Eliminating Barriers to Learning Through the Early Identification of Student Mental Health Issues

Participant Manual

Presented and developed by:
Placer County Office of Education, 2011
California Department of Education, 2011

Adapted from:
Substance Abuse and Mental Health Services Administration,
Center for Mental Health Services, 2004
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Acknowledgments
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All documents associated with the Eliminating Barriers to Learning Through the Early Identification of Student Mental Health Issues curricula are sponsored by the California Department of Education, Coordinated Student Support and Adult Education Division and made possible through funding of the Mental Health Service Act of 2004.

California Department of Education
1420 N Street
Sacramento, CA 95814
http://www.cde.ca.gov/index.asp

ADAPTED FROM
Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Eliminating Barriers for Learning; Social and Emotional Factors that Enhance Secondary Education, SAMHSA Pub. No. P040478M. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.
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## Handout I-A: Adolescent Development

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical</strong></td>
<td>• Increase in height/weight</td>
<td>• Secondary sex characteristics</td>
</tr>
<tr>
<td></td>
<td>• Hormonal changes</td>
<td>• Strength/dexterity</td>
</tr>
<tr>
<td></td>
<td>• Maturation of brain/neural system</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Secondary sex characteristics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Strength/dexterity</td>
<td></td>
</tr>
<tr>
<td><strong>Intellectual</strong></td>
<td>• Reasoning</td>
<td>• Logic/consequences</td>
</tr>
<tr>
<td></td>
<td>• Abstract thinking</td>
<td>• Concepts/ideas</td>
</tr>
<tr>
<td></td>
<td>• &quot;Thinking about thinking&quot;</td>
<td>• Metacognition</td>
</tr>
<tr>
<td><strong>Social-Emotional</strong></td>
<td>• Formation of attitudes, beliefs, and values (identity development)</td>
<td>• Self-direction</td>
</tr>
<tr>
<td></td>
<td>• Recognition of consequences of decisions made</td>
<td>• Sense of purpose</td>
</tr>
<tr>
<td></td>
<td>• Awareness of one's own and others' behavior; formation of ideas of</td>
<td>• Autonomy</td>
</tr>
<tr>
<td></td>
<td>appropriateness</td>
<td>• Conflict resolution</td>
</tr>
<tr>
<td></td>
<td>• Self-direction</td>
<td>• Self-esteem and self-efficacy</td>
</tr>
</tbody>
</table>
Caleb was asked to leave Mrs. Parker's class for the third time this week. As he waited in the main office to see the assistant principal, Caleb started to think about what his mother might say. It was already the fifth week of the second marking period and nothing about Caleb's behavior had changed. He was talking in class, twirling his house keys, and Mrs. Parker, according to Caleb, had it in for him. How could he explain any of this to the assistant principal? To his mother? He just seemed to always stand out somehow.

Caleb thought about the years of getting into trouble at school. He had attention-deficit/hyperactivity disorder and had taken medicine from first grade to sixth grade. He switched medicines at different times and he remembered how many headaches and stomachaches went along with those medicines. Sometimes he fell asleep in class or he felt really jumpy or upset. In sixth grade, he stopped taking the medicine. It just didn't seem to keep him focused anymore. "So what!" Caleb mumbled to himself. No more headaches.

Yet Caleb remembered how bad sixth grade had been. He was in trouble every day. He recalled how he accidentally got stuck in his chair, falling in between the seat and the backrest. How on earth did he do that? The other students had laughed and the teacher was so mad! So many things had happened and his grades just kept going down.

The school said they couldn't help him, but Caleb told the other kids he got kicked out. Caleb's mother had told him that he didn't have to pretend he was a bad kid to get others to like him. He told her that being bad was better than being sick.

Middle school had felt like a big zoo with all the guys acting like gorillas. Caleb felt angry thinking about how many fights he had to avoid. He just seemed to annoy people for no reason. To top it off, his teachers just seemed to hate him. He lost his work or didn't write down the assignments. Detention was a weekly event. He ended up going to the guidance office to eat his lunch so he could avoid all the guys who made his life miserable. Once he took two pints of chocolate milk out of the cafeteria and put them in his backpack. That was a big mistake! When he walked down the hallway, one of the guys kicked his backpack. By the time Caleb made it to the guidance office the pints were crushed open and milk was on all of his schoolwork. The secretary yelled at him for making a mess and kicked him out of the office.

All anyone ever told Caleb was that he didn't try hard enough. They would tell him he was smart but an underachiever, whatever that meant. Caleb decided he was just lazy. It seemed like each time, he would decide to keep his mouth shut, and then he would forget. His teachers wrote that he was disruptive, talkative, and didn't follow the rules of the class.

Caleb was called into the assistant principal's office. The assistant principal told Caleb that detention just didn't seem to have any consequences, so he was given two days of in-school suspension because the number of incidences was escalating. Caleb thought about his failing grades. At least in suspension he could catch up on his work, he imagined. \textit{Wait until my mother...}
sees my grades, Caleb worried to himself. *I don't think I have above a 30 in math and I am failing English, too.*

The bell rang. Caleb was going to be late for Earth Science and he'd forgotten to ask for a pass. Of course, the teacher probably wouldn't believe that he was at the office. Caleb decided he was in trouble anyway, so he might as well take his time. No one believed him, he decided. He thought maybe he should just do whatever he wanted. What was the point, anyway?
Handout I-C: Definitions: Serious Emotional Disturbances and Stigma

Serious emotional disturbances: Diagnosable disorders in children and adolescents that severely disrupt their daily functioning in the home, school, or community. These disorders include depression, attention-deficit/hyperactivity disorder, anxiety disorders, conduct disorder, and eating disorders.¹

Stigma: In these modules, stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma is not just a matter of using the wrong word or action. Stigma is about disrespect. It is the use of negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma, and the resulting discrimination, discourages individuals and their families from getting the help they need.² ³

¹ Glossary of Terms, Child and Adolescent Mental Health, Center for Mental Health Services; www.mentalhealth.samhsa.gov/publications/allpubs/CA-0005/default.asp
Handout I-D: How Stigma and Discrimination Keep Students and Families From Getting Help

Youth, parents, and educators all too often do not take steps toward seeking help because they do not know WHAT, WHY, or WHERE, as follows:

WHAT (Identification)
- They are reluctant to recognize behavior, thoughts, or feelings that impair youths' functioning.

WHY (Referral)
- They are aware of problems but believe they will pass.
- They do not encourage intervention/treatment because it would mean youth is "crazy."*
- They are aware of impairment but "it has nothing to do with school/job/sports."
- They are unsure how to address the concern.

WHERE (Treatment)
- They are unaware treatment is available.
- They are hesitant to reveal personal information because they fear a breach of confidentiality.
- They are afraid of being blamed.
- They feel ashamed or embarrassed.

* "Crazy" is a stigmatizing term that reflects misunderstanding of mental illnesses and serious emotional disturbances. It should be avoided.
Handout I-E: Teacher and Staff Roles

Supportive adults on school campus are critical to a student with mental health and emotional problems. Specific functions within a supportive adult role include:

- **Observer**—Notice social and academic behaviors that appear inappropriate or distressing. Take note of intensity, duration, frequency, and impact.

- **Catalyst**—Speak with the student; refer the student to a member of the pupil personnel support staff, such as a social worker, psychologist, or counselor; and partner with this professional to voice concerns to the parents/caregivers of the student. Make a referral to the school's intervention team or committee if academic or social difficulties are substantial.

- **Team member**—Be willing to work with parents, the student, the school, and others involved to provide feedback about the student's progress, any impact of medications, and what seems to be working.

- **Educator**—Refer to the student’s Individualized Education Plan (IEP) if one exists. Modify coursework as indicated. Ask for assistance from special education coordinators, if necessary, and let them know if the student seems to need more support than what is written in the IEP.

- **Role model**—Demonstrate empathic, encouraging, and hopeful responses when others are discouraged by the student's behavior, lack of progress, or "willfulness." When in doubt about how to respond, think before speaking out of anger, frustration, or discouragement. Youth with special needs can act in ways that make adults feel inadequate or incompetent. Don't take it personally. Separate the behavior from the person.

- **Collaborator**—Work with the student and school support staff to come up with ways to assist the student and identify what benefits the student most.
# Handout II-A: Risk and Protective Factors

## Risk Factors for mental health problems

### Community
- Drugs
- Firearms
- Crime
- Media
- Violence
- Mobility
- Poverty

### Family
- Family history of behavior
- Family conflict
- Family history of mental illness

### School
- Early antisocial behavior
- Academic failure in late elementary school
- Lack of commitment to school
- Individual/peer alienation and rebelliousness
- Friends who engage in a problem behavior
- Early initiation of a problem behavior

## Protective Factors against mental health problems

- An adult, such as a community leader, church member, schoolteacher, or parent, who cares about the youth and his/her future
- A genuine relationship with an adult who expresses clear and consistent rules and expectations about the youth's behavior, and discusses disappointments, poor decisions, and mistakes
- Recognition for involvement, accomplishments, and worth as a person
- Opportunities to be involved and to show skills that contribute
- An adult who shows consistent dedication to the youth's overall health and development

### Handout II-B: Adolescent Mental Health Continuum

<table>
<thead>
<tr>
<th></th>
<th>Less Severe</th>
<th>&gt;&gt;&gt;&gt;</th>
<th>&gt;&gt;&gt;&gt;</th>
<th>More Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Adjustment</strong></td>
<td>Adjusts to social situations</td>
<td>Some ups and downs in adjustment to social situations</td>
<td>Adjustment difficulties in social situations</td>
<td>Severe impairment in social situations</td>
</tr>
<tr>
<td><strong>Environment/ Coping Skills</strong></td>
<td>Adapts to environment</td>
<td>At times shows difficulty coping with environment</td>
<td>Ineffective or inconsistent coping with environment</td>
<td>Restricted coping, dependency, or crisis</td>
</tr>
<tr>
<td><strong>Emotional Responses</strong></td>
<td>Appropriate emotional responses</td>
<td>Emotional Responses inconsistent</td>
<td>Emotional responses are restricted, extreme, or inappropriate</td>
<td>Emotional responses are severely disproportionate</td>
</tr>
<tr>
<td><strong>Mood Control</strong></td>
<td>Controls mood</td>
<td>Some fluctuation in ability to control mood</td>
<td>Mood swings, sad mood, or consistent irritability</td>
<td>Mood seriously impairs day-to-day functioning</td>
</tr>
<tr>
<td><strong>Thought Patterns</strong></td>
<td>Thoughts consistent with goals, intentions, beliefs</td>
<td>Preoccupations, worries, or frustrations</td>
<td>Intrusive thoughts or obsessions</td>
<td>Bizarre or illogical thoughts</td>
</tr>
<tr>
<td><strong>Biological Patterns</strong> (includes sleep cycles, eating patterns, etc.)</td>
<td>Regular biological patterns</td>
<td>Minor disruptions to biological patterns</td>
<td>Consistent disruptions of biological patterns</td>
<td>Severe disruptions of biological patterns</td>
</tr>
</tbody>
</table>
About the Continuum:

- There is *no clear line* between mental health, mental health problems, and serious emotional disturbance. Behavior patterns run along a continuum.
- All symptoms do not appear with the same level of severity. Areas can be linked diagonally with each other—a youth with an eating disorder, for example, may adjust to social situations well but have disrupted biological patterns.
- Symptoms always should be looked at within the context of chronological and developmental age, as well as within the context of existing risk and protective factors.
- The continuum is a representative sample of symptoms and degrees of severity. Symptoms are not limited to the categories and behaviors described above.
Handout II-C: Serious Emotional Disturbances

Diagnosable disorders in children and adolescents that severely disrupt their daily functioning in the home, school, or community. These disorders include depression, attention-deficit/hyperactivity disorder, anxiety disorders, conduct disorder, and eating disorders.

The term SED, or serious emotional disturbance, as used in this training, refers to a clinical diagnosis by a mental health professional. It does not necessarily mean "qualifies for special education." Specific school/district policies regarding SEDs vary. In Module III, there will be an opportunity to address local policies regarding serious emotional disturbances.

Source:
Glossary of Terms, Child and Adolescent Mental Health, Center for Mental Health Services; www.mentalhealth.samhsa.gov/publications/allpubs/CA-0005/default.asp
Handout II-D: Problems Associated With Serious Emotional Disturbances

Adolescents with these problems are more likely to experience co-occurring social-emotional problems, face other health risks, and experience restricted opportunities. Each of these can manifest itself in the ways listed below.

**Co-Occurring Social-Emotional Problems**

- Higher incidences of other psychiatric conditions
- Impulsiveness
- Low self-esteem
- Poor social skills
- Limited interpersonal relationships, social supports, and social networks

**Health Risks**

- Drug use/abuse
- Alcohol use/abuse
- Higher rates of HIV/AIDS and sexually transmitted diseases
- Unwanted pregnancies
- Driving while intoxicated

**Restricted Opportunities**

- Low academic achievement
- Lower high school graduation rates
- Limited postsecondary entry
- Fewer employment opportunities
- Less financial independence
Handout II-E: Signs of Depression

The following signs may be symptoms of depression in children and adolescents if they persist for over 2 weeks:

- Suicidal thoughts
- Feelings of hopelessness
- Sad or irritable mood (irritability is more common in children and adolescents)
- Frequent crying
- Loss of interest or pleasure in social activities or previously enjoyed hobbies
- Withdrawal from others
- Self-injurious behavior (e.g., cutting, burning, or inflicting pain)
- Low self-esteem
- Feelings of worthlessness
- Physical complaints
- Change in body weight (gain or loss)
- Restlessness or agitation
- Change in appetite
- Difficulty falling asleep or sleeping too much
- Excessive fatigue
- Difficulty concentrating
Handout II-F: Depressive Disorders: Effects on Learning and Behavior

**Attention**: Attention can be disrupted by discomfort and physical symptoms such as headaches or stomach aches.

**Concentration**: Concentration is difficult to maintain for extended periods of time and affected by fatigue or intrusive thoughts related to guilt, hopelessness, or suicide.

