Teacher Knowledge Update

2015 version

teen mental health .org

Here's what we know about mental disorders:

- Disturbances of emotion, thinking, and/or behaviour
- May occur spontaneously (without a precipitant)
- Severe (problematic to the individual and others)
- Lead to functional impairment (interpersonal, social)
- Prolonged
- Often require professional intervention
- Derive from brain dysfunctions – brain disorder
- Is rarely, if ever, caused by stress alone

Mental disorders are NOT:

- It is not the consequence of poor parenting or bad behaviour
- It is not the result of personal weakness or deficits in personality
- It is not the manifestation of malevolent spiritual intent
- Only in exceptional cases is it caused by nutritional factors
- It is not caused by poverty

How is the Brain Involved?

- The brain is made up of: cells, connections amongst the cells and various neurochemicals
- The neurochemicals provide a means for the different parts of the brain to communicate
- Different parts of the brain are primarily responsible for doing different things (e.g. movement)
- Most things a brain does depends on many different parts of the brain working together in a network

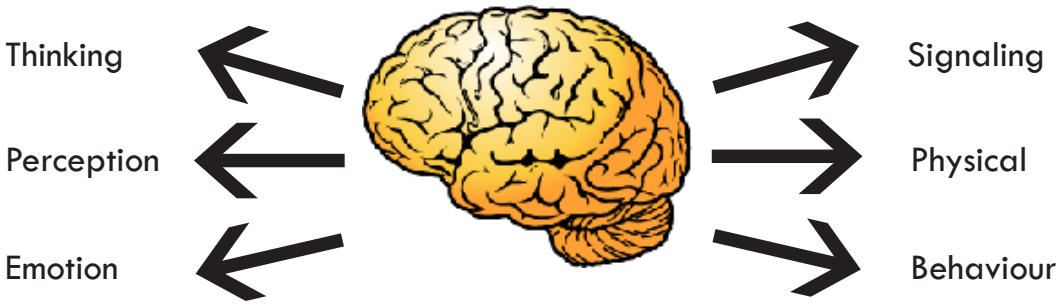
WHAT HAPPENS INSIDE THE BRAIN WHEN IT GETS SICK?

- A specific part of the brain that needs to be working on a specific task is not working well
- A specific part of the brain that needs to be working on a specific task is working in the wrong way
- The neurochemical messengers that help different parts of the brain communicate are not working properly

HOW DOES THE BRAIN SHOW IT'S NOT WORKING WELL?

- If the brain is not working properly, one or more of its functions will be disturbed
- Disturbed functions that a person directly experiences (such as sadness, sleep problems, etc.) are called SYMPTOMS
- Disturbed functions that another person sees (such as over activity, withdrawal, etc.) are called SIGNS
- BOTH signs and symptoms can be used to determine if the brain may not be working well
- The person's usual life or degree of functioning is also disrupted because of the signs and symptoms

Mental disorders are associated with disturbances in six primary domains of brain function:



When the brain is not functioning properly in one or more of its six domains, and the person experiences problems that interfere with his or her life in a significant way - they may have a mental disorder.

BUT...

Not all disturbances of brain functioning are mental disorders. Some can be a normal or expected response to the environment – for example: grief when somebody dies or acute worry, sleep problems and emotional tension when faced with a natural disaster such as a hurricane.

What's the Difference Between Mental Distress and Mental Disorders?

Distress:
Common; caused by a problem or event; usually not severe (may be severe); usually short lasting; professional help not usually needed; professional help can be useful;
DIAGNOSIS NOT NEEDED.

VS.

Disorders:
Less common; may happen without any stress; often with high severity; usually long lasting; professional help usually needed;
NEEDS TO BE DIAGNOSED.

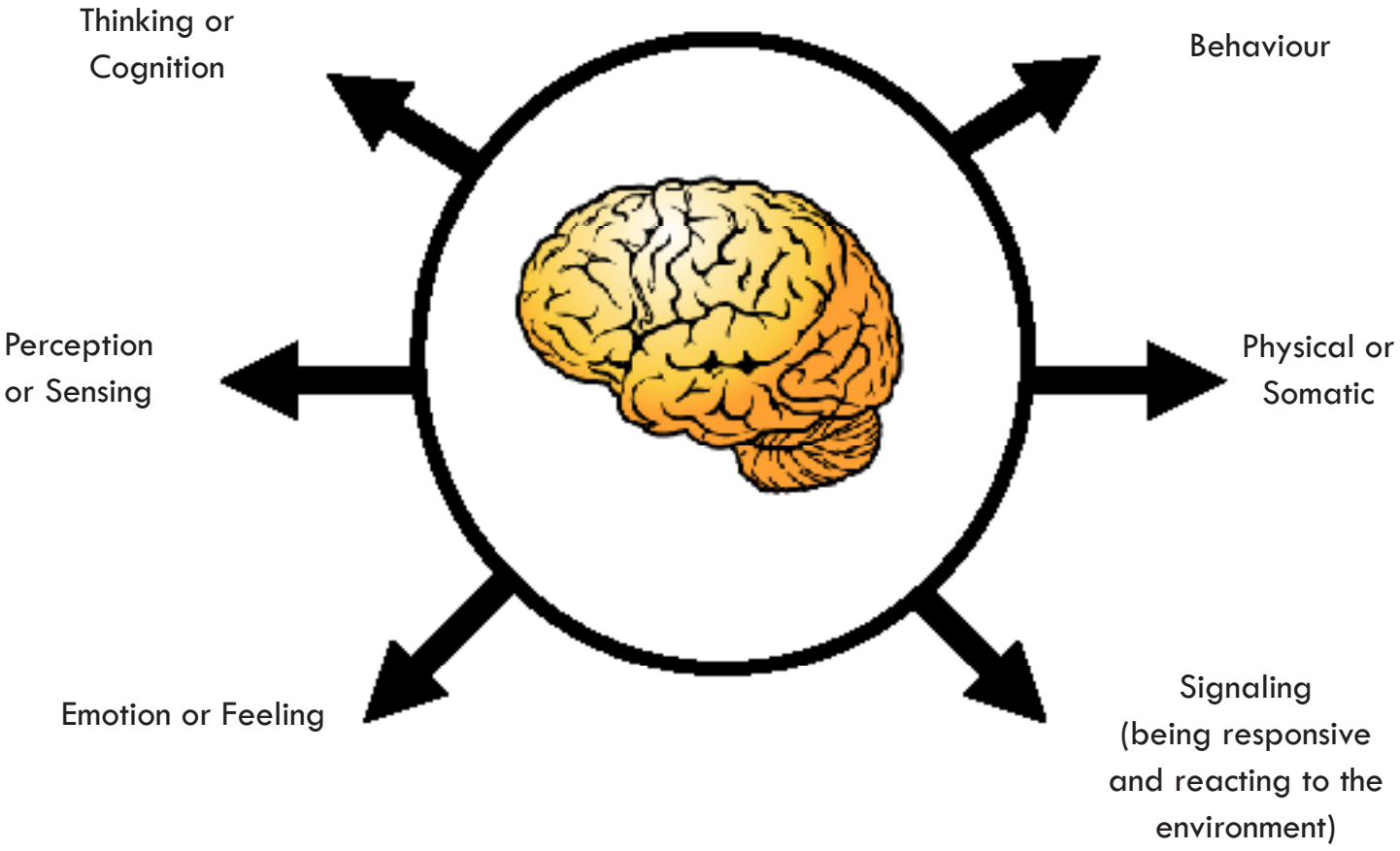
What Causes Mental Illness?

A variety of different influences to the brain can lead to mental illness. Basically there are TWO major causes that can be independent or can interact:

GENETICS (the effect of genes on brain development and brain function) and

ENVIRONMENT (the effect of things outside the brain on the brain – such as infection, malnutrition, severe stress, etc.)

