MENTAL HEALTH ISSUES AND STUDENTS

INDEPENDENT STUDY

A FIVE CREDIT CLASS

Course # HE402n/HE502n

INSTRUCTOR:

DR. MICHAEL SEDLER

Email: mike@communicationplus.net

(509) 443-1605

THE HERITAGE INSTITUTE

Please Do Not send in no more than 2 to 3 assignments at a time and I will send you back comments. Send them in numerical order (#1, #2, #3…).

Thank you for signing up for my independent study classes. You may take up to six months to complete this course and may obtain an additional 3 month extension. DO NOT send in any completed papers unless you have registered for the class!

The checklist in the manual is to help you plan your schedule to successfully complete this course. The last page of the manual includes a General Bibliography. If you prefer, you may choose an alternate book not on the suggested list.

On the following page, I have given you a brief biography/resume of my background. You will see that I have a Masters Degree in Social Work; my K-8 Teaching Certification and am a Licensed Social Worker with the State of Washington. My current primary role is as a consultant and trainer for schools, businesses and agencies. I also worked in education for 15 years as a Director of Special Education, a Behavior Intervention Specialist, School Social Worker, and Teacher.

I teach classes and seminars throughout the United States and in Canada. I am an adjunct professor through two Universities in Washington. I am available for on-site training, classes, and in services for agencies and schools. I anticipate this class will be enjoyable and full of learning. Please contact me if you would like me to be involved directly with your school or business.

Thank you, once again, for signing up for it and I look forward to working with you over the next weeks/months.

Sincerely,

Michael Sedler
(509) 443-1605
E-mail: mike@communicationplus.net
Website: www.michaelsedler.com
P.O. BOX 30310 - Spokane, WA. - 99223

** For those working in groups (400/500 level only!)- be sure to go to The Heritage Institute website at www.hol.edu and click on the "group collaboration" icon.

1. Each group member must pick a book to read (you may all choose the same book).

2. Each group member must read the entire manual.

3. Final evaluation/integration paper must be individually authored.

Please share about my classes with others. It is my main form of advertising

MICHAEL SEDLER

(509) 443-1605 (w); (509) 939-6302 (c)
Email: mike@communicationplus.net or michael@michaelsedler.com
website: www.michaelsedler.com

Education
B.A., Political Science
Master Degree, Social Work
Master Degree, Divinity
Doctorate Degree, Ministry
Teaching Certificate

Work Experience
Consultant/Trainer/Counselor
Director of Special Education
Developmental Disabilities Administration-behavior consultant
Supervisor, Educational Services
School Social Worker (K-12)
Behavior Intervention Specialist (K-12)
Classroom Teacher (elementary and middle school)
Assistant Pastor

Other Experiences
State Correctional Facility for Juveniles, Counselor and Supervisor
Community Mental Health Therapist
State Trainer in Autism (State of Washington)
Adjunct Professor for several Universities
Student Teacher Supervisor
Consultant for schools, business, churches throughout United States
Provide weekend marriage retreats
Interview and Speech Coach/Trainer for Miss Arizona, 3rd runner-up Miss America 2012

Author

When to Speak Up and When To Shut Up. (Jan., 2006 Revell Books, $5.99). Book from faith-based perspective.
Communication book discussing conflict, power struggles, listening strategies, asking questions.
(Over 400,000 copies sold).

What To Do When Words Get Ugly. (October, 2016 Revell Books, $5.99) (updated/edited version of "Stop The Runaway Conversation.") Two new chapters in addition to edits. Book from faith-based perspective.
Importance of not listening to negative discussions and how they impact a person's attitude.

Books are available through all bookstores, at www.bakerbooks.com, by calling 800 877 2665, or by checking with various online book companies. Revell Books is a division of Baker Publishing Group.

Both books also available in CD format as audio books.

INDEPENDENT STUDY COLLEGE COURSES

THE HERITAGE INSTITUTE (credits through Antioch University, Seattle, WA)
MICHAEL SEDLER, INSTRUCTOR

Register for courses anytime. (6-month period for completion from the date you register). ***Collaborate with fellow educators-only one set of assignments turned into instructor.*** (Check out "Group Collaboration Guidelines" at www.hol.edu). **Clock hours available for partial course completion.

The following are **3 CREDIT CLASSES** (3 quarter credits = 2 semester credits)

1. **Increasing Motivation and Self-Esteem in Students** (SS401p/SS501p)
Strategies to help students feel confident and help educators find more successful approaches with them.

2. **Parents: Adversary or Ally--A Cooperative Approach** (SS401q/SS501q)
Specific ideas on connecting with parents and helping better communication between school and home.

3. **Social Skills: A Foundation For Learning** (SS401v/SS501v)
Activities and ideas to encourage students to improve their peer and social relations.

4. **Understanding & Connecting With Aggressive Students**
(ED404d/ED504d)
Each person will increase their understanding of ways to de-escalate aggression and its' causes.

3 CREDIT COST: *$280-400/500* level; $195-clock hours (3 quarter = 2 semester)

The following are **5 CREDIT CLASSES**: **(5 quarter credits -3.3 semester credits)**

1. **Bullying Behaviors: Enough is Enough** (ED437q/ED537q)
Identification and interventions to reduce bullying behaviors and victim mentality within schools and community.

2. **Counseling Skills For Educators** (ED409r/ED509r)
Helpful ideas on listening skills, asking questions, and communicating with students.

3. **High Maintenance Behaviors & Interactions** (SS409f/SS509f)
This course investigates the many aspects of high needs people, behaviors and effective interactions.

4. **Mental Health Issues and Students** (HE402n/HE502n)
Understand various disorders (oppositional defiant, obsessive compulsive, bi-polar) and interventions.

5. **Nurturing Compassion Within Our Schools** (ED434y/ED534y)
Ideas to help adults and children learn to be more sensitive, kind, and compassionate toward one another.

6. **Organizational Teaching Skills** (ED429w/ED529w)
Increase your own organizational and time management skills as well as helping students in these areas.

7. **Stress Reduction in Staff and Students** *(HE401m/HE501m)*
Strategies to reduce stress, become more effective in life, and teach these skills to students.

8. **Student, Classroom and Whole-School Discipline** (ED419g/ED5I9g)
Focus is on negative talk, gossip and rumors within schools. Behavioral strategies for each above area.

9. **Youth Suicide** (SS404u/SS504u)
Specific discussions on signs and interventions for suicide prevention.

5- CREDIT COST: *$415-400/500* LEVEL; $315-clock hours (5 quarter = 3.3 semester)

NEXT PAGE FOR MORE CLASSES AND REGISTRATION INFORMATION

INDEPENDENT STUDY COLLEGE COURSES

THE HERITAGE INSTITUTE (credits through Antioch University, Seattle, WA)

MICHAEL SEDLER, INSTRUCTOR

The following are **6 CREDIT CLASSES**: **(6 quarter credits - 4 semester credits)**

1. Autism: Questions and Answers (ED445y/ED545y)

Understanding the general areas of autism, diagnosis, and overall strategies for interventions for children with special needs.

2. Establishing Rules and Boundaries (ED445x/ED545x)

Ideas to assist educators in setting up a successful work environment for children (rules, procedures, teaching tools).

3. Inspirational Education (ED452f/ED552f)

This course will re-charge the batteries and create a new excitement about teaching in each person.

4. The Impact Of Trauma and Loss in Students (ED464z/ED564z)

Strategies to support children who have experienced traumatic situations in life.

5. Why Children Act Out (ED458t/ED558t)

Recognize the underlying function of behaviors and interventions approaches.

6- CREDIT COST: $495--400/500 LEVEL; $380-clock hours (6 quarter = 4 semester)

REGISTRATION: **Call The Heritage Institute--*1 (360) 341-3020***

Or register on line at www.hol.edu

QUESTIONS: Please call Michael Sedler at (509) 443-1605. Leave message when necessary.

Email address: mike@communicationplus.net Website: www.michaelsedler.com

**For clock hours, only complete the first section of the course. Remember, clock hours may not transfer to other districts or states. You cannot go back and acquire credit once clock hours have been earned for a class.

COURSE TITLE: **MENTAL HEALTH ISSUES AND STUDENTS**

NO. OF CREDITS: **5 QUARTER CREDITS** **CLOCK HRS: 50**
[Semester Cr Equivalent: 3.3] **PDU'S: 50**
CEU'S: 5.0 (50 hrs)
PENNSYLVANIA ACT 48 : 50

INSTRUCTOR: **MICHAEL SEDLER, M.S.W.**
P.O. Box 30310
Spokane, WA. 99223
509/443-1605
Email: mike@communicationplus.net

ASSIGNMENT CHECKLIST

The assignment checklist will help you plan your schedule of work for this course. Check off items completed so that you can better monitor your progress. While you have six-months to complete your work, many will find a shorter time period convenient. **Complete no more than 2 to 3 assignments at a time for comments. Do NOT send further work until you receive comments from the instructor. Grades will be submitted once all assignments and the integration paper have been sent to instructor.**

For Washington Clock Hours, Oregon Professional Development Units, Continuing Education Credits or Pennsylvania ACT 48, **please complete the first 8 assignments.**

Assignment #1:
Read the entire manual and send a **one page summary** of what you hope to learn in this class.

Assignment #2:
Read a book from the bibliography or one of student's choice. If taking this course in a group, each person should read a book. Only one person needs to write a summary.
Critique the book based on personal experiences and insights. **Write a 2-3 page paper.**

Assignment #3:
Complete the following activities:

a) Self Injurious Behaviors (p. 21)
b) Attachment Disorder (p. 36)
c) Obsessive Compulsive Disorder (p. 48)

(Choose one of these pages and write a 1-2 page summary of your thoughts and insights on this topic).

Assignment #4:
After reading the article "Understanding Mental Health Issues in Children," (pages 11-15), **write a 2 page response**.

Assignment #5:
Discuss two specific disorders with a colleague. **Write a 2 to 3 page paper** on the discussion.

Assignment #6:
Read the case study on page 41. **Answer the questions and write a 1-2 page summary of your answers.**

Assignment #7:
Review a minimum of three websites on mental health issues. **Write a 1-2 paper summarizing one or more sites.**

Assignment #8:
Select a specific student to evaluate based on information in this manual. Choose one area of focus and share characteristics, behavior signs, and interventions approaches. **Write a 2 to 3 page summary**.

This completes the assignments required for Washington Clock Hours, Oregon PDUs, CEUs or Pennsylvania ACT 48.

Continue to the next section for additional assignments required for University Quarter Credit.

ADDITIONAL ASSIGNMENTS REQUIRED for 400 or 500 LEVEL UNIVERSITY QUARTER CREDIT
In this section you will have an opportunity to apply your learning to your professional situation. This course assumes that most participants are classroom teachers who have access to students. If you are not teaching in a classroom, please contact the instructor for course modifications. If you start or need to complete this course during the summer, please try to apply your ideas when possible with youth from your neighborhood, at a local public library or parks department facility, (they will often be glad to sponsor community-based learning), with students in another teacher's summer classroom in session, students from past years, or use one of your own children or a relative.

