives parents an opportunity to monitor and supervise the activity. It is also an opportunity to learn together.

For additional information see ***Facts for Families***:
#24 Know When to Seek Help For Your Child
#40 Influence of Music and Music Videos
#46 Home Alone Children

Children Online, "Facts for Families," No. 59 (12/11)

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 60 July 2013

Obsessive-Compulsive Disorder in Children and Adolescents

Obsessive-Compulsive Disorder (OCD), usually begins in adolescence or young adulthood and is seen in as many as 1 in 200 children and adolescents. OCD is characterized by recurrent intense obsessions and/or compulsions that cause severe discomfort and interfere with day-to-day functioning. Obsessions are recurrent and persistent thoughts, impulses, or images that are unwanted and cause marked anxiety or distress. Frequently, they are unrealistic or irrational. They are not simply excessive worries about real-life problems or preoccupations. Compulsions are repetitive behaviors or rituals (like hand washing, keeping things in order, checking something over and over) or mental acts (like counting, repeating words silently, avoiding). In OCD, the obsessions or compulsions cause significant anxiety or distress, or they interfere with the child's normal routine, academic functioning, social activities, or relationships.

The obsessive thoughts may vary with the age of the child and may change over time. A younger child with OCD may have persistent thoughts that harm will occur to himself or a family member, for example an intruder entering an unlocked door or window. The child may compulsively check all the doors and windows of his home after his parents are asleep in an attempt to relieve anxiety. The child may then fear that he may have accidentally unlocked a door or window while last checking and locking, and then must compulsively check over and over again.

An older child or a teenager with OCD may fear that he will become ill with germs, AIDS, or contaminated food. To cope with his/her feelings, a child may develop "rituals" (a behavior or activity that gets repeated). Sometimes the obsession and compulsion are linked; "I fear this bad thing will happen if I stop checking or hand washing, so I can't stop even if it doesn't make any sense."

Research shows that OCD is a brain disorder and tends to run in families, although this doesn't mean the child will definitely develop symptoms if a parent has the disorder. Recent studies have also shown that OCD may develop or worsen after a streptococcal bacterial infection. A child may also develop OCD with no previous family history.

Children and adolescents often feel shame and embarrassment about their OCD. Many fear it means they're crazy and are hesitant to talk about their thoughts and behaviors. Good communication between parents and children can increase understanding of the problem and help the parents appropriately support their child.

Most children with OCD can be treated effectively with a combination of psychotherapy

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

(especially cognitive and behavioral techniques) and certain medications for example, serotonin reuptake inhibitors (SSRI's). Family support and education are also central to the success of treatment. Antibiotic therapy may be useful in cases where OCD is linked to streptococcal infection.

Seeking help from a child and adolescent psychiatrist is important both to better understand the complex issues created by OCD as well as to get help.

For additional information see *Facts for Families*:
#24 Know When to Seek Help For Your Child
#47 The Anxious Child
#35 Tic Disorders
#21 Psychiatric Medication for Children
#52 Comprehensive Psychiatric Evaluation

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 61 February 2013

Children and Sports

Sports help children develop physical skills, get exercise, make friends, have fun, learn to play as a member of a team, learn to play fair, and improve self-esteem. American sports culture has increasingly become a money making business. The highly stressful, competitive, "win at all costs" attitude prevalent at colleges and with professional athletes affects the world of children's sports and athletics, creating an unhealthy environment. It is important to remember that the attitudes and behavior taught to children in sports carry over to adult life. Parents should take an active role in helping their child develop good sportsmanship. To help your child get the most out of sports, you need to be actively involved. This includes:

- providing emotional support and positive feedback,
- attending some games and talking about them afterward,
- having realistic expectations for your child,
- learning about the sport and supporting your child's involvement,
- helping your child talk with you about their experiences with the coach and other team members,
- helping your child handle disappointments and losing, and
- modeling respectful spectator behavior.

Although this involvement takes time and creates challenges for work schedules, it allows you to become more knowledgeable about the coaching, team values, behaviors, and attitudes. Your child's behavior and attitude reflects a combination of the coaching and your discussions about good sportsmanship and fair play.

It is also important to talk about what your child observes in sports events. When bad sportsmanship occurs, discuss other ways the situation could be handled. While you might acknowledge that in the heat of competition it may be difficult to maintain control and respect for others, it is important to stress that disrespectful behavior is not acceptable. Remember, success is not the same thing as winning and failure is not the same thing as losing.

If you are concerned about the behavior or attitude of your child's coach, you may want to talk with the coach privately. As adults, you can talk together about what is most important for the child to learn. While you may not change a particular attitude or behavior of a coach, you can make it clear how you would like your child to be approached. If you find that the coach is not responsive, discuss the problem with the parents responsible for the school or league activities. If the problem continues, you may decide to withdraw your child.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

As with most aspects of parenting, being actively involved and talking with your children about their life is very important. Being proud of accomplishments, sharing in wins and defeats, and talking to them about what has happened helps them develop skills and capacities for success in life. The lessons learned during children's sports will shape values and behaviors for adult life.

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 62 February 2013

Talking to Your Kids About Sex

Talking to your children about love, intimacy, and sex is an important part of parenting. Parents can be very helpful by creating a comfortable atmosphere in which to talk to their children about these issues. However, many parents avoid or postpone the discussion. Each year about 750,000 teenage girls become pregnant in the United States and three million teens get a sexually transmitted disease. Children and adolescents need input and guidance from parents to help them make healthy and appropriate decisions regarding their sexual behavior since they can be confused and overstimulated by what they see and hear. Information about sex obtained by children from the Internet can often be inaccurate and/or inappropriate.

Talking about sex may be uncomfortable for both parents and children. Parents should respond to the needs and curiosity level of their individual child, offering no more or less information than their child is asking for and is able to understand. Getting advice from a clergyman, pediatrician, family physician, or other health professional may be helpful. Books that use illustrations or diagrams may aid communication and understanding.

Children have different levels of curiosity and understanding depending upon their age and level of maturity. As children grow older, they will often ask for more details about sex. Many children have their own words for body parts. It is important to find out words they know and are comfortable with to make talking with them easier. A 5-year-old may be happy with the simple answer that babies come from a seed that grows in a special place inside the mother. Dad helps when his seed combines with mom's seed which causes the baby to start to grow. An 8-year-old may want to know how dad's seed gets to mom's seed. Parents may want to talk about dad's seed (or sperm) coming from his penis and combining with mom's seed (or egg) in her uterus. Then the baby grows in the safety of mom's uterus for nine months until it is strong enough to be born. An 11-year-old may want to know even more and parents can help by talking about how two people fall in love and then may decide to have sex.

It is important to talk about the responsibilities and consequences that come from being sexually active. Pregnancy, sexually transmitted diseases, and feelings about sex are important issues to be discussed. Talking to your children can help them make the decisions that are best for them without feeling pressured to do something before they are ready. Helping children understand that these are decisions that require maturity and responsibility will increase the chance that they make good choices.

Adolescents are able to talk about lovemaking and sex in terms of dating and relationships. They may need help dealing with the intensity of their own sexual feelings, confusion regarding their sexual identity, and sexual behavior in a relationship. Concerns

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

regarding masturbation, menstruation, contraception, pregnancy, and sexually transmitted diseases are common. Some adolescents also struggle with conflicts around family, religious or cultural values. Open communication and accurate information from parents increases the chance that teens will postpone sex and will use appropriate methods of birth control once they begin.

In talking with your child or adolescent, it is helpful to:

- Encourage your child to talk and ask questions.
- Maintain a calm and non-critical atmosphere for discussions.
- Use words that are understandable and comfortable.
- Try to determine your child's level of knowledge and understanding.
- Keep your sense of humor and don't be afraid to talk about your own discomfort.
- Relate sex to love, intimacy, caring, and respect for oneself and one's partner.
- Be open in sharing your values and concerns.
- Discuss the importance of responsibility for choices and decisions.
- Help your child to consider the pros and cons of choices.

By developing open, honest and ongoing communication about responsibility, sex, and choice, parents can help their youngsters learn about sex in a healthy and positive manner.

For additional information see *Facts For Families:*
#31 When Children Have Children
#30 Children and AIDS
#9 Child Sexual Abuse
#63 Gay and Lesbian Teens

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

Talking to Your Kids About Sex, "Facts for Families," No. 62 (05/05)

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 63 February 2013

Gay, Lesbian and Bisexual Adolescents

Growing up is a demanding and challenging task for every adolescent. One important aspect is forming one's sexual identity. All children explore and experiment sexually as part of normal development. This sexual behavior may be with members of the same or opposite sex. For many adolescents, thinking about and/or experimenting with people of the same sex may cause concerns and anxiety regarding their sexual orientation. For others, even thoughts or fantasies may cause anxiety. These feelings and behavior do not necessarily mean an individual is homosexual or bisexual.

Homosexuality is the persistent sexual and emotional attraction to someone of the same sex. It is part of the range of sexual expression. Homosexuality has existed throughout history and across cultures. Many gay, lesbian and bisexual individuals first become aware of and experience their sexual thoughts and feelings during childhood and adolescence. Recent changes in society's attitude toward sexuality have helped gay, lesbian, and bisexual teens feel more comfortable with their sexual orientation. In other aspects of their development, they are similar to heterosexual youngsters. They experience the same kinds of stress, struggles, and tasks during adolescence.

Parents need to clearly understand that sexual orientation is not a mental disorder. The cause(s) of homosexuality or bisexuality are not fully understood. However, a person's sexual orientation is not a matter of choice. In other words, individuals have no more choice about being homosexual or bisexual than heterosexual. All teenagers do have a choice about their expression of sexual behaviors and lifestyle, regardless of their sexual orientation.

Despite increased knowledge and information, gay, lesbian and bisexual teens still have many concerns. These include:

- feeling different from peers
- feeling guilty about their sexual orientation
- worrying about the response from their families and loved ones
- being teased and ridiculed by their peers
- worrying about AIDS, HIV infection, and other sexually transmitted diseases
- fearing discrimination when joining clubs, sports, seeking admission to college, and finding employment
- being rejected and harassed by others

Gay, lesbian, and bisexual teens can become socially isolated, withdraw from activities and friends, have trouble concentrating, and develop low self-esteem. Some may develop depression and think about suicide or attempt it. Parents and others need to be alert to

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

these signs of distress because recent studies show that gay, lesbian and bisexual youth account for a significant number of deaths by suicide during adolescence.

It is important for parents to understand their teen's sexual orientation and to provide emotional support. Parents may have difficulty accepting their teen's sexuality for some of the same reasons that the youngster wants to keep it secret. Gay, lesbian or bisexual adolescents should be allowed to decide when and to whom to disclose their homosexuality. Telling a person's sexuality before they are ready is called "outing" and can be traumatic. Parents and other family members may gain understanding and support from organizations such as Parents, Families and Friends of Lesbians and Gays (PFLAG).

Counseling may be helpful for teens who are uncomfortable with their sexual orientation or uncertain about how to express it. They may benefit from support and the opportunity to clarify their feelings. Therapy may also help the teen adjust to personal, family, and school-related issues or conflicts that emerge. Therapy directed specifically at changing sexual orientation is not recommended and may be harmful for an unwilling teen. It may create more confusion and anxiety by reinforcing the negative thoughts and emotions with which the youngster is already struggling.

For additional information about Parents, Families and Friends of Lesbians and Gays (PFLAG) visit PFLAG's website www.pflag.org or contact: PFLAG, **1726 M Street, NW Suite 400 Washington, DC 20036: (202) 467.8180; (202).467.8194 FAX.**

Also see other Facts for Families:
#62 Talking to Your Kids About Sex
#10 Teen Suicide
#4 The Depressed Child
#30 Children & AIDS, Lesbian, Gay, and Bisexual Parenting

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

without written consent from AACAP. Organizations are permitted to create links to AACAP's website and specific ***Facts*** sheets. For all questions please contact the AACAP Communications & Marketing Coordinator, ext. 154.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 64 February 2013

Foster Care

Around 400,000 children in the U.S. currently reside in some form of foster care. Children in foster care and foster parents are mostly invisible in communities and often lack many needed supports and resources. In situations of abuse and neglect, children may be removed from their parents' home by a child welfare agency and placed in foster care. Other reasons for foster placement include severe behavioral problems in the child and/or a variety of parental problems, such as abandonment, illness (physical or emotional), incarceration, AIDS, alcohol/substance abuse, and death.

African-American children make up approximately two thirds of the foster care population and remain in care longer. Approximately 50 percent of children who enter foster care are reunited with their birth parents within two years, although this number varies significantly by state. A significant number, however, can spend long periods of time in care awaiting adoption or other permanent arrangement. Making decisions about the future for a child in foster care is called permanency planning. Options include: returning the child to his/her birth parents; termination of parental rights (a formal legal procedure) to be followed, hopefully, by adoption; or long-term care with foster parents or relatives. Most states encourage efforts to provide the birth parents with support and needed services (e.g. mental health or drug/alcohol treatment, parent skills, training and assistance with child care and/or adequate housing) so their child can be returned to them. When parental rights have been terminated by the court, most states will try to place children with relatives (kinship foster care or relative placement) which may lead to adoption by the relative.

Being removed from their home and placed in foster care is a difficult and stressful experience for any child. Many of these children have suffered some form of serious abuse or neglect. About 80% of children in foster care have emotional, behavioral, or developmental problems. Physical health problems are also common. Most children, however, show remarkable resiliency and determination to go on with their lives. Children in foster care often struggle with the following issues:

- blaming themselves and feeling guilty about removal from their birth parents
- wishing to return to birth parents even if they were abused by them
- feeling unwanted if awaiting adoption for a long time
- feeling helpless about multiple changes in foster parents over time
- having mixed emotions about attaching to foster parents
- feeling insecure and uncertain about their future
- reluctantly acknowledging positive feelings for foster parents

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Foster parents open their homes and hearts to children in need of temporary care, a task both rewarding and difficult.

Reimbursement rates for foster parents are lower in most states than the true costs of providing routine care for the child. Important challenges for foster parents include:

- recognizing the limits of their emotional attachment to the child
- understanding mixed feelings toward the child's birth parents
- recognizing their difficulties in letting the child return to birth parents
- dealing with the complex needs (emotional, physical, etc.) of children in their care
- working with sponsoring social agencies
- finding needed support services in the community
- dealing with the child's emotions and behavior following visits with birth parents

Children in foster care who have emotional or behavioral problems may be referred for a psychiatric evaluation. Some child and adolescent psychiatrists provide consultation to Juvenile/Family Courts and child welfare agencies. Child and adolescent psychiatrists also provide comprehensive evaluations including diagnosis and the development of treatment plans. They also provide direct treatment (e.g. psychotherapy, family therapy, psychiatric medication) to a child. Children in foster care have special and complex needs which are best addressed by a coordinated team which usually includes the birth parents, foster parents, mental health professionals (including child and adolescent psychiatrists) and child welfare staff.

For additional information about foster care contact the Child Welfare League of America (CWLA) 440 First Street, NW, Third Floor, Washington, D.C. 20001-2085.

For additional information see other *Facts for Families:*
#09 Child Sexual Abuse
#05 Child Abuse - The Hidden Bruises
#15 The Adopted Child
#08 Children and Grief

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 65 February 2013

Children's Threats: When Are They Serious?

Every year there are tragedies in which children shoot and kill individuals after making threats. When this occurs, many people ask themselves, "How could this happen?" and "Why didn't we take the threat seriously?"

Most threats made by children or adolescents are not carried out. Many such threats are the child's way of talking big or tough, or getting attention. Sometimes these threats are a reaction to a perceived hurt, rejection, or attack.

What threats should be taken seriously?
Examples of potentially dangerous or emergency situations with a child or adolescent include:

- threats or warnings about hurting or killing someone
- threats or warnings about hurting or killing oneself
- threats to run away from home
- threats to damage or destroy property

Child and adolescent psychiatrists and other mental health professionals agree that it is very difficult to predict a child's future behavior with complete accuracy. A person's past behavior, however, is still one of the best predictors of future behavior. For example, a child with a history of violent or assaultive behavior is more likely to carry out his/her threats and be violent.

When is there more risk associated with threats from children and adolescents?
The presence of one or more of the following increases the risk of violent or dangerous behavior:

- past violent or aggressive behavior (including uncontrollable angry outbursts)
- access to guns or other weapons
- bringing a weapon to school
- past suicide attempts or threats
- family history of violent behavior or suicide attempts
- blaming others and/or unwilling to accept responsibility for one's own actions
- recent experience of humiliation, shame, loss, or rejection
- bullying or intimidating peers or younger children
- a pattern of threats
- being a victim of abuse or neglect (physical, sexual, or emotional)

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- witnessing abuse or violence in the home
- themes of death or depression repeatedly evident in conversation, written expressions, reading selections, or artwork
- preoccupation with themes and acts of violence in TV shows, movies, music, magazines, comics, books, video games, and Internet sites
- mental illness, such as depression, mania, psychosis, or bipolar disorder
- use of alcohol or illicit drugs
- disciplinary problems at school or in the community (delinquent behavior)
- past destruction of property or vandalism
- cruelty to animals
- firesetting behavior
- poor peer relationships and/or social isolation
- involvement with cults or gangs
- little or no supervision or support from parents or other caring adult

What should be done if parents or others are concerned?

When a child makes a serious threat it should not be dismissed as just idle talk. Parents, teachers, or other adults should immediately talk with the child. If it is determined that the child is at risk and the child refuses to talk, is argumentative, responds defensively, or continues to express violent or dangerous thoughts or plans, arrangements should be made for an immediate evaluation by a mental health professional with experience evaluating children and adolescents. Evaluation of any serious threat must be done in the context of the individual child's past behavior, personality, and current stressors. In an emergency situation or if the child or family refuses help, it may be necessary to contact local police for assistance or take the child to the nearest emergency room for evaluation. Children who have made serious threats must be carefully supervised while awaiting professional intervention. Immediate evaluation and appropriate ongoing treatment of youngsters who make serious threats can help the troubled child and reduce the risk of tragedy.

For additional information see *Facts for Families*:
#4 The Depressed Child
#55 Understanding Violent Behavior in Children
#37 Children and Firearms
#03 Teens: Alcohol and Other Drugs
#13 Children and TV Violence
#33 Conduct Disorder
#10 Teen Suicide

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

Children's Threats, "Facts for Families," No. 65 (05/05)

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 66 February 2013

Helping Teenagers Deal with Stress

Teenagers, like adults, may experience stress everyday and can benefit from learning stress management skills. Most teens experience more stress when they perceive a situation as dangerous, difficult, or painful and they do not have the resources to cope. Some sources of stress for teens might include:

- school demands and frustrations
- negative thoughts and feelings about themselves
- changes in their bodies
- problems with friends and/or peers at school
- unsafe living environment/neighborhood
- separation or divorce of parents
- chronic illness or severe problems in the family
- death of a loved one
- moving or changing schools
- taking on too many activities or having too high expectations
- family financial problems

Some teens become overloaded with stress. When it happens, inadequately managed stress can lead to anxiety, withdrawal, aggression, physical illness, or poor coping skills such as drug and/or alcohol use.

When we perceive a situation as difficult or painful, changes occur in our minds and bodies to prepare us to respond to danger. This "fight, flight, or freeze" response includes faster heart and breathing rate, increased blood to muscles of arms and legs, cold or clammy hands and feet, upset stomach and/or a sense of dread.

The same mechanism that turns on the stress response can turn it off. As soon as we decide that a situation is no longer dangerous, changes can occur in our minds and bodies to help us relax and calm down. This "relaxation response" includes decreased heart and breathing rate and a sense of well being. Teens that develop a "relaxation response" and other stress management skills feel less helpless and have more choices when responding to stress.

