

COMPANION GUIDE

What We Know About Highly Sensitive Children

Facts, sources and signs to understand, tell apart and know when to ask for help

2026 EDITION · COMPANION GUIDE TO "SENSITIVE KIDS FROM THE START"

"Understand before you act"

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ZEN BOOKS

What We Know About Highly Sensitive Children

Companion guide, 2026 edition. Companion material to "Sensitive Kids from the Start. Understanding high sensitivity from baby to teen. The complete guide for parents, teachers and therapists"

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Editorial line: understand before you act.

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This guide is for information and education. It does not replace an assessment by a health or education professional. No list in this guide can be used to score a child or to diagnose one.

The scientific data and sources were reviewed between 8 and 10 October 2026. The US and UK resources come from the author's verified source bank (October 2026); phone numbers and services change, so check them on the official website before relying on them. Later editions will carry their own review date.

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Before you start

The axe

A man lost his axe. He looked for it in the shed, under the workbench, among the firewood, and it wasn't there. Then he thought of the neighbour's son, a lad who was always hanging about, and he began to watch him.

And the more he watched him, the clearer it became. The boy walked the way a thief walks. He said hello the way a thief says hello, with his head slightly bowed. He spoke little, the way people do when they have something to hide. Even the way he leaned on the fence, hands in his pockets, was the way of someone who knows where there is an axe that isn't his.

A few days later the man went to dig in the vegetable patch, and the axe turned up under a mound of earth, right where he had left it the last evening he worked there. He cleaned it, hung it in the shed and went back to the fence. The neighbour's son walked past, nodded to him with his head slightly bowed and leaned on the fence with his hands in his pockets. And there was nothing about him, not his walk, not his voice, not his hands, that looked anything like a thief.

I think of that fence every time I hear a parent say "he's just very sensitive" in the same tone people use for "he's just very lazy". Sometimes the word comes from a book, sometimes from a grandmother, sometimes from an online forum. And from then on, everything the child does confirms it: the tantrum, the silence, the jumper that itches. The word explains so much that we stop needing to look.

How much of what you see in your child is your child, and how much is the word you are looking through?

Origin: Liezi, book VIII, "The man who lost his axe" (China, around the 4th century BC). Public domain. The original philosophical frame has been removed and the final scene at the fence added.

This guide exists to answer that question with facts. "Sensitive Kids from the Start" tells you what is going on in a child who processes the world in more depth, and why. This guide adds what a book can't carry inside it: what research has confirmed and what it hasn't, where sensitivity looks like other things and how it differs from them, what to expect at each age, and when it is worth booking an appointment. It is written to be consulted, not read in one sitting.

> HOW TO USE THIS GUIDE
>
> Four ways in, depending on what you need today.
>
> 1. **Get the big picture.** Part one gathers, in five short themes, the ideas that the book and this guide are built on. Use it as a map and a reminder.
> 2. **Check a fact.** Part two (what the science says) and part three (myths and facts) give every claim with its source, by first author and year. The full list, with PubMed identifiers, is at the end.
> 3. **Settle a doubt.** "Sensitivity or something else?" and "Stage by stage" are there to orient you, never to diagnose. If something in them sets off an alarm, part seven tells you what to take to the appointment.

4. **Talk to the school.** Part six explains, in outline, how support works in schools in the United States and the United Kingdom, and includes a school profile sheet and a letter to the teacher, ready to fill in.

What you won't find here are exercises, scripts or tracking sheets. Those are in "Sensitive Kids Aren't Fragile", the practical companion book for ages 4 to 12. The table in part eight shows, topic by topic, where each idea is explained and where it is practised.

Three caveats that apply to everything that follows

High sensitivity is a trait, not a diagnosis. It describes a way of processing what we perceive and feel. We all have it to some degree; some children have a lot of it. It is not in any diagnostic manual, and it doesn't need to be: it is neither an illness nor a disorder.

Similar is not the same. A child who is bothered by noise, needs routines and takes a while to join a group may be highly sensitive. They may also have anxiety, ADHD, autism, or several things at once. The difference lies not in the behaviour you see but in how it shows up, where, and how much it limits the child. When in doubt, ask: this guide tells you who.

Nothing in this guide can be used to score your child. There are validated scales, and the guide tells you which ones and at what age they can be used. But they are given and interpreted by a professional, and even then they are not a diagnosis.

The essentials in five themes

Five short themes, one after another. They don't replace the book: they collect the ideas that hold everything else up, as the evidence stands in 2026. If you have only a few minutes, start here.

1. What the trait is

The groundwork: what the trait is, how many children have it, where it comes from and what it isn't.

- High sensitivity is a temperament trait, not an illness or a disorder: it means processing what is perceived and felt in more depth.
- Between 20 and 35% of children fall into the high-sensitivity group on validated scales. It is a continuum, not a yes or no.
- It is largely inborn (twin studies attribute around 47% of the differences to heredity), but the environment shapes how it is expressed.
- Parenting doesn't cause the trait. Parents are not to blame, but they have a great deal of influence on how the child learns to handle it.
- There is no "sensitivity gene" and no evidence that these children have more dopamine or serotonin, a more reactive amygdala or a less developed vagus nerve. The brain mechanisms are still poorly understood.
- Sensitivity is not shyness or introversion. Many sensitive children watch before joining in; some are extroverts.
- Sensitivity can coexist with ADHD, autism or giftedness. When in doubt, a professional assessment, not a label.
- Validated scales exist to measure the trait (the HSC scale, with parent versions). No scale is a diagnosis.

2. Everyday challenges

Day-to-day life: intense emotions, overload, routines and cooperation.

- Intense emotions are not a whim. The child needs an adult to help them calm down (co-regulation) before they can do it alone.
- Protect and stretch at the same time: the aim is a safe environment that also helps the child grow, not sparing them everything that is hard.
- Sensory overload builds up over the day. It is easier to prevent than to put out.
- Affectionate touch often soothes. This guide doesn't attribute that effect to oxytocin or the vagus nerve, because it hasn't been shown in sensitive children.
- Routines and rituals bring predictability and make transitions easier.
- Every sensitive child is different: the trait combines with other temperament traits (activity level, persistence, the tendency to approach or withdraw).
- Cooperation is not obedience. Children cooperate better when they understand and feel heard.

