

When Something's Wrong

Strategies for Teachers

When Something's Wrong was originally developed under the leadership of Healthy Minds Canada. Many contributors are recognized on pages 159–165. The resource was further updated by Dr. Stan Kutcher in 2014.

In 2018, Healthy Minds Canada decided to cease independent operations and merged into Jack.org. The merger initiated the Healthy Minds Canada fund at Jack.org, supporting our efforts towards ongoing community mental health education across Canada. As part of the overall merger, Jack.org is honoured to be the custodian of this resource moving forward.

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HOW to Use This Handbook

A child's difficult or unusual classroom behaviour, emotional difficulties, or cognitive challenges creates tremendous stress for him/her, the teacher, and other students. In some cases, these challenges can be temporary; in others they may reflect a mental disorder.

When Something's Wrong: Strategies for Teachers has been designed to help you, the elementary or secondary school teacher, understand what may be happening and implement ways to help children with behavioural, emotional, and cognitive challenges that are due to common mental disorders.

The handbook is made up of eight sections, which can be used independently. For teachers using the **Mental Health and High School Curriculum Guide**:

www.teenmentalhealth.org/curriculum this handbook can be a resource used in lesson planning or in the classroom.

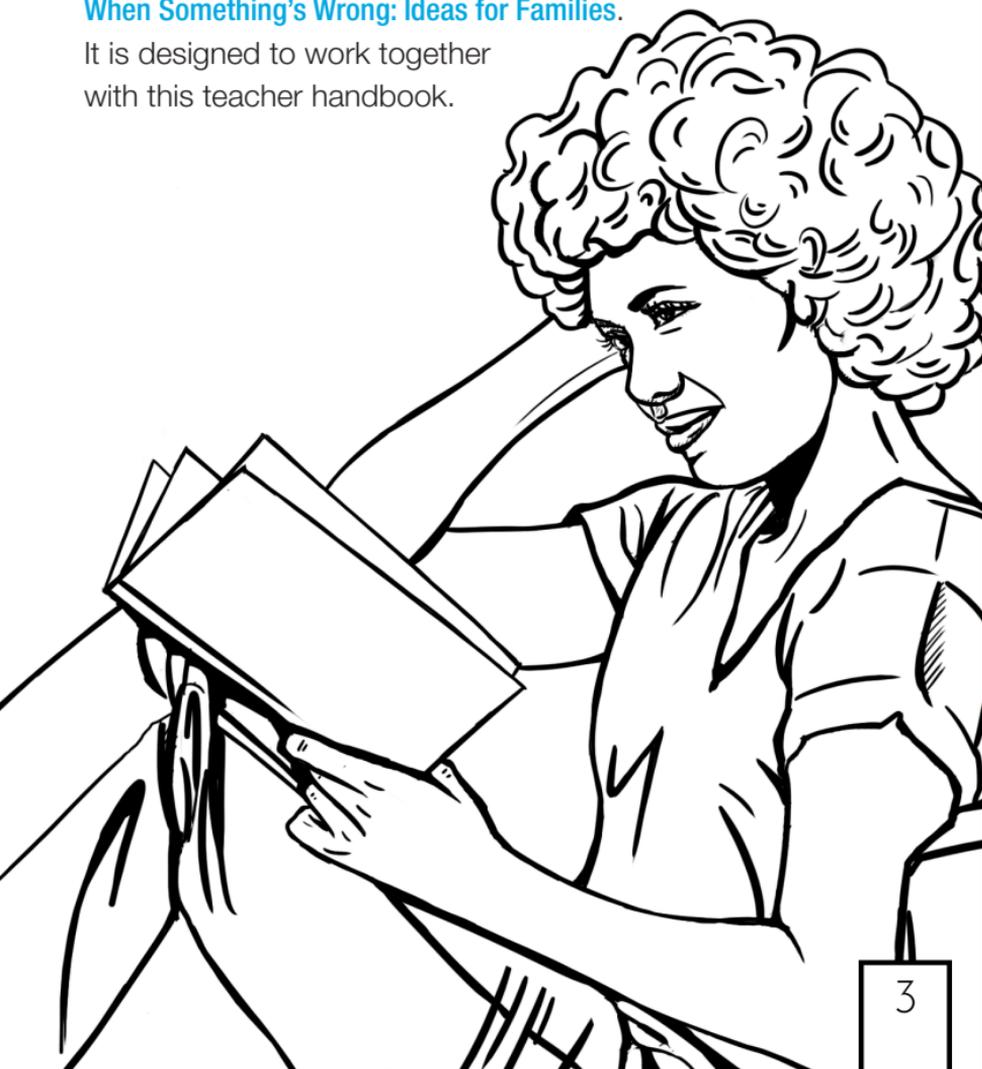
In each colour-coded section you will find

- ❖ A brief description of possible classroom behaviours that can accompany some of the more common childhood and youth mental disorders.
- ❖ Suggested strategies to help you deal with these issues in the classroom.
- ❖ Summaries of existing medical or therapeutic treatments.
- ❖ At the end of each section and at the end of the handbook you will find a list of resources for further information or professional assistance.

For further information and additional coping strategies, please see Healthy Minds Canada's second handbook,

When Something's Wrong: Ideas for Families.

It is designed to work together with this teacher handbook.



Sections included in the family handbook which are not found in this handbook include

-  Managing Problem Behaviour in Children.
.....
-  Posttraumatic Stress Disorder (PTSD).
.....
-  Borderline Personality Disorder (BPD).
.....
-  Working with Your Health Practitioner.

Please note that all data included in this handbook (i.e., statistics and figures) is based on available scientific literature at the time of printing.

The mental health domains addressed in these sections were selected by focus groups made up of teachers, guidance counsellors, psychologists, social workers, behaviour resource teachers, and child/adolescent psychiatrists. **When Something's Wrong: Strategies for Teachers** is a “quick reference” source. It can be used alone, or together with *When Being a Good Parent or Teacher is Not Enough*, a two-volume set presented by Health Education Consultants, in association with the American Academy of Child and Adolescent Psychiatry and written by Barbara N. Buchanan, M.D. and Anne E. Yarnevich, M.S.W. (Copyright 2000 by Health Education Consultants).



Two Canadian online resources with substantial teacher and student friendly resources largely designed for classroom use are:

www.teenmentalhealth.org and www.keltymentalhealth.ca.

This handbook is neither a diagnostic aid nor a diagnostic tool. Teachers can play an important role in the identification of young people who may have or be developing a mental disorder, but the role of a teacher does not include diagnosis. In some provinces, such as Ontario, the act of diagnosis by a teacher is not legally permitted. A diagnosis of a mental disorder is the role

of an appropriately qualified health provider and is essential for directing best evidence based treatments. If young people or parents are not comfortable with a diagnosis given by their health provider they can be encouraged to seek a second opinion from another qualified health provider. The purpose of this handbook is to provide the teacher with more information about common mental disorders that will affect students in their classrooms and to give the teacher useful strategies to help a student who has a mental disorder better cope with the classroom, academic, and social challenges that may accompany his/her condition. You may already use some of the strategies listed, but we hope it will provide additional suggestions that will be of value to you.

There are nine sections in this handbook covering the following disorders

01 Anxiety Disorders

02 Obsessive Compulsive Disorder

03 Mood Disorders

04 Substance-Related and Addictive Disorders

05 Eating Disorders

06 Disruptive, Impulse Control, and Conduct Disorders

07 Neurodevelopmental and Behavioural Disorders

08 Schizophrenia

09 Self-Injury and Suicide

INTRO

Epidemiologic data demonstrates that about **20%** of young people will develop a mental disorder and that about **70%** of all mental disorders can be diagnosed prior to **25** years of age. Many of these disorders will be of mild to moderate severity and all students with these disorders will benefit from early identification and the application of best evidence based interventions. Many children with these disorders will exhibit their difficulties in the classroom, through problems with emotions, behaviour or cognition. If you recognize a student who may have one or more of the disorders described below, please discuss your concerns with the most appropriate in-school professional, usually a guidance counsellor, psychologist, social worker, etc. and work out a plan with them for what can best assist the student. Usually, parents or caretakers may need to be involved. This involvement should be done in a considered and co-ordinated manner from the school, not in ad-hoc interventions. In many cases, out of school professional treatment may be required. In such situations, the classroom teacher should become part of the collaborative helping team working to best support the student in the school setting. All of these students can benefit from strategic classroom interventions provided by informed teachers.

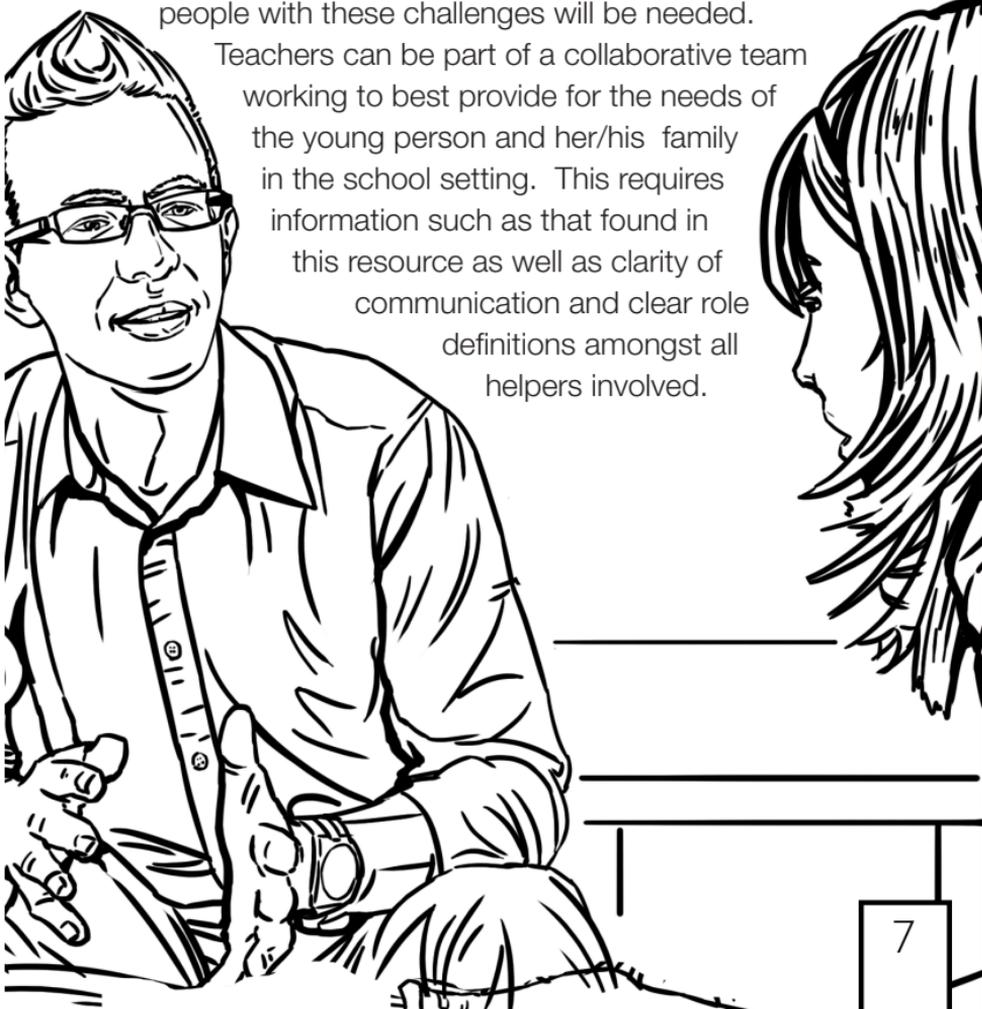
A team approach, involving teachers, parents, school support staff (psychologists, social workers, counsellors, and other in-school mental health care workers), public health nurses and other health professionals, may be required to provide optimal

assistance to some children and teenagers. The support system may vary from one school to another, but in all cases the teacher plays a central role in the day-to-day activities of the student. This may include: recognition of behavioural, emotional or cognitive difficulties that may indicate possible mental disorders, classroom support, and the use of appropriate classroom strategies.

Some mental health problems can also lead to significant behavioural, emotional or cognitive challenges for students (see below for more information). In recognizing mental health problems, it is important to consider that for some students these challenges may be related to socio-cultural adjustments to behavioural expectations that are different in Canada from their country of origin. Students undergoing major adjustments in the home (e.g. divorce, death) may also experience mental health problems that are expressed through behaviour, emotions or cognition in the school setting.

Given the complexities of these concerns, it is evident that a team approach to optimize assistance and support for young people with these challenges will be needed.

Teachers can be part of a collaborative team working to best provide for the needs of the young person and her/his family in the school setting. This requires information such as that found in this resource as well as clarity of communication and clear role definitions amongst all helpers involved.



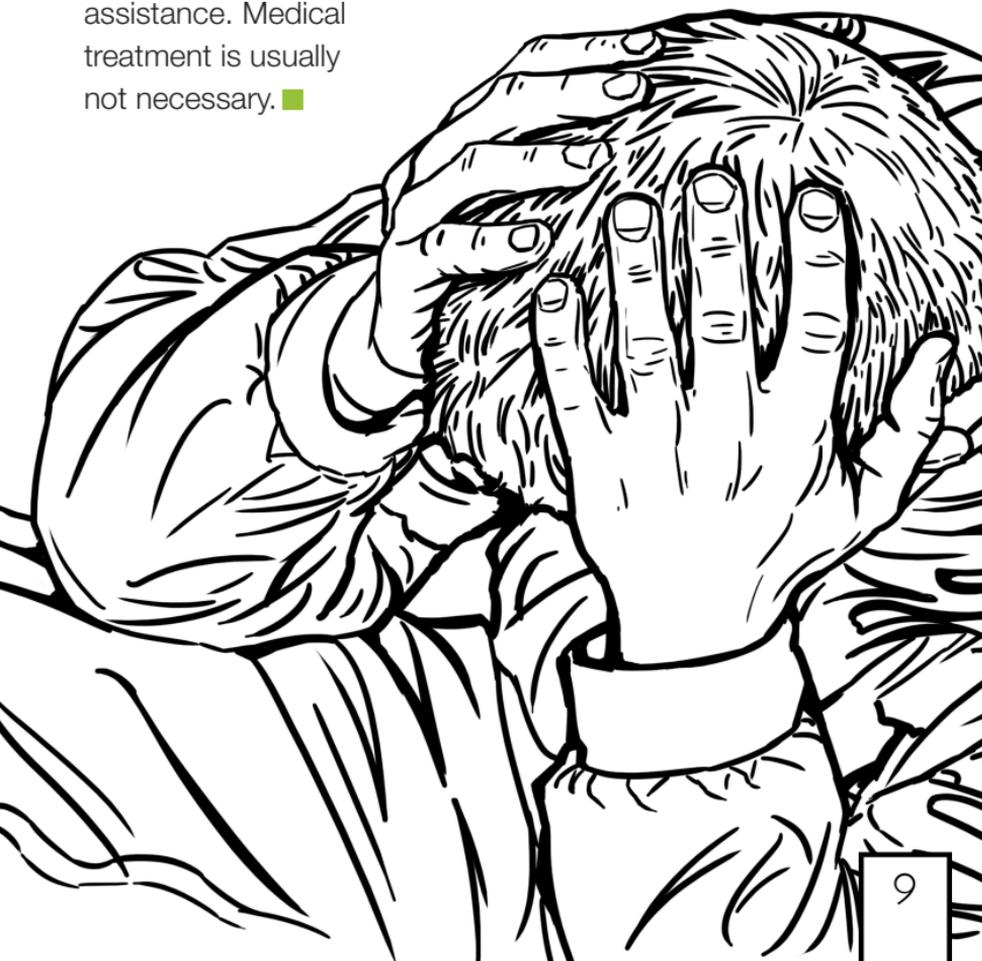
MENTAL DISTRESS, MENTAL HEALTH PROBLEMS, MENTAL DISORDERS

Mental Distress

Mental distress is the inner signal that an environmental stressor is demanding that the individual adapt to a challenge (e.g. writing an exam, going on a date, not making the sports team, giving a public performance, etc.). It is made up of emotional, cognitive, physical and behavioral components (such as: feeling anxious, feeling unhappy, thinking negative thoughts, experiencing headaches or stomach aches, avoidance, etc.). Mental distress is ubiquitous, part of good mental health, and the basis for resilience. It drives adaptation. Successful adaptation to the environmental stressor decreases mental distress and provides learning that accumulates for successful adaptations to upcoming and more developmentally complex stressors as they occur over the life-span. Young people experiencing mental distress do not require counselling, they are not “sick”, and they do not need treatment. Healthy stress management techniques and other wellness enhancing activities learned at home, from friends, trusted adults, and in schools are all that is needed to mitigate distress and move forward with life. Allowing young people to avoid mental distress can have negative impacts on development of resilience. ■

Mental Health Problems

Mental health problems are behavioural, emotional, physical and cognitive responses to a substantial environmental stimulus that is causing significant difficulty in adaptation. Usually this is because the stressor is of a nature or degree that the usual distress management strategies are not as effective (e.g. death of a loved one, divorce, socio-cultural adaptation, etc.). Sometimes the person experiencing a mental health problem will exhibit noticeable difficulties in everyday functioning, at school and outside of school. In addition to the distress management skills and wellness enhancing activities useful in mental distress, young people experiencing a mental health problem will often need additional support to help them through the difficult situation or assist them with problems in functioning (such as extra time for academic activities). In such cases, this support can come from a counsellor, a religious leader, community organization, human services provider or other similar sources. Sometimes a health provider such as a social worker, psychologist, or youth worker will be asked to provide assistance. Medical treatment is usually not necessary. ■



Mental Disorder

A mental disorder is a medical condition diagnosed by internationally recognized criteria (such as ICD or DSM) that arises from perturbations of usual brain function as a result of a complex interplay between a person's genes and environment. The presence of a mental disorder signifies that an individual needs best evidence based interventions (of many different types, such as medications, psychotherapies, social interventions, etc.) provided by appropriately trained health providers. While interventions that can help distress and mental health problems can also be used to help a person who has a mental disorder, and wellness enhancing activities are always indicated, a young person with a mental disorder requires a degree of care above and beyond that usually provided for a mental health problem. Mental disorders always require treatment using best evidence based care.



This is illustrated in the diagram below



The inter-relationship of mental health states © Dr. Stan Kutcher 2014

The idea that mental health and mental disorders occur on a spectrum with mental health at one end and mental disorders at the other is popular, but it is not correct. An individual may have both good mental health and a mental disorder at the same time, the same way an individual may have good physical health and have a physical disorder (for example: diabetes treated with medication and diet, or panic disorder treated with psychotherapy, etc.).

Furthermore, an individual does not move linearly and predictably across a continuum, from one state (mental health) to the next (mental health problems or concerns) to the next (mental illness). Over a 24 hour period, most if not all young people will experience mental distress, yet most will never develop a mental disorder. All people will experience a mental health problem during their life (indeed, most will experience many mental health problems) but most people will not develop a mental disorder. A person can also experience all states simultaneously (for example: a youth has ADHD – mental disorder, his grandfather has died – mental health problem, and he has lost the keys to the family car – mental distress). It is important not to confuse the different mental states when planning interventions in order to avoid application of unnecessary treatments and to avoid classification of usual life as pathology. Any intervention must be linked to the condition and the language we use should reflect the need that the youth has (for example: if the young person is feeling sad/upset because they failed an exam we do not call him/her “depressed” because Depression is a mental disorder and the youth is only experiencing mental distress). This is described in the chart below.

 This is described in the chart below

Pyramid Position	Event	Word
Distress	Lost my keys	Agitated
Distress	Did not make the team	Disappointed
Distress	Going on a first date	Nervous
Problem	Parent dies	Grief
Problem	Lost my job	Demoralization
Problem	Romantic breakup	Devastated
Disorder	None necessary	Depression

Use the Right Words! © Dr. Stan Kutcher 2014

Brief

Overview of Adolescent Brain Development

What is Adolescence?

Adolescence is a complex social-biological construct comprising the period between childhood and adulthood, beginning around puberty and ending at about age **25**. It is a time of substantive physical, emotional and cognitive development that can also be the first time signs of a mental disorder (including substance use disorders/addictions) appear. One important personal development goal of adolescence is the path to social, interpersonal, and economic independence from the family of origin. During this time, strong influence of friends, trying out new roles, and risk taking can lead to conflict with parents and caregivers. This can be a challenging time for teenagers and families, but it is an important part of growing up. If young people never learn to separate from their families, form strong relationships with peers, and try out new things, they will never have the ability or courage to leave home, find partners, and live as independent adults. Adolescent brains are uniquely programmed to do just that!

Is an Adolescent Brain Different from an Adult Brain?

Our brain controls everything in our bodies, for example

- ◆◆ What we think.
.....
- ◆◆ What we notice and understand.
.....
- ◆◆ What we feel.
.....
- ◆◆ How we behave.
.....
- ◆◆ How we move.
.....
- ◆◆ How we respond and react.
.....
- ◆◆ What we remember.

There are significant differences between an adolescent brain and an adult one. Just as teenagers’ bodies are still developing physically, so are their brains. Adolescence is an important time for the “reorganization” of the brain’s wiring, and this helps determine how the adult brain is going to work. During this period of time, changes in how the brain is formed and what it does impact many areas, including those involved in decision-making, impulse control and sleep/wake cycles. For example:

- ◆◆ The last part of the brain to mature is the frontal lobe – the part of the brain that affects the ability to plan, organize, think rationally, understand complex social cues and control desires. Since these skills are still being developed, a teen’s abilities in these areas may not be as strong as they will be in the future. This is especially true when they are in highly emotional situations.

❖ Brain changes during these years also impact sleep, and brain reorganization during adolescence naturally pushes young people towards a later sleep beginning time and a later awakening time. The needed duration of sleep however remains consistently high, about nine hours per night. These naturally occurring biological changes are exacerbated by environmental conditions such as presence of artificial light, online and electronically based activities (e.g. use of computers, cell phones, television, etc.). Common changes include not being tired at night, waking up later in the morning, and being most sleepy in the early to mid-morning. Getting enough sleep is necessary for brain growth and development and for learning. Teens who do not get enough sleep demonstrate numerous difficulties with emotional control, behaviour and cognition. The full implications of the impact of teen sleep-deprivation is not yet known but are thought to be related to numerous negative social, academic and interpersonal outcomes. Teachers know what it is like to teach math to a class of teenagers at eight in the morning!

❖ Brain development of neural circuits that impact motivation and reward appreciation are undergoing rapid development in teenagers. Teens are more likely to experience different responses to activities that entail risk than adults and are more likely to act on the basis of a smaller immediate reward rather than on the promise of a larger but delayed reward.

It is important to remember that even though our brains are not fully formed until adulthood, it does not mean that teenagers cannot make appropriate choices. In fact, young people can and do make sophisticated, complex, informed, and rational decisions. In emotional situations however, many teenagers may be less able than adults to control their impulses. This is because the parts of the brain that control planning, judging, and inhibit impulsive behaviors are not yet fully developed. Teens may be more likely to make decisions based on how they feel rather than on a calm analysis of the impact that their decision may have.

These brain development driven changes in teens are often portrayed in a negatively stereotyped manner. However, they are the underlying brain constructs that promote exploration, innovation and creativity, all domains in which teenagers excel. Indeed, one can argue that it is the teenage brain that has historically led to some of the most impressive inventions, artistic creations and social developments of human kind.

Difference in Brain Development between Boys & Girls

Not only are there differences between a teenage brain and an adult one, but there are also differences between female and male brains. For example, by age **6** the brain has reached **90-95%** of its maximum size for both sexes. But while a girl's brain reaches its full size around **11.5** years of age, this does not happen for boys until they are about **14.5** years old. It is no surprise then that boys and girls seem to mature differently - their brains actually grow at different rates.



Along with this difference, both boys and girls experience a rise in hormone levels, which are also controlled by the brain, the timing of their release is brain growth dependent. As children become teenagers, the brain sends signals to increase sex hormone production (testosterone in boys; testosterone, estrogen, and progesterone in girls). It is this increase in sex hormones partnered with the increased activation of brain driven reward systems that underlie the rapid and complex emergence of human sexual behaviors. However, the common perception that teenage behaviour is “caused” by hormones is based on a co-relation and is not causal. Although some teens can be a bucket of “raging hormones”, their emotions, behaviors, and cognitions are due to changes in how the brain controls these functions and not to the direct impact of the sex hormones themselves.

Why do Adolescents Do Risky Things?

Adolescents are more likely than children or adults to take risks because areas of their brain that control risk taking and pleasure seeking are going through huge changes and the brain feedback systems that modulate these behaviors are not yet fully formed. This is highly related to the maturation of the frontal lobes. Because teens’ frontal lobes have not fully developed, a teenager’s ability to control risk taking and impulsivity, plan ahead, and to use sound judgement and reasoning is not yet mature. It is not that they do not consider risk; it’s that they often value the reward more, and so are more likely to participate in risky behaviours. The influence of peers, strong emotional reactions, and a positive response to immediate pleasure are all a normal part of adolescent brain development. For these reasons, chances are higher that teenagers will act in ways that surprise and worry parents and other caregivers. It is also for this reason that youth are more likely than adults to be in car accidents, commit crimes, and have unprotected sex (resulting in sexually transmitted diseases or unwanted pregnancies).