Parents can help their teen in these ways:

- Monitor if stress is affecting their teen's health, behavior, thoughts, or feelings
- Listen carefully to teens and watch for overloading
- Learn and model stress management skills
- Support involvement in sports and other pro-social activities

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Helping Teenagers Deal with Stress, "Facts for Families," No. 66 (02/13)

Teens can decrease stress with the following behaviors and techniques:

- Exercise and eat regularly
- Avoid excess caffeine intake which can increase feelings of anxiety and agitation
- Avoid illegal drugs, alcohol and tobacco
- Learn relaxation exercises (abdominal breathing and muscle relaxation techniques)
- Develop assertiveness training skills. For example, state feelings in polite firm and not overly aggressive or passive ways: ("I feel angry when you yell at me" "Please stop yelling.")
- Rehearse and practice situations which cause stress. One example is taking a speech class if talking in front of a class makes you anxious
- Learn practical coping skills. For example, break a large task into smaller, more attainable tasks
- Decrease negative self talk: challenge negative thoughts about yourself with alternative neutral or positive thoughts. "My life will never get better" can be transformed into "I may feel hopeless now, but my life will probably get better if I work at it and get some help"
- Learn to feel good about doing a competent or "good enough" job rather than demanding perfection from yourself and others
- Take a break from stressful situations. Activities like listening to music, talking to a friend, drawing, writing, or spending time with a pet can reduce stress
- Build a network of friends who help you cope in a positive way

By using these and other techniques, teenagers can begin to manage stress. If a teen talks about or shows signs of being overly stressed, a consultation with a child and adolescent psychiatrist or qualified mental health professional may be helpful.

For additional information see *Facts for Families:*
#4 The Depressed Child
#47 The Anxious Child
#24 When to Seek Help

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

specific ***Facts*** sheets. For all questions please contact the AACAP Communications & Marketing Coordinator, ext. 154.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 67 February 2013

Children and the News

Children often see or hear the news many times a day through television, radio, newspapers, magazines, and the Internet. Seeing and hearing about local and world events, such as natural disasters, catastrophic events, and crime reports, may cause children to experience stress, anxiety, and fears.

There have also been several changes in how news is reported that have given rise to the increased potential for children to experience negative effects. These changes include the following:

- television channels and Internet services and sites which report the news 24 hours a day
- television channels broadcasting live events as they are unfolding, in "real time"
- increased reporting of the details of the private lives of public figures and role models
- pressure to get news to the public as part of the competitive nature of the entertainment industry
- detailed and repetitive visual coverage of natural disasters and violent acts

While there has been great public debate about providing television ratings to warn parents about violence and sex in regular programming, news shows have only recently been added to these discussions. Research has shown that children and adolescents are prone to imitate what they see and hear in the news, a kind of contagion effect described as "copy cat" events. Chronic and persistent exposure to such violence can lead to fear, desensitization (numbing), and in some children an increase in aggressive and violent behaviors. Studies also show that media broadcasts to not always choose to show things that accurately reflect local or national trends.

For example, statistics report a decrease in the incidence of violent crime nationally, yet, polls suggest the public believes crime is increasing because of the media's tendency to focus on violent crimes. Local news shows often lead with or break into programming to announce crime reports and devote significant broadcast time to detailed crime reporting. Market research suggests that stories of crime and violence increase newscasts' ratings.

The possible negative effects of news can be lessened by parents, teachers, or other adults by watching the news with the child and talking about what has been seen or heard. The child's age, maturity, developmental level, life experiences, and vulnerabilities should guide how much and what kind of news the child watches.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Guidelines for minimizing the negative effects of watching the news include:

- monitor the amount of time your child watches news shows
- make sure you have adequate time and a quiet place to talk if you anticipate that the news is going to be troubling or upsetting to the child
- watch the news with your child
- ask the child what he/she has heard and what questions he/she may have
- provide reassurance regarding his/her own safety in simple words emphasizing that you are going to be there to keep him/her safe
- look for signs that the news may have triggered fears or anxieties such as sleeplessness, fears, bedwetting, crying, or talking about being afraid

Parents should remember that it is important to talk to the child or adolescent about what he/she has seen or heard. This allows parents to lessen the potential negative effects of the news and to discuss their own ideas and values. While children cannot be completely protected from outside events, parents can help them feel safe and help them to better understand the world around them.

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 68 March 2011

Tobacco and Kids

Children's addiction to nicotine from cigarette smoking, smokeless tobacco (chew), and cigars is a major public health problem.

The *Facts* about teen smoking:

- Approximately 4.5 million U.S. teenagers smoke.
- Approximately 3,000 teenagers start smoking every day and one-third of them will die prematurely of a smoking related disease (American Cancer Society).
- High school students who smoke cigarettes are more likely to take risks such as ignoring seat belts, getting into physical fights, carrying weapons, and having sex at an earlier age.
- Tobacco is considered to be a "gateway drug" which may lead to alcohol, marijuana, and other illegal drug use.
- Most adult smokers started smoking before the age of 18.
- Tobacco use continues to be the most common cause of preventable disease and death in the United States.
- Cigarette smoking and tobacco use are associated with many forms of cancer.
- Smoking is the main cause of lung and heart disease.
- Smoking worsens existing medical problems, such as asthma, high blood pressure and diabetes.
- The earlier a person starts smoking, the greater the risk to his or her health and the harder it is to quit.

Children at MOST risk for Tobacco use:

- have parents, siblings, or friends who smoke
- exhibit characteristics such as toughness and acting grown up
- deny the harmful effects of tobacco
- have fewer coping skills and smoke to alleviate stress
- have poor self esteem and depression
- have poor academic performance, especially girls
- are very influenced by advertisements that relate cigarette smoking to being thin and/or suffer from eating disorders

What Parents can do to prevent Tobacco use:

- Parents are role models. If you smoke, quit. If you have not quit, do not smoke in front of your children and tell them you regret that you started.
- Do not allow smoking in your home and strictly enforce your No Smoking rule.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Ask whether tobacco is discussed in school.
- Ask about tobacco use by friends; compliment children who do not smoke.
- Do not allow your children to handle smoking materials.
- Do not allow your children to play with candy cigarettes. They are symbols of real cigarettes, and young children who use them may be more likely to smoke.
- Support school and community anti-smoking efforts and tell school officials you expect them to enforce no smoking policies.
- Make tobacco less readily available to children and teens -- support higher taxes on tobacco, licensing of vendors, and bans on unattended vending machines.
- Discuss with your children the false and misleading images used in advertising and movies which portray smoking as glamorous, healthy, sexy, and mature.
- Emphasize the short-term negative effects such as bad breath, yellowed fingers, smelly clothes, shortness of breath, and decreased performance in sports.
- Emphasize that nicotine is addictive.
- Help children to say "No" to tobacco by role playing situations in which tobacco is offered by peers.

If your child or teen has already begun to use tobacco, the following steps can help him or her to stop:

- Advise him/her to stop. Be non-confrontational, supportive, and respectful.
- Assist his/her efforts to quit and express your desire to help.
- Provide educational materials.
- Help your youngster identify personally relevant reasons to quit.
- If you smoke, agree to quit with your child and negotiate a quit date.
- Enlist the child's pediatrician or family physician to help the child stop smoking.
- If the child is abusing other drugs and/or alcohol or there are problems with mood or other disorders, evaluation by a child and adolescent psychiatrist or other mental health professional may be indicated.

For additional information see ***Facts for Families:***
#2 Teenagers with Eating Disorders
#3 Teens: Alcohol and Other Drugs
#4 The Depressed Child
#6 Children Who Can't Pay Attention
#33 Conduct Disorder
#66 Managing Stress

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 69 March 2011

Asperger's Disorder

Asperger's Disorder is the term for a specific type of pervasive developmental disorder which is characterized by problems in development of social skills and behavior. In the past, many children with Asperger's Disorder were diagnosed as having autism, another of the pervasive developmental disorders, or other disorders. While autism and Asperger's have certain similarities, there are also important differences. For this reason, children suspected of having these conditions require careful evaluation.

In general, a child with Asperger's Disorder functions at a higher level than the typical child with autism. For example, many children with Asperger's Disorder have normal intelligence. While most children with autism fail to develop language or have language delays, children with Asperger's Disorder are usually using words by the age of two, although their speech patterns may be somewhat odd.

Most children with Asperger's Disorder have difficulty interacting with their peers. They tend to be loners and may display eccentric behaviors. A child with Asperger's, for example, may spend hours each day preoccupied with counting cars passing on the street or watching only the weather channel on television. Coordination difficulties are also common with this disorder. These children often have special educational needs.

Although the cause of Asperger's Disorder is not yet known, current research suggests that a tendency toward the condition may run in families. Children with Asperger's Disorder are also at risk for other psychiatric problems including depression, attention deficit disorder, schizophrenia, and obsessive-compulsive disorder.

Child and adolescent psychiatrists have the training and expertise to evaluate pervasive developmental disorders like autism and Asperger's Disorder. They can also work with families to design appropriate and effective treatment programs. Currently, the most effective treatment involves a combination of psychotherapy, special education, behavior modification, and support for families. Some children with Asperger's Disorder will also benefit from medication.

The outcome for children with Asperger's Disorder is generally more promising than for those with autism. Due to their higher level of intellectual functioning, many of these children successfully finish high school and attend college. Although problems with social interaction and awareness persist, they can also develop lasting relationships with family and friends.

See additional ***Facts for Families***:
#4 The Depressed Child

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

#6 Children Who Can't Pay Attention
#11 The Autistic Child
#23 Mental Retardation
#16 Learning Disabilities
#49 Schizophrenia in Children
#60 Obsessive-Compulsive Disorder in Children and Adolescents
#00 Definition of a Child and Adolescent Psychiatrist

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 70 March 2011

Posttraumatic Stress Disorder (PTSD)

All children and adolescents experience stressful events which can affect them both emotionally and physically. Their reactions to stress are usually brief, and they recover without further problems. A child or adolescent who experiences a catastrophic event may develop ongoing difficulties known as posttraumatic stress disorder (PTSD). The stressful or traumatic event involves a situation where someone's life has been threatened or severe injury has occurred (ex. they may be the victim or a witness of physical abuse, sexual abuse, violence in the home or in the community, automobile accidents, natural disasters (such as flood, fire, earthquakes), and being diagnosed with a life threatening illness). A child's risk of developing PTSD is related to the seriousness of the trauma, whether the trauma is repeated, the child's proximity to the trauma, and his/her relationship to the victim(s).

Following the trauma, children may initially show agitated or confused behavior. They also may show intense fear, helplessness, anger, sadness, horror or denial. Children who experience repeated trauma may develop a kind of emotional numbing to deaden or block the pain and trauma. This is called ***dissociation***. Children with PTSD avoid situations or places that remind them of the trauma. They may also become less responsive emotionally, depressed, withdrawn, and more detached from their feelings.

A child with PTSD may also re-experience the traumatic event by:

- having frequent memories of the event, or in young children, play in which some or all of the trauma is repeated over and over
- having upsetting and frightening dreams
- acting or feeling like the experience is happening again
- developing repeated physical or emotional symptoms when the child is reminded of the event

Children with PTSD may also show the following symptoms:

- worry about dying at an early age
- losing interest in activities
- having physical symptoms such as headaches and stomachaches
- showing more sudden and extreme emotional reactions
- having problems falling or staying asleep
- showing irritability or angry outbursts
- having problems concentrating
- acting younger than their age (for example, clingy or whiny behavior, thumbsucking)

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- showing increased alertness to the environment
- repeating behavior that reminds them of the trauma

The symptoms of PTSD may last from several months to many years. The best approach is prevention of the trauma. Once the trauma has occurred, however, early intervention is essential. Support from parents, school, and peers is important. Emphasis needs to be placed upon establishing a feeling of safety. Psychotherapy (individual, group, or family) which allows the child to speak, draw, play, or write about the event is helpful. Behavior modification techniques and cognitive therapy may help reduce fears and worries. Medication may also be useful to deal with agitation, anxiety, or depression.

Child and adolescent psychiatrists can be very helpful in diagnosing and treating children with PTSD. With the sensitivity and support of families and professionals, youngsters with PTSD can learn to cope with the memories of the trauma and go on to lead healthy and productive lives.

For additional information see Facts for Families:
#4 The Depressed Child
#5 Child Abuse: The Hidden Bruises
#28 Responding to Child Sexual Abuse
#36 Helping Children After a Disaster
#47 The Anxious Child

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 71 March 2011

Multiracial Children

Multiracial children are one of the fastest growing segments of the U.S. population. The number of mixed-race families in America is steadily increasing, due to a rise in interracial marriages and relationships, as well as an increase in transracial and international adoptions. Publicity surrounding prominent Americans of mixed cultural heritage, such as athletes, actors, musicians, and politicians, has highlighted the issues of multicultural individuals and challenged long-standing views of race. However, despite some changes in laws and evolving social attitudes, multiracial children still face significant challenges.

Changing Times

- About two million American children have parents of different races.
- In the United States marriages between blacks and whites increased 400 percent in the last 30 years, with a 1000 percent increase in marriages between whites and Asians.
- In a recent survey, 47% of white teens, 60 % of black teens, and 90 % of Hispanic teens said they had dated someone of another race.

Emotional Needs of Multiracial Children

- Recent research has shown that multiracial children **do not** differ from other children in self-esteem, comfort with themselves, or number of psychiatric problems. Also, they tend to be high achievers with a strong sense of self and tolerance of diversity.
- Children in a multiracial family may have different racial identities from one another. Their racial identity is influenced by their individual physical features, family attachments and support, and experiences with racial groups.
- To cope with society biases, mixed-race children may develop a public identity with the "minority" race, while maintaining a private interracial identity with family and friends.
- Research has shown that children with a true multiracial or multicultural identity generally grow up to be happier than multiracial children who grow up with a "single-race" identity.
- Multiracial children in divorced families may have greater difficulties accepting and valuing the cultures of both parents.

The Role of Parents

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Some interracial families face discrimination in their communities. Some children from multiracial families report teasing, whispers, and stares when with their family.

Parents can help their children cope with these pressures by establishing open communication in the family about race and cultures, and by allowing curiosity about differences in skin color, hair texture, and facial features among family members. Parents can also help their children in the following ways:

- Assist children with developing coping skills to handle questions and/or biases about their background. Help children deal with racism without feeling personally assaulted.
- Encourage and support a multicultural life for the whole family, including becoming familiar with language, traditions, and customs of all family members. Live in a diverse community where the sense of being different or unacceptable is minimized.
- Understand that children may have feelings of guilt or disloyalty to a parent if they choose to adopt the racial identity and/or culture of one parent. Recognize that children may identify with different parts of their heritage at different stages of development or in varied settings in order to "fit in."
- Locate books, textbooks, and movies that portray multiracial individuals as positive role models, as well as books about the lives of multicultural families.
- Establish support networks for your child from the school, grandparents, relatives, neighbors, and the greater community.

For the majority of multiracial children, growing up associated with multiple races and cultures is enriching, rewarding, and contributes to healthy adult adjustment. Some multiracial children may be uncomfortable with their diverse heritages and may benefit from supportive counseling to help them clarify their feelings. Multiracial children who have emotional or behavioral problems may be referred for a psychiatric evaluation.

For additional information see ***Facts for Families***:
#57 Normal Adolescence: Part I
#58 Normal Adolescence: Part II
#15 Adopted Child
#64 Foster Care

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 72 July 2013

Children with Oppositional Defiant Disorder

All children are oppositional from time to time, particularly when tired, hungry, stressed or upset. They may argue, talk back, disobey, and defy parents, teachers, and other adults. Oppositional behavior is often a normal part of development for two to three year olds and early adolescents. However, openly uncooperative and hostile behavior becomes a serious concern when it is so frequent and consistent that it stands out when compared with other children of the same age and developmental level and when it affects the child's social, family and academic life.

In children with Oppositional Defiant Disorder (ODD), there is an ongoing pattern of uncooperative, defiant, and hostile behavior toward authority figures that seriously interferes with the youngster's day to day functioning. Symptoms of ODD may include:

- Frequent temper tantrums
- Excessive arguing with adults
- Often questioning rules
- Active defiance and refusal to comply with adult requests and rules
- Deliberate attempts to annoy or upset people
- Blaming others for his or her mistakes or misbehavior
- Often being touchy or easily annoyed by others
- Frequent anger and resentment
- Mean and hateful talking when upset
- Spiteful attitude and revenge seeking

The symptoms are usually seen in multiple settings, but may be more noticeable at home or at school. One to sixteen percent of all school-age children and adolescents have ODD. The causes of ODD are unknown, but many parents report that their child with ODD was more rigid and demanding that the child's siblings from an early age. Biological, psychological and social factors may have a role.

A child presenting with ODD symptoms should have a comprehensive evaluation. It is important to look for other disorders which may be present; such as, attention-deficit hyperactivity disorder (ADHD), learning disabilities, mood disorders (depression, bipolar disorder) and anxiety disorders. It may be difficult to improve the symptoms of ODD without treating the coexisting disorder. Some children with ODD may go on to develop conduct disorder.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Treatment of ODD may include: Parent Management Training Programs to help parents and others manage the child's behavior. Individual Psychotherapy to develop more effective anger management. Family Psychotherapy to improve communication and mutual understanding. Cognitive Problem-Solving Skills Training and Therapies to assist with problem solving and decrease negativity. Social Skills Training to increase flexibility and improve social skills and frustration tolerance with peers.

Medication may be helpful in controlling some of the more distressing symptoms of ODD as well as the symptoms related to coexistent conditions such as ADHD, anxiety and mood disorders.

A child with ODD can be very difficult for parents. These parents need support and understanding. Parents can help their child with ODD in the following ways:

- Always build on the positives, give the child praise and positive reinforcement when he shows flexibility or cooperation.
- Take a time-out or break if you are about to make the conflict with your child worse, not better. This is good modeling for your child. Support your child if he decides to take a time-out to prevent overreacting.
- Pick your battles. Since the child with ODD has trouble avoiding power struggles, prioritize the things you want your child to do. If you give your child a time-out in his room for misbehavior, don't add time for arguing. Say "your time will start when you go to your room."
- Set up reasonable, age appropriate limits with consequences that can be enforced consistently.
- Maintain interests other than your child with ODD, so that managing your child doesn't take all your time and energy. Try to work with and obtain support from the other adults (teachers, coaches, and spouse) dealing with your child.
- Manage your own stress with healthy life choices such as exercise and relaxation. Use respite care and other breaks as needed

Many children with ODD will respond to the positive parenting techniques. Parents may ask their pediatrician or family physician to refer them to a child and adolescent psychiatrist or qualified mental health professional who can diagnose and treat ODD and any coexisting psychiatric condition.

See also:
Oppositional Defiant Disorder Resource Center

This resource center offers a definition of the disorder, answers to frequently asked questions, and information on getting help.

For additional information see other ***Facts for Families***:
#6 Children Who Can't Pay Attention/ADHD
#16 Learning Disabilities
#4 The Depressed Child

#38 Manic-Depressive Illness in Teens
#52 Comprehensive Psychiatric Evaluation
#33 Conduct Disorder
#65 Children's Threats
#66 Helping Teenagers with Stress
#00 Definition of a Child and Adolescent Psychiatrist

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 73 July 2013

Self-Injury in Adolescents

Self-injury is the act of deliberately destroying body tissue, at times to change a way of feeling. Self-injury is seen differently by groups and cultures within society. This appears to have become more popular lately, especially in adolescents. The causes and severity of self-injury can vary. Some forms may include:

- carving
- scratching
- branding
- marking
- picking, and pulling skin and hair
- burning/abrasions
- cutting
- biting
- head banging
- bruising
- hitting
- tattooing
- excessive body piercing

Some adolescents may self-mutilate to take risks, rebel, reject their parents' values, state their individuality or merely be accepted. Others, however, may injure themselves out of desperation or anger to seek attention, to show their hopelessness and worthlessness, or because they have suicidal thoughts. These children may suffer from serious psychiatric problems such as depression, psychosis, Posttraumatic Stress Disorder (PTSD) and Bipolar Disorder. Additionally, some adolescents who engage in self-injury may develop Borderline Personality Disorder as adults. Some young children may resort to self-injurious acts from time to time but often grow out of it. Children with mental retardation and/or autism as well as children who have been abused or abandoned may also show these behaviors.