Assignment #9: (Required for 400 and 500 Level)
Which mental health issue do you see most often in your professional setting? How does this impact the child and those around him/her? How do others (adults and children) respond to this person? (**2 pages**)

Assignment #10: You must choose either "A" or "B" (Required for 400 and 500 Level)

Assignment #A:

- Develop a lesson to reflect what you've learned in this course.
- Implement your lesson with students in your classroom.
- Write a **2 page commentary** on what worked well and what could be improved.
- Include any student feedback on your lesson.

OR

Assignment #B:
Use this option if you do not have a classroom available.

- Develop a lesson to reflect what you've learned in this course. (Do not implement it.)
- Write a **2 page summary** concerning any noteworthy success you've had as a teacher with one or more students.

500 LEVEL ASSIGNMENT
Assignment #11: (500 Level only)
In addition to the 400 level assignments complete **one (1)** of the following options:

Option A) Mentor another individual in the concepts of this class. Have them share two or three key concepts that they would like to implement within their work or social setting. Develop a plan for the implementation of these ideas. **(1-2 pages).**

OR

Option B) Create a PowerPoint presentation for your staff based on this course and focused on perspectives or strategies you feel would be beneficial for your school. **Minimum of 15 slides**. Save this as a pdf.

OR

Option C) Another assignment of your own design, with instructor prior approval.

400 & 500 LEVEL ASSIGNMENT (To be completed by all participants taking this for credit)

Assignment #12: (Required for 400 and 500 Level Credit)

Write a 2 page Integration Paper answering these questions:

1. What did you learn vs. what you expected to learn from this course?
2. What aspects of the course were most helpful and why?
3. What further knowledge and skills in this general area do you feel you need?
4. How, when and where will you use what you have learned?
5. How and with what other school or community members might you share what you learned?

Must be individually authored for those taking this in a group.
Remember, each assignment must have name and course title on it. Send to Instructor.

QUALIFICATIONS FOR TEACHING THIS COURSE:
Mike Sedler, M.S.W., D. Min., brings over 40 year of educational experience as a special education director, social worker, behavior specialist and teacher to each of his classes. He provides consultation and seminars throughout the United States and Canada for schools, agencies and businesses. He has a graduate degree in Social Work, a Doctoral degree in Ministry, a Counseling license, as well as his teaching certification. Mike has worked with children of all ages, specifically with children exhibiting behavioral challenges, mental health concerns, and characteristics of Autism Spectrum Disorder. In addition, he taught general education classes in the elementary school and middle school arenas. All of Mike's classes are practical and "field tested" in schools and classrooms. Educators have found success in implementing Mike's clear and concise approaches. All of his course material may be immediately implemented into a school or a home.

NOTES: You may work collaboratively and submit joint assignments on all but the Integration Paper portion which must be individually authored. Alternatives to written assignments such as a video, audio tape, photo collage, etc. are permissible with prior approval of instructor.

Full credit will be given to each student as long as all work is turned in. If something is missing, I will be in contact with you. Failure is not an option. 😉

This course will cover many different mental health issues confronting today's youth. It is not intended as a counseling class, an exhaustive study of mental health, or as a substitute for information gained from someone in the medical or mental health profession.

The information is presented as an introduction to various disorders and how they impact our students. In addition, this manual will provide certain approaches and strategies to help you identify and intervene with students.

This is not a substitute for further personal reading or consulting with proper medical and counseling professionals. If you believe a person that you are connected to exhibits behaviors or characteristics of the specified disorders, please consult a professional in your area. (Does this sound like one of those commercials that lists all the side effects of a medication but still encourages you to take it?)

My concern is that it is easy for us to "diagnose" others due to having just the basic information. A person who has taken one psychology class thinks they can analyze everyone…true? So be careful and take the information as it is intended—to increase your knowledge base, to support students in school, and to provide you with additional strategies with difficult children.

If you have further questions, please feel free to email me or call me for guidance. Thank you for taking this class and enjoy.

P.S. If by reading this note you have become anxious and nervous about the class…take two Prozac and call me in the morning…just kidding! (sort of).

RESEARCH CONCLUSIONS ABOUT AT-RISK CHILDREN

(Children's Defense Fund, Federal Interagency on Child Family Statistics, National Centers for Disease Control)

1. **ALL CHILDREN CAN LEARN.** Research shows with absolute certainty that all children can learn (even the poor, language-challenged, learning-disabled, under-achieving). **We must examine our attitudes and expectations surrounding the concept of student learning.**

2. **SCHOOLS MAKE A DIFFERENCE.** Early 1960s and 1970s studies concluded that poverty yielded strong negative impact on learning. New studies challenge those findings. **Developing an environment and milieu of success will make a tremendous impact upon the students.**

3. **TEACHERS MAKE A DIFFERENCE.** The single most influential factor in student learning is teacher quality. An ineffective teacher may impact student learning to such a large degree that it inhibits growth for up to one year. **We are the most important factor in a child's learning. "*We can be an instrument of inspiration or a tool of torture*" (Gaim Ginott).**

4. **IMMEDIATE GAINS ARE POSSIBLE.** Research has found that by utilizing a combination of effective instructional strategies, positive interventions, and relationship connections, the impact on students can be immediate. **It may be helpful to examine a before and after "picture" of the child.**

5. **LOW PERFORMING SCHOOLS CAN BECOME HIGH PERFORMING SCHOOLS.** Successful models have been used to significantly raise the performance levels of low performing schools. **Don't let the current state of the classroom/school prevent you from attempting to make changes.**

6. **BEST PRACTICES WORK FOR AT-RISK STUDENTS.** By using a combination of well researched and documented interventions, achievement improves in students. **There are proven strategies that work. Are you willing to attempt some of these and make a change in your approach?**

Understanding Mental Health Issues in Children

(to be used with Assignment #4)

Mental Health Is Important

Mental health is how people think, feel, and act as they face life's situations. It affects how people handle stress, relate to one another, and make decisions. Mental health influences the ways individuals look at themselves, their lives, and others in their lives. Like physical health, mental health is important at every stage of life.

All aspects of our lives are affected by our mental health. Caring for and protecting our children is an obligation and is critical to their daily lives and their independence.

Children and Adolescents Can Have Serious Mental Health Problems

Like adults, children and adolescents can have mental health disorders that interfere with the way they think, feel, and act. When untreated, mental health disorders can lead to school failure, family conflicts, drug abuse, violence, and even suicide. Untreated mental health disorders can be very costly to families, communities, and the health care system.

Mental Health Disorders Are More Common in Young People Than Many Realize

Studies show that at least one in five children and adolescents have a mental health disorder. At least one in 10, or about 6 million people, have a serious emotional disturbance.

The Causes Are Complicated

Mental health disorders in children and adolescents are caused mostly by biology and environment. Examples of biological causes are genetics, chemical imbalances in the body, or damage to the central nervous system, such as a head injury. Many environmental factors also put young people at risk for developing mental health disorders. Examples include:

- Exposure to environmental toxins, such as high levels of lead;
- Exposure to violence, such as witnessing or being the victim of physical or sexual abuse, drive-by shootings, muggings, or other disasters;
- Stress related to chronic poverty, discrimination, or other serious hardships; and
- The loss of important people through death, divorce, or broken relationships.

Signs of Mental Health Disorders Can Signal a Need for Help

Children and adolescents with mental health issues need to get help as soon as possible. A variety of signs may point to mental health disorders or serious emotional disturbances in children or adolescents. Pay attention if a child you know has any of these warning signs:

A child or adolescent is troubled by feelings:

- Sad and hopeless for no reason, and these feelings do not go away
- Very angry most of the time and crying a lot or overreacting to things
- Worthless or guilty often
- Anxious or worried often
- Unable to get over a loss or death of someone important
- Extremely fearful or having unexplained fears
- Constantly concerned about physical problems or physical appearance
- Frightened that his or her mind either is controlled or is out of control

A child or adolescent experiences big changes such as:

- Showing declining performance in school
- Losing interest in things once enjoyed
- Experiencing unexplained changes in sleeping or eating patterns
- Avoiding friends or family and wanting to be alone all the time
- Daydreaming too much and not completing tasks
- Feeling life is too hard to handle
- Hearing voices that cannot be explained
- Experiencing suicidal thoughts

A child or adolescent experiences:

- Poor concentration and is unable to think straight or make up his or her mind.
- An inability to sit still or focus attention.
- Worry about being harmed, hurting others, or doing something "bad".
- A need to wash, clean things, or perform certain routines hundreds of times a day, in order to avoid an unsubstantiated danger.
- Racing thoughts that are almost too fast to follow.
- Persistent nightmares.

A child or adolescent behaves in ways that cause problems:

- Using alcohol or other drugs
- Eating large amounts of food, then purging, or abusing laxatives, to avoid weight gain
- Dieting and/or exercising obsessively
- Violating the rights of others or constantly breaking the law without regard for others
- Setting fires
- Doing things that can be life threatening
- Killing animals

It is easy for parents to identify their child's **physical** needs: nutritious food, warm clothes when it's cold, bedtime at a reasonable hour. However, a child's **mental** and **emotional** needs may not be as obvious. Good mental health allows children to think clearly, develop socially and learn new skills. Additionally, good friends and encouraging words from adults are all important for helping children develop self-confidence, high self-esteem, and a healthy emotional outlook on life.

A child's physical and mental health are *both* important.

Basics for a child's good <u>physical</u> health:

- Nutritious food
- Adequate shelter and sleep
- Exercise
- Immunizations
- Healthy living environment

Basics for a child's good <u>mental</u> health:

- Unconditional love from family
- Self-confidence and high self-esteem
- The opportunity to play with other children

- Encouraging teachers and supportive caretakers
- Safe and secure surroundings
- Appropriate guidance and discipline

Give children unconditional love. Love, security and acceptance should be at the heart of family life. Children need to know that your love does not depend on his or her accomplishments. Mistakes and/or defeats should be expected and accepted. Confidence grows in a home and school that is full of unconditional love and affection.

Nurture children's confidence and self-esteem:

- **Praise Them -** Encouraging children's first steps or their ability to learn a new game helps them develop a desire to explore and learn about their surroundings. Allow children to explore and play in a safe area where they cannot get hurt. Assure them by smiling and talking to them often. Be an active participant in their activities. Your attention helps build their self-confidence and self-esteem.
- **Set Realistic Goals -** Young children need realistic goals that match their ambitions with their abilities. With your help, older children can choose activities that test their abilities and increase their self-confidence.
- **Be Honest** - Do not hide failures from children. It is important for them to know that we all make mistakes. It can be very reassuring to know that adults are not perfect.
- **Avoid Sarcastic Remarks** - If a child loses a game or fails a test, find out how he or she feels about the situation. Children may get discouraged and need a pep talk. Later, when they are ready, talk and offer assurance.
- **Encourage children** - To not only strive to do their best but also to enjoy the process. Trying new activities teaches children about teamwork, self-esteem and new skills.