Classification of Mental Disorders:



Mental Disorders of Thinking & Cognition: (Psychotic disorders)

WHAT ARE PSYCHOTIC DISORDERS?

Psychotic disorders are a group of illnesses characterized by severe disturbances in the capacity to distinguish between what is real and what is not real. The person with psychosis exhibits major problems in thinking and behaviour. These include symptoms such as delusions and hallucinations. These result in many impairments that significantly interfere *with the capacity to meet ordinary demands of life. Schizophrenia is an example of a psychotic disorder that affects about 1% of the population.*

Who is at risk for developing Schizophrenia?

Schizophrenia (SCZ) often begins in adolescence and there often may be a genetic component although not always. A family history of SCZ, a history of birth trauma and a history of fetal damage in utero increases the risk for SCZ. Significant marijuana use may bring on SCZ in young people who are at higher risk for the illness.

What does Schizophrenia look like?

Delusions are erroneous beliefs that may involve misinterpretation of experiences or perceptions. One common type of delusion is persecutory (also commonly called paranoid) in which the person thinks that he or she is being harmed in some way by another person, force or entity (such as God, the police, spirits, etc.). Strongly held minority religious or cultural beliefs are not delusions.

Hallucinations are perceptions (such as hearing sounds or voices, smelling scents, etc.) that may occur in any sensory modality in the absence of an actual sensory stimulus. They can be normal during times of extreme stress or in sleep like states. Occasionally they can occur spontaneously (such as a person hearing their name called out loud) but these do not cause problems with everyday life and are not persistent.

Thinking is disorganized in form and in content. For example, the pattern of speaking may not make sense to others or what is being said may not make sense or be an expression of delusional ideas.

Behaviour can be disturbed. This can range from behaviours that are mildly socially inappropriate to very disruptive and even threatening behaviours that may be responses to hallucinations or part of a delusion. Self-grooming and self-care may be also compromised.

A young person with Schizophrenia will also demonstrate a variety of cognitive problems ranging from difficulties with concentration to "higher order" difficulties such as with abstract reasoning and problem-solving. Most people with Schizophrenia will also exhibit what are called "negative symptoms" which include: flattening of mood, decreased speech, and lack of will.

A person with Schizophrenia may exhibit delusions, hallucinations and disordered thinking (also called "positive symptoms") as well as negative symptoms at different times during the illness.

What are the criteria for the diagnosis of Schizophrenia?

1 – Positive symptoms as described above (delusions, hallucinations, disorganized thinking)
2 – Negative symptoms as described above
3 – Behavioural disturbances as described above
4 – Significant dysfunction in one or more areas of daily life (social, family, interpersonal, school/work, etc.)
5 – These features must last for at least 6 months during which time there must be at least one month of positive symptoms

What can I do if it is SCZ?

A young person with SCZ will require immediate effective treatment – usually in a specialty mental health program (first onset psychosis program). If an educator suspects SCZ a referral to the most appropriate health provider should be made following discussion with the parents about the concerns.

What do I need to watch out for?

Many young people with SCZ will demonstrate a slow and gradual onset of the illness – often over the period of 6 – 9 months or more. Early signs include: social withdrawal, odd behaviours, lack of attention to personal hygiene, excessive preoccupation with religious or philosophical constructs, etc. Occasionally the young person suffering in the prodrome may exhibit very unusual behaviours – often in response to a delusion or hallucinations. Sometimes it may be difficult to distinguish the onset of SCZ (also called a "prodrome") from other mental disorders – such as Depression or Social Anxiety Disorder. Young people suffering from the prodrome of SCZ may also begin abusing substances – particularly alcohol or marijuana and develop a substance abuse disorder concurrently. Occasionally the young person may share bizarre ideas or may complain about being persecuted by others or may appear to be responding to internal voices. Rarely these delusions or hallucinations may be accompanied by unexpected violent acts.

Questions to ask:

Can you tell me what you are concerned about? Do you feel comfortable in school (your class)? Are you having any problems thinking? Are you hearing or seeing things that others may not be hearing or seeing?

Mental Disorders of Emotion and Feeling: (Mood disorders)

There are two types of mood disorders which include unipolar mood disorders and bipolar mood disorders. Unipolar disorder is major depression, whereas Bipolar Disorder is when a person experiences cycles of Depression and Mania.

DEPRESSION

Not to be confused with the word "depression" which is commonly used to describe emotional distress or sadness, Depression means CLINICAL DEPRESSION, which is a mental disorder.

What are the different types of Depression?

There are two common kinds of clinical depression, Major Depressive Disorder (MDD) and Dysthymic Disorder (DD). Both can significantly and negatively impact on people's lives. They can lead to social, personal and family difficulties as well as poor vocational/educational performance and even premature death due to suicide. Additionally, patients with other illnesses such as heart disease and diabetes have an increased risk of death if they are also diagnosed with Depression. This is thought to be due to the physiological effects that Depression has on your body as well as lifestyle effects such as poor self-care, increased smoking and alcohol consumption. Individuals with clinical depression usually require treatment from health professionals but in mild cases may experience substantial improvement with strong social supports and personal counseling.

What do MDD and DD look like?

MDD is usually a life-long disorder beginning in adolescence or early adulthood and is characterized by periods (lasting months to years) of depressive episodes that are usually self-limiting. The episodes may be separated by periods (lasting months to years) of relative mood stability. Sometimes the depressive episodes may be triggered by a negative event (such as the loss of a loved one, severe and persistent stress such as economic difficulties or conflict) but often the episodes may occur spontaneously. Often there is a family history of Clinical Depression, Alcoholism, Anxiety Disorder or Bipolar Disorder. DD is a low-grade depression that lasts for many years. It is less common than MDD.

What is a depressive episode?

A depressive episode is characterized by three symptom clusters: 1.mood 2.thinking (often called cognitive) and 3.body sensations (often called somatic). MDD may present differently in different cultures, particularly in the somatic problems that people present with. Some symptoms include:

- Must be severe enough to cause functional impairment (stop the person from doing what he or she would otherwise be doing, or decrease the quality of what he/she is doing)
- Must be continuously present every day, most of the day for at least two weeks
- Cannot be due to a substance or medicine or medical illness and must be different from the persons usual state

These symptoms are:

Mood:

- Feeling "depressed", "sad", "unhappy" (or whatever the cultural equivalent of these descriptors is)
- Feeling a loss of pleasure or a marked disinterest in all or almost all activities
- Feelings of worthlessness, hopelessness or excessive and inappropriate guilt

Thinking:

- Diminished ability to think or concentrate or substantial indecisiveness
- Suicidal thoughts/plans or preoccupation with death and dying

Body Sensations:

- Excessive fatigue or loss of energy
- Significant sleep problems (difficulty falling asleep or sleeping excessively)
- Physical slowness or in some cases excessive restlessness
- Significant decrease in appetite that may lead to noticeable weight loss

Criteria:

FIVE of the above symptoms must be present EVERYDAY for MOST OF THE DAY during the same two week period; ONE of the FIVE symptoms MUST BE either depressed mood or loss of interest or pleasure.

Things to look for:

People with depression are at an increased risk for attempting suicide. Every person with depression should be monitored for suicide thoughts and plans. As a teacher you need to be aware that a depressed student who begins to talk about suicide needs to be referred to his/her health provider immediately.

What can I do if it is Depression?