Why do adolescents self-injure?

Self-injury is a complex behavior and symptom that results from a variety of factors. Adolescents who have difficulty talking about their feelings may show their emotional tension, physical discomfort, pain and low self-esteem with self-injurious behaviors. Although some teenagers may feel like the steam in the pressure cooker has been released following the act of harming themselves, others may feel hurt, anger, fear and hate. The effects of peer pressure and contagion can also influence adolescents to injure themselves. Even though fads come and go, most of the wounds on the adolescents' skin

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

will be permanent. Occasionally, teenagers may hide their scars, burns and bruises due to feeling embarrassed, rejected or criticized about their physical appearance.

What can parents and teenagers do about self-injury?
Parents are encouraged to talk with their children about respecting and valuing their bodies. Parents should also serve as role models for their teenagers by not engaging in acts of self-harm. Some helpful ways for adolescents to avoid hurting themselves include learning to:

- accept reality and find ways to make the present moment more tolerable.
- identify feelings and talk them out rather than acting on them.
- distract themselves from feelings of self-harm (for example, counting to ten, waiting 15 minutes, saying "NO!" or "STOP!," practicing breathing exercises, journaling, drawing, thinking about positive images, using ice and rubber bands)
- stop, think, and evaluate the pros and cons of self-injury.
- soothe themselves in a positive, non-injurious, way.
- practice positive stress management.
- develop better social skills.

Evaluation by a mental health professional may assist in identifying and treating the underlying causes of self-injury. Feelings of wanting to die or kill themselves are reasons for adolescents to seek professional care emergency. A child and adolescent psychiatrist can also diagnose and treat the serious psychiatric disorders that may accompany self-injurious behavior.

For additional information see ***Facts for Families***:
#4 Depression
#38 Manic Depressive Illness
#70 PTSD
#52 Comprehensive Psychiatric Evaluation
#66 Helping Teenagers with Stress
#5 Child Abuse
#10 Teen Suicide

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

website (www.aacap.org). ***Facts*** sheets may not be reproduced, duplicated or posted on any other website without written consent from AACAP. Organizations are permitted to create links to AACAP's website and specific ***Facts*** sheets. For all questions please contact the AACAP Communications & Marketing Coordinator, ext. 154.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 74 March 2011

Advocating for Your Child

According to *Mental Health: A Report of the Surgeon General (1999),* 1 in 5 will experience signs and symptoms of a psychiatric disorder during the course of the year. Some nine million children have serious emotional problems at any point in time. Yet, only 1 in 5 of these children are receiving appropriate treatment. When parents or teachers suspect that a child may have an emotional problem, they should seek a comprehensive evaluation by a mental health professional specifically trained to work with children and adolescents.

Signs and symptoms of childhood and adolescent emotional problems may include:

- School problems
- Frequent fighting
- Trouble sleeping
- Feeling sad
- Thoughts about suicide or running away
- Excessive weight loss or gain
- Troubling or disturbing thoughts
- Use of drugs or alcohol
- Withdraw or isolation
- Injuring or killing animals
- Stealing or lying
- Mood swings
- Setting fires
- Obsessive thoughts or compulsive behaviors
- Dangerous or self destructive behavior
- Trouble paying attention
- Anxiety or frequent worries

Throughout the evaluation process, parents should be directly involved and ask many questions. It's important to make sure you understand the results of the evaluation, your child's diagnosis, and the full range of treatment options. If parents are not comfortable with a particular clinician, treatment option, or are confused about specific recommendations, they should consider a second opinion.

Before a child begins treatment, parents may also want to ask the following:

- What are the recommended treatment options for my child?
- How will I be involved with my child's treatment?
- How will we know if the treatment is working?

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- How long should it take before I see improvement?
- Does my child need medication?
- What should I do if the problems get worse?
- What are the arrangements if I need to reach you after-hours or in an emergency?

You may also need to advocate to have your child seen in a timely way, by the most appropriate clinician. Most insurance plans now include some form of managed care, which may utilize provider panels with few mental health professionals. However, many states now have laws concerning reasonable access to specialists. If you have problems or questions, try calling the Department of Insurance, the Patient Ombudsman/Advocate, or the Department of Consumer Affairs at your insurance company.

Ongoing parental involvement and support are essential to the overall success of treatment. Depending on the nature of your child's problems, it may also be important to involve the school, community agencies, and/or juvenile justice system. In addition, it may be helpful to learn how to access other support services such as respite, parent skill building, or home-based programs. Local advocacy groups can also provide valuable information, experience and support for parents.

Although serious emotional problems are common in childhood and adolescence, they are also highly treatable. By advocating for early identification, comprehensive evaluation and appropriate intervention, parents can make sure their children get the help they need, and reduce the risk of long term emotional difficulties.

For additional information see ***Facts for Families***:
#00 Definition of a Child and Adolescent Psychiatrist
#24 Know When to Seek Help for Your Child
#25 Know Where to Seek Help for Your Child
#26 Know Your Health Insurance Benefits
#52 Comprehensive Psychiatric Evaluation.

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 75 May 2008

Pets and Children

Pets are part of many children's lives. Parental involvement, open discussion, and planning are necessary to help make pet ownership a positive experience for everyone. A child who learns to care for an animal, and treat it kindly and patiently, may get invaluable training in learning to treat people the same way. Careless treatment of animals is unhealthy for both the pet and the child involved.

Choosing an Appropriate Pet

While all kinds of pets can bring children pleasure, it is important to choose a pet that is right for your family, your home, and your lifestyle; and one that your child can help care for. Parents should be cautious about having aggressive animals as pets. Exotic and unusual animals may be difficult to care for and should be considered very carefully.

Caring for a Pet

Taking care of a pet can help children develop social skills. However, certain guidelines apply:

- Since very young children (under the age of 3-4 years) do not have the maturity to control their aggressive and angry impulses, they should be monitored with pets at all times.
- Young children (under 10 years) are unable to care for a large animal, a cat or a dog, on their own.
- Parents must oversee the pet's care even if they believe their child is old enough to care for a pet.
- If children become lax in caring for a pet, parents may have to take over the responsibility on their own.
- Children should be reminded in a gentle, not scolding way, that animals, like people, need food, water, and exercise.
- If a child continues to neglect a pet, a new home may have to be found for the animal.
- Parents serve as role models. Children learn responsible pet ownership by observing their parents' behavior.

Advantages of Pet Ownership

Children raised with pets show many benefits. Developing positive feelings about pets can contribute to a child's self-esteem and self-confidence. Positive relationships with pets can aid in the development of trusting relationships with others. A good relationship

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

with a pet can also help in developing non-verbal communication, compassion, and empathy. Pets can serve different purposes for children:

- They can be safe recipients of secrets and private thoughts--children often talk to their pets, like they do their stuffed animals.
- They provide lessons about life; reproduction, birth, illnesses, accidents, death, and bereavement.
- They can help develop responsible behavior in the children who care for them.
- They provide a connection to nature.
- They can teach respect for other living things.

Other physical and emotional needs fulfilled by pet ownership include:

- Physical activity
- Comfort contact
- Love, loyalty, and affection
- Experience with loss if a pet is lost or dies.

Although most children are gentle and appropriate with pets, some may be overly rough or even abusive. If such behavior persists, it may be a sign of significant emotional problems. Any child who abuses, tortures or kills animals should be referred to a child and adolescent psychiatrist for a comprehensive evaluation.

For more information see ***Facts for Families:***
#24 Know When to Seek Help for Your Child
#25 Know Where to Seek Help for Your Child
#52 Comprehensive Psychiatric Evaluation

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

Pets and Children, “Facts for Families,” No. 75 (05/08)

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 76 March 2011

Helping Your Teen Become a Safe Driver

A driver's license is one of the biggest status symbols among high school students. Getting a driver's license is not only a social asset but it makes the adolescent feel more independent than ever before. Parents no longer have to do the driving - the teen can get places on his or her own. Most teens count the hours and days until they can get their learners permit (usually age 16) and take their driving test to demonstrate driving competence. Some teens however, may be pushed to drive by peer or parental pressures before they feel ready. Parents often have many concerns and fear for their teen's safety on the road.

According to the American Automobile Association (AAA), teenage drivers account for only 7% of the driving population but are involved in 14% of fatal crashes. Traffic crashes are the #1 cause of death and injury for people ages 15-19. In 2006 4,800 teens died in motor vehicle collisions. Problems which contribute to the high crash rate of young drivers include: driving inexperience, lack of adequate driving skills, risk taking, poor driving judgement and decision making, distraction, alcohol consumption and excessive driving during high risk hours (11PM-5AM).

Learning to Drive (Learner's Permit)

When a teenager obtains a learner's permit they can start learning to drive with an adult present in the car to supervise and teach. In most cases the best way for teens to learn to drive is through a driver's education class. These classes are often sponsored by schools. In many states, completing a driver's education course results in reduction of the teen's automobile insurance costs. Private driving instruction is another alternative. AAA offers a training program (available on video or CD-ROM) "Teaching Your Teens to Drive: A Partnership for Survival". One teenager has even developed a website specifically for teens learning to drive (Teen New Driver Homepage - www.teendriving.com). Parents are in a unique position to show their children proper driving skills and to teach proper driving choices. Teen drivers need to get as much driving experience as possible after they obtain their learner's permit. Additional driving experience generally makes the teen a safer driver and eases the transition to driving independently. However, not all parents have the temperament to teach driving. Parents who find themselves yelling, making sarcastic remarks or being upsetting to the teen should ask their spouse, another relative or friend to help out.

The Driver' License (Driving Independently)

When teens pass the official driving test they receive their driver' license and can legally drive independently (some states have restrictions on 17 year old drivers). Parents, however, should not allow their teen to drive independently until the teen has sufficient experience and the parents are comfortable with the teen's level of driving skill. Parents

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

should talk candidly with their teen about the dangers and risks of distractions such as music from radio/CD/MP3 player, passengers, eating food and using cell phones. Parents should also discuss and demonstrate the importance of controlling emotions while driving (e.g. "road rage", drag racing, etc.). Teens should also be taught about the importance of defensive driving. Inexperienced drivers often concentrate on driving correctly and fail to anticipate the actions and mistakes or errors of other drivers. If the teen is taking medications (prescription or over-the-counter) or has any medical illnesses, parents should check with their family physician about possible effects on the teen's driving ability.

Parents should make sure that the vehicle their teen drives is in safe condition (brakes, tires, etc.) and working properly. The vehicle should have essential emergency equipment (flares, flashlight, jumper cables, etc.) and the teen should know how to use it. A cell phone is helpful for emergencies but parents must stress that it can be a dangerous distraction if it is used while driving.

Concern about the number of young people killed or injured in traffic crashes has prompted state legislation to reform the way teenagers are licensed to drive. A majority of states have adopted the Graduated Driver Licensing (GDL) system with varying state requirements. Recommended by the AAA, the GDL has teens earn driving privileges in a three-stage process: learner's permit at age 16, a probationary license after 6 months and an unrestricted driver's license at age 18.

Even though the driver's license allows the teen to drive independently, it is important that parents establish clear rules for safe and responsible driving and rules for the use of the car.

Rules for New Drivers

Rules for parents to consider when teens begin driving independently include:

- Parents should not allow young drivers unrestricted driving privileges until they have gained sufficient experience.
- Parents should limit their teen's driving alone in adverse weather conditions (rain, snow, ice, fog. etc.) and at night until the teen has sufficient skills and experience.
- Driving under the influence of alcohol or drugs is illegal and dangerous and should be strictly prohibited.
- Parents should work out when and where the teen is allowed to drive the car (e.g. to and from part-time job, etc.).
- Everyone in the car must wear seat belts at all times.
- Parents should determine whether and when their teen can drive passengers. Some states have established a law that no passengers are allowed in the car until the teen has logged a defined period of safe independent driving
- Parents should determine what behavior or circumstances will result in loss of the teen's driving privileges.
- Teens should not drive when fatigued or tired.
- Headphones should never be worn while driving.

- Teens should not text or talk on the phone while driving.
- Helmets must be worn when riding a motorcycle.
- Teens should be encouraged to take an annual defensive driving course after obtaining their license.

Supervised behind-the-wheel driving experience is the key to developing necessary habits and skills for safe driving. Parents need to work with their teens to help them gain the needed experience and judgement.

Additional/related Facts for Families:
#3 Teens: Alcohol and Other Drugs
#66 Helping Teenagers with Stress
#58 Normal Adolescent Development

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 77 March 2011

Grandparents Raising Grandchildren

Grandparents are an important resource for both parents and children. They routinely provide child care, financial assistance and emotional support. Occasionally they are called upon to provide much more including temporary or full time care and responsibility for their grandchildren.

An increasing number of children in the United States live in households headed by a grandparent. This trend is due to:

- increasing numbers of single parent families
- the high rate of divorce
- teenage pregnancies
- incarcerations of parents
- substance abuse by parents
- illness, disability or death of parents
- parental abuse or neglect

In many of these homes, neither of the child's biological parents is present. In most cases, children taken care of by grandparents move in with them as infants or preschoolers and remain with them for five years or more. These grandparents are a diverse group ranging in ages from their thirties to their seventies. Many grandparents are ready to simplify their lives and slow down. Giving that up and taking over the responsibilities of being a primary caregiver again can stir up many feelings including grief, anger, loss, resentment and possibly guilt. The transition can be very stressful and the emotional and financial burdens can be significant. Culture shock at having to deal with children and adolescents of a different generation can be great. Grandparent headed households have a significantly higher poverty rate than other kinds of family units.

Many grandparents in this care taking role underestimate or are unaware of the added burdens their new role as "parents" will place upon them. Grandparents often assume their role will be to nurture and reward children without having to set limits. When grandparents serve as primary caregivers, however, they must learn to set limits and establish controls as they did with their own children.

Many children living with grandparents arrive with preexisting problems or risk factors including abuse, neglect, prenatal exposure to drugs and alcohol, or loss of parents (due to death, abandonment or incarceration). This situation can create risks for both children and grandparents. Caring for your grandchild can also be very positive and rewarding. Grandparents bring the benefit of experience and perspective. They can also provide important stability and predictability for their grandchildren.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

It is very important for grandparents to receive support and assistance. Seeking out other family members, clergy, support groups and social agencies can be helpful. The Grandparents Information Center (sponsored by the American Association of Retired Persons) is a good place to get information, referrals and support. Financial aid may be available especially if the child was abandoned, neglected or abused. Mental health professionals including child and adolescent psychiatrists, community mental health centers, child welfare agencies and parent-teacher associations are other important resources for the grandparents.

Child and adolescent psychiatrists recognize the important role many grandparents play in raising their grandchildren. The better grandparents are able to meet their own needs, the better they can care for their grandchildren.

For additional information see ***Facts for Families:***
#1 Children and Divorce
#15 The Adopted Child
#64 Foster Care
#74 Advocating for Your Child

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 78 March 2011

When a Pet Dies

For many children, their first real experience with loss occurs when a pet dies. When a pet dies, children need consolation, love, support, and affection more than they need complicated medical or scientific explanations. Children's reactions to the death of a pet will depend upon their age and developmental level. Children 3 to 5 years of age see death as temporary and potentially reversible. Between ages 6 and 8, children begin to develop a more realistic understanding of the nature and consequences of death. Generally, it is not until 9 years of age that children fully understand that death is permanent and final. For this reason, very young children should be told that when a pet dies, it stops moving, doesn't see or hear anymore, and won't wake up again. They may need to have this explanation repeated several times.

There are many ways parents can tell their children that a pet has died. It is often helpful to make children as comfortable as possible (use a soothing voice, hold their hand or put an arm around them) and to tell them in a familiar setting. It is also important to be honest when telling children that a pet has died. Trying to protect children with vague or inaccurate explanations can create anxiety, confusion, and mistrust.

Children often have questions after a pet dies, including: Why did my pet die? Is it my fault? Where does my pet's body go? Will I ever see my pet again? If I wish hard and am really good can I make my pet come back? Does death last forever? It is important to answer such questions simply, but honestly, using terms and concepts the child understands.
Children may experience sadness, anger, fear, denial, and guilt when their pet dies. They may also be jealous of friends with pets.

When a pet is sick or dying, spend time talking with your child about his/her feelings. If possible, it is helpful to have the child say goodbye before the pet dies. Parents can serve as models by sharing their feelings with their children. Let your child know it is normal to miss pets after they die and encourage the youngster to come to you with questions or for reassurance and comfort.

There is no best way for children to mourn their pets. They need to be given time to remember their pets. It helps to talk about the pet with friends and family. Mourning a pet has to be done in a child's own way. After a pet has died, children may want to bury the pet, make a memorial, or have a ceremony. Other children may write poems and stories, or make drawings of the pet. It is usually best not to immediately replace the pet that has died.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

The death of a pet may cause a child to remember other painful losses, or upsetting events. A child who appears to be overwhelmed by their grief and not able to function in their normal routine may benefit from an evaluation by a child and adolescent psychiatrist or other qualified mental health professional.

For more information see *Facts for Families:*
#08 Children and Grief
#74 Children and Pets
#4 The Depressed Child

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 79 March 2011

Obesity in Children and Teens

The problem of childhood obesity in the United States has grown considerably in recent years. Between 16 and 33 percent of children and adolescents are obese. Obesity is among the easiest medical conditions to recognize but most difficult to treat. Unhealthy weight gain due to poor diet and lack of exercise is responsible for over 300,000 deaths each year. The annual cost to society for obesity is estimated at nearly $100 billion. Overweight children are much more likely to become overweight adults unless they adopt and maintain healthier patterns of eating and exercise.

What is obesity?

A few extra pounds do not suggest obesity. However they may indicate a tendency to gain weight easily and a need for changes in diet and/or exercise. Generally, a child is not considered obese until the weight is at least 10 percent higher than what is recommended for their height and body type. Obesity most commonly begins between the ages of 5 and 6, or during adolescence. Studies have shown that a child who is obese between the ages of 10 and 13 has an 80 percent chance of becoming an obese adult.

What causes obesity?

The causes of obesity are complex and include genetic, biological, behavioral and cultural factors. Obesity occurs when a person eats more calories than the body burns up. If one parent is obese, there is a 50 percent chance that their children will also be obese. However, when both parents are obese, their children have an 80 percent chance of being obese. Although certain medical disorders can cause obesity, less than 1 percent of all obesity is caused by physical problems. Obesity in childhood and adolescence can be related to:

- poor eating habits
- overeating or binging
- lack of exercise (i.e., couch potato kids)
- family history of obesity
- medical illnesses (endocrine, neurological problems)
- medications (steroids, some psychiatric medications)
- stressful life events or changes (separations, divorce, moves, deaths, abuse)
- family and peer problems
- low self-esteem
- depression or other emotional problems

What are risks and complications of obesity?

There are many risks and complications with obesity. Physical consequences include:

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- increased risk of heart disease
- high blood pressure
- diabetes
- breathing problems
- trouble sleeping

Child and adolescent obesity is also associated with increased risk of emotional problems. Teens with weight problems tend to have much lower self-esteem and be less popular with their peers. Depression, anxiety, and obsessive compulsive disorder can also occur.

How can obesity be managed and treated?

Obese children need a thorough medical evaluation by a pediatrician or family physician to consider the possibility of a physical cause. In the absence of a physical disorder, the only way to lose weight is to reduce the number of calories being eaten and to increase the level of physical activity. Lasting weight loss can only occur when there is self-motivation. Since obesity often affects more than one family member, making healthy eating and regular exercise a family activity can improve the chances of successful weight control for the child or adolescent.

