

Adjustment Disorder

Early Childhood Mental Health Fact Sheet

About the Disorder

Adjustment disorder is a change or regression in behavior or emotions in response to a specific environmental change in a child's life. A child struggling with this disorder will respond to the stress of change in a way that is excessive when compared to what is considered normal for that child. This disorder may also appear in children who are going through a change in placement. For example, a child who moves to a new foster home or is adopted into a new home—even the most wonderful, loving home ever imagined—may experience an adjustment disorder. Adjustment Disorder can manifest itself as anxiety, depression, or it may be indicated by behavior that is uncharacteristic for specific a child.

There is not a specific type of event that will necessarily lead to an adjustment disorder, and not all children will respond to unsettling events in the same way. For example, an unsettling event could happen to several children—even children in the same family—but only one of the children may experience an adjustment disorder. The way a child responds to an unsettling event may also be affected by a child's cultural background and everyday experience. Adjustment disorders occur in both males and females and can occur in children of all ages.

IMPORTANT

This fact sheet is not intended to be used as a diagnostic tool. It is meant to be used only as a reference for your own understanding and to provide information about the different kinds of behaviors and mental health issues you may encounter.

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.

What You May See

Children who are fussy and act out for a week when their parent returns to work are not showing signs of an adjustment disorder. They are experiencing new rules, new hours, and possibly a new feeding schedule and may, predictably, seem unsettled. A child who develops intense separation anxiety or is noticeably sad and/or withdrawn for an extended period of time after a significant family change, however, may be experiencing an adjustment disorder.

Infants and young children have little control over many aspects of their daily life. They do not, for example, decide where to live, which childcare they will attend, or how long they will stay at childcare. Changes in these areas, as well as stressors such as major illness, parental divorce, birth of a sibling, and excessive marital conflict, can lead children to develop an adjustment disorder. In response to these changes, a child who usually plays happily may become aggressive; a child who often plays alone may begin to engage other children in a negative way; a child who typically is very good natured may become upset easily and begin to have tantrums; and a child who has mastered a developmental milestone, such as toileting, may regress.

Children are wonderful observers of their world, however, they are not always accurate interpreters. When a child begins to appear stressed, parents and caregivers often find clues to the child's behavior when they are able to see the world from their child's perspective. Events that may not seem disturbing to adults, such as the birth of a new child, may affect children differently. It is often not the change itself but the child's perception of the environmental change that causes the stress and, sometimes, a subsequent adjustment disorder.

Symptoms

A child with Adjustment Disorder may exhibit one or all of the following:

- Appear subdued, irritable, anxious, or withdrawn
- Resist going to sleep
- Have frequent tantrums
- Regress in the ability to toilet independently
- Have increased separation anxiety
- Exhibit acting-out behaviors that are uncharacteristic for the child such as hitting or biting



Adjustment Disorder

(continued)

Strategies

Life can, at times, present unavoidable conflicts and difficulties. Although we cannot always control our children's environment, we do need to be attuned to when environmental changes begin to negatively affect the children in our care. Whenever possible, anticipating upheaval and preparing a child for changes in routines can often help a child to maintain a sense of security. Mentioning an anticipated change in a calm, relaxed way several times before the actual change takes place can reassure a child that although change may feel unsettling, their world will remain safe and secure.

Some changes in a child's environment are completely unexpected and may even cause the child's caregivers to have difficulty adjusting to the new circumstance. When unanticipated events disrupt a child's environment, allow the child time to get used to whatever has changed. For example, a preschool teacher may suddenly come down with a serious illness and be unable to return to the classroom for several months. In this case, take time to introduce any new teachers to the children and explain that the previous teacher may not be coming in for a while. Be sure to use a calm and self-assured manner. Children are pretty good at sensing when an adult is unsettled. Avoid lengthy explanations about what has occurred—children don't usually need in-depth explanations; they usually just need to be reassured that someone is in control and that their life will go on with as little disruption as possible.

Documenting Your Concerns and Next Steps

When documenting behavior, avoid generalizations such as "the child appears depressed or anxious"; instead, record specific behaviors you are seeing or not seeing. For example, "Caleb did not want to participate in art time; we were using finger paints today, which is typically one of Caleb's favorite activities" or "When we went outside, Caleb sat in the sandbox but did not climb or slide as he has done almost every day since joining our group" or "This is the third day in a row that Caleb has had trouble falling asleep at nap time." Also note what happened before and after the behavior. For example, did Caleb have a disagreement over a toy before art time.

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH's *A Guide to Early Childhood Mental Health*, available for order at www.macmh.org.

Ready Resources

- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- National Institute of Mental Health at www.nimh.nih.gov
- SAMHSA's National Mental Health Information Center at www.mentalhealth.samhsa.gov
- ZERO TO THREE at www.zerotothree.org

Information included in this fact sheet comes primarily from the DC:0-3R (Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood: Revised Edition).

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Anxiety Disorders

Early Childhood Mental Health Fact Sheet

About the Disorder

All young children feel anxious at times. Many infants and toddlers, for example, show great distress when separated from their parents, and preschoolers are often frightened of strangers, thunderstorms, or the dark. These anxieties are normal and are usually short-lived.

An anxiety disorder occurs, however, when a child experiences excessive worry, concern, or fear while involved in developmentally appropriate tasks, ordinary interactions, and everyday routines. Anxiety disorders in children are characterized by worry, concern, or fear that is exaggerated, pervasive, disproportionate to the situation at hand, and inappropriate for the child's age or developmental level. There are many types of anxiety disorders—here are the most common.

• **Generalized Anxiety Disorder**

Children experience excessive anxiety and worry more days than not for a period of more than six months. These children may have difficulty concentrating and/or difficulty falling or staying asleep. They often appear on edge or irritable and may have a more difficult time maintaining emotional stability. The child's anxiety and worry will interfere significantly with their functioning and/or development.

• **Separation Anxiety Disorder**

Separation from the caregiver causes the child excessive anxiety and distress that has intensity and duration beyond that of typical development and lasts more than one month; children experiencing this disorder often refuse to be held or comforted by a substitute caregiver. These children are also

often preoccupied with fears that their primary caregiver will have an accident or become sick; the child may also fear that they might have an accident or illness while separated from their primary caregiver. Children may also worry about getting lost or kidnapped. Physical complaints such as headaches, stomachaches, nausea, or vomiting are also common when separation from the caregiver occurs or is anticipated.

• **Specific Phobia**

Children experience excessive fear when they are in the presence of specific objects or exposed to certain situations; the fear may even occur when the child is just anticipating such experiences. The fear must last at least four months. Exposure to the object or situation will cause an immediate reaction by the child—usually crying, a tantrum, becoming immobile, or becoming “clingy.” The child will attempt to severely limit their own activities and their family's activities to avoid possible exposure to the feared object or situation.

• **Social Anxiety Disorder (Social Phobia)**

A child will have a persistent fear of social or performance situations that include people unfamiliar to the child or the child will be in a situation where they are under the scrutiny of others; this typically includes such things as play dates, large family gatherings, birthday parties, religious ceremonies, and/or collective sharing times at childcare or preschool; the fear must last at least four months. These situations may cause reactions such as crying, having a tantrum, becoming immobile, becoming clingy, or strongly resisting being involved in social situations. The child will avoid the feared social situation and may have anticipatory anxiety that interferes with their normal functioning and development.

