

Anxiety Disorder Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/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
- Low frustration tolerance
- Irritable
- Dizzy
- Shortness of breath
- Fear of new situations
- Drug or alcohol abuse
- Unrealistic, obsessive fears
- Tension about everyday life events

Resources: See macmh.org/edguidelink for more anxiety disorder specific resources.

About the Disorder

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

Excessive fear and anxiety are characteristics shared by all anxiety disorders. Fear is the emotional reaction to an actual threat; however, the fear experienced by a person with an anxiety disorder is related to an expected or impending threat. These fears and anxieties are also out of proportion to the perceived threatening situation.

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 disorders so that treatment can begin early—preventing academic, social, and vocational failure.

Anxiety disorders are among the most common mental health disorders of childhood and adolescence and are twice as likely to be experienced by females than males. The National Institute of Mental Health (NIMH) reports that approximately 8 percent of teens ages 13-18 have an anxiety disorder. About 50 percent of children and adolescents with an anxiety disorder also have a second anxiety disorder or other mental disorder such as depression.

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.

The most common anxiety disorders affecting children and adolescents are:

Generalized Anxiety Disorder

Students experience extreme, unrealistic worry related to upcoming events. They are often self-conscious, tense, irritable, easily tired, and have a very strong need for reassurance. They may have difficulty concentrating, sleeping, and suffer from aches and pains that appear to have no physical basis.

Specific Phobia

Students have excessive, immediate fears about a specific object or situation. Specific phobias center on animals, storms, water, or situations such as being in an enclosed space. Most individuals with a specific phobia, fear more than one object or situation. Because students with phobias will try to avoid the objects and situations they fear, the disorder can greatly restrict their lives.

Separation Anxiety Disorder

Separation from a parent or major attachment figure causes recurrent, developmentally inappropriate, excessive fear and anxiety. The fear of

separation may result in a student refusing to leave home or go to school. They may experience frequent nightmares, physical complaints, and a fear of being alone.

Social Anxiety Disorder (Social phobia)

Students have significant fear or anxiety of situations where they are being watched, criticized, or judged harshly by others. They will attempt to avoid the social situations they fear. This fear can be so debilitating that it may keep students from going to school.

Panic Disorder (Panic Attacks)

Panic attacks are periods of intense fear accompanied by a pounding heartbeat, sweating, dizziness, nausea, or a feeling of imminent death. The attacks are a repeated experience that can be expected or unexpected. Unexpected panic attacks seem to come out of the blue—they don't have a clear reason or trigger. Expected panic attacks have an apparent cue or trigger, such as an attack occurring in a similar situation. Students with a panic disorder will go to great lengths to avoid a panic attack. This may mean refusal to attend school or be separated from parents.

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 complete it correctly. 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, students are not likely to report 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 a flexible deadline for worrisome assignments.
- Have the student check with the teacher or have the teacher check with the student to ensure 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 a student's 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 student's regular schedule as possible.
- Encourage school attendance—to prevent absences, modify the student's class schedule or reduce the time spent at school.
- Introduce secondary students to new teachers each quarter.
- Maintain regular communication with parents when students remain at home.
- Ask parents what works at home.
- Consider the use of technology. Many students will benefit from easy access to appropriate technology, which may include applications that can engage student interest and increase motivation (e.g., computer-assisted instruction programs, YouTube or webinar demonstrations, videotape presentations).

*For additional suggestions on classroom strategies and modifications, see *An Educator's Guide to Children's Mental Health* chapter on Meeting the Needs of All Students.*

Attention-Deficit / Hyperactivity Disorder Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/Behaviors

The DSM-5 lists three types of ADHD

Inattentive type

- Short attention spans
- Problems with organization
- Trouble paying attention to details
- Unable to maintain attention
- Easily distracted
- Trouble listening even when spoken to directly
- Fail to finish their work
- Make lots of mistakes
- Forgetful
- Frequently lose things to complete tasks (pencil, book)

Hyperactive-Impulsive type

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

Combined type

Symptoms of both inattentive and hyperactive-impulsive type

Resources: See macmh.org/edguidelink for more ADHD specific resources.

About the Disorder

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

The DSM-5 classifies ADHD as a Neurodevelopmental Disorder. It lists three forms of ADHD: inattention, hyperactivity-impulsivity, and combined inattention, hyperactivity-impulsivity. Students with inattentive symptoms may be described as daydreamers or spaced out. These students are more socially withdrawn and have more frequent problems with mild anxiety than students with the hyperactive-impulsive type. They frequently experience forgetfulness and boredom. They may also have trouble remembering instructions and responsibilities, have problems with focusing, and have an aversion to mentally challenging tasks. Symptoms of inattentiveness may be difficult for teachers to detect, and many students—especially girls—are diagnosed much later or are never identified. Girls are more likely to have the inattentive type of ADHD.

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

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

The Centers for Disease Control and Prevention (CDC) reports that an estimated 11 percent of children ages 4-17 were diagnosed with ADHD in 2011 and that boys were almost twice as likely to be diagnosed than girls. ADHD is the leading cause of referrals to mental health professionals and special education programs, as well as the juvenile justice system. Students with the inattentive type (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 ADHD are at higher risk for learning disorders, anxiety disorders, conduct disorder, and mood disorders such as depression. Without proper treatment, students 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 disorder.

If you suspect that a student has ADHD, refer the student for a mental health assessment. Many students benefit from medications. A professional, such as a child psychiatrist, pediatrician, or neurologist who is experienced in treating ADHD, must manage medications. In addition, many mental health professionals will work with the family and school personnel to find ways to teach students with ADHD more effectively.

