Children's Mental Health Disorder Fact Sheet for the Classroom

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
- Fear of new situations
- Drug or alcohol abuse

About the Disorder

All children feel anxious at times. Many young children, for example, show great distress when separated from their parents. Preschoolers are often 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.
- **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.
- **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 panic disorder will go to great lengths to avoid a panic attack. This may mean refusal to attend school or be separated from parents.
- **Obsessive-Compulsive Disorder.** Students become trapped in a pattern of repetitive thoughts and behaviors. These may include repeated hand washing, counting, or arranging and rearranging objects.
- **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 over-react when startled or have difficulty sleeping.

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.

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.
- 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).

Resources

Anxiety Disorders Association of America
8730 Georgia Avenue, Suite 600
Silver Spring, MD 20910
240-485-1001
www.adaa.org

Child Development Institute
3528 East Ridgeway Road
Orange, CA 92867
714-998-8617
www.childdevelopmentinfo.com

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/anxiety/
Free educational materials for professionals and the public

SAMHSA'S National Mental Health Information Center—
Center for Mental Health Services
PO Box 42557
Washington, DC 20015
800-789-2647
www.mentalhealth.samhsa.gov

Publications

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

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.

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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 1 or 2 subjects or activities
- Under or over sensitivity to stimuli such as noise, light, or unexpected touch
- Victims of teasing and bullying

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.

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. 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 (i.e., spinning the wheels of a toy car rather than "driving" it around). The most outstanding characteristic of a child 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.

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.

Children's Mental Health Disorder Fact Sheet for the Classroom

Asperger's Syndrome

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. Although students with Asperger's may often 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.

Instructional Strategies and Classroom Accommodations

- Create a structured, predictable, and calming environment. Consult an occupational therapist for suggestions on handling sensory needs for your students.
- 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 "meltdown" and intervene before control is lost. Help your student 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.

Resources

Autism Society of America
7910 Woodmont Avenue, Suite 300
Bethesda, MD, 20814
301-657-0881 • 1-800-3AUTISM
www.autism-society.org
Advocacy, educational information, referrals

The Gray Center for Social Learning and Understanding
4123 Embassy Drive SE
Kentwood, MI 49546
616-954-9747
www.thegraycenter.org
Resources and information, including information on social stories

Online Asperger Syndrome Information & Support (OASIS)
www.udel.edu/bkirby/asperger
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 at www.asperger.net/bookstore

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Children's Mental Health Disorder Fact Sheet for the Classroom

Attention-Deficit/Hyperactivity Disorder

Symptoms or Behaviors

The U.S Department of Health and Human Services lists 3 forms of AD/HD, each with 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.

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 though 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 FASD.

Remember that AD/HD is a neurobiological disorder. Students can't get organized or learn social skills on their own, but you can find interventions that greatly increase their capacity to succeed.

Children's Mental Health Disorder Fact Sheet for the Classroom

Attention-Deficit/Hyperactivity Disorder

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. 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. Many teachers will choose to 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 will help you respond with 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 1 or 2 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.
- 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.
- Ask parents what works at home.

Resources

Attention Deficit Information Network
58 Prince Street, Needham, MA 02492
781-455-9895
www.addinfonetwork.org
Support, information, community 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
River Road South, Putney, VT 05346
www.landmark.edu
Specialized college and national research facility for students with AD/HD and learning disabilities

Publications

Identifying and Treating Attention Deficit Hyperactivity Disorder: A Resource for School and Home*, a report by the U. S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs, 2003.

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.

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

* Both reports are available from the Department's website at www.ed.gov or by calling 877-433-7827.

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Children's Mental Health Disorder Fact Sheet for the Classroom

Bipolar Disorder (Manic-Depressive Illness)

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.

Symptoms or Behaviors

According to the Child and Adolescent Bipolar Foundation, symptoms may include:

- 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)

Children's Mental Health Disorder Fact Sheet for the Classroom

Bipolar Disorder (Manic-Depressive Illness)

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.

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.

—These suggestions are from the Child and Adolescent Bipolar Foundation. For more suggestions, consult the Foundation web site at www.bpkids.org. This site is a rich resource for teachers.