Encourage Children to Play

To children, play is just fun. However, playtime is as important to their development as food and good care. Playtime helps children be creative, learn problem-solving skills and self-control. Good, hardy play, which includes running and yelling, is not only fun but helps many children to be physically and mentally healthy.

Sometimes it is important for children to have time with their peers. By playing with others, children discover their strengths and weaknesses, develop a sense of belonging, and learn how to get along with others. Consider finding a good children's program through neighbors, local community centers, schools, or your local park and recreation department.

Adults can be great playmates

Join the fun! Playing Monopoly or coloring with a child gives you a great opportunity to share ideas and spend time together in a relaxed setting. Teacher should join in group activities with children (play basketball, checkers, chess, card games-not Texas Hold-em ☺, board games, etc).

Play for fun

In our goal-oriented society, we often acknowledge only success and winning. This attitude can be discouraging and frustrating to children who are learning and experimenting with new activities. It's more important for children to participate and enjoy themselves.

TV use should be monitored

Try not to use TV as a "baby-sitter" on a regular basis. Be selective in choosing television shows for children. Some shows can be educational as well as entertaining.

School should be fun!

Starting school is a big event for children. "Playing school" can be a positive way to give them a glimpse of school life. Try to enroll them in a pre-school, Head Start, or similar community program which provides an opportunity to be with other kids and make new friends. Children can also learn academic basics as well as how to make decisions and cope with problems.

In the school setting, allow children to learn through laughter, fun assignments, and peer interaction. School can be enjoyable while educational.

Provide Appropriate Guidance And Instructive Discipline

Children need the opportunity to explore and develop new skills and independence. At the same time, children need to learn that certain behaviors are unacceptable and that they are responsible for the consequences of their actions.

As members of a family, children need to learn the rules of the family unit. Offer guidance and discipline that is fair and consistent. They will take these social skills and rules of conduct to school and eventually to the workplace.

Suggestions on guidance and discipline

- **Be firm, but kind and realistic with your expectations.** Children's development depends on your love and encouragement.
- **Set a good example**. You cannot expect self-control and self-discipline from a child if *you* do not practice this behavior.
- **Criticize the behavior, *not* the child**. It is best to say, "That was not a good thing you did," rather than "You are a bad boy or girl."
- **Avoid nagging, threats and bribery.** Children will learn to ignore nagging, and threats and bribes are seldom effective.
- **Give children the reasons "why" you are disciplining them** and what the potential consequences of their actions might be.
- **Talk about your feelings**. We all lose our tempers from time to time. If you do "blow your top," it is important to talk about what happened and why you are angry. A*pologize* if you were wrong!
- **Remember, the goal is not to control the child** but for him or her to learn self-control.
- **Provide a safe and secure home**.
- **It's okay for children to feel afraid sometimes**. Everyone is afraid of something at some point in life. Fear and anxiety grow out of experiences that we do not understand. If your children have fears that will not go away and affect their behavior, the first step is to find out what is frightening them. Be loving, patient and reassuring, not critical. Remember: the fear may be very real to the child.

Signs of Fear

Nervous mannerisms, shyness, withdrawal and aggressive behavior may be signs of childhood fears. A change in normal eating and sleeping patterns may also signal an unhealthy fear. Children who "play sick" or feel anxious regularly may have some problems that need attention.

Fear of school can occur following a stressful event such as moving to a new neighborhood, changing schools, or after a bad incident at school. Children may not want to go to school after a period of being at home because of an illness.

When to seek help

Parents and family members are usually the first to notice if a child has problems with emotions or behavior. Your observations with those of teachers and other caregivers may lead you to seek help for your child. If you suspect a problem or have questions, consult your pediatrician or contact a mental health professional.

Where to seek help

Information and referrals regarding the types of services that are available for children may be obtained from:

- Mental health organizations, hotlines and libraries
- Other professionals such as the child's pediatrician or school counselor
- Other families in the community
- Family network organizations and self-help groups
- Community-based psychiatric care
- Crisis outreach teams
- Education or special education services
- Family resource centers and support groups

SELF-INJURIOUS BEHAVIOR (SIB)

Before you start this section, write out a few sentences regarding your understanding of Self-Injurious Behaviors. How would you define it? What is your general understanding of it?

_____
_____
_____
_____

A recent study of a numerous college universities found 17% prevalence rate with an 11% repeat rate. A high school study in the United States and Canada found a 13% to 24% prevalence rate. A study in Britain estimated 10% of the youth aged 11 to 25 self-injure.

Definition: *the act of attempting to alter a mood state by inflicting physical harm serious enough to cause tissue damage to one's body.* Tattoos and body piercings are not typically considered self-injurious unless undertaken with the intention to harm the body.

NOTE: Individuals with a cognitive or developmental delay may self-injure for reasons not associated with the reasons stated below.

Most studies support that self-injury behaviors are initiated in middle adolescence between the ages of 12 and 15. It can last for days, weeks, months, or years. For many it is cyclical, meaning that it will occur for periods of time, stop, and then re-start at another time in life.

Connections with Suicide? Most studies find that self-injury is undertaken as a method to avoid suicide. However, studies also indicate that people with non-suicidal self-injury were over nine times more likely to report suicide attempts and six times more likely to have a suicide plan than people who were not self-injurious in their actions.

Self-Injury is strongly linked to childhood abuse and other disorders such as depression, anxiety, eating, substance abuse, post-traumatic stress, and borderline personality.

There is support that SIB shows addictive qualities and may serve as a form of self-medication for some individuals. Like suicide, there is a contagious impact upon a "community" and may follow epidemic-like patterns. However, over one-third of those surveyed indicated that the self-injury was hidden and a private act. Educators do report a fad-like quality when SIB is confirmed in a school.

Why does self-injury make some people "feel better?"

- **It reduces physiological and psychological tension rapidly**. Studies suggest that people who self-injure have their psychological and physiological tension reduced and brought down to a bearable baseline level almost immediately.

- **Some people never get a chance to learn how to cope effectively**. A history of abuse is common among self-injurers. They may have been taught at an early age that their feelings are bad or wrong; self-injury allows control.

- **Problems with neurotransmitters may play a role**. Problems in the serotonin levels may play a role in depression, aggression, or impulsive behaviors. Self-injury releases endorphins which is a natural painkiller and thus begins a cycle of injury.

WHY DO PEOPLE SELF-INJURE?

1. Arousal- it is often suggested that a person's level of arousal is associated with self-injurious behaviors. Under-arousal theory states that individuals function at a low level of arousal and engage in SIB to increase their arousal level. Basically, self-stimulation. The over-arousal theorists state that some people operate at a high arousal level and SIB releases anxiety or tension.
INTERVENTION: If under-aroused, increase in activity level may be helpful (exercise, outings, events). If over-aroused, use of relaxation techniques or removal of stimulus.

2. Pain- the person is feeling pain (emotional, psychological) and uses the self-injury to deflect the pain center.
INTERVENTION: Counseling or some other form of communication may help. This includes drawing, writing, musical outlets, etc.

3. Frustration- this fits in with the typical frustration model. A person is frustrated due to an event and becomes upset, even angry. They may hit the wall, bang the fist, or engage in some other aggressive injurious act.
INTERVENTION: Coping skills and social skills are helpful. Teaching the person to communicate the frustration in other ways may reduce the self-injurious act.

4. Communication- people with poor communication skills may resort to SIB as a form of communication. Remember, behavior is communication.
INTERVENTION: Simply stated, these people need to be taught functional communication skills. In other words, they can learn how to express feelings, how to share thoughts, and getting in touch with emotions.

5. Social Attention- there will always be a group that uses actions to gain attention.

INTERVENTION: If someone needs attention, give it to them. Only do so in appropriate ways and not when they demand it. Find positive ways to recognize/support the person.

6. Avoidance/Escape- self-injury may be used to avoid a task or situation. The SIB will focus the people away from the issues and re-focus on the injury.
INTERVENTION: It is important to follow through with the original request, demand, or focus.

Question: WHY DO YOU THINK PEOPLE SELF-INJURE?

_____

_____

_____

SELF-INJURIOUS BEHAVIOR INTERVENTION Sheet

PREVENTION

1. Focus on teaching coping skills to children. The more skills they have for various situations, the greater their capacity to find options to the problems.

2. Enhance social connections. Those who practice SIB also report high levels of perceived isolation, loneliness, and lack of affection from caregivers. Low self-esteem and high levels of shame are also found among them. Help them find a place of acceptance and worth within the school.

3. Avoid strategies aimed simply educating about the problem. Studies support that programs aimed only at educating about problems generally fail after a short time. Instead raise awareness of the underlying factors, discuss the solutions, and allow the students to investigate the issues through reports, speakers, and other personal experiences.

4. Equip staff and faculty to recognize and respond to signs of SIB. Look for intentional carving or cutting, burning, subdermal tissue scratching, ripping or pulling out of hair, self-bruising. Areas of particular focus include hands, wrists, stomach, and thighs.

The more we teach about concepts such as suicidal ideation, depression, bullying, and isolation, the greater the chance people will feel confident to address issues.

5. Connect with professional in the community. Increase the contact with professionals in the community. Allow them access to training, educating, and supporting students.

INTERVENTION

1. Avoid displaying shock, engaging in shame responses, or showing pity. ***It will only increase misunderstanding and potentially push the individual deeper into a "hidden shell".***

2. Remember, SIB is most often not a suicidal gesture. ***Allow the person to share what they were feeling and their purpose in self-injury. Be real and listen. If you are concerned about suicide, ask them clearly if that was their intent. Obtain help from a mental health professional or another person if you are uncertain as to how to respond.***

3. Self-Injury clearly serves a function—teaching more appropriate social skills and coping strategies should be our number one goal***. Focus on giving alternative strategies and options to the student.***

4. Develop guidelines for detection, intervention, and referral within your school. ***This is not an area that is often discussed and therefore most schools don't have procedures.***

5. Assess the level of group involvement and the potential for escalating behaviors within the school. ***The more people involved, the greater the chance of serious harm occurring.***

Resources: Cornell Research Program www.crpsib.com
Mental Health America www.nmha.org

Introspection on Self-Injurious Behaviors

(Connected to Assignment #3)

If you know anyone who has self-injured, use the following questions in relation to him/her. If you don't know anyone, then apply the questions as you might imagine in a situation. Remember, not all people who self-injure are habitual nor do they plan out their self-injurious actions. Also, it may happen at all ages (think of a toddler tantruming). In light of this, most of us know people (look in a mirror?) who have self-injured.

1. In your opinion, what is the most common reason for self-injury and why?

   _____

   _____

   _____

2. In your work setting, do you see self-injury? If so, do you feel it is effectively handled? If you don't see any, do you think it would be effectively handled? Why/Why Not?

   _____

   _____

   _____

3. Does your professional setting provide training and strategies for SIB? What about your community? Why do you think they do/don't provide specific programs, ideas, strategies for this issue?

