ANXIETY DISORDERS

SYMPTOMS OR BEHAVIORS

- Frequent absences
- Refusal to join in social activities
- Isolating behavior
- Many physical complaints
- Excessive worry about homework or grades
- Falling grades
- Frequent bouts of tears
- Frustration
- Irritable
- Fear of new situations
- Drug or alcohol abuse
- Unrealistic, obsessive fears
- Repeated unwanted thoughts and behaviors
- Tension about everyday life events

ABOUT THE DISORDER

All children feel anxious at times. Many young people worry about their academic performance, sporting activities, or even about being on time. Some very young children are frightened of strangers, thunderstorms, or the dark. These are normal and usually short-lived anxieties. But some children suffer from anxieties severe enough to interfere with the daily activities of childhood or adolescence.

Anxious students may lose friends and be left out of social activities. They commonly experience academic failure and low self-esteem. Because many young people with this disorder are quiet and compliant, the signs are often missed. Teachers and parents should be aware of the signs of anxiety disorder so that treatment can begin early, thus preventing academic, social, and vocational failure.

According to the U. S. Department of Health and Human Services, the most common anxiety disorders affecting children and adolescents are:

- **Generalized Anxiety Disorder.** Students experience extreme, unrealistic worry unrelated to recent events. They are often self-conscious and tense and have a very strong need for reassurance. They may suffer from aches and pains that appear to have no physical basis.

- **Phobias.** Students suffer unrealistic and excessive fears. Specific phobias center on animals, storms, water, or situations such as being in an enclosed space. Because students with phobias will try to avoid the objects and situations they fear, the disorder can greatly restrict their lives.

- **Social phobias.** These may center on a fear of being watched, criticized, or judged harshly by others. Because young people with phobias avoid the objects and situations they fear, this disorder can greatly restrict their lives. This fear can be so debilitating that it may keep students from going to school.

- **Obsessive-Compulsive Disorder.** Students become trapped in a pattern of repetitive thoughts (obsessions) and behaviors (compulsions). These may include repeated hand washing, counting, or arranging and rearranging objects. (See *An Educator's Guide to Children's Mental Health* pages 54–55 for more information.)

- **Panic Disorder.** Students suffer repeated attacks without apparent cause. These attacks are periods of intense fear accompanied by pounding heartbeat, sweating, dizziness, nausea, or a feeling of imminent death. Students with a panic disorder will go to great lengths to avoid a panic attack. This may mean refusal to attend school or be separated from parents.

- **Post-Traumatic Stress Disorder.** Students experience strong memories, flashbacks, or troublesome thoughts of traumatic events. These may include physical or sexual abuse or being a victim or witness of violence or disaster, such as a shooting, bombing, or hurricane. Young people with this disorder may try to avoid anything associated with the trauma. They also tend to overreact when startled or have difficulty sleeping. (See *An Educator's Guide to Children's Mental Health* pages 60–62 for more information.)

Anxiety disorders are among the most common mental health problems of childhood and adolescence. As many as 1 in 10 young people may suffer from an anxiety disorder. About 50 percent of children and adolescents with anxiety disorders also have a second anxiety disorder or other mental or behavioral disorder such as depression.

Among adolescents, more girls than boys are affected. It is not known whether anxiety disorders are caused by biology, environment, or both. Studies do, however, suggest that young people are more likely to have an anxiety disorder if their parents have anxiety disorders.

EDUCATIONAL IMPLICATIONS

Because students with anxiety disorders are easily frustrated, they may have difficulty completing their work. They may worry so much about getting everything right that they take much longer to finish than other students. Or they may simply refuse to begin out of fear that they won't be able to do anything right. Their fears of being embarrassed, humiliated, or failing may result in school avoidance. Getting behind in their work due to numerous absences often creates a cycle of fear of failure, increased anxiety, and avoidance, which leads to more absences. Furthermore, children are not likely to identify anxious feelings, which may make it difficult for educators to fully understand the reason behind poor school performance.

INSTRUCTIONAL STRATEGIES AND CLASSROOM ACCOMMODATIONS

- Allow students to contract a flexible deadline for worrisome assignments.
- Have the student check with the teacher or have the teacher check with the student to make sure that assignments have been written down correctly. Many teachers will choose to initial an assignment notebook to indicate that information is correct.
- Consider modifying or adapting the curriculum to better suit the student's learning style—this may lessen his/her anxiety.
- Post the daily schedule where it can be seen easily so students know what to expect.
- Encourage follow-through on assignments or tasks, yet be flexible on deadlines.
- Reduce school work load when necessary.
- Reduce homework when possible.
- Keep as much of the child's regular schedule as possible.
- Encourage school attendance—to prevent absences, modify the child's class schedule or reduce the time spent at school.
- Introduce secondary students to new teachers each quarter.
- Maintain regular communication with parents when students remain at home.
- Ask parents what works at home.
- Consider the use of technology. Many students will benefit from easy access to appropriate technology, which may include applications that can engage student interest and increase motivation (e.g., computer-assisted instruction programs, CD-ROM demonstrations, videotape presentations).

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

RESOURCES

Anxiety Disorders Association of America
8730 Georgia Avenue, Suite 600
Silver Spring, MD 20910
240-485-1001 • www.adaa.org
Offers publications, referrals to therapists, self-help groups

National Institute of Mental Health (NIMH)
Office of Communications
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
301-443-4513 • 866-615-6464
www.nimh.nih.gov/health/topics/anxiety-disorders/
Free educational materials for professionals and the public

SAMHSA'S National Mental Health Information Center—
Center for Mental Health Services
PO Box 2345
Rockville, MD 20847
800-789-2647
www.mentalhealth.samhsa.gov
Resources about child and adolescent mental health and links to other web-based materials for educators

Publications

- Both the NIMH and the SAMHSA websites have publications tabs that lead to several current and reliable publications. The Anxiety Disorders Association of America also has extensive resources for further reading listed on their website.

ASPERGER'S SYNDROME

SYMPTOMS OR BEHAVIORS

- Adult-like pattern of intellectual functioning and interests, combined with social and communication deficits
- Isolated from their peers
- Other students consider them odd
- Rote memory is usually quite good; they may excel at math and science
- Clumsy or awkward gait
- Difficulty with physical activities and sports
- Repetitive pattern of behavior
- Preoccupations with one or two subjects or activities
- Under or over sensitive to stimuli such as noise, light, or unexpected touch
- Victims of teasing and bullying
- Inappropriate or minimal social interactions
- Limited interests
- Peculiar preoccupations
- Often misses subtle social nuances
- Conversations almost always revolve around self rather than others
- Lack of "common sense"
- Few facial expressions
- Average to above-average verbal cognitive abilities
- Average to below-average nonverbal cognitive abilities
- Odd behaviors or mannerisms
- Obsession with complex topics such as patterns or music

ABOUT THE DISORDER

Asperger's Syndrome, a subset of the autism spectrum disorders, was first identified in the 1940s. Before knowledge of the diagnosis was expanded, the term "high functioning autism" was usually used. An increasing number of children are now being identified with this disorder. The cause of Asperger's Syndrome is not known, however, current research suggests that a tendency toward the condition may run in families. Students with Asperger's are also at risk for other psychiatric problems, including depression, attention deficit disorder, schizophrenia, and obsessive-compulsive disorder.

Asperger's is a neurobiological disorder that can impact behavior, sensory systems, and visual and auditory processing. Students with Asperger's Syndrome are usually highly verbal and test with average to above-average IQs.

A diagnosis of Asperger's Syndrome requires an atypical pattern of behaviors, interests, and activities. This neurological disorder impacts cognition, language, socialization, sensory issues, visual processing, and behavior. There is often a preoccupation with a single subject or activity (for example, a child may spend hours each day preoccupied with counting signs on the street or watching only the weather channel on television). Students may also show excessive rigidity (resistance to change), nonfunctional routines or rituals, repetitive motor movements, or persistent preoccupation with a part of an object rather than functional use of the whole object. The most outstanding characteristic of a student with Asperger's is impairment of social interactions, which may include failure to use or comprehend nonverbal gestures in others, failure to develop age-appropriate peer relationships, and a lack of empathy. The student may have difficulty using the right tone and volume of speech. They may stand too close or make poor eye contact, have trouble understanding age-appropriate humor and slang expressions, and may become fixated on a particular topic and bore others with frequent or repetitive talk. They may also exhibit an unusual sensitivity to sensory stimuli, (for example, they may be bothered by a light, or they may cover their ears to block out sounds in the environment that no one else notices).

Many parents and professionals have identified successful adults who may have undiagnosed Asperger's Syndrome because they have learned to compensate for their differences and use their fixations to their advantage when working toward achieving difficult goals. For others, ongoing needs may lead to a request for help from social services. Students may qualify as having a "related condition," especially if a functional skills test like the Vineland shows severe delays in social, self-care, and personal safety areas.

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EDUCATIONAL IMPLICATIONS

Many children with Asperger's have difficulty understanding social interactions, including nonverbal gestures. They may fail to develop age-appropriate peer relationships or be unable to share interests or show empathy. When confronted by changes in school routine, they may show visible anxiety, withdraw into silence, or burst into a fit of rage. Students may show no delays in language development; they usually have good grammatical skills, and an advanced vocabulary at an early age. Although students with Asperger's may appear to have a large vocabulary, (sometimes sounding like "little professors"), they can be very literal and have great difficulty using language in a social context. They may like school, but wish the other children weren't there. Students with Asperger's may also have problems with attention span and organization, and they may have visual-perceptual difficulties. In general, these students usually have average and sometimes above average intelligence.

