Definitions and Symptoms of Childhood and Adolescent Mental Health Disorders

The following descriptions and symptom lists are taken from the fifth edition of the *Diagnostic and Statistical Manual (DSM-5)* released by the American Psychiatric Association in 2013.

Contents:

Attention-Deficit/Hyperactivity Disorder (ADHD)

ADHD is a neurobiological disorder that initially presents in childhood or adolescence, before the age of 12. ADHD occurs in one of every 20 children, and occurs almost twice as frequently in boys as girls. It is *not* caused by bad parenting, nor does it mean a child lacks intelligence or discipline -- a child with ADHD simply cannot sustain the focus needed to complete tasks appropriate for their age and intelligence. As a result, children with ADHD seem unable to behave or follow the rules like other children, and they tend to perform better one-on-one than in groups. For a diagnosis of ADHD, the core symptoms of inattention and/or hyperactivity-impulsivity, must:

- Be present in a child for at least 6 months.
- Interfere with the child's functioning or development.
- Cause significant impairment in more than one setting, such as home, school, sports activities, etc. Children with ADHD typically act worse in school than they do at home.

For many children, the key identifier for ADHD is the early age of onset, generally before 12.

Predominantly Inattentive Presentation:

- Can't pay attention to details; are often caught daydreaming.

- Avoid, dislike, or are reluctant to engage in activities that require sustained attention, including play activities.
- Are highly distractible, forgetful, absent-minded, careless, disorganized; frequently lose things.
- Often do not finish school work (work may be full of errors, turned in late, or not turned in at all).
- Don't listen to or follow through on instructions.

Predominantly Hyperactive/Impulsive Presentation:

- Display extreme physical agitation; fidget, squirm, can't stay seated or remain still.
- May run or climb at inappropriate times.
- Constantly interrupt and speak out of turn, talk excessively, disrupt the classroom, or blurt out answers before a question is completed.
- Are "on the go" and act as if "driven by a motor."
- Intrude on others; difficulty waiting their turn; resort to even more inappropriate behavior when reprimanded.

Combined Presentation:

- This is the most common presentation; a mix of inattentive and hyperactive/impulsive symptoms that have been present for at least 6 months.

What Families Report Observing:

- Symptoms have been persistent since early childhood; the illness didn't come on suddenly, rather something seemed "off" from the very beginning.
- Their child never slows down, is exhausting and demanding; or the opposite, that the child seems "clueless" with their "head in the clouds."
- They often misread their child as bad or not bright or wonder why the child is always in trouble at school.

Co-occurring Disorders:

More than half of children with ADHD also have at least one other major childhood disorder:

- Approximately 50% of children with combined presentation ADHD also have Oppositional Defiant Disorder (ODD).
- Approximately 25% of children with inattentive presentation also have ODD.
- Approximately250% of children with combined presentation also have Conduct Disorder (CD).
- Approximately 30% have an anxiety or depressive disorder.

Some children experiencing symptoms of ADHD may actually be in the early stages of bipolar disorder, which should be ruled out before any stimulants or antidepressants are prescribed. These medications can trigger manic and psychotic episodes in children if a bipolar disorder is present.

ADHD in Adolescence:
Although hyperactivity symptoms often diminish in the teen years as the child is able to exercise more self-control, if ADHD remains untreated it can rebound in adulthood. More than half of children with ADHD can be expected to have difficulty as teenagers, including poor school performance, difficulty with peer relationships, and low self-esteem. A teen with ADHD and a history of co-occurring Conduct Disorder is at higher risk for continued difficulties that frequently result in school suspensions and expulsions. The high school dropout rate for this group is 12 times greater than the rate among teens not affected by ADHD.

For adolescents and teens with ADHD, there are certain signs to look for:

- High rate of co-occurring conduct disorder (50%).
- High risk for alcohol use, drug use, and early smoking.
- Increased antisocial behavior.
- Inattentive presentation is more common in girls; boys tend to “blow off” school, act impulsively, and feel persistently restless.
- School failure.
- Downward social drift to “outcast” school groups.
- Low self-esteem.

Anxiety Disorders

Anxiety disorders cause extreme discomfort and unease in situations generally regarded as non-threatening. To anyone dealing with anxiety, many normal events and expectations arouse intense dread and worry. Anxiety disorders are the most common mental illness experienced by children and adolescents. The effects of these conditions can be extreme, causing children to reduce contact with the outside world. Predictably, a key warning sign of anxiety disorders is not wanting to go to school. Frequent absences because the child complains of feeling sick in the mornings are common and may lead to an attendance review. Children with anxiety can appear rude and noncompliant when trying to avoid triggers (like reading out loud in class). However, they generally avoid the spotlight and try to be invisible to teachers and classmates.

