



Teacher Knowledge Update



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What are Mental Disorders?*

* Please note that we will use the phrases *mental disorder* and *mental illness* as synonyms.

Here's what we know about mental disorders:

- Disturbances of emotion, thinking, and/or behaviour
- Derive from perturbations in the function of various brain circuits
- Arise from a complex interplay between genetic and environmental factors
- May range in intensity
- Lead to functional impairment (interpersonal, social, vocational, etc.)
- Respond to evidence-based treatments provided by trained professionals

Mental disorders are not:

- The consequence of poor parenting or bad behaviour
- The result of personal weakness or deficits in personality
- The manifestation of malevolent spiritual intent
- Caused by poor nutrition
- Poverty or lifestyle choices

How is the brain involved?

- Everything that a person does, feels, thinks or experiences involves the functioning of their brain
- Most things a brain does depends on many different parts of the brain working together in a network
- 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

The Functions of the Brain

Thinking or
Cognition

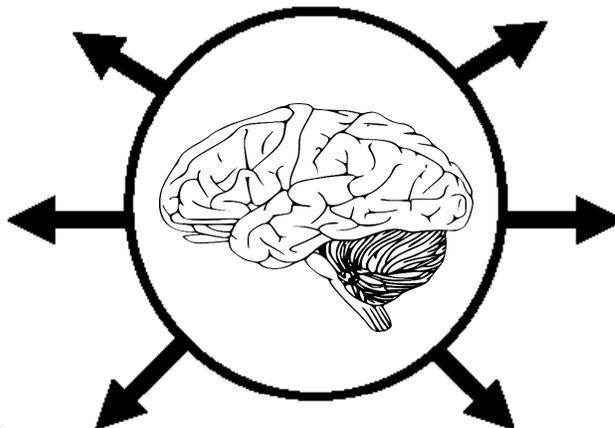
Behaviour

Perception
or Sensation

Physical or
Somatic

Emotion or
Feeling

Signaling
(being responsive and
reacting to the environment)



What happens inside the brain when it is not functioning effectively?

- A specific part of the brain that needs to be working in a specific manner is not working well
- A specific part of the brain that needs to be working in a specific manner is working in the wrong way
- Brain pathways that help different parts of the brain communicate are not working as they should

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 overactivity, 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 disrupted because of these signs and symptoms

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

- Thinking
- Perception
- Emotion
- Signaling
- Physical
- Behaviour

Each of these brain functions is the result of millions of cells (neurons) communicating with each other through various circuits, using various chemical messengers called neurotransmitters (e.g. serotonin, dopamine, etc.). When the brain is not functioning properly in one or more of its six domains, and the person experiences problems that interfere with their life in a significant way, these circuits are disrupted and the person may develop the signs and symptoms of a mental disorder.

Mental disorders are characterized by perturbations in these brain functions, but not all changes in these functions signify a mental disorder. For example, negative emotions are a characteristic of many mental disorders, but most negative emotions are not the result of a mental disorder. 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.

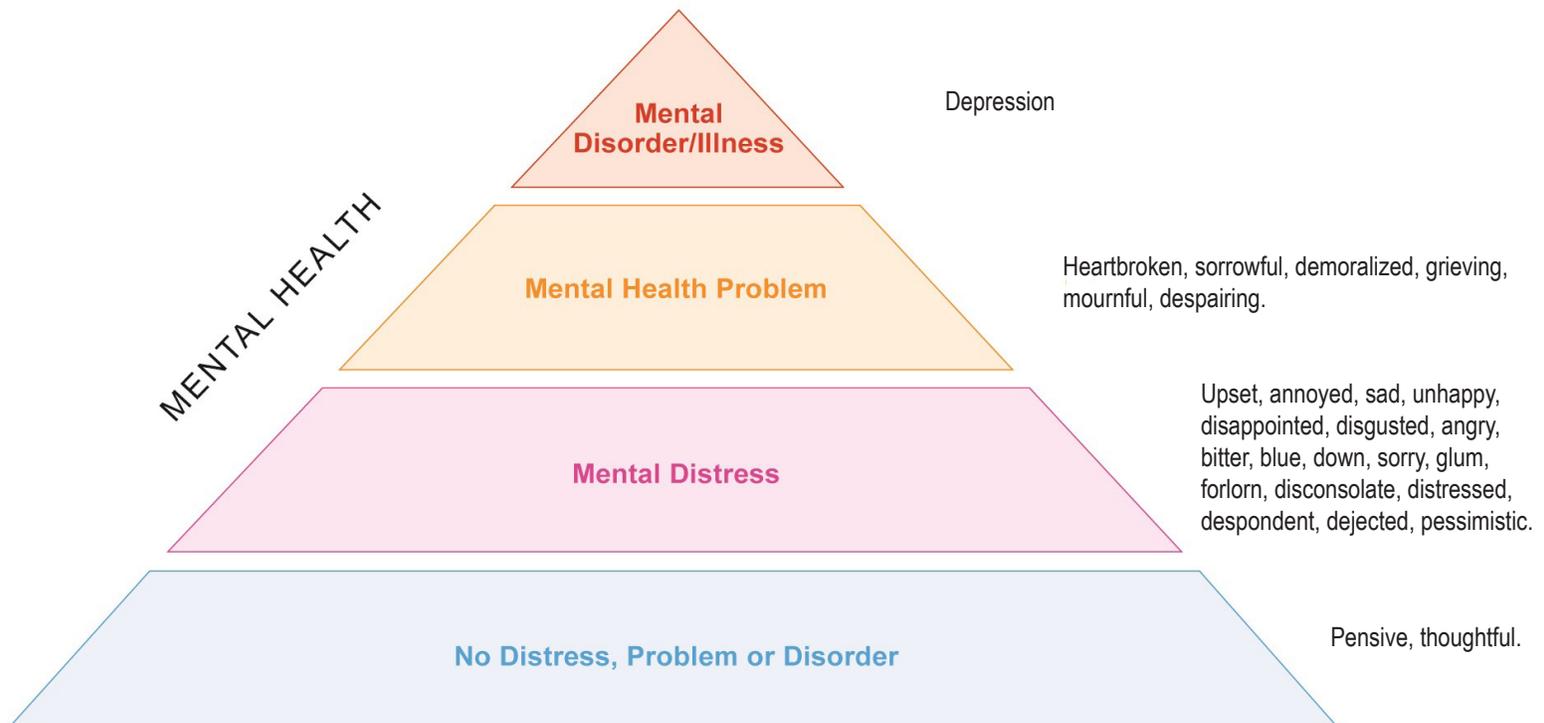
Mental Disorder? Yes, no, maybe.

