

Parents and Teachers as Allies

Recognizing Early-onset Mental Illness in
Children and Adolescents





National Alliance on Mental Illness

Find Help. Find Hope.

Parents and Teachers as Allies:

Recognizing Early-onset Mental Illness in Children and Adolescents

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The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has over 1,100 affiliates in communities across the country who engage in advocacy, research, support and education. Members of NAMI are families, friends and people living with mental illnesses.

NAMI

**3803 N. Fairfax Dr. Suite 100,
Arlington, VA 22203**

www.nami.org

(703) 524-7600

HelpLine: 1 (800) 950-NAMI (6264)



*P*arents and Teachers as Allies

Recognizing Early-onset Mental Illness in Children and Adolescents

Developed by Joyce Burland, Ph.D.,

Revised by Teri S. Brister, Ph.D.
NAMI Education, Training and Peer Support Center

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Introduction

On Jan. 3, 2001, the Surgeon General of the United States released a report stating that 12 percent of American children under the age of 18 have a diagnosable mental illness. Although welcome as a wake-up call to the nation, this belated recognition of children in crisis did not come as news to the millions of parents and teachers who were struggling every day to help these distressed youngsters.

The numbers are real; here is what we know:

- Thirteen percent of youth aged 8-15 live with mental illness severe enough to cause significant impairment in their day to day lives. This figure jumps to 21 percent in youth aged 13-18.
- Fifty percent of all lifetime cases of mental illness begin by age 14; 75 percent by age 24.
- The average delay between onset of symptoms and intervention/treatment is 8-10 years.
- Only 50 percent of youth with mental illness actually receive treatment.

We also know that the consequences of untreated mental illness are devastating:

- Approximately 50 percent of students aged 14 and older with mental illness drop out of high school; the highest dropout rate of any disability group.
- Seventy percent of youth in state and local juvenile justice systems have mental illness, with at least 20 percent experiencing severe symptoms.
- Suicide is the third leading cause of death in youth and young adults aged 15-24. Ninety percent of those who died by suicide had an underlying mental illness.

We know that the challenge of coping with serious behavioral challenges and mental illness among our youngest and most vulnerable has long been left to family caregivers and school personnel. Due to the lack of appropriate resources and services for youth with mental illnesses parents and teachers have by default, become primary providers of care. Schools and juvenile justice centers now act as mental health systems for these youth, and home is the principal refuge for care. With no formal preparation for this responsibility, parents and teachers are forced to become allies at the frontline in the battle to avoid the devastating consequences of unrecognized and untreated mental illness among our nation's youth.

Acknowledging and strengthening this alliance between home and school is critical. The main hope for youth at risk for serious mental illness lies in early identification, intervention and treatment, and the fact that childhood and adolescence are the most intensely watched developmental periods in life. Parents and teachers are the closest observers of our youth. Problems first surfacing at home are often amplified in the school setting; by law, schools provide the critical link between a youth in crisis and referral for evaluation. With early identification and intervention, young people with mental illness can be helped—potentially avoiding years of struggle for these youth and their families.

This monograph was prepared to help parents and teachers identify the key warning signs of early-onset mental illness in children and adolescents. It focuses on the specific,

age-related symptoms of mental illness in youth, which may differ from the criteria for the same diagnosis in an adult. This is not to suggest that, on top of everything else, parents and teachers should become diagnosticians and therapists, but both groups must be grounded in a common knowledge base and united in their willingness to identify those displaying the signs and to link them with services and supports.

This summary account of the symptoms of mental illness in children and adolescents—and a discussion of the issues these disorders raise for parents and teachers—is intended to provide an educational tool for advancing mutual understanding and communication. It is designed to travel on a two-way street:

- For teachers to use and give to parents of the children for whom they are concerned,
- And for parents to use and give to the teachers working with their children.

It may be that nature, in its wisdom, has singled out these two primary supervisory human networks for the job of identifying children at risk, knowing that the watchful eye of parents and teachers will sound the first alarm when a child fails to thrive. This booklet pays tribute to all those who are dedicated to this task.

Becoming Allies: Acknowledging Different Perspectives

“There’s a child in my class who I think has symptoms of psychiatric illness. It’s not just his behavior; it seems to be something deeper. I don’t know how to help him, how to approach his parents or where to refer them for help. This is something that everyone is reluctant to discuss. I care very much about this child and fear if we don’t get him some help soon, we may lose him.”

— A teacher in Rhode Island

“My son is a major challenge at home. He does things that are beyond our control despite everything we do to help him. His school performance has seriously declined. I know something is really wrong with him, but I can’t get his teachers at school to recognize he’s got a mental illness. They say it’s a “behavioral disorder” and that we should go to parenting class.”

— A mother in Virginia

An immediate problem in strengthening parent-teacher alliances to support children with mental illnesses is the uncomfortable nature of the subject itself. The topic of mental illness comes loaded with baggage—stigma, misinformation and blaming—which silences and divides us. In addition, knowledge about the causes of mental illnesses in youth continues to evolve, leaving parents and teachers confused as they try to sort the facts and compare the opinions of experts in the field.

Consequently, those attempting to build alliances may come from a number of perspectives. Many parents and teachers understand that mental illness in youth is real and must be taken seriously; many do not. Some do not hesitate to identify youth with potential mental health issues and seek immediate treatment; others are exceedingly reluctant to do so.

There remain many who do not believe that children and youth develop serious mental illness, despite major advances in our understanding of early onset mental illness. In some cases, children who are exhibiting symptoms of mental illness are viewed as choosing to act inappropriately.

To address these challenges, parents and teachers need only to focus on the fundamental objective: helping the youth who is struggling. Whatever the cause of the distress they are observing, parents and teachers are the primary early warning team. They witness the problem and can help youth at risk get a comprehensive psychiatric assessment. Acting quickly and decisively will lead to service and support that can save these children's childhoods and avoid further complications in their adult lives.

