When Something's Wr ng

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Strategies for Teachers

Canadian Psychiatric Research Foundation
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How to Use This Handbook

A child's difficult or unusual classroom behaviour creates tremendous stress for him/her, the teacher and the other students. In some cases, behavioural disturbances can be temporary; in others they may reflect a mental disorder. *When Something's Wrong: Strategies for Teachers* has been designed to help you, the elementary or secondary school teacher, understand and implement ways to help children with behaviour problems that are due to common mental disorders.

The handbook is made up of eight sections, which can be used independently:

- Anxiety Disorders
  - Separation Anxiety Disorder
  - General Anxiety Disorder (GAD)
  - Social Anxiety Disorder
  - Panic Disorder (PD)
  - Obsessive Compulsive Disorder (OCD)
- Autism
- Depression
- Eating Disorders
  - Anorexia and Bulimia Nervosa
- Impulse Control Disorders
  - Oppositional Defiant Disorder (ODD)
  - Conduct Disorder (CD)
  - Attention-Deficit/Hyperactivity Disorder (AD/HD)
- Schizophrenia
- Tourette Syndrome
- Resources

Anxiety Disorders
Autism
Depression
Eating Disorders
Impulse Control Disorders
Schizophrenia
Tourette Syndrome
Resources

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

In each colour-coded section you will find:

- A brief description of possible classroom behaviours that can accompany some of the more common childhood and youth mental health problems.
- Suggested strategies to help you deal with these issues in the classroom.
- Summaries of existing medical or therapeutic treatments.

At the end of each section and at the end of the handbook you will find:

- A list of resources for further information or professional help.

For further information and additional coping strategies, please see CPRF's second handbook *When Something's Wrong: Ideas for Families*. It is designed to work together with this teacher handbook.

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

- Managing Problem Behaviour in Children
- Posttraumatic Stress Disorder (PTSD)
- Borderline Personality Disorder (BPD)
- Bipolar Affective Disorder (formerly known as Manic Depression)
- Suicide
- Working with Your Health Practitioner

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

This handbook is not a diagnostic tool. A professional diagnosis is always essential, and a second opinion is recommended. The purpose of the handbook is to give the teacher useful strategies to cope with and assist a student with behaviour difficulty. You may already use some of the strategies listed, but we hope it will provide additional suggestions that will be of value, not only for students with mental health problems, but also for general classroom management.

It has been shown that one in five school children has a mental health problem. Many of these children will exhibit their difficulties in the classroom, through problems with mood, behaviour or thinking. A significant proportion may have a brain dysfunction for which effective treatment is available. If you recognize a student who may have one or more of the disorders described, initiate a referral through the appropriate school services. Early identification and treatment can lead to improved outcomes.

All of these young students can benefit from strategic classroom interventions provided by informed teachers.

A team approach, involving teachers, parents, school support staff (psychology, social work, behaviour resource), public health nurses and other health professionals, may be required to provide optimal assistance to some children and teenagers. The support system may vary from one school to another, but in all cases the teacher plays a central role in day-to-day activities. This may include: recognition of behavioural difficulties that may indicate possible mental disorders, classroom management, and the use of appropriate classroom strategies. In recognizing mental health problems, it is important to consider that some may be relative to cultural adjustments of ethnic groups or to behavioural expectations arising from differences in originating cultures of specific students. Students undergoing major adjustments in the home (e.g., divorce, death) may also experience adjustment difficulties that are expressed through behaviour. Ongoing communication between teacher, student, parent and other involved professionals will be necessary to apply the information in this handbook effectively.

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Anxiety Disorders

ANXIETY DISORDERS Anxiety disorders are mental disorders characterized by excessive or inappropriate levels of anxiety that are so severe they interfere significantly with daily living. Taken as a group, they are the most common mental disorders in youth, affecting up to ten percent of children and adolescents. Anxiety disorders arise from a complex interplay of genetic and environmental factors and different forms begin at different times during these years. For example, separation anxiety disorder usually begins during mid-childhood, while panic disorder usually has an onset in later adolescence. Anxiety disorders are not benign conditions. Untreated, they can lead to depression, alcohol abuse or other problems. Moderate to severe disorders lead to poorer academic, vocational and interpersonal outcomes, a decreased quality of life and higher utilization of health care systems. Early effective interventions can provide symptomatic relief, improve long-term outcomes, and possibly prevent the development of other psychiatric disorders. In classroom situations, these children may appear to be "shy" or avoidant. They may be reluctant to do group work or speak out in class.

In adolescence, social isolation or substance abuse may begin. Rarely, if ever, do youth with anxiety disorders act in a manner that disturbs classroom routine, and they are often not identified as having difficulties.

The common anxiety disorders are: Separation Anxiety Disorder, General Anxiety Disorder (GAD), Social Anxiety Disorder, Panic Disorder (PD), and Obsessive Compulsive Disorder (OCD).

For Posttraumatic Stress Disorder (PTSD), please see CPRF's *When Something's Wrong: Ideas for Families* handbook.

Separation Anxiety Disorder

Separation Anxiety Disorder is usually seen by mid-childhood. It is characterized by severe panic-like episodes that begin when the child is separated from his/her parent or caregiver and has difficulty participating in age-appropriate social activities such as sleep-overs, summer camp, etc. These episodes may come to a teacher's attention when children refuse to attend school, cry and have tantrums when left at school, refuse to participate, or exhibit excessive "homesickness" during over-night school trips.

Behaviour Characteristics

- ☐ refusal to attend school
- ☐ tantrums, tears, clinging when left at school by the parent
- ☐ excessive "homesickness" during over-night school trips
- ☐ clining to the teacher

Classroom Strategies

- Provide reassurance to both child and parent.
- Inform child and parent that the anxiety normally decreases over time, with the appropriate strategies.
- Use distraction techniques — for example, involve the child in other activities.
- Encourage reading, writing, drawing, painting in a journal to alleviate fears.
- Encourage and reward independent activities.
- Create a "coping" book whereby the child has a guide to help take various steps for dealing with his/her anxiety. For example:

  Stage 1 — In Class
  - Take five deep breaths.
  - Draw in journal.
  - Count from fifty backwards.
  - Visualize a calm place.