3. Parenting and emotional development

The central thesis: with these children, what parents do carries more weight.

- Parenting makes more of a difference with sensitive children, for better and for worse. It is the idea with the strongest scientific backing.
- Parents' self-care is not a luxury. Parental burnout is real and has its own theoretical model.

- Clear limits, held with empathy, in a predictable environment.
- Sensitive and less sensitive parents bring different things. Knowing your own sensitivity helps you not to confuse what belongs to the adult with what belongs to the child.
- Validating and naming emotions is the foundation of emotional and social competence.
- Correct without humiliating: harsh discipline harms reactive children more.
- Differences in sensitivity between siblings, and between partners, call for adjustment, not comparison.

4. From the cradle to young adulthood

The ages and stages, with particular care over babies and warning signs.

- High sensitivity cannot be identified in babies. We talk about a "highly reactive baby", without predicting what the child will become.
- Safe sleep, no exceptions: on the back, in a cot with a firm, flat mattress, nothing soft, no weighted blankets and no herbal remedies.
- Warning signs in crying and development: when to see the doctor and when to call 911 (US) or 999 (UK).
- Separations and fears: small, gradual steps. Avoiding everything keeps the fear going.
- If the insistence on sameness is very rigid, the child avoids eye contact or loses skills they already had, ask for an assessment: sensitivity doesn't rule out autism.
- Sadness or irritability almost every day for more than two weeks, or talk of dying: seek help without waiting. In the US, 988; in the UK, Samaritans on 116 123. Emergency services if there is immediate risk.
- School: start with the teacher, and know that the trait alone doesn't open the door to formal plans (504 plan or IEP in the US, EHC plan in England). If there is bullying, ask for the school's policy in writing.
- Adolescence is the stage of building identity and independence with the family as a secure base.

5. What helps in the long run

What helps over time, and what has been dropped because it isn't supported.

- Self-regulation is learned with support. Reducing unnecessary stressors doesn't mean avoiding everything.
- Sleep: a fixed bedtime and a flexible ritual. The recommended hours are the same as for any child.
- Weighted blankets, essential oils and apps are not treatments. Mindfulness has small effects.
- Screens: the World Health Organization advises no sedentary screen time before age 2 and no more than 1 hour a day from 2 to 4. For older children, the American Academy of Pediatrics now looks at content, sleep and a family media plan rather than a minute count.
- Communication: a calm tone, correcting in private, apologizing when it's due.
- Nursery and school: gradual settling-in and working together with the educators.
- Reliable resources: Sensitivity Research (Michael Pluess's group), the Child Mind Institute, HealthyChildren.org, the NHS website, and the crisis lines in part eight.

What the science says today

Ten fact sheets. Each has three lines: the finding as the researchers published it, what it means for a parent, and the source. Sources are given by first author and year; the full reference is at the end of the guide. If a claim isn't here, it most likely hasn't been confirmed in children.

Fact sheet 1. What it is

THE FINDING. "Environmental sensitivity" describes the differences between people in how they perceive and process their surroundings, the good and the bad. The sensory processing sensitivity described by Elaine Aron is one way of measuring that difference.

FOR PARENTS. It is not a diagnosis or a clinical label. It is a trait we all have to some degree and some children have a lot of. Saying a child "is" highly sensitive is a useful shortcut, but the accurate way to put it is that they score high on a scale that measures the trait.

Pluess 2015; Greven 2019.

Fact sheet 2. How many children

THE FINDING. On the HSC scale, the high-sensitivity group includes between 20 and 35% of children and adolescents aged 8 to 19. In preschoolers observed with a validated system, 22.5%.

FOR PARENTS. It is not rare: it is common. The groups are a way of sorting a continuum, and their boundaries shift with the sample and with who answers. In Germany, when parents answered, two groups emerged instead of three. What doesn't change is that there is no cut-off point that makes one child "sensitive" and another "not sensitive".

Pluess 2018; Weyn 2025; Wehrli 2026.

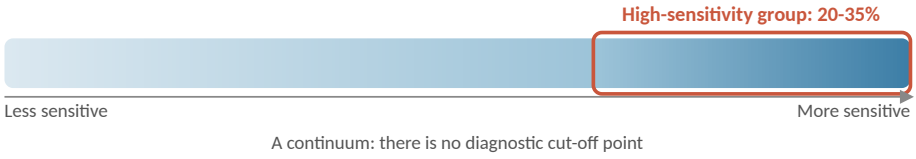


Figure 1. A continuum, not a switch. On the HSC scale, between 20 and 35% of children and adolescents aged 8 to 19 fall into the high-sensitivity group. The boundaries between groups shift with the sample and with who answers. Source: Pluess 2018; Weyn 2025; Wehrli 2026.



Figure 2. Heredity and environment. Share of the differences in sensitivity attributed to heredity in 2,868 adolescent twins. Source: Assary 2021.

Fact sheet 3. Heredity and environment

THE FINDING. In 2,868 adolescent twins, heredity explained 47% of the differences in sensitivity. The rest is attributed to the environment. There is no single gene: there are many genes, each with a small effect.

FOR PARENTS. The child arrives with a predisposition, and half the story is written by the environment. That rules out the two ideas that do the most harm: that the parents "made" the child sensitive, and that there is nothing to be done.

Assary 2021; Assary 2025.

Fact sheet 4. For better and for worse

THE FINDING. A meta-analysis of 84 studies found that children with a more reactive temperament suffer more under negative parenting and benefit more from positive parenting. In young children, sensitivity moderated the effect of parenting on behaviour problems.

FOR PARENTS. What you do at home counts for more with these children than with others, in both directions. It isn't a burden: it's leverage. It is the idea that holds the whole book together, and the one with the most support.

Slagt 2016; Slagt 2018; Belsky and Pluess 2009.