   _____

   _____

   _____

Before taking this class, how would you rate your knowledge of the topic of Self-Injurious Behaviors? (1 to 10, with one being least and 10 being most) Circle your answer.

1 2 3 4 5 6 7 8 9 10

After this section, do you feel like you have greater understanding and knowledge? If yes, in what ways? If no, what would have helped? _____

_____

_____

Write a one page summary of our thoughts on this topic.

Conduct Disorder and Oppositional Defiant Disorder

According to the DSM-V (Diagnostical and Statistical Manual-used for Mental Health Diagnosis), conduct disorder may be diagnosed when a child seriously misbehaves with aggressive or nonaggressive behaviors against people, animals or property that may be characterized as belligerent, destructive, threatening, physically cruel, deceitful, disobedient, or dishonest. This may include stealing, intentional injury, and forced sexual activity.

Conduct disorder is a repetitive and persistent pattern of behavior in which the basic rights of others, or major rules and values of society are violated, as shown by the presence of three (or more) of the following behavior patterns in the past 12 months, with at least one behavior pattern present in the past six months:

Aggression to people and animals:

1. Often bullies, threatens, or intimidates others.
2. Often initiates physical fights.
3. Has used a weapon that can cause serious physical harm to others (for example, a bat, brick, broken bottle, knife, gun).
4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Has stolen while confronting a victim (for example, mugging, purse snatching, extortion, armed robbery.
7. Has forced someone into sexual activity.

Destruction of property:

8. Has deliberately engaged in fire setting with the intention of causing serious damage.
9. Has deliberately destroyed others' property (other than by fire setting).

Deceitfulness or theft:

10. Has broken into someone else's house, building, or car.
11. Often lies to obtain goods or favors or to avoid obligations (in other words, "cons" others)
12. Has stolen items of nontrivial value without confronting a victim (for example, shoplifting, but without breaking and entering; forgery).

Serious violations of rules:

13. Often stays out at night despite parental prohibitions, beginning before age 13 years
14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
15. Is often truant from school, beginning before age 13 years

According to the DSM-IV, in order to diagnose conduct disorder in a teen, the disturbance in behavior must be causing significant problems in that person's life, including at school, with friends and family, and on the job. In other words, if a child gets into serious trouble one time, learns from the experience and never does it again, he or she probably does not have a conduct disorder.

According to Merck's Manual, the onset of conduct disorder is usually in late childhood or early adolescence. Conduct disorder appears to be much more common in boys than girls. Children with conduct disorder seem to have an inability to correctly "read" other people, and instead will misunderstand the intentions of others, many times believing that people are threatening them or putting them down, when this is not really the case. (Does this sound like most of your students...especially in middle school)? ☺ They tend to react to these supposed threats or put-downs in an aggressive manner with little show of feeling or remorse. They do not tolerate frustration well. They also tend to generally behave in a reckless manner, without regard for normal safety issues.

Boys with conduct disorder are more inclined to fight, steal and participate in acts of vandalism, such as fire setting. Girls with conduct disorder are more likely to lie, run away and be involved in severe sexual acting-out behavior. Both boys and girls with conduct disorder are at an extremely high risk of substance abuse along with severe difficulties getting along in school.

What are the signs of Oppositional Defiant Disorder (ODD)?

According to the DSM-IV, if a child's problem behaviors do not meet the criteria for Conduct Disorder, but involve a pattern of defiant, angry, antagonistic, hostile, irritable, or vindictive behavior, Oppositional Defiant Disorder may be diagnosed. These children may blame others for their problems. (Once again, our general school population?). Obviously, we must be careful not to diagnose everyone in their teenage years.

Oppositional Defiant Disorder is a pattern of negativistic, hostile, and defiant behavior lasting at least six months, during which four (or more) of the following are present:

1. Often loses temper.
2. Often argues with adults.
3. Often actively defies or refuses to comply with adults' requests or rules.
4. Often deliberately annoys people.
5. Often blames others for his or her mistakes or misbehavior.
6. Is often touchy or easily annoyed by others.
7. Is often angry and resentful.
8. Is often spiteful or vindictive.

It is important to note that a counselor or therapist will consider a diagnosis of oppositional defiant disorder only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level. In other words, the problems and conflicts between teens and parents are as old as time itself, and some conflict is normal and inevitable. However, when the parent/child conflict becomes increasingly severe and appears to be spiraling out of control, then ODD might be considered. Also, as teens are growing and learning, they will sometimes do some very ill-advised things that can cause them problems, both legally and in school. However, if this behavior does not repeat itself and is a one-time event, then a behavior disorder is probably not present.

For a diagnosis of ODD to be made, the disturbance in behavior must be causing significant problems in school, in relationships with family and friends, and in the workplace. ODD will not be diagnosed if the therapist suspects that the teen's behaviors are being directly caused by another psychotic or mood disorder, such as bipolar disorder.

Kids with oppositional defiant disorder will show some of the same behaviors as those listed above for conduct disorder, including being very negative, angry and defiant. However, with ODD, one does not generally see the mean or cruel behavior that is present in conduct disorder, such as cruelty to animals.

As you can see from the behaviors listed above, there is a large overlap between conduct disorder and oppositional defiant disorder, with similarities in both disorders that include defiance, rebellion against authority, school problems, disobedience, anger and resentment, and bullying of brothers and sisters. In order to differentiate between the two, one of the things a therapist will generally look at is how a teen treats animals. Is he or she mean or cruel to the family pets or kind to them? Another area that is looked at is whether or not there have been legal problems, what those legal problems were, and if they are recurring or one-time events. For example, many young teens experiment with shoplifting and end up getting caught, but this does not mean they have either a conduct disorder or ODD. However, if they keep doing it or their activities turn to more serious stealing behavior, it is probably safe to assume that there is a more serious behavior problem going on. Setting fires and stealing, such as breaking into cars and stealing stereos, are more serious offenses that would generally tend to indicate a conduct disorder rather than oppositional defiant disorder.

To further complicate the process of making a diagnosis, some research is now beginning to show that conduct disorder may be a component of childhood bipolar disorder and there is a possibility that the behaviors attributed to conduct disorder or ODD are perhaps motivated by a mood disorder. Bipolar disorder, formerly known as manic-depressive illness, described in simplest terms is a chemical imbalance in the brain that causes major mood swings, from elation to severe depression, which many times can be helped greatly with the right medication. This will be discussed later in this course. According to the book, The Bipolar Child, teens with bipolar disorder can experience mood shifts from very elated to very depressed several times in a day, making it nearly impossible for these teens to concentrate and get anything done. These mood shifts can cause symptoms that are similar to attention deficit hyperactivity disorder (ADHD), and therefore this is just one more diagnostic dilemma for the therapist. Other research shows that teens with ADHD can also present in a very similar way as those with either conduct disorder or ODD. The possibility that both conduct disorder and ODD may be a component of ADHD or bipolar disorder is being researched. Therefore, both bipolar disorder and ADHD as well as conduct disorder or ODD are processes that the psychiatrist/therapist must take into consideration when attempting to diagnose a teen who is displaying severe behavior problems, such as those listed above. The psychiatrist/therapist may resolve the problem of overlapping behaviors and disorders by assigning more than one diagnosis to a child (dual diagnosis). And as many parents have discovered, because distinguishing among these disorders can be quite difficult, their child may receive one diagnosis from the therapist or psychologist and a different diagnosis from the psychiatrist. This only further adds to the concerns of the parents, leaving them to wonder if anybody at all knows what is really going on!

According to Merck's Manual, more than half of teens with conduct disorder stop exhibiting these behaviors in early adulthood, but about one third of the cases persist, developing into antisocial personality disorder or other mood or anxiety disorders. Children with conduct disorder tend to have a higher than expected incidence of medical and psychiatric illness at follow-up.

Treatment of Conduct Disorder and ODD

Treatment of all medical, neurological and psychiatric conditions by the appropriate caregivers can improve self-esteem and self-control. These kids will sometimes respond favorably to a very structured approach with clearly stated rules and immediate consequences for breaking rules. A home rules contract, which is set up with the help of the therapist and enforced uniformly by all caregivers, can clarify rules and consequences and provide structure for the teen. However, in some cases, only separation from the current environment, i.e. removing the child from the influence of his peers and/or a bad home environment, with external discipline and consistent behavior management and modification offer hope for success.

Treatment may include:

- **Cognitive-behavioral approaches**
  The goal of cognitive-behavioral therapy is to improve problem solving skills, communication skills, impulse control, and anger management skills.
- **Family-therapy**
  Family therapy is often focused on making changes within the family system, such as improving communication skills and family interactions.
- **Peer-group therapy**
  Peer group therapy is often focused on developing social skills and interpersonal skills.
- **Medication**
  While not considered effective in treating conduct disorder, medication may be used if other symptoms or disorders are present and responsive to medication.

REBUILDING THE BROKEN BOND

Conduct Disorder and Oppositional Defiant Disorder require an adult who is willing to be firm, yet sensitive and supportive. Here are some guidelines to use when working with these children.

1. *Take Good Care Of Yourself*- have fun, enjoy life. You can't give what you don't have…are you in a good place in life?

2. *Use Personal Power To Establish Respect*- each child will learn to trust you as you show them compassion and sensitivity. Don't push too fast and look for small increments of growth.

3. *Create And Maintain A Heart To Heart Connection*- how do you show people that you care? Touch, smile, notes, cards, calls, etc. are all possible ways to connect with this type of child. Be persistent in your approach. They will attempt to push you away.

4. *Set Limits And Help The Child Accept Limits*- While they will fight against the boundaries and limits, each child needs the structure of life. Find a way to reinforce the positive behavior which will increase the likelihood of a re-occurrence of this behavior.

5. *Teach Self-Control*- Intrinsic (I like myself) versus Extrinsic (do you like me?) need to be focused on with this child. Too often the student asks for your approval instead of feeling good about his/her own ability. Be careful to not fall into the trap of being the "you can do it" person unless the child is also willing to put effort into the process.

6. *Unplug Control Battles That Will Short Circuit*- Avoid anger, frustration, power struggles, and a need for control. Remember, these children feel a passion for control and power. Find a way to give it to them within the boundaries set for them.

7. *Help The Child To Process Feelings*- What happened? How did I respond? What can I do next time? Give the child new strategies and skills for future struggles. Teaching social skills is essential.

8. *Build Self-Esteem*- Be positive, but not unrealistic. Be real…tell them the truth, but give them hope. Allow them to internalize their success and failures. Cheer them on, but be there to pick them up.

CONDUCT DISORDERS: THE SCOPE OF THE PROBLEM

GENERAL CHARACTERISTICS:
Most common disorder in children. Examples are defiance, disobedience, fighting, destruction of property, aggression.

2% to 10% of population. Intensity, duration, and frequency all high.

SKILL DEFICITS: *Multiple domains (school, community, home). Poor peer relations. Control issues.* Ideas: teach basic social skills such as getting along with others, how to make friends. Use social groups, peer modeling, cooperative learning, etc.

