Mental Illness in School-Aged Children

An Educator s Resource Guide

Upper Grand District School Board
Community Mental Health Clinic of Wellington/Dufferin
The Family Mental Health Network

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INTRODUCTION

All educators are familiar with students who exhibit inappropriate or negative behaviours. Such behaviours are frustrating for you to deal with, as an educator, and disabling for the students engaged in them. It may appear as willful behaviour, but for a special group of students, the behaviour results from psychiatric and/or psychological conditions and disorders. Although the age of onset for most of these disorders is during the late teens, doctors are seeing more and more younger children displaying symptoms of a major mental illness.

Current research indicates that early diagnosis and treatment of mental illness can lead to less frequent episodes and more successful long term outcomes. Educators, as trained and experienced observers, are in a unique position to facilitate this early diagnosis by providing detailed information on student behaviour for mental health care professionals. These psychiatrists and psychologists can then diagnose the specific disorder.

This manual is intended to be a quick reference to the types of mental illness and some common symptoms or signs you might observe. The manual is divided into five groups:

Affective Disorders, which include depression, bipolar or manic depression, and dysthymia.

Anxiety Disorders, which include obsessive-compulsive disorder, phobia, panic attack, separation anxiety, post-traumatic stress disorder, and generalized anxiety disorder.

Schizophrenia.

Eating Disorders, which include anorexia nervosa and bulimia nervosa

Substance Abuse Disorder.

We hope you find this guide useful in your learning environment.

Remember - mental illness can be treated.

HOPE

New Treatments Bring Hope to People with Mental Illnesses

The best prognosis for children and adolescents with mental illness comes from getting treatment quickly.

There are new and highly effective medications and treatments that allow people dealing with mental illness to live full and rewarding lives.

How to Help

Educators are in a good position to observe symptoms. However, it is important to consult with the resource staff, since many behaviours can result from a variety of causes.
At the school level consult with the Child/Youth Worker, Psychology staff or Social Worker as well as the administrative staff.
If educators feel the situation requires immediate attention, please indicate this to support staff.
After the consultation, the team may advise that a parent meeting be scheduled.
Families may get help from their family doctors or the Community Mental Health Clinic in their area (phone numbers are on the back page).
Educators legally can not make a diagnosis, but may suggest involvement with the resource staff.

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DID YOU KNOW?

Forty percent of people with schizophrenia attempt suicide and 10% are successful.

In Canada, one in ten high school students reported having thought about suicide at least once during the preceding week. (Jamison,1999).

Fifty-nine percent of manic-depressive patients reported symptoms of the illness during or before adolescence; however, half did not receive assistance for their illness for five years or more (National Depressive and Manic-Depressive Association, 1997).

Nine percent of children and between 13% and 17% of adolescents meet the criteria for an anxiety diagnosis (Patterson, Schaefer, Witt, & Young, 1999).

The behaviour of children with schizophrenia may change slowly over time. . . children who used to enjoy relationships with others may start to become more shy or withdrawn and seem to be in their own world. . . These early problems may first be noticed by the child s school teachers. (American Academy of Child & Adolescent Psychiatry, 1998).

Mental illness in children may be masked by another disorder such as, attention deficit hyperactivity disorder, delinquency, conduct disorder, substance abuse or physical complaints which seem to have no cause.

Approximately 51% of those with a lifetime mental illness also experience substance abuse disorder.

AFFECTIVE DISORDERS

Affective disorders include disorders which affect mood, such as depression, bipolar disorder (manic-depression) and dysthymia.

Studies show that at any one time 10% to 15% of the child and adolescent population suffers from some type of depression. The prevalence of full fledged major depression has been estimated at 5% of children aged 9 to 17. Dysthymic disorder has been estimated to occur in approximately 3% of adolescents.

Depression is the most frequently diagnosed mood disorder in children and adolescents, with an episode lasting an average of 7 - 9 months (Mental Health: A Report of the Surgeon General, 1999).

Dysthymic Disorder is a persistent, low level depression. The child or adolescent is typically depressed for most of the day, on most days and symptoms may continue for many years. The child or adolescent may feel that this mood is normal because of its duration and may not complain of being depressed.

