

Mental and Physical Conditions Encountered in Child Protection and Juvenile Justice

2007 Edition



“Mental and Physical Conditions Encountered in Child Protection and Juvenile Justice” is intended to be used as a resource for Department of Health and Human Service workers, attorneys, judges, CASA volunteers and others who work with families in the child protection or juvenile justice systems.

We have included summaries of a variety of mental and physical conditions including current information about definition, prevalence, cause, treatment, and family and developmental considerations. Information is also provided about psychotropic medication, common street drugs, and commonly used psychological tests. Internet locations are included so readers can easily update the information presented.



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For more information or additional copies, please call 402/472-3479.

Physical Conditions



Apnea and SIDS

Definition:

Apnea is Greek for “no breathing” and is used to refer to the temporary cessation of breathing.

Apnea of Prematurity refers to an unstable breathing pattern in premature infants (less than 37 weeks gestation) characterized by periodic slowing of breathing with periods of apnea of longer than 20 seconds.

Sudden Infant Death Syndrome (SIDS) is the “sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history.” Some infants are discovered in bed apparently not breathing and are resuscitated. Although this used to be called a “near-miss SIDS” it is now termed an “apparent life-threatening event” (ALTE) because its relation to SIDS is uncertain.

Sleep Apnea occurs in older children and adults in association with chronic obstruction of the respiratory tract, loud snoring, and periodic cessation of breathing during sleep. It is not discussed in this paper.

Incidence:

In 2003, the U.S. rate of SIDS was 52.9 for every 100,000 live births. However, the rate for non-Hispanic black infants was double at 108.8 and even higher for American Indians/Alaska Natives

at 124.0. The rate in Hispanic infants was only 25.6 per 100,000. SIDS is rare in the first month of life, increases to a peak between two and three months of age, and then decreases throughout the rest of the first year.

SIDS is unexpected, usually occurring in otherwise apparently healthy infants from 1 month to 1 year of age. A SIDS death occurs

SIDS remains the leading cause of death in the United States among infants between 1 month and 1 year of age and behind only congenital anomalies and complications of prematurity as the leading overall cause of death for all infants less than 1 year of age.

ALTE occurs in approximately 2% to 3% of infants, or about twice as commonly as SIDS. However, infants with histories of ALTE episodes and premature infants with histories of apnea comprise a very small percentage of all SIDS cases.

Cause:

The cause of SIDS is unknown. Most researchers now believe that babies who die of SIDS are born with one or more conditions that make them especially vulnerable to stresses that occur in the normal life of an infant, including both internal and external influences.

In an individual case, the diagnosis of SIDS should never be used without an autopsy, a thorough investigation of the death scene, and a careful review of victim and family history.

The autopsy provides anatomical evidence through microscopic examination of tissue samples and vital organs. A definitive diagnosis cannot be made without a thorough postmortem examination that fails to point to any other possible cause of death. Also, if a cause of SIDS is ever to be uncovered, scientists will most likely detect that cause through

Key Protection and Safety Issues

Prevention should be emphasized when working with any family with a small infant. Most importantly, infants should be put to sleep on their backs and parents should not smoke around their infants or when pregnant. Bedding should be firm without pillows or fluffy blankets. Breast feeding may offer some protection and should be encouraged because it is good for infants in many ways.

SIDS must be differentiated from other causes of infant death including intentional maltreatment. Because SIDS is a diagnosis of exclusion, it should not be made without an autopsy, a thorough investigation of the death scene, and a careful review of the victim and family case history.

Cases of more than one SIDS in a family should raise strong concerns that other causes either intentional or unintentional are responsible. One study (Wolkind 1993) reviewed 57 such cases in 24 families and concluded that intentional injury was responsible in over half. Siblings of a single child with SIDS are not at high risk and there is little evidence of a genetic component in most SIDS cases.

quickly and is often associated with sleep, with no signs of suffering. More deaths are reported in the fall and winter and there is a 60- to 40-percent male-to-female ratio. A death is diagnosed as SIDS only after all other alternatives have been eliminated; SIDS is a diagnosis of exclusion.

When considering the overall number of live births each year,

evidence gathered from a thorough pathological examination.

A thorough *death scene investigation* involves interviewing the parents, other caregivers, and family members; collecting items from the death scene; and evaluating that information. Although painful for the family, a detailed scene investigation may shed light on the cause, sometimes revealing a recognizable and possibly preventable cause of death.

A *comprehensive history* of the infant and family is especially critical to determine a SIDS death. Often, a careful review of documented and anecdotal information about the victim's or family's history of previous illnesses, accidents, or behaviors may further corroborate what is detected in the autopsy or death scene investigation. Investigators should be sensitive and understand that the family may view this process as an intrusion, even a violation of their grief. It should be noted that, although stressful, a careful investigation that reveals no preventable cause of death may actually be a means of giving solace to a grieving family.

Associated Conditions:

Although we do not know the cause of SIDS, there is increasing evidence of factors that increase the risk of SIDS. Infants who are put to sleep on their stomachs are at an increased risk for SIDS.

Education campaigns have been mounted with the "back to sleep" message, urging placing infants on their back to sleep. Strong evidence has now accumulated that these campaigns have been followed by SIDS rate declines. Covering of the baby's head by bedding is also strongly related to SIDS. The infant's sleeping environment should be carefully set up to ensure that the baby's head, including the face, cannot be obstructed during sleep and that soft pillows are not used.

used sparingly because there is no evidence that they prevent SIDS and they add a significant stress to the family. A 1988 Consensus Panel, convened by several US federal agencies, recommended that home monitors should not be used for infants at normal SIDS risk (less than 2/1,000 live births) or for premature infants without symptoms. Those infants where home monitoring is definitely indicated because of their very high risk, include survivors of severe apparent life-threatening events (occurring during sleep and requiring CPR), siblings of two or more infants with SIDS, and premature infants who are still mildly or moderately symptomatic with apnea of prematurity but who are otherwise ready for hospital discharge.

For More Information

The Centers for Disease Control and Prevention has SIDS related information at <http://www.cdc.gov/SIDS> The National SIDS Resource Center offers a gateway into a wealth of SIDS materials including bereavement support at <http://www.sidscenter.org/> A good reference is: Distinguishing Sudden Infant Death from Child Abuse Fatalities, in *Pediatrics*, 118, 241 (2006)

Parental smoking, both before and after birth, is strongly associated with SIDS. There is some evidence that the risk of SIDS is increased when infants are too warm, therefore infants should be maintained in a comfortable temperature zone. Although there have been worries about the role of immunizations, SIDS has not been associated with immunizations, which of course are common around the time that SIDS occurs.

Management/Treatment:

Electronic cardiorespiratory monitors are sometimes used in the home for infants who are at high risk of SIDS. Monitors should be

Long-Term Outlook:

By definition, children with SIDS die. However, the impact of this death on the family can be devastating and long lasting.

Family and Developmental Issues:

The loss of a child to SIDS can be devastating to parents, family, and community. The child usually dies at home in sleep when protection and safety are expected to be the greatest. Families need clear information about the condition in order to alleviate unwarranted guilt. Mourning must be supported in parents and children.

Asthma

Definition:

Asthma is a chronic respiratory condition resulting in episodes of breathing difficulty due to narrowed airways. Individuals with asthma experience intermittent and often rapidly developing breathing difficulty because the small tubes leading to the air sacs in the lungs become too narrow. Typically, when the air tubes become narrow the child breathes with a wheezing sound; however, some children show only shortness of breath, chest tightness, or a chronic cough. When an attack is very severe the wheezing may be less because the individual cannot move enough air to wheeze. The severity of asthma spans a wide range from very serious—nearly 5000 people died from asthma in 1991—to mild or moderate which is more common.

Prevalence:

Asthma affects nearly 5 million children and almost twice as many adults across the United States. Asthma is 26% more prevalent in black children than in white children. Black children with asthma experience more severe disability and have more frequent hospitalizations than do white children

Cause:

Like many conditions, asthma results from combinations of genetic and environmental factors. Predisposing environmental factors include exposure to substances that promote allergy, and certain respiratory infections. Recent evidence shows that treating young infants with antibiotics increases the chances that they

will develop asthma, possibly by eliminating protective bacteria—another good reason to be cautious in using antibiotics when they are not needed.

Associated Conditions:

Individuals with asthma may also experience other allergic symptoms including hay fever or skin rashes like hives or eczema.

Key Protection and Safety Issues

The identification and management of asthma should be taken seriously by anyone who works with families. Besides the life threatening nature of severe asthma, chronic asthma contributes to poor functioning in children who have it and in chronic stress in their families.

Proper identification and management of asthma should be able to dramatically reduce its impact in most children. Signs of poorly controlled asthma include: persistent cough, coughing, wheezing, chest tightness, or shortness of breath after vigorous physical activity, on a recurring basis and low level of stamina during physical activity or reluctance to participate.

Avoidable environmental asthma triggers such as cigarette smoke and cockroach infestation should be avoided for all children and especially those with asthma. Adults should not be allowed to smoke around children with asthma.

Asthma is a common cause of school absenteeism, which may result in poor school performance.

Management/Treatment:

Treatment consists of four important aspects:

1. Regular medical care to identify related health problems and to manage treatment;
2. Identification and avoidance of the things in the environment that trigger an attack;
3. Medication to reduce the inflammation in the airways that contributes to airway constriction;
4. Medication to relax the muscles that tighten around the small airways.

With optimal management the symptoms can usually be controlled.

Triggers: Identifying and avoiding triggers is a mainstay of treatment for asthma. Most triggers consist of allergens that reach the lungs through the air. Pollen, house dust mites, and animal dander are



common triggers. Cigarette smoke, both first and second-hand, increases both the frequency and severity of attacks. Cockroaches appear to be an especially important source of particles that trigger asthma and account for a severe form of asthma in low-income children exposed in their homes. Other children may be triggered by cold air or by exercise. Respiratory infections with viruses or bacteria may trigger an attack. Emotional stress may also increase the frequency and severity of asthma attacks.

Acute Treatment: When children experience an acute asthmatic attack they can have great difficulty breathing and require immediate medical care. Increasing fluids to keep the child hydrated, and a personal presence and reassurance to help calm the child can both help. If the child has an inhaler with bronchodilator medication, this should be given. An injection of epinephrine can give rapid relief and some children with severe

asthma may need to keep this on hand for emergency treatment.

Anti-inflammatory Medication: Inhaled steroid medications and/or a medication called chromlyns so-

For More Information

A good source of information about asthma is the National Library of Medicine at <http://www.medlineplus.gov> and search for asthma. Federal treatment guidelines are available at <http://www.nhlbi.nih.gov/health/prof/lung/asthma/practgde.htm>

dium are the most common ongoing anti-inflammatory medications. To be effective they should be given before an acute attack. They cut down on the swelling and irritation caused by inflammation.

Bronchodilating Medications: Several medications are available to relax the muscles around the small airways. These may be used either to treat an acute attack or on a preventive basis.

Long-Term Outlook:

Asthma can be severe and may cause death. Among 5-24 year old children, the asthma death rate nearly doubled from 1980 to 1993.

In 1993, blacks in this age group were 4 to 6 times more likely to die from asthma than whites; and males were 1.5 times at greater risk than females. Some children will outgrow their asthma symptoms.

Others will continue to have difficulties into adulthood.

Family and Developmental Issues:

Stress and asthma interact. Family stresses may serve as a trigger for some children's attacks. In most families, recurrent asthma attacks contribute to family stress. As children grow older it is crucial that they learn how to manage their own asthma including the identification and avoidance of triggers, the importance of following medication routines, and the steps to take to treat an acute attack.

Otitis Media

Definition:

Otitis media (OM) is an infection of the middle ear—the part just behind the ear drum. Acute OM is accompanied by signs of an active infection with a bulging ear drum and often considerable pain. OM with effusion is a more chronic condition with fluid behind the ear drum but no active infection.

Prevalence:

Seventy-five percent of children experience at least one episode of OM by their third birthday. Almost half of these children will have three or more ear infections during their first three years.

Cause:

OM usually results from a bacterial or viral infection that has first given the child an upper respiratory infection (URI). OM is more common in children because their immune systems are still developing, the tube that connects the middle ear to the back of the throat is smaller and easier to block, and

the child's adenoids may contribute to blocking this tube.

Associated Conditions:

An untreated infection can travel from the middle ear to the nearby parts of the head, including the brain. Although the hearing loss caused by OM is usually temporary, untreated OM may lead to permanent hearing impairment. Persistent fluid in the middle ear and chronic OM can reduce a child's hearing at a time that is

Key Protection and Safety Issues

Children with hearing loss, and the resulting speech and language delays are at increased risk for child maltreatment. In addition, families in homes with poverty, disorganization, isolation, and other risk factors may not recognize the early signs of OM, and may not comply with medical treatment if it is diagnosed and treated. Contact with Protection and Safety workers can help families develop the resources needed to more effectively prevent and/or treat OM and its resulting complications.

critical for speech and language development. Children who have early hearing impairment from frequent ear infections are likely to have speech and language disabilities.

Although many people believe that allergies are an important cause of OM, the association between allergy and OM with effusion is not clear from the research.

Management/Treatment:

Early recognition and treatment of OM is important to prevent complications. However, OM is often difficult to detect because most children affected by this disorder do not yet have sufficient speech and language skills to tell someone what is bothering them. Common signs to look for are: unusual irritability, difficulty sleeping, tugging or pulling at one or both ears, fever, fluid draining from the ear, loss of balance, unresponsiveness to quiet sounds or other signs of hearing difficulty such as sitting too close to the television or being inattentive.

Because many cases of OM resolve without antibiotic treatment, and because the too frequent use of antibiotics carries risks as well, many physicians are taking a “watchful waiting” approach in children over two who otherwise appear well. A prescription may be written, but filled only if the child does not improve or worsens. Other physicians will treat all cases right away. When antibiotics are given, they must be taken for the entire prescribed course, usually 10 to 14 days. Often, because the child feels better soon, the medication is stopped and treatment is incomplete. Analgesics may be prescribed for pain, but neither antihistamines nor decongestants are recommended as helpful in the treatment of OM at any stage.

If the fluid persists after the infection for more than 3 months and is



associated with a loss of hearing, many physicians suggest the insertion of "tubes" in the affected ears. This operation, called a tympanostomy, can usually be done on an outpatient basis under anesthesia. The tube normally stays in the eardrum for six to twelve months after which time it usually comes out spontaneously. If a child has enlarged or infected adenoids, the surgeon may recommend removal of the adenoids at the same time the ear tubes are inserted. Removal of the adenoids has been shown to reduce episodes of OM in some children but not

those who are under four years of age. Research, however, has shown that removal of a child's

risk factor for impaired speech and language development. In general, the earlier the hearing problem begins and the more severe it is, the worse its effects on speech and language development and on subsequent school performance.

For More Information

The National Library of Medicine has an information page on ear infections at <http://www.nlm.nih.gov/medlineplus/earinfections.html> with links to parent information in both English and Spanish as well as many other helpful resources.

tonsils does not reduce occurrences of OM.

Long-Term Outlook:

Recurrent OM or persistent OM with fluid is the most common cause of hearing loss in children. Congenital or early onset hearing impairment is widely accepted as a

Family and Developmental Issues:

Children are more likely to have recurrent OM when they have been in daycare settings, when their parents smoke at home, and when bottle fed rather than breast fed.

Seizures and Epilepsy

Definition:

A *seizure* is a period of abnormal brain electrical activity with a definite beginning and end. Because this electrical activity may occur in any part of the brain, abnormal sensations, emotions, behaviors, or most dramatically, rhythmic muscle contractions, convulsions or loss of consciousness may accompany a seizure. A person is said to have *epilepsy* if they have had two or more unprovoked seizures. (A seizure can be provoked by an external cause such as a poisoning, fever, or electrical shock.) Epilepsy is an ancient term and often carries with it misconceptions based upon thousand of years of fear and ignorance. Epilepsy may represent the malfunctioning of a tiny group of cells with no other adverse impact on the person, or it may be a reflection of widespread brain dysfunction. Seizures are classified as *partial*, if only a limited part of the brain and/or body is affected, or *generalized* if the seizure results in a convulsion of all parts of the body and/or in disruption of consciousness. Some seizures do not fit neatly into these two categories. Some people experience sensations or feelings, called an *aura*, before a seizure starts. After a generalized seizure, most people have a period of drowsiness and sometimes confusion called a *post-ictal state*.

Febrile seizures are convulsions that occur in infants and small children during a fever. Most commonly, febrile seizures last only a minute or two and are symmetrical. A child with febrile seizures is not considered to have epilepsy since they are provoked

by fever. *Absence seizures* (also called petit mal seizures) are manifest by brief periods of staring followed by a resumption of normal activity.

Prevalence:

About 9% of the population will experience a seizure at some time in their life, but only about 3% will be diagnosed with epilepsy. The risk of the onset of seizures is highest in the first year of life and decreases in adolescence, remaining relatively constant through adult life until it dramatically increases after age sixty. About 1 in 25 children will experience febrile seizures.

Cause:

In children, the majority of seizures with known cause are due to birth and neonatal injuries, stroke or other blood vessel problems, congenital or metabolic disorders, head injuries, infection, cancer, or heredity. In adults, stroke or other

Key Protection and Safety Issues

The protection and safety worker should insure that seizures that occur in children and family members are properly evaluated. Seizures should be considered any time that unusual behavior has an abrupt beginning and ending, or a period of anticipation or aura. When medication is prescribed, the worker should insure that the treatment plan is followed. Society's lack of understanding about the many different types of seizures is one of the biggest problems for people with epilepsy. It is important to understand the nature of each individual's seizures including the frequency, character, aura and/or post-ictal state if any, and the side effects of any medications.

blood vessel problems, head trauma, drug or alcohol abuse, cancer, infection, and heredity all are known to cause seizures. However, for both children and adults, a definite cause cannot be determined in most cases.

