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The Twelve Most Common Behavioral and Psychiatric Problems in Children and Adolescents©

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Please also read our companion article **Major Ways Therapy Helps Children**. The two articles compliment one another.

The developmental periods of Childhood and Adolescence are marked by rapid changes and challenges. During these years, **between about 1 in 6 children aged 3 through 17 will have behavioral or psychiatric problems** and another 1 in 6 will have some period of emotional, behavioral, or family difficulties sufficient to merit getting help.

Introduction

We will explain the twelve most common **psychiatric** problems of youth in the clinic. A psychiatric problem is defined as a group of symptoms and impairments, that is, difficulties in life functioning, that occur together. For example, in obsessive compulsive disorder, we have obsessions, ruminating, and uncomfortable thoughts that a person recognizes as unusual, and yet the child still has compulsions meant to cancel or reduce the anxiety about those thoughts. Notice these different symptoms appear together The condition can be debilitating in that it may cause a number of impairments in functioning. In psychiatry and psychology, we call these **psychiatric disorders**.

On the other hand, many of the children we see do not have full blown psychiatric disorders. They may have a problem in adjustment to something that's happened. They may be responding to some life event in the family, such as a birth, a death, a move, a change in school, or an experience of child abuse or neglect, or some other life circumstance.

They may have some sudden symptom, such as a new period of sleep disturbance with nightmares. They may suddenly have a reduction in the level of their school performance. Many of these symptoms, problems, and behaviors are not full-blown psychiatric disorders, but they are matters of considerable concern. *In order to get help, you never have to wait for a full-blown psychiatric condition to develop. To get help, we will work with any child who is presenting with problems that are of concern to the child or of concern to the parents.*

We will now explain 12 psychiatric disorders that appear in childhood. While there are others, such as developmental disorders and learning disorders, we have centered on the 12 that we most commonly see in the clinic.

Again, let us say any problem that is of concern to a family is of concern to a mental health professional, family therapist, or child therapist. **The faster you come for help, the easier and more quickly we can help.** The goal is to get the child on track to be a healthy, happy youth on track developmentally.

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Problems that are allowed to continue for a length of time are often much more difficult to change. For example, one child missed the May and June weeks of school with what we call "school avoidance." He was afraid to go to school after witnessing some bullying. He expected the bullies to pick on him. Because he felt awkward, he worried

that if he went into class, he would be looked at and he would be ridiculed as a result. Every morning he felt he had a stomach ache. He started to stay up very late at night and was too tired in the morning to get up for school. He refused to go. His parents were literally at their wits end But summer came and they hoped that, in the fall semester, he would do better. They didn't bring him to the clinic in until the end of October when he had then missed four months, two in the spring and two in the fall. He was now he was now very out-of-sync academically and socially with his age-mates. Part of the treatment was to involve the school for tutoring and to work with the school counselor so that the boy would have a place to go when he became anxious. We also worked out a plan where his parents would take him to the school building and sit with him outside for a while and then sit with him inside and then go to the counselor's office. It took by steady degrees two months before he could spend half a day in school We used desensitization techniques to help him overcome the anxiety and eventually he was able to return to school full time.

Again, any concern that you have with any symptom or behavior or any impairment in which the child is developmentally becoming out-of-sync with their age mates is a good reason to start therapy.

Let us go on to describe 12 psychiatric disorders that are common in children and adolescents.

With any of these problems, in order to fit the criteria for a psychiatric diagnosis, **the behaviors or symptoms have to appear in most situations and most of the time**. Occasional appearance of a symptom does not place the child in these categories. Once again, if the behavior or symptoms concerns you, set up an evaluation.

Over the past century, mental health professionals have researched methods and protocols to help with all of these emotional and behavioral problems. Some of the methods require 1-on-1 work with the youth. Some require work with the family.

Be prepared to be an aid to your child's care by participating in famly therapy when you are asked.

Often, family members, including parents and guardians, may not see they have a role to play in the child's psychotherapy. **Therapists know which treatments are supported by evidence and experience and require parent participation. Be prepared to be an aid to your child's care by participating when you are asked.**

1. Attention-Deficit/Hyperactivity Disorder (AD/HD)

Symptoms and Behaviors: A neurodevelopmental disorder that includes Inattentiveness, has a hard time keeping attention on whatever may be important to attend to, often leaves a trail of unfinished tasks, may be hyperactive (excessive fidgeting, inability to stay seated, blurts out in class, does not inhibit speaking when person should), distractible, hard time focusing and concentrating, often disorganized, difficulty trying anything (including homework) that looks hard to do, trouble with tasks that have a sequence of steps (e.g., cleaning, long division), and impulsive (interrupting, acting without much thought, speaking out without thinking). Partners and family members report the person does not seem to hear and retain messages and communications. Short-term memory is poor. May be able to focus to a high degree on what interests him or her. May have mood swings – rapidly frustrated or upset, with rapid shift to positive mood. Remember, for it to be AD/HD, these signs are present every day and do not disappear or stop.

For example, 8-year-old Max often forgets his homework, frequently interrupts conversations, blurts out answers in class without being called upon, and has difficulty waiting for his turn in games. When a game is not going his way, he gets frustrated and walks away. His family does not check his school bag, so he often doesn't finish his work or turn in work he actually finished. Example: Alex, a 10-year-old, has trouble staying focused on homework for more than a few minutes, frequently jumps up from his seat in class, disturbs the kids at desks next to his, and often interrupts conversations. When his dad sits down to supervise homework, Alex shows he is easily frustrated and makes a fuss. He shows rapid mood swings, can be upset one minute and happy the next.

Psychotherapeutic Treatments: Family Behavior Therapy, including behavior management techniques and parent training. Cognitive Behavioral Therapy (CBT) to help manage difficult situations and improve self-control. Individual therapy helps when there are additional challenges, such as trauma or abuse. These clients often have lost self-esteem and need help to feel better about themselves which affects their motivation. The most effective help for youth is family-based. Families need to learn the special ways to manage AD/HD. For adults,

> Family Therapy is essential for youth with AD/HD. Families learn to manage the behaviors. Children with AD/HD need more repetitions to master skills. They need more supervision for longer than other children, such as doing homework together, overseeing the use of money, reminders and assistance.

2. Anxiety Disorders

Symptoms and Behaviors: Anxiety disorders in children manifest as *excessive* fear or worry in many situations and without much relief. Other signs of anxiety are similar to symptoms you may see in other problems, such as restlessness, difficulty concentrating, irritability, muscle tension, and sleep disturbances – often with nightmares. Anxiety includes physical reactions, such as rapid heart rate, perhaps rapid breathing, sweating, diarrhea, and other physical symptoms .

That shows in different types of fears. All children have fears. We are focused here on the excessive, pervasive, unremitting levels of anxiety. These anxieties are very common and may be lasting.

Phobias - common types include the dark, monsters, water, dogs, spiders, enclosed spaces, a loved one getting hurt.

Generalized anxiety disorder – worry about things that may happen, often imagined, often highly unlikely events, but this fear does not come up only occasionally, rather it is almost daily, and it causes high anxiety.

Separation anxiety – fear of leaving a loved one or being apart because of the belief something bad will happen to the person, often showing as a fear of leaving to go to school or reluctance to go out, fear of being alone, physical symptoms when apart or expecting to be apart.

Social anxiety – fear of social situations because of expecting to be judged and criticized, sometimes showing as school avoidance, differs from shyness because of the high level of anxiety, and can show as shy bladder (the fear of using public toilets). In school avoidance based upon social anxiety, missing school, truancy, refusal to go, due to anxiety about being observed or judged.

For instance, 13-year-old Emma experiences intense fear of social situations, leading to avoidance of school and extracurricular activities. She finds excuses to stay home, such as illness, working herself up into stomach aches (that are real). Example, Sara, a 9-year-old, experiences intense worry about her parents' safety when they are apart, leading to difficulties in going to school. Example: Lily, a 13-year-old, complains of headaches and stomachaches every morning, has missed many days of school, and says she feels anxious at the thought of going to school. Example: Noah, an 8-year-old, becomes extremely upset when his parents leave for work, refuses to go to school, and complains of stomachaches.

Psychotherapeutic Treatments: EMDR and Systematic Desensitization help with desensitizing anxiety. Some of these anxieties begin with actual events that are frightening and still bother the child even though they are in the past. We have techniques for overcome the power of past events. Cognitive Behavioral Therapy (CBT) focuses on managing anxiety symptoms and developing coping strategies. Exposure therapy and desensitization help with specific phobias. We use gradual exposure to school, so going to the building, then going in briefly, then going part of the day, building up to full attendance. Therapists work with school personnel and may coordinate with the pediatrician or child psychiatrist. Behavioral Activation is a method to introduce small changes working towards eventual goals.

Each of these conditions requires a tailored approach that may also involve collaboration with other healthcare professionals and the school. **Family therapy and family involvement is almost always essential**.

3. Autism Spectrum Disorder (ASD)

Symptoms and Behaviors: ASD is a neurodevelopmental disorder affecting communication, social interaction, and behavior. Children with ASD may have difficulty with most social interactions and exhibit repetitive behaviors, show restricted interests (perhaps very focused interest on a limited number of topics), challenges in responding to sensory input (overly stimulated easily). Desires sameness and predictable environment. In severe cases, rocking and repetitive motions. Difficulty understanding abstract words. May not learn speech. Easily and severely frustrated when something deviates from what the child expects. Can get what is called dysregulated – upset and angry, perhaps even destructive – and can be very difficult to calm down. Mild cases may not have significant delay in language and cognitive development and may appear fairly average in many situation. In ASD, these symptoms are all the time.

Example: Emily, a 12-year-old, excels academically, especially in science, not so much in language subjects, but struggles to make friends and understand social cues. Does not show empathy, takes comments literally and misses some of the meaning in what others say. Example: Ben, a 7-year-old, rarely makes eye contact, has a deep knowledge of and obsession with trains, and becomes extremely upset by loud noises and deviations in any routines, and only tolerates a small number of foods. Labels in clothes and certain textures bother him. 5-year-old Aiden, for example, has limited verbal communication, understands speech but cannot use or rarely uses speech, and shows a strong preoccupation with lining up his toys in a specific order. Communication from others does not seem to be of interest to him.

Psychotherapeutic Treatments: Social skills training, and family psycho-education to understand limitations and how to manage them. Intensive early intervention programs, such as Applied Behavior Analysis (ABA), to improve communication and interaction. May need to be in a special ASD class in school with teachers expert in ASD. Note, these approaches may not give support to families, so clinicians who do family work can be consulted to help families manage the unremitting challenges of raising a child with ASD.

ASD treatment in moderate and severe cases is specialized and requires professionals called Behavior Analysts. They are found in programs that specifically provide ABA therapy. Classrooms for ASD are specialized. The earlier this care is delivered, the better. ABA may not be available unless started by age 7.

A general clinic can help with mild cases and with the crucial family therapy and parent support that the family needs.

4. Depression

Symptoms and Behaviors: Childhood depression includes persistent feelings of sadness, the blues, hopelessness, perhaps listlessness, withdrawal (such as staying in the bedroom), and a lack of interest in activities. Sleep cycles may reverse so the youth is up much of the night and sleeps away part of the daytime. Even children can have thoughts of worthlessness and thoughts of death and suicide. Always take them seriously.

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Example: 12-year-old Sarah has been consistently sad, withdrawn, and no longer enjoys her favorite hobbies. This began after the loss of a favorite grandmother followed by a close friend cutting off their relationship. Example: Josh, an 11-year-old, has lost interest in soccer, which he used to love, has trouble sleeping, and frequently says he feels "empty." Depression is almost always preceded by a loss or other stressful change or event in the family or in the child's life.

Psychotherapeutic Treatments: Insight-oriented psychodynamic therapy helps get to the root cause of the symptoms. Cognitive Behavioral Therapy (CBT) addresses negative thought patterns, Interpersonal Therapy (IPT) improve relationships. Family therapy helps with overcoming the child's isolation and improving feelings of security, worth, and attachment. If the child mentions suicide or dying, both individual and family therapy are recommended. If one reason for depression is that a parent is severely depressed, making the parent less emotionally available, or the parent has their own significant problems, such a drinking, we will want to help the parent as well and work with the family and the child.

5. Oppositional Defiant Disorder (ODD)

All the proven therapies for ODD involve family therapy sessions.

Symptoms and Behaviors: ODD is characterized by a pattern of angry, irritable, negative, defiant and sometimes vindictive behavior towards authority figures. The pattern includes non-compliance, usually in a hostile way. It can be passive-aggressive, meaning the child expresses anger by failing to do what he or she promises, out of hostile motives. This pattern is not occasional or intermittent. It is persistent and much of the time. It almost always starts with some event in the child's life. It is common in families in which the adults behave differently towards the child's behavior and do not agree on how to manage the child's hostile behavior.

It is not merely an occasional bout of temper. We manage anger outbursts in a similar way to ODD, but, with angry feelings, there are mostly positive feelings and compliance in-between episodes of hostility. In ODD, the child is hostile much of the time.

Example: 10-year-old Leo regularly argues with his parents, defies rules, and deliberately annoys his siblings, picking on them for no apparent reason. He resists homework and promises to comply with instructions, then does not do so. When pressured to get something done, he gets furious – covering up the fact that his months or years of defiance have left him behind in skills needed for getting along with others and getting his work done. He prefers his video games to interacting and gets very angry when asked to stop playing.

Psychotherapeutic Treatments: Parent management training (PMT), Parent-Child Interaction Training (PC-IT), and Systemic Family therapy teach effective management strategies. Parents can become frustrated and interact negatively or helplessly with these children and that only reinforces the problems. **All the proven therapies for ODD involve family sessions**. These children also fall behind in learning age-appropriate problem-solving skills, social skills, and emotional controls. CBT and Skills Training therapies can also help.

6. Conduct Disorder

Symptoms and Behaviors: Conduct disorder involves a range of antisocial behaviors such as aggression, property destruction, lying, hurting or mistreating others, or theft. The child may act as if he or she had no conscience about breaking rules, hurting dogs or other animals or even other children, and lying about it. They tend to rationalize their behavior (make excuses, blame others). This is not occasional harm to property or others, but happens frequently and without remorse.

Example: 15-year-old Mia has a history of bullying smaller girls, vandalism against the property of the school or just random cars, and shoplifting items she wants. She had some excuse for every behavior, such as the person deserved it, it just seemed like fun, or no one would care. Example: Jade, a 12-year-old, has been in trouble for fighting other kids at school, usually picking fights, vandalizing a neighbor's car tires, and stealing from stores and from her parents' wallets. She seems to have no compunction about these behaviors.

Psychotherapeutic Treatments: Multi-systemic Therapy (MST) addresses factors in the family, school, and community that may be contributing to the behavior. It wraps treatment and services around the family in order to stop the behavior before it can turn into antisocial adult problems. One form of Cognitive Behavioral Therapy (CBT) regarding criminal-like thinking patterns challenges the distorted ideas that reinforce the behavior. As in any therapy, we are also looking at the historical roots behind the behavior and the family problems that may of stimulated it in the first place – and which unwittingly reinforce it.

7. Eating Disorders

Symptoms and Behaviors: Eating disorders, including anorexia nervosa and bulimia (binge-purge cycles), but also binge eating, involve unhealthy preoccupations with food, body weight, and shape. The child may be thin, but thinks she is fat. Children may purge by vomiting or by excessive exercising or taking laxatives. Eating disorders do occur in males, though less often than girls. Feeding disorders also appear in early childhood and may involve a compulsion to eat things that are not foods or may involve some refusal to eat. Eating Disorders are usually every day, every time there is food or a meal.

Example: 14-year-old Zoe has been excessively restricting her food intake, leading to significant weight loss and health concerns. She is 10% below the weight level at the bottom of the chart for her age and is preoccupied with weighing less. She thinks she is overweight, which we think of as a distorted body image. She resists all efforts by the family to encourage her to eat. Example: Sophie, a 16-year-old, restricts her food intake severely, is terrified of

gaining weight, and has lost a significant amount of weight. Example: April is an 18 year-old girl who began purging after she over ate a few months earlier. She found this to be a satisfying pattern in which she could eat 2000 to 3000 calories at a time and then vomit the entire amount. This took place 5-6 times a week. When she noticed some blood coming from her esophagus at one point, she switched from purging from vomiting to taking a large amount of laxatives every day. One of the hallmarks of bulimia is secrecy, and she was doing most of this in a way that no one would find out.

Psychotherapeutic Treatments: Family-Based Treatment to involve the family in the recovery process, to have the family stop pressuring the child, to work with the professionals on a behavioral plan. Cognitive Behavioral Therapy (CBT) to address distorted thoughts about body image and food. Note that anorexia can be fatal, so any person who is significantly underweight needs medical attention from an eating disorders specialist and probably hospitalization. The lack of nutrients can affect thinking and judgment, so a period of hospital treatment with feeding can improve both weight and thinking.

8. Obsessive-Compulsive Disorder (OCD)

Symptoms and Behaviors: OCD is characterized by unwanted, repetitive thoughts (obsessions) and behaviors (compulsions). The behaviors are used to satisfy or cancel the thoughts. Both the thoughts and the compulsions can seem quite odd. The child can believe the obsessive thoughts, such as that stepping on the sidewalk cracks will predict harm to someone, or may have the insight the thought is irrational, but, nonetheless, the child cannot stop the ritual or compulsion. OCD is an everyday problem that can be impairing. A person may need to retrace their steps out of fear of having harmed someone along the way, quadruple check the door is locked, organize and reorganize their work before doing it, have to dress in a certain invariant pattern. Fear of contamination (germs), need for exact order and symmetry, doing an activity in an unvarying pattern, and checking behaviors (e.g., the stove, the door, windows) are the most common OCD behaviors. Again, OCD has to appear most of the time, not just as an occasional quirk. If you have seen the movie As Good As It Gets or the show Monk, you have seen an adult version of OCD and how OCD gets in the way.

Example: 9-year-old Jack spends hours washing his hands to alleviate his fears of contamination and arranging his belongings symmetrically. He does not touch any public door knob or elevator button. He carries hand sanitizer wherever he goes. He will not go to his friends' houses because they are not immaculate.

Psychotherapeutic Treatments: The most researched procedure is called Exposure and Response Prevention (ERP), in which the child is exposed to the feared situation and stays in that situation until the anxiety stops. Families are included in the exposures and learn to manage the child's anxieties. EMDR helps desensitize the situations the child worries about and some of the obsessional thoughts.

9. Post-Traumatic Stress Disorder (PTSD)

Symptoms and Behaviors: PTSD can develop after a traumatic event – e.g., house fire, child abuse, witnessing a fatal accident, being in a car accident, being molested – and includes symptoms such as flashbacks, feeling as thought the event was happening all over again, nightmares, hypervigilance (jumpiness), severe anxiety, and avoiding any situation that reminds the child of the event. Some child act as if they were numb. To be PTSD, the reactions continue weeks after the event. Without help, PTSD can be a lifelong burden. Acute Stress Disorder (ASD) is when these symptoms appear in the first 30 days after the event. Treating ASD may prevent PTSD. A related condition is Complex PTSD in which the trauma is not merely one event, but is a series of events the child cannot prevent or get away from. Often, these events involve sexual abuse or a parent who is abusive.

> Children are developmentally motivated to master what has happened to them. Attempts at mastery may show in repetitive patterns of play, in avoidance of situations that remind them of what has happened, or in what we call turning **passive into active** in which the child actually exposes themselves to situations that are somewhat similar to their trauma situations. In any of these cases, the child is unconsciously repeating behavior in order to master what has happened.

Example: 11-year-old Lily, who witnessed a car accident, experiences recurring nightmares and becomes extremely anxious around vehicles. Example: Omar, a 10-year-old, was in a collision in which his mother was severely injured. He has nightmares about it, avoids talking about what happened, and jumps at loud noises. He cries when he is required to be in a vehicle. Example: 15 year-old Sally was sexually abused and now she is flirtatious, hostile, feels worthless, thinks sexuality is how she can valued.

Psychotherapeutic Treatments: EMDR helps overcome the emotional power of the memory. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) helps process the trauma and develop coping mechanisms. Play therapy is effective for younger children. Other exposure and desensitization methods are also effective.

10. Substance Abuse

Symptoms and Behaviors: Substance abuse in adolescents involves the harmful use of substances like alcohol, tobacco, or drugs. These are illegal for teens. Teens become addicted to alcohol and drugs much more quickly than adults. Teens deny they are using, say they have the drugs holding them for some other child, use in secret, may not realize how very much they are using (especially when vaping cannabis). The user cannot control the use, increasingly neglects responsibilities, has increasing interpersonal conflicts. Teens may be gambling or playing card games for money.

Example: 16-year-old Alex has been increasingly using marijuana, leading to declining grades, inattentiveness, poor memory in school, and social withdrawal. He is defensive and hostile when his use is point out by his parents. Example: Chris, a 16-year-old, drinks alcohol heavily on weekends, has been caught smoking marijuana, and his grades have dropped. He has been stopped for driving without a license.

Psychotherapeutic Treatments: Motivational Interviewing to enhance motivation to change, Cognitive Behavioral Therapy (CBT) to develop coping and refusal skills. A lot of research points to Family Therapy as essential. Residential treatment may be part of the program.

11. Sleep Problems in Childhood

Symptoms and Behaviors: Sleep problems are common. Difficulty falling asleep (insomnia), difficulty staying asleep, resistance going to bed, wanting to sleep in parent's room, sleepwalking, nightmares, refusal to sleep in child's own bed.

However, night terrors are different. They are common in small children. They seem to be in a nightmare, but are still asleep and hard to waken. That is normal and not a psychological disorder. As children mature, night terrors almost always cease.

Example: Ava, a 6-year-old, resists going to bed, wakes up multiple times at night, and is tired during the day. She resuses to sleep in her own bed. Example: 9 year-old Alexandria crawls into bed with her mother during the night. Mother cannot get her to go to her room. She reports being scared, cold, not wanting to be alone. Example: Eleanor began requiring her

father to stay in her room until she fell asleep. This began at age 3 and continues 3 years later. She panics when he leaves the room while she is awake.

Psychotherapeutic Treatments: Behavioral interventions to establish healthy sleep habits and routines, relaxation techniques, Cognitive Behavioral Therapy for Insomnia (CBT-I) for older children.

12. Bipolar Disorder in Childhood

Symptoms and Behaviors: Yes, bipolar disorder often appears in late childhood and adolescents. Episodes of mania (elevated mood, increased activity or energy, extreme agitation or restlessness, rages risky behaviors, rapid thoughts, periods of not needing sleep) and depression (low mood, lack of interest, fatigue, withdrawal, despair, oversleeping).