INSTRUCTIONAL STRATEGIES AND CLASSROOM ACCOMMODATIONS

- Create a structured, predictable, and calming environment. Consult an occupational therapist for suggestions on handling your student's sensory needs.
- Foster a climate of tolerance and understanding in the classroom. Consider assigning a peer helper to assist the student in joining group activities and socializing. Make it clear to the class that teasing and harassment of any student is not allowed.
- Enjoy and make use of your student's verbal and intellectual skills. Fixations can be used by making the chosen subject the center of teaching and using the student's expertise to raise peer interest and respect (i.e., have him give a report or make a model of his favorite subject to share with the class).
- Use direct teaching to increase socially acceptable behaviors, expected greetings and responses, and group interaction skills. Demonstrate the impact of words and actions on other people during real-life interactions and increase awareness of emotions, body language, and other social cues.
- Create a standard way of presenting change in advance of the event. A key phrase like "today will be different" may be helpful if used consistently. You may also want to mention changes—for example, "tomorrow we'll have a substitute teacher"—both privately to the student and to the class as a whole.
- Learn the usual triggers and the warning signs of a rage attack or "melt-down" and intervene before control is lost. Help your student to learn self-calming and self-management skills. Remain calm and non-judgmental to reduce stress—remind yourself that your student "can't" rather than "won't" react as others do.
- Provide whatever support and information you can to the parents. Children with Asperger's Syndrome often have sleep disorders, and the family may be sleep-deprived. Other parents show frustration due to the long search for a diagnosis and services. They may also face disbelieving professionals or family members who erroneously blame poor parenting for the behaviors they see.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

RESOURCES

Autism Society of America
4340 East-West Highway
Suite350
Bethesda, MD, 20814
301-657-0881 • 1-800-328-8467
www.autism-society.org
Advocacy, educational information, referrals

The Gray Center for Social Learning and Understanding
100 Pine St. Suite 121
Zealand, MI 49464
616-748-6030
www.thegraycenter.org
Resources and information, including information on social stories

Online Asperger Syndrome Information & Support (OASIS@MAAP)
www.aspergersyndrome.org
Information, support, links

Publications

Asperger's Syndrome: A Guide for Parents and Professionals, by Tony Atwood, Taylor & Francis Group, 1997.

The OASIS Guide to Asperger Syndrome, by Patricia Romanowski Bashe and Barbara L. Kirby, Crown Publishing, 2001.

Video

Visual Supports in the Classroom for Students with Autism and Related Pervasive Developmental Disorders, by Jennifer Savner, Autism Asperger Publishing Co. (AAPC), 1999. Available from www.asperger.net/bookstore

Attention-Deficit/ Hyperactivity Disorder (AD/HD)

Symptoms or Behaviors

The U.S Dept. of Health and Human Services lists three types of AD/HD—each has different symptoms.

Children with inattentive disorder may:

- Have short attention spans
- Have problems with organization
- Fail to pay attention to details
- Be unable to maintain attention
- Be easily distracted
- Have trouble listening even when spoken to directly
- Fail to finish their work
- Make lots of mistakes
- Be forgetful

Children with hyperactive-impulsive disorder tend to:

- Fidget and squirm
- Have difficulty staying seated
- Run around and climbs on things excessively
- Have trouble playing quietly
- Be "on the go" as if driven by a motor
- Talk too much
- Blurt out an answer before a question is completed
- Have trouble taking turns in games or activities
- Interrupt or intrude on others

Children with combined attention-deficit/hyperactivity disorder show symptoms of both inattention and hyperactivity or impulsivity.

About the Disorder

Children and teens with attention-deficit/hyperactivity disorder (AD/HD) may be overactive and be unable to pay attention and stay on task. They tend to be impulsive and accident-prone. They may answer questions before raising their hand, forget things, fidget, squirm, or talk too loudly. On the other hand, some students with this disorder may be quiet and "spacey" or inattentive, forgetful, and easily distracted.

The U.S. Department of Health and Human Services lists three forms of AD/HD, inattentive, hyperactive-impulsive, and combined inattentive, hyperactive-impulsive. Students with inattentive symptoms may be described as "daydreamers" or "spaced out." These students are more socially withdrawn and have more frequent problems with mild anxiety than students with the hyperactive-impulsive type. They frequently experience forgetfulness and boredom. They may also have trouble remembering instructions and responsibilities, have problems with focusing, and have an aversion to mentally challenging tasks. Symptoms of inattentiveness may be difficult for teachers to detect, and many students—especially girls—are diagnosed much later or are never identified. Girls are more likely to have the inattentive type of AD/HD.

Students with hyperactive-impulsive symptoms of AD/HD often experience difficulty controlling their actions. Teachers frequently mistake their impulsive tendencies as rudeness, disregard for others, or willful disobedience. These students are likely to explore new situations with enthusiasm and touch objects without asking for permission. Their unrestrained behavior may lead to careless accidents and the disapproval and irritation of teachers and rejection from peers. Because of the nature of this type of AD/HD, it is typically identified more easily than the inattentive type. The hyperactive type of AD/HD appears to be more prevalent in boys than in girls.

Symptoms may be situation-specific. For example, students with AD/HD may not exhibit some behaviors at home if that environment is less stressful, less stimulating, or is more structured than the school setting. Or students may be able to stay on task when doing a project they find enjoyable, such as an art project. They may have a harder time when they have to work on something that is more difficult for them.

An estimated 5 percent of children have a form of attention-deficit/hyperactivity disorder (ADD or AD/HD). More boys than girls are diagnosed with AD/HD, and it is the leading cause of referrals to mental health professionals and special education programs, as well as the juvenile justice system. Students with ADD (those who are not hyperactive) tend to be overlooked in school or dismissed as "quiet and unmotivated" because they can't get organized or do their work on time.

Students with AD/HD are at higher risk for learning disorders, anxiety disorders, conduct disorder, and mood disorders such as depression. Without proper treatment, children are at risk for school failure. They may also have difficulty maintaining friendships, and their self-esteem will suffer from experiencing frequent failure because of their disability.

If you suspect that a student has AD/HD, refer the student for a mental health assessment. Many children benefit from medications. This must be managed by an experienced professional, such as a child psychiatrist, pediatrician, or neurologist who is experienced in treating AD/HD. In addition, many mental health professionals will work with the family and school personnel to find ways to teach children with AD/HD more effectively.

Children identified with AD/HD at a young age should be monitored because changing symptoms may indicate related disorders such as bipolar disorder, Tourette's disorder, or underlying conditions such as Fetal Alcohol Spectrum Disorders (FASD). Remember that AD/HD is a neurobiological disorder. Students can't get organized or learn social skills on their own, but educators can find interventions that may greatly increase a student's capacity to succeed.

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EDUCATIONAL IMPLICATIONS

Children with ADD or AD/HD may have trouble staying on task or finishing assignments. They may lose books, supplies, and homework. Students may blurt out answers before teachers can finish asking the question. They may be irritable, impatient, hard to discipline, clumsy, reckless, and accident-prone. Students with AD/HD may struggle with low tolerance for frustration and have trouble following rules. Often they are "poor sports" in games, and they may seem intrusive or bossy in their play. As a result, students with AD/HD face social challenges because their peers may perceive them as immature and annoying. Other children may dislike them. They may come to see themselves as bad and lazy, and powerless to do any better. This "chain of failure" can lead to depression, low self-esteem, behavior problems, and, unfortunately, school failure.

INSTRUCTIONAL STRATEGIES AND CLASSROOM ACCOMMODATIONS

- Have the student check with the teacher or have the teacher check with the student to make sure that assignments have been written down correctly. Sone teachers initial an assignment notebook to indicate that information is correct.
- Consider a Functional Behavioral Assessment (FBA). Understanding the purpose or function of the student's behaviors may help you respond with more effective interventions.
- Once you have a better understanding of a student's behaviors and learning style, consider modifying or adapting the curriculum and environment.
- Provide consistent structure and clearly define your expectations.
- When giving instructions or tasks, it's helpful to break them into numerous steps. Give the student one or two steps at a time.
- Allow the student to turn in late work for full credit.
- Allow the student to redo assignments to improve score or final grade.
- Allow the student to move about within reason. For example, give them tasks that require them to get out of their seat, such as passing out papers, or give them short breaks to exercise or stretch.
- Catch your student being good. Look for positive behaviors to reward and reinforce. Many students with AD/HD receive constant criticism for their behavior, which creates a cycle of negative behavior, poor self-esteem, and attention seeking.
- Have a secret code to help the child recognize that he/she has gotten off task and must refocus. This helps the student stay on task without embarrassment.
- Allow a child to use tables or formulas—memorization may be very difficult.
- Allow the child to answer directly in a booklet. This reduces the amount of movement and distraction during an assignment.
- Teach students with AD/HD self-monitoring techniques. Help them identify social cues from their peers and adults that would suggest a need for a behavior change. Also help students identify an aid or technique that will help them calm down or refocus, such as exercise, short breaks away from stimulation, or meditation.
- Reduce stress and pressure whenever possible. Children with ADD or AD/HD are easily frustrated. Stress and pressure can break down a student's self-control and lead to inappropriate behaviors.
- Teach social skills.
- Ask parents what works at home.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

RESOURCES

Children and Adults with Attention-Deficit/ Hyperactivity Disorder (CHADD)
8181 Professional Place, Suite 150
Landover, MD 20785
301-306-7070 • 800-233-4050
www.chadd.org
Support, information, resource center

Landmark College
1 River Road South
Putney, VT 05346
802-387-6718 • www.landmark.edu
Specialized college and national research facility for students with AD/HD and learning disabilities

Publications

Teaching Children with Attention-Deficit/Hyperactivity Disorder: Instructional Strategies and Practices, a report by the U. S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs, 2004. Available from the Department's website at www.ed.gov or by calling 877-433-7827.

Teaching the Tiger: A Handbook for Individuals Involved in the Education of Students with Attention Deficit Disorders, Tourette Syndrome, or Obsessive-Compulsive Disorder, by Marilyn P. Dornbush and Sheryl Pruitt, Hope Press, 1996. Available from www.hopepress.com

Bipolar Disorder

(Manic-Depressive Illness)

Symptoms or Behaviors

- An expansive or irritable mood
- Depression
- Rapidly changing moods lasting a few hours to a few days
- Explosive, lengthy, and often destructive rages
- Separation anxiety
- Defiance of authority
- Hyperactivity, agitation, and distractibility
- Strong and frequent cravings, often for carbohydrates and sweets
- Excessive involvement in multiple projects and activities
- Impaired judgment, impulsivity, racing thoughts, and pressure to keep talking
- Dare-devil behaviors
- Inappropriate or precocious sexual behavior
- Delusions and hallucinations
- Grandiose belief in own abilities that defy the laws of logic (become a rock star overnight, for example)

From the Child and Adolescent Bipolar Foundation

About the Disorder

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in a person's mood, energy, and ability to function. Different from the normal ups and downs that everyone goes through, the symptoms of bipolar disorder are severe. They can result in damaged relationships, poor job or school performance, and even suicide.

More than 2 million American adults, or about 1 percent of the population age 18 and older in any given year, have bipolar disorder. Children and adolescents can also develop bipolar disorder. It is more likely to affect the children of parents who have the illness. Like diabetes or heart disease, bipolar disorder is a long-term illness that must be carefully managed throughout a person's life.