Associated conditions:

Seizures can occur in isolation in a person whose brain function is otherwise normal, or may occur along with a wide range of neurological conditions. In addition, seizures and/or the treatment of seizures can cause complications, including injuries related to seizures (such as fractures or drowning) and rarely sudden unexplained deaths. Estimates of the prevalence of psychiatric disorders in those with epilepsy vary widely, but depression is believed to be the most common. Epidemiological research on the prevalence of psychiatric disorders, symptoms, and reactions to psychosocial barriers and stresses is lacking. Current studies suggest that persons with epilepsy have a higher prevalence of disability.

Management/Treatment:

Treatment of a single seizure is controversial because it is not known whether or not the seizure will reoccur. A thorough evaluation is warranted to search for underlying preventable problems. Many physicians will not treat unless a second seizure occurs. When drug therapy with anticonvulsant medication is instituted, the majority of patients respond with good control. It is preferable to use a single agent at the lowest possible dose. The goal of therapy is to find the specific therapy that offers the greatest seizure control and the fewest and most tolerable side effects. More than 20 different anticonvulsant drugs are now available on the market, all with different benefits and side effects. The choice of which drug to prescribe, and at what dosage, depends on many

different factors, including the type of seizures a person has, the person's lifestyle and age, how frequently the seizures occur, and, for a woman, the likelihood that she will become pregnant. In many cases, drug levels in the blood can be monitored. It is very important to insure that the patient is taking the medication regularly. Additional treatment issues include teaching the patient self-management of his condition including monitoring seizures, safety in situations where a seizure may occur, and psychosocial reactions to the fear of seizures. Approximately 20% of patients who receive antiepileptic drug therapy experience recurring seizures. Partial seizures are considered to be more likely to be intractable than other forms of epilepsy. Options in these situations include referral to specialized epilepsy centers for additional medication management, use of nonpharmacologic treatment devices, surgery, or some combination of the above.

If you witness a seizure

The National Institutes of Health (NIH) recommend the following if you see someone having a seizure with convulsions and/or loss of consciousness:

1. Roll the person on his or her side to prevent choking on any fluids or vomit.
2. Cushion the person's head.
3. Loosen any tight clothing around the neck.
4. Keep the person's airway open. If necessary, grip the person's jaw gently from the outside and tilt his or her head back.
5. DO NOT restrict the person from moving unless he or she is in danger.

6. DO NOT put anything into the person's mouth, not even medicine or liquid. These can cause choking or damage to the person's jaw, tongue, or teeth. Contrary to widespread belief, people cannot swallow their tongues during a seizure or any other time.
7. Remove any sharp or solid objects that the person might hit during the seizure.
8. Note how long the seizure lasts and what symptoms occurred so you can tell a doctor or emergency personnel if necessary.
9. Stay with the person until the seizure ends.

3. Don't shake the person or shout.
4. Stay with the person until he or she is completely alert.

When to Call 911

Call 911 immediately if:

- this is a first seizure or you think it might be. (If in doubt, check to see if the person has a medical identification care or jewelry stating that he or she has epilepsy or a seizure disorder);
- the person is pregnant or has diabetes;
- the seizure happened in water;
- the seizure lasts longer than 5 minutes;
- the person does not begin breathing again and return to consciousness after the seizure stops;
- another seizure starts before the person regains consciousness;
- the person injures himself or herself during the seizure.

For More Information

This information has been derived from excellent Internet resources from the National Institute of Neurological Diseases and Stroke (http://www.ninds.nih.gov/health_and_medical/pubs/seizures_and_epilepsy_htr.htm) and the Centers for Disease Control (www.cdc.gov/Epilepsy/faqs.htm).

After the seizure ends, the person will probably be groggy and tired. He or she may have a headache and be confused or embarrassed. Be patient with the person and try to help him or her find a place to rest if he or she is tired or doesn't feel well. If necessary, offer to call a taxi, a friend, or a relative to help the person get home safely.

For a non-convulsive seizure the NIH recommends remembering that the person's behavior is not intentional. The person may wander aimlessly or make alarming or unusual gestures. The following guidelines may help:

1. Remove any dangerous objects from the area around the person or in his or her path.
2. Don't try to stop the person from wandering unless he or she is in danger.

Long-term outlook:

The long-term outlook for individuals with epilepsy depends on the presence of related neurological conditions and the success of anticonvulsant therapy. For individuals with no other neurological problems who achieve good control, there may be no long-term problems related to the disorder. Others experience the whole range of impairments from associated neurological conditions, poor seizure control, and medication side effects. Care should be taken, however, not to let unwarranted discrimination or irrational fears on the part of others negatively impact on a person's life.

Toilet Training Difficulties: Encopresis and Enuresis

Definition:

Most children can control their bowels and are toilet trained by the time they are four years of age. *Encopresis* is the diagnostic label given to problems beyond age four in controlling bowel movements that are not caused by an illness or disability.

Enuresis is the diagnostic label given to problems with urinary incontinence that occur beyond age five. Note that before age five, bedwetting is common enough to be considered a variation of normal, and is not labeled enuresis. Most children begin to stay dry at night around three years of age, but approximately 15% will continue to wet the bed.

Prevalence:

Approximately 1% of five-year-olds have encopresis. Encopresis is apparently more prevalent in

lower socioeconomic families so it is likely that it is more prevalent in child protection populations. For five-year-olds, approximately 7% of males and 3% of females have problems with enuresis and for 18-year-olds, approximately 1% of males and virtually no females still have problems with bedwetting. Males are more likely to have night problems (bedwetting) while

tribute to bedwetting, especially if the bedwetting begins after the child has been dry for a period of months. Bedwetting does run in families, especially for boys.

Associated conditions:

Encopresis and enuresis are somewhat associated with each other. Children who have these conditions often feel ashamed or embarrassed and often avoid situations that would lead to more embarrassment. There is some association between encopresis and short attention spans, low frustration tolerance, hyperactivity and poor coordination.

Management:

School age children with these problems should first have a complete physical examination by a physician to rule out any underlying medical problems. Encopresis is often treated with a combination of educational, psychological, medical and behavioral methods. Most children can be helped, but without treatment, problems can persist for years. Early treatment of a soiling problem can prevent and reduce much social and emotional suffering.

Most urinary incontinence fades away naturally as the child matures. Bladder training, moisture alarms, and medications can be used for children who are experiencing significant social or emotional difficulties as a result of their incontinence.

Long term outlook:

These conditions generally improve as the child develops and

Key Protection and Safety Issues

Unrealistic expectations about when children should develop bladder and bowel control are common in abusive parents. Unfortunately, "accidents" around toilet training often precipitate abusive incidents in these families. Protection and safety workers need to help parents develop realistic expectations for their children, and may need to assist parents in developing effective and supportive toilet training methods. Children who have soiling or wetting problems beyond age four should have complete physical exams and appropriate interventions if they are indicated.

girls are more likely to have daytime problems. Both encopresis and enuresis are more common in boys than girls.

Causes:

Encopresis may be caused by inadequate, inconsistent toilet training and psychosocial stress. It may be associated with fecal retention and subsequent impaction with subsequent leakage and loss of control. Enuresis is often a result of slower physical development, specifically, small bladder capacity, long sleeping periods, and underdevelopment of the body's alarms that signal a full or emptying bladder. Stressful events may also con-



rarely persist into adulthood. Encopresis generally requires professional treatment. In most cases, children will outgrow enuresis without treatment although treatments can accelerate that process.

Family and developmental issues:

Bowel and bladder control develops in most children without too

many complications. When control does not develop within average time periods (such as by the time children begin school) there can be interruptions to other aspects of development (peer relationships, independence, etc.).

Bladder control problems are likely to be a result of physical immaturity or responses to stressful events. Bowel control prob-

lems are often a result of struggles over toilet training. Both result in more work, and thus more stress, for parents. It should be noted, that with very rare exceptions, children who have these problems usually feel ashamed and wish that they could maintain control. Parental anger is generally not helpful and makes the child feel worse.

For More Information

The following sources were adapted for this article and will be helpful for those wishing more information:

http://kidney.niddk.nih.gov/kudiseases/pubs/bedwetting_ez/index.htm retrieved June, 2007;

<http://www.aacap.org/page.wv?name=Bedwetting§ion=Facts+for+Families> retrieved June, 2007;

<http://www.aacap.org/page.wv?name=Problems+With+Soiling+and+Bowel+Control§ion=Facts+for+Families>,
retrieved June, 2007.

http://www.aap.org/publiced/BK5_Soiling.htm retrieved August 2007.

A guide for helping parents deal with normal toilet training issues, entitled "Surviving Toilet Training", is available on the Child Welfare Information Gateway at

<http://www.childwelfare.gov/preventing/supporting/resources/toilettraining.cfm>.

Cognitive Conditions



Mental Retardation

Definition:

Mental retardation refers to a condition that begins before 18 years of age with tested intellectual functioning more than two standard deviations (s.d.) below the mean (<70 on a standard test) *and* with significant impairment in the ability to acquire skills needed for daily living. (See Psychological Tests elsewhere in this booklet.) There is a debate about the use of the term “mental retardation” especially among individuals and family members so affected, but consensus has not emerged about alternative terms.

Nebraska special education law uses the term “Mental Handicap” to refer to individuals with mental retardation. The modifier “mild”, “moderate”, or “severe/profound” is used to describe individuals who have a tested I.Q. score of between 56-70 (statistically between 2 and 3 s.d. below the mean), 41-55 (between 3 and 4 s.d. below the mean), and 40 or less (more than 4 s.d. below the mean) respectively.

It should be recognized that tested I.Q. score reflects a narrow measure of an extremely varied and complex set of mental capacities. Individuals may have significant cognitive difficulties that interfere greatly with the ability to function in school and society while still testing in the normal range of I.Q. scores (See Learning Disabilities elsewhere in this booklet). Conversely, two individuals with the same low I.Q. score may have very different learning abilities with very different functional effects.

Prevalence:

Mental retardation affects between 1% and 3% of the population. In part, this reflects the societal decision to consider individuals as mentally retarded when their scores are more than two standard

deviations from the mean, a statistical measure that identifies the lowest 2.5% of the population.

Cause:

The most common cause of mental retardation is “unknown”. This would include most children with neglectful lack of stimulation and diffuse or unknown genetic factors. In only about 25% of children can a specific cause be identified. The most common identifiable causes of mental retardation are Down Syndrome, Fragile X Syndrome, Fetal Alcohol Spectrum Disorders (FASDs) and traumatic brain injury (TBI). Mental retardation is a factor in most but not all children with Autistic Spectrum Disorders. Each of these conditions is reviewed separately in this booklet.

Associated Conditions:

A wide range of conditions may result in mental retardation and therefore the group of individuals with mental retardation is extremely varied. In the past, many individuals with mental retardation also had severe brain injuries that affected a wide range of behaviors and abilities. Fear and bias resulted in laws that prevented indi-

viduals with mental retardation from marrying, that required institutionalization or that required sterilization. Still today, fear and discrimination on the part of others is a common associated condition for those with mental retardation.

Management/Treatment:

Early recognition and the provision of individualized educational services are keys to improving the outcomes for individuals with mental retardation. These, along with supportive community services, can help most individuals with mental retardation participate productively in society. It is difficult to underestimate the importance of early and comprehensive interventions.

Long-Term Outlook:

The long-term outlook for individuals with mental retardation is greatly influenced by the educational and social supports provided and by the self-help skills learned. The history of treatments for individuals with Down Syndrome provides a dramatic example. In 1929, when most children with Down Syndrome were institutionalized and often subjected to pro-



found institutional neglect, their life expectancy was only 9 years. Now an individual with Down Syndrome can expect to live into their fifties and beyond. With early intervention and community support, individuals with Down Syndrome may experience a wide range of meaningful relationships and work environments.

Family and Developmental Issues:

Families may need help recognizing a child's intellectual limitations and identifying special education resources that can evaluate and help plan for individual needs. Parents who themselves have mental retardation may need help

providing an appropriately stimulating environment for their children. As with all families, appropriate supports are important to successful child rearing

For More Information

The Centers for Disease Control and Prevention (CDC) provides a good overview of issues related to mental retardation, including links to more resources at [http:// www.cdc.gov/ncbddd/dd/ddmr.htm](http://www.cdc.gov/ncbddd/dd/ddmr.htm)

Autism Spectrum Disorders

Definition:

Autism spectrum disorders are a group of brain disorders that are characterized by deficits in a person's social interaction and verbal and nonverbal communication, and generally include repetitive behaviors or interests. ASD is defined by a certain set of behaviors that can range from the very mild to the severe. Although people with ASD do not have exactly the same symptoms and deficits, they tend to share certain social, communication, motor, and sensory problems that affect their behavior in predictable ways. Most developing children with ASD do not show normal social engagement with others, including smiling, eye contact, cuddling. These children also demonstrate significant impairment in their communication skills, ranging from complete muteness, to early signs of babbling and language development that stops, to late language development. Children with ASD often have repetitive behaviors that may appear quite odd, such as flapping their arms, or they may obsessively organize their toys or develop a persistent intense preoccupation with something.

The more severe form of ASD is autistic disorder and the milder form is called Asperger syndrome. If a child has symptoms of either but does not specifically fit either diagnosis, the diagnosis would be pervasive developmental disorder not otherwise specified. Other rare, very severe disorders included in the autism spectrum disorders are Rett syndrome and childhood disintegrative disorder.

Prevalence:

Autism spectrum disorders are found in every country and region of the world, and in families of all racial, ethnic, religious, and economic backgrounds. The most recent reports from the Centers for Disease Control and Prevention found the U.S. prevalence is 6.6 per 1000 children. Earlier prevalence studies suggest that ASD is more common in boys than girls.

Associated conditions:

Many children with ASD have some degree of mental impairment. Many ASD children are highly attuned or even painfully sensitive to certain sounds, textures, tastes, and smells. About one-fourth of autistic children develop seizures. Two genetic disorders, Fragile X syndrome and Tuberous Sclerosis, are sometimes associated with autism.

Management:

A number of treatment programs have been demonstrated to be effective in improving autistic children's social skills, behaviors, and general adjustment. These typically include highly structured developmental and behavioral approaches. Early intervention is very important and can help many affected children avoid some of the most debilitating outcomes of this disorder. Parent involvement has also emerged as a major factor in treatment success. Parents work with

teachers and therapists to identify the behaviors to be changed and the skills to be taught.

Children with autism spectrum disorders generally meet the eligibility requirements for federally mandated educational assessments and interventions. Children under age 3 should be eligible for an early intervention program. In Nebraska, these programs are administered by the Department of Education through local school districts.

There are no specific medications that address the problems of autism. However, some medications that are used to treat anxiety

Key Protection and Safety Issues

Children with ASD require extraordinary patience from their caretakers. Because of their serious impairments, often including language impairments, their ability to protect themselves or seek help is quite limited. Thus, they would be quite vulnerable to child maltreatment.

Workers should assume that the stresses on a family with an ASD child are extraordinary. Intensive services to the child and his or her family are almost always necessary. An autistic child who needs out of home placement will require highly skilled caretakers.

Early recognition of social and language delays along with a referral to the special education early intervention resources at the Early Development Network can improve a child's chances to maximize functioning.

Cause:

Autism is caused by abnormalities in brain structures or functions. Genetic factors appear to play a role in the vulnerability to ASD. Current research is underway to determine how the brain abnormalities occur and what external factors increase the risks. A thorough review of the link between thimersosal (a mercury based preservative that is no longer used in vaccinations) and autism found no such link. Current studies are exploring possible environmental factors including mercury, lead and other heavy metals.

and depression have been successful in addressing some of the symptoms of autism.

In trying to do everything possible to help their children, many parents are quick to try new treatments. Some treatments are developed by reputable therapists or by parents of a child with autism, yet when tested scientifically, cannot be proven to help. Facilitated communication, holding therapy, auditory integration training, and the Dolman/Delcato Method (people are made to crawl and move as infants) are all treatment approaches that have failed to demonstrate effectiveness.

Long term outlook:

People do not outgrow autism spectrum disorders. Some adults with ASD, especially those with high-functioning autism or with Asperger syndrome, are able to work successfully in mainstream jobs. However, communication and social difficulties are likely to continue to be problematic. The majority of adults with more severe forms of autism need lifelong training, ongoing supervision, and

reinforcement of skills. The public schools' responsibility for providing these services ends when the person turns 21 years old. As the child becomes a young adult, the family is faced with the challenge of creating a home-based plan or selecting a program or facility that can offer such services.

For More Information

This information has been adapted from the following publication: National Institute of Mental Health, (2004 with Jan. 2007 addendum), Autism Spectrum Disorders, Pervasive Developmental Disorders, retrieved March 6, 2007, <http://www.nimh.nih.gov/publicat/autism.cfm>

Family and developmental issues:

Children with ASD do not follow the typical patterns of child development. In some children, hints of future problems may be apparent from birth. In most cases, the problems become more noticeable as the child slips farther behind other children of the same age. Other children start off well enough. But between 18 and 36 months old, they suddenly reject people, act strangely, and lose language and social skills they had already acquired. Adolescence may bring on more autistic or ag-

gressive behaviors as a response to the normal stresses and confusion of that age period. High functioning ASD adolescents may become painfully aware of their 'differentness' and may become depressed.

