Students with Mental Disorders[1]

How widespread is the problem?

A MECA (methodology for Epidemiology of Mental Disorders in Children and Adolescents) Study found almost 21% of children (8.4 million) aged 9-17 had a diagnosable mental or addictive disorder that caused at least some impairment. When criteria were limited to *significant* impairment, the estimate dropped to 11% or 4 million children that have a psychiatric disorder.[2]

Table 1. Children and adolescents ages 9-17 with mental or addictive disorders,* combined MEC sample.

Disorders	Prevalence
Anxiety disorders	13.0%
Mood disorders	6.2%
Disruptive disorders	10.3%
Substance use disorders	2.0%
Any disorder	20.9%
• Disorders include diagnosis-specific impairment and Child Global Assessment Scale <or= 70 (mild global impairment). Source: Shaffer et al., 1996	

- 1 in 10 children suffer from a mental, behavioral, or learning problem that interferes with their ability to function effectively in school or in the community (Stoep et al. 2005).
- 12% of American children have a mental health disorder, yet only 20% of these children receive treatment (Davis et al., 2006).
- 1 in 5 adults have a diagnosable mental disorder.

Most Common Mental Disorders in Childhood and Youth

- ADHD
- Mood Disorders
- Anxiety Disorders
- Substance-Related Disorders
- Disruptive Behavior Disorders
- Pervasive Developmental Disorders (Autism Spectrum Disorders)

ADHD

[1] Adapted from Dana Edwards, Ph.D. ASCA National Conference

[2] MECA Study reported on 1,285 youth (ages 9-17) with disruptive and/or depressive disorders who had used mental health or substance abuse services.

Table 2. ADHD[3]

ADHD I: ADHD Primarily-Inattentive Type	ADHD/HI: ADHD Primarily Hyperactive-Impulsive Type		ADHD/C: ADHD Combined Type
	Hyperactivity	**Impulsivity**	
• Careless with details • Fails to sustain attention in tasks • Appears not to listen • Does not finish instructed tasks • Avoids tasks that require sustained mental effort • Loses things • Easily distracted by extraneous stimuli • Forgetful in daily activities	• Fidgets with hands or feet or squirms in seat • Leaves seat in classroom or when should be seated • Runs about or climbs excessively and inappropriately cannot play or engage in leisure activities quietly • Always "on the go" or "driven by a motor" • Talks excessively	• Blurts out answers before question is complete • Has difficulty awaiting their turn • Interrupts other's conversations or games	6-9 behaviors described in both domains

Table 3. Prevalence Data

	Prevalence	Gender Differences	Median Age of Onset
ADHD	308% of school age population	More frequent in males than females (2:1 to 9:1)	Symptoms are present by age 7; difficult to diagnose before age 4

Table 4. Medications for ADHD

	Stimulants Methylphenidate (Ritalin, Concerta, Focalin) Amphetamine (Adderall, Dexedrine, Vyvanse)	**Non-stimulant** Atomoxetine (Straterra)	**Anti-hypertensive/ Alpha Agonist** Clonidine (used to help pm irritability & insomnia)

[3]Source: *DSMIV-R*

Side Effects	Appetite reduction Insomnia Irritability Headache GI problems Growth suppression Equal number of studies show no, reduced and heightened risk for substance abuse Cardiovascular issues	Sedation GI problems Appetite reduction Irritability Headache Aggressive behavior Suicidality (Black Box warning) Liver toxicity	Sedation Dizziness

Mood Disorders

Depression		**Bipolar Disorder** (Alters between depressed and manic symptoms)	
Major Depressive Disorder (lasts at least 2 weeks) • Appears sad or moody and may swing from sadness to anger • Changes in sleep and appetite • Irritability • Separation anxiety when apart from parents • Exaggerated fears • Loss of interest and/or pleasure in activities • Tired most of the time, little energy • Trouble with making decisions or concentrating • Feelings of worthlessness or guilt • May complain of vague physical complaints	**Dysthymic Disorder** • Milder, but more chronic, long standing depressed mood connected to the child's personality or temperament • More common in adolescence than childhood • Similar symptoms to a milder degree but may persist for a year or longer but have a symptom-free interval no longer than 2 months *Source: DSMIV-R & AACAP*	**Depressive Symptoms** • Irritability, depressed mood, persistent sadness, frequent crying • Thoughts of death or suicide • Loss of enjoyment in favorite activities • Frequent complaints of physical illnesses such as headaches or stomach aches • Low energy level, fatigue, poor concentration, complaints of boredom • Major change in eating or sleeping patterns, such as oversleeping or overeating	**Manic Symptoms** • Severe changes in mood- either unusually happy or silly, or very irritable, angry, agitated or aggressive • Unrealistic highs in self-esteem • Great increase in energy and the ability to go with little or no sleep for days without feeling tired • Increase in talking- the adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted • Distractibility • Repeated high risk taking behavior