Resources

Child & Adolescent Bipolar Foundation (CABF)
1000 Skokie Boulevard, Suite 425, Wilmette, IL 60091
847-256-8525
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)
Colonial Place Three
2107 Wilson Boulevard, Suite 300, Arlington, VA 22201
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—*Center for Mental Health Services*
PO Box 42557, Washington, DC 20015
800-789-2647
www.mentalhealth.samhsa.gov

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

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

- In addition to these publications, many of the websitesabove also recommend publications and have information about current research.

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.

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Children's Mental Health Disorder Fact Sheet for the Classroom

Conduct Disorder

Symptoms or Behaviors

- Bullying or threatening classmates and other students
- Poor attendance record or chronic truancy
- History of frequent suspension
- Little empathy for others and a lack of appropriate feelings of guilt and remorse
- Low self-esteem 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 4 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 3 or more characteristic behaviors in the past 12 months. At least 1 of these behaviors must have been evident during the past 6 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 1/3 are 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 lifelong 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.

Conduct Disorder

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, 1-to-1 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.
- Be aware that adults can unconsciously 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. Maintain calm, respect, and detachment. 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 non-negotiable.
- 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.

Resources

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue NW, Washington, DC 20016-3007
800-333-7636
www.aacap.org

American Academy of Family Physicians
PO Box 11210, Shawnee Mission, KS 66207
800-274-2237
www.aafp.org

The Council for Exceptional Children (CEC)
1110 North Glebe Road, Suite 300, Arlington, VA 22201
703-620-3660
www.cec.sped.org

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—*Center for Mental Health Services*
PO Box 42557, Washington, DC 20015
800-789-2647
www.mentalhealth.samhsa.gov

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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

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
- 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.

Depression

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 motivate the child.

Resources

The Council for Exceptional Children (CEC)
1110 North Glebe Road, Suite 300, Arlington, VA 22201
703-620-3660
www.cec.sped.org

NAMI (National Alliance for the Mentally Ill)
Colonial Place Three
2107 Wilson Boulevard, Suite 300, Arlington, VA 22201
703-524-7600 • 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
866-615-6454
www.nimh.nih.gov
Free educational materials for professionals and the public

SAMHSA'S National Mental Health Information Center—*Center for Mental Health Services*
PO Box 42557, Washington, DC 20015
800-789-2647
www.mentalhealth.samhsa.gov

SA/VE (Suicide Awareness Voices of Education)
9001 East Bloomington Freeway, Suite 150
Bloomington, MN 55420
952-946-7998
www.save.org

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.

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.

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Eating Disorders

Symptoms or Behaviors

- Perfectionistic attitude
- Impaired concentration
- Withdrawn
- All or nothing thinking
- Depressed mood or mood swings
- Self-deprecating statements
- Irritability
- Lethargy
- Anxiety
- Fainting spells and dizziness
- Headaches
- Hiding food
- Avoiding snacks or activities that include food
- Frequent trips to the bathroom

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 4 and 5 years of age are expressing the need to diet, and it's estimated that 40 percent of 9 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.

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 overachieving. 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 worries 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.

Eating Disorders

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.

Resources

Eating Disorders Resources/Gürze Books
PO Box 2238
Carlsbad, CA 92018
760-434-7553 • 800-756-7533
www.gurze.net

National Association of Anorexia Nervosa and Associated Disorders
PO Box 7
Highland Park, IL 60035
847-831-3438
www.anad.org
Hotline counseling, referrals, information, and advocacy

National Eating Disorders Association
603 Stewart Street, Suite 803
Seattle, WA 98101
206-382-3587
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, 2001.

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

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.

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.