  Stage 2 — Outside
  - Take time out.
  - Walk down hall.
  - Go to mentor or teacher.

  Stage 3 — Outside
  - Go to office.
  - Get medication, if required.
  - Call home.

- Provide student with frequent feedback, praise, encouragement and support.
- Use "whole class" relaxation techniques.

General Anxiety Disorder (GAD)

General Anxiety Disorder is thought to affect some three to five percent of youth and is often found together with other anxiety disorders or depression. It tends to have an onset in early adolescence and is associated with inhibited temperament or excessive childhood shyness. Young people with GAD worry incessantly about most things. It is the extreme, severe nature of their worries that leads to a diminished quality of life.

Behaviour Characteristics

- ☐ constant worry or tension
- ☐ extreme need for reassurance
- ☐ somatic symptoms (headaches, stomach aches)
- ☐ avoidance of stressful situations such as tests
- ☐ clingy behaviour in young children

Classroom Strategies

- Reassurance alone may not be sufficient to resolve this anxiety condition.
- Establish down–to–earth, realistic expectations and interactions.
- Encourage physical exercise to reduce anxiety.
- Check in with the student at the beginning of each day.
- Create a "things to do today" sheet. This gives the student an overview of the work expected for the day. Prepare the child/adolescent in advance for any changes in daily routines.
- Modify the child's program if necessary.
- Encourage use of a study schedule to prepare for tests and assignments. The schedule needs to clearly outline the activity and amount of work to be completed each day.
- Give clear directions.
- Create a "coping" book, as outlined under Separation Anxiety Disorder.

Social Anxiety Disorder

Social Anxiety Disorder usually manifests itself in adolescence. It is characterized by severe anxiety, at times mixed with panic, that occurs only in social situations and is often accompanied by blushing. It is the most common of the anxiety disorders and may precede the development of depression. Up to 30 percent of youth with social anxiety disorder develop problems with alcohol use. It can be severely debilitating and can result in social isolation.

Behaviour Characteristics

- ☐ refusal or severe reluctance to participate in activities that will permit social scrutiny; e.g., public speaking; eating or dressing in public; social activities, such as dances; gathering in social settings, such as malls
- ☐ physical symptoms such as blushing, a shaky voice, nervousness, or sweating prior to or during social situations
- ☐ strong fear that others will notice their anxiety

Classroom Strategies

- Gradual desensitization — through small group activity, for example.
- Do not force the student into situations that are humiliating; for example, forced speaking in front of the class; instead, provide an option such as a group presentationor a presentation to a small group. Allow use of multi-media presentations to reduce amount of speaking.
- Reassure the student that he/she is not alone in feeling embarrassed.
- Encourage relaxation techniques, such as visualization and deep breathing.
- Ask friendly classmates to invite the child to talk, play or join a club.

Panic Disorder (PD)

Panic Disorder expresses itself in later adolescence. It can affect up to five percent of youth and often occurs with depression or other anxiety disorders. It is characterized by a sudden onset of severe panic that arises suddenly, and without warning, in situations where there is no danger. Symptoms include: shortness of breath, heart palpitations, dizziness, tingling, urgent urination and intense fear. Often, attacks are accompanied by a strong desire to flee the location in which they occur. Repeated attacks lead to anticipation anxiety, and then to avoidance of locations in which they have occurred or from which there is no easy exit. In some cases this can lead to agoraphobia.

Behaviour Characteristics

- ☐ panic attack in the classroom, which can lead to a need to "escape"
- ☐ avoidance of school
- ☐ intense physical symptoms (e.g., shortness of breath, heart palpitations, dizziness, sweating)
- ☐ intense fear during the attack

Classroom Strategies

- Permit leaving the classroom if a panic attack occurs but set a time for return; attacks usually last five to ten minutes.
- Encourage "coping" behaviour and discourage avoidance.
- Create a "coping" book, as outlined under Separation Anxiety Disorder.
- Model calm behaviour.
- Use relaxation and deep breathing techniques to help reduce fear and stress (e.g., visualize a calm and safe place, take five deep breaths).

Obsessive Compulsive Disorder (OCD)

Obsessive Compulsive Disorder, which can begin throughout youth, affects up to three percent of the population and is characterized by intrusive, unwanted ideas, thoughts or fears (obsessions) and repeated ritualized actions or behaviours (compulsions) performed to dispel the anxiety brought on by obsessions. It may occur with tics (see Tourette Syndrome) or with depression. It can lead to significant functional disruption and a reduced quality of life.

Children with OCD often suffer the added stress of teasing, rejection, and even bullying from peers. Encourage the student to talk about the disorder with classmates, friends and family, and thereby increase acceptance of it.

Behaviour Characteristics

- ☐ persistent perfectionism; e.g., written schoolwork erased and rewritten to the point of making holes in the paper
- ☐ constant questioning, asking for reassurance
- ☐ repeating rituals
- ☐ having to do something exceedingly slowly to feel it has been done properly

Classroom Strategies

- Keep up normal routines in the classroom. Routine and structure can help a child reduce the rituals and encourage exposure to what may otherwise have been avoided.
- Provide brief, clear, explicit instructions, well-structured assignments.
- Use humour, not ridicule, to help the child distance himself/herself from irrational fears.
- Try not to get involvedin the child's rituals by responding to an obsessive need for reassurance.
- Do not criticize his/her obsessive behaviours. See them as symptoms, not faults.
- Recognize and reward small improvements; e.g., finishing a task on time without continual erasing to make it perfect.
- Modify expectations during a stressful time. Stress, particularly in the area of change, can increase symptoms of anxiety. Try to provide schedules and advance warning and preparation for changes in routines.
- Do not compare the child with other children in the classroom. The behaviours are part of an illness.
- Provide a warm and supportive learning environment where mistakes are viewed as a natural part of the learning process.

Treatment

Treatment of anxiety disorders usually requires a combination of treatment interventions by qualified medical or mental health professionals. Medications may be used along with other forms of treatment such as Cognitive Behavioural Therapy, sometimes in conjunction with family therapy or counselling.