Students identified with ADHD 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 a Fetal Alcohol Spectrum Disorder (FASD). Remember that ADHD is a neurobiological disorder. Students can't get organized or learn social skills on their own, but educators can find interventions that may greatly increase a student's capacity to succeed.

Educational Implications

Children with ADHD may have trouble staying on task or finishing assignments. They may lose books, supplies, and homework. Students may blurt out answers before teachers can finish asking the question. They may be irritable, impatient, hard to discipline, clumsy, reckless, and accident-prone. Students with ADHD may struggle with low tolerance for frustration and have trouble following rules. Often they are poor sports in games, and they may seem intrusive or bossy in their play. As a result, students with ADHD face social challenges because their peers may perceive them as immature and annoying, or students 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 ensure that assignments have been written down correctly. Some teachers initial an assignment notebook to indicate that information is correct.
- Consider a Functional Behavioral Assessment (FBA). Understanding the purpose or function of the student's behaviors may help you respond with more effective interventions.
- Once you have a better understanding of a student's behaviors and learning style, consider modifying or adapting the curriculum and environment.
- Provide consistent structure and clearly define your expectations.
- When giving instructions or tasks, it's helpful to break them into numerous steps. Give the student one or two steps at a time.
- Allow the student to turn in late work for full credit.
- Allow the student to redo assignments to improve score or final grade.
- Allow the student to move about within reason. For example, give them tasks that require them to get out of their seat, such as passing out papers, or give them short breaks to exercise or stretch.
- Teach social skills.
- Catch your student being good. Look for positive behaviors to reward and reinforce. Many students with ADHD 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 student recognize that they have gotten off task and must refocus. This helps the student stay on task without embarrassment.
- Allow a student to use tables or formulas—memorization may be very difficult.
- Allow the student to answer directly in a booklet. This reduces the amount of movement and distraction during an assignment.
- Teach students with ADHD self-monitoring techniques. Help them identify social cues from their peers and adults that would suggest a need for a behavior change. Also help students identify an aid or technique that will help them calm down or refocus, such as exercise, short breaks away from stimulation, or meditation.
- Reduce stress and pressure whenever possible. Students with ADHD 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.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health chapter on Meeting the Needs of All Students.

Autism Spectrum Disorder Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/Behaviors

- Isolate themselves from their peers
- Considered odd by other students
- Clumsy or awkward gait
- Difficulty with physical activities and sports
- Repetitive pattern of behavior
- Problem with time and spatial awareness
- Preoccupation with one or two subjects or activities
- Under or over sensitive to stimuli such as noise, light, or unexpected touch
- Victim of teasing and bullying
- Inappropriate or minimal social interactions
- Limited interests
- Peculiar preoccupations
- Often misses subtle social nuances
- Conversations almost always revolve around self rather than others
- Lack common sense
- Few facial expressions
- Odd behaviors or mannerisms
- Obsession with complex topics such as patterns or music

Resources: See macmh.org/edguidelink for more autism spectrum disorder specific resources.

About the Disorder

Autism spectrum disorder (ASD) is a neurodevelopmental disorder that can cause significant communication, social, and behavioral impairment. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines ASD as a single disorder that includes disorders that were once diagnosed separately, including Asperger's syndrome and pervasive developmental disorder not otherwise specified (PDD). The cause of autism is not known. However it is generally believed that both genetics and environment play a role.

The Centers for Disease Control and Prevention (CDC) estimates that about 1 in 68 children has been identified with ASD. ASD occurs in all ethnic, racial, social, and economic groups and is almost 5 times more common among boys than among girls. Symptoms begin in early childhood, however, they are often not identified until later in a child's life.

The symptoms of ASD are unique for each child or adolescent. ASD symptoms may vary greatly from mild to very severe. A student's ability to learn and think may range from gifted to extremely challenged. The symptoms fall into two main areas: impairment in social communication and interactions, and repetitive and restrictive behaviors.

Communication and social interactions present significant challenges for students with ASD. Students with ASD frequently avoid eye contact, interpret communication literally, and misread nonverbal cues. They often have difficulty participating in reciprocal communication or back-and-forth conversation patterns and misunderstand sarcasm, jokes and metaphors. Students with these symptoms also struggle to use language "in context," such as using tone of voice to match the setting. They may not tolerate social interactions that don't go "their way" or as they expected. Their social skills may not be age appropriate and they are generally socially awkward. Students with ASD have difficulty developing friendships with students their own age. Their interests can be overly focused or fixated and consequently they may resist trying new games or activities. Students with ASD may also have repetitive behaviors such as flapping their arms, lining up toys or repeating the words said by another person. They depend on rigid routines and schedules and are intolerant to any changes. Disruptions may result in strong verbal complaints or physical outbursts that appear out of context to the situation.

Educational Implications

Symptoms of ASD may vary greatly from student to student. Students may appear to be in their own world and seem oblivious to classroom materials, people, or events. While they might seem distracted, they are often actually paying close attention to teachers and the material being presented. Many students with ASD have difficulty understanding social interactions, including nonverbal gestures. They may fail to develop age-appropriate peer relationships or be unable to share interests or show empathy. When confronted by changes in school routine, they may show visible anxiety, withdraw into silence, or burst into a fit of rage. Students with ASD can be very literal and have great difficulty using language in a social context. They may like school, but wish the other students weren't there. Teaching must be direct and targeted to the students' specific difficulties. This includes social skills, communication, and academic subject matter as well as routines like standing in line. Students with ASD have sensitivities that are easily triggered by overly loud, fast-paced, or critical tones of voice. A clear, patient, and calm teacher is essential to helping students with ASD. Parents and professionals who are familiar with the student may be the best source of information and support for educators.