As their brains develop, teenagers start to better control their impulses and better manage risk taking and thrill seeking. During adolescence they manage complex social interactions, develop important complex cognitive skills, better understand the needs and feelings of others, and better develop their capacity to take responsibility for their own lives and the lives of others. In other words, they have managed to grow into functioning adults.

Are Adolescents More at Risk for Mental Disorders & Addictions?

Dramatic changes in brain development during these years may make some young people more vulnerable to mental disorders or addiction, and adolescence is a time when such challenges often emerge. **70%** of adults identify that their mental disorder began before the age of **25**. But while there is a higher chance that mental disorders and/or addiction will emerge during these years compared to other developmental stages, it is important to remember that this risk is not the same for everyone. Many youths try drugs, but very few become drug addicts, and experimentation is a part of the developmental process. Most youths will proceed through adolescence without developing a mental disorder.

Some domains that researchers have found to increase risk include

- ◆◆ **Sleep:** Teenagers need around 9 hours of sleep yet they have to get up early for school and often have trouble falling asleep early. Not getting enough sleep on an ongoing basis may increase the risk for some mental health problems and mental disorders. However, most teens who do not get enough sleep do not develop a mental disorder. For more on adolescents and sleep check out www.teenmentalhealth.org/toolbox/healthy-sleeping/.

❖ **Stress:** teenagers manage stress differently than adults, especially social stress. An event that has little impact on an adult may have a more substantive and long-lasting impact on a teenager. This is because the brain development dependent capacities necessary to manage such situations have not yet been fully realized, not because teens are “just being teens”.

❖ **Predisposition:** some youth have a greater predisposition towards risky behaviours, mental disorders and/or addictions because of genetic factors. There is also a link between some of these conditions and early exposure to toxic environments such as alcohol in utero or persistent and severe adverse experiences in early life.

Helping Teens Develop Healthy Coping Strategies

Without understanding brain development, teenagers can seem to behave in ways that make little to no sense. This can make it hard for parents and other caregivers, as well as the teenagers themselves and other adults in their lives. Contrary to some common beliefs, teenagers require and appreciate the help of trusted responsible adults as they navigate the challenges of this phase of their lives.

There are many ways that adults can help

- ❖ Be there for them. Continue to positively influence and guide your teenager. While it may not seem like it, they still need you as much as they ever did. Be patient, understanding, empathetic, involved, and supportive. Try to see things from their point of view. Even if you do not understand why something is so upsetting to them, they need you to take their feelings seriously.
- ❖ Give them opportunities to take on adult roles, both at home and in the community.

❖ Listen more and talk less. Listen to what they say to you and be open to their opinions and ideas. Pay attention not only to what they say, but when they say it. Does your teen open up to you when you are sitting and talking, or is it when you or they are busy with another activity, like cooking dinner or playing a computer game? Listen to their words and cues and have conversations in the ways that makes them feel the most comfortable. If it's on their own terms, there is a better chance that they will confide in you.

❖ Respect their opinions. Discuss your family values and expectations with them and allow them to make their own choices whenever possible. This does not mean do not have clear and rational rules! It's better to have a few clear and rational rules that are fairly enforced than many rules that either do not make sense or are not possible to enforce.

❖ Explain clearly and respectfully. Whenever possible, explain your decisions to your teenager, especially as they relate to him or her. Although parents have the right and responsibility to make decisions, explaining your reasoning not only increases the likelihood that your teen will understand (and maybe agree), it also models to them how to reason through their own decision making.

❖ Problem-solve with them. Practice role-playing with them, allowing them to take the lead. Help them figure out how they would manage/solve different situations. Remember that getting things wrong is one way of learning how to get things right. We all learn from our failures.

❖ Challenge them. Encourage behaviours/activities that are challenging, new and stimulating. Allow for appropriate and increasing amounts of independence, freedom, responsibility and opportunities for exploration. This may help them to avoid boredom and lessen their chances of being tempted to participate in risky behaviours that have substantial negative consequences.

❖ When you are wrong, admit it. It takes courage and responsibility to admit that one made a mistake. We all make mistakes. Admitting your mistake and then taking the proper steps to remedy the error is an important life lesson for your teen, and modeling how to do that will help them and will also help your relationship.

❖ Let them sleep in on the weekend. Teenagers need more sleep than adults. While they may have to wake up early for school, on non-school days allow them to sleep in late. They are indeed catching up and repaying their sleep debt. Sufficient sleep is important for memory and learning, and impacts emotional regulation, cognition, and behaviour. But, at the same time, help them with improving their sleep hygiene. Check out: www.teenmentalhealth.org/toolbox/healthy-sleeping/.

❖ Get help. If you are not sure if particular behaviors, emotions, or ways of thinking are normal for teens, ask a health professional who knows about teen behaviors. If there is a problem, early identification of the problem is the first step to getting the right kind of help as soon as it is needed. Your family doctor, school social worker or a psychologist is the right person to tell you if the adolescent in your life is “just being a normal teenager” or if there is a problem (and in this case, what support or best evidence based interventions are available to help you). To help you get the best evidence base care from your health provider, check out these resources:



Evidence Based Medicine

www.teenmentalhealth.org/toolbox/evidence-based-medicine-patients/

Evidence Based Medicine for Youth

www.teenmentalhealth.org/toolbox/evidence-based-medicine-youth/

Communicating With Your Health Care Provider:
What Every Person Should Ask

www.teenmentalhealth.org/toolbox/communicating-health-care-provider-every-person-ask/

R esources

Teen Brain Teen Mind, Dr. Ron Clavier. Key Porter Books, 2009.
You and Your Adolescent, Dr. Laurence Steinberg. Simon and Schuster, 2011.

Parenting Your Teen

www.teenmentalhealth.org/toolbox/parent-teen/

Teening Your Parent

www.teenmentalhealth.org/resources/entries/teening-your-parent1

The Teen Brain (video)

www.youtu.be/EGdlpaWi3rc

Teen Brain learning resource on TeenMentalHealth.org

www.teenmentalhealth.org/live/the-teen-brain/

The Nature of Things: Surviving the Teenage Brain (video)

www.cbc.ca/natureofthings/episodes/surviving-the-teenage-brain

ANXIETY DISORDERS

Anxiety Disorders are mental disorders characterized by excessive or inappropriate levels of anxiety that are so severe that they interfere significantly with daily living.

Taken as a group, they are the most common mental disorders in youth, affecting up to **10%** of children and adolescents. Anxiety Disorders arise from a complex interplay of genetic and environmental factors and different forms begin at different times during these years. For example, Separation Anxiety Disorder usually begins during mid-childhood, while Panic Disorder usually has an onset in later adolescence. Anxiety Disorders are not benign conditions. Untreated, they can lead to Depression, alcohol abuse or other mental disorders and various mental health problems. Moderate to severe Anxiety Disorders lead to poorer academic, vocational, and interpersonal outcomes, a decreased quality of life and higher utilization of health care systems. Effective early interventions can provide symptomatic relief, improve long-term outcomes, and possibly prevent the development of other psychiatric disorders. In classroom situations, these children may appear to be “shy” or avoidant. They may be reluctant to do group work or speak out in class.

In adolescence, social isolation or substance abuse may begin as a result of an Anxiety Disorder. Rarely, if ever, do youths with Anxiety Disorders act in a manner that disturbs classroom routine, and they are often not identified as having major difficulties.

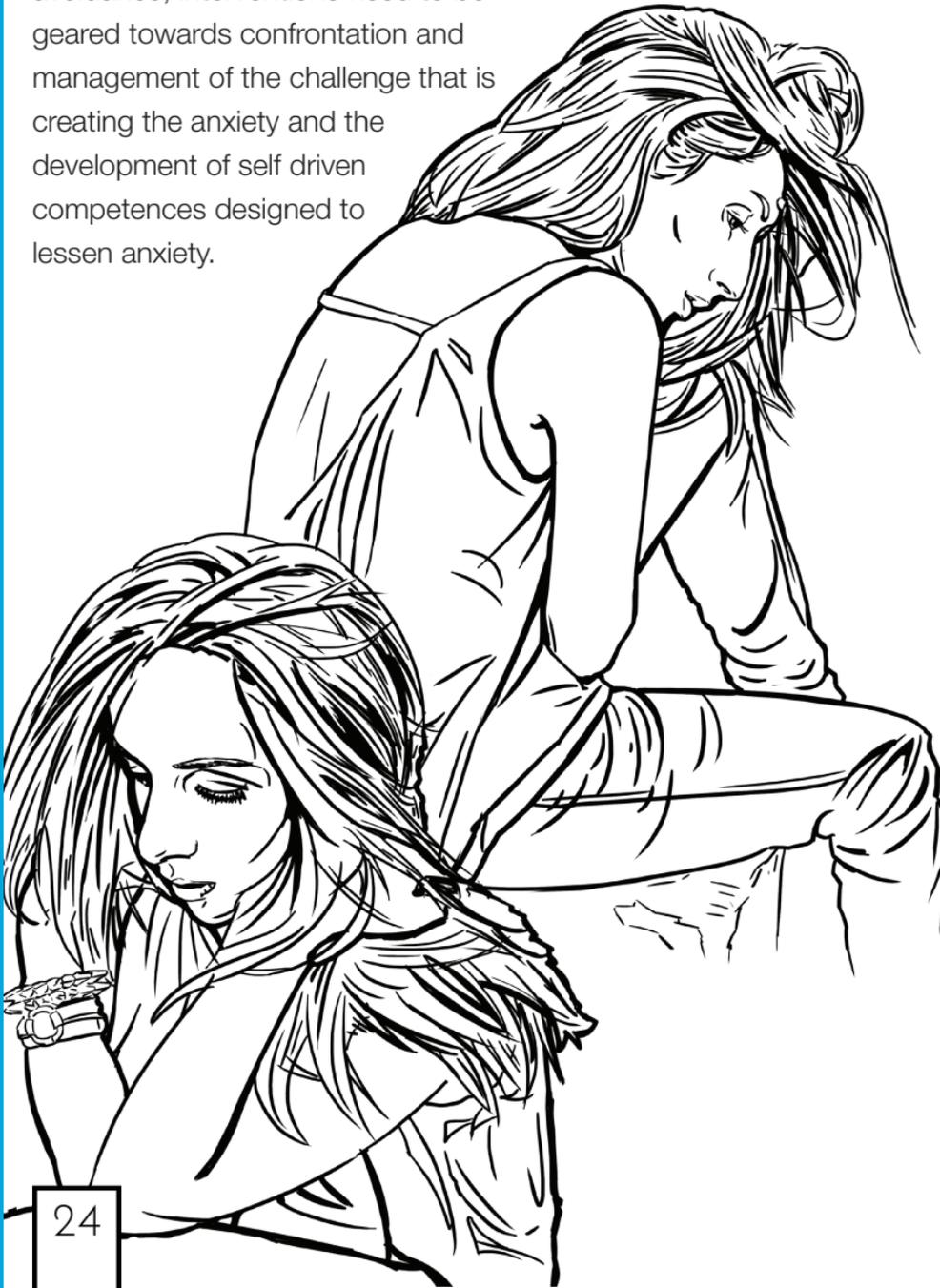
The most common Anxiety Disorders are:

- ◆◆ Separation Anxiety Disorder,
.....
- ◆◆ Generalized Anxiety Disorder (GAD),
.....
- ◆◆ Social Anxiety Disorder,
.....
- ◆◆ Social Anxiety Disorder, and Panic Disorder (PD).

Remember, Anxiety Disorders are not the same thing as feeling anxious or stressed. Feeling anxious is normal and expected. Anxious feelings are part of everyday life and are necessary to help us learn how to overcome life's usual challenges and become resilient. Most stress that we experience on a day to day basis is also helpful to us. We perform better with a little bit of stress. Usual anxiety is a signal from our brains that we need to adapt to something that is happening in our environment. Successful adaptation leads to less anxiety and to the learning of skills that we can then employ in life's future challenges. It is very important not to confuse normal and healthy anxiety with Anxiety Disorders. This section is about Anxiety Disorders, not the healthy and helpful kind of anxiety that we all need to feel and adapt to so that we can learn new skills and be successful. Also remember that classroom interventions for young people with Anxiety Disorders should be applied as part of an overall integrated treatment plan that involves the teacher and in-school student service providers (such as a guidance counsellor, psychologist or social worker). It is essential for youth with usual and expected anxiety and for young people who have an Anxiety Disorder that educators do not support avoidant behaviors. Furthermore, students with anxiety disorders can become bullying targets. If this occurs, the school needs to take the necessary interventions.

Avoidant Behaviors

Avoidant behaviors are very common in anxious young people, and if they are supported, the anxiety becomes worse, not better. Additionally, the young person does not learn the needed adaptation skills to be able to overcome the anxiety on their own. Indeed, permission to avoid can lead to worsening anxiety and more maladaptive behaviors. Thus, supporting of avoidant behaviors can make anxiety worse. Instead of supporting avoidance, interventions need to be geared towards confrontation and management of the challenge that is creating the anxiety and the development of self driven competences designed to lessen anxiety.



SEPARATION ANXIETY DISORDER

Separation Anxiety Disorder can usually be diagnosed by mid-childhood. It is characterized by severe panic-like episodes that begin when the child is separated from his/her parent or caregiver. As a result, the child has difficulty participating in age-appropriate social activities such as sleepovers, summer camp, etc. These episodes may come to a teacher's attention when children refuse to attend school, cry and have tantrums when left at school, refuse to participate, or exhibit excessive "homesickness" during overnight school trips. For an animated video (suitable for sharing with students) describing Separation Anxiety Disorder, check out:

www.youtube.com/watch?v=jEkFp0Ux40Q

Separation Anxiety Disorder is thought to affect about **1-2%** of children and decreases in prevalence over time.



Common Signs & Symptoms

- ❖ Refusal to attend school.
.....
- ❖ Tantrums, tears, clinging when left at school by the parent.
.....
- ❖ Excessive "homesickness" during over-night school trips.
.....
- ❖ Clinging to the teacher.
.....
- ❖ Persistent and unrealistic worries about unlikely events that will lead to separation (e.g. kidnapping, death of a parent, etc.).
.....
- ❖ Persistent complaints of physical problems (e.g. headache, stomach ache, etc.).

GENERALIZED ANXIETY DISORDER (GAD)

Generalized Anxiety Disorder (GAD) is thought to affect **1-3%** percent of youth and is often found together with other Anxiety Disorders or Depression. It is rarely diagnosed prior to puberty although many individuals who later develop GAD were described as “anxious” children. GAD may be associated with inhibited temperament or excessive childhood shyness, but can also be seen in more outgoing children and even in some young people with Attention Deficit Hyperactivity Disorder (ADHD). Young people with GAD worry incessantly about most things. It is the extreme, persistent, overwhelming and severe nature of their worries that leads to a diminished quality of life. The worry leads to avoidance and the avoidance accentuates the worries. Young people with GAD frequently complain of physical symptoms such as headaches, stomach aches, muscle aches and pains. Their bodies express their anxiety through physical symptoms. They tend to avoid situations and activities that are related to their worries. Avoidance of these situations and activities actually has the effect of worsening, not decreasing, their anxiety.



Common Signs & Symptoms

- ❖ Constant worry or tension.
.....
- ❖ Extreme need for reassurance.
.....
- ❖ Physical symptoms (headaches, stomach aches, fatigue).
.....
- ❖ Avoidance of stressful situations, such as tests.
.....
- ❖ Difficulty concentrating.
.....
- ❖ Clingy behaviour in young children.



What to Do © Dr. Stan Kutcher 2014

- ❖ GAD is highly treatable with specific psychological interventions such as Cognitive Behavior Therapy (CBT). Referral to an expert on that type of therapy is recommended.
.....
- ❖ Reassurance is not helpful - at best, it only provides minor and temporary decrease in symptoms, and excessive reassurance can encourage “clingy” behavior.
.....
- ❖ Provide simple and practical suggestions about specific items of anxiety. For example, “Since you’re worrying about your test, why don’t you make sure to set aside 1 hour to study today?”
.....
- ❖ Do not reinforce avoidance.



What to Ask © Dr. Stan Kutcher 2014

- ❖ Would you or others consider you to be a master worrier?
.....
- ❖ Do you tend to worry about most things more than most other people you know?
.....
- ❖ What are your most common worries?
.....
- ❖ Does your body “worry” by getting headaches, stomachaches, etc.?
.....
- ❖ How does worrying get in the way of doing things you like to do and enjoying life?
.....
- ❖ Do you sometimes feel overwhelmed by your worries?

SOCIAL ANXIETY DISORDER

Social Anxiety Disorder can sometimes be diagnosed in middle childhood but it more commonly can be observed in adolescence. It is characterized by severe anxiety, at times mixed with panic episodes, that occurs only in social situations and is often accompanied by blushing. Young people with Social Anxiety Disorder feel under scrutiny by others and experience intense embarrassment in usual and normal social situations. Social Anxiety Disorder is the most common of the anxiety disorders in this age group, with a prevalence rate of **2-5%** and may precede the development of Depression and alcohol misuse. Up to **30%** of youth with Social Anxiety Disorder develop problems with alcohol use. While many cases are mild to moderate in severity, it can be severely debilitating and can result in social isolation. Children with Social Anxiety Disorder may also present with "selective mutism", unable to speak at school despite fluency in language when they do speak and normal speech at home. To view an animated video (that is also appropriate for students) addressing Social Anxiety Disorder, check out: www.youtube.com/watch?v=kitHQUWrA7s



Common Signs & Symptoms

Refusal or severe reluctance to participate in activities that will permit social scrutiny; e.g. public speaking, eating or dressing in public, social activities such as dances, gathering in social settings such as malls.

- ❖ Physical symptoms such as blushing, a shaky voice, nervousness, or sweating prior to or during social situations.
- ❖ Persistent and severe negative "self-talk" - their "inner voice" tells them that others are critically evaluating them and they feel embarrassed (this "inner voice" is not the auditory hallucinations that we find in psychosis).
- ❖ Strong fear that others will notice their anxiety and that they will be negatively evaluated.



What to Do © Dr. Stan Kutcher 2014

- Provide information about what you think the problem is to the young person and inform them that there is effective help for their concerns.
.....
- Social Anxiety Disorder is highly treatable with cognitive behavior therapy so a referral to someone with that skill set is indicated. Medications can also help – the most common kind prescribed are Selective Serotonin Reuptake Inhibitors (SSRIs).
.....
- Exposure treatment is also useful (helping the student face his/her fears) – sometimes a teacher along with a student support worker (psychologist, social worker) can create a classroom exposure plan.
.....
- Public speaking organizations, such as Toast Masters, are helpful for youth whose anxiety is limited to public speaking.



What to Ask © Dr. Stan Kutcher 2014

- It seems to me that there are times when you are feeling a bit more stressed than usual. What kinds of situations cause you to feel anxious, embarrassed or panicky?
.....
- What do you do when you feel this way?
.....
- How do these feelings/thoughts affect your life?
.....
- What do these feelings, thoughts stop you from doing that you would otherwise do?
.....
- Have you thought about what the problem could be?

PANIC DISORDER (PD)

Panic Disorder is usually diagnosed in adolescence. It can affect up to **3%** of youth and may occur together with Depression or other Anxiety Disorders. It is characterized by a sudden onset of severe panic that arises suddenly, and without warning, in situations where there is no danger. This is called a panic attack. Occasional panic attacks are not the same as panic disorder and can occur without any psychiatric diagnosis. Symptoms experienced during a panic attack include: shortness of breath, heart palpitations, dizziness, tingling, urgent urination and intense fear. Often, attacks are accompanied by a strong desire to flee the location in which they occur. In Panic Disorder, these panic attacks are frequent, persistent and lead to impaired functioning. Repeated attacks lead to anticipation anxiety (intense worry that another attack will happen in the near future), and then to avoidance of locations and situations in which they have occurred or from which there is no easy exit. If this avoidance is extreme, persistent and significantly interferes with the person's life, he or she may also be diagnosed with Agoraphobia. To view an animated video (that is also appropriate for students) addressing Panic Disorder, check out:

www.youtube.com/watch?v=R3S_XYaEPUs



Common Signs & Symptoms

- ❖ Panic attacks in the classroom or elsewhere, which can lead to a need to "escape".
- ❖ Avoidance of school or situations/locations where "escape" is difficult.
- ❖ Intense physical symptoms (e.g., shortness of breath, heart palpitations, dizziness, sweating).
- ❖ Intense fear during the attack (e.g.: dying, having a heart attack, cannot breathe, etc.).



What to Watch For © Dr. Stan Kutcher 2014

- ❖ Does the young person have panic attacks (rapid onset of panic feelings and physical symptoms such as rapid or irregular heartbeat, breathing problems, tingling, lightheadedness, etc.)?
.....
- ❖ Does the young person worry about having a panic attack?
.....
- ❖ Does the young person avoid going to places where a panic attack has occurred, or where they think they might have one?
.....
- ❖ Do panic attacks negatively affect the young person's life and prevent them from doing what they would like to do?
.....
- ❖ School avoidant behaviours similar to those seen in Social Anxiety Disorder are often present.



What to Do © Dr. Stan Kutcher 2014

- ❖ Provide information about what you think the problem is to the young person and inform them that there is effective help for their concerns.
.....
- ❖ PD is highly treatable with cognitive behaviour therapy so a referral to someone with that skill set is indicated. Medications can also help and can be very effective.
.....
- ❖ Worry Reducing Prescription - do not reinforce avoidance.



SUGGESTED CLASSROOM STRATEGIES TO HELP STUDENT WITH AN ANXIETY DISORDER

- ❖ Provide age appropriate information about Anxiety Disorders to both young person and parent. Inform child and parent that Anxiety Disorders are very responsive to treatment.
.....
- ❖ Encourage and reward activities that successfully address the anxiety.

- ❖ Provide student with frequent and appropriate feedback, praise, encouragement and support. Focus on their “working hard” to do well, not on who they are or how smart they are.
.....
- ❖ Discourage parents from picking their child up from school early or supporting other types of avoidance when he or she expresses distress.
.....
- ❖ For brief periods of anxiety-related school avoidance (2 weeks or less) encourage prompt return to class; longer anxiety-related absences may require professional consultation and a gradual re-integration plan developed together with parents and mental health care providers.
.....
- ❖ Establish down-to-earth, realistic expectations and interactions.
.....
- ❖ Encourage physical exercise to reduce anxiety.
.....
- ❖ Check in with the student at the beginning of each day to review the day’s expectations.
.....
- ❖ Create a “things to do today” sheet. This gives the student an overview of the work expected for the day. Prepare the child/ adolescent in advance for any changes in daily routines.
.....
- ❖ Encourage use of a study schedule to prepare for tests and assignments. The schedule needs to clearly outline the activity and amount of work to be completed each day.
.....
- ❖ Give clear directions and provide clear expectations.
.....
- ❖ Break large assignments into smaller chunks, to help a child who is feeling overwhelmed by these.
.....
- ❖ Do not promote or support avoidance of anxiety provoking situations. Allowing the young person to avoid the anxiety provoking situation does not help, and it usually makes the anxiety worse.

- ❖ For perfectionists, encourage brainstorming and writing rough drafts, and provide incentives for work completion regardless of errors.

- ❖ Do not permit or support avoidance of usual school and classroom activities, such as tests, examinations or class trips.

- ❖ With the assistance of the young person's treatment team, help create a "coping" book whereby the student has a guide to help them select various anxiety limiting strategies for specific anxiety provoking situations.

Stage 1: Inside

- Teach the student the "Box Breathing Technique" and have them practice using it in class.

Box Breathing can help your student's heart rate return to normal, which helps him or her to calm down. Here's how you do it: If possible, have the student sit and close his/her eyes. If not, ask them to focus on their breathing.

1. Inhale the breath (preferably through your nose) for 4 seconds
2. Hold the breath for 4 more seconds. You're not trying to deprive yourself of air; you're just giving the air a few seconds to fill your lungs.
3. Exhale slowly through the mouth for 4 seconds.
4. Pause for 4 seconds (without speaking) before breathing in again.

Encourage the student to repeat this process as many times as possible. Even 30 seconds of deep breathing will help them feel calmer and more in control. If the student is in the middle of class or another large group of people, he or she can do the breathing exercises without closing the eyes

- Teach the student to count from fifty backwards slowly while focusing on breathing evenly in and out.

- Teach the student to visualize a calm place and breathe slowly while doing so (this technique may need to be taught by a counsellor).

Stage 2: Outside

- Take time out, BUT, do not promote avoidance of an anxiety provoking situation.
- Walk down hall while doing box breathing.
- Go to mentor or teacher.

Stage 3: Outside

- Go to office.
- Get medication, if required.

Call home if absolutely needed but limit the time spent on the phone. Establish the criteria by which the young person will be able to call home. Keep a record of the number and duration of the calls as information for further interventions by the treatment team. Decreasing phone contact should be a goal of interventions if this strategy is being used. Keep a record of number and duration of calls to monitor if this is helping or not.