SUBSTANCE ABUSE: *Greater possibility of abuse than general population. Medicating of senses and social acceptance.* Ideas: know about drugs, the impact, signs and symptoms.

SEXUAL BEHAVIOR: *At risk for early sexual acting out.* Ideas: avoid lectures. Be open to discussions about appropriate relationships, what they look like, how people should treat one another.

DEPRESSION: *As many as 50% of Conduct Disorder children are diagnosed with depression. Conversely, 33% of depressed children have conduct disorder.* Ideas: understand teen depression (article in back of manual). Have a resource list of support systems available for children.

ANTI-SOCIAL BEHAVIORS: *Manipulation, control are major themes. (fire setting, cruelty to animals, stealing).* Ideas: use resource list of counselors, set clear classroom/school boundaries, increase supervision when possible.

FAILURE TO BOND: *Attachment issues. Fear of connecting, need for control, lack of trust.* Ideas: use of friendship groups, cross age/peer tutor concept, help them understand trust by being open and honest.

AGGRESSIVE TENDENCIES: *Boys tend toward violence and girls tend toward sexual (not mutually exclusive).* Ideas: know about de-escalation strategies, ways to avoid power struggles, and how to relationally connect with children who have problems with their emotions.

Symptom Comparison: ADHD, Bipolar Disorder, Attachment Disorder

Symptom	ADHD	Bipolar Disorder	Attachment Disorder
Age of onset	Birth, 6, 13	2-3, 7, 13-35	Birth to 3
Family history	ADHD, academic difficulties, alcohol & substance abuse	Mood disorders, academic difficulties, alcohol & substance abuse, adoption, ADHD	Abuse & neglect, severe emotional & behavioral disorders, alcohol & substance abuse, abuse & neglect in parent's own early life
Incidence	Approx. 6% of general population	2-3% of general population	3-6% of general population
Cause	Genetic, exacerbated by stress	Genetic, exacerbated by stress & hormones	Psychological secondary to neglect, abuse, abandonment
Duration	Chronic & unremittingly continuous, tends toward improvement	May or may not show clear behavioral episodes & cyclicity; worsens over years with increased severe and dramatic symptoms	Dependent on life circumstances, including treatment & innate temperament; worsens without treatment, resulting in antisocial character disorders
Attention span	Short, leading to lack of productivity	Dependent on interest & motivation, distractible	Usually prolonged secondary to hyper vigilance, under stress can shorten
Impulsivity	Secondary to inattention or oblivious, regret	Driven, "irresistible," grandiosity, thrill-seeking, counter-phobia, little regret	Usually deliberate actions; poor cause-and-effect thinking; no remorse
Hyperactivity	50% are hyperactive, disorganized	Wide ranges, with hyperactivity common in children	Common
Self-esteem	Low, rooted in ongoing performance difficulties	Low because of inherent unpredictability of mood	Low, rooted in abandonment, feel worthless/unloved, masked by anger
Symptom	**ADHD**	**Bipolar Disorder**	**Attachment Disorder**

Attitude	Friendly in a genuine manner	Highly unpredictable, dysphoric, moody, negativistic	Superficially charming, phony, distrusting, emotionally distant, non-intimate
Control issues	Tend to desire to seek approval; get into trouble by inability to complete tasks	Intermittent desire to please (based on mood), tend to push limits and relish power struggles	Controlled and controlling, only for self-gain, underhanded, covert & punitive
Oppositional/defiant	Argumentative, but will relent with some show of authority, re-directable	Usually overtly & prominently defiant, often not relenting to authority	Covertly or overtly defiant, passive aggressive
Blaming	Self-protective mechanism to avoid adverse consequences	Enjoys "getting away with it"	"Crazy lying," self-centered "primary process" distortions, remain in control
Fire setting	Play with matches out of curiosity, non-malicious	Play with matches/fire setting	Revenge motivated, malicious; danger seeking secondary to despair
Anger, irritability, temper, rage	Situational, in response to over stimulation, low frustration tolerance & need for immediate gratification; rage reaction is usually short lived	Secondary to limit setting or attempts by authority figures to control their excessive behavior, can last for extended periods of time; overt, assaultive	Chronic, revenge oriented; eternal "victim" position, with rationalizations for destructive retaliation; hurtful to innocent others and pets
Entitlement	Overwhelming need for immediate gratification	Feel entitled to get what they want, grandiose	Compensation for abandonment & deprivation
Conscience development **Symptom**	Capable of demonstrating remorse when calmed down **ADHD**	Limited conscience development, less cruel than RAD **Bipolar Disorder**	Very "street smart," good survival skills, con artists, calculating, lack of remorse **Attachment Disorder**
Sensitivity	Oblivious to their circumstances,	Acutely aware of circumstances and are "hot reactors"	Hyper vigilant, compensating for past helplessness;

	inappropriateness shows as result		limited emotional repertoire, insensitive
Perception	Flooded by sensory overestimation, hyperactive, distractible, shuts down	Self-absorbed, preoccupied with internal need fulfillment, narcissistic	Self-centered, primary process, primitive distortions
Peer relationships	Makes friends easily, but not able to keep them	Can be charismatic or depressed, depending on mood, conflicts are the rule	Very poor, controlling & manipulative; not able to maintain relationships
Sleep disturbances	Over-stimulated, once asleep "sleeps like a rock"	Inability to relax because of racing mind; nightmares common	Hyper vigilance creates light sleepers; tends to need little sleep, arise early in am
Motivation	Less resourceful, more adult dependent; OK starters, poor finishers	Grandiose; believe they are resourceful, gifted, creative, self-directed, variable energy & enthusiasm	Consistently poor initiative, limited industriousness, intentional inefficiency
Learning difficulties	Commonly have auditory perceptual difficulties, lack fine motor coordination	Non-sequential, nonlinear learners, verbally articulate	Early life abuse/neglect can create diverse learning problems
Anxiety	Uncommon, unless performance related	Emotionally wired & high potentials for anxiety, fears & phobias. Somatic symptoms common.	Appear invulnerable; poor recognition, awareness or admission of fears
Sexuality **Symptom**	Emotionally immature & sexually naïve **ADHD**	Sexual hyperawareness, pseudo maturity, and high activity level **Bipolar Disorder**	Uses sex as means of power, control, or of infliction of pain, sadistic **Attachment Disorder**
Substance abuse	Strong tendencies, more out of coping mechanisms for low self-esteem	Strong tendencies in attempt to medically treat either hypomanic/depressive moods	Sporadic/uncommon, need to maintain control

Optimal environment	Low stimulation & stress, support & structure	Clear & assertive, limits, encouragement	Balance of security & stability, limits and clear expectations, nurturance and encouragement
Psychopharmacology	Some of the medications used: Ritalin, Adderall, Concerta, Strattera, Wellbutrin; Clonidine, Imipramine & Nortirptyline useful as adjunctive treatments	Medications helpful to stabilize mood: Lithium, Carbamazepine, Valproic Acid, Verapamil, Risperdal	Antidepressants, Clonidine, may help decrease hypervigilance, does not help characterological traits

ATTACHMENT DISORDERS

Before you start this section, write out a few sentences regarding your understanding of Attachment Disorder. How would you define it? What is your general understanding of it?

_____
_____
_____
_____

Attachment Disorders are one of the least researched and most poorly understood disorders in the area of mental health. It is difficult to diagnose and equally difficult to treat.

Definition: *failure to form normal attachments and characterized by inappropriate ways of relating socially in most contexts.*

The onset of the attachment disorder should be seen before the age of five, there is usually a history of significant neglect, and a lack of identifiable, preferred attachment figures. However, there are cases of children demonstrating attachment issues that appear to be raised in solid, loving families. There are a disproportionate number of Attachment issues found in children who have been adopted.
This does not mean every adopted child has these issues. However, I believe it is a good strategy to have counseling support available for all children being adopted, especially those adopted past the age of two.

Symptoms: poor social interactions, aggression toward self and others, failure to grow from emotional experiences, lack of social reciprocity with peers and family, lack of normal connectedness with others, inability to bond or connect in an emotional way, failure to initiate relationships and to sustain lasting relationships.

Types Of Attachment:

- Secure- One who seeks his/her primary caregiver when distressed; is easily comforted; can become absorbed in play; is curious and responsive to environment. Behaviors- confident, compassionate, responsive, give and take relationships.
- Insecure/Anxious or Ambivalent- often children who have been neglected. They are afraid for people to leave them so they cling to their caretakers, rarely letting them out of their sight, and panicking if they can't find the caretaker. They easily feel rejected or betrayed. They may sabotage the relationship

when the caregiver feels close or manipulate with guilt when the caregiver is more distant.
Behaviors- clingy, impulsive, defeatist, co-dependent, high risk behavior

- Insecure/Avoidant- friendly with everyone and anyone but not forming real attachments to anyone. They have been hurt when they allowed themselves to trust and love, so they avoid at all cost. Gradually they become more distant and hostile toward others, less compliant, and socially isolated. They are angry and distant and typically have been abused and neglected in their childhood.
  Behaviors- hostile, bullying, needy but rejecting, "user/taker", blames others.
- Insecure/Disorganized- these children may alternate between each area, showing signs of clinging, fighting, hostility, and isolation. Emotions of fear, distress, confusion, and apprehension are expressed. Behaviors may manifest in cruelty and destruction toward objects and animals.
  Behaviors- depressed, inhibited, vulnerable, physical illness, prone to medications.

INTERVENTIONS FOR Attachment disorders

"We do not treat anger and behavior in order to create a bond. We create a compassionate bond which in and of itself changes the anger and behavior."

Home Interventions:

- **Attachment therapy is crucial for the family.**

1. Any therapy should educate the parents about attachment issues. It should help one understand how the child thinks, feels, and acts. This will increase compassion for the child.
2. Therapy should teach parents how to protect themselves from the child's pathology. Many parents feel victimized and frustrated with the child. Parents must learn to secure their own emotional safety in spite of the child's frequent hurtful approaches.
3. Therapy should teach bonding and attachment activities. "Talking" will not help the child. Experiences should impact the body, mind, soul, and spirit. Logical, thoughtful, and analytical approaches will fail.
4. Attachment therapy may employ controversial "holding Therapy" for nurturing and control. I personally do not advocate this type of therapy, but it is used and some people have found success.

The goal of therapy is not to directly reduce the anger or to change behavior, it is to attach the child to significant adults.

- **Social connections may build empathy**

5. Find significant ways to "bond" as a family. Take vacations, enjoy activities, build memories with the child.
6. Develop times for the child to interact and socialize with others. Involve them in extra-curricular activities and outings.
7. Find other adults that may be able to speak into their lives and build a relationship.
8. Don't quit! It may become overwhelming and discouraging at times. Parents may need counseling as well in order to hold onto hope for the future.