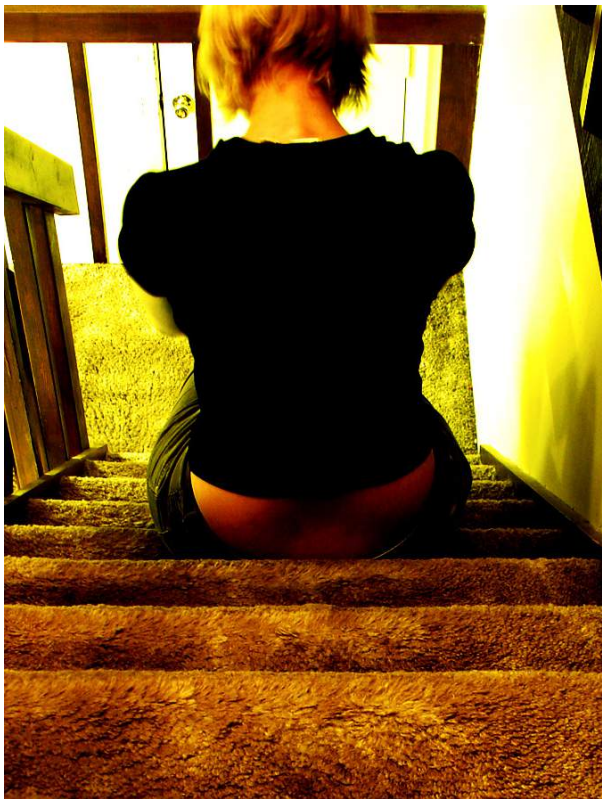
You can identify the disorder and counsel the person with the disorder (including education of the person and family) if it is mild and if you are trained in counseling. If the disorder is more intense or the person is suicidal you should immediately refer the person to the health professional best suited to treat the depression. Ideally this should be done in collaboration and with the active support of the school guidance counselor or identified school based mental health provider. Once an intervention occurs and the young person is back at school it is important that you be part of the ongoing treatment team and help develop and address learning needs. You may also need to continue to provide realistic emotional support.

Questions to ask:

Have you lost interest or pleasure in the things that you usually like to do? Have you felt sad, low, down or hopeless? Are you feeling like ending it all? IF the student answers yes to either of these, further assessment of all of the symptoms should be directed to the appropriate health care sector.

BIPOLAR DISORDER

- Illness is characterized by cycles (episodes) of depression and mania
- Cycles can be frequent (daily) or infrequent (many years apart)
- During depressive or manic episodes the person may become psychotic
- Suicide rates are high in people with bipolar mood disorder



In Bipolar Disorder how is 'mania' different from feeling extremely happy?

- Mood is mostly elevated or irritable
- Many behavioural, physical and thinking, problems
- Significant problems in daily life because of the mood
- Mood may often not reflect the reality of the environment
- Is not caused by a life problem or life event

Bipolar Disorder - what to look for:

- History of at least one depressive episode and at least one manic episode
- Rapid mood changes including irritability and anger outbursts
- Self-destructive or self-harmful behaviours – including: spending sprees, violence towards others, sexual indiscretions, etc.
- Drug or alcohol overuse, misuse or abuse
- Psychotic symptoms including: hallucinations and delusions

Mental Disorder of Signaling: (The Anxiety Disorders)

WHAT IS GENERALIZED ANXIETY DISORDER?

GAD is described as excessive anxiety and worry occurring for an extended period of time about several different things. This persistent apprehension, worry and anxiety causes distress and leads to physical symptoms.

Who is at risk for developing GAD?

GAD often begins in childhood or adolescence and there is also a genetic or familial component. Once GAD is present, the severity can fluctuate and exacerbations often occur during times of stress. Other psychiatric disorders are also risk factors for GAD such as depression, panic disorder and agoraphobia.

What does Generalized Anxiety Disorder look like?

Generalized Anxiety Disorder (GAD) is characterized by excessive anxiety and worry about many different things. The worry is out of proportion to the concern or event. This anxiety and worry must be noticeably greater than the usual socio-cultural norms. Youth with GAD often do not present with panic attacks as in panic disorder. Often they present with physical complaints such as headaches, fatigue, muscle aches and upset stomach. These symptoms tend to be chronic and young people may miss school or social activities because of these physical symptoms.

How do you differentiate GAD from normal worrying?

Anxiety can be broken into four categories:

1) ***Emotions*** – i.e. feeling fearful, worried, tense or on guard.
2) ***Body Responses*** – anxiety can cause many different responses of the body including increased heart rate, sweating, and shakiness, shortness of breath, muscle tension and stomach upset.
3) ***Thoughts*** – when experiencing anxiety, people are more likely to think about things related to real or potential sources of danger and may have difficulty concentrating on anything else. An example is thinking something bad is going to happen to a loved one.
4) ***Behaviours*** – people may engage in activities that can potentially eliminate the source of the danger. Examples include avoiding feared situations, people or places and self-medicating with drugs or

alcohol.

When does anxiety become a disorder?

These physical, emotional and behavioural responses to perceived danger are normal reactions that we experience everyday. Many times this 'anxiety response' is automatic, and every creature has these automatic responses as a way of protecting themselves from danger. However, anxiety becomes a problem when:

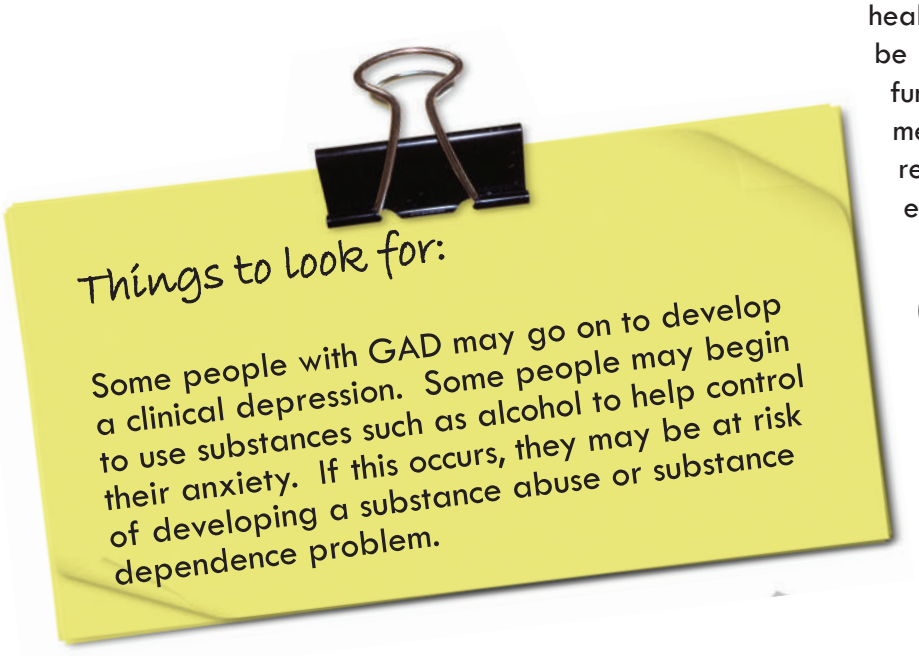
- It is greater intensity and/or duration then typically expected given the context
- It leads to impairment or disability in work, school or social environments
- It leads to avoidance of daily activities in an attempt to lessen the anxiety

What are the criteria for the diagnosis of GAD?

1. Excessive anxiety and worry occurring for at least 6 months about several things
2. Difficulty controlling the worry
3. The anxiety and worry are associated with 3 or more of the following:
    a. Restlessness or feeling on edge, fatigued, difficulty concentrating, muscle tension or sleep disturbance
4. Anxiety and worry are not due to substance abuse, a medical condition or a mental disorder
5. The anxiety and physical symptoms cause marked distress and significant impairment in daily functioning

What can I do if it is Generalized Anxiety Disorder?

The first thing is to identify the problem for the young person and elicit assistance from a helper knowledgeable about the problem. Some people with GAD will experience improvements in their anxiety and functioning with supportive cognitive-based counseling. Others may require medication. Referral to an appropriate health professional for medical attention could be considered if the GAD is severe and if the functional impairment is extensive. For some, merely knowing that they have GAD and receiving supportive counseling may be helpful enough.



Questions to ask?