• **Anxiety Disorder NOS (Not Otherwise Specified)**

Although not often used, this category may be used when a child exhibits some symptoms of an anxiety disorder but, taken together, the symptoms do not fulfill the diagnostic criteria of a specific anxiety disorder. A parent or caregiver may see uncontrollable crying or screaming, agitation and/or irritability, sleeping and/or eating disturbances, separation distress, or social anxiety. Caregivers should be careful to notice if the onset of the symptoms occurred after the child endured a trauma; in that case, the child may be at risk for posttraumatic stress disorder.

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Anxiety Disorders

(continued)

What You May See When

Children with anxiety disorders usually exhibit an excessive level of fear toward normal challenges and/or when learning new skills. Infants may display anxiety by crying inconsolably or screaming; sleeping and eating disturbances may also indicate a higher level of anxiety. Toddlers and preschoolers experiencing an anxiety disorder may exhibit recklessness and aggression directed toward themselves or others. For example, a toddler may be so afraid of the dark that the lights being turned down at nap time cause him to aggressively run from the room, or a child may become aggressive and run reckless when confronted with a new but developmentally appropriate activity such as finger painting.

It is also common for children to react with somatic complaints such as stomachaches or headaches.

Symptoms

- Multiple fears
- Specific fears
- Limited play repertory
- Difficulty with transitions between activities
- Reckless and defiant behavior
- Excessive stranger anxiety
- Excessive separation anxiety
- Excessive inhibition due to anxiety
- Lack of impulse control

Strategies

- Avoid belittling the fear or anxiety; instead, validate the concern without confirming that the fear is real. For example, “You are worried about your dad leaving—that can be scary to think about.”
- Use and teach positive self-talk; listen to what the child says and help them to replace negative thoughts with positive ones. For example, if your child says “I can’t go outside because their might be a dog and dogs are scary,” you can say “Some dogs outside are mean and may be scary, but not all dogs are. I’ll help you figure out which ones aren’t mean so you can feel okay outside.”
- If the anxiety is around learning or mastering new skills, teach building-block skills. For example, if a child seems overwhelmed at the thought of getting dressed by themselves, teach them to zipper or button first, then work toward the goal of independent dressing over time.

- For separation anxiety, try using a transitional object—something the child receives from their caregiver to hold while the caregiver is gone.
- Help the child verbalize their feelings and fears. With young children, help them to distinguish between a little bit scared and a whole lot scared.
- Teach relaxation and deep-breathing exercises to children who are able to understand and participate in these activities. Blowing bubbles and pretending to blow bubbles, learning to whistle, or actively trying to move their bellies in and out are all fun ways for children to learn deep breathing.

Documenting Your Concerns and Next Steps

When documenting behavior, be as specific as possible and avoid generalizations such as “Shayla looked anxious.” Instead, record specific behaviors you are seeing or not seeing and provide as much detail as seems relevant. Also include the context in which the behavior occurred. For example, noting that “Shayla held her blanket tight and got teary-eyed as the children lined up to go outside” is more informative than “Shayla wouldn’t line up to go outside.”

If a child’s behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child’s behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

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Ready Resources

- Anxiety Disorder Association of America at www.adaa.org
- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- National Institute of Mental Health at www.nimh.nih.gov
- SAMHSA’s National Mental Health Information Center at www.mentalhealth.samhsa.gov
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Attention-Deficit/ Hyperactivity Disorder (AD/HD)

Early Childhood Mental Health Fact Sheet

About the Disorder

Although the symptoms of Attention-Deficit/Hyperactivity Disorder (AD/HD) can sometimes appear in preschoolers, the diagnosis of AD/HD in preschoolers is very difficult. Many of the symptoms required for an AD/HD diagnosis—difficulty sustaining attention and effort, lack of attention to detail, seeming not to listen, difficulty following through on tasks and instructions, disorganization, distractibility, talking excessively, difficulty waiting one's turn, and interrupting others—are actually developmentally appropriate behaviors for young children who are in the process of learning impulse control and self-regulation. To further complicate matters, language delays, developmental problems, anxiety, depression, and adjustment disorders are all things that can imitate AD/HD.

Of course, some preschool children actually do have AD/HD, and they need treatment and intervention. For these children there will likely be a qualitative difference in the way they exhibit the behaviors listed above. Because the symptoms of AD/HD are similar to developmentally appropriate behaviors and can be imitated by other health concerns, it is exceedingly important that qualified and skilled professionals conduct the assessment of very young children. In fact, preschoolers suspected of having AD/HD may need to be evaluated by a pediatrician, psychologist or psychiatrist, neurologist, speech pathologist, and/or developmental pediatrician to develop a full understanding of a child's behaviors.

Although pinpointing an actual diagnosis may be a difficult and complex task, helping a child develop proper social and

academic skills during early childhood can be crucial to their future success.

What You May See

Most children have more energy than adults—they can play hard all day long and still not seem tired. Some children do have a naturally higher energy level than others, but a preschooler with AD/HD will likely have more difficulty sitting and listening to a story, they may behave more aggressively toward other children when they get distracted or bored, or they will interrupt much more often than other children. And although the early years are a time when children naturally struggle to learn impulse control, children with AD/HD will have a more difficult time learning to control their impulses.

AD/HD in the Early Childhood Years

Although the revised *Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood* (DC:03R) does not list diagnostic criteria for AD/HD, we are providing a fact sheet about it because of the increase in the number of children younger than age 5 who are being diagnosed and treated for the disorder.

The American Academy of Pediatrics recognizes that AD/HD is difficult to diagnose in this population because young children are developing so rapidly and because many children display symptoms of AD/HD as part of their typical development in their early years. Despite this acknowledged difficulty, epidemiological data suggests that approximately 2 percent of children aged 3–5 years meet diagnostic criteria for AD/HD.

In fact, a 1990 review showed that 34 percent of pediatricians and 15 percent of family physicians had prescribed psychostimulant medications to preschoolers with AD/HD. Other studies indicate the growing use of stimulants in preschoolers during the 1990s. Stimulant medication treatment in preschoolers increased approximately three-fold in the early 1990.

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Attention-Deficit/Hyperactivity Disorder (AD/HD)

(continued)

Symptoms

- Difficulty sustaining attention and effort
- Lack of attention to detail
- Seemingly unable to listen
- Difficulty following through on tasks and instructions
- Disorganized
- Easily distracted
- Talks excessively
- Has difficulty waiting one's turn
- Interrupts others
- Lacks impulse control

Strategies

- Be patient and stay calm if the child is acting out.
- Teach the behaviors you would like the child to exhibit. Understand that the child may be practicing new skills and have patience.
- Teach calming skills such as deep breathing exercises. Blowing bubbles and pretending to blow bubbles, learning to whistle, or actively trying to move their bellies in and out are all fun ways for children to learn deep breathing.
- Teach strategies for impulse control—for example, say “I know you are excited to take a turn, why don’t you march in place until your turn.”
- Play games that teach the child to anticipate what may happen next.
- Give the child plenty of time to respond when working to solve a problem.
- Provide structure and clearly define expectations.
- Give one direction at a time, for example, say “Let’s put the toys away” instead of “Pick up your toys, get your boots, and then we will go outside to play.”
- Sharing books like *Jumpin’ Johnny Get Back to Work!: A Child’s Guide to ADHD/Hyperactivity* by Gordan Michael can sometimes be helpful.