Understanding how to differentiate a mental disorder from the usual “slings and arrows of outrageous fortune” is a core mental health literacy competency. This is discussed in the next section below and also repeated in the “Definitions” section of Module 2.

In the following diagram we can see the inter-relationship of different mental health states, discussed in more details below. They are unique states with different but related characteristics. On the right side of the figure are the various states and on the left side are the words that more properly describe each state. It is essential that our language be clear and convey what we intend it to mean. Using the word Depression when we mean upset is confusing and unhelpful in advancing understanding and communication.



THE INTER-RELATIONSHIP OF MENTAL HEALTH STATES: LANGUAGE MATTERS



Check out Dr. Kutcher's video blog, *The Inter-Relationship of Mental Health States: Language Matters* at: <https://www.youtube.com/watch?v=LsowyMnqCRs&t=1s>

Mental Health

There are many different definitions of mental health. Some are more clear and helpful than others. They all try to capture one important thing. That is, that a healthy brain is what gives us mental health. The brain is an important part of the body and the body and brain are linked. It is really not possible to consider them separately. We know that what is good for your body will be good for your brain as well, and vice-versa. Here is a definition that is clear and useful:

“Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with people and the ability to change and cope with adversity.”

– Surgeon General USA, (1999)

Basically, mental health means having the capacity to be able to successfully adapt to the challenges that life creates for people. These challenges are both positive and negative. In order to adapt to them our brains need to apply all of their capacities of: emotions, cognition/thinking, signaling functions and behaviours. Our brains learn how to apply these capacities over time and as we grow and develop we are able to take on more and more challenges and become successful in dealing with them. This is because we have faced these challenges and learned to deal with them.

Sometimes people forget that negative emotions are a part of good mental health. Crying, feeling sad, getting annoyed or angry, etc. are all normal responses to life challenges. So are negative thoughts such as: “this is

too hard for me” or “I am not a good person” or “people don’t like me”. So are negative behaviours, such as yelling at somebody or avoiding a situation that makes us feel stressed. It does not mean that we don’t have good mental health just because we feel stressed. Indeed, being able to identify stress and learn how to successfully overcome it in a way that solves the problem causing it is fundamental to having good mental health.

For example: feeling stressed about writing an examination could lead to a negative behaviour – such as going out to party with friends to drink and “forget” about the stress. Or it could lead to a neutral behaviour – such as going for a run or meditating to “release” the stress but not studying for the exam. But if that is your entire adaptive response you likely will not do well on your exam. The important coping strategy that your stress response should be eliciting from you here is to study or to get help from your instructor to assist you in understanding something that you may not know very well. If you add this coping strategy to your stress “releasing” activity you will be much more likely to succeed and that is a sign of good mental health. There will be more information on this important topic in Module 6.

Key Point:

It is important to understand that everyone has mental health just like everyone has physical health. And, just like a person can have good physical health and at the same time have a physical illness, people can have good mental health and a mental illness at the same time.

To understand mental health it is necessary to understand the three related components of mental health: mental distress, mental health problems and mental disorder. These are illustrated in the triangle diagram.

Mental Distress

Mental distress is the inner signal of anxiety or “stress” that a person has when something in their environment is demanding that they adapt to a challenge (for example: writing a test, giving a presentation in front of the class, asking a person to go out on a date, failing to make a school sports team, etc.). This is called a “stress signal” or “stress response”. A stress response has different components to it: emotions/feelings (such as worrying, unhappiness, feeling energized, annoyance), cognitions/thinking (negative thoughts such as “I am not good at anything”, “I wish I did not have to do this”, or positive thoughts such as “this is something I need to solve”, “it may be difficult but I can do this”, “I should ask my friend for their advice”), physical symptoms (such as stomach aches and headaches, the stomach “butterflies”) and behaviours (such as avoidance of the situation, engagement of the challenge, positive energy, withdrawal from others, yelling at someone or helping someone). As we can see, the stress response can have both negative and positive components! We need to make sure we don’t always focus on the negative ones.

Everybody experiences mental distress (often called “stress”) every day. It is a part of good mental health. It is a signal that tells us to try something new to solve the challenge we are facing. As the person who feels distress tries to develop solutions or strategies to solve the challenges (often called “stressors”) they figure out what works and what does not work well. Successfully dealing with the stressor (also called solving the problem) leads to learning what strategy worked and use of that strategy in similar situations in the future. The distress goes away once the person has successfully overcome the challenge. But the learning and skill sets remain and are ready to be used another time. This process is called adaptation or resilience building.

Young people experiencing everyday mental distress do not require counselling - they are not “sick” and they do not need treatment. They can learn how to manage the stress response and how to use the “stress signal” to develop new skills. They learn these skills by trial and error by obtaining advice from friends, parents, teachers, trusted adults and from other sources (such as the media). They can also use techniques that are part of general health management, such as: exercise, having enough sleep, being with friends and family, eating properly and staying away from drugs and alcohol. Sometimes what the young person tries does not work (for example: instead of studying for an exam they go out and party with their friends, instead of getting



a good night's sleep before an exam they try to stay up all night and study) and as a result their distress may increase. But making wrong choices is part of learning how to make good choices. This is a normal part of growing up. Allowing young people to avoid everyday mental distress, or to focus only on teaching them how to modulate the stress response instead of how to use it to learn new skills, can have negative impacts on their development of skills that they need to learn in order to have successful adult lives.