Can you tell me about your worries? Do you or others see you as someone who worries much more than he/she should? Do you or others consider you to be someone who worries much more than most people do? Do you have trouble "letting go of the worries"? Do you sometimes feel sick with worry – in what way? What things that you enjoy doing or would like to do are made less enjoyable or are avoided because of the worries? What if anything do you find makes the worries better – is this for a short or a long time?

SOCIAL PHOBIA

What is Social Phobia?

Social Phobia, also known as Social Anxiety Disorder, is characterized by the presence of an intense fear of scrutiny by others, which may result in embarrassment or humiliation.

What does Social Phobia look like?

Young people with social phobia fear doing something humiliating in front of others, or of offending others. They fear that others will judge everything they do in a negative way. They believe they may be considered to be flawed or worthless if any sign of poor performance is detected. They may cope by trying to do everything perfectly, limiting what they are doing in front of others and gradually withdraw from contact with others. Youth with Social Phobia often experience panic symptoms in social situations. As a result they tend to avoid social situations such as parties or school events. Some may have a difficult time attending class or may avoid going to school altogether. Although young people with Social Phobia recognize that their fears are excessive and irrational, they are unable to control it and therefore avoid situations that trigger their anxiety. The presentation of Social Phobia may vary across cultures and although it may occur in children it usually onsets in the adolescent years. It must not be confused with "shyness" and the strength of the fears may wax and wane over time.

What are the criteria for diagnosis of Social Phobia?

The following must be present for someone to have Social Phobia:

- Marked and persistent fear of social or performance situations in which the person is exposed to unfamiliar people; fear of embarrassment or humiliation
- Exposure to the feared situation almost always provokes marked anxiety or panic
- The person recognizes that the fear is excessive or inappropriate
- The avoidance or fear causes significant impairment in functioning and distress
- The feared social or performance situations are avoided or else endured with intense anxiety or distress
- The symptoms are not due to a substance, medicine or general medical condition

In children, Social Phobia may be expressed by crying, tantrums, and a variety of clingy behaviours. Other psychiatric diagnoses that Social Phobia must be differentiated from include: Panic Disorder, Pervasive Developmental Disorder, and Schizoid Personality Disorder.

What can I do if it is Social Phobia?

The first step is the identification of the problem. Often, people with Social Phobia will have suffered for many years without knowing the reason for their difficulties. Sometimes just informing and educating them about the problem can be helpful, particularly in mild cases. Treatment is not indicated unless the problem is causing significant functional impairment but counseling using cognitive behavioural techniques and exposure to the anxiety-provoking situation in the company of a counselor may help the person better deal with their difficulties. If the disorder is severe,

referral to an appropriate healthcare provider is indicated, and the counselor can provide ongoing support. A teacher may be able to assist in behaviour modification programs (such as getting used to a classroom situation). If you think a student may have Social Phobia it is important not to draw attention publically to their difficulties but speak with them in private about what you notice – be supportive.

What do I need to watch out for?

Some young people with Social Phobia will use excessive amounts of alcohol to help decrease their anxiety in social situations. In some cases, Social Phobia can be a risk factor for the abuse of alcohol or other substances. In young children it is important to differentiate Social Phobia from Pervasive Developmental Disorders such as Autism. Children with autism, in contrast to children with Social Phobia, will not demonstrate age-appropriate social relationships with family members or other familiar people.

Questions to ask

Do situations that are new or associated with unfamiliar people cause you to feel anxious, distressed or panicky? When you are in unfamiliar social situations are you afraid of feeling embarrassed? What kinds of situations cause you to feel that way? Do those feelings of embarrassment, anxiety, distress or panic stop you from doing things you would otherwise do? What have you not been able to do as well as you would like to do because of those difficulties?

WHAT IS PANIC DISORDER?

Panic Disorder is characterized by recurrent, unexpected, anxiety (panic) attacks that involve triggering a number of frightening physical reactions. The frequency and severity of panic attacks can vary greatly and can lead to agoraphobia (fear of being in places in which escape is difficult).

Who is at risk for developing Panic Disorder?

The onset of Panic Disorder is commonly between the ages of 15-25. People who have first-degree relatives with Panic Disorder have an 8x higher risk of also developing Panic Disorder themselves. Panic Disorder is associated with an area of the brain that regulates alertness. Disturbance in this area of the brain is one explanation for why panic attacks occur.

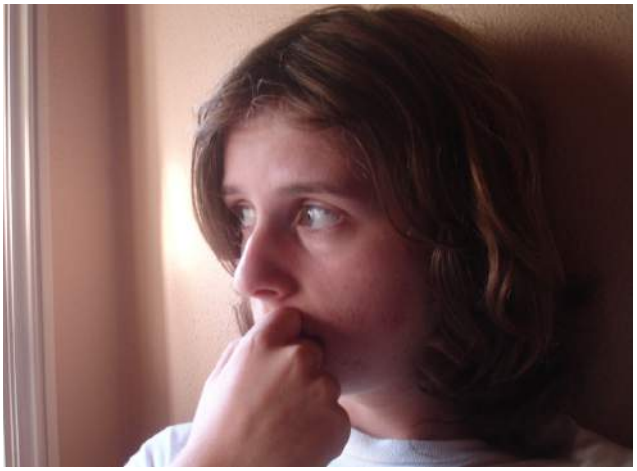
What does Panic Disorder look like?

Young people with Panic Disorder experience recurrent, unexpected panic attacks and they greatly fear having another attack. They persistently worry about having another attack as well as the consequences of having a panic attack. Some may fear they are 'losing their mind' or feel they are going to die. Often they will change their behaviour to avoid places or situations that they fear might trigger a panic attack. In time, the person may come to avoid so many situations that they become bound to their home.

What are the components of a panic attack?

The person has four of more of the following symptoms which peak within 10 minutes:

1. Palpitations, pounding heart or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensations of shortness of breath or smothering
5. Feeling of choking



6. Chest pain or discomfort
7. Nausea or abdominal pain
8. Feeling dizzy, unsteady, lightheaded or faint
9. Feeling of unreality or being detached from oneself
10. Fear of losing control or going crazy
11. Fear of dying
12. Numbness or tingling in the body
13. Chills or hot flashes

What are the criteria for Panic Disorder?

Assessing Panic Disorder involves evaluating 5 areas:

1. Panic attacks
2. Anticipatory anxiety
3. Panic related phobic avoidance
4. Overall illness severity
5. Psychosocial disability

For a diagnosis of Panic Disorder, a patient must have:

1. Recurrent unexpected panic attacks
2. One or more of the attacks has been followed by ≥1 month of:
   - Persistent concern of having additional attacks
   - Worry about the implications of the attack or its consequences
   - A significant change in behaviour as a result of the attacks
3. Can be ± agoraphobia
4. Panic attacks are not due to substance abuse, medications or a general medical condition
5. Panic attacks are not better accounted for by another mental disorder

Things to look for:

Youth with panic disorder are at a high risk for developing depression. If the person appears sad or hopeless and has suicidal thoughts, a diagnosis of depression must also be suspected. Some young people with panic disorder may also develop substance abuse (particularly alcohol) and counseling around these issues is very important.

What can I do if it is a Panic Attack?

The first thing is to identify the panic attack and provide a calm and supportive environment until the attack passes. Education about panic attacks and panic disorder is often very helpful and should ideally be provided by a professional with good knowledge in this area.

Counseling using cognitive behavioural methods may be of help and medications can be used as well. The teacher's role in helping a young person suffering from a panic disorder can also involve assisting them in dealing with their anxieties about having another attack and also helping them with strategies to combat avoidance of social situations. Therefore it is a good idea for a teacher to be part of the treatment planning and treatment monitoring for a youth with panic disorder.

Questions to ask?

Can you describe in your own words what happens when you have one of these episodes (some people will refer to them as "spells")? How many of these episodes have you had in the last week? In the last month? What do these episodes mean to you? What do these episodes stop you from doing that you would otherwise usually do? What do you do when these episodes occur? Do you ever feel that you would like to be dead or think that your problem is so great that you should kill yourself? How do your family, friends, loved ones, etc. react to these episodes? What do they say is the problem?