The forms of anxiety most prevalent in childhood are Separation Anxiety, Generalized Anxiety, and Social Anxiety.

Symptoms of Separation Anxiety:

- Intense anxiety over being separated from parents; overwhelming homesickness when apart.
- Worry that parents will die; clinging to the parent and following them from room to room.
- Refusal to sleep alone; will not go to sleepovers.
- Claims of sickness to avoid going to school (sick feelings disappear if they stay home).

Symptoms of Generalized Anxiety Disorder:

- General excessive worry, especially about how they look or what people think about them.
- Dread they will do things wrong; perfectionism; often re-do work.
- Excessive seriousness, uptight, unsure feelings, hypersensitivity to criticism.
- Often don't respond to reassurances from teachers or parents; continual worry even though school work is excellent.

Symptoms of Social Anxiety Disorder:

- Fear about social situations in which the child is exposed to possible scrutiny by peers as well as adults.
- Restriction of social contacts exclusively to close family members.
- Fear of being singled out, judged, evaluated, or called on in class.
- Social situations often provoke fear or anxiety that may be expressed through crying, tantrums, freezing, clinging, or shrinking from others.
- May be more anxious about specific situations (such as eating in front of others, using public bathrooms, etc.).

Symptoms of Panic Disorder:

- Recurrent sudden onset of pounding heart, rapid heartbeat, chest pain and discomfort, shortness of breath.
- Sweating, trembling, and shaking.
- Feelings of choking, nausea, and dizziness.
- Feelings of unreality.
- Fear of dying, losing control, or "going crazy."
- Worry about the recurrence of the next panic attack.

What Families Report Observing:

- Worry and concern over repeated absences from school.
- "Meltdowns" often occur when they try to force activities that trigger anxiety.
- Find themselves in a "catch-22:" accommodating anxious behaviors risks school failure, but insisting on attendance and social contact means the child continually falls apart.

Co-occurring Disorders:

Mood disorders (such as depression and bipolar) often coexist with anxiety disorders at every age.

Anxiety Disorders in Adolescence:

The onset of anxiety disorders in adolescence reaches its peak in the mid-teen years and often occurs after a loss or change in the teeanger's life. The high rate of illness in the teen population is also concerning, because teens with anxiety disorders often cannot calm themselves down and are highly susceptible to alcohol and drug addiction. These substances may initially reduce anxiety and be used as a form of self-medication. At this older age, adolescence can have severe panic attacks, become confirmed "worry warts," or literally shut down all communication and interaction.

Symptoms of anxiety disorders in teens are similar to those experienced by adults. These symptoms can result in a sense of forced isolation and feelings of failure. Older children with anxiety disorders may realize their reactions are excessive and unreasonable, but they are unable to change them. COnsequently, they may also experience feelings of demoralization and low self-esteem.

Depressive Disorders

Children and adolescents can experience symptoms of depression that are as severe as those experienced in adults, but often the symptoms look different based on age. Spotting childhood depression requires knowing the unique ways children express the depression they feel. The core symptom is not necessarily sadness, but irritability and aggressiveness. The mood disturbance also frequently plays out in imagined body pains and a noticeable drop in school performance. Another key indicator is the abruptness of behavior change; a sociable, likable child who is doing well suddenly develops problems with peers and ignores schoolwork.

Early identification and intervention are essential to prevent a chronic and relapsing course of illness, which is often the prognosis for early-onset depression in children.

Symptoms of Depressive Disorders:

- Irritability, aggressiveness, combativeness.
- Feeling angry, sullen, groundless.
- Anxious complaints about headaches or stomach aches; may have extensive medical evaluations that find no cause for these symptoms (this is often the only significant diagnostic identifier).
- A drop in grades, refusing to do homework, refusing to go to school, feeling anxious about tests.
- Negative self-esteem, down on themselves; believe they are weird, ugly, dumb; may have thoughts of death.
- Overly sensitive to criticism.
- Overreaction to disappointment and frustration; become tearful, give up easily.
- Inability to have fun; withdraw, mope, won’t join in activities.
- Feelings of lethargy, apathy; have difficulty with sleeping or oversleeping; can’t get up in the morning and are sleepy in school.
- Psychotic symptoms: as many as one-third may experience hallucinations (seeing/hearing things), delusions (false beliefs), or paranoia (suspiciousness).