Mental Health Problems

Mental health problems may arise when a person is faced with a much larger stressor than usual. These occur as an expected part of normal life and are not mental illnesses. For example: death of a loved one, moving to a new country, having a serious physical illness, etc. When faced with these large stressors, everyone experiences strong negative emotions (such as: sadness, grief, anger, demoralization, etc.). These emotions are also accompanied by substantial difficulties in other domains such as: cognitive/thinking (for example: "nothing will ever be the same", "I don't know if I can go on in my life", etc.), physical (for example: sleep problems, loss of energy, numerous aches and pains), and behavioural (for example: social withdrawal, avoidance of usual activities, angry outbursts, etc.).

Sometimes the young person experiencing a mental health problem will exhibit noticeable difficulties in everyday functioning - at school and outside of school. In addition to the distress management skills and general health enhancing activities that are useful in decreasing mental distress, young people experiencing a mental health problem will often need additional support to help them through the difficult situation or assist them with problems in functioning (such as extra time for academic activities, time away from school to be with their families, etc.). In such cases, this support can come from a counsellor, a religious leader, or another person that has the skills needed to help effectively. Medical treatment (medication or psychotherapy) is usually not necessary. The presence of a supportive adult (such as a teacher, parent or neighbour) is a key component that can help young people deal with a mental health problem.

Mental Disorders

A mental disorder is very different from mental distress and from a mental health problem. It arises from a complex interplay between a person's genetic makeup and the environment in which they live or have been exposed to at different times in their lives. A mental disorder (also called a mental illness) is a medical condition diagnosed by trained health professionals (such as doctors, mental health clinicians, psychiatric nurses and psychologists) using internationally established diagnostic criteria. A person with a mental disorder is best helped by a trained health professional providing best evidence-based treatments. Mental disorders are the result of changes that arise in usual brain function as a result of a complex interplay between a person's genes and environment. When a person has a mental disorder, their brain is not working as it should be.

A person with a mental disorder will experience significant, substantial and persistent challenges with emotions/feelings (for example: Depression, panic attacks, overwhelming anxiety, etc.), cognition/thinking (delusions, disordered thoughts, hopelessness, suicidal thoughts, etc.), physical (for example: fatigue, lethargy, excessive movement, etc.), and behaviour (for example: school refusal and withdrawal from family and friends, suicide attempt, poor self-care, etc.). The presence of a mental disorder signifies that an individual needs best evidence-based interventions that may be of many different types (such as medications, psychotherapies, social interventions, etc.), provided by appropriately trained health care providers. While interventions that can help distress and mental health problems can also be used to help a person who has a mental illness, and general health enhancing activities are always useful, a young person with a mental disorder requires a degree of care above and beyond that usually provided for a mental health problem. Mental disorders require treatment using best evidence-based care by trained health professionals (such as: mental health officers, doctors, psychiatric nurses, psychologists, nurses, etc.).

And: a person can be in each of these states at the same time. For example, over the course of one day, a person can be laughing and having fun with their friends (no distress, problem or disorder), can experience distress (lost their house key), be experiencing a mental health problem (their uncle with whom they were close died earlier this week and they feel sad, lonely and cry), and have a mental disorder (such as Attention Deficit Hyperactivity Disorder).

What causes mental disorders?

A variety of different influences on the brain can lead to a mental disorder. 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 trauma, etc.)

Both genetic and environmental factors exert their impact by affecting how brain cells and circuits function.

Diagnosis of Mental Disorders

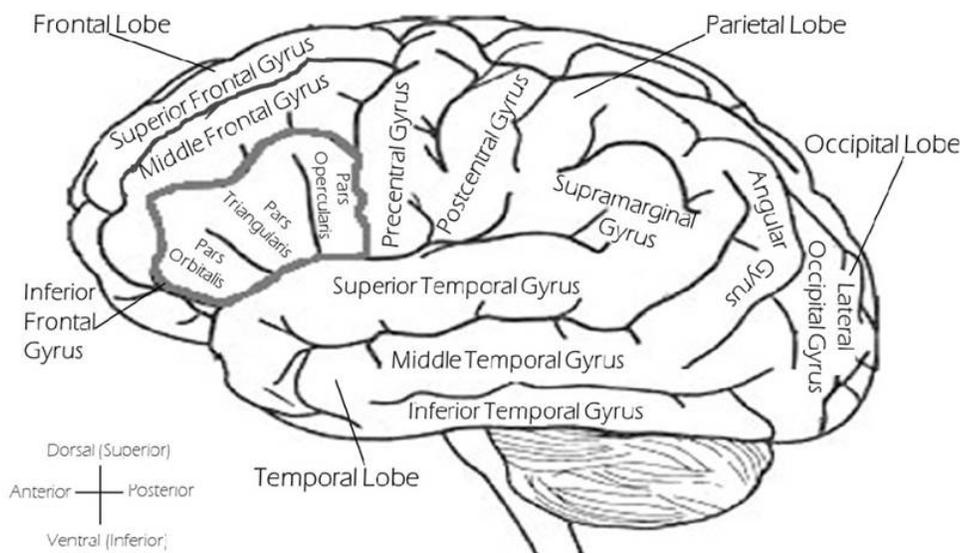
Diagnosis is one of the responsibilities of a trained and regulated health professional (e.g. psychologist, family physician, psychiatrist). It is not the professional competency of a teacher or other educator. If a teacher is concerned that a student may have a mental disorder, the teacher should make their concerns known to the person in the school most responsible for assessment of a student’s health state. Usually this is a counsellor, psychologist or a school nurse.

Remember to be cognizant of the language used. If a teacher says “Mary is Depressed” or “Michael has ADHD”, that can be considered to be assigning a diagnosis. Instead of this approach, carefully describe what you see. For example, “Mary looks sad, is crying much of the time and is not getting her school work done” or “Michael is getting up and down from his seat most of the time and is having difficulty sustaining his attention”.

If a student has a mental disorder, the teacher should become part of that person’s “circle of care team” and discharge their responsibilities consistent with their professional competencies, roles and responsibilities. Teachers are not therapists but they can be mentors, coaches and important supports.

