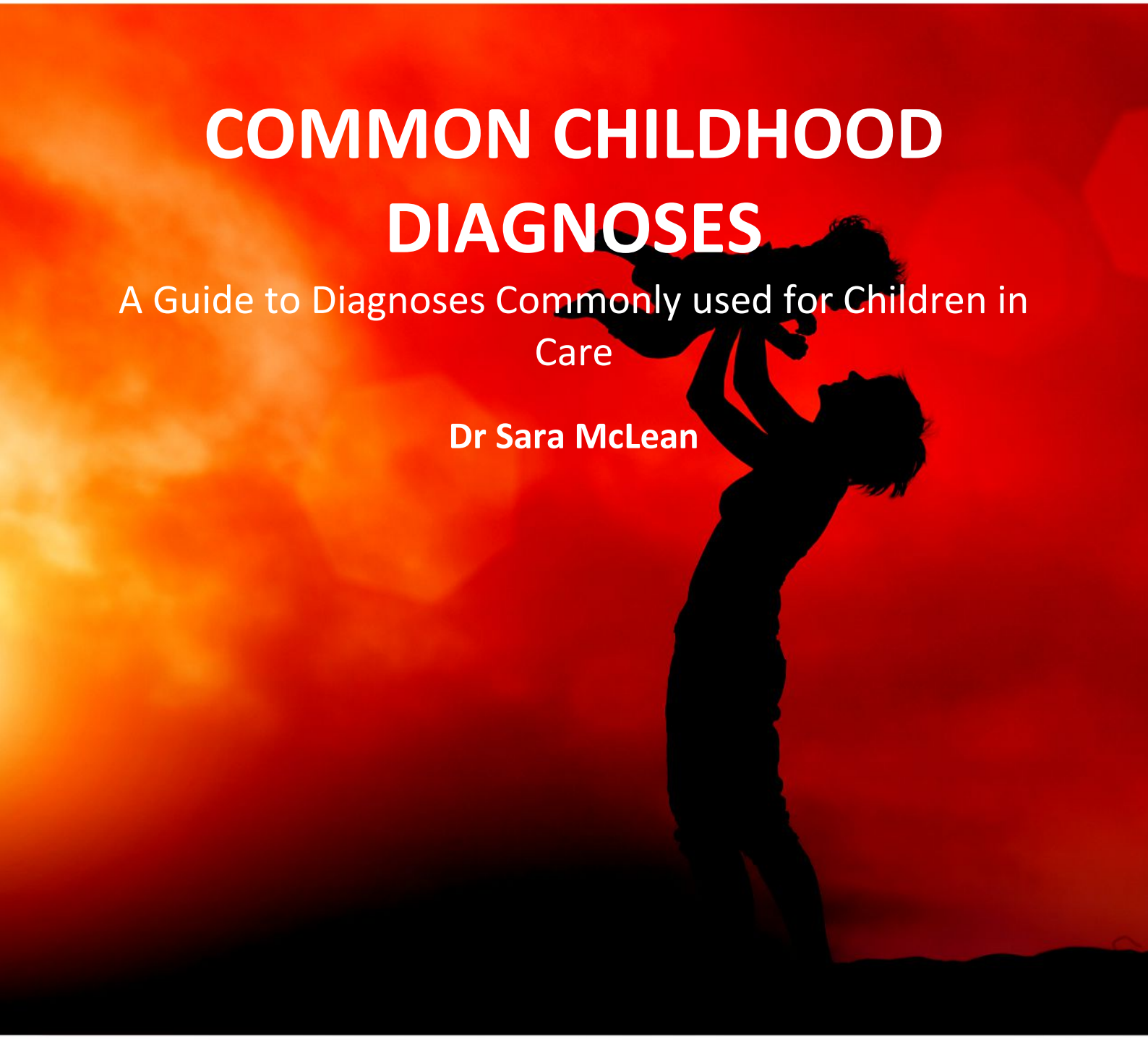
FOSTERING DIFFERENCE

COMMON CHILDHOOD DIAGNOSES

A Guide to Diagnoses Commonly used for Children in Care



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‘It ain't what they call you, it's what you answer to’

W.C. Fields

Acknowledgment:

This resource is part of a series of resources for foster parents who are raising children living with developmental difference caused by early life adversity. The guides are intended to provide general educational information only, and are not a substitute for professional assessment and intervention.

