Children's Mental Health Disorder Fact Sheet for the Classroom[1]

Disorder	Symptoms or Behaviors	About the Disorder	Educational Implications	Instructional Strategies and Classroom Accommodations
Anxiety	▪ Frequent Absences ▪ Refusal to join in social activities ▪ Isolating behavior ▪ Many physical complaints ▪ Excessive worry about homework/grades ▪ Frequent bouts of tears ▪ Fear of new situations ▪ Drug or alcohol abuse	All children feel anxious at times. Many feel stress, for example, when separated from parents; others fear the dark. Some though suffer enough to *interfere with their daily activities.* Anxious students may lose friends and be left out of social activities. Because they are quiet and compliant, the signs are often missed. They commonly experience academic failure and low self-esteem. As many as 1 in 10 young people suffer from an AD. About 50% with AD also have a second AD or other behavioral disorder (e.g. depression). Adolescent girls are more affected than boys. Etiology is unknown (biological or environmental) but studies suggest that young people are at greater risk if their parents experienced AD. The most common anxiety disorders are:[2] ▪ **Generalized:** extreme, unrealistic worry unrelated to recent events. They are often self-conscious and tense; they may suffer from aches and pains that appear to have no physical basis. ▪ **Phobias:** unrealistic and excessive fears. Specific phobias center on animals, storms, or situations such as being in an enclosed space. ▪ **Panic Disorder:** repeated attacks of intense fear w/o apparent cause. They may be accompanied by pounding heartbeat, nausea or a feeling of imminent death. Some may go to great lengths to avoid the attacks (such as refusing to attend school). ▪ **Obsessive Compulsive Disorder:** being trapped in a pattern of repetitive thoughts and behaviors. These may include hand washing, counting, or arranging and rearranging objects. ▪ **Post Traumatic Stress Disorder:** experiencing strong memories, flashbacks, or troublesome thoughts of traumatic events. These may include events of abuse, violence and/or disaster. They may try to avoid anything associated with event. They may over-react when startled or have sleep disorders.	Students are easily frustrated and may have difficulty completing work. They may suffer from perfectionism and take much longer to complete work. Or they may simply refuse to begin out of fear that they won't be able to do anything right. Their fears of being embarrassed, humiliated, or failing may result in school avoidance. Getting behind in their work due to numerous absences often creates a cycle of fear of failure, increased anxiety, and avoidance, which leads to more absences. Furthermore, children are not likely to identify anxious feelings, which may make it difficult for educators to fully understand the reason behind poor school performance.	▪ Allow students to contract a flexible deadline for worrisome assignments. ▪ Have the student check with the teacher or have the teacher check with the student to make sure that assignments have been written down correctly. Many teachers will choose to initial an assignment notebook to indicate that information is correct. ▪ Consider modifying or adapting the curriculum to better suit the student's learning style-this may lessen his/her anxiety. ▪ Post the daily schedule where it can be seen easily so students know what to expect. ▪ Encourage follow-through on assignments or tasks, yet be flexible on deadlines. ▪ Reduce school workload when necessary. ▪ Reduce homework when possible. ▪ Keep as much of the child's regular schedule as possible. ▪ Encourage school attendance- to prevent absences, modify the child's class schedule or reduce the time spent at school. ▪ Ask parents what works at home. ▪ Consider the use of technology. Many students will benefit from easy access to appropriate technology, which may include applications that can engage student interest and increase motivation (e.g. computer assisted instruction programs, CD-ROM demonstrations, videos).
Asperger's Syndrome	▪ Adult-like pattern of intellectual functioning and interests, combined with social and communication deficits ▪ Isolated from peers ▪ Rote memory is usually quite good; they may excel in math and science ▪ Clumsy or awkward gait ▪ Difficulty with physical activities and sports ▪ Repetitive pattern of behavior ▪ Preoccupations with 1 or 2 subjects or activities ▪ Under or over sensitivity to stimuli such as noise, light, or unexpected touch ▪ Victims of teasing and bullying	Asperger's is a subset of the autism spectrum disorders. Before our knowledge base expanded it was referred to as "high functioning autism." It is a neurobiological disorder that impacts behavior, sensory systems, and visual and auditory processing. Students are usually highly verbal and test average to above-average IQ's. The disorder impacts cognition, language, socialization, sensory issues, visual processing and behavior. There is often a preoccupation with a single subject or activity. They might also display excessive rigidity (resistance to change), nonfunctional routines or rituals, repetitive motor movements, or persistent preoccupation with a part of an object rather than functional use of the whole (i.e. spinning the wheels of a toy car rather than "driving" it around). The most common characteristic occurs with impairment of social interactions, which may include failure to use or comprehend nonverbal gestures in others, failure to develop age-appropriate peer relationships and a lack of empathy.	Many youth with Asperger's have difficulty understanding social interaction, including nonverbal gestures. Forming age-appropriate relationships and displaying empathy are challenges. When confronted with change to routine they may show visible anxiety, withdraw into silence or burst into a fit of rage. They may be very articulate but can be very literal and have problems using language in a social context. They may like school, but wish the other children weren't there.	▪ Create structured, predictable, and calming environments. Consult an occupational therapist for sensory needs suggestions. ▪ Foster a climate of tolerance and understanding. Consider assigning a peer helper to help in joining group activities and socializing. Teasing should not be allowed. ▪ Celebrate the student's verbal and intellectual skills. ▪ Use direct teaching to increase socially acceptable behavior. Demonstrate the impact of words and actions on others; increase the awareness of non-verbal cues. ▪ Create a standard way of presenting change in advance. ▪ Learn the usual triggers and warning signs of a rage attack or "meltdown." Help them learn self-management. ▪ Remain calm and non-judgmental. ▪ Help support parents, some may feel professionals are blaming them for "poor parenting" skills.