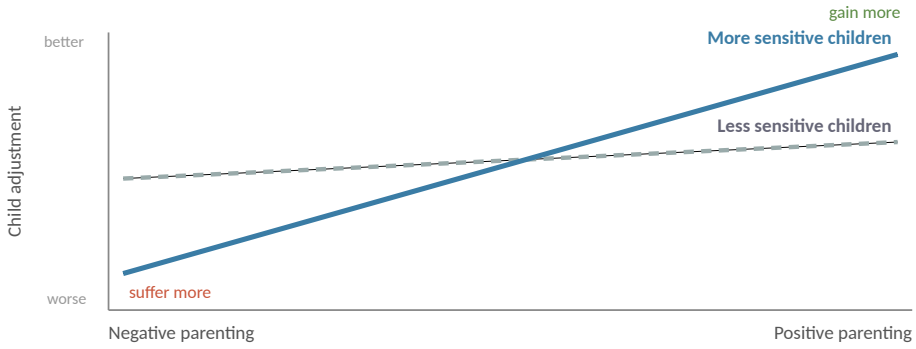


Diagram of differential susceptibility. The lines show the direction of the effect, not the values of any one study.

Figure 3. For better and for worse. Children with a more reactive temperament do worse than other children under negative parenting and better under positive parenting (meta-analysis of 84 studies). Source: Slagt 2016; Belsky and Pluess 2009.

Fact sheet 5. They get more out of a good environment

THE FINDING. In a trial with 2,042 Italian pupils, the more sensitive boys benefited more from the KiVa anti-bullying programme: less victimization and fewer internalizing symptoms. The effect was seen in boys; no effect is reported for girls. In another study, a resilience programme worked better for the most sensitive girls aged 11 to 13.

FOR PARENTS. A good school, a good intervention or a good home pays off more with them. Researchers call this "vantage sensitivity". When something works for your child, it tends to work better than it does for others.

Nocentini 2018; Pluess and Belsky 2013; Pluess and Boniwell 2015.

Fact sheet 6. Two sides of the trait

THE FINDING. The part of the trait to do with being easily aroused and having a low sensory threshold is linked to more internalizing problems (anxiety, sadness). The part to do with aesthetic sensitivity is linked to better school performance and more prosocial behaviour.

FOR PARENTS. "Sensitive" mixes different things. One child may get overwhelmed easily and another may take great pleasure in detail, and both score high on the scale. Not all sensitive children are alike, and it is worth knowing which side weighs more in yours.

Marhenke 2025; Attary and Ghazizadeh 2021.

Fact sheet 7. Sensitive is not the same as anxious

THE FINDING. In children, sensitivity correlates with neuroticism (the tendency towards negative emotion) at r = 0.42: there is overlap, but they are far from being the same thing. It is unrelated to extraversion.

FOR PARENTS. A sensitive child can also be anxious. If so, the anxiety is treated as anxiety, with what is known to work, and not left alone "because they're sensitive".

Lionetti 2019 (J Res Pers).

Fact sheet 8. There is no biological test

THE FINDING. Observed sensitivity in 541 preschoolers was not related to candidate genes, cortisol or the electroencephalogram. In adolescents, it was not related to heart rate or cortisol either.

FOR PARENTS. No blood test, scan or genetic test can tell you whether a child is highly sensitive. Be wary of anyone who offers one.

Weyn 2025; Weyn 2022; Licht 2020.

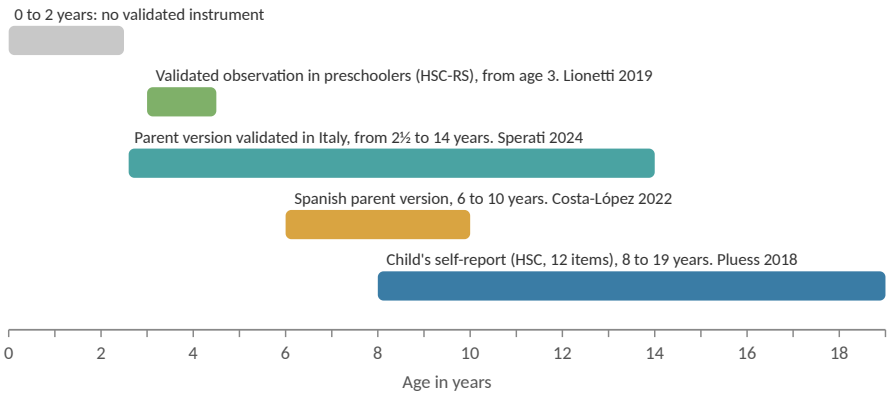


Figure 4. When sensitivity can be assessed. The ages at which a validated instrument exists to assess the trait. None of them is diagnostic, and all are given and interpreted by a professional. Sources: Lionetti 2019 (Dev Psychol); Sperati 2024; Costa-López 2022; Pluess 2018.

Fact sheet 9. How it is measured

THE FINDING. The HSC scale has 12 items and is completed by the child from age 8. There is a parent version validated in Italy (from 2½ to 14 years) and a Spanish parent version tested on 141 children aged 6 to 10 with good internal consistency (alpha of 0.84). For preschoolers there is a validated observation system from age 3.

FOR PARENTS. Scales orient; they don't diagnose. They are copyrighted and can be downloaded free of charge, with registration, from sensitivityresearch.com. This guide doesn't reproduce their items. If an online quiz promises to tell you in ten questions whether your child "is an HSC", it is none of these scales.

Pluess 2018; Sperati 2024; Costa-López 2022; Lionetti 2019 (Dev Psychol); Sensitivity Research.

Fact sheet 10. What we still don't know

THE FINDING. In 2,375 Japanese adolescents, sensitivity did not moderate the effect of the environment: only additive effects were seen (more internalizing problems and more prosocial behaviour). There are no studies that follow the same children from childhood to adulthood with the same scale.

FOR PARENTS. The science of this trait is young. Many popular ideas (sharper senses, more creativity, more empathy as a group) have not been shown in children. What has been shown fits in these ten fact sheets; the rest, for now, is hypothesis or popularization.

Iimura 2026; Greven 2026.

Myths and facts

Eighteen claims that circulate about sensitive children, each with a verdict. There are four possible verdicts: FALSE when research says the opposite; PARTLY when there is some truth, badly told; NO DATA when nobody has studied it in children; TRUE when it has been confirmed. Many of these claims still appear in popular books and websites.

FALSE 1. "Sensitive children need less sleep."

The recommended hours don't change with temperament: from 1 to 2 years, 11 to 14 hours; from 3 to 5, 10 to 13; from 6 to 12, 9 to 12; from 13 to 18, 8 to 10. If your child sleeps clearly less, that is a reason to see the doctor, not a trait.