Ways to manage obesity in children and adolescents include:

- start a weight-management program
- change eating habits (eat slowly, develop a routine)
- plan meals and make better food selections (eat less fatty foods, avoid junk and fast foods)
- control portions and consume less calories
- increase physical activity (especially walking) and have a more active lifestyle
- know what your child eats at school
- eat meals as a family instead of while watching television or at the computer
- do not use food as a reward
- limit snacking
- attend a support group (e.g., Overeaters Anonymous)

Obesity frequently becomes a lifelong issue. The reason most obese adolescents gain back their lost pounds is that they tend to go back to their old habits of eating and exercising. An obese adolescent must therefore learn to eat and enjoy healthy foods in moderate amounts and to exercise regularly to maintain a desired weight. Parents of an obese child can improve their child's self-esteem by emphasizing their strengths and positive qualities rather than just focusing on their weight problem.

When a child or adolescent with obesity also has emotional problems, a child and adolescent psychiatrist can work with the child's family physician to develop a comprehensive treatment plan. Such a plan would include reasonable weight loss goals, dietary and physical activity management, behavior modification, and family involvement.

For more information see *Facts for Families:*
#02: Teenagers with Eating Disorders
#04: The Depressed Child
#54: Children and Watching TV
#61: Children and Sports
#66: Helping Teenagers with Stress

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 80 March 2011

Bullying

Bullying is a common experience for many children and adolescents. Surveys indicate that as many as half of all children are bullied at some time during their school years, and at least 10% are bullied on a regular basis.

Bullying behavior can be physical or verbal. Boys tend to use physical intimidation or threats, regardless of the gender of their victims. Bullying by girls is more often verbal, usually with another girl as the target. Bullying has even been reported in online chat rooms, through e-mail and on social networking sites.

Children who are bullied experience real suffering that can interfere with their social and emotional development, as well as their school performance. Some victims of bullying have even attempted suicide rather than continue to endure such harassment and punishment.

Children and adolescents who bully thrive on controlling or dominating others. They have often been the victims of physical abuse or bullying themselves. Bullies may also be depressed, angry or upset about events at school or at home. Children targeted by bullies also tend to fit a particular profile. Bullies often choose children who are passive, easily intimidated, or have few friends. Victims may also be smaller or younger, and have a harder time defending themselves.

If you suspect your child is bullying others, it's important to seek help for him or her as soon as possible. Without intervention, bullying can lead to serious academic, social, emotional and legal difficulties. Talk to your child's pediatrician, teacher, principal, school counselor, or family physician. If the bullying continues, a comprehensive evaluation by a child and adolescent psychiatrist or other mental health professional should be arranged. The evaluation can help you and your child understand what is causing the bullying, and help you develop a plan to stop the destructive behavior.

If you suspect your child may be the victim of bullying ask him or her to tell you what's going on. You can help by providing lots of opportunities to talk with you in an open and honest way.

It's also important to respond in a positive and accepting manner. Let your child know it's not his or her fault, and that he or she did the right thing by telling you. Other specific suggestions include the following:

- Ask your child what he or she thinks should be done. What's already been tried? What worked and what didn't?

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Seek help from your child's teacher or the school guidance counselor. Most bullying occurs on playgrounds, in lunchrooms, and bathrooms, on school buses or in unsupervised halls. Ask the school administrators to find out about programs other schools and communities have used to help combat bullying, such as peer mediation, conflict resolution, and anger management training, and increased adult supervision.
- Don't encourage your child to fight back. Instead, suggest that he or she try walking away to avoid the bully, or that they seek help from a teacher, coach, or other adult.
- Help your child practice what to say to the bully so he or she will be prepared the next time.
- Help your child practice being assertive. The simple act of insisting that the bully leave him alone may have a surprising effect. Explain to your child that the bully's true goal is to get a response.
- Encourage your child to be with friends when traveling back and forth from school, during shopping trips, or on other outings. Bullies are less likely to pick on a child in a group.

If your child becomes withdrawn, depressed or reluctant to go to school, or if you see a decline in school performance, additional consultation or intervention may be required. A child and adolescent psychiatrist or other mental health professional can help your child and family and the school develop a strategy to deal with the bullying. Seeking professional assistance earlier can lessen the risk of lasting emotional consequences for your child.

For more information see *Facts for Families:*
#33: Conduct Disorder
#55: Understanding Violent Behavior in Children
#65: Children's Threats
#66: Helping Teenagers with Stress

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 81 March 2011

Fighting and Biting

All people have aggressive feelings. As adults, we learn how to control these feelings. Children, however, are often physically aggressive B they hit, bite and scratch others. These behaviors are fairly common and often appear by the child's first birthday. Parents often struggle over how to manage their child's aggressive and/or destructive behavior.

While some biting can occur during normal development, persistent biting can be a sign that a child has emotional or behavioral problems. While many children occasionally fight with or hit others, frequent and/or severe physical aggression may mean that a child is having serious emotional or behavioral problems that require professional evaluation and intervention. Persistent fighting or biting when a child is in daycare or preschool can be a serious problem. At this age, children have much more contact with peers and are expected to be able to make friends and get along.

BITING

Many children start aggressive biting between one and three years of age. Biting can be a way for a child to test his or her power or to get attention. Some children bite because they are unhappy, anxious or jealous. Sometimes biting may result from excessive or harsh discipline or exposure to physical violence. Parents should remember that children who are teething might also bite. Biting is the most common reason children get expelled from day care.

What to do:

- Say "no", immediately, in a calm but firm and disapproving tone.
- For a toddler (1-2 years), firmly hold the child, or put the child down.
- For a young child (2-3 years) say, "biting is not okay because it hurts people."
- Do NOT bite a child to show how biting feels. This teaches the child aggressive behavior.
- If biting persists, try a negative consequence. For example, do not hold or play with a child for five minutes after he or she bites.

If these techniques or interventions are not effective, parents should talk to their pediatrician or family physician.

FIGHTING AND HITTING

Toddlers and preschool age children often fight over toys. Sometimes children are unintentionally rewarded for aggressive behavior. For example, one child may push

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

another child down and take away a toy. If the child cries and walks away, the aggressive child feels successful since he or she got the toy. It is important to identify whether this pattern is occurring in children who are aggressive.

What to do:

- It is more effective to intervene before a child starts hitting. For example, intervene as soon as you see the child is very frustrated or getting upset.
- When young children fight a lot, supervise them more closely.
- If a child hits another child, immediately separate the children. Then try to comfort and attend to the other child.
- For a toddler (1-2 years) say, "No hitting. Hitting hurts."
- For a young child (2-3 years) say, "I know you are angry, but don't hit. Hitting hurts." This begins to teach empathy to your child.
- Do NOT hit a child if he or she is hitting others. This teaches the child to use aggressive behavior.
- Parents should not ignore or down play fighting between siblings.

When hitting or fighting is frequent, it may be a sign that a child has other problems. For example, he or she may be sad or upset, have problems controlling anger, have witnessed violence or may have been the victim of abuse at day care, school, or home.

Research has shown that children who are physically aggressive at a younger age are more likely to continue this behavior when they are older. Studies have also shown that children who are repeatedly exposed to violence and aggression from TV, videos and movies act more aggressively. If a young child has a persistent problem with fighting, biting or aggressive behavior, parents should seek professional assistance from a child and adolescent psychiatrist or other mental health professional who specializes in the evaluation and treatment of behavior problems in very young children.

For more information, see ***Facts for Families***:
#52 Comprehensive Psychiatric Evaluation
#55 Understanding Violent Behavior in Children
#72 Oppositional Defiant Disorder
#43 Discipline

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 82 March 2011

Starting School

Starting school is a major milestone for children and parents. School is a place away from home where a child will have some of his greatest challenges, successes, failures, and embarrassments. Because school is beyond the control of parents, it can be stressful for both the child and the parents.

At school, a child will learn about how the world works, about appropriate social interactions, and about people outside his family. He will learn about himself, his strengths, weaknesses, interests, and who he is socially. He will have to perform in a way that he never has had to at home. He has to separate from parents, cope with social and academic challenges, and make friends.

Starting school can be both fun and stressful. Many children show some anxiety about school. Anxiety can occur at the beginning of a new school year or when a child changes schools. A child who has been in day care may be more comfortable with the daily ritual of separation. These children may be less anxious for the first few days of nursery school, preschool, or kindergarten.

If parents have mixed feelings (e.g. guilt, fear, or anxiety) about sending a child to school, it can add to the child's hesitancy, or reluctance. A child's experience starting school is influenced by his preparation and his parents' feelings and attitude.

What Parents Can Do To Help Their Child:

- Show interest and be supportive and encouraging.
- Talk to your child about what to expect, such as the activities (nap, snacks, and story-time), the schedule, the toys, and the other children.
- Take your child to school to get used to the layout (where his classroom is, where the bathrooms are, which cubbyhole or coat hook is his, etc.) and to introduce him to the teacher.
- Let your child know it's normal to feel nervous or worried about being away from parents and suggest that he take a familiar object or a family picture to school.
- Getting on the bus with a favorite playmate or carpooling with a friend can ease the daily transition from home to school. Identifying a buddy at school can also help decrease apprehension about being alone in the new setting.
- Make the getting-ready-for-school ritual as stress-free as possible. For example, lay out all his notebooks and clothes the night before. Having the child help with school preparations (example, make his lunch) the night before can also reduce stress for everyone.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

What To Do If Your Child Has Difficulties:

- If your child has significant difficulty with separation, consider staying for a portion of the first day or two. Discuss this plan with the teacher. As he becomes more comfortable, make your stay shorter, until eventually, you stay only long enough to help him off with his coat, greet the teacher, and say goodbye.

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 83 March 2011

Services in School for Children with Special Needs: What Parents Need to Know

Some children experience difficulties in school, ranging from problems with concentration, learning, language, and perception to problems with behavior and/or making and keeping friends. These difficulties may be due to one or more of the following:

- physical disorders,
- psychiatric disorders,
- emotional problems,
- behavioral problems,
- learning disorders (or disabilities).

Children with such special needs are usually entitled to receive additional services or accommodations through the public schools. Federal law mandates that every child receive a free and appropriate education in the least restrictive environment possible. To support their ability to learn in school, three Federal laws apply specifically to children with special needs:

- The Individuals with Disabilities Education Act (IDEA) (1975)
- Section 504 of the Rehabilitation Act of 1973
- The Americans with Disabilities Act (ADA) (1990).

Different states have different criteria for eligibility, services available, and procedures for implementing these laws. It is important for parents to be aware of these laws and related regulations in their particular area.

The Laws

IDEA is a federal law (1975, amended by the Office of Special Education Programs in 1997) that governs all special education services for children in the United States. Under IDEA, in order for a child to be eligible for special education, they must be in one of the following categories:

- serious emotional disturbance
- learning disabilities
- mental retardation

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- traumatic brain injury
- autism
- vision and hearing impairments
- physical disabilities
- other health impairments.

Section 504 is a civil rights statute (1973) that requires that schools not discriminate against children with disabilities and provide them with reasonable accommodations. It covers all programs or activities, whether public or private, that receive any federal financial assistance. Reasonable accommodations include untimed tests, sitting in front of the class, modified homework and the provision of necessary services. Typically, children covered under Section 504 either have less severe disabilities than those covered under IDEA or have disabilities that do not fit within the eligibility categories of IDEA. Under Section 504, any person who has an impairment that substantially limits a major life activity is considered disabled. Learning and social development are included under the list of major life activities.

The ADA (1990) requires all educational institutions, other than those operated by religious organizations, to meet the needs of children with psychiatric disorders. The ADA prohibits the denial of educational services, programs or activities to students with disabilities and prohibits discrimination against all such students.

Evaluation of Your Child

As a parent, you may request an evaluation of your child to determine his or her needs for special education and/or related services. The evaluation may include psychological and educational testing, a speech and language evaluation, occupational therapy assessment and a behavioral analysis. These are the steps you need to take:

1. Meet with your child's teacher to share your concerns and request an evaluation by the school's child study team. Parents can also request independent professional evaluations.
2. Submit your requests in writing for evaluations and services. Always date your requests and keep a copy for your records.
3. Keep careful records, including observations reported by your child's teachers and any communications (notes, reports, letters, etc.) between home and school.

The results of the evaluation determine your child's eligibility to receive a range of services under the applicable law. Following the evaluation, an Individualized Education Program (IEP) is developed. Examples of categories of services in IEPs include: Occupational Therapy, Physical Therapy, Speech and Language Therapy, and/or the provision of a classroom aide.

Parents do not determine whether their child is eligible under the law, however, parents are entitled to participate in the development of the IEP. Additionally, the findings of school's evaluation team are not final. You have the right to appeal their conclusions and

determination. The school is required to provide you with information about how to make an appeal.

What a Parent Can Do

Children with special needs are entitled rights to services in school under federal and state laws. Parents should always advocate for their child and must be proactive and take necessary steps to make sure their child receives appropriate services. The process can be confusing and intimidating for parents. Here are some tips:

- Parents should request copies of their school district's Section 504 plan. This is especially important when a school district refuses services.
- If the school district does not respond to your request, you can contact a U.S. Department of Education Office of Civil Rights Regional Office for assistance.
- If the school district refuses services under the IDEA or Section 504 or both, you may choose to challenge this decision through a due process hearing (a legal hearing in which you and your child have an advocate who can help express your views and concerns).
- It may also be necessary to retain your own attorney if you decide to appeal a school's decision.
- Other resources for parents include: the State Department of Education, Bazelon Center for Health Law at www.bazelon.org.

For additional information see ***Facts for Families:***
#06 Children Who Can't Pay Attention/ADHD
#11 The Child With Autism
#16 Children With Learning Disabilities
#23 Mental Retardation
#69 Asperger's Disorder
#74 Advocating for Your Child

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 84 March 2011

Talking to Kids about Mental Illness

Kids are naturally curious and have questions about mental illnesses. Understanding mental illnesses can be challenging for adults as well as for children. Myths, confusion, and misinformation about mental illnesses cause anxiety, create stereotypes, and promote stigma. During the past 50 years, great advances have been made in the areas of diagnosis and treatment of mental illnesses. Parents can help children understand that these are real illnesses that can be treated.

In order for parents to talk with a child about mental illnesses, they must be knowledgeable and reasonably comfortable with the subject. Parents should have a basic understanding and answers to questions such as, what are mental illnesses, who can get them, what causes them, how are diagnoses made, and what treatments are available. Some parents may have to do a little homework to be better informed.

When explaining to a child about how a mental illness affects a person, it may be helpful to make a comparison to a physical illness. For example, many people get sick with a cold or the flu, but only a few get really sick with something serious like pneumonia. People who have a cold are usually able to do their normal activities. However, if they get pneumonia, they will have to take medicine and may have to go to the hospital. Similarly, feelings of sadness, anxiety, worry, irritability, or sleep problems are common for most people. However, when these feelings get very intense, last for a long period of time and begin to interfere with school, work, and relationships, it may be a sign of a mental illness that requires treatment.

Parents should be aware of their child's needs, concerns, knowledge, and experience with mental illnesses. When talking about mental illnesses, parents should:

- communicate in a straightforward manner
- communicate at a level that is appropriate to a child's age and development level
- have the discussion when the child feels safe and comfortable
- watch their child's reaction during the discussion
- slow down or back up if the child becomes confused or looks upset

Considering these points will help any child to be more relaxed and understand more of the conversation.

Pre-School Age Children

Young children need less information and fewer details because of their more limited ability to understand. Preschool children focus primarily on things they can see, for

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

example, they may have questions about a person who has an unusual physical appearance, or is behaving strangely. They would also be very aware of people who are crying and obviously sad, or yelling and angry.

School-Age Children

Older children may want more specifics. They may ask more questions, especially about friends or family with emotional or behavioral problems. Their concerns and questions are usually very straightforward. "Why is that person crying? Why does Daddy drink and get so mad? Why is that person talking to herself?" They may worry about their safety or the safety of their family and friends. It is important to answer their questions directly and honestly and to reassure them about their concerns and feelings.

Teenagers

Teenagers are generally capable of handling much more information and asking more specific and difficult questions. Teenagers often talk more openly with their friends and peers than with their parents. As a result, some teens may have already have misinformation about mental illnesses. Teenagers respond more positively to an open dialogue which includes give and take. They are not as open or responsive when a conversation feels one-sided or like a lecture.

Talking to children about mental illnesses can be an opportunity for parents to provide their children with information, support, and guidance. Learning about mental illnesses can lead to improved recognition, earlier treatment, greater understanding and compassion, as well as decreased stigma.

For additional information, see ***Facts for Families:***
#39 Children of Parents with Mental Illness
#62 Talking to Kids About Sex

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 85 March 2011

Reactive Attachment Disorder

Reactive Attachment Disorder (RAD) is a complex psychiatric illness that can affect young children. It is characterized by serious problems in emotional attachments to others. RAD usually presents by age 5, but a parent, caregiver or physician may notice that a child has problems with emotional attachment by their first birthday. Often, a parent brings an infant or very young child to the doctor with one or more of the following concerns:

- severe colic and/or feeding difficulties
- failure to gain weight
- detached and unresponsive behavior
- difficulty being comforted
- preoccupied and/or defiant behavior
- inhibition or hesitancy in social interactions
- disinhibition or inappropriate familiarity or closeness with strangers.

The physical, emotional and social problems associated with RAD may persist as the child grows older.

Most children with Reactive Attachment Disorder have had severe problems or disruptions in their early relationships. Many have been physically or emotionally abused or neglected. Some have experienced inadequate care in an institutional setting or other out-of-home placement such as a hospital, residential program, foster care or orphanage. Others have had multiple or traumatic losses or changes in their primary caregiver. The exact cause of Reactive Attachment Disorder is not known although research suggests that inadequate care-giving is a possible cause.

Children who exhibit signs of Reactive Attachment Disorder need a comprehensive psychiatric assessment and individualized treatment plan. These signs or symptoms may also be found in other psychiatric disorders. A child should never be given this label or diagnosis without a comprehensive evaluation.

Treatment of this complex disorder involves both the child and the family. Therapists focus on understanding and strengthening the relationship between a child and his or her primary care givers. Without treatment, this condition can affect permanently a child's social and emotional development. However, unconventional and forced treatments such as "rebirthing" strategies are potentially dangerous and should be avoided.

Parents of a young child who shows signs or symptoms of Reactive Attachment Disorder should:

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- seek a comprehensive psychiatric evaluation by a qualified mental health professional prior to the initiation of any treatment
- make sure they understand the risks as well as the potential benefits of any intervention
- feel free to seek a second opinion if they have questions or concerns about the diagnosis and/or treatment plan

Reactive Attachment Disorder is a serious clinical condition. Fortunately, it is relatively rare. Evaluating and treating children with complex child psychiatric disorders such as Reactive Attachment Disorder is challenging. There are no simple solutions or magic answers. However, close and ongoing collaboration between the child's family and the treatment team will increase the likelihood of a successful outcome.

For additional information see: ***Facts for Families***:
#5 Child Abuse : The Hidden Bruises
#7 Children Who Won't Go to School
#15 The Adopted Child
#47 Anxious Child
#52 Comprehensive Psychiatric Evaluation
#64 Foster Care

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 86 August 2013

Psychotherapies for Children and Adolescents

Psychotherapy is a form of psychiatric treatment that involves therapeutic conversations and interactions between a therapist and a child or family. It can help children and families understand and resolve problems, modify behavior, and make positive changes in their lives. There are several types of psychotherapy that involve different approaches, techniques and interventions. At times, a combination of different psychotherapy approaches may be helpful. In some cases a combination of medication with psychotherapy may be more effective.

Different types of psychotherapy: (alphabetical order)

- **Cognitive Behavior Therapy (CBT)** helps improve a child's moods, anxiety and behavior by examining confused or distorted patterns of thinking. CBT therapists teach children that thoughts cause feelings and moods which can influence behavior. During CBT, a child learns to identify harmful thought patterns. The therapist then helps the child replace this thinking with thoughts that result in more appropriate feelings and behaviors. Research shows that CBT can be effective in treating a variety of conditions, including depression and anxiety. Specialized forms of CBT have also been developed to help children coping with post-traumatic stress disorder.