OBSESSIVE COMPULSIVE DISORDER

Obsessive Compulsive Disorder (OCD) is an anxiety disorder characterized by obsessions and/or compulsions. Obsessions are persistent, intrusive, unwanted thoughts, images or impulses that the person recognizes as irrational, senseless, intrusive or inappropriate but is unable to control. Compulsions are repetitive behaviours, which the person performs in order to reduce anxiety associated with an obsession. Examples of these are counting, touching, washing and checking. Both can be of such intensity that they cause a great deal of distress and significantly interfere with the person's daily functioning. Obsessions are different from psychotic thoughts because the person knows that they are their own thoughts (not put inside their head by some external force) and the person does not want to have the thoughts. Compulsions are different from psychotic behaviours because the person knows why he/she is doing the activity and can usually say why they are doing them.

Who is at risk for developing OCD?

OCD often begins in adolescence or early adulthood, although it can start in childhood. It is quite common and affects both men and women. First-degree relatives of people with OCD are more likely to develop OCD. It is important to note that people with OCD are at a higher risk for developing depression and other anxiety disorders.

What does OCD look like?

OCD should not be confused with superstitions or those repetitive checking behaviours that are common in everyday life. They are not simply excessive worries about real life issues. A person with OCD will have significant symptoms of either obsessions or compulsions or both. These symptoms will be severe enough to cause marked distress, are time consuming (take up more than one hour per day) and significantly interfere with a person's normal activities (work, school, social, family, etc.).

Obsessions:

- Recurrent and persistent thoughts, impulses or images that are experienced as intrusive and not appropriate and cause significant distress or anxiety
- These symptoms cannot be simply excessive worries about everyday life
- The person with these symptoms tries to suppress or ignore them. The person may try to neutralize, decrease or suppress the thoughts with some other thought or action.
- The person knows that the thoughts are coming from his/her own mind

Compulsions:

- Repetitive behaviours (such as checking, washing, ordering) or mental acts (such as counting, praying, repeating words silently) that the person feels driven to perform in response to an obsession or according to rigid rules
- These behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation BUT are not realistically connected to the obsessions they are meant to neutralize

How do you differentiate between OCD and Psychosis?

This is a very important step to take if you suspect someone has OCD. In general, patients with OCD have insight into the senselessness of their thoughts and actions and often try to hide their symptoms. This distinguishes OCD from psychotic disorders such as Schizophrenia because those patients lack any insight into the senseless nature of their symptoms.

What can I do if it is OCD?

You can educate the student about OCD and how it is treated. If the symptoms are associated with impairment

Things to look for:

There are two main things to watch out for. The first is the possibility that the symptoms could be part of a psychosis. Therefore it is very important to rule out a psychosis disorder. The second thing to watch for is the effect OCD has on the young person's classmates. Sometimes students with severe OCD will try to involve their classmates (or their teachers) in their compulsions. If this happens then it can cause significant problems at school. Educating yourself about OCD and the importance of not participating in the OCD rituals important.

(social or academic) you should send the student to the school guidance or health professional who can then refer the person to the professional best suited to provide treatment and you can continue to provide education and support to the student if that is mutually agreed to. Often young people will be treated with cognitive behavioural therapy (CBT). Sometimes this may require a teacher's input. It is important to know if any academic modifications need to be made to enhance learning opportunities for young people with OCD so including the teacher in treatment planning and treatment monitoring is usually necessary.

Questions to ask:

Are you having thoughts that are coming into your mind that you do not want to be there? Can you tell me what those thought are? Do those thoughts cause you to feel uncomfortable or anxious or upset? Do you think that those thoughts are true? Where do you think those thoughts are coming from? How are you trying to deal with or stop the thoughts from coming? What do the thoughts stop you from doing that you would otherwise be doing? How much of the time are those thoughts on your mind?

Please describe the things that you are doing that are causing distress to you or other people. Can you tell me why you are doing those things? What do you think will happen if you do not do those things? What do those things that you are doing stop you from doing that you would otherwise be doing? How much time do you spend doing those rituals?

WHAT IS POST TRAUMATIC STRESS DISORDER?

Post Traumatic Stress disorder (PTSD) develops after a trauma occurs that was either experienced or witnessed by the young person. It involves the development of psychological reactions related to the experience such as recurrent, intrusive and distressing recollections of the event. These may be in the form of nightmares, flashbacks and/or hallucinations.

Who is at risk for developing PTSD?

Not all people who have experienced a traumatic event will develop PTSD. Indeed, most will not. Risk factors include personal or family history of depression or anxiety, severity of the trauma and early separation from parents.

What does PTSD look like?

The symptoms of PTSD develop within 6 months following the traumatic event and are organized into three categories:

Re-experiencing Symptoms – recurrent, intrusive, distressing recollections or memories of the event in the form of memories, dreams, or flashbacks in which the individual perceives himself/herself to be re-living the event as though it was actually happening again in the present.

Avoidance & Numbing Symptoms – avoidance of anything – people, places, topics of conversation, food, drink, weather conditions, clothing, activities, situations, thoughts, feelings – that are associated with or are reminders of the traumatic event. In addition the person may experience a general numbing of emotions, a loss of interest in previously enjoyed activities, detachment from family and friends, and a sense of hopelessness about the future.

Hyperarousal Symptoms – sleep problems (difficulties falling asleep or staying asleep), irritability, angry outbursts, hypervigilance, exaggerated startle response, and difficulty concentrating.

What are the criteria for the diagnosis of PTSD?

1. The person has been exposed to a traumatic event in which both of the following were present:
    a. The person felt their life was in danger or witnessed someone else's life put in danger
    b. The person experienced extreme fear, helplessness or horror
2. The traumatic event is re-experienced, including one or more of:
    a. Recurrent intrusive memories, dreams or nightmares reliving the event which causes psychological distress.
3. Avoidance of things associated with the event including 3 or more of:
    a. Avoid thoughts, feelings or conversations, avoid activities, places or people, inability to recall aspect of the trauma, decreased interest or participation in activities, feeling detached or estranged from others, restricted range of affect, sense of foreshortened future.
4. Persistent symptoms of increased arousal including 2 or more of:
    a. Difficulty falling or staying asleep, irritability, difficulty concentrating, hypervigilance, exaggerated startle response
5. Duration of symptoms greater than 1 month:
    a. Severity of symptoms causes marked distress and impairment in daily functioning.

How does PTSD differ from Acute Stress Disorder or normal grieving?

PTSD must be distinguished from normal responses (such as grief, distress) to such situations and from Acute Stress Disorder (ASD). ASD has similar symptoms to PTSD but ends or is diminished greatly usually without formal treatment within four weeks of the traumatic event. Duration and severity of PTSD symptoms may vary over time with complete recovery occurring within half a year (or less) in half or more cases.

Things to look for:

Some people who are exposed to significantly traumatic events may have exacerbations of pre-existing mental health problems such as anxiety, depression or psychosis. Identification and proper effective interventions for these people in the post traumatic situation is important. Substance abuse, especially involving alcohol is very common in people who have PTSD. Therefore it is important to screen for this problem in people with PTSD and to treat appropriately.

What can I do if it is PTSD?

The first thing is to identify the young person with PTSD and help them find a knowledgeable helper who can provide education to them about what the problem is and how it can be treated. It is important not to confuse PTSD with normal responses to traumatic events or with ASD. Do not create pathology where it does not exist! For people with PTSD, supportive counseling using cognitive therapy methods may be of help. If the disorder is causing significant distress and impairment, referral to an appropriate health care provider is indicated, as medication may be needed.

What questions can I ask?

Are you bothered by memories or thoughts of a very upsetting event that has happened to you? Make sure that you ask about frequency and persistence of symptoms and include clear evidence of functional impairment before considering PTSD.