What Families Report Observing:

- Nothing ever pleases the child; the child seems to “hate themself and everything else.”
- Feels like the well-adjusted child they are familiar with “went somewhere,” and that they have a “totally different kid.”
- Admit that this child is “no fun” and is hard to like; report sadness and confusion with the change in their child.

- The child tries to “put on a good face” in public and displays the worst of the symptoms at home.

Co-occurring Disorders in Children:
One-third of children ages 6 to 12 diagnosed with major depressive disorder will develop bipolar disorder within a few years. Anxiety disorders and substance use disorders coexist with mood disorders at every age level.

Depressive Disorder in Adolescence:
In this age group, twice as many girls are affected as boys. Because older children are more adept at hiding behaviors they fear will make them lose face, depression in teens can be masked by outstanding school performance, school leadership, and “ideal behavior.” Other adolescents with depression who cannot rely on popularity or academic performance to disguise their condition try not to attract attention at school. Depressive symptoms in adolescents can be detected by talking to the teenager and watching behavior patterns closely. Family input is critical because many of the symptoms occur at home, when peers are not around.

Symptoms of depressive disorders to look for in teens include:

- Feel sad, hopeless, empty; crying in class.
- Appear lethargic, slow-moving, sleepy; conversely, inability to control hyperactivity may signal depression.
- Decelopy extreme sensitivity in interpersonal relationships; are highly reactive to rejection or criticism; may “drop” friends they’re having problems with.
- Arre irritable, grouchy; prefer to sulk and cannot be cajoled into a better mood.
- Overreact to disappointment or failure; often take months to recover from setbacks.
- Feel restless and aggressive; become antisocial (lie to parents, cut school, shoplift, etc.).
- Think they are different, no one understands them, “everyone” looks down on them.
- Become more and more solicited from family and peers; often shift down to an out-of-the-mainstream peer group or hang out exclusively with one friend.
- Become self-destructive; at high risk of self-medicating with drugs and alcohol.
- Stop caring about their appearance or basic hygiene.
- Commonly have morbid imaginings and thoughts of death.

Co-occurring Disorders in Adolescents:
Fifty percent of adolescents with major depressive disorder also have an anxiety disorder that existed before the onset of the depression. Anxious states increase the risk of suicide.

Ninety percent of adolescents who die by suicide have a psychiatric diagnosis of a mood disorder and alcohol/substance use. While suicide in children under the age of 12 is rare, it is the third-leading cause of death among adolescents ages 15 ro 24. Althought girls have a higher rate of attempted suicide, boys die by suicide more often. They are placed at an increased risk if they drink heavily. Suicide can be a tragic consequence of mood disorders, which, when recognized, are highly treatable.

Bipolar Disorder

An important note: There continues to be controversy in the psychiatric community around the diagnosis of bipolar disorder in childhood and adolescence. To address some of this confusion, a new diagnostic category--Disruptive Mood Dysregulation Disorder--was added to the DSM-5 in 2013 to provide an alternative for practitioners to consider during the evaluation process.

Bipolar disorder can involve sharp swings from episodes of manic “highs” to periods of depressive “lows,” or a mixed state in which manix energy combines with the depressed mood. Two cornerstones for an accurate diagnosis of bipolar disorder in children are: (1) the presence of a strong family history of bipolar disorder and (2) an early-onset symptom pattern that is unique to this age group. There are a growing number of accounts of families whose children are struggling with a form of “pediatric mania” in which mood shifts occur repeatedly throughout the day and the child is caught in long periods of ultra-rapid mood cycling. These parents report that they cope with frequent, severe, prolonged, explosive rages at home as well as unpredictable, aggressive, oppositional episodes that swing back to the child’s “other” upbeat mood. Silly and full of energy one moment, the child will suddenly become angry, disruptive, and defiant. These children are often charming, funny, verbally and artistically gifted, and bright. They can also be bossy, intrusive, insistent, and difficult.