Bipolar Disorder, also called Manic Depression, is characterized by mood swings from high, energetic, irritable moods to low, depressive moods. Bipolar disorder manifests itself differently in children and late adolescents. In children the cycling of moods is often so rapid (many times per day) that it appears that both moods are occurring at the same time. There also does not appear to be a time of wellness between the two moods. In late adolescence, there tend to be definite periods of highs or manias, with euphoria, racing thoughts, and/or irritability; and depression, which could manifest itself as a major depressive episode. There are typically periods of wellness in between the mania and depression.

Fifteen percent of those with *untreated* depression or bipolar disorder commit suicide.

DEPRESSION

Depression in children and adolescents may be difficult to recognize. It may be masked by other disorders such as Attention Deficit Disorder (ADD), hyperactivity, delinquency, or physical complaints which seem to have no cause. Also, temporary bouts of sadness are common in children as they are in adults (DIRECT, 2000). The diagnosis of a full-fledged major depression in children between the ages of nine and seventeen has been estimated at 5% (Mental Health: A Report of the Surgeon General, 1999).

Symptoms of Depression

Prolonged sadness
Lethargy
Apathy
Concentration and memory problems
Eating problems
Sleeping problems
Suicidal thoughts
Low self-esteem

Behaviours Typical of Depression

Complains of being too tired to do things and a physical ailment has been ruled out.
Withdraws from classmates and friends
Shows a marked decline in schoolwork or no longer finishes assignments
Has lost or gained a significant amount of weight, which is not attributable to a physical ailment
Complains of frequent headaches, stomachaches.
Preoccupation with death or suicide attempts

BIPOLAR DISORDER

Studies have reported that between one-fifth to one-fourth of children with Attention Deficit Hyperactivity Disorder (ADHD) have bipolar disorder or develop it later on (Steele & Fisman, 1997). Children with ADHD have the ability to calm themselves after a few minutes; children with bipolar disorder do not calm down quickly. Sleep disorders and irritability often occur with bipolar disorder (Papalos, 2000). The first episode of bipolar disorder tends to be depression. Adolescent bipolar disorder is similar to adult bipolar disorder. Adolescents experience longer periods of mania and depression than do children.

Symptoms of Bipolar Disorder

Mania

- Stubborn, reckless, oppositional and bossy behaviour
- Irritability and/or agitation
- Hyperactivity
- Grandiose ideas or thoughts
- Sleep disturbance
- Distractibility, shortened attention span and/or inability to concentrate
- Suicidal thoughts

Depression

See symptoms for depression, p.4

Behaviours Typical of Bipolar Disorder

Mania

- Speaks very rapidly and loudly
- School work may be done very quickly and creatively but often in a disorganized, chaotic fashion
- Exaggerated ideas about capabilities and importance
- Becomes promiscuous in dress and actions

DYSTHYMIC DISORDER

Dysthymic disorder is a low-grade, chronic depression. Children or adolescents may not realize they have a disorder because they do not remember feeling any differently. Seventy percent of children or adolescents with dysthymia go on to develop a major depression (Mental Illness: A Report of the Surgeon General, 1999). Children and adolescents with dysthymia show fewer symptoms than do those with major depression; however, it s chronic nature tends to interfere more with normal adjustment (Mental Illness: A Report of the Surgeon General, 1999). The treatment outcome for children and adolescents with dysthymia appears to be poorer than with other disorders.

Symptoms of Dysthymia

Unhappiness
Pessimism
Negativity
Hypersensitivity
Difficult to please

Behaviours Typical of Dysthymia

Rarely seems pleased with anything.
Shows no interest in school activities
Rarely completes homework or classroom assignments
Shows little energy for anything
Is withdrawn and has few, if any, friends

ANXIETY DISORDER

There are seven different types of anxiety disorders:

Phobia, extreme fear and/or avoidance of specific things or situations

Separation Anxiety, fear of separating from an attachment figure, that causes distress and affects social, academic or job functioning

General Anxiety Disorder, uncontrollable worry about a number of events or activities

Panic Attacks, unexpected and repeated periods of intense fear or discomfort, including racing heartbeat or feeling short of breath.

