FREE MATERIAL · FAMILIES, SCHOOLS AND CLINICS

When there are no words

Emotional distress in children and adolescents — how to notice, how to ask and what to do.

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Why this booklet exists

Asking for help is an act of communication. Not every child has the means to make it.

Most of what is said about prevention assumes that a person in distress will manage to say so — that she will have the word, the opportunity, and the confidence that someone will believe her.

For many children and adolescents, and especially for neurodivergent ones, none of those three is guaranteed.

Someone with no word for what she feels cannot ask for help. Not for lack of wanting, but because the resource is not there. Building that capacity is not a therapeutic detail — it is a protective factor.

What this booklet is

Guidance for adults who live and work with children and adolescents. **It does not replace mental health care**, is not a risk assessment tool, and does not qualify anyone to manage a crisis — that belongs to professionals in the field. If the situation is urgent, go straight to the last page.

What makes it hard to see

Four reasons a neurodivergent child's distress goes unnoticed.

Alexithymia

Difficulty identifying and naming one's own emotional state. A child can be in intense distress and be unable to produce a word for it. “What are you feeling?” may bring no answer at all — and that does not mean there is nothing there.

Interoception

Difficulty noticing and locating internal sensation. “Where do you feel that in your body?” works for many people and not for these children. External anchors are needed: a visual scale, a reference in context, a description of what changes in behaviour.

Masking

Many neurodivergent adolescents hold the appearance that everything is fine all day — at school, in therapy, in front of visitors — and fall apart when they get home. An adult who sees only part of the day may see nothing.

No emotional vocabulary

Communication systems are almost always built around requests: water, toilet, preferred item, "more". They rarely include **sadness, fear, exhaustion, shame, pain, "I can't take it", "help me"**. Without those words available, a request for help simply has no way out.

Signs that something changed

The question is not "is she like this?" but "has she always been like this?"

What points to distress is not an isolated behaviour but **the change from that particular child's usual functioning**. The same presentation can be routine for one and an alarm for another.

- **Loss of interest** in activities, topics or people she always liked — including her special interest.
- **Changes in sleep**: new difficulty falling asleep, waking at night, sleeping too much.
- **Changes in eating** not explained by long-standing selectivity.
- **New withdrawal**, or dropping contacts she used to keep.
- **Irritability or crying outside her pattern.**
- **A drop in performance** or refusal to go to school.
- **Self-deprecation**: "I'm a burden", "everyone would be better off without me", "I ruin everything".
- **Regression** of established skills.
- **Neglect of things that mattered** to her.
- **Goodbyes**: giving away treasured things, thank-you messages for no reason, "if I'm not here".

Two signs that call for action the same day

Any talk of not wanting to be here, of vanishing or disappearing. And any sign that the child may be hurting herself.

Do not wait for confirmation. Seek a mental health assessment immediately — and see the last page of this booklet.

How to ask

Asking directly does not put the idea in anyone's head.

That fear is the most common one among families and schools, and it delays many referrals. The settled guidance among mental health professionals is the opposite: asking directly and warmly **opens space** for the person to speak, and usually brings relief to someone who was alone with it.

Opening the conversation

- Choose a moment without rush and without an audience. Side by side usually works better than face to face — in the car, walking, drawing together.
- Start from the observation, not the question: **"I've noticed you haven't been sleeping and you stopped gaming. Is something going on?"**
- If silence comes, hold it. Silence is not refusal; sometimes it is the time the person needs.
- Offer a hypothesis instead of an open question if naming is hard: **"are you more sad, more tired, or more irritated?"**
- If the conversation points to serious distress, ask clearly and without euphemism whether she has been thinking of not wanting to be here. No alarm in your voice.

If the answer is yes

Do not panic in front of her — an intense adult reaction is what makes many children retreat and stop telling. Thank her for telling you, say you will look for help together, and **do not leave her alone**. Seek care the same day.

What to say and what not to say

Helps

✓ “I'm glad you told me.”

✓ “I don't know exactly what to do, but I'll stay with you and we'll find someone who does.”

✓ “What you're feeling is big, and it isn't nonsense.”

✓ “You don't have to sort this out on your own.”

✓ “I'm here tomorrow too.”

Does not help

✗ “That's silly, you have everything.”

✗ “Other people have it much worse.”

✗ “You're doing this for attention.”

✗ Any version that turns distress into a moral failing.

✗ “Don't tell anyone about this.”

✗ Promising secrecy. Tell the truth: you will need to involve someone who can help.

> **About “doing it for attention”**
>
> Even where there is a communicative element in the behaviour, that does not make it less serious. **A child who has to reach this point in order to be heard is, in herself, asking for help.** Treating it as manipulation is the fastest way to make her stop asking.

If the child does not speak

This is where speech and language work enters prevention.

A child without a functional communication system cannot report distress, pain, fear or discomfort — and when she reaches a health service, she often cannot answer what she is asked.