- **Dialectical Behavior Therapy (DBT)** can be used to treat older adolescents who have chronic suicidal feelings/thoughts, engage in intentionally self-harmful beaviors or have Borderline Personality Disorder. DBT emphasizes taking responsibility for one's problems and helps the person examine how they deal with conflict and intense negative emotions. This often involves a combination of group and individual sessions.

- **Family Therapy** focuses on helping the family function in more positive and constructive ways by exploring patterns of communication and providing support and education. Family therapy sessions can include the child or adolescent along with parents, siblings, and grandparents. ***Couples therapy*** is a specific type of family therapy that focuses on a couple's communication and interactions (e.g. parents having marital problems).

- **Group Therapy** is a form of psychotherapy where there are multiple patients led by one or more therapists. It uses the power of group dynamics and peer

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

interactions to increase understanding of mental illness and/or improve social skills. There are many different types of group therapy (e.g. psychodynamic, social skills, substance abuse, multi-family, parent support, etc.).

- **Interpersonal Therapy (IPT)** is a brief treatment specifically developed and tested for depression, but also used to treat a variety of other clinical conditions. IPT therapists focus on how interpersonal events affect an individual's emotional state. Individual difficulties are framed in interpersonal terms, and then problematic relationships are addressed

- **Play Therapy** involves the use of toys, blocks, dolls, puppets, drawings and games to help the child recognize, identify, and verbalize feelings. The psychotherapist observes how the child uses play materials and identifies themes or patterns to understand the child's problems. Through a combination of talk and play the child has an opportunity to better understand and manage their conflicts, feelings, and behavior.

- **Psychodynamic Psychotherapy** emphasizes understanding the issues that motivate and influence a child's behavior, thoughts, and feelings. It can help identify a child's typical behavior patterns, defenses, and responses to inner conflicts and struggles. ***Psychoanalysis*** is a specialized, more intensive form of psychodynamic psychotherapy which usually involved several sessions per week. Psychodynamic psychotherapies are based on the assumption that a child's behavior and feelings will improve once the inner struggles are brought to light.

Psychotherapy is not a quick fix or an easy answer. It is a complex and rich process that, over time, can reduce symptoms, provide insight, and improve a child or adolescent's functioning and quality of life.

At times, a combination of different psychotherapy approaches may be helpful. In some cases a combination of medication with psychotherapy may be more effective. Child and adolescent psychiatrists are trained in different forms of psychotherapy and, if indicated, are able to combine these forms of treatment with medications to alleviate the child or adolescent's emotional and/or behavioral problems.

Click here to find a Child and Adolescent Psychiatrist near you.

For more information see ***Facts for Families***:
#25 Know Where to Seek Help for Your Child
#52 Comprehensive Psychiatric Evaluation
#53 What is Psychotherapy for Children and Adolescents
#21 Psychiatric Medication for Children
#00 Definition of a Child and Adolescent Psychiatrist

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 87 March 2011

Talking to Children about Terrorism and War

In today's world, parents are faced with the challenge of explaining violence, terrorism and war to children. Although difficult, these conversations are extremely important. They give parents an opportunity to help their children feel more secure and understand the world in which they live. The following information can be helpful to parents when discussing these issues:

Listen to Children:

- Create a time and place for children to ask their questions. Don't force children to talk about things until they're ready.
- Remember that children tend to personalize situations. For example, they may worry about friends or relatives who live in a city or state associated with incidents or events.
- Help children find ways to express themselves. Some children may not be able to talk about their thoughts, feelings, or fears. They may be more comfortable drawing pictures, playing with toys, or writing stories or poems directly or indirectly related to current events.

Answer Children's Questions:

- Use words and concepts your child can understand. Make your explanation appropriate to your child's age and level of understanding. Don't overload a child with too much information.
- Give children honest answers and information. Children will usually know if you're not being honest.
- Be prepared to repeat explanations or have several conversations. Some information may be hard to accept or understand. Asking the same question over and over may be your child's way of asking for reassurance.
- Acknowledge and support your child's thoughts, feelings, and reactions. Let your child know that you think their questions and concerns are important.
- Be consistent and reassuring, but don't make unrealistic promises.
- Avoid stereotyping groups of people by race, nationality, or religion. Use the opportunity to teach tolerance and explain prejudice.
- Remember that children learn from watching their parents and teachers. They are very interested in how you respond to events. They learn from listening to your conversations with other adults.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Let children know how you are feeling. It's OK for them to know if you are anxious or worried about events. However, don't burden them with your concerns.
- Don't confront your child's way of handling events. If a child feels reassured by saying that things are happening very far away, it's usually best not to disagree. The child may need to think about events this way to feel safe.

Provide Support:

- Don't let children watch lots of violent or upsetting images on TV. Repetitive frightening images or scenes can be very disturbing, especially to young children.
- Help children establish a predictable routine and schedule. Children are reassured by structure and familiarity. School, sports, birthdays, holidays, and group activities take on added importance during stressful times.
- Coordinate information between home and school. Parents should know about activities and discussions at school. Teachers should know about the child's specific fears or concerns.
- Children who have experienced trauma or losses may show more intense reactions to tragedies or news of war or terrorist incidents. These children may need extra support and attention.
- Watch for physical symptoms related to stress. Many children show anxiety and stress through complaints of physical aches and pains.
- Watch for possible preoccupation with violent movies or war theme video/computer games.
- Children who seem preoccupied or very stressed about war, fighting, or terrorism should be evaluated by a qualified mental health professional. Other signs that a child may need professional help include: ongoing trouble sleeping, persistent upsetting thoughts, fearful images, intense fears about death, and trouble leaving their parents or going to school. The child's physician can assist with appropriate referrals.
- Help children communicate with others and express themselves at home. Some children may want to write letters to the President, Governor, local newspaper, or to grieving families.
- Let children be children. They may not want to think or talk a lot about these events. It is OK if they'd rather play ball, climb trees, or ride their bike, etc.

War and terrorism are not easy for anyone to comprehend or accept. Understandably, many young children feel confused, upset, and anxious. Parents, teachers, and caring adults can help by listening and responding in an honest, consistent, and supportive manner. Most children, even those exposed to trauma, are quite resilient. Like most adults, they can and do get through difficult times and go on with their lives. By creating an open environment where they feel free to ask questions, parents can help them cope and reduce the possibility of emotional difficulties.

For additional information see other ***Facts for Families***:
#36 Helping Children After a Disaster
#13 Children and TV Violence

#47 The Anxious Child
#54 Children and Watching TV
#67 Children and the News
#55 Understanding Violent Behavior in Children

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 88 March 2011

Families in the Military

Global conflict and unrest have led to deployment of large numbers of military personnel (active duty, Reserves, National Guard). As a result of duty assignments, members of the military are often separated for lengthy periods of time from their families and sent to distant, dangerous or unknown locations. A family that loses the active presence of a parent through separation faces significant challenges and stress. During the parent's deployment, family members may feel isolated, unsupported and anxious. They may also experience financial stress. Media coverage of events can also increase concern.

Some families must also deal with the trauma of having a parent seriously injured or killed. Families who have little or no contact with extended family and/or the military community may be especially vulnerable to stress. In families with existing medical, emotional or behavioral problems, a parent being away can be especially difficult.

While most families and children manage successfully, it is important for parents to be aware of signs of stress and possibly serious problems. The responses of children to stress of separation are determined by their individual makeup and developmental age. The following are some common reactions:

- **Infants (Birth - 12 months)** may respond to disruptions in their schedule, physical environment or availability of caregivers with decreased appetite, weight loss, irritability and/or apathy.

- **Toddlers (1-3 yrs.)** may become sullen, tearful, throw temper tantrums or develop sleep problems.

- **Preschoolers (3-6 yrs.)** are more aware of the absence of a parent than younger children and their behavior may regress in areas such as toilet training, sleep, separation fears, physical complaints, or thumb sucking. They may personalize situations and express a fear that, "Daddy left because I was angry at him" or "Mommy stays away because she doesn't love me".

- **School age children (6-12 yrs.)** are more aware of the realities behind their parent leaving and the potential dangers. They may show irritable behavior, aggression or whininess. They also may become more regressed and fearful that their parent may be injured or die.

- **Teenagers (13-18 yrs.)** may be rebellious, irritable or more challenging of authority. Parents need to be alert to high-risk behaviors such as problems with the law, sexual acting out, and drug/alcohol abuse.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

A parent leaving home on a military assignment increases the burden on all family members. The following suggestions can ease the stress:

- Talk as a family before the reassignment, sharing information, feelings, worries and plans for the future. Let your child know that the family member is making a valuable contribution to their country and the world.
- Emphasize the need for the family to pull together during the parent's absence with everyone sharing in family responsibilities.
- Continue family traditions, structure and discipline. This is reassuring and stabilizing to children.
- Utilize available means (e.g. letters, email, phone) for the family members to communicate with the deployed parent.
- Share information with children based upon their developmental level and ability to understand. No news is usually more stressful and difficult to deal with than bad news.
- Monitor children's exposure to TV coverage of war events and political discussions of the war.
- Encourage the open and honest expression of worries, feelings, and questions.
- Consider having children participate in a project associated with their parent's deployment (e.g. classroom letter writing project, keeping a journal or scrapbook).
- Don't make promises that you can't keep.
- Initiate and maintain a close relationship and communication with your child's teachers and school.
- Utilize extended family, community and spiritual resources and other natural supports that are available both within and outside the military.
- As a single parent at home, make sure that you also take care of yourself so that you can be available to your children.

Although a joyous occasion, when a family member returns home after a long absence, a period of adjustment will be necessary. Roles, responsibilities and routines must be re-established. The emotional readjustment will require time and patience. This can be a difficult time and all family members will need extra support. This is especially true if there has been a serious injury. If a parent or a child develops emotional or behavioral problems or is having serious difficulties with the adjustment, they should be referred for evaluation by a qualified mental health professional.

While it is a difficult time for families, most children can and do adjust successfully to the separation and stress involved when a parent in the military is deployed.

For additional information, see ***Facts for Families***;
#89 Coming Home: Adjustments For Military Families
#77 Grandparents Raising Children
#24 Know When to Seek Help for Your Child
#25 Know How to Seek Help for Your Child

Center for the Study of Traumatic Stress Fact Sheets
Sesame Workshop's "When Parents Are Deployed"

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 89 March 2011

Coming Home: Adjustment for Military Families

Military families look forward to being together after a long deployment with many mixed emotions. Each family member will have different expectations. Every family situation is different. However it is important to remember the needs and feelings of the returning family member, the adult at home and the children.

Understanding the Returning Family Member

- Military deployments, especially in a combat zone, can significantly change an individual's life.
- The deployment involved the loss of many comforts that people back home take for granted: contact with family, comfortable living conditions, a variety of good food, time to relax, etc.
- The deployment involved hard work and enormous responsibility. If in a war zone, there was the constant threat of loss of life or injury. The family member may have witnessed injuries, deaths and destruction.
- What sustains military personnel on a dangerous deployment is devotion to duty, a close connection with fellow soldiers and the desire to return to the comforts of home, family and community.
- The returning family member may seem preoccupied with the experience of their deployment. They may be unable to talk about it or may excessively talk about it.
- The returning family member may have suffered physical or emotional injury or disability.
- The returning family member may expect extra attention and support for some time after their return.
- The returning family member may have serious concerns about their financial or employment future.

Understanding the Adult that Stayed at Home

- Life has gone on and the adult at home has had to keep the family moving forward during the deployment. They may have had to take over many functions normally performed by the deployed family member.
- Often the adult at home has handled many small and not so small crises. These problems are old news at home but may be big surprises for the returning family member.
- The adult at home may expect extra attention and credit regarding the performance during the deployment. They also may expect the returning family

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

members to automatically accept the family as it now exists and begin to perform a role with which they are uncomfortable or unfamiliar.

Understanding the Children

- Children generally are excited about a reunion with their returning parent. However, the excitement of the reunion is stressful for children. Children may also be anxious and uncertain about the reunion.
- Children's responses are influenced by their developmental level. Toddlers may not remember the parent well and act shy or strange around them. School age children may not understand the returning parent's need to take care of themselves and to spend time with their spouse. Teenagers may seem distant as they continue their activities with friends.
- Children may need a period of time to warm up and readjust to the returning parent. This should not be misinterpreted or taken personally.

Understanding the Family

- Couples may find the deployment has strained their relationship. Time and negotiation will help the couple work toward a new loving relationship.
- Family problems that existed before the deployment frequently reappear after the deployment.
- Extended family members such as grandparents, aunts and uncles may have provided support and service to the family during the deployment. They may have difficulty redefining their role with the family.

Give Everyone Time

- All family members will need time to adjust to the changes that accompany the return of the deployed family member.
- Open discussion of expectations prior to the return home are helpful if they are possible.
- Families should utilize the help offered by the military and other organizations to readjust to the reunion.
- Most families will change. Children have been born or have grown. An adult at home may have become more independent. The returning family member had a life changing experience. The goal is to form a healthy, new life together.

Reunion of a military family after a long deployment is a cause for celebration. Some patience and understanding will go a long way to help the whole family successfully reunite with a minimum of problems. While most families cope successfully with the stress of the deployment and following reunion, problems can develop. If significant problems develop, the family should seek help from a qualified mental health professional.

For additional information, see ***Facts for Families***:
#88 Families in the Military
#77 Grandparents Raising Children
#24 Know When to Seek Help for Your Child
#25 Know How to Seek Help for Your Child

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 90 March 2011

Children and Movies

Watching movies, videos, and DVDs can be a fun activity in which children and adolescents can use their imagination and fantasy. Parents should, however, consider the following issues when planning to watch movies at a theatre or at home:

- Although going to a movie theater can be exciting, movies can create anxiety for children with loud noises and frightening and upsetting scenes.
- Younger children may have trouble telling the difference between make-believe and reality. They can be upset when a parent figure dies in a movie or frightening things happen to children.
- Some children cannot tolerate the darkness of a movie theater, even with their parents present.
- Viewing movies with sex, violence, drug abuse, adult themes, and offensive language can have a negative effect on children and adolescents. Many movies are ***not*** appropriate for children or teenagers.
- Older children and adolescents may copy risky and possibly dangerous things they see in movies.
- Having a TV, VCR, or DVD player in children and adolescents' bedrooms encourages movie watching without adult supervision.
- Movies should not replace child-care or be left on as background noise.
- If parents are unsure whether a movie is appropriate, they should view the movie in private before watching it as a family.

Tips and Recommendations for Parents:

- Check a movie's Motion Picture Association of America (MPAA) rating and read reviews before it is viewed. Movie reviews can be found online, and on AACAP's website.
- Discuss upsetting or frightening events seen in a movie.
- Turn the movie off or leave the theater if your child becomes upset or frightened.
- Use the same care and attention to a movie's content when choosing a movie to watch at home for a child or adolescent as you would a movie in the theater.
- Deciding when a teenager can go to a movie without parental supervision depends on the teenagers' maturity and the friends going with your teenager.
- All ages of children should have their movie watching supervised by their parents or adult caretakers.
- Parents can and should be active participants in their children and adolescents' movie watching experiences.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Watching movies together can be a rewarding experience. It can be an opportunity for your child to have fun with family and friends. If your child or adolescent, however, develops strong and persistent emotional reactions or behavior from seeing a movie, then consider having your child evaluated by a qualified mental health professional.

See also ***Facts For Families***:
#13 Children and TV Violence
#40 Influence of Music and Music Videos
#46 Home Alone Children
#54 Children and Watching TV
#67 Children and The News
#00 Definition of a Child and Adolescent Psychiatrist

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 91 March 2011

Children and Video Games: Playing with Violence

Video gaming (playing video games) has become a popular activity for people of all ages. Many children and adolescents spend large amounts of time playing them. Video gaming is a multibillion-dollar industry – bringing in more money than movies and DVDs. Video games have become very sophisticated and realistic. Some games connect to the Internet, which can allow children and adolescents to play online with unknown adults and peers.

While some games have educational content, many of the most popular games emphasize negative themes and promote:

- the killing of people or animals
- the use and abuse of drugs and alcohol
- criminal behavior, disrespect for authority and the law
- sexual exploitation and violence toward women
- racial, sexual, and gender stereotypes
- foul language, obscenities, and obscene gestures

There is growing research on the effects of videogames on children. Some video games may promote learning, problem solving and help with the development of fine motor skills and coordination. However, there are concerns about the effect of violent video games on young people who play videogames excessively.

Studies of children exposed to violence have shown that they can become: “immune” or numb to the horror of violence, imitate the violence they see, and show more aggressive behavior with greater exposure to violence. Some children accept violence as a way to handle problems. Studies have also shown that the more realistic and repeated the exposure to violence, the greater the impact on children. In addition, children with emotional, behavioral and learning problems may be more influenced by violent images.

Children and adolescents can become overly involved and even obsessed with videogames. Spending large amounts of time playing these games can create problems and lead to:

- poor social skills
- time away from family time, school-work, and other hobbies
- lower grades and reading less
- exercising less, and becoming overweight

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- aggressive thoughts and behaviors

Tips for Parents
Parents can help their children enjoy these games and avoid problems by:

- checking the Entertainment Software Rating Board (ESRB) ratings to learn about the game's content.
- selecting appropriate games—both in content and level of development.
- playing videogames with their children to experience the game's content.
- setting clear rules about game content and playing time, both in and outside of your home.
- strongly warning children about potential serious dangers of Internet contacts and relationships while playing games online.
- talking with other parents about your family's video game rules.
- remembering that you are a role model for your children – including video games you play as an adult.

If parents are concerned that their child is spending too much time playing video games or appears preoccupied or obsessed with aggressive or violent video games, they should first set some limits (for example – playing the games for one hour after all homework is done) and try to encourage the child to participate in other activities. If there is continued concern about their child's behavior or the effects of videogames, a consultation with a qualified mental health professional may be helpful.

For additional information see also *Facts for Families*:
#13 Children and TV Violence,
#40 The Influence of Music and Music Videos,
#54 Children and Watching TV, and
#59 Children Online.

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 92 August 2013

Children with Lesbian, Gay, Bisexual and Transgender Parents

Millions of children in the United States have lesbian, gay, bisexual and/or transgender (LGBT) parents. Some children of LGBT parents were conceived in heterosexual marriages or relationships. An increasing number of LGBT parents have conceived children and/or raised them from birth, either as single parents or in ongoing committed relationships. This can occur through adoption, alternative insemination, surrogate or foster parenting. A small number of states currently have laws supportive of LGBT couple adoption.

What effect does having LGBT parents have on children?

Sometimes people are concerned that children being raised by a gay parent will need extra emotional support or face unique social stressors.Current research shows that children with gay and lesbian parents do not differ from children with heterosexual parents in their emotional development or in their relationships with peers and adults. It is important for parents to understand that it is the the quality of the parent/child relationship and not the parent's sexual orientation that has an effect on a child's development. Research has shown that in contrast to common beliefs, children of lesbian, gay, or transgender parents:

- Are not more likely to be gay than children with heterosexual parents.
- Are not more likely to be sexually abused.
- Do not show differences in whether they think of themselves as male or female (gender identity).
- Do not show differences in their male and female behaviors (gender role behavior).

Raising children in a LGBT household

Although research shows that children with gay and lesbian parents are as well adjusted as children with heterosexual parents, they can face some additional challenges. Some LGBT families face discrimination in their communities and children may be teased or bullied by peers. Parents can help their children cope with these pressures in the following ways:

- Prepare your child to handle questions and comments about their background or family.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Allow for open communication and discussions that are appropriate to your child's age and level of maturity.
- Help your child come up with and practice appropriate responses to teasing or mean remarks.
- Use books, Web sites and movies that show children in LGBT families.
- Consider having a support network for your child (For example, having your child meet other children with gay parents.)
- Consider living in a community where diversity is more accepted.