Instructional Strategies and Classroom Accommodations

- Create a structured, predictable, and calming environment. Consult an occupational therapist for suggestions on handling your student's sensory needs.
- Foster a climate of tolerance and understanding in the classroom. Consider assigning a peer helper to assist the student in joining group activities and socializing.
- Use direct teaching to increase socially acceptable behaviors, expected greetings and responses, and group interaction skills.
- 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.
- If projects are required, break down each step and help the students to see them as "pieces of the puzzle" which will eventually all fit together.
- Learn the usual triggers and the warning signs of a "melt-down" and intervene before control is lost. Help the students learn self-calming and self-management skills.
- Use a team approach when developing curriculum and classroom adaptations. Occupational therapists and speech-language pathologists can be very helpful, and evaluations for assistive/augmentative technology should be done early and often.
- When teaching basic skills, use materials that are age-appropriate, academically appropriate, positive, and relevant to students' lives.
- Avoid long strings of verbal instruction. Use written checklists, picture charts, or object schedules instead. If necessary, give instructions one step at a time.
- Minimize visual and auditory distractions. Modify the environment to meet the students' sensory needs.
- Help students develop functional learning skills through direct teaching. (Teach them to work left to right and top to bottom.)
- 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 students avoid eye contact 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.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health chapter on Meeting the Needs of All Students.

Bipolar Disorder Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/Behaviors

- Irritable mood
- Very sad – lasting a long time
- Feeling worthless or guilty
- Loss of interest in activities that were previously enjoyed
- Talking a lot
- Racing thoughts
- Explosive, lengthy, and destructive rages
- Separation anxiety
- Defiance of authority
- Hyperactivity, agitation
- Difficulty concentrating or paying attention
- Overly silly or joyful mood that is unusual for the student
- Excessive involvement in multiple projects and activities
- Impaired judgment and impulsivity
- Risk-taking behaviors
- Inappropriate or precocious sexual behavior
- Delusions and hallucinations
- Thoughts of suicide
- Inflated self-esteem or grandiose belief in own abilities (become a rock star overnight, for example)
- Complaints of frequent pain, such as headaches and stomach aches

Resources: See macmh.org/edguidelink for more bipolar disorder specific resources.

About the Disorder

Bipolar disorder 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. Symptoms can range from extremely happy or short tempered to long periods of extreme sadness. They can result in damaged relationships, poor job or school performance, and even suicide.

The DSM-5 states that bipolar disorder can develop at any age; however, the average onset of bipolar is 18. About 2 to 3 percent of the population age 18 and older in any given year, have bipolar disorder. Children/youth with bipolar disorder are more likely to have parents or siblings who have the disorder. Like diabetes or heart disease, bipolar disorder is a long-term illness that must be carefully managed throughout a person's life. There is no cure for bipolar disorder but treatment can help children/youth recover and live productive and enjoyable lives.

Unlike adult-onset bipolar disorder, children and young adolescents with the illness often experience more severe symptoms and frequent mood changes. 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 children/youths with bipolar disorder. Older adolescents who develop the illness may have more classic, adult-type episodes and symptoms.

Bipolar disorder in students can be hard to tell apart from other disorders 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.

Students with bipolar disorder are at a higher risk for suicide. A large study on bipolar disorder of over 400 children and teens, reported by the National Institute on Mental Health (NIMH), found that "more than one-third of study participants made at least one serious suicide attempt." The DSM-5 reports that, "the risk of suicide in individuals with bipolar disorder is estimated to be 15 times greater than the general population." It's important to remember that any student who has suicidal feelings, talks about suicide, or attempts suicide should be taken seriously and should receive immediate help from a mental health professional.

Educational Implications

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

Students may have fluctuations in cognitive abilities. They often have an impaired ability to plan, organize, concentrate, and use abstract reasoning. These students may experience heightened sensitivity to perceived criticism, are easily frustrated and may cry for no apparent reason, or they may be seemingly inconsolable when distressed. Students may also have inflated self-esteem. They may over-estimate their abilities. A student might believe, for example, that they are the smartest kid in the whole school. Teachers may notice how irrational these students seem to be, and that trying to reason with them often doesn't work. Most of the students with bipolar disorder experience extremely high levels of anxiety that interfere with their ability to logically assess a situation.

Many students with bipolar disorder will be on medications that can affect their ability to think clearly or lead to physically uncomfortable side effects that interfere with school performance.

Instructional Strategies and Classroom Accommodations

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

*For additional suggestions on classroom strategies and modifications, see *An Educator's Guide to Children's Mental Health* chapter on Meeting the Needs of All Students.*

Conduct Disorder Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/Behaviors

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

Resources: See macmh.org/edguidelink for more conduct disorder specific resources.

About the Disorder

Children and adolescents with conduct disorder are highly visible, demonstrating a complicated group of behavioral and emotional problems. Students with conduct disorder tend to be impulsive, dishonest, and not concerned about the feelings of others. Serious, repetitive, and persistent misbehavior is the essential feature of this disorder.

These behaviors fall into four main groups: aggressive behavior toward people or animals, destruction of property, deceitfulness or theft, and serious violations of rules. To receive a diagnosis of conduct disorder the symptoms must cause significant impairment in social and academic functioning.

Diagnosing conduct disorder can be a dilemma because children/youth 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 students with conduct disorder also have learning disabilities and about 1/3 may be depressed.