Resources

Anxiety Disorders Association of Canada
(Ask for a referral to your provincial chapter for local resources)
Toll-Free: 1-888-223-2252
E-mail: contactus@anxietycanada.ca
Web: www.anxietycanada.ca

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

Got Issues Much? Celebrity Teens Share Their Traumas and Triumphs
(Randi Reisfeld, Marie Morreale, Scholastic, 1999).

Also Relevant:

Canadian Centre on Substance Abuse (CCSA)
Phone: (613) 235-4048
Web: www.ccsa.ca

Centre for Addiction and Mental Health
Phone: (416) 535-8501
Web: www.camh.net

AUTISM Autism is an Autistic Spectrum Disorder of neurobiological origin that appears about four times more frequently in boys than girls. It usually manifests itself before the age of three and, with no known environmental component, occurs throughout the world in families of all ethnic, racial and social backgrounds. There appears to be a genetic predisposition, with about a four percent increased risk among siblings of children with the disorder.

Autism affects the way sensory input is processed by the brain, leading to an inability to develop normal communication and language skills and, in many cases, an associated diagnosis of cognitive impairment. Children with autism frequently fail to develop useful speech, and those who do develop it have trouble initiating and sustaining conversations. Although a few have distinct skills in certain areas, such as music or mathematics, they often have considerable cognitive difficulties in other areas. Many children with autism are able to learn, however, especially if early diagnosis and intervention take place during the preschool years.

Autism belongs to a group of related disorders called Autism Spectrum Disorders (ASD), which includes Asperger's Syndrome (difficulties similar to autism, but children with this disorder are higher functioning and their symptoms may not appear until school age or later). Also included in this group are the more rare disorders, Rett Syndrome and Childhood Disintegrative Disorder.

Autism

Behaviour Characteristics

There are many differences among children with autism and the various behaviour characteristics may be present in widely differing degrees.

- underdevelopment or lack of non-verbal speech and other communication skills needed for social interaction and learning
- repetitive or idiosyncratic use of language
- lack of interest in activities and relationships with others, including peers; little or no eye contact and, in extreme cases, complete withdrawal
- lack of empathy and awareness of the needs of others
- compulsive behaviours, such as fixations or repetitive body movements, and inflexible adherence to rituals or routines
- toileting and sleeping difficulties
- short attention span and inability to focus on a task
- lack of reaction, or over-reaction, to sensory input — children with autism may be so unaware of pain that they can hurt themselves and not respond; they also need more time than others to shift between auditory and visual stimuli
- excessive anxiety and problems with self-control, which can lead to temper tantrums, or possibly even aggression or self-injurious behaviour
- seizures, which may sometimes develop in late childhood or adolescence
- possibly, the presence of special abilities

Classroom Strategies

Research indicates that the most successful method for educating children with autism involves structured, intensive behavioural interventions.

- Provide as much structure as possible; a highly structured, skill-oriented program designed to meet the individual needs of the child works best.
- Emphasize the development of language and social skills.
- Seat the child near your desk.
- Give clear, concrete instructions and repeat frequently.
- Break each skill into discrete units and allow the child to practice it over and over until he/she has mastered it.
- Reward the child for each small step in skill mastery.
- Write "Social Stories" from the point of view of the student to help him/her cope with social, learning and behavioural challenges. These stories — written simply and in the first person — should include a description of the situation and the desired positive response ("I can try," "I am calm," "I am proud of myself when...," etc.).
- Keep up normal classroom routines; routine and structure can help reduce the child's anxiety and attendant behaviour problems. Visual and/or written "Things to Do" charts for daily routines or weekly planning can be useful.
- Ensure supervision for transitions (e.g., recess, lunch).
- Provide parents with frequent feedback, encouragement and support. Where significant behaviour problems exist, try to involve them in developing a joint behaviour management program.
- Look for activities the child is good at and encourage and reward these activities.
- Work closely with the child's multi–disciplinary team of other teachers and health professionals

Treatment

Although in many cases symptoms of autism may decrease or change, they tend to be chronic over the child's life. The focus is therefore on encouraging the highest level of development possible given the limitations inherent in the disorder. A supportive environment and a multi–faceted educational and behavioural approach, tailored to the needs and abilities of the individual, seem to produce the best results. Although it can be expensive, time-consuming, and not always readily available, language and social skills may be greatly improved through Early Intensive Behavioural Intervention (20 to 40 hours a week for two years prior to age six). In some cases, controlled diet or carefully monitored medication — **to alleviate specific symptoms only** — can be helpful. Supportive counselling may help families cope with the physical and emotional demands of caring for a child with this disorder.

Resources

Autism Society Canada
P.O. Box 22017
16 Heron Rd.
Ottawa, ON K1V 0C2
Phone: (613) 789-8943
Email: info@autismsocietycanada.ca
Web: www.autismsocietycanada.ca
(See the "Resources" section of the Web site for a good list of additional information sources)

Canadian Autism Intervention Research Network
The Offord Centre for Child Studies, Faculty of Health Sciences, McMaster University, 107 Patterson Building, Chedoke Site
1200 Main Street West
Hamilton, ON L8N 3Z5
Web: www.cairn-site.com

Center for the Study of Autism
Informational Web Site: www.autism.org

Depression

DEPRESSION Clinical depression is rare before puberty and normally begins during adolescence, affecting about five to eight percent of youth. Clinical depression is a "whole body" illness that involves the mood, thoughts and behaviour of the person. It is also a disorder with a strong genetic component. Unrecognized and untreated, depression is the most common cause of teen suicide. It goes beyond "feeling blue" or the feelings involved in coping with a loss or disappointment. When a child or teen displays lethargy, apathy, a bleak outlook and an irritable personality, it can be confusing and difficult to look beyond the behaviours.

Children and adolescents who are depressed need to be treated in a sensitive manner. They need to feel a sense of belonging in the classroom by being part of class meetings and problem-solving activities. Although there is a tendency to leave a quiet student alone, it is important to make a special contact with a depressed child each day.

The great majority of people with a mood disorder like depression or Bipolar Affective Disorder (formerly known as Manic Depression) can be helped with the appropriate treatment.

For information on Bipolar Affective Disorder and suicide, please see CPRF's *When Something's Wrong: Ideas for Families* handbook.