[1] Minnesota Association for Children's Mental Health, St. Paul Minnesota, www.macmh.org.
[2] U.S. Department of Health and Human Services, 2007.

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Disorder	Symptoms or Behaviors	About the Disorder	Educational Implications	Instructional Strategies and Classroom Accommodations
Attention-Deficit/ Hyperactivity Disorder (AD/HD)	3 forms of AD/HD ▪ **Inattentive disorder** ▪ Short attention span ▪ Problems with organization ▪ Failure to pay attention ▪ Easily distracted ▪ Trouble listening even when spoken to directly ▪ Failure to finish work ▪ Makes lots of mistakes ▪ Forgetful ▪ **Hyperactive-impulsive disorder** ▪ Fidget and squirm ▪ Difficulty staying seated ▪ Runs around and climbs on things excessively ▪ Trouble with playing quietly ▪ Be "on the go" as if "driven by a motor" ▪ Talk too much ▪ Blurt out answers before question is completed ▪ Has trouble "taking turns" in activities ▪ Interrupts or intrudes on others Children with combined **attention-deficit/ hyperactivity disorder** show symptoms of both**.**	Youth with AD/HD may be overactive. And be able to pay attention on task. They tend to be impulsive and accident-prone. They may answer questions before raising their hand, forget things, fidget, squirm or talk too loudly. On the other hand, some students with this disorder may be quiet and "spacey" or inattentive, forgetful and easily distracted. **Symptoms may be situation-specific.** For example, students with AD/HD may not exhibit some behaviors at home if that environment is less stressful, less stimulating or is more structured than school. Or students may stay on task when doing a project they enjoy, such as art. An estimated 5% of children have a form of AD/HD. More boys are diagnosed than girls; it is the leading cause of referrals to mental health professionals, SPED, and juvenile justice programs. Students with ADD only, tend to be overlooked or dismissed as "quiet and unmotivated" because they can't organize their work on time. Students with AD/HD are at higher risk for learning disorders, anxiety disorder, conduct disorder, and mood disorders such as depression. Without proper treatment children are at high risk for school failure. They may also have difficulty maintaining friendships, and their self-esteem will suffer from experiencing frequent failure because of their disability. If you suspect AD/HD refer the student for mental health assessment. Many will benefit from medication. This must be managed by an experienced mental health professional (psychiatrist, pediatrician, neurologist) in treating AD/HD. Multi-disciplinary approaches that include family, school and mental health can prove successful. Children identified at an early age should be monitored because changing symptoms may indicate related disorders such as bipolar depression, Tourette's disorder, or underlying conditions such as FASD (Fetal Alcohol). Remember that AD/HD is a neurobiological disorder. Students can't get organized or learn social skills on their own, but you can find interventions that greatly increase their capacity to succeed.	Students may experience fluctuations in mood, energy, and motivation. These fluctuations may occur hourly, daily, in specific cycles, or seasonally. As a result, a student with bipolar disorder may have difficulty concentrating and remembering assignments, understanding assignments with complex directions, or reading and comprehending long, written passages of text. Students may experience episodes of over-whelming emotion such as sadness, embarrassment or rage. They may also have poor social skills and have difficulty getting along with their peers.	▪ Provide the student with recorded books as an alternative to self-reading when the student's concentration is low. ▪ Break assigned reading into manageable segments and monitor the student's progress, checking comprehension periodically. ▪ Devise a flexible curriculum that accommodates the sometimes rapid changes in the student's ability to perform consistently in school. ▪ When energy is low, reduce academic demands; when energy is high, increase opportunities for achievement. ▪ Identify a place where the student can go for privacy until he/she regains self-control. *- These suggestions are from the Child and Adolescent Bipolar Foundation. For more suggestions, consult the Foundation web site at www.bpkids.org. This site is a rich resource for teachers.*
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Bipolar Disorder	▪ Expansive or irritable mood ▪ Depression ▪ Rapidly changing mood lasting a few hours to a few days ▪ Explosive, lengthy and often destructive rages ▪ Separation anxiety ▪ Defiance of authority ▪ Hyperactivity, agitation and distractibility ▪ Strong and frequent cravings, often for carbohydrates and sweets ▪ Excessive involvement in multiple projects and activities ▪ Impaired judgment, impulsivity, racing thoughts ▪ Dare-devil behavior ▪ Inappropriate or precocious sexual behavior ▪ Delusions, hallucinations, grandiose beliefs	Also know as manic-depressive illness, bipolar disorder, is a brain disorder that causes unusual shifts in a person's mood energy, and ability to function. The symptoms are severe and can result in damaged relationships, poor job or school performance, and even suicide. More than 2 million adults (1% of the population18 and older) in any given year have bipolar. Children and adolescents can also develop the disorder. Like diabetes, or heart disease, it is a long term illness that requires careful management. Youth with the illness experience very fast mood swings between depression and mania many times a time. Manic children are more likely to be irritable and prone to destructive tantrums than to be happy or elated. Older adolescents tend to develop classic, adult-type episodes and symptoms. Bipolar disorder in youth is often hard to differentiate from symptoms of other disorders (e.g. drug abuse). Effective treatment requires appropriate evaluation and diagnosis. Adolescents with bipolar are at higher risk of suicide. Any talk about of feelings of suicide require immediate referral.	