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Children's Mental Health Disorder Fact Sheet for the Classroom

Fetal Alcohol Spectrum Disorders (FASD)

Symptoms or Behaviors

Early Childhood (1-5 yrs)

- Speech or gross motor delays
- Extreme tactile sensitivity or insensitivity
- Erratic sleeping and/or eating habits
- Poor habituation
- Lack of stranger anxiety
- Rage
- Poor or limited abstracting ability (action/consequence connection, judgment & reasoning skills, sequential learning)

Elementary years

- Normal, borderline, or high IQ, but immature
- Blames others for all problems
- Volatile and impulsive, impaired reasoning
- School becomes increasingly difficult
- Socially isolated and emotionally disconnected
- High need for stimulation
- Vivid fantasies and perseveration problems
- Possible fascination with knives and/or fire

Adolescent years (13-18 yrs)

- No personal or property boundaries
- Naïve, suggestible, a follower, a victim, vulnerable to peers
- Poor judgment, reasoning, and memory
- Isolated, sometimes depressed and/or suicidal
- Poor social skills
- Doesn't learn from mistakes

About the Disorder

Fetal Alcohol Spectrum Disorders (FASD) refers to the brain damage and physical birth defects caused by a woman drinking alcohol during pregnancy. One disorder, Fetal Alcohol Syndrome (FAS), can include growth deficiencies, central nervous system dysfunction that may include low IQ or mental retardation, and abnormal facial features (for example, small eye openings, small upturned nose, thin upper lip, small lower jaw, low set ears, and an overall small head circumference).

Children lacking the distinguishing facial features may be diagnosed with Fetal Alcohol Effects (FAE). A diagnosis of FAE may make it more difficult to meet the criteria for many services or accommodations. The Institute of Medicine has recently coined a new term to describe the condition in which only central nervous system abnormalities are present from prenatal alcohol exposure: Alcohol Related Neuro-developmental Disabilities (ARND).

Because FAS/FAE are irreversible, lifelong conditions, children with FASD have severe challenges that may include developmental disabilities (e.g., speech and language delays) and learning disabilities. They are often hyperactive, poorly coordinated, and impulsive. They will most likely have difficulty with daily living skills, including eating (this is due to missing tooth enamel, heightened oral sensitivity, or an abnormal gag reflex).

Learning is not automatic for them. Due to organic brain damage, memory retrieval is impaired, making any learning difficult. Many of these children have problems with communication, especially social communication, even though they may have strong verbal skills. They often have trouble interpreting actions and behaviors of others or reading social cues. Abstract concepts are especially troublesome. They often appear irresponsible, undisciplined, and immature as they lack critical thinking skills such as judgment, reasoning, problem solving, predicting, and generalizing. In general, any learning is from a concrete perspective, but even then only through ongoing repetition.

Because children with FAS/FAE don't internalize morals, ethics, or values (these are abstract concepts), they don't understand how to do or say the appropriate thing. They also do not learn from past experience; punishment doesn't seem to faze them, and they often repeat the same mistakes. Immediate wants or needs take precedence, and they don't understand the concept of cause and effect or that there are consequences to their actions. These factors may result in serious behavior problems, unless their environment is closely monitored, structured, and consistent.

Resources

ARC Northland
201 Ordean Building, 424 West Superior
Duluth, MN 55802
218-726-4725 • 800-317-6475
arcdu@aol.com
Information, fact sheets

Fetal Alcohol Diagnostic Program (FADP)
400 Ordean Building, 424 West Superior
Duluth, MN 55802
218-726-4858 • fadp@charterinternet.com
FASD evaluations based on University of Washington's 4-digit diagnostic method; trainings on learning to diagnose FASD

FAS Community Resource Center (FAS-CRC)
7725 East 33rd Street
Tucson, AZ 85710
www.come-over.to/FASCRC
Lots of useful, supportive information

Fetal Alcohol Syndrome Family Resource Institute
PO Box 2525
Lynnwood, WA 98036
www.fetalalcoholsyndrome.org
Information and support; latest research findings

National Organization on Fetal Alcohol Syndrome (NOFAS)
900-17th Street NW, Suite 910
Washington, DC 20006
202-785-4585 • 800-66NOFAS
www.nofas.org

Thunder Spirit Center at Chrysalis
4432 Chicago Avenue
Minneapolis, MN 55409
612-871-0118, ext. 415
www.chrysaliswomen.org/tsc.htm
Specialized programs for children affected by fetal alcohol exposure

Fetal Alcohol Spectrum Disorders (FASD)

Educational Implications

Children with FASD need more intense supervision and structure than other children. They often lack a sense of boundaries for people and objects. For instance, they don't "steal" things, they "find" them; an object "belongs" to a person only if it is in that person's hand. They are impulsive, uninhibited, and over-reactive. Social skills such as sharing, taking turns, and cooperating in general are usually not understood, and these children tend to play alongside others but not with them. In addition, sensory integration problems are common, and may lead to the tendency to be high strung, sound-sensitive, and easily over-stimulated.