Additional Strategies for Social Anxiety Disorder

- ⇒ Do not force the student into situations that are potentially humiliating; for example, forced speaking in front of the class or forced to participate in a group activity at recess, instead, develop a gradual desensitization process to help them overcome this fear. This means conquering little fears before tackling larger fears. You can work with the student, their family and their therapist or counsellor to develop a list of tasks that gradually become more challenging. Every task mastered and anxiety situation endured is a step towards success. Do not support avoidance.
- ⇒ Encourage one to one friendships first before expecting the child to interact in groups.
- ⇒ To help reduce self-consciousness, ask specific, factual questions that do not require the student to express his or her opinion.

- ❖ If a child shows selective mutism refer for mental health assessment and interventions.

- ❖ Instead of solo presentations to the class, provide an option such as a group presentation or a presentation to a small group. Allow use of multi-media presentations to reduce amount of speaking.



Additional Strategy for Panic Disorder

- ❖ If a panic attack occurs in class and it is of an intensity that the student cannot control, permit him/her to leave class but return within a specific period of time (usually between 10 and 15 minutes).



Treatments for Anxiety Disorders

Treatments for Anxiety Disorders are similar across all of the Anxiety Disorders and usually combine avoidance busting interventions with self-management techniques designed to lessen anxious feelings and negative thoughts. The mainstay of treatment is good information about the disorder (psychoeducation) and often in mild cases this can provide some good symptomatic relief. Otherwise, various types of psychotherapy can be used. The best researched is Cognitive Behavior Therapy (CBT) but more recently a variety of other therapies (such as mindfulness) are being applied with some early positive results. Some of these can be delivered successfully in groups. Most therapies require substantial amounts of practice outside therapy sessions and numerous online resources are available as well.

Medications are sometimes needed but are reserved for youth who do not respond adequately to psychotherapies. The medicines of choice are the Serotonin Specific Reuptake Inhibitors (SSRI), but for short term interventions some benzodiazepines such as Clonazepam can be used.

Additionally, a variety of complementary treatments such as stress resolving exercises can be added. Self management and healthy living skills (www.teenmentalhealth.org/imteen) can be helpful. Family therapy may be needed in cases where family functioning is contributing to impairment. It is important that

teachers and student services providers work in collaboration with health and mental health care professionals to ensure that the best possible treatments are provided to young people and that interventions occurring in the classroom are consistent with an overall treatment plan.

R esources

Anxiety Disorders Association of Canada

www.anxietycanada.ca

Anxiety BC (2014)

www.anxietybc.com/parent/anxiety.php

American Academy of Child and Adolescent Psychiatry (2014)

www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Anxiety_Disorder_Resource_Center/Home.aspx

Kelty Mental Health Resource Center: Anxiety (2014)

www.keltymentalhealth.ca/mental-health/disorders/anxiety-children-and-youth

Teen Mental Health

www.teenmentalhealth.org

OBSESSIVE COMPULSIVE DISORDER

Obsessive Compulsive Disorder, which can begin during childhood (but mostly in later adolescence), may affect about **2%** of the population. It is characterized by persistent, recurrent, intrusive, unwanted ideas, thoughts or fears (obsessions) and persistent, recurrent, repeated ritualized actions or behaviours (compulsions) performed to dispel the anxiety brought on by obsessions. It may occur with tics (see Tourette Syndrome), Depression or other related disorders such as Trichotillomania (Hair Pulling Disorder) and Excoriation (Skin Picking Disorder). It can lead to significant functional disruption and a reduced quality of life. OCD is not the same thing as perfectionism or careful attention to detail. Many young people can be “obsessive” about their schoolwork or quality of their performance (such as playing a musical instrument), but they do not have OCD. To view an animated video (that is also appropriate for students) addressing OCD, check out: www.youtube.com/watch?v=ua9zr16jC1M

Young people with OCD often suffer the added stress of teasing, rejection, and even bullying from peers. If this situation is occurring, the school must take necessary steps to address the bullying. This may require the intervention of school administrators as well as the involvement of parents.



Common Signs & Symptoms

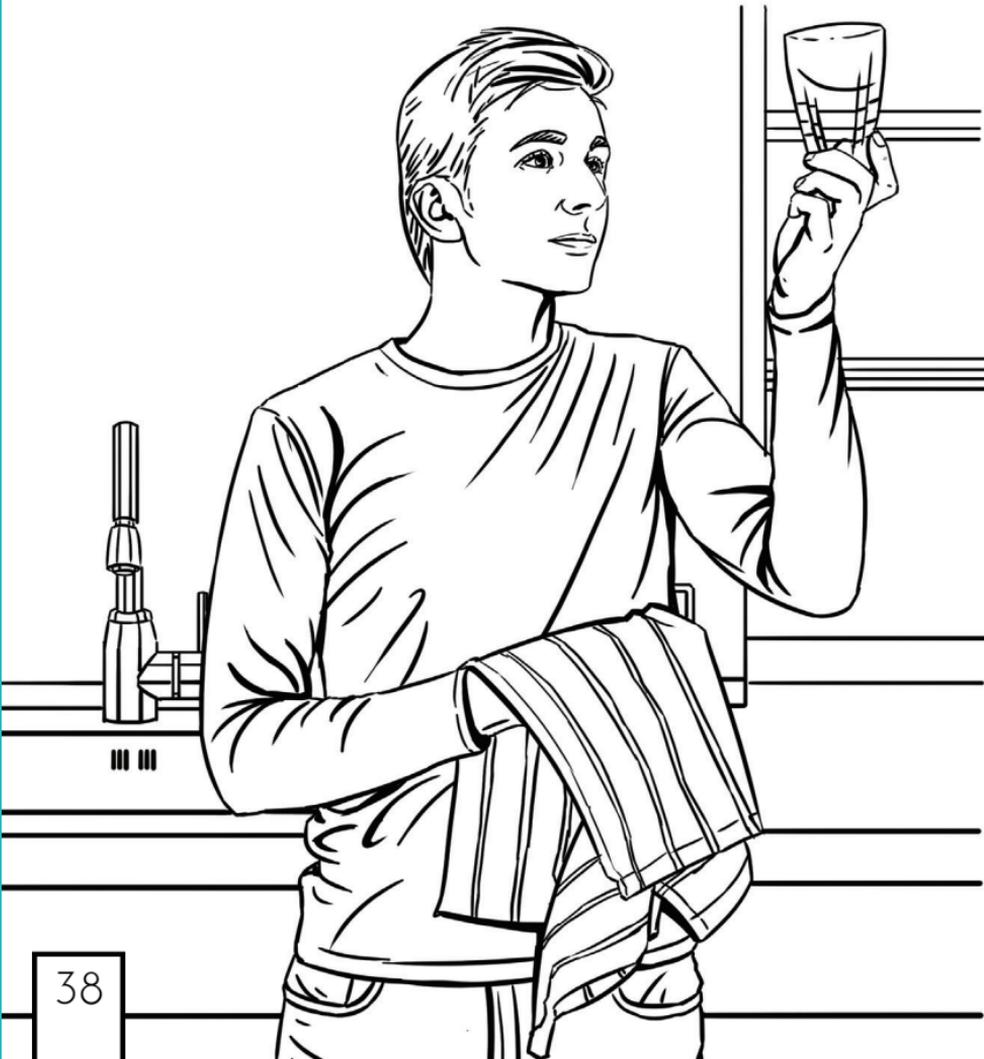
- ❖ Presence of obsessions (persistent, recurrent, driven and unwanted thoughts, words or images) and compulsions (persistent, recurrent, driven and unwanted behaviors).

- ❖ Constant questioning, asking for reassurance.

- ❖ Persistent perfectionism; e.g. written schoolwork erased and rewritten to the point of making holes in the paper.

- ❖ Repeating rituals (these can be obvious: touching, tapping; or silent: counting, etc.).

- ❖ Having to do something exceedingly slowly to feel it has been done properly.





What to Watch For © Dr. Stan Kutcher 2014

- ❖ Does the person have repetitive behaviors or rituals such as checking; counting; etc. that they can not easily stop?
.....
- ❖ Does the person have repetitive thoughts that are upsetting to them and that they can not easily stop.
.....
- ❖ Do these behaviors or thoughts cause them difficulties in their everyday life?
.....
- ❖ Perfectionist in school work. Never seem to complete assignments thought spent lots of time on them. Rituals in the classroom (entering; sitting).
.....



What to Do © Dr. Stan Kutcher 2014

- ❖ Provide information about what you think the problem is to the young person and inform them that there is effective help for their concerns.
.....
- ❖ OCD is best treated with a combination of Cognitive Behavior Therapy (a therapy that reduces anxiety by teaching the youth adaptive thoughts, adaptive behaviours, and other coping strategies) and an SSRI type medication.
.....
- ❖ Thought Stopping is a technique where the student uses self-talk and visualization to change their thoughts every time they start to focus on their obsessions.
.....
- ❖ Usually requires specialty mental health care.
.....
- ❖ Worry Reducing Prescription – do not reinforce obsessions or compulsive behaviours.



Suggested Classroom Strategies to Help Students with OCD

- ❖ Keep up normal routines in the classroom. Routine and structure can help a child reduce the rituals and encourage exposure to what may otherwise have been avoided.
- ❖ Provide brief, clear, explicit instructions and well-structured assignments.
- ❖ Use humour, not ridicule, to help the child distance himself/herself from irrational fears.
- ❖ Try not to get involved in the child's rituals by responding to an obsessive need for reassurance. Going along with rituals is not helpful and can make functional impairment worse.
- ❖ To reduce perfectionism, encourage brainstorming and writing rough drafts, and provide incentives for work completion regardless of errors.
- ❖ Work with professionals and parents to determine how to best limit the effect of rituals on classroom behavior, starting with those situations where the child already has some ability to control them.
- ❖ Modify expectations during a stressful time. Stress, particularly in the area of change, can increase symptoms of anxiety. Try to provide schedules and advance warning and preparation for changes in routines.
- ❖ Do not compare the child with other children in the classroom. The behaviours are part of an illness.
- ❖ Recognize and reward small improvements, e.g. finishing a task on time without continual erasing to make it perfect.
- ❖ Do not criticize his/her obsessive behaviours. See them as symptoms, not faults.



Treatment

Treatment of OCD usually requires a combination of best research based interventions by qualified medical or mental health professionals. Medications are usually necessary and the medicines of choice are the Serotonin Specific Reuptake Inhibitors (SSRI). Occasionally other medications such as Clonazepam may be used. Cognitive Behavioural Therapy is also a mainstay of treatment for OCD. Usually, an SSRI medication and CBT are combined. Additionally, a variety of complementary treatments such as stress resolving exercises can be added. Family therapy may be needed if a young person's rituals or other symptoms are causing substantial family difficulties, It is important that teachers and student service providers work in collaboration with health and mental health care professionals to ensure that the best possible treatments are provided to young people and that interventions occurring in the classroom are consistent with an overall treatment plan.

For more information on treatments of mental disorders in young people, check out: www.teenmentalhealth.org.

R

esources

The Canadian OCD Network

www.canadianocdnetwork.com

Child Mind Institute: A Teacher's Guide to OCD in the Classroom: www.childmind.org/en/posts/articles/2011-11-28-teachers-guide-ocd-classroom

International OCD Foundation – OCD in Kids

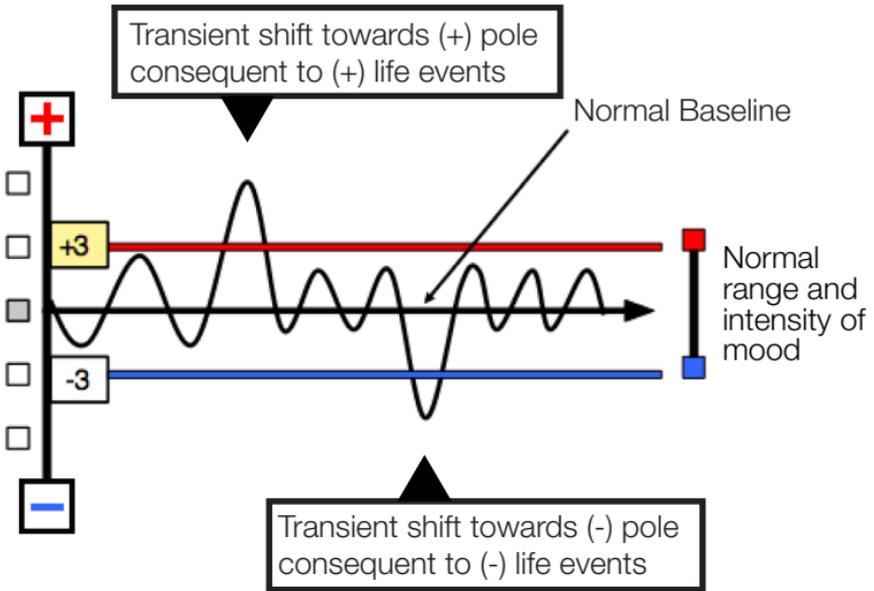
www.ocfoundation.org/ocdinkids/

OCD Education Station - Managing OCD in the Classroom

www.ocdeducationstation.org/role-of-school-personnel/managing-ocd-in-the-classroom/

MOOD DISORDER

A mood is a self-experienced emotional state that has both positive and negative components. Everyone has and is aware of usual mood states that are by nature internally regulated and at the same time environmentally sensitive. This brain based regulatory control allows individuals' mood states to oscillate within a relatively closely defined range, and mood changes in both positive and negative directions due to environmental inputs tend to be returned to their usual "resting" state over time. A good way to understand this is to think of normal mood as being controlled by a "brain thermostat" that regulates mood, returning it to its normal or usual range when it becomes too high or too low.



“Normal Mood Graph” © Dr. Stan Kutcher 2014

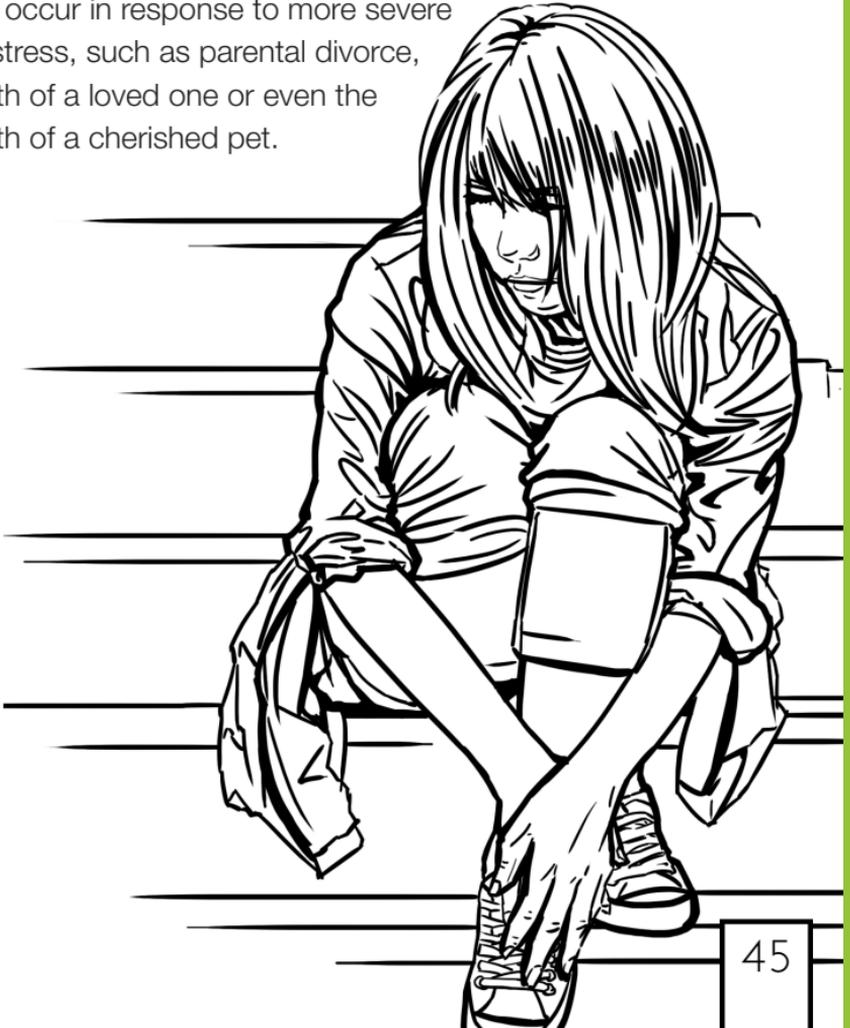
A Mood Disorder is a mental disorder that occurs when the usual thermostatic control of mood fails and the individual's mood becomes stuck in a sphere outside the usual range or when the mood states begin to oscillate widely and rapidly, well outside the usual range. These changes can occur following the experience of a significant and substantial environmental impact or spontaneously. A Mood Disorder is not the sadness, distress, or demoralization that occurs with the usual and expected stressors of everyday life. Because mood is linked to thinking, behaviour, and physical states, when an individual experiences a Mood Disorder, their symptoms include disturbances in mood, in how they think, in how they behave and in their physical state as well. A Mood Disorder is a mental illness that is diagnosed according to established criteria, is functionally impairing, and is not part of the usual ups and downs of life.

Mood Disorders are rarely diagnosed before puberty and frequently come to attention between the ages of **12** and **25** years. They are usually episodic in nature with periods during which the person is suffering from the negative impacts of the disorder interspersed by periods of relative mood stability.

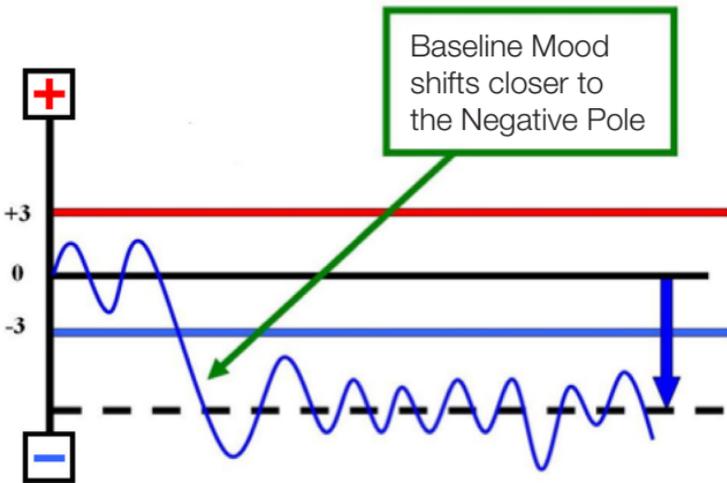
The most common form of a Mood Disorder is Major Depressive Disorder, which may affect about **4-6%** of young people by **25** years of age. Bipolar Disorder is another type of mood disorder that may affect about **1-2%**. Mood Disorders can be mild, moderate or severe and mild cases may not be identified easily. Adolescent suicide is highly related to mental disorders in general, and to mood disorders more specifically.

MAJOR DEPRESSIVE DISORDER (MDD)

Depressed, sad or otherwise negative feelings are a normal response to life's trials and tribulations. It is normal for a child or adolescent to feel down from time to time, such as when they experience a romantic breakup, do poorly at a task (such as an examination, athletic competition, etc.), or experience social rejection (such as not being included in the "in group"). Equally expected but less common are the negative emotional states that occur in response to more severe life stress, such as parental divorce, death of a loved one or even the death of a cherished pet.



Clinical Depression (referenced using the word Depression with the first letter in capitals), however, is very different than usual sadness and other negative feelings. Depression is a “whole body” illness that involves the mood, thoughts, physical functioning, and behaviours of a person. In Depression, the usual working of the mood thermostat is impaired, and the mood gets “stuck” in a low point.



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Depression often begins for the first time during adolescence, affecting about **5%** of youth by age **25**. However, it can occasionally show up in children as well. It affects twice as many girls as boys and, unrecognized and untreated, Depression is the most common cause of teen suicide (see Suicide section in this handbook). As with other mental disorders, Depression is caused by a combination of genetic and environmental factors. Young people who have a sibling or parent with Depression have a greater risk of developing Depression themselves, particularly girls who have a mother with Depression. In teenagers, Depression can be characterized by substantive and severe irritability as well as sadness and other negative mood states that occur in combination with other signs and symptoms of Depression.

It is important to keep in mind that environmental stressors such as ongoing and severe family conflict, the death of a loved one, physical or sexual abuse, parental divorce, or moving to

a new city or country can trigger depressive feelings in young people. Yet, most teenagers will be able to successfully resolve these challenges with time and support. It is only the very small minority in whom such events may trigger Depression.

Common Signs & Symptoms

These occur in four different domains: behaviours, cognition, physical function, and emotions. These are different than the usual characteristics of the person have a negative impact on their life and mostly begin gradually and increase in intensity and number over time.

- ❖ Persistent, significant, and sustained sad, bleak or empty mood.
- ❖ Increased irritability and/or agitation, aggressiveness, combativeness.
- ❖ Lack of energy or excessive fatigue.
- ❖ Hopelessness.
- ❖ Loss of confidence.
- ❖ Indecision; lack of concentration and/or forgetfulness.
- ❖ Decrease in school grades, missed assignments.
- ❖ Often wanting to stay in bed or at home.
- ❖ Lack of interest and pleasure in activities usually enjoyed.
- ❖ Eating disturbance, weight loss when not dieting, or weight gain.
- ❖ Significant sleep disturbances (sleeping much of the time, early awakening).

- ❖ Social withdrawal from family and friends; social isolation.
.....
- ❖ Frequent physical complaints, such as headaches or stomach aches.
.....
- ❖ Distorted, negative thinking (e.g. "My life is a total failure").
.....
- ❖ Suicidal writing or notes, or suicidal actions.
.....
- ❖ May begin or increase substance use/misuse.



What to Look For © Dr. Stan Kutcher 2014

- ❖ Difficult to explain frequent and persistent physical complaints (headaches; stomach aches; fatigue; etc).
.....
- ❖ Loss of interest in usual life activities.
.....
- ❖ Loss of pleasure in those things usually found to be pleasurable - hopelessness.
.....
- ❖ Thoughts of death/suicide or preparation for death.
.....
- ❖ Decreased functioning at home at work/school with family or with peers/friends - withdrawal and concentration.



What to Ask © Dr. Stan Kutcher 2014

- ❖ How are you feeling inside of yourself? - How long have you been feeling that way?
.....
- ❖ Have you been feeling down, like nothing really matters, hopeless?
.....
- ❖ What does the way that you are feeling now prevent you from doing? - What would you be doing if you were not feeling the way you are feeling now?

❖ Do not agree to keep self-harm or suicide confidential.

❖ Are you thinking or feeling that life is not worth living or that you would be better off dead? What have you thought about doing?



Treatment for Depression

Treatment for Depression is based on best evidence from scientific research. It is delivered by health providers expert in its application and includes psychological (such as Cognitive Behaviour Therapy) and medical (such as antidepressant) components. Sometimes family therapy is also provided. An individual student's treatment will be customized for her/his needs. All treatments for Depression decrease risk of suicide. On average it takes about 8-12 weeks of treatment before significant improvement takes place and treatment often can be continued for months or even years. Medical and psychological treatments are often complemented by healthy living and self-care strategies that have been demonstrated to have additional benefits. For more about these check out: www.teenmentalhealth.org/imteen

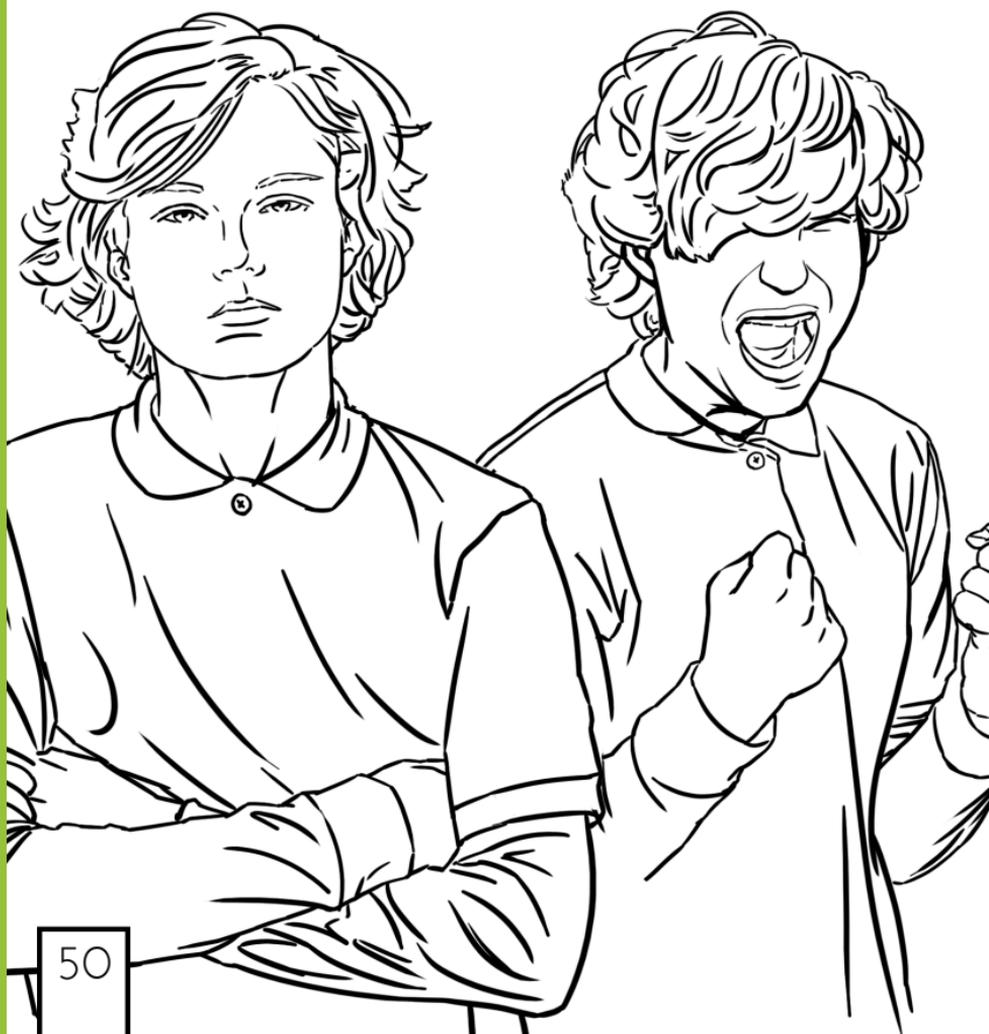
Professional treatment beyond usual personal and social support for young people demonstrating some depressive symptoms as a result of usual or expected distress is not needed, although counselling can be helpful if the student is showing persistent emotional turmoil or their day to day functioning is being negatively impacted by a mental health problem.