Post-Traumatic Stress Disorder, a specific psychological reaction that may occur in response to the experience of traumatic events; re-experiencing the trauma, avoiding reminders of the trauma; and/or continuous heightened arousal

Obsessive-Compulsive Disorder, persistent, recurrent thoughts which are frequently irrational or unrealistic, followed by repetitive behaviours or rituals which reduce the anxiety caused by the obsessive thoughts

Social Phobia, persistent fear of embarrassment in social situations, during a performance or speaking in class or in public.

The prevalence of anxiety disorders is higher than any other mental disorder occurring in children (Mental Illness: The Surgeon General s Report, 1999). During a one year period, 13% of all children aged 9 to 17 will suffer an anxiety disorder. These disorders may occur alone or in conjunction with other disorders, like bipolar disorder. Anxiety disorders appear in young children, although they may not fully develop until adolescence.

PHOBIA

A phobia is a persistent fear that is restricted to a certain object or event that is out of proportion to that stimulus. The situation is avoided whenever possible, or is endured with intense anxiety.

Symptoms of Phobia

Avoidant behaviour is associated with the phobia
Anticipatory anxiety or what if scenarios may be apparent
Fear or anxiety occurs every time the stimulus is encountered
Realization that their response to a situation is excessive or exaggerated

Behaviours Typical of Phobia

May feign illness to avoid a phobic situation
May cling to someone or something
May throw and temper tantrum
May fear fire drills, dogs, thunderstorms, large groups of people or injections

OBSESSIVE-COMPULSIVE DISORDER

Obsessive-compulsive disorder is characterized by recurrent, unwanted thoughts that cause considerable anxiety. The child or adolescent tries to control the anxiety by performing compulsive behaviours. The compulsions may be repeated thoughts or actions. This disorder usually begins in adolescence and is seen in 1 in 200 children and adolescents.

Symptoms of Obsessive-Compulsive Disorder

Unwanted, intrusive thoughts or images that are often inappropriate
Attempts to hide or suppress inappropriate thoughts
Repetition of an action to eliminate the unwanted thought or image
Repetitive behaviours are often logically unconnected to the obsessive thoughts
Repetitive behaviours are often counted

Behaviours Typical of Obsessive-Compulsive Disorder

Thoughts of being dirty or carrying germs may elicit repeated and excessive hand washing
May be repeatedly late because s/he must check and recheck that the door to her/his house is locked
Repeated erasure of work, often until page is worn through

PANIC ATTACK

Panic attacks are incidents of extreme fear which cause the fight or flight response. These incidents come on suddenly and without warning. Bodily sensations caused by the panic attack are often misinterpreted and aggravate the anxiety.

Symptoms of Panic Attack

Fear that something terrible is going to happen
Racing or pounding heartbeat
Dizziness or lightheadedness
Shortness of breath, trembling or shaking
Fear of losing control, going crazy, or dying

Behaviours Typical of Panic Attack

May appear anxious all of the time, even when not experiencing a panic attack
May avoid situations where a panic attack may occur
In severe cases, may avoid certain places or situations (agoraphobia)
May use alcohol or drugs to decrease anxiety

SEPARATION ANXIETY

About 4% of all children and young adolescents suffer from separation anxiety. Separation anxiety is equally distributed between boys and girls. (Mental Illness: The Surgeon General s Report, 1999). Separation anxieties are normal for very young children but inappropriate for older children or adolescents. This disorder often is associated with depression.

Symptoms of Separation Anxiety

Unrealistic and persistent fear of being away from an attachment figure (parents or others to whom the student is attached)
Fear of separation that is no longer age-appropriate
Unrealistic fear that a calamitous event will happen to the attachment figure while separated
Reluctant to face or avoids separating situations
Anticipation of separation causes distress

Behaviours Typical of Separation Anxiety

Clings to attachment figure when s/he is dropped off at school
Has a temper tantrum when s/he is dropped off at school
Refuses to go on school outings or trips if the attachment figure isn t able to go also
Feels the need to call home often during the day to check on attachment figure
May feign an illness at school to be with the attachment figure

SOCIAL PHOBIA

Students with social phobia suffer from a fear of social or performance situations which could be potentially embarrassing for them. The prevalence rate for social phobia or social anxiety disorder is estimated to be 4% and occurs equally in boys and girls (Wagner, 1999).