Paruthi 2016; WHO 2019.

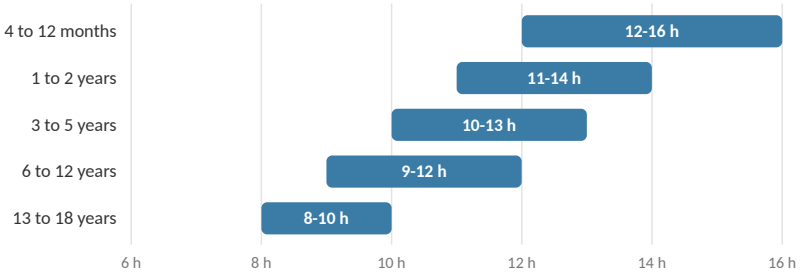


Figure 5. How much sleep a child needs, sensitive or not. Recommended hours of sleep per 24 hours, naps included, according to the American Academy of Sleep Medicine. Temperament doesn't change them. Source: Paruthi 2016.

NO DATA 2. "They have more dopamine and serotonin."

No study has measured neurotransmitters in sensitive children. There are only exploratory studies in adults on variants or methylation of a few genes, and they say nothing about the levels of anything.

Chen 2015; Bellia 2024.

FALSE 3. "The 5-HTTLPR gene is the marker of a sensitive child."

In 405 adults there was no relationship between that variant and sensitivity, and large genetic studies have ruled out the classic candidate genes for complex traits.

Licht 2020; Border 2019.

FALSE 4. "Their vagus nerve is less developed."

No study shows this. The polyvagal theory behind the idea is heavily disputed by current physiology.

Grossman 2023.

NO DATA 5. "Their amygdala is hyperreactive."

The imaging study usually cited was done with 18 adults and showed more activation in the insula and the cingulate, not the amygdala. In adolescents, no measurable physiological differences have been found.

Acevedo 2014; Weyn 2022.

PARTLY **6. "One in five children is highly sensitive."**

The 15-20% figure comes from Elaine Aron. On validated scales, the high group is between 20 and 35%, and it is a continuum with no diagnostic cut-off. The underlying idea (it is common) is true; the exact figure isn't.

Pluess 2018.

PARTLY **7. "They're born this way and it can't be changed."**

The basis is partly genetic (heritability of 47%), but the environment explains the other half and shapes how the trait is expressed. The trait doesn't change; what does change, a great deal, is what the child does with it.

Assary 2021.

FALSE **8. "You can tell from the first weeks that a baby is highly sensitive."**

There is no validated instrument for infants. Validated observation starts at around 3 years and the self-report scale at 8. The "high reactivity" Jerome Kagan measured at 4 months is a different construct and does not predict sensitivity.

Lionetti 2019 (Dev Psychol); Sensitivity Research; Kagan 2018.

FALSE **9. "You should spare them what they find hard."**

Family accommodation (avoiding the situation or making escape easy) is linked to more anxiety. A programme that teaches parents to reduce it (SPACE) was as effective as cognitive behavioural therapy with the child.

Iniesta-Sepúlveda 2021; Lebowitz 2020.

FALSE **10. "Weighted blankets help them sleep."**

In the controlled trial with autistic children they did not improve sleep. In babies they are advised against for safety reasons.

Gringras 2014; Moon 2022.

PARTLY **11. "Their senses are sharper."**

They feel more sensitive, but in adults sensitivity did not improve sensory detection or tactile acuity. One study did find some advantage in detecting degraded words. What changes seems to be not the sense itself but what is done with what comes in.

Gubler 2026; Schaefer 2022; Williams and Blagrove 2024.

FALSE **12. "Being sensitive is the same as being shy or anxious."**

They overlap in part, but the HSC scale is relatively independent of other traits and unrelated to extraversion. There are shy sensitive children and sensitive children who walk into any room.

Lionetti 2019 (J Res Pers); Pluess 2018.

FALSE **13. "If they're sensitive, they can't have ADHD or autism."**

Sensitivity correlates with ADHD traits and, genetically, with autistic traits. They can coexist, and when they do, what is needed is an assessment of the other condition, not the sensitive label.

Panagiotidi 2020; Assary 2024.

FALSE **14. "Hitting a pillow helps let the anger out."**

Venting anger by hitting something increased anger and aggression in the classic experiment. Doing nothing worked better.

Bushman 2002.

FALSE

15. "Sugar makes them hyper."

A meta-analysis of 23 double-blind studies found no effect of sugar on behaviour or cognition. Caffeine, on the other hand, is best avoided.

Wolraich 1995.

FALSE

16. "Mindfulness apps cut anxiety by 30%."

The "Columbia study" that used to be cited doesn't exist. In the largest school trial carried out (8,376 pupils), mindfulness did not outperform usual lessons; compared with an active control, the effect is small.

Kuyken 2022; Dunning 2019.

FALSE

17. "A blue-light filter solves the problem of screens before bed."

Night mode did not improve sleep. What works is switching off and taking the phone out of the bedroom: having access to it at night is linked to sleeping less.

Duraccio 2021; Carter 2016.

FALSE

18. "Sensory processing disorder is an official diagnosis."

It is not in the DSM-5. The American Academy of Pediatrics advises against diagnosing it as a separate condition and considers the evidence for sensory integration therapy limited. Sensory difficulties are real, but they appear within autism, ADHD, anxiety and other conditions.

Zimmer and Desch 2012.

> WATCH OUT FOR THESE
>
> Three more that didn't make the list for lack of space but are worth keeping in mind. "Essential oils calm them": no data in children, and a risk of poisoning (Lee 2020). "Fidget spinners help them concentrate": false in children with ADHD (Graziano 2020). "They are bullied more because they are empathetic": no data; what there is, is evidence that they get more out of anti-bullying programmes (Nocentini 2018).

Sensitivity or something else?

This is the part that settles the most doubts and calls for the most care. The table is not for diagnosing. Its message is a single one: similar is not the same, and if in doubt, ask. In every column of the table there may be strong reactions to sounds or textures; the UK autism guideline lists this as a possible sign, and that doesn't mean every child who is bothered by clothing labels is autistic.