To learn more about treatment for mental disorders such as Depression check out:

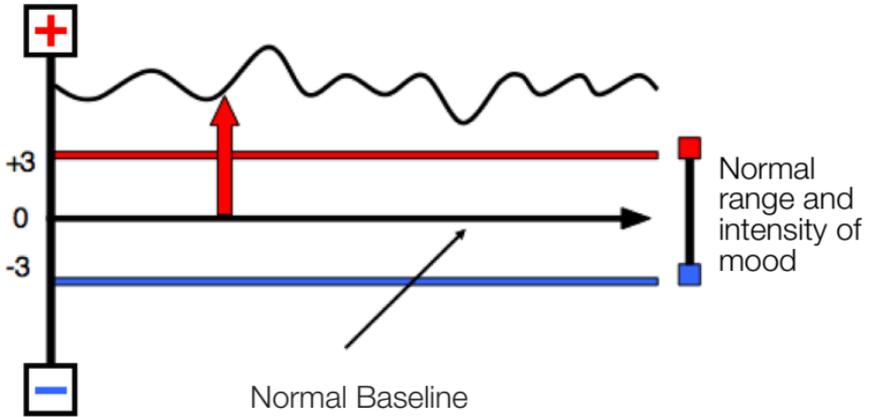
www.teenmentalhealth.org/learn/mental-disorders/depression/

BIPOLAR DISORDER

Bipolar Disorder (formerly known as Manic Depression) affects about **1%** of the population. It is a fluctuating and reoccurring illness that causes unusual shifts in a person's mood, energy, thinking and ability to function. The symptoms of bipolar disorder are much more severe than the normal ups and downs that every person goes through and commonly occur spontaneously (i.e. not brought on by stressful life events). A person with this disorder goes through seriously disabling periods of both Depression and excessive highs (these are called Manic or Hypomanic episodes. Hypomanic episodes are less intense than Manic episodes). There are two categories of Bipolar Disorder: **Type One**, characterized by Manic and Depressive episodes, and **Type Two**, characterized by Hypomanic and Depressive episodes. Both can be severely disabling.



In Bipolar Disorder, the brain's "mood thermostat" is not functioning normally and moods can rapidly swing from Mania or Hypomania to Depression, or can get stuck in one of the episodes for a protracted period of time.



What Happens if the Baseline Shifts Toward the Positive Pole - Mania or Hypomania

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Bipolar Disorder typically develops in adolescence or early adulthood. However, some people have their first symptoms during childhood, and some develop them late in life. Although the exact cause of the disorder is not known, genetics play a very important role.

Bipolar Disorder is episodic in nature and episodes can range in duration from days to months. At any point in time a person can be in the course of an episode (Mania, Hypomania, Depression) or between episodes. In some people, environmental stressors, such as drugs, jet-lag, or death of a loved one may trigger an episode, but usually episodes begin spontaneously. The first lifetime episode of Bipolar Disorder is often Depression with one of the other episodes occurring later. Rates of suicide and substance misuse/abuse are much higher in Bipolar Disorder than in many other mental illnesses.



Common Signs & Symptoms

Signs and symptoms of Bipolar Disorder are associated with episodes of the illness. During episodes functioning is impaired to varying degrees. In periods between episodes persons with Bipolar Disorder may have few if any symptoms and many function well with ongoing medication treatments. In both Depressive and Manic episodes, a person with Bipolar Disorder may experience psychotic symptoms such as hallucinations (disturbances of perception) and delusions (disturbances of thought). Psychotic symptoms are not experienced in Hypomania.

Depressive Episodes

The signs and symptoms of Depressive episodes in Bipolar Disorder are the same as those described in Depression above, but hallucinations and delusions can also occur.

Manic Episodes

During a Manic Episode the signs and symptoms may include

- ❖ Persistently and abnormally elevated, expansive and/or irritable mood.
.....
- ❖ Abnormally and persistently increased goal-directed activity or energy.
.....
- ❖ Inflated self-esteem or grandiosity.
.....
- ❖ Significantly decreased need for sleep (e.g. three hours).
.....
- ❖ Intense restlessness or physical agitation (pacing, cannot sit still, etc.).
.....
- ❖ Feelings of euphoria.

- ❖ Hypersensitivity to criticism, rapid mood changes.
- ❖ Racing thoughts (a subjective description) and excessive speech.
- ❖ Poor judgement and excessive involvement in various life domains (sexuality, investments, social relationships, etc.) that may have a high potential for painful consequences.
- ❖ Easily distracted, flits from one idea or activity to another.
- ❖ Increased use of alcohol and drugs.
- ❖ Denial that anything is wrong, fanciful ideas, unrealistic schemes.
- ❖ Hallucinations and delusions.

Hypomanic Episodes are characterized by similar signs and symptoms as Manic Episodes but these are less intense, may be of shorter duration, do not include psychosis and may not cause as much functional impairment during the episode as seen with Manic Episodes.



Suggested Classroom Strategies

- ❖ Know what to look for in Depression. Young people who develop Depression may slide beneath the teacher's radar as the disorder is internalizing and rarely leads to the disturbance of other students. However, be careful not to call all negative moods or depressive symptoms a Depression.
- ❖ If you have concerns that the student may have Depression, share that concern with the most appropriate student service provider (such as a guidance councillor, psychologist, or nurse).
- ❖ If a student confides about suicidal ideation do not promise to keep it secret. Share it immediately with the most appropriate student services provider and administrator.

- ❖ Know what to expect with Mania or Hypomania. If you are concerned that a student is showing significant and persistent signs and symptoms of Mania or Hypomania you need to immediately involve your school administrator and student services provider.

- ❖ Learning expectations may need to be modified due to the impact of Depression on cognition. This may include a decreased course load, more time for assignments, extra academic assistance, etc. Students with Bipolar Disorder may develop significant difficulties with mathematics that will require additional assistance.

- ❖ Be cognizant of and watch for signs of substance misuse.



What Schools Should Do

- ❖ Ensure that there is a policy and procedures in place that all school staff know to follow if they are concerned about the mental health of a student.

- ❖ Provide contextualized education to all staff about child and youth mental health and mental disorders (mental health literacy) and make widely available the Kids Help Phone resource: **1-1800-668-6868**, www.org.kidshelpphone.ca/en.

- ❖ Assign a teacher liaison to participate in the treatment plan (including school reintegration after absence) in collaboration with health care providers and to be the school contact point for parent/caretaker interactions.

- ❖ Participate in social and academic evaluations needed to develop and monitor the treatment plan. These should be conducted when the student is not in a Manic, Hypomanic or Depressed state.

- ❖ Ensure the presence of policies and procedures designed to address bullying.



What Schools Should Not Do



Create, apply and support interventions that do not help the school or students or for which there is no substantive evidence of effectiveness or safety.



Treatment for Bipolar Disorder

Treatment of Bipolar Disorder always includes medication designed to return the mood to usual and to prevent the onset of further episodes. Medication treatment is always individualized and may include lithium, anti-convulsants (medicines that are usually used to control seizures), anti-depressants, and anti-psychotics (medicines that are usually used to treat psychosis). In very severe cases, electroconvulsive therapy may be used. In addition, a variety of psychological, social and educational/vocational rehabilitation interventions are also used. Family therapy may sometimes be provided. During Manic episodes or severe Depressive episodes hospitalization is often required. Treatment for Bipolar Disorder is usually life-long.

Treatments are often complemented by healthy living and self-care strategies that have been demonstrated to have additional benefits. For more about these check out:

www.teenmentalhealth.org/imteen.

For young people with Bipolar Disorder, maintenance of daily routine, particularly a healthy sleep pattern is needed. To find out more about how to deal with sleep difficulties, check out:

www.teenmentalhealth.org/toolbox/healthy-sleeping/.

R esources

Mood Disorders Society of Canada

www.mooddisorderscanada.ca

Organization for Bipolar Affective Disorder

www.obad.ca

Teen Mental Health

www.teenmentalhealth.org/learn/mental-disorders/depression/

National Institute of Mental Health. Bipolar Disorder in Children and Teens (2014)

www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-teens-easy-to-read/index.shtml

American Academy of Child and Adolescent Psychiatry. Bipolar Disorder Resource Center (2014)

www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Bipolar_Disorder_Resource_Center/Home.aspx

Kelty Mental Health Resource Center. Dealing with Depression (2014)

www.keltymentalhealth.ca/blog/2012/10/new-dealing-depression-online-resource-teens-now-available

National Institute of Mental Health. Depression in Children and Adolescents (2014):

www.nimh.nih.gov/health/publications/depression-in-children-and-adolescents/index.shtml

SUBSTANCE RELATED & ADDICTIVE DISORDERS

These disorders encompass a large number of different categories of drugs (including alcohol and tobacco). In young people, alcohol and tobacco are currently the most commonly used substances, with a minority of youth who use these substances demonstrating Substance Use Disorders or Substance-Induced Disorders (Intoxication, Withdrawal). The causes of these disorders are not well understood but the best evidence currently available shows both genetic and environmental influences acting together are at play. These disorders tend to begin during the teen years, perhaps as the result of maturation of certain brain systems that are related to sexual development.

The difference between these two classifications

Substance Use Disorders are characterized by continued use of the substance in spite of a number of related negative and harmful behaviours and physical and cognitive symptoms,

A **Substance-Induced Disorder** is the direct impact of a substance on a person at a single point in time (such as in Intoxication or Withdrawal) For example, Alcohol Use Disorder comprises a long-standing pattern of difficulties arising as a result of the continued use of alcohol in spite of those difficulties, while Alcohol Intoxication (being very drunk and showing problematic behaviours because of that) can occur at any time, even if a person does not have an Alcohol Use Disorder.

However, they can also occur together. So, a person could have Alcohol Intoxication Disorder and an Alcohol Use Disorder at the same time.

There are many different types of Substance Use Disorders and a person can simultaneously have one or more of those disorders, at a single point in time or over the course of their life, depending on the substance used. For example, a person can have an Alcohol Use Disorder plus a Cannabis Use Disorder at the same time. Or, for example, a person can have an Opioid Use Disorder for a few years and then stop using opioids and later develop a Phencyclidine Use Disorder. Below is a list of Substance Use Disorders as they appear in the 5th edition of the Diagnostic and Statistical Manual (DSM V), the diagnostic system for mental disorders.

- ◆◆ Alcohol Use Disorder.

- ◆◆ Cannabis Use Disorder.

- ◆◆ Phencyclidine Use Disorder.

- ◆◆ Inhalant Use Disorder.

❖ Opioid Use Disorder.

❖ Sedative, Hypnotic or Anxiolytic Use Disorder.

❖ Stimulant Use Disorder.

❖ Tobacco Use Disorder.

❖ In addition, Gambling Disorder is included in this group.

A Substance Use Disorder can occur with compounds that are both legal and illegal. Some Substance Use Disorders can occur with compounds that are used for treatment purposes, when those substances are used for non-therapeutic purposes.

Teenagers often have not used a substance long enough to develop a diagnosed Substance Use Disorder. In fact, most teens who use substances such as alcohol or cannabis never go on to develop a Substance Use Disorder. Even for those teens who have been diagnosed with Alcohol Intoxication a number of times, most never go on to develop an Alcohol Use Disorder. That does not mean that we do not intervene for young people who are misusing substances. The key issue here is substance misuse, not a Substance Use Disorder. Substance misuse can lead to negative outcomes that can be severe. For example, a young person may have a few drinks and get into a car and start driving (or get into a car that someone else who has been drinking is driving). This puts the youth at higher risk for a negative health outcome (motor vehicle accident) even though he or she does not have a mental disorder. Much of the public health interventions that are directed towards teens are to decrease the harm related to misuse of a substance and to try to prevent Substance Use Disorders from occurring.



What to Look For © Dr. Stan Kutcher 2014

- ❖ Participant in “drug sub-culture”, e.g., listens to music that glorifies drug use, wears clothing that references drug use, spends time with known drug users.
.....
- ❖ Signs of intoxication in the classroom or in the school building.
.....
- ❖ Frequently late after lunch or breaks.
.....
- ❖ Declining grades.
.....
- ❖ Has dropped out of social or other school activities in which he or she was previously involved.



What to Do © Dr. Stan Kutcher 2014

- ❖ Discuss your concerns with teachers and get their input. Know your school policy on drugs and alcohol.
.....
- ❖ Discuss with the young person how he/she is doing and share that you have some concerns.
.....
- ❖ Encourage the student to seek specialty assistance – involve his/her parents.
.....
- ❖ Do not engage in debates about the pros and cons of any illicit drug.
.....
- ❖ Do not agree to keep information about drug use secret.
.....
- ❖ Always assess for the presence of a learning disability and untreated/undiagnosed ADHD as these disorders commonly co-occur with substance use.

Concurrent Disorders

When someone has a number of different mental disorders and one of them is a Substance Use Disorder, the term “concurrent disorder” or “dual diagnosis” is sometimes used (although sometimes the term “dual diagnosis” is also used to denote a mental disorder plus intellectual impairment). Concurrent disorders are complicated because they can include any combination of mental illness and any kind of Substance Use Disorder. For example, a person could have Depression or Schizophrenia or Bulimia Nervosa. Each of these is quite a different disorder. The Substance Use Disorder can also be quite variable and may include legal, (such as alcohol or prescription medications) and/or illegal (such as heroin or cocaine) compounds. A further complication is that any of the various possible disorders can be mild, moderate or severe. This means that symptoms of any one disorder can be easily identified or overlooked, depending on how obvious they are. Some symptoms may be common across diagnostic categories, such as psychosis, which can arise from a psychotic disorder such as Schizophrenia or may be the result of drug use alone.

People who have a mental illness have a higher chance of also having a Substance Use Disorder or a substance use problem. The most common combination is a mood/anxiety disorder and a Substance Use Disorder. Rates of mental disorders in adults with Substance Use Disorders may be three to four times higher than in the general population.

The causes of concurrent disorders

The causes of concurrent disorders are not well understood. Both genetic and environmental reasons are likely at play as well as the interaction between an individual’s genetic makeup and their environment. No one factor is known to cause any concurrent disorder.

For some individuals living with a mental disorder, substance use may arise as a result of their attempt to help control some

of their symptoms (for example, smoking a cigarette to help with anxiety). For some, this may develop into substance misuse or a Substance Use Disorder.

Excessive use of substances, whether or not this leads to a Substance Use Disorder or not, can be harmful to a person living with a mental disorder. For example, some substances can interfere with the treatment effect of medications, and some substances can make symptoms of mental disorders worse. Substances can also lead to impairments in thinking and reasoning that can negatively affect self-care, impair social, interpersonal and educational/vocational success, and decrease chances of recovery.

Because concurrent disorders can include any combination of mental illness and any kind of Substance Use Disorder, there is no one specific set of symptoms that identify an individual as having a concurrent disorder. Individuals with concurrent disorders can exhibit a large variety of different behavioural, emotional and cognitive problems. Sometimes these symptoms may change over time, depending to some extent on the type of substances being used or the time that the individual is seen in relationship to the time a substance was taken.



Suggested Classroom Strategies

- ❖ Know your school and school board policies about drug use and drug availability in schools and follow that policy (even if your personal opinions run counter). Do not tacitly or openly support substance misuse by individual students (this does not mean do not explore the complex issues of substance use/misuse with your students – especially with compounds such as cannabis, alcohol and tobacco).
- ❖ Know about any unique substance abuse problems occurring in your community (for example: a pocket of prescription drug abuse, a glue-sniffing cohort of young people, etc.) and be prepared to discuss them in your classroom if the issue arises.

- ❖ Be knowledgeable about the effects of most common substances misused by young people (alcohol, tobacco and cannabis), particular the signs of intoxication.

- ❖ Be aware of student sub-cultural groups. Does the student in your classroom belong to a group of young people known to the school to be involved in drug use?

- ❖ If a student shows signs of intoxication at school (e.g. inappropriate sexual or aggressive behaviour, slurred speech, incoordination, etc.) bring the student to the most appropriately trained health professional in the school (such as a guidance counsellor or in-school nurse).

- ❖ Be aware that behaviours such as persistently returning to class late after lunch or spare period, irregular but recurring episodes of quiet and withdrawn behaviours, and irritability or emotional instability, may indicate impact of substances.



What Schools Should Do

- ❖ Have clear policies about drug use on school campus and inform all staff (teachers, administrative, and other) and students of those policies.

- ❖ Provide valid, best evidence based information on substance use, misuse and Substance Use Disorders using interventions of proven effectiveness. Provide information to students on where they can go to get help if they have substance use/misuse concerns.

- ❖ Create policies and procedures for addressing school identified substance use/misuse concerns with parents.



What Schools Should Not Do

- ❖ Do not apply drug education or other interventions that are not known to be effective or that could cause harm or increase rates of drug misuse.



Treatment of Substance Use Disorders & Concurrent Disorders

Treatment of these disorders can be complicated. For many Substance Use Disorders, medical or medically supervised treatment of Intoxication or Withdrawal is needed in addition to the treatment for the Substance Use Disorder. This may require hospitalization if the severity warrants it. Treatment for Substance Use Disorders usually focuses on a combination of psychological, social and familial interventions provided by health professionals trained in how to administer them and working in specialty youth substance abuse treatment facilities. For young people, these are usually conducted in outpatient settings although for some youth, a period of treatment in a residential facility may be needed. Sometimes, depending on the substance, medications are used as well. For young people with a concurrent disorder, interventions combine treatments for the mental disorder and for the substance at the same time. It is not uncommon for persons receiving treatment for Substance Use Disorder to experience a number of relapses before finally achieving recovery.

Resources

Canadian Centre on Substance Abuse

www.ccsa.ca

Centre for Addiction and Mental Health

www.camh.ca/en/hospital/Pages/home.aspx

Children's Mental Health Ontario - Substance Abuse

www.kidsmentalhealth.ca/parents/substance_abuse.php

NIDA (National Institute on Drug Abuse) for Teens

www.teens.drugabuse.gov/about-us/additional-resources

EATING DISORDERS

Eating disorders can be physically damaging and potentially life-threatening. They can affect every aspect of a child or adolescent's life, including their physical, psychological and emotional health. There are several types of eating disorders: Avoidant/Restrictive Food Intake Disorder, Anorexia Nervosa, Bulimia Nervosa, and Eating Disorder Not Otherwise Specified. Anorexia Nervosa and Bulimia Nervosa will be addressed here.

About **0.4%** of the population will have a diagnosis of Anorexia Nervosa over the period of a year. Bulimia Nervosa is more common and affects up to **1.5%** of the population. Eating disorders are most common among adolescents and young adults between the ages of **12-25** years old. In general, girls are more likely than boys to develop eating disorders. Eating disorders can sometimes also be diagnosed in children, including young boys. Some factors that have been shown to increase the chances developing an eating disorder but are not a direct cause of an eating disorder include:

- ❖ Dieting.
.....
- ❖ Genetics.
.....
- ❖ Co-Existing Mental Disorders (e.g. Depression, Anxiety Disorders).
.....
- ❖ Girls who experience early puberty.
.....
- ❖ Participating in competitive athletic activities where there is a high emphasis on body weight (e.g. gymnastics, figure skating, ballet, track and cross-country, wrestling and rowing).
.....
- ❖ Chronic illness, such as Diabetes Mellitus.

ANOREXIA NERVOSA

Adolescents with Anorexia Nervosa (AN) have serious weight loss or failure to gain weight during a period of growth, an overwhelming fear of being overweight and ultimate desire to be thin, and are usually dissatisfied with their overall body weight, shape and size. It is much more common in girls than in boys. No matter how thin they get, people with AN believe that they are still fat or may be terrified about becoming fat. As a result, they engage in behaviours that will cause them to lose weight. Adolescents with AN become obsessed with food and dieting. They may count calories, or limit the types or amount of food they allow themselves to eat. They may attempt to get rid of the food they have eaten by purging (self-induced vomiting, sometimes by taking ipecac), excessive exercise, fasting, taking laxatives, diuretics, diet pills or using herbal remedies. Girls with Anorexia Nervosa who have had at least one menstrual period will usually stop menstruating. People with AN have the highest mortality rate of any psychiatric disorder – approximately 1 in 20 patients will die of the disease, usually due to cardiovascular problems, electrolyte imbalances or suicide.



Common Signs & Symptoms

- ❖ Significant reduction in eating, coupled with a denial of hunger.
.....
- ❖ Extreme fear of weight gain or becoming fat, even if extremely underweight.
.....
- ❖ Pre-occupation with weight, body image or distorted body image.
.....
- ❖ Skipping meals or frequently saying that they “have already eaten”.
.....
- ❖ Counting calories, fat grams and weighing or measuring food.
.....
- ❖ Unusual food practices.
.....
 - Pushing food around the plate.
.....
 - Cutting food into tiny pieces.
.....
 - Disposing of food in a napkin.
.....
 - Getting up and down from the table many times during the meal.
.....
 - Always standing at the table.
.....
 - Always eating the same food at the same time daily.
.....
 - Preference for foods of a certain texture or colour.
.....
 - Minimizing caloric intake (obsessive calorie counting).
.....
- ❖ Preoccupation with cooking or baking and refusing to eat any of the foods themselves.
.....
- ❖ Inflexible and resistant to changes in routine pertaining to food and eating.

- ❖ Withdrawing from friends, family and social activities.
.....
- ❖ Thinning or loss of hair.
.....
- ❖ Significant unexplained weight loss or failure to gain weight during a period of expected growth, in the absence of medical illness.
.....
- ❖ Wears baggy or layered clothing in attempt to hide weight loss and to keep warm.
.....
- ❖ Feeling cold when healthy adolescents are at a normal temperature.
.....
- ❖ Loss of menstrual periods or delay in the onset of the first menstrual period.
.....
- ❖ Lack of growth in height.
.....
- ❖ Delay in onset or progression of puberty.
.....
- ❖ Early satiety or bloated feeling.
.....
- ❖ Appearance of fine, downy hair on the body also known as "lanugo hair".

BULIMIA NERVOSA

Bulimia Nervosa (BN) is another type of eating disorder that develops in the mid-teen years and is more common in girls than in boys. Adolescents with BN "binge and purge." Binging refers to an episode of rapidly eating a much larger than normal amount of food in a short period of time accompanied by feeling out of control of the eating. In an effort to prevent weight gain, the young person will purge after they have binged. Methods of purging may include self-induced vomiting, excessively exercising, fasting after a binge, taking laxatives, diuretics, ipecac, diet pills or using herbal remedies. The binging and purging is usually done secretly.

Most people with BN are not underweight. Most are of normal weight or even overweight.