Unlike many adults with bipolar disorder (whose episodes tend to be more clearly defined), children and young adolescents with the illness often experience very fast mood swings between depression and mania many times within a day. Children with mania are more likely to be irritable and prone to destructive tantrums than to be overly happy and elated. Mixed symptoms also are common in youths with bipolar disorder. Older adolescents who develop the illness may have more classic, adult-type episodes and symptoms.

Bipolar disorder in children and adolescents can be hard to tell apart from other problems that may occur in these age groups. For example, while irritability and aggressiveness can indicate bipolar disorder, they also can be symptoms of attention-deficit/hyperactivity disorder, conduct disorder, oppositional defiant disorder, or other types of mental disorders more common among adults such as schizophrenia. Students with bipolar disorder may be prone to drug use, which can aggravate symptoms. Furthermore, drug use alone can mock many of the symptoms of bipolar disorder, making an accurate diagnosis difficult.

For any illness, however, effective treatment depends on appropriate diagnosis. Children or adolescents with emotional and behavioral symptoms should be carefully evaluated by a mental health professional. In addition, adolescents with bipolar disorder are at a higher risk for suicide. Any child or adolescent who has suicidal feelings, talks about suicide, or attempts suicide should be taken seriously and should receive immediate help from a mental health professional.

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EDUCATIONAL IMPLICATIONS

Students may experience fluctuations in mood, energy, and motivation. These fluctuations may occur hourly, daily, in specific cycles, or seasonally. As a result, a student with bipolar disorder may have difficulty concentrating and remembering assignments, understanding assignments with complex directions, or reading and comprehending long, written passages of text. Students may experience episodes of overwhelming emotion such as sadness, embarrassment, or rage. They may also have poor social skills and have difficulty getting along with their peers.

Students may have fluctuations in cognitive abilities. They often have an impaired ability to plan, organize, concentrate, and use abstract reasoning. These students may experience heightened sensitivity to perceived criticism, are easily frustrated and may cry for no apparent reason, or they may be seemingly inconsolable when distressed. Teachers may notice how "irrational" these students seem to be, and that trying to reason with them often doesn't work. Most of the students with bipolar disorder experience extremely high levels of anxiety that interfere with their ability to logically assess a situation. Medications can cause a child to not be able to think clearly or they can lead to physically uncomfortable side effects that interfere with school performance.

INSTRUCTIONAL STRATEGIES AND CLASSROOM ACCOMMODATIONS

- Provide the student with recorded books as an alternative to self-reading when the student's concentration is low.
- Break assigned reading into manageable segments and monitor the student's progress, checking comprehension periodically.
- Devise a flexible curriculum that accommodates the sometimes rapid changes in the student's ability to perform consistently in school.
- When energy is low, reduce academic demands; when energy is high, increase opportunities for achievement.
- Identify a place where the student can go for privacy until he or she regains self-control.
- Create a plan for students to help them calm themselves, such as listening to soothing music, drawing, or walking. Be sure to practice the plan with the student in advance.
- Accommodate late arrival due to inability to awaken—this may be a medication side effect or a seasonal problem.
- Because transitions may be particularly difficult for these children, allow extra time for moving from one activity to another.
- Adjust the homework load to prevent the child from becoming overwhelmed.
- Allow children to discreetly attend to physical discomforts caused by medication side effects, for example a child's excessive thirst may lead to the need for frequent bathroom breaks.
- Ask parents or the student's physician about the student's mood cycles and adapt curriculum, activities, or classroom supports as needed.

—Some of these suggestions are from the Child and Adolescent Bipolar Foundation. For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

RESOURCES

Child & Adolescent Bipolar Foundation (CABF)
820 Davis Street, Suite 520
Evanston, IL 60201
847-492-8519• www.bpkids.org
Educates families, professionals, and the public about early-onset bipolar disorders

Depression and Bipolar Support Alliance (DBSA)
730 North Franklin Street, Suite 501
Chicago, IL 60610
312-642-0049 • 800-826-3632
www.dbsalliance.org
Support groups, patient support, patient assistance programs, advocacy, publications, referrals, book catalog

NAMI (National Alliance for the Mentally Ill)
3803 North Fairfax Drive Suite 100
Arlington, VA 22203
800-950-6264 • www.nami.org
Medical and legal information, helpline, research, publications

National Institute of Mental Health (NIMH)
Office of Communications
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
866-615-6464 • www.nimh.nih.gov
Free educational materials for professionals and the public

SAMHSA'S National Mental Health Information Center
PO Box 2345
Rockville, MD 20847
800-789-2647 • www.mentalhealth.samhsa.gov
Resources about child and adolescent mental health and links to other web-based materials for educators

Publications
The Bipolar Child: The Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder, by Demitri Papolos and Janice Papolos, Broadway, 2002.
www.bipolarchild.com

The Explosive Child: A New Approach for Understanding Easily Frustrated, Chronically Inflexible Children, by Ross W. Greene, HarperCollins, 2001.

Conduct Disorder

Symptoms or Behaviors

- Bullying or threatening classmates and other students
- Poor attendance record or chronic truancy
- Noncompliance
- History of frequent suspension
- Little empathy for others and a lack of appropriate feelings of guilt and remorse
- Low self-esteem that is masked by bravado
- Lying to peers or teachers
- Stealing from peers or the school
- Frequent physical fights; use of a weapon
- Destruction of property

About the Disorder

Children and adolescents with conduct disorder are highly visible, demonstrating a complicated group of behavioral and emotional problems. Serious, repetitive, and persistent misbehavior is the essential feature of this disorder.

These behaviors fall into four main groups: aggressive behavior toward people or animals, destruction of property, deceitfulness or theft, and serious violations of rules.

To receive a diagnosis of conduct disorder, a child or adolescent must have displayed three or more characteristic behaviors in the past 12 months. At least one of these behaviors must have been evident during the past six months.

Diagnosing conduct disorder can be a dilemma because children are constantly changing. This makes it difficult to discern whether the problem is persistent enough to warrant a diagnosis. In some cases, what appears to be conduct disorder may be a problem adjusting to acute or chronic stress. Many children with conduct disorder also have learning disabilities and about ⅓ may be depressed. Many children stop exhibiting behavior problems when they are treated for depression.

The U.S. Department of Health and Human Services estimates that between 6 and 16 percent of males and 2 to 9 percent of females under age 18 have conduct disorder that ranges in severity from mild to severe.

Other serious disorders of childhood and adolescence commonly associated with conduct disorder are attention-deficit/hyperactivity disorder (AD/HD) or oppositional defiant disorder (ODD). The majority of children and adolescents with conduct disorder may have life-long patterns of antisocial behavior and be at higher risk for a mood or anxiety disorder. But for many, the disorder may subside in later adulthood.

The social context in which a student lives (poverty or a high crime area, for example) may influence what we view as antisocial behavior. In these cases, a diagnosis of conduct disorder can be misapplied to individuals whose behaviors may be protective or exist within the cultural context.

A child with suspected conduct disorder needs to be referred for a mental health assessment. If the symptoms are mild, the student may be able to receive services and remain in the regular school environment. More seriously troubled children, however, may need more specialized educational environments.

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EDUCATIONAL IMPLICATIONS

Students with conduct disorder like to engage in power struggles. They often react badly to direct demands or statements such as: "You need to..." or "You must..." They may consistently challenge class rules, refuse to do assignments, and argue or fight with other students. This behavior can cause significant impairment in both social and academic functioning. They also work best in environments with high staff/student ratios, one-to-one situations, or self-contained programs when there is plenty of structure and clearly defined guidelines. Their frequent absences and their refusal to do assignments often leads to academic failure.

INSTRUCTIONAL STRATEGIES AND CLASSROOM ACCOMMODATIONS

- Make sure curriculum is at an appropriate level. When work is too hard, students become frustrated. When it is too easy, they become bored. Both reactions lead to problems in the classroom.
- Avoid "infantile" materials to teach basic skills. Materials should be age-appropriate, positive, and relevant to students' lives.
- Remember that praise is important but needs to be sincere.
- Consider the use of technology. Students with conduct disorder tend to work well on computers with active programs.
- Students with conduct disorder often do well in programs that allow them to work outside the school setting.
- Sometimes adults can subconsciously form and behaviorally express negative impressions of low-performing, uncooperative students. Try to monitor your impressions, keep them as neutral as possible, communicate a positive regard for the students, and give them the benefit of the doubt whenever possible.
- Remember that children with conduct disorder like to argue. Remain respectful, calm, and detached. Avoid power struggles and don't argue.
- Give the student options. Stay away from direct demands or statements such as: "You need to..." or "you must..."
- Avoid escalating prompts such as shouting, touching, nagging, or cornering the student.
- Establish clear classroom rules. Rules should be few, fair, clear, displayed, taught, and consistently enforced. Be clear about what is nonnegotiable.
- Have your students participate in the establishment of rules, routines, schedules, and expectations.
- Systematically teach social skills including anger management, conflict resolution strategies, and how to be assertive in an appropriate manner. For example, discuss strategies that the students may use to calm themselves when they feel their anger escalating. Do this when the students are calm.
- Maximize the performance of low-performing students through the use of individualized instruction, cues, prompting, the breaking down of academic tasks, debriefing, coaching, and providing positive incentives.
- Structure activities so the student with conduct disorder is not always left out or the last one picked.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

RESOURCES

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue NW
Washington, DC 20016-3007
202-966-7300 • www.aacap.org
Fact sheets on variety of topics and current research info

The Council for Exceptional Children (CEC)
1110 North Glebe Road, Suite 300
Arlington, VA 22201
888-232-7733 • www.cec.sped.org
Resources for professional development and information for educators

National Institute of Mental Health (NIMH)
Office of Communications
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
866-615-6464 • www.nimh.nih.gov
Free educational materials for professionals and the public

SAMHSA'S National Mental Health Information Center
PO Box 2345
Rockville, MD 20847
800-789-2647
www.mentalhealth.samhsa.gov
Resources about child and adolescent mental health and links to other web-based materials for educators

Publications
The Explosive Child: A New Approach for Understanding Easily Frustrated, Chronically Inflexible Children, by Ross W. Greene, HarperCollins, 2001.