Traits that look alike, and how they differ

What parents see	High sensitivity	Autism	ADHD	Anxiety
Bothered by noises, labels, textures	Common. Usually over-responsiveness, eased by turning the stimulus down	Common. May be over-responsiveness or under-responsiveness (not reacting to pain or noise)	May occur	May occur
Needs routines, finds change hard	Finds sudden changes hard; adapts with warning and time	Rigid insistence on sameness, extreme distress at change, restricted interests	Struggles through disorganization, not a need for sameness	Avoids the new out of anticipatory fear
Little eye contact, plays alone	Not part of the trait. Watches before joining in, but shares and imitates	Reduced eye contact and social gestures, little shared or imaginative play	Not typical	May withdraw with strangers (social anxiety)
Distracted, can't sit still	Distracted in noisy or busy places; regains focus in calm	May occur	Inattention or hyperactivity in two or more settings (home, school, friends), also in calm surroundings	Distracted by worries
Meltdowns and tantrums	After overload or tiredness; predictable	"Meltdowns" with overload or change	Impulsive, out of frustration	In the face of what is feared
Doesn't speak at school	May take a while to take part	Underlying social and communication difficulty	Not typical	Selective mutism or social anxiety: a reason to seek help
Eats very few foods	Rejects some textures	Extreme selectivity	Not typical	May occur. If it affects weight, seek help (avoidant/restrictive food intake disorder)
Avoids social situations	Prefers small groups; enjoys close friends	Difficulty understanding friendship	Conflicts through impulsivity	Persistent avoidance that limits daily life

Sources for the table: NICE CG128 (autism in under-19s, appendix "Features suggesting possible autism"); Ben-Sasson 2009; NICE NG87 (ADHD, rec. 1.3.3); Wolraich 2019; NICE CG159 (social anxiety); Muris 2026 (selective mutism); Zimmer and Desch 2012; Sanchez-Cerezo 2023 (ARFID); Panagiotidi 2020.

THE FACT

What about "sensory processing disorder"? It is at the heart of many websites and quite a few therapies, but it is not a recognized diagnosis (myth 18). What that label describes appears, when it appears, within other

> conditions. If you have been told your child "has SPD", the useful question for the professional is what lies behind it and what assessment has ruled other things out.

Warning signs by age

These are reasons to book an appointment, not diagnoses. They are ordered by the age at which they usually appear; a sign from an earlier age band still counts if it appears later.

From 0 to 2 years

- Constant, inconsolable crying that is different from usual, with fever or refusing feeds: see the doctor. Fits (seizures), a blue or grey colour, floppiness, difficulty breathing, projectile vomiting or no wet nappy for more than 8 hours: emergency services (911 in the US, 999 in the UK). NHS, "Soothing a crying baby".
- By around 9 months doesn't look when called by name; by around 1 year doesn't wave bye-bye. CDC, milestones at 9 and 12 months; Zubler 2022.
- Loss of language or social skills the child already had: urgent referral. NICE CG128, rec. 1.3.1.
- In the US, the American Academy of Pediatrics recommends autism screening at the 18- and 24-month well-child visits, alongside ongoing developmental surveillance; the M-CHAT-R/F is the questionnaire most often used. If you are worried before then, say so: you don't need to wait for a screening visit. In the UK, raise concerns with your health visitor or GP. Hyman 2020; Robins 2014; NICE CG128.

From 3 to 5 years

- Little social eye contact, little imaginative or shared play, plays alone, insists on everything staying the same, extreme reactions to change, extreme food selectivity. NICE CG128.
- Tantrums that are unpredictable, very long or destructive, or daily. 83.7% of preschoolers have tantrums sometimes; what stands out is frequency, duration and having no trigger. Wakschlag 2012.
- Intense separation distress that doesn't ease over the weeks. Lebowitz 2020.
- Regular snoring or mouth breathing during sleep: see the doctor, who will decide whether an ear, nose and throat specialist is needed.

From 6 to 11 years

- Inattention, impulsivity or hyperactivity at home, at school and with friends, also in calm surroundings. NICE NG87.
- Social fear that stops the child going to school, speaking in class or having friends for weeks or months; doesn't speak at school. NICE CG159; Muris 2026.
- Persistent school refusal. What most sets it apart from a bad patch is the anxiety and the learning needs that often lie underneath. Leduc 2024.
- Rituals that eat up time or that the child feels compelled to do ("it has to be exactly like this"), beyond sensory discomfort. NICE CG31.
- Sadness or irritability almost every day for more than two weeks, loss of interest, withdrawal, changes in sleep or appetite. NICE QS48.

From 12 to 18 years

- The signs of depression above, falling behind at school, talking about dying or self-harm: seek help without waiting. In the US, call or text 988; in the UK, Samaritans on 116 123. 911 or 999 if there is immediate risk. NICE QS48; NICE NG225.
- Restricting food, weight loss, vomiting or binge eating. NICE NG69.
- Aversion to change that leads to distress or aggression, little understanding of friendship, gestures and eye contact that don't fit together: possible autism not picked up earlier. NICE CG128.
- Using substances to "cope" with stress or to fit in. Sensitivity doesn't predict more use, but it does predict using for coping reasons. Rioux 2026.

Who to turn to in the US and the UK

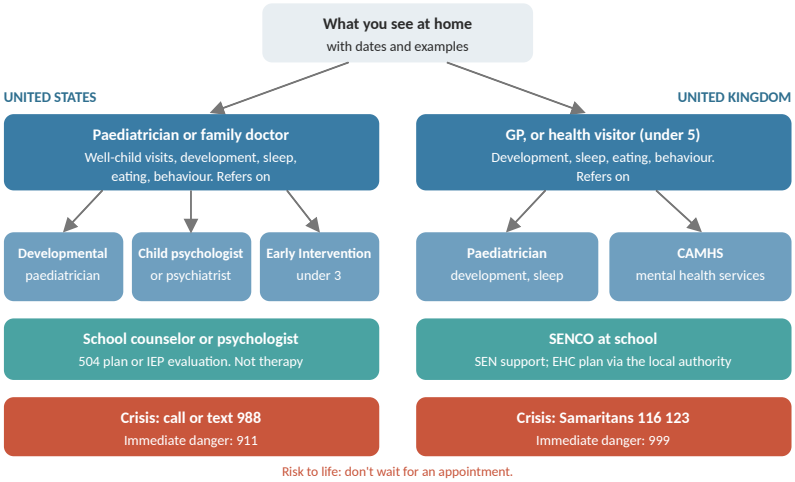


Figure 7. Who to turn to. The first doors in each country and where they refer. Systems vary by state in the US and by nation within the UK. Sources: Hyman 2020; NICE CG128; NICE NG87; 34 CFR 104 and 300; SEND code of practice; 988 Lifeline; Samaritans.