The task of rearing a child with ASD is among the most demanding and stressful that a family faces. The child's screaming fits and tantrums can put everyone on edge. Because the child needs almost constant attention, brothers and sisters often feel ignored or jealous. The tensions can strain a marriage. Families may also be uncomfortable taking their child to public places. Many parents feel deeply disappointed that their child may never engage in normal activities or attain some of life's milestones.

Acknowledgments

Prevalence data came from a February 2007 report from the U.S. Centers for Disease Control and Prevention, retrieved March 6, 2007 at: <http://www.cdc.gov/od/oc/media/pressrel/2007/r070208.htm>

Down Syndrome

Definition:

Down Syndrome is the most common genetic disease in humans and is caused by extra genetic material from the 21st chromosome. It is not always recognized in early infancy because infants may show some or all of the characteristic traits which are:

- low muscle tone,
- flat facial profile with a somewhat depressed nasal bridge and a small nose;
- upward slant to the eyes;
- abnormal shape of the ears;
- a single deep crease on the center of the palm;
- excessive ability to extend the joints;
- fifth finger with 1 flexion crease instead of 2;
- epicanthal folds -- small skin folds on the inner corner of the eyes;
- excessive space between large and second toes;
- and enlargement of tongue in relationship to size of mouth.

Individuals with Down Syndrome have some degree of mental retardation which is usually in the mild to moderate range and is not indicative of the many strengths and talents they may have.

Prevalence:

Down Syndrome occurs in about 1 in every 1000 births. This is about 24 children per year in Nebraska. Most children with Down Syndrome are born to mothers who are less than 35 years old, but older mothers are at increased risk. At 35 years, the risk is about 1 in 350 births. By 40 years of age the risk is 1 in 100 births, and by 45 years of age, it is as high as 1 in 30

births. Once a mother has had a child with Down Syndrome, the risk of recurrence is 1 in 100. There are over 350,000 individuals with Down Syndrome living in the United States and over 2000 in Nebraska.

Cause:

The cause of the extra chromosomal material is not known. In a small number of individuals, the

Key Protection and Safety Issues

Any child who is different can become the focus of abnormal family relationships and subsequent neglect or abuse. It is especially important that children with Down Syndrome be identified early and referred for evaluation and early intervention services provided by the public school system. In addition, early and comprehensive medical care can identify and greatly reduce risks from accompanying physical problems including heart disease and infections. Appropriate intervention and education for the family can greatly reduce the stresses felt by the family and increase the chances that the parents and child will experience healthy attachment and optimal development.

extra genetic material is stuck to another chromosome which raises the recurrence risk dramatically. Genetic testing can identify this increased risk.

Associated Conditions:

Children with Down Syndrome are at increased risk for certain health problems. Up to 50 percent of individuals with Down Syndrome are born with congenital heart defects. The majority of heart defects in children with Down Syndrome can now be surgically corrected with resulting long-term health improvements. Increased susceptibility to infection, respiratory problems, obstructed digestive tracts and childhood leukemia also occur with greater frequency among children who have Down Syn-

drome. However, advances in medicine have rendered most of these health problems treatable, and the majority of people born with Down Syndrome today have a life expectancy of approximately 55 years.

Adults with Down Syndrome are at increased risk for Alzheimer's disease. Whereas approximately 6% of the general population will develop the disease, the figure is about 25% for people with Down Syndrome. Many individuals with Down Syndrome have the changes in the brain associated with Alzheimer's, but do not necessarily develop the clinical disorder.

Management / Treatment:

Medical conditions such as heart disease or intestinal malformations must be identified and treated early. After these, the most important

management issue for Down Syndrome is to institute an early intervention program consisting of a caring, stimulating, and responsive environment. Children with Down Syndrome qualify for special education services from the public schools beginning at birth and including both evaluation and intervention services.

Many medical treatments have been proposed for Down Syndrome but none have proven effective. These treatments have included thyroid hormone, pituitary extract, glutamic acid, dimethyl sulfoxide, Sicca cell therapy, five-hydroxytryptophan, various vitamin and mineral therapies and lately, memory enhancing drugs such as piracetam. Sicca cell therapy has been shown by several

reports to be dangerous. Careful studies looking at the use of vitamin supplementation showed no benefit. An early study suggested that they did, however, when a follow up study was done to look for a placebo effect, no benefit was found.

Long-Term Outlook:

Not long ago most individuals with Down Syndrome died before they were 20, and those who were institutionalized often did not survive into adolescence. Today, in a caring social environment with appropriate medical care, their life expectancy may be 55 years or more. Individuals with Down Syndrome are integrated into the regular education system, take part in all the activities in

their community, and socialize with people with and without disabilities. As adults they may ob-

ated with this condition, they are overwhelmingly unique and must be treated as individuals. Females with Down Syndrome go through normal pubertal changes and are fertile, although they are at up to a 50% risk of having a child with Down Syndrome. Males also experience normal, or somewhat delayed pubertal changes but are almost always infertile.

For More Information

Because the public schools have an obligation to serve every child with a disability from birth, ChildFind and Early Intervention services provide an ideal source of both evaluation and intervention for a child with Down Syndrome. The statewide Childfind number is 1-888-806-6287. Each Educational Service Unit has an Early Intervention Program. Many sources of good information about Down Syndrome can be found by entering "Down Syndrome" into the National Library of Medicine's MedlinePlus website at <http://www.medlineplus.gov>.

tain employment and live in group homes or other independent housing arrangements.

Family and Developmental Issues:

People with Down Syndrome are people first. While they may have characteristics generally associ-

Acknowledgments:

This information has been adapted from excellent material about Down Syndrome available at the National Down Syndrome Society website at www.ndss.org.

Fetal Alcohol Spectrum Disorders

(FASDs)

Definition:

Fetal Alcohol Spectrum Disorders is an inclusive term that refers to the range of adverse effects to a fetus from exposure to alcohol during pregnancy. Fetal Alcohol Syndrome, or FAS, refers to individuals who show *all three* of the common results of exposure to alcohol during fetal development: typical facial features and typical brain dysfunction *and* typical growth resulting in small size. Fetal Alcohol Effects (FAE) has been used to refer to affected individuals who do not show all three defects. Two newer, more precise, but not yet popular terms are Alcohol Related Neurodevelopmental Disorder (ARND) and Alcohol Related Birth Defects (ARBD). ARND refers to the behavioral and/or cognitive effects of fetal alcohol exposure, and ARBD refers to structural problems in the heart, kidneys, bones, or hearing.

Typical facial features, many of which relate to slow growth of the mid-facial structures, include:

- narrow eye slits which make the eyes appear wide-spaced;
- epicanthal skin folds (over the inner corner of the eye);
- short nose;
- flat mid-face and cheeks;
- long space between the nose and a thin upper lip;
- flat filtrum (the normal ridges above the upper lip); and
- a small lower jaw

Sometimes the ears are small, low, or tipped back, but these are very non-specific features.

Typical brain dysfunction includes mental retardation, usually in the mild to moderate range; symptoms of Attention Deficit Hyperactivity Disorder, including short attention span, impulsivity and hyperactivity; specific learning disabilities; and inappropriate social judgment. Frequently a child with FAS will

have been effected by alcohol in utero.

Cause:

By definition, Fetal Alcohol Spectrum Disorders are caused by the effects of alcohol on the developing fetus. Ethyl alcohol is a tiny molecule which is soluble in both water and lipids, and which therefore permeates every part of the mother's body, the placenta, and the child's body and brain. By dissolving in all cell membranes, the alcohol disrupts cell connections and the growth of all tissues. The effects are therefore more pervasive and frequently more devastating than for many other prenatal drug exposures. Although the final effects on the child depend on the amount and timing of alcohol exposure, there is no safe threshold, and even mild, social drinking has been shown to reduce the average IQ of a group of children.

Key Protection and Safety Issues

Children with FAS are at high risk for abuse and neglect because they are difficult to parent, because of stresses in their family, and because of attachment and other relationship difficulties that are common in the syndrome. Early recognition and mobilization of interventions for the child and supports for the family may reduce this risk.

Early evaluation and mobilization of community resources is important. Although FAS/FAE are not mentioned in Nebraska's Special Education Regulations (Rule 51), children with FAS or FAE often qualify for special education services either because of their mental retardation, their behavior disorder, or under the category of "Other Health Impaired." Every child with FAS should be referred to the Early Development Network (See Special Education late in this booklet) for evaluation for special services.

appear social and verbal in ways that belie their underlying intellectual deficits.

Typical growth includes height and weight both less than the 3rd percentile (less than 97 of 100 children of the same age).

Prevalence:

It is estimated that FAS occurs in between 1 and 2 babies per 1000 live births. This estimate may be low because the diagnosis is often missed. Milder effects, or FAE, may be as much as 3 times more common. Some experts have estimated that between 1/3 and 2/3 of all children in special education

Associated Conditions:

Alcohol effects on the child's neurological system may result in a child with a difficult, irritable temperament. Alcoholism may also affect the adults in the child's life, disrupting the social and emotional environment which the child is raised. These factors combine to produce secondary developmental affects which can be alleviated by early diagnosis and support. Inappropriate social judgement may place the child at risk of abuse by unrelated adults. Many children with FAS appear to have trouble understanding consequences and specific learning disabilities can complicate the child's ability to

learn in school beyond their overall intellectual deficits.

Management/Treatment:

Children with FAS/FAE may be difficult to parent and difficult to teach. Early diagnosis is important to provide support and respite for the child's caregivers and to provide needed structure and consistency in the child's environment. A careful evaluation of the child's intellectual capabilities and deficits is important in the preschool years. Children with FAS/FAE require structure, consistency, variety, brevity and persistence. Attention Deficit symptoms should be managed as with other causes of ADHD, although stimulant medication may be less effective.

Because these children lack internal structure, caretakers need to provide external structure for them. It is important to be consistent in response and routine so that the child feels the world is predictable. Because of serious problems maintaining attention, it is

important to be brief in explanations and directions, but also to use a variety of ways to get and keep their attention.

Finally, we must repeat what it is we want them to learn, over and over again. Social skills training explicitly teaching children about

For More Information

This article draws from the excellent material about FAS and FAE on the website of the National Organization for Fetal Alcohol Syndrome at <http://www.nofas.org>.

Excellent resources are available from the CDC at <http://www.cdc.gov/ncbddd/fas/fasask.htm> and at the National Library of Medicine at <http://www.medlineplus.gov>.

stranger skills and social conventions is generally thought to be important although studies have not demonstrated its effectiveness.

Long-Term Outlook:

Facial structures continue to grow through childhood so that the facial features are much less distinct by adolescence. Children with FAS usually remain shorter than the 3rd percentile. Most remain thin as well, although eating patterns in some may result in obe-

sity. The neurological effects of FAS and FAE are permanent and no treatments are known which will eliminate them. Children with FAS are at risk for psychiatric problems, criminal behavior, unemployment, and incomplete education. Early identification and implementation of special educa-

tion programs, and the establishment of a loving, nurturing, and stable home increases the chances that a person with FASDs will reach their full potential.

Family and Developmental Issues:

All alcohol issues in the family must be recognized and managed. Ongoing alcoholism will limit a primary caretaker's ability to deal with a difficult infant. Alcoholism in a spouse will add significant stress to an already stressful situation. Initial attachment between parent and child can be disrupted by the child's temperament and behaviors, the mother's guilt over the effects of her drinking, and/or either parent's stresses and alcohol problems.

Fragile X Syndrome

Definition:

Fragile X syndrome is the most common form of mental retardation that can be passed from parent to child. (Down syndrome is more common, but most of the time it occurs spontaneously and is not passed from parent to child.) Intellectual effects can range from mild learning disabilities to severe retardation but most have mild to moderate retardation. Boys are affected more than girls and 80% of boys with the syndrome have a tested I.Q. of less than 75. Children with the syndrome often have behavioral problems including excessive shyness, social anxiety, and/or aggression. As they get older, these children may have increasing physical effects including long ears and jaws and loose joints.

Cause:

Fragile X syndrome is caused by a mutation in the gene for a protein essential for brain development. This mutation can exist in various forms from mild to

severe. Some people are carriers who show no effects themselves but can pass on the condition in a more severe form. In general, each generation inherits a more severe form of the gene than the last. Because the problem is on the X chromosome, fathers can only pass the condition on to daughters and mothers can pass it on to either sons or daughters.

Prevalence:

The exact prevalence is unknown. It is estimated that about 1 in 1000

Key Protection and Safety Issues

Children with Fragile X syndrome may have learning problems, impulsivity, hyperactivity, attention problems, excessive shyness, social awkwardness, and/or aggressive behaviors that put them at increased risk of abuse and/or neglect. Workers should insure that children are referred for proper medical diagnosis and for individualized special education services at the earliest opportunity. As the child enters adolescence, transition planning for adult services may require active advocacy with the school and with community services.

males and about twice as many females have the pre-symptomatic

form of the condition that can be passed on to children. One study has estimated that 1 in 4000 females and up to twice as many males have the full syndrome. Although it may be more common in females, it is more severe in males. Because of the great variability in the expression of the syndrome, it may frequently go undiagnosed and its prevalence underestimated.

Associated Conditions:

Most males and about one third of females show some degree of autistic-like behavior. About one third of all children with Fragile X show enough of these behaviors to have the diagnosis of autism. But among all children with autism, only a small number have Fragile X syndrome. Most males and between one third and one half of females with Fragile X have the symptoms of ADHD. About 20% of children with Fragile X syndrome have seizures which can usually be controlled with medication. Individuals with Fragile X may develop joint problems due to loose joints, and may have heart valve problems causing a murmur.

Management/Treatment:

There is no cure for Fragile X syndrome. However, management of the symptoms with special education resources and behavioral and/or physical therapy and sometimes medication can help a child minimize disability. Early intervention is especially important but it is never too late to institute treatment.

Long-Term Outlook:

The long-term outlook depends on the severity of the inherited form



of the syndrome, and the degree that intellectual, behavioral, social, and medical problems have been recognized and addressed. Early institution of special education supports, and effective transition from special education to adult vocational and living supports is important to maximize adult functioning.

Family and Developmental Issues:

Because parents may have the

can be affected, Fragile X syndrome can cause significant challenges and stresses in a family. The inheritance of the condition is

more complex and more variable than most conditions and genetic counseling can be important. The attention problems, learning problems and social problems caused by the syndrome

can be especially stressful and require competent support.

For More Information

The NIH and the CDC sites below are very complete sources of information about Fragile X. The information in this section has been drawn from many sources including the National Institutes of Health (NIH) at <http://www.nichd.nih.gov/publications/pubs/fragileX/> and the Centers for Disease Control at http://www.cdc.gov/ncbddd/single_gene/fragilex.htm

syndrome as well (although usually in a milder form), and because more than one child in a family

Speech Disorders, Language and Learning Disorders

Definition:

A learning disability (LD) is a disorder that affects people's ability to either interpret what they see and hear or to link information from different parts of the brain. These limitations can show up in many ways—as specific difficulties with spoken and written language, coordination, self-control, or attention. Such difficulties extend to schoolwork and can impede learning to read or write, or to do math.

“Learning disability” is not a diagnosis in the same sense as “chicken pox” or “mumps”. Chicken pox and mumps imply a single, known cause with a predictable set of symptoms. Rather, LD is a broad term that covers a pool of possible causes, symptoms, treatments, and outcomes. Not all learning problems are necessarily learning disabilities. Many children are simply slower in developing certain skills. Because children show natural differences in their rate of devel-



opment, sometimes what seems to be a learning disability may simply be a delay in maturation. To be diagnosed as a learning disability, specific criteria must be met.

Learning disabilities can be di-

ffer with school performance, they often accompany academic skills disorders.

Prevalence:

Learning disabilities affect approximately fifteen percent of otherwise school able children.

Cause:

The causes of learning disabilities are diverse and complex. Today, a leading theory is that learning disabilities stem from subtle disturbances in brain structures and functions. In many cases, the disturbance begins before birth. Factors that may cause these disturbances include genetic factors; tobacco, alcohol, and other drug use; pregnancy or delivery complications; or toxins in the child's environment.

Key Protection and Safety Issues

Children with severe learning disabilities will be more frustrating and challenging to their parents, consequently raising their risks of being abused. In neglectful families, parents may not be aware of their children's developmental delays so workers need to be vigilant in identifying any delays and making appropriate referrals. There is evidence that the vast majority of children who are removed from their homes have serious speech and language delays or disorders that would greatly benefit from intensive early intervention services. Thus, workers need to be attune to appropriate developmental expectations for children in their supervision and they need to vigorously advocate for appropriate services.

The cycle of failure, acting out, and low self-esteem that results from learning disabilities places teens at increased risk for entering the juvenile justice system.

Associated

Conditions:

Many children have more than one type of learning disability and as mentioned above, attention deficit disorder often accompanies specific learning disabilities. Behavioral and social problems are often associated with learning disabilities.

Management:

Appropriate specialized educational planning is the most significant management issue for children with learning disabilities. In addition, the frustrations that often arise in children and families dealing with learning disabilities can often be helped by individual or family counseling or support

vided into three broad categories:

- Developmental speech and language disorders (these include developmental articulation, expressive language, and receptive language disorders)
- Academic skills disorders (these include developmental reading disorders (also known as dyslexia) writing disorders, and arithmetic disorders)
- “Other,” a catch-all term that includes certain coordination disorders and learning handicaps not covered by the other terms

Attention disorders, with or without hyperactivity, are not considered learning disabilities in themselves. However, because attention problems can seriously inter-

groups. Although medications are often helpful for children with attention problems (see ADHD section of this workbook), there are no medications that have been found to be useful for speech, language, arithmetic or other academic skill disabilities. In trying to do everything possible to help their children, many parents have tried different treatments. The following treatments have been tested scientifically, and have not been proven to be effective for children with learning disabilities: megavitamins, colored lenses, special diets, sugar-free diets, body stimulation or manipulation.