Students may experience fluctuations in mood, energy, and motivation. They may occur hourly, daily, in specific cycles, or seasonally. As a result, a student with bipolar may have difficulty concentrating and remembering assignments, understanding assignments with complex directions, or reading and comprehend-ing long passages of text. Students may experience episodes of overwhelming emotion such as sadness, embarrassment, or rage. They may also have poor social skills and have difficulty getting along with their peers.	▪ Provide the student with recorded books as an alternative to self-reading when the student's concentration is low. ▪ Break assigned reading into manageable segments and monitor the student's progress checking comprehension periodically.. ▪ Devise a flexible curriculum that accommodates the sometimes rapid changes in the ability to perform consistently in school. ▪ When energy is low, reduce academic demands; when energy is high, increase opportunities for achievement. ▪ Identify a place where the student can go for privacy until he or she regains self-control. *- These suggestions are from the Child and Adolescent Bipolar Foundation. For more suggestions, consult the Foundation web site at www.bpkids.org. This site is a rich resource for teachers.*

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Conduct Disorder (CD)	▪ Bullying or threatening classmates and others ▪ Poor attendance record or chronic truancy ▪ History of frequent suspension ▪ Little empathy for others and a lack of appropriate feelings of guilt and remorse ▪ Low self-esteem masked by bravado ▪ Lying to peers or teachers ▪ Stealing from peers at school ▪ Frequent physical fights; use of a weapon ▪ Destruction of property	Youth with conduct disorder are highly visible, demonstrating a complicated group of behavioral and emotional problems. Serious, repetitive, and persistent misbehavior is the essential feature. These behaviors fall into 4 main groups: 1) aggressive behavior toward people or animals 2) destruction of property 3) deceitfulness/theft and 4)serious violations of rules. To receive a diagnosis, the youth must have displayed 3 or more characteristic behaviors in the past 12 months. At least 1 must have been evident during the part 6 months. Diagnosing can be a dilemma because youth are constantly changing. Many children with CD also have learning disabilities and about 1/3 are depressed. Many stop exhibiting the behavior problems when treated for depression. USDHHS estimate between 6 and 16% of males and 2 to 9% of females under 18 have CD that ranges in severity from mild to severe. Other disorders associated with CD are AD/HD or oppositional defiant (ODD). The majority of youth with CD may have life-long patterns of anti-social behavior and are at higher risk for mood or anxiety disorder. But for many, the disorder may subside in later adulthood. Social context (poverty, high crime) may influence what we view as anti-social behavior. In these cases, CD may be misapplied to individuals whose behaviors may be protective or exist within cultural context. A child with suspected CD needs to be referred for assessment. If symptoms are mild, the child may receive services and remain in the school environment. More seriously troubled youth, however, may need more specialized educational environments.	Students with CD like to engage in power struggles. They often react badly to direct demands or statements such as: ”You need to…” or “You must…” They may consistently challenge class rules, refuse to do assignments, and argue or fight with other students. This behavior can cause significant impairment in both social and academic functioning. They also work best in environments with high staff/student ratios, 1-1 situations, or self-contained programs when there is plenty of structure and clearly defined guidelines. Their frequent absences and their refusal to do assignments often leads to academic failure.	▪ Make sure curriculum is at an appropriate level. Frustration sets in easily if too hard; boredom if it is too easy. Both will lead to problems in the classroom. ▪ Avoid “infantile” materials to teach basic skills. Materials should be age appropriate, positive, and relevant to problems in the classroom. ▪ Consider using technology. Computers with active program tend to work well with CD. ▪ Students with CD tend to work well in programs that allow them to work outside the school setting. ▪ Be aware that adults can unconsciously form and behaviorally express negative impressions of low-performing, uncooperative students. Try to monitor your impressions, keep them neutral as possible, communicate a positive regard for students, and give them the benefit of the doubt whenever possible. ▪ Youth with CD like m to argue. Maintain calm, respect, and detachment. Avoid power struggles and arguments. ▪ Give students options. Stay away from direct demands or statements such as: “You need to…” or “you must.” ▪ Avoid escalating prompts such as shouting, touching, nagging, or cornering a student. ▪ Establish clear and consistent rules. Rules should be few, fair, clear, displayed, taught and consistently enforced. Be clear about what is non-negotiable. ▪ Have your students participate in the establishment of rules, routines, schedules, and expectations. ▪ Teach social skills such as anger management, conflict resolution skills and appropriate assertiveness.
