Module 4

Understanding Mental Health, Mental Illness and Related Issues in Young People

Module 4 includes two sections. Section 1 provides an overview of key considerations regarding understanding of mental illness and common mental illnesses found in children. Section 2 focuses specifically on mental illnesses that are commonly found in adolescents.

Learning objectives

After completing this module, you will:

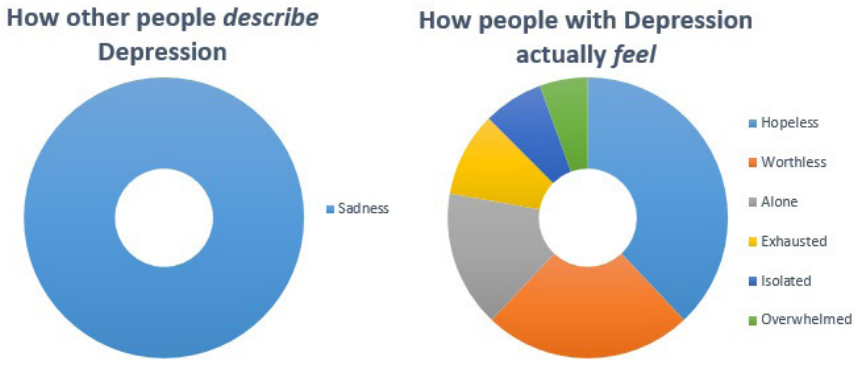
- Have a better understanding about how a mental illness is diagnosed;
- Have a better understanding of many of the more common mental illnesses affecting young people;
- Know about some useful classroom strategies that can be applied to help a student who has a mental illness.

Introduction

Earlier in this course you learned about stigma and how to use language to better identify different emotional states and how to use it to help separate normal and expected emotional states (such as mental distress and a mental health problem) from the language used to classify mental illness. For example: sad, unhappy, disappointed, dismayed, demoralized and disenchanted are not the same as Depression and worrying, feeling nervous and apprehensive are not the same as Anxiety. A similar phenomenon is found in using language that describes emotions that are intense, prolonged and which may increase risk for a mental illness to describe normal and usual everyday experiences. One of the more common examples of this is the use of the word "trauma" to describe feeling upset. Umbrage, inconvenience and anger are not traumatic experiences – sexual and physical abuses, neglect, living in a war zone, are.

When we use the terminology of mental illness to describe common emotions or behaviours, we begin to associate normal states with illness. This may unintentionally increase stigma as the depth, severity and impairment that exists with mental illness can be underestimated and thus belittle and undervalue the experience of someone who has a mental illness. This incorrect use of words can also have the opposite impact. It can suggest that normal and usual emotional states are mental illnesses and that people who are experiencing these need professional treatments. This can lead to unnecessary therapy or medication use and the volume of demand can overcome the limited supply of trained care providers, thus having the unintended consequence of making it even more difficult for those who have a mental illness to access the care that they need.

Here is how a person who lives with the mental illness Depression showed this difference:



While a person who has a mental illness will also experience the normal range of emotions, the nature, quality,

intensity and duration of the symptoms of the Mental Illness that they experience are significantly different than those arising in everyday life. In addition, they will experience numerous other symptoms associated with the illness (such as fatigue, pain, loss of interest, social isolation, etc.) and will exhibit functional impairment (such as doing poorly at school) as a result of the illness. Teachers can help students better understand this essential point. One way to help differentiate a mental illness from a normal emotional state is to capitalize the word describing the illness. For example: Depression (the illness) instead of depression (a negative emotional state).

Over 70% of all mental illness can be diagnosed prior to age 25 years, making childhood and adolescence a crucial time for the identification of symptoms suggestive of a mental illness, decreasing stigma associated with mental illness and enhancing access to effective mental health care for those who need it. This underlines the importance of ensuring that the individuals who interact with children and youth on a daily basis, particularly teachers, are mental health literate.

What is a diagnosis of Mental Illness?