Like all children, most children with LGBT parents will have both good and bad times. They are not more likely than children of heterosexual parents to develop emotional or behavioral problems. If LGBT parents have questions or concerns about their child, they should consider a consultation with a qualified mental health professional.

For additional information see Facts for Families:
#1 Children and Divorce
#15 The Adopted Child
#24 When to Seek Help
#27 Stepfamily Problems
#62 Talking to Your Kids About Sex
#63 Gay and Lesbian Teens
#64 Foster Care

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 93 December 2011

Drinking Alcohol in Pregnancy (Fetal Alcohol Effects)

According to the American College of Obstetrics and Gynecology, pregnant women should not drink any form of alcohol. Pregnant women who think they have should be aware of the serious and negative effects of alcohol on the development of the baby (fetus). In the United States, prenatal exposure to alcohol is the most common cause of birth defects. Exposure to alcohol during pregnancy causes damage to the brain and affects the child's behavior, these effects can be prevented by 100 percent.

Thousands of children are born with the effects of prenatal exposure to alcohol. While many people drink, alcohol is poisonous to the child that grows inside the womb. The ingestion of even an alcoholic beverage per day during pregnancy the baby in development can be exposed to the risk of serious birth defects. A small amount of alcohol can cause permanent damage to the child. The use of alcohol during pregnancy can cause serious problems in children and adolescents:

- Infants may show slow growth and developmental delay, unusual facial features, irritability, brain and neurological disorders, mental retardation and problems with their attachment to their fathers.
- Kids and school-age children may have problems with learning, low tolerance for frustration, inadequate social boundaries and difficulty reading.
- Teenagers can have continuous learning problems, depression, anxiety and inappropriate sexual behavior.

Fetal Alcohol Problems (AFP) described the negative effects and problems caused by drinking alcohol while pregnant. Fetal Alcohol Syndrome (SFA) is a more specific group of symptoms caused by drinking alcohol while you are pregnant. A child is diagnosed with Fetal Alcohol Syndrome (SFA) when there is a prenatal exposure to alcohol and has:

- Facial deformities.
- Slow and retarded development.
- Brain and neurological problems.

Children who are suspected of SFA must be carefully evaluated by a pediatrician, child and adolescent psychiatrist or other clinical experience. Fetal alcohol exposure is often overlooked as the cause of the problems in the child's behavior. The effects of alcohol on the developing brain during pregnancy are not reversible. However, early intervention can reduce the severity of the disability and improve the chances of success for the child.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

The early intervention for EAF or SFA includes occupational therapy, special education and speech therapy evaluations.

If you are pregnant and find that it is impossible to stop drinking, talk with your obstetrician to help stop. It is important to get treatment to stop drinking as soon as possible. There are programs available either inpatient, outpatient and residential. Local programs (for example, "12-step program" of Alcoholics Anonymous) can provide support to quit drinking.

For further information see *Facts for Families*:
3 Teens: Alcohol and Other Drugs
17 Children of Alcoholics
23 Children who are Mentally Retarded
31 When Teens are Sons
41 How to Choose a Treatment for Substance Abuse
45 The Children's Exposure to Lead

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 94 December 2011

Preventing and Managing Medication-Related Weight Gain

Psychiatric medications can be very helpful, even life-saving, for some children and adolescents. However, some of these medications may lead to weight gain. The antipsychotic medications, in particular, have also been associated with problems controlling blood sugar, cholesterol and triglycerides. These changes can increase the risk of a child or adolescent developing diabetes and heart related problems. Parents should discuss the risks and benefits of specific medications with their child's physician.

A comprehensive psychiatric evaluation by a qualified physician should be done before a child or adolescent is prescribed any of these medications.

Weight gain is possible with many medications. Some examples of medications that can lead to weight gain include:

- Antipsychotics: such as aripiprazole (*Abilify*), chlorpromazine (*Thorazine*), clozapine (*Clozaril*), olanzapine (*Zyprexa*), pimozide (*Orap*), quetiapine (*Seroquel*), risperidone (*Risperdal*), ziprasidone (*Geodon*)
- Mood stabilizers: such as lithium, valproic acid (*Depakote/Depakene*), carbamazepine (*Tegretol*)
- Antidepressants: such as mirtazapine (*Remeron*), paroxetine (*Paxil*), imipramine (*Tofranil*)

At the start of treatment your child's height and weight should be measured. Their BMI (Body Mass Index) can be calculated and adjusted for their age and gender. This provides you and your child's psychiatrist with baseline information so that any changes can be followed over time.

It is very important to let your child's doctor know if your child or family members have problems with diabetes, blood sugar, cholesterol, triglycerides, or heart disease. To make treatment with these medications as safe as possible, your child's psychiatrist or physician will weigh them and order certain laboratory tests from time to time.

When on these medications appetite can increase. Children and adolescents may also not recognize when they are full. The following tips and ideas can help both prevent and manage medication-related weight gain in children and adolescents:

Dietary guidance:

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Use portion control for all food at meals and snacks – measure and limit size of portions (example – pour out an amount of snack rather than eating out of box or bag)
- Use more healthy food choices (example - fresh fruits and vegetables for snacks)
- Limit snacks and junk food
- Substitute low calorie for higher calorie snacks (example – pretzels instead of chips/nuts)
- Drink several large glasses (or bottles) of water throughout the day
- Limit sugar containing beverages (sodas, juice, etc.)
- Have other family members be understanding and supportive (example – don't eat high calorie foods in front of the child or teen)

Tips for meals

- Schedule regular meal times
- Plan menus – limit fast food
- Use meal time for the family to talk – don't just eat and run
- Sit down to eat – don't stand and eat
- Chew all food more slowly
- Avoid eating in front of the TV
- Remember: portion control (measure and limit size of portions)

Tips to increase activity level

- Limit time spent sitting watching TV, on the computer or playing video games
- Increase walking – walk after each meal, wear a pedometer to make it fun
- Use stairs instead of elevators
- Encourage exercise and sports involvement
- Use forms of activities that are fun and interesting (playing outdoors, riding bikes, rollerblading, swimming, bowling, dancing, etc.)

Following these tips can limit weight gain when taking psychiatric medications and help reduce the risk of serious medical problems.

If weight gain continues to be a problem for your child, speak to your health care provider.

See other *Facts for Families*:
#52 Comprehensive Psychiatric Evaluation
#21 Psychiatric Medication for Children Part I – How Medications Are Used
#29 Psychiatric Medication for Children Part II: Types of Medication
#51 Questions to Ask About Psychiatric Medications
#79 Obesity in Children and Teens

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 95 December 2011

The Teen Brain: Behavior, Problem Solving, and Decision Making

Many parents do not understand why their teenagers occasionally behave in an impulsive, irrational, or dangerous way. At times, it seems like they don't think things through or fully consider the consequences of their actions. Adolescents differ from adults in the way they behave, solve problems, and make decisions. There is a biological explanation for this difference. Studies have shown that brains continue to mature and develop throughout childhood and adolescence and well into early adulthood.

Scientists have identified a specific region of the brain called the **amygdala** which is responsible for instinctual reactions including fear and aggressive behavior. This region develops early. However, **the frontal cortex**, the area of the brain that controls reasoning and helps us think before we act, develops later. This part of the brain is still changing and maturing well into adulthood.

Other specific changes in the brain during adolescence include a rapid increase in the connections between the brain cells and pruning (refinement) of brain pathways. Nerve cells develop myelin, an insulating layer which helps cells communicate. All these changes are essential for the development of coordinated thought, action, and behavior.

Changing Brains Mean that Adolescents Act Differently From Adults

Pictures of the brain in action show that adolescents' brains function differently than adults when decision-making and problem solving. Their actions are guided more by the amygdala and less by the frontal cortex. Research has also demonstrated that exposure to drugs and alcohol before birth, head trauma, or other types of brain injury can interfere with normal brain development during adolescence.

Based on the stage of their brain development, adolescents are more likely to:

- act on impulse
- misread or misinterpret social cues and emotions
- get into accidents of all kinds
- get involved in fights
- engage in dangerous or risky behavior

Adolescents are less likely to:

- think before they act

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- pause to consider the potential consequences of their actions
- modify their dangerous or inappropriate behaviors

These brain differences don't mean that young people can't make good decisions or tell the difference between right and wrong. It also doesn't mean that they shouldn't be held responsible for their actions. But an awareness of these differences can help parents, teachers, advocates, and policy makers understand, anticipate, and manage the behavior of adolescents.

For additional information see *Facts for Families*:
#57 & #58 Adolescent Development
#56 Parenting
#76 Helping Your Teen Become a Safe Driver

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 96 July 2013

Hair Pulling (Trichotillomania)

It is common for children and adolescents to play with their hair. However, frequent or obsessive hair pulling can lead to serious problems. The medical term for severe hair pulling is trichotillomania.

People with trichotillomania pull hair on various parts of their bodies, including the scalp, face, arms, legs and pubic areas. They may not notice the hair pulling until they need to cover up bald patches with hair clips, a hat, wig or scarf. People with trichotillomania are not able stop pulling their hair.

As many as 1 person in 100 has the following signs and symptoms of trichotillomania:

- recurrent hair pulling resulting in noticeable hair loss, unrelated to baldness or alopecia
- pleasure, excitement, or relief when pulling out hair
- embarrassment or shame resulting from hair loss
- problems at home, school or work

The cause of trichotillomania is not known. For some children, trichotillomania becomes damaging and very difficult to control. Hair pulling can occur anytime but may become worse in stressful situations.

Most children with trichotillomania feel shame, embarrassment or guilt about their hair loss. Younger children may not notice or be bothered by hair loss. Older children and adolescents may be teased, have low self esteem, anxiety or depression.

Parents can become frustrated, as it is very difficult to understand that children with trichotillomania can't simply stop pulling their hair. Neither parents nor children are to blame for the hair pulling behavior. Punishing children for pulling hair is unlikely to decrease the behavior and can lead to problems with self-esteem. In order to avoid punishment or embarrassment, children try to hide or deny they are pulling their hair.

Frequently used treatments for trichotillomania include:

- cognitive behavioral therapy (CBT) is a specialized form of behavior therapy. It involves helping a child recognize thoughts, feelings and behaviors associated with hair pulling. The goal of this therapy is to increase the awareness of hair pulling and replace it with alternative behaviors
- medication therapy is also used to decrease the anxiety, depression and obsessive compulsive symptoms that accompany trichotillomania

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Family therapies and support groups are also available. Children with trichotillomania should be evaluated by a trained and qualified mental health professional. Treatment is most effective when it is comprehensive and individualized to the needs of the child and family.

See Trichotillomania Organization Web site, www.Trich.org.

For additional information, see *Facts for Families*:
#21 Psychiatric Medication for Children
#24 When to Seek Help for Your Child
#47 The Anxious Child
#60 OCD
#66 Helping Teenagers With Stress
#86 Psychotherapies for Children and Adolescents

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 97 April 2011

Residential Treatment Programs

Residential treatment programs provide intensive help for youth with serious emotional and behavior problems. While receiving residential treatment, children temporarily live outside of their homes and in a facility where they can be supervised and monitored by trained staff.

Residential treatment can help children and adolescents whose health is at risk while living in their community. For example, the programs are helpful for youth that have not responded to outpatient treatments, who have education needs that cannot be met in less restrictive settings or who are in need of further intensive treatment following inpatient psychiatric care.

Effective residential treatment programs provide:

- A comprehensive evaluation which assesses a youth's emotional, behavioral, medical, educational, social and leisure needs, and support these needs safely.
- An Individualized Treatment Plan that considers the needs of the child or adolescent.
- Individual and group therapy.
- Psychiatric care coordinated by a child and adolescent psychiatrist.
- Ways for a child's family and community to be involved. Model residential programs encourage and provide opportunities for family therapy and contact through on-site visits, home passes, telephone calls and other modes of communication.
- Nonviolent and predictable way to help youth with emotional and behavioral issues. The use of physical punishment, manipulation or intimidation should not occur in any residential treatment program.

Figuring out which Residential Treatment Program is the best fit for your child and for your family can be challenging. The following are tips for evaluating residential treatment programs:

- Identify and research the programs that are licensed to provide care. States differ in how they license programs, and some programs are accredited by national agencies.
- Check online and with the program to hear about families' and youths' experiences with the program and if possible speak to a family whose child completed the program. If the program has been reported to state authorities, find out why, and ask about the outcomes of any investigations.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Seek out programs that are close to home to provide appropriate care for your child. If the program is far from home, be sure that there is a plan for intensive family and community involvement. Be wary of programs that withhold family contact.
- Be sure that the residential program has a method of maintaining safe behaviors, promoting positive behaviors, and preventing aggression. Make sure that punishments and verbal intimidations are prohibited.
- Look for programs experienced in helping youth with similar issues. Also make sure that their treatments are based on therapies that have proven helpful for you with issues similar to those of your child.
- Ask questions of the staff at the program. If staff is unable to answer your questions, they should refer you to someone at the program who can. In addition, be sure to ask how you can monitor your child's progress. You should be able to find out about how your child is doing at any time.
- Ask the therapist or psychiatrist who works with your child in your community for his or her view on potential programs, and to help you obtain more information.

See also ***Facts for Families:***

- #24 When To Seek Help For Your Child
- #25 Where To Find Help For Your Child
- #32 11 Questions To Ask Before Psychiatric Hospitalization Of Your Child Or Adolescent
- #42 The Continuum Of Care For Children And Adolescents
- #74 Advocating For Your Child

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 98 September 2011

Children and Gangs

Gangs are groups of children, adolescents and young adults who share a common identity and are involved in wrongful or delinquent activities. Most gang members tend to be adolescents or young adults, however, recent trends indicate that children are being recruited into gangs at a much earlier age, some when they are in elementary school. Traditionally, gang activity has been confined to cities but gangs are no longer just in large cities, they also exist in smaller towns and rural areas. Gangs can include people of every gender, race, culture and socioeconomic group.

Some children and adolescents are motivated to join a gang for a sense of connection or to define a new sense of who they are. Others are motivated by peer pressure, a need to protect themselves and their family, because a family member also is in a gang, or to make money.

One of the worst effects of gang membership is the exposure to violence. Gang members may be pressured to commit a crime to become part of the gang. Consequences of gang membership may include exposure to drugs and alcohol, age-inappropriate sexual behavior, difficulty finding a job because of lack of education and work skills, removal from ones family, imprisonment and even death.

Risk factors that can lead children and adolescents to join a gang include:

- Growing up in an area with heavy gang activity
- A history of gang involvement in the family (family members who are current or former gang members)
- A history of violence in the home
- Too little adult supervision
- Unstructured free time, particularly during after-school hours and on the weekends
- A lack of positive roles models and exposure to media (television, movies, music) that glorifies gang violence
- Low self esteem
- Sense of hopelessness about the future because of limited educational or financial opportunity
- Underlying mental-health issues or behavioral disorders, such as oppositional defiance disorder (ODD) and attention-deficit/hyperactivity disorder (ADHD)

Parents can help to decrease the risk that their child will become involved in a gang by:

- Closely monitoring where their child is and what they are doing

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Involving them in extracurricular activities such as afterschool programs, or athletics, art, community organizations or religious groups.
- Meeting their children's friends and their parents.
- Not allowing children to wear, write, or gesture any gang-associated graffiti, markings, signs, or symbols.
- Educating your child about the potential negative consequences of gang involvement and criminal behavior
- Letting your child know that gang members can end up injured, dead or in jail

There are many signs that parents and guardians can use to tell if a child is involved in a gang. These include:

- Having unexplained money, items, or clothing
- Wearing clothing of all one type, style, or color, or changing appearance with special haircuts, tattoos or other body markings
- Using of hand signs, special slang or words with hidden messages, or having gang graffiti on walls or personal items
- Associating with known gang members
- Withdrawing from family, not obeying curfews, worsening attitude with adults and peers
- Using or possessing drugs
- Carrying weapons

If you have concerns that your child is involved in a gang, it is important to discuss it with them. Confronting a child who is suspected of gang activity is not easy. Parents and children may fear gang retaliation. They may worry about giving up protection or money that they receive because of their child's gang involvement. Parents may have to deal with the legal consequences of their child's past behavior. However it is important to intervene to protect your child from drugs and violence and criminal activity. If you suspect your child is involved in gang activity, access agencies in your community for help. You can involve your child in other activities and limit unstructured time. Many communities have local gang prevention task forces. Police departments have Juvenile Officers who are willing to meet with parents to with early gang intervention. Juvenile Officers are familiar with gang behaviors and repeat offenders, and can tell you if your child is on dangerous path. A trained mental health professional can help parents evaluate and treat mental health problems that may have contributed to gang involvement.

For additional information see Facts for Families:

ADHD #6
Conduct Disorder #33
Oppositional Defiant Disorder #72
Discipline #43
Fighting, Biting #81
Firearms #37
Role Models #99

Violence on TV #13
Violent Behavior #55, #01
Music/Music Videos #40

Recommended Websites for further information on gang prevention and identification:
National Gang Center: http://www.nationalgangcenter.gov/
National Youth Gang Center: www.iir.com/nygc
US Department of Justice: http://www.ojjdp.gov/programs/antigang/

If you find *Facts for Families*© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to ***Campaign for America's Kids***, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

Facts for Families© information sheets are developed, owned and distributed by AACAP. Hard copies of ***Facts*** sheets may be reproduced for personal or educational use without written permission, but cannot be included in material presented for sale or profit. All ***Facts*** can be viewed and printed from the AACAP website (www.aacap.org). ***Facts*** sheets may not be reproduced, duplicated or posted on any other website without written consent from AACAP. Organizations are permitted to create links to AACAP's website and specific ***Facts*** sheets. For all questions please contact the AACAP Communications & Marketing Coordinator, ext. 154.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 99 September 2011

Children and Role Models

A role model is a person whose serves as an example by influencing others. For many children, the most important role models are their parents and caregivers. Children look up to a variety of role models to help shape how they behave in school, relationships or when making difficult decisions. Children also look up to other relatives, teachers and peers. Children may try to copy the behavior and appearance of celebrities, such as athletes and entertainers, and characters from books, TV, movies and video games. Some parents may want to help their children choose positive role models. Here are some helpful suggestions for discussing role models with your child and for serving as a positive role model for your child:

- Have your child identify what qualities he admires in his role model
- Give examples of people in your community who you feel have positive qualities and are a good influence on others
- Talk about people you look up to for guidance and inspiration

Negative role models, however, may also influence children. Sometimes widely admired public figures can make poor personal choices. Young children may assume that the behaviors of negative role models are typical, safe and acceptable. Parents and caregivers can intervene by emphasizing that role models who embrace inappropriate behavior, violence, sexuality, race and gender stereotypes, and drug and alcohol abuse are not acceptable.

Some suggestions to help you talk to your child about role models who have made mistakes are:

- Remind your child that all people have good and bad qualities and that anyone can make a mistake. Explain that it is important to apologize and to learn from our mistakes
- Ask your child what he thinks of the role model's behavior
- Ask what he would have done differently in the situation
- Give example of more positive and healthy ways to handle the situation

If you have concerns that your child is being negatively influenced by his role model, work with your child to identify more appropriate role models.

- Encourage your child to become involved in activities that reflect your values, such as religious programs, athletics, after school programs, clubs and volunteering.
- Remind your child that he or she does not have to do everything that the role model does. Your child can copy what he or she likes but still be him or herself.
- Give examples of people in your community who you feel have positive qualities and are a good influence on others.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

A qualified mental health professional can help if you are troubled by recent changes in your child's behavior or attitude due to his or her choice of role model.

Related Facts for Families:

Children Who Steal #12
Violence on TV #13
Music/Music Videos #40
Children and Watching TV #54
Children and Sports #61
Children and Movies #90

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 100 November 2011

Children and Social Networking

Social Networking Sites play an important role in the lives of many young people. Over 60% of 13-17 year olds have at least one profile on a social networking site, many spending more than 2 hours per day on social networking sites.