What the system has to contain

- **Internal states**: sad, afraid, tired, angry, lonely, ashamed, nervous.
- **Intensity**: a little, medium, a lot — or a three-band visual scale.
- **Pain** and where it is.
- **Refusal and limits**: “no”, “stop”, “I didn't like it”, “I want to leave”, “leave me alone”.
- **Asking for help**: “help me”, “I want to talk to someone”, “I'm not okay”.
- **People**: who the adults are that she can turn to.

> **Independent access**
>
> The system has to be used by the child herself, **with no physical support from another person and no hand being guided**. Communication that depends on an adult's hand cannot be treated as hers — and in a moment of distress, the wrong adult may be the one nearby.

Building this vocabulary takes months. That is why it cannot be left until it is needed.

Eating and self-injury

Two areas where the reading usually goes wrong — in both directions.

Eating disorders and self-injurious behaviour often appear alongside emotional distress, and both are especially misread when the adolescent is neurodivergent.

Selectivity is not an eating disorder

Many autistic children eat very few foods. That is usually **sensory** — texture, smell, temperature, colour, the sound of chewing — or tied to routine and predictability. It has nothing to do with weight, body shape or wanting to lose weight.

And an eating disorder is not selectivity

The reverse error is more dangerous and very common: a real eating disorder in an autistic adolescent is dismissed as “that's his selectivity”. Meanwhile, nobody treats it.

The question that separates them

What drives the restriction? If the answer involves texture, smell or routine, it is selectivity. If it involves weight, body shape, guilt, control or compensating after eating, it is something else — and needs specialist assessment.

A second question helps: **is this new?** Selectivity is usually lifelong. A recent change in the relationship with food deserves attention.

What to observe

- No longer eating with the family or with peers.
- New, rigid rules about what is allowed.
- Guilt, distress or irritation after meals.
- Going to the bathroom right after eating, repeatedly.
- Hiding the body in loose clothing, or avoiding being seen.
- Exercise that cannot be interrupted, even when ill or injured.
- Preoccupation with weight and body taking up much of the day.
- Physical changes — hair loss, feeling cold constantly, dizziness, changes in the menstrual cycle.

An eating disorder is a health condition, not a choice

It is not vanity, not a phase, and does not pass with pressure. Early treatment changes the outcome substantially. **Do not wait for it to get "serious enough".**

Self-injury: the difference that matters

Not every behaviour that harms has the same function.

In neurodivergent people there are often self-injurious behaviours tied to **regulation** — appearing in sensory overload, frustration or uncommunicated pain, usually long-standing and following the same pattern.

And there is self-injury tied to **emotional distress** — generally more recent, done in private, hidden, accompanied by shame, and linked to anguish the person can neither name nor bear.

> **Three questions that orient you**
>
> **Is it new?** Long-standing behaviour is a different conversation.
> **Is it hidden?** Concealment points to emotional distress.
> **When does it happen?** In sensory overload, or after distress, rejection, conflict?
>
> Both situations need care. But the referral differs, and treating one as if it were the other does not help.

What not to do

✗ **Do not search the body** or demand to see. It breaks trust and does not protect.

✗ **Do not react with horror or punishment.** An intense adult reaction is what silences most.

✗ **Do not demand a promise** that it will not happen again. A promise is not treatment, and breaking it becomes one more reason to hide.

✗ **Do not treat it as blackmail** or attention-seeking.

✗ **Do not police food** or comment on body, weight or appearance — neither the adolescent's nor your own in front of them.

What to do

✓ **Talk about the distress**, not about the mark or the plate.

✓ **Seek specialist assessment** — both cases need a team, not advice.

✓ **Talk with the health team** about making the environment safer during treatment.

✓ **Keep the relationship.** A bond with an adult who neither panics nor gives up is one of the most consistent protective factors.

✓ **Look after yourself too.**

What protects

Protective factors are not motivational phrases. They are concrete things that get built.

- **At least one trusted adult** the child can name — ideally three. A child who can name none is a priority for follow-up.
- **Emotional vocabulary available**, whether spoken, on a board, in an app or in signs.
- **Predictable routine** and a sense of belonging to some group.
- **The experience of being taken seriously** about something small. That is what makes her believe she will be heard when it is big.
- **Access to mental health care** when needed, without it being treated as shameful.
- **An environment where she does not have to mask constantly** in order to be accepted.
- **Company that does not depend only on adults** — friendship is a protective factor.

> ### The smallest gesture that protects most
>
> Taking seriously what seems small. The child who is heard when she complains about something trivial learns that speaking is worth it — and she is the one who will manage to speak when it is serious.

Looking after those who care

Mother, father, teacher, therapist — anyone accompanying a child in distress carries constant fear, guilt and the sense of being about to fail. That has a real cost and is

usually ignored. You do not have to hold it alone, and seeking your own support is not weakness. **If you are the one in distress, the contacts on the next page are for you too.**

This booklet offers guidance on care and communication. It is not legal advice and does not describe the laws or services of any particular country. Procedures for reporting and for hearing a child differ between countries — always check what applies where you are.

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Local contacts

Fill this page in with the services available where you are.

Every country organises child protection differently. Before you need them, find out which of these exist near you and write them down here.

Emergency number

Child protection authority

Police / specialised unit

Health service

Free legal assistance

School contact

Other notes