Mental illnesses are diagnosed according to internationally defined criteria. There are two different diagnostic systems currently used. One is the Diagnostic and Statistical Manual (the DSM, currently in its 5th edition) and one is the International Classification of Disease (the ICD, currently in its 11th edition). Because no independent biological markers have yet been identified (such as an EEG in a "heart attack") that are specific to any mental disorder, diagnoses are assigned on the basis of signs and symptoms that occur together in clusters, predict outcomes in the absence of treatments and exhibit similar outcomes in response to specific treatments. Diagnoses are comprised of signs (what an independent observer can see) and symptoms (what the person experiences). Because of the nature of how the brain functions, various signs and symptoms can occur in more than one diagnosis. For example, inattention and excessive activity are both found in Mania and in Attention-Deficit/Hyperactivity Disorder. But how they are expressed and how they are experienced differ. Thus, diagnoses need to be applied only in the context of a complete assessment conducted by a person with substantial mental health expertise. Also, because signs and symptoms may be confusing and complex a diagnostic review for mental illness is not usually something that can be done quickly or by checklist alone. It takes time and experience to do a diagnostic assessment effectively.

A diagnosis is always considered to be a hypothesis about what is happening to the brain's usual functioning that leads to the signs and symptoms the person is exhibiting/experiencing. A diagnosis is not a label and it does not describe a person – it provides direction about what kind of treatment may be more likely to help, and what kinds of treatment are unlikely to help. As new information is obtained (including how the person responds to the treatment), an initial diagnosis may be modified or changed.

What does treatment mean?

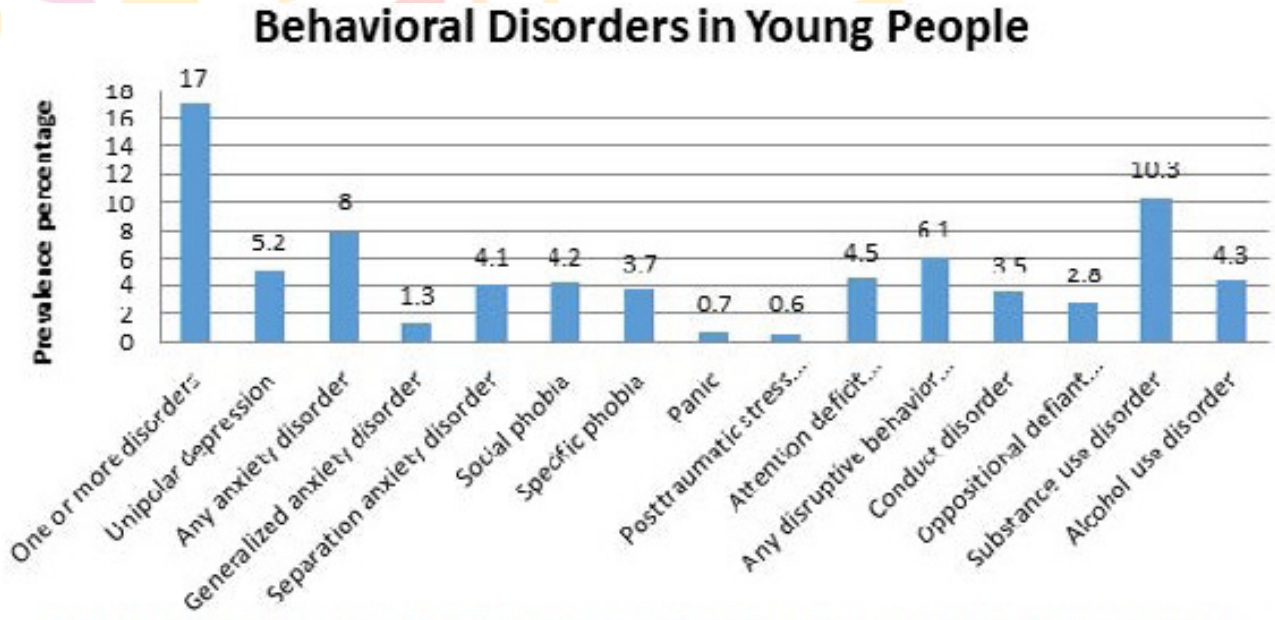
A treatment for a mental illness has three different purposes. The first is to help relieve the signs and symptoms of the illness. The second is to help the person recover from their illness. The third is to prevent the illness from recurring.