Table 5. Differences between Bipolar Disorder and ADHD

Bipolar Disorder	ADHD
Mood/anxiety symptoms primary • Euphoric/giddy • Severe irritability common • Grandiose • Decreased need for sleep • Pressured fragmented speech • Racing thoughts fluctuate • Psychosis can occur • Can become aggressive • Distractible • Family history of mood disorders • Comorbid with other mood, anxiety, somatic symptoms	Mood/anxiety symptoms secondary • Low self-esteem • Difficulty settling for night • Energetic and quick • Rapidity of thoughts constant • Usually on the go, hyper • No psychosis • Can become aggressive • Distractible • Family history of disruptive behavior disorders, co morbid with OCD, tics *Source: Aryeh Levensen, M.D.*

Table 6. Medications for Mood Disorders

	Mood Stabilizers (Antimanic meds)	Anticonvulsants
Med Tx for Bipolar Disorder	Lithium (best for more "pure" mania and little depression). Only FDA approved drug for Tx of BPD in children ages 12 yrs. and older & not typically used for those under 8.	Depakote Tegretol Topamax Lamictal Neurontin Topamax
Side effects	Drowsiness Weakness Nausea Fatigue Hand tremor Increased thirst Increased urination Weight gain Thyroid problems	GI problems Headache Double vision Dizziness Anxiety Confusion Liver dysfunction (may increase testosterone level in women < 20 and produce polycystic ovary syndrome- obesity and amenorrhea)

Table 7. Meds Commonly used to TX Anxiety & Mood Disorders in Pediatric Populations

Trade Name	Treats	Side Effects
Anafranil*	OCD Depression	Drowsiness, dizziness, tremors, HA, dry mouth, fatigue, risk of seizure onset w/prolonged use

Klonopin	GAD, separation anxiety, panic attacks	Decreased appetite, stomachaches, insomnia, cognitive & psychomotor impairment, potential for dependence
Prozac*	OCD, social phobia, depression	HA, restlessness, insomnia, fatigue, nausea, disinhibition, decrease appetite and tremors
Luvox*	GAD, OCD, social phobia, separation anxiety	GI problems, insomnia, HA, weakness
Paxil*	Depression in adolescents, OCD	Drowsiness, HA, nausea, dizziness, dry mouth Safety in kids under 18 not established.
Zoloft*	OCD, depression	Nausea, diarrhea, insomnia, reduced appetite, drowsiness
BuSpar	GAD and social phobia	Nausea, dizziness, drowsiness, overexcitement Safety in kids under 18 not established.
Clonidine (Catepres)	PTSD	Dry mouth, drowsiness, and decrease in blood pressure. Safety in kids under 12 not established.
Luvox*	Depression	Nausea, drowsiness, insomnia, HA, hyperactivity, weight loss, dermatitis
Inderal	PTSD (beta blocker, hyperthyroidism)	Drowsiness, reduction in blood pressure, drowsiness, insomnia

*Black Box warning by FDA: (Source: Abrams, Flood, & Phelps, 2006)

Anxiety Disorders

- Among the most common type of psychopathology in children.
- Affects 10-20% of children and youth population.
- Anxiety in childhood predicts anxiety disorders, major depression, suicide attempts, and psychiatric hospitalization in adulthood.

Table 8. Types of Anxiety Disorders

Separation Anxiety Disorder	Social Anxiety Disorder	Generalized Anxiety Disorder	Specific Phobia
• Constant thoughts and intense fears about the safety of parents and caretakers • Refusing to go to school • Frequent stomachaches and other physical complaints • Extreme worries about sleeping away from home • Being overly clingy • Panic or tantrums at	• Fears of meeting or talking to people • Avoidance of social situations • Anxious about being embarrassed in social settings • Few friends outside the family • May cling, freeze or cry in social settings • Present for at least 6 months	• May worry/ anticipate about things before they happen • Individual finds it difficult to control worry • May feel restless (keyed up), irritable, muscle tension and have difficulty concentrating or sleeping and is easily fatigued • May have nervous habits, perfection-istic tendencies and	• Extreme fear about a specific thing or situation (e.g. dogs, insects, or needles) • The fears cause significant distress and interfere with usual activities • Some fears are simply transitory in childhood and only warrant attention if it causes significant impairment • Present for at least 6 months

times of separation from parents • Trouble sleeping or nightmares • Present for at least 4 weeks		need help for approval • Fears of embarrassment or making mistakes • Occurrence is common in higher SES levels where performance expectations are high • Present at least for 6 months	