School Interventions:

1. Communicate with the parents. They often feel isolated and are perceived as distant and harsh. Develop a connection with other caregivers in the child's life.
2. Remember, you are not the parent and not the therapist. Your relationship will be important, but temporary. They will move on to another grade or school. You will be one more loss unless you develop a true connection with the child and a supportive lasting memory.
3. Acknowledge the child's positive decisions and behaviors.
4. Allow natural consequences for poor decisions and behaviors to occur. Avoid rescuing the child due to their difficulties.
5. Use stories, speakers, and real life situations to present feelings and empathy.
6. Remain calm and in control of emotions. They know how to "push buttons" and we must avoid power struggles.
7. Empathize, but don't pity. Keep expectations high.
8. Find a place for them to feel wanted and connected. This may be helping out at the school or with a specific person.
9. Remember, they need to connect with others. The child may feel safer with adults.

Possible Skills—peer connections, helping others, random acts of kindness, preferring others, organization, managing stress, following through, expressing feelings, decision making.

Resources-

Attachment Disorder Site	www.attachmentdisorder.net
Association for Treatment and Training In the Attachment of Children	www.attach.org

Attachment Disorder Case Study (connected to Assignment #3)

[Choose one of the following, depending on your interest and teaching level]

Scenario #1: Jerry is a fourteen year old boy who will be entering 9th grade at Martin High School. He will be in one of your classes next year (or in your specific setting).

OR

Scenario #2: Jerry is a nine year old boy who will be in your 3rd grade class next year (or in your specific setting).

Background:

- Tendency to isolate himself
- When with peers, bossy and poor social skills
- He would rather be with adults, but tends to cling when with them
- Few friends
- History of stealing and lying at home and in community
- Jerry was in the foster care system for several years before being adopted by the Turners
- His adoptive parents (Bill/Carol Turner) have just started family counseling
- The Turners have expressed frustration and they feel emotionally drained
- Jerry is frequently in disagreements with peers, often blaming them for picking on him
- At times, Jerry will appear to tell the adult what he/she wants to hear but lack any real understanding of the issues
- He is very controlling and wants to be in charge. One area of concern is his tendency to "act like the adult in charge" and tell others what to do
- In general, Jerry does not seem to care or need other people. He will "like you" then "hate you" without apparent reasons

Assignment:

1. Fix him (just kidding).
2. What are the major barriers to Jerry's being successful in school and his future life?
3. Discuss general strategies that you would use in a classroom (or in your specific setting).
4. Develop a plan for Jerry's success that includes both home and school involvement. List specific strategies and ideas.

Write a one page summary of your answers including any thoughts on this topic.

BIPOLAR DISORDER

Before you start this section, write out a few sentences regarding your understanding of Bipolar Disorder. How would you define it? What is your general understanding of it?

_____
_____
_____
_____

As high as 7% of child and adolescent population (1% preschoolers; 2% elementary age; 3- 5% adolescents).
5 to 1 ratio (boys to girls) in childhood; 2 to 1 ratio (girls to boys) in adolescence
Families that have mental health issues of depression, bipolar disorder, anxiety disorder, or substance abuse have children more prone to mood disorders (bipolar and depression).

Definition: *a medical condition in which people have mood swings out of proportion, or seemingly unrelated, to things going on in their lives. These swings affect thoughts, feelings, physical health, behavior, and functioning.*

Frequent psychiatric illnesses that accompany or can mimic bipolar disorder include anxiety, phobias, obsessive compulsive disorder, childhood schizophrenia, ADHD, substance abuse, oppositional defiant disorder, learning disorders, and delinquent behaviors.

Cause: Bipolar disorder may result from a chemical imbalance within the brain. The brain's functions are controlled by chemicals called neurotransmitters. An imbalance of one of these neurotransmitters, such as norepinephrine, may cause bipolar disorder. When levels of this chemical are too high, mania occurs. When levels of norepinephrine drop below normal levels, a person may experience depression. *Other scientists believe that bipolar disorder may also be a result of premature death of brain cells that deal with mood and emotion. This causes the brain to lose control of mood.*

Bipolar Disorder is characterized by recurrent episodes of mania and depression. These extreme shifts interfere with normal functioning.

Manic Symptoms:
Severe changes in mood (extremely irritable or overly silly and elated; Overly inflated self-esteem; grandiosity; Increased energy; Decreased need for sleep (able to go with very little sleep for days); Distractibility (attention moves constantly); Disregard of risk (risky activities and behavior); Increased talking (talks too much,

too fast; changes topics quickly); Hyper-sexuality (increased sexual thoughts, feelings, behaviors).

Depressive Symptoms:
Persistent sad or irritable mood; Loss of interest in activities once enjoyed; Significant change in appetite or body weight; Difficulty sleeping or oversleeping; Physical agitation or slowing; Loss of energy; Feelings of worthlessness or inappropriate guilt; Difficulty concentrating; Recurrent thoughts of death or suicide.

Write out several areas you have just learned about Bipolar Disorder:

1.
2.
3.

TREATMENT FOR BIPOLAR DISORDER

Medication: mood stabilizers and antidepressants.

Mood Stabilizers- improve symptoms during manic episodes as well as reducing symptoms of depression.
Lithium, Depakote, Lamictal and Tegretol most common mood stabilizers. Anti-depressants used include Wellbutrin, Prozac, Zoloft, Paxil, Effexor, and Luvox. Other medications utilized are anti-psychotics such as Zyprexa, Abilify, Risperdal, and Seroqual.

1. Maintain a stable sleep pattern. *When a child's sleep pattern is interrupted, it may cause a chemical change in the body.*
2. Maintain a regular pattern of activity. *Avoid too many activities and being overloaded with school, extra-curricular events, and socializing.*
3. Do not mix alcohol or drugs with medication. *Not only do alcohol and drugs alter the chemical make-up of the body and interfere with medication, but the mixing of them may create dangerous side-effects.*
4. Be cautious of the use of "over the counter" cold medicine and the amount of caffeine intake. *Once again, even the smallest amount of other medication may create an imbalance to the prescribed medication.*
5. Find a physician who works well with the family. *It is important to be able to talk about frustrations and concerns.*
6. Family counseling may be helpful. *This will allow other members of the family to gain ideas and knowledge about the disorder.*

Three types of therapy that may be helpful:
1. Behavioral - focus on ways to decrease stress.
2. Cognitive- change the negative thoughts and life outlook.
3. Interpersonal- reduce strain in relationships due to disorder.

A trained and licensed therapist may be utilized for these areas.

BIPOLAR DISORDER INTERVENTION Sheet

Interventions for Home

- Develop a close relationship with the child
- Provide communication outlets for the child (keeping a diary, writing in a journal)
- Watch carefully for mood changes
- Avoid power struggles (minimize arguing over small areas—pick and choose battles)
- Monitor risky behaviors (call for professional guidance when necessary)
- Communicate with other systems (school, extra-curricular areas, other families)
- Provide opportunities for activities (minimize isolation, but monitor too much action)
- Take care of the adults
- Develop a routine for the family
- Contact a professional (doctor, counselor, etc.) immediately if the child shows areas of decline in their moods, attitude, or behavior.

Interventions for School (classroom, school-wide)

- Display feeling posters & signs in the school (positive statements, words of encouragement)
- Utilize student support groups (lunch time discussion groups, before school meetings…find a way for students to help students)
- Help students identify physical locations of stress (where are the "zones" that create an increase in anxiety for a student?)
- Introduce activities to increase the safety of taking a risk (guessing games, new recess games, in-class challenges, teach the concept of failing and succeeding)
- Be sure to reinforce expression of feelings
- Be educated about signs of depression, suicidal indicators, and about disorders
- Have a resource list (as the educator). Who can you talk to for more information?

Interventions for Individuals

- Teach proactive skills (be prepared for changes, frustration, use of pre-teaching)
- Show an interest in each child (let them know you "notice" them)
- Communicate regularly with the family (use of a weekly note or phone call)
- Arrange the opportunity for the child to take a short rest or have down time
- Empower the child to be able to make decisions about his/her own life (help them make an action plan for the coming day, week, or month)
- Provide opportunities for appropriate peer interaction and social opportunities (don't wait for them to occur as they may be negative in occurrence for the child)
- Develop strategies for the child to have choices and options in his/her life. Help to minimize a sense of "have to or else" feelings.

Resources:

Child and Adolescent Bipolar Foundation	www.bipolarchild.com
National Institute of Mental Health	www.nimh.nih.gov
Positive Behavior Interventions and Support	www.pbis.org

BI POLAR CASE STUDY

(connected to assignment #6)

Twice during the past six months, 15 year old Carla tried to commit suicide and was placed in an inpatient psychiatric program by her parents. The first attempt was when Carla mixed alcohol and prescription medications. She tried to hurt herself because she was "no good" and "didn't care anymore." During the past months, Carla has been very depressed for weeks at a time. There have been several times where she seemed to "snap out" of her cycle only to revert back within a couple of days or within a week.

During these stretches, her parents report that she has no energy and constantly seems tired and fatigued. They find her tearful and crying on most nights. She refuses to interact with the family and does not want to be part of outings, activities, or vacations. She has a difficult time sleeping at night and is often irritable during the day. In her words, "I just want to disappear."

At school, her once "A" and "B" grades have plummeted to "C's" and "D's". Her teachers indicate that her once happy and bright moods are now dark and unfriendly. Last year, she was very involved in the drama club including several major parts in school performances. This year, she refuses to try out and thinks she is ugly and lousy at acting. She has difficulty concentrating, is easily distracted, and unable to make basic decisions such as what subject to choose for her English paper.

Her friends call her to get together, but Carla refuses to call them back. She believes they don't like her anymore and just isn't interested in socializing. Again, she complains of having no energy.

Everyone is concerned for Carla, but not sure how to proceed. She has been brought before the Crisis Team (that is you) for support.

Assignment:

1. List the major concerns you have for Carla.
2. Make suggestions for home interventions.
3. Develop strategies for school interventions.
4. If you were a friend of Carla's, what would you do to help her?

Write a 1-2 page summary of your answers and thoughts.

ADD/ADHD DEFINITION AND GUIDELINES

The DSM-V Criteria

(The Diagnostical and Statistical Manual for Mental Health Disorders)

What is ADHD?

ADHD is a neurodevelopmental disorder affecting both children and adults. It is described as a "persistent" or on-going pattern of inattention and/or hyperactivity-impulsivity that gets in the way of daily life or typical development. Individuals with ADHD may also have difficulties with maintaining attention, executive function (or the brain's ability to begin an activity, organize itself and manage tasks) and working memory.

There are three presentations of ADHD:

- Inattentive
- Hyperactive-impulsive
- Combined inattentive & hyperactive-impulsive

The criteria of symptoms for a diagnosis of ADHD:

Inattentive presentation:

- Fails to give close attention to details or makes careless mistakes.
- Has difficulty sustaining attention.
- Does not appear to listen.
- Struggles to follow through on instructions.
- Has difficulty with organization.
- Avoids or dislikes tasks requiring a lot of thinking.
- Loses things.
- Is easily distracted.
- Is forgetful in daily activities.