**Self-appraisal/expectations**: Lack of enjoyment, feelings of low self-worth, expectations of failure, sensitivity to feedback, and negative thoughts about the future impede motivation and effort.

**Rehearsal**: Deficits in attention, concentration, and motivation may make it difficult to retain and retrieve information for the purpose of rehearsal.

**Mastery**: Cognitive and emotional impairments may interfere with the mastery of material.

**Behavior**: Excessive absences; sleepiness or restlessness during class; slow responding or no participation; overall avoidance of social interaction or typical activities of peers; crying or expressions of excessive guilt and sadness.
Handout II-G: Risks for Suicide

Risks for Suicide

- A current plan to commit suicide
- Past attempts
- Reported feelings of hopelessness
- Thoughts about death
- Special arrangements for possessions or giving away possessions
- Severe emotional distress
- Substantial change in behavior accompanied by negative feelings and thoughts
- Access, use, or abuse of drugs or alcohol
- History of impulsive, reckless, or dangerous behavior
- A sense of isolation
- No perceived support from others
- Inability to generate alternatives to solve a difficult problem or conflict, or a sense of "no way out."

Information on suicide prevention can be found at the Substance Abuse and Mental Health Services Administration's National Strategy for Suicide Prevention Web site: [www.mentalhealth.samhsa.gov/suicideprevention](http://www.mentalhealth.samhsa.gov/suicideprevention)

Schools are encouraged to develop a comprehensive plan for suicide prevention. A detailed description of such a plan can be found in Keith A. King, "Developing a Comprehensive School Suicide Prevention Program," *Journal of School Health*, April 2001, Vol 71, No. 4, pages 132-137.
Anxiety Disorder

Attention: Attention can be disrupted by a sense of impending doom or the feeling that something is wrong.

Concentration: Concentration is difficult to maintain during moments of intense anxiety, or is affected by irritability, restlessness, or a feeling of being out of control.

Self-appraisal/expectations: Expectations of poor outcomes or a sense of inability to bring about good results.

Rehearsal: Disruptions in attention or worries about performance can interfere with effective rehearsal.

Mastery: It often is difficult to retrieve or demonstrate previously learned information when feeling acute anxiety.

Behavior: Freezing during exams; asking for help when unnecessary; talking about worries, "what if" statements, or exaggerated/irrational fears; being overly prepared for tasks or exams; seeming upset or frantic when worries escalate.

Attention-Deficit/Hyperactivity Disorder

Attention: Problems with attention are the hallmark of this disorder. Either the youth is overly attentive to insignificant details or completely inattentive. The youth often misses information due to daydreaming, overactivity, or attention to other aspects of the environment.

Concentration: Highly distractible or impulsive but concentration improves when task has full attention.

Self-appraisal/expectations: Often fails to use prior experiences to accurately predict abilities; may overestimate or underestimate the demands of tasks and skills required; prior negative social feedback can impact motivation and sense of competence.

Rehearsal: Lack of organization and attention often interferes with time on task; frustration can come from missing important information regarding the procedures involved; patience and persistence weakly linked to rehearsal.

Mastery: May show lopsided skills or have certain elements mastered but not other elements important to whole concepts; gaps in knowledge can lead to difficulty with building on previous learning.

Behavior: Excessively talkative during class; hard to redirect or has difficulty following verbal or written directions; impulsive social behavior; annoying others or poor acceptance by peers;
disorganized with materials; forgetful and missing multiple assignments.
Handout II-I: Eating Disorders (Anorexia): Effects on Learning and Behavior

**Attention:** Targeted attention appropriate to task, note-taking, and other skills associated with high performance.

**Concentration:** May show very intense concentration and self-discipline.

**Self-appraisal/expectations:** Perfectionist; overly hard on or punitive toward oneself; may assign more work to self than necessary.

**Rehearsal:** High expectations for mastery and repeated rehearsal.

**Mastery:** Information typically mastered to high degree but seemingly not good enough.

**Behavior:** High expectations; may be involved in rigorous athletic or physical competition; ritualistic with food or avoidance of meals; underweight; voices concerns about body size, shape, or weight; discusses dieting or avoidance of food.
Handout II-J: Indicators of Need

Children and adolescents with mental health issues need to get help as soon as possible. A variety of signs may point to mental health disorders or serious emotional disturbances in children or adolescents. Pay attention if a child or adolescent you know has any of these warning signs persisting for longer than seems appropriate:

A child or adolescent is troubled by feeling:

- Sad and hopeless for no reason, and these feelings do not go away;
- Very angry most of the time and crying a lot or overreacting to things;
- Worthless or guilty often;
- Anxious or worried often;
- Unable to get over a loss or death of someone important;
- Extremely fearful or having unexplained fears;
- Constantly concerned about physical problems or physical appearance; or
- Frightened that his or her mind either is controlled or is out of control.

A child or adolescent experiences big changes, such as:

- Showing declining performance in school;
- Losing interest in things once enjoyed;
- Experiencing unexplained changes in sleeping or eating patterns;
- Avoiding friends or family and wanting to be alone all the time;
- Daydreaming too much and not completing tasks;
- Feeling life is too hard to handle;
- Hearing voices that cannot be explained; or
- Experiencing suicidal thoughts.

A child or adolescent experiences:

- Poor concentration and is unable to think straight or make up his or her mind;
- An inability to sit still or focus attention;
- Worry about being harmed, hurting others, or doing something "bad";
- A need to wash, clean things, or perform certain routines hundreds of times a day, in order to avoid an unsubstantiated danger;
- Racing thoughts that are almost too fast to follow; or
- Persistent nightmares.

A child or adolescent behaves in ways that cause problems, such as:

- Using alcohol or other drugs;
• Eating large amounts of food and then purging, or abusing laxatives, to avoid weight gain.
• Dieting and/or exercising obsessively;
• Violating the rights of others or constantly breaking the law without regard for other people;
• Setting fires;
• Doing things that can be life threatening; or
• Killing animals.

Source:
Child and Adolescent Mental Health, Center for Mental Health Services,
http://www.mentalhealth.org/publications/allpubs/CA-0004/default.asp
Fact Sheet #1: What Is a Depressive Disorder?

A depressive disorder is an illness that involves the body, mood, and thoughts. It affects the way a person eats and sleeps, the way one feels about oneself, and the way one thinks about things. A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better. Without treatment, symptoms can last for weeks, months, or years. Appropriate treatment, however, can help most people who suffer from depression.

TYPES OF DEPRESSION

Depressive disorders come in different forms, just as is the case with other illnesses such as heart disease. This pamphlet briefly describes three of the most common types of depressive disorders. However, within these types there are variations in the number of symptoms, their severity, and persistence.

Major depression is manifested by a combination of symptoms (see symptom list) that interfere with the ability to work, study, sleep, eat, and enjoy once pleasurable activities. Such a disabling episode of depression may occur only once but more commonly occurs several times in a lifetime.

A less severe type of depression, dysthymia, involves long-term, chronic symptoms that do not disable, but keep one from functioning well or from feeling good. Many people with dysthymia also experience major depressive episodes at some time in their lives.

Another type of depression is bipolar disorder, also called manic-depressive illness. Not nearly as prevalent as other forms of depressive disorders, bipolar disorder is characterized by cycling mood changes: severe highs (mania) and lows (depression). Sometimes the mood switches are dramatic and rapid, but most often they are gradual. When in the depressed cycle, an individual can have any or all of the symptoms of a depressive disorder. When in the manic cycle, the individual may be overactive, over-talkative, and have a great deal of energy. Mania often affects thinking, judgment, and social behavior in ways that cause serious problems and embarrassment. For example, the individual in a manic phase may feel elated, full of grand schemes that might range from unwise business decisions to romantic sprees. Mania, left untreated, may worsen to a psychotic state.

SYMPTOMS OF DEPRESSION AND MANIA

Not everyone who is depressed or manic experiences every symptom. Some people experience a few symptoms, some many. Severity of symptoms varies with individuals and also varies over time.

Depression

• Persistent sad, anxious, or "empty" mood
• Feelings of hopelessness, pessimism
• Feelings of guilt, worthlessness, helplessness
• Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex
• Decreased energy, fatigue, being "slowed down"
• Difficulty concentrating, remembering, making decisions
• Insomnia, early-morning awakening, or oversleeping
• Appetite and/or weight loss or overeating and weight gain
• Thoughts of death or suicide; suicide attempts
• Restlessness, irritability
• Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

**Mania**

• Abnormal or excessive elation
• Unusual irritability
• Decreased need for sleep
• Grandiose notions
• Increased talking
• Racing thoughts
• Increased sexual desire
• Markedly increased energy
• Poor judgment
• Inappropriate social behavior

**CAUSES OF DEPRESSION**

Some types of depression run in families, suggesting that a biological vulnerability can be inherited. This seems to be the case with bipolar disorder. Studies of families in which members of each generation develop bipolar disorder found that those with the illness have a somewhat different genetic makeup than those who do not get ill. However, the reverse is not true: Not everybody with the genetic makeup that causes vulnerability to bipolar disorder will have the illness. Apparently additional factors, possibly stresses at home, work, or school, are involved in its onset.

In some families, major depression also seems to occur generation after generation. However, it can also occur in people who have no family history of depression. Whether inherited or not, major depressive disorder is often associated with changes in brain structures or brain function.

People who have low self-esteem, who consistently view themselves and the world with pessimism or who are readily overwhelmed by stress, are prone to depression. Whether this represents a psychological predisposition or an early form of the illness is not clear.

In recent years, researchers have shown that physical changes in the body can be accompanied by mental changes as well. Medical illnesses such as stroke, a heart attack, cancer, Parkinson's
disease, and hormonal disorders can cause depressive illness, making the sick person apathetic and unwilling to care for his or her physical needs, thus prolonging the recovery period. Also, a serious loss, difficult relationship, financial problem, or any stressful (unwelcome or even desired) change in life patterns can trigger a depressive episode. Very often, a combination of genetic, psychological, and environmental factors is involved in the onset of a depressive disorder. Later episodes of illness typically are precipitated by only mild stresses, or none at all.

**Depression in Women**

Women experience depression about twice as often as men.\(^1\) Many hormonal factors may contribute to the increased rate of depression in women—particularly such factors as menstrual cycle changes, pregnancy, miscarriage, postpartum period, pre-menopause, and menopause. Many women also face additional stresses such as responsibilities both at work and home, single parenthood, and caring for children and for aging parents.

A recent NIMH study showed that in the case of severe premenstrual syndrome (PMS), women with a preexisting vulnerability to PMS experienced relief from mood and physical symptoms when their sex hormones were suppressed. Shortly after the hormones were re-introduced, they again developed symptoms of PMS. Women without a history of PMS reported no effects of the hormonal manipulation.\(^6,7\)

Many women are also particularly vulnerable after the birth of a baby. The hormonal and physical changes, as well as the added responsibility of a new life, can be factors that lead to postpartum depression in some women. While transient "blues" are common in new mothers, a full-blown depressive episode is not a normal occurrence and requires active intervention. Treatment by a sympathetic physician and the family's emotional support for the new mother are prime considerations in aiding her to recover her physical and mental well-being and her ability to care for and enjoy the infant.

**Depression in Men**

Although men are less likely to suffer from depression than women, 3 to 4 million men in the United States are affected by the illness. Men are less likely to admit to depression, and doctors are less likely to suspect it. The rate of suicide in men is four times that of women, though more women attempt it. In fact, after age 70, the rate of men's suicide rises, reaching a peak after age 85.

Depression can also affect the physical health in men differently from women. A new study shows that, although depression is associated with an increased risk of coronary heart disease in both men and women, only men suffer a high death rate.\(^2\)

Men's depression is often masked by alcohol or drugs, or by the socially acceptable habit of working excessively long hours. Depression typically shows up in men not as feeling hopeless and helpless, but as being irritable, angry, and discouraged; hence, depression may be difficult to recognize as such in men. Even if a man realizes that he is depressed, he may be less willing than a woman to seek help. Encouragement and support from concerned family members can make a difference. In the workplace, employee assistance professionals or worksite mental
health programs can be of assistance in helping men understand and accept depression as a real illness that needs treatment.

**Depression in the Elderly**

Some people have the mistaken idea that it is normal for the elderly to feel depressed. On the contrary, most older people feel satisfied with their lives. Sometimes, though, when depression develops, it may be dismissed as a normal part of aging. Depression in the elderly, undiagnosed and untreated, causes needless suffering for the family and for the individual who could otherwise live a fruitful life. When he or she does go to the doctor, the symptoms described are usually physical, for the older person is often reluctant to discuss feelings of hopelessness, sadness, loss of interest in normally pleasurable activities, or extremely prolonged grief after a loss.