Table 9. Obsessive-Compulsive Disorder and Post Traumatic Stress Disorder

OCD	PTSD
Obsessions- persistent ideas, thoughts, impulses or images Repeated thoughts about contamination Repeated doubts Need to have things in a certain order Sexual imagery *Compulsions*- repetitive behaviors Repetitive hand washing, ordering, checking, counting, repeating words The goal of the repetitive actions is to reduce anxiety Gradual declines in schoolwork secondary to the other symptoms is often reported	Symptoms usually present within the first three months after the trauma, although there may be a delay Symptoms are due to the **direct exposure** to an event which involves an actual or threatened death, serious injury or threat to the physical integrity of another person; or **learning** about unexpected death or violent death, serious harm, or threat of death or injury experienced by a family member or other significant person *Source: DSM IV-R & AACAP*

Disruptive Behavior Disorders

Table 10. Disruptive Behavior Disorders

Oppositional Defiant Disorder (ODD)	Conduct Disorder (CD)
• Frequent temper tantrums • Excessive arguing with adults • Active defiance and refusal to comply with adult requests and rules • Deliberate attempts to annoy or upset	Aggression to people and animals • Bullies, threatens or intimidates others • Often initiates physical fights • Has used a weapon that could cause serious physical harm to others (e.g., a

people • Blaming others for his or her mistakes or misbehavior • Often being touchy or easily annoyed by others • Frequent anger and resentment • Mean and hateful talking when upset (perhaps obscene) • Seeking revenge • Dawdle and procrastinate in activities Presents in a number of settings (home, school, community) and results in significant impairment. *Sources: AACAP & DSM IV-R*	bat, brick, broken bottle, knife or gun) • Is physically cruel to people or animals • Steals from a victim while confronting them • Forces someone into sexual activity Destruction of property • Deliberately engaged in fire setting with the intent to cause damage • Deliberately destroys other's property Deceitfulness, lying or stealing • Has broken into someone else's building, house, or car • Lies to obtain goods, or favors or to avoid obligations • Steals items while confronting a victim (e.g., shoplifting, but without breaking and entering) Serious violations of rules • Often stays out at night despite parental objections • Runs away from home • Often truant from school

Table 11. Meds Commonly used to TX ODD and CD

Meds Used to Tx DBD	**Mood Stabilizers**	**Antipsychotics (Neuroleptics)**
	• Lithium • Divalproex sodium (Depakote)	• Clozapine (*Clozaril),* • Risperidone *(Risperdal)* • Quetiapine *(Seroquel)* • Olanzapine *(Zyprexa)* • Ziprasidone *(Geodon)* • Aripiprazole *(Abilify)*
Side Effects	• Lithium: polyuria (increased urine), polydipsia (increased thirst), motor tremor, increase in appetite, dry mouth, muscular weakness • Depakote: abdominal pain, HA, drowsiness, dizziness, • Both: memory reduction	• Sedation • Extrapyramidal effects (involuntary muscle movements) • Headaches • Nausea • Weight gain with risperdal

	• *Also treated with CNS Stimulants & Clonidine*	

Table 12. DBD Prevalence Factors

DBD	Prevalence	Gender Differences	Age of Onset
Conduct Disorder	Males: 6-16% Females: 2-9%	• More common in males, especially childhood on-set type • Males exhibit more stealing, fighting, vandalism, school discipline problems • Females: more lying, truancy, running away, substance abuse and prostitution	• Childhood onset: before age 10; • Adolescent on-set after age 10; • Rare after 16 yrs.
Oppositional Defiant Disorder	2-16% of population	• Generally the same, except males may have more confrontational behavior and more persistent symptoms	• Usually evident by age 8; onset is gradual

Pervasive Developmental Disorders

Table 13. Pervasive Developmental Disorders (AKA Autism Spectrum Disorder)