Other serious disorders of childhood and adolescence commonly associated with conduct disorder are attention-deficit/hyperactivity disorder (ADHD) or oppositional defiant disorder (ODD). The majority of students with conduct disorder may have life-long patterns of antisocial behavior and be at higher risk for a mood or anxiety disorder. Without treatment, many students cannot adapt to the demands of adulthood; they will have ongoing relationship problems and difficulty holding a job.

The causes of conduct disorder are unknown, but studies of twins and adopted children suggest that conduct disorder has biological (including genetic), psychological, and social components. The DSM-5 states that the quality of the child's family life seems to be an important factor in the development of conduct disorder. Certain environmental factors may increase the risk of disruptive behavior disorders including: harsh or inconsistent parenting, domestic violence, physical abuse, neglect, multiple/different caregivers, substance abuse by parents or care giver, and poverty. Other contributing factors may be an imbalance of certain chemicals in the brain. Studies have shown that impairment in frontal lobe and low serotonin levels may also be factors in causing conduct disorder.

The social context in which a student lives (poverty or a high crime area, for example) may influence what is viewed 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.

Educational Implications

Students with conduct disorder like to engage in power struggles. They often react badly to direct demands or statements such as: “You need to...” or “You must....” They may consistently challenge class rules, refuse to do assignments, and argue or fight with other students. This behavior can cause significant impairment in both social and academic functioning. They also work best in environments with high staff/student ratios, one-to-one situations, or self-contained programs when there is plenty of structure and clearly defined guidelines. A student’s frequent absences and 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 using “infantile” materials to teach basic skills. Materials should be age appropriate, positive, and relevant to students’ lives.
- Remember that praise is important but needs to be sincere.
- Consider the use of technology. Students with conduct disorder tend to work well on computers with active programs.
- Students with conduct disorder often do well in programs that allow them to work outside the school setting.
- Sometimes adults can subconsciously form and behaviorally express negative impressions of low-performing, uncooperative students. Try to monitor your expressions, 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 students with conduct disorder like to argue. Remain respectful, calm, and detached. Avoid power struggles and don’t argue.
- Give the student options. Stay away from direct demands or statements such as: “You need to...” or “You must....”
- Avoid escalating prompts such as shouting, touching, nagging, or cornering the student.
- Establish clear classroom rules. Rules should be few, fair, clear, displayed, taught, and consistently enforced. Be clear about what is nonnegotiable.
- Have the 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, breaking down of academic tasks, debriefing, coaching, and providing positive incentives.
- Structure activities so the student with conduct disorder is not always left out or the last one picked.

*For additional suggestions on classroom strategies and modifications, see *An Educator’s Guide to Children’s Mental Health* chapter on Meeting the Needs of All Students.*

Eating Disorder Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/Behaviors

- Controlled emotional expression
- Inflexible thinking
- Impaired concentration
- Withdrawn
- Concerned about eating in public
- Depressed mood or mood swings
- Self-deprecating statements
- Irritability
- Lethargy
- Fainting spells, dizziness, fatigue, and overall weakness
- Headaches
- Hiding food
- Avoiding snacks or activities that include food
- Frequent trips to the bathroom
- Refusing to eat or lying about how much was eaten
- Throwing up after meals
- Increased anxiety about weight
- Feeling cold all the time
- A need to control environment
- Over exercising

Resources: See macmh.org/edguidelink for more eating disorder specific resources.

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 adolescents and young adults, the beginnings of eating disorders are increasingly found in younger children. Children as young as four and five years of age are expressing the need to diet. The Agency for Healthcare Research and Quality reported that hospitalizations for eating disorders for children under the age of 12 increased by 119% between 1999 and 2006. Eating disorders are not limited to girls and young women. The National Institute of Health (NIH) reports that between 5 and 15 percent of adolescents with eating disorders are boys. Possible causes include a combination of biology, psychological problems, and environment. A report from the National Institute on Mental Health (NIMH) states that individuals may carry certain genes that make them vulnerable to developing eating disorders and psychological factors, such as low self-esteem, perfectionism, and impulsive behavior, also play a role. The environment is considered a contributing factor as well. For example, the media emphasizes that to be popular or successful one must be thin.

Students with anorexia fail to maintain 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. Students with this disorder tend to be perfectionists and overachievers. In teenage girls with anorexia, menstruation may cease, leading to the same kind of bone loss suffered by menopausal women. Anorexia can cause serious physical problems and potentially life-threatening conditions.

Students 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. Bulimia can have serious effects on health including tooth decay, heart problems, pancreatitis, ruptured esophagus, and chronic constipation.

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.

Students who have eating disorders are obsessed with food. Their lives revolve around thoughts and worry about their weight and their eating. Students with an eating disorder are at risk for alcohol and drug use as well as depression. There is also an elevated risk of suicide for students with anorexia or bulimia.

The earlier a student seeks treatment for eating disorders, the greater the likelihood of recovery.

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/or vomiting. These students often lack the energy and drive necessary to complete assignments or homework.

Instructional Strategies and Classroom Accommodations

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

*For additional suggestions on classroom strategies and modifications, see *An Educator’s Guide to Children’s Mental Health* chapter on *Meeting the Needs of All Students*.*

Fetal Alcohol Spectrum Disorder Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/Behaviors

Early Childhood (1–5 years)

- 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 and reasoning skills, sequential learning)

Elementary years

- Normal, borderline, or high IQ, but immature
- Blames others for all problems
- Volatile and impulsive, impaired reasoning
- School is 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 years)

- 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

Resources: See macmh.org/edguidelink for more FASD specific resources.

About the Disorder

Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term describing a range of conditions and disabilities that can occur in an individual whose mother drank alcohol during pregnancy. Unfortunately, FASD cannot be cured and the damage to the brain is permanent.