The Heart of the Matter: Children Robbed of Childhood

“What I remember most is the suffering. Kids are supposed to be happy. Boy, that’s a joke. I was depressed for years and felt totally odd and isolated, almost despised. Growing up was a really miserable experience until I got help.”

— A young man in therapy, recalling his childhood

There is now compelling evidence that mental illnesses in children and youth begin early, that untreated mental illness places children at risk of developing the most debilitating forms of illness, and that the impact of untreated mental illness on their growing years can be devastating. When children have symptoms that they cannot control, childhood becomes a painful ordeal. All the building blocks necessary to prepare them for adulthood are kicked out from under them. Many of their symptoms cause poor functioning in school; they fall behind, can't compete, fail. Behaviors driven by their symptoms are extremely difficult; they become lightning rods for criticism, ridicule and rejection. In the starkest sense, untreated mental illness is a thief of childhood. It steals away every benefit this precious and critical span of development should provide for growing children.

When consequences this serious threaten a child's potential and effective services and supports are at hand to stabilize a child's life, delaying effective interventions for any reason can compromise a child's entire future. Parents and teachers must be empowered as allies to confront any and all conventions standing in the way of early identification and early intervention.

Keys to Early Symptom Recognition, Intervention and Treatment

“I’m so thankful we finally got to see a psychiatrist. When he told me Michael had obsessions because of an illness in his brain, everything fell into place. I suddenly thought of the whole animal kingdom and what it would mean for a bird to have a bum wing. I figure wing is to bird as brain is to boy. We have to treat Michael’s brain.”

— The mother of a 9-year-old

There is now compelling evidence that mental illness in children does occur, that untreated mental illness places children at risk of developing the most debilitating forms of illness and that the impact of untreated mental illness on their growing years is devastating.

It is normal for all growing children and adolescents to be reactive to stresses in their environment and to express their feelings in their behavior. Many youth experience poverty, deprivation and/or abuse, and many must get through traumatic periods of loss and/or family instability. Children can have difficulties when they shift from one developmental stage to another or feel overwhelmed by academic and social challenges. Parents and teachers witness a range of environmental stressors that can cause children and adolescents to act out, rebel and show challenging behavior.

However, mental illness is different. With early-onset mental illness children are challenged by a chemical disturbance in their brains that controls their behavior and undermines their ability to deal with their world, whatever it may be. Environmental stress can trigger the onset of mental illness and certainly make the experience worse for children; There's a lot we still don't understand about what causes mental illness. In general, doctors think mental illness is caused by a combination of a variety of biological and environmental factors.

The primary problem is, of course, identifying which behaviors are normal developmental challenges, even if they are extreme, and which signal the early warning signs of emerging mental illness. This is a call that only a qualified mental health professional should make following a comprehensive screening and assessment.

Unhappily, because mental illness in children is often not well-recognized, children with mental illness are more likely not to receive the services and supports that they need. Any child with persistent behavioral difficulties should have a psychiatric evaluation. Verifying clinical symptoms is basic, but qualified mental health professionals also look for a group of clinical features that have particular diagnostic significance: intensity, duration and level of distress. Children with untreated serious mental illness experience constant, unrelieved and challenging symptoms. Parents and teachers must watch for early signs of severity and impaired functioning so they can speed the referral to a qualified mental health professional. For children with mental illness, this step is the threshold to recovery and hope.

Parents and Teachers Learning and Working Together as Allies

"I had a big discussion with my daughter's teacher. She thought it was wrong to saddle Becky with a psychiatric label. I told her, 'What difference does it make? She's already been labeled a rotten kid. What could be worse for Becky than that?'"

— The father of a 14-year-old

This dad is reporting from his unique position in his child's private world. On the public side of the child's life, the teacher is weighing the social cost of a psychiatric diagnosis. The father has an "insider" view, which the teacher in the classroom may not have. He knows that, given

the depressed state that he sees in his child at home, nothing must stand in the way of seeking help for her. With shared insight, parent and teacher can become allies for action.

Maintaining two-way communication between the public and private parts of a child's life is absolutely essential for teachers and parents to gain the information necessary for early intervention on the child's behalf. Behaviors a teacher sees frequently in school may not occur at home; behaviors seen at home may not happen at school. In the privacy of home, children are more likely to express their true feelings; in school, the teacher will pick up on heightened behaviors caused by the stress of required work and negative encounters with peers. It is impossible to put these separate pieces of a child's experience into a meaningful whole unless parents and teachers work together. As allies, they can identify the early warning signs of mental illness and become a singularly effective early-intervention team.

In the summaries that follow, the symptoms of early-onset mental illnesses in children are followed by the symptoms for adolescents. In the case of children under age 13, every effort has been made to describe behaviors commonly seen in school and to include typical observations from parents in the home.

Signs of Early-onset Mental Illnesses in Children and Adolescents

The following descriptions and symptom lists are taken from the fifth edition of the Diagnostic and Statistical Manual (DSM-5) developed by the American Psychiatric Association in 2013.

Attention-Deficit/Hyperactivity Disorder (ADHD)

ADHD is a neurobiological disorder that presents initially in childhood or adolescence, before the age of 12 years. ADHD is more common in boys than girls, a ratio of about 2-to-1 in children. ADHD occurs in one of every 20 children. It is not caused by bad parenting nor do these children lack intelligence or discipline—they simply cannot sustain the focus needed to complete tasks appropriate for their age and intelligence. As a result, children with ADHD seem unable to behave or follow the rules like other children. They characteristically perform better one-on-one than they do in groups. For a diagnosis of ADHD, the core symptoms of inattention and/or hyperactivity-impulsivity, must:

- Be present in a child for at least six months;
- Interfere with the child's functioning or development, and
- Cause significant impairment in more than one setting (for example home, school, sports activities; these children typically act worse in school than they do at home).

For many children, the key identifier for ADHD is the early age of onset, before age 12.

Predominantly Inattentive Presentation

- Can't pay attention to details; are often caught daydreaming.
- Avoid, dislike or are reluctant to engage in activities that require sustained attention; including play activities.