Mental Disorder of Physical: (Eating Disorders)

WHAT IS AN EATING DISORDER?

There are two main types of eating disorders – Anorexia Nervosa and Bulimia Nervosa. While there may be some overlapping in symptoms between the two, they are likely to have different causes and the treatments for them differ.

Who is at risk for developing an eating disorder?

Eating disorders usually begin in adolescence and may continue into adulthood. Girls are much more commonly affected than boys.

What does Anorexia Nervosa look like?

Anorexia Nervosa (AN) is characterized by excessive preoccupation with body weight control, a disturbed body image, an intense fear of gaining weight and a refusal to maintain a minimally normal weight. Post-pubertal girls also experience a loss of menstrual periods. There are two subtypes of AN – a restricting subtype (in which the young person does not regularly binge or abuse laxative or self-induce vomiting) and a binge-eating/purging subtype (in which the young person regularly binges and abuses laxatives or self-induces vomiting).

What does Bulimia Nervosa look like?

Bulimia Nervosa (BN) is characterized by regular and recurrent binge-eating (large amounts of food over a short time accompanied by a lack of control over the eating during the episode) and by frequent

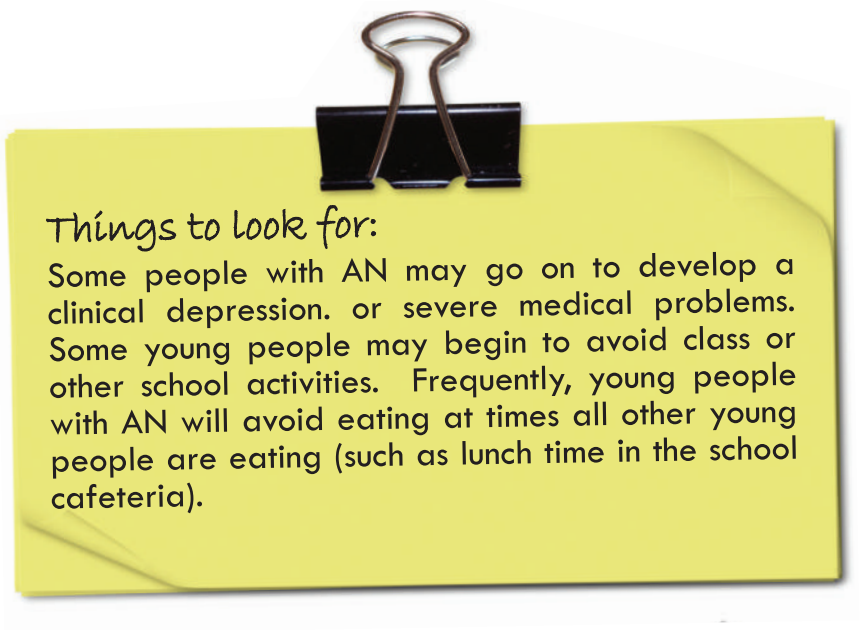
and inappropriate behaviours designed to prevent weight gain (including but not limited to: self-induced vomiting, use of laxatives, enemas, excessive exercise).

How do you differentiate an eating disorder from normal teenage eating?

Eating patterns in young people can be very erratic. Food fads are common as are periods of dieting and food restriction (often in response to concerns about weight). Adolescence is also a period in which some young people experiment with food types and eating experiments that may differ substantially from those common to their families or communities. These are not eating disorders.

What are the criteria for the diagnosis of AN?

1 – Refusal to maintain body weight at or above a minimally normal weight for age and height resulting in a body weight less than 85% of that expected.
2 – Intense fear of gaining weight or becoming fat while underweight.
3 – Substantial disturbances in body image (considers self to be fat even though is underweight) or denial of seriousness of current low body weight.
4 – Loss of menstrual periods in post-pubertal girls.



The prevalence of AN is about 0.2 – 0.5 percent.

What can I do if it is AN?

Young people with AN do not complain about having AN and most deny that they have a problem with being underweight. Usually a friend, teacher or family member will notice the severe weight loss. An educator who is concerned that a student may have AN should gently and supportively discuss the issue with the young person and if after that discussion it seems as if there is a possibility of AN, the young person should be referred to the appropriate support person or health provider in the school for further assessment and intervention. Suggestions that the young person eat more or negative comments on the youth's weight are counterproductive.

What are the criteria for the diagnosis of BN?

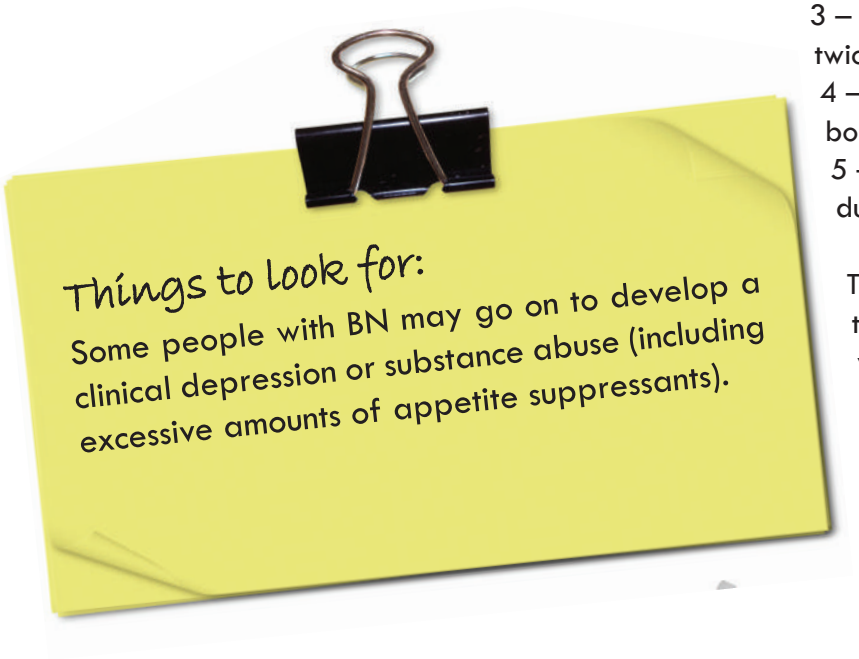
1 – Recurrent episodes of binge-eating where both of the following are present: a) – eating large amounts of food in a short period of time; b) – feeling that eating is out of control.

2 – Recurrent inappropriate behaviours in order to control weight (such as: self-induced vomiting; misuse of laxative, diuretics, enemas or other medications, fasting or excessive exercise.)

3 – The above must occur an average at least twice a week for a period of 3 months.

4 – Self perspective is overly influenced by body shape and weight.

5 – The above does not occur exclusively during AN.



There are two subtypes of BN – the purging type (characterized by self-induced vomiting or misuse of laxative, diuretics, enemas, etc.); the non-purging type (no use of the above).

The prevalence of BN is about 1 – 3 percent.

What can I do if it is BN?

Young people with BN do not complain about having BN and most deny that they have a problem with eating. BN is often hidden. Classroom discussions about BN and other eating problems should be undertaken with the sensitivity that there may be a young person with unknown or unrecognized BN in the group.

Questions to ask:

How do you feel about yourself? Has anyone asked you if you were having problems with your eating? Do you sometimes feel that your eating may be out of control?

Mental Disorders of Behaviour: (ADHD, Substance Abuse, Conduct Disorder)

SUBSTANCE DEPENDENCE AND ABUSE

There is a spectrum of harm that can develop from using various substances. Along this spectrum of harm is abuse and dependence.

What is Substance Abuse?

The abuse of substances is a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use, substance-related absences, suspensions or expulsions from school, neglect of children or household)
2. Recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by substance use)
3. Recurrent substance-related legal problems (e.g. arrests for substance-related disorderly conduct)
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse about consequences of intoxication, physical fights)

What is Substance Dependence?