The Human Brain: Where Mental Health Lives

- Planning
- Calculating
- Self-awareness sequencing
- Judgment
- Comprehension
- Contemplation
- Reasoning
- Decoding symbols
- Focusing
- Paying attention
- Memory





Mental Disorders of Cognition & Perception: Psychotic Disorders

Psychotic disorders are a group of illnesses characterized by noticeable 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 is usually a genetic component. A family history of SCZ, a history of birth trauma and a history of fetal brain damage in utero increases the risk for SCZ. Significant marijuana use may bring on SCZ in young people who are at genetic risk for the illness.

What does Schizophrenia look like?

Delusions are fixed erroneous beliefs that are held with conviction and may involve misinterpretation of experiences. One common type of delusion is persecutory (also commonly called paranoid) in which the person thinks they are being harmed in some way by another person, force or entity (such as God, the police, spirits, etc.). Strongly held religious minority 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. In SCZ, hallucinations are experienced as real perceptions.

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. Rates of suicide in SCZ can approach 10% of those with the illness.

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 motivation.

A person with Schizophrenia may exhibit delusions, hallucinations and disordered thinking (also called “positive symptoms”) as well as negative symptoms (such as social withdrawal, lack of hygiene and motivation, etc.) at different times during the illness.

What are the criteria for the diagnosis of Schizophrenia?

1. Positive symptoms (delusions, hallucinations, disorganized thinking)
2. Negative symptoms (apathy, loss of pleasure, amotivation)
3. Behavioural disturbances (withdrawal, agitation, unexpected responses)
4. Significant dysfunction in one or more areas of daily life (social, family, interpersonal, schoolwork, 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 access to effective treatment – usually in a specialty mental health program (first onset psychosis program). If a teacher suspects SCZ, the most appropriate student services provider should become involved. If concerns are shared, a referral to the most appropriate specialty mental health provider should be made and discussion with the parents about the concerns initiated.

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 a 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. This phase of the illness is called the “prodrome”. Occasionally the young person suffering in the prodrome may exhibit unusual behaviours – often in response to a delusion or hallucinations. Sometimes it may be difficult to distinguish the early onset of SCZ (the 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 Use 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.

Treatment for SCZ includes medications and a variety of psychological, social or vocational interventions depending on the person’s needs. Hospitalization during acute psychotic episodes is often required.

Questions to consider asking:

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 major types of mood disorders: unipolar mood disorders and bipolar mood disorders. Unipolar disorder can be a Major Depression or Dysthymic Disorder, whereas Bipolar Disorder occurs 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. Here, when we refer to the clinical condition we capitalize the letter “D”: Depression.



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 people's lives. They can lead to social, personal and family difficulties as well as poor vocational/educational performance and premature death due to suicide.

Additionally, patients with other illnesses such as heart disease and diabetes have an increased risk of early 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 Depression usually require treatment from health professionals but in mild cases may experience substantial improvement with strong social supports and personal counselling.

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 in the early course of the illness. 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 job loss or living in a conflict zone) but often the episodes occur spontaneously. Often there is a family history of 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. physical (often called somatic). MDD may present differently in different cultures, particularly in the somatic problems that people identify. The symptoms of Depression must be distinguished from other negative emotional states such as grief. The symptoms of Depression:

- Must be severe enough to cause functional impairment (stop the person from doing what they would otherwise be doing, or decrease the quality of what they are doing)
- Must be continuously present everyday, 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 person's usual state

These symptoms are:

Mood:

- Feeling "depressed", "sad", "unhappy" (or whatever the cultural equivalent of these descriptors are)
- 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

Physical:

- Excessive fatigue or loss of energy (not just feeling tired)

- 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. The symptoms must be substantial and different from the emotional, cognitive and physical challenges of everyday life.

What can I do if it is Depression?

If you are concerned that your student may have Depression, it is necessary to discuss this with the most appropriate health services provider in your school (e.g. counsellor, psychologist). The school-based health provider can provide counselling and support (including suggestions for self-help strategies). If the disorder is more intense or the person is suicidal, the school counsellor should immediately refer the person to the health professional best suited to treat the Depression. Once an intervention occurs and the young person is back at school it is important that the teacher 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 such as encouragement of self-help activities (exercise, health eating, etc.)

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 that life is not worth living? If the student answers yes to either of these, further assessment of all of the symptoms should be conducted by the person in the school best trained to deal with this issue.

Things to look for:

People with Depression are at an increased risk for attempting suicide. Every person with Depression should be monitored for suicidal 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 their health provider immediately and your role is to bring this concern to the most appropriate, responsible professional in your school. To view an animated video on Depression visit: <https://www.youtube.com/watch?v=i8EPzkxAiVw&t=10s>

Treatment of Depression includes evidence-based psychotherapies such as Cognitive Behavioural Therapy (CBT) and medications.

Bipolar Disorder

- Illness is characterized by cycles (episodes) of Depression and Mania
- Depressions are similar to those that occur in MDD
- Mania includes mixed mood states of euphoria and irritability
- 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 Disorder



In Bipolar Disorder how is ‘Mania’ different from feeling extremely happy?

- Mood is mostly elevated or irritable but can change rapidly
- Behavioural, physical and thinking problems are present
- Significant problems in daily life because of 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
- 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

A student with possible Bipolar Disorder requires immediate referral to a highly qualified mental health services provider.

Treatment of Bipolar Disorder will include medications as well as other evidence-based interventions. Hospitalizations for acute manic or Depressive states may be needed.

Mental Disorder of Signaling: The Anxiety Disorder

It is important to remember that anxiety is not the same thing as “stress”. Many people confuse anxiety (which is a state of constant, severe and persistent hyperarousal not driven by danger) with the stress response (our brain/body signals that alert about an environmental challenge we need to address). When anxiety reaches such predominance that it interferes with a person’s function and enjoyment of life - it is called Anxiety Disorder.

What is Generalized Anxiety Disorder (GAD)?