Recognizing how depressive symptoms in older people are often missed, many health care professionals are learning to identify and treat the underlying depression. They recognize that some symptoms may be side effects of medication the older person is taking for a physical problem, or they may be caused by a co-occurring illness. If a diagnosis of depression is made, treatment with medication and/or psychotherapy will help the depressed person return to a happier, more fulfilling life. Recent research suggests that brief psychotherapy (talk therapies that help a person in day-to-day relationships or in learning to counter the distorted negative thinking that commonly accompanies depression) is effective in reducing symptoms in short-term depression in older persons who are medically ill. Psychotherapy is also useful in older patients who cannot or will not take medication. Efficacy studies show that late-life depression can be treated with psychotherapy. Improved recognition and treatment of depression in late life will make those years more enjoyable and fulfilling for the depressed elderly person, the family, and caretakers.

**Depression in Children**

Only in the past two decades has depression in children been taken very seriously. The depressed child may pretend to be sick, refuse to go to school, cling to a parent, or worry that the parent may die. Older children may sulk, get into trouble at school, be negative, grouchy, and feel misunderstood. Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child is just going through a temporary "phase" or is suffering from depression. Sometimes the parents become worried about how the child's behavior has changed, or a teacher mentions that "your child doesn't seem to be himself." In such a case, if a visit to the child's pediatrician rules out physical symptoms, the doctor will probably suggest that the child be evaluated, preferably by a psychiatrist who specializes in the treatment of children. If treatment is needed, the doctor may suggest that another therapist, usually a social worker or a psychologist, provide therapy while the psychiatrist will oversee medication if it is needed. Parents should not be afraid to ask questions: What are the therapist's qualifications? What kind of therapy will the child have? Will the family as a whole participate in therapy? Will my child's therapy include an antidepressant? If so, what might the side effects be?

The National Institute of Mental Health (NIMH) has identified the use of medications for depression in children as an important area for research. The NIMH-supported Research Units
on Pediatric Psychopharmacology (RUPPs) form a network of seven research sites where clinical studies on the effects of medications for mental disorders can be conducted in children and adolescents. Among the medications being studied are antidepressants, some of which have been found to be effective in treating children with depression, if properly monitored by the child's physician.  

DIAGNOSTIC EVALUATION AND TREATMENT

The first step to getting appropriate treatment for depression is a physical examination by a physician. Certain medications as well as some medical conditions such as viral infection can cause the same symptoms as depression, and the physician should rule out these possibilities through examination, interview, and lab tests. If a physical cause for the depression is ruled out, a psychological evaluation should be done, by the physician or by referral to a psychiatrist or psychologist.

A good diagnostic evaluation will include a complete history of symptoms, i.e., when they started, how long they have lasted, how severe they are, whether the patient had them before and, if so, whether the symptoms were treated and what treatment was given. The doctor should ask about alcohol and drug use, and if the patient has thoughts about death or suicide. Further, a history should include questions about whether other family members have had a depressive illness and, if treated, what treatments they may have received and which were effective.

Last, a diagnostic evaluation should include a mental status examination to determine if speech or thought patterns or memory have been affected, as sometimes happens in the case of a depressive or manic-depressive illness.

Treatment choice will depend on the outcome of the evaluation. There are a variety of antidepressant medications and psychotherapies that can be used to treat depressive disorders. Some people with milder forms may do well with psychotherapy alone. People with moderate to severe depression most often benefit from antidepressants. Most do best with combined treatment: medication to gain relatively quick symptom relief and psychotherapy to learn more effective ways to deal with life's problems, including depression. Depending on the patient's diagnosis and severity of symptoms, the therapist may prescribe medication and/or one of the several forms of psychotherapy that have proven effective for depression.

Electroconvulsive therapy (ECT) is useful, particularly for individuals whose depression is severe or life threatening or who cannot take antidepressant medication. ECT often is effective in cases where antidepressant medications do not provide sufficient relief of symptoms. In recent years, ECT has been much improved. A muscle relaxant is given before treatment, which is done under brief anesthesia. Electrodes are placed at precise locations on the head to deliver electrical impulses. The stimulation causes a brief (about 30 seconds) seizure within the brain. The person receiving ECT does not consciously experience the electrical stimulus. For full therapeutic benefit, at least several sessions of ECT, typically given at the rate of three per week, are required.

Medications
There are several types of antidepressant medications used to treat depressive disorders. These include newer medications—chiefly the selective serotonin reuptake inhibitors (SSRIs)—the tricyclics, and the monoamine oxidase inhibitors (MAOIs). The SSRIs—and other newer medications that affect neurotransmitters such as dopamine or norepinephrine—generally have fewer side effects than tricyclics. Sometimes the doctor will try a variety of antidepressants before finding the most effective medication or combination of medications. Sometimes the dosage must be increased to be effective. Although some improvements may be seen in the first few weeks, antidepressant medications must be taken regularly for 3 to 4 weeks (in some cases, as many as 8 weeks) before the full therapeutic effect occurs.

Patients often are tempted to stop medication too soon. They may feel better and think they no longer need the medication. Or they may think the medication isn't helping at all. It is important to keep taking medication until it has a chance to work, though side effects (see section on Side Effects on page 13) may appear before antidepressant activity does. Once the individual is feeling better, it is important to continue the medication for at least 4 to 9 months to prevent a recurrence of the depression. Some medications must be stopped gradually to give the body time to adjust. Never stop taking an antidepressant without consulting the doctor for instructions on how to safely discontinue the medication. For individuals with bipolar disorder or chronic major depression, medication may have to be maintained indefinitely.

Antidepressant drugs are not habit-forming. However, as is the case with any type of medication prescribed for more than a few days, antidepressants have to be carefully monitored to see if the correct dosage is being given. The doctor will check the dosage and its effectiveness regularly.

For the small number of people for whom MAO inhibitors are the best treatment, it is necessary to avoid certain foods that contain high levels of tyramine, such as many cheeses, wines, and pickles, as well as medications such as decongestants. The interaction of tyramine with MAOIs can bring on a hypertensive crisis, a sharp increase in blood pressure that can lead to a stroke. The doctor should furnish a complete list of prohibited foods that the patient should carry at all times. Other forms of antidepressants require no food restrictions.

Medications of any kind—prescribed, over-the-counter, or borrowed—should never be mixed without consulting the doctor. Other health professionals who may prescribe a drug—such as a dentist or other medical specialist—should be told of the medications the patient is taking. Some drugs, although safe when taken alone can, if taken with others, cause severe and dangerous side effects. Some drugs, like alcohol or street drugs, may reduce the effectiveness of antidepressants and should be avoided. This includes wine, beer, and hard liquor. Some people who have not had a problem with alcohol use may be permitted by their doctor to use a modest amount of alcohol while taking one of the newer antidepressants.

Antianxiety drugs or sedatives are not antidepressants. They are sometimes prescribed along with antidepressants; however, they are not effective when taken alone for a depressive disorder. Stimulants, such as amphetamines, are not effective antidepressants, but they are used occasionally under close supervision in medically ill depressed patients.

Questions about any antidepressant prescribed, or problems that may be related to the
medication, should be discussed with the doctor.

Lithium has for many years been the treatment of choice for bipolar disorder, as it can be effective in smoothing out the mood swings common to this disorder. Its use must be carefully monitored, as the range between an effective dose and a toxic one is small. If a person has preexisting thyroid, kidney, or heart disorders or epilepsy, lithium may not be recommended. Fortunately, other medications have been found to be of benefit in controlling mood swings. Among these are two mood-stabilizing anticonvulsants, carbamazepine (Tegretol®) and valproate (Depakote®). Both of these medications have gained wide acceptance in clinical practice, and valproate has been approved by the Food and Drug Administration for first-line treatment of acute mania. Other anticonvulsants that are being used now include lamotrigine (Lamictal®) and gabapentin (Neurontin®): their role in the treatment hierarchy of bipolar disorder remains under study.

Most people who have bipolar disorder take more than one medication including, along with lithium and/or an anticonvulsant, a medication for accompanying agitation, anxiety, depression, or insomnia. Finding the best possible combination of these medications is of utmost importance to the patient and requires close monitoring by the physician.

**Side Effects**

Antidepressants may cause mild and, usually, temporary side effects (sometimes referred to as adverse effects) in some people. Typically these are annoying, but not serious. However, any unusual reactions or side effects or those that interfere with functioning should be reported to the doctor immediately. The most common side effects of tricyclic antidepressants, and ways to deal with them, are:

- **Dry mouth**—it is helpful to drink sips of water; chew sugarless gum; clean teeth daily.
- **Constipation**—bran cereals, prunes, fruit, and vegetables should be in the diet.
- **Bladder problems**—emptying the bladder may be troublesome, and the urine stream may not be as strong as usual; the doctor should be notified if there is marked difficulty or pain.
- **Sexual problems**—sexual functioning may change; if worrisome, it should be discussed with the doctor.
- **Blurred vision**—this will pass soon and will not usually necessitate new glasses.
- **Dizziness**—rising from the bed or chair slowly is helpful.
- **Drowsiness as a daytime problem**—this usually passes soon. A person feeling drowsy or sedated should not drive or operate heavy equipment. The more sedating antidepressants are generally taken at bedtime to help sleep and minimize daytime drowsiness.

The newer antidepressants have different types of side effects:

- **Headache**—this will usually go away.
- **Nausea**—this is also temporary, but even when it occurs, it is transient after each dose.
- **Nervousness and insomnia (trouble falling asleep or waking often during the night)**—these
may occur during the first few weeks; dosage reductions or time will usually resolve them.

- **Agitation (feeling jittery)**—if this happens for the first time after the drug is taken and is more than transient, the doctor should be notified.
- **Sexual problems**—the doctor should be consulted if the problem is persistent or worrisome.

**Herbal Therapy**

In the past few years, much interest has risen in the use of herbs in the treatment of both depression and anxiety. St. John’s wort (*Hypericum perforatum*), an herb used extensively in the treatment of mild to moderate depression in Europe, has recently aroused interest in the United States. St. John’s wort, an attractive bushy, low-growing plant covered with yellow flowers in summer, has been used for centuries in many folk and herbal remedies. Today in Germany, Hypericum is used in the treatment of depression more than any other antidepressant. However, the scientific studies that have been conducted on its use have been short-term and have used several different doses.

Because of the widespread interest in St. John’s wort, the National Institutes of Health (NIH) conducted a 3-year study, sponsored by three NIH components—the National Institute of Mental Health, the National Center for Complementary and Alternative Medicine, and the Office of Dietary Supplements. The study was designed to include 336 patients with major depression of moderate severity, randomly assigned to an 8-week trial with one-third of patients receiving a uniform dose of St. John’s wort, another third sertraline, a selective serotonin reuptake inhibitor (SSRI) commonly prescribed for depression, and the final third a placebo (a pill that looks exactly like the SSRI and the St. John’s wort, but has no active ingredients). The study participants who responded positively were followed for an additional 18 weeks. At the end of the first phase of the study, participants were measured on two scales, one for depression and one for overall functioning. There was no significant difference in rate of response for depression, but the scale for overall functioning was better for the antidepressant than for either St. John’s wort or placebo. While this study did not support the use of St. John’s wort in the treatment of major depression, ongoing NIH-supported research is examining a possible role for St. John’s wort in the treatment of milder forms of depression.

The Food and Drug Administration issued a Public Health Advisory on February 10, 2000. It stated that St. John’s wort appears to affect an important metabolic pathway that is used by many drugs prescribed to treat conditions such as AIDS, heart disease, depression, seizures, certain cancers, and rejection of transplants. Therefore, health care providers should alert their patients about these potential drug interactions.

Some other herbal supplements frequently used that have not been evaluated in large-scale clinical trials are ephedra, gingko biloba, echinacea, and ginseng. Any herbal supplement should be taken only after consultation with the doctor or other health care provider.

**PSYCHOTHERAPIES**

Many forms of psychotherapy, including some short-term (10-20 week) therapies, can help
depressed individuals. "Talking" therapies help patients gain insight into and resolve their problems through verbal exchange with the therapist, sometimes combined with "homework" assignments between sessions. "Behavioral" therapists help patients learn how to obtain more satisfaction and rewards through their own actions and how to unlearn the behavioral patterns that contribute to or result from their depression.

Two of the short-term psychotherapies that research has shown helpful for some forms of depression are interpersonal and cognitive/behavioral therapies. Interpersonal therapists focus on the patient's disturbed personal relationships that both cause and exacerbate (or increase) the depression. Cognitive/behavioral therapists help patients change the negative styles of thinking and behaving often associated with depression.

Psychodynamic therapies, which are sometimes used to treat depressed persons, focus on resolving the patient's conflicted feelings. These therapies are often reserved until the depressive symptoms are significantly improved. In general, severe depressive illnesses, particularly those that are recurrent, will require medication (or ECT under special conditions) along with, or preceding, psychotherapy for the best outcome.

**HOW TO HELP YOURSELF IF YOU ARE DEPRESSED**

Depressive disorders make one feel exhausted, worthless, helpless, and hopeless. Such negative thoughts and feelings make some people feel like giving up. It is important to realize that these negative views are part of the depression and typically do not accurately reflect the actual circumstances. Negative thinking fades as treatment begins to take effect. In the meantime:

- Set realistic goals in light of the depression and assume a reasonable amount of responsibility.
- Break large tasks into small ones, set some priorities, and do what you can as you can.
- Try to be with other people and to confide in someone; it is usually better than being alone and secretive.
- Participate in activities that may make you feel better.
- Mild exercise, going to a movie, a ballgame, or participating in religious, social, or other activities may help.
- Expect your mood to improve gradually, not immediately. Feeling better takes time.
- It is advisable to postpone important decisions until the depression has lifted. Before deciding to make a significant transition—change jobs, get married or divorced—discuss it with others who know you well and have a more objective view of your situation.
- People rarely "snap out of" a depression. But they can feel a little better day-by-day.
- **Remember**, positive thinking will replace the negative thinking that is part of the depression and will disappear as your depression responds to treatment.
- Let your family and friends help you.