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Depression	▪ Sleeping in class ▪ Defiant or disruptive ▪ Refusal to participate in activities ▪ Not turning in homework assignments, failing tests ▪ Excessive tardiness ▪ Fidgety or restless, distracting other students ▪ Isolating, quiet ▪ Frequent absences ▪ Failing grades ▪ Refusal to do school work and general non-compliance with rules ▪ Talks about dying or suicide	All children feel blue or sad at times, but feelings of sadness with great intensity that persist for weeks/months may be a symptom of major depressive disorder or dysthymic disorder (chronic depression). These disorders affect a young person’s thoughts, feeling, behavior, body and can lead to school failure, alcohol/drug abuse and even suicide. Recent studies reported by USDHHS show that as many as 1 in every 33 children may have depression; among adolescents, the ratio may be as high as 1 in 8. Boys appear to suffer earlier in childhood. During adolescence, the illness is prevalent among girls. Depression is hard to diagnose, more difficult to treat, more severe, and more likely to reoccur than adult forms. Depression also affects a child’s development. A depressed child becomes “stuck” and unable to pass through normal developmental stages. Common symptoms are: ▪ Sadness that won’t go away ▪ Hopelessness ▪ Irritability ▪ School avoidance ▪ Changes in sleeping and eating patterns ▪ Frequent complaints of aches and pains ▪ Thoughts of death or suicide ▪ Self-deprecating remarks ▪ Persistent boredom, low energy, or poor concentration ▪ Increased activity	Students experiencing depression may display a marked change in their interest in schoolwork and activities. Their grades may drop significantly due to lack of interest, loss of motivation, or excessive absences. They may withdraw and refuse to socialize with peers or participate in group projects.	▪ Reduce some classroom pressures. ▪ Break tasks into smaller parts. ▪ Reassure students that they can catch up. Show them the steps they need to take and be flexible and realistic about your expectations. (School failures and unmet expectations can exacerbate the depression). ▪ Help students use realistic and positive statements about their performance and outlook for the future. ▪ Help students recognize and acknowledge positive contributions and performance. ▪ Depressed students may see issues in black and white terms- all bad or all good. It may help to keep a record of their accomplishments that you can show to them occasionally. ▪ Encourage gradual social interaction (i.e. small group work). ▪ Ask parents what would be helpful in the classroom to reduce pressure or motivate the child. *This fact sheet must not be used for the purpose of making a diagnosis. It is to be used only as a reference for your own understanding and to provide information about different kinds of behaviors and mental health issues you may encounter in the classroom.*

		Students who used to enjoy playing with friends may now spend most of their time alone or they may start "hanging out" with a completely different peer group. Activities that were once fun hold no interest. They may talk about dying or suicide. Depressed teens may "self-medicate" with alcohol or drugs. Children who cause trouble at home or at school may actually be depressed, although they may not seem sad. Younger children may pretend to be sick, be overactive, cling to their parents, seem accident prone, or refuse to go to school. Older children and teens often refuse to participate in family and social activities and stop paying attention to their appearance. They may also be restless, grouchy, or aggressive. Most mental health professionals believe that depression has a biological origin. Research indicates that children have a greater chance of developing depression if one or both of their parents suffered from this illness.		**Resources:** The Council for Exceptional Children: www.cec.sped.org National Institute for Mental Health: www.nimh.nih.gov SAMHSA'S National Mental Health Information: www.mentalhealth.sahsa.gov SA/VE (Suicide Awareness Voices of Education) www.save.org National Alliance for Mental Health (NAMI) www.nami.org
Disorder	**Symptoms or Behaviors**	**About the Disorder**	**Educational Implications**	**Instructional Strategies and Classroom Accommodations**
Eating Disorder (ED)	▪ Perfectionistic attitude ▪ Impaired concentration ▪ Withdrawn ▪ All or nothing thinking ▪ Depressed mood or mood swings ▪ Self-deprecating statements ▪ Irritability ▪ Lethargy ▪ Anxiety ▪ Fainting spells and dizziness ▪ Headaches ▪ Hiding food ▪ Avoiding snacks or activities that include food ▪ Frequent trips to the bathroom	Nearly all of us worry about our weight; however, when one becomes so obsessed with their weight and the need to be thin they may develop an eating disorder. The two most common are anorexia nervosa and bulimia nervosa. Once seen in teens and young adults, these disorders are increasingly seen in younger children as well. Children as young as 4 and 5 are expressing the need to diet, and it's estimated that 40% of 9 year olds have already dieted. Eating disorders aren't limited to girls-between 10 and 20% of adolescents with ED are boys. Individuals with anorexia fail to maintain minimally normal body weight. They engage in abnormal eating behavior and have excessive concerns about food. They are intensely afraid of even the slightest weight gain, and their perception of their body shape and size