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A Foster parents' guide to common diagnoses and what these mean for children's behaviour

Children in care are likely to come with at least one diagnostic label. This resource gives a brief overview of the common diagnoses and what the implications of these diagnoses might be for supporting your child. Each diagnosis comes with unique developmental differences.

Attachment Disorder

You may hear your child being labelled with an 'attachment disorder' or as having a 'reactive attachment disorder'. These are common descriptions given to children in care; normally by medical professionals.

Attachment disorders are the result of a 'failure' in the early caregiving relationship; in which there hasn't been an opportunity for a child to form a bond with a caregiver during the critical first years of life. 'Attachment disorder' is a diagnosis that is hotly contested and debated. But it is a diagnosis that is often used to describe children in foster care.

'Attachment disorder' was first identified amongst children raised in institutional care from an early age. These orphanage children were raised *without any consistent caregiver* (attachment figure); and were living with very minimal emotional and physical stimulation. These children often went on to develop Reactive Attachment Disorder; where they showed profound disturbances in their social interactions later in life.

In the past, many children in foster care were described as having Reactive Attachment Disorder. We know understand that this kind of disorder only occurs for children who are raised *without any specific caregiver*; or in those children that are raised with *so many caregivers* early in life that they don't have a chance to form relationship with any specific carer. While most children entering foster care have very poor early caregiving; there is usually still one attachment figure present for their first years of life. While poor quality early caregiving is common; complete failure to form an attachment bond is actually extremely rare and only happens in extreme circumstances.

Your child should only receive a diagnosis of Reactive Attachment disorder if there is a history of extremely pathological early caregiving; in which there was either a complete absence of consistent caregiving or there was other extremely abnormal caregiving situations (for example multiple different foster placements as an infant); AND there are clear disturbances in interpersonal relationships.

There are two types of 'attachment disorders', each associated with quite different difficulties in interpersonal behaviours:

1. Reactive attachment disorder (RAD); and
2. Disinhibited social engagement disorder (DSED).

Despite the differences in the two forms of attachment disorder, they can both be considered as the result of early failure to form a specific bond with a consistent and reliable caregiver. The interpersonal behaviours that children with this disorder show are thought to reflect the fact that they never had the opportunity to attach to and rely on any one important adult for comfort and support.

Despite the popularity of 'attachment issues' in books and articles on foster children; true attachment disorders are still thought to be relatively rare amongst most children who have been removed from biological parents and placed in care. That is, most of these children have still formed an attachment to their parent (s); despite the difficult circumstances in which they have been raised.

Other than being able to describe the social behaviour of children with an attachment disorder, there is little research about other ways to tell if your child has an attachment disorder. Anecdotally, attachment disorder is often associated with extreme neglect, and children who experience are also likely to display malnourishment, failure to thrive, dysregulation of appetite and/or food hoarding behaviours. At this stage, it is important to remember that we still can't really tell by a child's appearance or behaviour at the time of entering care whether or not they have an attachment disorder. The formal diagnosis of attachment disorder is dependent on a child's caregiving history and their current social behaviour:

- Symptoms of **Reactive Attachment Disorder (RAD)** include failure to seek comfort when distressed; refusal to respond to/accept comfort; minimal social and emotional responses to others; limited expression of joy and other emotions.
- Symptoms of **Disinhibited Social Engagement Disorder (DSED)** include marked lack of reticence in approaching and seeking interaction with unfamiliar adults (adults outside of family unit); displaying overly friendly or familiar behaviour towards strangers such as sitting on laps, hugging or leaving with strangers. These children give little sign of you being an important part of their life, often failing to seek you out for reassurance in unfamiliar situations.

It is important to emphasise that many children in foster care are described as having 'attachment difficulties'. However, genuine attachment disorder, as described above, appears extremely rare. Most children are likely to have formed an attachment of some sort to their biological parent (s). Therefore it is unlikely (though not impossible) that your child has a genuine attachment disorder; although they may well have significant difficulty in forming trusting, close relationship due to their disruptive early experiences.

Most studies indicate that the behaviour of a child with DSED (the socially inhibited form of attachment disorder) will improve over time, when placed in high quality foster care. Their behaviour generally improves as they form bonds with their foster caregivers. Children with the 'disinhibited' type of attachment disorder (RAD) may retain most of their disinhibited behaviour over time, despite becoming settled into a good quality foster home. Their social behaviour does not necessarily improve ***despite*** forming significant bond with their foster caregivers.