Behaviour Characteristics

- ☐ voiced hopelessness
- ☐ increased irritability or agitation
- ☐ lack of energy or excessive fatigue
- ☐ indecision, lack of concentration, or forgetfulness
- ☐ frequent physical complaints, such as headache or stomach ache
- ☐ social withdrawal; e.g., from peers and extra curricular activities
- ☐ decrease in grades and missed assignments
- ☐ eating disturbance, weight loss or weight gain
- ☐ significant sleep disturbances
- ☐ suicidal writings or notes
- ☐ may show addictive behaviour, such as heavy smoking, heavy drinking, heavy use of other drugs, or increased use of these substances

Classroom Strategies

- Don't compare the child to others; instead, make positive statements that reflect his/her own past successes.
- Express optimism that the child will again be able to perform up to his/her own ability.
- Don't take it personally when your efforts appear to be rejected — the depression has led to distorted thinking and perceptions, making it impossible for him/her to respond with appreciation.
- Provide other expressive outlets, such as journal writing, creative writing, drawing, role playing and drama.
- Make a special contact with the student each day — maybe a specific greeting at the door followed by a question about something that has been of interest to him/her.
- Educate all your students whenever and wherever possible about the topic of depression and the warning signs of suicidal thinking and behaviour.
- Encourage a healthy lifestyle, especially lots of physical exercise, which creates mood-enhancing hormones in the body.
- Get help immediately if you are aware that the student is expressing suicidal thoughts.

Treatment

Treatment of depression includes medication or a specific psychotherapy such as Cognitive Behavioural Therapy or Interpersonal Therapy. Particular attention to the possibility of suicide must be maintained.

Resources

The Mood Disorders Society of Canada
3-304 Stone Road West, Suite 763
Guelph, ON N1G 4W4
Phone: (519) 824-5565
E-mail: info@mooddisorderscanada.ca
Web: www.mooddisorderscanada.ca

Child and Adolescent Bipolar Foundation
1000 Skokie Blvd., Suite 570
Wilmette, IL 60091 USA
Phone: (847) 256-8525
Email: cabf@bpkids.org
Web: www.bpkids.org

Also Relevant:

Canadian Centre on Substance Abuse (CCSA)
Phone: (613) 235-4048
Web: www.ccsa.ca

Centre for Addiction and Mental Health
Phone: (416) 535-8501
Web: www.camh.net

Centre for Suicide Prevention
1202 Centre Street S.E., Suite 320
Calgary, AB T2G 5A5
Phone: (403) 245-3900
Email: csp@suicideinfo.ca
Web: www.suicideinfo.ca
(Information and resources available; can direct you to local or provincial organizations and services; can direct you to local crisis centres)

Eating Disorders

EATING DISORDERS Anorexia and Bulimia Nervosa are serious forms of eating disorders. Anorexia (self-starvation) affects about three percent of the population; bulimia (the binge-purge syndrome) is more common. Excessive concern with body weight, body image and food characterizes both disorders, which can start in childhood and which more often affect females. To become thin, people with anorexia starve themselves, while those with bulimia binge on high-calorie foods and then purge.

Some groups are at higher risk for these disorders, including athletes (e.g., gymnasts or ballet dancers) and those who work in certain industries, such as fashion models.

Eating disorders are almost exclusive to developed cultures where there is an abundance of food and being "thin" is highly valued (e.g., North America, Europe).

Other eating disorders that now are also currently being discussed and researched are Exercise Bulimia and Binge-Eating Disorder. For more information, see CPRF's *When Something's Wrong: Ideas for Families* handbook.

Behaviour Characteristics

Anorexia Nervosa

- signs of starvation: thinning or loss of hair; appearance of fine, raised white hair on the body; bloated feeling; yellowish appearance of the palms or soles of feet; dry, pasty skin
- loss of menstrual periods
- significant weight loss in the absence of related illness
- significant reduction in eating, coupled with a denial of hunger
- unusual eating habits: preference for foods of a certain texture or colour; compulsively arranging food; unusual mixtures of food

Bulimia Nervosa

- evidence of binge eating: actual observation; verbal reports; large amounts of food missing
- frequent weight fluctuations
- evidence of purging (vomiting, laxative/ diuretic abuse, emetics, frequent fasting, excessive exercise)
- swelling of parotid glands under the jaw (caused by frequent vomiting)
- frequent, unusual dental problems
- evidence of calloused knuckles caused during purging

Classroom Strategies

- Know the warning signs of anorexia and bulimia.
- Discuss your concerns with the student.
- Convey your concerns about his/her health and functioning — don't focus on weight loss or body size.
- Expect to be rejected by the child/adolescent when you discuss your concerns about his/her possibly having an eating disorder. This is an illness of denial and distorted thoughts regarding body image.
- Go with the student to get help from a resource person, such as a guidance counsellor, public health nurse or social worker.
- Teach media literacy and critical thinking regarding body images in advertisements.
- Keep in mind that others in the student's life may be giving positive feedback on the student's "great will–power" or "perfect figure." These kinds of comments may help to reinforce the student's destructive behaviour.

Treatment

Treatment of eating disorders is difficult and multifaceted. For both anorexia and bulimia, an evaluation should be done by a mental health professional to rule out underlying anxiety or depression and to assess various risk factors like perfectionism, sexual abuse and a family history of eating disorders. A medical and endocrinological evaluation is also necessary. Regaining weight and maintaining it at a reasonable level is the goal of treatment for anorexia. Remission of the binge–purge cycle is the goal of treatment for bulimia.

A large part of treatment involves helping the young person reshape his/her negative and unrealistic body image. In serious cases, hospitalization may be necessary.