Although they can focus their attention on the task at hand, they have multiple obstacles to learning. Since they don't understand ideas, concepts, or abstract thought, they may have verbal ability without actual understanding. Even simple tasks require intense mental effort because of their cognitive impairment. This can result in mental exhaustion, which adds to behavior problems. In addition, since their threshold for frustration is low, they may fly into rages and temper tantrums.

A common impairment is with short-term memory, and in an effort to please, students often will make up an answer when they don't remember one. This practice can apply to anything, including schoolwork or behaviors. These are not intentional "lies," they just honestly don't remember the truth and want to have an answer. Since they live in the moment and don't connect their actions with consequences, they don't learn from experience that making up answers is not appropriate.

Resources (continued)

Publications

Fantastic Antoine Grows Up: Adolescents and Adults with Fetal Alcohol Syndrome, by Judith Kleinfeld, Barbara Morse, and Siobhan Wescott, University of Alaska Press, 2000.

Fantastic Antoine Succeeds!: Experiences in Educating Children with Fetal Alcohol Syndrome, by Judith Kleinfeld and Siobhan Wescott, University of Alaska Press, 1993.

Fetal Alcohol Syndrome: Practical Suggestions and Support for Families and Caregivers, by Kathleen Tavenner Mitchell. Available through NOFAS

Instructional Strategies and Classroom Accommodations

- Be as consistent as possible. The way something is learned the first time will have the most lasting effect. *Re-learning is very difficult and therefore any change is difficult.*
- Use a lot of repetition. These students need more time and more repetition than average to learn and retain information. Try using mnemonics like silly rhymes and songs. Also have them repeatedly practice basic actions and social skills like walking quietly down the hall or when to say "thank you." Be positive, supportive, and sympathetic during crises; these are children who "can't" rather than "won't."
- Use multi-sensory instruction (visual, olfactory, kinesthetic, tactile, and auditory). More senses used in learning means more possible neurological connections to aid in memory retrieval.
- Be specific, yet brief. These students have difficulty "filling in the blanks." Tell them step-by-step, but not all at once. Use short sentences, simple words, and be concrete. Avoid asking "why" questions. Instead, ask concrete who, what, where, and when questions.
- Increase supervision—it should be as constant as possible, with an emphasis on *positive reinforcement* of appropriate behavior so it becomes habit. Do not rely on the student's ability to "recite" the rules or steps.
- Model appropriate behavior. Students with FASD often copycat behavior, so always try to be respectful, patient, and kind.
- Avoid long periods of deskwork (these children *must* move). To avoid the problem of a student becoming overloaded from mental exhaustion and/or trying to sit still, create a self-calming and respite plan.
- Post all rules and schedules. Use pictures, drawings, symbols, charts, or whatever seems to be effective at conveying the message. Repeatedly go over the rules and their meanings aloud at least once a day. *Rules should be the same for all students, but you may need to alter the consequences for a child with FASD.*
- Use immediate discipline. If discipline is delayed, the student with FASD will not understand why it's happening. Even if the student is told immediately that a consequence will happen the next day, he or she will likely not make the connection the next day. *Never take away recess as a consequence—children with FASD need that break to move around.*
- Ensure the student's attention. When talking directly to the student, be sure to say his or her name and make eye contact. Always have the student paraphrase any directions to check for understanding.
- Encourage use of positive self-talk. Recognize partially correct responses and offer positive incentives for finishing work. Try to set them up for success, and recognize successes every day! (or even every hour).

For specific adaptations for teens with FASD and for tips on setting up an FASD-friendly classroom environment, call ARC Northland (see Resources for contact information).

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Much of the FASD information and the information for the Instructional Strategies and Classroom Accommodations section was taken from handouts provided by ARC Northland–Duluth. Used with permission.