- Are highly distractible, forgetful, absent-minded, careless, disorganized; frequently lose things.
- Often do not finish school work (work may be full of mistakes, turned in late or not at all).
- Don't listen to or follow through on instructions.

Predominantly Hyperactive/Impulsive Presentation

- Display extreme physical agitation; fidget, squirm, can't stay seated or remain still.
- May run or climb at times when it is inappropriate to do so.
- Constantly interrupt and speak out of turn; talk excessively; disrupt the classroom; blurt out answers before a question is completed.
- Are "on the go" and act as if "driven by a motor."
- Intrude on others; difficulty waiting their turn; resort to even more inappropriate behavior when reprimanded.

Combined Presentation

- Most common, a mix of inattentive and hyperactive/impulsive symptoms that have been present for at least six months.

What families report observing:

- Symptoms have been persistent since early childhood; the illness didn't come on suddenly, but something was "off" from the very beginning.
- The child never slows down, is exhausting and demanding or the opposite, that the child is "clueless" with "head in the clouds."
- They often misread the child as bad or not bright or wonder why the child is always in trouble at school.

Co-occurring Disorders

More than one-half of children with ADHD have at least one other major childhood disorder.

- Approximately 50 percent of children with combined presentation ADHD also have oppositional defiant disorder.
- Approximately 25 percent of children with inattentive presentation also have oppositional defiant disorder.
- Approximately 25 percent with combined presentation ADHD also have conduct disorder.
- Approximately 30 percent have an anxiety disorder or a depressive disorder.

Some children experiencing symptoms of ADHD may actually be in the early stages of bipolar disorder, which should be ruled out before any stimulants or antidepressants are prescribed. These medications can trigger manic and psychotic episodes in children if a bipolar disorder is present.

ADHD in Adolescence

Although hyperactivity symptoms often diminish in the teen years as the child is able to exercise more self-control, if ADHD remains untreated it can rebound in adulthood.

Problems surfacing at home are often amplified in the school settings; by law, schools provide the critical link between a child in crisis and referral for evaluation.

More than half of those with ADHD in their childhood will continue to have difficulty as teenagers; poor school performance, difficulty with peer relationships and low self-esteem are also common. A teen with ADHD and a history of co-occurring conduct disorder and oppositional defiant disorder is at high risk for continued antisocial behavior and may be frequently dismissed and suspended from school. The school dropout rate for this group is 12 times greater than the rate among teens that are not affected by ADHD.

- High rate of conduct disorder: 50 percent.
- High risk for alcohol use, drug use and early smoking.
- Increased antisocial behavior and delinquency.
- Inattentive presentation, more common in girls; boys “blow off” school, act impulsively, “can’t get it together,” feel persistently restless.
- School failure; downward social drift to “outcast” school groups; low self-esteem.

Anxiety Disorders

Anxiety disorders cause extreme discomfort and unease in situations generally regarded as unthreatening. To anyone dealing with anxiety, many normal events and expectations arouse intense dread and worry. Anxiety disorders are the most common mental illnesses experienced by children and adolescents. The forms of this disorder most prevalent in childhood are separation anxiety (terror at being apart from a parent), generalized anxiety (over-anxiousness, excessive, unwarranted worrying) and social anxiety (severe shyness and avoidance of social contact). The effects of these disorders can be extreme causing children to reduce contact with the outside world. Predictably, a key warning sign of anxiety disorders is not wanting to go to school. Frequent absences because the child complains of feeling sick in the mornings are common and may lead to an attendance review.

These children can appear rude and noncompliant when trying to avoid things that trigger anxiety (like reading out loud). However, they generally avoid the spotlight and try to be invisible to the teacher and classmates.

Separation Anxiety in youth

- Intense anxiety at being separated from parents; overwhelming homesickness when apart.
- Worry that parents will die; clinging to the parent and following parent from room to room.
- Refusal to sleep alone and will not go on sleep-overs.
- Claims of sickness to avoid going to school (sick feelings disappear if they stay home).

Generalized Anxiety Disorder

- General excessive worry, how they look, what people think about them.
- Dread they will do things wrong; perfectionist; re-do work.
- Excessive seriousness, uptight, unsure feelings, hypersensitivity to criticism.

- Don't respond to reassurances from teachers or parents; continual worry, even though school work is excellent.

Social Anxiety Disorder

- Fear about social situations in which the child is exposed to possible scrutiny by their peers as well as adults.
- Restriction of social contacts exclusively to close family members.
- Fear of being singled out, judged, evaluated, called on in class.
- Social situations almost always provoke fear or anxiety that may be expressed by crying, tantrums, freezing, clinging or shrinking from others.
- May be more anxious about specific situations (eating in private, using public bathrooms).

Panic Disorder

- Recurrent sudden onset of pounding heart, rapid heartbeat; chest pain and discomfort; shortness of breath.
- Sweating, trembling, shaking.
- Feelings of choking, nausea and dizziness.
- Feelings of unreality.
- Fear of dying, losing control or "going crazy."
- Worry about the recurrence of the next panic attack.

What families report observing:

- Worry and concern over repeated absences from school.
- "Meltdowns" occur when they try to force activities which generate anxiety.
- Find themselves in a catch-22; accommodating anxious behaviors risking school failure, yet insisting on attendance and social contact means the child continually falls apart.

Co-occurring Disorders

Mood disorders and anxiety disorders co-exist at every age.

Anxiety Disorders in Adolescence

The onset of anxiety disorders in adolescence reaches its peak in the mid-teen years and often occurs after a loss or change in the teenager's life. The high rate of illness in this population is doubly unfortunate because teens with anxiety disorders cannot calm themselves down and are highly susceptible to alcohol and drug addiction. These substances initially reduce anxiety and are frequently used as a form of self-medication. At this older age, adolescents will have heart-stopping panic attacks or become confirmed "worry warts" or literally shut down all communication and interaction. Symptoms of anxiety disorders in teens are similar to those experienced by adults. This illness results in a sense of forced, inescapable isolation and feelings of failure. Older children with anxiety disorders know their reactions are excessive and unreasonable, but they are powerless to change them. Consequently, they experience constant demoralization and low self-esteem.

Depressive Disorders

Depressive disorders affect 25 percent of children and 8 percent of adolescents. Children and adolescents can experience symptoms of depression that are as severe as those experienced in

adulthood, but often the symptoms look different based on the age of the child. Spotting childhood depression requires knowing the unique ways children express the depression they feel. The core symptom is not necessarily sadness, but irritability and aggressiveness. The mood disturbance also frequently plays out in imagined body pains and a noticeable drop in school performance. Another key indicator is the abruptness of behavior change; a sociable, likeable child who is doing well suddenly develops problems with peers and ignores schoolwork. Early detection and treatment are essential to prevent a chronic and relapsing course of illness, which is the prognosis for early-onset depression in children.

- Show extreme irritability, aggressiveness, combativeness.
- Feel mad all the time, sullen, groundless; have anxious complaints about headaches, stomachaches; may have extensive medical evaluations that find no cause for these symptoms (this is often the only significant diagnostic identifier).
- Experience drop in grades; won't do homework; refuse to go to school; feel extreme anxiety about tests.
- Develop negative self-concept, are down on themselves; believe they are weird, ugly, dumb, picked-on; have thoughts of death.
- Are hypersensitive to criticism.
- Overreact to disappointment and frustration; become tearful, give up easily.
- Become unable to have fun, withdraw, mope, won't join in activities.
- Become lethargic, apathetic, dispirited; have difficulty with sleeping, oversleeping; can't get up in the morning and are sleepy in school.
- One-third experience psychotic symptoms: hallucinations(seeing/hearing things), delusions (false beliefs) or paranoia (suspiciousness).

What families report observing:

- Nothing ever pleases the child; child seems to “hate himself and everything else;” report the well-adjusted child they are familiar with “went somewhere,” that they have a “totally different kid;” sadness and confusion with change in their child.
- Admit that this child is no fun and is hard to like.
- The child tries to “put on a good face” in public and displays the worst of the symptoms at home.

Co-occurring Disorders

One-third of children ages 6 through 12 diagnosed with major depressive disorder will develop bipolar disorder within a few years. Anxiety disorders and substance use disorders co-exist with mood disorders at every age level.

Depressive Disorder in Adolescence

There is a marked increase in the incidence of depression in the teenage years, with a peak of onset at age 15. In this age group, twice as many girls are affected as boys. Because older children are more adept at hiding behaviors they fear will make them lose face, depression in teens can be masked by outstanding school performance, school leadership and “ideal behavior.” Other adolescents with depression who cannot rely on popularity or academic performance to disguise their condition try not to attract attention at school. A recent comprehensive screening of high school students for depression found that half of those who

qualified for referral and treatment were not known to school psychologists or social workers as being in need of help. Depressive symptoms in adolescents can be detected by talking to the teenager and watching behavior patterns closely. Family input is critical because many of the symptoms occur at home, when peers are out of sight.

- Feel sad, hopeless, empty; crying in class.
- Appear lethargic, slow-moving, sleepy; conversely, inability to control hyperactivity may signal depression.
- Develop extreme sensitivity in interpersonal relationships; are highly reactive to rejection or criticism; “drop” friends they’re having problems with.
- Are irritable, grouchy; prefer to sulk and cannot be cajoled into a better mood.
- Overreact to disappointment or failure; often take months to recover from setbacks.
- Feel restless and aggressive; become antisocial (lie to parents, cut school, shoplift).
- Think they are different, no one understands, “everyone” looks down on them.
- Become more and more isolated from family and schoolmates; often shift down to an out-of-the-mainstream peer group or “hang out” exclusively with one friend.
- Become self-destructive; at high risk of “self-medicating” with drugs and alcohol.
- Stop caring about their appearance.
- Commonly have morbid imaginings and thoughts of death.

Co-occurring Disorders

Fifty percent of adolescents with major depressive disorder also have an anxiety disorder that existed before the onset of the depression. Anxious states increase the risk of suicide.

Ninety percent of adolescents who die by suicide have a psychiatric diagnosis of a mood disorder and alcohol/substance use. While suicide in children under the age of 12 is rare, it is the third-leading cause of death among adolescents ages 15 to 24. Girls have a higher rate of attempted suicide; boys complete more suicides and are at highest risk if they drink heavily. Suicide is a tragic consequence of mood disorders, which—when recognized—are highly treatable.

Bipolar Disorder

This mood disorder can involve sharp swings from episodes of manic “highs” to periods of depressive “lows” or a mixed state in which manic energy combines with the depressed mood. Two cornerstones for diagnosis of bipolar disorder in children are 1) the presence of a strong family history of bipolar disorder and 2) an early-onset symptom pattern that is unique to this age group. There are a growing number of accounts of families whose children are struggling with a form of “pediatric mania” in which mood shifts occur repeatedly throughout the day and the child is caught in long periods of ultra-rapid mood cycling. These parents report that they cope with frequent, severe, prolonged, explosive rages at home as well as unpredictable, aggressive, oppositional episodes that swing back to the child’s “other” upbeat mood. Silly and full of energy one moment, the child will suddenly become angry, disruptive and defiant. These children are often charming, funny, verbally and artistically gifted and bright. They can also be bossy, intrusive, insistent and difficult.

- Hair-trigger arousal system is set off by the slightest irritant or change.

- Overreaction takes the form of irritable, oppositional, negative behavior.
- Multiple mood shifts; the child acts like two different people.
- Usually rage is controlled in school, in front of classmates.
- Hyperactivity: highly distractible, inattentive; decreased need for sleep.
- Grandiose behavior: tell the teacher how to run the class or attempt to take over the class.
- Overt hypersexual activities and comments in the classroom.
- Great sensitivity to temperature and often heat-intolerant.
- Insatiable craving for carbohydrates and sweets.
- Psychotic episodes of auditory hallucinations (common); may not be reported.

What families report observing:

- The child was “always different;” with ragged sleep cycles, night terrors, violent nightmares; first reaction to any request is “no!”
- Say child typically has severe separation anxiety; will refuse to go to school.
- Describe rages as seizures: “wild-eyed,” violent tantrums of kicking, hitting, biting, screaming foul words, thrashing that lasts for hours.
- The child has serious sleep disturbance: hard to rouse, gains energy through the day and “bounces off the wall” by end of school day.
- Child has extreme physical sensitivity: clothes must feel “just right,” food temperature must be “just right.”
- Say child is more difficult at home than at school.

Co-occurring Disorders

The development of bipolar disorder in children may involve clusters of symptoms at various ages that look like ADHD, ODD, CD and depressive disorder.

Bipolar Disorder in Adolescence

The onset of bipolar disorder in adolescence can be extremely difficult. Talents and strengths the child developed while growing up are swept away, leaving the teenager feeling lost and alone at a critical stage of development. Reckless behaviors driven by mania bring painful, embarrassing attention to the youth, while depressive episodes make active participation in school life almost impossible. In adolescence, this illness can strike with great severity with pronounced psychosis and grandiose delusions. A lesser state of elation (hypomania) can persist, making the adolescent feel all-powerful and invincible and unlikely to listen to advice from adults. Teens with this illness are at high risk for drug and alcohol abuse and it doesn't take long for them to get a reputation for bad behavior. However, they do feel genuine remorse for their destructive actions even though they are likely to repeat them.

Manic Phase

- Difficulty sleeping; high activity level late at night.
- Increased goal-setting and unrealistic expectations (boasting of becoming a rock star when they can't sing or a prominent “big shot” when they are failing at school).
- Very rapid and insistent speech.
- All-or-nothing mentality (if not exactly their way, it's worthless).
- Spending sprees (running up large credit card bills over the phone).
- Aggressive, touchy, irritable.

Medicating a child whose problems can be effectively remedied by therapy alone is as clinically misguided as denying medication to a child whose condition cannot improve without it.

- Reckless driving; drinking and driving; repeated car accidents.
- Hypersexuality, provocativeness.
- Lying and making up stories; sneaking out of class; sneaking out of house at night to party.
- Psychotic episodes: delusions (false beliefs), hallucinations (seeing/hearing things), paranoia (suspiciousness); may have romantic delusions about teachers.

Depressive Phase

- Crying; extreme sadness.
- Moodiness, irritability (picks fights with others).
- Tremendous fatigue, oversleeping, lethargy; carbohydrate cravings.
- Insecurity, separation anxiety, low self-esteem.
- School avoidance; feigning sickness to stay home; constant physical complaints.
- Self-isolation; pushing people away.
- Suicidal thoughts and attempts.

Co-occurring Disorders

The majority of adolescents diagnosed with bipolar disorder also have symptoms of ADHD.

Disruptive Mood Dysregulation Disorder (DMDD)

The core feature of DMDD is chronic, severe persistent irritability, with two prominent symptoms. The first is frequent temper outbursts that typically occur in response to frustration. The outbursts can be verbal or physical in the form of aggression against property, self or others. The second primary symptom is the presence of chronic, persistently irritable or angry mood between outbursts. This irritable mood is present for most of the day, nearly every day and observed by everyone who is in contact with the child. This diagnosis was added to the DSM-5 in an effort to prevent an inaccurate diagnosis of bipolar disorder for children who experience these symptoms consistently, rather than episodically as in bipolar disorder. This diagnosis is made when the symptoms have been present for at least 12 months and symptoms have been observed in more than one setting (at home, at school, with peers).

- Severe temper outbursts (verbal rages; physical aggression toward people or property) that are out of proportion to the situation.
- Outbursts are inconsistent with the developmental level of the child.
- Outbursts occur on average 3-4 times per week.
- Mood between outbursts is irritable or angry most of the day, nearly every day and noticed by everyone at home and at school.

What families report observing about the child:

- The child does not get along with anyone at home or at school; children or adults.
- Low frustration tolerance makes it difficult to participate in family activities; even

simple things like meals with the family.

- The rest of the family walks on eggshells to keep from “setting off” a tantrum.

Co-Occurring Disorders

Rates of other diagnoses along with DMDD are extremely high. In fact it is rare for a child or adolescent to have the single diagnosis of DMDD. Most commonly the other diagnoses include anxiety, depressive disorders and even autism spectrum symptoms. Children diagnosed with DMDD should not meet the criteria for bipolar disorder; if that is the case, only the diagnosis of bipolar disorder is made.

Disruptive Mood Dysregulation Disorder in Adolescence

The onset of DMDD is before the age of 10 years, and the diagnosis is only valid for youth between the ages of 7-18 years. The symptoms of DMDD likely will change as the child matures; approximately half of children with this diagnosis will continue to experience the symptoms one year later or longer.

Obsessive-Compulsive Disorder (OCD)

This disorder involves the recurrence of senseless, intrusive, continuous, anxiety-producing thoughts and impulses (obsessions) which children attempt to ward off with rigidly patterned, irrational behaviors (compulsions). Almost as common as ADHD, this condition affects more than one million children and adolescents, with boys twice as likely to experience it as girls.

Symptoms can start as early as ages three or four, but in the U.S. the average age of onset of OCD symptoms is 19.5 years of age with 25 percent of cases beginning by age 14 years. Younger children may not interpret their compulsive behaviors as unusual: to them, they are just “absolutely necessary.” Blocking or preventing their compulsive responses can trigger extreme tantrums. Older children will often become exhausted in an effort to hide their condition from peers. With OCD, there is a striking similarity of symptoms among children and adults, with 50 percent of adults with OCD reporting their conditions started before the age of 15.

Obsessions

- Fear of contamination, dread of germs.
- Fixation on lucky/unlucky numbers.
- Fear of catastrophic danger to self or others (fire, death, illness).
- Need for symmetry and exactness (objects or furniture must be placed “just so”).
- Excessive doubts.

Compulsions

- Ritual hand-washing, showering, grooming, cleaning.
- Repetitive counting, touching, getting up and down, going in and out, writing/erasing/rewriting.
- Continuous checking and questioning; arguing, hoarding or collecting.
- Children may not be able to articulate the purpose, or their need for these behaviors.

What families report observing

- They must cooperate with compulsive rituals to placate the child and avoid confrontations and tantrums.
- The child is often too exhausted to play or join in family activities.
- Experience extreme frustration with child's inability to control irrational behaviors.
- Disclose that ritual compulsions swamp home life but are more subdued in public.

Co-occurring Disorders

- Thirty percent of individuals with OCD also have motor tic disorders
- Seventy-six percent of adults with OCD also have a diagnosis of an anxiety disorder
- Sixty-three percent also have a diagnosis of depressive or bipolar disorder
- Twenty to 40 percent of adolescents with eating disorders have OCD
- Adolescents with OCD are at high risk for depression.

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

These disorders involve disobedience that grossly violates accepted behavioral norms for children. This is the child who, beyond all understanding, refuses to cooperate or a child who relishes playing a destructive, villainous role with others. Boys with this disorder outnumber girls. Core symptoms are inflexibility in ODD and physical aggression and cruelty in CD. Although it seems inconceivable, children as young as age three can display symptoms of these disorders. Genetically vulnerable, these children are often at high risk because of disadvantages such as poverty, abuse and neglect. Because these children are so relentless and show so little remorse over their actions, attempts to control or discipline them tend to make them even more defiant. It is difficult not to spot these disorders. Children with such extreme antisocial behaviors require early identification and early intervention to get their lives back on track.

Oppositional Defiant Disorder (willful behaviors):

- Negative, hostile, defiant behavior; will not comply with requests made by adults.
- Persistent arguing with adults; belligerent, obstinate.
- Intense rigidity and inflexibility; feel entitled to make unreasonable demands.
- Touchy, resentful, spiteful; blame others when apprehended.

Conduct Disorder (intentional behaviors):

- Aggression and cruelty toward people and animals; bullying with bats, pipes, weapons.
- Destructiveness (setting fires, defacing or destroying property).
- Deceitfulness (lying, stealing, "conning").
- Disobedience (truancy, running away from home).
- Lack of remorse for antisocial behaviors.

What families report observing:

- Get angry and exasperated with the child who won't ever obey or cooperate (ODD).
- Are shocked, horrified and embarrassed by the child's sadistic behaviors (CD).
- Feel frightened and intimidated and worry constantly about danger of injury to siblings (CD).
- Are overwhelmed by criticism from family and friends.

- Report that the many suspensions from school add to their burdens at home.
- Can't take the child anywhere; feel ostracized and housebound.

Co-occurring Disorders:

Fifty percent of children with ODD have ADHD; 40 percent with CD have ADHD and almost as many have a depressive disorder.

Oppositional Defiant Disorder/Conduct Disorder in Adolescence

A child with ODD or CD at age 7 will, without treatment, pose a considerable threat to society at age 15. Bigger, stronger, conditioned by years of oppositional resistance and bullying, this teenager will persist in antisocial behaviors that “up the ante” in danger to others. There is also a late-onset of conduct disorder, starting after age 10 in which a child will become aggressive and antisocial as a primary way of interacting with others. Because these children do not have a close connection to their classmates, they can become loners who feel they have nothing to lose by acting worse.

- Truancy, school failure, frequent expulsion from school.
- Reckless, accident-prone behavior.
- Low self-esteem covered by a cocky or “tough” demeanor.
- Early sexual activity.
- Early drug and alcohol abuse.
- Sociopathic behaviors causing serious harm to others, such as physical abuse, intimidation and rape.
- Frequent encounters with the criminal justice system.

Childhood-onset Schizophrenia

Early onset schizophrenia is a chronic brain disorder marked by delusions and hallucinations in the acute stage and by apathy, withdrawal and lack of motivation in the residual stage. The childhood form of this illness is rare, affecting one in 40,000 children under the age of 15. Unfortunately, the early expression of this disorder is extremely severe, involving significant abnormality in brain structure and causing pronounced disruption in brain development. The defining sign of childhood schizophrenia is the slow gradual emergence of psychotic symptoms as well as their persistence after the onset of the illness. Because the onset process is so protracted, ancillary signs of detection are useful; early-onset schizophrenia is often preceded by developmental disturbances such as lags in motor and speech/language development; poor functioning in attention, memory and decision-making and grade failure. Childhood-onset schizophrenia is rarely observed before the age of 5 and can be differentiated from autism by this later age of onset.

- Early pattern of inhibition, withdrawal and sensitivity.
- Problems with conduct.
- Anxious and disruptive in social settings.
- Poor motivation and follow-through.
- School failure or required placement in special education.
- Inability to make friends; disinterested in forming relationships.
- Confusion about what is real: hearing voices of someone not there (hallucinations)

or sense of being followed or threatened (delusions and paranoia).

- Showing no emotion; speaking rarely; sitting still for long periods of time.
- Inappropriate expression of emotion (laughing at sad events).
- Little or no eye contact; little expression of body language.

What families report observing:

- The child hears voices saying bad things about him or her or stares at things that are not there.
- Worries that the child shows no interest in making or having friends and prefers isolation to any involvement in social activities.
- Say that odd behaviors are not limited just to certain situations but are pervasive in every realm of the child's life.
- Describe that the child appears "blank" all the time: delays answering questions, doesn't respond at all or frequently asks for statements to be repeated.

Young Adult-onset Schizophrenia

The average age of onset of the adult form of schizophrenia is 18 for young men and 25 for young women. However, many teenagers of both genders report that onset symptoms of schizophrenia started in their later years of high school. This illness is far more common than childhood schizophrenia; it strikes one out of 100 people and it ranks among the top 10 causes of disability in developed countries worldwide. Consequently, early identification and intervention provide the best chance for immediate stabilization and reduction of long-term disability. Adult schizophrenia commonly begins with an acute psychotic episode which follows a "prodromal" period of progressive decline. The residual symptoms of the illness can severely limit the functional capacity of young people with this brain disorder and the early years of illness are marked by repeated bouts of psychosis, hospitalization and risk of suicide.

Prodromal Onset Symptoms

- Persistent, uncontrollable crying not linked with any recognizable source of sadness.
- Agitation and precipitous weight loss; sudden lack of attention to hygiene.
- Withdrawal and isolation, marked decline in school performance.
- Odd sensory experiences; odd beliefs and rituals.
- Feelings of cosmic importance (omnipotence) or intense religiosity.
- Suspiciousness; fear of being watched or disliked by peers (paranoia).

Acute "Positive" Symptoms (Behaviors "added to" the personality by the illness)

- Delusions (false beliefs) and hallucinations (seeing/hearing things not there).
- Grossly disorganized behavior, bizarre actions and incoherent speech.
- Bizarre body postures; pacing, rocking, grimacing; extreme negativism.

Residual "Negative" Symptoms (Attributes "taken from" the personality by the illness)

- Flat, blunted emotional responses; total absence of spontaneity.
- Lack of motivation; inability to initiate and persist in goal-directed activities.
- Inability to relate to others or understand the basics of reciprocal relationships.
- Lack of insight that one is ill.

- Poverty of speech; brief, laconic replies and decrease in fluency of speech.

What families report observing:

- Report that a high-functioning teenager is “falling apart” and becoming unrecognizable to family and friends or that a shy, reclusive child is getting dramatically more so and is doing unpredictable, bizarre things.
- Say they feel engulfed by fear and panic, that something is going terribly wrong.

Understanding Family Reactions to the Symptoms and Behaviors Associated with Mental Illness

“This must be terribly tough on them, but the hardest part for me is when parents balk about getting a psychiatric consultation. They know their child has a serious problem but drag their feet about doing what’s necessary. I don’t know how to reach them when this happens.”

— A sixth-grade teacher

The path from onset to acceptance of mental illness in a child is a long and difficult process. Many parents are able to take decisive steps right away, but it is not uncommon for parents to resist accepting that their child has a mental illness.

Parents describe this experience as a “triple-whammy:” a family crisis, a marital crisis and a personal crisis. From thousands of testimonies heard in family support groups, it is evident that parents go through a predictable emotional cycle of feelings that are normal responses to trauma. This process is described in much of the professional literature on family coping and adaptation to mental illness. The chart on page 19 lists the various stages that mark the path parents typically follow.

The teacher’s comment above relates to stage one. Out of ignorance or fear at what mental illness means for them, parents initially cling to any alternative explanation, particularly those that seem to promise a solution that does not require taking the child to a “shrink.” This stage often blends with the anger of stage two (Why him? Why her? Why us?) and frustration that the child can’t simply “self-correct” so there won’t be a problem.

The following suggestions, based on needs parents identify, are guidelines for teachers working to engage parents in the early stages of emotional turmoil over their child’s mental illness.

Here’s what teachers can do:

Remove feelings of blame. Parents are hounded by constant feelings of guilt and are hypersensitive to any indication that they are the cause of their child’s illness. Parents report that feeling blamed for their child’s problem scares them away and makes them defensive and distrusting. It is helpful for the teacher to offer direct comments such as “you are not to blame if your child has a mental illness” or “I know how difficult things must be at home, but that’s

because of the strain you're under. It does not cause mental illness.”

Acknowledge denial and anger as normal. Let parents know that you believe anyone facing a child potentially having a serious health condition would react similarly and that their hesitation and frustration are absolutely understandable.

Communicate empathy and compassion for the parents' dilemma. A warm, accepting attitude goes a long way toward building trust.

De-stigmatize mental illness. Compare mental illnesses to other childhood illnesses like juvenile diabetes and epilepsy. Stress that thousands of children with mental illness are receiving highly effective mental health services and supports. Emphasize that more and better research is underway to ensure safe, effective care for children.

Emphasize that early identification and intervention are essential protective steps for their child. Explain that taking this action will lessen the severity of the illness and will keep the child from developing more serious forms of the illness in later years. Stress that treatment works, that linking children with effective services and supports enables them to reach their full potential.

Be particularly sensitive to parents with special circumstances. Be aware of the unique needs of single parents, dual working couples and parents from diverse socio-economic, racial and ethnic communities.

Provide parents with resources: Tell them education is the key to understanding. Give them this Parents and Teachers as Allies booklet. Encourage them to contact the local or state NAMI organization for information about referrals, support groups and education classes. Urge them to attend so they can get the support they need for themselves.



Predictable Stages of Emotional Reactions among Family Members Dealing with Mental Illness

(Adapted from the NAMI Family-to-Family education program)

I. DEALING WITH THE CATASTROPHIC EVENT

Crisis/Shock: feeling overwhelmed, dazed. “We don’t know how to deal with it.”

Denial: A protective response. We “normalize” what is going on, find reasons for what is happening that don’t involve mental illness. We decide all this is not really serious or there is a perfectly logical explanation for these events or it will pass...or all three.

Hoping against Hope: The dawning of recognition and the hope that this is not a life event, that somehow everything will magically go back to normal.

Needs: *Support *Comfort *Empathy for confusion *Help finding resources
*Early intervention *Prognosis *Empathy for pain *NAMI

II. LEARNING TO COPE

Anger/Guilt/Resentment: We start to “blame the victim,” insisting that the child should “snap out of it.” We harbor tremendous guilt, fearing that it really is our fault. We torment ourselves with self-blame.

Recognition: The fact that a mental illness happened to someone we love becomes a reality for us. We know it will change our lives together.