Resources

The National Eating Disorder Information Centre
CW 1-211
200 Elizabeth Street
Toronto, ON M5G 2C4
Phone: (416) 340-4156
Toll-Free: 1-866-NEDIC-20 (1-866-633-4220)
Web: www.nedic.ca

National Association of Anorexia Nervosa and Associated Disorders
Box 7
Highland Park, IL 60035
Phone: (847) 831-3438
Web: www.anad.org

National Eating Disorders Association (NEDA)
603 Stewart Street, Suite 803
Seattle, WA 98101
Phone: (206) 382-3587
E-mail: info@NationalEatingDisorders.org
Web: www.nationaleatingdisorders.org

Impulse Control Disorders

IMPULSE CONTROL DISORDERS A variety of behavioural disturbances are described as impulse control disorders. These include: Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), and Attention-Deficit/Hyperactivity Disorder (AD/HD). Altogether, these disorders affect up to eight to ten percent of youth. AD/HD has a prevalence of about three to five percent. Impulse control disorders normally begin before puberty. The onset of impulse control symptoms after puberty suggests another disturbance such as mood or psychotic disorder. Impulse control disorders can be associated with poor academic and/or vocational outcomes. They often co-exist with one or more language or learning disabilities and can lead to substance/alcohol abuse or criminal activity. In many cases of CD or ODD, appropriate adult guidance and limit-setting are helpful. With AD/HD, medical treatments may be necessary. Many youth with CD/ODD exhibit outbursts of anger and/or acts of violence. Youth with AD/HD tend to be inattentive, hyperactive and impulsive. A few young people may seem to show no remorse for activities that hurt or harm others. These youth may be exhibiting a more severe behavioural-social disturbance called sociopathy. They require interventions of a different type and magnitude than youth with usual impulse control disorders.

Oppositional Defiant Disorder (ODD)

Oppositional Defiant Disorder usually becomes evident before eight years and not later than early adolescence. ODD is a pattern of defiant, disobedient, and hostile behaviour towards authority figures. ODD can be more common in families that include a parent with a mood disorder. Many youth with ODD have a background of untreated AD/HD or a language or learning disability. Boys with this disorder outnumber girls.

Behaviour Characteristics

- ☐ outbursts of anger
- ☐ low frustration tolerance
- ☐ low self – esteem covered by cocky or "tough" demeanor
- ☐ swearing
- ☐ deliberately challenging people
- ☐ often arguing with adults
- ☐ history of conflict with teachers and peers
- ☐ use of drugs or alcohol in school
- ☐ history of academic problems and school failure
- ☐ early sexual activity

Classroom Strategies

- Teach the use and concept of self-talk to assist children in reducing their anger; e.g., "I have a right to be mad, but I'm not going to lose it." Also, if they have kept their cool, teach them to praise their own success; e.g., "I really handled that well."
- Encourage an angry child who is old enough to write to put his/her angry feelings in writing.
- Look for situations in which you can problem-solve together. Give the child responsibility he/she can handle easily and give praise for success.
- Help children develop emotional literacy so they can learn words to express angry feelings. Script language for them.
- Be a positive role model — try not to lose your temper.
- Communicate your observations in a neutral, non–confrontational manner; e.g., "I notice that you don't follow instructions when given" or "I notice that you have been arguing."
- Provide opportunities for a variety of expressive outlets; e.g., story – writing, painting, drama, clay, or using a punching bag in a safe place.

Classroom Strategies

- Establish clear expectations, rules and boundaries for the whole class. Establish clear consequences and rewards.
- Try to develop a mentoring relationship between the student and another teacher or caring adult.
- Encourage an aggressive child to engage in sports; e.g., jogging, tennis, aerobics, karate.
- Have a child/adolescent who is angry run around the schoolyard or track.
- Provide a safe place for children to go when they are angry — a place to calm down.
- Untreated, this disorder can get progressively worse and can put you and others in danger, emphasizing the importance of a professional diagnosis.

Conduct Disorder (CD)

Conduct Disorder is characterized by a persistent behaviour pattern where the child or adolescent violates the rights of others or the accepted rules of behaviour. Children with conduct disorder usually initiate aggressive behaviour and react aggressively to others. They may group together to take advantage of other children. Boys with this disorder outnumber girls.

Other mental/neurological disorders (untreated AD/HD and depression are common in youth with CD).

Untreated, this disorder can get progressively worse and can put you and others in danger, emphasizing the importance of a professional diagnosis.

Behaviour Characteristics

- ☐ aggressive behaviour;
  e.g., bullying, threatening, physical fighting, cruelty to animals, stealing (may use a weapon)
- ☐ destruction of property;
  e.g., fire-setting, breaking windows, throwing objects
- ☐ lack of empathy; e.g., callousness and absence of guilt feelings, blaming others for one's own misbehaviour
- ☐ frequent disobeying of class rules
- ☐ use of drugs or alcohol at school
- ☐ early sexual activity
- ☐ open displays of hostility/ "toughness"
- ☐ academic problems with reading and verbal skills
- ☐ deceitfulness (e.g., lying, stealing, "conning")

Classroom Strategies

- Actively teach what is appropriate and what is not with young children. Specifically define what is considered unacceptable behaviour.
- Have firm, clear rules and consistent natural consequences for unacceptable behaviours.
- Avoid consequences that are too extreme — either too harsh or too easy.
- Provide lots of positive feedback when the student does something well.
- Observe the child's negative behaviour as a symptom of a disorder you are both working to solve together.
- Encourage a child/ adolescent to behave appropriately when angry by engaging in physical outlets suggested in the ODD section.
- Encourage social opportunities for the student to express feelings and work on activities he/she does well (e.g., sports, the arts, recreation activities).
- Try to develop a mentoring relationship between the student and another teacher or caring adult.
- Suggest a support group for parents of children with conduct disorder.

Attention-Deficit/Hyperactivity Disorder (AD/HD)

The three main symptoms of Attention-Deficit/Hyperactivity Disorder, also known as Attention Deficit Disorder (ADD) or Hyperactivity Disorder, are inattention, hyperactivity, and impulsivity. Although most normal children have these symptoms at times, children with AD/HD have one or more of these symptoms more frequently and more severely than their peers. If left untreated, AD/HD can cause significant problems with relationships and performance at home, in school, and in the community.