Hyperactive-impulsive presentation:

- Fidgets with hands or feet or squirms in chair.
- Has difficulty remaining seated.
- Runs about or climbs excessively in children; extreme restlessness in adults.
- Difficulty engaging in activities quietly.
- Acts as if driven by a motor; adults will often feel inside like they were driven by a motor.
- Talks excessively.
- Blurts out answers before questions have been completed.
- Difficulty waiting or taking turns.
- Interrupts or intrudes upon others.

Combined inattentive & hyperactive-impulsive presentation:

- Has symptoms from both of the above presentations.

GENERAL INTERVENTION PRINCIPLES FOR ADD/ADHD

- **Immediate Feedback/Consequences**
  ADD children learn best from feedback that comes quickly. Seconds vs. minutes vs. hours.

- **Frequent Feedback**
  Friendly reminders. Helpful messages. ADD children have difficulty in sustaining motivation—need assistance.

- **Stronger Reinforcement**
  May need to be more powerful than for other kids (more often, more visible, more tangible). This may be only temporarily necessary.

- **Incentives Before Consequences**
  Easy to move into reprimands and punishment. Positive reinforcement, rewards, and praise may not flow naturally. Use the positive first!

- **Actions Speak Louder Than Words**
  Nagging, pleading, lecturing, and begging won't work well. The adult gets frustrated, less energy for positives. An overly emotional adult and over aroused child is a poor formula for success.

- **Consistency**
  Predictability and structure is necessary.

- **Advance Planning For Problems**
  Plan ahead for problems. Replace "I hope he/she handles…" with "What can I do to help him/her…"

- **Remind Child Of The Plan**
  One hallmark of ADD is forgetfulness (did you forget that?). Avoid "By this age they should remember…" Instead, " ADD children have a tendency to…" Remind yourself to remind the child.

Think of one child you know or have had in class that exhibit ADD/ADHD behavior. What strategies worked best for him/her?

_____
_____
_____
_____

CLASSROOM MANAGEMENT FOR ADD STUDENTS

1. BUILDING RAPPORT:

- Get to know students
- Greet students at door
- Give extra attention

2. CLASSROOM STRUCTURE

- Post a written schedule
- Prompt with specific cues
- Cue when changes or transitions occur
- Develop a homework routine
  a. Row captains
  b. Copy down assignments
  c. Completed work in designated spots

3. CLASSROOM RULES

- Have a few good rules
- Keep rules short and simple
- Post rules
- Teach rules

4. GIVING REPRIMANDS

- Point to the rule
- Reprimand privately, connecting to rules
- Be brief and to the point
- Use good, strong nonverbal (eye contact, body language)

5. SCHEDULING

- Schedule challenging work prior to enjoyable activity
- Develop necessary individualized plans for students
- Modify assignments

6. CLASSROOM SET-UP

- Give the student choices
- Use of other students as support, role models, and helpers
- Make a second seat or work station for the child to allow them to move from one seat to another. Movement is essential for this child.
- Seat away from major external distractions
- Careful group seating

OBSESSIVE-COMPULSIVE DISORDER (OCD)

Before you start this section, write out a few sentences regarding your understanding of Obsessive-Compulsive behaviors. How would you define it? What is your general understanding of it? (And, the television show Monk is close in many areas).

_____
_____
_____
_____

3.3 million Americans affected (2.3% of population)
Men and women equally impacted
Typically begins in adolescence or early childhood. This is an anxiety disorder.

Definition: *a medical disorder that causes repetitive thoughts (obsessions) or behaviors (compulsions) that are difficult to control.*

Cause: Abnormal functioning of the brain is the general evidence. Not caused by family issues or attitudes. Using a technique called positron emission tomography (PET), the brain activity appears different than others without OCD.

Possible Symptoms at Home (often more intrusive than school)

- Repeated obsessional thoughts (fears, panic)
- Repeated actions and compulsions (rituals to prevent consequences)
- Pre-occupation with the obsessions and compulsions
- Extreme distress if ritual is interrupted
- Attempts to hide obsessions/compulsions
- Concerns over being "crazy" or "weird" due to OCD

Possible Symptoms at School (may be able to successfully suppress OCD)

- Difficulty concentrating (due to repetitive thoughts)
- Social isolation and withdrawal
- Low self-esteem in social and academic endeavors
- Poor problem-solving (misunderstandings, clashes, being picked on)
- Repetition and perseveration in behavior or actions
- Poor impulse control and extreme anxiety in certain social situations
- Compounding disorders or disabilities (ADHD, learning issues, depression)

INTERVENTIONS FOR OBSESSIVE-COMPULSIVE DISORDERS

Psychological Interventions:

1. Cognitive behavior therapy- counseling to become aware of thought patterns and alternative approaches. Behavior change through developing a more positive thought process.
2. Individual counseling/therapy- children with OCD often carry a sense of failure and low self-esteem. Counseling may help reduce the self-blame and general feeling of failure.
3. Parent guidance sessions- parenting skills and strategies to help the adults to address the complex issues in the child. This may include family therapy.
4. Group therapy- a safe place to share general feelings and to learn social skills with peers.

Biological/Medical interventions:
Several medications have been approved by the food and drug administration for treatment of OCD. Celexa, Lexapro, Paxil, Luvox, Prozac, and Zoloft belong to a group called Selective Serotonin Reuptake Inhibitors (SSRI). Ananfranil (antidepressant) also is effective.
Effectiveness may be seen within a 2 to 4 week period, though it may take up to 10 to 12 weeks for particular individuals.

By increasing the level of serotonin in the brain, antidepressants help to regulate the communication between different parts of the brain.

Medication Concerns:

- Some concern of possible suicidal thoughts when taking these medications.
- Many side effects including agitation, restlessness, irritability, headaches.
- Children with bi-polar disorder will find a worsening of the manic symptoms.

Home Interventions:

1. Understand the illness
2. Listen to the child's feelings- -isolation will foster depression. Parents need to be a source of support.
3. Plan for transitions. Anticipate and plan transition times such as going to school, to bed, activities, and events.
4. Adjust expectations until symptoms improve. Set attainable goals to increase success and self-esteem. Help the child find a positive direction.
5. Praise the child for efforts to resist symptoms. Look for the small, baby steps of progress.
6. Talk as a family about what to say to people outside the family. Finding a pat statement or phrase will help everyone feel more comfortable.
7. Understand parental limits. Find a balance between supportive flexibility and appropriate limit setting.
8. Help the child distinguish between himself/herself and the illness.
9. It is good for the child to recognize the aspects of this disorder. It is not good for them to use it as an excuse for behavior.

School Interventions:

1. Check in upon arrival to evaluate the child's perspective.
2. Identify ways that teachers can assist the child to recognize and break out of obsession or compulsion.
3. Give the child choices and alternative approaches.
4. Be careful to not "violate" the ritual...teach them alternative approaches.
5. Assist with peer interactions (teach social skills).
6. Be aware that transitions may be difficult. Prepare the child, make lists, discuss the changes, and be open to modifying assignments, tasks, and expectations.
7. Encourage the child to develop their own game plan. Empower them.
8. Anticipate problems around social interactions.

Possible Skills to teach include—dealing with boredom/stress, analyzing tasks, organization, self-talk, problem solving, self-monitoring and control, stress management, patience, goal setting.

Resources-

Obsessive Compulsive Foundation www.ocfoundation.org

OCD Web Site www.geonius.com/ocd/

Obsessive-Compulsive Introspection

(connected to assignment #3)

Think of your own general behavior. Do you have any characteristics of Obsessive-compulsive behavior? (organization, cleaning, habits, quirks, tendencies, rituals, etc). Don't we all?
List them on this page:

_____

_____

_____

Do you know anyone who shows any obsessive-compulsive tendencies? List characteristics below:

_____

_____

_____

Over the next week, notice habits and patterns in the lives of people around you. Make a list of areas that you think fall into obsessive patterns.

_____

_____

_____

In your opinion, what makes this disorder difficult for children in our schools?

_____

_____

_____

Write a one page summary of your answers and any thoughts on this topic.

Teen Depression

A GUIDE FOR PARENTS AND TEACHERS

Teenage depression isn't just bad moods and occasional melancholy. Depression is a serious problem that impacts every aspect of a teen's life. Left untreated, teen depression can lead to problems at home and school, drug abuse, self-loathing—even irreversible tragedy such as homicidal violence or suicide. Fortunately, teenage depression can be treated, and as a concerned parent, teacher, or friend, there are many things you can do to help.

There are as many misconceptions about teen depression as there are about teenagers in general. Yes, the teen years are tough, but most teens balance the requisite angst with good friendships, success in school or outside activities, and the development of a strong sense of self. Occasional bad moods or acting out is to be expected, but depression is something different. Depression can destroy the very essence of a teenager's personality, causing an overwhelming sense of sadness, despair, or anger.
Whether the incidence of teen depression is actually increasing, or we're just becoming more aware of it, the fact is that depression strikes teenagers far more often than most people think. And although depression is highly treatable, experts say only 20% of depressed teens ever receive help. Unlike adults, who have the ability to seek assistance on their own, teenagers usually must rely on parents, teachers, or other caregivers to recognize their suffering and get them the treatment they need. So if you have an adolescent in your life, it's important to learn what teen depression looks like and what to do if you spot the warning signs.

Signs and symptoms of teen depression

Teenagers face a host of pressures, from the changes of puberty to questions about who they are and where they fit in. The natural transition from child to adult can also bring parental conflict as teens start to assert their independence. With all this drama, it isn't always easy to differentiate between depression and normal teenage moodiness. Making things even more complicated, teens with depression do not necessarily appear sad, nor do they always withdraw from others. For some depressed teens, symptoms of irritability, aggression, and rage are more prominent..

SIGNS AND SYMPTOMS OF DEPRESSION IN TEENS

- Sadness or hopelessness
- Irritability, anger, or hostility
- Tearfulness or frequent crying
- Withdrawal from friends and family
- Loss of interest in activities
- Changes in eating and sleeping habits
- Restlessness and agitation
- Feelings of worthlessness and guilt
- Lack of enthusiasm and motivation
- Fatigue or lack of energy
- Difficulty concentrating
- Thoughts of death or suicide

If you're unsure if an adolescent in your life is depressed or just "being a teenager," consider how long the symptoms have been present, how severe they are, and how different the teen is acting from his or her usual self. While some "growing pains" are to be expected as teenagers grapple with the challenges of growing up, dramatic, long-lasting changes in personality, mood, or behavior are red flags of a deeper problem.