- In addition to this publication, many of the websites listed above also recommend publications and have information about current research

Depression

Symptoms or Behaviors

- Sleeping in class
- Defiant or disruptive
- Refusal to participate in school activities
- Excessive tardiness
- Not turning in homework assignments, failing tests
- Fidgety or restless, distracting other students
- Isolating, quiet
- Frequent absences
- Failing grades
- Refusal to do school work and general non-compliance with rules
- Talks about dying or suicide
- Inability to concentrate
- Forgetfulness
- Overreaction to criticism
- Lack of energy or motivation

About the Disorder

All children feel sad or blue at times, but feelings of sadness with great intensity that persist for weeks or months may be a symptom of major depressive disorder or dysthymic disorder (chronic depression). These depressive disorders are more than "the blues"; they affect a young person's thoughts, feelings, behavior, and body, and can lead to school failure, alcohol or drug abuse, and even suicide. Depression is one of the most serious mental, emotional, and behavioral disorders suffered by children and teens.

Recent studies reported by the U.S. Department of Health and Human Services show that as many as 1 in every 33 children may have depression; among adolescents, the ratio may be as high as 1 in 8. Boys appear to suffer more depression in childhood. During adolescence, the illness is more prevalent among girls.

Depression that occurs in childhood is harder to diagnose, more difficult to treat, more severe, and more likely to reoccur than depression that strikes later in life. Depression also affects a child's development. A depressed child may get "stuck" and be unable to pass through the normal developmental stages.

The most common symptoms of depression in children and teens are:

- Sadness that won't go away
- Frequent fearfulness
- Extremely sensitive to failure or rejection
- Low self-esteem and guilt
- Hopelessness
- Irritability
- School avoidance
- Changes in eating and sleeping patterns
- Frequent complaints of aches and pains
- Thoughts of death or suicide
- Self-deprecating remarks
- Persistent boredom, low energy, or poor concentration
- Increased activity

Students who used to enjoy playing with friends may now spend most of their time alone, or they may start "hanging out" with a completely different peer group. Activities that were once fun hold no interest. They may talk about dying or suicide. Depressed teens may "self-medicate" with alcohol or drugs.

Children who cause trouble at home or at school may actually be depressed, although they may not seem sad. Younger children may pretend to be sick, be overactive, cling to their parents, seem accident prone, or refuse to go to school. Older children and teens often refuse to participate in family and social activities and stop paying attention to their appearance. They may also be restless, grouchy, or aggressive.

Most mental health professionals believe that depression has a biological origin. Research indicates that children have a greater chance of developing depression if one or both of their parents have suffered from this illness.

Educational Implications

Students experiencing depression may display a marked change in their interest in schoolwork and activities. Their grades may drop significantly due to lack of interest, loss of motivation, or excessive absences. They may withdraw and refuse to socialize with peers or participate in group projects.

Instructional Strategies and Classroom Accommodations

- Reduce some classroom pressures.
- Break tasks into smaller parts.
- Reassure students that they can catch up. Show them the steps they need to take and be flexible and realistic about your expectations. (School failures and unmet expectations can exacerbate the depression.)
- Help students use realistic and positive statements about their performance and outlook for the future.
- Help students recognize and acknowledge positive contributions and performance.
- Depressed students may see issues in black and white terms—all bad or all good. It may help to keep a record of their accomplishments that you can show to them occasionally.
- Encourage gradual social interaction (i.e., small group work).
- Ask parents what would be helpful in the classroom to reduce pressure or to motivate the child.
- Spend extra time with the student, when necessary, and assist the student with planning and time management.
- Reduce some classroom pressures by being flexible with deadlines or by providing notes or helping the student find a notetaker from the class.
- For disability-related reasons, students may need to miss class or even leave the room in the middle of the class. Your understanding and any assistance with filling in the gaps will help reduce the stress and anxiety related to getting behind or missing assignments.
- Allow the student to tape-record lectures.
- Clearly define (and put in writing) the course requirements, dates of exams, and when assignments are due; provide advance notice of any changes.
- When in doubt about how to assist the student, try asking what they need.
- Encourage school administration to identify personnel and resources to support teachers of students with depression.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

Resources

The Council for Exceptional Children (CEC)
1110 North Glebe Road, Suite 300
Arlington, VA 22201
888-232-7733 • www.cec.sped.org
Resources for professional development and information for educators

NAMI (National Alliance for the Mentally Ill)
3803 North Fairfax Drive Suite 100
Arlington, VA 22203
703-524-7600 • 800-950-6264 • www.nami.org
Medical and legal information, helpline, publications

National Institute of Mental Health (NIMH)
Office of Communications
6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663
866-615-6464 • www.nimh.nih.gov
Free educational materials for professionals and the public

SAMHSA'S National Mental Health Information Center
PO Box 2345
Rockville, MD 20847
800-789-2647
www.mentalhealth.samhsa.gov
Resources about child and adolescent mental health and links to other web-based materials for educators

SA/VE (Suicide Awareness Voices of Education)
8120 Penn Avenue South Suite 470
Bloomington, MN 55421
952-946-7998 • www.save.org
Resource information, materials for public awareness campaigns, reading lists for wide range of ages

Publications

- Both the NIMH and the SAMHSA websites have publications tabs that list several current and reliable publications. The other websites listed above also have extensive listings of resources.

Eating Disorders

Symptoms or Behaviors

- Perfectionistic attitude
- Impaired concentration
- Withdrawn
- All-or-nothing thinking
- Depressed mood or mood swings
- Self-deprecating statements
- Irritability
- Lethargy
- Fainting spells and dizziness
- Headaches
- Hiding food
- Avoiding snacks or activities that include food
- Frequent trips to the bathroom
- Refusing to eat or lying about how much was eaten
- Throwing up after meals
- Increased anxiety about weight
- Calluses or scars on the knuckle (from forced throwing up)
- Denial
- Over exercising

About the Disorder

Nearly all of us worry about our weight at some time in our lives. However, some individuals become so obsessed with their weight and the need to be thin that they develop an eating disorder. The two most common eating disorders are anorexia nervosa and bulimia nervosa.

Once seen mostly in teens and young adults, these disorders are increasingly seen in younger children as well. Children as young as four and five years of age are expressing the need to diet, and it's estimated that 40 percent of nine year-olds have already dieted. Eating disorders are not limited to girls and young women—between 10 and 20 percent of adolescents with eating disorders are boys. Possible causes include feeling stressed out or upset about something in their life or feeling a need to be "in control."

Individuals with anorexia fail to maintain a minimally normal body weight. They engage in abnormal eating behavior and have excessive concerns about food. They are intensely afraid of even the slightest weight gain, and their perception of their body shape and size is significantly distorted. Many individuals with anorexia are compulsive and excessive about exercise. Children and teens with this disorder tend to be perfectionists and overachieve. In teenage girls with anorexia, menstruation may cease, leading to the same kind of bone loss suffered by menopausal women.

Children and teens with bulimia go on eating binges during which they compulsively consume abnormally large amounts of food within a short period of time. To avoid weight gain, they engage in inappropriate compensatory behavior, including fasting, self-induced vomiting, excessive exercise, and the use of laxatives, diuretics, and enemas.

Athletes such as wrestlers, dancers, or gymnasts may fall into disordered eating patterns in an attempt to stay thin or "make their weight." This can lead to a full-blown eating disorder.

Adolescents who have eating disorders are obsessed with food. Their lives revolve around thoughts and worry about their weight and their eating. Youth who suffer from eating disorders are at risk for alcohol and drug use as well as depression.

If you suspect a student may be suffering from an eating disorder, refer that student immediately for a mental health assessment. Without medical intervention, an individual with an eating disorder faces serious health problems and, in extreme cases, death.

EDUCATIONAL IMPLICATIONS

Students with eating disorders may look like model students, often leading the class and being very self-demanding. Others may show poor academic performance. When students with eating disorders are preoccupied with body image and controlling their food intake, they may have short attention spans and poor concentration. These symptoms may also be due to a lack of nutrients from fasting and vomiting. These students often lack the energy and drive necessary to complete assignments or homework.

INSTRUCTIONAL STRATEGIES AND CLASSROOM ACCOMMODATIONS

- Stress acceptance in your classroom; successful people come in all sizes and shapes.
- Watch what you say. Comments like "You look terrible," "What have you eaten today?" or "I wish I had that problem" are often hurtful and discouraging.
- Stress progress, not perfection.
- Avoid pushing students to excel beyond their capabilities.
- Avoid high levels of competition.
- Reduce stress where possible by reducing assignments or extending deadlines.
- Assist student in developing a strong sense of identity based on their strengths and abilities rather than appearance.
- Use "I" statements like, "I'm concerned about you because you refuse to eat breakfast or lunch." Or, "It makes me afraid to hear that you are vomiting."
- Express continued support.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

RESOURCES

Eating Disorders Resources/ Gürze Books
PO Box 2238
Carlsbad, CA 92018
760-434-7533 • 800-756-7533
www.bulimia.com
Book lists, fact sheets, links to other useful sites

National Association of Anorexia Nervosa and Associated Disorders
ANAD School Guidelines Program
To request a free copy:
ANAD
P.O. Box 640 Naperville, IL 60566
or call 630-577-1333
Helpline 630-577-1330
www.anad.org anadhelp@anad.org
Hotline counseling, referrals, information, and advocacy

National Eating Disorders Association
603 Stewart Street, Suite 803
Seattle, WA 98101
206-382-3587 Helpline: 800-931-2237
www.nationaleatingdisorders.org
Educational resources on prevention for schools, health professionals, and individuals

Publications

Body Image, Eating Disorders, and Obesity in Youth, edited by Kevin Thompson and Linda Smolak, American Psychological Association, 2008.

Children and Teens Afraid to Eat: Helping Youth in Today's Weight-Obsessed World, by Frances Berg, Gürze Books, 2001.

Healthy Body Image: Teaching Kids to Eat and Love Their Bodies Too! (2nd ed.), by Kathy Kater, National Eating Disorders Association 2005.

How Did This Happen?: A Practical Guide to Understanding Eating Disorders for Coaches, Parents, and Teachers, by the Institute for Research and Education HealthSystem Minnesota, 1999.

Real Kids Come in All Sizes: Ten Essential Lessons to Build Your Child's Body Esteem, by Kathy Kater, Broadway Books, 2004.