Although there are no formal interventions for attachment disorder, it can be useful to think of this developmental difference as a form of **anxiety** disorder; in which there is a fundamental fear of emotionally relying on their caregiver. Many of the approaches that help anxious children are likely to help the child with an attachment disorder. This includes providing safe and predictable caregiving; setting clear expectations and rewarding small steps in the right direction (for example, rewarding recognition of family (for DSED) or rewarding positive social interaction and acceptance of comfort (for RAD)).

Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is a developmental difference that causes a child to be inattentive, impulsive and frequently also to be very active and restless. Children can have difficulties with attention and impulse control with or without being hyper-active. The child with ADHD has normal intelligence but can have difficulty in achieving success at school due to the difficulties they experience in maintaining concentration and attention and 'staying on task' in a learning environment. The child who is hyper-active can have difficulty sitting still in a classroom environment and may have poor sleep at night.

If your child has this developmental difference, you will benefit from support from a Psychologist and a Paediatrician. A Psychologist will use behavioural techniques to make the school environment more manageable for your child; and will provide you with specific parenting skills that are suited to the child with a short attention span. A Paediatrician will be able to prescribe stimulant medication that is can be effective in many cases. Stimulants like Ritalin or dexamphetamine, that 'rev up' other children, act in a paradoxical way for children who are already very active; and act to calm the child's

nervous system and make it easier for them to concentrate. These medications can affect your child's appetite so need to be monitored carefully. Many foster parents also believe that a child who has ADHD is very sensitive to additives in food and they monitor their child's diet accordingly. If your child has this developmental difference, the resource in this series 'Guide to Executive Functioning Difficulties' may be useful. See www.fosteringdifference.com.au

Anxiety Disorder

Anxiety disorders appear common amongst children in care. Some children react more quickly and intensely to situations that are perceived as threatening or dangerous. This is most likely due to their temperament- their genetic makeup. These children may be more prone to develop and anxiety disorder. If these children also happen to live families where violence or threats are common; they are extremely likely to go on to develop an anxiety disorder of some form. Anxiety disorders can be overlooked by parents and teachers, because the child's difficulty is 'internalised'- they usually keep their worries and fears to themselves -and do not usually cause the kinds of major behavioural difficulties and classroom disruptions that other children can.

Basically, all anxiety disorders share common features. All anxiety disorders feature a fear of something; and avoidance of something that is perceived as dangerous (where, realistically there is actually little or no danger involved). A child with anxiety over-estimates or inflates the threat involved in doing something (like talking in public, or failing a test, or going to school). They then avoid that activity. Children with anxiety concerns typically have very few coping skills other than avoiding. The treatment of anxiety is complex and best done in conjunction with a Psychologist. Treatment typically includes challenging the child's irrational beliefs and creating a stepped out plan for addressing the feared activity or situation in small increments.

There are a range of anxiety disorders, some are more common than others. Here are some anxiety disorders that are common amongst children in care:

Obsessive Compulsive Disorder: In this anxiety disorder, a child has persistent and unwanted thoughts that they feel they must act on. For example, they may have repetitive and persistent thoughts about germs, or about impending doom. There is typically also a belief in the need to perform some action that is associated with these unwanted thoughts. For example, a child who is troubled by unwanted thoughts about germs and contamination, may believe that they need to wash their hands in a ritualised way- *and that this ritualised behaviour will ward off any danger* of being contaminated. Other ritualised behaviours include switching lights on and off a certain number of times or in a certain pattern, checking doors, counting, or organising objects in ritualised ways.

The main feature of obsessive compulsive disorder that children feel compelled to enact certain behaviours- there is a firm belief that carrying out ritualised behaviours such as counting, and

washing *is the only way* to protect themselves or others from harm. This disorder may be linked to early magical thinking in children, and may previously have been an important way for your child to feel as though they have some control over their lives and whether or not bad things will happen.

Generalised Anxiety Disorder: In this form of anxiety disorder, a child worries excessively about past, present and future events. For example they may worry about the consequences of what they have said or done in the past. They may worry about upcoming events and magnify or catastrophize about the likely outcome. The hallmark feature of generalised anxiety disorder is that children believe that the activity of 'worrying' itself gives them a measure of control over what will happen. This feeling of control may previously have been important to foster children who have had very little actual control over their lives and what happens to them.