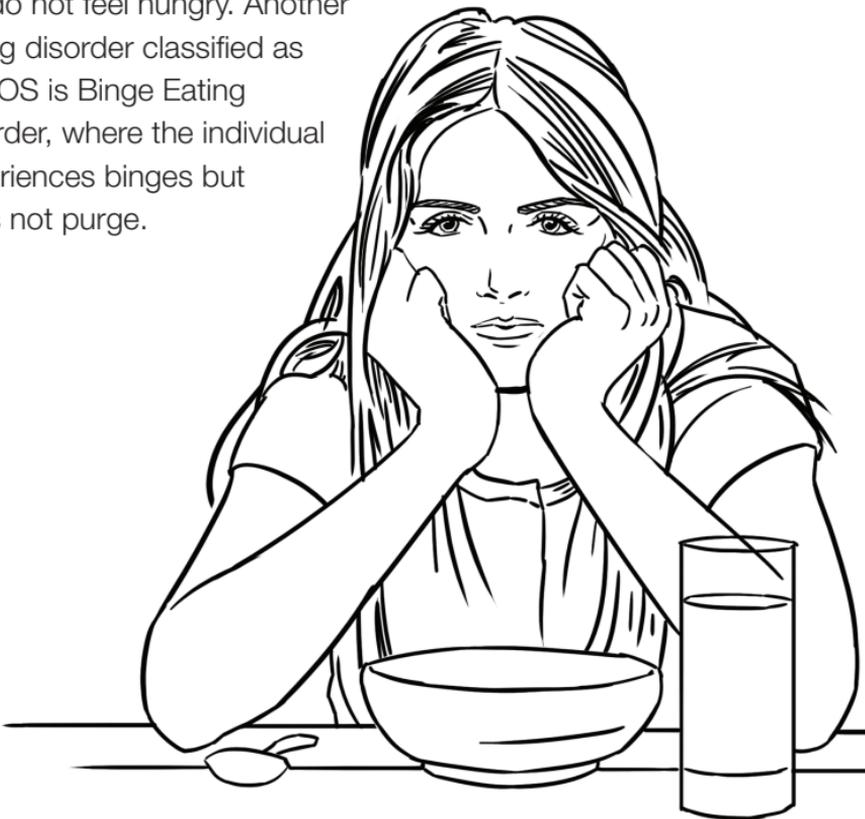
Common Signs & Symptoms

- ❖ Critical of their body shape, weight and size.
.....
- ❖ Recurrent episodes of binge eating.
.....
- ❖ Peers observing a binge.
.....
- ❖ Reports by the adolescent him/herself of a binge eating.
.....
- ❖ Large amounts of food missing.
.....
- ❖ Recurrent episodes of self-induced vomiting.
.....
- ❖ Regularly disappears to the washroom after meals.
.....
- ❖ Empty food containers in the adolescent's bedroom.
.....
- ❖ Evidence of misuse of laxatives, diuretics abuse, enemas, ipecac, using herbal remedies to lose weight or curb one's appetite, fasting, excessive exercise.
.....
- ❖ Dramatic weight fluctuations (not necessarily weight loss).
.....
- ❖ Delay in onset or progression of puberty.
.....
- ❖ Swollen glands or "chipmunk cheeks" (swelling of parotid glands in children and adolescents who vomit frequently).
.....
- ❖ Loss of menstrual periods or irregular menstrual periods.

- ❖ Dental problems such as eroded tooth enamel and dental cavities.
- ❖ Callus or scars on the back of the hand or knuckles from using fingers to cause a gag reflex and help with self-induced vomiting.

EATING DISORDER OTHERWISE NOT SPECIFIED

Any child or adolescent with a clinically significant eating disorder that does not meet criteria for Anorexia Nervosa or Bulimia Nervosa receives a diagnosis of Eating Disorders Not Otherwise Specified (EDNOS). Most children and adolescents with eating disorders fit into this category. One example of an eating disorder recently recognized that fits in this category is Food Avoidance Emotional Disorder (FAED), seen in children in which emotional problems affect appetite and result in the avoidance of food. Children with FAED recognize that they need to put on weight, but do not feel hungry. Another eating disorder classified as EDNOS is Binge Eating Disorder, where the individual experiences binges but does not purge.





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- Engage student in supportive conversation about physical health (AN) or observed behavior (BN).
- With AN be prepared for high levels of anxiety and denial.
- With BN be prepared for cathartic expression.
- Support plans and processes that engage the student in seeking professional help - do not support disordered eating, secrets or self-harm behaviors.
- Parental involvement can be complex - make sure that this is not done only by you but in co-ordination with the health care team - assist teachers in communication with parents.
- Make sure there is a crisis plan in place - watch for self-harming behaviors (cutting, etc.).



Suggested Classroom Strategies

- Know the warning signs of Anorexia Nervosa and Bulimia Nervosa.
- Discuss your concerns with the student. Do not get into an argument about her/his eating. Ensure that your tone of voice is not accusatory.
- Keep in mind that others in the student's life may be giving positive feedback on the student's "great willpower" or "perfect figure." These kinds of comments may help to reinforce the student's destructive behaviour.
- Expect to be rejected by the child/adolescent when you discuss your concerns about his/her possibly having an eating disorder. This is an illness of denial and distorted thoughts regarding body image.

- ❖ Go with the student to get help from a resource person, such as a guidance counsellor, public health nurse or social worker.
- ❖ Focus your conversation on your concerns about his/her health and functioning. Don't focus on eating habits, weight loss or body size.



What Schools Should Do

- ❖ Create an environment that recognizes normal weight and size variability and social acceptance.
- ❖ Build an environment where there is a broad range of meal options.
- ❖ Have policies that address weight and size discrimination.
- ❖ Offer information to teachers on how to deliver appropriate information about body image, healthy eating and healthy lifestyles.
- ❖ Create environments where adult role models examine their own teaching practices to ensure that body image discrimination does not occur in their teaching methods.
- ❖ Have policies in place against weight-based teasing, taunting and negative talk about a child's body in general.
- ❖ Provide adequate time for lunch.
- ❖ Help young people learn about and enjoy healthy, active lifestyles.
- ❖ Promote physical activity and non-dieting approaches to eating.
- ❖ Encourage an environment where young people feel safe to communicate issues like bullying and pressure to diet or look a certain way.
- ❖ Create policies and procedures for addressing school identified mental health concerns with parents.



What Schools Should Not Do

- ❖ Do not teach children and adolescents about eating disorders in earlier years, as it may encourage them to experiment with this new information.
- ❖ Do not talk negatively about bodies, about restricting food intake to lose weight, about “being fat” or about going on diets.
- ❖ Do not create classroom activities that may glamorize eating disorders, such as bringing in guest speakers to talk about their experience with an eating disorder or assigning projects on eating disorders.
- ❖ Do not conduct group weigh-ins or body-fat testing.



Treatment

The diagnosis of an eating disorder is applied following a careful clinical assessment that includes both mental health and physical components. Treatment of eating disorders is often carried out by an interdisciplinary team of health and mental health providers and includes medical monitoring, nutritional rehabilitation, psychological treatment and in some cases medication. Family-based treatment has become the treatment of choice for children and younger adolescents with eating disorders. This strategy promotes parental involvement in restoring a child or adolescent to healthy weight and eating habits.

The treatment for children or adolescents with an eating disorder may involve inpatient hospitalization, outpatient treatment, day hospitalization, or residential treatment. Children and adolescents who are severely malnourished and medically compromised require hospitalization. The goals of hospitalization should be nutritional rehabilitation, weight restoration and treatment of the acute medical complications.

It is important that teachers and student services providers work in collaboration with health and mental health care professionals to ensure that the best possible treatments are provided to young people and that interventions occurring in the classroom are consistent with an overall treatment plan.

R esources

AboutKidsHealth - The Student Body

www.aboutkidshealth.ca/thestudentbody

The Kelty Center:

www.keltymentalhealth.ca/mental-health/disorders/eating-disorders

National Association of Anorexia Nervosa
and Associated Disorders

www.anad.org

National Eating Disorder Information Centre

www.nedic.ca

DISRUPTIVE IMPULSE-CONTROL CONDUCT DISORDERS

Students with these types of disorders have persistent, significant, and substantive difficulty in self-control of behaviors that often result in serious disruptions in classrooms, school and community activities. The predominant emotional feature is persistent, significant, and substantive deregulation of anger control (and to a lesser extent, irritability). Depending on the disorder, these behaviors may also violate the rights of others and include destruction of property, aggression, and challenges to expected social norms and authority figures (such as teachers). Young people with these disorders frequently do not view themselves as having a problem but justify their behaviors as an appropriate response to demands or circumstances. The most common of these are **Oppositional Defiant Disorder (ODD)** and **Conduct Disorder (CD)**. These are more common in males than in females and may have substantial environmental influences on their development and activation. Young people with ODD and/or CD tend to have higher rates of learning disorders and Attention Deficit/Hyperactivity Disorder.

Youth with CD in particular are at higher risk for life trajectories that include higher rates of incarceration, involvement in crime, poor economic/vocational outcomes and Substance Use Disorders. Within the group of young people diagnosed with CD is a sub-group that demonstrates additional features of sociopathy. For some youth, disturbances of behavior and emotional control that can suggest ODD and/or CD may be manifestations of another mental disorder such as Schizophrenia or Bipolar Disorder.

Great care needs to be taken, however, to not diagnose any and all negative or oppositional activities as a mental disorder. Normal, usual, and expected disagreements with authority figures, breaking of rules due to differences of opinion or age-appropriate defiance, and establishment of independent actions are not mental disorders.

OPPOSITIONAL DEFIANT DISORDER (ODD)

ODD usually becomes evident before puberty. ODD is a pattern of persistent, defiant, disobedient, and hostile behaviours combined with angry/irritable mood and vindictiveness. These features are significantly greater than age expected norms and lead to functional impairment for the individual and distress in their environments (school, home, sports team, etc.).



Common Signs & Symptoms

- ❖ Frequent and persistent arguments with authority figures.
.....
- ❖ Deliberate refusal to comply with rules in multiple settings.
.....
- ❖ Deliberately annoying others.
.....
- ❖ Frequently losing his/her temper.

❖ Often angry and resentful.

❖ Often blames others for his/her mistakes and behaviors.

❖ Often vindictive.

CONDUCT DISORDER

Young people with CD show repetitive, persistent, significant and substantial behaviors in which the rights of others or major age-appropriate social norms or rules are violated. CD can begin in childhood or adolescence, but cases of CD beginning in childhood may often carry on to that student's adolescence, and place the student at higher risk for negative outcomes in their adult lives. Additional qualifiers include: lack of remorse or guilt, lack of empathy, lack of concern about performance in school or other important activities, and shallow/insincere emotional range.

Youth with CD frequently initiate aggressive and violent behaviors against others and react aggressively to challenge. They may bully, threaten, intimidate, or cause physical harm to others. Additionally, they may cause property damage (such as breaking windows, fire setting, etc.), break and enter, and steal. They frequently break household rules and may run away from home. Youth with CD have a higher risk for criminal activity, traffic accidents, poor economic/vocational outcomes, incarceration, and early onset Substance Use Disorders.

The severity of negative behaviors may increase over time (for example, shoplifting progressing to automobile theft). A sub-group of youth with CD may meet criteria for Anti-Social Personality Disorder in adulthood. CD is related to both genetic and environmental influences. Young people with CD have higher rates of Attention Deficit/Hyperactivity Disorder and Substance Use Disorders.



Common Signs & Symptoms

- ❖ Bullying, threatening others.
.....
- ❖ Often initiates physical fights, has been physically cruel to people/animals.
.....
- ❖ Has used a weapon (bottle, gun, pipe, bat, etc.).
.....
- ❖ Forced someone into sexual activity.
.....
- ❖ Deliberately destroyed others' property (including fire setting).
.....
- ❖ Broken into a person's house or car.
.....
- ❖ Stolen without confronting a victim (e.g. shoplifting).
.....
- ❖ Often lies to obtain goods or favours.
.....
- ❖ Ignores parental rules/prohibitions (staying out at night; using drugs, running with a gang).
.....
- ❖ Numerous running away from home episodes or truancy from school.
.....
- ❖ Stolen from a victim (mugging, extortion, armed robbery, etc.).



Suggested Classroom Strategies

- ❖ Be consistent in application of expectations and application of appropriate consequences for negative behaviors. Follow through on the promises and expectations you make to the student.
.....
- ❖ Set clear expectations for behavior. Reward positive behaviors and the absence of negative behaviors by positive self-affirming statements (e.g. "You did a good job today in controlling your anger. Keep up the good work"). If a token economy (tangible rewards for positive behaviors) is part of the intervention be clear and consistent in its application.

- ❖ Teachers should be provided information about any specific self-management techniques that are being used by the treatment team (such as anger diffusion, positive self-talk, etc.). They can help reinforce the use of these techniques in the classroom setting.

- ❖ Encourage students with ODD to keep a daily diary of their angry feelings (including when the anger was experienced, how strong it was, how long it lasted for, and what the student did to help diffuse the anger) and review it daily, providing positive feedback for efforts used. Do this only as part of a clearly defined treatment protocol.

- ❖ Help the student identify and label various different emotional states, such as disappointment, unhappiness or anxiety, as being different from anger.

- ❖ Provide healthy outlets for expression of emotion and energy, such as exercise, writing, painting, drama, etc.

- ❖ Try to develop a mentoring relationship between the student and another teacher or caring adult who can be a positive role model.

- ❖ Provide a designated safe place for students to go when they are angry — a place to calm down.



Treatments for OCD & CD

Treatments for youth with ODD and CD depend on the severity of the disorder and the environment in which the young person exhibits the disorder. There are a variety of different interventions and treatments, including behavior therapies, parent effectiveness training, and social skills training. If the young person also has ADHD, treatment must be directed toward that disorder. Learning difficulties may require specific educational interventions. In some cases, medications directed toward aggressive outbursts may be considered. Residential or quasi-residential settings (such as day treatment programs or group homes) may be needed for some youth. Incarcerated youth may or may not obtain effective interventions during the period of their incarceration. Relapse from treatment is common.

R esources

Conduct Disorders.com

www.conductdisorders.com

Minnesota Association for Children's Mental Health -
Conduct Disorder Fact Sheet for the Classroom

www.macmh.org/publications/fact_sheets/Conduct.pdf

This fact sheet is easy to print out to keep on hand. It's a great resource for teachers.

The Reach Institute – Conduct Disorder/Oppositional Defiant Disorder

www.thereachinstitute.org/conduct-disorderoppositional-defiant-disorder.html

The Child Mind Institute – Fast Facts, Myths about Conduct Disorders (2014)

www.childmind.org/en/myths-about-conduct-disorder/

NEURODEVELOPMENTAL BEHAVIOURAL DISORDERS

Neurodevelopmental Disorders are disorders of brain development that can be diagnosed early in life, persist over the life span and are characterized by many different cognitive, emotional, physical and behavioural symptoms. The range of challenges in personal, social, academic and occupational functioning varies greatly, across the disorders and within each disorder as well. As a child grows and develops, symptom type or severity may also change as a result of how brain development is occurring over time. Young people with a diagnosis of Neurodevelopmental Disorders often require numerous therapeutic interventions across a wide range of functional domains to help optimize outcomes. All Neurodevelopmental Disorders are spectrum disorders, meaning they are comprised of a group of related signs and symptoms based in the same cause – genetic variations and/or exposure to a brain toxin before birth. A spectrum disorder also means that people exposed to that same toxin have different varieties and degrees of signs and symptoms, some more significantly impairing than others.

ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER (ADHD)

ADHD is a neurodevelopmental disorder that can be diagnosed in childhood (usually when the child is of school age) that arises from a complex interplay between genetic and environmental factors resulting in delay of maturation of and connectivity between some brain regions. It consists of substantial, persistent and age inappropriate symptoms of inattention and/or hyperactivity and impulsivity that lead to significant functional impairment (at school, with peers, in extra-curricular activities and at home). ADHD diagnoses are assigned as predominantly hyperactivity, predominantly inattention-impulsivity, or combined.

ADHD is not to be confused with symptoms of over-activity or difficulties in focusing attention due to other factors. Symptoms may vary in type and severity depending on the setting and ADHD cannot be diagnosed on the basis of symptoms and functional challenges found only in one setting (for example: at home and not at school). In younger children, hyperactivity tends to be dominated by excessive gross motor activity (such as running, jumping, climbing) while in adolescence, motor symptoms may primarily be fidgeting and restlessness. Boys are twice as likely as girls to be diagnosed with ADHD and in girls ADHD often



manifests without hyperactivity, predominantly with inattentive features. ADHD affects between **3 – 5%** of the school aged population and prevalence rates may diminish with age due to brain maturation over time.

Some young people with ADHD may exhibit mild delays in language and social development but about **30%** (or more) may also have a specific learning disability. Young people with a specific learning disability may demonstrate some of the features of ADHD in the classroom but these symptoms will not be significantly present in other situations.

Presence of untreated ADHD is associated with substantially poorer short and long-term outcomes including: higher rates accidental injury, substance abuse/addiction, traffic accidents, vocational difficulties, interpersonal problems, negative family relationships, conduct disorder and lower rates of achievement in many domains including socio-economic success.



Suggested Classroom Strategies

- ❖ Teachers should know if the child is taking a medication and what the anticipated outcomes and possible side effects may be. Whenever possible, teachers should be involved in treatment decisions as they can be expected to impact classroom and rest of school activities.

- ❖ Have a consistent routine with clear expectations for outcomes. As much as possible, maintain a predictable and organized classroom setting, minimizing novel and possibly distracting stimuli. Keep noise to a minimum.

- ❖ Assist the student with organizational skills: strategies such as a single assignment book or a daily schedule that the student is cued to complete as part of usual classroom routine.

- ❖ Provide explicit, clear and simple instructions. Try to keep instructions to one or two items.

- ❖ Find appropriate outlets for channeling of physical activities – such as within classroom chores, provide a “squeeze ball” for using at the desk, etc.

- ❖ State expectations clearly and positively. For example: “Please sit down”,not, “ Don’t get up”.

- ❖ Provide timely, frequent and appropriate praise and recognition for positive outcomes, large and small.

- ❖ Provide visual aid and cues – calendars, schedules, etc. in obvious places in the classroom. Refer to them frequently. Write instructions as well as providing oral instructions.

- ❖ Provide consistent and non-punative responses to challenging behavior, developed in collaboration with student service providers and administration.

- ❖ Communicate regularly with parents/caretakers, not just at crisis points or when difficulties occur.

- ❖ Discuss concerns about academic work or behavior in private with the student, not in front of the class or their peers.

- ❖ Reduce the frequency of timed tests and provide evaluations (tests) that are of manageable duration (for example: instead of giving 2 essay questions to be answered consecutively, rather give one and the another at a later time).

- ❖ Provide students with evidence based best learning techniques such as pre-study questions and frequent reviews of material.



What Schools Should Not Do

- ❖ Draw attention to the student’s difficulties in front of their peers. Avoid sarcasm and public criticism.

- ❖ Lower expectations of achievement or support avoidance of challenging situations.

- ❖ Remove opportunities for daily physical activity.



Treatment of ADHD is based on a comprehensive and careful diagnostic evaluation that should include academic performance and learning challenges. Treatment is directed toward helping ameliorate the symptoms of ADHD and addressing existing functional impairments and may be necessary for prolonged periods of time. Medications such as psychostimulants are usually needed to help achieve symptom improvement but are not usually sufficient to address all the needs of the young person. Various behavioural, social and educational interventions may also be necessary. Family based treatments (such as parent effectiveness training) can be helpful in some cases. Interventions for moderate to severe manifestations of ADHD that do not include medications are not likely to demonstrate substantive positive results in symptom relief. Assessment for treatment and for treatment effects should involve the input of parents/ caretakers and teachers, as developmentally appropriate.

Resources

United States Department of Education, Teaching Children with Attention Deficit Hyperactivity Disorder: Instructional Strategies and Practices.

www2.ed.gov/rschstat/research/pubs/adhd/adhd-teaching-2008.pdf

Alberta Education: Supporting Every Student: Attention Deficit/Hyperactivity Disorder.

www.education.alberta.ca/admin/supportingstudent/diverselearning/adhd.aspx

Center for ADHD Awareness, Canada.

www.caddac.ca/cms/page.php?2

The Canadian ADHD Resource and Alliance.

www.caddra.ca/

FETAL ALCOHOL SPECTRUM DISORDER (FASD)

Fetal Alcohol Spectrum Disorder (FASD) occurs when a developing fetus is exposed to alcohol before it is born, resulting in permanent brain damage. Although it is only one type of Neurodevelopmental Disorder, it may be quiet common and may occur with greater frequency in populations where maternal alcohol use during pregnancy is high. It is also one of the most preventable of the neurodevelopmental disorders. The effects of FASD are life-long, and include physical, mental, behavioural and learning disabilities. FASD is the leading cause of neurodevelopmental disabilities in Canadian children.

Research has identified a link between exposure to alcohol before birth and fetal brain damage. Even moderate drinking may increase the risk for development of FASD. It is not clear what amounts of alcohol use are safe during pregnancy and the amount may vary from individual to individual. At this time, because of the lack of medical consensus on this issue, public health advice is to not drink alcohol at any time during pregnancy.

FAS has 5 classifications

- ❖ **FAS without confirmed maternal alcohol exposure.** When all 3 of the above-mentioned issues are noted, but prenatal alcohol exposure is not confirmed.
- ❖ **Alcohol-Related Birth Defect (ARBD).** when prenatal alcohol exposure is confirmed and birth defects in the heart, joints and limbs are present.
- ❖ **Partial FAS with confirmed alcohol exposure.** When prenatal alcohol exposure is confirmed, central nervous system dysfunction is present and some of the growth and facial features common in FAS are noted.

- ❖ **Alcohol-Related Neurodevelopmental Disorder (ARND).** When prenatal alcohol exposure is confirmed, and even if facial and growth abnormalities are not present, neuro-cognitive dysfunction and behaviours associated with FAS are noted. Many people who in the past would have been diagnosed with Fetal Alcohol Effect (FAE) would now be considered to have ARND, as the term FAE is no longer commonly used.

- ❖ **FAS with confirmed maternal alcohol exposure.** When alcohol consumption is confirmed and all 3 of the following issues are noted:

- **Facial abnormalities:** shorter than usual separation between upper and lower eyelids (shorter Palpebral fissures); flatter than usual groove between nose and upper lip (the philtrum); thinner than usual upper lip (thin vermilion border).
- **Growth restriction:** weight and height at or below the 10th percentile.
- **Central Nervous System Dysfunction:** abnormalities in brain structure; cognitive and developmental impairments; a pattern of behaviours including extreme hyperactivity, poor judgement and aggressiveness.



Common Signs & Symptoms

Physical features FASD may include

- ❖ Hearing, visual, dental problems.
- ❖ Heart problems.
- ❖ Joint and/or limb abnormalities.
- ❖ Abnormalities in the reproductive, urinary and neurotubal (such as the spinal cord) systems.
- ❖ Smaller brain size or compromised parts of the brain.

Cognitive, Behavioural and Emotional features of FASD can include

- ❖ Difficulty processing information through the senses (things are seen, heard, smelled, tasted and/or felt).
- ❖ Various learning difficulties.
- ❖ Poor judgement.
- ❖ Inability to predict/understand consequences.
- ❖ Emotional lability (including rapid emotional changes).
- ❖ Aggressiveness.
- ❖ Sleep disturbances, including night terrors.
- ❖ Impulsiveness.

Secondary Disabilities

Due to the mental, behavioural and cognitive disabilities common in FASD, individuals are also at increased risk for:

- ❖ Other mental illnesses.
- ❖ Drug and/or alcohol problems and Substance Use Disorders.
- ❖ Suicide attempts.
- ❖ Significant difficulties in school, with employment, and in independent living.
- ❖ Inappropriate sexual behaviours.

❖ Trouble with the law.

❖ Interpersonal and social difficulties.

❖ Victimization/bullying.



Suggested Classroom Strategies

❖ Be realistic. FASD is a lifelong disability. Have realistic expectations that are continuously re-evaluated, so the student is able to meet them and succeed.

❖ Remember that a child with FASD is not acting out purposely. They have a permanent disability that affects their capacity to follow instructions and manage behaviours.

❖ Provide opportunities for physical movement throughout the school day as youth with FASD may not be able to sit still for long periods of time.

❖ Provide opportunities for success, these may not be primarily academic.

❖ Focus on the student's strengths, skills and interests.

❖ Provide only a few directions at a time. Simple and concrete instructions, repeated often are best.

❖ Establish set rules and routines for every part of the school day and within each classroom and make sure these are clearly stated and understood.

❖ Learn what triggers behaviours and note the early signs of frustration/sensory overload. Help the child recognize these signs themselves and facilitate a change an activity/environment so the situation can be redirected.

- ❖ When negative behaviours occur, focus on the main problem and ignore smaller ones.
- ❖ Help the child learn and practice how to express emotions and develop social skills.
- ❖ Decrease classroom stimulation, avoid clutter, too many colours, and large crowds around the student, as too much stimulation can be overwhelming.
- ❖ Ensure curriculum and games are simple and limit choices so as not to overwhelm.



What Schools Should Do

- ❖ Assign a school liaison to the treatment team working with the child/family and ensure that communication between the school and the treatment team and within the school between the school liaison, teachers and all staff occurs in a systematic manner.
- ❖ Participate in the social, educational and academic evaluations needed to create a comprehensive treatment plan.
- ❖ Ensure a policy and process to address negative and inappropriate behaviors (such as bullying).
- ❖ Provide a forum in which parents/caretakers can appropriately access the school liaison to discuss challenges and concerns.
- ❖ Create policies and procedures for addressing school identified mental health concerns with parent.



What Schools Should Not Do

- ❖ Apply unrealistic interventions that will lead to failures in social, academic or other outcomes.



Treatment of FASD

Numerous medical and therapeutic specialists should be consulted as part of an interdisciplinary team addressing the wide range of cognitive, emotional and behavioural problems common with FASD. Treatment for FASD is most effective when school, family, community and medical resources join together to manage the effects of FASD, treat any secondary disabilities already present, and work together to reduce the risks of further disabilities. Ideally, a caseworker (nurse or social worker) is assigned to help coordinate the medical specialists, various therapists, school and other community resources involved in the care and treatment of the person with FASD and their family. Treatment usually involves finding ways to adapt to the individual's environment and practicing of basic life and social skills. Treatment will not “cure” FASD.