Symptoms of Bipolar Disorder:

- Hair-trigger arousal system that can be set off by the slightest irritant or change.
- Overreaction that can take the form of irritable, oppositional, negative behavior.
- Multiple mood shifts; your child may act like 2 different people.
- Often rage is controlled in school in front of classmates.
- Hyperactivity: may be highly distractible, inattentive; may have a decreased need for sleep.
- Grandiose behavior: attempts to tell the teacher how to run the class or to take over the class.
- Overt hypersexual activities and comments in the classroom.
- Sensitivity to temperature and often heat-intolerant.
- Craving for carbohydrates and sweets.
- Psychotic episodes, usually auditory hallucinations that are often not reported.

What Families Report Observing:

- The child was “always different;” with ragged sleep cycles, night terrors, violent nightmares; first reaction to any request is “no!”
- Say child typically has severe separation anxiety; will often refuse to go to school.
- Describe rages as seizures: child appears “wild-eyed,” violent tantrums of kicking, hitting, biting, screaming foul words, thrashing that lasts for hours.
- The child experiences sleep disturbance” hard to wake, gains energy through the day, and “bounces off the wall” by end of school day.
- Child has extreme physical sensitivity: clothes must feel “just right,” food temperature must be “just right.”

- Say child is more difficult at home than at school.

Co-occurring Disorders in Children:
The development of bipolar disorder in children may involve clusters of symptoms at various ages that look like ADHD, ODD, CD, and depressive disorder.

Bipolar Disorder in Adolescence:
The onset of bipolar disorder in adolescence can be extremely difficult. Some talents and strengths the child developed while growing may be swept away, often leaving the teenager feeling lost and alone at a critical stage of development. Reckless behaviors driven by mania can bring painful, embarrassing attention, while depressive episodes can make active participation in school life almost impossible. In adolescence, this illness can strike with severity and may include symptoms of psychosis (auditory and visual hallucinations) and even grandiose delusions, feeling that they are very powerful and important. The adolescent may feel all-powerful and invincible; if so they are unlikely to listen to advice from adults. Teens with this illness are at high risk for drug and alcohol abuse. These teens often feel genuine remorse for their destructive actions, but unfortunately they often repeat those actions.

Symptoms of a Manic Phase:
- Difficulty sleeping; high activity level late at night.
- Increased goal-setting and unrealistic expectations (boasting of becoming a rock star when they can't sing, or a prominent "big shot" when they are failing in school).
- Very rapid and insistent speech.
- All-or-nothing mentality (if not exactly their way, it's worthless).
- Spending sprees (running up large credit card bills online or over the phone).
- Aggressive, touchy, irritable.
- Reckless driving; drinking and driving; repeated car accidents.
- Hypersexuality, provocativeness.
- Lying and making up stories; sneaking out of class; sneaking out of the house at night to party.
- Psychotic episodes: delusions (false beliefs), hallucinations (seeing/hearing things), paranoia (suspiciousness); may have romantic delusions about teachers.

Symptoms of a Depressive Phase:
- Crying, extreme sadness.
- Moodiness, irritability (picks fights with others).
- Tremendous fatigue, oversleeping, lethargy; carbohydrate cravings.
- Insecurity, separation anxiety, low self-esteem.
- School avoidance; feigning sickness to stay home; constant physical complaints.
- Self-isolation; pushing people away.
- Suicidal thoughts and attempts.

Co-occurring Disorders in Adolescence:
The majority of adolescents diagnosed with bipolar disorder also have symptoms of ADHD.

Disruptive Mood Dysregulation Disorder (DMDD)

The core feature of DMDD is chronic, severe, persistent irritability, with two prominent symptoms. The first is frequent temper outbursts that typically occur in response to frustration. The outbursts can be verbal or physical in the form of aggression against property, self, or others. The second primary symptom is the presence of chronic, persistently irritable or angry mood between outbursts. This irritable mood is present for most of the day, nearly every day, and observed by everyone who is in contact with the child. This diagnosis was added to the DSM-5 in an effort to prevent an inaccurate diagnosis of bipolar disorder for children who experience these symptoms consistently, rather than episodically as in bipolar disorder. This diagnosis is made when the symptoms have been present for at least 12 months and have been observed in more than one setting (at home, at school, with peers, etc.).

Symptoms of DMDD:

- Severe temper outbursts (verbal rages; physical aggression toward people or property) that are out of proportion to the situation.
- Outbursts are inconsistent with the developmental level of the child.
- Outbursts occur on average 3–4 times per week.
- Mood between outbursts is irritable or angry most of the day, nearly every day, and noticed by everyone at home and at school.