Obsessive-Compulsive Disorder (OCD)

Symptoms or Behaviors

- Unproductive time retracing the same word or touching the same objects over and over
- Erasing sentences or problems repeatedly
- Counting and recounting objects, or arranging and rearranging objects on their desk
- Frequent trips to the bathroom
- Poor concentration
- School avoidance
- Anxiety or depressed mood
- Is preoccupied
- Needs constant reassurance
- Perseverates

About the Disorder

Obsessive-compulsive disorder (OCD) is an illness that causes people to have unwanted thoughts (obsessions) and to repeat certain behaviors (compulsions) over and over again. OCD has a neurobiological basis. This means it is a biological disease of the brain, just as diabetes is a biological disease of the pancreas. OCD is not caused by bad parenting, poverty, or other environmental factors.

Doctors once believed that obsessive-compulsive disorder was a rare condition, but it's now known to be one of the more common mental illnesses. Recent studies show more than 3 million Americans have obsessive-compulsive disorder. OCD often begins during adolescence or early childhood. About ⅓ to ½ of adult cases began in childhood, and it affects males and females equally.

Students with OCD may have obsessive thoughts and impulses that are recurrent, persistent, intrusive, and senseless—they may, for instance, worry about contamination from germs. They may also perform repetitive behaviors in a ritualistic manner—for example, they may engage in compulsive hand washing. An individual with OCD will often perform these rituals, such as hand washing, counting, or cleaning, in an effort to neutralize the anxiety caused by their obsessive thoughts. Most students with OCD know that their obsessions and compulsions make no sense, but they can't ignore or stop them. Eventually, these behaviors and thoughts may take up more and more of their day, making it virtually impossible to lead a normal life.

OCD is sometimes accompanied by other disorders, such as substance abuse, attention-deficit/hyperactivity disorder, eating disorders, or another anxiety disorder. When a student has another disorder, the OCD is more difficult to treat or diagnose. Symptoms of OCD may coexist or be part of a spectrum of other brain disorders such as Tourette's disorder (see *An Educator's Guide to Children's Mental Health* pages 66–67) or autism (see *An Educator's Guide to Children's Mental Health* pages 58–59).

The exact cause of obsessive-compulsive disorder is not known. Some researchers believe that its cause is biological while others think that the cause may be related to both biological and environmental factors. Brain imaging studies suggest that an insufficient level of serotonin, one of the brain's chemical messengers, may contribute to obsessive-compulsive disorder. People with obsessive-compulsive disorder who take medications that enhance the action of serotonin often show great improvement. Research done at the National Institute of Mental Health suggests that OCD in some individuals may be an auto-immune response triggered by antibodies produced to counter strep infection. This phenomenon is known as PANDAS.

Students with OCD often experience high levels of anxiety and shame about their thoughts and behavior. Their thoughts and behaviors are so time consuming that they interfere with everyday life.

Common obsessions are:

- Aggression
- Sex
- Loss
- Orderliness and symmetry
- Doubt
- Fear of dirt or germs (contamination)
- Fear of harming a friend or family member
- Fear of thinking evil or sinful thoughts

Common compulsive behaviors are:

- Cleaning and washing
- Hoarding or saving
- Touching
- Avoiding
- Seeking reassurance
- Checking
- Counting
- Repeating
- Ordering or arranging

Students who show symptoms of OCD should be referred for a mental health assessment. Behavior therapy and pharmacological treatment have both proven successful in treating this disorder.

Minnesota Association for Children's Mental Health • MACMH
165 Western Avenue North, Suite 2, Saint Paul , MN 55102 • www.macmh.org • info@macmh.org • 651-644-7333

EDUCATIONAL IMPLICATIONS

Compulsive activities often take up so much time that students can't concentrate on their schoolwork, leading to poor or incomplete work and even school failure. In addition, many students with OCD find verbal communication very difficult. Students with OCD may feel isolated from their peers, in part because their compulsive behavior leaves them little time to interact or socialize with their classmates. They may avoid school because they are worried that teachers or their peers will notice their odd behaviors. If asked "why" a behavior is repeated, many students say, "It doesn't feel right."

INSTRUCTIONAL STRATEGIES AND CLASSROOM ACCOMMODATIONS

- Try to accommodate situations and behaviors that the student has no control over.
- Educate the student's peers about OCD.
- Be attentive to changes in the student's behavior.
- Try to redirect the student's behavior. This works better than using consequences.
- Allow the student to do assignments such as oral reports in writing.
- Allow the student to receive full credit for late work.
- Allow the student to redo assignments to improve scores or final grades.
- Consider a Functional Behavioral Assessment (FBA). Understanding the purpose or function of the student's behaviors will help you respond with effective interventions and strategies. For example, a punitive approach or punishment may increase the student's sense of insecurity and distress and increase the undesired behavior.
- Post the daily schedule in a highly visible place so the student will know what to expect.
- Using diplomacy and with the student's consent, educate the student's peers about OCD.
- Keep transitions to a minimum, and prepare the student for them when possible. Allowing time before and after transitions will help the student regain concentration.
- Consider the use of technology. Many students struggling with OCD will benefit from easy access to appropriate technology, which may include applications that can engage student interest and increase motivation (e.g., computer-assisted instruction programs, CD-ROM demonstrations, as well as videotape presentations).

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

RESOURCES

Anxiety Disorders Association of America
8730 Georgia Avenue, Suite 600
Silver Spring, MD 20910
240-485-1001 • www.adaa.org
Offers publications, referrals to therapists, self-help groups

International OCD Foundation, Inc.
112 Water Street, Suite 501
Boston, MA 02109
617-973-5801• www.ocfoundation.org
Free brochures, referrals, newsletter, support groups

NAMI (National Alliance for the Mentally Ill)
3803 North Fairfax Drive Suite 100
Arlington, VA 22203
703-524-7600 • 800-950-6264
www.nami.org
Medical and legal information, helpline, research, and publications

National Institute of Mental Health (NIMH)
Office of Communications
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
866-615-6464 • www.nimh.nih.gov
Educational materials for professionals and the public

SAMHSA'S National Mental Health Information Center
PO Box 2345
Rockville, MD 20847
800-789-2647 • www.mentalhealth.samhsa.gov
Resources about child and adolescent mental health and links to other web-based materials for educators

Publications

- Both the NIMH and the SAMHSA websites have publications tabs that lead to several current and reliable publications. The other websites listed above also have extensive listings of resources.

Oppositional Defiant Disorder (ODD)

Symptoms or Behaviors

- Sudden unprovoked anger
- Arguing with adults
- Defiance or refusal to comply with adults' rules or requests
- Deliberately annoying others
- Blaming others for their own misbehavior
- Easily annoyed by others
- Being resentful and angry
- Is spiteful or vindictive
- Frequent temper tantrums or outbursts
- Speaking harshly or unkind when upset

About the Disorder

Oppositional defiant disorder (ODD) is diagnosed when a child displays a persistent or consistent pattern of defiance, disobedience, and hostility toward various authority figures, including parents, teachers, and other adults. These behaviors cause significant difficulties with parents, friends, and teachers. Oppositional defiant disorder is sometimes a precursor of conduct disorder. Conduct disorder, however, involves more deliberate aggression, destruction, deceit, and serious rule violations, such as staying out all night or chronic school truancy. Students with ODD seem angry much of the time. They are quick to blame others for mistakes and act in negative, hostile, and vindictive ways. All students exhibit these behaviors at times, but in those with ODD, these behaviors occur more frequently than is typical in individuals of comparable age and level of development.

Students with ODD generally have poor peer relationships. They often display behaviors that alienate them from their peers. In addition, these students may have an unusual response to positive reinforcement or feedback. For instance, when given some type of praise they may respond by destroying or sabotaging the project that they were given recognition for. Oppositional defiant disorder usually does not occur alone—50 to 65 percent of children with ODD also have attention-deficit/hyperactivity disorder. ODD also commonly occurs with anxiety and depressive disorders as well as with learning disabilities.

The causes of ODD are unknown, but studies of twins and adopted children suggest that conduct disorder has both biological (including genetic) and psychosocial components The quality of the child's family life seems to be an important factor in the development of ODD. Certain environmental factors in the family may increase the risk of disruptive behavior disorders including: poor parenting skills, domestic violence, physical abuse, sexual abuse, neglect, poverty, and substance abuse by parents or caregivers. Some students develop ODD as a result of stress and frustration from divorce, death, loss of family, or family disharmony. ODD may also be a way of dealing with depression or the result of inconsistent rules and behavior standards.

If not recognized and corrected early, oppositional and defiant behavior can become ingrained. Other mental health disorders may, when untreated, lead to ODD. For example, a student with AD/HD may exhibit signs of ODD due to the experience of constant failure at home and school.

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165 Western Avenue North, Suite 2, Saint Paul , MN 55102 • www.macmh.org • info@macmh.org • 651-644-7333

EDUCATIONAL IMPLICATIONS

Students with ODD may consistently challenge class rules, refuse to do assignments, and argue or fight with other students. This behavior can cause significant impairment in both social and academic functioning. Stubbornness and testing of limits are common. However, the *constant* testing of limits and arguing can create a stressful classroom environment. As children with ODD progress in school, they experience increasing peer rejection due to their poor social skills and aggression. These children may be more likely to misinterpret their peers' behavior as hostile, and they lack the skills to solve social conflicts. Students with ODD are more likely to resort to aggressive physical actions rather than verbal responses.

INSTRUCTIONAL STRATEGIES AND CLASSROOM ACCOMMODATIONS

- Remember that students with ODD tend to create power struggles. Try to avoid these verbal exchanges. State your position clearly and concisely.
- Not all acts of defiance must be engaged—know which ones to overlook.
- Establish a rapport with the child who has ODD. If this child perceives you as reasonable and fair, you'll be able to work more effectively with him or her.
- Give two choices when decisions are needed. State them briefly and clearly.
- Establish clear classroom rules. Be clear about what is nonnegotiable.
- Post the daily schedule so students know what to expect.
- Praise students when they respond positively.
- Make sure academic work is at the appropriate level. When work is too hard, students become frustrated. When it is too easy, they become bored.
- Avoid "infantile" materials to teach basic skills. Materials should be positive and relevant to students' lives.
- Pace instruction. When students with ODD have completed a designated amount of a non-preferred activity, reinforce their cooperation by allowing them to do something they prefer or find more enjoyable or less difficult.
- Allow sharp demarcation to occur between academic periods, but hold transition times between periods to a minimum.
- Systematically teach social skills, including anger management, conflict resolution strategies, and how to be appropriately assertive. Practice self-calming strategies (when the students are calm) for students to use when they feel their anger rising.
- Provide consistency, structure, and clear consequences for the student's behavior.
- Select material that encourages student interaction. Students with ODD need to learn to talk to their peers and to adults in an appropriate manner. However, all cooperative learning activities must be carefully structured.
- Minimize downtime and plan transitions carefully. Students with ODD do best when kept busy.
- Maximize the performance of low-performing students through the use of individualized instruction, cues, prompting, the breaking down of academic tasks, debriefing, coaching, and providing positive incentives.
- Allow students to redo assignments to improve their score or final grade.
- Structure activities so a student with ODD is not always left out or picked last.
- Ask parents what works at home.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

RESOURCES

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue NW
Washington, DC 20016-3007
202-966-7300
www.aacap.org
Information on child and adolescent psychiatry, fact sheets, current research, practice guidelines

Anxiety Disorders Association of America
8730 Georgia Avenue, Ste 600
Silver Spring, MD 20910
240-485-1001 • www.adaa.org
Offers publications, referrals to therapists, self-help groups

National Institute of Mental Health (NIMH)
Office of Communications
6001 Executive Boulevard,
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Free educational materials for professionals and the public

SAMHSA'S National Mental Health Information Center
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800-789-2647
www.mentalhealth.samhsa.gov
Resources about child and adolescent mental health and links to other web-based materials for educators

- The NIMH and the SAMHSA websites each have publications tabs that lead to several current and reliable publications. The other websites listed above also have extensive listings of resources.