GAD is excessive anxiety and worry occurring for an extended period of time. This persistent, excessive anxiety and worry causes marked emotional distress, leads to many physical symptoms and causes functional impairment.

Who is at risk for developing GAD?

GAD often begins in childhood or adolescence and there is a genetic or familial component. Once GAD is present, the severity can fluctuate and exacerbations often occur during times of increased stress.

What does GAD look like?

Generalized Anxiety Disorder is characterized by excessive anxiety and worry about many different things. The state of hyperarousal is constant and the worries are out of proportion to the situation or event. This anxiety and worry must be persistent and noticeably greater than the usual socio-cultural norms. Youth with GAD often 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?

GAD symptoms can be broken into four categories:

- 1) Emotions – i.e. feeling fearful, worried, tense or on guard.
- 2) Body responses – many different body changes including increased heart rate, sweating and shakiness, shortness of breath, muscle tension and stomach upset.
- 3) Thoughts – with GAD, 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. In GAD, the state of hyperarousal occurs when there is no real danger.

When does anxiety become a disorder?

- The state of hyperarousal is intense, persistent and excessive
- 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
2. Difficulty controlling the worry
3. The anxiety and worry are associated with 3 or more of the following: 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 symptoms cause marked emotional distress and significant impairment in daily functioning

What can I do if it is GAD?

The first thing is to identify the problem for the young person and involve the school's student services provider who can elicit assistance from a person knowledgeable about the problem. Some people with GAD will experience improvements in their anxiety and functioning with supportive cognitive-based counselling. 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 counselling from the school-based provider 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 they 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 is Social Anxiety Disorder (SAD)?

Social Anxiety Disorder (sometimes called Social Phobia) is characterized by the presence of an intense fear of scrutiny by others, which can be perceived to result in embarrassment or humiliation.

What does SAD look like?

Young people with SAD 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 withdrawing from contact with others. Youth with SAD may 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 SAD recognize that their fears are excessive and irrational, they are unable to control them and therefore avoid situations that trigger their anxiety. The presentation of SAD 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 its intensity may wax and wane over time.

What are the criteria for diagnosis of SAD?

The following must be present for someone to have SAD:

- 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 a general medical condition

What can I do if it is SAD?

The first step is the identification of the problem. Often, youth with SAD 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. Treatment is not indicated unless the problem is causing significant functional impairment but counselling using cognitive behavioural techniques and exposure to the anxiety-provoking situation in the company of a counsellor may help the person better deal with their difficulties. If the disorder is severe, referral to an appropriate healthcare provider is needed, and the counsellor 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 SAD 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 SAD will use excessive amounts of alcohol to help decrease their anxiety in social situations. In some cases, SAD can be a risk factor for the abuse of alcohol or other substances.

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?

To view an animated video on SAD visit: <https://www.youtube.com/watch?v=kitHQUWrA7s>

What is Panic Disorder?

Panic Disorder is characterized by panic attacks which are rapidly onsetting, recurrent, unexpected episodes that include a number of frightening physical reactions, fear and irrational thoughts. 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). Typically a panic attack comes on “out of the blue” and lasts less than 20 minutes.

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 a much higher risk of also developing Panic Disorder themselves.

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 during a panic attack. 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.

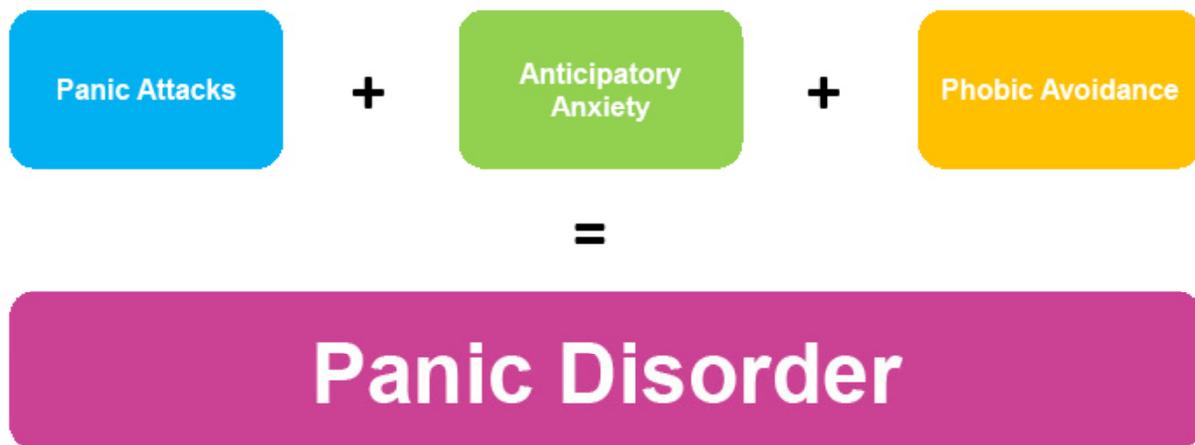
What are the components of a panic attack?

The person has four or 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

The Panic Disorder Triad



What are the criteria for Panic Disorder?

Assessing Panic Disorder involves evaluating five 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 behavior as a result of the attacks
- 3) Agoraphobia
- 4) Panic attacks that are not due to substance abuse, medications or a general medical condition
- 5) Panic attacks that are not better accounted for by another mental disorder

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.

Counselling or psychotherapy 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 stop you from doing that you would otherwise usually do? What do you do when these episodes occur?

Things to look for:

Youth with panic disorder are at higher 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 problems (particularly alcohol) and counselling around these issues is very important. To view an animated video on Panic Disorder visit: https://www.youtube.com/watch?v=R3S_XYaEPUs

Treatments for Anxiety Disorders include evidence-based psychotherapies and in some cases, medications. Accommodations in school should be applied with the goal of improving function not avoidance.