Resources

Alberta Education - Teaching Students with FASD

www.education.alberta.ca/admin/supportingstudent/diverselearning/fasd.aspx

Provincial Outreach Program for FASD

www.fasdoutreach.ca/teacher-resources/print-resources/print-resources

FASD and Educational Strategies

www.psychiatry.emory.edu/PROGRAMS/GADrug/Edfas.htm

AUTISM SPECTRUM DISORDER

Autism Spectrum Disorder (ASD) includes symptoms across multiple domains of brain functioning and demonstrates the presence of persistent difficulties in social interaction and social communication across all contexts. Additionally, young people with ASD demonstrate numerous restricted and repetitive patterns of behaviours, activities or interests that may evolve or change in severity or nature over time. Some young people with ASD demonstrate pervasive, sustained and substantial impairments in language or intellectual development. It appears more frequently in males than females and is found globally, regardless of socio-cultural, ethnic, racial or economic status. Depending on severity, ASD symptoms are usually significant enough to be noticed by age two years and signalled by delayed language development that is accompanied by lack of social interaction with others, unusual or repetitive play patterns and the emergence of intensely applied, repetitive and restricted daily activities. Occasionally, young people with ASD may demonstrate exceptional capacity in one or more domains (such as calendar understanding, numeric manipulation) or encyclopaedic knowledge about a highly limited area (such as baseball statistics). Some young people with ASD will show improvements in symptoms over time (usually with intensive treatments). Regression of skills (such as language or self-care) is not common and indeed, if it occurs, should trigger consideration of other conditions. The most important prognostic factors for long-term outcome in ASD are the presence of functional language by age five (a good sign) and the presence of significant intellectual impairment (not a good sign). Epilepsy occurring in the presence of ASD is associated with more day-to-day challenges and less robust long-term outcomes. ■

While the reason for ASD in any one individual may be difficult to determine, we understand that both genetic and environmental factors can be at play. ASD runs in families and while some

people will have ASD based on known mutations in specific genes, the most common genetic basis is likely to involve functional changes in many different genes. Ongoing research into these genetic components and the interaction between genes and environments in ASD is underway. Cultural factors do not lead to ASD but may operate to either enhance or delay recognition or treatment of the disorder.

Previously, a variety of diagnostic categories were provided within the overall grouping of ASD. With increasing research, these have been subsumed into one category in the new Diagnostic and Statistical Manual of Mental Disorders: 5th Edition (DSM-V), with items specifying the degree and nature of difficulties experienced. So, young people with previous diagnoses of Asperger's Disorder or Pervasive Developmental Disorder not Otherwise Specified would now receive a diagnosis of Autism Spectrum Disorder with a specific identified (for example: Asperger's Disorder would not be classified as ASD without accompanying language impairment).

Diagnostically, for ASD to be present a young person must demonstrate both

- ◆◆ Persistent, sustained and substantial deficits in social communication and social interaction.
- ◆◆ Restricted, repetitive patterns of behaviour, interests or activities.

These phenomena must have been present during early development and must cause significant impairments in social, interpersonal, academic or occupational functioning. Young people with ASD may also demonstrate other neurodevelopmentally associated difficulties such as easy distractibility or hyperactivity. ASD is not the same as childhood onset schizophrenia, and hallucinations and delusions (the hallmark features of psychosis) are not present in ASD.

Behavioural Characteristics

There are many different behavioural characteristics that are found amongst young people with ASD, and the same characteristic can be present in different degrees in different youths or may change over time as the young person's brain grows and develops. These difficulties include:

- ❖ Underdevelopment or lack of speech.
.....
- ❖ Underdevelopment of the understanding or expression of language.
.....
- ❖ Underdevelopment or lack of other types of communication skills needed for social interaction (such as social smiling, social frowning, etc.).
.....
- ❖ Uncommon use of language (for example, repetition, echolalia, mutism, etc).
.....
- ❖ Compulsive-like behaviours, such as fixations on a specific activity or repetitive body movements (such as rocking).
.....
- ❖ Difficulties in social relationships with others, including adults and peers.
.....
- ❖ Little or no eye contact and, in extreme cases, complete social withdrawal.
.....
- ❖ Difficulty understanding the meaning of facial expressions.
.....
- ❖ Appears to lack empathy and awareness of the needs of others.
.....
- ❖ Difficulty in understanding the intent or motivations of others.

- ❖ Inflexible attachment to rituals or routines.
.....
- ❖ Ability to concentrate for prolonged amounts of time in preferred areas, but difficulty maintaining sustained concentration in other areas.
.....
- ❖ Diminished or distorted sensory awareness: under or overreaction to sensory inputs (i.e. sounds, lights, touch) – some children may be so unaware of pain that they can hurt themselves and not respond; others may have an inability to verbalize physical discomfort.
.....
- ❖ Activities and play can be rigid and repetitive.
.....
- ❖ Difficulty imitating the play of other children or playing collaboratively with others.
.....
- ❖ Excessive anxiety and challenges with self-control, which can lead to temper outbursts, aggression towards others or self-injurious behavior.
.....
- ❖ May possess extraordinary talents or special abilities in certain limited or circumscribed areas.
.....
- ❖ Seizures of various types, which may sometimes develop in late childhood or adolescence. These may be convulsive or non-convulsive (i.e. falling, loss of bladder or bowel control, loss of attention).
.....
- ❖ Some children may exhibit restrictive food preference (i.e. pickiness) and persistent digestive system symptoms (i.e. constipation, diarrhoea, abdominal pain).
.....
- ❖ May have toileting and sleeping difficulties.



Suggested Classroom Strategies

Because the symptoms in ASD can be so varied in type, amount and severity, interventions must be based on a good understanding of the needs, abilities and challenges faced by the child. It would be uncommon for a teacher to not know that a student has been diagnosed with ASD and for a student with ASD to not have had a rigorous diagnostic assessment prior to school entry. Thus, one of the most important issues that a classroom teacher will need to address is determining how to best work with the child and his/her parents as part of the team of health and human services providers. A good understanding of the young person's strengths and difficulties, a good understanding of the treatment plan, and a good understanding of the expectations of the teacher as part of the treatment team is the basis for classroom intervention.

There is no "one size fits all" approach to supporting the child with ASD in the classroom. The type, nature and amount of support needed will vary from child to child. Teachers will often require assistance from teacher's aides or other help providers. The importance of understanding the needs of the child with ASD and the complexities of how successful interventions can be tailored to meet those needs can be better appreciated by learning from first voice accounts of people living with ASD reflecting on what was helpful to them. A good example of such an account can be found at: www.iidc.indiana.edu/?pageId=601, but keep in mind that these accounts may not be reflective of the child that you have in your classroom.

While the importance of tailoring classroom interventions to meet the unique strengths and difficulties of each child cannot be underemphasized and is the key driver for what, how and when interventions are done, some general classroom "tips" should be considered. These may be particularly helpful when assisting young people who have ASD with better social and language skills.

These tips include

- ❖ Use task analysis – break down complex tasks into more simple sequential activities.
.....
- ❖ Use simple, direct language.
.....
- ❖ Address specific social skills such as appropriate social distance and taking turns.
.....
- ❖ Provide clear, concise instructions and limited choices.
.....
- ❖ Repeat instructions calmly if the student does not seem to fully understand what is expected.
.....
- ❖ Provide meaningful small but immediate rewards for positive outcomes frequently.
.....
- ❖ Don't use sarcasm, idioms or metaphors.
.....
- ❖ Have a clear and consistent schedule, including times for free movement and play.
.....
- ❖ Avoid overstimulation, including from other children or classroom ambiance (such as noise).
.....
- ❖ Prepare the student for changes that will occur in routines and provide supervision and support for daily stressors such as recess and lunch times.
.....
- ❖ Try not to take the student's behaviours personally, understand what stressors commonly trigger difficulties and do your best to manage these.
.....
- ❖ Meet regularly with the student's parents and treatment team to review and refine what you are doing.

- ❖ Have a quiet location for the student to be able to go to if he/she begins to feel overstimulated.

Most provinces have developed specific teaching resources. Seek out those that are suggested in your province. For additional resources see below.



Treatment for ASD

Although in many cases symptoms of ASD may decrease or change in type as the child develops, they tend to be chronic and persistent. The focus is therefore on encouraging the highest level of development possible given the limitations inherent in the disorder. A supportive environment and a multi-faceted educational and behavioural interventions approach, tailored to the needs and abilities of each child, seem to produce the best results.

Although it can be expensive, time-consuming, and not always readily available, language and social skills may be greatly improved through Early Intensive Behavioural Intervention (20 to 40 hours a week for two years prior to age six). This behavioural intervention is also called Applied Behavioral Analysis (ABA) and involves one-on-one behaviour therapy with a trained therapist and a specific way of interacting with the child. Parents can also effectively be taught ABA, which ensures consistent and persistent application of ABA interventions. In some cases, controlled diet or carefully monitored medication, may help to improve certain symptoms (for example: gastrointestinal problems, seizures, violent outbursts) but they do not address the core components of ASD. Supportive counselling may help families cope with the physical and emotional demands of caring for a child with this disorder.

There are many sensational, erroneous and frequent media reports that some environmental factors, (such as diet or vaccinations) cause ASD. These can lead to difficulties for parents and health care providers alike. In some cases, such reporting has substantial and negative outcomes that can lead to harm. For example, unfounded fears of vaccination have led to decreased vaccination rates and subsequent increases

in childhood diseases that bring substantial and significant health risks with them for the child and for the community. There is also no cure for ASD and entrepreneurial purveyors of heavily marketed untested and ineffective interventions notwithstanding, referral of concerned parents to reputable health providers (such as academic health sciences centers) for second opinions or more comprehensive information can be suggested if asked. As with all persons, children with autism benefit from good general health maintaining activities such as exercise and balanced diet.

Resources

Autism Society Canada

www.autismsocietycanada.ca

Center for the Study of Autism

www.autism.com

Indiana Resource Center for Autism – Teaching Tips for Children and Adults with Autism

www.iidc.indiana.edu/?pageld=601

Teaching Community – 22 Tips for Teaching Students with ASD

www.teaching.monster.com/benefits/articles/8761-22-tips-for-teaching-students-with-autism-spectrum-disorders

TOURETTE'S DISORDER

Tourette's Disorder (TD) is a brain disorder characterized by persistent motor and vocal tics. Tics are involuntary, sudden, rapid muscle movements or vocalizations that recur at irregular intervals. Tics range in severity from mild to more exaggerated movements and sounds, generally increasing as a result of environmental factors like stress or excitement. Not all young people who have tics have TD, and mild/minor tics can also occur normally, under some stressful conditions.

TD is a hereditary condition. It results from the interaction of several genes. It is not necessary for a parent to have TD in order to pass TD along to their child. However, usually a person with TD has another family member, direct or extended, who also has TD or one or more of the conditions that commonly occur alongside TD.

Tics in TD are the result of a physical impulse, known as a "premonitory urge". Performing the tic is the only way to relieve this urge, but only for a certain period, after which the urge builds again.

In some cases tics cause physical pain. For example, repeated throat clearing can lead to a sore throat. Another common tic, facial twitching, may result in headaches. Tics can also be embarrassing because they appear to be intentional when they are not. As a result, some individuals with TD may try to suppress their tics in order to avoid being teased or singled out.

While it is sometimes possible to suppress tics for a short period, suppression actually increases the need to tic and often leads to more intense tics later on. Once someone with TD stops suppressing their tics, they will come out in a more intense "burst". This is called the "rebound effect". It is common for young people to try to suppress their tics during school and let them out when they get home.

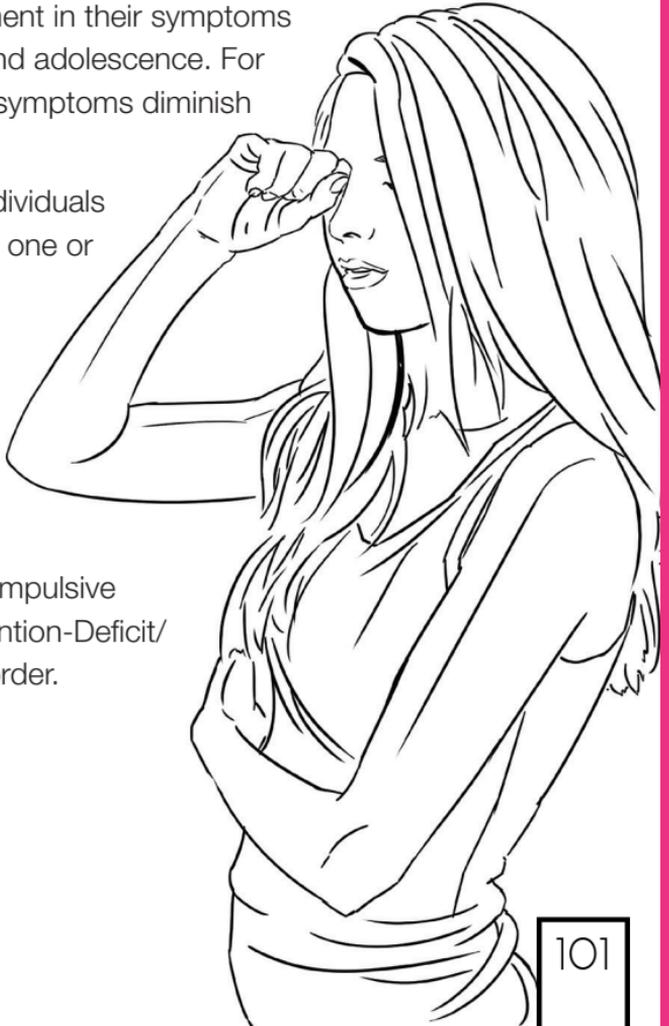
It is important to remember that tics are not behaviours, choices, or habits. They are involuntary symptoms of a neurological condition. Just because they can sometimes be suppressed

does not make them something that can be controlled. In fact, tic suppression is not recommended as a tic management strategy because it is extremely difficult and draining. Tic suppression takes up a large amount of physical and emotional energy. As a result, if a person is concentrated on suppressing their tics, they will likely have difficulty concentrating on anything else including school work and other activities.

The most common symptoms that first appear are facial tics, such as rapid blinking or mouth twitching. In some cases, involuntary sounds such as throat clearing or sniffing may be the initial sign, in others, motor (i.e. movement) and vocal tics can appear at the same time. TD usually appears in childhood around the age of six or seven. Tics may fluctuate in intensity, severity, duration, and frequency throughout the day, and over days, weeks, months or longer. This is called "waxing and waning".

Typically, tic severity and frequency peaks around puberty. In some cases, individuals with TS notice a gradual improvement in their symptoms as they age beyond adolescence. For some people, tic symptoms diminish by adulthood.

The majority of individuals with TD also have one or more common co-occurring conditions or "co-morbidities". The two most common co-morbidities are Obsessive Compulsive Disorder and Attention-Deficit/Hyperactivity Disorder.





Common Signs & Symptoms

- ❖ Tics – involuntary movements or vocalizations ranging in complexity from blinking, facial twitching, head or body jerking, shoulder shrugging, throat clearing, sniffing, tongue clicking, yelping, to jumping, twirling, bending, touching others; and, rarely, hitting or biting oneself, uttering ordinary words or phrases out of context or, even more rarely, explosively vocalizing socially unacceptable words.
- ❖ Fatigue, along with sleepiness or irritability and hyperactivity, caused by sleep disturbances.
- ❖ Learning challenges due to executive dysfunction including problems with organization and/or eye-hand coordination difficulties with handwriting and written math work; generally, difficulties with expressing thoughts in written form.
- ❖ Poor self-esteem and/or school performance due to TD symptoms or, in some cases, from Obsessive Compulsive Disorder, Attention Deficit/Hyperactivity Disorder or impulse control difficulties.



Suggested Classroom Strategies

- ❖ Consider a preferential seating arrangement. This does not necessarily mean seating the student near your desk, though it may be helpful in some cases. It may also be better for the student to seat them near the door so they can quickly exit should they need to go to a safe space and tic.
- ❖ Allow extra time for work and assist with the development of routines and time management skills.
- ❖ Create a reassuring classroom structure: establish a daily routine; give tasks in manageable chunks with clear, concrete instructions. Be flexible with expectations of output based on the student's symptom variability.

- ❖ Recognize progress rather than criticizing setbacks.
.....
- ❖ Trying to suppress tics is stressful and distracting for the student. Allow him/her to move discreetly and to leave the classroom if symptoms become overwhelming. Ensure that the student can make a graceful exit.
.....
- ❖ Provide appropriate accommodations for tics such as a cup for spitting tics or tennis balls on chair legs to reduce the noise creating by certain motor tics.
.....
- ❖ Provide opportunities for movement breaks.
.....
- ❖ Set untimed tests; if tics are an issue, use a private room where suppressing them is not necessary.
.....
- ❖ Use aids and other assistive technology such as a computer or tape recorder to help the student overcome handwriting difficulties and produce work equal to his/her ability.
.....
- ❖ If the student agrees, a presentation to the class or school is often helpful. Many organizations have trained presenters who regularly give presentations in class settings.
.....
- ❖ Provide additional positive behaviour supports to help the student manage transitions. This can be done by giving time countdowns such as “ten minutes left... five minutes left...” and so on. You may also wish to practice the unexpected to ensure the student becomes more comfortable with these scenarios. If possible, try to let the student know what to expect for a given day so that they can be prepared. For example, let them know you will be away in advance if you can.

- ❖ Encourage parents to let you know if their son or daughter had a particularly tough night, so you know what to expect and can adjust your expectations of the student's academic performance.

- ❖ Minimize unstructured time such as in-between classes or in the morning before the bell rings, as these periods can be stressful for the student. For example, consider allowing the student to come to class five minutes before or after the bell to avoid placing the student in a crowded hallway.

- ❖ Children with TD often suffer the added stress of teasing, rejection, and even bullying, from peers. Encourage the child to talk about the disorder with classmates and, through this sharing, increase class acceptance of tics. If he/she is uncomfortable about such disclosure, talk to the child and his/her parents to determine the best approach.

- ❖ Involve the parents and the child in determining any special education needs and how best to manage TD in the classroom.



NOTE: While children with TD cannot be held accountable for their tics since they don't have control over them, they should be encouraged to take personal responsibility for the outcome of their tics. For example, if a person has a spitting tic, they should be encouraged to apologize for spitting at someone. They should not be punished for spitting at someone. They should be encouraged to apologize for spitting because this was unintentional. If they swear at someone, and this swearing is a tic, they should apologize for hurting someone's feelings but should not be punished for using inappropriate language.



Treatment for TD

The majority of young people with Tourette's Disorder are not significantly disabled by their tics or behaviour symptoms and therefore do not require medication. However, there are medications to help control symptoms that interfere with functioning. The type and dosage of medication needed to achieve maximum relief of symptoms, with minimal side effects, varies for each child and must be determined carefully by a doctor. Other forms of treatment, such as psychotherapy, relaxation techniques or biofeedback, may help the child and his/her family cope with associated psychosocial problems and stress. Partial and sometimes full remission can occur at any time and may be short or long-lived. Tic symptoms seem to stabilize and become less severe during or after adolescence, however not in all cases. There is currently no cure for TD.

R

esources

Life's A Twitch

www.lifesatwitch.com

Tourette Syndrome Foundation of Canada

www.tourette.ca

Children's Hospital of Eastern Ontario. Resources, Tourette Syndrome

www.cheo.on.ca/En/tourette

SCHIZOPHRENIA

Schizophrenia is a type of psychosis, a brain disorder that is characterized by disturbances in perception (the five senses) and disorganization in thinking (cognition) and behavior. This disorder has nothing to do with a split or multiple personality, although this is a common misconception. Young people who are experiencing schizophrenia may often be referred to as suffering from a “first onset psychosis”.

The symptoms of Schizophrenia fall into three categories, known as “negative” symptoms (social withdrawal, apathy, emotional unresponsiveness, lack of pleasure, etc.), “positive” symptoms (delusions, hallucinations, bizarre behaviour, etc.) and “cognitive” symptoms (difficulty with attention, memory, decision making, complex planning, etc.).

Schizophrenia affects about **1%** of the population. This prevalence appears to be the same across countries, cultures and socioeconomic groups. The disorder is usually diagnosed in the adolescent or early adult years and normally begins gradually with the “negative” symptoms becoming more prominent over time, followed by the onset of “positive” symptoms.

The causes of Schizophrenia are complex. Current evidence indicates that genetic factors are the most important, but that environmental stressors such as drug abuse, childhood head injury, and infection during a pregnancy (e.g. the influenza virus) can also play a part in the development of Schizophrenia.

It is important to note that Schizophrenia is associated with a much higher risk of suicide than many other mental illnesses.

 **Common Signs & Symptoms**

- ❖ Loss of ability to relax, concentrate, or sleep during usual hours.
.....
- ❖ Showing little or no emotion.
.....
- ❖ Sitting still for long periods of time.
.....
- ❖ Delusions — false beliefs that have no basis in reality (e.g. “someone is spying on me”).
.....
- ❖ Hallucinations — hearing voices that make insults or give commands. Other types of hallucinations can occur (e.g. seeing things, feeling things, etc.) but hearing voices is the most common – command hallucinations (voices telling the person to do things) may occasionally and rarely lead to bizarre and unpredictable behaviors including self-harm and harm to others.
.....
- ❖ Disordered thinking/disorganized speech - illogical thinking and loose associations between thoughts.
.....
- ❖ Marked impairment in school performance (decrease in grades).
.....
- ❖ Difficulty relating to others, social isolation or withdrawal.
.....
- ❖ Marked impairment in personal hygiene and grooming.
.....
- ❖ Lack of insight into obvious problems with cognition, emotions, behaviors.

- ❖ Peculiar or bizarre behaviours, such as talking to an inanimate object, collecting garbage, or hoarding food possible suicidal thoughts and behaviours.



What to Watch For © Dr. Stan Kutcher 2014

- ❖ Is the child acting differently or in a comparatively strange and unusual manner?
.....
- ❖ Does the child show signs of or admit to having hallucinations?
.....
- ❖ Does the child have a thought form disorder - does their speech make sense?
.....
- ❖ Is the child isolated from others?
.....
- ❖ Is the child espousing bizarre and unusual ideas?
.....
- ❖ Has there been a decline in many areas of functioning?



What to Do © Dr. Stan Kutcher 2014

- ❖ Discuss concerns with other teachers and support staff.
.....
- ❖ Investigate the family situation and discuss concerns with appropriate family members.
.....
- ❖ Suggest that the youth seek mental health assessment immediately.
.....
- ❖ Provide mental health assessors with needed information, following appropriate consent provision.
.....
- ❖ Participate in discussions with the young person, health providers and family about school related issues - modification of school/ academic activities.
.....
- ❖ Clarify role of school with regards to potential crisis situations.



Suggested Classroom Strategies

- ❖ Keep in mind that the early symptoms of schizophrenia can be similar to other disorders and illnesses, such as mood disorders or epilepsy. A youth demonstrating signs and symptoms thought to be a psychosis should receive a specialty mental health assessment as soon as possible.

- ❖ Try to express a low degree of emotional response to the student's behavior.

- ❖ Try not to take the student's negative behavior personally. He or she is behaving this way due to illness and not by choice.

- ❖ If your student expresses thoughts that are distorted or delusional, do not try to disprove them. Make a calm statement of disagreement and then leave it. Appealing to reason and logic will not be productive.

- ❖ Communicate in brief, clear sentences. Give instructions one at a time.

- ❖ Seek professional help, above all. Work with the mental health team and discuss and apply jointly agreed upon modifications to classroom activities and academic expectations.



Treatment of Schizophrenia

The treatment of schizophrenia requires a range of interventions that target the many challenges experienced by the young person and family. Symptoms of schizophrenia generally respond well to anti-psychotic medications (although some people do not respond well and there may be a period of trial and error until the best medication is found), and there are many different ones available in Canada. The majority of people with schizophrenia will improve significantly with the appropriate medication and many will find their hallucinations and delusions

subside greatly. Many of these medications may also help improve negative symptoms as well, making it more likely for patients to benefit from social therapies. It is also necessary and important for people to stay on their medication in order to prevent the return of symptoms once they recover from an acute phase. Many people with schizophrenia will have difficulty taking medication every day; there are now many antipsychotic medications available in long-acting formulations that can be given as an intramuscular injection every **2-4** weeks. These long-acting forms of medication are associated with greatly reduced risk of relapsing.

During an acute psychotic episode with many “positive” symptoms, hospitalization is often needed. The best approach to recovering from schizophrenia includes taking medication, attending social therapies, and leading a healthy lifestyle (including effective stress management activities, eating a proper diet, and exercising regularly, getting adequate amounts of sleep, etc.), avoiding drugs and alcohol, and various vocational and educational rehabilitation interventions.