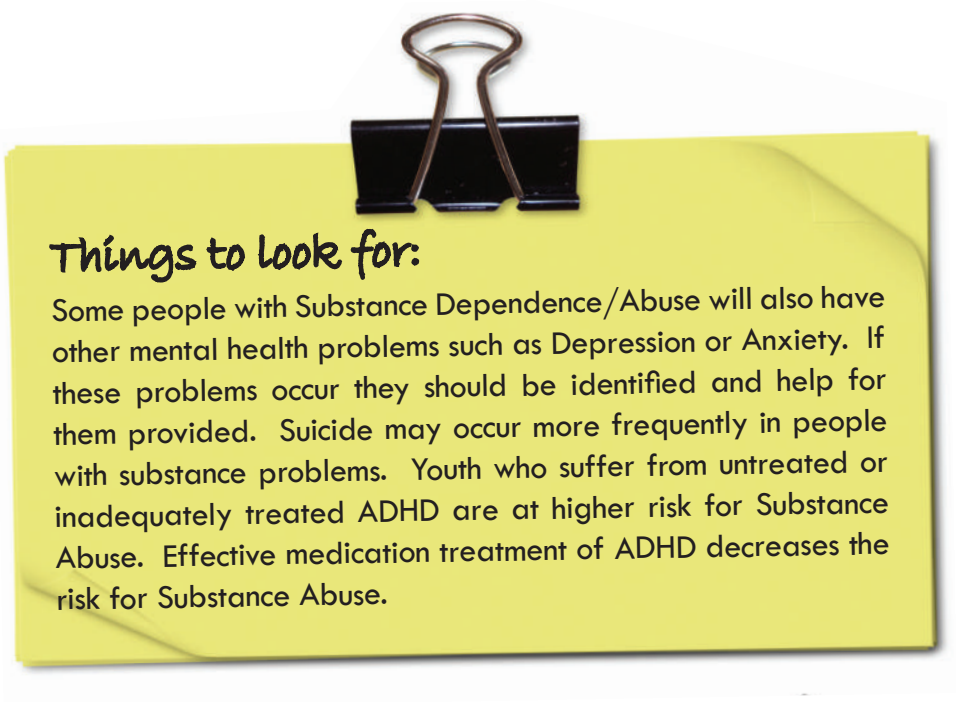
Substance dependence is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
   - A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
   - Markedly diminished effect with continued use of the same amount of substance.
2. Withdrawal, as manifested by either of the following:
   - the characteristic withdrawal syndrome for the substance.
   - the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities to obtain the substance, use the substance, or recover from its effects.
6. Important social, occupational or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

What are types of substances that can be abused?

The abuse of substances includes those that are legal and illegal. The definition of a drug as a legal or illegal substance does not determine if the substance can induce dependence or abuse. Substances include such things as alcohol, nicotine, cannabis, amphetamines, cocaine, inhalants, opioids, hypnotics and others.

A variety of substances can be safely used in moderation by most people as social modifiers (for example, beer or other alcohol taken with meals or in social situations). Substances which may be abused in some situations can be therapeutic in others – for example, heroin or cocaine can be used to treat pain under medical supervision but are also well known to be addictive substances when used for non-medical purposes.



What can I do if it is Substance Abuse/Dependence?

First, it is important to identify the problem. In some situations, cultural, social or economic factors may impede the identification of the substance problem. The person with the problem will often deny the problem exists and sometimes the person's family or loved ones will also deny that the problem exists. Young people often proceed though a path of substance misuse for a long time (years) before some of them go on to abuse. Most young people who misuse substances likely do not go on to abuse them – therefore substance misuse, although a risk factor for substance abuse is not necessarily predictive of substance abuse. Academic and social problems characterize the young person who suffers from substance abuse – failing grades, missing classes, Monday morning absences, aggression, etc.

Questions to ask:

Try to determine the amounts of the substance used – remember that use can be continuous (for example: daily) or in binge patterns (large amounts used sporadically – such as every three to five days). Determine if the young persons problems are due in whole or in part to excessive use of substances. One particularly important question is "How does taking (name of substance here) help you or hinder you in your school and social life?"

Substance abuse/dependence in young people usually requires professional intervention. Issues such as confidentiality will often arise so it is important that teachers understand what the expectations and limits to confidentiality regarding substance abuse/dependence are in their setting.

Often the advice of a teacher or coach is an important step towards treatment for a young person abusing substances. Non-judgemental but realistic advice from a teacher can sometimes lead them to the realization that they need help. Some young people traffic in the substances that they use. The teacher therefore needs to know the school policy on drugs and abide by it.

What is Attention Deficit Hyperactivity Disorder?

Attention Deficit Hyperactivity Disorder (ADHD) is characterized by a persistent pattern of hyperactivity, impulsivity and substantial difficulties with sustained attention that is outside the population norm and is associated with substantial functional impairments at school, home and with peers. This disorder begins before age seven and continues into adolescence or for some people, even into adulthood.

Who is at risk for ADHD?

ADHD has a genetic component and runs in many families and is more common in boys than in girls. Girls who have ADHD often do not have similar problems with hyperactivity although they have similar problems with sustaining attention. Young people who have learning disabilities and youth with Tourette's Syndrome have higher rates of ADHD. Young people with Conduct Disorder may have ADHD which has not been recognized or treated and which may contribute to their social and legal difficulties.

What does ADHD look like?

Problems with sustaining attention may result in substantial difficulties in on-task behaviours. Young people with ADHD frequently make multiple careless errors, do not complete their academic or house tasks and may start numerous activities. They are easily distracted by stimuli in their environment (such as noises) and often will begin to avoid tasks that require significant attention (such as housework). Young people with ADHD will often rush into things such as games or other activities without taking the time to learn the rules or determine what they should do.

Hyperactivity is often manifested by difficulties staying still in one place – such as sitting at a desk or in a group. Younger children may run around the room (or climb on furniture, etc.) instead of focusing on group activities. Most young people with ADHD have trouble sitting still and are very active – often they will fidget, talk excessively, make noises during quiet activity and generally seem 'wound up' or 'driven'.

Impulsivity is often shown as impatience or low frustration tolerance. Young people with ADHD will often interrupt others, fail to listen to instructions, rush into novel situations without thinking about the consequences, etc. This type of behaviour may lead to accidents. Many youth with ADHD also do not seem to be able to learn from negative experiences – it is as if the impulsivity overrides learning about dangers.

These difficulties can be less pronounced in activities that require a great deal of physical participation and are constantly engaging. Sometimes young people with ADHD seem less distracted when they are playing games that they like –especially games that do not require sustained attention (such as video games). Symptoms are more likely to be noticed when the young person is in a group setting in which sustained and quiet attention is needed or when he/she is working in an environment in which there are many distractions.

What are the criteria for diagnosis of ADHD?

There must be a number of symptoms from each of the following categories: inattention, hyperactivity, impulsivity, PLUS a duration of at least six months to a degree that the person demonstrates maladaptive behaviours and trouble functioning that is inconsistent with their level of development.

Inattention (at least six of the following)

1- Failure to give close attention or many careless errors in work requiring sustained attention (such as school work)
2 - Difficulty sustaining attention in tasks or play
3 - Does not seem to listen when spoken to directly
4 - Does not follow through on instructions
5 - Has difficulty organizing tasks and activities
6 - Avoids tasks that require sustained attention (such as homework)
7 - Loses things needed for tasks and activities
8 - Easily distracted by the environment

9 - Forgetful in daily activities

Hyperactivity

1 - Fidgets or squirms while seated
2 - Leaves seat in classroom or when is supposed to be seated
3 - Runs about or climbs excessively when not appropriate
4 - Has difficulty in solitary play or quiet activities
5 - Is usually on the go, as if motor driven
6 - Often talks excessively

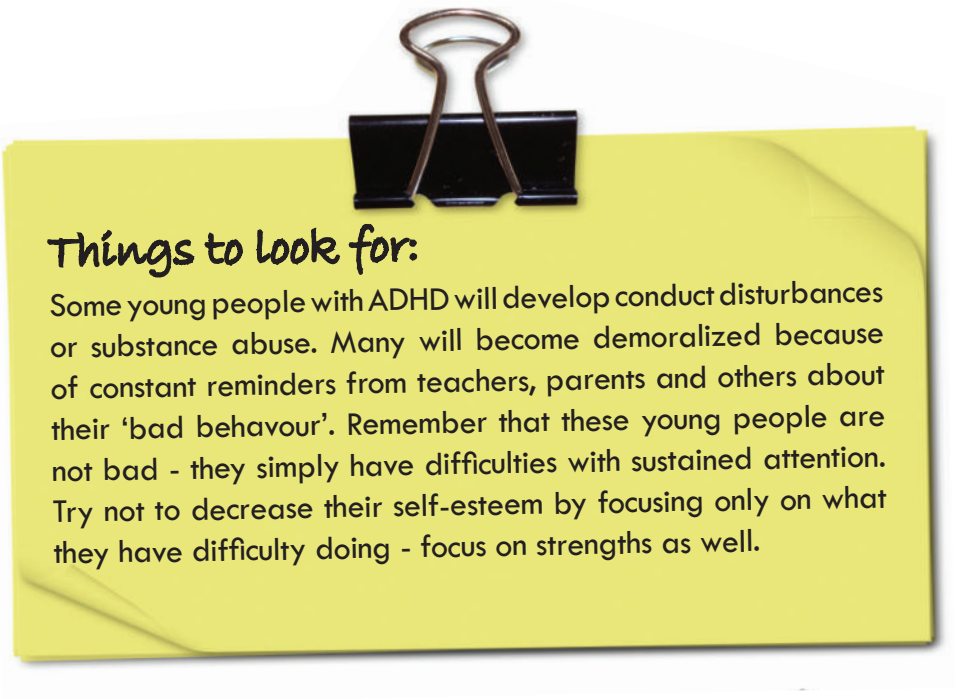
Impulsivity (are included in the number of symptoms for hyperactivity)

7 - Blurts out comments or answers to questions before he/she should
8 - Has difficulty waiting for his/her turn
9 - Often interrupts or intrudes on others

What can I do if it is ADHD?

ADHD can be treated with a combination of medications and other assistance – such as social skills training and cognitive behavioural therapy. The most effective treatment for symptoms is medication. Because learning difficulties are common, young people with ADHD should undergo educational testing to determine if their learning disability is present. Sometimes youth with ADHD will benefit from modifications to their learning environments such as having quieter places in which to work or having homework done in small amounts over long periods of time.

Some young people with ADHD will develop conduct disturbances or substance abuse. Many will become demoralized because of constant reminders from teachers, parents and others about their 'bad behaviour'. Remember that these young people are not bad - they simply have difficulties with sustained attention. Try not to decrease their self-esteem by focusing only on what they have difficulty doing - focus on their strengths as well.



Questions to ask?

Are you having difficulties focusing on your schoolwork? Is it hard for you to finish your work if there are noises or distractions? Do your parents or teachers seem to be nagging you all the time to do your work and sit still?

What is suicide?

Suicide the act of ending one's life. Suicide itself is not a mental disorder but one of the most important causes of suicide is mental illness – most often Depression, Bipolar Disorder (Manic Depression), Schizophrenia, and Substance Abuse.

Suicide is found in every culture and may be the result of complex social, cultural, religious and socio-economic factors in addition to mental disorders. The reasons for suicide may vary from region to region because of these factors. It is therefore important to know what the most common reasons for suicide are in the region in which you are working. This may be difficult to determine accurately because of the "taboos" and stigma around suicide.

The preferred methods of completing suicide may vary from location to location – ranging from firearms to fertilizer poisoning to self-burning to overdosing on pills. Therefore, it is also important to know the most common methods of suicide in the region in which you are working.

What does suicide look like?

Not all self-harm behaviours are attempts to commit suicide. There may be many reasons for self-harm behaviours besides suicide. These include a person attempting to cry for help - for example, from a person who is stuck in a harmful situation that they cannot escape such as ongoing sexual abuse. Certain types of personality disorders can cause youth to perform self-harm behaviors. A suicide attempt is distinguished from a self-harm behavior by the person's intent to die.

Suicidal behavior has three components: ideation, intent, and plans.

1. Suicidal ideation includes ideas about death or dying, wishing that he/she were dead, or ideas about committing suicide. These ideas are not persistent. These ideas can be fairly common in people with mental disorders or in people who are in difficult life circumstances. Most people with suicidal ideation do not go on to commit suicide but the suicidal ideation is a risk factor for suicide.
2. The second component is suicidal intent. With suicidal intent, the idea of committing suicide is better formed and more consistently held than in suicidal ideation. A person with suicidal intent may think about committing suicide most of the time, imaging what life would be like for friends and family without him/her, etc. The strongest intent occurs when the person decides that she/he will commit suicide.
3. The third component is the suicide plan. This is a clear plan of how the act of suicide will occur. Vague plans (such as "someday I will jump off a bridge") are considered as part of intent. In a suicide plan the means of committing suicide will be identified and obtained (such a gun, poison, etc.) and the place and time will be chosen. The presence of a suicide plan constitutes a psychiatric emergency.

What can I do if it is Suicide?

The first thing is to identify the presence of suicide ideation, intent and plans. Young people who have thoughts of suicide ideation or have intents may benefit from supportive or cognitive based counseling. The presence of a suicide plan should lead to placement of the person in a situation in which he/she can be safe and secure. That

situation should be therapeutic and not punitive and should be accompanied by supportive and cognitive counseling. The family or loved ones may require support and help as well. Non-judgmental supportive counseling may be of assistance in such situation. If a suicide has happened, the family or loved ones may benefit from non-judgmental supportive bereavement counseling.

If a teacher is faced with a student who is talking about or writing about suicide then it is important to include an educator from guidance or health to assess the situation. Generally it is better to err on the side of caution and take the young person to a location in which they can be safe. Schools should have policies about how to deal with a suicidal youth – know your school's policy. If there is no policy, bring this issue to the attention of the principal.

If a young person commits suicide, there can be negative repercussions amongst peers, classmates and teachers. It is important not to force students or others into reliving or analyzing the event. Traditional critical incident stress debriefing interventions have not been shown to be helpful and may even cause harm. A supportive space for those students who wish to use it should be provided after school hours and a teacher or guidance counselor known to the students should ideally be available for those who wish to talk. Each community will have its own traditions for dealing with this kind of event and it is not necessary to create highly effective responses to a suicide in the school setting.

What are risk factors for suicide?

The following are the most common (and strongest) risk factors for suicide in young people. Remember that a risk factor does not mean something that causes an event to happen. Rather, it is something that is related to an event that happens.

- Sex (male)
- Depression or other mental disorder
- Previous suicide attempt
- Family history of suicide
- Excessive alcohol or drug use
- Impulsivity or juvenile justice history

Suicide risk is high in people with mental disorders, in particular those with: Depression (of all kinds), Bipolar Disorder (Manic Depression), Schizophrenia, and Substance Abuse. If a young person talks to you about suicide, take them seriously – it is a myth that people who talk about suicide will not attempt suicide.

Questions to ask?

Ask about ideation: "Have you been thinking about dying, harming yourself or suicide?"
Ask about intent: "Have you decided that you would be better off dead or that you should kill yourself?"
Ask about plans: "What plans have you made to kill yourself (and obtain the details)?"

What should I do:

1. If you suspect that a young person may have a mental disorder, it is necessary to refer them to the designated mental health professional (guidance counselor, psychologist, social worker) in the school.
2. If you suspect that a young person may be suicidal, immediately contacting your school designated emergency coordinator or principal is necessary.