There are many terms under the FASD umbrella including these medical diagnoses:

- Fetal Alcohol Syndrome (FAS)
- Alcohol Related Neuro-developmental Disorders (ARND)
- Alcohol Related Birth Defects (ARBD)
- Partial Fetal Alcohol Syndrome (pFAS)

Effects of an FASD vary widely from person to person and may include physical, mental, social, behavioral, and/or learning disabilities with lifelong implications. A person with an FASD might have abnormal facial features, poor coordination, hyperactive behavior, short attention span, learning disabilities, and poor reasoning and judgment skills. See "Symptoms or Behaviors" for additional behaviors you may observe.

For many people with an FASD, brain damage is the most serious effect. Due to organic brain damage, memory retrieval is impaired, which may make any learning difficult. Many students with an FASD 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 because 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 students with an FASD 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.

Much of the FASD information and the information for the Instructional Strategies and Classroom Accommodations section were taken from documents provided by ARC Northland–Duluth, used with permission, with edits from Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). MOFAS is the leading voice and resource on FASD statewide.

Educational Implications

Students with an FASD need more intense supervision and structure than other students. 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 can be impulsive, uninhibited, and over-reactive. In general, social skills such as sharing, taking turns, and cooperating are usually not understood, and a student with an FASD tends 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 it is more difficult for them to 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, their threshold for frustration is low and can result in rages and temper tantrums.

A common impairment is 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 cannot connect their actions with consequences, they don't learn from experience that making up answers is not appropriate.

Instructional Strategies and Classroom Accommodations

While there is not a standard approach to working with students with an FASD, there are strategies that work, based on the following guidelines:

- **Be as consistent as possible.** Students with an FASD do best in an environment with few changes, this includes language. Teachers and parents can coordinate with each other to use the same words for key phases and oral directions.
- **Be concrete.** Students with an FASD do well when people talk in concrete terms. Do not use words with double meanings. Because their social-emotional understanding is far below their chronological age, it helps to think younger when providing assistance and giving instructions. Structure is the key that makes their world makes sense. Students with an FASD achieve and are successful because their world provides the appropriate structure as a permanent foundation. Likewise, stable routines that don't change from day to day will make it easier for students with an FASD to know what to expect next and decrease their anxiety, enabling them to learn. Break all tasks down to one step at a time. Students with an FASD can't always see the parts of a whole nor can they always understand a sequence — help them to see the parts and the order of an activity or task.
- **Use a lot of repetition.** Students with an FASD can have chronic short term memory problems; they forget things they want to remember as well as information that has been learned and retained for a period of time. In order for something to make it to long term memory, it may simply need to be re-taught and re-taught.
- **Be specific, yet brief.** Say exactly what you mean. Remember that students with an FASD have difficulty with abstractions, generalization, and may not be able to fill in the blanks when given a direction. Do not rely on the students' ability to recite the rules or steps. Tell them step by step what to do, developing appropriate habit patterns. Always have students paraphrase any directions to check for understanding.
- **Increase supervision.** Because of their cognitive challenges, students with an FASD bring a naiveté to daily life situations. They need constant supervision, as with much younger students, to develop patterns of appropriate behavior.
- **Model appropriate behavior.** Students with an FASD often copycat behavior, so always try to be respectful, patient, and kind.
- **Keep things simple.** Remember to keep it simple. Students with an FASD are easily over-stimulated, leading to shutdown at which point no more information can be assimilated.

For additional suggestions on classroom strategies and modifications, see [An Educator's Guide to Children's Mental Health chapter on Meeting the Needs of All Students](#).

Major Depressive Disorder Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/Behaviors

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

Resources: See macmh.org/edguidelink for more major depressive disorder specific resources.

About the Disorder

All children/youth 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 persistent depressive disorder (chronic depression). These depressive disorders are more than “the blues”; they affect a young person’s thoughts, feelings, behavior, and body. Depressive disorders can lead to school failure, alcohol or drug abuse, and even suicide. Major depressive disorder is one of the most common and serious mental health disorders experienced by children and adolescents.

Depression can occur at any age but the risk for depression increases as a child gets older. The National Institute of Mental Health (NIMH) estimates that about 11 percent of adolescents have a depressive disorder by age 18. During adolescence the disorder is more prevalent among girls.

The DSM-5 states that depression that occurs in childhood is harder to diagnose, more difficult to treat, and more likely to reoccur than depression that strikes later in life. Youth who experience a severe depression also have a greater likelihood of recurrence. Children and adolescents who experience adverse childhood experiences (ACEs) are at risk for developing depression and at even greater risk if they experience multiple ACEs.

Students who are depressed may display sadness that won’t go away, hopelessness, thoughts of death or suicide, low energy, poor concentration, changes in eating and sleeping patterns, and frequent complaints of aches and pains. However, they also can present symptoms that many adults do not associate with depression, such as frequent fearfulness, extreme sensitivity to failure or rejection, low self-esteem and guilt, irritability, school avoidance, persistent boredom, increased activity, and self-deprecating remarks.

Students who used to enjoy playing with friends may 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. Older students with a depressive disorder may self-medicate with alcohol or drugs.