**How Family and Friends Can Help the Depressed Person**

The most important thing anyone can do for the depressed person is to help him or her get an appropriate diagnosis and treatment. This may involve encouraging the individual to stay with
treatment until symptoms begin to abate (several weeks), or to seek different treatment if no improvement occurs. On occasion, it may require making an appointment and accompanying the depressed person to the doctor. It may also mean monitoring whether the depressed person is taking medication. The depressed person should be encouraged to obey the doctor's orders about the use of alcoholic products while on medication. The second most important thing is to offer emotional support. This involves understanding, patience, affection, and encouragement. Engage the depressed person in conversation and listen carefully. Do not disparage feelings expressed, but point out realities and offer hope. Do not ignore remarks about suicide. Report them to the depressed person's therapist. Invite the depressed person for walks, outings, to the movies, and other activities. Be gently insistent if your invitation is refused. Encourage participation in some activities that once gave pleasure, such as hobbies, sports, religious or cultural activities, but do not push the depressed person to undertake too much too soon. The depressed person needs diversion and company, but too many demands can increase feelings of failure.

Do not accuse the depressed person of faking illness or of laziness, or expect him or her "to snap out of it." Eventually, with treatment, most people do get better. Keep that in mind, and keep reassuring the depressed person that, with time and help, he or she will feel better.

WHERE TO GET HELP

If unsure where to go for help, check the Yellow Pages under "mental health," "health," "social services," "suicide prevention," "crisis intervention services," "hotlines," "hospitals," or "physicians" for phone numbers and addresses. In times of crisis, the emergency room doctor at a hospital may be able to provide temporary help for an emotional problem, and will be able to tell you where and how to get further help.

Listed below are the types of people and places that will make a referral to, or provide, diagnostic and treatment services.

- Family doctors
- Mental health specialists, such as psychiatrists, psychologists, social workers, or mental health counselors
- Health maintenance organizations
- Community mental health centers
- Hospital psychiatry departments and outpatient clinics
- University- or medical school-affiliated programs
- State hospital outpatient clinics
- Family service, social agencies, or clergy
- Private clinics and facilities
- Employee assistance programs
- Local medical and/or psychiatric societies

FURTHER INFORMATION
Please visit the following link for more information about organizations that focus on depression:

REFERENCES


This brochure is a new version of the 1994 edition of Plain Talk About Depression and was written by Margaret Strock, Information Resources and Inquiries Branch, Office of Communications, National Institute of Mental Health (NIMH). Expert assistance was provided by Raymond DePaulo, MD, Johns Hopkins School of Medicine; Ellen Frank, MD, University of Pittsburgh School of Medicine; Jerrold F. Rosenbaum, MD, Massachusetts General Hospital; Matthew V. Rudorfer, MD, and Clarissa K. Wittenberg, NIMH staff members. Lisa D. Alberts, NIMH staff member, provided editorial assistance.

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NIH Publication No. 00-3561 Printed 2000
Fact Sheet #2: Child and Adolescent Bipolar Disorder: 
An Update from the National Institute of Mental Health

Research findings, clinical experience, and family accounts provide substantial evidence that bipolar disorder, also called manic-depressive illness, can occur in children and adolescents. Bipolar disorder is difficult to recognize and diagnose in youth, however, because it does not fit precisely the symptom criteria established for adults, and because its symptoms can resemble or co-occur with those of other common childhood-onset mental disorders. In addition, symptoms of bipolar disorder may be initially mistaken for normal emotions and behaviors of children and adolescents. But unlike normal mood changes, bipolar disorder significantly impairs functioning in school, with peers, and at home with family. Better understanding of the diagnosis and treatment of bipolar disorder in youth is urgently needed. In pursuit of this goal, the National Institute of Mental Health (NIMH) is conducting and supporting research on child and adolescent bipolar disorder.

A Cautionary Note

Effective treatment depends on appropriate diagnosis of bipolar disorder in children and adolescents. There is some evidence that using antidepressant medication to treat depression in a person who has bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer.

In addition, using stimulant medications to treat attention deficit hyperactivity disorder (ADHD) or ADHD-like symptoms in a child with bipolar disorder may worsen manic symptoms. While it can be hard to determine which young patients will become manic, there is a greater likelihood among children and adolescents who have a family history of bipolar disorder.

If manic symptoms develop or markedly worsen during antidepressant or stimulant use, a physician should be consulted immediately, and diagnosis and treatment for bipolar disorder should be considered.

Symptoms and Diagnosis

Bipolar disorder is a serious mental illness characterized by recurrent episodes of depression, mania, and/or mixed symptom states. These episodes cause unusual and extreme shifts in mood, energy, and behavior that interfere significantly with normal, healthy functioning.

Manic symptoms include:

- Severe changes in mood, either extremely irritable or overly silly and elated
- Overly-inflated self-esteem; grandiosity
- Increased energy
- Decreased need for sleep, ability to go with very little or no sleep for days without tiring
- Increased talking, talks too much, too fast; changes topics too quickly; cannot be interrupted
• Distractibility, attention moves constantly from one thing to the next
• Hypersexuality, increased sexual thoughts, feelings, or behaviors; use of explicit sexual language
• Increased goal-directed activity or physical agitation
• Disregard of risk, excessive involvement in risky behaviors or activities

Depressive symptoms include:

• Persistent sad or irritable mood
• Loss of interest in activities once enjoyed
• Significant change in appetite or body weight
• Difficulty sleeping or oversleeping
• Physical agitation or slowing
• Loss of energy
• Feelings of worthlessness or inappropriate guilt
• Difficulty concentrating
• Recurrent thoughts of death or suicide

Symptoms of mania and depression in children and adolescents may manifest themselves through a variety of different behaviors. When manic, children and adolescents, in contrast to adults, are more likely to be irritable and prone to destructive outbursts than to be elated or euphoric. When depressed, there may be many physical complaints such as headaches, muscle aches, stomachaches or tiredness, frequent absences from school or poor performance in school, talk of or efforts to run away from home, irritability, complaining, unexplained crying, social isolation, poor communication, and extreme sensitivity to rejection or failure. Other manifestations of manic and depressive states may include alcohol or substance abuse and difficulty with relationships.

Existing evidence indicates that bipolar disorder beginning in childhood or early adolescence may be a different, possibly more severe form of the illness than older adolescent- and adult-onset bipolar disorder. When the illness begins before or soon after puberty, it is often characterized by a continuous, rapid-cycling, irritable, and mixed symptom state that may co-occur with disruptive behavior disorders, particularly attention deficit hyperactivity disorder (ADHD) or conduct disorder (CD), or may have features of these disorders as initial symptoms. In contrast, later adolescent- or adult-onset bipolar disorder tends to begin suddenly, often with a classic manic episode, and to have a more episodic pattern with relatively stable periods between episodes. There is also less co-occurring ADHD or CD among those with later onset illness.

A child or adolescent who appears to be depressed and exhibits ADHD-like symptoms that are very severe, with excessive temper outbursts and mood changes, should be evaluated by a psychiatrist or psychologist with experience in bipolar disorder, particularly if there is a family history of the illness. This evaluation is especially important since psychostimulant medications, often prescribed for ADHD, may worsen manic symptoms. There is also limited evidence suggesting that some of the symptoms of ADHD may be a forerunner of full-blown mania.
Findings from an NIMH-supported study suggest that the illness may be at least as common among youth as among adults. In this study, one percent of adolescents ages 14 to 18 were found to have met criteria for bipolar disorder or cyclothymia, a similar but milder illness, in their lifetime. In addition, close to six percent of adolescents in the study had experienced a distinct period of abnormally and persistently elevated, expansive, or irritable mood even though they never met full criteria for bipolar disorder or cyclothymia. Compared to adolescents with a history of major depressive disorder and to a never-mentally-ill group, both the teens with bipolar disorder and those with subclinical symptoms had greater functional impairment and higher rates of co-occurring illnesses (especially anxiety and disruptive behavior disorders), suicide attempts, and mental health services utilization. The study highlights the need for improved recognition, treatment, and prevention of even the milder and subclinical cases of bipolar disorder in adolescence.

**Treatment**

Once the diagnosis of bipolar disorder is made, the treatment of children and adolescents is based mainly on experience with adults, since as yet there is very limited data on the efficacy and safety of mood stabilizing medications in youth. The essential treatment for this disorder in adults involves the use of appropriate doses of mood stabilizers, most typically lithium and/or valproate, which are often very effective for controlling mania and preventing recurrences of manic and depressive episodes. Research on the effectiveness of these and other medications in children and adolescents with bipolar disorder is ongoing. In addition, studies are investigating various forms of psychotherapy, including cognitive-behavioral therapy, to complement medication treatment for this illness in young people.

NIMH is attempting to fill the current gaps in treatment knowledge with carefully designed studies involving children and adolescents with bipolar disorder. Data from adults do not necessarily apply to younger patients, because the differences in development may have implications for treatment efficacy and safety. Current multi-site studies funded by NIMH are investigating the value of long-term treatment with lithium and other mood from adults do not necessarily apply to younger patients, because the differences in development may have implications for treatment efficacy and safety. Current multi-state studies funded by NIMH are investigating the value of long-term treatment with lithium and other mood stabilizers in preventing recurrence of bipolar disorder in adolescents. Specifically, these studies aim to determine how well lithium and other mood stabilizers prevent recurrences of mania or depression and control subclinical symptoms in adolescents; to identify factors that predict outcome; and to assess side effects and overall adherence to treatment. Another NIMH-funded study is evaluating the safety and efficacy of valproate for treatment of acute mania in children and adolescents, and also is investigating the biological correlates of treatment response. Other NIMH-supported investigators are studying the effects of antidepressant medications added to mood stabilizers in the treatment of the depressive phase of bipolar disorder in adolescents.

**Valproate Use**

According to studies conducted in Finland in patients with epilepsy, valproate may increase testosterone levels in teenage girls and produce polycystic ovary syndrome in women who began taking the medication before age 20.5 Increased testosterone can lead to polycystic
ovary syndrome with irregular or absent menses, obesity, and abnormal growth of hair. Therefore, young female patients taking valproate should be monitored carefully by a physician.

For more information

Visit the following link for more information on NIMH.
http://www.nimh.nih.gov/about/nimh.cfm

Please visit the following links for more information about organizations that focus on child and adolescent mental health and bipolar disorder.

References


Fact Sheet #3: Facts About Anxiety Disorders

Most people experience feelings of anxiety before an important event such as a big exam, business presentation, or first date. Anxiety disorders, however, are illnesses that fill people's lives with overwhelming anxiety and fear that are chronic, unremitting, and can grow progressively worse. Tormented by panic attacks, obsessive thoughts, flashbacks of traumatic events, nightmares, or countless frightening physical symptoms, some people with anxiety disorders even become housebound. Fortunately, through research supported by the National Institute of Mental Health (NIMH), there are effective treatments that can help.

How Common Are Anxiety Disorders?

Anxiety disorders, as a group, are the most common mental illness in America. More than 19 million American adults are affected by these debilitating illnesses each year. Children and adolescents can also develop anxiety disorders.

What Are the Different Kinds of Anxiety Disorders?

- **Panic Disorder**—Repeated episodes of intense fear that strike often and without warning. Physical symptoms include chest pain, heart palpitations, shortness of breath, dizziness, abdominal distress, feelings of unreality, and fear of dying.

- **Obsessive-Compulsive Disorder**—Repeated, unwanted thoughts or compulsive behaviors that seem impossible to stop or control.

- **Post-Traumatic Stress Disorder**—Persistent symptoms that occur after experiencing or witnessing a traumatic event such as rape or other criminal assault, war, child abuse, natural or human-caused disasters, or crashes. Nightmares, flashbacks, numbing of emotions, depression, and feeling angry, irritable or distracted and being easily startled are common. Family members of victims can also develop this disorder.

- **Phobias**—Two major types of phobias are social phobia and specific phobia. People with social phobia have an overwhelming and disabling fear of scrutiny, embarrassment, or humiliation in social situations, which leads to avoidance of many potentially pleasurable and meaningful activities. People with specific phobia experience extreme, disabling, and irrational fear of something that poses little or no actual danger; the fear leads to avoidance of objects or situations and can cause people to limit their lives unnecessarily.

- **Generalized Anxiety Disorder**—Constant, exaggerated worrisome thoughts and tension about everyday routine life events and activities, lasting at least six months. Almost always anticipating the worst even though there is little reason to expect it; accompanied by physical symptoms, such as fatigue, trembling, muscle tension, headache, or nausea.

Anxiety Disorders  One-Year Prevalence (Adults)
### What Are Effective Treatments for Anxiety Disorders?

Treatments have been largely developed through research conducted by NIMH and other research institutions. They help many people with anxiety disorders and often combine medication and specific types of psychotherapy.

A number of medications that were originally approved for treating depression have been found to be effective for anxiety disorders as well. Some of the newest of these antidepressants are called selective serotonin reuptake inhibitors (SSRIs). Other antianxiety medications include groups of drugs called benzodiazepines and beta-blockers. If one medication is not effective, others can be tried. New medications are currently under development to treat anxiety symptoms.

Two clinically-proven effective forms of psychotherapy used to treat anxiety disorders are behavioral therapy and cognitive-behavioral therapy. Behavioral therapy focuses on changing specific actions and uses several techniques to stop unwanted behaviors. In addition to the behavioral therapy techniques, cognitive-behavioral therapy teaches patients to understand and change their thinking patterns so they can react differently to the situations that cause them anxiety.

### Do Anxiety Disorders Co-Exist with Other Physical or Mental Disorders?

It is common for an anxiety disorder to accompany depression, eating disorders, substance abuse, or another anxiety disorder. Anxiety disorders can also co-exist with illnesses such as cancer or heart disease. In such instances, the accompanying disorders will also need to be treated. Before beginning any treatment, however, it is important to have a thorough medical examination to rule out other possible causes of symptoms.

### For more information

Please visit the following link for more information about organizations that focus on anxiety disorders.

QUIZ: How Much Do You Know About Anxiety Disorders?

Fear and anxiety are a necessary part of life. Whether it's a feeling of anxiety before taking a test or a feeling of fear as you walk down a dark street, normal anxiety can be protective and stimulating. Unfortunately, more than 19 million Americans with anxiety disorders face much more than just "normal" anxiety. Instead, their lives are filled with overwhelming anxiety and fear that can be intense and crippling. Although anxiety disorders can be disabling, research supported and conducted by the National Institute of Mental Health (NIMH) has provided insight into their causes and has resulted in many effective treatments.

1. Which of the following are disorders of the brain?
   - a. Stroke, epilepsy, multiple sclerosis
   - b. Anxiety disorders, schizophrenia, depression, alcohol addiction
   - c. Autism, anorexia, learning disabilities, dyslexia, migraines
   - d. Alzheimer's disease, Tourette syndrome, Parkinson's disease, brain tumor
   - e. All of the above

2. True or False? Post-traumatic stress disorder, once referred to as shell shock or battle fatigue, is a condition that only affects war veterans.

3. True or False? Someone who feels compelled to spend a great deal of time doing things over and over again such as washing their hands, checking things, or counting things has an anxiety disorder.

4. What is the most common mental health problem in the United States?
   - a. Depression
   - b. Schizophrenia
   - c. Anxiety disorders

5. Which of the following diseases/disorders are real medical illnesses?
   - e. Anxiety disorders
   - f. Diabetes
   - g. High blood pressure
   - h. All of the above

6. Which of the following are symptoms of an anxiety disorder known as panic disorder?
   - a. Chest pains
   - b. Dizziness
   - c. Nausea or stomach problems
   - d. Fear of dying
   - e. All of the above

7. True or False? Anxiety disorders often occur with other illnesses.

8. True or False? Most people successfully take control of the symptoms of anxiety disorders by sheer willpower and personal strength.
ANSWERS TO QUIZ
1. Which of the following are disorders of the brain?

Answer: e. All of the above.

Brain research demonstrates that disorders as different as stroke, anxiety disorders, alcohol addiction, anorexia, learning disabilities, and Alzheimer's disease all have their roots in the brain. Every American will be affected at some point in his or her life, either personally or by a family member's struggle, with a brain disorder.

2. Post-traumatic stress disorder, once referred to as shell shock or battle fatigue, is a condition that only affects war veterans.

Answer: False.

Individuals who have experienced or witnessed a traumatic event or ordeal, such as a terrorist attack, a tornado, a rape or mugging, or a car accident, can be at risk for developing post-traumatic stress disorder (PTSD). Many people with this anxiety disorder repeatedly relive the trauma in the form of nightmares and disturbing recollections during the day. They may also experience sleep problems, depression, feeling detached or numb, or being easily startled.

3. Someone who feels compelled to spend a great deal of time doing things over and over again such as washing their hands, checking things, or counting things has an anxiety disorder.

Answer: True.

A person plagued by the urgent need to engage in certain rituals, or tormented by unwelcome thoughts or images, may be suffering from an anxiety disorder called obsessive-compulsive disorder (OCD). Most healthy people can identify with having some of the symptoms of OCD, such as checking the stove several times before leaving the house. But the disorder is diagnosed only when such activities consume at least an hour a day, are very distressing, and interfere with daily life. OCD affects men and women equally. It can appear in childhood, adolescence, or adulthood, but on the average, it first shows up in the teens or early adulthood.

4. What is the most common mental health problem in the United States?

Answer: c. Anxiety disorders.

Anxiety disorders are the most common mental health problem in America. More than 19 million Americans suffer from anxiety disorders, which include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, phobias, and generalized anxiety disorder.

5. Which of the following diseases/disorders are real medical illnesses?

Answer: d. All of the above.

Anxiety disorders, diabetes, and high blood pressure are all real medical illnesses. Brain scientists have shown that anxiety disorders are often related to the biological makeup and life
experiences of the individual, and they frequently run in families. Unfortunately, misconceptions about mental illnesses like anxiety disorders still exist. Because many people believe mental illness is a sign of personal weakness, the condition is often trivialized and is left untreated. The good news is that effective treatments are available for anxiety disorders.

6. Which of the following are symptoms of an anxiety disorder known as panic disorder?

Answer: e. All of the above.

Panic disorder is characterized by unexpected and repeated episodes of intense fear accompanied by physical symptoms that may include chest pain, heart palpitations, shortness of breath, dizziness, or abdominal distress. These sensations often mimic symptoms of a heart attack or other life-threatening medical conditions. Left untreated, people with panic disorder can develop so many phobias about places or situations where panic attacks have occurred that they become housebound.

7. Anxiety disorders often occur with other illnesses.

Answer: True.

It is common for an anxiety disorder to accompany depression, eating disorders, substance abuse, or another anxiety disorder. Anxiety disorders can also co-exist with illnesses such as heart disease, high blood pressure, irritable bowel syndrome, thyroid conditions, and migraine headaches. In such instances, the accompanying disorders will also need to be treated. So, it is important, before beginning any treatment, to have a thorough medical examination to determine the causes of symptoms.

8. Most people successfully take control of the symptoms of anxiety disorders by sheer willpower and personal strength.

Answer: False.

Many people misunderstand anxiety disorders and other mental illnesses and think individuals should be able to overcome the symptoms by sheer willpower. Wishing the symptoms away does not work—but there are treatments that can help. Treatment for anxiety disorders often involves medication, specific forms of psychotherapy, or a combination of the two.

Publication No. OM-99 4152 Printed January 1999
Fact Sheet #4: Attention Deficit Hyperactivity Disorder

In recent years, attention deficit hyperactivity disorder (ADHD) has been a subject of great public attention and concern. Children with ADHD—one of the most common of the psychiatric disorders that appear in childhood—can't stay focused on a task, can't sit still, act without thinking, and rarely finish anything. If untreated, the disorder can have long-term effects on a child's ability to make friends or do well at school or work. Over time, children with ADHD may develop depression, poor self-esteem, and other emotional problems.

- ADHD affects an estimated 4.1 percent of youths ages 9 to 17 in a 6-month period.\(^1\)
- About 2 to 3 times more boys than girls have ADHD.\(^2\)
- Children with untreated ADHD have higher than normal rates of injury.\(^3\)
- ADHD often co-occurs with other problems, such as depressive and anxiety disorders, conduct disorder, drug abuse, or antisocial behavior.\(^4,5\)
- Symptoms of ADHD usually become evident in preschool or early elementary years. The disorder frequently persists into adolescence and occasionally into adulthood.\(^6\)

**Diagnosis and Treatment**

Effective treatment depends on appropriate diagnosis of ADHD. A comprehensive medical evaluation of the child must be conducted to establish a correct diagnosis of ADHD and to rule out other potential causes of the symptoms. ADHD can be reliably diagnosed when appropriate guidelines are used.\(^7,8\) Ideally, a health care practitioner making a diagnosis should include input from both parents and teachers. But some health practitioners diagnose ADHD without all this information and tend to either overdiagnose the disorder or underdiagnose it.

Research has shown that certain medications, stimulants in most cases, and behavioral therapies that help children with ADHD control their activity level and impulsiveness, pay attention, and focus on tasks are the most beneficial treatments.\(^9\) Stimulants commonly prescribed for ADHD include methylphenidate (Ritalin\(^*\)), dextroamphetamine (Dexedrine\(^*\)), and amphetamine (Adderall\(^*\)). Despite data showing that stimulant medications are safe,\(^8\) there are widespread misunderstandings about the safety and use of these drugs, and some health care practitioners are reluctant to prescribe them. Like all medications, those used to treat ADHD do have side effects and need to be closely monitored.

**Problems Faced by Families**

Parents need to carefully evaluate treatment choices when their child receives a diagnosis of ADHD. When they pursue treatment for their children, families face high out-of-pocket expenses because treatment for ADHD and other mental illnesses is often not covered by insurance policies. In schools, treatment plans are often poorly integrated. In addition, there are few special education funds directed specifically for ADHD. All of these factors lead to children who do not receive proper and adequate treatment. To overcome these barriers, parents may want to look for school-based programs that have a team approach involving parents, teachers, school psychologists, other mental health specialists, and physicians.
Research Findings

Brain imaging research using a technique called magnetic resonance imaging (MRI) has shown that differences exist between the brains of children with and without ADHD. In addition, there appears to be a link between a person's ability to pay continued attention and the use of glucose—the body's major fuel—in the brain. In adults with ADHD, the brain areas that control attention use less glucose and appear to be less active, suggesting that a lower level of activity in some parts of the brain may cause inattention.

Research shows that ADHD tends to run in families, so there are likely to be genetic influences. Children who have ADHD usually have at least one close relative who also has ADHD. And at least one-third of all fathers who had ADHD in their youth have children with ADHD. Even more convincing of a possible genetic link is that when one twin of an identical twin pair has the disorder, the other is likely to have it too.

Data from 1995 show that physicians treating children and adolescents wrote 6 million prescriptions for stimulants. Of all the drugs used to treat psychiatric disorders in children, stimulant medications are the most well studied. A 1998 Consensus Development Conference on ADHD sponsored by the National Institutes of Health and a recent, comprehensive scientific report confirmed many earlier studies showing that short-term use of stimulants is safe and effective for children with ADHD.

In December 1999, NIMH released the results of a study of nearly 600 elementary school children, ages 7 to 9, which evaluated the safety and relative effectiveness of the leading treatments for ADHD for a period up to 14 months. The results indicate that the use of stimulants alone is more effective than behavioral therapies in controlling the core symptoms of ADHD—inattention, hyperactivity/impulsiveness, and aggression. In other areas of functioning, such as anxiety symptoms, academic performance, and social skills, the combination of stimulant use with intensive behavioral therapies was consistently more effective. (Of note, families and teachers reported somewhat higher levels of satisfaction for those treatments that included the behavioral therapy components.) NIMH researchers will continue to track these children into adolescence to evaluate the long-term outcomes of these treatments, and ongoing reports will be published.

For More Information

Please visit the following link for more information about organizations that focus on attention deficit hyperactivity disorder.


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NIH Publication No. 01-4589
References


Fact Sheet #5: Childhood-Onset Schizophrenia:
An Update from the National Institute of Mental Health

A child's stage of development must be taken into account when considering a diagnosis of mental illness. Behaviors that are normal at one age may not be at another. Rarely, a healthy young child may report strange experiences—such as hearing voices—that would be considered abnormal at a later age. Clinicians look for a more persistent pattern of such behaviors. Parents may have reason for concern if a child of 7 years or older often hears voices saying derogatory things about him or her, or voices conversing with one another, talks to himself or herself, stares at scary things—snakes, spiders, shadows—that are not really there, and shows no interest in friendships. Such behaviors could be signs of schizophrenia, a chronic and disabling form of mental illness. Fortunately, schizophrenia is rare in children, affecting only about 1 in 40,000, compared to 1 in 100 in adults. The average age of onset is 18 in men and 25 in women. Ranking among the top 10 causes of disability worldwide, schizophrenia, at any age, exacts a heavy toll on patients and their families. Children with schizophrenia experience difficulty in managing everyday life. They share with their adult counterparts psychotic symptoms (hallucinations, delusions), social withdrawal, flattened emotions, increased risk of suicide and loss of social and personal care skills. They may also share some symptoms with—and be mistaken for—children who suffer from autism or other pervasive developmental disabilities, which affect about 1 in 500 children. Although they tend to be harder to treat and have a worse prognosis than adult-onset schizophrenia patients, researchers are finding that many children with schizophrenia can be helped by the new generation of antipsychotic medications.

Symptoms and Diagnosis

While schizophrenia sometimes begins as an acute psychotic episode in young adults, it emerges gradually in children, often preceded by developmental disturbances, such as lags in motor and speech/language development. Such problems tend to be associated with more pronounced brain abnormalities. The diagnostic criteria are the same as for adults, except that symptoms appear prior to age 12, instead of in the late teens or early 20s. Children with schizophrenia often see or hear things that do not really exist, and harbor paranoid and bizarre beliefs. For example, they may think people are plotting against them or can read their minds. Other symptoms of the disorder include problems paying attention, impaired memory and reasoning, speech impairments, inappropriate or flattened expression of emotion, poor social skills, and depressed mood. Such children may laugh at a sad event, make poor eye contact, and show little body language or facial expression.

Misdiagnosis of schizophrenia in children is all too common. It is distinguished from autism by the persistence of hallucinations and delusions for at least 6 months, and a later age of onset—7 years or older. Autism is usually diagnosed by age 3. Schizophrenia is also distinguished from a type of brief psychosis sometimes seen in affective, personality, and dissociative disorders in children. Adolescents with bipolar disorder sometimes have acute onset of manic episodes that may be mistaken for schizophrenia. Children who have been victims of abuse may sometimes claim to hear voices of—or see visions of—the abuser. Symptoms of schizophrenia
characteristically pervade the child's life, and are not limited to just certain situations, such as at school. If children show any interest in friendships, even if they fail at maintaining them, it is unlikely that they have schizophrenia.

**Treatment**

Treatments that help young patients manage their illness have improved significantly in recent decades. As in adults, antipsychotic medications are especially helpful in reducing hallucinations and delusions. The newer generation "atypical" antipsychotics, such as olanzapine and clozapine, may also help improve motivation and emotional expressiveness in some patients. They also have a lower likelihood of producing disorders of movement, including tardive dyskinesia, than the other antipsychotic drugs such as haloperidol. However, even with these newer medications, there are side effects, including excess weight gain that can increase risk of other health problems. The NIMH is conducting research studies to improve treatments (www.clinicaltrials.gov). Children with schizophrenia and their families can also benefit from supportive counseling, psychotherapies, and social skills training aimed at helping them cope with the illness. They likely require special education and/or other accommodations to succeed in the classroom.

**Causes**

Although it is unclear whether schizophrenia has a single or multiple underlying causes, evidence suggests that it is a neurodevelopmental disease likely involving a genetic predisposition, a prenatal insult to the developing brain, and stressful life events. The role of genetics has long been established; the risk of schizophrenia rises from 1 percent with no family history of the illness, to 10 percent if a first degree relative has it, to 50 percent if an identical twin has it. Prenatal insults may include viral infections, such as maternal influenza in the second trimester, starvation, lack of oxygen at birth, and untreated blood type incompatibility. Studies find that children share with adults many of the same abnormal brain structural, physiological, and neuropsychological features associated with schizophrenia. The children seem to have more severe cases than adults, with more pronounced neurological abnormalities. This makes childhood-onset schizophrenia potentially one of the clearest windows available for research into a still obscure illness process.

For example, unlike most adult-onset patients, children who become psychotic prior to puberty show conspicuous evidence of progressively abnormal brain development. In the first longitudinal brain imaging study of adolescents, magnetic resonance imaging (MRI) scans revealed fluid filled cavities in the middle of the brain enlarging abnormally between ages 14 and 18 in teens with early-onset schizophrenia, suggesting a shrinkage in brain tissue volume. These children lost four times as much gray matter, neurons and their branchlike extensions, in their frontal lobes as normally occurs in teens. This gray matter loss engulfs the brain in a progressive wave from back to front over 5 years, beginning in rear structures involved in attention and perception, eventually spreading to frontal areas responsible for organizing, planning, and other "executive" functions impaired in schizophrenia. Since losses in the rear areas are influenced mostly by environmental factors, the researchers suggest that some non-genetic trigger contributes to the onset and initial progression of the illness. The final loss pattern is consistent with that seen in adult schizophrenia. Adult-onset patients' brains may
have undergone similar changes when they were teens that went unnoticed because symptoms had not yet emerged, suggest the researchers.

In addition to studies of brain structural abnormalities, researchers are also examining a group of measures associated with genetic risk for schizophrenia. Early-onset cases of illness have recently proven crucial in the discovery of genes linked to other genetically complex disorders like breast cancer, Alzheimer's, and Crohn's diseases.\(^3\) Hence, children with schizophrenia and their families may play an important role in deciphering schizophrenia's molecular roots. Evidence suggests that the rate of genetically-linked abnormalities is twice as high in children as in adults with the illness. Similarly, schizophrenia spectrum disorders, thought to be genetically related to schizophrenia, are about twice as prevalent among first-degree relatives of childhood-onset patients. In one recent study, a third of the families of individuals with childhood onset schizophrenia had at least one first-degree relative with a diagnosis of schizophrenia, or schizotypal or paranoid personality disorder.\(^11\) This profile of psychiatric illness is remarkably similar to that seen in parents of adult-onset patients, adding to the likelihood that both forms share common genetic roots. Other anomalies associated with adult schizophrenia, such as abnormal eye movements, are also more common in families of children with the illness.

Families of children with schizophrenia who are interested in participating in research are encouraged to fill out the NIMH Childhood-Onset Schizophrenia Survey, to help determine eligibility for studies.

**For More Information**

Please visit the following link for more information about organizations that focus on schizophrenia.


**REFERENCES**


2. NIMH Schizophrenia publications.


5. American Academy of Child and Adolescent Psychiatry. Practice parameters for the


Handout III-A: Action Plan

Stage I. Know your building and district policies, procedures, and resources. This sounds obvious, but schools do not have the time to advertise every support service available. Every district has procedures in place to work with students and staff. For example:

- Pre-referral teams, student support teams, or other working groups may be in place.
- School psychologists, social workers, nurses, special educators, and counselors may be available within the building or at the district level.

The key for staff is to learn how to access these professionals and other school resources.

Stage II. Voice your concern/ask for help. This part is scariest. Tips for teachers and other staff:

- Take time to review relevant cultural proficiency factors that may influence how you approach the student and how the student will perceive the approach.
- Set aside private one-to-one time with the student, and let the student know right at the beginning of the time together that this conference is about your observations of his or her need for assistance.
- You may want to reassure the student that this conference is not a punishment or act of discipline.
- Also make known to the student that in order to help, you may have to share your concern with others, but will not share details of the conversation unless there is an immediate threat to the student's well-being.
- Discuss with the youth what action you will take together to obtain assistance.
- If you have doubts about having a one-to-one conference with the youth, seek support from internal resources or caregivers first.

Stage III. Follow up. It is important to stress that helping students isn't about shifting the problem to someone else. Following up reassures youth that you are someone who DOES care. Tips for teachers and other staff:

- Work with the youth and others involved to intervene at the level of the classroom. Make modifications where necessary to promote successful learning.
- Refrain from public statements that will violate the youth's privacy and confidentiality.
- Obtain support from internal resources to ensure that classroom modifications are appropriate and monitor whether adaptations are working for the youth.
- Check with internal resources to ensure that help is being accessed.

The action plan should be tailored to the needs of the student and his or her family and should include all the resources inside and outside the school that can meet his or her needs. Not all students will show an immediate beneficial response to intervention. Continue to provide support for the student within the classroom and provide feedback to the student at every hint of progress.
### Handout III-B: Worksheet: Toward Capacity Building

<table>
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<tr>
<th>Resource</th>
<th>What needs does this resource meet for students? Families? Staff?</th>
<th>When should an Educator access this resource?</th>
<th>How should an Educator access this resource? Administrator? Other staff?</th>
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Handout III-C: Potential Partners

- School social workers
- School psychologists
- School wellness coordinators
- School nurses
- School counselors
- School-based mental health clinic
- School-based health clinic
- Student Attendance Review Board (SARB)
- School or district’s positive school climate committee/team

- Families
- Parent advocates
- Family liaisons
- Outreach workers
- Peer and adult mentors

- Principal
- Vice principals
- Instructional leaders
- School board
- Superintendent

- Committee on special education
- Intervention team or committee
- Special educators
- Physical, speech, occupational therapists

- Attendance office
- Truant officers
- Transportation department

- System of care partners
- Case managers
- Family/private psychologist
- Mental health providers outside school
- Community-based agencies and partners
- Cultural leaders and liaisons of cultural sub-groups
- Faith-based leaders and support programs
Juanita ran into several difficulties in the latter part of elementary school and her grades deteriorated when she transitioned into middle school. Her family was unsure about the ups and downs that Juanita showed. She had always been bouncy, energetic, and creative, but she seemed at times unusually animated. Just before starting high school Juanita's behavior was a tremendous concern for the family. She would stay up all night, rarely eat, and seem to possess a ton of energy. Other times she slept all day, hardly spoke to anyone, and locked herself in her room. At first the family thought she might be using drugs. This created a lot of tension and conflict in the family. Many arguments took place at home about Juanita's talkativeness, her insomnia, and the way she seemed to snap at people in a grumpy and even hostile tone. The family grew even more concerned for Juanita after she ran away for three days. She said she wanted to live the life of an artist and that rules didn't apply to her life.

Juanita's family sought help by going to their church. Their minister referred them to a counseling center. The family and Juanita discovered that much of Juanita's behavior was not typical for a teenager. Her behavior really showed symptoms of a bipolar mood disorder. Juanita improved with medication. She participated in family counseling and attended a group with other teenagers who experienced emotional disturbances.

Although Juanita showed improvement, her work at school was uneven. She skipped some classes and received excellent grades in other classes. Math was her least favorite class. Her teacher, Mrs. Farrell, noticed that Juanita would show up to class without assignments, often tardy, and disorganized. Mrs. Farrell also noticed that Juanita possessed certain flair: she painted her notebooks, wore handmade jewelry, and seemed to invent her own style. Mrs. Farrell decided to discuss what she observed with Juanita.

Mrs. Farrell approached Juanita at her desk while the other students were taking a pop quiz. The teacher guessed that Juanita was unprepared for the quiz because she had missed the last two days of class and didn't have the assignments. She whispered to Juanita and asked her to quietly step out into the hall for a moment. In the hallway, Mrs. Farrell told Juanita that she noticed Juanita seemed to be artistic and wondered if Juanita may not enjoy math. Juanita boldly told her she hated it. Mrs. Farrell asked if Juanita could meet with her after school to find ways to make the class work for her. Mrs. Farrell was unsure how to discuss the topic with Juanita but she was willing to spend the time with her.

When Juanita met Mrs. Farrell after school she immediately asked the teacher how Mrs. Farrell was going to "make her" like math. Mrs. Farrell told Juanita that it seemed that they couldn't resolve Juanita's dislike for math in one day. However, they might be able to find ways to see how math may not be so different from other things Juanita does like. And even if they couldn't agree on that, they could agree that it was within Juanita's power to come to class and ask for help with the work if she was confused.

Juanita agreed with Mrs. Farrell about asking for help. She told Mrs. Farrell that she knew about what it meant to ask for help because of having emotional problems and more specifically, bipolar disorder. She described the last few years to Mrs. Farrell and told her about living with side effects from medication.
Mrs. Farrell was not prepared for what she heard, but knew that Juanita was sharing something very real, very personal, and very important for her success as student. Mrs. Farrell asked Juanita if she ever felt that bipolar disorder got in the way of schoolwork. Juanita confessed that sometimes she felt very tired or worn out. She also said that she sometimes felt really hyper, but didn’t mind that as much. Some classes make her feel more relaxed, like art class. Math wasn’t one of those classes.

Mrs. Farrell told Juanita she felt that they could make progress by making a plan to help Juanita with math. She and Juanita agreed to pay attention to when Juanita felt jumpy and confused in class. They also agreed that Juanita could ask for help with the class.

Juanita showed up to class on time the next day. After class she asked Mrs. Farrell if they could meet to talk about her assignments. Mrs. Farrell agreed to meet with Juanita. They developed a small plan for Juanita to follow. The plan included a built-in way for Juanita to reward herself for handing in assignments. The plan also included a way for Juanita to work on math without distractions from television, the telephone, and things Juanita said took her away from her work.

Juanita seemed genuinely ready to take a new approach to class. Mrs. Farrell, however, noticed that Juanita seemed very talkative in class over the next few weeks. When she saw Juanita in the hallway, she seemed rowdy and loud. She asked Juanita to meet with her. When they met, Mrs. Farrell told Juanita that she would like to talk with her parents, too. She told Juanita that the plan had seemed to help at first but now something else seemed to be getting in the way. Juanita told Mrs. Farrell not to call her parents. She said they were fighting a lot lately. Mrs. Farrell said she couldn’t do that because she was much too concerned about Juanita.

Mrs. Farrell held a conference with Juanita and her parents. Juanita’s parents were upset with Juanita, and they were concerned about whether she was taking her medication. Mrs. Farrell asked Juanita’s parents to consult with their daughter’s doctor.

Juanita was absent for one week after the conference. Mrs. Farrell was very concerned. When Juanita returned, she went to Mrs. Farrell and told her that she had been hospitalized, and that they were trying new medicine for her. She said she felt unstable and scared. Mrs. Farrell told Juanita that the adults in her life would be there to support her. Mrs. Farrell realized that Juanita would need reassurance to build her confidence back. During the weeks that followed, Juanita seemed to do her best with getting back on track in class.

At the end of the term she received a 70 percent on her report card. The grade was a huge improvement from the 50 percent she received the previous quarter.
Handout IV-A: S.U.C.C.E.S.S.

"S.U.C.C.E.S.S." is a method to assess the classroom environment for barriers to learning.

**Spend time scanning the classroom** during group and individual work assignments. Make a note of areas for improvement, such as problem solving skills of individual learners, conflict-resolution skills during group work, and level of respect among learners. Also make a note of areas that show improvement and provide feedback.

**Ask school resources**, such as the principal, volunteers, aides, other teachers, or senior students to observe the classroom and provide feedback about the quality of instructional methods, the variety of presentation of lesson concepts, and the flow of information.

**Check with students on the types of feedback most favorable to them.** Have them fill out an index card that completes this sentence: "My teacher knows I am learning when ________________." Next, find out how they provide their own feedback. Have them complete this sentence: "I can tell I am learning when ________________." This will allow students to reflect on the process of learning. If grades are the most cited outcome, help students identify other ways they may observe their own learning (i.e., being able to speak at length about a topic, teaching to someone else, relating concepts to life outside the classroom, etc.).

**Choose times, such as academic quarters** or easy-to-remember intervals during each term, to determine the need for mini-lessons on organization and study skills.

**Evaluate the need for additional support** for individual learners and access resources for these students.

**Set up a systematic way to gauge effort against performance.** Consider students' effort in your evaluation of their performance and provide constructive feedback with the purpose of praise or incentive to encourage consistent effort.

**Size up your own progress.** Monitor your skills and celebrate success!
Handout IV-B: Mrs. Rogers and a Lesson on Stigma

Here is how Mrs. Rogers handled stigmatizing behavior in her 11th grade English class:

"Jessica handed Carl her paper. We were grading them in class. I overhead her tell Carl, 'Don't touch it. I don't want your freakiness. Just don't touch it.' Carl sometimes stood out because he covered his hands with the sleeves of his shirt. His neighboring classmates were most prone to notice this behavior. Jessica was particularly verbal about Carl. I wanted to take action before but never knew exactly what to say. Things get said so fast and I am moving along with the lesson. This time I was prepared to take action.

"I told all the students to stop what they were doing. I said that I wanted to try something different. Rather than passing their papers to a neighbor to grade them, I told the students to pass their papers forward. Once the papers were stacked at the head of all the rows I announced that we would have a new grading policy. All papers would either get a zero or 100, but it wouldn't be based on whether the paper was correct or incorrect. It would be up to the class to decide how we would first make two stacks, and then give one stack of papers a zero and the other 100. At first the students seemed confused. Of course, not one student liked the idea. They mostly stated that it was unfair. There was no good way to make that decision. I agreed with them and asked them whether or not they ever witnessed this type of unfairness in the way people act toward each other. One student likened unfair behavior to ways that others stereotype and gave an example about kids who live in a trailer park. Another student said, 'It's like when we have different groups in the cafeteria.' I let them give examples and then referred back to the stacks of papers. I said that as a class we should agree to not judge these stacks and more importantly, to not judge each other. I handed back the papers and we started again. It took up some class time but it was very memorable."
Handout IV-C: Brett's Story

Brett's High School Report Card: "Assignments Missing"

Teachers see that Brett hardly ever turns in his homework assignments. While he is shy and quiet, he seems capable of understanding and carrying out the assignments. Mrs. Harris decides to take a few minutes to ask Brett about his missing work. A frustrated Brett pours out his story:

"I try to go to another bus stop in the morning. Sticky Fingers—that's what I call him, he's always stealing something from somebody—he's there with the other guys. They either throw stuff or smoke or mess with the mailboxes that are on an island right at the stop. I took a cab to school yesterday just to get away from them. But I forgot some work and the driver didn't want to wait for me to go get it so I just left it. It was due and I'll probably get a zero.

"When I do take the bus, they try to start a fight by saying stupid junk. They are loud and they are always saying something to somebody. I see them in the hall at school but I avoid them. Sometimes they yell, 'Yeah, we're going to get you later, dude.' I take the late bus so I won't fight with them. I sit in class thinking about how I can get some big kid to scare them or punch Sticky Fingers or something. He's a real dummy. Last week he took my book bag and chucked it across the street. All the papers blew out. They all laughed because I had to pick up all the junk. I only picked up my book bag and left a bunch of papers. I really got into trouble because I didn't know what to say when I had to hand in my biology project."
## Handout IV-D: Adolescent Development and Classroom Climate

<table>
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<tr>
<th>Aspect of Development</th>
<th>Classroom strategy</th>
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</thead>
</table>
| Youth strive for independence            | • Support autonomy and innovation in the classroom  
• Stress order through consistency, fairness, and respect  
• Promote involvement in classroom governance through shared values, needs, and goals |
| Youth endeavor to define themselves      | • Differentiate between the behavior and the person  
• Use attribution statements regarding intrinsic desire to feel successful |
| Youth compare themselves to peers        | • Model positive attitude, acceptance, and respectful behavior  
• Forbid ridicule, sarcasm, or inequality to exist in the classroom  
• Make obvious the worth of all students |
| Youth learn from social interactions     | • Develop collaborative and cooperative learning activities  
• Seize opportunities to directly teach conflict resolution  
• Directly teach how to accept and learn from mistakes; and stress improvement as the yardstick to measure success  
• Model trust, empathy, and appropriate risk taking |
| Youth experiences shape future learning  | • Promote critical thinking  
• Expect success; put forth obtainable goals  
• Give immediate and consistent feedback  
• Show how to build on strengths  
• Help others to view students positively |
Handout IV-E: Mr. Fox and Tardiness

**Aspect of Development:** Youth strive for independence

**Behavior:** Late for class

**Classroom Strategy:**
- Support autonomy and innovation in the classroom.
- Stress order through consistency, fairness, and respect.
- Promote involvement in classroom governance through shared values, needs, and goals.

Mr. Fox's response to tardiness: "I have noticed that some of the students in this class are arriving late. I usually hear that it takes too long to get from the last class to my classroom. On the other hand, some students are coming from the same area of the building and they arrive on time. What I also notice is that when we start late, I have to teach right up until the bell rings. Some of you are still writing down your assignments for the next day. That doesn't seem fair. Do you all think that tardiness for class is acceptable?

"What I would like to do is to take about five minutes of our class time today to talk about hallway routes to my classroom." Mr. Fox starts to hand out index cards. "I want each one of you to write down on this index card where your class before this one is located in the building. Are you coming from the West Wing? Write that down. Are you coming from the gym? Write that down. Hand your cards up, please. I am going to look over these cards. Tomorrow, I will ask about which routes the students who travel the furthest take and how long it takes to get to this class."

*In this example Mr. Fox is capitalizing on students' know-how in getting from point A to point B and the level of individual responsibility that is part of getting to class on time. Students choose their own routes, decide to avoid quick chats with friends or a feverish dash to their locker, and ultimately show respect for coming to class on time. Students are navigators of their own routes, so to speak. Mr. Fox develops this line of reasoning with his students during his "mini-lesson" on punctuality.*
## Handout IV-F: School & Classroom Strategies for Tapping Resilience Checklist

Circle degree to which each protective factor is present...  
1=low; 5=high

### Caring and Support

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<thead>
<tr>
<th>Rating</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Creates and sustains a caring climate</td>
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<td>2</td>
<td>Aims to meet basic developmental needs</td>
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<td>3</td>
<td>Is available/responsive</td>
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<td>4</td>
<td>Has long term commitment</td>
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<td>Creates one-to-one time</td>
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<td>1</td>
<td>Actively listens/gives voice</td>
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<td>2</td>
<td>Uses appropriate self-disclosure</td>
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<td>3</td>
<td>Pays attention</td>
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<td>Shows interest</td>
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<td>Believes/sees the innocence</td>
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<td>Checks in</td>
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<td>Gets to know hopes and dreams</td>
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<td>3</td>
<td>Gets to know life context</td>
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<td>4</td>
<td>Gets to know interests</td>
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<td>Shows respect</td>
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<td>Fundamental positive regard</td>
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<td>Is nonjudgmental</td>
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<td>Looks beneath “problem” behavior</td>
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<td>Reaches beyond the resistance</td>
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<td>Uses humor/smiles</td>
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<td>Flexibility</td>
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<td>Patience</td>
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<td>Uses community-building process</td>
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<td>Creates small, personalized groupings</td>
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<td>Creates opportunities for peer-helping</td>
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<td>1</td>
<td>Uses cross-age mentoring</td>
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</table>

### Creates connections to resources:

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<tr>
<td>1</td>
<td>Education</td>
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<tr>
<td>2</td>
<td>Employment</td>
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<td>3</td>
<td>Recreation</td>
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<td>4</td>
<td>Health and social services</td>
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### Environmental Strategies for Tapping Resilience Checklist

Circle degree to which each protective factor is present...

1=low; 5=high

#### High Expectations

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<td>Sustains a high expectation climate</td>
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<td>Models innate resilience</td>
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<td>Believes in innate resilience of all</td>
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<td>Believes in innate capacity of all to learn</td>
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<td>Strives to develop holistic competencies</td>
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<td>Sees culture as an asset</td>
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<td>Shows common courtesy</td>
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<td>Respects others</td>
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<td>Challenges and supports (“You can do it, I’ll be there to help.”)</td>
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<td>Connects learning to interests, strengths, experiences, goals, and dreams</td>
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<td>Encourages creativity and imagination</td>
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<td>Conveys optimism and hope</td>
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<td>Affirms/encourages the best in others</td>
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<td>Attributes the best possible motive to behavior</td>
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<td>Articulates clear expectations/boundaries</td>
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<td>Models boundary-setting/adaptive distancing</td>
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<td>Uses rituals and traditions</td>
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<td>Recognizes strengths and interests</td>
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<td>Mirrors strengths and interests</td>
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<td>Uses strengths and interests to address concerns/problems</td>
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<td>Uses a variety of instructional strategies to tap multiple intelligences</td>
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<td>Employs authentic assessment</td>
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<td>Helps to reframe self image from at-risk to at-promise</td>
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<td>Helps to reframe problems to opportunities</td>
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<td>Teaches healthy thinking process</td>
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<td>Sees students as constructors of own knowledge and meaning</td>
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<td>Teaches critical analysis</td>
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<td>Encourages self-awareness of moods and thinking</td>
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</tbody>
</table>
Environmental Strategies for Tapping Resilience Checklist

Circle degree to which each protective factor is present...
1=low; 5=high

**Opportunities for Participation**

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Fact Sheet #6: Positive School Climate: An Update from the California Department of Education

Positive School Climate
Information regarding the importance of positive school climate and resources to improve school climate.

Why School Climate Matters
A growing body of research shows that school climate strongly influences students' motivation to learn and improve academic achievement. When school members feel safe, valued, cared for, respected, and engaged, learning increases. Schools that provide students with support to meet these basic needs allow them to grow socially and emotionally and avoid problems ranging from emotional distress to drug use to violence—in addition to helping them achieve academically.

Creating a Positive School Climate
Positive school climate must be a shared mission, created and sustained by students, parents, and school staff, and supported by the community. Efforts to improve school climate must be an integral part of school improvement plans in order to have a positive and sustainable effect. Too often, fragmented solutions are implemented, are marginalized in the school, and improvements are short-lived. In order to achieve meaningful and sustainable improvements, schools must have a clear sense of their vision and goals. Schools also need to understand the barriers to learning that their students experience beyond the school and address those barriers before students can achieve and thrive.

Surveying students, teachers, and school staff is the first step in creating a positive school climate. Survey results can provide schools with information about how each group of individuals perceives conditions for learning. Such information can then be used to design prevention and intervention programs specific to the needs of the school community. The California School Climate, Health, and Learning Survey is available at: www.cal-schls.wested.org

Safe and Supportive Schools supports statewide measurement of conditions for learning (school climate) and targeted programmatic interventions to improve those conditions. In October 2010, California became one of 11 states selected to receive a Safe and Supportive Schools (S3) grant from the U.S. Department of Education, Office of Safe and Drug-Free Schools. This four-year grant is intended to support statewide measurement of conditions for learning (known also as school climate), as well as targeted programmatic interventions to improve

1 California Department of Education (http://www.cde.ca.gov/ls/ss/se/schoolclimate.asp)
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those conditions. The S3 grant addresses issues of school safety and bullying, substance abuse, positive relationships, other learning support, and student engagement. The grant will target California's comprehensive high schools (grades nine through twelve) with the greatest needs in multiple areas of school climate.

The four-year grant period runs from October 2010 through September 2014.

The CDE has established the following goals for S3:

- Improve conditions for learning, including school climate and school safety, in high schools with the greatest needs, as identified by data.
- Build local school district capacity to implement data-driven school improvements.
- Integrate school climate reform into school-wide improvements.
- Establish a comprehensive and sustainable model for school climate improvement to guide school and district efforts throughout the state.

A Safe and Supportive School Climate Makes A Difference

What is School Climate?

- The learning conditions and quality of the environment that affect the attitudes, behaviors, and performance of both students and staff:
  - Norms, goals, and values
  - Personal relationships
  - Instructional practices
  - Leadership and supports
  - Physical setting and organization

The Problem

- Most school reform focuses on curriculum, instruction, and governance. However necessary, this is often not sufficient.
- Lack systematic focus on climate and the context in which learning occurs.
  - How and why youth learn
  - The health and psychosocial barriers to learning that students face
- Without a positive school climate, students will not benefit from improvements in curriculum and instruction, and reform efforts will fall short.

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2 Adapted from Accessible Alternative Version (AAV) of the Importance of a Safe and Supportive School Climate (PPT; 2MB; 16 slides) from the Safe and Supportive Schools Orientation Webinar, January 19, 2011. http://www.cde.ca.gov/ls/ss/se/ssclimateaav.asp
How Does it Affect Achievement?

- “… all research…finds a positive correlation between better school climate and increased student learning and achievement” (Jones et al. 2008).
- School climate directly influences the cognitive as well as psychosocial development of students, promoting greater school connectedness, and engagement.
- Indirectly influences achievement through its effect on teacher performance and retention, and by improving parent involvement.

What is a Positive School Climate (PSC)?

- Engages students in learning, staff in teaching, and parents in their children’s education.
- Sense of school connectedness and shared values.
- Strives to address all learning barriers: focused on well-being and the whole child.
- Students, staff, and parents work together and support one another in implementing a shared vision:
  - Between staff and students.
  - Among staff and students.
  - Between school and parents.

U.S. Department of Education S3 Model

Organizational chart of Safe and Supportive Schools Model

Key Principle: Developmentally Supportive

- School improvement research aligns with research showing that school and life success cannot optimally occur if the basic developmental needs of youth are not met.
Safety, love, respect, belonging, mastery, health

“It is not coincidental that many of the qualities associated with engaging schools also have been found to foster healthy youth development.” (National Research Council, *Engaging Schools*, 2004)

**Three Key Developmental Supports**

- Caring Relationships
- High Expectations
- Opportunities for Meaningful Participation and Decision Making

These are linked to acquisition of skills needed to learn and to positive academic outcomes, as well as health, social, and psychological development.

**Developmental School Climate Framework**
A School Climate Model for Success

Quality curriculum + quality teachers = High Performing Students

Ready, able, engaged in learning:

- Health
- Safety
- High Expectations
- Meaningful Participation
- Caring Relationships
- Strong Parent/Community Ties

The Safety/Bullying Challenge

- Both physical and psychological (social-emotional) safety are basic conditions for learning.
- Concerns over safety and harassment adversely affect school attendance, ability to concentrate on learning, and performance:
  - Causes emotional (anxiety, stress) and physical distress.
- Thirty-seven percent of California secondary students report some harassment in the past year:
  - About half, more than once
- Affects witnesses as well as victims.

Health

- Poor health reduces attendance.
- Can impede readiness, motivation, and ability to learn:
  - Intoxicated, stressed, anxious, fearful, tired, hungry, ill.
- “Growing numbers of children are coming to school with health-related problems that impede their learning.” Council Chief State School Officers, 1998

The Teacher Challenge

- Twenty-two percent of new teachers in California quit within four years.
- School climate among most important factors in whether teachers stay or leave:
  - Workplace conditions and supports: relationships/colllegiality, expectations, participation, and decision making
- A positive climate for students enables teachers to focus on teaching and be more effective.
• If teachers do not feel positive toward school, students will not.


**California Healthy Kids Survey (CHKS) Data Confirm**

• Low-performing secondary schools have poorer climate indicators than high-performing, even after controlling for poverty and race/ethnicity.
  - Higher in health-risk behaviors and lower in school developmental supports, safety, and connectedness.
• Test score improvements over one year related to lower student health-risk behavior and more positive climates.
• Continuation schools that beat the odds have higher supports and better climates, but not necessarily resources.

**Conclusion**

• Efforts to improve schools need to not only address issues of curriculum, instruction, and governance, but also foster safe and supportive conditions that engage students in learning, teachers in teaching, and parents in their student’s education.
  - Failure to address these school climate factors may explain the insufficiency of so many school reform efforts.
• The first step is assessment: The California School Climate, Health, and Learning Survey (Cal-SCHLS) Data System.  *[www.cal-schls.wested.org](http://www.cal-schls.wested.org)*

Questions: Hilva Chan | [hchan@cde.ca.gov](mailto:hchan@cde.ca.gov) | 916-319-0194
Handout V-A: The Cultural Competence Continuum

**Cultural Destructiveness**
Organizations and individuals at this extreme operate on the assumption that one race is superior and that it should eradicate “lesser” cultures.

**Cultural Incapacity**
Although these organizations and individuals do not intentionally seek to cause harm, they believe in the superiority of their own racial or ethnic group and assume a paternalistic posture toward “lesser” groups.

**Cultural Blindness**
Organizations and individuals believe that color or culture make no difference and that all people are the same. They may view themselves as unbiased and believe that they address cultural needs.

**Cultural Pre-Competence**
Organizations and individuals realize weaknesses in their attempts to serve various cultures and make some efforts to improve services. May add (token) staff and board members from cultures they serve and provide basic cultural training, but then become complacent.

**Cultural Competence**
Organizations and individuals accept/respect differences and participate in continuing self-assessment. Expand cultural knowledge and resources, adopting service models that better meet the needs of minority populations. Seek advice/consultation from representatives of the culture served.

**Cultural Proficiency**
Organizations and individuals hold diversity in high esteem. Seek to add knowledge base of culturally competent practice by conducting research, developing new approaches, and disseminating the results. Hire staff who are specialists in cultural competent practice.

Source:
Handout V-B: Joan’s Story

Joan decided to move her family to an isolated Native American reservation to accept a one-year teaching position at the reservation’s high school. Her vibrant 16 year-old son had some initial hesitancy about leaving his friends and athletic teams, but his out-going, adventurous nature convinced him it would be an exciting cross-cultural experience ...and may even assist him in getting accepted into a great college.

After getting settled, Joan was surprised she was the only white staff member at the school. She was relieved to be reading a few great books on how to teach Native American students, for the cultural differences she experienced were far greater than she anticipated.

Once the rush of the first few weeks pasted, Joan noticed her son’s dynamic, extraverted personality was very different from his classmates. In her class he was the only student to steadily ask questions, maintain eye contact, and interject differing perspectives. For the first time, his voice seemed louder than those around him. What she had always considered to be his strong “leadership skills” soon became an irritation among the staff. By October the staffs’ kindness to her began to wane. She could feel the tension in the air. Then, in early November the principle explained to Joan there was a meeting she needed to attend. The school wanted to refer her son for mental health services at the small, local Native American clinic.

Consider how Joan may respond.

What questions may she ask?
### Handout V-C: Cultural Values and Styles Scale

**Basketball Story**

In each row, use a ☐ to mark the values demonstrated by the first set of boys in the story. Use a ☐ to mark the values demonstrated by the second set of boys in the story.

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Source:
### Handout V-D: Cultural Values and Styles Scale II

#### Part 1

*In each row, mark the box that most closely identifies your values. Consider: Is there someone you admire who has differing values?*

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<tr>
<td>Direct communication style</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>Indirect communication style</td>
</tr>
<tr>
<td>Analytical, linear problem solving</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>Intuitive problem solving</td>
</tr>
<tr>
<td>Emphasis on individual performance</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>Emphasis on group performance</td>
</tr>
<tr>
<td>Communication primarily verbal</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>Communication primarily nonverbal</td>
</tr>
<tr>
<td>Emphasis on task and product</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>Emphasis on relationship and process</td>
</tr>
<tr>
<td>Openly express disagreement</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>Try to maintain group harmony</td>
</tr>
<tr>
<td>More comfortable with informal tone</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>More comfortable with formal tone</td>
</tr>
<tr>
<td>Value competition</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>Value collaboration</td>
</tr>
<tr>
<td>Prefer adherence to schedules</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>Prefer flexibility in adhering to schedules</td>
</tr>
</tbody>
</table>

Source:
Part 2

How do cultural values and styles translate into worldviews?

Since our perceptions are shaped by our view of the world, teachers and schools staff need to examine and understand how the see the world. One’s worldview is learned through socialization, from childhood to adulthood, and constantly reinforced by the culture in which we live. It is the taken-for-granted view of “the way things are” and most of the time unquestioned and invisible.

In each row, mark the box that most closely identifies your worldview.

- People are responsible for their own actions
- The outcome of events is beyond our control
- It is dishonest to give vague and tentative answers
- It is best to avoid direct and honest answers in order not to hurt or embarrass someone
- Intelligent, efficient people use time wisely and are always punctual
- Being punctual to work or meetings is not as important as spending time with family or close friends
- Stoicism is the appropriate way to grieve
- Loudly crying and moaning is the appropriate way to grieve
- The best way to gain information is to ask direct questions
- It is rude and intrusive to ask direct questions
- It is proper to call people by their first names to show that you are friendly
- It is disrespectful to call people by their first names unless they give you permission to do so
- It is rude not to look at a person who is speaking to you.
- It is rude to engage in direct eye contact with persons of higher status.

Adapted from Luckmann 1999

Source:
**Handout V-E: What Can You Do to Boost Multi-cultural Mental Wellness?**

**Teachers**
*Please use the left column to highlight areas you will focus on strengthening in the next 2 months.*

<table>
<thead>
<tr>
<th>Teacher – Family Communication</th>
<th>How are you already doing this?</th>
<th>What step(s) can you take to strengthen this area?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Invite parents and families to actively participate in their child’s education.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Beware that families from diverse linguistic or cultural backgrounds may not initiate requests for help or use in-school resources available to address mental health issues. Provide orientations to inform parents and families about school resources.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Extend opportunities for parent/family participation and information in a variety of ways (not exclusively forms/papers sent home with student).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Facilitate home-school communication and collaboration.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Teacher – Student Communication**

| ☐ Pronounce students’ names correctly and learn key phrases in their native language. |  |  |
| ☐ Allow students to share their thoughts, ideas and feelings through use of cooperative groups, role plays, dialogue journals and other forms of active and interactive learning. |  |  |
| ☐ Enhance students’ self-image, motivation and cultural pride by using culturally-relevant materials and encouraging discussion and actions that honor their cultural and linguistic heritage. |  |  |
| ☐ Learn as much as possible about the cultural and linguistic background of students you teach. Recognize that not all families will offer background/cultural information if it is solicited as a “fill in the form.” |  |  |

**Teacher – Staff Communication**

| ☐ Seek help from school psychologists or other school mental health professionals if students exhibit academic, behavioral and/or mental health problems. |  |  |
### School Counselors and Psychologists

*Please use the left column to highlight areas you will focus on strengthening in the next 2 months.*

<table>
<thead>
<tr>
<th></th>
<th>How are you already doing this?</th>
<th>What step(s) can you take to strengthen this area?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>Hold parent and family education workshops on child development and child and adolescent age appropriate mental health issues.</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Consult with teachers and families to provide information about in-school and community mental health resources for children and adolescents.</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>When necessary, provide group or individual counseling to students at-risk for mental health problems.</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Provide organized opportunities for students to develop a support system, e.g., peer mentoring.</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Connect students from culturally and linguistically diverse backgrounds with supportive and empathic children, particularly when the students with diverse backgrounds are new to the school and community.</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Help all children value multicultural environments and appreciate a multicultural world.</td>
<td></td>
</tr>
</tbody>
</table>
### All School Staff & Volunteers

*Please use the left column to highlight areas you will focus on strengthening in the next 2 months.*

| □ | Establish rapport and build trust through displays of respect and appropriate social greetings. | How are you already doing this? | What step(s) can you take to strengthen this area? |
| □ | Understand the attitudes about mental health issues, treatment, and help-seeking behaviors within different cultures represented in the student body. | | |
| □ | Use a problem-solving orientation that systematically considers cultural difference. | | |

---

**Source:**
**Handout V-F: Strengthening Cultural Competence in Schools**

Please use the left column to highlight areas you will focus on strengthening in the next 2 months.

<table>
<thead>
<tr>
<th>Principle</th>
<th>How are you already doing this?</th>
<th>What step(s) can you take to strengthen this area?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Principle 1</strong>&lt;br&gt;Maintain a referral base of multicultural professionals to direct students and families to.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Principle 2</strong>&lt;br&gt;Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Principle 3</strong>&lt;br&gt;Recognize the importance of culture and respect diversity. Ensure your school communicates a sense of acceptance and is welcoming of diverse groups (e.g. posters and pamphlets are representative of a variety of ethnic groups).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Principle 4</strong>&lt;br&gt;Ensure that teachers and staff receive cross-cultural education and training, and their effectiveness in providing culturally competent care is assessed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Principle 5</strong>&lt;br&gt;Maintain a current profile of the cultural composition of the school/community.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Principle 6**
Enhance efforts to recruit, retain, and promote staff/volunteers who are representative of the district/community area.

**Principle 7**
Work with community leaders who reflect the cultural diversity of youth at your school.

**Principle 8**
Ensure that services and information are culturally and linguistically competent. Offer and provide competent language assistance in a timely manner.

**Principle 9**
Develop a strategic plan that identifies the goals, policies, and plans to provide services to culturally diverse populations.

Sources:
(1) Cunningham, D. L., Ozdemir, M., Summers, J., & Ghunney, A. (August 2006). *Cultural competence and school mental health*. Baltimore, MD: Center for School Mental Health Analysis and Action, Department of Psychiatry, University of Maryland School of Medicine
Handout V-G: Additional Resources for Strengthening Cultural Competency

Cultural Competence and School Mental Health.
This 7-age brief presents an overview of why increasing cultural competency is critical for school mental health programs. It includes step-by-step recommendations for how schools can strengthen cultural competency to eliminate barriers to learning for minority students, as well as a resource list of useful websites for school personnel to consult.

Privilege: Unpacking the Invisible Knapsack
This essay is a classic anti-racism article that is widely used in trainings and journal articles to concretely articulate dynamics of Privilege in our everyday lives.

Power and Privilege in Schools.
The August issue of the newsletter Equity Matters presents an introductory discussion on how Power and Privilege manifests in schools. It includes recommended books, videos and links for school personnel working on this complex issue.

Psychological Treatment of Ethnic Minority Populations
This publication is a collaboration between four psychological organizations to present recommendations in working with specific racial/ethnic minority populations. It includes chapters specific to working with populations of Asian American/Pacific Islander, Latino/Hispanic, American Indian, and African descent.

The Safe Space Kit: Guide to Being an Ally to LGBT Students.
This user-friendly Guide provides practical tips to help educators create a safe space for LGBTQ students. It includes background information about LGBT students and anti-LGBT bias, concrete
tips for how to support LGBT students individually, and steps for making broader change at classroom and school-wide levels. A referral list for LGBT youth is included at the end of Guide.


*Just the facts about sexual orientation and youth: A primer for principals, educators, and school personnel.*
This 13-page booklet provides an overview of sexual orientation development in adolescence, the role of schools in protecting students’ legal right to equal treatment, as well as position statements from medical and mental health professional organizations regarding adolescent sexual orientation and therapy. The booklet is endorsed by national professional associations in the fields of pediatrics, education, psychology, and social work.


**Training Materials for Culturally Responsive Classrooms**
Equity Alliance offers free on-line training materials for building culturally responsive classrooms, as well as a range of other school-based trainings. Trainings include PowerPoint presentations, trainer’s guides and participant handouts.

Available from Equity Alliance, Arizona State University. http://www.equityallianceatasu.org

Additional training materials for Culturally Responsive Classrooms available from http://ea.niusileadscape.org/lc/Category/Culturally%20Responsive?order_by=&order_dir=ASC&current_page=4