is significantly distorted. Many individuals with anorexia are compulsive and excessive about exercise. Children and teens with this disorder are perfectionists and overachieving. In teenage girls with anorexia, menstruation may cease, leading to the same kind of bone loss suffered by menopausal women. Youth with bulimia go on eating binges during which they compulsively consume large amounts of food within a short period of time. To avoid weight gain, they engage in inappropriate compensatory behavior, including fasting, self-induced vomiting, excessive exercise, and the use of laxatives, diuretics, and enemas. Athletes such as wrestlers, dancers, or gymnasts may fall into disordered eating patterns in an attempt to stay thin or "make their weight." This can lead to a full blown disorder. Adolescents who have eating disorders are obsessed with food. Their lives revolve around thoughts and worries about their weight and their eating. Youth who suffer from eating disorders are at risk for alcohol and drug abuse as well as depression. If you suspect a student may be suffering from an eating disorder, refer that student immediately for a mental health assessment. Without medical intervention, an individual with an eating disorder faces serious health problems and, in extreme cases, death.	Students with eating disorders may look like model students, often leading the class and being very self-demanding. Others may show poor academic performance. When students with eating disorders are preoccupied with body image and controlling their food intake, they may have short attention spans and poor concentration. These symptoms may also be due to a lack of nutrients from fasting and vomiting. These students often lack the energy and drive necessary to complete assignments or homework.	▪ Stress acceptance in your classroom; successful people come in all sizes and shapes. ▪ Watch what you say. Comments like "You look terrible," "What have you eaten today?" or "I wish I had that problem" are often hurtful and discouraging. ▪ Stress progress, not perfection. ▪ Avoid pushing students to excel beyond their capabilities. ▪ Avoid high levels of competition. ▪ Reduce stress where possible by reducing assignments or extending deadlines. **Resources:** Eating Disorders Resources/Gurze Books www.gurze.net National Association of Anorexia Nervosa and Associated Disorders: www.anad.org (*hotline counseling, referrals, information and advocacy*) National Eating Disorders Association www.nationaleatingdisorders.org *How Did This Happen? A Practical Guide to Understanding eating Disorders for Coaches, Parents and Teachers*, by the Institute for research and Education HealthSystem Minnesota, 1999.

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Fetal Alcohol Spectrum Syndrome (FASD) **Resources:** FAS Community Resource Center www.come-over.to/FASCRC Fetal Alcohol Syndrome Family Resource Institute www.fetalalcoholsyndrome.org National Organization on Fetal Alcohol Syndrome (NOFAS) www.nofas.org	***Early Childhood (1-5 yrs.)*** ▪ Speech or gross motor delays ▪ Extreme tactile sensitivity or insensitivity ▪ Erratic sleep and/or eating habits ▪ Poor habituation ▪ Lack of stranger anxiety ▪ Rage ▪ Poor or limited abstracting ability (action/ consequence connection, judgment and reasoning skills, sequential learning) ***Elementary Year*** ▪ Normal, borderline, or high IQ, but immature ▪ Blames others for problems ▪ Volatile and impulsive, impaired reasoning ▪ School becomes increasingly difficult ▪ Socially isolated and emotionally disconnected ▪ High need for stimulation ▪ Vivid fantasies and perseveration problems ▪ Possible fascination with knives and/or fire ***Adolescent Years (13-18 yrs)*** ▪ No personal or property boundaries ▪ Naïve, suggestible, a follower, a victim, vulnerable to peers ▪ Poor judgment, reasoning, and memory ▪ Isolated, sometimes depressed and/or suicidal ▪ Poor social skills ▪ Doesn't learn from mistakes	Fetal Alcohol Spectrum Disorder refers to the brain damage and physical birth defects caused by women drinking alcohol during pregnancy. Fetal Alcohol Syndrome (FAS), can include growth deficiencies, central nervous system dysfunction that may include low IQ or mental retardation, and abnormal facial features (e.g. small eye openings, small upturned nose, thin upper lip, small lower jaw, low set of ears, and an overall small head circumference). Children lacking the distinguishing facial features may be diagnosed with Fetal Alcohol Effects (FAE). A diagnosis of FAE may make it more difficult to meet the criteria for many services or accommodations. The Institute of Medicine has recently coined a new term to describe the condition in which only the central nervous system abnormalities are present from prenatal alcohol exposure: Alcohol Related Neuro-developmental Disabilities (ARND). Because FAS/FAE are irreversible, lifelong conditions, children with FASD have severe challenges that may include developmental disabilities (e.g. speech and language delays) and learning disabilities. They are often hyperactive, poorly coordinated, and impulsive. They will most likely have difficulty with daily living skills, including eating (as a result of missing tooth enamel, heightened oral sensitivity, or an abnormal gag reflex). Learning is not automatic for them. Due to organic brain damage, memory retrieval is impaired, making learning difficult. Many of these children have problems with communication, especially social communication, even