What Families Report Observing:

- The child has difficulty getting along with people at home and at school; children and adults.
- Low frustration tolerance makes it difficult to participate in family activities; even simple things like meals with the family.
- The rest of the family walks on eggshells to keep from “setting off” a tantrum.

Co-occurring Disorders:

Rates of other diagnoses along with DMDD are extremely high. In fact it is rare for a child or adolescent to have the single diagnosis of DMDD. Most commonly the other diagnoses include anxiety, depressive disorders, and even autism spectrum symptoms. Children diagnosed with DMDD should not meet the criteria for bipolar disorder; if that is the case, only the diagnosis of bipolar disorder is made.

DMDD in Adolescence:

The onset of DMDD is before the age of 10 years, and the diagnosis is only valid for youth between the ages of 7 to 18 years. The symptoms of DMDD likely will change as the child matures; approximately half of children with DMDD will continue to experience the symptoms one year later or longer.

Obsessive-Compulsive Disorder (OCD)

This condition involves the recurrence of senseless, intrusive, continuous, anxiety-producing thoughts and impulses (obsessions) which children attempt to ward off with rigidly patterned, irrational behaviors (compulsions). Almost as common as ADHD, this condition affects more than one million children and adolescents, with boys twice as likely to experience it as girls.

Symptoms can start as early as ages 3 or four, but in the U.S. the average age of onset of OCD symptoms is 19.5 years of age, with 25% of cases beginning by age 14. Younger children may not interpret their compulsive behaviors as unusual: to them, they are just "absolutely necessary." Blocking or preventing their compulsive responses can trigger extreme tantrums. Older children will often become exhausted in an effort to hide their condition from peers. With OCD, there is a striking similarity of symptoms among children and adults.

Obsessions:

- Fear of contamination, dread of germs.
- Fixation on lucky/unlucky numbers.
- Fear of catastrophic danger to self or others (fire, death, illness).
- Need for symmetry and exactness (objects or furniture must be placed "just so").
- Excessive doubts.

Compulsions:

- Ritual hand washing, showering, grooming, cleaning.
- Repetitive counting, touching, getting up and down, going in and out, writing/erasing/rewriting.
- Continuous checking and questioning; arguing, hoarding, or collecting.
- Children may not be able to articulate the purpose, or their need for these behaviors.

What Families Report Observing:

- They must cooperate with compulsive rituals to placate the child and avoid confrontations and tantrums.
- The child is often too exhausted to play or join in family activities.
- Experience extreme frustration with their child's inability to control irrational behaviors.
- Disclose that ritual compulsions swamp home life but are more subdued in public.

Co-occurring Disorders:

- 37% of individuals with OCD also have motor tic disorders.
- 76% of adults with OCD also have a diagnosis of an anxiety disorder.
- 63% also have a diagnosis of depressive or bipolar disorder.
- 20–40% of adolescents with eating disorders have OCD.
- Adolescents with OCD are at high risk for depression.

Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD)

These conditions involve disobedience that grossly violates accepted behavioral norms for children. This is the child who, beyond all understanding, refuses to cooperate or a child who relishes playing a destructive role with others. Boys with this disorder outnumber girls. Core symptoms are inflexibility in ODD and physical aggression and cruelty in CD. Children as young as age 3 can display symptoms of these conditions. Genetically vulnerable, these children are often at high risk because of disadvantages such as poverty, abuse, and neglect. Because these children are so relentless and show so little remorse over their actions, attempts to control or discipline them tend to make them even more defiant. It is difficult not to spot these conditions. Children with such extremely antisocial behaviors require early identification and early intervention to get their lives back on track.

Symptoms of Oppositional Defiant Disorder (Willful Behaviors):

- Negative, hostile, defiant behavior; will frequently not comply with requests made by adults.
- Persistent arguing with adults; belligerent, obstinate.
- Intense rigidity and inflexibility; feels entitled to make unreasonable demands.
- Touchy, resentful, spiteful; blames others when apprehended.

Symptoms of Conduct Disorder (Intentional Behaviors):

- Aggression and cruelty toward people and animals; bullying with weapons.
- Destructiveness (setting fires, defacing or destroying property).
- Deceitfulness (lying, stealing, “conning”).
- Disobedience (truancy, running away from home).
- Lack of remorse for antisocial behaviors.