Documenting Your Concerns and Next Steps

When documenting behavior, be as specific as possible and avoid generalizations like “Pete is always hyperactive”; instead, record specific occurrences. Here’s an example: “At lunch time, Pete was reminded three times of the clean-up chores that follow lunchtime. When Pete finished his lunch, he left the table and began playing without washing his hands, busing his dishes, or taking off his bib. When I redirected him to do the clean-up chores, he threw his plate on the floor and then sat down and screamed.” That is a much more complete picture than, “Pete can’t stay focused on tasks he is asked to do.” When noting worrisome behaviors, also look for patterns and areas of development where the child may need additional teaching. Does the child need different teaching methods or to learn skills in a different order than other children?

If a child’s behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child’s behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

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Ready Resources

- Children and Adults with Attention-Deficit/Hyperactivity Disorder at www.chadd.org
- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- SAMHSA’s National Mental Health Information Center at www.mentalhealth.samhsa.gov
- National Institute of Mental Health at www.nimh.nih.gov
- ZERO TO THREE at www.zerotothree.org

Information included in this fact sheet came primarily from the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision).

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Depression

Early Childhood Mental Health Fact Sheet

About the Disorder

Most children will, at some time, show signs of sadness, be whiny, or engage in their play halfheartedly. These times are usually short-lived and can often be linked to an oncoming illness, boredom with an activity, or a minor disruption in their routine. However, when these feelings or behaviors are consistently evident for longer than two weeks, the child may be suffering from depression.

Depression in children can be experienced in different ways. Some children may experience a low-grade feeling of sadness and/or lethargy nearly all the time, while others will experience intense periods of sadness that come and go. Regardless of the type of depression, research findings suggest that depression in preschool-aged children is typically characterized by symptoms of sadness and/or irritability. The symptoms, however, can look different—one child may appear sad and withdraw from activities, while another child may appear irritated and aggressive. In addition, children may exhibit joylessness—even though they may be engaging in playful activities, they will not be having fun.

In young children, these symptoms may be somewhat difficult to recognize because infants and toddlers don't always have clear ways to indicate these somewhat complex feelings. Actually depression can be especially difficult to recognize because some of its symptoms are similar to some of the cues infants use to get their everyday needs met. For example, an infant who is fussy or whiny may be getting in their first tooth and may need extra comforting. However, as a child's skills develop and their personality emerges, caregivers may be able to gain a clearer understanding of the

child's usual temperament. Therefore, as a child matures, the ability to recognize depression as a change from the child's normal behavior may become easier.

What You May See When

In very young children depression may appear as irritability, isolation, consistently aggressive or destructive play, or being accident prone. Extreme anxiety may also be noted. These indicators must be a change from the child's usual emotional state. With depression, the depressed mood or sadness will occur across settings and activities and impede the child's development or impair their functioning.

When – Infancy

What – A baby experiencing depression may be whiny, lethargic, show signs of sadness, or play half-heartedly; their sleep patterns may be disrupted and they may lose weight. These children may either sleep more than usual or be more wakeful than is normal; they may also lose interest in their favorite toys.

When – Toddlers & Preschoolers

What – Toddlers and preschoolers, along with the indications above, may express feelings of sadness verbally and tend to be socially withdrawn. They may also complain of headaches or stomachaches, seem apathetic, have trouble concentrating and /or regress in some skill areas. For example, they may have trouble paying attention, have trouble solving problems, or they may even engage in creative play that offers clues about their feelings.

Symptoms

- Depressed or irritable mood
- Diminished interest or pleasure in developmentally appropriate activities
- Reduced capacity to protest (may seem apathetic)
- Emotional withdrawal
- Lethargic
- Sad facial expression
- Regression in skills
- Regression in developmental milestones
- Excessive whining
- Reduced repertory of social interactions
- Change in sleep patterns
- Weight loss

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Depression

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Strategies

- When developing strategies for a child who is exhibiting symptoms of depression, remember that acknowledging feelings is critical to emotional development.
- Allow the child to initiate play, then be sure to show interest in the objects they select for play.
- Allow the child time to express their needs and wants—then relay back to them what they said and ask the child if you have accurately identified how they feel.
- Verbalize emotional expression with the child (for example, “Your face looks happy, are you enjoying this story? Your body looks frustrated, do you need help?”)

Helping Children Express Their Feelings

Because all children—even those who never experience depression—will have feelings of sadness at some point, it is critical to engage in activities designed to help them recognize and express their feelings and emotions appropriately.

By about age 3 children are able to verbally label their own emotions, identify emotional states from pictures, and link emotions to social situations (The birthday party made me feel excited!). Preschool children may also begin to understand the experience of more than one feeling at a time, including the experience of conflicting emotions. The capacity to understand and experience emotions continues to increase during the preschool period. By age 5, children are learning to verbalize rather than act upon feelings, and they are gaining important insights into self-regulation.

Caregivers and others involved in children’s lives can help support this development. For example, when a caregiver acknowledges that a child is feeling mad, sad, frustrated, or tired, the caregiver can offer the child the support they need to be able to release tension and begin to problem solve.

Trusted adults can also help children focus on positive thoughts and actions rather than negative ones by teaching positive self-talk and coping strategies. Another excellent way to teach about emotions is to regularly express your own feelings of anger and frustration (“I’m feeling frustrated right now”) as well as feelings of joy and happiness (I’m feeling happy about going outside to play) in very simple and easy-to-understand language. This will help them be better able to deal with a wide range of emotional experiences.

- For infants who seem sad or depressed, be sure to hold, comfort, rock, and soothe them.
- In group situations, avoid games that may be socially isolating, such as one that requires picking teams.
- Openly give encouragement and positive reinforcement.

Documenting Your Concerns and Next Steps

When documenting behavior, always be specific. Avoid generalizations such as “Grace looked depressed” or “Kyle seems really sad this week”; instead, record specific behaviors you are seeing or are not seeing. For example, “Kyle looked away when I held his favorite sparkly keys this morning. He did not appear to want to play with any of the toys; he fussed and looked away with each one I offered him. I held him and rocked him, but he made very little eye contact with me and did not seem soothed by my singing. This is the 5th day that Kyle has exhibited this very uncharacteristic behavior.”

If a child’s behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child’s behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

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Ready Resources

- iFred—the International Foundation for Research and Education on Depression at www.ifred.org (formerly www.depression.org)
- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- National Institute of Mental Health at www.nimh.nih.gov
- SAMHSA’s National Mental Health Information Center at www.mentalhealth.samhsa.gov
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Deprivation/Maltreatment Disorder of Infancy and Reactive Attachment Disorder

Early Childhood Mental Health Fact Sheet

About the Disorder

Deprivation or maltreatment disorder of infancy is characterized by disturbed and developmentally inappropriate attachment behaviors in which a child rarely or minimally turns to a specific attachment figure for comfort, support, protection, and nurturance. This disorder may develop when a child has a limited chance to form a primary attachment. Circumstances that can result in a child developing this disorder include frequent changes in caregivers, child abuse and neglect, or the unavailability of an attachment figure—for example, if the child is in an institution or if the attachment figure has a substance abuse problem or is experiencing severe depression.