Students who cause trouble at home or at school may actually be experiencing depression, although they may not seem sad. Younger students may pretend to be sick, be overactive, cling to their parents, seem accident prone, or refuse to go to school. Older students 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 experienced 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. Be flexible and realistic about classroom 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.
- Students with a depressive disorder may see issues in black and white—all bad or all good. It may help to keep a record of their accomplishments that you can show to them at low points.
- Encourage gradual social interaction (i.e., small group work).
- Ask parents what would be helpful in the classroom to reduce pressure or to motivate the student.
- Spend extra time with the student, when necessary, and assist the student with planning and time management.
- Reduce some classroom pressures by being flexible with deadlines, providing notes, or helping the student find a note-taker from the class.
- For disability-related reasons, students may need to miss class or even leave the room in the middle of the class. Your understanding and any assistance with filling in the gaps will help reduce the stress and anxiety related to getting behind or missing assignments.
- Allow the student to record lectures.
- Clearly define (and put in writing) the course requirements, dates of exams, and when assignments are due; provide advance notice of any changes.
- When in doubt about how to assist the student, try asking what they need.
- Encourage school administration to identify personnel and resources to support students with depression.

*For additional suggestions on classroom strategies and modifications, see *An Educator's Guide to Children's Mental Health* chapter on Meeting the Needs of All Students.*

Obsessive-Compulsive Disorder Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/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
- Opening a desk or book with a sleeve or tissue
- Repeatedly checking: homework, backpack, locker, or phone
- Poor concentration
- School avoidance
- Anxiety or depressed mood
- Preoccupied
- Needs constant reassurance
- Perseverates

Resources: See macmh.org/edguidelink for more OCD specific resources.

About the Disorder

Obsessive-compulsive disorder (OCD) is an illness that causes people to have unwanted thoughts, urges, or images (obsessions) and to repeat certain behaviors or mental acts (compulsions) over and over again. OCD has a neurobiological basis. This means it is a biological disease of the brain, just as diabetes is a biological disease of the pancreas.

Doctors once believed that obsessive-compulsive disorder was a rare condition, but it is now known to be one of the more common mental illnesses. The DSM-5 reports that over 3 million Americans have obsessive-compulsive disorder. Researchers believe that OCD runs in families and often begins during adolescence or childhood. Boys have an earlier onset of OCD than girls, some beginning prior to age 10.

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

OCD is sometimes accompanied by other disorders, such as substance abuse, depressive disorder, bipolar disorder, eating disorder, or anxiety disorder. When a student has another disorder, the OCD is more difficult to treat or diagnose. Symptoms of OCD may coexist or be part of a spectrum of other brain disorders such as Tourette's disorder (see pages 74–75) or autism (see pages 52–53).

The exact cause of OCD is not known. Some researchers believe that its cause is biological while others think that the cause may be related to both biological and environmental factors. Brain imaging studies suggest that an insufficient level of serotonin, one of the brain's chemical messengers, may contribute to OCD. People with OCD who take medications that enhance the action of serotonin often show great improvement. Research done at the National Institute of Mental Health (NIMH) 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 Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS).

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

Common obsessions are:

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

Common compulsions are:

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

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.
- Be attentive to changes in the student's behavior.
- Try to redirect the student's behavior. This works better than using consequences.
- Allow the student to do assignments such as oral reports in writing.
- Allow the student to receive full credit for late work.
- Allow the student to redo assignments to improve scores or final grades.
- Consider a functional behavioral assessment (FBA). Understanding the purpose or function of the student's behaviors will help you respond with effective interventions and strategies. For example, a punitive approach or punishment may increase the student's sense of insecurity and distress, and increase the undesired behavior.
- Post the daily schedule in a highly visible place so the student will know what to expect.
- Using diplomacy and with the student's consent, educate the student's peers about OCD.
- Keep transitions to a minimum, and prepare the student for them when possible. Allowing time before and after transitions will help the student regain concentration.
- Consider the use of technology. Many students struggling with OCD will benefit from easy access to appropriate technology, which may include applications that can engage student interest and increase motivation (e.g., computer-assisted instruction programs, on-line demonstrations, as well as YouTube presentations).

*For additional suggestions on classroom strategies and modifications, see *An Educator's Guide to Children's Mental Health* chapter on Meeting the Needs of All Students.*

Oppositional Defiant Disorder Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/Behaviors

- Sudden, unprovoked anger
- Arguing with authority figures
- Defiance or refusal to comply with rules or requests
- Deliberately annoys others
- Blaming others for their own misbehavior
- Easily annoyed by others
- Frequently resentful and angry
- Often spiteful or vindictive
- Frequent temper tantrums or outbursts
- Speaking harshly or unkind when upset
- Destruction of property
- Irritable mood
- Poor peer relationships

Resources: See macmh.org/edguidelink for more ODD specific resources.

About the Disorder

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

Oppositional defiant disorder usually does not occur alone—50 to 65 percent of children with ODD also have attention-deficit/hyperactivity disorder (ADHD). ODD also commonly occurs with anxiety and depressive disorders as well as with learning disabilities.

The causes of ODD are unknown, but studies of twins and adopted children suggest that ODD has biological (including genetic), psychological, and social components. The DSM-5 states that the quality of the child's family life seems to be an important factor in the development of ODD. Certain environmental factors may increase the risk of disruptive behavior disorders including: harsh or inconsistent parenting, domestic violence, physical abuse, neglect, multiple/different caregivers, and poverty. Other contributing factors may be an imbalance of certain chemicals in the brain, such as serotonin, or developmental delays. Some students may develop ODD as a result of stress and trauma from divorce, death, loss of family, or family disharmony.

A student presenting ODD symptoms should have a comprehensive evaluation by a mental health professional. Treating oppositional defiant disorder and its related disorders (ADHD, depression, anxiety disorders, and learning disabilities) often includes several types of therapy and training, such as cognitive therapy, psychotherapy, and social skills training. Students with ODD respond well to evidence-based, specialized treatment and can recover over time.