- **United States.** The paediatrician (or family doctor) is the first door for everything above: they follow development at well-child visits and refer on, to a developmental-behavioural paediatrician, a child psychologist or psychiatrist, or, under age 3, to your state's Early Intervention programme. At school, the school counselor or school psychologist can help with school difficulties and evaluations; they are not a substitute for treatment. Hyman 2020; Wolraich 2019.
- **United Kingdom.** The GP, and the health visitor for children under 5, are the first door. They refer to a paediatrician or to children and young people's mental health services (CAMHS); waiting lists are often long. At school, the SENCO coordinates support for special educational needs. NICE CG128; NICE NG87; SEND code of practice.
- **988 Suicide & Crisis Lifeline (US).** Call or text 988, or chat online. 24/7, free and confidential, for the young person and for worried family members.
- **Samaritans (UK and Ireland), 116 123.** 24 hours, free. Young people can also call **Childline on 0800 1111** or text SHOUT to 85258.
- **911 (US) and 999 (UK).** Emergencies with immediate risk to life.

Stage by stage, from 0 to 18

Four stages. For each one: what to expect, what to keep an eye on, and one useful fact that rarely gets mentioned. The full list of warning signs is in part four.

From 0 to 1 year

EXPECT. Crying, especially in the first months: colic affects one baby in five. The baby needs an adult to calm down. Between 12 and 16 hours of sleep from 4 to 12 months, naps included. Differences in reactivity from very early on: around 20% of 4-month-olds show "high reactivity" in Kagan's studies.

WATCH FOR. The warning signs in crying. Not responding to their name by around 9 months. Safe sleep, always. And the parents' mood: postnatal depression also affects around 8.75% of fathers.

WHAT CAN'T BE DONE. Knowing whether the child will be highly sensitive. There is no validated instrument at this age, and Kagan's high reactivity is something else. Mismatches between baby and adult, and their repair, are a normal part of the relationship, not a failure.

AAP HealthyChildren (colic); Paruthi 2016; Kagan and Snidman 1999; Moon 2022; Rao 2020; Tronick 1989.

From 1 to 5 years

EXPECT. Tantrums (83.7% of preschoolers have them sometimes). Shyness or caution with anything new; watching before joining in. Strong preferences about clothes or food. Between 11 and 14 hours of sleep from 1 to 2 years, and between 10 and 13 from 3 to 5. Screens: no sedentary screen time before age 2, and no more than 1 hour a day from 2 to 4, "and less is better". In many children, afternoon cortisol is higher on nursery days than at home.

WATCH FOR. The signs listed for 0 to 2 and 3 to 5 years. Withdrawal that grows when parents are very controlling or overprotective. Separation distress that doesn't ease.

USEFUL FACT. With inhibited preschoolers, six sessions for the parents alone reduced anxiety diagnoses a year later, without trying to change the child's temperament. Sensitivity can already be observed with a validated system at around 3 or 4 years, and in that study it moderated the effect of parenting at ages 3 and 6.

Wakschlag 2012; Rubin 2002; Nystad 2022; Rapee 2005; Lionetti 2019 (Dev Psychol); WHO 2019.

From 6 to 11 years

EXPECT. Tiredness and letting off steam on getting home from school (the popular term "after-school restraint collapse" is not a research finding, but any parent will recognize it). Few, close friendships. Sensitivity to criticism. Between 9 and 12 hours of sleep. Screens: the American Academy of Pediatrics no longer sets a minute count and asks families to look at content, sleep and a family media plan. From age 8 the child can complete the HSC scale themselves.

WATCH FOR. Inattention across settings, social anxiety, school refusal, bullying, persistent sadness.

USEFUL FACT. The more sensitive children who perceive little support from their parents develop less of a sense of a "secure base" and more internalizing problems. And a good classroom climate buffers loneliness in shy or reactive

children: school matters as much as home.

Paruthi 2016; Munzer 2026; Bosmans 2025; Katulis 2023; Gaffney 2021.

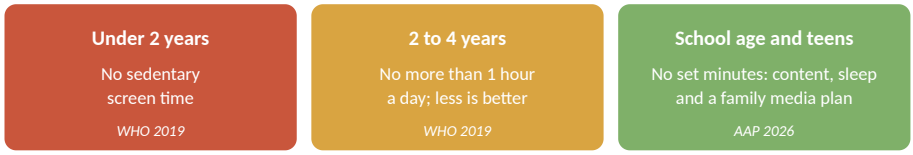
From 12 to 18 years

EXPECT. The World Health Organization places adolescence between 10 and 19 years. More intense emotions, a search for identity, between 8 and 10 hours of sleep with a tendency to go to bed late. Phones out of the bedroom at night: having access to one is linked to sleeping less.

WATCH FOR. Depression, self-harm, eating disorders, substance use. In adolescents, more sensitivity is linked to more internalizing problems and also to more prosocial behaviour: the two sides.

SOCIAL MEDIA. There are no studies on sensitive teenagers and social media. What is known is that its effect varies a great deal from one teenager to another: in a 100-day study, a minority (37%) came out more stressed and the rest did not. Look at your teenager, not at the average.

WHO, "Adolescent health"; Paruthi 2016; Carter 2016; Iimura 2026; Siebers 2026; Beyens 2020; NICE QS48, NG225 and NG69.



In the UK, the RCPCH sets no fixed limits and advises no screens in the hour before bed. The same applies to a sensitive child.

Figure 6. Screens: the references in the US and the UK. Screen-use references by age. Sources: WHO 2019 (under-5s); Munzer 2026 (AAP policy statement); RCPCH 2019.