Example: Mia, a 13-year-old, has periods where she feels on top of the world, stays up all night writing stories, followed by weeks where she hardly gets out of bed. Example: 16 year-old Max would have episodes for a few days in which he would get so enraged to an irrational degree that he would grab a knife and making threatening remarks, stay up for 30-40 hours, show severe agitation and pacing, seem to speak rapidly as if his voice could not keep up with his thoughts. Then his mood collapsed and he slept 16 hours a day over the course of a week, stayed up until dawn, and articulated thoughts of worthlessness.

Psychotherapeutic Treatments: Family-focused therapy, psychoeducation to help manage the problems, and Cognitive Behavioral Therapy (CBT) to manage symptoms and prevent relapse. Medication is essential to even out moods. Children showing Bipolar symptoms should be evaluated rapidly. It is not unusual for them to lose a semester or a year while being evaluated and stabilized.

In Addition

Children and adolescents may have other significant psychiatric problems**. Psychosis, such as schizophrenia**, often begins in adolescence. New interventions for first-time episodes of psychosis have had some success. Any youth showing signs of hallucinations and delusions should receive aggressive treatment as quickly as possible.

Grief, loss, and separation are as impactful on children as they are for anyone else Separation from parents or parent loss can leave lifelong impressions that could make the child prone to other problems later.

Gender dysphoria means distress at one's assigned or apparent gender. Some of these children feel they should be another gender. Note that on a genetic level, gender does not conform neatly to our social notion of male and female. Genetically, variations do occur.

Reactive Attachment Disorder is a significant problem often due to early separation from caregivers, being in many foster homes, or parenting neglect. The child does not emotional bond or form meaningful relationships (even with adoptive parents), does not attach or show comfort or love, may hoard food, takes items of use without asking, may tantrum when their efforts at security are blocked, does not value rules, rewards, and punishments.

Reactions to **child abuse and child neglect** can be severe and lasting. Neglect can be a cause of Reactive Attachment Disorder or Complex PTSD, two lifelong conditions. Professionals with experience working with these children are familiar with some of the impacts and understand how to structure mental health care.

Children may have more than one of these psychiatric disorder. For example, AD/HD child commonly show depression or anxiety. Or PTSD often leads to depression. Some children are more prone to adolescent drug use. Many other combinations are often observed.

Lastly, children may have more than one of these psychiatric disorder! Experienced therapists know how to evaluate the child and determine the best course of action.

Conclusion - 7 Important Points

1. Recognizing and addressing these common behavioral and psychiatric problems in children and adolescents is crucial for their normal development and mental health.

2. Families adapt to children's problems. As a result, te family often benefits from education and intervention.

3. **Early intervention,** appropriate therapy, and family support play vital roles in helping young individuals navigate these challenges and lead fulfilling lives.

We cannot stress enough the crucial importance of
*early intervention
*family therapy and parental involvement
*knowing the therapist's treatment plan
*asking when more intensive therapy, such as day treatment, inpatient, or residential, might be necessary
*monitoring progress and talking about any slow progress with the therapist

4. We covered the psychiatric problems of children. Children often have problems we label as sub-clinical. That means the problem is not as severe as the descriptions in this article. Nonetheless, they concern the family and, often, the youngster. Never wait to get help until the problem is severe. *The quicker you seek help, the easier and faster we can help the child.*

5. *Almost all treatments involve the family in some way*. Child therapists know when the child is better served by individual sessions versus family sessions or by a combination.

6. Some of these problems are the early manifestation of problems that may last years. We want to help with the management of these conditions as early as possible. It is essential to keep the child on track developmentally and not let the condition put the child out-of-sync with peers.

7. Often, the child's parents or siblings also need help. The clinicians will determine the best combination of individual and family sessions to help the whole family. Therapists may view a child's problems as an opportunity to help the entire family.

For additional information or help, check out other articles on child problems on this website and read about family therapy on the Family Therapy tab.

Call 414-540-2170 or write referrals@shorehavenbhi.com