Educational Implications

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

Instructional Strategies and Classroom Accommodations

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

*For additional suggestions on classroom strategies and modifications, see *An Educator's Guide to Children's Mental Health* chapter on Meeting the Needs of All Students.*

Posttraumatic Stress Disorder Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/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, stomach ache, dizziness, or discomfort in another part of the body
- Fear of certain places, things, or situations that remind them of the event
- Avoidance
- Denial of the event, inability to recall important aspects of it
- A sense of a foreshortened future
- Difficulty concentrating and easily startled
- Self-destructive behavior
- Irritability
- Impulsiveness
- Anger and hostility
- Depression and overwhelming sadness or hopelessness

Resources: See macmh.org/edguidelink for more PTSD specific resources.

About the Disorder

Children/youth who are involved in or who witness a traumatic event that involved intense fear, helplessness, or horror are at risk for developing posttraumatic 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 traumatic event, children/youth 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, intrusive, 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 student is reminded of it by an object, place, or situation. During a flashback, the student may actually lose touch with reality and re-enact the event.

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

A combination of treatment approaches is often used for PTSD. Various forms of psychotherapy have been shown to be effective, including cognitive-behavioral, family, and group therapies. To help students express their feelings, play therapy and art therapy can be useful. Exposure therapy is a method where the student 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.

Recent research by the Centers for Disease Control and Prevention (CDC) has established the relationship between traumatic childhood experiences and the risk for physical and mental illness. The Adverse Childhood Experience (ACE) study showed a strong relationship between the level of traumatic stress in childhood and physical, mental and behavioral problems later in life. Support from family, school, friends, and peers can be an important part of recovery for students with PTSD. With sensitivity, support, and help from mental health professionals, a student can learn to cope with their trauma and go on to lead a healthy and productive life.

Educational Implications

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

Instructional Strategies and Classroom Accommodations

- Try to establish a feeling of safety and acceptance within the classroom. Greet the student warmly each day, make eye contact, and let the student know that he/she is valued and that you care. You can make a tremendous impact on a student by what you say (or don't say); a student's self-perception often comes from the actions of others.
- Don't hesitate to interrupt activities and avoid circumstances that are upsetting or re-traumatizing for the student. For example, a movie or assignment about a natural disaster may trigger memories of the traumatic event the student has been through. Watch for increased symptoms during or following certain situations, and try to prevent these situations from being repeated.
- Provide a consistent, predictable routine through each day as much as possible. A regular pattern will help re-establish and maintain a sense of normalcy and security in the student's life. If the schedule does change, try to explain beforehand what will be different and why. Consistency shows students that you have control of the situation; they may become anxious if they sense that you are disorganized or confused. However, allow students 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 student to become restless and anxious).
- If a student wants to tell you about the traumatizing incident, do not respond by encouraging the student to forget about it. PTSD symptoms may be a result of trying to do just that. This request also minimizes the importance of the trauma and students may feel a sense of failure if they can't forget. Just listening can be very assuring.
- Reassure students 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 students, you can also use games like *Duck, Duck, Goose*.
- For some students, any physical contact by a teacher or peer may be misinterpreted and result in an aggressive or emotional response.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health chapter on Meeting the Needs of All Students.

Reactive Attachment Disorder Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/Behaviors

- Destructive to self and others
- Absence of empathy
- Lacks interest in playing with toys
- Noticeable and consistent awkwardness or discomfort
- Poor eye contact
- Aggressive behavior toward peers
- Lack of cause and effect thinking
- Resists comforting gestures
- Dismisses comforting comments
- Observes others closely but doesn't engage in social activities
- Unwilling to ask for support or assistance
- Learning difficulties
- Poor peer relationships
- No impulse control
- Chronic nonsensical lying
- Frequently irritable
- Unexplained sadness or fearfulness
- Bossy—needs to be in control
- Manipulative

Resources: See macmh.org/edguidelink for more RAD specific resources.

About the Disorder

The main feature of reactive attachment disorder (RAD) is the inability to develop healthy emotional attachments to parents or caregivers. RAD begins before age five and is associated with grossly inadequate, negligent or pathological care that disregards the child's basic emotional and physical needs. In some cases, it is associated with repeated changes of a primary caregiver.

The term attachment is used to describe the process of bonding that takes place between infants and caregivers in the first two years of life, and most important, the first nine months of life. When a caregiver fails to respond to a baby's emotional and physical needs, responds inconsistently, or is abusive, the child may lose the ability to form meaningful relationships and the ability to trust. Children/youth with RAD haven't bonded with their caregiver. They have learned that the adults in their lives are untrustworthy. They have developed a protective shell around their emotions, isolating themselves from dependency on adult caregivers.

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

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

Students with RAD may show a wide range of symptoms. Younger students may display soothing behaviors such as rocking and head banging, or biting and scratching themselves. Older students may be withdrawn, irritable, and oversensitive to criticism. Teachers may also notice signs of self-injury and risk-taking behaviors. These symptoms may increase during times of stress or threat.

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. (See school-wide positive behavioral interventions and supports (SWPBIS) on pages 30-31)
- Model and teach appropriate social behaviors. One of the best ways to teach these students social skills is to model the behavior and then narrate for the child what you are doing and why.
- Avoid power struggles. When intervening, present yourself in a matter-of-fact style. This reduces the student's desire to control the situation. When possible, use humor. If students can get an emotional response from you, they will feel as though they have hooked you into the struggle for power and they are winning.
- Address comprehension difficulties by breaking assigned reading into manageable segments. Monitor progress by periodically checking if the student is understanding the material.
- Break assignments into manageable steps; this helps to clarify complex, multi-step directions.
- Identify a place for the student to go to regain composure during times of frustration and anxiety. Do this only if the student is capable of using this technique and there is an appropriate supervised location.