though they may have strong verbal skills. They often have trouble interpreting actions and behaviors of others or reading social cues. Abstract concepts are especially troublesome. They often appear irresponsible, undisciplined, and immature as they lack critical thinking skills such as judgment, reasoning, problem solving, predicting, and generalizing. In general, any learning is from a concrete perspective, but even then only through ongoing repetition. Because FAS/FAE children don't internalize morals, ethics, or values (these are abstract concepts), they don't understand how to do or say the appropriate thing. They also do not learn from past experience; punishment doesn't seem to faze them, they often repeat the same mistakes. Immediate wants or needs take precedence, and they don't understand the concept of cause and effect or that there are consequences to their actions. These factors may result in serious behavior problems, unless their environment is closely monitored, structured, and consistent. *This fact sheet must not be used for the purpose of making a diagnosis. It is to be used only as a reference for your own understanding and to provide information about different kinds of behaviors and mental health issues you may encounter in the classroom.*	Children with FASD need more intense supervision and structure than other children. They often lack a sense of boundaries for people and objects. For instance, they don't "steal" things, they "find" the; an object "belongs" to a person only if it is in that person's hand. They are impulsive, uninhibited, and over-reactive. Social skills such as sharing, taking turns, and cooperating in general are usually not understood, and these children tend to play alongside others but not with them. In addition, sensory integration problems are common, and may lead to the tendency to be high strung, sound-sensitive, and easily over-stimulated. Although they can focus their attention on the task at hand, they have multiple obstacles to learning. Since they don't understand ideas, concepts, or abstract thought, they may have verbal ability without actual understanding. Even simple tasks require intense mental effort because of their cognitive impairment. This can result in mental exhaustion, which adds to behavior problems. In addition, since their threshold for frustration is low, they may fly into rage and tantrums. A common impairment is with short-term memory, and in an effort to please, students often will make-up an answer when they don't remember one. This practice can apply to anything, including schoolwork or behaviors. These are not intentional "lies," they honestly don't remember the truth and want to have an answer. Since they live in the moment and don't connect their actions with consequences, they don't learn from experience that making up answers isn't appropriate.	▪ Be consistent as possible. The way something in learned from the first time will have the most lasting effect. *Re-learning is very difficult, therefore change is difficult.* ▪ Use a lot repetition. They need more time and more reps than average to learn and retain information. Try using mnemonics like silly rhymes and songs. Have them repeatedly practice basic actions and social skills like walking quietly down the hall or saying "thank you." Be positive, supportive, and sympathetic during crisis; these are children who "can't" rather than "won't." ▪ Use multi-sensory instruction (visual, olfactory, kinesthetic, tactile, and auditory). More senses used in learning means more possible neurological connections to aid in memory retrieval. ▪ Be specific, yet brief. They have difficulty "filling in the blanks." Tell them step-by-step, but not all at once. Use short sentences, simple words, and be concrete. Avoid asking "why" questions. Instead, ask concrete who, what, where, and when questions. ▪ Increase supervision- it should be as constant as possible, with an emphasis on *positive reinforcement* of appropriate behavior so it becomes habit. Do not rely on the student's ability to 'recite" the rules or steps. ▪ Model appropriate behavior. Students with FASD often copycat behavior, so always try to be respectful, patient, and kind. ▪ Avoid long periods of deskwork (these children *must* move). To avoid the problem of a student becoming overloaded from mental exhaustion and/or trying to sit still, create a self-calming and respite plan. ▪ Post all rules and schedules. Use pictures, drawings, symbols, charts, or whatever seems to be effective at conveying the message. Repeatedly go over the rules and their meanings aloud at least once a day. *Rules should be the same for all students, but you may need to alter the consequences for a child with FASD.* ▪ Use immediate discipline. They won't understand why it's happening if it is delayed. Even if the student is told immediately that a consequence will happen the next day, he/she will not make the connection the next day. *Never take away recess as a consequence- children with FASD need that break to move around. Denying them that will only compound the problem.* ▪ Ensure the student's attention. When talking directly to the student, be sure to say his/her name and make eye contact. Have them paraphrase directions to check for understanding. ▪ Encourage the use of self-talk. Recognize partially correct responses and offer positive incentives for finishing work. Try to set them up for success, and recognize successes every day (or even every hour)!

Disorder	Symptoms or Behaviors	About the Disorder	Educational Implications	Instructional Strategies and Classroom Accommodations
Obsessive-compulsive Disorder (OCD)	▪ Unproductive time retracing the same word or touching the same objects over and over ▪ Erasing sentences or problems repeatedly ▪ Counting and recounting objects, or arranging and rearranging objects on their desk ▪ Frequent trips to the bathroom ▪ Poor concentration ▪ School avoidance ▪ Anxiety or depressed mood	Obsessive-compulsive disorder (OCD) has n neurobiological basis. This means it is a biological disease of the brain, just as diabetes is a biological disease of the pancreas. OCD is not caused by bad parenting, poverty, or other environmental factors. Children with OCD may have obsessive thoughts and impulses that are recurrent, persistent, intrusive, and senseless- they may, for instance, worry about contamination from germs. They may also perform repetitive behaviors in a ritualistic manner- for example, they may engage in compulsive hand washing. An individual with OCD will often perform these rituals, such as hand washing, counting, or cleaning, in an effort to neutralize the anxiety caused by their obsessive thoughts. OCD is sometimes accompanied by other disorders, such as substance abuse, attention-deficit/hyperactivity disorder, eating disorders, or another anxiety disorder. When a student has another disorder, the OCD is more difficult to treat or diagnose. Symptoms of OCD may coexist or be part of a spectrum of other brain disorders such as Tourette's disorder or autism. Research done at the National Institute of Mental health suggests that OCD in some individuals may be an auto-immune response triggered by antibodies produced to counter strep infection. This phenomenon is known as PANDAS. Students with OCD often experience high levels of anxiety and shame about their thoughts and behavior. Their thoughts and behaviors are so time-consuming that they interfere with everyday life. Common compulsive behaviors are: ▪ Cleaning and washing ▪ Hoarding ▪ Touching ▪ Avoiding ▪ Seeking pressure ▪ Checking ▪ Counting ▪ Repeating ▪ Ordering ▪ Or arranging Common obsessions are: ▪ Aggressions ▪ Contamination ▪ Sex ▪ Loss ▪ Religion ▪ Orderliness and symmetry ▪ Doubt Children who show symptoms of OCD should be referred for a mental health assessment. Behavior therapy and pharmacological treatment have both proven successful.	Compulsive activities often take up so much time that students can't concentrate on their schoolwork, leading to poor or incomplete work and even school failure. In addition, many students with OCD find verbal communication very difficult. Students with OCD may feel isolated from their peers, in part because their compulsive behavior leaves them little time to interact or socialize with their classmates. They may avoid school because they are worried that teachers or peers will notice their odd behaviors. If asked "why" a behavior is repeated, many students say: "It doesn't feel right." *This fact sheet must not be used for the purpose of making a diagnosis. It is to be used only as a reference for your own understanding and to provide information about different kinds of behaviors and mental health issues you may encounter in the classroom.*	▪ Try to accommodate situations and behaviors that the student has no control over. ▪ Educate the student's peers about OCD. ▪ Be attentive to changes in the student's behavior. ▪ Try to redirect the student's behavior. This works better than using "consequences." ▪ Allow the student to do assignments such as oral reports in writing. ▪ Allow the student to receive full credit for late work. ▪ Allow the student to redo assignments to improve scores or final grade. ▪ Consider a Functional Behavioral Assessment (FBA). Understanding the purpose or function of the student's behavior will help you respond with effective interventions and strategies. Fr example, a punitive approach or punishment may increase the student's sense of insecurity and distress and increase the undesired behavior. ▪ Post the daily schedule in a highly visible place so that the student will know what to expect. ▪ Consider the use of technology. Many students struggling with OCD will benefit from easy to access appropriate technology, which may include applications that can engage student interest and increase motivation (e.g., computer-assisted instruction programs, CD-ROM demonstrations, as well as video-tape presentations). **Resources:** Obsessive-Compulsive Foundation of America: www.ocfoundation.org SAMHSA"S National Mental Health Information Center- *Center for Mental Health Services* www.mentalhealth.samhsa.gov Anxiety Disorders Association of America www.adaa.org National Institute of mental health (NIMH) www.nimh.nih.gov

Disorder	Symptoms or Behaviors	About the Disorder	Educational Implications	Instructional Strategies and Classroom Accommodations
Oppositional Deviant Disorder (ODD) *This fact sheet must not be used for the purpose of making a diagnosis. It is to be used only as a reference for your own understanding and to provide information about different kinds of behaviors and mental health issues you may encounter in the classroom.*	▪ Sudden unprovoked anger ▪ Arguing with adults ▪ Defiance or refusal to comply with adults' rules or requests ▪ Deliberately annoying others ▪ Blaming others for their misbehavior ▪ Being resentful and angry	Students with ODD seem angry much of the time. They are quick to blame others for mistakes and act in negative, hostile, and vindictive ways. All students exhibit these behaviors at times, but in those with ODD, these behaviors occur more frequently than is typical in individuals of comparable age and level of development. Students with ODD generally have poor peer relationships. They often display behaviors that alienate them from their peers. In addition, these students may have an unusual response to positive reinforcement or feedback. For instance, when given some type of praise they may respond by destroying or sabotaging the project that they were given recognition for. Some students develop ODD as a result of stress and frustration from divorce, death, loss of family, or family disharmony. ODD may also be a way of dealing with depression or the result of inconsistent rules and behavior standards. If not recognized and corrected early, oppositional and deviant behavior can become ingrained. Other mental health disorders may, when untreated, lead to ODD. For example, a student with AD/HD may exhibit signs of ODD due to the experience of constant failure at home and school.	