A change or improvement in the caregiving situation will usually lead to some remission of the symptoms.

What You May See When

A young child with a deprivation, maltreatment, or attachment disorder will usually follow one of three patterns of behavior. At times a child's behavior may fit one of the patterns listed below, but the behavior may be due to a delay or disorder of relating and communicating rather than to deprivation or maltreatment.

• Emotionally withdrawn or inhibited pattern

A child with the emotionally withdrawn or inhibited type will rarely seek comfort when feeling stress. Whether the disorder becomes apparent in infancy or during the toddler years, these children will not respond to efforts made to comfort or reduce stress. The child may show excessive levels of irritability, sadness, or fear, and typically will not

participate in social and emotional turn-taking or sharing. The child may appear depressed or emotionally withdrawn.

• Indiscriminate or disinhibited pattern

The indiscriminate or disinhibited child will not form selective attachments but will seemingly attach to relative strangers. The child may behave in an overly familiar way with any adult. For toddlers and preschoolers, the absence of checking in with a caregiver when exploring unfamiliar play spaces and a willingness to go off with unfamiliar adults are both characteristic of this pattern.

• Combination of the two

This child will exhibit characteristics consistent with both the emotionally withdrawn/inhibited pattern and the indiscriminate or disinhibited pattern.

Symptoms

Note: A child may exhibit some but not all the symptoms listed here.

Emotionally Withdrawn or Inhibited—This may look like a depressive disorder and is difficult to distinguish, but remember the child will lack an attachment figure.

- Does not seek comfort when feeling stress
- Attachment behaviors, such as cooperation, showing affection, and reliance on others for help seem to be missing or very restricted
- Appears emotionally blunted
- Frozen watchfulness
- Avoids or fails to respond to social cues
- Does not initiate social interactions
- May resist comforting

Indiscriminate or Disinhibited

- Lacks the typical social shyness around unfamiliar adults that is typical of 2 to 4 year olds
- May resist comforting by primary caregiver
- May seek proximity and comfort indiscriminately, even with strangers
- Lacks the ability to protect themselves (willingness to go with strangers)

Mixed Deprivation/Maltreatment Disorder—This will have symptoms from both patterns of behavior.

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Deprivation/Maltreatment Disorder of Infancy and Reactive Attachment Disorder (continued)

Strategies

- Make sure the child has a sense of security and receives consistent nurturing while they are in your care.
- Empathize with the child and understand the child's reluctance to form an attachment; try not to take it personally and continue to engage the child.
- Provide a secure and trusting relationship—for example, tell the child that you are there for them and that you care about them. And follow up your words with acts of caring. Take advantage of every opportunity to comfort the child when they are experiencing difficulty by being their ally when they are faced with stressful situations. Whenever possible, give the child loving attention—for example, read to them, tell them stories, or sing to them.
- Avoid distancing strategies—use “time with” or “time in” instead of “time out.”
- Show sensitive responses to the child's invitations for social interactions, no matter how small the invitation appears. Even though you may feel rejected by the child, continue to respond to any invitations by the child to engage you. If a baby coos, offer a verbal response as well as a warm smile. When an older child offers to show you their toy, take a keen interest and make sure the child sees how much you appreciate their effort to relate to you.
- Be emotionally available to the child—for example, respond to the child's expressions of emotion, no matter how small. When the child talks of something that frightened them or something that made them happy, let the child know that you understand their feelings—share in their joy and comfort them when they are frightened.

Child Abuse and Neglect

Abuse and/or neglect is characterized by a caregiver's persistent disregard for their child's basic physical needs, their emotional needs, and their need for comfort, stimulation, and affection. When a caregiver neglects or abuses a child in a physical or psychological way long enough to undermine their basic sense of security and attachment, the child may develop an attachment disorder. This neglect can essentially stop the emotional development of a young child. However, because all children have a unique temperament and internal resiliency, not every child who has been neglected or abused will experience this disorder.

Note: The presence of neglect or abuse alone does not create this diagnosis.

Documenting Your Concerns and Next Steps

When a caregiver does become concerned about a child's behavior, it is important to record in as much detail as possible the frequency and intensity of the behavioral difficulties so that there is a greater chance of understanding the problem and arriving at workable solutions. A caregiver may worry about the care a child is receiving. Often it helps to write out a list of concerns and keep a log of behavior concerns or behavior changes in the child.

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH's *A Guide to Early Childhood Mental Health*, available for order at www.macmh.org.

Ready Resources

- Family Attachment Counseling Center at www.familyattachment.com
- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- National Institute of Mental Health at www.nimh.nih.gov
- SAMHSA's National Mental Health Information Center at www.mentalhealth.samhsa.gov
- ZERO TO THREE at www.zerotothree.org

Information included in this fact sheet comes primarily from the DC:0-3R (*Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood: Revised Edition*).

Funding for the development and publication of this fact sheet was sponsored in part by a grant from the Minnesota Department of Education using federal dollars from CFDA 84.323A, Special Education - Program Improvement Grants.

Fetal Alcohol Spectrum Disorders (FASD)

Early Childhood Mental Health Fact Sheet

About the Disorder

Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term that describes a wide range of effects that can occur in a child whose mother drank alcohol during pregnancy. Prenatal alcohol exposure can cause significant brain damage. The effects of FASD typically include physical, mental, and learning disabilities as well as behavioral deficits and problems with socialization.

FASD includes the following categories:

- Fetal alcohol syndrome (FAS)—This is indicated by a pattern of neurological, behavioral, and cognitive deficits along with specific facial features.
- Alcohol-related neurodevelopmental disorder (ARND)—This term is used when only central nervous system abnormalities are present as a result of the fetal alcohol exposure. ARND is characterized by problems with memory and motor skills.
- Alcohol-related birth defects (ARBD)—This is indicated by defects in the growth of skeletal and major organ systems.
- Fetal alcohol effects (FAE)—This term is sometimes used to describe children who had prenatal exposure to alcohol but do not have all the symptoms (particularly the facial features) associated with FAS.

Some children will have no physical symptoms of FAS. If it is certain that a child was exposed to alcohol before birth but there are no physical symptoms and the child's early childhood screening appears to be within normal development, a follow-up screening may be necessary when the child is older if behavioral or learning deficits become apparent.

IMPORTANT

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While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.

What You May See

An infant with FASD may be very irritable, fussy, and/or cry a lot for no apparent reason. As a child with FASD grows, parents and caregivers may begin to notice that the child's development of gross motor skills is delayed—for example the child may walk or run with an awkward gait, have difficulty tossing and catching a ball, and/or struggle to be able to hop on one foot. The child may also exhibit cognitive deficits—for example the child may have trouble problem solving, difficulty planning future actions, and problems taking in, storing, and recalling information. Because of damage to the brain, a child with FASD is sometimes overly sensitive to sensory input—for example they may be upset by bright lights, loud noises, and tags on their clothes.