Children's Mental Health Disorder Fact Sheet for the Classroom

Obsessive-Compulsive Disorder

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

About the Disorder

Obsessive-compulsive disorder (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.

Children 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.

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 or autism.

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 compulsive behaviors are:

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

Common obsessions are:

- Aggression
- Contamination
- Sex
- Loss
- Religion
- Orderliness and symmetry
- Doubt

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

Obsessive-Compulsive Disorder

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.
- 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).

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

NAMI (National Alliance for the Mentally Ill)
Colonial Place Three
2107 Wilson Boulevard, Suite 300, Arlington, VA 22201
703-524-7600 • 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

Obsessive-Compulsive Foundation, Inc.
676 State Street, New Haven, CT 06511
203-401-2070
www.ocfoundation.org
Free brochures, referrals, newsletter, support groups

SAMHSA'S National Mental Health Information Center—*Center for Mental Health Services*
PO Box 42557, Washington, DC 20015
800-789-2647
www.mentalhealth.samhsa.gov

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.

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.

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Oppositional Defiant Disorder

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 misbehavior
- Easily annoyed by others
- Being resentful and angry

About the Disorder

Students with oppositional defiant disorder (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.

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.

Oppositional Defiant Disorder

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. The constant testing of limits and arguing can create a stressful classroom environment.

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.
- Choose your battles wisely.
- Give 2 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.
- Avoid making comments or bringing up situations that may be a source of argument for them.
- 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. Both reactions lead to problems in the classroom.
- 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 assertive in an appropriate manner. Discuss strategies that the students may use to calm themselves when they feel their anger escalating. Do this when students are calm.
- Praise students when they respond positively.
- 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 the student with ODD is not always left out or is the last one picked.
- Ask parents what works at home.

Resources

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue NW
Washington, DC 20016-3007
800-333-7636
www.aacap.org
Information on child and adolescent psychiatry, fact sheets, current research, practice guidelines

Anxiety Disorders Association of America
8730 Georgia Avenue, Suite 600
Silver Spring, MD 20910
240-485-1001
www.adaa.org

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

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Children's Mental Health Disorder Fact Sheet for the Classroom

PDD and 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
- Sensitive or over-reactive to touch
- May rarely speak, repeat the same phrases over and over, or repeat what is said to them (echolalia)
- Avoids eye contact
- Self injury

About the Disorder

PDD, the acronym for pervasive developmental disorders, includes Rett's syndrome, childhood disintegrative disorder, and Asperger's Syndrome. Pervasive developmental disorder not otherwise specified (PDD-NOS) also belongs to this category.

Autistic disorder belongs to the category of disorders known as PDD. According to the U. S. Department 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 3 years of life and is 4 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 certain set of behaviors, but because a child can exhibit any combination of the behaviors in any degree of severity, no 2 children with autism will act the same.

The terminology can be confusing because over the years autism has been used as an umbrella term for all forms of PDD. This means, for example, 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. In Minnesota and nationally these are all known as 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. Under Minnesota law, 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; although there is provision in state law allowing services for "related conditions."

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 is suspected to have autistic disorder should be evaluated by a multidisciplinary team. This team may be comprised of a neurologist, psychiatrist, developmental pediatrician, speech/language therapist, and learning specialist familiar with autism spectrum disorders.

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. Technical assistance, consultation, and training are available to all schools in Minnesota through the Minnesota Autism Network. Contact your director of special education for more information (see *Resources* on the following page for contact information).

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

PDD and Autism Spectrum Disorders

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 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.

Resources

Autism Research Institute
4182 Adams Avenue, San Diego, CA 92116
619-281-7165 • www.autism.com/ari
Provides research-related information, diagnostic checklists, articles, and many links

Autism Society of America
7910 Woodmont Avenue, Suite 300, Bethesda, MD 20814
301-657-0881 • 800-3AUTISM
www.autism-society.org
Advocacy, educational information, referrals

Minnesota Autism Network
State Specialist: 612-638-1528
To find Regional Low Incidence Facilitators, go to
http://education.state.mn.us/html/026290.htm

Publications
The Hidden Curriculum: Practical Solutions for Understanding Unstated Rules in Social Situations, by Brenda Smith Myles, Melissa L. Trautman, and Ronda L. Schelvan, Autsim Asperger Publishing Co., 2004. Available from 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

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Children's Mental Health Disorder Fact Sheet for the Classroom

Post-Traumatic Stress Disorder

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
- Denial of the event or inability to recall an important aspect 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 1 month. Symptoms usually begin within 3 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 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.