Autistic Disorder	Asperger's Disorder
• Markedly abnormal or impaired development in social interaction and communication and restrictive repertoire of activity and interest (narrow focus on one thing) • Delay in or total lack of development of spoken language • Interest in nonfunctional rituals • Abnormalities in posture • Trouble understanding simple questions,	• Significantly higher cognitive and intellectual level than child with autism • No significant delays in language; usually speak by age 2; as they age speech patterns are often odd, their words spoken in a monotone. Similar traits are often found in family members. • Coordination difficulties • Restrictive repetitive patterns of behavior, interest, and activities

directions, or jokes • Impairment in use of multiple nonverbal behaviors (e.g., eye-to-eye gaze, gestures) • Difficulty in developing appropriate peer relations • Lack of social or emotional reciprocity • There may be an associated diagnosis of mental retardation (moderate range- IQ 35-50) • If there is a period of normal development, it cannot extend past age 3 yrs.	• May display eccentric behaviors • Difficulty interacting with peers • Tend to be loners • Have little empathy for others • Highly egocentric • At risk for other psychiatric problems including depression, attention deficit disorder, schizophrenia, and OCD *Source: DSM IV-R & AACAP*

Table 14. PDD Prevalence Factors

PDD/ASD	Prevalence	Gender Differences	Median Age of Onset
Autistic Disorder	22 per 10,000	• 4 to 5 times higher in males • Females are more likely to exhibit severe mental retardation	• Prior to age 3; • often diagnosed by 30 months
Asperger's Disorder	26-71 per 10,000	• more common in males	• later onset than Autistic Disorder • motor delays or clumsiness is often noted in preschool • social impairments become noticeable in the context of school

Meds for Autism and Asperger's Disorder

Antidepressants, Antipsychotics, Mood stabilizers, Clonidine or low doses of stimulants have little effect on the core symptoms, but can help control the secondary symptoms of hyperactivity, excitability, moodiness, destructiveness, aggression, self-injury, tantrums and sleeplessness.

Substance-Related Disorders

Substance Abuse	Substance Dependence
Maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by 1 or more of the following (occurring within a 12-month period) • Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home • Recurrent substance abuse in situations that are physically hazardous • Recurrent substance-related legal problems • Continued substance use despite having persistent or recurrent social or interpersonal problems that are exacerbated by the effects of the substance	Maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by 3 or more of the following (occurring within a 12-month period) • Tolerance- a need for increased amounts of the substance to achieve the desired effect • Withdrawal- the substance is taken to relieve or avoid withdrawal symptoms • The substance is often taken in larger amounts or over a longer period than was intended • There is a persistent desire or unsuccessful effort to cut down • A great deal of time is spent in activities necessary to obtain the substance • Important social, occupational or recreational activities are given up or reduced because of substance use • The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem

Implications for Counselors

Suggestions When Working with Students

Social and Emotional Learning (SEL) is defined as "the process through which children enhance their capacity to recognize and mange their emotions, appreciate the perspectives of others, establish pro-social goals and solve problems, and use a variety of interpersonal skills to effectively and ethically handle developmentally relevant tasks." (Elias, Bruene-butler, Blum & Schuyler, 2000, p. 254).

Mood Mastery and Self-Regulation

The ability to identify and soothe your own emotions and the capacity to handle your own temperamental disposition. A child/teen with mood mastery and self regulation can:

- Express their needs
- Process and temper emotions
- Withstand frustration and delay gratification
- Thoughtfully solve problems
- Improve connections with others (Taffel, 1999)

When teaching these students in small counseling groups or in classroom guidance, counselors can utilize lessons and activities that teach these types of skills.

Classroom meetings are an excellent venue for teaching these types of skills that can generalize to the classroom. *(See Edwards & Mulls article for a thorough explanation of classroom meetings.)*

Encouragement Techniques- Help the Student- Feel *connected*- with teachers and peers, and **you**! **Feel** *capable*- "Never, on a routine basis, do for a child what he/she can do for him/her self." (Frank Walton) find their strengths and genuinely complement them, focus on what they get RIGHT and areas of improvement, make mistakes a "learning opportunity" and minimize the effect of mistakes, acknowledge the difficulty of a task): *Count/contribute* (ask students to help with daily tasks, let students teach each other or the class, ask the students to decorate a bulletin board and/or classroom, and involve class in service (social interest) projects.