R esources

CAMH – First-Episode Psychosis

www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/psychosis/first_episode_psychosis_information_guide/Pages/first_episode_psychosis_information_guide.aspx

NAMI – About the First Episodes of Psychosis

www.nami.org/Template.cfm?Section=First_Episode

Psychosis Sucks

www.psychosissucks.ca

Schizophrenia Society of Canada

www.schizophrenia.ca

Center for Addiction and Mental Health. First Episode Psychosis, An Information Guide

www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/psychosis/first_episode_psychosis_information_guide/Pages/first_episode_psychosis_information_guide.aspx

SELF-INJURY & SUICIDE

NON-SUICIDAL SELF-INJURY

Non-suicidal Self-Injury is when someone hurts him or herself on purpose, without any plan to end their life. In the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) it is referred to as Non-suicidal Self-Injury in the section that identifies mental disorders requiring further study. These injuries are done intentionally and voluntarily, are not meant to be life threatening, and do not include the intent to die. They are not suicide attempts and usually involve superficial cutting (with a knife, razor, etc.) or burning (e.g. cigarette). There can be many reasons for Non-suicidal Self-Injury including: obtaining relief from negative emotions, attempting to resolve an interpersonal difficulty, inducing a positive emotional state, etc. Sometimes youth developing a mental disorder such as Schizophrenia, Bulimia Nervosa or Bipolar Disorder also exhibit Non-suicidal Self-Injury.

At this time, good epidemiological data on the prevalence of self-injury is not available but clinicians are reporting increased awareness of this problem. It is purported that significant numbers of youth who self-injure do not seek medical or psychiatric care. Tattooing, piercing, and cultural/religious markings do not fit the definition of non-suicidal self-injury.

Self-injuring behaviours usually start between the ages of **13-22** and in some cases, may become an ongoing habit or coping style. Self-injuring behaviors may sometimes be found together with Suicidal Behavior Disorder (repeated self-injury with the intent to die), although it is important to recognize that they are two distinct concerns. In some young people, close contact with youth who self-injure may be a causal factor.

One obvious impact of self-injury is that it results in physical harm. Most self-injuries are relatively minor and may be treated at home or school, others may need a visit to the doctor or the emergency room, and some may be serious enough to require hospitalization. It is not uncommon for youth to hurt themselves more severely than intended.

While self-injuring behaviour is not the same as suicidal behaviours, it is important to note that youth who self-injure are at a higher risk of suicidal thoughts, suicide attempts and death by suicide.

 **What to Watch For** © Dr. Stan Kutcher 2014

- ❖ Unexplained cuts, burns, injuries (especially on arms, legs, abdomen).
.....
- ❖ Wearing clothing that doesn't match the climate or weather (especially long sleeves/pants in warm weather).
.....
- ❖ Wearing excessive jewellery that covers common sites of self-injury.
.....
- ❖ Increased secrecy or long periods of isolation (particularly in bathrooms).
.....
- ❖ Seeing bandages and first aid materials in knapsack/bags.



What to Do © Dr. Stan Kutcher 2014

- ❖ If you suspect self-injury bring your concerns to the attention of a student services provider (e.g. counsellor).
.....
- ❖ Find a private moment and talk to the student about appropriate secrets and ones that need to be disclosed for their own safety or the safety of their friends.
.....
- ❖ Ask the student directly if they are self-injuring.
.....
- ❖ Listen without judgement and try to understand the self-injury from their perspective.
.....
- ❖ Tell child of your concerns for their well-being, suggest that there may be better ways to address problems than self-injury.
.....
- ❖ Talk to child about options for help (family doctor, counsellor/psychologist, peer groups, etc.).
.....
- ❖ Set up a meeting with the student services provider and if necessary accompany the student to it.
.....
- ❖ Be aware of suicide risk.



Treatment of Self-Injury

Treatment of non-suicidal self-injury can be complex, depending on the causes or related components of the self-injury. One important direction in treatment is to help the person substitute positive coping strategies to take the place of self-injury as a coping strategy. Interventions require the skills of professionals trained in treatment of youth who self-injure and various psychological therapies can be applied. Occasionally, medications may be used and family therapy can also be

employed. If the young person has a mental disorder such as Bulimia Nervosa, this will also be an additional focus for treatment. It is important for the mental health treatment team to work closely with the school to ensure a common approach to self-harm behaviors. A school based crisis intervention plan should be agreed to and put into place. It is vital that teachers do not agree to keep self-harm confidential. Some young people with Non-suicidal Self-Injury can elicit various different and incongruent emotional, cognitive and behavioural responses from the different professionals involved in their care. It is essential for the various health, education, and other providers involved in care to “be on the same page”.

Resources

CMHA – Youth And Self-Injury

www.cmha.ca/mental_health/youth-and-self-injury/#.UthFZf3IZFI

Interdisciplinary National Self-Injury in Youth Network Canada (INSYNC)

www.insync-group.ca

Mayo Clinic. Self Injury/Cutting

www.mayoclinic.org/diseases-conditions/self-injury/basics/definition/con-20025897

S.A.F.E Alternatives

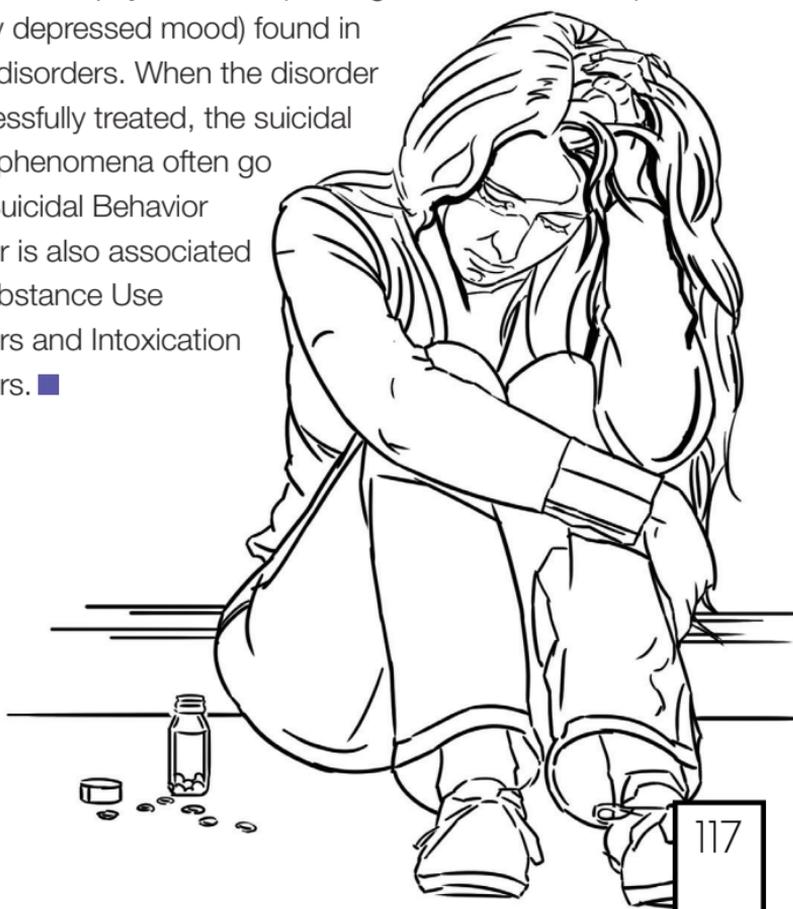
www.selfinjury.com

Self-Injury Outreach & Support (SiOS)

www.sioutreach.org

SUICIDAL BEHAVIOUR DISORDER

Suicide is defined as “intentional, self-inflicted death.” In the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM V) it is referred to as Suicidal Behavior Disorder in the section that identifies mental disorders requiring further study. There are three different levels of suicide related phenomenon: suicidal thoughts (also called suicidal ideation), suicide plans, and suicide action. These vary greatly in their prevalence with suicidal ideas being reported by up to **30%** of young people, with rates of completed suicide in Canada at about **4-6 per 100,000** for young people (below age **25** years). Suicide rates in Canada are higher in age groups older than youth with an overall current rate of about **12 per 100,000**. Most young people who have suicidal ideas never attempt suicide and most youth who attempt suicide never die by suicide. However, suicide risk is higher in young people who have previously attempted suicide and who have a family member who has died by suicide. Suicidal ideas and actions are often related to the disordered thinking (such as hopelessness, psychosis, etc) or negative mood states (such as severely depressed mood) found in mental disorders. When the disorder is successfully treated, the suicidal related phenomena often go away. Suicidal Behavior Disorder is also associated with Substance Use Disorders and Intoxication Disorders. ■



Most people who think about suicide do not want to die, so if others around them can help them when they are having suicide ideation progress can be made. All talk of suicide and any suicidal behaviour should be taken seriously because determination of degree of risk for suicide is difficult and complex. A proper assessment of suicide risk provided by a trained mental health professional should be sought immediately. Often this will be most easily accessed through a hospital emergency room, a youth crisis center or a mobile mental health crisis response team.

 **Common Signs & Symptoms**

Most people who are thinking about suicide give clues. Signs can be expressed directly or indirectly and picked up by different people. For example, a parent may not be aware of particular signs his/her child might show, but a close friend might notice a strange or sudden shift in behaviour, mood or cognition.

Here are some of the clues related to Suicidal Behavior Disorder to be aware of:

- ❖ Depression (please see Mood Disorders in this handbook) or any other mental disorder (other mental disorders with higher suicide rates are: Bipolar Disorder, Schizophrenia).
.....
- ❖ Expressions of helplessness or hopelessness; statements that link that negative emotional/cognitive state to suicidal phenomenon:
.....
 - “I just can’t take it anymore.”
.....
 - “It won’t matter soon.”
.....
 - “I might as well be dead.”
.....
 - “Nobody will miss me.”
.....
 - “You’d be better off without me.”

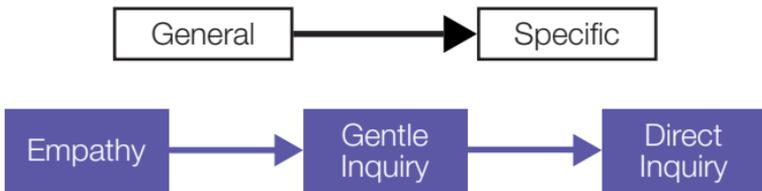
- ❖ Social isolation or withdrawal.

- ❖ Loss of interest in most things, from one's appearance to school activities, including things that were once important to the person.

- ❖ Preoccupation with death or loss.

- ❖ Talk or planning of suicide, preparation for death, such as making a will, giving away belongings and valuables, calling to say goodbye.

- ❖ One or more previous suicide attempts (risk of trying again increases significantly).



I can see how difficult things have been for you lately...

You seem to be having a hard time...

Would you help me understand how this has been for you?

Tell me more about what has been difficult for you lately.

Have you been feeling or thinking that life may not be worth living?

Have you ever tried to do anything to yourself that could have seriously harmed you or killed you? Are you planning to?



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- ❖ Do not agree to keep information about suicide confidential.
.....
- ❖ Notify the student services provider (such as a counsellor) in your school who has responsibility for evaluation and action related to a student who is exhibiting suicidal ideation and behaviour.
.....
- ❖ Take the student to the student services provider and assist in the implementation of the established school protocol as per the role assigned to you.
.....
- ❖ Provide non-judgemental support to the student when they return to class. Work with the mental health care team on the intervention program developed.



Treatment of Suicidal Behaviour

Suicide is complex. Treatment can involve a variety of approaches provided by mental health care providers, including individual and family therapy, as well as medication. A recent type of behaviour therapy called Dialectic Behavior Therapy (DBT) may be helpful for some young people who exhibit persistent and frequent suicide related phenomenon. All effective treatments for mental disorder decrease suicide risk.

There is a plethora of programs marketed as youth suicide prevention available. None of these (for example: Signs of Suicide, Yellow Ribbon) have been found to actually decrease youth suicide rates. There is no good evidence that providing suicide prevention courses to teachers or other educators will result in suicide prevention. Some evidence exists that special “gatekeeper” programs where key educators and health providers are trained to recognize and treat suicidal youth may be helpful. Before schools invest in purchasing or applying suicide prevention programs they should carefully investigate the evidence for their effectiveness.

R esources

Canadian Association for Suicide Prevention
www.suicideprevention.ca

Centre for Suicide Prevention
www.suicideinfo.ca

Kids Help Phone
[1-800-668-868](tel:1-800-668-868)

See General resources

Who to contact for immediate assistance:

Ambulance, Fire, Police. **911**

The Emergency Department of your local Hospital



LOSSARY



Acute

means that something (usually a disorder or a symptom) has come on quickly with a high degree of impact on a person.

Addiction

is continuing to use a substance (for example alcohol or cocaine) for non-medical purposes despite wanting or trying to stop using it. Addictions have a negative impact on many areas of a person's functioning in life. For example if a person's substance use gets in the way of positive relationships with friends or family; success at school or work, it is interfering with their life. An addiction is characterized by: Abuse of a chemical; Behaviour of drug seeking and daily focus on the drug; Craving for the substance. People who are addicted will often experience withdrawal when they stop using a substance. But, withdrawal does not equal addiction. Withdrawal is a common physical response to quickly stopping a chemical that affects the brain.

Agoraphobia

a fear and avoidance of situations where you might feel unsafe or unable to escape if you have a panic attack.

Anhedonia

is a word used to describe a lack of pleasure. Sometimes, people suffering with depression will experience anhedonia. For example the person doesn't feel good when they are doing the things that normally make them feel good, such as playing a favourite game, swimming, watching movies, etc. Anhedonia due to depression will get better once the depression has been successfully treated.



Anorexia Nervosa (commonly referred to as Anorexia)

is a type of eating disorder. The main features that a person with Anorexia will experience are: refusing to maintain a minimally reasonable body weight, intense fear of gaining weight, and an unrealistic perception of their body image (for example: they think or feel that they are much larger or heavier than they actually are).. The word “anorexia” means loss of appetite but many youth with anorexia actually struggle to suppress their appetite. Anorexia Nervosa can be treated with various psychological and family focused therapies.

Antidepressant medicine

a medicine that is usually used to treat the symptoms of depression or anxiety disorders. The antidepressant called “fluoxetine” is considered to be the most useful for helping in adolescent depression. It usually takes 6 to 8 weeks or more for an antidepressant medicine to work in treating depression.

Anti-social personality disorder

is a type of personality disorder. People with anti-social personality disorder have a long pattern of violating the rights of others. It begins in childhood or early adolescence and continues into adulthood. Other common terms for anti-social personality disorder are sociopath or psychopath. People with this personality disorder will often harm others without feeling remorse or guilt.

Anxiety

is a type of body signal, or group of sensations that are generally unpleasant. A person with anxiety experiences a variety of physical sensations that are linked with thoughts that make them feel apprehensive or fearful. A person with anxiety will often also think that bad things may happen even when they are not likely to happen. For example you may be thinking about your puppy falling and

getting hurt when it is on the bed and this makes you feel anxious. Anxiety is normal and everyone experiences it. It is a signal that we need to adapt to life's challenges by learning how to cope. When you have so much anxiety that it interferes with your normal routine or many parts of your life such as, school, work, recreation, friends or family—that is when it becomes a problem and maybe even a disorder. Typical sensations of anxiety include: worry; ruminations; “butterflies”; twitchiness; restlessness; muscle tension; headaches; dry mouth; feeling as if air is not coming into your lungs; etc.

Anxiety Disorders

are a group of common mental disorders. People with an Anxiety Disorder will experience things like mental and physical tension about their surroundings, apprehension (negative expectations) about the future, and will have unrealistic fears (see anxiety). It is the amount and intensity of the anxiety sensations and how they interfere with life that makes them Disorders. Some common types of Anxiety Disorders are; Social Anxiety Disorder; Panic Disorders; Separation Anxiety Disorder; Generalized Anxiety Disorder. Anxiety Disorders can be effectively treated with psychological therapies or medications.

Asperger's

is often considered to be a developmental disorder that can usually be diagnosed prior to adolescence. People with Asperger's experience repetitive and restrictive behaviours and interests that may lead to impaired functioning at work and socially. Asperger's is considered one of the several disorders on the Autism Spectrum and is unique because there is no significant delay in language development. Many people with Asperger's live full and productive lives without any (or minimal) treatment. Recent research is challenging the idea that Asperger's is a disorder but much more study of this is needed.



Attention Deficit Disorder (ADD)

is a term used in the past to diagnose what is now called ADHD (see attention deficit hyper-activity disorder).

Attention Deficit Hyper-Activity Disorder (ADHD)

is a mental disorder that is usually lifelong and associated with a delay in how the brain matures and how it processes information. People with ADHD usually have varying degrees of difficulty paying attention, being impulsive, and being over active which causes problems at home, in school, and in social situations. There are three kinds of ADHD: Inattentive Type, Hyperactive-impulsive Type and Combined Type. People with Inattentive Type mostly have problems paying close attention to things or being able to pay attention for long periods of time, so it is harder for them to focus on schoolwork or things that take a lot of concentration for more than a short period of time. People with Hyperactive-Impulsive means being on the go and are often not very good about thinking things through before they act. People with Combined Type have problems with inattention and hyperactivity/impulsivity. ADHD can be treated effectively with medication and behavioural techniques. About 1/3 of young people with ADHD may have a learning disability, so anyone who is diagnosed with ADHD should have special learning tests done.

Antipsychotics

are medicines that are often used to help treat psychosis. Sometimes they can also be used to treat mood swings (such as severe depression or mania) or extreme behaviours (such as aggressive outbursts). This can be confusing if a person is being treated with an antipsychotic medicine and does not have a psychosis. If you are being treated with an

antipsychotic medicine make sure you understand why it is being used and its risks and benefits. Check out the “Evidence Based Medicine for Teens” on: www.teenmentalhealth.org.

Atypical antipsychotics

are newer types of medicines that help treat psychosis. Sometimes they can be used to treat mood swings (such as severe depression or mania) or extreme behaviours (such as aggressive outbursts). See “Antipsychotics” above.

Autism Spectrum Disorder (ASD)

is a life-long mental disorder in which the person suffers with significant abnormal development of social interaction, verbal and non-verbal communication. A person with Autism has trouble understanding the feelings of others (empathy) and usually does not understand many social norms (rules that tell us what is socially acceptable). Language difficulties range from the inability to speak to automatic sounding repetitive phrases to normal language that sounds formal and emotionless. People with Autism Disorder may also display repetitive behaviours (for example, continuous flapping of hands) and strong need to follow a precise daily schedule and routine. In Autism symptoms can vary from extremely severe to mild. Numerous treatments are available to help improve many of the symptoms of Autism but as yet there is no single best treatment for Autism. The causes of Autism are complex and not well understood but the popular perception that vaccinations cause Autism is not correct.

Avolition

means having little or no motivation or drive to do things. For example, not getting dressed or not wanting to go out with family or friends, this is not the same thing as “lazy”.

B

Benzodiazepines

are medications that are used to treat a number of different mental disorders – most commonly anxiety. They can also be used to treat severe restlessness and agitation. When properly used they can be very helpful.

Bipolar Disorder (manic depression)

is a mood disorder. People with Bipolar Disorder have experienced at least one full depressive episode and at least one manic episode. Most people with Bipolar Disorder have their first episode before age 25 and it is usually a Depression. Bipolar Disorder can be effectively treated with medications and various psychological therapies.

Bipolar Disorder type 2 (hypo-manic depression)

is a mood disorder. People with Bipolar Disorder type 2 experience at least one full Depressive episode and at least one hypo-manic episode. Hypo-manic episodes are similar to manic episodes but are not as severe. These episodes may last days to months. Bipolar Disorder type 2 can be effectively treated with medications and psychological therapies.

Borderline personality disorder (BPD)

is a personality disorder. People with borderline personality disorder have difficulty in regulating their emotions and can experience intense bouts of anger, depression, and anxiety that may last from hours to days or longer. These bouts occur over and over again, often in response to minor life stressors or just on their own. People with BPD have unstable moods, stormy relationships, poor self-image, and self-harming behaviours which can lead to impulsive aggression, self-injury, risk taking and substance abuse.

Bulimia Nervosa

is an eating disorder often just called Bulimia characterized by excessive uncontrollable eating (binges of large amounts of food) over a short period of time, which is then followed by actions that try to get rid of the calories consumed (e.g. vomiting, laxative abuse, excessive exercise). This behaviour is repetitive and often followed by feelings of depression, self-disgust, and guilt. Bulimia can be effectively treated with psychological therapy or medications.

C

Chronic

means something that is there most of the time for a long time. Often used to describe a disorder that lasts for years or more.

Clinical

an activity that takes place between a health provider and a patient (for example: diagnosis, treatments; etc.).

Cognition

the mental processes associated with thinking, learning, planning, memory etc.

Cognitive Symptoms

are disruptions in normal thoughts. Some medical disorders can interfere with cognition. For example: negative thoughts in depression (“I am a useless person”) or delusions (see below) in psychosis (“The FBI is plotting against me”) or difficulties in planning or problem solving, etc.

C

Cognitive Behavioural Therapy

is a form of psychotherapy (talk therapy), designed to help treat various mental disorders. It focuses on changing the persons' thoughts and behaviours to help reverse the person's symptoms and help increase the person's functioning. Also known as CBT.

Community treatment

this means providing various kinds of treatments and services in the community instead of in the hospital. For example: in the doctor's office; in a health clinic or health center; in a school; etc.

Completed suicide

is the death of a person following a purposeful self-inflicted act with the intent to die. However, a more clear way of saying this is "die by suicide". It is important not to confuse self-harm with suicide attempts.

Comorbidity (also known as dual diagnosis)

describes the presence of two disorders that may be associated in a person. For example someone who has been diagnosed with a Substance Abuse Disorder of Alcohol and Depression.

Compulsions

are repetitive behaviours used to suppress (push out of thought) obsessive thoughts or to follow strong urges. Some types of compulsions include: counting; checking; tapping; etc. While mild and occasional compulsions are common, severe and persistent compulsions can be part of Obsessive Compulsive Disorder.

Concussion

a concussion is a brain injury that is caused by a blow to the head or body that leads to problems with brain function due to brain damage. It can occur without a loss of consciousness and can be caused by what seems to be a mild blow or bump. A concussion can occur in any sport or recreational activity, as a result of a fall or a collision or other mishap. A concussion can lead to many difficulties in thinking, emotions or behaviour and sometimes can lead to a mental disorder such as Major Depressive Disorder or Dysthymia. A concussion requires proper medical treatment. You can find out more about concussions in young people here: www.teenmentalhealth.org.

Conduct Disorder (CD)

is a disruptive behaviour disorder. The individual with CD shows a persistent pattern of aggressive behaviours lasting over 6 months that are unacceptable to society. Examples include stealing, fighting, starting fires, etc.). Young people with CD often get into difficulty with the law.

D

Delusion

is a disturbance of cognition where a person has fixed false beliefs that something has occurred or will occur that is not real. A common delusion is the belief that someone is trying to harm them, even though nobody is. Delusions are often associated with psychosis.

Depressant

any substance (medication or drug) that slows down a person's thinking and/or physical functioning. Examples include some pain killers and alcohol.

D

Depression

is a term used to describe a state of low mood or a mental disorder. This can be confusing because people may often feel depressed but will not have the mental disorder called Depression. People with a Depression could be experiencing either Major Depressive Disorder or Dysthymic Disorder. The most common type of Depression as a mental disorder is a Major Depressive Disorder (MDD). A person with MDD feels very low /sad/depressed or irritable and also experiences: lack of interest; less pleasure; hopelessness; fatigue; sleep problems; loss of appetite; suicidal thoughts. MDD has a negative impact on a person's life; home; family; school/work; friends etc. Depression can also be part of a Bipolar Disorder (see above). MDD can be effectively treated with psychological therapies or medications.

Depressive Episode

describes a period of Depression in MDD or Bipolar Disorder. It includes at least 5 or more of these symptoms being present most of the time, mostly every day for 2 or more weeks: depressed mood; a clear decrease in interest or pleasure in most or all (once enjoyable) activities; a significant weight gain or loss without dieting or loss of appetite; unable to get enough sleep or too much sleep (Insomnia or Hypersomnia); slow movements or purposeless movements from mental tension such as, nervousness or restlessness, which is observable by others (also known as psychomotor agitation or retardation); feeling tired or having less than a normal amount of energy; feeling worthless or a lot of inappropriate guilt; diminished ability to think or concentrate, or indecisiveness (have difficulties making decisions); recurrent (happening again and again) thoughts of death, suicidal ideation (thoughts and/or ideas about death or dying), suicide plan, or suicide attempt.

Diagnosis

is a description that identifies a medical or mental disorder or illness. In North America a diagnosis is determined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) and by the International Classification of Diseases (ICD). A diagnosis is a medical act provided by doctors, psychologists and others trained in diagnosis. A diagnosis is not a label.

Disorder

an abnormality in mental or physical health; disorder is often used as another name for illness.

Distress

is mental or physical suffering. Distress is a part of normal life. Distress is not a mental disorder.

Double Depression

is a mental disorder which is characterized by the presence of both Major Depressive Disorder and a less severe depression known as Dysthymic Disorder in one individual.

DSM-5

is a diagnostic manual published by the American Psychiatry Association that names and describes mental disorders. It divides mental disorders into categories called diagnoses based on lists of criteria (signs and symptoms). Its name is the Diagnostic and Statistical Manual (DSM); the 5 refers to the version of the manual as it is updated over time.

D

Dysthymic Disorder

is a mood disorder. People with Dysthymic Disorder experience persistent low mood for two or more years (or one year for children) but experience fewer depressive symptoms than in Major Depressive Disorder. This low grade depression can result in many difficulties at home; school/work; with family; with friends. Dysthymia can be effectively treated with psychology therapies or medication.