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health chapter on Meeting the Needs of All Students.

Schizophrenia Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/Behaviors

- Confused thinking (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 (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
- Problems planning and organizing
- 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
- Unpredictable agitation
- Poor memory

Resources: See macmh.org/edguidelink for more schizophrenia specific resources.

About the Disorder

Schizophrenia is a severe, disabling brain disorder 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. Students in middle and high school will likely be in the early stages of the illness. Schizophrenia can be difficult to recognize in its early phases and the symptoms often are blurred with other psychiatric disorders.

Schizophrenia usually comes on gradually in what is known as the prodrome, and teachers are often the first to notice the early signs. The early signs are usually non-specific. For example, students who once enjoyed friendships with classmates may seem to withdraw into a world of their own. They may say things that don't make sense and talk about strange fears and ideas. Students may also show a gradual decline in their cognitive abilities and struggle more with their academic work. Since the disorder can come on quite gradually, it may be difficult to appreciate this decline in cognition without a longitudinal perspective over several academic years. The typical prodromal period lasts about two to three years. Some students 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, saying little of substance, or 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 consequently it may be difficult to differentiate schizophrenia from a severe depression, substance induced disorder, or bipolar disorder. Students who show signs of schizophrenia need a thorough mental health assessment.

Early diagnosis and treatment of schizophrenia is important. The DSM-5 reports about 20 percent of people with schizophrenia will attempt suicide; 5 to 6 percent will succeed. Students with this disease are usually treated with a combination of medication and individual and family therapy. 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. New research, however, reveals that treating a person's first episode of psychosis can have significant positive affects on the trajectory of the illness. Early intervention can improve symptoms and restore adaptive functioning.

According to the DSM-5 schizophrenia affects about 1 percent of the general population and in a greater degree for people who have a relative with the disorder. 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 currently not known.

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, mental health providers, and medical professionals who are treating the student. These individuals can provide the information needed to understand the student's behaviors, the effects of the psychotropic medication, and how to develop a learning environment.
- Often it is helpful to have a team meeting to discuss the various aspects of the student's education and development.
- Encourage other students to be kind and to extend their friendship.

—From *Schizophrenia: Youth's Greatest Disabler*, produced by the British Columbia Schizophrenia Society, available at www.mentalhealth.com/book/p40-sc02.html

For additional suggestions on classroom strategies and modifications, see An Educator's Guide to Children's Mental Health chapter on Meeting the Needs of All Students.

Tourette's Disorder Fact Sheet



Minnesota Association for
Children's Mental Health

165 Western Avenue North, Suite 2
Saint Paul, MN 55102-4613

Symptoms/Behaviors

Symptoms and behaviors must be excessive or frequent.

- 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

Resources: See macmh.org/edguidelink for more Tourette's disorder specific resources.

About the Disorder

Tourette's disorder is a neurological disorder that has dramatic consequences for children/youth. The Center for Disease Control (CDC) estimates that over 138,000 American youth are diagnosed with Tourette's disorder and it affects an approximate additional 2 million people 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 neurotransmitters in the brain.

Vocal and motor tics are the symptoms of Tourette's disorder. They are involuntary, come and go over time, changing in type, location, frequency, and intensity. The DSM-5 describes tics as "a sudden, rapid, recurrent, nonrhythmic motor movement or vocalization." Children/youth experience their most severe tics before they are in their mid teens. All students with Tourette's disorder present multiple motor and vocal tics, although not necessarily simultaneously. Many students have symptoms mild enough that they never seek help; many others find their symptoms subside after they reach adulthood.

The CDC estimates that 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 (eye blinking, head jerking, coughing, snorting) or complex (jumping, swinging objects, mimicking other people's gestures or speech, rapid repetitions of a word or phrase). In fact, the range of tics exhibited by people with Tourette's disorder is so broad that family members, teachers, and friends may find it hard to believe that these actions or vocalizations are not deliberate.

Like someone compelled to cough or sneeze, people with Tourette's disorder may feel an irresistible urge to carry out their tics. Others may not be aware of the fact they are ticcing. Some people can suppress their tics for hours at a time, but this leads to stronger outbursts of tics later on. Often, students repress 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 (ADHD), obsessive-compulsive disorder (OCD), or difficulties with impulse control. Sensory integration problems may explain some behaviors. Problems such as depression and anxiety may underlie visible tics, and stress is known to worsen symptoms.

Educational Implications

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

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

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

Instructional Strategies and Classroom Accommodations

- Educate other students about Tourette's disorder, encourage the student to provide his own explanations, and encourage peers to ignore tics when possible.
- Do not urge the student to stop 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. Prearrange a signal and a quiet, safe place for the student to go to relax or rest.
- Provide a private, quiet place for test taking. Remove time limits when possible.
- Help the student learn to predict outbursts and be able to request a break. Self-management techniques may be a necessary lifetime skill for the student.
- Reduce handwriting tasks and note taking. Provide note takers or photocopies of overheads during lectures and encourage computer use for composition tasks. Handwriting problems are common due to hand, arm, or shoulder tics.
- Give students with Tourette's disorder special responsibilities that they can do well. Encourage them to show their skills in sports, music, art, or other areas.
- Provide structured, predictable scheduling to reduce stress and ensure adult supervision in group settings.

*For additional suggestions on classroom strategies and modifications, see *An Educator's Guide to Children's Mental Health* chapter on Meeting the Needs of All Students.*