The Not-so-Fab Four: Addressing Common Mental Health Issues in Youth

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This handout does not follow the presentation slide-for-slide. Instead, it serves as a place for me to share material that is more in-depth than the presentation, along with some note taking space.

Thoughts on Intro:

Section on ADHD

These are the criteria for an ADD/ADHD diagnosis in the DSM-5

Inattention: Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:

- Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
- Often has trouble holding attention on tasks or play activities.
- Often does not seem to listen when spoken to directly.
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
- Often has trouble organizing tasks and activities.
- Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
- Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
- Is often easily distracted
- Is often forgetful in daily activities.

Hyperactivity and Impulsivity: Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person's developmental level:

- Often fidgets with or taps hands or feet, or squirms in seat.
- Often leaves seat in situations when remaining seated is expected.
- Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
- Often unable to play or take part in leisure activities quietly.
- Is often "on the go" acting as if "driven by a motor".
- Often talks excessively.
- Often blurts out an answer before a question has been completed.
- Often has trouble waiting his/her turn.
- Often interrupts or intrudes on others (e.g., butts into conversations or games)

In addition, the following conditions must be met:

- Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
- Several symptoms are present in two or more setting, (e.g., at home, school or work; with friends or relatives; in other activities).
- There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
- The symptoms do not happen only during the course of schizophrenia or another psychotic disorder. The symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Strategies:

- Structure: Classrooms are structured so that rules and routines are well known by the students and consistently followed.
- Transitions among lessons and activities are smooth. The teacher is able to give the impression that the he or she is aware of all activities by students in the classroom.
- Minimize distraction where possible. For example, the student can be seated away from potentially distracting areas (such as doors, windows, and computers) or seated near another student who is working on a shared assignment.
- Organizing lesson plans and instruction in a way that minimizes interruptions
- Increasing teacher awareness in the classroom by letting students know you are aware of their actions at all times.
- Work on the most difficult concepts early in the day (schedule hardest classes early)
- Give directions to one assignment at a time instead of directions to multiple tasks all at once
- Vary the pace and type of activity to maximize the student's attention

Resources:

My article on executive functioning: bit.ly/exec-func

National Resource Center on ADHD help4adhd.org

ERIC search for academic articles bit.ly/eric-adhd

Teaching Teens With ADD, ADHD & Executive Function Deficits: A Quick Reference Guide for Teachers and Parents by Chris A. Zeigler Dendy

ADHD in the Schools, Third Edition: Assessment and Intervention Strategies by George J. DuPaul, Gary Stoner, Robert Reid

How To Reach And Teach Children with ADD / ADHD: Practical Techniques, Strategies, and Interventions by Sandra F. Rief

The ADHD Workbook for Kids: Helping Children Gain Self-Confidence, Social Skills, and Self-Control by Lawrence Shapiro

Smart but Scattered: The Revolutionary "Executive Skills" Approach to Helping Kids Reach Their Potential by Peg Dawson and Richard Guare

Superparenting for ADD: An Innovative Approach to Raising Your Distracted Child by Edward M. Hallowell, Peter S. Jensen

Parenting Children with ADHD: 10 Lessons That Medicine Cannot Teach by Vincent J. Monastra

Section on Mood Disorders:

Other less common mood disorders include:
Dysthymia – a low level, longer lasting depression . It has to last at least a year, so it is hard to justify because of this duration. Dysthymic disorder can be characterized as a chronic low-grade depression, persistent irritability, and a state of demoralization, often with low self-esteem. The symptoms also must not be caused by another mood disorder, such as MDD or bipolar disorder, a medical condition, substance abuse, or just related to ADHD itself (low self-esteem stemming from poor functioning in school, for example). Finally, the symptoms must be shown to significantly impair the child's social, academic, or other areas of functioning in daily life.

To be diagnosed with dysthymic disorder, a child must also have at least 2 of the following symptoms:

- Poor appetite or overeating
- Insomnia or excessive sleeping
- Low energy or fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Feelings of hopelessness

Cyclothymia – it can be a precursor to bipolar. Not to be too irreverent, but it's like bipolar light, with mood swings that have seemingly no cause.

Disruptive Mood Dysregulation Disorder (DMDD) is a relatively new diagnosis in the field of mental health. Children with DMDD have severe and frequent temper tantrums that interfere with their ability to function at home, in school or with their friends. Some of these children were previously diagnosed with bipolar disorder, even though they often did not have all the signs and symptoms. Research has also demonstrated

that children with DMDD usually do not go on to have bipolar disorder in adulthood. They are more likely to develop problems with depression or anxiety.

Many children are irritable, upset or moody from time to time. Occasional temper tantrums are also a normal part of growing up. However, when children are usually irritable or angry or when temper tantrums are frequent, intense and ongoing, it may be signs of a mood disorder such as DMDD.