AD/HD tends to run in families. It is estimated that approximately three to five percent of school-aged children have it, and AD/HD is reported two to three times more often in boys than in girls. Children with AD/HD often most clearly show symptoms in situations that require sustained and quiet focus. In most cases, AD/HD continues throughout adolescence and into adulthood, although the symptoms change somewhat and may decrease in intensity over time. While distractibility and impulsivity tend to remain, hyperactivity may take on the form of restlessness or nervous energy. In fact, this high energy level, which can also be accompanied by a high level of enthusiasm, intuitiveness and creativity, has been described as one of the advantages of having mild AD/HD, especially if it is socially or occupationally enhancing.

AD/HD is often found along with language and learning disabilities, behaviour problems, and changes in mood. It can also be found with other impulse control disorders (CD/ODD). These symptoms can make it difficult to distinguish AD/HD from other mental disorders such as Fetal Alcohol Syndrome (FAS), making it extremely important to get a professional diagnosis as early as possible.

Impulse Control Disorders

Behaviour Characteristics

- ☐ constant distraction by external stimuli
- ☐ difficulty listening and following directions — the child may appear to daydream frequently
- ☐ difficulty concentrating and attending to task
- ☐ poor attention to detail; makes careless mistakes
- ☐ inconsistent performance in school work — one day he/she may be able to do a task, the next day not
- ☐ disorganization — the student loses belongings, his/her desk may be very disorganized and messy
- ☐ low self-esteem due to poor work performance

If also Hyperactive and/or Impulsive:

- ☐ appearing to be in constant motion
- ☐ fidgeting with hands or feet, squirming, falling from chair
- ☐ finding nearby objects to play with
- ☐ roaming continually around classroom, great difficulty remaining in seat
- ☐ talking excessively
- ☐ blurting things out, often inappropriately
- ☐ often interrupting, intruding on others
- ☐ problem waiting for his/her turn
- ☐ engaging in physically dangerous activities
- ☐ displaying aggressive behaviour
- ☐ difficulty with transitions
- ☐ social immaturity, low frustration tolerance

Classroom Strategies

- Raise questions. If you suspect you may be dealing with AD/HD, make sure a professional evaluation has been done. Keep questioning until you are convinced!
- Ask the child what will help. Children with AD/HD are often very intuitive. They can tell you how they learn best if you ask them.
- Children with AD/HD need structure. Make lists. Have as predictable a schedule as possible.
- Break down large tasks into small tasks. This is one of the most crucial teaching techniques for children with AD/HD. Mix high and low interest tasks.
- Keep a list of "Things to Do" by the student's desk so he/she can check off tasks as they are completed. Use incentives.
- Repeat directions and keep them brief. Have the student repeat them back to you.
- Allow for escape-valve outlets, such as leaving class for a moment. If this can be built into the rules of the classroom, it will allow the child to leave the room rather than "lose it".
- Seek out and praise success as much as possible.
- Use feedback that helps the child become self-observant. Children with AD/HD often have no idea how they come across. Ask questions like "Do you know what you just did?" or "Why do you think that other girl looked sad when you said what you said?", or say "Stop" and "Look". Perhaps develop a private signal system to let the student know when "off track".
- Provide consistent and immediate consequences and try to make them positive rather than negative.
- Provide the child with a work area that is as "distraction-free" as possible.
- Know your limits. Don't be afraid to ask for help. Being a teacher in a classroom with a student who has AD/HD can be extremely challenging.
- Work closely with the child's parents or caregivers.

Treatment

Youth with ODD/CD are often treated with a variety of interventions. Behavioural therapies may be the most effective. When dealing with young people and impulse control disorders, it is very important to make sure that all co-morbid disorders (disorders that co-occur) are appropriately screened for and treated.

Research indicates that the best treatment for AD/HD includes early diagnosis along with a combination of medication, behavioural therapy, classroom modifications, and individual and family counselling. Medication is often necessary to address the core symptoms of the disorder. The appropriate medication for AD/HD can have significant benefits, such as an increase in attention span and academic productivity, a decrease in impulsivity, and an improvement in peer and teacher relationships. Professionals who are considered to be qualified to make a diagnosis of AD/HD include licensed clinical, educational, and neuro-psychologists, psychiatrists, or other professionals with training and expertise in the diagnosis of mental disorders, such as pediatricians.

Resources

ADDsupport.org
(A Canadian Web site designed to help families and professionals find information and resources on AD/HD)
Web: www.addsupport.org

Children and Adults with Attention-Deficit/ Hyperactivity Disorder (CH.A.D.D.)
8181 Professional Place, Suite 150
Landover, MD 20785
Phone: 1-800-233-4050
Web: www.chadd.org

ConductDisorders.com (Web site that includes a parent message board and links to information about CD, ODD, and related problems)
Web: www.conductdisorders.com

Learning Disabilities Association of Canada (LDAC)
Phone: (613)238-5721
Email: information@ldac-taac.ca
Web: www.ldac-taac.ca

Schizophrenia

SCHIZOPHRENIA Schizophrenia is a brain disorder that is characterized by disturbances in perception and disorganization in thinking and behaviour. This disorder has nothing to do with a split or multiple personality, which is a common misperception. It is comprised of two groups of symptoms: negative (such as social withdrawal, apathy, emotional unresponsiveness) and positive (such as delusions, hallucinations, bizarre behaviour).

Schizophrenia affects about one percent of the population. This prevalence appears to be the same across countries, cultures, and socioeconomic groups. The disorder usually begins in the adolescent or early adult years and normally begins with the "negative" symptoms.

The causes of the disorder are a topic of ongoing research. Current evidence indicates that genetic factors are the most important, but that non-genetic factors such as drug abuse, childhood head injury and infection during a mother's pregnancy (e.g., the influenza virus) can also play a part in the development of schizophrenia.

It is important to note that schizophrenia is associated with a high risk of suicide, so early intervention and treatment is key.