Youth with Anxiety Disorders will often use avoidance as a preferred coping strategy. Avoidance makes the anxiety worse and limits a person's ability to deal with it. Indeed, the basic therapeutic intervention for Anxiety Disorders is to help the young person learn to not avoid. In the school setting, be sure that avoidance is not enabled. If accommodations are needed they should be limited in duration and be focused on helping the student regain function. Accommodations for an Anxiety Disorder should be part of a treatment plan designed to restore functioning so that accommodations are no longer needed. They are a means to an end, not an end in themselves.

Examination anxiety does not exist! There is no such thing as “examination anxiety”. There is the stress response to taking an examination. It is normal. It is expected. It has a purpose – to prepare your students to take the examination (or job interview or any other life task or challenge). Calling this normal stress response “examination anxiety” creates an expectation of disorder, and creates an unnecessary pathology. In some cases this label is used to support avoidance.

Most students experience mild to moderate degrees of examination induced stress response. They need to be assured this is normal and has a purpose – to drive behaviours that will help achieve success. The intensity of the response can be decreased using the box-breathing technique taught in Module 6.

Some students with a pre-existing Anxiety Disorder will experience an enhanced stress response to the



examination stressor. Some students who have learned to fear or avoid the examination stressor may also experience an enhanced stress response. Avoidance of the stressor for these students is not helpful – it actually leads to a lack of resilience and even learned helplessness. For students with an exaggerated stress response, desensitization techniques that can be taught by a school counsellor and reinforced by the teacher should be applied from the beginning of the school year. In addition study skill development, cognitive reframing of the stress response from fear to preparation/excitement and the practice of stress reduction techniques should be employed. Accommodation should be used as a step towards full participation. It is a means to an end, not an end in itself.

Other Mental Disorders with Hyper Arousal Symptoms

What is Obsessive Compulsive Disorder?

Obsessive Compulsive Disorder (OCD) is 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 they are 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 can affect anybody. First-degree relatives of people with OCD are more likely to develop OCD.

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 also 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.).

To view an animated video on OCD visit: <https://www.youtube.com/watch?v=ua9zr16jC1M>

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 their 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

What can I do if it is OCD?

If you are concerned your student has OCD, you should send the student to the school guidance or health professional who can then refer the student to the professional best suited to provide treatment and you can continue to provide support to the student as part of their “circle of care”. Usually young people will be treated with Cognitive Behavioural Therapy (CBT) and a Selective Serotonin Reuptake Inhibitor (SSRI) medication. 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? Do those thoughts cause you to feel uncomfortable or anxious or upset? Do you think that those thoughts are true? 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? 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?

Treatment for OCD requires applications of both medications and an evidence-based psychotherapy such as CBT.

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 psychotic 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 ritual is important.

What is Post Traumatic Stress Disorder?

Post Traumatic Stress Disorder (PTSD) develops after a significant 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. Recent widening of diagnostic criteria have included repeated or extreme indirect exposure in the performance of professional duties. This is not the same as watching tragic events on the television.

It is essential not to confuse normal negative emotions with PTSD. Feeling upset about a stressful event is not PTSD. Feeling upset when remembering a stressful time or event is not PTSD. The word trauma and the phrase “traumatic experience” should be reserved for severe, substantive and significant (often life-threatening) events. They should not be used to describe stress-provoking and difficult, unusual or common challenges of life.

Who is at risk for developing PTSD?

Not all people who have experienced a traumatic event will develop PTSD. Most will not. Risk factors include personal or family history of Depression, severity and persistence of the trauma.

What does PTSD look like?

The symptoms of PTSD develop around 6-8 weeks following the traumatic event and are organized into different categories:

- ***Intrusion Symptoms*** – recurrent, intrusive, distressing recollections or memories of the event in the form of memories, dreams, or flashbacks in which the individual perceives themselves to be re-living the event as though it was actually happening again in the present.
- ***Avoidance Symptoms*** – avoidance of things – 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 sadness, numbing of emotions, a loss of interest in previously enjoyed activities, detachment from family and friends, and a sense of hopelessness about the future.
- ***Hyper Arousal Symptoms*** – sleep problems (difficulties falling asleep or staying asleep), irritability, aggression, angry outbursts, hypervigilance, self-destructive behaviour, exaggerated startle response, and difficulty concentrating.
- ***Negative Cognitive/Emotional Symptoms*** – Unable to recall key aspects, persistent and disturbed negative feelings, self-blaming, guilt, shame, detachment, decreased interest in activities.

The symptoms have to be present for at least one month and must cause functional impairment (at home, at school, at work, etc.)

For some people, these symptoms may not appear until a number of months after the experienced event.

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

It is normal to remember traumatic events and to feel distress or discomfort when doing so. This is not PTSD.

- The person experienced extreme fear, helplessness or horror
2. The traumatic event is re-experienced, including one or more of:
 - 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:
 - Avoiding thoughts, feelings or conversations, avoiding 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:
 - Difficulty falling or staying asleep, irritability, difficulty concentrating, hypervigilance, exaggerated startle responseshort time accompanied by a lack of control over the eating during the episode) and by frequent and
 5. Duration of symptoms greater than 1 month:
 - Severity of symptoms causes marked distress and impairment in daily functioning.

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

It is normal to remember traumatic events and to feel distress or discomfort when doing so. This is not PTSD.

PTSD must be distinguished from normal responses (such as grief, acute stress response, etc.) to such situations and from Acute Stress Disorder (ASD). ASD has similar symptoms to PTSD but ends or is diminished greatly sometimes without formal treatment within about four weeks of the traumatic event. Psychotherapies or SSRI medication may be used to treat ASD. Duration and severity of PTSD symptoms may vary over time with recovery occurring within half a year (or less) in about half of cases.

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. The role of the school is not to treat but to suggest treatment. It is important not to confuse PTSD with normal responses to traumatic events (often called an acute stress response) or with ASD. Do not create pathology where it does not exist! For people with PTSD, supportive counselling using cognitive therapy methods may be of help. If the disorder is causing significant distress and impairment, referral to a specialist health care provider is indicated, as medication or specific types of psychotherapeutic treatments 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? What kinds of things are you experiencing? How is the affecting your life?

Things to look for:

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

Treatment for PTSD usually requires both an evidence-based psychotherapy plus medication.