Minnesota Association for Children's Mental Health • 1-800-528-4511 (MN only)
165 Western Avenue North, Suite 2, Saint Paul, MN 55102 • www.macmh.org

Post-Traumatic Stress Disorder

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, making it difficult for teachers to respond with helpful interventions. Children with PTSD will often regress. They may act younger than their age, which can result in increased emotional and behavioral problems. They may become clingy, whiny, impatient, impulsive, and/or aggressive. They may be unable to perform previously acquired skills, even basic functions like speech. Their capacity for learning may be decreased. They often have difficulty concentrating, are preoccupied, and become easily confused. They may 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 action of others.
- Don't hesitate to interrupt activities and avoid circumstances that are upsetting or re-traumatizing for the child. 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).
- Make yourself available and open to listening, remembering to always respect the child's need for confidentiality.
- Do not tell a child to forget about the incident. 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.
- 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.

Resources

National Center for PTSD
VA Medical Center
White River Junction, VT 05009
802-296-5132
www.ncptsd.org
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

PTSD Alliance
www.ptsdalliance.org

SAMHSA'S National Mental Health Information Center—*Center for Mental Health Services*
PO Box 42557
Washington, DC 20015
800-789-2647
www.mentalhealth.samhsa.gov

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.

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Children's Mental Health Disorder Fact Sheet for the Classroom

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 or problems
- 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 5 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 2 years of life, and most important, the first 9 months of life. When a caregiver fails to respond to a baby's emotional and physical needs, responds inconsistently, or is abusive, the child loses the ability to form meaningful relationships and the ability to trust.

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. Students may display "soothing behaviors" such as rocking and head banging, or biting, scratching, or cutting themselves. These symptoms will increase during times of stress or threat.

Reactive Attachment Disorder (RAD)

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 light and 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 to help 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.

Resources

Association for Treatment and Training in the Attachment of Children (ATTACh)
95 West Grand Avenue, Suite 206
Lake Villa, IL 60046
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.

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.

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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 2 to 3 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 good 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.

Schizophrenia

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 you will need 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

Resources

NAMI (National Alliance for the Mentally Ill)
Colonial Place Three
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201
703-524-7600 • 800-950-6264
www.nami.org

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

National Mental Health Association
2001 North Beauregard Street, 12th Floor
Alexandria, VA 22311
800-969-6642 • www.nmha.org
Fact sheets, news updates, referrals, support groups

Publications

Children with Schizophrenia, by Devyn Noble and Sandy Lenz, 1995. Available from Education Services Room 0601, Glenrose Rehabilitation Hospital, 10230-111 Avenue
Edmonton, Alberta T5G 0B7
Phone: 780-471-7912

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.

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Tourette's Disorder

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 neurotransmitter in the brain. Although Tourette's disorder is classified as a mental health disorder, it is usually 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. 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 ticing. 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, or difficulties with impulse control. Sensory integration problems may explain some behaviors. Depression and anxiety may underlie more visible symptoms.

Tourette's Disorder

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 under the emotional or behavioral disorders (EBD) classification, unless the coexisting conditions are severe. Some may qualify for services under the category of Other Health Disability (OHD) or Specific Learning Disability (SLD). Others who do not qualify under either the EBD, OHD, or SLD categories may do well in a general education classroom with accommodations (504 plans).

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 whenever 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 safe place for the student to go to relax or rest.
- Provide a private, quiet place for test taking. Remove time limits when possible.
- Reduce handwriting tasks and note taking. Provide note takers or photocopies of overheads during lectures and encourage computer use for composition tasks.
- 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.

Resources

Tourette's Syndrome Association, Inc.
42-40 Bell Boulevard., Suite 205
Bayside, NY 11361-2874
718-224-2999
www.tsa-usa.org

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.

Video

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

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