Grief: We deeply feel the tragedy of what has happened to the child who is stricken. We grieve that our future together is uncertain. This sadness does not go away.

Needs: *Vent feelings *Keep hope *Education *Self-care *Networking *Skill training
*Letting go *Co-operation from system *NAMI

III. MOVING INTO ADVOCACY

Understanding: We gain a solid, empathic sense of what our child is experiencing. We gain real respect for the courage it takes for our child to cope with this illness.

Acceptance: Yes, we finally say, bad things do happen to good people. It’s nobody’s fault. It is a sad and difficult life experience, but we will hang in there and manage.

Advocacy/Action: We can now focus our anger and grief to advocate for others and fight discrimination. We join public advocacy groups. We get involved.

Needs: *Activism *Restoring balance in life *Responsiveness from system *NAMI

If medals were minted for rising above the call of duty as an educator, they would certainly go to the legions of teachers who take action to identify children with mental illnesses and press for effective mental health services and supports.

Navigating the Referral Process as Allies

“If the truth be told, I’m not given much leeway to be proactive about early intervention. One supervisor told me it’s not my job to identify mental illness. Some administrators with the final say always settle for talk therapy and won’t go the medical route. Getting appropriate psychiatric treatment usually means I have to buck the whole system.”

— A high school teacher in Vermont

In most school systems today, a referral for clinical services is a long-delayed, last step in a series of team meetings and administrative reviews that typically lead to an evaluation by a psychologist or social worker. While these mental health professionals can ably provide support and counseling, they are rarely trained to complete a comprehensive mental health evaluation and to develop an effective treatment plan. However, a psychiatric evaluation and assessment generally will not be pursued unless these evaluators recommend it.

The most effective way to put a child on a fast track to effective mental health services and supports is for the parents to take the initiative, find a qualified mental health professional, get an accurate diagnosis and present the school with medical evidence that their child has a mental illness. If a child psychiatrist cannot be located in their geographical area, parents should seek help from a neurologist or pediatrician. For families who cannot afford these options or are apprehensive about them, the teacher can start the process for the child to be identified by the school authorities as a student requiring special education services. Close collaboration during the review process means the teacher can help the parents understand why they must advocate for an evaluation by a qualified mental health professional every step of the way.

We will someday live in a world where screening for mood disorders and other mental illness in young people is an accepted, customary practice. Until that time, children and adolescents will not receive the critical early intervention they deserve unless parents and teachers unite to identify mental illness and to “double-team” the child into the appropriate treatment.

As guardians of their children’s future, parents must take the responsibility for educating every important adult in their child’s home and school life. As mentors of these children’s potential, teachers need to educate every person in the child’s world at school with power to connect them with effective services and supports. This is why parents and teachers constitute the primary, indispensable alliance. They are not just the first line of defense; they are often the only line of defense.

Strengthening the Alliance: How NAMI Can Help

NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raise awareness and build a community for hope for all of those in need. The four pillars of NAMI's mission—support, education, advocacy and research—are carried out by thousands of NAMI members who serve in their communities as support group leaders, family and individual contacts, teachers and advocates. This network of experienced volunteers can be an invaluable source of help for parents and teachers in their quest for information, education and support. Connecting with this powerful grassroots know-how will greatly reduce the doubt, isolation and shame parents feel. Key resources offered by many NAMI affiliates are:

NAMI Basics: a 6-session, peer education course taught by trained NAMI members. The curriculum is designed for parents and caregivers of children and adolescents with mental illnesses. www.nami.org/basics

NAMI Ending the Silence: a 50-minute presentation for health/science/psychology students in middle school or high school provided by trained NAMI members. The presentation provides students with an opportunity to learn about mental illnesses through power point, video, and personal testimony. They learn symptoms and indicators of mental illness, and are given ideas about how to help themselves, friends or family members who may be in need of support. www.nami.org/ets

NAMI Parents and Teachers as Allies: a 2-hour, in-service program for school professionals and families designed to help them better understand the early warning signs of mental illnesses in children and adolescents and how best to communicate with families and intervene. www.nami.org/pta

NAMI Child and Adolescent Action Center: Provides public health education, brochures and fact sheets about early-onset mental illnesses in children and adolescents, produces family guides and resources for caregivers and professionals who work with children. The Center also provides technical assistance to NAMI state and affiliate leaders on issues impacting children, youth and young adults with mental illness and their families. www.nami.org/CAAC

NAMI Family-to-Family Education Program: a 12-session, peer education course taught by trained NAMI members in 48 states. Although the curriculum covers only mental illnesses diagnosed in adults, the course is appropriate for families of teenagers who have adult disorders. The course is also available in Spanish in select communities. www.nami.org/f2f

NAMI Family Support Groups: Local group meetings in towns and cities across the nation, these confidential gatherings of caregivers in need offer a haven of understanding based on lived experience with mental illness. www.nami.org/fsg

NAMI Connection Recovery Support Groups are offered for individuals 18 years of age and older living with mental illness. www.nami.org/connection

NAMI HelpLine: A toll-free service providing support, referral and information. Over 60 fact sheets on a variety of topics are available along with referrals to NAMI's network of local affiliates in communities across the country. Information and referrals are also offered in Spanish. 1 (800) 950-NAMI (6264) or info@nami.org.

www.nami.org: A source of information about all facets of NAMI advocacy at the national and state levels; current information on research; basic information about major mental illnesses, newest medication strategies, discussion groups and best treatment practices.

To order this booklet, please visit the NAMI Store at www.nami.org/store.



As guardians of their children's future, parents must take the responsibility for educating every important adult in their child's home and school life. As mentors of these children's potential, teachers need to educate every person in the child's world at schools with power to link those in need with mental health services and supports.



National Alliance on Mental Illness

Find Help. Find Hope.

**3803 N. Fairfax Dr.
Arlington, VA 22203
(703) 524-7600
HelpLine: 1 (800) 950-6264
www.nami.org**