Symptoms of Social Phobia

Fear of any public performance such as reading aloud in class, writing on the blackboard, athletic or musical performances
Fear of social interactions such as starting a conversation, joining a conversation or speaking to an adult

Behaviours Typical of Social Phobia

Becomes sick to his/her stomach before performing in front of other people
Is unable to answer questions in class even though s/he is a capable student
Does not interact with peers or is unable to sustain a conversation
Gets frequent headaches and has to spend considerable time in the health room
In adolescence, these students may be at risk for substance abuse

POST TRAUMATIC STRESS DISORDER

Post Traumatic Stress Disorder (PTSD) is a psychological response to the experience of traumatic events (National Centre for War-Related PTSD, 1998). There are a number of different ways a child or adolescent can react to trauma. One or more of the symptoms of PTSD may be displayed.

Symptoms of Post Traumatic Stress Disorder

Loss of interest in activities
Sleep disorders
Physical symptoms such as headaches or stomach-aches
Sudden and extreme emotional reactions
Irritability or angry outbursts
Problems concentrating
Acting younger than his/her age (clingy, whiny behaviour or thumb sucking)

Behaviours Typical of Post Traumatic Stress Disorder

Engages in repetitive play that re-enacts the trauma
Becomes preoccupied with other traumatic events
Withdraws or wants to be alone
Loses interest in significant activities
School performance becomes poor or shows a loss of motivation
Has attention and concentration problems

GENERALIZED ANXIETY DISORDER

Students with generalized anxiety disorder are fearful of any number of upcoming events and occurrences. They worry excessively about everything. The prevalence rate of generalized anxiety disorder in the population as a whole is 3%.

Symptoms of Generalized Anxiety Disorder

Overly conforming behaviour
Perfectionistic behaviour
Need for constant reassurance and approval about the performance
Persistent worry even when the student isn t being judged on anything and has always performed well in the past

Behaviours Typical of Generalized Anxiety Disorder

Worries excessively about academic performance or athletic ability
Worries excessively about being on time
Worries excessively about natural disasters such as earthquakes
Tends to redo tasks if there are any imperfections

SCHIZOPHRENIA

Schizophrenia is an illness that causes strange thinking and feeling and unusual behaviour (American Academy of Child & Adolescent Psychiatry, 1998). Most children with schizophrenia show delays in language and other functions long before their psychotic symptoms appear (Rapoport, 1997). Children who used to enjoy relationships with others may start to become more shy or withdrawn and seem to be in their own world. These early problems may first be seen by the child s teacher (American Academy of Child & Adolescent Psychiatry, 1998). Approximately 1% of the total population has schizophrenia. However, schizophrenia in children under 12 is rare.

Paranoid schizophrenia appears with the same frequency in children and adults. The disease is similar to that seen in adults. However, the child or adolescent tends to hallucinate or have delusions from his/her experiences. For example, they may think that television villains are out to get them, or their parents aren t real but impersonators (Lott, 1999).

Childhood-onset schizophrenia is usually characterized by a slow onset . These children may show their first developmental problems between the ages of six and seven. They may meet one or more criteria for pervasive developmental disorder (PDD), such as lack of interest in peers, poor eye contact, motor stereotypes (such as arm and hand flapping) and odd speech, but do not meet full criteria for PDD or autism (Rapoport, 1999).

Both adult-onset schizophrenia and childhood-onset schizophrenia occur equally in males and females (Rapoport, 1997).