MINNESOTA ASSOCIATION FOR CHILDREN'S MENTAL HEALTH • MACMH
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Pervasive Development Disorder (PDD) & Autism Spectrum Disorders

Symptoms or Behaviors

- Repetitive, nonproductive movement like rocking in one position or walking around the room
- Trailing a hand across surfaces such as chairs, walls, or fences as the student passes. Great resistance to interruptions of such movements
- May rarely speak or may repeat the same phrases over and over
- May repeat what is said to them (echolalia)
- Avoids eye contact
- Self injurious

About the Disorder

PDD, or pervasive developmental disorders, includes Rett's syndrome, childhood disintegrative disorder, and Asperger's Syndrome (see *An Educator's Guide to Children's Mental Health* page 40). Pervasive developmental disorder not otherwise specified (PDD-NOS) also belongs to this category.

Autistic disorder also belongs to the category of disorders known as PDD. According to the U. S. Dept. of Health and Human Services, 1 in 1,000 to 1 in 1,500 have autism or a related condition. Autism appears in the first three years of life and is four times more prevalent in boys than girls. It occurs in all racial, ethnic, and social groups. Autism is a neurologically based developmental disorder; its symptoms range from mild to severe and generally last throughout a person's life. The disorder is defined by a set of behaviors, but because a child can exhibit any combination of the behaviors in any degree of severity, no two children with autism will act the same.

The terminology can be confusing because autism is used as an umbrella term for many forms of PDD. This means that a student with Asperger's Syndrome may be described as having a mild form of autism, or a student with PDD-NOS may be said to have autistic-like tendencies. Both are considered to be autism spectrum disorders.

Although the American Psychiatric Association classifies all forms of PDD as "mental illness," these conditions often affect children in much the same way a developmental disability would. For example, in the state of Minnesota, autism and Rett's are considered developmental disabilities (DD), which means that children with these conditions are eligible for case management and other DD services. Children with Asperger's, childhood disintegrative disorder, or PDD-NOS may or may not be eligible for these services.

Diagnosis of autism and other forms of PDD is based on observation of a child's behavior, communication, and developmental level. According to the Autism Society of America, development may appear normal in some children until age 24–30 months; in others, development is more unusual from early infancy. Delays may be seen in the following areas:

- **Communication** Language develops slowly or not at all. Children use gestures instead of words or use words inappropriately. Parents may also notice a short attention span.
- **Social Interaction** Children prefer to be alone and show little interest in making friends. They are less responsive to social cues such as eye contact.
- **Sensory Impairment** Children may be overly sensitive or under-responsive to touch, pain, sight, smell, hearing, or taste and show unusual reactions to these physical sensations.
- **Play** Children do not create pretend games, imitate others, or engage in spontaneous or imaginative play.
- **Behavior** Children may exhibit repetitious behavior such as rocking back and forth or head banging. They may be very passive or overactive. Lack of common sense and upsets over small changes in the environment or daily routine are common. Some children are aggressive and self-injurious. Some are severely delayed in areas such as understanding personal safety.

A child who seem to have an autistic disorder should be evaluated by a multidisciplinary team, which may include a neurologist, psychiatrist, developmental pediatrician, a learning specialist, and a speech/language therapist.

Early intervention is important because the brain is more easily influenced in early childhood. Children with autism respond well to a highly structured, specialized education and behavior modification program tailored to their individual needs. Children with autism range from above average to below average intelligence. Schools need to seek the assistance of trained professionals in developing a curriculum that will meet the child's specific needs. Most states have technical assistance, consultation, and training available to educators. Contact the special education office in your state department of education.

Good communication and collaboration between the school personnel and parents is very important and can lead to increased success.

EDUCATIONAL IMPLICATIONS

Each child's behavior is unique. Parents and professionals who are familiar with the student are the best source of information. In general, children with autism usually appear to be in their own world and seem oblivious to classroom materials, people, or events. But a child's attention to you or the material you are presenting may be quite high, despite appearances. Teaching must be direct and personalized in all areas. This includes social skills, communication, and academic subject matter as well as routines like standing in line. Patience, firmness, consistency, and refusing to take behaviors personally are the keys to success.

INSTRUCTIONAL STRATEGIES AND CLASSROOM ACCOMMODATIONS

- Use a team approach to curriculum development and classroom adaptations. Occupational therapists and speech-language pathologists can be of enormous help, and evaluations for assistive/augmentative technology should be done early and often.
- To teach basic skills, use materials that are age-appropriate, positive, and relevant to students' lives.
- Maintain a consistent classroom routine. Objects, pictures, or words can be used as appropriate to make sequences clear and to help students learn independence.
- Avoid long strings of verbal instruction. Use written checklists, picture charts, or object schedules instead. If necessary, give instructions a step at a time.
- Minimize visual and auditory distractions. Modify the environment to meet the student's sensory integration needs; some stimuli may actually be painful to a student. An occupational therapist can help identify sensory problems and suggest needed modifications.
- Help students develop functional learning skills through direct teaching. For example, teach them to work left to right and top to bottom.
- Help students develop social skills and play skills through direct teaching. For example, teach them to understand social language, feelings, words, facial expressions, and body language.
- Many children with autism are good at drawing, art, and computer programming. Encourage these areas of talent.
- Students who get fixated on a subject can be motivated by having "their" topic be the content for lessons in reading, science, math, and other subjects.
- If the student avoids eye contact or looking directly at a lesson, allow them to use peripheral vision to avoid the intense stimulus of a direct gaze. Teach students to watch the forehead of a speaker rather than the eyes if necessary.
- Some autistic children do not understand that words are used to communicate with someone who has a "separate" brain. Respond to the words that are said and teach techniques for repairing "broken" communication. Consult your school's speech language pathologist for more information about your student's communication.
- Help students learn to apply their learning in different situations through close coordination with parents and other professionals who work with the student.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

RESOURCES

Autism Research Institute
4182 Adams Avenue
San Diego, CA 92116
866-366-3361 • www.autism.com
Provides research-related information, diagnostic checklists, articles, and many links

Autism Society of America
4340 East-West Highway Suite 350
Bethseda, MD 20814
301-657-0881 • 800-328-8476
www.autism-society.org
Advocacy, educational information, referrals

Publications

The Hidden Curriculum: Practical Solutions for Understanding Unstated Rules in Social Situations, by Brenda Smith Myles, Melissa L. Trautman, and Ronda L. Schelvan, Autism Asperger Publishing Co., 2004. Available at www.asperger.net/bookstore

Pervasive Developmental Disorders: Diagnosis, Options, and Answers, by Mitzi Waltz, Future Horizons, 2003.

Right from the Start: Behavioral Intervention for Young Children with Autism, by Sandra L. Harris and Mary Jane Weiss, Woodbine House, 1998.

Videos

Autism Spectrum Disorders and the SCERTS™ Model: A Comprehensive Educational Approach, developed by Barry M. Prizant, Brookes Publishing Co. Video booklet also available.

Visual Supports in the Classroom for Students with Autism and Related Pervasive Developmental Disabilities, by Jennifer Savner, Autism Asperger Publishing Co. (AAPC), 1999. Available from www.asperger.net/bookstore

Post-Traumatic Stress Disorder (PTSD)

Symptoms or Behaviors

- Flashbacks, hallucinations, nightmares, recollections, re-enactment, or repetitive play referencing the event
- Emotional distress from reminders of the event
- Physical reactions from reminders of the event, including headache, stomachache, dizziness, or discomfort in another part of the body
- Fear of certain places, things, or situations that remind them of the event
- Avoidance
- Denial of the event or inability to recall important aspects of it
- A sense of a foreshortened future
- Difficulty concentrating and easily startled
- Self-destructive behavior
- Irritability
- Impulsiveness
- Anger and hostility
- Depression and overwhelming sadness or hopelessness

About the Disorder

Children who are involved in or who witness a traumatic event that involved intense fear, helplessness, or horror are at risk for developing post-traumatic stress disorder (PTSD). The event is usually a situation where someone's life has been threatened or severe injury has occurred, such as a serious accident, abuse, violence, or a natural disaster. In some cases, the "event" may be a re-occurring trauma, such as continuing domestic violence.

After the event, children may initially be agitated or confused. Eventually this develops into denial, fear, and even anger. They may withdraw and become unresponsive, detached, and depressed. Often they become emotionally numb, especially if they have been subjected to repeated trauma. They may lose interest in things they used to enjoy.

Students with PTSD often have persistent frightening thoughts and memories of the experience. They may re-experience the trauma through flashbacks or nightmares. These occur particularly on the anniversary of the event or when a child is reminded of it by an object, place, or situation. During a flashback, the child may actually lose touch with reality and re-enact the event.

PTSD is diagnosed if the symptoms last more than one month. Symptoms usually begin within three months of the trauma, but occasionally not until years after; they may last from a few months to years. Early intervention is essential, ideally immediately following the trauma. If the trauma is not known, then treatment should begin when symptoms of PTSD are first noticed. Some studies show that when children receive treatment soon after a trauma, symptoms of PTSD are reduced.