The symptoms of DMDD include:

- Severe temper outbursts at least three times a week
- Sad, irritable or angry mood almost every day
- Reaction is bigger than expected
- Child must be at least six years old
- Symptoms begin before age ten
- Symptoms are present for at least a year
- Child has trouble functioning in more than one place (e.g., home, school and/or with friends)

Some of the symptoms associated with DMDD are also present in other child psychiatric disorders, such as depression, bipolar disorder and oppositional defiant disorder. Some children with DMDD also have a second disorder, such as problems with attention or anxiety. This is why it is particularly important to get a comprehensive evaluation by a trained and qualified mental health professional.

(section on DMDD from the American Academy of Child & Adolescent Psychiatry).

Depression:

Resources

Teaching Students with Mental Health Disorders bit.ly/students-depression

"Interventions That Work." *Educational Leadership* (October 2010 | Volume 68 | Number **2** |Pages 46-51)

Responding to a Student's Depression by R. Marc A. Crundwell and Kim Killu

Depression and Bipolar Support Alliance dbsalliance.org

For kids with mood disorders dbsalliance.org/pdfs/storm.pdf (basically a story illustrated by kids)

National Alliance on Mental Health nami.org

Back to Normal: Why Ordinary Childhood Behavior is Mistaken for ADHD, Bipolar Disorder, and Autism Spectrum Disorder by Enrico Gnaulati

The Emperor's New Drugs: Exploding the Antidepressant Myth by Irving Kirsch

Strategies

Here is a wide menu of possible strategies to help youth with depression in school. (Many suggestions are from http://studentsfirstproject.org/wp-content/uploads/School-and-Classroom-Depression-Strategies.pdf)

Give frequent feedback on academic, social, and behavioral performance.	Develop modifications and accommodations to respond to the student's fluctuations in mood, ability to concentrate, or side effects of medication.
Teach the student how to set goals and self-monitor.	Assign one individual to serve as a primary contact and coordinate interventions.
Teach problem-solving skills.	Frequently monitor whether the student has suicidal thoughts.
Monitor student's eating, but do not become a food gatekeeper. Allow healthy "grazing" throughout the school day.	Develop a home–school communication system to share information on the student's academic, social, and emotional behavior & any developments concerning meds/side effects.
Give the student opportunities to engage in social interactions.	Provide built-in opportunities for the student to talk with a supportive adult who has the time and ability to listen attentively.
Validate the student's experience and feelings ("I know that things are really hard for you right now").	Provide the student with opportunities for "self time out" to regroup when they are feelings excessively sad or irritable.
Teach the student to identify their mood patterns and appropriate ways to communicate anger, frustration, sadness, etc.	Help the student to identify automatic negative thoughts and strategies for reframing these negative thoughts; encourage positive self-talk .
Design daily lessons so that the student has to actively respond to an assignment (i.e. write on the board).	Integrate physical activity (i.e. walking on the track, shooting hoops) throughout the school day, not just contingent upon achievement.
Allow flexible deadlines for work completion.	Provide student with written copies of class notes and/ or assignments.
Avoid lowering grades for non-academic reasons such as messy work.	Model how to reframe mistakes into opportunities.
Provide the student with additional, meaningful responsibilities	Allow student more time to respond when asking questions or making requests.
Discourage student from participating in activities that result in increased negative feelings about themselves.	Demonstrate unconditional acceptance of the student (though not his or her behavior if it is inappropriate).
Separate student from peers who are negative or who frequently point out the failings of others.	Coach the student in ways to organize, plan, and execute tasks demanded daily or weekly.
Provide opportunities for physical activity throughout the school day.	Model that it is okay to make mistakes; point out and make light of your own mistakes.

Section on Conduct disorder

Diagnosing Criteria: manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6_months:

Aggression to people and animals

- often bullies, threatens, or intimidates others
- often initiates physical fights
- has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
- has been physically cruel to people
- has been physically cruel to animals
- has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
- has forced someone into sexual activity

Destruction of property

- has deliberately engaged in fire setting with the intention of causing serious damage
- has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

- has broken into someone else's house, building, or car
- often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
- has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules

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

The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning. If the individual is age 18 years or older, he/she can't be diagnosed with this if the criteria are met for Antisocial Personality Disorder.

Childhood-Onset Type. This subtype is defined by the onset of at least one criterion characteristic of Conduct Disorder prior to age 10 years.

Individuals with Childhood-Onset Type are usually male, frequently display physical aggression toward others, have disturbed peer relationships, may have had Oppositional Defiant Disorder during early childhood, and usually have symptoms that meet full criteria for Conduct Disorder prior to puberty. These individuals are more likely to have persistent Conduct Disorder and to develop adult Antisocial Personality Disorder than are those with Adolescent-Onset Type.

Adolescent-Onset Type. This subtype is defined by the absence of any criteria characteristic of Conduct Disorder prior to age 10 years.