Symptoms of Schizophrenia

Flat emotions, lack of spontaneity
Difficulty functioning at work or school
Lack of close friends or confidants
Altered perceptions, such as hearing voices and seeing things
Confusion about what is real or imaginary
Odd thinking and speaking processes, talking about things irrelevant to context.
Problems with abstract thinking
Suspicion or paranoid thinking
Exaggerated self-opinion and unrealistic sense of superiority

Behaviours Typical of Schizophrenia

Talking about strange fears or ideas
Becoming more clingy towards parents
Saying things that don t make sense
Becoming more shy or withdrawn
Seeming to be in their own world
Decrease in facial expressions, monotone speech
Confusing television with reality
Attempting suicide

TOURETTE SYNDROME

Tourette Syndrome is a chronic tic disorder. A tic is defined as a repetitive involuntary movement or vocalization. In Tourette Syndrome the tics go through periods of worsening and improvement. It is identified by having more than one motor tic and at least one vocal tic (Packer, 2000). Tourette Syndrome usually begins between the ages of 3 and 10, with the worst symptoms occurring between the ages of 9 and 13. Over one half of the children suffering from Tourette Syndrome improve during the teen and early adult years. Tourette Syndrome can be accompanied by Attention Deficit Hyperactivity Disorder (ADHD), Obsessive Compulsive Disorder, and/or learning disabilities.

Symptoms of Tourette Syndrome

Uncontrollable, repetitive motor movements, sometimes including several parts of the body at the same time
Uncontrollable, repetitive vocalizations which may or may not accompany motor tics
Tics seem to occur in bouts, with waxing and waning of tics within a bout

Behaviours Typical of Tourette Syndrome

Repetitive, unconscious movement involving one or more parts of the body, such as eye blinking, twitching, jumping, or touching objects or people
Repetitive, unconscious vocalizations such as humming, throat clearing, grunting, sniffing, or coughing
Repeating phrases or words, sometimes inappropriate, without the corresponding emotions associated with them

EATING DISORDERS

There are many different types of eating disorders, but the two most common ones are anorexia nervosa and bulimia nervosa. Eating disorders are rampant in Western culture, where food is plentiful. They are rarely found in countries, where food is scarce.

A study, at a major Canadian eating disorder centre, revealed that referral rates for anorexia nervosa increased slowly between 1975 and 1986 whereas those for bulimia nervosa rose from virtually none in 1975 to 140 per year in 1986 (Durand & Barlow, 1997).

These disorders tend to be most prevalent in young females. Ninety to 95% of cases fall within that group. However, doctors are now seeing an increase in cases from young males. Although, males are more apt to hide their eating disorders.

Between 40% and 96% of all eating disordered patients experience depression and anxiety. It is not clear whether the mental illness causes and/or results from eating disorders. The long-term prognosis for eating disorders is dependent on the type of the disorder. People with bulimia nervosa undergoing therapy, have a 1% to 3% mortality rate. Another study found that 20% of women with bulimia were still battling the disease after ten years (Well-Connected, 1999). The long-term prognosis for anorexia nervosa is not as good. To date, there is no one effective treatment for anorexia nervosa. Although 60% of people with anorexia recover after treatment, many remain very thin and still display traits of the disorder, which could keep them at risk for recurrence. Studies of anorexic patients have reported death rates among those not treated at 20% (ANRED, 1998b). Suicide has been estimated, in some studies, to comprise as many as half of the deaths of anorexic women. Males with anorexia are at particularly high risk for life-threatening illness, perhaps because they are diagnosed later than females (Well-Connected, 1999).

Student athletes are also at high risk for eating disorders. One study of male and female athletes found that 1/4 were binge eating at least once per week and more than 5% actually gorged and became nauseated (ANRED, 1998a).

ANOREXIA NERVOSA

Anorexia nervosa leads to a state of starvation, where a person loses between 15% and 60% of their body weight. Anorexia is broken into two types: anorexia restrictor or anorexia bulimia. Approximately one half of people with anorexia are anorexia restrictors who reduce their weight by severe dieting. The other half are anorexia bulimics who maintain their emaciation by purging the food from their bodies by inducing vomiting and/or overusing laxatives. Although both types of anorexia are serious, anorexia bulimia is much more damaging to the body (Well-Connected, 1999).

Symptoms of Anorexia Nervosa

Student refuses to maintain normal body weight and for their age and height
Student denies the dangers of low weight
Student is terrified of becoming fat
Student is terrified of gaining weight even if s/he is normal weight

Behaviours Typical of Anorexia Nervosa

Tends to skip meals or eat only a small amount
Always has a diet pop in hand
Wears baggy clothes, often in layers, to hide fat, to hide emaciation and to stay warm
Spends lots of time in front of a mirror and usually finds something about themselves to criticize
Becomes irrational, argues with people who try to help, then withdraws, sulks or throws a temper tantrum
Has trouble concentrating
Holds to rigid, perfectionist standards for self and others

BULIMIA NERVOSA

Bulimia nervosa is more common than anorexia. It is characterized by bingeing and purging. Bulimia nervosa usually begins in early adolescence when teenagers attempt restrictive diets, fail and react by binge eating. People with bulimia then purge the food by inducing vomiting, overusing laxatives, diet pills or drugs to reduce fluids. They may revert to restrictive dieting which cycles back to bingeing if they do not go on to become anorexic. Fourteen binge-purges per week are common. Their body weight will be normal or high if the illness does not progress on to anorexia. However, their body weight may fluctuate by more than 10 pounds due to the binge-purge cycle. Estimates of the prevalence of bulimia nervosa among young women range from 3% to 10%. Because people with bulimia often hide their purging and do not become noticeably overweight, this problem could be grossly underestimated (Well-Connected, 1999).

Symptoms of Bulimia Nervosa

Begins binge eating
Vomits, misuses laxatives, exercise or fasts to get rid of calories
Diets when not bingeing. Becomes hungry and binges again
Believes self-worth requires them to be thin
Weight may be normal or near normal unless anorexia is also present

Behaviours Typical of Bulimia Nervosa

Student has great difficulty discussing feelings, which may include anxiety, depression, self-doubt, shame and deeply buried anger
Student excuses self from the table to vomit
Student has problems with lack of impulse control that can lead to rash decisions about money, stealing, commitments, careers and all forms of social risk taking

SUBSTANCE ABUSE DISORDER

Alcohol or a substance abuse can result in a failure to fulfill obligations at school, work or home; or lead to hazardous situations, such as driving a car while under the influence, recurrent substance-related legal problems; and/or breakdown in relationships with family and friends.(American Psychiatric Association, 1994). Those most at risk for serious alcohol and drug problems may have any or all of the following: a family history of substance abuse, a mental illness, or low self-esteem.

Symptoms of Substance Abuse Disorder

Fatigue, repeated health complaints, red and glazed eyes, a lasting cough
Irritability, low self-esteem, sudden mood changes
Decreased interest in school
Changes to less conventional styles in dress and music
A general lack of interest in anything

Behaviours Typical of Substance Abuse Disorder

Irresponsible behaviour, poor judgement
Starting arguments
Breaking rules, discipline problems
Drop in grades
Truancy
New friends who are less interested in standard home and school activities
Problems with the law

REFERENCES

American Academy of Child & Adolescent Psychiatry. (1998). Schizophrenia in children. Facts for Families #49. [On-line]. Available: http://www.aacap.org/publications/factsfam/schizo.htm

American Academy of Child & Adolescent Psychiatry. (1997). Schizophrenia in children. Harvard Mental Health Letter, Dec. 1997. [On-line]. Available: http://schizophrenia.nami.org/youth/skzphrn.htm

American Academy of Child and Adolescent Psychiatry. (1998). Teens: Alcohol and other drugs. Facts for Families #3. [On-line]. Available: http://www.aacap.org/publications/factsfam/teendrug.htm

American Psychiatric Association. (1994). Alcohol/substance abuse: Symptoms. Diagnostic and statistical manual of mental disorders, fourth edition. [On-line]. Available: http://www.mentalhelp.net/disorders/sx15.htm.

ANRED: Anorexia Nervosa and Related Eating Disorders. (1998a). Athletes with eating disorders: Overview [On-line]. Available: http://www.anred.com/ath-intro.html

ANRED: Anorexia Nervosa and Related Eating Disorders. (1998b). Statistics: How many people have eating and exercise disorders? [On-line]. Available: http://www.anred.com/stats.html

DIRECT - Depression and Anxiety Information Resource and Education Centre. (2000). Children and depression. [On-line]. Available: http://www.fhs.mcmaster.ca/direct/depress/pb233.html

Durand, V.M. & Barlow, D.H. (1997). Abnormal Psychology: An Introduction. Pacific Grove: Brooks/Cole Publishing Company.

Jamison, K.R. (1999). Night falls fast: Understanding suicide. New York: Alfred A. Knopf.

Lott, D.A. (1999). Childhood-onset schizophrenia: Latest NIMH findings. Psychiatric Times. XVI, (9). [On-line]. Available: http://www.mhsource.com/pt/pt990973.html.

Mental Health: A Report of the Surgeon General. Chapter 3: Children and Mental Health. (1999). [On-line]. Available: http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec5.html

National Center on Addiction and Substance Abuse at Columbia University. (1999). CASA study reveals dangerous connection between teen substance abuse and sex. [On-line]. Available: http:// www.casacolumbia.org/newsletter1457/newsletter_show.htm?doc_id=21642

National Centre for War-Related PTSD. (1998). Post traumatic stress disorder general information: trauma reactions in children. National Centre Brochures #6. [On-line]. Available: http://www.ncptsd.unimelb.edu.au/resources/brochures/brochure6.html

National Depressive and Manic-Depressive Association. (1997). A Guide to Depressive and Manic-Depressive Illness: Diagnosis, Treatment and Support. National Depressive and Manic-Depressive Association pamphlet.

Packer, L.E. (1999, Nov.). Primer on Tourette. [On-line]. Available: http://www.tourettesyndrome.net/faq.htm

Papolos, D.F., (2000, Feb.). Facts About Childhood-Onset Bipolar Disorder. [On-line]. Available: http://www.bpkids.org/printing/003.htm

Patterson, J., Schaefer, J., Witt, K., & Young, R., (1999). Teaching Highly Anxious Children: A Resource Guide. Waterloo Region District School Board.

Rapoport, J.L., (1997). What is known about childhood schizophrenia. Harvard Mental Health Letter, Dec. 1997. [On-line]. Available: http://schizophrenia.nami.org/youth/skzphrn.htm

Rapoport, J.L., et al. (1999). Progressive cortical change during adolescence in childhood-onset schizophrenia. Archives of General Psychiatry, 56 (7). pp. 649-654.

Steele, M. & Fisman, S. (1997). Bipolar disorder in children and adolescents: Current challenges. Canadian Journal of Psychiatry, 42. 632-636.

Wagner, K.D. (1999). Unspoken suffering: Social anxiety disorder in children. Psychiatric Times XVI. 9. [On-line]. Available: http://www.mhsource.com:80/pt/p990966.html

Well-Connected. (1999). Eating disorders: anorexia and bulimia nervosa. [On-line]. Available: http://www.noah.cuny.edu/wellconn/eatdisorders.html

WORLD WIDE WEB SITES

First Episode Psychosis

www.clarke-inst.on.ca/care/prime_clinic.html
www.psychiatry.unc.edu/steps/wsigns.htm

Children and Depression

www.fhs.mcmaster.ca/direct/depress/pb233.html
www.webofcare.com
www.ldanatl.org/articles/seab/weinberg/table1.html

Children and Bipolar Disorder

www.bpkids.org/printing/about.htm
www.bpkids.org/printing/003.htm
www.ldanatl.org/articles/seab/weinberg/table2.html
www.aacap.org/publications/factsfam/bipolar.htm
www.nami.org:80/cgi-bin/printfyl.cgi?/nami/www/youth/bipolar.html
www.nami.org:80/cgi-bin/printfyl.cgi?/nami/www/research/childrens.html

Children and Anxiety Disorders

www.aacap.org/publications/factsfam/ocd.htm
www.nami.org:80/cgi-bin/printgyl.cgi?/nami/www/disorder/ocd-adol.html
www.aacap.org/publications/factsfam/panic.htm
www.mhsource.com:80/pt/p990966.html
www.ncptsd.unimelb.edu.au/resources/brochures/brochure6.html
www.aacap.org/publications/factsfam/ptsd70.htm
www.fhs.mcmaster.ca/direct/anxiety/page8b.html

Children and Schizophrenia

health.excite.com/content/article/1728.51014
www.aacap.org/publications/factsfam/schizo.htm
www.mhsource.com/pt/p990973.html
schizophrenia.nami.org/yourh/skzphm.htm
www.chovil.com

Tourette Syndrome

www.tourettesyndrome.net/faq.htm
www.aacap.org/publications/factsfam/tics.htm
www.tourette.ca/articles/article2.html

Eating Disorders

www.noah.cuny.edu/wellconn/eatdisorders.html
eatingdisorders.mentalhelp.net
healthlink.mcw.edu/article/901290364.html
www.anred.com

Substance Abuse Disorder

mentalhelp.net/disorders/sx15.htm
www.casacolumbia.org/newsletter1457/newsletter_show.htm?doc_id=21642
www.samhsa.gov/press/99/990623nr.htm
www.aacap.org/publications/factsfam/teendrug.htm

BOOKS

Mental Illness

Carter, R, & Golant S.K. (1998). Helping someone with mental illness. Times Books.

Lafond, V. (1994). Grieving Mental Illness. Toronto: University of Toronto Press

Suicide

Jamison, K.R. (1999). Night falls fast: Understanding suicide. New York: Alfred A. Knopf.

Depression

Fassler, D.G. & Dumas, L.N.. (1998). Help me I m sad : Recognizing, treating and preventing childhood and adolescent depression. U.S.A.: Penguin Books.

Jamison, K.R. (1997). An unquiet mind. New York: Alfred A. Knopf.

Steele, D. (1998). His bright light: The story of Nick Traina. Delacourt Press.

Wurtzel, E. (1997). Prozac nation: Young and depressed in America: A memoir. Riverhead Books.

Anxiety Disorders

Johnston, H.F. (1997). Obsessive compulsive disorder in children and adolescents: A Guide. Dean Foundation.

March, J.S. (Ed.) (1995). Anxiety disorders in children and adolescents Guilford Press.

Marshall, J.R. (1995). Social phobia: From shyness to stage fright. Basic Books.

Soloman, J. & Carol G. (Eds.) (1999). Attachment disorganization. Guilford Press.

Schizophrenia

Friedman, M. (2000). Everything you need to know about schizophrenia. Rosen Publishing Group.

Torrey, E. F. (1995). Surviving schizophrenia: A manual for families, consumers, and providers. New York: Harper Collins.

Tourette Syndrome

Comings, D. (1990). Tourette syndrome and human behavior. Paperback.

Dornbush, M.P. & Pruitt S.K. (1995). Teaching the tiger: A handbook for individuals involved in the education of students with attention deficit disorders, tourette syndrome or obsessive compulsive disorder. Paperback.

Moe, B. (2000). Coping with tourette syndrome and tic disorders. Library Binding.

Eating Disorders

Buckroyd, J. (1996). Element guide to eating disorders. Penguin Books of Canada, Ltd.

Claude-Pierre, P. (1997). The secret language of eating disorders. Random House of Canada.

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OTHER RESOURCES

Community Mental Health Clinic
http://www.freespace.net/~cmhc

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Guelph, Ontario N1E 4J3
(519) 821-2060

Fergus Clinic
234 St. Patrick Street East
Fergus, Ontario N1M 1M6
843-5742/1-800-265-7723

Arthur Clinic
131 Frederick Street West, Box 645
Arthur, Ontario N0G 1A0

Erin Clinic
45 Main Street, Box 786
Erin, Ontario N0B 1T0

Mt. Forest Clinic
392 Main Street North, Suite 2
Mt. Forest, Ontario N0G 2L2

Orangeville Clinic
10 First Street (2nd Floor)
Orangeville, Ontario L9W 2C4

Palmerston Clinic
600 Whites Road
Palmerston, Ontario N0G 2P0

Canada Mental Health Association Wellington Office
147 Wyndham Street North
Guelph, Ontario N1H 4E9
836-6220

Dufferin Office
162 Broadway, Unit 15
Orangeville, Ontario L9W 1K3
938-8776

Guelph Distress Centre
821-3760
Toll Free 1-888-821-3760

Homewood Health Centre
150 Delhi Street
Guelph, Ontario N1E 6K9
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Community Alcohol and Drug Services
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