Social Phobia: In this form of anxiety disorder a child is excessively shy and avoids any situations that could potentially involve social evaluation of any sort. For example, a child will avoid meeting new people, talking in class, performing in public or may even avoid any public situations that expose them to scrutiny such as eating in a public restaurant. These children avoid the potential for embarrassment or being viewed in a negative light by avoiding as many novel social situations as possible. Without encouragement, these children can have very limited social connections and friendships. Social anxiety may be common amongst children of parents who are socially isolated; or amongst children who have previously been neglected in terms of their need for positive social interactions.

Separation Anxiety: In this anxiety disorder a child's central fear is of something bad happening to a loved one while they are separated from them. Separation anxiety is a normal developmental stage for babies and toddlers (up to 2years of age) that corresponds to a young child's growing cognitive development and understanding of their own vulnerability and 'separateness' from their parent.

Separation anxiety is common in fostered children. The child will avoid being separated from their caregiver and will often experience 'somatic' illnesses such as stomach aches, and headaches that allow them to stay home from school and remain close to their caregiver. For foster children, fear of something bad happening to their caregiver is a somewhat realistic fear. Remember that many children have witnessed one or more parents being harmed and, ultimately, they have also actually experienced premature separation from their parent (s) when placed in care. Separations anxiety may be especially acute during the initial stages of a placement, but should resolve over time. It may re-emerge during especially difficult times and times of transition for the child (moving to a new school, entering high school etc).

Post-traumatic Stress Disorder (PTSD): is another common anxiety disorder for children in care. In this form of anxiety disorder a child seeks to avoid reminders of a traumatic event that they have experienced and survived. PTSD is explained in more detail later in this resource.

Autism Spectrum Disorder (was also known as Aspergers)

Autism Spectrum Disorder is a term used to describe a lifelong disorder that affects a child's development across several important areas. The term 'spectrum' is included in the name of this disorder to indicate that all children with this disorder are affected differently (across a 'spectrum' from mild to severe). Until recently the term 'Aspergers' was used to indicate a milder form of Autism but now only the one term –Autism Spectrum Disorder (ASD)- is used to capture the full range of difficulties that children with this disorder can experience.

The main areas affected by Autism Spectrum Disorder (ASD) are 1) pervasive difficulties with social communication, social interaction and social skills and 2) a restricted range of interests together with fixed or repetitive patterns of behaviour.

A diagnosis should only be made as a result of a multi-disciplinary assessment; typically involving a Psychologist and a Speech Pathologist. Ideally, the assessment should include both a caregiver interview and observation of the child. For a child to obtain a diagnosis of ASD, other neurological causes must be ruled out. Symptoms must be present in the early developmental period (but the symptoms may show themselves until the social demands placed on a child exceed their limited capacities).

The developmental differences involved with Autism involve two broad areas; 1) social interaction and 2) restricted or repetitive interests.

Deficits in social communication and social interaction:

Children with Autism Spectrum Disorder will struggle with social communication and social interaction. They will have difficulty with social- emotional interaction, particularly in reciprocity (for example they cannot manage the normal 'back and forth' of conversation; they may not reciprocate in conversations by sharing interests or emotions when others do). Their conversation may be 'one-way'-and focus on their interests rather than the interests of the person they are conversing with. They may demonstrate poor non-verbal body language in social communication, for example by not giving appropriate eye contact; or lacking facial expression. They may not be able to read other's body language well. They can struggle in forming, understanding, and maintaining friendships and other social relationships. They may not understand how to adjust their behaviour to suit various social contexts or settings, or have difficulty with shared imaginative play. The impairments in social interaction and social language suffered by children with Autism can be mild, moderate or severe (they may be completed non-verbal).

Restricted, repetitive patterns of behaviour or interests:

In addition to difficulties with social communication, children with Autism Spectrum Disorder will also demonstrate at least two of the following four features:

1. Stereotyped or repetitive movements, or speech or use of objects (for example echolalia, repetitive movements of hands);
2. Lack of flexibility and insistence on sameness and routines (for example shows distress over small changes, has difficulty with transitions, needs to eat same food every day);
3. Shows highly restricted and fixated interests of abnormal intensity (for example intense interest in trains, timetables; attachment to unusual objects);
4. Hyper-reactivity (or under-reactivity) to the sensory aspects of the environment (for example fascination with lights, adverse response to sounds or textures).