Behaviour Characteristics

- loss of ability to relax, concentrate or sleep in the early stages
- showing no emotion, sitting still for long periods of time
- denying that anything might be wrong
- odd speech and expressions
- delusions — false beliefs that have no basis in reality; e.g., "someone is spying on me"
- hallucinations — hearing voices that make insults or give commands; sufferers more often hear voices than see things that are not there
- disordered thinking — illogical thinking and loose associations between thoughts
- marked impairment in school performance (decrease in grades)
- difficulty relating to others, social isolation or withdrawal
- marked impairment in personal hygiene and grooming
- peculiar or bizarre behaviours, such as talking to an inanimate object, collecting garbage, or hoarding food
- possible suicidal thoughts and behaviours (especially in early stages)

Classroom Strategies

- Keep in mind that the symptoms of schizophrenia can be similar to other disorders and illnesses, such as mood disorders or epilepsy. A professional diagnosis is essential.
- Try to express a low degree of emotional response to the student's behaviour.
- Try not to take the student's negative behaviour personally. He or she is behaving this way due to illness and not by choice.
- If your student expresses thoughts that are distorted or delusional, do not try to disprove them. Make a calm statement of dis-agreement and then leave it. Appealing to reason and logic will not be productive.
- Communicate in brief, clear sentences. Give instructions one at a time.
- Seek professional help, above all. Work with a team. Continue (as much as possible) with the student's daily activities.

Treatment

The treatment of schizophrenia requires a range of interventions. Symptoms of schizophrenia generally respond well to anti-psychotic medications, and there are many different ones available in Canada. The majority of people with schizophrenia will improve greatly with the appropriate medication and many will find their hallucinations and delusions subside significantly. Many of these medications will help improve negative symptoms as well, making it more likely for patients to benefit from social therapies. It is also necessary and important for people to stay on their medication in order to prevent the return of symptoms once they recover from an acute phase. Extensive research to create better, long-acting medicines is ongoing (e.g., new long-acting atypical medications that are injected into the body are now available).

The best approach to recovering from schizophrenia includes taking medication, attending social therapies, and leading a healthy lifestyle, including effective stress management activities, eating a proper diet, and exercising regularly.

Resources

Schizophrenia Society of Canada
50 Acadia Avenue, Suite 205
Markham, ON L3R 0B3
Phone: (905) 415-2007
Toll-free: 1-888-SSC-HOPE (1-888-772-4673)
Email: info@schizophrenia.ca
Web: www.schizophrenia.ca
(Also able to direct you to further resources in your province or community)

Schizophrenia.com
(An online, not-for-profit information, support and education centre)
Web: www.schizophrenia.com

Tourette Syndrome

TOURETTE SYNDROME Tourette Syndrome (TS) is a neurochemical disorder characterized by tics—involuntary, sudden rapid movements or vocalizations that recur at irregular intervals. Although people with TS can usually suppress their symptoms to some extent, like sneezes, tics are ultimately irresistible; hence the use of "involuntary" to describe them. Tics range in severity from mild to more exaggerated movements and sounds (see the following list of Behaviour Characteristics for examples) and tend to increase with stress or excitement. Children with TS can be misunderstood because of the complexity and suppressibility of symptoms; parents, friends and teachers may find it hard to believe that these behaviours really are involuntary.

TS is a childhood onset disorder, with symptoms typically appearing around the age of seven. Estimated to affect in the neighbourhood of one in 100 people, it is four times more common among boys than girls, for reasons that are unknown. The most common first symptoms are facial tics, such as rapid blinking or mouth twitching. In some cases, involuntary sounds such as throat clearing and sniffling may be the initial sign; in others, motor and vocal tics can appear at the same time.

Generally inherited, it is thought that TS may result from the interaction of several genes with environmental or other factors. Many (but certainly not all) children with the syndrome have associated problems such as Obsessive Compulsive Disorder or Attention-Deficit/Hyperactivity Disorder (AD/HD). More information about these disorders can be found in the respective sections of this handbook.

Behaviour Characteristics

- tics — involuntary movements or vocalizations ranging in complexity from blinking, facial twitching, head or body jerking, shoulder shrugging, throat clearing, sniffling, tongue clicking, yelping, etc., to jumping, twirling, bending, touching others and, **rarely**, hitting or biting oneself, uttering ordinary words or phrases out of context or, **even more rarely**, explosively vocalizing socially unacceptable words
- fatigue, with attendant sleepiness or irritability and hyperactivity, caused by associated sleep disturbances
- learning problems related to organization and/or eye-hand coordination difficulties with handwriting and written math work; generally, difficulties with expressing thoughts in written form
- behaviour problems resulting from poor self-esteem and/or school performance due to TS symptoms or, in some cases, from obsessive compulsive, attention deficit or impulse control difficulties

Classroom Strategies

The following strategies recognize two important characteristics of Tourette Syndrome: 1) tics tend to increase with stress, and 2) they tend to decrease with concentration on absorbing activities.

- Seat the child near your desk if that reduces stress.
- Create a reassuring classroom structure: establish a daily routine; give tasks in manageable chunks with clear, concrete instructions.
- Encourage concentration by integrating the student's interests with the curriculum.
- Allow extra time for work and assist with the development of routines and time management skills.
- Recognize progress rather than criticize disorganization.
- Trying to suppress tics is stressful and distracting for the student. Allow him/her to move discreetly and to leave the classroom if symptoms become overwhelming.

Classroom Strategies

- Set untimed tests; if tics are a problem, use a private room where suppressing them is not necessary.
- Use aids such as a computer or tape recorder to help the student overcome handwriting difficulties and produce work equal to his/her ability.
- Involve the parents and the child in determining any special education needs and how best to manage TS in the classroom.
- Arrange extra help (e.g., informal support from the special education resource teacher, peer tutoring, or tutoring outside of the school) for children who need it.
- Recognize that TS does not affect intelligence.
- Where significant behaviour problems exist, provide immediate, constructive feedback and try to develop a joint behaviour management program with parents, involving regular and frequent communication. Ensure supervision for transitions (e.g., recess, lunch).
- Students with any neurobiological disorder are at higher risk of depression (see the section on Depression for symptoms and strategies). Get help immediately if you are aware that the student is expressing suicidal thoughts.
- Children with TS often suffer the added stress of teasing, rejection, and even bullying, from peers. Encourage the child to talk about the disorder with classmates and, through this sharing, increase class acceptance of tics. If he/she is uncomfortable about such disclosure, talk to the child and his/her parents to determine the best approach. **If the student agrees**, a presentation to the class or school is often helpful.