Compared with those with the Childhood-Onset Type, these individuals are less likely to display aggressive behaviors and tend to have more normative peer relationships (although they often display conduct problems in the company of others). These individuals are less likely to have persistent Conduct Disorder or to develop adult Antisocial Personality Disorder. The ratio of males to females with Conduct Disorder is lower for the Adolescent-Onset Type than for the Childhood-Onset Type. (diagnosing information from the American Academy of Child & Adolescent Psychiatry)

Strategies

- Avoid commands; embrace options ("Would you rather this or this" as opposed to "You need to" or "You should").
- Use appropriate materials (avoid "infantile" materials), and keep the work at the zone of proximal development (not too hard and not too easy).
- Avoid escalating by shouting, physical touch, or cornering a student, staring, pointing your finger, or placing your hands on your hips.
- Stay neutral (avoid letting your negative impressions show on your face).
- Have very few, very clear rules. Have them prominently displayed and fairly enforced. Include students in their development.
- Breakdown tasks to allow for feelings of accomplishment.
- Provide lots of authentic positive feedback privately. Greet with genuine welcome. Check in often ("How are you doing?")
- You will not win a power struggle. Do not engage (stay calm and detached).
- Teach social skills when the child is not agitated.
- Use punishment sparingly – it simply doesn't work. Have a crisis plan and share it ahead of time.
- Proactively monitor to redirect before escalation.
- Listen in a way that shows you're listening – nod, reflect, paraphrase.
- Avoid sarcasm (even though it can be soooo fun).
- When redirecting/addressing issues, remind student of his/her value and make it clear that it's simply the behavior that is unwanted by you, not him/her.
- Allow cool-down breaks (in the corner of the room or outside with supervision) for all students.
- Ask students what's going on – don't assume you know. ("What do you think…"). Avoid asking "why" – no one knows, really.
- Be positive ("I'll come help you when you get back to your seat" instead of "If you don't sit down, I can't help you").
- Increase your array of options – don't respond to every issue as if it's defcon 5.
- Keep discussion brief. Avoid going on and on with even the most amazing of lectures on behavior.
- Balance the energy level of the response with the level of the outburst. A child who is physically tantruming isn't going to want to color.
- Keep yourself relaxed. Breathe out for a second longer than you breathe in a few times.
- Gently acknowledge the emotion to help students name it ("Are you feeling…?" "It looks like you may be feeling…").

Resources:

Parenting a Child Who Has Intense Emotions: Dialectical Behavior Therapy Skills to Help Your Child Regulate Emotional Outbursts and Aggressive Behaviors by Pat Harvey ACSW LCSW-C (Author), Jeanine Penzo LICSW (Author)

Multi-systemic Therapy: mstservices.com

Section on Anxiety

DSM-5 criteria for generalized anxiety disorder include:

- Excessive anxiety and worry about several events or activities most days of the week for at least six months
- Difficulty controlling your feelings of worry
- At least three of the following symptoms in adults and one of the following in children: restlessness, fatigue, trouble concentrating, irritability, muscle tension or sleep problems
- Anxiety or worry that causes you significant distress or interferes with your daily life
- Anxiety that isn't related to another mental health condition, such as panic attacks or post-traumatic stress disorder (PTSD), substance abuse, or a medical condition

Generalized anxiety disorder often occurs along with other mental health problems, which can make diagnosis and treatment more challenging. Some disorders that commonly occur with generalized anxiety disorder include:

- Phobias
- Panic disorder
- Depression
- Substance abuse
- PTSD

Strategies

- Seat away from overly excited students.
- Make it easy to follow the directions, repeating them and posting them clearly.
- Give a heads up that you're going to call on him/her.
- Allow student to present to you privately or videotape it at home.
- Give extended time where possible.
- Avoid embarrassing the student.
- Facilitate friendships and help locate a safe person.
- Prepare for changes in routine (field trips, substitutes, testing, fire drills, etc.).
- Allow cool down times (get a drink, wash face, breathe). Have silent signal for when this is needed.
- Allow student to choose where to sit during large group activities (to side, in back, etc.).
- Be kind about make up work after absences.
- Give time estimates for homework.
- Teach deep breathing (exhale for longer periods) and practice with the child.
- Play soothing music (sonicaid is a good one) or any spa-like music.
- Allow student to hold a comforting object.

Resources

Dissertation on anxiety reducing strategies bit.ly/anxiety-students

The Anxiety Workbook for Teens: Activities to Help You Deal with Anxiety and Worry by Lisa M. Schab

From Worrier to Warrior: A Guide to Conquering Your Fears by Daniel B. Peters

Make Your Worrier a Warrior: A Guide to Conquering Your Child's Fears by Daniel B. Peters

iwilllisten.org

REFLECTION

Of the four categories discussed, the one that resonated with me the most as the biggest issue on my campus/in my district is:

Of the four categories discussed, the one that the educators have the most difficulty handling is:

Follow-up: Book I want to read: Idea I want to share: Strategy(ies) I want to try:

Affective Domain: As a result of this training, I have more empathy for students and families who are struggling with: As a result of that empathy, I will change this: