Mental Health 101 for K-8 Students

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Prevention First

Resource Guide

Introduction

This guide is to be a supplement to the webinar

"Mental Health 101 for
K-8 Students"

Included in this guide will be information from the webinar and supplemental information related to the topic

Overview

- Developmental Stages; Review of Normal versus Abnormal Child Development
- Why Schools?
- DSM-IV TR
- Common Mental Health Issues, Review of Symptoms and Practice Skills

Erik Erickson's Stages of Development

Psychosocial Crisis Stage	Life Stage	age range, other descriptions
1. Trust v Mistrust	Infancy	0-1½ yrs, baby, birth to walking
2. Autonomy v Shame and Doubt	Early Childhood	1-3 yrs, toddler, toilet training
3. Initiative v Guilt	Play Age	3-6 yrs, pre-school, nursery
4. Industry v Inferiority	School Age	5-12 yrs, early school
5. Identity v Role Confusion	Adolescence	13-18 yrs, puberty, teens*

When working with children in the K-8 setting, it is important to consider their stage of development. What might be developmentally normal behavior for a 4 or 5 year old can be a sign of an issue that needs to be addressed in a 8 or 9 year old.

Mental Health Issue or Not? Red Flags or Not?

- If a child falls asleep every afternoon in class during the lesson?

- If a child is late for school often?

- If a child has frequent suspensions for not following directions in class?

- If a child has a temper tantrum?

- If a child is unkempt?

Children give us clues by their behaviors, presentation and affect. They may not have the ability to articulate what their issues are. We need to attend to the clues they provide us to determine when to intervene.

Developmental Goals (ages 6 to 12)

Ages 6 to 12

- To develop industry
  - Begins to learn the capacity to work
  - Develops imagination and creativity
  - Learns self-care skills
  - Develops a conscience
  - Learns to cooperate, play fairly, and follow social rules

Normal Difficult Behavior Ages 6 to 12

- Arguments/Fights with Siblings and/or Peers
- Curiosity about Body Parts of males and females
- Testing Limits
- Limited Attention Span
- Worries about being accepted
- Lying
- Not Taking Responsibility for Behavior

Cries for Help/More Serious Issues
Ages 6-12

- Excessive Aggressiveness
- Serious Injury to Self or Others
- Excessive Fears
- School Refusal/Phobia
- Fire Fixation/Setting
- Frequent Excessive or Extended Emotional Reactions
- Inability to Focus on Activity even for Five Minutes
- Patterns of Delinquent behaviors

Adolescence

"At your age, Tommy, a boy's body goes through changes that are not always easy to understand."

Developmental Goals

Developing Identity

The child develops self-identity and the capacity for intimacy

- Continue mastery of skills
  - Accepting responsibility for behavior
  - Able to develop friendships
  - Able to follow social rules

Normal Difficult Behavior

- Moodiness!
- Less attention and affection towards parents
- Extremely self involved
- Peer conflicts
- Worries and stress about relationships
- Testing limits
- Identity Searching/Exploring
- Substance use experimentation
- Preoccupation with sex

These are very typical issues that most, if not all, adolescents will struggle with. Overreaction to these normal developmental challenges can be detrimental. Support and being an active listener is often sufficient intervention.

Cries for Help- Ages 13-18

- Sexual promiscuity
- Suicidal/homicidal ideation
- Self-mutilation
- Frequent displays of temper
- Withdrawal from usual activities
- Significant change in grades, attitude, hygiene, functioning, sleeping, and/or eating habits
- Delinquency
- Excessive fighting and/or aggression (physical/verbal)
- Inability to cope with day to day activities
- Lots of somatic complaints (frequent flyers)

"Could someone help me with these?
I'm late for math class."
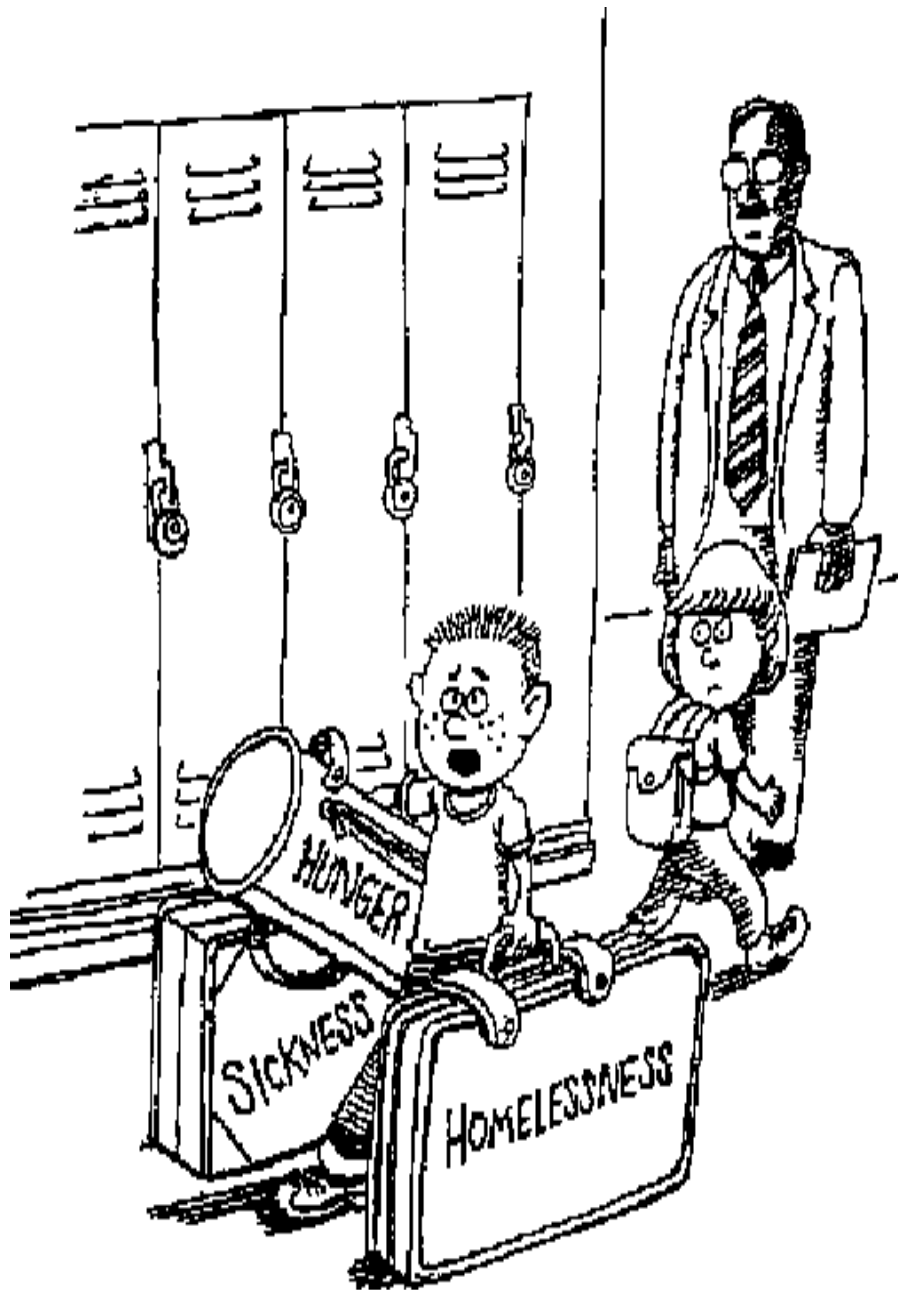
Schools: The Most Universal Natural Setting

- Over 55 million youth attend 114,700 schools (K-12) in the U.S.

- 6.8 million adults work in schools

- Combining students and staff, approximately 20% of the U.S. population can be found in schools during the work week.

Overview of Children's Mental Health Needs

- Between 20% to 38% of youth in the U.S. have diagnosable mental health disorders

- Between 9% to 13% of youth have serious disturbances that impact their daily functioning

- Between one-sixth to one-third of youth with diagnosable disorders receive any treatment

- Schools provide a natural, universal setting for providing a full continuum of mental health care

Workforce Issues

- 15% of teachers leave after year 1
- 30% of teachers leave within 3 years
- 40-50% of teachers leave within 5 years

(Smith and Ingersoll, 2003)

Stability and consistency are two of the most important factors for children to be able to meet the challenges of normal development. For our students that have challenges with this in the home environment, having this in the school setting can be crucial. Try not to match up students with issues with staff that have a less amount of experience.

Opportunities in Schools

- Can do observations of children in a natural setting
- Can outreach to youth with internalizing disorders
- Can provide three tiers of service (universal, selective, and indicated)
- Can be part of a multidisciplinary team involving school staff, families, and youth

What is the DSM?

- A reference guide for diagnosing mental health concerns
- Published by the American Psychiatric Association in May 2000
- For each Diagnosis provides specific criteria that needs to be met

Depressive Disorders

- Major Depressive Disorder

- Dysthymic Disorder

- Depressive Disorder Not Otherwise Specified (NOS)

Depression

Epidemiology

- 2.5% of children, up to 5% of adolescents
- Prepubertal-1:1/F:M; adolescence-4:1/F:M
  - Average length of untreated Major Depressive Disorder – 7.2 months
  - Recurrence rates-40% within 2 years

Heredity

Most important risk factor for the development of depressive illness is having at least one affectively ill parent

Major Depressive Disorder

I. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning.   At least one symptom is either (1) depressed mood or (2) loss of interest or pleasure.

- Depressed mood most of the day, nearly every day, as indicated by subjective report or based on the observations of others. In children and adolescents, this is often presented as irritability.
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
- Significant weight loss when not dieting or weight gain (change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day (observable by others)
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or inappropriate guilt nearly every day
- Diminished ability to think, concentrate, make a decision nearly every day

Major Depressive Disorder

II.   Symptoms cause clinically significant distress or impairment in social or academic functioning

III.   Symptoms are not due to the direct physiological effects of a substance (drugs or medication) or a general medical condition

Although there is a different diagnostic category for individuals who suffer from Bereavement, many of the symptoms are the same and counseling techniques may overlap.

Dysthymic Disorder

- Major difference between a diagnosis of Major Depressive Disorder and Dysthymia is the intensity of the feelings of depression and the duration of symptoms.

- Dysthymia is an overarching feeling of depression most of the day, more days than not, that does not meet criteria for a Major Depressive Episode.

- Impairs functioning and lasts for at least one year in children and adolescents, two in adults.

What depression may look like:

- Negative thinking – "I can't, I won't"
- Social withdrawal
- Irritability
- Poor school performance (not just grades)
- Lack of interest in peer activities
- Muscle aches or lack of energy
- Reports of feeling helpless a lot of the time.
- Lowering their confidence-level about intelligence, friends, future, body, etc.
- Getting into trouble because of boredom.

What Works for Depression

- Psychoeducation
- Cognitive/Coping
- Problem Solving
- Activity Scheduling
- Skill-building/Behavioral Rehearsal
- Social Skills Training
- Communication Skills

Cognitive/Coping

- Change cognitive distortions
- Increase positive self talk
- Identify the type of event that will trigger the irrational thought.
- Help students become aware of their thoughts
- Recognize and get rid of negative self talk
- Counter negative thoughts with realistic positive self talk
- Believe the positive self talk!
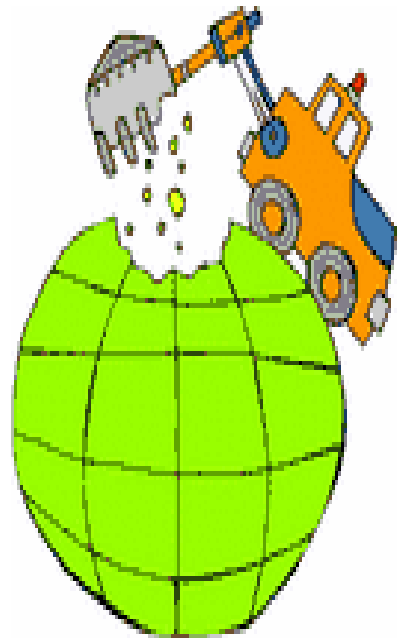
Cognitive Distortions

- **<u>Exaggerating</u>** - Making self-critical or other critical statements that include terms like never, nothing, everything or always.

"I'm never going to be asked out on a date."

- **<u>Filtering</u>** - Ignoring positive things that occur to and around self but focusing on and inflating the negative.

"My new hair cut looks awful; people are laughing at me."

- **<u>Labeling</u>** - Calling self or others a bad name when displeased with a behavior

"My parents are dictators; they are always telling me what to do."

Cognitive Distortions

- **<u>Discounting</u>** - Rejecting positive experiences as not important or meaningful.

After getting a compliment from the teacher… "Anybody could have drawn that; I don't have any special ability."

- **<u>Catastrophizing</u>** - Blowing expected consequences out of proportion in a negative direction.

After not making the team… "My life is over; I'll never have any friends or any fun."

- **<u>Self-blaming</u>** - Holding self responsible for an outcome that was not completely under one's control.

"My parents argue so much because of me; if I acted better they wouldn't have to separate."

Anxiety

- Panic Disorder
- Obsessive Compulsive Disorder
- Specific Phobias
- Separation Anxiety Disorder
- Posttraumatic Stress Disorder
- Generalized Anxiety Disorder

Anxiety - Prevalence

- 13% of youth ages 9 to 17 will have an anxiety disorder in any given year

- Girls are affected more than boys

- ~1/2 of children and adolescents with anxiety disorders have a 2nd anxiety disorder or other co-occurring disorder, such as depression

Impact of trauma on learning

- Decreased IQ and reading ability (Delaney-Black et al., 2003)

- Lower grade-point average (Hurt et al., 2001)

- More days of school absence (Hurt et al., 2001)

- Decreased rates of high school graduation (Grogger, 1997)

- Increased expulsions and suspensions (LAUSD Survey)

Effective Practice Strategies

- Modeling
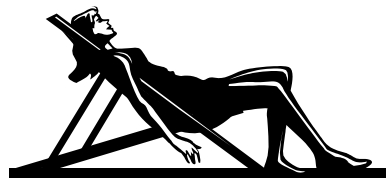- Relaxation
- Cognitive/Coping
- Exposure

What is <u>Modeling</u>?

- Demonstration of a desired behavior by a therapist, confederates, peers, or other actors to promote the imitation and subsequent performance of that behavior by the identified youth

What is <u>Relaxation</u>?

- Techniques or exercises designed to induce physiological calming, including muscle relaxation, breathing exercises, meditation, and similar activities.

- Guided imagery exclusively for the purpose of physical relaxation is considered relaxation.

Relaxation: Deep Breathing

- Breathe from the stomach rather than from the
  lungs

- Can be used in class without anyone noticing

- Can be used during stressful moments such as
  taking an exam or while trying to relax at home

- Children should breathe in to the count of 5, and
  out to the count of 5. Adolescents should breathe
  in and out to the count of 8

- Have them take 3 normal breaths in between deep breaths

- Have them imagine a balloon filling with air, then totally emptying

Relaxation: Mental Imagery/Visualization Tips

- Have the student close his/her eyes and imagine a relaxing place such as a beach

- While they imagine this, describe the place to them, including what they see, hear, feel, and smell

- Younger students may use a picture or drawing to help them

Relaxation: Progressive Muscle Relaxation

- Alternating between states of muscle tension and relaxation helps differentiate between the two states and helps habituate a process of relaxing muscles that are tensed

- Many good tapes/c.d.'s available on relaxation

ADHD Prevalence

- Range from 1-16% depending on criteria used

- 3-5% prevalence in school-age children

- Male: female ratio is 3:1 to 10:1

- Occurs more frequently in lower SES

ADHD DSM-IV Diagnosis

- 6 or more inattentive items
- 6 or more hyperactive/impulsive items
- Persistent for at least 6 months
- Clinically significant impairment in social, academic, or occupational functioning
- Inconsistent with developmental level
- Some symptoms that caused impairment before the age of 7
- Impairment is present in two or more settings (school, home, work)

Inattention

1) Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
2) Often has difficulty sustaining attention in task or play activities
3) Often does not seem to listen when spoken to directly
4) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositionality or failure to understand instructions)
5) Often has difficulty organizing tasks and activities
6) Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort
7) Often loses things necessary for tasks or activities
8) Is often easily distracted by extraneous stimuli
9) Is often forgetful in daily activities

Hyperactivity

1) Often fidgets with hands or feet or squirms in seat

2) Often leaves seat in classroom or in other situations in which remaining seated is expected

3) Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

4) Often has difficulty playing or engaging in leisure activities quietly

5) Is often "on the go" or often acts as if "driven by a motor"

6) Often talks excessively

Impulsivity

1) Often blurts out answers before questions have been completed
2) Often has difficulty awaiting turn
3) Often interrupts or intrudes on others
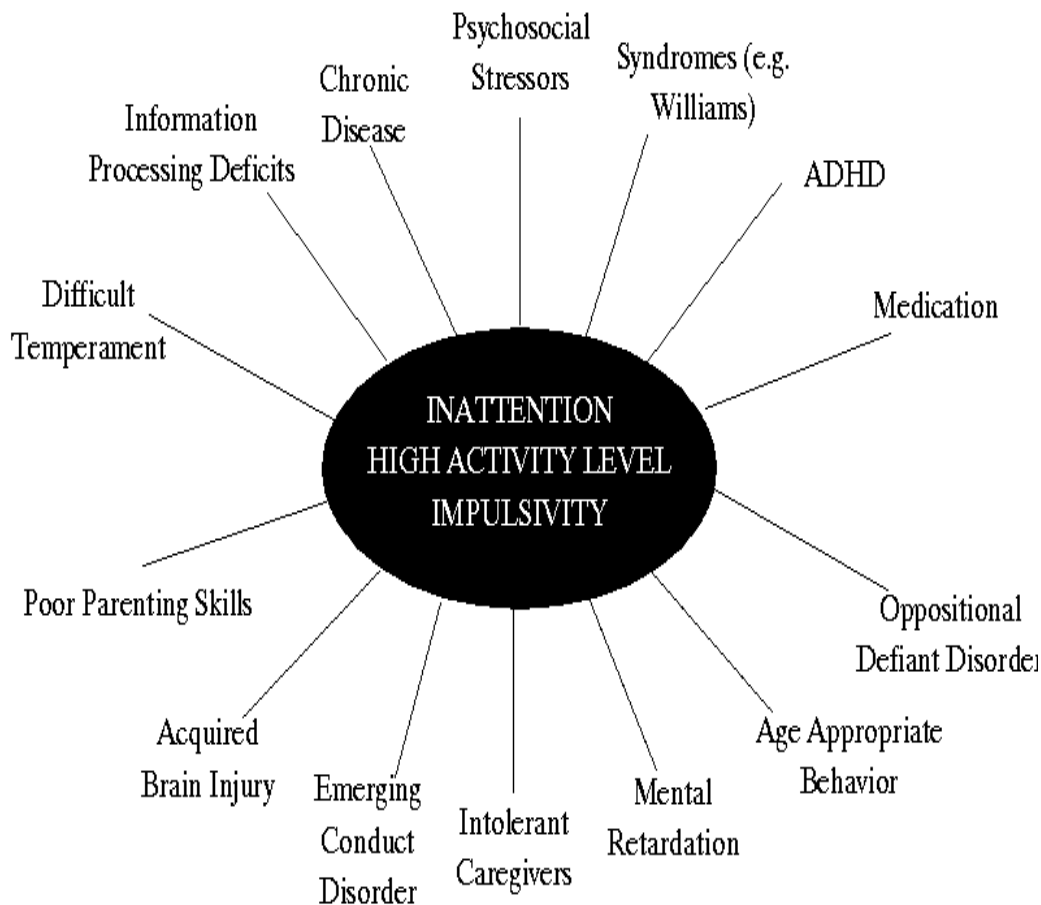
Make sure it is ADHD!

Figure from Blackman, 1999

There are many similarities between ADHD and other disorders. Make sure that the student has a thorough evaluation to make sure their diagnosis is accurate. The diagnosis informs the interventions and appropriate interventions for one diagnosis can be counterproductive with another diagnosis.

What Doesn't Work for ADHD?

- Treatments with little or no evidence of effectiveness include
  - Special elimination diets
  - Vitamins or other health food remedies
  - Psychotherapy or psychoanalysis
  - Biofeedback
  - Play therapy
  - Chiropractic treatment
  - Sensory integration training
  - Social skills training
  - Self-control training

While there may be isolated incidence of success with one of these interventions, the research does not support their effectiveness in the general ADHD population

Basic Principles for Effective Practice for ADHD

- Clear and brief rules
- Swift consequences
- Frequent consequences
- Powerful consequences
- Rich incentives
- Change rewards
- Expect failures
- Anticipate

Praise

- Praising correctly increases compliance in youth with ADHD
  - Praise can include
    - Verbal praise, Encouragement
    - Attention
    - Affection
    - Physical proximity

Giving Effective Praise

- Be honest, not overly flattering
- Be specific
- No "back-handed compliments" (i.e., "I like the way you are working quietly, why can't you do this all the time?")
- Give praise immediately

Ignoring and Differential Reinforcement

- Train staff and teachers to **selectively**
  - Ignore mild unwanted behaviors

    AND

  - Attend to and REINFORCE alternative positive behaviors

How to ignore

- Visual cues
  - Look away once child engages in undesirable behavior
  - Do not look at the child until behavior stops

- Postural cues
  - Turn the front of your body away from the location of child's undesirable behavior
  - Do not appear frustrated (e.g., hands on hip)
  - Do not vary the frequency or intensity of your current activity (e.g., talking faster or louder)

How to ignore

- Vocal cues
  - Maintain a calm voice even after your child begins undesirable behavior
  - Do not vary the frequency or intensity of your voice (e.g., don't talk faster or shout over the child)

- Social cues
  - Continue your intended activity even after your child begins undesirable behavior
  - Do not panic once child's begins inappropriate behavior (i.e., do not draw more attention to child)

When to Ignore

- When to ignore undesirable behavior
    - Child interrupts conversation or class
    - Child blurts out answers before question completed
    - Child tantrums

- Do **not** ignore undesirable behavior that could potentially harm the child or someone else

Differential reinforcement

Step One: Ignore (stop reinforcing) the child's undesirable behavior

Step Two: Reinforce the child's desirable behavior in a systematic manner

- The desirable behavior should be a behavior that is incompatible with the undesirable behavior

Example:

- Target behavior: Interrupting
- Desirable behavior: Working by himself
- Reward schedule: 5 minutes
  - If child goes 5 minutes without interrupting, the child receives reinforcement
  - If child interrupts before 5 minutes is up, the child does not receive reinforcement and the reward schedule is reset

Defining Disruptive Behaviors

- Types of Disruptive Behavior Disorders (DBD):
  - ADHD
  - Oppositional Defiant Disorder (ODD) – loses temper, argues with adults, easily annoyed, actively defies or refuses to comply with adults.
  - Conduct Disorder (CD) – aggression toward peers, destruction of property, deceitfulness or theft, and serious violation of rules.

Oppositional Defiant Disorder

"You left your D@%& car in the driveway again!"

Oppositional Defiant Disorder

A pattern of negativistic, hostile and defiant behavior lasting greater than 6 months of which you have 4 or more of the following:

- Loses temper
- Argues with adults
- Actively defies or refuses to comply with rules
- Often deliberately annoys people
- Blames others for his/her mistakes
- Often touchy or easily annoyed with others
- Often angry and resentful
- Often spiteful or vindictive

Oppositional Defiant Disorder
(ODD)

- Prevalence-3-10%

- Male to female -2-3:1

- Outcome-in one study, 44% of 7-12 year old boys with ODD developed into CD

- Evaluation-Look for comorbid ADHD, depression, anxiety & Learning Disability/Mental Retardation

Conduct Disorder
(CD)

- Aggression toward people or animals

- Deceitfulness or Theft

- Destruction of property

- Serious violation of rules
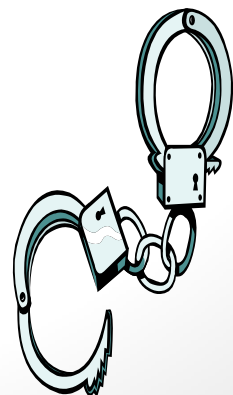
Conduct Disorder
(CD)

- Prevalence-1.5-3.4%
- Boys greatly outnumber girls (3-5:1)
- Co-morbid ADHD in 50%, common to have LD
- Course-remits by adulthood in 2/3. Others become Antisocial Personality Disorder
- Can be diagnosed as early onset (before age 10) or regular onset (after age 10)

Practices that Work with DBD

- Praise
- Commands/limit setting
- Tangible rewards
- Response cost
- Psychoeducation
- Problem solving

Steps to Making Effective Commands

1. To make eye contact with the child before giving command
2. To reduce other distractions while giving commands
3. To ask the child to repeat the command
4. To watch the child for one minute after giving the command to ensure compliance
5. To immediately praise child when s/he starts to comply

# Effective Commands/Limit Setting with Adolescents

- Praise teens for appropriate behavior
- Tell teen what **to** do, rather than what **not** to do
- Eliminate other distractions while giving commands
- Break down multi-step commands
- Use aids for commands that involve time
- Present the consequences for noncompliance
- Not respond to compliance with gratitude

Setting up a Reward System for Children at School

- School staff tracks the child's behavior and reports it to the parent daily.
  - Rewards can given at home or at school
- Choose a few target behaviors at school
  - Choose one that the child will be successful with most of the time
  - Set up a system for school report card or school/home note system
- Set up a daily report card targeting one to three behaviors
- Can also set up guidance counselor, tutor or peer as "coach" for organizational skills or other targets

Acting Out Cycle

Peak

Acceleration

De-escalation

Agitation

Trigger

Calm

Recovery
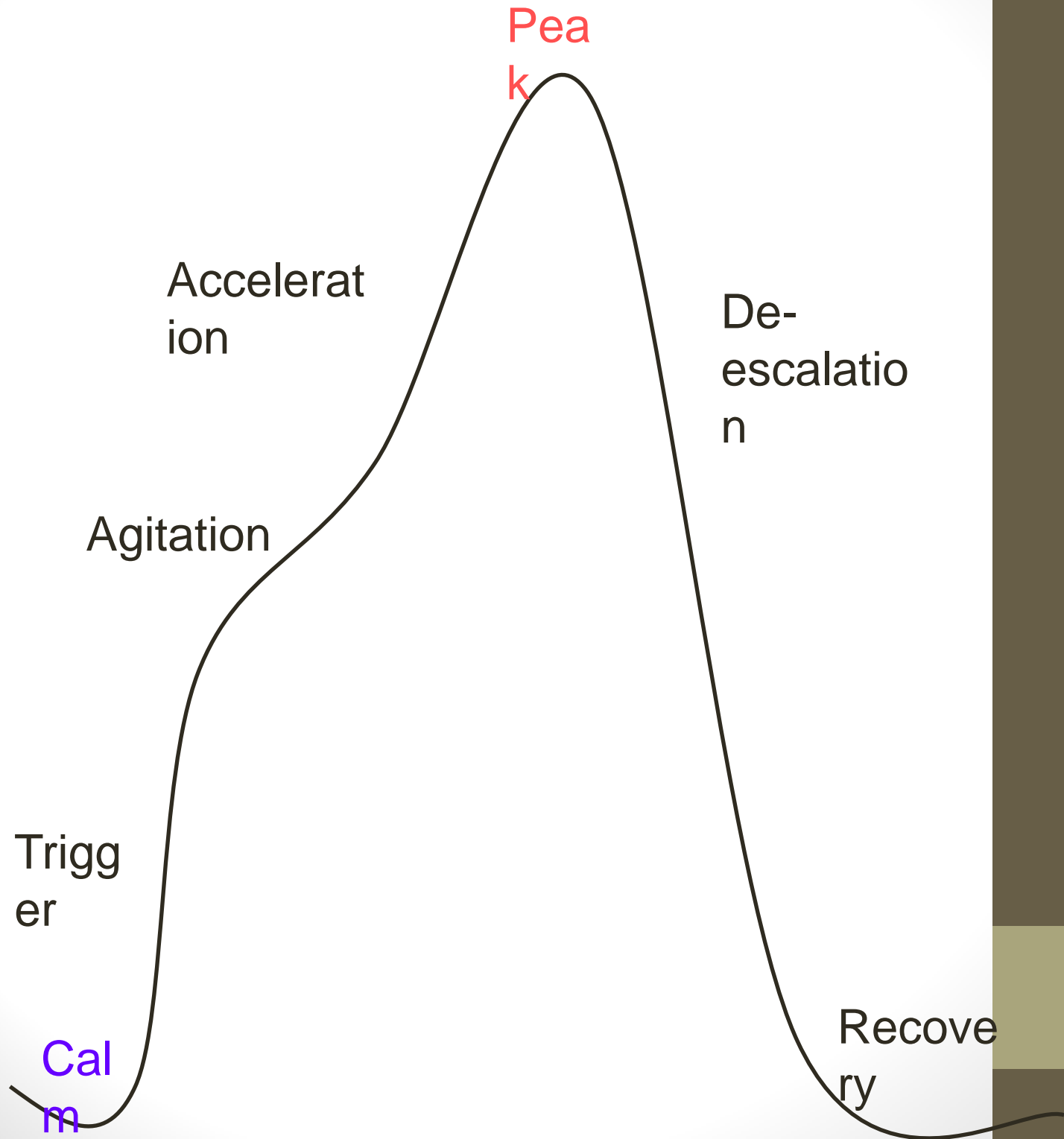
Parting Words.......

General Strategies

- Use active listening
- Don't be afraid to show that you care
- Be a good role model
- Take the time to greet students daily
- Show genuine interest in their lives and hobbies
- Find and reinforce the positives
- Move beyond labels and leave assumptions at home!
- Smiles are contagious
- Take the time to problem solve with students
- Involve families in a child's education
- Instill hope about the future