Treatment

The majority of young people with Tourette Syndrome are not significantly disabled by their tics or behaviour symptoms and therefore do not require medication. However, there are medications to help control symptoms that interfere with functioning. The type and dosage of medication needed to achieve maximum relief of symptoms, with minimal side effects, varies for each child and must be determined carefully by a doctor. Other forms of treatment, such as psychotherapy, relaxation techniques or biofeedback, may help the child and his/her family cope with associated psychosocial problems and stress. Partial and sometimes full remission can occur at any time and may be short or long–lived. Tic symptoms seem to stabilize and become less severe during or after adolescence.

Resources

Life's a Twitch!
(Life's a Twitch® is a Web site on Tourette Syndrome and associated disorders)
Web: www.lifesatwitch.com

Tourette Syndrome Foundation of Canada
194 Jarvis Street, Suite 206
Toronto, ON M5B 2B7
Phone: (416) 861-8398
Toll-Free: 1-800-361-3120
Web: www.tourette.ca

Resources

Resources

FOR MORE INFORMATION

Note: Please also see the individual sections in this handbook for additional resources that are more specific to each section topic.

American Academy of Child and Adolescent Psychiatry
(One of the most comprehensive, valid, and reliable organizations to access information in the area of mental health and mental illness)
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016-3007
Phone: (202) 966-7300
Web: www.aacap.org

Bullying.org
Bullying.org is a nonprofit Internet resource created to help people deal with the issue of bullying through the sharing of resources and the guiding of people towards non-violent solutions to the challenges and problems associated with bullying.
Web: www.bullying.org

Canadian Academy of Child and Adolescent Psychiatry
555 University Avenue
Toronto, ON M5J 1X8
Phone: (416) 813-6540
E-mail: elizabeth.manson@sickkids.on.ca
Web: www.canacad.org

Canadian Centre on Substance Abuse (CCSA)
Phone: (613) 235-4048
Web: www.ccsa.ca

Canadian Health Network
(Web site designed to help people find excellent resources from non-profit health information providers across Canada, as well as key international resources)
Web: www.canadian-health-network.ca

Canadian Mental Health Association
180 Dundas St. W., Ste. 2301
Toronto, ON M5G 1Z8
Phone: (416) 484-7750
E-mail: info@cmha.ca
Web: www.cmha.ca

Canadian Psychiatric Association
141 Laurier Ave. West, Suite 701
Ottawa, ON K1P 5J3
Phone: (613) 234-2815
E-mail: cpa@cpa-apc.org
Web: www.cpa-apc.org

Resources

Canadian Psychiatric Research Foundation (CPRF)
(author of this handbook)
133 Richmond St. West, Suite 200
Toronto, ON M5H 2L3
Phone: (416) 351-7757
E-mail: admin@cprf.ca
Web: www.cprf.ca

Centre for Addiction and Mental Health (CAMH)
Phone: (416) 535-8501 (main switchboard)
Web: www.camh.net

BOOK: Got Issues Much? Celebrity Teens Share Their Traumas and Triumphs (Randi Reisfeld, Marie Morreale, Scholastic, 1999).

KidsHaveStressToo
c/o The Psychology Foundation of Canada
2 St. Clair Ave. E., Suite 200
Toronto, ON M4T 2T5
Phone : (416) 644-4944
E-mail: info@psychologyfoundation.org
Web: www.kidshavestresstoo.org

Kids Help Phone
Kids Help Phone provides young people with counselling over the phone or online, a place where they can express themselves and ask questions and where they can find out more information on issues they face. Call **1-800-668-6868** or visit the Web site at www.kidshelphone.ca. The service is available 24-hours a day and is completely anonymous and confidential.

Learning Disabilities Association of Canada
323 Chapel Street
Ottawa, ON K1N 7Z2
Phone: (613) 238-5721
Web: www.ldac-taac.ca

The Nation's Voice on Mental Illness (NAMI)
Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
Phone: (703) 524-7600
Toll-free: 1-800-950-NAMI (6264)
TDD: (703) 516-7227*
Web: www.nami.org
Web (for NAMI's Child and Adolescent Action Centre):
www.nami.org/youth

Resources

BOOKLET: Parents and Teachers as Allies, Recognizing Early-onset Mental Illness in Children and Adolescents, Second Edition, 2003. NAMI, The Nation's Voice on Mental Illness. This booklet can be obtained from NAMI by calling (703) 524-7600. NAMI's Web site is www.nami.org, for further information.

National Institute of Mental Health (NIMH)
6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: (301) 443-4513
Toll-Free: 1-866-615-NIMH (6464)
Web: www.nimh.nih.gov

PsychDirect – Evidence Based Mental Health Education & Information
PsychDirect is a Canadian public education Web site of the Department of Psychiatry & Behavioural Neuroscience, McMaster University, Hamilton, Ontario.
E-mail: admin@psychdirect.com
Web: www.psychdirect.com

School Psychology Resources Online
School psychology resources for psychologists, parents and educators, and research learning disabilities, AD/HD, functional behavioural assessment, autism, adolescence, parenting, psychological assessment, special education, mental health, and more.
Web: www.schoolpsychology.net

Final Notes:

Remember that many of the above-listed organizations can direct you to local offices, resources, and services.

Most communities prepare a directory of local community agencies and services to help. It is often found in a "Blue Book" or on a Web site.

There are many resources available for the topics addressed in this handbook, and those listed in this handbook are only a selection of suggestions. Resources listed in this handbook are not necessarily endorsed by the Canadian Psychiatric Research Foundation, and their use should not replace a professional diagnosis by a health care practitioner. These resources should, however, help you to learn more about what you may be dealing with, and to get the help that you need.

When Something's Wrong (WSW) Handbook Series

When Something's Wrong: Strategies for Teachers provides information and classroom strategies to help educators understand and assist students with mood, behaviour or thinking disorders.

When Something's Wrong: Strategies for Families has been designed to give parents, caregivers or other family members useful strategies to cope with and assist their child with mood, behaviour or thinking difficulties.

When Something's Wrong: Strategies for Employers will be available fall of 2007

To order copies of handbooks from this series, please visit our website at www.cprf.ca

Canadian Psychiatric Research Foundation
Fondation canadienne de la recherche en psychiatrie

For further information
or to donate, contact:

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