As the child's development continues, parents and caregivers may notice that the child has verbal skills that exceed their level of understanding, which will sometimes lead a child to say they understand something when they don't. They are also likely to have difficulty following multiple directions. These challenges are frustrating and can lead the child to emotional outbursts. Along with auditory processing problems, parents may also see a child develop oppositional behaviors and a pattern of not completing tasks or chores they are asked to do.

As a child with FASD has more social interactions, parents and caregivers may notice that the disorder can cause the child to misinterpret others' words, actions, or body movements, which can make it harder for the child to determine how to respond to different situations. It is also typical for children with FASD to miss social cues and be unable to entertain themselves. This too can lead to social problems and acting out.

Symptoms

- May cry a lot and be irritable as an infant
- May have tremors
- Sensitive to sights, sounds, and touch
- Easily over-stimulated, then hard to soothe
- Problems with bonding
- Inappropriate social interactions (for example willingness to leave with a stranger or hugging strangers—strangers can be either child or adult)
- Unable to comprehend danger and does not respond well to verbal warnings
- Prone to temper tantrums and noncompliance



Fetal Alcohol Spectrum Disorders (FASD)

(continued)

Symptoms (continued)

- Difficulty handling changes in routine
- Motor skills lag behind children of the same age
- May be disinterested in food
- May have disrupted sleep
- Distractible, unable to concentrate, poor memory
- Inconsistent behaviors, skill levels from day to day
- May be able to state a rule but not follow it
- No recognizable play themes or organization
- Has difficulty with requests or instructions that have more than two steps

Strategies

Because damage to the developing brain varies, each child's development will be different; however, the following strategies work well with many children who have FASD:

- Speak simply and concretely. Avoid words with double meanings, sarcasm, and irony.
- Give only one-step or two-step directions.
- Simplify the child's environment and take steps to avoid sensory triggers.
- Be consistent and structure the day so there are predictable routines.
- Repeat and re-teach frequently. Rules, expectations, and directions may not be remembered from day to day. Review behavioral expectations with the child before each event.
- Use pictures, charts, and demonstrations. Allow children to find their own way of performing a task when possible.
- Provide skills training and use a lot of role playing.
- Supervise all activities—children with FASD can be socially naïve and are easily victimized.
- Use direct teaching of skills that are missing. Materials similar to those designed for students with autism are

FASD

It is important to approach parents supportively and non-judgmentally. Although parental confirmation of prenatal drinking can be vital in obtaining services for a child, it is sometimes necessary to treat the symptoms (such as oversensitivity to stimuli or social delays), without raising the question or needing confirmation of a FASD.

often helpful in teaching behaviors like social interactions, waiting in line, and asking for help.

- Use teaching strategies that focus on the child's strengths; whenever possible give the child jobs to do that require the child's strengths.

Documenting Your Concerns and Next Steps

When documenting behavior, avoid generalizations such as "Roberto never remembers the rules for circle time." Instead, provide observations such as "Each day this week I have had to remind Roberto that when another child is speaking during circle time he must raise his hand and wait until the other child is done." Often it helps to write out a list of concerns or keep a log of the situations where the child appears to have difficulty. Recording the frequency of the behavior and what the child said and did as well as what the caregiver said and did can help to identify specific triggers and/or learning deficits.

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH's *A Guide to Early Childhood Mental Health*, available for order at www.macmh.org.

Ready Resources

- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- National Institute of Mental Health at www.nimh.nih.gov
- National Organization on Fetal Alcohol Syndrome at www.nofas.org
- SAMHSA's National Mental Health Information Center at www.mentalhealth.samhsa.gov
- ZERO TO THREE at www.zerotothree.org

This fact sheet is based on information from SAMHSA'S (U.S. Department of Health and Human Services Substance Abuse and Mental Health Services) EASD Center for Excellence and NOFAS (National Organization on Fetal Alcohol Syndrome).

Funding for the development and publication of this fact sheet was sponsored in part by a grant from the Minnesota Department of Education using federal dollars from CFDA 84.323A, Special Education - Program Improvement Grants.

Pervasive Developmental Disorders (PDD)

Early Childhood Mental Health Fact Sheet

About the Disorder

**For children younger than 24 months, “Multi-System Development Disorder” (MSDD) is preferred. For more on MSDD, see box on the back of this fact sheet.*

Pervasive developmental disorders (PDD) include autistic disorder, Rett’s disorder, childhood disintegrative disorder, Asperger’s syndrome, and PDD-NOS (not otherwise specified). For children with autism, the disorder will progress continually; children with other disorders in this category may develop normally and then experience a regression. For all disorders of this type, however, the onset will occur in early childhood, and except for Rett’s Disorder, which has been seen only in females, the rates of occurrence are higher in males than in females. This category of disorders involves a delay in a child’s development of basic social, communicative, and learning skills.

Children with this diagnosis may have impairments in the use of several nonverbal behaviors such as eye contact, facial expressions, body posture, as well as other gestures used in social interactions and to communicate. Because every child is unique and PDD covers a wide spectrum of symptoms and behaviors, no two children with this diagnosis will behave the same. In general, however, children with a PDD diagnosis have difficulty establishing social relationships, resist change, and need consistent structure and routine.

What You May See

In children for whom the onset of the disorder occurs during infancy, parents and caregivers may notice a lack of socially directed smiles and that the child does not respond to their caregiver’s voice. This sometimes leads caregivers to be concerned that their child may be deaf. Infants may also exhibit sensory sensitivities, avoid direct eye contact, be inflexible with regard to routines, and/or they may seem

clumsy. They may also have an aversion to affection and/or physical contact—during infancy this may mean the child seems uncomfortable when being cuddled.

As the child matures and begins to play with toys, they may tend to relate to the inanimate environment better than they relate to people. For example, a child with autism may be clearly enamored with a certain toy, but will not likely rush to share the special toy with their primary caregiver. The child may also seem to have little understanding of the needs of others and may even seem not to notice another person’s distress. It is these behaviors that lead to difficulty in developing friendships and problems with social skills.

It may seem that young children with PDD have little or no interest in establishing friendships. They may even seem as though they have not formed a secure bond or attachment to a particular caregiver. As children with a PDD diagnosis get older, they often desire friendships and express sadness or depression as they gain understanding of being different. Early intervention, therefore, is especially important because it can help them to develop necessary and useful social skills, communication skills, and cognitive skills. With intense behavioral intervention, some preschoolers with autism have achieved higher IQ scores, more expressive speech, and a reduction in behavior problems.

What You May See – At a Glance

The spectrum of PDD is broad—some of these characteristics may be more indicative of autism than Asperger’s.

When – Infancy

What – May exhibit sensory sensitivities, avoid direct eye contact, be inflexible with regard to routines, and/or may seem clumsy; may reject cuddling.

When – Toddler

What – As a child with PDD matures, the initial indications may become more pronounced. Beyond avoiding eye contact, they will avoid direct interactions; language problems may become more apparent or a regression in language development may occur; inflexibility with regard to routine will be more fixed; difficulties in processing visual, auditory, and tactile sensations may appear; and problems with vestibular (sense of balance and equilibrium) and proprioceptive (sense of one’s body in space) sensations may occur.

When – Preschooler

What – Children at this age may not engage in socially imitative play or they may engage in limited types of play; they may also begin to have more pronounced difficulties with peer relationships.