A combination of treatment approaches is often used for PTSD. Various forms of psychotherapy have been shown to be effective, including cognitive-behavioral, family, and group therapies. To help children express their feelings, play therapy and art therapy can be useful. Exposure therapy is a method where the child is guided to repeatedly re-live the experience under controlled conditions and to eventually work through and finally cope with their trauma. Medication may also be helpful in reducing agitation, anxiety, depression, or sleep disturbances.

Support from family, school, friends, and peers can be an important part of recovery for children with PTSD. With sensitivity, support, and help from mental health professionals, a child can learn to cope with their trauma and go on to lead a healthy and productive life.

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EDUCATIONAL IMPLICATIONS

The severity and persistence of symptoms vary greatly among children affected by PTSD. Their symptoms may come and go for no apparent reason, and their mood may change drastically. Such variability can create a perception that there are no explanations for behavior or that they are unpredictable—this can make it difficult for teachers to respond with helpful interventions. Children with PTSD will often regress and be unable to perform previously acquired skills, even basic functions like speech. Some children may act younger than their age and/or become clingy, whiny, impatient, impulsive, or aggressive. Their capacity for learning may also be decreased. These children may also have difficulty concentrating, become preoccupied, or they may become easily confused. They may also lose interest in activities, become quiet and/or sad, and avoid interaction with other children.

INSTRUCTIONAL STRATEGIES AND CLASSROOM ACCOMMODATIONS

- Try to establish a feeling of safety and acceptance within the classroom. Greet the child warmly each day, make eye contact, and let the child know that he/she is valued and that you care. You can make a tremendous impact on a child by what you say (or don't say); a child's self-perception often comes from the actions of others.
- Don't hesitate to interrupt activities and avoid circumstances that are upsetting or re-traumatizing for the child. For example, a move or assignment about a natural disaster may trigger memories of the traumatic event the student has been through. Watch for increased symptoms during or following certain situations, and try to prevent these situations from being repeated.
- Provide a consistent, predictable routine through each day as much as possible. A regular pattern will help re-establish and maintain a sense of normalcy and security in the child's life. If the schedule does change, try to explain beforehand what will be different and why. Consistency shows children that you have control of the situation; they may become anxious if they sense that you are disorganized or confused. However, allow children choices within this pattern wherever possible. This will give them some sense of control and help to build self-confidence.
- Try to eliminate stressful situations from your classroom and routines: make sure your room arrangement is simple and easy to move through; create a balance of noisy versus quiet activity areas and clearly define them; and plan your day or class period so that it alternates between active and quiet activities (being forced to maintain the same level of activity for too long may cause the child to become restless and anxious).
- If a child wants to tell you about the traumatizing incident, do not respond by encouraging the child to forget about it. PTSD symptoms may be a result of trying to do just that. This request also minimizes the importance of the trauma and children may feel a sense of failure if they can't forget. Just listening can be very assuring.
- Reassure children that their symptoms and behaviors are a common response to a trauma and they are not "crazy" or bad.
- Incorporate large-muscle activities into the day. Short breaks involving skipping, jumping, stretching, or other simple exercises can help relieve anxiety and restlessness. For young children, you can also use games like London Bridge or Ring around the Rosy.
- For some students, any physical contact by a teacher or peer may be misinterpreted and result in an aggressive or emotional response.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

RESOURCES

National Center for PTSD
802-296-6300
Lifeline: 800-273-8255
www.ptsd.va.gov
ncptsd@va.gov
Links to interdisciplinary index database, publications, books, research quarterly, clinical quarterly, assessment instruments

National Institute of Mental Health (NIMH)
Office of Communications
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
866-615-6464
www.nimh.nih.gov
Free educational materials for professionals and the public

SAMHSA'S National Mental Health Information Center
PO Box 2345
Rockville, MD 20847
800-789-2647
www.mentalhealth.samhsa.gov
Resources about child and adolescent mental health and links to other web-based materials for educators

Publications
- The NIMH and the SAMHSA websites each have publications tabs that lead to many current and reliable publications. The other websites listed above also have extensive listings of resources.

Reactive Attachment Disorder (RAD)

Symptoms or Behaviors

- Destructive to self and others
- Absence of guilt or remorse
- Refusal to answer simple questions
- Denial of accountability—always blaming others
- Poor eye contact
- Extreme defiance and control issues
- Stealing
- Lack of cause and effect thinking
- Mood swings
- False abuse allegations
- Sexual acting out
- Inappropriately demanding or clingy
- Poor peer relationships
- Abnormal eating patterns
- Preoccupied with gore, fire
- Toileting issues
- No impulse control
- Chronic nonsensical lying
- Unusual speech patterns
- Bossy—needs to be in control
- Manipulative—superficially charming and engaging

About the Disorder

The essential feature of reactive attachment disorder (RAD) is a markedly disturbed and developmentally inappropriate social relatedness with peers and adults in most contexts. RAD begins before age five and is associated with grossly inadequate or pathological care that disregards the child's basic emotional and physical needs. In some cases, it is associated with repeated changes of a primary caregiver.

The term "attachment" is used to describe the process of bonding that takes place between infants and caregivers in the first two years of life, and most important, the first nine months of life. When a caregiver fails to respond to a baby's emotional and physical needs, responds inconsistently, or is abusive, the child may lose the ability to form meaningful relationships and the ability to trust.

Children with RAD haven't bonded and are unable to trust. They have learned that the adults in their lives are untrustworthy. They have developed a protective shell around their emotions, isolating themselves from dependency on adult caregivers. In the first few years of life they have learned that the world is a scary place, and that they cannot rely on anyone else to protect them.

Conventional parenting techniques do not work with these children, neither do traditional therapies, especially since most therapies are based on the child's ability to form a trusting relationship with the therapist. Natural consequences seem to work better than behavioral methods such as lectures or charts. Structure is important, but only when combined with nurturing.

The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* describes two types of RAD: "inhibited" and "disinhibited." Inhibited RAD is the persistent failure to initiate and respond to most social interactions in a developmentally appropriate way. Disinhibited RAD is the display of indiscriminate sociability or a lack of selectivity in the choice of attachment figures (excessive familiarity with relative strangers by making requests and displaying affection).

Aggression, either related to a lack of empathy or poor impulse control, is a serious problem with these students. They have difficulty understanding how their behavior affects others. They often feel compelled to lash out and hurt others, including animals, smaller children, peers, and siblings. This aggression is frequently accompanied by a lack of emotion or remorse.

Children with RAD may show a wide range of emotional problems such as depressive and anxiety symptoms or safety-seeking behaviors. To feel safe these children may seek any attachments—they may hug virtual strangers, telling them, "I love you." At the same time, they have an inability to be genuinely affectionate with others or develop deep emotional bonds. Younger students may display "soothing behaviors" such as rocking and head banging, or biting, scratching, or cutting themselves. Older students may be superficially charming and engaging, shallow, manipulative, grandiose, jealous, and oversensitive to rejection. Teachers may also notice signs of self injury and risk-taking behaviors. These symptoms will increase during times of stress or threat.

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EDUCATIONAL IMPLICATIONS

Many of these students will have developmental delays in several domains. The caregiver-child relationship provides the vehicle for developing physically, emotionally, and cognitively. In this relationship, the child learns language, social behaviors, and other important behaviors and skills. The lack of these experiences can result in delays in motor, language, social, and cognitive development.

The student may have difficulty completing homework. They often fail to remember assignments and/or have difficulty understanding assignments with multiple steps. They may have problems with comprehension, especially long passages of text. Fluctuations in energy and motivation may be evident, and they may often have difficulty concentrating.

The student with RAD often feels a need to be in control and may exhibit bossy, argumentative, and/or defiant behavior, which may result in frequent classroom disruptions and power struggles with teachers.

INSTRUCTIONAL STRATEGIES AND CLASSROOM ACCOMMODATIONS

- Consider a Functional Behavioral Assessment (FBA). Understanding the purpose or function of the student's behaviors will help you respond with effective interventions. For example, a punitive approach or punishment may increase the student's sense of insecurity and distress and consequently increase the undesired behavior.
- Be predictable, consistent, and repetitive. Students with RAD are very sensitive to changes in schedules, transitions, surprises, and chaotic social situations. Being predictable and consistent will help the student to feel safe and secure, which in turn will reduce anxiety and fear.
- Model and teach appropriate social behaviors. One of the best ways to teach these students social skills is to model the behavior and then narrate for the child what you are doing and why.
- Avoid power struggles. When intervening, present yourself in a matter-of-fact style. This reduces the student's desire to control the situation. When possible use humor. If students can get an emotional response from you, they will feel as though they have hooked you into the struggle for power and they are winning.
- Address comprehension difficulties by breaking assigned reading into manageable segments. Monitor progress by periodically checking if the student is understanding the material.
- Break assignments into manageable steps; this helps to clarify complex, multi-step directions.
- Identify a place for the student to go to regain composure during times of frustration and anxiety. Do this only if the student is capable of using this technique and there is an appropriate supervised location.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

RESOURCES

Association for Treatment and Training in the Attachment of Children (ATTACh)
PO Box 533
40 Cleveland
Lake Villa, IL 60046
866-453-8224 • www.attach.org
International coalition of professionals and families concerned with RAD

Families by Design/ Nancy Thomas Parenting
PO Box 2812
Glenwood Springs, CO 81602
970-984-2222
www.attachment.org
Articles, referrals, training, publications on holding therapy, therapeutic parenting, and more

www.RADKID.org
Online resource center for RAD and related mental health issues

Publications

Attachment, Trauma, and Healing: Understanding and Treating Attachment Disorder in Children and Families, by Terry M. Levy and Michael Orlans, The Child Welfare League of America, 1998.

Children Who Shock and Surprise: A Guide to Attachment Disorders, by Elizabeth Randolph, Tapestry Books, 1999.

Parenting the Hurt Child: Helping Adoptive Families Heal and Grow, by Gregory Keck and Regina M. Kupecky, Pinon Press, 2002.

Schizophrenia

Symptoms or Behaviors

- Confused thinking (for example, confusing what happens on television with reality)
- Vivid and bizarre thoughts and ideas
- Hallucinations: Hearing, seeing, feeling, or smelling things that are not real or present
- Delusions: Having beliefs that are fixed and false (i.e., believing that aliens are out to kill them because of information that they have)
- Severe anxiety and fearfulness
- Extreme moodiness
- Severe problems in making and keeping friends
- Feelings that people are hostile and "out to get them"
- Odd behavior, including behavior resembling that of a younger child
- Disorganized speech
- Lack of motivation

About the Disorder

Schizophrenia is a medical illness that causes a person to think and act strangely. It is rare in children less than 10 years of age and has its peak age of onset between the ages of 16 and 25. This disorder affects about 1 percent of the population, and thus middle and high school teachers will likely see children who are in the early stages of the illness. Schizophrenia can be difficult to recognize in its early phases, and the symptoms often are blurred with other psychiatric disorders.