Long term outlook:

Learning disabilities can be lifelong conditions that, in some cases, affect many parts of a per-

son's life: school or work, daily routines, family life, and other relationships. In some people, many overlapping learning disabilities may be apparent. Other

For More Information

National Institutes of Mental Health
(www.nimh.nih.gov/publicat/learndis.htm).

people may have a single, isolated learning problem that has little impact on other areas of their lives.

Family and developmental issues:

Because school achievement is so central to many school-age children, learning disabilities can have a significant impact on children's self-esteem and peer relationships.

Some children with learning disabilities may be immature compared to their peers. Children may internalize their failures and frustrations and it is not uncommon for them to begin acting out their distress. By the time they reach adolescence, many will unfortunately be caught up in a cycle of failure, low self-esteem, acting out, punishment, further failure, etc.

Having a child with a learning disability may also be an emotional burden for the family. Parents often sweep through a range of emotions: denial, guilt, blame, frustration, anger, and despair. Brothers and sisters may be annoyed or embarrassed by their sibling, or jealous of all the attention the child with LD gets.

Psychological and Behavioral Conditions



Addiction, Alcohol and Drug Abuse

Definition:

Substance dependence and substance abuse, whether for alcohol or other drugs, are defined in the DSM-IV-TR as two distinct disorders.

Substance dependence (and alcohol dependence) are maladaptive patterns of use leading to significant impairment as shown by three or more of the following: tolerance; withdrawal symptoms; increasing use over a longer time than intended; persistent desire or unsuccessful attempts to control use; a great deal of time spent obtaining, using, or recovering; giving up important social, occupational, or recreational activities; and continued use despite the knowledge of physical and/or psychological problems caused. Evidence of physiological as well as psychological dependence is important to this definition. Alcohol dependence is often called alcoholism.

Substance abuse (and alcohol abuse) are manifested by one or more of the following: recurrent use resulting in a failure to fulfill major role obligations at work, school, or home; recurrent use in situations in which it is physically hazardous; recurrent substance-related legal problems; or continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the use. Substance abuse and alcohol abuse are defined by the problems created by the use rather than by the physical or psychological effects. Many individuals

with substance dependence also experience these problems.

As a legal drug, alcohol is used by a large number of people. For most people, alcohol is a pleasant accompaniment to social activities or meals. However, patterns of risky drinking can be identified before either alcohol abuse or alcohol dependence are present. A risky drinking pattern for men is

often characterized as morally weak or as having criminal tendencies. Many people think that drug abusers and addicts should be able to stop taking drugs if they are willing to change their behavior. While addiction begins with a conscious choice to use drugs, addiction is not just "a lot of drug use." Changes occur in the brain that can turn drug use into drug dependence, a chronic, relapsing illness.

Key Protection and Safety Issues

Alcohol and substance abuse are involved in a majority of abuse and neglect cases. If the substance problems contribute to the child maltreatment, they must be effectively addressed before progress can be made. As mentioned above, these problems are treatable. However, treatment programs have to quickly be made available to individuals in order to help parents overcome their problem behaviors. Protection and safety workers need to forcefully advocate on behalf of parents in order to obtain effective treatment in a timely manner.

Maternal alcohol abuse during pregnancy causes fetal alcohol syndrome (FAS) or fetal alcohol effects (FAE). See elsewhere in this workbook for further information.

Finally, many youth in the juvenile justice system use alcohol or other drugs and may be in the beginning stages of addiction. Treatment at this time may help these youth avoid some of the more serious health effects and brain changes that will occur with sustained use.

considered more than 14 drinks in a week, or more than five drinks in a day. Because women are physiologically more susceptible to the effects of alcohol, risky drinking for women is more than seven drinks in a week or 4 drinks in a day. (A standard drink is one 12-ounce bottle of beer or wine cooler, one 5-ounce glass of wine, or 1.5 ounces of 80-proof distilled spirits)

Many people view drug abuse and addiction as strictly a social problem. People who take drugs are

often characterized as morally weak or as having criminal tendencies. Many people think that drug abusers and addicts should be able to stop taking drugs if they are willing to change their behavior. While addiction begins with a conscious choice to use drugs, addiction is not just "a lot of drug use." Changes occur in the brain that can turn drug use into drug dependence, a chronic, relapsing illness.

Prevalence:

More than 6% of men and between 2% and 3% of women experience alcohol dependence. 11% of men and 4% of women experience alcohol abuse. However, according to the National Institute on Alcohol Abuse and Alcoholism (NIAAA) over 40% of males and nearly 25% of females engage in risky drinking patterns which put them at risk for adverse consequences. 53% of adults in the U.S. report that one or more of their close relatives have a drinking problem. According to the Substance Abuse and Mental Health Services Administration (SAM-

HSA) approximately 8% of the population over 12 years of age use illicit drugs. Half of these use marijuana alone, about 20% use marijuana with other drugs, and the rest use other drugs without marijuana.

Cause:

Although social forces and individual choice do contribute to beginning alcohol and/or drug use and abuse, research provides overwhelming evidence that drugs and alcohol have long-term effects on brain metabolism and activity.

Addiction to most drugs and alcohol results in the reduction of dopamine receptors in key centers of the brain related to reward and pleasure. Genetic differences make some people more vulnerable to alcoholism and drug abuse than others. Some of these genetic differences involve changes in the dopamine receptors. Current research is underway to pinpoint the genes that influence vulnerability to alcoholism and drug abuse. It should be remembered that genetic influences raise the risks of addiction, but that most people with these genetic differences do not become addicted.

Associated conditions:

People who abuse one substance often also abuse others. There are specific physical conditions that are associated with different abused substances (for example, liver problems with alcohol abuse). Also, depression, anxiety, paranoia, and suicidal ideation are fairly common in people with serious substance abuse problems.

Management/treatment:

A variety of approaches are used in treatment programs to help people deal with their cravings and to avoid relapses. Addiction is clearly treatable and recent evidence suggests that treatment of addiction is as successful as the treatment of diabetes or hypertension. All are chronic illnesses marked by relapses, and treatment improves outcomes. The nature of

the treatment depends on the severity of the individual's abuse and/or addiction. Treatment may include detoxification, medication, and individual and/or group counseling. Many support groups exist to help people avoid relapses (e.g. AA) and successful treatment programs usually have a peer support component. According to SAMSHA, treatment that involves less than 90 days of intensive in- and out-patient treatment are of "little or no benefit."

Long-term outlook:

While alcoholism and drug addiction are treatable, cures are not available. That means that even if an individual has been sober for a long while and has regained

For More Information

The Lincoln Council on Alcoholism and Drugs (<http://www.lcad.org>) has information about local resources available in many different languages. Local AA meetings in Nebraska can be found by going to www.area41.org. Local NA meetings in Nebraska can be found by going to www.nebraskana.org/meetings.htm. Al-anon and Alateen support groups are for family members. Information is available at www.al-anon.alateen.org/ or at (800) 344-2666.

health, he or she remains susceptible to relapse and must continue to work at avoiding all alcohol or other substances. Still, with treatment and determination to remain sober, many alcoholic and addicted individuals can successfully overcome their destructive patterns and resume healthy and rewarding lifestyles.

Family and developmental issues:

Alcohol and/or drug abuse by one individual has profound effects on

all family members. Not only do impaired individuals behave erratically and irrationally, but also economic, time and other resources are drained from the family to help the individual fulfill his or her cravings for drugs or alcohol. Family members often need to participate in the treatment of their affected member.

The majority of adolescents use alcohol and/or other illicit drugs in some form (approximately 66% of 12-graders had used alcohol during the past year; approximately 31% of 12-graders had used marijuana at some time). Most of these youth will not go on to develop serious problems with alcohol or other drugs, but some will.

It is difficult to differentiate between developmentally normal "experimenting" and more troublesome patterns that are the precursors of alcoholism or addiction.

Acknowledgments:

Portions of this have been adapted from publications

by the National Institute of Alcohol Abuse and Alcoholism (www.niaaa.nih.gov) and the National Institute of Drug Abuse (www.nida.nih.gov), especially SAMHSA at www.samhsa.gov. Statistics are available from the "Monitoring The Future" study at www.monitoringthefuture.org.

Common Street Drugs

This table is available from the National Institute of Drug Abuse (NIDA) by going to <http://www.drugabuse.gov/DrugPages/DrugsofAbuse.html>. The information below was accessed in August, 2007.

Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule*/ How Adminis- tered**	Intoxication Effects/Potential Health Consequences
Cannabinoids			
hashish	boom, chronic, gangster, hash, hash oil, hemp	I/s w a l l o w e d , smoked	euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination, cough, frequent respiratory infections; impaired memory and learning; increased heart rate, anxiety; panic attacks; tolerance, addiction
marijuana	blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, weed	I/s w a l l o w e d , smoked	
Depressants			
barbiturates	Amytal, Nembutal, Seconal, Phenobarbital: barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II, III, V/injected, swallowed	reduced anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration/fatigue; confusion; impaired coordination, memory, judgment; addiction; respiratory depression and arrest; death Also, for barbiturates—sedation, drowsiness/depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness, life-threatening withdrawal for benzodiazepines—sedation, drowsiness/dizziness for flunitrazepam—visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug's effects for GHB—drowsiness, nausea/vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death for methaqualone—euphoria/depression, poor reflexes, slurred speech, coma
benzodiazepines (other than flunitrazepam)	Ativan, Halcion, Librium, Valium, Xanax: candy, downers, sleeping pills, tranks	IV/swallowed, injected	
flunitrazepam***	Rohypnol: forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies	IV/swallowed, snorted	
GHB***	gamma-hydroxybutyrate: G, Georgia home boy, grievous bodily harm, liquid ecstasy	I/swallowed	
methaqualone	Quaalude, Sopor, Parest: ludes, mandrex, quad, quay	I/injected, swal- lowed	

Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule*/ How Adminis- tered**	Intoxication Effects/Potential Health Consequences
Dissociative Anesthetics			
ketamine	Ketalar SV: cat Valiums, K, Special K, vitamin K	III / i n j e c t e d , snorted, smoked	increased heart rate and blood pressure, impaired motor function/memory loss; numbness; nausea/vomiting
PCP and analogs	phencyclidine; angel dust, boat, hog, love boat, peace pill	I, II / i n j e c t e d , s w a l l o w e d , smoked	Also, for ketamine—at high doses, delirium, depression, respiratory depression and arrest for PCP and analogs—possible decrease in blood pressure and heart rate, panic, aggression, violence/loss of appetite, depression
Hallucinogens			
LSD	lysergic acid diethylamide: acid, blotter, boomers, cubes, micro-dot, yellow sunshines	I / s w a l l o w e d , absorbed through mouth tissues	altered states of perception and feeling; nausea; persisting perception disorder (flashbacks)
mescaline	buttons, cactus, mesc, peyote	I / s w a l l o w e d , smoked	Also for LSD and mescaline—increased body temperature, heart rate, blood pressure; loss of appetite, sleeplessness, numbness, weakness, tremors
psilocybin	magic mushroom, purple passion, shrooms	I / s w a l l o w e d	for LSD—persistent mental disorders for psilocybin—nervousness, paranoia
Opioids and Morphine Derivatives			
codeine	Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine: Captain Cody, schoolboy; (with glutethimide) doors & fours, loads, pancakes and syrup	II, III, IV, V / i n j e c t e d , s w a l l o w e d	pain relief, euphoria, drowsiness/nausea, constipation, confusion, sedation, respiratory depression and arrest, tolerance, addiction, unconsciousness, coma, death Also, for codeine—less analgesia, sedation, and respiratory depression than morphine
Opioids and Morphine Derivatives continued on next page . . .			

Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule*/ How Adminis- tered**	Intoxication Effects/Potential Health Consequences
Opioids and Morphine Derivatives continued from previous page . . .			
fentanyl and fen- tanyl analogs	Actiq, Duragesic, Sublimaze: Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	I, II/injected, smoked, snorted	pain relief, euphoria, drowsiness/ nausea, constipation, confusion, sedation, respiratory depression and arrest, tolerance, addiction, unconsciousness, coma, death for heroin—staggering gait
heroin	diacetyl-morphine: brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse	I / i n j e c t e d , smoked, snorted	
morphine	Roxanol, Duramorph: M, Miss Emma, monkey, white stuff	II, III/injected, s w a l l o w e d , smoked	
opium	laudanum, paregoric: big O, black stuff, block, gum, hop	II, III, V/ s w a l l o w e d , smoked	
oxycodone HCL	Oxycontin: Oxy, O.C., killer	II/s w a l l o w e d , snorted, injected	
hydrocodone bitar- trate, acetamino- phen	Vicodin: vike, Watson-387	II/swallowed	
Stimulants			
amphetamine	Biphetamine, Dexedrine: ben- nies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/injected, swal- lowed, smoked, snorted	increased heart rate, blood pres- sure, metabolism; feelings of exhilaration, energy, increased mental alertness/rapid or irregular heart beat; reduced appetite, weight loss, heart failure, nerv- ousness, insomnia Also, for amphetamine—rapid breathing/tremor, loss of coordi- nation; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addic- tion, psychosis
Stimulants continued on next page . . .			

Notes to table

* Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Some Schedule V drugs are available over the counter.

** Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.

*** Associated with sexual assaults.



ADHD (Attention Deficit Hyperactivity Disorder)

Definition:

ADHD stands for Attention Deficit Hyperactivity Disorder. It is defined in the DSM-IV to describe children who experience severe difficulties with attention, impulse control and hyperactivity. For the term to be appropriate, these difficulties must have started before 7 years of age and must occur in more than one setting (i.e., not just at home or just at school). In addition they must be severe enough to impair social, academic or occupational functioning, and must not be due to another more serious mental disorder.

Children may exhibit primarily the attention symptoms, primarily the impulsive/hyperactivity symptoms, or most commonly both. An older term, ADD (Attention Deficit Disorder) is sometimes used to refer to children when the hyperactivity/impulsivity symptoms are minimal. Because the symptoms that define ADHD occur in all children, ADHD can be thought of as a “dimension on which children vary” rather than a disorder that one either has or doesn’t have.

There is no “test” for ADHD. The diagnosis should be made by a medical or mental health professional with experience in childhood behavioral disorders using information from both home and school. The diagnosis involves a judgment about the severity of the

symptoms and the resulting dysfunction and whether these warrant being labeled as a serious mental disorder. It is important to recognize that children may have problems with attention, impulsivity, or hyperactivity that are bothersome to some adults without warranting the label ADHD.

Prevalence:

Because there is not a precise and objective measure of the symptoms that define ADHD, its prevalence depends upon the clinical judgment of a diverse group of professionals. Most estimates are

symptoms may be less likely to be referred for treatment, especially girls who have the inattention aspect of ADHD without the hyperactive/impulsive symptoms. Although the label may be applied to children as young as 3 years, the problems are most commonly recognized in the early grade school years.

Cause:

The most common cause of ADHD is “Unknown.” It is clear that genetic factors are often important because the condition often runs in families. Children who are known to be affected by fetal alcohol exposure very frequently exhibit the symptoms of ADHD. Smoking during pregnancy is also associated with the diagnosis. Although poor or inconsistent parenting can result in many behavior problems, it is probably not common for parenting practices alone to cause particular symptoms of ADHD.

Associated Conditions:

Children with carefully diagnosed ADHD frequently exhibit other problems as well.

About 25% will have specific learning disabilities in language or math skills. It is important to recognize and manage these learning disabilities with specific intervention and support. Up to 40% of children with ADHD also exhibit symptoms of Oppositional/Defiant

Key Protection and Safety Issues

Because of difficult child behaviors and common family disruptions, a child with ADHD is at increased risk for abuse and neglect. In addition, a child with ADHD is at increased risk of injury even if the family is not neglectful. It is important to recognize the symptoms of ADHD in both children and parents so that appropriate management can be instituted.

The stimulant medications used to treat ADHD are sometimes prescribed without sufficient attention to behavioral management and family support, and sometimes without adequate assessment of potential specific learning disabilities. All of these are important to reduce the need for medication and to increase the effectiveness of medication when it is needed. In addition, careful monitoring of the behavioral and potential side-effects of the medication is important and should be shared with the prescribing physician.

There is no evidence that treating with stimulants increases a child’s chances of abusing these drugs. However, stimulant medications can be abused and have a street value. It is crucial to insure that prescribed medication actually gets to the child and does not get diverted. Some individuals seek stimulant medication for their children in order to obtain and sell the medications.

that 4 to 5 percent of school age children demonstrate ADHD, but individual professionals may be much more or much less strict. In clinical practice, boys outnumber girls 6:1 or more, although in population studies the ratio is more commonly around 3:1. This indicates that girls with the same

or Conduct Disorder which should also be addressed separately.

Children with Tourette Syndrome, a genetic condition involving multiple motor and vocal tics, often present with ADHD symptoms one or more years before they show tics. ADHD occurs in children of all degrees of intelligence, and all socioeconomic levels.

Management/Treatment:

Because children with ADHD behave as if they were insensitive to normal rewards and consequences -- an aspect that may have brain-related causes -- an important part of management involves instituting consistent and predictable systems of behavior management in which reinforcements are more frequent, more intense, more timely, and more salient than usually needed for children of a similar age. This is important for children with attention problems whether or not they warrant an ADHD label. In addition, parents, teachers, and other caretakers need support and an understanding of the condition.