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Pervasive Developmental Disorders (PDD)

(continued)

Symptoms and Behaviors

- Inflexible adherence to routines or rituals
- Avoidance of eye contact
- Impairment in non-verbal communication
- Abnormally intense focus or interest in a specific area (for example, may be intensely focused on vehicle wheels or may insist that every toy is a guitar)
- Language problems may be apparent—the child may rarely speak, may be unable to initiate or sustain a conversation, or may repeat phrases over and over
- Lack of varied play
- Lack of social imitative play typical of developmental level (for example, will not have tea parties or play store)
- May lack sensitivity to or be highly sensitive to sounds, lights, smells, touch, and/or the taste and texture of foods

Strategies

- Provide a highly structured environment.
- Use graphic or visual schedules.
- Prepare the child for changes and transitions.

Multi-System Developmental Disorder (MSDD)

For children younger than 24 months, Multi-System Developmental Disorder (MSDD) is preferred.

A child with MSDD does not totally lack the ability to develop a social/emotional relationship with a primary caregiver but will have impairment in developing this relationship. The child may avoid contact with caregivers, but will give slight cues that show attachment. These children have difficulty forming, maintaining, and/or developing communication, including pre-verbal gestures. For many toddlers with MSDD, language does not serve a communicative intent. They may memorize parts of songs or dialogue but they do not use speech to communicate.

A child with MSDD may have major difficulty processing visual, auditory, tactile, proprioceptive (spatial awareness of one's body), and vestibular sensations. Most have poor motor planning—they lack the ability to sequence their movements to create a desired outcome—and may appear very clumsy when learning a new skill. Infants and toddlers diagnosed with MSDD also show impairments in processing sensations. For example, they may be extremely sensitive to touch (startling or even having a tantrum when touched lightly), or they may show great pleasure in heavy pressure (being sat on or wedging themselves in small spaces behind furniture).

Early interventions can be very successful in helping a child with MSDD develop processing tools and coping strategies. An assessment and intervention plan that utilizes a speech therapist, occupational therapist, family psychologist, and other professionals as necessary is crucial.

- Teach basic skills such as responding to their name, sitting with a group, and following directions.
- Teach social skills like taking turns and looking at the person you are talking to; if eye contact is too intense, teach the child to look at a person's forehead or nose instead.
- Structure playtime to help the child interact with peers (for example, assign peer buddies or establish cooperative groups to ensure inclusion).
- Find a creative way to show affection—although some children with PDD do not like to be touched, some do enjoy firm hugs.
- Ask the child's primary caregiver if there are any strategies (such as language games the child plays at speech therapy) that could be incorporated into the child's play.

Documenting Your Concerns and Next Steps

When documenting behavior, avoid generalizations such as "Katie appears to have autistic tendencies or difficulty communicating." Instead, record specific behavior, for example, "This afternoon we did not go outside because it was raining—Katie threw the blocks and laid on the floor crying for 30 minutes and no amount of redirecting or consoling seemed to help. I think I am beginning to see a pattern with Katie; she has exhibited similar difficulty with changes in the schedule at other times as well."

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH's *A Guide to Early Childhood Mental Health*, available for order at www.macmh.org.

Ready Resources

- Autism Society of America at www.autism-society.org
- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- National Institute of Mental Health at www.nimh.nih.gov
- SAMHSA's National Mental Health Information Center at www.mentalhealth.samhsa.gov
- ZERO TO THREE at www.zerotothree.org

Information included in this fact sheet comes from the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision) and DC:0-3R (Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood: Revised Edition).

Funding for the development and publication of this fact sheet was sponsored in part by a grant from the Minnesota Department of Education using federal dollars from CFDA 84.323A, Special Education - Program Improvement Grants.

Posttraumatic Stress Disorder (PTSD)

Early Childhood Mental Health Fact Sheet

About the Disorder

Young children who have been exposed to an event that is life threatening (threatened death or serious injury), that is perceived as life threatening, or that threatens the physical safety of a caregiver can develop Posttraumatic Stress Disorder (PTSD). The trauma may be a sudden unexpected event, a series of connected events, or an enduring situation. Typically, the traumatic experience is so overwhelming and out of the ordinary compared to one's usual experience that one's ability to cope is overpowered. A child with PTSD will likely experience recurrent and intrusive thoughts and memories of the traumatic event, they may have flashbacks (a child may freeze or stare into space for a time), or they may suffer physical stress when reminded of the event (pounding heart, upset stomach). A child who has persistent symptoms that interfere with daily functioning requires immediate intervention.

What You May See

After experiencing or re-experiencing a traumatic event, young children will often appear very disorganized and overwhelmed. Although infants do not have the ability to communicate their distress verbally or through play, it doesn't mean they can't experience PTSD. (See box for more on emotional development.) For infants, the symptoms of the disorder may be a difficulty in going to sleep or a pattern of disrupted sleep, an exaggerated startle response, increased irritability or fussiness, and/or intense separation anxiety.

A parent or caregiver may notice that the child sometimes engages in post-traumatic play by reenacting the trauma; unfortunately this type of play does not reduce their anxiety

about the trauma because they do not incorporate solutions or alternative endings during their play. Also, the play will be less imaginative than the child's usual play. In addition, some children may ask repeated questions about the subject of the trauma. For example, a child who has been bitten by a dog may ask numerous questions about dogs and may want to look at pictures of dogs. These children will be distressed but will still obsess about the topic of the trauma.

Symptoms of PTSD can sometimes be difficult to differentiate from age-appropriate behaviors such as temper tantrums. Frequency can also be difficult to determine because of varying developmental levels—for example, how many tantrums do 2 year olds usually have per week? Also be aware that as the child processes the trauma, their memories of the event may change because they are trying to make sense of the events; as this processing continues and the child begins to heal, allow for change in the story.

Emotional Development During Early Childhood

Observable emotions develop throughout the first year of life. Some emotions that are critical to the diagnosis of PTSD are sadness, which develops around 3 months; recognizing fear in others, which develops around 5 months; anger and surprise, which develop around 6 months; and fear, which develops around 9 months.

By the age of 9 months, infants are able to reproduce events (behaviorally) from the day before, which indicates the development of explicit memory. Though traumatic events can be visualized with varying degrees of clarity and depth perception depending on visual abilities developed during the first 6 months, infants don't have the developmental abilities to express observable symptoms of PTSD until around 9 months of age.

Full verbal recollection (further development of explicit memory) of a traumatic event is likely if the trauma occurs after 28 to 36 months of age. A child will be able to give a full narrative of what they understand/remember about trauma event around that age. The behavioral expression of trauma is also dependent on each child's motor development.