Solution-Focused Questioning

1. Elicit descriptions of change that have occurred prior to the session'
    a. "It has been my experience that many people notice that things are better between the time they set up an appointment and the time they come in for the session. Have you noticed such changes in your situation? What do you hope will change as a result of our meeting today?"
2. Find exceptions: Help the student discover times and situations when the problem does not occur.
    a. "I'll bet there are times when you expect the problem to occur and it doesn't. How do you account for this? How do you make this happen? When is the problem less frequent?"
3. Help the student define goals and prompt them to notice small changes.
    a. "How will you know when things have gotten better? What will be better?"
4. When students have a difficult time stating their goals in specific terms, the miracle question is helpful. *The Miracle Question* (Berg & Miller, 1992, p. 13)
    a. "Suppose that one night, while you were asleep, there was a miracle and the problem that brought you here is solved. However, because you are asleep, you don't know the miracle has happened. When you wake up in the morning, what will be different that will tell you that this miracle has taken place? What else?"
5. Scaling questions: Help students know where they are and where they'd like to be.
    a. "On a scale of 1-10, with 1 being failure and 10 being complete success, how would you rate how you are doing with your problem right now? When you are a ___ (one or two points higher than the former response) what will be happening differently?"
6. Highlight the coping strategies that students use when facing their problems. This demonstrates to them that they already use successful strategies and can encourage them to continue using them or use them more frequently.
    a. "How do you manage to keep going?"

Techniques/Suggestions to Use in Consultation

Most memorable Observation by Frank Walton (based on Adlerian Psychology)

This technique is used to get at the parent's beliefs about what should and should not be present in their families. These expectations can cause problems in parenting when they are not present or are not present to the degree they believe is necessary for a healthy family.

"Somewhere around the age of 12, 13 or 14 you looked around your family and said, "I like this. I'm going to make sure that when I have family, this is my family. More times than not, though, you looked around and you said, "this is distasteful, I don't like this and I am going to make darn sure that when I have a family this will not be in my family."

Potential problems in thinking: "You: *over-estimate* the number of times "it" will happen, or *over-exaggerate* the awfulness of "it," or *underestimate* your ability to handle it." **This type of thinking is what often gets us into trouble in our parenting.**

Strategies for Parenting & Teaching Youth with Early On-Set Bipolar Spectrum Disorder David McIntosh & Jeffery Trotter)

1. Youth with EOSBD may benefit from structured, regular routines at home and school. Routine daily activities should be followed as consistently as possible, even on holidays and weekends. Other caregivers should be given the "house rules" and be sure to follow them. If possible, select highly structured teachers to teach these children. Older students must use organizers and assignment completion checklists.
2. These students may have erratic school performance at times. Teachers can help by shortening assignments and assigning activities that they know the student can complete on time. Adults need to recognize when a break is needed so the student can decompress before getting frustrated. Priority should be given to meeting the emotional needs of the student. Learning ways to control anger is just as important as learning academic material.
3. During manic episodes, these students may display inflated self-esteem or grandiosity. Parents can recognize and address these behaviors. Older students may over commit to activities and projects which could cause embarrassment if not completed. Show patience and redirect the student's energy. Younger students may embellish stories which can result in teasing by peers.
4. Younger and older students with EOBSD have a decreased need for sleep. They may also have difficulty going to sleep, staying asleep, and engage in activities at night instead of sleeping. Provide 30-60 minutes transition time before going to bed instead of abruptly telling the child it is time to go to bed. Use a quiet time right before bedtime with no noise, low lights, and non-physical activities such as reading, working a puzzle, or doing relaxation exercises. A cool sleeping environment with some background noise (fan running, noise machine) may help. It is important that teachers understand that these youth may not get as much sleep and not to blame the parents as bad parents if the child is sleepy at school.
5. Some of these children and youth engage in reckless activities. Younger children may jump off rocks, climb dangerous objects etc. Older children/youth may drive recklessly, use drugs, engage in sexual activities, visit inappropriate web sites, etc. Parents must be sure to

supervise activities, put computers in central locations, and use locks on items and cabinets when necessary.

6. Some youth may engage in hyper sexuality and inappropriate public displays of affection. Parents need to understand developmentally appropriate sexual behaviors while putting limits on behaviors when necessary. Youth with EOBSD may need more than an abstinence lesson. Medication can help reduce impulsivity, supervision by parents is critical. If students engage in appropriate PDA at school, their free time should be limited/supervised. The student can visit the counselor during class changes or after school.
7. These children can display dramatic changes in appetite. They may feel the urge to overeat or not eat much at all. Parents should consult with a physician to monitor growth and nutrition issues, especially if the child is on medication. Parents can provide nutritious snacks in the child's book bag and inform the teacher of the need for these snacks.