Effects of teen depression

The negative effects of teenage depression go far beyond a melancholy mood. Many rebellious and unhealthy behaviors or attitudes in teenagers are actually indications of depression. See the table below for some of the ways in which teens "act out" or "act in" in an attempt to cope with their emotional pain:

Untreated Depression Can Lead to…

Problems at school	Depression can cause low energy and concentration difficulties. At school, this may lead to poor attendance, a drop in grades, or frustration with schoolwork in a formerly good student.
Running away	Many depressed teens run away from home or talk about running away. Such attempts are usually a cry for help.
Substance abuse	Teens may use alcohol or drugs in an attempt to "self-medicate" their depression. Unfortunately, substance abuse only makes things worse.
Low self-esteem	Depression can trigger and intensify feelings of ugliness, shame, failure, and unworthiness.
Eating disorders	Anorexia, bulimia, binge eating, and yo-yo dieting are often signs of unrecognized depression.
Internet addiction	Teens may go online to escape from their problems. But excessive computer use only increases their isolation and makes them more depressed.
Self-injury	Cutting, burning, and other kinds of self-mutilation are almost always associated with depression.
Reckless behavior	Depressed teens may engage in dangerous or high-risk behaviors, such as reckless driving, out-of-control drinking, and unsafe sex.
Violence	Some depressed teens (usually boys who are the victims of bullying) become violent. As in the case of the Columbine school massacre, self-hatred and a wish to die can erupt into violence and homicidal rage.
Suicide	Teens who are seriously depressed often think, speak, or make "attention-getting" attempts at suicide. Suicidal thoughts or behaviors should always be taken very seriously.

Talk to your teen

The first thing you should do if you suspect depression is to talk to your teen about it. In a loving and non-judgmental way, share your concerns with your teenager. Let him or her know what specific signs of depression you've noticed and why they worry you. Then encourage your child to open up about what he or she is going through. If the child resists, step back and be supportive. Avoid being a part of the problem by pushing them before they are ready. However, if you are seriously concerned about the child harming him/herself, get immediate help…regardless of whether they want it or not.

Offer support	Let depressed teenagers know that you're there for them, fully and unconditionally. Hold back from asking a lot of questions (teenagers don't like to feel patronized or crowded), but make it clear that you're ready and willing to provide whatever support they need.
Be gentle but persistent	Don't give up if your adolescent shuts you out at first. Talking about depression can be very tough for teens. Be respectful of your child's comfort level while still emphasizing your concern and willingness to listen.

Listen without lecturing	Resist any urge to criticize or pass judgment once your teenager begins to talk. The important thing is that your child is communicating. Avoid offering unsolicited advice or ultimatums as well.
Validate feelings	Don't try to talk teens out of their depression, even if their feelings or concerns appear silly or irrational to you. Simply acknowledge the pain and sadness they are feeling. If you don't, they will feel like you don't take their emotions seriously.

If your teen claims nothing is wrong, but has no explanation for what is causing the depressed behavior, you should trust your instincts. Remember that denial is a strong emotion. Furthermore, teenagers may not believe that what they're experiencing is the result of depression. If you see depression's warning signs, seek professional help. Neither you nor your teen is qualified to either diagnose depression or rule it out, so see a doctor or psychologist who can.

Visit your family doctor

Make an immediate appointment for your teen to see the family physician for a depression screening. Be prepared to give your doctor specific information about your teen's depression symptoms, including how long they've been present, how much they're affecting your child's daily life, and any patterns you've noticed. The doctor should also be told about any close relatives who have ever been diagnosed with depression or another mental health disorder.

As part of the depression screening, the doctor will give your teenager a complete physical exam and take blood samples to check for medical causes of your child's symptoms. In order to diagnose depression, other possible causes of your teen's symptoms must first be ruled out. The doctor will check for medical causes of the depression by giving your teenager a complete physical exam and running blood tests. The doctor may also ask your teen about other things that could be causing the symptoms, including heavy alcohol and drug use, a lack of sleep, a poor diet (especially one low in iron), and medications (including birth control pills and diet pills).

In severe cases of depression, medication may help ease symptoms. However, antidepressants aren't always the best treatment option. They come with risks and side effects of their own, including a number of safety concerns specific to children and young adults. It's important to weigh the benefits against the risks before starting your teen on medication.

Supporting a teen through treatment

As the depressed teenager in your life goes through treatment, the most important thing you can do is to let him or her know that you're there to listen and offer support. Now more than ever, your teenager needs to know that he or she is valued, accepted, and cared for.

- **Be understanding.** Living with a depressed teenager can be difficult and draining. At times, you may experience exhaustion, rejection, despair, aggravation, or any other number of negative emotions. During this trying time, it's important to remember that your child is not being difficult on purpose. Your teen is suffering, so do your best to be patient and understanding.
- **Encourage physical activity.** Encourage your teenager to stay active. Exercise can go a long way toward relieving the symptoms of depression, so find ways to incorporate it into your teenager's day. Something as simple as walking the dog or going on a bike ride can be beneficial.
- **Encourage social activity.** Isolation only makes depression worse, so encourage your teenager to see friends and praise efforts to socialize. Offer to take your teen out with friends or suggest social activities that might be of interest, such as sports, after-school clubs, or an art class.
- **Stay involved in treatment.** Make sure your teenager is following all treatment instructions and going to therapy. It's especially important that your child takes any prescribed medication as instructed. Track changes in your teen's condition, and call the doctor if depression symptoms seem to be getting worse.
- **Learn about depression.** Just like you would if your child had a disease you knew very little about, read up on depression so that you can be your own "expert." The more you know, the better equipped you'll be to help your depressed teen. Encourage your teenager to learn more about depression as well. Reading up on their condition can help depressed teens realize that they're not alone and give them a better understanding of what they're going through.

The road to your depressed teenager's recovery may be bumpy, so be patient. Rejoice in small victories and prepare for the occasional setback. Most importantly, don't judge yourself or compare your family to others. As long as you're doing your best to get your teen the necessary help, you're doing your job.

Supporting Children's Mental Health: Tips for Parents and Educators

Create a sense of belonging. Feeling connected and welcomed is essential to children's positive adjustment, self-identification, and sense of trust in others and themselves. Building strong, positive relationships among students, school staff, and parents is important to promoting mental wellness.

Promote resilience. Adversity is a natural part of life and being resilient is important to overcoming challenges and good mental health. Connectedness, competency, helping others, and successfully facing difficult situations can foster resilience.

Develop competencies. Children need to know that they can overcome challenges and accomplish goals through their actions. Achieving academic success and developing individual talents and interests helps children feel competent and more able to deal with stress positively. Social competency is also important. Having friends and staying connected to friends and loved ones can enhance mental wellness.

Ensure a positive, safe school environment. Feeling safe is critical to students' learning and mental health. Promote positive behaviors such as respect, responsibility, and kindness. Prevent negative behaviors such as bullying and harassment. Provide easily understood rules of conduct and fair discipline practices and ensure an adult presence in common areas, such as hallways, cafeterias, locker rooms, and playgrounds. Teach children to work together to stand up to a bully, encourage them to reach out to lonely or excluded peers, celebrate acts of kindness, and reinforce the availability of adult support.

Teach and reinforce positive behaviors and decision making. Provide consistent expectations and support. Teaching children social skills, problem solving, and conflict resolution supports good mental health. "Catch" them being successful. Positive feedback validates and reinforces behaviors or accomplishments that are valued by others.

Encourage helping others. Children need to know that they can make a difference. Pro-social behaviors build self-esteem, foster connectedness, reinforce personal responsibility, and present opportunities for positive recognition. Helping others and getting involved reinforces being part of the community.

Encourage good physical health. Good physical health supports good mental health. Healthy eating habits, regular exercise and adequate sleep protect kids against the stress of tough situations. Regular exercise also decreases negative emotions such as anxiety, anger, and depression.

Educate staff, parents and students on symptoms of and help for mental health problems. Information helps break down the stigma surrounding mental health and enables adults and students recognize when to seek help. School mental health professionals can provide useful information on symptoms of problems like depression or suicide risk. These can include a change in habits, withdrawal, decreased social and academic functioning, erratic or changed behavior, and increased physical complaints.

Ensure access to school-based mental health supports. School psychologists, counselors, and social workers can provide a continuum of mental health services for students ranging from universal mental wellness promotion and behavior supports to staff and parent training, identification and assessment, early interventions, individual and group counseling, crisis intervention, and referral for community services.

Provide a continuum of mental health services. School mental health services are part of a continuum of mental health care for children and youth. Build relationships with community mental health resources. Be able to provide names and numbers to parents.

Establish a crisis response team. Being prepared to respond to a crisis is important to safeguarding students' physical and mental well-being. School crisis teams should include relevant administrators, security personnel and mental health professionals who collaborate with community resources. In addition to safety, the team provides mental health prevention, intervention, and postvention services.

MENTAL HEATLH ISSUES AND STUDENTS
BIBLIOGRAPHY

You may choose a book from this list or one of your own choosing that is compatible to this course. Please let the instructor know if you choose a book that is not on this list.

Alter, Robin and Clarke, Crystal. *The Anxiety Workbook For Kids*. New Harbinger Publications, 2016. Illustrations and activities for children (grades P-6th.) www.newharbinger.com

Attached, Emily and Fernandez, Marzia. *Mental Health Workbook.* Audio book, 2020. Amazon Books www.amazon.com This book helps ones to understand anxiety, attachment and recovery from struggles. (P-12).

Campbell, Elizabeth. *Helping Skills Training for Nonprofessional Counselors.* Routledge Publications, 2019. Skills for adults who work with children. (P-12) www.routledge.com

Cavanagh, Sarah. *Mind Over Monsters.* Beacon Press, 2023. A compassionate approach to Youth Mental Health. www.beacon.org

Cooley, Myles. *A Practical Guide to Mental Health and Learning Disorders for Every Educator.* The title says it all. Free Spirit Publishing, 2018. www.freespiritpublishing.com

Dikel, William. *Student Mental Health. W.W. Norton and Company, 2022.* Comprehensive book on disorders. (P-12). www.norton.com

Fitzell, Susan Gingras. *Transforming Anger to Personal Power.* Research Press. 2019. Teaching anger management (grades 6 – 12). www.researchpress.com

Hurley, Katie. *The Depression Workbook for Teens.* Althea Press, 2019. . A workbook to help teens work through feelings of depression (grades 7-12). www.amazon.com

Misher, Peter. *For All You Do: Self Care and Encouragement for Teachers*. 2021. Andrews McMeel Publishing. www.andrewsmcmeel.com\

Phifer, Lisa and Sibbald, Laura. *Trauma-Informed Social Emotional Toolbox*. Pesi Publishing, 2020. Empower children and adolescents to cope with trauma and build resiliency. (P-12) www.pesi.com

The following two books are written by your instructor and contain a faith based perspective and biblical references. These are available on line or through bookstores. Both books are available in CD format as audio books.

What To Do When Words Get Ugly. Michael Sedler. Revell Books, 2016 (edited/revised edition). Examines the topic of gossip and how it impacts people. (Adult) www.bakerbooks.com 1-800-877-2665

When to Speak Up and When to Shut Up. Michael Sedler. Revell Books, 2006. Communication book discussing conflict and encouragement. (Adult) www.bakerbooks.com 1-800-877-2665 **(over 400,000 copies sold).**