The diagnosis of Autism Spectrum Disorder is a complex process; and must be conducted by trained professionals. General information about Autism Spectrum Disorder is available from these sites: See Autism Spectrum Australia https://www.autismspectrum.org.au/ and Australian Autism Alliance http://www.australianautismalliance.org.au/ .

This kind of developmental difference will necessitate life-long accommodations to your child's environment; and in how you interact with your child (see resources in this series 'Guide to Sensory Regulation Difficulties' and 'Guide to Language and Communication Problems': www.fosteringdifference.com.au .

Central Auditory Processing Disorder (CAPD)

Central auditory processing is the ability to interpret, organise and remember what we have heard (through our auditory senses). A child's central auditory processing ability normally develops alongside a child's receptive and expressive language skills in the first five years of life.

Central Auditory Processing Disorder (CAPD) is a condition where a child is unable to process and understand the information she has heard; and where this difficulty is not due to a hearing problem or intellectual difficulty.

Basically, the brain of a child with CAPD can't easily make sense of what their ears are hearing. This is because their brain distorts the auditory signal; or it can't easily discriminate between auditory signals; especially when there is competing auditory input. A hallmark feature of CAPD is the child's inability to understand what people are saying when there is background noise, especially other people speaking at the same time. For this reason, the child with CAPD has great difficulty in a

classroom setting where they are required to listen to the teacher while screening out competing conversations.

As a result of CAPD, a child can also have difficulty discriminating the sounds that make up words (phonological decoding weakness); can have flat or monotonic speech (prosody weakness); and have difficulty in organising speech and language concepts. Many foster carers report that a child with this disorder will also have difficulty with spatial concepts and organisation.

Many Audiologists now provide screening for CAPD, which includes a background screening to ensure your child's hearing is intact. However, it may be useful to obtain a referral to a Paediatrician to rule out other causes. Many foster parents report that a child's classroom learning can be greatly enhanced by providing a child with an FM sound amplification system. These systems amplify the teacher's voice relative to the background noise and thereby help the child to focus. An Audiologist that conducts CAPD assessments will be able to recommend suitable equipment and strategies to support your child in their classroom learning.

This developmental difference will mean that your child will struggle to concentrate and filter out irrelevant background noise in settings such as classrooms or family functions. If your child has this developmental difference, many of the strategies in the resource 'Guide to Language and Communication Problems in Children' will be useful. See www.fosteringdifference.com.au

Intellectual Disability

A diagnosis of Intellectual Disability refers to a measure of your child's intellectual functioning and how it compares to other children the same age. In simple terms, a child's IQ (Intelligence Quotient), a measure of the child's Intellectual functioning- it reflects what range of cognitive functioning your child has- relative to other children the same age.

An IQ score is the most common way that a Psychologist gets an accurate view of a child's intelligence. A child's intelligence is a measure of their ability to perform across a range of different tasks; assessing both verbal and non-verbal ability; when compared with same age peers. An IQ assessment that is carried out by a registered Psychologist is psychometrically sound (valid); and therefore a good indication of their everyday functioning, under most circumstances.

Your child's IQ score can be less accurate, however, if your child has not been exposed to literacy skills; if English is your child's second language; or if your child is extremely anxious or unmotivated during the testing. The assessment report from a Psychologist will usually indicate whether or not the results are likely to be accurate (that is, whether or not they are likely to reflect a child's true ability). While there are limitations to an IQ score, when combined with other measures it remains the most reliable way we have of assessing child's cognitive functioning; and therefore whether or not your child has an Intellectual Disability.

In order for your child to get a diagnosis of Intellectual Disability, there are three major criteria that must be met:

1. there must be significant limitations in their intellectual functioning;
2. there must be significant limitations in their adaptive behaviour; and
3. these difficulties must have begun before the age of 18.

'Intellectual Disability' is a term used to describe a child who has significant limitations in their ability to reason, learn and problem solve; together with significant difficulties with adaptive functioning (adaptive skills are those skills needed to carry out normal daily activities; to communicate and to socialise). In order to get a diagnosis of intellectual disability, a child has to be assessed as having well below average IQ and significant difficulty in two or more tasks of daily living (communicating, work, home living, self-care and others). Let's look at each area in turn.

Assessment of Intellectual functioning:

Normally, an IQ test is given in order to assess the child's mental capacity for learning, reasoning, problem solving, and so on. An IQ test score below or around 70—or as high as 75—indicates to the Psychologist that the child's intellectual functioning is limited. The Table below gives an indication of how IQ scores correspond with intellectual functioning:

Wechsler Intelligence Scale for Children Fifth Edition (WISC-V) IQ classification		Alternate Wechsler IQ Classifications (Groth-Marnat, 2009)
IQ Range	IQ Classification	Description of Functioning
130 and above	Extremely High	Very superior
120–129	Very High	Superior

110–119	High Average	High average
90–109	Average	Average
80–89	Low Average	Low average
70–79	Very Low	Borderline
69 and below	Extremely Low	Extremely low

Assessment of Adaptive functioning:

In order to get a diagnosis of Intellectual Disability, a child must also experience difficulties in more than one area of adaptive functioning.

A Psychologist may ask you to complete a structured questionnaire that asks about your child's functioning in the following three adaptive skill areas:

> *Conceptual skills*—Development of language and literacy; understanding of money, time, and number concepts; and capacity for self-direction.
>
> *Social skills*—Understanding and use of interpersonal skills, level of social responsibility, sense of self-esteem, gullibility and naïveté (i.e., wariness); capacity for social problem solving; and the ability to follow rules, obey laws, and avoid being victimized.
>
> *Practical skills*—Ability to undertake activities of daily living (personal care); ability to engage in occupational skills; manage travel/transportation, schedules/routines, safety, use of money, use of the telephone and healthcare skills.

If your child has a diagnosis of Intellectual disability, it will probably mean your child will learn things more slowly and need more repetition to learn new tasks. They may benefit from you breaking down complex tasks into smaller 'chunks' of a more manageable size.

Intellectual Disability can be caused by some genetic disorders, exposure to viruses or toxins during pregnancy, childhood infections, birth trauma, head injury or profound neglect during early infancy. Intellectual Disability may be mild or severe, and the child's verbal ability and comprehension and life skills can vary accordingly.

If your child has a diagnosis of Intellectual Disability they will be functioning at a developmental level that is lower than their actual age and you will need to adjust your expectations accordingly. For more information about how to adjust expectations to meet your child's developmental level see www.fosteringdifference.com.au

Post-Traumatic Stress Disorder (PTSD)

All of us are likely to experience a stressful event in our lives, and generally we recover well if given enough time and support. However, sometimes an event is so stressful it is considered traumatic.

A trauma/ traumatic event can be any extremely stressful event; whether it is experienced directly; witnessed; or even if you heard about it happening to someone important in your life. Traumatic events usually involve the death/ near death of someone significant to a child. They can also occur when or a child is exposed to, or witnesses, violence or threats of violence towards themselves or someone significant to them, such as their mother or father.

Post-traumatic stress disorder (PTSD) refers to a set of symptoms that can develop following such a traumatic event. These include flashbacks or intrusive images; avoidance of reminders of the event; and feelings of anxiety or depression. There are quite specific criteria for being diagnosed with PTSD that include how many symptoms the child is experiencing and how long the symptoms have been present.

Some people who have PTSD can also experience dissociation. Dissociation is an altered state of awareness in which one can feel as though things are not real; 'de-realization'; or that things aren't really happening: 'de-personalization'. Dissociation is thought to be a protective response that can happen when a child experiences a threat or danger that they experience as overwhelming and inescapable. Dissociation usually happens when your child is faces with something that reminds them of a traumatic event- a sight, sound or smell that triggers a traumatic memory. When your child experiences dissociation when they may report feeling 'not real' or that its' 'like a dream'. You may observe them 'tuning out' or seeming 'in another world'.

We believe that the high stress of a traumatic event affects how memories are formed during this time; and these distorted memories underlie the symptoms of PTSD; in which memories appear to be 're-lived' in a vivid way -as though they are actually occurring. If your child is suffering from PTSD, you may find that they are 'triggered' by events or reminders of past trauma. Once triggered, you child is likely to enter a 'Fight, Flight or Freeze state' in which they will be responding in an automatic and physical way to danger ***as though that danger was happening right at that moment***. The flight, flight or freeze response is and evolutionary adaptive survival response over which a ***child has no control***.

If your child has PTSD, you can support them by understanding the situations in which they are likely to be triggered and avoiding these as much as possible. Your child may also benefit from specific tailored therapy in which traumatic events are re-experienced and re-processed over time, and in a safe and supportive environment. A registered Psychologist will be able to deliver evidence based trauma interventions to your child (such as Trauma focused CBT; Trauma processing therapies or EMDR).

Sensory Processing Disorder

Sensory Integration Dysfunction (often called sensory processing disorder) refers to a neurological disorder that causes difficulty in processing, synthesising and integrating information coming in from the five senses (sight, hearing, touch, smell, taste) as well as the body's sense of position in space – proprioception-and the body's sense of movement -vestibular system). The child's brain has difficulty in discriminating and analysing this information; or they may processes it in an inefficient way, causing confusion or fatigue. For a child to get a diagnosis of sensory integration dysfunction, they must have normally functioning senses – in other words this difficulty is not caused by hearing or sight problems.

Sensory Processing Disorder is often associated with a diagnosis of Autism, FASD or Dyslexia (Specific Learning Difficulty) Children with sensory integration dysfunction can have higher or lower sensitivity to sensory input, especially touch. If you suspect that your child has difficulty in processing and integrating sensory information, you may find the strategies in the resource 'Foster parents' guide to Sensory Regulation Difficulties' useful. See www.fosteringdifference.com.au

Sensory assessments are usually completed by Occupational Therapists. Some Occupational Therapists specialise in the assessment and intervention of Sensory Integration Dysfunction and will be able to offer therapeutic support for your child. Children with this Sensory Integration Dysfunction can also benefit from addressing proprioceptive and vestibular difficulties. Effective support usually involves scheduling special sensory activities throughout the day and being aware and monitoring your child's sensory environment.

Specific Learning Difficulty

For a child to receive a diagnosis of specific learning difficulty, the child must have general intellectual functioning at least in the average range (see the criteria on Intellectual Disability above). At the same time they must have specific difficulties with learning in the area of reading, spelling, writing or mathematics. A child can have one or more than one of these specific learning difficulties. They have specific difficulty with one or more of the skills that are central to academic success, but these difficulties are not due to general Intellectual delay. The most common example of a Specific Learning Difficulty is dyslexia, which can take different forms.

While any registered Psychologist can conduct an assessment for Specific Learning Difficulty; there are Psychologists that *specialise* in this kind of assessment (usually Educational Psychologists). It is worth explaining the kind of assessment you want prior to having your child assessed for a Specific Learning Difficulty. The Psychologist you approach should be able to tell you if they have experience in conducting these kind of assessments.

The formal assessment of Specific Learning Difficulties is complex and involves comparing your child's level of ability in academic tasks to that expected from your child given their general intelligence, and with a child of comparable age and intelligence. Other possible causes of learning difficulty such as a visual or hearing impairment; emotional disturbance; or cultural or economic disadvantage; lack of access to adequate teaching; and intellectual disability must all be ruled out. All of these factors can also have an effect on a child's learning. The child with a learning difficulty can have adequate attention span and cognitive development; but has persistent and unexplained difficulty in processing the symbols and letters that represent mathematical and written concepts.

Put simply, a child may be diagnosed with a specific learning difficulty when there is unexpectedly poor performance in at least one aspect of learning, rather than an overall delay in all aspects of learning (for example, a child may have difficulty in reproducing letter shapes; but can otherwise be developing normally and have normal learning capacity).

If your child has this developmental difference, then any learning environment will be extremely stressful for them. The discrepancy between their actual capability on the one hand; and their extreme limitations in the key tasks of schooling (i.e., reading, spelling or writing) can make your child feel very frustrated and ashamed. Early identification and intervention allows the child to develop strategies that accommodate their very different learning needs. When specific learning problems are not identified and addressed, they can cause behaviour difficulties due to the child's frustration and avoidance of academic tasks.

The Australian Learning Disability Association website provides more detailed information about Specific Learning Difficulties and useful contacts; see www.adcet.edu.au/oao

Learning Disabilities Australia is a not-for-profit organisation that provides support and resources for teachers and professional educators in Australia. See www.ldaustralia.org

SPELD is a non-profit organisation that provides advice and services to children and adults with specific learning difficulties. This includes specialised assessments of learning difficulty. There are SPELD offices in most Australian States; see www.auspeld.org.au or phone (08) 9217 2500.

To find out more about Developmental Difference and your child, visit

www.fosteringdifference.com.au