Different treatments can be used together to achieve these goals. One treatment alone may not be able to effectively address all the person's needs. Treatments are always applied using a risk: benefit ratio analysis. The questions that are asked are: what are the risks of no treatment; what are the risks of the treatment; and what are the benefits of the treatment? Decisions about providing a treatment are based on the answers to those questions. Evidence for effectiveness and safety of treatment is necessary to help determine which treatments could be likely to help more. Also, just like in the rest of medicine and because every person is unique, not everyone responds similarly to any specific treatment. Sometimes a period of trial and error in trying out treatments is necessary before the "best" treatment for any individual person is found. A more

detailed discussion about treatment is found in Module 6.

Common Mental Illnesses

Approximately one in five Canadians will develop a mental illness in their lifetime and 70% of those people could have been diagnosed before they turned 25. In childhood and adolescence, mental illnesses contribute the largest single amount to medical disability and are much more common than other kinds of illnesses. They also make the largest contribution to early mortality through suicide in young people (about 90% of youth who die by suicide in Canada are thought to have a mental illness). Early diagnosis allows for earlier treatment and more successful outcomes, when symptoms are often still mild to moderate in intensity and respond better to evidence-based interventions. Early treatment can also prevent the development of negative life events that can arise as a result of the illness (such as failing a grade or beginning to abuse drugs). This makes childhood and adolescence a crucial time for the identification and treatment of young people who have a mental illness and underlines the importance of ensuring that the individuals who interact with children and youth on a daily basis (e.g., teachers) are mental health literate.



Source: National Research Council and Institute of Medicine of the National Academies: Preventing mental, emotional, and behavioral disorders among young people. 2009

Mental illnesses are medical illnesses; however, instead of a disorder of the pancreas, such as diabetes, mental illnesses are disturbances of usual brain function. The brain has six key functions: thinking, perception, emotion, signaling, physical movements and behaviour, which were described in Module 3. A mental illness occurs when one or more of these brain functions fail to work as they should. By understanding not only the signs and symptoms of the mental illness, but the underlying mechanisms that are not functioning properly, we can develop interventions (clinical, academic and social) to best help students who are experiencing a mental illness.

With respect to mental illness, **the role of the teacher is not to diagnosis or treat** but rather to recognize that there may be a problem, refer appropriately and work effectively in the classroom and in collaboration with other professionals (such as school counselors, psychologists and mental health clinicians) to assist and support children and adolescents once they have been identified.

Activity 4.1: Review the PowerPoint “Understanding Diagnosis of Mental Illness” and reflect on the following.

How are mental illnesses diagnosed? Why does language used to describe negative emotions need to be clearly differentiated from language used to describe mental illness? How can teachers help their students better use language to describe and differentiate various emotional states?

Activity 4.2: Watch this video blog before we delve into the common mental illnesses in childhood and adolescence. https://www.youtube.com/watch?v=l0aNQ4cwsjw&feature=youtu.be

Section 1: Mental Illnesses in Childhood

(See later in this module for common Mental Illnesses in adolescence)

The following descriptors provide you with some basic information about these more common mental illnesses that can be diagnosed in childhood. For more information about these and for the criteria applied to make these diagnoses check out the relevant sections of the Diagnostic and Statistical Manual of Mental Disorders (5th Edition).

Additional information is also found in the Teacher Knowledge Update (http://teenmentalhealth.org/curriculum/teacher-knowledge-update/activity-2-teacher-knowledge-update-self-study-guide/) that accompanies this online course.

Note: The Teacher Knowledge Update is online in our toolkit and can be found in the Mental Health and High School Curriculum Guide.

Autism Spectrum Disorder (ASD)

ASD is a neurodevelopmental disorder, occurring more commonly in males, that affects about one percent of the population. In the last decade this diagnosis has increased significantly, perhaps due to an expansion of the diagnostic criteria or for other reasons. ASD is characterized by substantial, pervasive and sustained impairment in: reciprocal social communication and social interaction; restricted and repetitive behaviours, interests and activities and functional impairment. The severity of these varies and the diagnosis is usually made in the first 2 to 5 years of life. Some people with ASD exhibit severe language and/or intellectual impairment as well as challenges with motor skills and various types of behavioural challenges. Others will have mild to moderate symptoms.