E

Eating Disorders

are a group of mental disorders related to eating. People with (an) eating disorder(s) excessively control their eating, exercise and weight. These disorders include Bulimia, Anorexia Nervosa, Binge Eating Disorder, and Eating Disorder Not Otherwise Specified. Eating disorders can be effectively treated using various psychological and medical treatments.

Electro Convulsive Therapy (ECT)

is a form of treatment for mental disorders in which improvements in the disorder are produced by the passage of an electric current through the brain. ETC is given with anaesthetic and is most often used to treat severe mood disorders. Its name has the word convulsion in it which means “uncontrollable shaking”. This used to occur in the past but does not happen now because the electric current is given while the person is under anaesthetic.

Electro-Encephalography (EEG)

this is a technique that measures the electrical activity occurring in the brain by putting electrodes on top of a person’s scalp. It is often used to assess sleep disorders or to diagnose epilepsy.

Euphoria

this word means a much exaggerated sense of happiness or joy. In a mental disorder this can be found in Bipolar Disorder.

Evidence Based Medicine (EDM)

is the standard of medical care that happens when the health provider uses the best available scientific information to provide the kind of care the patient needs. For how you can be sure that your health care provider (doctor, nurse, social worker psychologist, etc.) is using EBM check out the EBM materials (for young people and for parents) at www.teenmentalhealth.org.

Extraversion

this is personality type where someone is very outgoing and sociable. People with this personality feature are often called “extroverts”.

F

Functional Impairment

is a state in which a person is not functioning as they usually would or not functioning well in one or more area of life (i.e. family, friends, intimate relationships, work, school, etc.).

G

Generalized Anxiety Disorder (GAD)

is a mental disorder which is characterized by excessive anxiety and worry about numerous possible events (not any single, specific event) that leads to problems with daily functioning. People with GAD worry all the time and experience many physical symptoms because of the worry (headaches; stomach aches; sore muscles; etc.). GAD can be effectively treated with psychological therapies or medications.

G

Genetic disposition

this describes the probability that a disorder may be due to genetic factors passed on from parents to their children.

Grandiosity

is having a highly exaggerated and unsubstantiated belief in your importance, ideas or abilities. Unrealistic amounts of grandiosity can be found in Mania and Hypomania.

Grief

is normal emotional suffering experienced by a person from a loss of a loved one (e.g. it is experienced when a family member dies). It is different from a depressive disorder. Grief is not a mental disorder.

H

Hallucination

is a disturbance of how your brain perceives the world. A person with an hallucination experiences senses that aren't real (i.e. sound, sight, smell, taste, or touch). For example, a person with psychosis is hallucinating if they hear voices that aren't occurring in reality.

Health

is a state of physical, mental, social, and spiritual wellbeing and not just the absence of disease or infirmity. It includes mental health.

Health Care Professionals

are the trained professionals who help with the care of people who are sick or who help people and communities stay well. Examples include: doctors, nurses, psychiatrists, psychologists, occupational therapists, social workers, etc.

Holistic

is used to describe an a type of care that focuses on the whole person, which takes into account their physical and mental state as well as their social background rather than just treating the symptoms of an illness alone.

Hormones

are chemicals formed in one part of the body and carried to another body part or organ where they have an impact on how that part functions. They are important in growth, development, mood, and metabolism (food uptake and break down). For example, serotonin is a hormone in the brain that affects mood; growth hormone comes from the pituitary gland to many parts of the body and affects growth; testosterone affects sexual functioning; etc.

Hospitalization

being kept or staying in a hospital as a patient for doctors and other health care professionals to decide on a diagnosis and implement a treatment plan for the patient. Hospitalization for a mental disorder is usually used only if the disorder is severe or the person is in a crisis situation.

Hypomanic Phase (hypomania)

is a milder form of a manic phase. It is usually a part of bipolar disorder. Hypomania can be effectively treated with medication and psychological therapies.

I

Illness

has the same meaning as disease. However, having an illness can mean you have one disease or multiple diseases.

I

International Classification of Diseases of the World Health Organization (ICD)

is a book that classifies medical conditions (disorders and diseases) and groups of conditions. These conditions are determined by an international expert committee. This system is used worldwide for all medical diagnoses including mental disorders.

Introversion

means to look inward, for a person to mostly focus on their inner selves and less on their social surroundings. People that have this personality characteristic are often called “introverts”.

Involuntary status

is a term used to describe someone who has been admitted into a psychiatric facility (usually a hospital) against their will or without their consent, under the authority and protection of the law.

K

Knowledge Translation

is similar to changing a document from English to French. It is usually used in reference to changing scientific information into a format that can be easily understood for a specific group of people. (E.g. children, adolescents, teachers, adults not in a scientific professional setting, etc.). It is also used to describe how best scientific evidence can be used to improve the care of patients by health professionals.

M

Manic Phase

is one of the two phases of bipolar disorder (the other is Depression). It is a period of time during which the person with mania experiences very high energy and excessive activity elevated to the point where they may have difficulty controlling themselves or acting in an expected manner. Three or four of the

following symptoms must be present for an episode to be considered to be a manic phase: Inflated (really high) self-esteem or grandiosity; Decreased need for sleep; More talkative than usual or pressure to keep talking; Racing thoughts; Distractibility; Increase in goal-directed activity; Excessive involvement in pleasurable activities that have a potential for painful or negative consequences, such as spending sprees or gambling. A manic phase often requires hospitalization for treatment. It can be effectively treated with medications plus other therapies.

Medication

is another word for medicine and is in most cases prescribed by a medical doctor. Medications are regulated by government authorities (in Canada that is Health Canada, in the United States that is the Food and Drug Agency). There are many different classes of medications that are used to treat mental disorders (such as: antidepressants; antipsychotics; anti-anxiety). Medications can also be used to treat specific symptoms that are part of a disorder (such as: aggression).

Mental Disorder

is a disturbance of brain function that meets internationally accepted criteria (DSM or ICD) for a diagnosis. Mental disorders occur as a result of complex interaction between a person's genetic makeup and their environment. Many effective treatments (provided by health professionals) for mental disorders are available. Sometimes people use the term "mental health disorder" when they mean mental disorder. This is not necessary and can be confusing.

M

Mental Health

is a state of emotional, behavioural, and social wellbeing, not just the absence of mental or behavioural disorder. It does not mean lack of distress. A person can have a mental disorder and mental health at the same time. For example: a person may have a Major Depressive Disorder that has been effectively treated and is still taking treatment for the disorder. Now they have mental health as well as a mental disorder.

Mental Health Issue

is a broad term used to describe mental distress, mental suffering or mental disorder. It is so broad that many researchers and health professionals think it is meaningless. We advise not using this term, but instead being clear about what you are talking about.

Mental Health Nurse (clinical nurse with a specialty in psychiatry)

is a registered nurse who specializes in the maintenance of mental health and the treatment of mental disorders. This type of nurse usually works directly with people in a clinical setting, such as in a hospital or community clinic. Mental Health nurses have many skills used in the diagnosis and treatment of people with mental disorders.

Mental Health Professional

is a broad category of health care workers who work to help other people improve their mental health or treat mental disorders. . Examples are psychiatrists, clinical social workers, psychiatric nurses, psychologists, mental health counsellors, child and youth workers, etc. They have all received training in working with people who are living with a mental disorder.

Mental Health Promotion

these are activities that try to improve the mental health of people or try to reduce risk for the development of various mental health or social problems.

Mental Illness

refers to a range of brain disorders that affect mood, behaviour, and thought process. Mental illnesses are listed and defined in the DSM and the ICD. The terms mental illness and mental disorder are often used interchangeably.

Mental retardation

is the below average general mental functioning that can be first noticed during childhood and is associated with problems in adjusting to different environments. A diagnosis of mental retardation means that the person has shown to perform lower than average (compared to others their age) in two areas: measured intelligence (IQ) and an overall rating of the individual's level of performance in school, at work, at home and in the community.

Mood

is the ongoing inner emotional feeling experienced by a person.

Mood Disorders

are a group of mental disorders related to problems in how the brain is controlling emotions. A person with a mood disorder experiences an abnormal change in mood. These include: MDD; Bipolar Disorder; and Dysthymia.

M

Mood stabilizers

medicines used to help normalize mood. They are usually used to treat Bipolar Disorder. Some of these are: lithium; valproate; carbamazepine. Some of these medicines are also commonly used in the treatment of epilepsy.

N

Narcissistic

is a quality or trait of a person who interprets and regards everything in relation to their own self and not to other people. It is associated with an unrealistic and highly inflated self worth.

Negative symptoms

are symptoms of Schizophrenia that follow a lessening of executive functioning (conscious choice, intention, decision making; problem solving) in the brain. The person either has less of something (for example energy) or is unable to do something (for example unable to get out of bed). These symptoms include: inertia (inability to get one's self going), lack of energy, lack of interaction with their friends and family members, poverty of thought (significantly fewer thoughts), social withdrawal, and blunted affect (less emotionally responsive).

O

Obsessive-Compulsive Disorder (OCD)

is a type of mental disorder. People with obsessive-compulsive disorder experience persistent unwanted and recurring thoughts (obsessions) and/or persistent and unwanted repetitive behaviours (compulsions). Repetitive behaviours are carried out with the goal of preventing or getting rid of the obsessions or of releasing a strong feeling of inner tension. These behaviours may provide temporary relief for the person while not performing them can cause extreme anxiety. Examples of obsessions include repetitive thoughts of germs or contamination. Examples of

compulsions include repetitive or excessive touching, counting, hand washing, and cleaning. OCD can be effectively treated with medications and psychological therapies.

Obsessions

are repetitive, persistent, unwanted thoughts that the person cannot stop and which cause significant distress and impair the person's ability to function. Mild and occasional obsessive thoughts are normal, but when they become severe and persistent they can be part of Obsessive Compulsive Disorder.

P

Panic Attack

is a sudden experience of intense fear or psychological and physical discomfort that develops for no apparent reason and that includes physical symptoms such as dizziness, trembling, sweating, difficulty breathing or increased heart rate. Occasional panic attacks are normal. If they become persistent and severe, the person can develop a Panic Disorder.

Panic Disorder

is a mental disorder. A person with panic disorder has panic attacks, expects and fears the attacks and avoids going to places where escape may be difficult if a panic attack happens. Sometimes, people with Panic Disorder can develop Agoraphobia. Panic Disorder can be effectively treated with psychological therapies or medications.

Patient advocate

is a person who helps a patient (or a patient's family) with problems and complaints in relation to care or help that they are getting from any agency or institution (hospital, clinic, psychiatric clinic, etc.). Patient advocates can speak on behalf of the patient (or family) and can often be helpful during times of disagreement between the patient (or family) and health care professionals. Many hospitals employ people who act as patient advocates.

P

Perception

is the mental process of becoming aware of or recognizing information that comes from the five senses: sight, sound, smell, touch or taste. Proprioception (knowing where your body parts are without looking) is also a type of perception.

Personality Disorders

is a general term for a group of behavioural disorders characterized by lifelong behaviour patterns. People with Personality Disorders don't adjust or function well in changing social environments. Signs of these patterns may include poor judgment; emotional control; impulse control; relationship functioning; etc.

Positive symptoms

are symptoms found in psychosis, often in Schizophrenia. They include hallucinations, delusions, loose associations (unclear connections between ideas or disorganized flow of conversation topics), ambivalence (wanting to act one way but act in a way that is opposite to that), or unstable or quickly changing emotions.

Posttraumatic Stress Disorder (PTSD)

This mental disorder can happen to people who experience a really scary, painful, or horrific event in which they felt scared or helpless and during which they were in danger of death or severe injury. People who develop PTSD will have flashback memories, or nightmares, of the event and will avoid things that remind them of the event. For example, if a person was assaulted in a park they may be too fearful to go to parks and have to find new routes to work. PTSD can be effectively treated with psychological interventions or medications.

Prognosis

is an educated guess, based on previous evidence and scientific study, of how the disorder will affect the person over time. Your health provider will estimate the length of time the disorder will be present and how it may affect you. A prognosis can change over time, for example; if a treatment is very helpful then the prognosis may improve.

Protective factor

is anything that decreases a person's chances of getting a disorder or having a negative outcome. Protective factors can be aspects of a person's health, lifestyle or environment, such as a supporting family or community. Their actual effect in any one person is not easy to predict and it is not clear if they all actually have a direct effect or are just examples taken from healthy people compared to people who are not well.

Psychiatrist

is a doctor who specializes in the practice of psychiatry (the treatment of people who have a mental disorder and the prevention of mental disorders). Psychiatrists are medical doctors who have had many years of additional training in psychiatric medicine.

Psychiatry

is the medical specialty focused on understanding, diagnosing and treating mental disorders.

Psychologist

is a Ph. D level specialist in psychology licensed to practice professional psychology (e.g., clinical psychology), or qualified to teach psychology as a discipline (academic psychology), or whose scientific specialty is a subfield of psychology (research psychology).

P

Psychomotor agitation

are movements that happen because of mental tension. It is often described as a way of relieving mental tension. For example, pacing back and forth and peeling or biting skin around fingers.

Psychomotor retardation

are slow thoughts as well as movements that are slowed down.

Psychosis

is a mental state in which a person has lost the ability to recognize reality. Symptoms can vary from person to person but may include changes in thinking patterns, delusions, hallucinations, changes in mood, or difficulty completing everyday tasks (like bathing or shopping). Mental disorders such as schizophrenia can include psychosis as a symptom. Psychosis can be effectively treated with medications and other additional treatments.

Psychotherapy

is a type of treatment for emotional, behavioural, personality, and other psychiatric disorders based mainly on person to person communication. Psychotherapies can be evidence based (supported by many good research studies) or non-evidence based (not supported by many good research studies). It is important for a patient to know what the evidence to support the psychotherapy that they are being treated with is. To find out more about any psychotherapy, check out the Evidence Based Medicine booklet at: www.teenmentalhealth.org.

R

Recreation Therapist

is a professional that is trained in the specific area of therapy that uses recreational and leisure methods, such as games and activities, to improve a person's physical, mental, emotional, and relationship functioning.

Recreation Therapy

is a type of therapy that uses methods such as games and group activities to improve a person's physical, mental, emotional, and relationship functioning.

Recovery

is when a person with a mental disorder is doing as well as they can be and is feeling mentally healthy – even if they still have a mental disorder.

Relapse

is when a person with a mental disorder who has been in remission or recovery gets sick again.

Remission

is when a person's symptoms decrease and they return to their usual state after having an active phase of a disorder.

Risk factor

is anything that increases a person's chances of getting a disorder (can be aspects of a person's health, genetics, lifestyle or environment). Remember, risk factors increase a person's chances of getting a disorder – they do not cause the disorder. And, risk factors can be weak or strong. So having a specific risk factor may or may not be important for the person.

S

Schizoaffective Disorder

is a psychotic disorder that has symptoms of both Schizophrenia and a major mood disorder. People with Schizoaffective disorder can be effectively treated with medications and other additional treatments.

Schizophrenia

is a mental disorder that can usually be diagnosed between the ages of 15 and 25. People who have Schizophrenia experience delusions and hallucinations (psychotic symptoms) and many other problems that can make day to day living difficult. While schizophrenia runs in families some people can get schizophrenia without a family history of the disorder. Schizophrenia can be treated with medications and additional interventions that can improve the lives of people with the disorder.

Seasonal Affective Disorder (SAD)

is a type of Major Depressive Disorder that usually happens to people only or mostly at certain times of year (for example: winter).

Selective Serotonin Reuptake Inhibitors (SSRIs)

are a group of medications used to treat Depression or Anxiety Disorders. These medications work mainly in the serotonin system of the brain.

Self-harm

is any injury that a person inflicts on themselves without the intent to die. Examples of self-harming behaviours include: burning or cutting following an emotionally upsetting event; burning or cutting as a method of manipulation or threat; burning or cutting as a way of solving a problem.

Separation Anxiety Disorder

is an Anxiety Disorder that can be diagnosed in children which makes it very hard for them to be away from their parent. People with Separation Anxiety Disorder can be helped with psychological treatments.

Serotonin

is a neurotransmitter that helps in regulating many different brain functions, including mood, anxiety and thinking.

Social Anxiety Disorder (also known as Social Phobia)

is an anxiety disorder regarding the fear of having to be in social situations. A person with Social Anxiety Disorder also avoids the situations that make them feel anxious. Examples include, the fear of public speaking, the fear of going to a party because other people are “judging” them, performing in front of other people. People with Social Anxiety Disorder can be effectively treated with psychotherapy or medication.

Social Worker

is a professional who is educated to deal with social, emotional, and environmental problems that may be associated with a disorder or disability. Services provided by social workers may include case management (connecting patients with programs that meet their needs), counselling, human service management, social welfare policy analysis, and policy and practice development.

Sociopath (or psychopath)

is a person with antisocial personality disorder.

S

Sociopathy

are the behaviour patterns and personality traits a sociopath displays such as superficial (fake) charm, having a lack of remorse (doesn't feel badly/guilty about doing something wrong), and others.

Somatic

describes the physical body. For example: sore muscles, fatigue, headache, etc. are all somatic (also known as physical) sensations.

Specific Phobia

is an Anxiety Disorder. A person with a specific phobia experiences fear in the presence of an object or situation; snakes; fear of heights; fear of the dark; etc. Specific phobias often do not need to be treated. If they do, behaviour therapy is usually used.

Stigma related to mental illness

is attaching negative qualities to mental disorders (for example, thinking people with a mental disorder are dangerous). Stigma is a strong force and is harmful in that it may keep people from speaking about their disorder, getting help, or receiving treatment. It can create a false image of what mental disorders are and may force people to limit their social interactions, work, education, or to not seek help if they have a mental disorder.

Stress

is the body's reaction when forces such as infections or toxins disrupt the body's normal physiological equilibrium (homeostasis). Psychological stress develops in response to when a person perceives a threat, real or imagined, and determines whether they have the skills or resources to cope with the perceived threat. Stress is necessary for learning how to adapt. An appropriate amount of stress can be good for you. Too much stress can lead to a variety of health problems.

Stimulants

are a group of medications that improve various aspects of brain function: such as; alertness; concentration; etc. They are often used to treat ADHD.

Substance abuse

is an unhealthy pattern of drug, alcohol or other chemical use that may lead to relationship, education, work, mental and/or physical problems.

Substance dependence

is a pattern of actions, physical, and mental symptoms that develop from abuse of a substance (drug). A person who has a substance dependency may develop tolerance to the substance's effects and may experience withdraw symptoms when they stop using the substance. They crave the substance and engage in behaviour designed to access and use the substance –even if the behaviour or substance is harmful to them. A similar term is “Addiction”.

Suicide

is death that occurs as a result of an action designed to end one's life.

Suicide Attempt

a purposeful act with the intent to end one's life that does not cause death.

Suicidal Ideation

refers to thoughts, images or fantasies of harming or killing oneself.

Suicidal intent

is the commitment and expectation of death by suicide. (Future tense: the person intends to take their life. Past tense: the person intended to take their life).

S

Suicidal Plan

is the mentally created plan to attempt to end one's life

Supported decision making

is the process in which a vulnerable person is provided advice, support, and assistance by their support network so they can make and communicate their own decisions.

Symptom

is an occurrence of any type experienced by a person that differs from their normal in structure, behaviour, sensation, emotion or cognition that indicates illness or disease.

Syndrome

is a collection of signs (what a person observes about another person) and symptoms (what a person experiences) that describes a disease.

Systematic Desensitization

is a type of psychological treatment which gradually introduces things that a person fears so that they gradually overcome their fears.

T

Teen mental health

is a teen's state of emotional and spiritual wellbeing and not just the absence of disease. Focusing to improve the mental health and ability of teens' academic, social, physical, and other functioning will, in turn, increase their ability to contribute to society in the short term and in the long term in meaningful ways it is based on the brains ability to adapt.

Therapist

is a person who is professionally trained and/or skilled in the practice of a particular type of therapy.

Therapy

is the treatment of disease or disorder by any method.

Tolerance

is when a person becomes less responsive to a medication or other treatment over time.

Trauma

is any painful or damaging injury or event-that harms a person's physical or mental health.

Treatment

medical, psychological, social or surgical management and care of a patient.

Trichotillomania

is a mental disorder. People with Trichotillomania pull out their hair over and over again leaving noticeable hair loss. The person usually experiences tension before pulling the hair or if they try to stop themselves from pulling the hair and feel either pleasure or relief when pulling the hair out. The location of the hair can be anywhere on the body but is commonly from the scalp, eyebrows and eyelashes. Psychological treatments and sometimes medications are usually used to help with this disorder.

V

Voluntary admission

is being admitted as a patient to a mental health unit for treatment (usually in a hospital) based on a person's agreement to be admitted.

Voluntary patient

is a person who stays in a psychiatric facility (usually a hospital) by their own consent or with the consent of the substitute decision maker.

W Withdrawal

is a brain response to a sudden stopping of use of a medication or drug. Symptoms of withdrawal can include: nausea, chills, cramps, diarrhea, hallucinations, etc. Withdrawal often occurs in addiction/substance dependence but most people who experience it are not addicted. Another meaning of withdrawal is the self directed avoidance of social contact. This can be seen in some mental disorders such as: Depression, Schizophrenia; Panic Disorder; etc.

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Pugh, M. B. (Ed.). (2000). Stedman's Medical Dictionary. Baltimore, Maryland: Lippincott Williams and Wilkins.

G

ENERAL RESOURCES

Canadian Health Network

is the process in which a vulnerable person is provided advice, support, and assistance by their support network so they can make and communicate their own decisions.

 www.canadianhealthcarenetwork.ca

Canadian Mental Health Association

The Canadian Mental Health Association is a nation-wide charitable mental health organization. Its website has a variety of information on mental health and mental illness. You can find your local branch and its contact information via their website.

 www.cmha.ca

Centre for Addictions and Mental Health

The Centre for Addictions and Mental Health (CAMH) is a leading addiction and mental health teaching hospital in Toronto. Under “About Addiction and Mental Health” it has resources on many different mental disorders and substance abuse.

 www.camh.net

Children's Mental Health Ontario

CMHO provides resources for children and their parents and caregivers. They also have a section on their website that contains resources for teachers.

 www.kidsmentalhealth.ca

Kids Help Phone

A pioneering and world-leading child and youth counselling service. It is Canada's go-to electronic based mental health counselling resource for youth aged 5 to 20. Available via internet and phone 24/7 when guidance offices are closed, when family is not around and when social service agencies don't operate. One-on-one all professional, confidential and anonymous counselling. Providing information and referrals into local communities right across Canada. 100% free of charge - operating in English or in French.

 www.KidsHelpPhone.ca

Kelty Mental Health Center

The Kelty Center is a resource center located within the BC Children's Hospital. In addition to providing help to youth, they also provide help and education for parents, teachers, and other caregivers.

 www.keltymentalhealth.ca

Mindyourmind.ca

Mindyourmind.ca is an award-winning, innovative internet resource for youth who are looking for the information on mental health and creative stress management.

 www.mindyourmind.ca

Ontario Shores Centre for Mental Health Sciences

Ontario Shores Centre for Mental Health Sciences (Ontario Shores) is a public teaching hospital providing a range of specialized assessment and treatment services to those living with complex and serious mental illness. Exemplary patient care is delivered through safe and evidence-based approaches where successful outcomes are achieved using best clinical practices and the latest advances in research. For a full list of locations, please visit their website.

 www.ontarioshores.ca

Teen Mental Health.org

This website provides a vast database on many aspects of mental health, specific to adolescents and young adults. It is a reliable source of information, training programs and resources for national and international mental health activities. There is a section of their website dedicated to providing information to educators and it hosts the Transitions resource for supporting youth moving from secondary to post-secondary education and the Mental Health and High School Curriculum Guide resource, the only evidence based mental health literacy resource in Canada.

 www.teenmentalhealth.org

Jack.org is a charity that trains and empowers young leaders to revolutionize mental health. With thousands of young leaders across every province and territory in Canada, Jack.org is working towards a Canada where all young people understand how to take care of their own mental health and look out for each other. This collection of resources have been vetted by our professional programs team. Many of them are developed in conjunction with young leaders from the Jack.org network.

 www.jack.org/resources

Who to contact for immediate assistance

Ambulance, Fire, Police : 911

The Emergency Department of your local Hospital

TeleHealth: 1-877-797-0000

Kids Help Phone: 1-800-668-6868

FINAL NOTE

- ❖ Many of the above-listed organizations can direct you to local offices, resources, and services.
.....
- ❖ Most communities prepare a directory of local community agencies and services to help families. It is often found in a “Blue Book” or on a Web site.
.....
- ❖ There are many resources available for the topics addressed in this handbook, and those listed in this handbook are only a selection of suggestions. Resources listed in this handbook are not necessarily endorsed by the Canadian Psychiatric Research Foundation, and their use should not replace a professional diagnosis by a health care practitioner. These resources should, however, help you and your family to learn more about what you may be dealing with, and to get the help that you need.
.....
- ❖ * A TDD/TTY is a special device that lets people who are deaf, hard of hearing, or speech-impaired use the telephone to communicate, by allowing them to type messages back and forth to one another instead of talking and listening. A TDD/TTY is required at both ends of the conversation in order to communicate.

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