What does Bulimia Nervosa look like?

Bulimia Nervosa 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 inappropriate behaviours designed to prevent weight gain (including but not limited to: self-induced vomiting, use of laxatives, enemas, and/or 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 patterns 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.

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.

Treatments for AN are based on maintenance of an appropriate body weight and psychological interventions. Medications are not effective in AN. Treatment for AN usually requires a sub-specialty mental health eating disorders service.

Things to look for:

Some people with AN may go on to develop Depression or other severe medical problems. Some young people may begin to avoid class or other school activities. Frequently, young people with AN will avoid eating at times all other young people are eating (such as lunch time in the school cafeteria).

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 laxatives, 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 BN.

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).

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.

Treatment for BN includes both psychological therapies and medications.

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 Related Disorders, Conduct Disorder

Substance Use Disorder

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

Substance Related Disorders

Substance use and substance misuse occur commonly in young people and are not the same as Substance Use Disorders or Substance Induced Disorders. However, the onset of the latter most commonly occurs during the teen years. Currently, alcohol and tobacco are the most commonly used substances with marijuana ranking a more distant third on the list. Clinical interventions to help young people who are misusing substances are often provided based on the realization that some types of substance misuse may raise the probability of substance related harm, even if the young person does not go on to develop a Substance Use Disorder. Indeed, most people who misuse substances in their youth do not go on to develop a Substance Use Disorder.

To this end, the CRAFFT (as described below) youth substance assessment measure can be used to identify those young people for whom a clinical intervention may be indicated before they go on to develop a Substance Use Disorder. Young people who have engaged in one or more items on the CRAFFT screening tool could be considered as candidates for early intervention.

Substance Use Disorders (SUDs) are characterized by excessive and continued use of substances in spite of



numerous negative consequences (physical, social, academic/vocational, interpersonal and legal). People with SUDs crave the substance and exhibit persistent drug seeking behaviours which can include various anti-social components, such as theft. Young people who meet diagnostic criteria for a SUD require intensive treatment that may include short-term residential care. Treatment relapse is common.

Adolescent Alcohol & Substance Use Screen (CRAFFT):

- C** Have you ever ridden in a **CAR** driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- R** Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?
- A** Do you ever use alcohol/drugs while you are **ALONE**?
- F** Do you ever **FORGET** things you did while using alcohol or drugs?
- F** Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
- T** Have you gotten into **TROUBLE** while you were using alcohol or drugs?

Substance Induced Disorder describes the impact of a substance on a person at a particular point in time. For example, this includes intoxication or withdrawal.

Substance Induced Disorder (SID) can occur without the presence of Substance Use Disorder. For example, a young person can be intoxicated from excessive use of alcohol and behave inappropriately or dangerously (driving a car) or be admitted for emergency medical care due to an inability to function or as a result of a neurological event (such as a seizure). During this time, the person would be considered to exhibit a Substance Induced Disorder. Many young people, especially if they are involved in binge drinking of alcohol, can meet diagnostic criteria for SID if excessive amounts of alcohol are ingested over a short period of time. This would be called Alcohol Induced Disorder.

Some SIDs can, in the short term, be difficult to distinguish from certain types of mental disorders, such as psychosis or mood disorders. This is because the substance can elicit delusions and hallucinations or severe Depressions or extreme excitement and agitation. In such cases, admission to hospital is often indicated - both to treat the SID and also to differentiate symptoms related to an SID from those of a psychosis or mood disorder.

With Substance Use Disorder, the person demonstrates a longstanding pattern of negative behaviours as described above related to the persistent seeking out of and use of a particular substance. For example, a person with Alcohol Use Disorder could be intoxicated for hours in a day, may steal to obtain funds to purchase alcohol, may neglect their personal hygiene when drinking, may run afoul of the law or act inappropriately at school, etc. This pattern of behaviour would occur frequently over time and would be associated with significant functional impairment (for example: failing at school; legal charges, traffic accidents while drinking, etc.).

Individuals with SUDs may frequently also demonstrate SID at numerous points over time, while many people who demonstrate SID at infrequent time points may not meet diagnostic criteria for SUD.

There are many types of SUDs. A SUD can occur with substances that are legal (for example: tobacco or alcohol) or illegal. These include but are not limited to: Alcohol Use Disorder, Cannabis Use Disorder, Opioids Use Disorder, etc. Not infrequently, the type of SUD can change over time or a person can meet criteria for more than one SUD concurrently.

Treatments are a combination of psychological and social (often peer-supported) interventions. Sometimes medications are used depending on the substance and the situation.

What is Attention Deficit Hyperactivity Disorder?

Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder 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 early in life and continues into adolescence and for some people, into adulthood.

Who is at risk for ADHD?

ADHD has a genetic component and is more common in boys. Girls who have ADHD often do not have similar problems with hyperactivity although they have problems with sustaining attention and impulsivity. 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. About 30% of youth with ADHD have a learning disability.

What does ADHD look like?

Not all students who demonstrate challenges with sustained attention have ADHD. 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 home-based tasks and may start but not complete numerous activities. They are easily distracted by stimuli in their environment (such as noise) and often will begin to avoid tasks that require significant attention (such as homework). 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 quickly 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 they are 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. These must be significantly greater than other students of similar age.

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) Blurts out comments or answers to questions before they should
- 2) Has difficulty waiting their turn
- 3) Often interrupts or intrudes on others
- 4) Often “acts” without thinking
- 5) Fidgets or squirms while seated
- 6) Leaves seat in classroom when they are supposed to be seated
- 7) Runs about or climbs excessively when not appropriate
- 8) Has difficulty in solitary play or quiet activities
- 9) Is usually on the go, as if motor driven
- 10) Often talks excessively
- 11) Impulsivity

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 a 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 longer periods of time.

Some young people with ADHD will develop conduct disturbances or substance misuse. 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 Conduct Disorder?