IMPORTANT

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Posttraumatic Stress Disorder (PTSD)

(continued)

Symptoms

- Preoccupied with the event
- Compulsively reenacting the event in play
- Exaggerated startle response
- Flashbacks
- Temporary loss of previously acquired developmental skills, such as talking or toileting
- Increased irritability, outbursts of anger or extreme fussiness, or temper tantrums
- Increased social withdrawal
- Aggression toward peers, adults, or animals
- Diminished interest in significant activities, including play, social interactions, and daily routines
- Protest going to bed
- Repeated nightmares; night terrors
- Fear of the dark, fear of toileting alone, and other new fears
- Constriction in play

Strategies

- Create a space of trust, safety, and acceptance; build trust with the child.
- Be warm and welcoming.
- Use plenty of soothing techniques, holding, rocking, and/or gentle talking (take into account the child's temperament when using these techniques).
- Give the child a lot of verbal empathy and support.
- Physical proximity of a trusted person may be necessary.
- Assist the child in developing an accurate narrative of the traumatic event; correct misconceptions and distortions. Use storytelling to help develop alternative endings.
- Avoid circumstances that are upsetting or re-traumatizing for the child.
- If the child has an emotional response to a reminder of the event or if the child appears to be re-living the event, help the child to recognize that the emotion belongs to the past and that it is not what is happening at the present time.
- Respond empathetically when a child loses a skill that they had mastered before the traumatic event. Toilet training is the most common in this category. Return to teaching the skill to the child just as you had done the first time.

- Paints, clay, dolls, and water play provide some children with outlets for their feelings; incorporate this type of play into your day.

Documenting your Concerns and Next Steps

When documenting behavior, avoid generalizations such as "Trevor seems anxious about loud noises." Instead write down what situations cause a child to have increased anxiety. Recording the frequency of the behavior and what the child said and did as well as what happened right before and after the change in behavior can help identify areas of concern. Also assess if there have been any traumatic events in the child's life. A parent may confide in you that the child witnessed domestic abuse—if so, provide the parent with resources in the community that can offer support and guidance. It is also a good idea to have resources and fact sheets on domestic abuse, substance abuse, and maternal depression available for parents.

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

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Ready Resources

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- National Institute of Mental Health at www.nimh.nih.gov
- The Posttraumatic Stress Disorder Alliance at www.ptsdalliance.org
- SAMHSA's National Mental Health Information Center at www.mentalhealth.samhsa.gov
- ZERO TO THREE at www.zerotothree.org

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Regulation Disorder of Sensory Processing

Early Childhood Mental Health Fact Sheet

About the Disorder

Young children with this disorder struggle to regulate their emotions and behaviors as well as their motor abilities in response to sensory stimulation. The sensory stimulation can include touch, sight, sound, taste, smell, sensation of movement in space, and awareness of the position of one's body in space. A child's struggle with these sensory inputs leads to impairment in their development and functioning. These children have trouble maintaining a calm, alert, or affectively positive state. The three types of regulation disorder of sensory processing are:

- hypersensitive, which has two subcategories—fearful/cautious and negative/defiant;
- hyposensitive/under-responsive; and
- sensory stimulation-seeking/impulsive.

For all types of this disorder, parents report that their children get upset easily, often lose their temper, have difficulty adapting to change, are overly sensitive, and/or have a difficult temperament.

What You May See

• **Hypersensitive**

These children experience sensory stimulation such as light touch, loud noises, bright lights, and rough textures as distressing. They may show an excessive startle reaction, aggression, increased distractibility, and they may attempt to escape from the stimulus. Infants may respond by being irritable or fussy. They may not be comforted easily being cuddled or sung to. In fact, these types of responses could be what the child is reacting against. Parents and caregivers may also notice hypersensitivity when trying to introduce new foods to the child because of the child's very low tolerance for a variety of textures, tastes, and smells. As children with the hypersensitive pattern mature, they typically display limited interest in sensory motor play, engage in exploration less often

than is expected for their age, and exhibit difficulty in fine motor coordination. All of this is usually due to the fact that they self-limit activities because of their sensitivity.

Children with a hypersensitive sensory processing disorder fall into one of two sub-categories, either fearful/cautious or negative/defiant. Children who show signs of the fearful/cautious pattern will show stress when routines change, are very shy and clingy in new situations, have a limited ability to self soothe, and express excessive fears and worries. These children are very cautious, inhibited, and fearful. The negative/defiant hypersensitive child may appear negativistic, stubborn, controlling, and will often do the opposite of what is asked or expected. The child may be slow to engage in new experiences, is aggressive when provoked, and exhibits compulsiveness and perfectionism.

• **Hyposensitive/Under-Responsive**

These children require high-intensity sensory input before they are able to respond. They are quiet and watchful at times and may appear withdrawn and difficult to engage. Infants may appear delayed or depressed and lack the desire to explore their environment. As preschoolers, they often have fewer words for dialogue and show a limited range of behaviors, ideas, and fantasies. These children will seek out activities that they know will provide them with adequate sensory stimulus—they may spin on a sit-n-spin, swing for long periods of time, or jump up and down on a bed. They tend to show disinterest in exploring relationships, have poor-quality motor skills, engage in limited exploratory activity, and have limited flexibility when involved in activities.

• **Sensory Stimulation-Seeking/Impulsive**

Infants with this pattern will crave and seek sensory stimulation. Preschoolers will appear excitable, have intrusive behaviors, and exhibit a daredevil style. The motor activities of these children are often unfocused so they may appear clumsy due to poor motor planning.

These children may seem aggressive and fearless or impulsive and disorganized. Their behavior patterns involve high activity—for example, they will shriek with joy if you sit on them because they seek contact and stimulation through deep pressure. At times, this desire for contact coupled with poor motor planning and disorganized motor skills can lead to things being broken, unintended intrusions into others' physical space, and unprovoked hitting. These actions are often misinterpreted as aggressive, so other children may respond with aggression, which may then lead the child with the sensory stimulation-seeking/impulsive disorder to develop aggressive behaviors.

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Regulation Disorder of Sensory Processing

(continued)

Symptoms

Children who have difficulty regulating and processing sensory input typically exhibit three features: 1) sensory processing difficulties, 2) motor difficulties, and 3) a specific behavioral pattern. A child with this disorder will be sensitive (either over or under) to touch, sights, sounds, smells, and sensations of movement in space.

- A child may be irritated by some types of clothes and shoes
- Bright, florescent lights may cause irritability or a meltdown
- A child may have a very limited diet and strongly resist foods because of the texture
- Routine tasks, such as brushing teeth and combing and/or cutting hair, may be nearly impossible to accomplish
- Toddlers may love or hate rough and tumble play
- A child may appear annoyed when touched too gently—in infants, this may mean they won't want to be cuddled or they may prefer firm swaddling
- A child may have difficulty sleeping if a room isn't completely dark

Strategies

For all children:

- Show soothing and empathetic support of the child's individual needs.
- Announce transitions to the child who needs extra time to adjust; when significant changes are happening (such as moving to a new room), a slow and gradual change with plenty of emotional support can help a child adjust.
- Show the child empathy and love. A caregiver who can manage warmth even in the face of negativism or rejection will help the child's emotional development—it may take time, but don't give up!
- Help the child engage, attend to, interact with, and explore the environment.

For hypersensitive children:

- Provide quiet, calm spaces when possible.
- Watch for cues from the child that the environment is overly stimulating (for example, some children love loud noises, but a hypersensitive child may cover their ears).
- Find out the best way to show comfort, and help the child's peers to show comfort in similar ways (for example, let the child's peers know how close is too close).

For under-responsive children:

- Provide interactive input and exaggerated gestures.
- Reach out to the child; use animated expressions.