Schizophrenia usually comes on gradually in what is known as the prodrome, and teachers are often the first to notice the early signs. The early signs are usually non-specific. For example, students who once enjoyed friendships with classmates may seem to withdraw into a world of their own. They may say things that don't make sense and talk about strange fears and ideas. Students may also show a gradual decline in their cognitive abilities and struggle more with their academic work. Since the disorder can come on quite gradually, it may be difficult to appreciate this decline in cognition without a longitudinal perspective over several academic years. The typical prodromal period lasts about two to three years. Some children show difficulties with attention, motor function, and social skills very early in life, before the prodrome, whereas others have no problems at all before the illness sets in.

The symptoms of schizophrenia include hallucinations (hearing and seeing things that are not there), delusions (fixed false beliefs); and difficulties in organizing their thoughts. A student may talk and say little of substance or the child may have ideas or fears that are odd and unusual (beyond developmental norms). Many, but not all individuals with schizophrenia may show a decline in their personal hygiene, develop a severe lack of motivation, or they may become apathetic or isolative. During adolescence the illness is not fully developed, and thus it is at times difficult to differentiate schizophrenia from a severe depression, substance abuse disorder, or bipolar affective disorder. Students who show signs of schizophrenia need a thorough mental health assessment.

Early diagnosis and treatment of schizophrenia is important. About 50 percent of people with schizophrenia will attempt suicide; 10 to 15 percent will succeed. Young people with this disease are usually treated with a combination of medication and individual and family therapy. They may also participate in specialized programs. Medications can be very helpful for treating the hallucinations, delusions, and difficulties in organizing thoughts. Unfortunately, the difficulties with motivation, personal hygiene, apathy, and social skills are often the least responsive to medications.

The cause of schizophrenia is not known, although it is believed to be a combination of genetic and environmental factors. The exact environmental factors that contribute to the development of schizophrenia are also not known.

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EDUCATIONAL IMPLICATIONS

Students with schizophrenia can have educational problems such as difficulty concentrating or paying attention. Their behavior and performance may fluctuate from day to day. These students are likely to exhibit thought problems or physical complaints; or they may act out or become withdrawn. Sometimes they may show little or no emotional reaction; at other times, their emotional responses may be inappropriate for the situation.

INSTRUCTIONAL STRATEGIES AND CLASSROOM ACCOMMODATIONS

- Reduce stress by going slowly when introducing new situations.
- Help students set realistic goals for academic achievement and extra-curricular activities.
- Obtaining educational and cognitive testing can be helpful in determining if the student has specific strengths that can be capitalized upon to enhance learning.
- Establish regular meetings with the family for feedback on health and progress.
- Because the disorder is so complex and often debilitating, it will be necessary to meet with the family, with mental health providers, and with the medical professionals who are treating the student. These individuals can provide the information needed to understand the student's behaviors, the effects of the psychotropic medication, and how to develop a learning environment.
- Often it is helpful to have a "team meeting" to discuss the various aspects of the child's education and development.
- Encourage other students to be kind and to extend their friendship.

—From "Schizophrenia: Youth's Greatest Disabler," produced by the British Columbia Schizophrenia Society, available at www.mentalhealth.com/book/p40-sc02.html • For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

RESOURCES

NAMI (National Alliance for the Mentally Ill)
3803 North Fairfax Drive Suite 100
Arlington, VA 22203
703-524-7600 • 800-950-6264
www.nami.org
Medical and legal information, helpline, research, publications

National Association for Research on Schizophrenia and Depression (NARSAD)
60 Cutter Mill Road, Suite 404
Great Neck, NY 11021
800-829-8289 516-829-0091
www.narsad.org • info@narsad.org
Research updates and fact sheets

Mental Health America
2000 North Beauregard Street, 6th Floor
Alexandria, VA 22311
800-969-6642 703-684-7722
www.nmha.org
Fact sheets, news updates, referrals, support groups

Publications

Schizophrenia: A Handbook for Families © Minister of Supply and Services Canada 1991
http://www.phac-aspc.gc.ca/mh-sm/pubs/schizophrenia-schizophrenie/disclaimer-eng.php

Surviving Schizophrenia: A Manual for Families, Consumers and Providers, by E. Fuller Torrey, HarperCollins, 2002.

When Madness Comes Home: Help and Hope for Families of the Mentally Ill, by Victoria Secunda, Hyperion, 1998.

Tourette's Disorder

(also known as Tourette Syndrome)

Symptoms or Behaviors

- Throat clearing
- Barking
- Snorting
- Hopping
- Vocal outbursts
- Mimicking of other people
- Shoulder shrugging
- Facial grimaces
- Facial twitches
- Blinking
- Arm or leg jerking
- Finger flexing
- Fist clenching
- Lip licking
- Easily frustrated
- Sudden rage attacks

About the Disorder

Tourette's disorder is a neurological disorder that has dramatic consequences for some 200,000 Americans and affects an approximate additional 2 million to some degree. Boys identified with Tourette's disorder outnumber girls 3 to 1; the disorder affects all races and ethnic groups. Researchers have traced the condition to a single abnormal gene that predisposes the individual to abnormal production or function of dopamine and other neuro-transmitters in the brain. Although Tourette's disorder is classified as a mental health disorder, it can be treated by a neurologist as well as a psychiatrist.

The disorder is still poorly recognized by health professionals. About 80 percent of people with Tourette's disorder diagnose themselves or are diagnosed by family members after learning about the disorder in the media. You may be able to help the family by documenting the tic behaviors. Many people have symptoms mild enough that they never seek help; many others find their symptoms subside after they reach adulthood.

Indicators of Tourette's disorder include:

- The presence of multiple motor and vocal tics, although not necessarily simultaneously
- Multiple bouts of tics every day or intermittently for more than a year
- Changes in the frequency, number, and kind of tics and in their severity
- Marked distress or significant impairment in social, occupational, or other areas of functioning, especially under stressful conditions
- Onset before age 18

An estimated 25 percent of students in the U. S. have a tic at some time in their life. Not all students with tics have Tourette's disorder, although they may have a related tic disorder. Tics may be simple (for example, eye blinking, head jerking, coughing, snorting) or complex (for example, jumping, swinging objects, mimicking other people's gestures or speech, rapid repetitions of a word or phrase). In fact, the range of tics exhibited by people with Tourette's disorder is so broad that family members, teachers, and friends may find it hard to believe that these actions or vocalizations are not deliberate.

Like someone compelled to cough or sneeze, people with Tourette's disorder may feel an irresistible urge to carry out their tics. Others may not be aware of the fact they are ticcing. Some people can suppress their tics for hours at a time, but this leads to stronger outbursts of tics later on. Often, children "save up" their tics during school hours and release them when they return home and feel safe from harassment or teasing.

Somewhere between 50 to 70 percent of students with Tourette's disorder have related learning disabilities, attention-deficit/hyperactivity disorder (AD/HD), obsessive-compulsive disorder (OCD), or difficulties with impulse control. Sensory integration problems may explain some behaviors. Problems such as depression and anxiety may underlie visible tics, and stress is known to worsen symptoms.

Educational Implications

Tics, such as eye blinking or shoulder shrugging, can make it difficult for students to concentrate. But suppressing tics is exhausting and takes energy away from learning.

Tics may also be disruptive or offensive to teachers and classmates. Peers may ridicule the child with Tourette's disorder or repeatedly "trigger" an outburst of tics to harass. Tension and fatigue generally increase tics.

Please note: Most students with Tourette's disorder do not qualify for special education services unless the coexisting conditions are severe. However, some may qualify for Section 504 accommodations.

Instructional Strategies and Classroom Accommodations

- Educate other students about Tourette's disorder, encourage the student to provide his own explanations, and encourage peers to ignore tics when possible.
- Be careful not to urge the student to "stop that" or "stay quiet." Remember, it's not that your student won't stop—they simply can't stop.
- Do not impose disciplinary action for tic behaviors.
- To promote order and provide a diversion for escalating behavior, provide adult supervision in the hallways, during assemblies, in the cafeteria, when returning from recess, and at other high-stress times.
- Refer to the school occupational therapist for an evaluation of sensory difficulties and modify the environment to control stimuli such as light, noise, or unexpected touch.
- Help the student to recognize fatigue and the internal and external stimuli that signal the onset of tics. Pre-arrange a signal and a quiet, safe place for the student to go to relax or rest.
- Provide a private, quiet place for test taking. Remove time limits when possible.
- Help the student learn to predict outbursts and be able to request a break. Self-management techniques may be a necessary lifetime skill for the student.
- Reduce handwriting tasks and note taking. Provide note takers or photocopies of overheads during lectures and encourage computer use for composition tasks. Handwriting problems are common due to hand, arm, or shoulder tics.
- Give students with Tourette's disorder special responsibilities that they can do well. Encourage them to show their skills in sports, music, art, or other areas.
- Provide structured, predictable scheduling to reduce stress and ensure adult supervision in group settings.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health *pages 18–24.*

Resources

Tourette's Syndrome Association, Inc.
42-40 Bell Boulevard., Suite 205
Bayside, NY 11361-2874
718-224-2999 • www.tsa-usa.org
Extensive information and resources–some specially for educators

www.tourettesyndrome.net
Developed by Dr. Leslie E. Packer
This website covers Tourette's Syndrome and related disorders

Publications

Children with Tourette Syndrome: A Parent's Guide, edited by Tracy Haerle, Woodbine House, 1992.

An Educator's Guide to Tourette Syndrome, by S. Bronheim. Available from www.tsa-usa.org

Teaching the Tiger: A Handbook for Individuals Involved in the Education of Students with Attention Deficit Disorder, Tourette's Syndrome, or Obsessive-Compulsive Disorder, by Marilyn P. Dornbush and Sheryl K. Pruitt, Hope Press, 1995.

Videos

Be My Friend. Designed for young children. Available from TSA-MN, by calling 952-918-0305.

I Have Tourette's but Tourette's Doesn't Have Me. DVD includes broadcast seen on HBO plus resources and supplementary information. Available from the Tourette Syndrome Association at www.tsa-usa.org.