School in the US and the UK

The first thing to know is that high sensitivity is not, on its own, a disability or a special educational need in either country. That isn't bad news: it means what you can ask for are ordinary, informal adjustments agreed with the teacher, and no paperwork is needed to ask. Formal plans exist for children with a condition that limits their learning; if you suspect anxiety, ADHD, autism or a learning difficulty, that is the route. What follows is an outline, not legal advice: rules and procedures vary by state in the US and by nation within the UK.

United States

- **The classroom teacher** is the first point of contact. A parent-teacher conference early in the year is the natural place to share what helps. The **school counselor** and the **school psychologist** can join when there are difficulties.
- **A Section 504 plan** sets out accommodations for a student with "a physical or mental impairment which substantially limits one or more major life activities"; learning is one of them. The trait alone doesn't meet that definition; a diagnosed anxiety disorder or ADHD that limits learning may. 34 CFR 104.3(j); OCR 2016.
- **An IEP** (individualized education program, under the IDEA) is for a child who has one of the disability categories in the regulations (such as autism, emotional disturbance, other health impairment or a specific learning disability) and who, by reason of it, needs special education and related services. It sets out present levels of performance, measurable annual goals, how progress will be measured, the services and supports, and accommodations in assessments. 34 CFR 300.8; 34 CFR 300.320.
- **Asking for an evaluation.** Put the request in writing to the school, keep a copy and note the date. Each state has a federally funded Parent Training and Information Center that can explain the local process (parentcenterhub.org).
- **Bullying.** All 50 states have anti-bullying laws, and there is no specific federal anti-bullying law. Ask for your district's policy and for how incidents are reported. StopBullying.gov.

United Kingdom

- **The class teacher** is the first point of contact, and the **SENCO** (special educational needs coordinator) coordinates support in the school. The system below is England's; Scotland, Wales and Northern Ireland have their own.
- **SEN support** is what the school itself puts in place for a child with special educational needs. It does not require a diagnosis. SEND code of practice; GOV.UK.
- **An EHC plan** (education, health and care plan) is for children who need more support than SEN support can provide. Parents can ask the local authority for an assessment; the authority decides within 16 weeks, and a final plan is issued within 20 weeks. GOV.UK, "Extra help - EHC plans".
- **Disability.** Under the Equality Act 2010, disability means an impairment with a "substantial and long-term" adverse effect on normal day-to-day activities. The trait itself is not one. Equality Act 2010, s. 6(1).

- **Bullying.** State schools must have a behaviour policy with measures to prevent all forms of bullying. Ask to see it.
  GOV.UK, "Bullying at school".

In both countries, the practical consequence is the same. Without a recognized need, ask for ordinary adjustments agreed with the teacher: where the child sits, warning before changes, short breaks. If you suspect ADHD, autism, anxiety or a learning difficulty, ask for an evaluation.

> THE ESSENTIALS
>
> You are not going to school to have your child recognized as "an HSC". You are going to describe specific behaviours, suggest two or three adjustments that cost nothing and agree how you'll keep talking. The two tools that follow are made for exactly that. Don't include scale scores and don't use the label as a diagnosis: describe what you see.

Letter to the teacher before the first meeting

A model, not a rigid template. Change whatever you need and cut what doesn't apply. What matters is the order: first what you observe, then what you ask for.

[School]
[Grade or year, and class]
For the attention of [teacher's name]
[Date]

Dear [name],

We are the parents of [child's name], in [grade or year]. We're writing before the first meeting to introduce ourselves and share some information that may help in class. There isn't a problem: we just want to save everyone some time.

At home we notice three things that may also show up in the classroom. [Name] takes a while to join in new activities, and joins in more easily when they know in advance what's going to happen. Very noisy places tire them out sooner than other children, and when they're tired you can tell because [what you see: they go quiet, cry, get angry]. And they take correction better when it's given privately and in a calm tone. [Replace with what you observe in your child: two or three specific behaviours, no labels.]

We'd love to know how you see them in class, at break and at lunchtime, and whether anything stands out to you.

If you agree, we'd like to suggest three adjustments that don't involve extra work: [a seat away from the door or the window], [a short heads-up before changes of activity] and [a short break when you see they're overwhelmed]. We've attached a one-page profile with what helps them and what they find hard.

[If relevant:] If at any point you think it would help for the school counselor or the SENCO to see them, we'd like to know as soon as possible.

Could we talk again in [a month] to see how things are going? You can email us at [email] or call us on [phone].

Thank you for your time.

[Names and signature]
Attached: school profile of the child.

School profile of the child

One page. Fill it in by hand or copy it. It goes with the letter to the teacher and works just as well for the first meeting of the school year.

Basic details	Name: Grade or year: _____ Date: _____ Completed by (mother, father, both):
What they are like, in a few lines	Three words that describe them: What they enjoy:
What helps in the classroom	Preferred seat: Advance warning of changes: Breaks and how to give instructions:
What they find hard	Noise, changes, tests, group work, break time, lunchtime:
Signs they are getting overwhelmed	What you see before a meltdown:
What to do if they are overwhelmed	What works at home, in one or two sentences:
How they take correction	For example, a preference for being corrected privately and in a calm tone:
Strengths	Where they can shine:
Health information	Only if the family wishes to share it (diagnoses, follow-up):
Contact	Phone or email, and the family's preferred channel:

Questions to take to the appointment

Twelve questions for the paediatrician, GP or psychologist. You don't need to ask them all: pick the three or four that match your concern and take them written down. Appointments are short, and what isn't asked doesn't get answered.

1. Is what's happening expected for their age, or is it worth looking into?
2. Is their development (language, play, relationships with other children) on track for their age?
3. Is there anything that suggests ADHD, autism, anxiety or another difficulty, as well as or instead of sensitivity?
4. What should we observe and note down before the next appointment (when it happens, where, how long it lasts)?
5. Does it also happen at school? Would it help for the teacher, the school counselor or the SENCO to give their view?
6. Do they get the sleep they need for their age? Do the snoring or mouth breathing need checking?
7. Is the way they eat affecting their growth or nutrition?
8. When should we come back, and what signs would mean bringing the appointment forward?
9. If a referral is needed, to whom (a developmental paediatrician, child and adolescent mental health services, early intervention), and how long is the usual wait?
10. If it's anxiety, can we access an evidence-based therapy, such as cognitive behavioural therapy with gradual exposure, or a parent programme?
11. What are we doing at home that helps, and what might be keeping the problem going (for example, sparing them everything they find hard)?
12. Are there reliable resources you would recommend (HealthyChildren.org from the American Academy of Pediatrics, the NHS website, guides, parent groups)?