- Give robust responses to the child's cues, however slight the cues may be.

For sensory stimulation-seeking/impulsive children:

- Provide the child with constructive opportunities for sensory and affective involvement.
- Encourage and teach the child to recognize their own limits, especially with regard to issues of safety.
- Encourage the use of imagination and support exploration of the external environment.

Documenting your Concerns and Next Steps

When documenting a child's sensory sensitivities being very observant and specific is especially important. For example, noting that "Jonah rarely eats all his lunch" is not as informative as "Jonah didn't have yogurt at snack today, and I noticed he rarely eats pudding when it's packed in his lunch." Or saying that "Michelle washes her hands a lot" is not as descriptive as "Michelle washes her hands immediately after activities that involve paint or anything goeey—even silly putty, which doesn't stay on your hands." Keeping close tabs on when a child has an unusual response to sensory stimuli may help to discover a pattern that will help determine which sensory stimuli trigger a response.

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH's *A Guide to Early Childhood Mental Health*, available for order at www.macmh.org.

Ready Resources

- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- National Institute of Mental Health at www.nimh.nih.gov
- SAMHSA's National Mental Health Information Center at www.mentalhealth.samhsa.gov
- ZERO TO THREE at www.zerotothree.org

Information included in this fact sheet comes primarily from the DC:0-3R (Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood: Revised Edition).

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Tourette Syndrome

Early Childhood Mental Health Fact Sheet

About the Disorder

Tourette Syndrome (TS) is a neurological disorder characterized by tics—involuntary, rapid, sudden movements and vocalizations (though they may not occur simultaneously) that occur repeatedly in the same way. For children with Tourette Syndrome (also known as Tourette's Disorder), onset typically occurs before 7 years of age, and the disorder is usually recognized two to three years after onset. In most children, the severity peaks at 9 to 11 years of age. About 5 to 10 percent of children have an intensifying course with little or no improvement. In about 85 percent of children, symptoms diminish during and after adolescence.

The symptoms include:

- Both multiple motor and one or more vocal tic(s) present at some time during the illness; however, the motor and vocal tics may not necessarily occur simultaneously;
- The occurrence of tics many times a day (usually in bouts) nearly every day or intermittently throughout a span of more than one year; and
- Periodic changes in the number, frequency, type (vocal or motor), and location of the tics; severity of the tics will wax and wane; symptoms can sometimes disappear for weeks or months at a time.

Research at the National Institute of Mental Health suggests that some cases of TS (and related Obsessive Compulsive Disorder) may be an auto-immune response triggered by antibodies produced to counter strep infection. This phenomenon is known as PANDAS. There is also a confirmed genetic basis for TS; therefore, parents seeking medical assistance for possible tic behavior in their children

should mention to their medical professionals any similar tic-like behaviors observed in other family members. Both psychiatrists and neurologists are qualified to diagnose a case of Tourette Syndrome.

What You May See

During infancy, symptoms of Tourette Syndrome are usually not evident. Around age 3, a child may begin to show motor or vocal tics. The most common first symptom in children with Tourette Syndrome is a facial tic, such as rapidly blinking eyes or twitches of the mouth. Tics of the limbs as well as involuntary sounds such as throat clearing and sniffing may also be initial signs. The tics, however, may be somewhat difficult to recognize because speech patterns and motor skills are still developing. By about age 4 when speech patterns and motor development are well established, vocal and motor tics may become more apparent. Vocal tics may include vocal outbursts, imitating or echoing the words of others, throat clearing, coughing, or snorting. Motor tics may be as simple as blinking, wrinkling the nose, or lip licking; or they may be as complex as arm or leg jerks, kicking, twirling, or fist clenching. You may also see that a child who is experiencing tics may be teased by others who don't realize that the tics are involuntary.

The complexity of some symptoms is often perplexing to family members, friends, and others who may find it hard to believe that the actions or vocal utterances are involuntary. Tics do, over time, change and vary in severity. For example, tics typically increase as a result of tension or stress, and decrease with relaxation or when focusing on an absorbing task. And although they can often be controlled or suppressed for brief periods of time, they are experienced as irresistible and, as with the urge to sneeze, eventually must be expressed.

Symptoms

- Repetitive eye blinking
- Repetitive clearing of the throat
- Repetitive coughing
- Repetitive lip licking
- Repetitive fist clenching
- Imitating or echoing the words of others
- Imitating or echoing the motions of others
- Leg jerks
- Vocal outbursts

IMPORTANT

This fact sheet is not intended to be used as a diagnostic tool. It is meant to be used only as a reference for your own understanding and to provide information about the different kinds of behaviors and mental health issues you may encounter.

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.



Tourette Syndrome

(continued)

Strategies

- Interventions for a child with Tourette Syndrome should emphasize teaching the child to successfully navigate developmentally appropriate tasks. The goals should be to help the child develop friendships, experience trust, and feel competent completing activities—not stopping the tics.
- Teach relaxation and deep breathing exercises to children who are able to understand and participate in these techniques. Blowing bubbles and pretending to blow bubbles, learning to whistle, or actively trying to move their bellies in and out are all fun ways for children to learn deep breathing.
- Teach the child to tune into and identify their emotions and levels of frustration—increased frustration or anxiety can cause an increase in tic behaviors.

Common Co-Occurring Disorders with Tourette Syndrome • (adapted from www.tsa-usa.org)

Some children who have Tourette Syndrome (TS) may also have other mental health concerns.

Obsessive Compulsive Disorder (OCD)

Children may have repetitive thoughts that can become unwanted or bothersome, or they may feel compelled to do something over and over and/or in a certain way. Examples include touching an object with one hand after touching it with the other hand to “even things up” or begging for a sentence to be repeated many times until it “sounds right.”

Attention-Deficit/Hyperactivity Disorder (AD/HD)

AD/HD occurs in many people with TS. Children may show signs of hyperactivity before TS symptoms appear. Indications of AD/HD may include difficulty with concentration, failing to finish what is started, not listening, acting before thinking, shifting constantly from one activity to another, needing a great deal of supervision, and general fidgeting. AD/HD without hyperactivity includes all of the above symptoms except for the high level of activity.

Difficulties with impulse control may result, in rare instances, in overly aggressive behaviors or socially inappropriate acts. Also, defiant and angry behaviors can occur.

Sleep Disorders are fairly common among people with TS. These include difficulty getting to sleep, frequent awakenings, or walking or talking in one’s sleep.

- Do not punish the child for engaging in tics or what may appear to be strange habits such as lip licking or excessive blinking.
- Because stress can cause a child’s tics to increase, simplify the child’s environment and take steps to avoid sensory triggers such as bright lights, loud noises, or chaotic activity.

Documenting Your Concerns and Next Steps

When recording information about a child who appears to have tics, being very observant and specific is especially important. Because tics can be related to frustration and anxiety, it is also helpful to record what was happening just before the tics occurred. Avoid generalizations such as “It seems like Stephan licks his lips all day.” Instead try to associate specific events with tic behavior. For example, noting that “Stephan seemed to lick his lips when he couldn’t find the last piece to the puzzle” may give more information about what triggers tics in Stephan. Recording the frequency of the tics as well as what the caregiver said and did can help to identify areas of concern.

If a child’s behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child’s behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

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