Social networking sites can present opportunities to youth who participate with them but like any activity there are also associated risks and it is important for parents to help their children use these sites wisely.

Some potential benefits are:

- Staying connected to friends
- Developing new social contacts with peers with similar interests
- Sharing content of self-expression such as art work, music and political views
- Developing and expressing your individual identity

Online social networking can involve new risks such as:

- Bullying online "cyber bullying"
- Sharing too much information
- Vulnerability to predatory adults
- Sharing photos or video that you later regret
- Exposure to large amounts of commercial advertisements which may not be age appropriate
- Risk of identity theft
- Reduced amount of time for physical activity

If your child is thinking about using social networking sites there are many ways to help them use them safely and appropriately. **Discuss freely with your child and guide them in their usage of social networking sites by suggesting they:**

- Keep control of their information by restricting access to their page
- Keep their full name, address, telephone number, social security number and bank or credit card number to themselves
- Post only information they are comfortable with everyone seeing
- Talk to their parents before considering meeting anyone face to face they have met on line and review the risks involved

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Young people need support and education to develop the skills needed to understand the risks and opportunities of social networking sites so talk to your child before they sign up for an account about:

- The rules in your household on social networking sites
- The monitoring you will do on their internet usage
- The limits on time allowed on these sites that may occur if their usage interferes with family time or external social activities.

Social networking sites are a widely accepted part of many teenagers' lives and proactive parenting can help them be a fun part of their teenager's social life. However if you feel your adolescent is spending too much time on social networking sites or is involved in inappropriate behaviors while using these sites please seek out the help of a professional who can help you and your child find balance and appropriateness in the usage of this medium.

Related Facts for Families:

Children Online #59
Music/Music Videos #40
Children and Watching TV #54
Children and Movies #90
Children and The News #67

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 101 April 2012

Complementary and Integrative Medicine

Complementary and integrative medicine, also called complementary and alternative medicine (CAM) refers to a wide array of health care practices not currently considered to be part of mainstream medicine. Widespread use of CAM for various conditions requires that families, patients and health care professionals have a basic understanding of CAM.

Definitions:

- **Conventional/Western Medicine**
  Medical care in systems based on the laws of science and the application of the scientific method.
- **Complementary Medicine**
  Non-conventional, healing practices used in conjunction with conventional/traditional medicine practices.
- **Integrative Medicine**
  A new medical specialty focused on the use of evidenced based treatments that combine aspects of CAM and conventional medicine.

Basic Philosophies Include:

- **Prevention is key to good health**. Taking steps to improve your health *before* you get sick is the best way to maintain health. A healthy lifestyle that promotes a balanced diet, regular exercise and proper sleep creates the best foundation for wellness.
- **Your body has the ability to heal itself**. Alternative medicine practitioners help your body to do its own healing via natural healing processes.
- **Learning and healing go hand in hand**. Alternative medicine practitioners emphasize a healing partnership as a key part of the healing process.
- **Holistic Care**. The focus is on recognizing your physical health, mental well-being, relationships and spiritual needs are interconnected.

Complementary and Integrative Medicine and Children:
A wide range of therapies are used in children including herbs, dietary supplements, massage, acupuncture, naturopathy and homeopathy.

The American Academy of Pediatrics (AAP) reports that families use CAM in 20-40 percent of healthy children and in over 50 percent of children with chronic, recurrent and incurable illnesses. Despite this high rate of CAM usage families frequently do not inform their healthcare providers of what treatments they are using. Some groups of children are more likely to use CAM than others. Parents who use CAM are more likely to treat their children with it. Children with chronic disabling or recurrent conditions are among those who have higher CAM use.

CAM usage by families where children have mental health diagnoses is widespread. Studies have suggested CAM usage at nearly 50 percent of children with autism and 20 percent of children with ADHD. Unfortunately, psychiatrists are informed of CAM usage less than 50 percent of the time.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Tips for Youth and Family:

- Few high quality studies have examined how CAM therapies may affect young people. Results from studies in adults do not necessarily apply to children. Children and adolescents' immune and central nervous systems are not fully developed which can make them respond to treatments differently than adults.
- If you are considering an alternative approach educate yourself about its risks and benefits. Find out what conditions the therapy helps and which conditions it might worsen.
- Herbs and supplements may interact with medicines or other supplements.
- A substance that is natural may not necessarily be safe.
- Herbs and supplements are not regulated by the Food and Drug Administration. The preparations can differ a great deal from brand to brand.
- It is important to discuss CAM with your health care provider. All healthcare providers working with your child should be fully informed of all the treatments that your child is utilizing or considering. Supplements and herbal medications may interact with your prescription medications.
- Herbs and supplements should not be thought of as a substitute for healthy eating. The benefits of the nutrients you get through foods in your diet are not necessarily reproducible in a supplement. Proper diet, sleep and exercise are fundamental for children's well-being and are necessary to get the greatest benefit from any treatment.

When seeking care from a CAM practitioner, as with any healthcare provider, it is important to ask about the practitioner's:

- Education and training
- Training and experience in assessing and treating mental health conditions in youth
- Collaboration with other providers including physicians and other healthcare professionals
- Licensing (some states have licensing requirements for certain CAM practitioners)

Additional Information Can be Obtained from:

The National Center for Complementary and Alternative Medicine and the National Institution of Health (NCCAM).
Consortium of Academic Health Centers in Integrative Medicine (CAHCIM)
Consumer Labs

For more information see *Facts for Families*:
#6 Children Who Can't Pay Attention
#11 The Child with Autism
#21 Psychiatric Medications for Children and Adolescents Part I: How Medications Are Used
#29 Psychiatric Medications for Children and Adolescents Part II: Types of Medications
#51 Psychiatric Medications for Children and Adolescents Part III: Questions to Ask

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 102 May 2012

Hearing Voices and Seeing Things

Children often hear or see things that may scare or upset them. The wind at night, a creak in the house, or a shadow on the wall may feel frightening, especially for younger children. At times, children may imagine that they hear or see things as part of a game or as a result of their worries and fears. Younger children may even have an imaginary friend they want to sit next to at the table and have conversations with. These examples are usually just part of the normal growth of a child. They can most often be managed with understanding and gentle reassurance on the part of parents.

Hallucinations are when one has heard, seen or experienced something that is not there. They can occur in any of our senses including sound, sight, touch, taste and smell. An auditory hallucination is when one has heard something that is not there. It is the most common type of hallucination. A visual hallucination is when one has seen something that is not there. Hallucinations may occur as part of normal development or may be a sign that your child is struggling with some type of emotional problems. This may be related to issues at home, school, with friends, or from experiencing upsetting thoughts and feelings.

In some cases hallucinations may occur as a sign of a psychiatric illness such as a psychosis, or other serious medical problems. Psychotic disorders in children, while not common, are serious and severely interfere with a child's thinking and functioning. Children who are psychotic often appear confused and agitated. They also may have disorganized speech, thinking, emotional reactions, and behavior, sometimes accompanied by hallucinations or delusions (a fixed, false and often bizarre belief).

Hearing voices or seeing things that are not there can be a part of normal development but they may also happen as a result of the following:

- **When a youngster is under severe emotional stress**
  Children coping with the death of a parent or dealing with lots of stressors in their lives will sometimes hear voices or see things.
- **Certain physical illnesses**
  Examples may include migraines, seizures, infections, a very high fever, and problems with the thyroid or adrenal glands.
- **Adverse effects of medication**
  The use of certain medications, such as steroids or pain medicine, can cause hallucinations under rare circumstances. Many other medications can also lead to hallucinations when used in higher doses than prescribed or recommended. Illegal drugs such as alcohol, marijuana, amphetamines, cocaine and LSD are a frequent cause of hallucinations.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- **Nonpsychotic psychiatric illnesses**
  Children who hear voices telling them to do bad things often have behavior problems. Voices that refer to suicide or dying may occur in children who are depressed. The content of a hallucination may help us understand what type of illness a child is having. Children who see things that are not there may be very anxious or depressed.
- **Psychotic illnesses**
  This includes schizophrenia, major depressive disorder with psychotic features, and bipolar disorder. In addition to hallucinations, psychotic illnesses are characterized by delusions, disorganized and/or bizarre behavior and moods that don't correspond with what is going on in someone's life. Children may show social withdrawal, and inappropriate and unusual use of language. Looking for these symptoms can be very helpful in telling the difference between psychotic and nonpsychotic illnesses.

What should you do if you are worried about your child hearing voices or seeing things?

Talk to your child and try to clarify what he is experiencing. Consider how your child is doing in all areas of his life such as at school, with friends, in the neighborhood, and with family. Any child with disordered thinking or behavior should be evaluated immediately. If you are concerned, speak with your family physician or pediatrician. They may be able to help or will be able to refer you to a child and adolescent psychiatrist who is trained to evaluate, diagnose and treat children with emotional and behavior problems.

For more information see *Facts for Families*:
#38 Bipolar Disorder in Teens
#49 Schizophrenia in Children
#52 Psychiatric Evaluation

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 103 June 2012

Know Your Rights: Consent and Confidentiality

Patients and families often wonder what their rights are when they see a doctor. They may have questions about what will happen to the personal and private information they share. They may also worry about whether they can refuse to follow their doctor's recommendations.

There are federal and state laws governing the rules regarding privacy, consent and confidentiality. Health Insurance Portability and Accountability Act (HIPPA) is a federal regulation requiring physicians to protect the privacy and security of medical records. Doctors also have a code of medical ethics that guides their professional behavior.

Consent

Informed consent is an important part of the doctor patient relationship. It occurs when the benefits and risks of a procedure are explained to a patient or guardian and then they give permission for a medical procedure to take place. Patients have the right to either give informed consent or to refuse. In situations where the state feels that the parents' decision to refuse treatment is not in the best interest of the child, the state can challenge the parents' decision in court.

Some states allow children 12 and older to make some of their own medical decisions without the knowledge or agreement of their parents. Twenty states and the District of Columbia give minors the ability to consent to outpatient mental health services. Forty four states and the District of Columbia authorize minors who abuse drugs or alcohol to consent to outpatient counseling without a parent's consent.

Confidentiality

Once a doctor patient relationship has been established then the patient has the following rights:

- to obtain complete information about their medical care
- to inspect their medical records within five days of making a written request
- to have their medical records kept confidential unless written consent for release is provided by the patient or legal guardian
- to sue any person who unlawfully releases their medical information without their consent

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Youth over the age of 12 may ask that their information not be shared with their parents. Unless the information is specifically protected by state law the doctor is not legally required to agree to the request. Some states that allow minors to consent to certain procedures often allow care to remain confidential from parents, but there are exceptions. Adolescents may be able to provide consent to treatment but this does not guarantee privacy.

Doctors are required to release medical information even without the patient's written consent when they have concerns that the child or others may be at risk for immediate harm. Also, doctors must release information when ordered by a court. A doctor or health insurance company may also release medical records without consent to billing, claims management services for the health insurance company. Privacy rules require the doctor to make reasonable efforts to only disclose the minimal amount of information necessary for the purpose requested.

Rules about confidentiality are different in healthcare agencies, schools and social service agencies. It can be helpful to check about which rules apply when you get your care.

Consent, privacy and confidentiality are important aspects in psychiatric care. If you feel that your rights have been violated you can bring up your concerns to your doctor or the state licensing body.

For related information, see the following *Facts for Families:*
#24 When to Seek Help for Your Child
#25 Where to Find Help for Your Child
#52 Psychiatric Evaluation

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 104 June 2012

Peer Pressure

Peers play a large role in the social and emotional development of children and adolescents. Their influence begins at an early age and increases through the teenage years. It is natural, healthy and important for children to have and rely on friends as they grow and mature.

Peers can be positive and supportive. They can help each other develop new skills, or stimulate interest in books, music or extracurricular activities.

However, peers can also have a negative influence. They can encourage each other to skip classes, steal, cheat, use drugs or alcohol, or become involve in other risky behaviors. The majority of teens with substance abuse problems began using drugs or alcohol as a result of peer pressure.

Kids often give in to peer pressure because they want to fit in. They want to be liked and they worry that they may be left out or made fun of if they don't go along with the group.

The following are some tips to help kids deal with peer pressure:

- Stay away from peers who pressure you to do things that seem wrong or dangerous.
- Learn how to say "no," and practice how to avoid or get out of situations which feel unsafe or uncomfortable.
- Spend time with other kids who resist peer pressure. It helps to have at least one friend who is also willing to say "no."
- If you have problems with peer pressure, talk to a grown up you trust, like a parent, teacher or school counselor.

Parents can also help by recognizing when their child is having a problem with peer pressure. The following are tips for parents to help your child deal with peer pressure:

- Encourage open and honest communication. Let kids know they can come to you if they're feeling pressure to do things that seem wrong or risky.
- Teach your child to be assertive and to resist getting involved in dangerous or inappropriate situations or activities.
- Get to know your child's friends. If issues or problems arise, share your concerns with their parents.
- Help your child develop self-confidence. Kids who feel good about themselves are less vulnerable to peer pressure.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Develop backup plans to help kids get out of uncomfortable or dangerous situations. For example, let them know you'll always come get them, no questions asked, if they feel worried or unsafe.

If your child has ongoing difficulties with peer pressure, talk to his or her teacher, principal, school counselor or family doctor. If you have questions or concerns about your child's mood, self-esteem or behavior, consider a consultation with a trained and qualified mental health professional.

Other related *Facts for Families* include:
#57 Normal Adolescent Development - Middle School and Early High School Years
#58 Normal Adolescent Development - Late High School - Years and Beyond
#80 Bullying
#98 Children and Gangs
#99 Children and Role Models
#100 Children and Social Networking

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 105 August 2012

Physical Punishment

All children misbehave. Every parent faces challenge of how to discipline his or her child. It can be frustrating when a child acts out or has significant behavior problems.

Children need limits and rules. There are many ways to give children rules and help change their behavior. Examples include positive reinforcement, time-out, taking away of privileges, and physical punishment. Physical punishment, sometimes called corporal punishment, is anything done to cause pain or discomfort in response to your child's behaviors.

Examples of physical punishment include:

- spanking (one of the most common methods of physical punishment)
- slapping, pinching, or pulling
- hitting with an object, such as a paddle, belt, hairbrush, whip, or stick
- making someone eat soap, hot sauce, or other unpleasant substances

Parents who were physically punished as children are more likely to physically punish their own children.

Physical punishment may influence behavior in the short-term. However, physical methods of discipline can result in the following consequences in your child:

- bullying other children
- being aggressive
- behavioral problems
- fearing his or her parents
- poor self-esteem
- thinking that hitting is okay

In extreme situations, physical punishment can lead to more severe and abusive behavior towards children. Abuse can cause injury, loss of custody, arrest, jail-time, and in even the death of a child.

Other Options for Managing Behavior

There are many ways to encourage your child to have good behavior. The most important place to start is to have a healthy, positive, and supportive relationship with your child. Managing your child's behavior works best when you let your child know in advance what you expect of him or her. Clear limit setting provides children with a sense of safety, stability, predictability, and security. Make sure you also praise your child's

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

good behavior. Praising a good behavior is called positive reinforcement and leads to more of that behavior.

As a parent, it can be overwhelming to try and find an effective method of discipline. If you are using physical punishment, consider using other methods to promote good behavior in your child. If you have trouble with other approaches, speak with your child's pediatrician, a child and adolescent psychiatrist, or another qualified mental health professional about the behavioral problems your child is experiencing.

For more information on effective discipline methods, please see our *Facts for Families* #43 Discipline.

Other related *Facts for Families* include:
#5 Child Abuse: The Hidden Bruises
#24 When to Seek Help for Your Child
#25 Where to Find Help for Your Child
#55 Understanding Violent Behavior in Children and Adolescents
#81 Toddler Behavior: Fighting and Biting

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 106 July 2013

Marijuana and Teens

Many teenagers experiment with marijuana. Friends, peer pressure, and portrayal of marijuana in the media often affect a teenager's decision to use. Parents can also play an important role in teaching their children about the risks of using drugs.

Buying and using marijuana is illegal. Still, teen marijuana use is at its highest in 30 years, and teens are now more likely to use marijuana than tobacco. In 2011, a national study showed that one in eight 8th graders, one in four 10th graders, and one in three 12th graders have used marijuana in the past year.

There are over 200 different street names for marijuana. Many of them are based on the type of drugs or tobacco that is mixed in with the marijuana, "brands" from various areas in the country or around the world, or specially bred strains. Some common names include blunt, bud, pot, spliff, and weed. "K2" and "spice" are examples of synthetic (man-made) marijuana-like drugs. There are also street names for smoking marijuana, including blazing, bonging, puffing, and toking.

Parents and Prevention

Talking with your child when they are in elementary or middle school in an honest and open way can prevent drug use in the future. The following are tips on for how to discuss marijuana with your child:

- Ask what he/she has heard about using marijuana. Listen carefully, pay attention, and do not interrupt. Avoid making negative or angry comments.
- Offer your child facts about the risks and consequences of smoking marijuana
- Ask your child to give examples of the effects of marijuana. This will help you make sure that your child understands what you talked about.
- If you choose to talk to your child about your own experiences with drugs, be honest about your reasons, be careful not to glamorize marijuana or other drugs, and discuss the negative things and dangers that resulted from you or your friends' drug use

Sometimes parents may suspect that their child is already using marijuana. The following are common signs of marijuana use:

- Dizziness
- Acting silly for no reason
- Being hungry and eating more than usual
- Red eyes or use of eye drops
- Increased irritability or grumpiness
- Reduced motivation and lack of interest in usual activities
- Trouble remembering things that just happened

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- A smell on clothes, or the use of incense or other deodorizers
- Owning clothing, posters, or jewelry encouraging drug use
- Having pipes or rolling papers
- Stealing money or having money that cannot be accounted for

Many teenagers believe that marijuana is safer than alcohol or other drugs. When discussing marijuana with your child, it is helpful to know the myths and the facts. The following are some common myths about marijuana:

- *"It is harmless and natural, it is only an herb, and it won't affect me long-term"*
- *"It is not addictive"*
- *"It doesn't hurt me as much as smoking tobacco"*
- *"It makes me feel calm"*
- *"It doesn't affect my thinking or my grades"*
- *"It's safe because it is used as medicine for cancer and other diseases"*

Effects of Marijuana

Regular use of marijuana can lead to dependence, which causes users to have a very hard time stopping. When teens use marijuana regularly, they may crave marijuana and give up important activities to use marijuana. If they stop using, they may suffer from withdrawal symptoms which can include irritability, anxiety, and changes in mood, sleep, and appetite.

Marijuana can also cause serious problems with learning, feelings, and health. Tetrahydrocannabinol (THC) is the active ingredient in marijuana. THC affects the brain's control of emotions, thinking, and coordination.

Use of marijuana can lead to:

- School difficulties
- Problems with memory and concentration
- Increased aggression
- Car accidents
- Use of other drugs or alcohol
- Risky sexual behaviors
- Increased risk of suicide
- Increased risk of psychosis

Long-term use of marijuana can lead to:

- The same breathing problems as smoking cigarettes (coughing, wheezing, trouble with physical activity, and lung cancer)
- Decreased motivation or interest
- Lower intelligence
- Mental health problems, such as depression, anxiety, anger, moodiness, and psychosis
- Decreased or lack of response to mental health medication
- Increased risk of side effects from mental health medication

Medical Marijuana
Currently, only man-made forms of THC are approved by the Food and Drug Administration (FDA) for a very small number of specific medical uses. **There are no FDA-approved medical reasons for children or teenagers to use marijuana or THC in any form.**

"Medical marijuana" is not checked for ingredients, strength, or safety. There is no evidence that medical marijuana is any safer than other marijuana.

The use of marijuana is illegal in the United States and prohibited by Federal law. However, medical marijuana laws are different from state to state. Several states allow the use of medical marijuana for adults. Almost all of these states still say that it is a crime for minors to sell, have, or use marijuana.