It has been known for 70 years that stimulant medication improves the symptoms of ADHD. However, stimulant medication should be used only when the symptoms continue despite a program of behavior management and support and the appropriate management of any learning disabili-

ties, all of which should continue after medication is started.

The most common and best understood stimulant is methylphenidate (Ritalin®). Amphetamines such as dextroamphetamine (Dexadrine®) or Adderol® (a mixture of amphetamines) are very similar. Methylphenidate and amphetamines are effective in 80% of children with ADHD. The short acting forms of these medications, require 2 or 3 doses per day, including a noon dose. Longer acting versions of most ADHD medications are available. Other medications are sometimes used. All medications for ADHD should be considered symptomatic treatment. They are effective only while they

symptoms of conduct disorder or specific learning disabilities have the most favorable outlook. Despite this, ADHD is associated with a very high degree of school failure, employment failure, accidents, and problems with the law. Because of the genetic aspects, the possibility that attention problems may be affecting the parents of children with ADHD should be considered. The disorganization, impulsivity, inattention, and learning disabilities associated with ADHD can all contribute to parenting difficulties and problems in dealing with the system of social supports.

Family and Developmental Issues:

Parenting a child without the symptoms of ADHD can be challenging. The child with ADHD can shake the confidence of the most experienced parent. Although the label is not appropriate for infants, an infant who will later have the symptoms of ADHD may sleep little, have a high degree of activity, and be difficult to soothe or hold. When the child becomes more mobile he or she may climb out of the crib or onto the furniture. Explaining that some children are more difficult than others and that these are not necessarily signs of parenting failure and providing support and suggestions is very important. If attention problems are present in one or both parents, a chaotic pattern of family interactions is common.

For More Information

The Centers for Disease Control maintains a helpful ADHD web resource at <http://www.cdc.gov/ncbddd/adhd/>

CHADD (Children and Adults with Attention-Deficit/Hyperactivity Disorder), a national support and information resource for ADHD, maintains a federally-funded National Resource Center for ADHD at <http://www.help4adhd.org/>

Several treatment guidelines for ADHD are available at <http://www.guideline.gov>.

are given and by themselves have not been shown to improve the long-term outlook for children with ADHD.

Long-Term Outlook:

At least a third of individuals with ADHD symptoms in grade school will continue to have similar problems into adult life and an adult version of ADHD is increasingly being diagnosed. Children with ADHD who have higher intelligence and who do not have the

Adjustment Disorders

Definition:

Adjustment Disorders are disturbances in emotion or behavior that are the result of a known stressor or stressors. Typically, the symptoms are of more intensity than would be expected from the stressor, or they substantially interfere with work or relationships. By definition, adjustment disorders begin within 3 months of the onset of a stressor and last no longer than 6 months after the stressor or its consequences have ended.

Prevalence:

Adjustment disorders are fairly common with rates in the general population ranging between 2% and 8%, and rates following particular stressors (e.g., following heart surgery) as high as 50%. It is suspected that people who are living in poverty have more stressors and subsequently are at higher risk for this disorder.

Causes:

By definition, an Adjustment Disorder is viewed as triggered by a stressor. If the stressor is acute (e.g., job loss), the symptoms typically begin immediately and subside within a few months. If the stressor or its consequences persist (e.g., family illness), the symptoms tend to persist as well.

Associated conditions:

People experiencing an Adjustment Disorder typically experience work, school, and/or relation-

ship difficulties. In addition, suicide attempts or completed suicides, substance abuse, and physical complaints are common.

Treatment:

Supportive psychotherapy or counseling that focuses on problem clarification, enhancing coping, and stress reduction tech-

Key Protection and Safety Issues

Because of the serious dysfunction that often accompanies an adjustment disorder, parents who experience these difficulties are often unable to properly care for their children. Child neglect may be a feature of some of these cases. If the precipitating stressor for the parent is short term or resolvable, it is expected that the disturbance will be short term, especially if focused supportive counseling is available. Thus, short term interventions are expected to restore parents to their optimal levels of care giving.

niques are generally successful in minimizing the symptoms of an adjustment disorder. Usually antidepressant or antipsychotic medications are not used. However, sometimes short term use of an anti-anxiety medication is helpful in controlling anxiety and sleep disturbances.

Long term outlook:

Adjustment disorders are by definition a relatively short-term disorder. If the symptoms worsen or persist long after the original stressor has been eliminated, it is likely that the individual is suffering from a more severe psychological problem.

Family and developmental issues:

Adjustment disorders can occur in any age group. Events that are directly experienced by one family member (e.g., illness, job loss), can also be stressors to other family members. Consequently, it is common for more than one family member to have the symptoms of an adjustment disorder. Cultural variations need to be considered to determine whether the individual's response to a stressor is more disruptive than would be expected.

Adjustment Disorders may also result from the stressors associated with children and families involved in the child protection or juvenile justice systems (e.g., children who are

removed from their homes may have behavioral or school problems; parents whose child has been arrested may begin drinking). It is important for workers to recognize that some of the individual or family dysfunction that they observe may be an acute reaction to a recent stressor rather than a longstanding pattern of functioning.

Acknowledgments:

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), (2000), American Psychological Association: Washington, D.C.

For More Information

For more information on adjustment disorders in children and adolescents, see:
http://www.healthsystem.virginia.edu/uvahealth/peds_mentalhealth/adjdis.cfm

Anxiety Disorders

Definitions:

Anxiety disorders last at least 6 months and can become worse if not treated. They need to be differentiated from the relatively mild, brief anxiety responses that people have after a stressful event.

Generalized anxiety disorder (GAD) is much more than normal anxiety people experience day to day. GAD involves chronic and exaggerated worry and tension, even though nothing seems to provoke it. Having this disorder means always anticipating disaster, often worrying excessively about health, money, family, or work. Sometimes, though, the source of the worry is hard to pinpoint. Simply the thought of getting through the day provokes anxiety.

People with GAD can't seem to shake their concerns, even though they usually realize that their anxiety is more intense than the situation warrants. People with GAD also seem unable to relax. They often have trouble falling or staying asleep. Their worries are accompanied by physical symptoms, especially trembling, twitching, muscle tension, headaches, irritability, sweating, or hot flashes. They may feel lightheaded or out of breath. They may feel nauseated or have to go to the bathroom frequently. Or they might feel as though they have a lump in their throat.

Panic Disorders: People with panic disorders have feelings of terror that strike suddenly and repeatedly with no warning. Symptoms often include a pounding heart, sweatiness, weakness, faintness or dizziness. Individuals

with this disorder can't predict when an attack will occur, and many develop intense anxiety between episodes, worrying when and where the next one will strike. In between times there is a persistent, lingering worry that another attack could come any minute.

Phobias occur in several forms. A specific phobia is a fear of a particular object or situation. Social phobia is a fear of being painfully embarrassed in a social setting. Agoraphobia, which often accom-

an anxiety disorder in any given year.

Causes:

There appears to be a genetic component in the development of anxiety disorders. Parts of the brain and specific neurotransmitters that play a significant role in fear and anxiety have been identified. Considerable research is needed to understand more about these processes and how to effectively decrease fear and anxiety responses.

Associated Conditions:

Many individuals with one type of anxiety disorder also have another anxiety disorder. Further, a number of other *psychiatric* / psychological problems are associated with anxiety disorders including: depressive disorders, eating disorders, substance abuse disorders, and attention deficit disorder. Irritable bowel syndrome and mitral valve prolapse are associated with panic disorder.

Management:

Individuals who appear to have anxiety disorder symptoms first need to have a thorough medical assessment because some medical problems (e.g., thyroid dysfunction, heart problems, or neurological problems) can appear similar to anxiety disorders. Most anxiety disorders can be successfully treated with a combination of medication and behavior therapy or psychotherapy (depending on the specific disorder).

Long term outlook:

GAD generally develops gradually and most often begins in child-

Key Protection and Safety Issues

General anxiety disorders, phobias, obsessive-compulsive disorders, and panic disorders don't raise particular protection and safety issues except for the fact that they may interfere with individuals' general ability to function as parents. Children with such disorders may present particular stresses in families and may be vulnerable to parental frustration, anger, and resentment.

Workers should be alert to symptoms of the various anxiety disorders and make appropriate referrals when necessary.

panies panic disorder, is a fear of being in any situation that might provoke a panic attack, or from which escape might be difficult if one occurred.

Obsessive-Compulsive Disorder (OCD) is characterized by uncontrollable anxious thoughts (obsessions) or rituals (compulsions). Individuals suffering from OCD might compulsively wash their hands, check that appliances are turned off, or count things. Additionally, they might be preoccupied by thoughts of violence or sex or other thoughts they find unacceptable.

Prevalence:

About 40 million American adults age 18 and over (about 18%) have

hood or adolescence. Panic disorders generally begin in young adulthood but they are sometimes seen in children. OCD can first appear in childhood, but generally emerges during adolescence or early adulthood. Phobias usually first appear in adolescence or adulthood. They start suddenly and tend to be more persistent than childhood phobias. In contrast, when children have specific phobias they often disappear by the time they become adults.

As mentioned above, most anxiety disorders can be successfully treated. Untreated however, they

often develop into very disabling conditions with people narrowing their “zone of comfort” to more and more limited places and experiences.

Family and developmental issues:

For More Information

The following source was used in the preparation of this document: National Institutes of Mental Health, Anxiety Disorders - <http://www.nimh.nih.gov/healthinformation/anxietymenu.cfm> (retrieved, June, 2007).

Serious anxiety disorders affect not only the sufferer but the whole family. The family often has a difficult time accepting the fact

that the person with an anxiety disorder cannot stop the distressing behavior. Family members may show their anger and resentment resulting in an increase in symptoms. Or, family members may find themselves continually accommodating or giving constant reassurance to the affected individual. When serious anxiety disorders develop in childhood or adolescence they often interfere with the young person’s normal developmental process of becoming gradually independent from their family.

Bipolar Disorder

Definition:

Bipolar disorder is a serious mental illness characterized by recurrent episodes of depression, mania, and/or mixed symptom states. These episodes cause unusual and extreme shifts in mood, energy, and behavior that interfere significantly with normal, healthy functioning.

Formerly called manic-depressive illness, Bipolar disorder is a type of depression. Bipolar disorder involves cycles of depression and elation or mania. Symptoms of mania include:

- Inappropriate elation
- Inappropriate irritability
- Severe insomnia
- Grandiose notions
- Increased talking
- Disconnected and racing thoughts
- Increased sexual desire
- Markedly increased energy
- Poor judgment
- Inappropriate social behavior

Sometimes the mood switches between depression and mania are dramatic and rapid, but most often they are gradual. Mania often affects thinking, judgment, and social behavior in ways that cause serious problems and embarrassment. For example, unwise financial decisions may be made when an individual is in a manic phase. Bipolar disorder is often a chronic recurring condition.

Bipolar disorder has been classified as follows:

- Bipolar I disorder - the classic form with recurrent episodes of mania and depression
- Bipolar II disorder – milder forms of hypomania that alternate with depression
- Rapid-cycling bipolar disorder – four or more episodes of illness that occur within a 12-month period. Some people experience multiple episodes within a single week, or even day.

Key Protection and Safety Issues

Bipolar disorder elevates suicidal risk. It is important to carefully and continually assess for this risk in both parents with the disorder as well as with children and youth. Anyone who talks about suicide should be taken seriously.

When a parent is in the throes of a manic or depressive episode, their ability to safely meet the needs of their children may be seriously compromised. However, treatment for parents with bipolar disorder is likely to be effective. It is likely to be needed long-term. Thus, planning for parents with bipolar disorder needs to include a long-term plan. Further, the high co-occurrence of alcohol or other drug abuse may also require treatment for those problems.

Children and youth with bipolar disorder or with a confusing set of symptoms that may be bipolar need the attention and supervision of psychiatrists who are specially trained to work with young people. In the underserved areas of the state, this may require special arrangements.

Symptoms of mania may appear different in children and young adolescence and more typically include irritability and destructive outbursts rather than euphoria and elation.

Prevalence:

Bipolar disorder affects approximately 5.7 million American adults, or about 2.6 percent of the U.S. adult population in a given year. The median age of onset for

bipolar disorders is 25 years. The prevalence in adolescents and children is difficult to assess, but a recent study found that one percent of adolescents met the full criteria for bipolar. Bipolar disorder has been diagnosed in children under 12, but it is quite rare. About 60% of affected adults report that their first episode occurred during adolescence.

Cause:

Bipolar disorder tends to run in families. However, other factors, as yet undetermined, appear to work with a genetic vulnerability to produce the disorder.

Associated conditions:

Alcohol and drug abuse and anxiety disorders are common associated conditions. Attention deficit hyperactivity disorder and conduct disorders may co-occur with bipolar in children and adolescents, and these disruptive behavior disorders often confuse the initial diagnosis of bipolar disorder.

Those with later onset illness (older adolescents or adults) tend to have a sudden onset, often with a classic manic episode with

relatively stable periods between episodes.

Management/treatment:

A combination of medication and psychotherapy is the most effective approach to stabilizing the disorder and preventing new severe episodes in adults. Because of the chronicity of bipolar disorder it is important for individuals to continue with their treatment even when their conditions have stabi-

lized. There is limited data on the efficacy and safety of mood stabilizing medications with children and youth. Differences in development and growth make the application of data from adult research to children and adolescents problematic. For example, one commonly used medication, Valproate, has been associated with increased testosterone levels and polycystic ovary syndrome in young women who begin the medication before they turn 20. Studies are currently underway carefully testing the effects of commonly used mood stabilizers and anti-depressants in the treatment of adolescents and children. Because of the complexities and rapidly developing knowledge base in the treatment of children and adolescents with bipolar disorder, it is critical to have child/

adolescent psychiatrists involved in their diagnosis and treatment.

Long-term Outlook:

Most people with bipolar disorder are free of symptoms between episodes, but continued treatment appears to be strongly related to preventing future episodes. A small percentage of people experience chronic symptoms despite treatment.

Family and Developmental Issues:

The problems of depression fluctuating with periods of impulsive and irrational behaviors will interfere with consistent, effective parental functioning. Developmental issues requiring child psychiatry expertise in the diagnosis and treatment of bipolar disorder in young people, have been noted

above. Additionally, it is important to consider that any serious mental illness, such as bipolar disorder, can significantly interfere with the healthy transition through developmental milestones and the acquisition of age appropriate emotional and behavioral competencies. For example, adolescent onset of bipolar disorder can contribute to school truancy that, without appropriate and successful intervention, may have a long term effect on a youth's educational and consequent vocational trajectory.

Acknowledgments:

This article draws from the National Institutes of Mental Health publication, *The Numbers Count: Mental Disorders in America*, 2006 at <http://www.nimh.nih.gov/publicat/numbers.cfm>, retrieved, March 2007.

For More Information

The following sources were used in the preparation of this document: National Institute of Mental Health, (2001, addendum 2007), *Bipolar Disorder*, <http://www.nimh.nih.gov/publicat/NIMHbipolar.pdf>, retrieved March, 2007. *Child and Adolescent Bipolar Disorder: An Update from the National Institute of Mental Health*, 2000, retrieved, March, 2007.

Borderline Personality Disorder

Definition:

The chief characteristics of a Borderline Personality Disorder (BPD) are unstable mood, chaotic interpersonal relationships, impulsiveness (e.g., excessive spending, promiscuity, gambling, shoplifting, drug or alcohol abuse), and poor self-image. Individuals with this disorder often report chronic feelings of boredom and emptiness as well as intense, inappropriate anger. The disorder usually is first diagnosed in early adulthood and it tends to be a pervasive condition. Adolescents often display some of the symptoms of BPD but are not typically diagnosed with the condition because it is difficult to predict whether the problematic behaviors will abate with maturity.

Recurrent suicidal threats, gestures, or behavior and other self-mutilating behavior are common in the more severe forms of the disorder.

Prevalence:

Borderline Personality Disorder is more common than either schizophrenia or bipolar disorder and affects approximately 2% of U.S. adults, primarily young women.

Cause:

The precise causes of BPD are not known. As with most mental disorders, there is likely a genetic contribution and an environmental contribution. Children who are raised in disturbed environments or who are abused and/or neglected appear to be at more risk for developing this serious personality disorder. Current neurosci-

ence research is identifying brain mechanisms that appear to underly the impulsivity, mood instability, aggression, anger, and negative emotions seen in BPD.

Associated Conditions:

Conditions that are commonly associated with BPD are Depression, Substance Abuse or Addiction, and other Personality Disorders.

Key Protection and Safety Issues

Parents with BPD are likely to have extreme difficulty in providing a safe, nurturing, stable environment for their children. Difficulties with relationships, impulsiveness, and propensities for intense anger make parents with BPD at increased risk for abusing their children. Individuals with BPD will present challenges to Protection and Safety Workers who are trying to develop a positive working relationship with them.

Abused and neglected children, especially those who have not had stable, permanent living arrangements may be at risk for developing BPD. Although, they will likely not be diagnosed with this condition until they are adults, many adolescents may display the main characteristics of the condition contributing to high risk behaviors, poor educational achievement, and suicidal risk.

Management/Treatment:

The pervasive nature of BPD and the significant difficulties with interpersonal relationships associated with the disorder present challenges to effective treatment. Long term consistent psychotherapy, coupled with medication can often help the individual from acting out his or her feelings, but many people with this condition have difficulty maintaining a long term therapeutic relationship. A new psychosocial treatment called dialectical behavior therapy (DBT) has generated promising empirical support for its effectiveness.