HOW TO PREPARE FOR THE APPOINTMENT

- Bring specific examples with dates: "last Tuesday, after school, she cried for forty minutes", not "she cries a lot".
- If the school has said anything, bring it in writing or noted down.
- Bring the list of medicines and supplements your child takes. Don't give melatonin without asking first: in the United States, reported paediatric ingestions rose by 530% between 2012 and 2021 (Lelak 2022).
- Go together if you can. Combining the mother's and the father's views describes the child better than either one alone (Sperati 2026).
- Write the answers down during the appointment. Half of them are forgotten on the way out.

Verified resources and cross-references

Only resources that exist and that are in the author's verified source bank for this edition. The right-hand column says where each one was checked. Phone lines and services change: check the official website before relying on any of them. All of them will be checked again before the next edition.

Resource	What it is	Where checked
988 Suicide & Crisis Lifeline (US)	Call or text 988, or chat online. 24/7, free and confidential	988lifeline.org, October 2026
Samaritans, 116 123 (UK and Ireland)	Phone line, 24 hours, free	samaritans.org, October 2026
Childline, 0800 1111 (UK)	Free helpline for children and young people, with online chat with a counsellor	childline.org.uk, October 2026
Shout, text SHOUT to 85258 (UK)	Text support, 24/7, free	giveusashout.org, October 2026
911 (US) and 999 (UK)	Emergencies with immediate risk to life	-
HealthyChildren.org	The American Academy of Pediatrics' website for parents: safe sleep, colic, development, the Family Media Plan	healthychildren.org, 2024-2026
NHS website	Health information for families in the UK, including "Soothing a crying baby"	nhs.uk, revised 22-04-2026
Safe to Sleep (NICHD, US) and The Lullaby Trust (UK)	Safe sleep guidance for babies	safetosleep.nichd.nih.gov; lullabytrust.org.uk, 2026
CDC, "Learn the Signs. Act Early."	Developmental milestones by age, with checklists for parents	cdc.gov; Zubler 2022
StopBullying.gov (US) and GOV.UK, "Bullying at school" (UK)	What the law requires of schools on bullying	stopbullying.gov; gov.uk, 2026
Section 504 and IDEA (US)	OCR "Parent and Educator Resource Guide to Section 504" (2016); IDEA regulations at ecfr.gov; Parent Centers at parentcenterhub.org	ecfr.gov; parentcenterhub.org, 2026
SEND code of practice and EHC plans (England)	Statutory guidance for SEN support and EHC plans, and the GOV.UK page for parents	gov.uk, updated 24-09-2026
Sensitivity Research	Website of Michael Pluess's research group. HSC scales, free with registration and under copyright	sensitivityresearch.com, October 2026
Child Mind Institute	Resources on ADHD, anxiety, autism and school refusal. Does not cover high sensitivity	childmind.org, October 2026
SPACE	Parent-based programme for child anxiety; information and trained therapists. In the UK, mostly private or in NHS pilots	spacetreatment.net, October 2026
Lebowitz, E. R. (2021). "Breaking Free of Child Anxiety and OCD". Oxford University Press	Book for parents based on the SPACE programme	Publisher's catalogue, October 2026

Resource	What it is	Where checked
Aron, E. N. (2002). "The Highly Sensitive Child". Broadway Books	The work where the concept began. Popular writing, not evidence	Publisher's catalogue, October 2026

Where it is explained and where it is practised

This guide and "Sensitive Kids from the Start" explain. "Sensitive Kids Aren't Fragile", the practical companion book for ages 4 to 12, trains. The table shows, topic by topic, where to find what. A dash in the last column means there is no obvious match in the practical book.

Topic	Where in this guide	Practised in "Sensitive Kids Aren't Fragile"
What high sensitivity is	Part one; fact sheets 1 and 6	-
How many, heredity and the science	Fact sheets 2, 3, 8, 9 and 10	-
For better and for worse: the weight of parenting	Fact sheets 4 and 5	-
Telling it apart from autism, ADHD and anxiety	Part four	-
When to seek help and warning signs	Parts four and seven	-
Sensory overload	Fact sheet 6; myths 10 and 18	Yes: overload and the "tank"
Intense emotions and meltdowns	Myth 14; table in part four	Yes: calming tools such as balloon breathing
Routines and transitions	Part five	Yes
Fears, separations and gradual exposure	Myth 9; part five	Yes: the bravery ladder
Sleep	Myths 1, 10 and 17; part five	-
Babies: safe sleep and crying	Part four; part five (0 to 1 year)	-
School and working with the teacher	Part six	Yes: the one-page brief and the model letter
Bullying	Parts six and eight	-
Screens and social media	Myth 17; part five	-
Communication and correction	Fact sheet 4	Yes: daily talk time
Sensitive parents and self-care	Part one	-
Adolescence	Part five (12 to 18 years)	-

How far this guide goes

This guide is reference material. It doesn't assess your child, it doesn't diagnose them and it doesn't replace anyone. What it does is put in front of you what is known today, with its source, so that the conversation with the paediatrician, the psychologist or the teacher starts from higher ground.

There is one way of using this guide worth avoiding: reading the table in part four, finding two matches and deciding that your child has a certain condition, or that they don't. Both decisions belong to the professional. Yours is to book the appointment.

WHEN TO SEEK HELP WITHOUT WAITING

- They lose language or social skills they already had.
- Sadness or irritability almost every day for more than two weeks, or they talk about dying. In the US, 988; in the UK, Samaritans on 116 123; 911 or 999 if there is immediate risk.
- They stop going to school, or stop speaking there, for weeks.
- They restrict food, lose weight, vomit or binge.
- Tantrums are daily, very long or destructive, or separation distress doesn't ease over the weeks.
- They sleep clearly less than is right for their age, or snore regularly.

And one last thing. The man in the story didn't find his axe by watching the neighbour: he found it by digging where he had left it. Almost everything you need to know about your child is in what they do, when and where. Looking at that, calmly and with dates, is what best prepares you for any appointment. And it is also, though it may not seem so, what reassures most.

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