Conclusion
Marijuana use in teens can lead to long-term problems. Teens rarely think they will end up with problems related to marijuana use, so it is important to begin discussing the risks with your child early and continue this discussion over time. Talking openly with your child will help with prevention. If your child is already using, open communication will help you know more about his or her use. If you have concerns about your child's drug use, talk with your child's pediatrician or a qualified mental health professional.

Related Facts for Families include:
#3 Teens: Alcohol and Other Drugs
#41 Substance Abuse Treatment for Children and Adolescents: Questions to Ask
#68 Tobacco and Kids
#93 Drinking Alcohol in Pregnancy (Fetal Alcohol Effects)

For more information about marijuana, drugs, and teenagers, you can check out:

HBO Series on Drugs and Addiction
- http://www.hbo.com/addiction/adolescent_addiction/221_marijuana.html

National Institute on Drug Abuse (NIDA)
- Information for Parents about Drugs: http://drugabuse.gov/parent-teacher.html
- Information for Parents about Drugs: http://drugabuse.gov/students.html
- Information about Marijuana: http://drugabuse.gov/DrugPages/Marijuana.html
- Marijuana Facts for Teens and Parents: http://drugabuse.gov/MarijBroch/Marijteens.html

See also: *Your Child* (1998 Harper Collins) / *Your Adolescent* (1999 Harper Collins)

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 107 December 2012

Religion, Spirituality and Your Mental Health Care

Religion and spirituality can be important in the lives of youth and families. Religion and spirituality can:

- serve as sources of strength and coping during times of stress and illness
- serve as the basis for family values and traditions
- contribute to moral and social development

Many religious institutions also offer valuable community services and support for children and families, such as child care, shelters, food, recreation programs, and emergency aid.

Religion and spirituality can have positive influences on children and families, but some situations can also lead to distress. Normal adolescent development can lead to questioning religious beliefs or taking on other religious beliefs that may cause family conflict. Sometimes your family's religious beliefs may differ from those your child is exposed to in everyday life (school, sports, and community activities). Being aware of how stressful this can be is important. Talking openly with your child can be helpful.

Child and adolescent psychiatrists appreciate the importance of religion and spirituality. A comprehensive mental health evaluation often includes questions about your child and family's religious and spiritual beliefs. If religion and spirituality are an important part of your family's life the following tips may be helpful:

- Your clinician should respect and be curious about the role of religion in the life of your child and your family.
- Your clinician does not have to be of the same religious and spiritual background as your family to provide good healthcare care to your child.
- With your permission, in some situations, it can be helpful for your clinician to speak to your religious or spiritual leader.

If you feel like your clinician is not aware of or receptive to the importance of religion and spirituality in your family discuss it with them. If the concerns continue, consider finding another clinician.

Differences in religion can cause conflict within a family. Sometimes children and adolescents find it helpful to talk to friends or other family members who observe their religion to help clarify and discuss beliefs and practices. If you and your child are having conflicts about religion, it may also be helpful to consult with your clergyperson. If the

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

conflicts do not improve and get in the way of your family getting along, consider consulting a trained mental health professional. If your child has a sudden or extreme change in his or her religious practices, this may be a sign of an underlying mental health problem. In these cases, it may be helpful to consult with a child and adolescent psychiatrist or another trained mental health professional.

For more information, see Facts for Families:
#22 Normality
#24 When to Seek Help for Your Child
#25 Where to Find Help for Your Child
#36 Helping Children After a Disaster
#52 Comprehensive Psychiatric Evaluation

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 108 April 2013

Telepsychiatry and Your Child

Telepsychiatry is the use of videoconferencing to provide psychiatric evaluation, consultation and treatment. This technology is used by a child and adolescent psychiatrist to provide care to a patient (a child or teen and a parent) at a distant location. High quality audio and video can make a telepsychiatry consultation seem almost like an in-person appointment.

Why use telepsychiatry?

Some youth who struggle with mental health problems do not live near a child and adolescent psychiatrist or other mental health expert. It is difficult for many families to travel to a distant city to get the help they need. Sometimes, their doctor or counselor requests a telepsychiatry consultation from a child and adolescent psychiatrist. Telepsychiatry is also sometimes used in emergency room settings.

How does telepsychiatry work?

Telepsychiatry appointments are similar to regular doctor visits except that the doctor and patient are in different locations. A staff member or therapist may also be present to participate in the appointment with the youth and parent. Both locations will have a television screen or computer monitor that allows two-way communication.

What are the benefits of telepsychiatry?

The main benefit is that youth obtain expert care that is not available near their homes. Telepsychiatry also helps to minimize the inconvenience and costs of traveling to distant cities, especially if the youth needs ongoing visits. The psychiatrist can also consult with other professionals taking care of the youth, such as the primary care physician, therapist, or teacher. Telepsychiatry usually does not cost more than an in-person visit.

Will telepsychiatry be as effective as regular visits?

Research with adults shows that telepsychiatry is just as effective as treatment provided in-person. Research with youth and families is just beginning. It shows that children, families and referring doctors are very satisfied with the care received through telepsychiatry. Treatment recommendations, prescriptions, and laboratory tests can be coordinated by the telepsychiatrist or the referring doctor's office.

Do telepsychiatrists get special training?

Most telepsychiatrists learn from other telepsychiatrists, or staff at the medical center, or from a company that hires them to provide telepsychiatry services. There is no state or national certificate. Recently, practice guidelines have been developed by the American Academy of Child and Adolescent Psychiatry and by the American Telemedicine Association.

Will my insurance cover telepsychiatry?

Insurance coverage for telepsychiatry varies by state. Parents should ask their local clinic, insurance provider, or psychiatrist. It is important to let the insurance company know that there are no available child and adolescent psychiatry resources in the area, and that telepsychiatry is not telephone therapy.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Below are some questions to ask before starting telepsychiatry to learn how the consultation or treatment will proceed:

- Why is telepsychiatry being recommended for my child and how will it help?
- What are other treatment alternatives and how do they compare?
- Is this a one-time consultation or will my child be in ongoing treatment?
- How much will it cost and how will the services be paid?
- What are the arrangements for laboratory tests and prescriptions?
- What happens if there is an emergency?
- How will my child's privacy be protected?
- Is the technology secure?
- What happens if the equipment doesn't work?

Consultation and ongoing treatment with a child and adolescent psychiatrist using telepsychiatry can be very helpful for many children and adolescents. If parents still have questions or doubts, they can ask the referring provider, the telepsychiatrist, or they can seek a consultation for a second opinion.

For additional information, see *Facts for Families*:
#00: The Child and Adolescent Psychiatrist
#52: Comprehensive Psychiatric Evaluation
#21: Psychiatric Medication for Children and Adolescents: Part I
#29: Psychiatric Medication for Children and Adolescents: Part II
#51: Psychiatric Medication for Children and Adolescents: Part III
#86: Psychotherapies for Children and Adolescents

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 109 April 2013

Helping Children Exposed to Domestic Violence

As many as ten million children and adolescents witness violence between their caregivers each year. This kind of violence is called domestic violence or intimate partner violence. The US Department of Justice defines domestic violence as "a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner." Domestic violence can be verbal, physical, sexual, or psychological. Domestic violence can occur between heterosexual or same sex couples.

Parents or caregivers involved in a violent relationship may think that the fighting does not affect their children. Even children who do not see domestic violence are affected by the conflict in the family. Children may develop serious emotional and behavioral problems. These problems are not always recognized by their parents or caregivers. As a result, children do not always get the help they need.

When there is domestic violence between partners, there is often child abuse as well. Sometimes children get hurt accidentally. Children need to be assessed for their health and safety when domestic violence occurs.

Symptoms to watch out for in young children include:

- Anxiety or increased fear
- Depression
- Loss of interest in school, friends or other things they enjoyed in the past
- Sleep problems including nightmares or bedwetting
- Increased aggression
- Anger
- Spending more time alone
- Fighting at home or at school
- Bullying or being bullied
- Changes in appetite

Symptoms to watch out for in adolescents include:

- Drug or alcohol abuse
- Skipping school
- Changes in peer groups
- New rebellious or oppositional behavior
- Declining grades
- Social withdrawal
- Depression or anxiety
- Loss of interest in school, friends or other things they enjoyed in the past

Children and adolescents exposed to domestic violence should be evaluated by a trained mental health professional. There are good treatments for the emotional and behavioral problems caused

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

by domestic violence. Treatment can include individual, group or family therapy, and in some cases, medication may also be helpful. It is critical for the child/children and victimized parent to receive treatment in a setting where they feel safe.

It is important to remember that the non-abusive parent needs support as well. There is no typical victim—domestic violence can happen to anyone. Shame or embarrassment often gets in the way of victims getting help.

If domestic violence happens once, it usually happens again. It is important to put a crisis plan in place, both for the caregiver and the child. A crisis plan should include a safe place to stay, friends or relatives who can help with childcare, transportation and financial support.

The National Domestic Violence Hotline for victims is 1-800-799-SAFE (7233), 1-800-787-3224 (TTY) or www.thehotline.org. Information about local programs or resources is also available through this service.

For more information, see the following Facts for Families:
#4 The Depressed Child
#5 Child Abuse: The Hidden Bruises
#18 Children's Bedwetting
#34 Children's Sleep Problems
#53 What is Psychotherapy for Children and Adolescents
#70 PTSD

Also visit the Child Abuse Resource Center.

References:
http://www.ovw.usdoj.gov/domviolence.htm

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to *Campaign for America's Kids*, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 110 May 2013

Disruptive Mood Dysregulation Disorder

Disruptive Mood Dysregulation Disorder (DMDD) is a relatively new diagnosis in the field of mental health. Children with DMDD have severe and frequent temper tantrums that interfere with their ability to function at home, in school or with their friends. Some of these children were previously diagnosed with bipolar disorder, even though they often did not have all the signs and symptoms. Research has also demonstrated that children with DMDD usually do not go on to have bipolar disorder in adulthood. They are more likely to develop problems with depression or anxiety.

Many children are irritable, upset or moody from time to time. Occasional temper tantrums are also a normal part of growing up. However, when children are usually irritable or angry or when temper tantrums are frequent, intense and ongoing, it may be signs of a mood disorder such as DMDD.

Symptoms of DMDD

The symptoms of DMDD include:

- Severe temper outbursts at least three times a week
- Sad, irritable or angry mood almost every day
- Reaction is bigger than expected
- Child must be at least six years old
- Symptoms begin before age ten
- Symptoms are present for at least a year
- Child has trouble functioning in more than one place (e.g., home, school and/or with friends)

Some of the symptoms associated with DMDD are also present in other child psychiatric disorders, such as depression, bipolar disorder and oppositional defiant disorder. Some children with DMDD also have a second disorder, such as problems with attention or anxiety. This is why it is particularly important to get a comprehensive evaluation by a trained and qualified mental health professional.

What To Do

The treatment for DMDD will be individualized to the needs of the particular child and his or her family. It may include individual therapy, as well as work with the child's family and/or school. It may also include the use of medication to help address specific symptoms.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

Parents of children with DMDD should learn as much as they can about the disorder. They should ask lots of questions about the risks and benefits of specific treatment options before deciding what is best for their child. If they have questions or concerns about the diagnosis or treatment alternatives, they should always feel free to get a second opinion.

Having a child with DMDD can be a challenging experience. Appropriate treatment for your child is important. However, it is also important to make sure you have the information, support and assistance you need.

More information about children with DMDD and other challenging behaviors is available from:

The Balanced Mind Foundation at www.thebalancedmind.org
National Alliance on Mental Illness at www.nami.org
Mental Health America at www.mentalhealthamerica.net

For more information, see Facts for Families:

#4 The Depressed Child
#6 The Child Who Can't Pay Attention (ADHD)
#33 Conduct Disorder
#38 Bipolar Disorder
#47 The Anxious Child
#52 Comprehensive Psychiatric Evaluation
#55 Understanding Violent Behavior in Children and Adolescents
#72 Oppositional Defiant Disorder

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute Facts for Families, as well as other vital mental health information, free of charge.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 111 December 2013

College Students with ADHD

Many students with Attention Deficit Hyperactivity Disorder (ADHD) attend college. College students with ADHD face a number of challenges, including choosing a supportive school and community where they can:

- find and access medical services
- get help with organizing their schedule and life
- succeed academically

Most people with ADHD are diagnosed before college. However, some people may not recognize the signs and symptoms of ADHD until they are at college. Trying to balance school work and the freedom of living away from home for the first time may be challenging. It can be natural to feel unfocused, distracted, overwhelmed, or disorganized when attending college. However, if these issues have caused significant problems in the past and are getting in the way of current functioning, the student may have ADHD.

If a student is struggling, it may be helpful to seek consultation with a qualified mental health professional. The diagnosis of ADHD is made based on a comprehensive clinical assessment. This may include information from multiple sources, including rating scales, getting history from the student, family, or past teachers if possible. There is no single test (brain imaging, blood testing, or psychological testing) that can reliably diagnose ADHD. Research shows that medication is the most effective treatment for ADHD. Cognitive-behavioral therapy, social skills training, and academic support can also be helpful.

There are many ways to successfully manage ADHD before and during college.

Preparing for and Staying Organized While at College

- Consider the best college environment to meet your needs, such as class size, workload, academic calendar, and availability of support services. Resources to help you find the best college include: high school counselors, parents, friends who are in or have attended college, and national ADHD organizations or websites.

- Learn about the medical services available at colleges before choosing where to go. Some college and university health centers do not prescribe ADHD medications. You may need to find a doctor in the surrounding community. Think about the transportation options and ease of access to that provider.

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- Talk with your doctor about how to best manage your medications when at college. Do not make changes in your medication without consulting your doctor. Ask your current doctor and the doctor at college to coordinate care. It is also helpful to have a history of your medications and your response to those medications for your new doctor.

- If you have used tutors or support before college, think about continuing at college, at least for a little while.

- If you need specific support or accommodations, register at the college disability office. If you have a summary of treatment or any psychological tests that were done within the last 3 years, bring them to the visit.

- Practice using planners, calendars, or scheduling apps while still in high school. The demands on time management and organization increase greatly in college. Even if your parents helped you in the past, it is important to learn to do it yourself.

Managing Medications at College

- Many medications prescribed for ADHD have to be monitored regularly. While at college, you need to schedule and keep your own medical appointments. Changes to your medication should only be made after talking with your doctor.

- Learn how to use pharmacy services. Pay attention to prescription start dates and expiration dates. Many medications prescribed for ADHD are "controlled substances" so states may have additional rules on how these medicines can be provided, including limits on how often prescriptions can be refilled.

- Taking medication that is not prescribed for you, sometimes called "diversion" or "academic doping," is illegal and unsafe. Your medications were prescribed by your doctor who knows you and your medical history. They should only be taken by you. There are serious cardiac, neurological, and psychological risks of misusing ADHD medications. There can also be serious risks to mixing medications with alcohol or other drugs.

- Keep medications safely stored or hidden to protect against theft. If medications are stolen, report it to campus or local police.

Adjusting to the academic, social, and organizational demands of college is difficult for most students. It can be especially difficult for students with ADHD. Arranging for support from medical and school professionals can help students with ADHD have a successful college experience, as well as a long career after graduation.

For additional information, see the ADHD Medication Guide and ***Facts for Families***:
#4 The Depressed Child
#6 Children Who Can't Pay Attention/ADHD
#16 Children with Learning Disabilities
#22 Normality
#41 Substance Abuse Treatments for Children and Adolescents: Questions to Ask
#47 The Anxious Child
#57, #58 Normal Adolescent Development
#66 Helping Teenagers with Stress

# # #

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute *Facts for Families*, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to ***Campaign for America's Kids***, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,700 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 112 December 2013

Finding Mental Healthcare for Children of Immigrants

Each year, many immigrants and refugees move to the United States. Coming to a new country can be an exciting new beginning, but adjusting to a new home, language, and culture can be difficult. These changes can be especially hard on children, who can feel sad, anxious, or angry. They may have difficulty talking about their feelings, misbehave, do poorly in school, or have trouble fitting in and making friends.

Finding a mental health professional who can understand and help with these problems can be difficult. There are many reasons that parents wait to ask for help. These can include:

- trouble speaking or understanding English
- trouble understanding the mental health system in the United States
- thinking the clinician will not understand the culture
- being afraid of being blamed
- not having transportation
- not having health insurance or money to pay
- worrying that friends or family will find out
- worrying about legal status
- worrying about the school, court, or police becoming involved
- thinking that getting help will keep your child from going to college

If you and your child have moved to the United States and are looking for help from a mental health professional, it is helpful for you to know that there are rules every clinician needs to follow. The clinician must respect your privacy and keep your information private. The clinician needs your permission to talk to anyone about you and your child, including teachers, doctors, and family members. They cannot contact the police or other authorities unless your child is being badly hurt or is in danger of hurting themselves or others.

Immigrant families often want to see a mental health professional who has a similar background. Families may feel it is easier to talk with someone who already understands their culture. Some of the ways that families can find a clinician who shares their cultural background are:

- talking with members of their cultural community
- talking with a spiritual or religious leader

3615 Wisconsin Avenue, NW ■ Washington, DC 20016-3007 ■ 202.966.7300 ■ (FAX) 202.966.2891
http://www.aacap.org

- checking newspapers, magazines, or websites
- talking with the school counselor or teacher

Talking to a professional from a different culture or background can still be very helpful. If the professional does not speak the same language, interpreters are available. Let your professional know before the visit so that arrangements can be made. It is best not to use your child, a friend, or a family member as an interpreter.

The professional may want to speak to you separately from your child. If your child is already an adult, it is helpful to tell the professional if your family would like to be included in part of the appointment.

Families can help their clinician understand the differences in their culture and backgrounds. If your clinician does not ask, it will be helpful for you to bring up subjects that help the professional understand some of the differences in your culture, such as:

- cultural values and religious beliefs
- traditional medicines or treatments used
- parenting practices and discipline methods
- the role of family and community in your child's life
- what is expected of children at different ages
- how and when feelings are shown
- worries or questions you may have about your child

It will also be very helpful for the professional to know what life was like in the home country, and why you left. It will also be important to talk about any stressful experiences that happened before, during, or after the immigration.

One of the challenges that families face is that parents and children may adjust to their new lives differently. Many parents have a harder time adapting to a new culture than their children. The differences between the new culture and the way you were raised in your home country might make you worried that your child will learn different beliefs and values. It is important to tell your clinician about how each member of the family has been adapting to the new culture.

Immigrating to a new country and adapting to a new culture and language can be very difficult. Parents may struggle with finding timely help for their child. There are mental health professionals who share or are aware of the differences in language, culture, and background and can help your child do better in the new country.

For additional information, see ***Facts for Families***:
#0 Definition of a Child and Adolescent Psychiatrist
#4 The Depressed Child
#6 Children Who Can't Pay Attention/ADHD
#24, #25 Seeking Help for Your Child
#26 Understanding Your Mental Health Insurance

#43 Discipline
#47 The Anxious Child
#52 Comprehensive Psychiatric Evaluation
#71 Multiracial Children
#80 Bullying
#103 Know Your Rights: Consent and Confidentiality
#107 Religion, Spirituality and Your Mental Health Care

See also: Your Child (1998 Harper Collins) / Your Adolescent (1999 Harper Collins)

Facts about Stigma and Mental Illness in Diverse Communities:
www.nami.org/contentmanagement/contentdisplay.cfm?ContentFileID=5148

# # #

If you find ***Facts for Families***© helpful and would like to make good mental health a reality, consider donating to the **Campaign for America's Kids**. Your support will help us continue to produce and distribute *Facts for Families*, as well as other vital mental health information, free of charge.

You may also mail in your contribution. Please make checks payable to the AACAP and send to ***Campaign for America's Kids***, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 8,500 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

If you need immediate assistance, please dial 911.