Severe, persistent and challenging behaviours that threaten the safety, security or physical integrity of others are the phenomena that comprise Conduct Disorder (CD). Youth with CD act with aggression and even violence towards others, either in response to a challenge or without provocation. They threaten (verbally and physically) and intimidate others and can cause physical harm to others, including assault with a weapon. They commonly engage in property damage or theft and frequently violate norms of social behaviour such as running away from home, lying, school truancy and bullying of others occurs. Young people with CD have higher rates of substance misuse, difficulties with the law (for example: arrests and convictions), traffic accidents, school non-completion and poorer economic/vocational outcomes. They may be involved in various illegal activities including crimes against people and property. A sub-group of those with CD may later in life meet diagnostic criteria for Anti-Social Personality Disorder and rates of Attention Deficit Hyperactivity Disorder and Substance Use Disorder are higher in youth with CD.

Behaviours Related to Mental Disorders: Suicide and Self-Harm

What is suicide?

Suicide is the act of ending one's life. Suicide is the outcome of a behaviour, it 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 Use Disorder.

Suicide is found in every culture and is 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 this, it is 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. For more information, check out this link: <http://teenmentalhealth.org/learn/suicide/>.

How are suicide and self-harm different?

Self-harm is a behavior initiated for many different reasons. These include but are not limited to: onset of a mental illness, experience of overwhelming stress (such as ongoing sexual abuse), pressure to be part of a subculture, and/or different problem-solving skills. Teachers should not try to “understand” or “control” youth who self-harm. Referral to a specialized mental health provider is needed.

Self-harm behaviours are not attempts to die. Suicide attempts are distinguished from self-harm behaviours by a person's wish to die.



Educators may be faced with situations in which they encounter students self-harming. Do not panic. Calmly bring the student to the most appropriate “in school” support. When discussing self-harm, it is useful to explain the behaviour as an attempt to solve a problem and to note that better solutions exist. Encourage the student to work towards using those. Do not get involved in discussions about self-harm.

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

1. Suicidal ideation includes ideas about death or dying, wishing that they were dead, or ideas about committing suicide. These ideas are not persistent for some youth but for some they can become so. 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 attempt suicide but the suicidal ideation is a risk factor for suicide.
2. The second component is suicidal intent. With suicidal intent, the idea of suicide is better formed and more consistently held than in suicidal ideation. A person with suicidal intent may think about suicide most of the time, imagining what life would be like for friends and family without them, etc.
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 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.

Students who exhibit suicide ideation or have intents may benefit from supportive or cognitive based counselling. The presence of a suicide plan should lead to placement of the person in a situation in which they can be safe and secure. That situation should be therapeutic and not punitive, and should be accompanied by supportive and cognitive counselling. Any mental disorder should be treated. If a suicide has happened, the family or loved ones may benefit from non-judgmental supportive bereavement counselling.

Do not keep suicide concerns or self-harm behaviours confidential.

If a teacher is faced with a student who is talking about or writing about suicide then it is important to include the most appropriate student services provider to assess the situation.

Supportively accompany them to the most responsible student health provider in the school so that an assessment of risk can be conducted. 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 dies by 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. Bringing grief counsellors into a school is not usually helpful. A supportive space for those students who wish to use it should be provided after school hours and a teacher or guidance counsellor 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. Self-harm can become a preferred (but unhelpful) approach to problem-solving. Certain mental illnesses (such as Bipolar Disorder) may lead to self-harm because of unstable mood. Sometimes self-harm behaviours can become part of a group identity. Contagion effects can occur in both self-harm and suicide attempts.

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 cause an event to happen. Rather, it is something that increases the probability of an event.

- Depression or other mental disorder
- Previous suicide attempt
- Family history of suicide
- Excessive alcohol or drug use

Suicide risk is higher in people with mental disorders, in particular those with: Depression, Bipolar Disorder (Manic Depression), Schizophrenia, and Substance Use Disorder. If a young person talks to you about suicide, take them seriously and take them to the person in the school best able to help. Do not keep suicide or self-harm confidential. It is not helpful to engage in persistent public discourse about suicide or self-harm. Youth need to know that the presence of suicidal thoughts is a signal that they need help and that they should reach out to a responsible adult for assistance.

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 approach a trusted adult for assistance. Youth who self-harm can be counseled to seek alternative and better methods to solve problems.

Questions to ask?

It seems as if things have been difficult for you - can you share how you are feeling? When you are feeling this way, do you think you would be better off dead or that life is not worth living? Have you been thinking about taking your own life?

The focus of suicide education is to frame the presence of suicidal thoughts as a signal to seek help from a trusted adult.

Treatments for suicide risk are based on rapid access to effective ongoing care for a mental disorder. For self-harm, evidence-based psychotherapies are used.

Confidentiality

When speaking to students, ensure that they understand what will and will not remain confidential. Know your professional expectations and the legal parameters in your jurisdiction as well as the policies of your school. Harm to self or others cannot be held in confidence. Remember that any electronic interaction (such as email, texting, etc.) that you have with a student cannot be assumed to be or remain confidential. When speaking with



parents, remember that the student may expect confidentiality from parents, parents from student and even parents from each other. Providing information on confidentiality to students and parents (for example, on the school website) is useful. Always document your interaction with a student in which a mental health concern has been raised.

What to do?

If you are concerned about a student, involve your school's student services provider (counsellor, social worker, psychologist, etc.) as soon as possible. Discuss the situation and come up with a mutually acceptable plan. Remember that what you are addressing is not your sole responsibility. A teacher is not a diagnostician, is not a counsellor and is not the student's friend. Be careful not to get caught in the problem-solving (teacher becomes responsible for solving the student's problem) or understanding (teacher's role is to understand the student) traps. Provide clear messages about drug use, self-harm and dangerous behaviour. Provide a confidential ear with clear limits to confidentiality.

Teachers should be part of the circle of care that surrounds a student in need. This requires input from teachers and the sharing of necessary information. If your school does not have a process for enlisting appropriate teacher participation in a circle of care, raise this issue with your administration.

For more information on mental health and mental disorders, as well as access to useful (and free) classroom and teacher-friendly resources, visit www.teenmentalhealth.org.