If substance abuse is present, then specific treatment of that problem

is essential. Brief hospitalizations are sometimes necessary during acutely stressful episodes or if suicidal or other self-destructive behaviors appear.

Long Term Outlook:

Emerging evidence suggests that the future for people diagnosed with BPD is not as bleak as previously thought. BPD appears to be worse in young adulthood and may gradually get better with age. Many individuals appear to find greater stability in their lives during their 30s and 40s.

Family and Developmental Issues:

The severe disturbances to interpersonal relationships and mood that characterize BPD contribute to significant family dysfunction. Friends and relatives of individuals with BPD find themselves constantly "walking on eggshells" to avoid precipitating an enraged outburst, a suicidal episode, or other extreme behaviors.

Impulsive behaviors, including gambling, spending and substance abuse, often place major strains on the family's stability.

Although signs of BPD are often evident during adolescence, many adolescents do outgrow the significant disturbances to mood and interpersonal relationships that characterize the disorder. Providing treatment to adolescents with these characteristics may help prevent a disorder that persists into adulthood.

For More Information

The following sources were used in the preparation of this document:

MayoClinic.com (1998-2007) Borderline personality disorder.

<http://www.mayoclinic.com/health/borderline-personality-disorder/DS00442> (retrieved, March, 2007).

National Institutes of Mental Health (2001), Borderline Personality Disorder: Raising questions, finding answers,

<http://www.nimh.nih.gov/publicat/bpd.cfm> (retrieved March, 2007)

learning or conduct disorders are at higher risk for depression. Thus, children in the child welfare or juvenile justice system are expected to be at a higher risk for significant depression.

Causes:

Major depression seems to occur, generation after generation, in some families. However, it can also occur in people who have no family history of depression. Whether inherited or not, major depressive disorder is often associated with having too little or too much of certain neuro-chemicals.

Psychological makeup also plays a role in vulnerability to depression. People who have low self-esteem, who consistently view themselves and the world with pessimism, or who are readily overwhelmed by stress are prone to depression.

A serious loss, chronic illness, difficult relationship, financial problem, or any unwelcome change in life patterns can also trigger a depressive episode. Very often, a combination of genetic, psychological, and environmental factors is involved in the onset of a depressive disorder.

Associated Conditions:

Anxiety symptoms, substance abuse, and serious chronic medical illnesses are commonly seen in

individuals with depression. Individuals with eating disorders often develop major depression. Psychotic symptoms are often present with severe major depression.

Management:

Depression needs to be carefully evaluated because treatment choice will depend on the outcome of the evaluation. There are a variety of antidepressant medications and psychotherapies that can be used to treat depressive disorders. Some people do well with psychotherapy, some with antidepressants. Some do best with combined treatment; medication to

at any age. Stress appears to play a prominent role in triggering the first one or two episodes, but not later episodes. An average episode lasts about 9 months. Some people have isolated episodes that are separated by many years, whereas others have clusters of episodes or increasingly frequent episodes. About 20% have a chronic course. Dysthymic disorder is often a chronic condition.

Family and Developmental Issues:

The symptoms of depression and bipolar disorder affect many aspects of a person's functioning.

Consequently, if one member of a family is suffering it is likely that all members of the family are affected in some way. Children or adolescents who are depressed require considerable efforts from family members to get them appropriate treatment and keep them safe. Depressed children, with their decreased pleasure and spontaneity, are likely to be less engaging with other family members and may add considerably to family stress. Depressed parents are often unable to carry out their parenting function and are often restricted in their ability to emotionally connect to their children. They may also be affected in their ability to financially support their family.

For More Information

The following sources were used in the preparation of this document: National Institute of Mental Health
<http://www.nimh.nih.gov/healthinformation/depressionmenu.cfm>
retrieved, March, 2007.

American Academy of Child and Adolescent Psychiatry, Facts for Families: Depression,
<http://www.aacap.org/page.wv?section=Facts+for+Families&name=The+Depressed+Child> , retrieved, March, 2007.

gain relatively quick symptom relief and psychotherapy to learn more effective ways to deal with life's problems. Electroconvulsive therapy (ECT) is sometimes used for individuals whose depression is severe or life threatening or who cannot take antidepressant medications.

Long term Outlook:

For major depression, the average age at onset is 25, but it may begin

Disruptive Behavior: Oppositional Defiant and Conduct Disorders

Definition:

Oppositional Defiant Disorder is characterized by a pattern of negativistic, hostile, and defiant behaviors, without the more serious violations of basic rights of others that are seen in Conduct Disorders (see next paragraph). Children with Oppositional Defiant Disorder are argumentative with adults, frequently lose their temper, swear, and are often angry, resentful and easily annoyed by others.

The diagnosis of Conduct Disorder indicates a more serious and persistent pattern of conduct problems than Oppositional Defiant Disorder. Youth with this diagnosis have shown a persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms or rules are violated. Such conduct problems include aggression to people and animals, destruction of property, deceitfulness or theft, running away or truancy. If a Conduct Disorder begins before age 15, and the serious conduct problems persist beyond age 18, the person would be considered to have an Antisocial Personality Disorder (this cannot be diagnosed until a person is 18).

Prevalence:

Between five and 15% of school age children are estimated to have oppositional defiant disorder. One to four percent of 9-17-year olds are estimated to have conduct disorder. Both disorders are considerably more common in males.

Risk factors:

Many factors seem to raise the likelihood that a child will develop a conduct disorder, including early maternal rejection, separation from parents without adequate substitute caregiver, early institutionalization, family neglect,

Key Protection and Safety Issues

Growing up in the child welfare system creates enormous risks for the development of conduct disorders. Several of the risk factors listed above, child abuse or neglect, negative family and social experiences, early institutional living, and frequent shifting of parent figures, are all relatively common experiences for children on child protection caseloads. Every effort should be made by workers to minimize these experiences for children whenever possible.

Children who have developed severe conduct problems present huge management problems for workers and institutionalization often appears to be the most attractive option. However, workers need to advocate forcefully for those interventions that have the best demonstrated effectiveness for such youth: community-based, family-centered, multimodal, and long-term approaches.

abuse, or violence, parental mental illness, parental marital discord, large family size, crowding, poverty.

Associated conditions:

Learning problems and attention deficit disorder are often found in children with disruptive behavior disorders. There is also a high rate of depression, suicidal thoughts, suicide attempts and suicide. Other commonly associated conditions are substance abuse, poor relationships, sexually transmitted diseases, and high rates of injury.

Management:

A variety of promising treatments have been developed for children with Oppositional Defiant Disorders and youth with Conduct Disorders. A comprehensive evaluation is a necessary first step to identify any associated conditions that also need to be addressed in treatment. The basic components of effective treatment programs include individual psychotherapy for the child/youth (the type of psychotherapy seems to not matter), family therapy, and interventions in the school or community. Intervention effectiveness is most consistent and enduring when the intervention is multimodal and involves well designed and coordinated components. Treatments often need to be ongoing to continually address the serious conduct problems. Family focused and coordinated interventions appear to

be the most successful for adolescents who have most serious conduct disorders and/or who are most likely to be violent.

Institutionalization may be necessary when antisocial behavior is extreme, but demonstration projects of intensive multimodal family centered treatment approaches have been successful even with youth with very serious violent conduct disorders.

Long term outlook:

The long term outlook for conduct disorders is variable. Many children with conduct disorders, particularly disorders involving group

activity, will achieve reasonable social and occupational adjustment as adults. Unfortunately, severe forms of conduct disorders are often the precursors to adult antisocial personality disorders with accompanying illegal activity. In general, the early onset of serious conduct problems is associated with greater risk of continuation into adult life as Antisocial Personality Disorder.

Not surprisingly, parents with Antisocial Personality Disorder pose great risks to their children. Today's children or youth with conduct disorders, without effective treatment, may be tomorrow's child abusers and neglectful parents.

Family and Developmental Issues:

Some stubbornness, tantrums, aggressiveness, and destructiveness are common in all children, especially during particular devel-

Oppositional Defiant or Conduct Disorder. Even symptoms that last many months can just be a reaction to some kind of stressful situation.

Children and adolescents who are constantly violating social norms create significant stresses for families. Parents of antisocial aggressive children often have realistic concerns about the safety and well being of their other children. Although loosely structured family life is not a likely cause of conduct disorders, children with oppositional defiant or conduct disorders need highly structured expectations and predictable consequences in order to develop the behavioral and emotional controls they need.

For More Information

Much of the information in this article was taken from the following materials produced by SAMHSA and the American Academy of Child and Adolescent Psychiatry at the following websites (all retrieved June, 2007):

<http://mentalhealth.samhsa.gov/publications/allpubs/CA-0010/default.asp>

<http://www.aacap.org/page.ww?name=Children+With+Oppositional+Defiant+Disorder§ion=Facts+for+Families>

<http://www.aacap.org/page.ww?section=Facts+for+Families&name=Conduct+Disorder>

opmental stages. Children are constantly changing as they mature and it is not always easy to tell when a problem is persistent enough to deserve a diagnosis of

Eating Disorders

Definitions:

People who intentionally starve themselves suffer from an eating disorder called *anorexia nervosa*. The disorder, which usually begins in young people around the time of puberty, involves extreme weight loss - at least 15% below the individual's normal body weight. Many people with the disorder look emaciated but are convinced they are overweight. Sometimes they must be hospitalized to prevent starvation. One in twenty individuals with anorexia die from starvation, cardiac arrest, other medical complications, or suicide.

People with *bulimia nervosa* consume large amounts of food and then rid their bodies of the excess calories by vomiting, abusing laxatives or diuretics, taking enemas, or exercising obsessively. Some use a combination of all these forms of purging. Because many individuals with bulimia "binge and purge" in secret and maintain normal or above normal body weight, they can often successfully hide their problem from others for years.

Binge-eating disorder resembles bulimia in the consumption of large amounts of food but does not involve purging of the food.

Prevalence:

The vast majority (more than 90%) of individuals suffering from anorexia and bulimia are adolescent and young adult women. Approximately 65% of individuals suffering from binge eating are female. Between 0.5% and 3.7% of adolescent girls develop anorexia nervosa; another 2 to 3 per-

cent develop bulimia. These disorders also occur in men and older women, but much less frequently.

Cause:

Eating disorders appear to run in families - with female relatives most affected. Genetic, environmental, personality, and behavioral factors all appear to contribute to the development of eating disorders.

Associated Conditions:

Many individuals with eating disorders also suffer from other psychiatric illnesses, primarily depression, but including anxiety, personality or substance abuse disorders. Many are at risk for suicide. Eating disorders cause a

deny that they have a problem. Because people with eating disorders can also hide their problem, it is often years before they are encouraged into treatment. The longer abnormal behaviors persist, however, the more difficult it is to overcome the disorder and its effects on the body. In some cases, long-term treatment may be required.

The complex interaction of emotional and physiological problems in eating disorders calls for a comprehensive treatment plan, involving a variety of experts and approaches. Ideally, the treatment team includes an internist, a nutritionist, an individual psychotherapist, and a psychiatrist who is knowledgeable about psychoactive medications useful in treating these disorders.

Long Term Outlook:

Treatment is generally effective for most individuals with eating disorders but there are usually many relapses on the road to recovery. As mentioned above, one tenth of young women with anorexia nervosa will die of a complication of the illness. The earlier a person gets into treatment the more promising the outlook for the treatment.

Family and Developmental Issues:

Eating disorders usually emerge in adolescence and it is generally believed that the timing is related to the young woman's changing body and societal messages about the value of thinness. Some studies have found that mothers who are overly concerned about their daughters' weight and physical

Key Protection and Safety Issues

Workers need to consider the possibility of eating disorders in adolescent girls who have been abused or neglected as well as girls in the juvenile justice system. Because of the complicated, long term, and potential costly nature of proper treatment for eating disorders, workers may need to become forceful advocates to ensure that adolescents in their care obtain the appropriate treatment. Given that the girls are likely to deny their need for treatment, these cases may require considerable effort. However, as mentioned above, early initiation of treatment offers the best hope for success, and lack of successful treatment can result in deadly consequences.

variety of medical complications, some of them life threatening. These include damage to the heart and brain, anemia, reduced muscle mass, brittle bones, tooth decay, etc.

Management:

Eating disorders are most successfully treated when diagnosed early. Unfortunately, even when family members confront the ill person about his or her behavior, or physicians make a diagnosis, individuals with eating disorders may

attractiveness, and fathers and brothers who are overly critical of the weight of their daughter/sister seem to put girls at higher risk for developing an eating disorder.

After an eating disorder is diagnosed or considered, parents often focus intensely on their daughters' food consumption, weight loss, bathroom visits, etc. While the potential life threatening nature of eating disorders makes that under-

standable, it appears to be counterproductive for families to become overly involved in the daily management of their daughters' nutrition.

For More Information

Much of this information was taken from the National Institute of Mental Health publication entitled *Eating Disorders* that is available at www.nimh.nih.gov/publicat/eatdis.htm and was updated from the NIMH publication entitled *Eating Disorders: Facts about Eating Disorders and the Search for Solutions* available at <http://www.nimh.nih.gov/publicat/eatingdisorders.cfm> retrieved June, 2007.

Munchausen Syndrome By Proxy

Definition:

Munchausen Syndrome by Proxy (MBP) is a rare form of maltreatment (abuse and/or neglect) in which a parent intentionally and repeatedly exaggerates, fabricates, and/or induces a medical or mental health problem in their child. There have been a few reported cases of MBP involving caretakers who are not parents to the person under their care. The following elements are typically involved in MBP cases:

- MBP poses serious dangers to children and has involved poisonings, unnecessary surgeries, invasive diagnostic procedures, etc.
- MBP is a form of child maltreatment and generally includes aspects of both abuse (causing harm) and neglect (failing to provide appropriate care).
- MBP is a specific form of maltreatment although it may include elements of physical, emotional, sexual abuse, and neglect.
- MBP is deliberate and calculated behavior. It does not result from parents being mistaken about their child's symptoms.
- MBP is repeated behavior involving frequent doctors' appointments, emergency room visits, and hospitalizations.
- MBP involves exaggeration, fabrication, and/or induction of symptoms and problems. It may co-exist with a true symptom or problem.
- MBP may involve physical, psychological, or behavioral symptoms or a combination. These problems tend to be of types that

cannot be independently confirmed, tend to be dramatic, and are typically problems that cannot be ignored by health care providers because of their potential gravity.

There is professional debate as to whether MBP should be viewed as a specific diagnosis or whether it is just a descriptive label for a form of child abuse. It is not yet accepted by the DSM-IV as a mental health diagnosis.

Prevalence:

There is little epidemiological data regarding MBP but estimates of

Key Protection and Safety Issues

Investigations of MBP require a different approach than investigations of other types of child maltreatment because the perpetrator's deceptive practices generally require some deceptive practices in the investigation process in order to confirm or rule out MBP. A multidisciplinary investigative team approach is highly recommended as is consultation with an MBP expert. Once the MBP is suspected, a high-priority, rapid effort should be made to confirm it or rule it out, both because MSB can be dangerous to the child and because it is not fair to maintain a cloud of suspicion if real but undiagnosed medical conditions may be present.

If a parent is confirmed to be an MBP perpetrator, extreme caution should be exercised regarding reunification. Genuine and remorseful admission of MBP behaviors and a commitment to changing behaviors and long term treatment should be required before reunification is considered. Even with these, any reunification plan must include very long-term (years) monitoring. The guarded prognosis for MBP prognosis suggests that many parents will revert to these abusive behaviors after the current situation is resolved.

prevalence in the general population suggested about one in 200,000 children may be a victim of MBP. This estimate would result in about two children with the condition in Nebraska. The difficulty in confirming or ruling out

MBP makes these prevalence data speculative rather than definitive estimates.

Cause:

The causes of MBP are not known although some investigators believe that the presence of a personality disorder is an underlying condition.

Associated Conditions:

Some investigators speculate that if MBP perpetrators would be comprehensively assessed virtually all would meet the diagnostic criteria for a personality disorder. Some MBP perpetrators are diagnosed with depression.

Management/ Treatment:

The most significant management issue regarding MBP is its accurate identification/confirmation. Confirmations of MBP should involve careful review of medical, school, mental health, and other relevant records to explore suspicious patterns, discrepancies, and inconsistencies in information. Records should always be obtained directly from the original source. Interviews may provide new information and they may also clarify, corroborate or suggest discrepancies in information already obtained. Diagnostic separation is often an excellent tool to confirm or eliminate the possibility of MBP.

It typically is accomplished through a hospitalization or foster placement with a non-relative or friend. Covert electronic surveillance has been useful in obtaining confirmatory evidence of MBP

behaviors. However, surveillance activities need to be planned carefully within a context of appropriate legal, ethical, and practical considerations. Polygraphs are controversial and imprecise. Mental health evaluations are not appropriate to determine the presence or absence of MBP. However, mental health professionals may gather useful information that can be helpful to an investigation of MBP. One important caveat is that even outwardly cooperative individuals may not be honest in mental health evaluations.

Long-Term Outlook:

The prognosis for an MBP perpetrator to stop the abusive pattern is guarded. Little is known about the

violation of trust between a parent and child, physical intrusion, deception, and extremely morally deviant parental behavior. Small studies have suggested long-term negative outcomes to victims of MBP' but more research is needed.