What Families Report Observing:

- Often get angry and exasperated with the child who won’t ever obey or cooperate (ODD).
- Are shocked, horrified, and embarrassed by the child’s sadistic behaviors (CD).
- Often feel frightened and intimidated and worry constantly about the danger of injury to siblings (CD).
- Are overwhelmed by criticism from family and friends.
- Report that many suspensions from school add to their burdens at home.
- Can’t take the child anywhere; often feel ostracized and housebound.

Co-occurring Disorders:

Fifty percent of children with ODD have ADHD; 40% with CD have ADHD, and almost as many have a depressive disorder.

Oppositional Defiant Disorder/Conduct Disorder in Adolescence:

A child with symptoms of ODD or CD at age 7 can potentially pose a considerable threat to society at age 15, without intervention and treatment. Without treatment, the antisocial behaviors can persist and may escalate in terms of danger to others. There is also a late-onset of conduct disorder, starting after age 10, in which a child may become aggressive and antisocial as a primary way of interacting with others. Because these children often do not have a close connection to their classmates, they can become loners who feel they have nothing to lose by acting worse. Symptoms include:

- Truancy, school failure, frequent expulsion from school.
- Reckless, accident-prone behavior.
- Low self-esteem covered by a cocky or “tough” demeanor.
- Early sexual activity.
- Early drug and alcohol abuse.
- Sociopathic behaviors causing serious harm to others, such as physical abuse, intimidation, and sexual assault.
- Frequent encounters with the criminal justice system.

Childhood-Onset Schizophrenia

Early-onset schizophrenia is a chronic mental illness marked by delusions and hallucinations in the early stage and by apathy, withdrawal, and lack of motivation in the later stage. The childhood form of this illness is rare, affecting 1 in 40,000 children under the age of 15. Unfortunately, the early expression of this disorder is extremely severe, involving significant abnormality in brain structure and causing pronounced disruption in brain development. The defining sign of childhood schizophrenia is the slow, gradual emergence of psychotic symptoms as well as their persistence after the onset of the illness. Because the onset process is so protracted, ancillary signs of detection are useful. Early-onset schizophrenia is often preceded by developmental disturbances such as lags in motor and speech/language development; poor functioning in attention, memory, and decision-making; and grade failure. Childhood-onset schizophrenia is rarely observed before the age of 5 and can be differentiated from autism by this later age of onset.

Symptoms of Childhood-Onset Schizophrenia:

- Early patterns of inhibition, withdrawal, and sensitivity.
- Problems with conduct.
- Anxious and disruptive in social settings.
- Poor motivation and follow-through.
- School failure or required placement in special education.
- Inability to make friends; disinterested in forming relationships.
- Confusion about what is real: hearing voices of someone not there (hallucinations) or sense of being followed or threatened (delusions and paranoia).
- Showing no emotion; speaking rarely; sitting still for long periods of time.
- Inappropriate expression of emotion (laughing at sad events).

- Little or no eye contacts; little expression of body language.

What Families Report Observing:

- The child hears voices saying bad things about him or her, or stares at things that are not there.
- Worries that the child shows no interest in making or having friends and prefers isolation to any involvement in social activities.
- Say that odd behaviors are not limited just to certain situations but are pervasive in every realm of the child's life.
- Describe that the child appears "blank" all the time: delays answering questions, doesn't respond at all, or frequently asks for statements to be repeated.

Young Adult-Onset Schizophrenia:

The average age of onset of the adult form of schizophrenia is 18 for young men and 25 for young women. However, many teenagers of both genders report that onset symptoms of schizophrenia started in their later years of high school. This illness is far more common than childhood schizophrenia; it strikes 1 out of 100 people and it ranks among the top 10 causes of disability in developed countries worldwide. Consequently, early identification and intervention provide the best chance for immediate stabilization and reduction of long-term disability. Adult schizophrenia commonly begins with an acute psychotic episode which follows a "prodromal" period of progressive decline. The residual symptoms of the illness can severely limit the functional capacity of young people with this mental illness and the eraly years of illness are marked by repeated bouts of psychosis, hospitilization, and risk of suicide.

Prodromal Onset Symptoms:

- Persistent, uncontrollable crying not linked with any recognizable source of sadness.
- Agitation and precipitous weight loss; sudden lack of attention to hygiene.
- Withdrawal and isolation, marked decline in school performance.
- Odd sensory experiences; odd beliefs and rituals.

Source: Parents and Teachers as Allies: Recognizing Early-onset Mental Illness in Children and Adolescents, Fifth Edition, 2014, National Alliance on Mental Illness, Arlington, VA