ASD has a genetic basis involving many different genes, but the exact pattern or patterns of heritability has not yet been fully established. ASD is not caused by vaccinations or diet nor is it the same thing as childhood onset schizophrenia. Some people with ASD may demonstrate exceptional capabilities in one or more domains, such as encyclopedic information about sports statistics, numeric manipulation, etc.

For some young people with ASD, early application of an intervention called Applied Behavioural Analysis can result in significant symptomatic improvement. The earlier a diagnosis is made and an effective treatment is applied, the more likely it is that improvement may occur. Specialized ASD diagnostic and treatment centers, usually associated with pediatric hospitals and universities, are available in most Canadian provinces.

Classroom strategies for students with ASD need to be developed based on the needs, capabilities and strengths of each individual child. Information about teaching tips and strategies have been developed by many credible educational organizations and are easily found online. An example is one hosted by the Ontario Teacher's Federation, which can be found at: https://www.teachspeced.ca/teaching-strategies-students-special-needs?q=node/667.

Attention-Deficit/Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder with a strong genetic

component characterized by a persistent pattern of hyperactivity, impulsivity and substantial difficulties with sustained attention that is outside the population norm and is associated with substantial functional impairments at school, home and with peers. This disorder begins early in life, affects about 5 percent of the population and continues into adolescence and for some people, into adulthood. ADHD is more commonly found in boys. Girls who have ADHD often do not have similar problems with hyperactivity although they have problems with sustaining attention and impulsivity. Young people who have learning disabilities and youth with Tourette's Syndrome have higher rates of ADHD. Young people with Conduct Disorder may have ADHD which has not been recognized or treated and which may contribute to their social and legal difficulties. About 30% of youth with ADHD have a concurrent learning disability. ADHD should not be confused with symptoms of over-activity or difficulties focusing attention due to other factors (such as, lack of sleep, social deprivation, etc.).

Youth with ADHD exhibit difficulties with sustained attention. When tasks are more enjoyable or meaningful they will be able to better focus. Because they persistently orient to stimuli that others may ignore, students with ADHD appear more symptomatic in stimulus rich environments, such as open classrooms. Most young people with ADHD have trouble sitting still and are very active – often they will fidget, talk excessively, make noises during quiet activity and generally seem 'wound up' or 'driven'. Impulsivity is often shown as impatience or low frustration tolerance. Young people with ADHD will often interrupt others, fail to listen to instructions, rush into novel situations without thinking about the consequences, etc. This type of behaviour may lead to accidents.

These difficulties can be less pronounced in activities that require a great deal of physical participation and are constantly engaging. Sometimes young people with ADHD seem less distracted when they are playing games that they like – especially games that do not require sustained attention (such as video games). Symptoms are more likely to be noticed when the young person is in a group setting in which sustained and quiet attention is needed or when they are working in an environment in which there are many distractions.

ADHD can be treated with a combination of medications and other assistance – such as social skills training and cognitive behavioural therapy. The most effective treatment for symptoms is medication. Because learning difficulties are common, young people with ADHD should undergo educational testing to determine if a learning disability is present. Sometimes youth with ADHD will benefit from modifications to their learning environments such as having quieter places in which to work or having homework done in small amounts over longer periods of time.

Some young people with ADHD will develop conduct disturbances or substance misuse. Many will become demoralized because of constant reminders from teachers, parents and others about their 'bad behaviour'. Remember that these young people are not bad - they simply have difficulties with sustained attention. Try not to decrease their self-esteem by focusing only on what they have difficulty doing - focus on their strengths as well.

Classroom strategies should be developmentally appropriate and teachers can often participate in assessing the impact of medication interventions. Specific classroom interventions need to be tailored to the needs of the student. Some good sources for these can be found through the following link: www.education.alberta.ca/admin/supportingstudent/diverselearning/adhd.aspx

Watch a video on ADHD, suitable for sharing with students: https://www.youtube.com/watch?v=rLghxG3mGMM

Separation Anxiety Disorder (SepAD)

SepAD is found equally in both sexes and usually diagnosed by mid-childhood and is characterized by developmentally inappropriate and intense fear or anxiety related to separation from home, parents or other attachment figures. It should not be confused with shyness or a "slow-to-warm up" temperament. The prevalence of SepAD is about 4 percent in childhood and decreases over the life span. In school age children,

SepAD often manifests itself as refusal or severe reluctance to go to school. Students with SepAD may also demonstrate challenges in participating in various independent (away from home) activities such as not going to camp and not participating in sleep-overs. In adolescents, this can be expressed as not going on school trips or participating in other similar types of activities.