For More Information

For a discussion from a prosecutor's point of view on MSP, see Dawn Wilsey's article for the American Prosecutors Research Institute (APRI) at http://www.ndaa-apri.org/publications/newsletters/update_volume_14_number_8_2001.html

A comprehensive recent book on the subject is *Munchausen by Proxy* by Louisa Lasher, 2004 Haworth Maltreatment and Trauma Press (ISBN 0-7890-1217-0)

long-term outcomes to victims of MBP. Some theorists have speculated that MBP shares common features with incest including a

Family and Developmental Issues

Theories about family dynamics in these cases are speculative. It seems that most non-offending partners of perpetrators do not suspect that MBP is occurring. Victims of MBP are generally infants or young children. Even regarding older victims, there is no evidence that they should be assumed to be colluding in their maltreatment.

Post Traumatic Stress Disorder

Definition:

Post traumatic stress disorder (PTSD) is a debilitating condition that follows a terrifying event. Often, people with PTSD have persistent frightening thoughts and memories of their ordeal and feel

feel irritable, more aggressive than before, or even violent. Seeing things that remind them of the incident may be very distressing, which could lead them to avoid certain places or situations that bring back those memories

tized person develops PTSD or PTSD symptoms. There is some evidence that susceptibility to the disorder runs in families.

Associated Conditions:

Depression, substance abuse, and other anxiety disorders are common accompanying conditions.

Management:

A combination of medication and psychotherapy, especially cognitive behavior therapy, usually treats PTSD symptoms effectively.

Long Term Outlook:

The course of PTSD is variable; some people have symptoms that resolve quickly while others have a condition that becomes chronic. Treatment is generally very effective in treating the symptoms.

Family and Developmental Issues:

A child's risk of developing PTSD is related to the seriousness of the trauma, whether the trauma is re-

Key Protection and Safety Issues

Children who have been abused or neglected, or who have been exposed to family violence are at considerable risk for developing PTSD or PTSD symptoms. Preventing children from experiencing trauma is the best approach. Once trauma has occurred, early interventions that make children safe and that provide them the feeling of safety are essential to the child's well-being.

PTSD should be considered in the parents of abused or neglected children, including parents who "fail to protect" their children from another adult. The emotional numbing and detachment symptoms of PTSD can contribute to parental inability to confront and protect a child from abusive situations. Treatment of underlying PTSD may help a parent develop the ability to protect her children.

emotionally numb, especially with people to whom they were once close. PTSD, once referred to as shell shock or battle fatigue, was first brought to public attention by war veterans, but it can result from any number of traumatic incidents. These include kidnapping, serious accidents such as car or train wrecks, natural disasters such as floods or earthquakes, violent attacks such as a mugging, rape, or torture, or being held captive. Sexual abuse or family violence can also cause PTSD.

Whatever the source of the problem, some people with PTSD repeatedly relive the trauma in the form of nightmares and disturbing recollections during the day. These are called flashbacks. They may also experience sleep problems, depression, feeling detached or numb, or being easily startled. They may lose interest in things they use to enjoy and have trouble feeling affectionate. They may

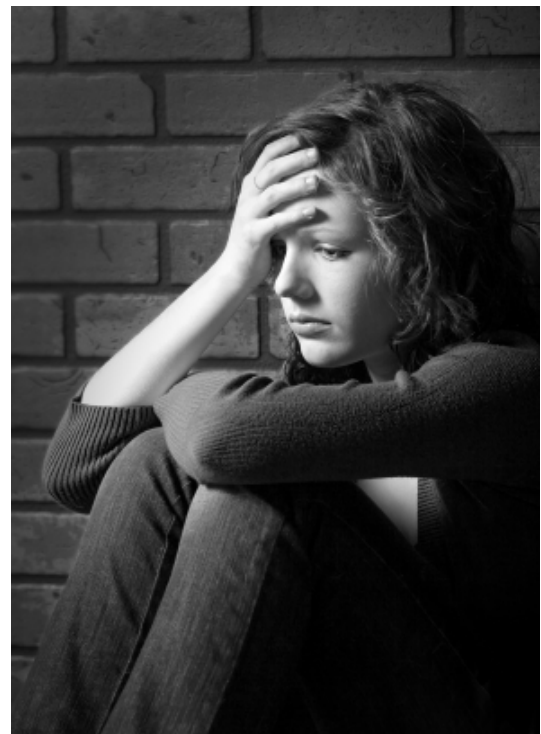
Post traumatic stress symptoms may be present in children/adolescents who have been direct victims of or who have been exposed to physical or sexual abuse. Adults who have been themselves victimized may be suffering from these symptoms or from a full blown disorder.

Prevalence:

About 3.5% of American adults (over age 18) have PTSD in a given year. PTSD can develop at any age, including childhood, but the median age of onset is 23 years.

Cause:

By definition, PTSD is the result of directly experiencing or witnessing a terrifying event. However, not every trauma-



peated, and whether the child has been provided a safe situation and the feeling of safety following the trauma. If children experience repeated trauma they may develop a kind of emotional numbing to deaden or block the pain and

trauma. This numbing and detachment can have a very serious negative impact on a child's healthy development. Consequently, it is important that children who have PTSD symptoms or who have suffered known trauma

be treated quickly and effectively so that the PTSD symptoms do not cause long-standing cognitive, emotional, and relationship disturbances.

For More Information

The following sources were used in the preparation of this document:

National Institutes of Mental Health, Anxiety Disorders -
<http://www.nimh.nih.gov/healthinformation/anxietymenu.cfm> (retrieved, June, 2007).

National Institutes of Mental Health, Post Traumatic Stress Disorder-
<http://www.nimh.nih.gov/healthinformation/ptsdmenu.cfm> (retrieved, June, 2007).

American Academy of Child & Adolescent Psychiatry- Facts for Families- Post Traumatic Stress Disorder-
http://www.aacap.org/cs/root/facts_for_families/posttraumatic_stress_disorder_ptsd (retrieved, June, 2007).

Reactive Attachment Disorder

Definition:

Reactive Attachment Disorder (RAD) is characterized by significantly disturbed and developmentally inappropriate patterns of social relatedness that begin before age 5. There are two subtypes of this disorder. Children with the Inhibited Type fail to initiate and respond to social situations in a developmentally appropriate manner. Children with the Disinhibited Type are indiscriminately sociable or show a lack of selectivity in their choices of attachment figures. A diagnosis of RAD requires a history of grossly pathological care. It describes the relationship dysfunction and not the wide range of other problems sometimes experienced by children with early disrupted relationships.

Prevalence:

Data are limited, however this disorder appears to be uncommon. It is increasingly diagnosed in maltreated children because, by definition, maltreated children meet the requirement of pathological care.

Causes:

By definition, a diagnosis of RAD requires a history of maltreatment that is presumed to be the cause of the disturbed patterns of relatedness. It is important to note that grossly pathological care does not always result in the development of RAD. Some children are able to form stable attachments and social relationships even in the face of serious maltreatment.

Associated conditions:

Feeding difficulties, failure to thrive, and growth delays can be associated with RAD. Although it is has been commonplace to link RAD with conduct disorders and antisocial behaviors, no direct link has been established.

Key Protection and Safety Issues

Protecting children from abuse and neglect is the most significant activity that workers can do to prevent the occurrence of RAD. For children who have been maltreated, the risk of RAD appears to be increased by multiple placements in foster or group care. Vigorous child protection work aimed towards finding and maintaining safe and permanent homes for children who cannot return to their parents is crucial.

Workers should be wary of diagnoses of RAD that include symptoms other than social relatedness, and of treatments that have not been demonstrated to be effective and that may, in fact, be harmful.

Treatment:

There is limited knowledge about effective treatments for attachment-disordered treatment. A concern has been that popular treatment techniques have developed that lack a sound theoretical basis or empirical support. The most well known, and controversial, is rage reduction therapy (also known as coercive, holding or attachment therapy). These repeated treatments involve prolonged restraint of the child, prolonged noxious stimulation (tickling, poking), and interference with bodily functions. When the child breaks down to the point of surrender, he is given to his caregiver(s). It is theorized that the child's attachment difficulties are caused by repressed rage and that after helping the child release his rage he will be capable of healthy relationships. These interventions appear to be traumatizing espe-

cially in that they are directed towards children who are extremely vulnerable because of their history of maltreatment and multiple placements. They also can be unsafe and a death has been attributed to therapy involving forced holding.

Interventions that have developed for child maltreatment generally are likely to be promising for children with RAD. The therapist focuses on ensuring the child's safety, stabilizing crises, and working to increase the child's feelings of trust. Caregivers are included in the treatment to assist them in providing a secure, stable relationship to a child who has difficulties engaging.

Long Term Outlook:

The outlook for these children appears to depend on individual factors in the child and caregivers, the severity and duration of the maltreatment, and the nature of intervention. It appears that considerable improvement or remission occurs if a long term supportive environment is provided, although even after the child has developed selective attachments he may continue to show indiscriminate sociability.

Developmental Issues:

Attachment quality seems to be affected by the age of the infant/child at the time of the caregiving disruptions, with more serious disturbance related to earlier disruptions. However, the developmental course of attachment disturbances is not well understood.

Acknowledgments:

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), (2000), American Psychiatric Association: Washington, D.C.

For More Information

Medline Medical Encyclopedia: Reactive attachment disorder of infancy or early childhood,
<http://www.nlm.nih.gov/medlineplus/ency/article/001547.htm> (retrieved, June, 2007).

American Academy of Child & Adolescent Psychiatry, Facts for Families: Reactive Attachment Disorder
http://www.aacap.org/cs/root/facts_for_families/reactive_attachment_disorder (retrieved, June, 2007).

Schizophrenia and Other Psychotic Disorders

Definition:

Schizophrenia is a term used to describe a complex, extremely puzzling condition - the most chronic and disabling of the major mental illnesses. Schizophrenia may be one disorder, or it may be many disorders, with different causes. Because of the disorder's complexity, few generalizations hold true for all people who are diagnosed as schizophrenic. Common symptoms of schizophrenia include disordered thinking, inappropriate or blunted emotional responsiveness, delusional thinking, and hallucinations.

Psychosis is a symptom of schizophrenia, but it can occur in other mental illness as well. General symptoms of psychosis can include delusions, hallucinations, disorganized speech and grossly disorganized or catatonic behavior. Schizophreniform Disorder has similar symptoms to schizophrenia, except that its duration is less than six months. Schizoaffective Disorder has an accompanying mood disorder. In Psychotic Disorder Due to a General Medical Condition, the psychotic symptoms are considered to be a direct physiological consequence of a general medical condition. In Substance-Induced Psychotic Disorder, the psychotic symptoms are considered to be a direct physiological consequence of a drug of abuse, a medication, or an environmental toxin.

Prevalence:

Approximately 1 percent of the population develops schizophrenia during their lives. This disorder affects men and women with equal frequency. The first psychotic symptoms of schizophrenia are

appear to be less common than schizophrenia. Prevalence rates for Psychotic Disorder Due to a General Medical Condition vary depending on the contributing medical conditions. However, psychotic disorders may be present in approximately 20% of individuals with endocrine disorders, 15% of those with systemic lupus erythematosus, and 40% of individuals with temporal lobe epilepsy.

Cause:

There is no known single cause of schizophrenia. It appears that genetic factors produce a vulnerability to schizophrenia, with environmental factors contributing to different degrees in different individuals.

Associated Conditions:

Almost any symptom can occur as an associated feature. Psychomotor abnormalities (pacing, rocking, etc.), ritualistic behaviors, depression, and hypochondriasis are relatively common.

Management/Treatment:

Antipsychotic medications are very effective in treating certain schizophrenic symptoms in a large majority of schizophrenic patients and in other patients with psychotic symptoms. Many of these medications have significant short term and long term side effects. These medications relieve psychotic symptoms of hallucinations, delusions, and incoherence but generally do not address the

Key Protection and Safety Issues

A severe mental illness, such as schizophrenia, would undoubtedly interfere with a parent's ability to effectively care for his/her children. Studies of schizophrenic persons, who have not had criminal histories, do not find them to be more violent than the general population, so it would not be expected that schizophrenic parents would be at increased risk for abusing their children. However, serious parental mental illness is a large risk factor for neglect. Whatever the maltreatment concern, if a parent suffers from schizophrenia that illness needs to be treated before the parent can be expected to improve his or her parenting skills.

A small, but significant, number of teens in the juvenile justice system are apparently suffering from schizophrenia or are in the early stages of the development of that illness. As mentioned above, appropriate diagnosis is sometimes difficult to make during adolescence. However, proper treatment to reduce or eliminate psychotic symptoms is necessary before other issues can be addressed.

often seen in the teens or twenties in men and in the twenties or early thirties with women. Less obvious symptoms, such as social isolation or withdrawal or unusual speech, thinking, or behavior may precede and/or follow the psychotic symptoms.

Children over the age of 5 can develop schizophrenia, but it is very rare before adolescence.

Detailed information on the prevalence of other psychotic disorders is lacking but Schizophreniform and Schizoaffective Disorders

psychosocial impairment suffered by many people with schizophrenia. Consequently, most schizophrenic patients also benefit from interventions aimed at developing their social and work skills and/or helping them cope more effectively with their illness. These interventions include vocational training, individual supportive reality-based psychotherapy, family therapy, group therapy, self help groups, partial hospitalization, or independent living services. Treatments that have not been found to be effective include electroconvulsive therapy (ECT), large doses of vitamins, and hemodialysis.

For psychotic disorders clearly caused by other events (medical condition or substance exposure), treatment of the underlying general medical condition or removal of the substance often clears up the psychotic symptoms. However, psychotic symptoms may persist long after the medical event or substance exposure.

Long-Term Outlook:

Studies that have followed schizophrenic patients for long periods, from the first breakdown to old age, reveal that a wide range of outcomes is possible. A review of almost 2,000 patients' life histories suggests that 25% achieve full recovery, 50% recover at least partially, and 25% require long term care. It is important to note that many schizophrenic patients improve enough to lead independent, satisfying lives.

The long term outlook for schizoaffective disorder appears to be somewhat better than for schizophrenia.

For More Information

Portions of this article have been directly adapted from a National Institute of Mental Health publication at <http://www.nimh.nih.gov/publicat/schizo.htm> and updated at <http://www.nimh.nih.gov/publicat/schizoph.cfm> (retrieved, June 2007) and from the American Academy of Child and Adolescent Psychiatry, Facts for Families series on *Schizophrenia in Children* which is available at http://www.aacap.org/cs/root/facts_for_families/schizophrenia_in_children.

Family and Developmental Issues:

The behavior of children who are in the early stages of schizophrenic development may change slowly over time. For example, children who used to enjoy relationships with others may 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 much sense. In adolescence, it is not abnormal to withdraw at times nor to become preoccupied with "off-beat" ideas. It is generally very difficult to differentiate between this typical pattern, drug involvement, and the early stages of schizophrenia. Also, schizophrenia often begins around the same time that individuals are leaving or have left home (college, military service, jobs). Consequently, family members may not

be around to notice changes in the person's behavior until the symptoms have become quite severe. Finally, the timing of the typical onset of schizophrenia for males is during the late teens or early twenties. This severely impacts on the normal developmental tasks of this time: gaining independence, completing education, establishing intimate relationships, and beginning careers.

Sometimes only the family or others close to the affected person will be aware of strange behavior or ideas that the person has expressed. Families may need to take an active role in having the person evaluated and treated and this is sometimes difficult if the person resists treatment. Since laws regarding involuntary commitment have become very strict, families may be frustrated in their attempts to see that a severely mentally ill individual gets needed help. Family members may be unsure of how to respond when the person expresses bizarre delusions or reports hallucinations. In sum, schizophrenia in the family causes enormous stresses for all involved.

With the de-institutionalization of seriously mentally ill people that has occurred over the past twenty to thirty years, families are increasingly called upon to provide for the basic needs of the affected person, such as food, clothing, and shelter. Without such family long-term support, people with schizophrenia often wind up on the streets or in jails, where they rarely receive the kinds of treatment they need.

Assessments

formation may confirm the physician's hunch that the individual has chronic hypertension that requires ongoing treatment or later information may suggest that something else is going on. Test results are never the "definitive truth" about an individual and it is especially important in legal settings, where the stakes are high, that caution be placed on interpreting the results.

Reliability, validity, and relevance: Test reliability, validity, and relevance all need to be considered in evaluating the weight that should be given to test findings. Test reliability refers to the extent to which a test will get the same result from the same person at different times or when tested by different people. For example, an IQ test should produce fairly similar

scores whether the individual was tested on Tuesday or Saturday and whether the test was administered by Dr. Smith or Dr. Jones. Test validity refers to the accuracy of the test in measuring what it states to measure. The ACT is used to predict college success, so students who score high on the ACT

For More Information

The American Psychological Association has published guidelines for psychological evaluation in child protection matters. It can be accessed at <http://www.apa.org/practice/childprotection.html>.

Additional information about specific tests and their recommended use can be obtained from the website of the test publisher.

should do well in college. Clinicians who administer psychologi-

cal tests should be able to provide information about the reliability and validity of any test they use. Finally, it is important to consider whether information from a particular test is relevant to the reason that a person is being tested (e.g., IQ tests are relevant if there are questions about an individual's cognitive abilities and if information about those abilities will result in differences in decisions that are made about the person). If clinicians cannot report information about the reliability and validity of a test that they use, or if they report that "reliability scales" on a particular test suggest that the test taker was apparently overly defensive or not truthful, extreme caution should be taken in interpreting any results from the test at all.

Common Psychological Tests

Intelligence Tests

Wechsler Adult Intelligence Scale (WAIS), Wechsler Intelligence Scale for Children (WISC), and Wechsler Preschool and Primary Scale of Intelligence (WPPSI)

These are the most commonly used individually administered clinical instruments designed to assess intellectual abilities. Each subtest measures a different facet of intelligence. These tests can be used for school planning and placement and also for differential diagnosis of neurological and psychiatric disorders that affect mental functioning. These tests undergo regular revisions and typically have numbers noting the version (e.g. WAIS III, WISC IV, WPPSI III).