Treatment is primarily psychological, with behavioural therapy or cognitive behavioural therapy usually applied as a first line intervention. Teachers may be involved in supporting these behavioural interventions. Avoidance is common and should not be encouraged or supported as it makes the symptoms of SepAD worse and decreases the chance for young people to learn adaptive strategies.

Watch an animated video on SepAD, suitable for sharing with students:
https://www.youtube.com/watch?v=jEkFp0Ux4OQ&t=18s

Obsessive-Compulsive Disorder (OCD)

Although Obsessive-Compulsive Disorder (OCD) is most commonly diagnosed in adolescents and adults, approximately 25% of males who develop OCD will develop it before age 10. For a detailed description of OCD, please refer to the OCD part of the Common Mental Illnesses in Adolescences: Fast Facts for Teachers document.

Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD)

ODD can usually be diagnosed prior to puberty and is more common in boys. It is a persistent pattern of defiant, hostile and disobedient behaviours combined with common mood states of irritability and anger as well as frequent vindictive acts. ODD is more common in boys and the population prevalence is about 3 percent. Parent management training may be helpful in decreasing symptoms of ODD as harsh, inconsistent and neglectful parenting have been associated with a child developing ODD. Bullying can be a school-based manifestation of ODD. Clear rules and non-punitive natural consequences for problematic behaviours paired with positive reinforcement for pro-social behaviours should be applied as consistently as possible.

Severe, persistent and challenging behaviours that threaten the safety, security or physical integrity of others are the phenomena that comprise Conduct Disorder (CD). Youth with CD act with aggression and even violence towards others, either in response to challenge or without provocation. They threaten (verbally and physically) and intimidate others and can cause physical harm to others, including assault with a weapon. They commonly engage in property damage or theft and frequently violate norms of social behaviour. Running away from home, lying, school truancy and bullying of others occurs. Young people with CD have higher rates of substance misuse, difficulties with the law (for example: arrests and convictions), traffic accidents, school non-completion and poorer economic/vocational outcomes. They may be involved in various illegal activities including crimes against people and property. A sub-group of those with CD may later in life meet diagnostic criteria for Anti-Social Personality Disorder and rates of Attention Deficit Hyperactivity Disorder and Substance Use Disorder are higher in youth with CD.

Classroom strategies for ODD and CD are similar. For some useful links check out: https://www.brandonuteachertools.net/conduct-disorder.html and http://smhp.psych.ucla.edu/pdfdocs/conduct/conduct.pdf

Section 2: Understanding Mental Illness in Adolescents

This section of Module 4 is presented only as a PowerPoint (Activity 4.3). It may be helpful if you print off the "Understanding Mental Illness in Adolescents: Fast Facts for Teachers" (found in the Deeper Dive section) and use the hard copy format to make notes as you follow the slide presentation.

Activity 4.3: Review the PowerPoint "Understanding Mental Illness in Adolescents".

Supplementary Resources

The Mental Health and High School Curriculum Guide http://teenmentalhealth.org/product/mental-health-high-school-curriculum/

Know Before You Go http://teenmentalhealth.org/product/know-before-you-go/

Transitions http://teenmentalhealth.org/ransitions/

Self-Assessment

1. A diagnosis of a mental disorder must include a biological test (such as a brain scan) to be considered useful.
2. Treatment is primarily directed at understanding the root cause of the problem.
3. Separation Anxiety Disorder is always due to environmental factors, such as overprotective parenting.
4. Medications (such as psychostimulants) are often an effective treatment for the symptoms of ADHD.
5. Autism Spectrum Disorder is known to have a genetic component but the exact genes involved have not yet been identified.
6. Most mental disorders can be diagnosed before age 25 years.

Self-Assessment Answer Key

1) F 2) F 3) F 4) T 5) T 6) T