Developmental Assessments

Bayley Scales of Infant Development

This is an established assessment tool for evaluating developmental delays in infants and toddlers. The Bayley can be used both to assess delays and also to assess a child's progress.

Vineland Adaptive Behavior Scale

The Vineland measures personal and social skills used for every day living. It is generally used in assessments with persons with developmental delays or other disabilities. It can be used with young children.

Neuropsychological Tests

Halstead-Reitan Neurological Test Battery

This set of ten tests assessing elements of memory, abstract thought, language, sensory-motor integration, perception, and motor

dexterity is used to assess brain damage.

Bender Visual-Motor Gestalt Test

This is a brief test that provides information about an individual's visual-motor memory and simple motor and perceptual skills. It can be used with individuals 3 years and older.

Achievement Tests

Woodcock-Johnson Psycho-Educational Battery, Revised

This is a battery of standardized tests measuring cognitive abilities, scholastic aptitudes, and achievement. The tests of achievement provide an assessment of reading, mathematics, written language, and knowledge.

Wide Range Achievement Test (WRAT)

This is a test of reading, spelling and arithmetic that is used to measure basic skills rather than comprehension, reasoning, and judgement processes.

Behavior Checklists

Child Behavior Checklist (Achenbach)

This is a 118 item checklist of children's problems and competencies that is completed by parents or parent surrogates. The problem scales include withdrawn behaviors, anxiety and depression, thought problems, attention problems, delinquent behaviors, and aggressive behaviors. The competency scales include how well the child gets along with others, their school functioning, and the kinds of activities they are involved in. A teacher version of this test (TRF) is also available

Personality Tests and Tests of Emotional Adjustment

Beck Depression Inventory

This is a very brief self report survey that measures the severity of depression in adults and adolescents.

Millon Clinical Multiaxial Inventory (MCMI) and Millon Adolescent Clinical Inventory (MACI)

These are self-report instruments designed to assess emotional, behavioral, or interpersonal difficulties. The adolescent version was developed for clinical, residential, and correctional settings for the evaluation of troubled adolescents and may be used for developing diagnoses and treatment plans.

Minnesota Multiphasic Personality Inventory-2 and Minnesota Multiphasic Personality Inventory: Adolescent Profile

The MMPI is a widely used objective personality inventory. It includes 567 statements that the individual rates as true or false. Most individuals of average intelligence take approximately 1 hour to complete this test. The MMPI yields information about the individual's test taking attitude as well as information on ten clinical scales. A number of supplementary scales have been developed as well as adolescent norms.

Projective Tests

Projective tests, including the following, are very subjectively interpreted and consequently have weak reliability and validity. Their usefulness in forensic child welfare or juvenile justice settings is questionable.

Children's Apperception Test (CAT) and Thematic Apperception Test (TAT)

The TAT is a set of picture cards that are used to stimulate stories or descriptions about relationships or social situations. Clinicians interpret these responses to identify "drives, emotions, sentiments, and conflicts."

Draw A Person

This test uses the task of human figure drawings to reveal intellectual ability as well as psychological adjustment.

Rorschach Inkblot Test

This is a set of abstract designs that are interpreted by individuals. The interpretations are analysed as a measure of psychological and intellectual functioning.

Rotter Incomplete Sentences Blank

This is a measure of personality adjustment that provides 40 sentence beginnings that are to be completed. It is assumed that the responses reflect the individual's wishes, desires, fears, and attitudes. There are forms for adults, high school students, and college students.

Screening Instruments

Denver Developmental Screening Test

This is a widely used brief screening process used by health care professionals, educators, and social service providers to identify developmental strengths and weaknesses in infants, toddlers, and young children.

Massachusetts Youth Screening Instrument (MAYSI)

The MAYSI is a brief screening tool designed to assist juvenile justice facilities in identifying youths at admission who might have special mental health needs.

Acknowledgments

Information regarding individual tests was generally obtained from the websites of the test publishers.

Interventions

General Category	Subgroup	Considerations	Common Examples generic name(Trade Name®)
Stimulants	<p>Traditional (Labeled “traditional” here because methylphenidate and amphetamines have been used for more years than any psychoactive medication.)</p>	<p>These have the best demonstrated safety and efficacy of any psychoactive medication. Unlike others, these medications start working quickly (from day one) and can be stopped abruptly. Used for ADHD symptoms (short attention span, impulsivity, hyperactivity), they are short acting (3-4 hours) unless specially formulated for time release. Adderall® extends the time of action by using a mixture of amphetamines and Concerta® by specially crafted capsules. Transient headaches and stomachaches are most common side-effects; muscle twitches are more troubling. Black box warning notes rare serious cardiac side-effects; caution is needed in children with heart problems. All have abuse potential, are controlled substances, and have a “street value” that demands vigilance.</p>	<p>methylphenidate (Ritalin®) also as (Concerta®) d-methylphenidate (Focalin®)</p> <p>d-amphetamine (Dexedrine®) mixed amphetamines (Adderall®)</p>
	<p>Other</p>	<p>Atomoxetine is actually an SSRI antidepressant with stimulant effects useful for ADHD--the “non-stimulant stimulant.” (Note the SSRI “black box” warning.)</p> <p>Clonidine was originally for high blood pressure, but has central stimulant effects that help with ADHD symptoms. It helps with tics rather than cause them, and makes some kids sleepy--good at night but not at school. Watch blood pressure when it is used.</p>	<p>atomoxetine (Strattera®)</p> <p>clonidine (Catapres®)</p>

General Category	Subgroup	Considerations	Common Examples generic name(Trade Name®)
Antidepressant	SSRI Antidepressants Serotonin Specific Reuptake Inhibitors	These newer antidepressants have fewer side-effects than tricyclics. Like most psychoactive medication they may take a week or more to show effects and should never be stopped abruptly. Their use treating depression in children is less well documented than in adults. Fluoxetine is the only one approved for use in children, but others are used “off label”. These medications may be very effective in treating obsessive-compulsive symptoms. (Prozac®, Luvox®, and Zoloft® are approved for this use in children.) SSRIs are sometimes used to reduce anxiety or aggression with less research support. The black box warning calls attention to the demonstrated increase in suicidal thinking when on antidepressants.	citalopram (Celexa®) escitalopram (Lexapro®) fluoxetine (Prozac®) fluvoxamine (Luvox®) paroxetine (Paxil®) reboxetine (Vestra®) sertraline (Zoloft®) venlafaxine (Effexor®)
	Tricyclic Antidepressants	These older antidepressants have several serious side-effects including heart rhythm problems, dry mouth and urinary retention. Because of this, they are rarely used for depression. They have been shown to help with bedwetting in children (perhaps related to the urinary retention side-effect) and ADHD symptoms and may still be used this way. EKG monitoring is recommended. The black box warning about suicidal thoughts applies to this group as well.	amitriptyline (Elavil®) desipramine (Norpramin®) imipramine (Tofranil®)
	Other	Bupropion is sometimes used for ADHD or bipolar disorder. A sustained release version (Zyban®) is used to assist in smoking cessation. Bupropion carries the same black box warning as the SSRIs.	bupropion (Wellbutrin®)

General Category	Subgroup	Considerations	Common Examples generic name(Trade Name®)
Antipsychotic	Atypical	<p>These drugs avoid the serious side-effects of the typical antipsychotics (although they are occasionally seen) and can be very helpful in treating major psychotic symptoms. They have helped to greatly reduce the institutionalization of individuals with serious and chronic psychosis. They are also used to treat agitation and aggression in children who are not psychotic and to treat bipolar disorder in children. Risperidone has been approved to treat aggression, self-injury, and anger outbursts in adolescents and children with autism. These drugs occasionally stimulate weight gain that can be a serious side-effect. They can also interfere with cognitive functioning and attention should be given to children's school performance when these drugs are used.</p>	<p>aripiprazole (Abilify®) clozapine (Clozaril®) olanzapine (Zyprexa®) risperidone (Risperdal®) quetiapine (Seroquel®) ziprasidone (Geodon®)</p>
	Typical	<p>These were the first medications to help with the active symptoms of schizophrenia, such as hallucinations. They have serious side-effects including involuntary twisting of the neck and Parkinson-like slowing and tremor. Because of these side-effects, they have largely been replaced by the atypical antipsychotics. These drugs are also called "major tranquilizers" and are used for immediate quieting of acute agitation. They all have the side-effect of affecting cognitive performance.</p>	<p>chlorpromazine (Thorazine®) fluphenazine (Prolixin®) haloperidol (Haldol®) thioridazine (Mellaril®) thiothixene (Navane®) trifluoperazine (Stelazine®)</p>

General Category	Subgroup	Considerations	Common Examples generic name(Trade Name®)
Mood Stabilizing	Lithium	This was the first drug to show results in treating the very troubling cycling between mania and depression seen in adult bipolar disorder. It is also used successfully for pediatric bipolar disorder. Lithium has a very narrow therapeutic window, which means that the dose that causes very serious side-effects is only slightly above the dose that results in effective treatment. Side-effects include serious and sometimes fatal heart arrhythmia. Because it is a salt, variations in water and salt intake affect the blood level of lithium which must be measured frequently for safe use.	Lithium chloride (Eskalith®) Also as (Lithobid®)
	Anticonvulsant mood stabilizers	For unknown reasons, this group of medications, developed to control seizures, also stabilizes mood swings in bipolar disorder and may be helpful in children with these behaviors. Although infrequent, side-effects including liver problems can be present and should be monitored.	carbamazepine (Tegretol®) divalproex (Depakote®) gabapentin (Neurontin®) lamotrigine (Lamictal®) oxycarbazepine (Trileptal®) topiramate (Topomax®)
Antianxiety	Benzodiazapines	Sometimes called minor tranquilizers, benzodiazepines include a wide range of drugs with different strengths and time course. Valium® and Librium® are the oldest in this class. They are both relatively long-acting and may build up in the bloodstream. Serax® and Xanax® are newer, shorter-acting preparations. Halcion® is a very short acting preparation useful primarily for sleep problems. These drugs are primarily for the relief of anxiety in adults on a short-term basis. They are rarely used in children. Some benzodiazepines are used for the emergency treatment of seizures in children. Long term use brings a real risk of drug dependency.	diazepam (Valium®) chlordiazepoxide (Librium®) clorazepate (Tranxene®) clonazepam (Klonopin®) lorazepam (Ativan®) alprazolam (Xanax®) oxazepam (Serax®) triazolam (Halcion®)
	Other	Buspirone is the only non-benzodiazepine listed by the FDA as an antianxiety agent. It must be used for two weeks before full antianxiety effects are seen. Although only FDA approved for individuals over 18 years of age, it has been used “off-label” for the treatment of ADHD and aggression in children.	buspirone (BuSpar®)

Mother-Child Dyadic Therapy:

There has been recent promising evidence for intensive, one-on-one therapy for neglectful or otherwise high-risk mothers and their babies. The best researched program is a 25-week, twice-weekly intervention during which therapists work with individual mothers and children to encourage healthy, nurturing interactions that are the basis of the mother-infant attachment bond.

Multisystemic Therapy:

Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in youth. MST addresses the multiple known factors related to

delinquency across the key settings or systems within which the youth live (e.g., family, peers, school, neighborhood). MST strives to promote behavior

rigorous scientific evaluations, (2) a clearly defined and empirically grounded treatment theory, (3) a focus on provider accountability and adherence to the treatment model, and (4) empowerment of the youth's caregivers to manage current and future difficulties. MST is the only therapy proven to be effective for adolescents with oppositional behavior and conduct disorder.

Substance Abuse Treatment:

Specific interventions for substance abuse are beyond the scope of this booklet. Generally, the most effective interventions are comprehensive and include interventions for co-occurring mental health problems and other related problems (e.g., educational, vocational, violence, health).

For More Information

A helpful starting point is, "Mental Health: A Report of the Surgeon General"

<http://www.surgeongeneral.gov/library/mentalhealth/home.html>

The information on multisystemic therapy was adapted from the MST website: <http://www.mstservices.com>

The information on attachment therapy was informed by material from the American Academy of Child & Adolescent Psychiatry:

http://www.aacap.org/cs/root/policy_statements/coercive_interventions_for_reactive_attachment_disorder

For more information about effective interventions for substance abuse, see SAMHSA's National Registry of Evidence-based Programs and Practices at: <http://www.nrepp.samhsa.gov>

change within the youth's natural environment, using the strengths of each system to facilitate change. The strengths of MST include: (1) proven long-term effectiveness through 20+ years of

Special Education

Definition:

Every child is entitled to a free, appropriate, public education (FAPE); disabilities or special educational needs cannot be a barrier to this entitlement. Free means just that—parents cannot be asked to pay any cost of the child’s education. Special Education services are available to eligible Nebraska children from birth to age 21 because of state and federal funding designed to help school districts provide this education to children with special needs. The federal law establishing this funding is called the Individuals with Disabilities Education Act (IDEA). The rules defining the school district’s responsibilities and the parent’s and child’s rights are contained in Rule 51 of the Nebraska Department of Education (NDE).

Eligibility:

To receive special education services, a child must fit one of the following 13 categories:

- Autism
- Behavioral disorders
- Deaf-blindness
- Developmental delay
- Hearing impairment
- Mental handicap
- Multiple disabilities
- Orthopedic impairment
- Other health impairments
- Specific learning disability
- Speech or language problems
- Traumatic brain injury
- Visual impairment.

Schools must conduct a complete multi-disciplinary evaluation at no cost to the family.

Section 504:

Whether or not a child with a disability fits into one of these categories (and therefore qualifies for Special Education services) the school has a civil rights responsibility to accommodate all children’s special educational needs to avoid discrimination on the basis

Key Protection and Safety Issues

Children who are maltreated are more likely to have special educational needs, sometimes caused by maltreatment. Conversely, children in Special Education are more likely to be maltreated because of their vulnerability and increased family stresses.

The service coordination services provided to eligible children from birth to three years of age can greatly aid DHHS in providing safety, permanency, and well being. Referrals to the EDN are required for all maltreated children under three years of age and can be made for any child in this age group who have problems with behavior or development.

Children with disabilities need a strong advocate. When parents cannot or will not advocate for their children, Protection and Safety workers can effectively advocate for the child if they know and understand the Special Education rules in Rule 51.

A child’s IEP and/or IFSP contains important information for meeting Protection and Safety requirements and should be in the DHHS file and reviewed by the Protection and Safety worker.

of disability. This federal civil rights responsibility is specified in Section 504 of the Rehabilitation Act of 1973—the same law that requires wheelchair ramps. Although schools do not receive state or federal funding to comply with this civil rights responsibility, Section 504 gives important rights to children with disabilities and their families. When children do qualify for Special Education and the school follows all of the requirements of Rule 51, the civil rights

requirements of Section 504 will also be met.

Individualized Educational Program (IEP):

For children eligible for Special Education, the school must create an individualized educational program or IEP based on a comprehensive evaluation. Because it must be individualized, it must reflect the child’s needs and not just the child’s category. It must be in the least restrictive environment (LRE), as close as possible to the regular classroom and the child’s neighborhood school. Importantly, LRE requirements do not require all children to be integrated into the regular classroom; sometimes this would be *more* restrictive than a specialized setting, depending on the child’s needs. Parents must sign off on the IEP which must be updated every year and completely rewritten every three years.

Individualized Family Service Plan (IFSP):

From birth to three years of age, Nebraska provides additional specialized services through the Early Development Network (EDN) to children eligible for Special Education. Funding for this program comes from IDEA - Part C and is administered jointly in Nebraska by DHHS and NDE. For these children, an Individualized Family Service Plan (IFSP) is written. Although the schools must meet only the educational parts of the IFSP, the plan itself must be much

broader, including medical needs and other family needs. The EDN provides a services coordinator to help the family coordinate the services of the IFSP.

Because of provisions placed in the federal Child Abuse Prevention and Treatment Act (CAPTA), Protection and Safety workers are required to refer every child under three who has substantiated abuse or neglect to the EDN. After age three, the school switches to an IEP and no services coordinator is provided, but the requirement to provide Special Education Services continues until the child is 21 years old or graduates from high school.

Due Process:

Rule 51 contains extensive protections for parents who disagree with the school's provision of a special education program. Par-

ents must consent both to the evaluation and to the services. They may obtain a second opinion at no cost if they do not agree with

For More Information

The federal government provides information about IDEA at <http://idea.ed.gov>. Rule 51 is available at <http://www.nde.state.ne.us/LEGAL/cover51.html>. Information about the Early Development Network is available at <http://www.nde.state.ne.us/edn> and a tutorial to help better understand IFSPs is available at <http://www.answers4families.org/ifspweb>.

the school's assessment. The school must provide mediation, and if the parent wishes, they are entitled to an impartial due-process hearing to resolve disputes.

Surrogate Parent:

Most of the time, parents retain their educational rights even if they have lost custody of their child. Schools must make reasonable attempts to obtain consent from the parent. Rule 51 defines

parent to include foster parent or relative serving in a parent role, but DHHS is specifically prohibited from filling this role. If the parent is not available, the school must appoint a surrogate parent to protect the child's rights.

Discipline:

Rule 51 contains special procedures for applying disciplinary rules to children served in Special Education.

Any behavior that is determined to be a manifestation of the child's disability must be dealt with, not by imposing discipline, but by re-evaluating the child's IEP and placement to find a setting which accommodates this aspect of the child's disability. With behavior that has no relationship to the child's disability, the school may impose a disciplinary change of placement, but is still required to provide a free, appropriate education in some setting.