Students with ODD may consistently challenge the class rules, refuse to do assignments, and argue or fight with other students. This behavior can cause significant impairment in both social and academic functioning. The constant testing of limits and arguing can create a stressful classroom environment. **Resources:** American Academy of Child and Adolescent Psychiatry www.aacap.org Anxiety Disorders Association of America www.adaa.org SAMHSA"S National Mental Health Information Center- *Center for Mental Health Services* www.mentalhealth.samhsa.gov	▪ Remember that students with ODD tend to create power struggles. Try to avoid these verbal exchanges. State your position clearly and concisely. ▪ Choose your battles wisely. ▪ Give 2 choices when decisions are needed. State them briefly and clearly. ▪ Establish clear classroom rules. Be clear about what is nonnegotiable. ▪ Post the daily schedule so students know what to expect. ▪ Praise students when they respond positively. ▪ Avoid making comments or bringing up situations that may be a source of argument for them. ▪ Make sure academic work is at the appropriate level. When work is too hard, students become frustrated. When it is too easy, they become bored. Both reactions lead to classroom problems. ▪ Avoid "infantile" materials to teach basic skills. Materials should be positive and relevant to students' lives. ▪ Pace instruction. When students with ODD have completed a designated amount of a non-deferred activity, reinforce their cooperation by allowing them to do something they prefer or find more enjoyable or less difficult. ▪ Allow sharp demarcation to occur between academic periods, but hold transition times between periods to a minimum. ▪ Systemically teach social skills, including anger management, conflict resolution strategies, and how to be assertive in an appropriate manner. Discuss strategies that the students may use to calm themselves when they feel anger escalating. Do this when students are calm. ▪ Praise students when they respond positively. ▪ Provide consistency. Structure, and clear consequences for the student's behavior. ▪ Select material that encourages student interaction. Students with ODD need to learn to talk to peers and to adults in an appropriate manner. However, all cooperative learning activities must be carefully structured. ▪ Minimize downtime and plan and plan transitions carefully. Students with ODD do best when kept busy. ▪ Maximize the performance of low-performing students through the use of individualized instruction, cues, prompting, the breaking down of academic tasks, debriefing, coaching, and providing positive incentives. ▪ Allow students to redo assignments to improve their score or final grade. ▪ Structure activities so the student with ODD is not always left out. ▪ Ask parents what works at home.

Disorder	Symptoms or Behaviors	About the Disorder	Educational Implications	Instructional Strategies and Classroom Accommodations
Pervasive Developmental Disorders (PDD) *This fact sheet must not be used for the purpose of making a diagnosis. It is to be used only as a reference for your own understanding and to provide information about different kinds of behaviors and mental health issues you may encounter in the classroom.*	▪ Repetitive, nonproductive movement like rocking in one position or walking around the room ▪ Training a hand across surfaces such as chairs, walls, or fences as the student passes ▪ Great resistance to interruptions of such movements ▪ Sensitive or over-reactive to touch ▪ May rarely speak, repeat the same phrases over and over, or repeat what is said to them (echolalia) ▪ Avoids eye contact ▪ Self injury	PDD, the acronym for pervasive developmental disorders, includes Rett's Syndrome, childhood disintegrative disorder, and Asperger's Syndrome. Pervasive developmental disorder not otherwise specified (PDD-NOS) also belongs to this category. Autistic disorder belongs to the category of disorders known as PDD. According to the USDHHS, 1 in 1,000 to 1 in 1,500 have autism or a related condition. Autism appears in the first 3 years of life and is 4 times more prevalent in boys than girls. It occurs in all racial, ethnic, and social groups. Autism is a neurologically based developmental disorder; its symptoms range from mild to severe and generally last throughout a person's life. The disorder is defined by a certain set of behaviors, but because a child can exhibit any combination of the behaviors in any degree of severity, no 2 children with autism will act the same. The terminology can be confusing because over the years autism has been used as an umbrella term for all forms of PDD. This means, for example, that a student with Asperger's may be described as having a mild form of autism, or a student with PDD-NOS may be said to have autistic- like tendencies. Nationally, these are all known as autism spectrum disorders. Although the American Psychiatric Association classifies all forms of PDD as "mental illness," these conditions often affect children in much the same way a developmental disability would. Some states recognize autism and Rett's as developmental disabilities (DD), which means that children with these conditions are eligible for case management and other DD services. Children with Asperger's, childhood disintegrative disorder, or PDD-NOS may or may not be eligible- depending on the specific state law. Diagnosis of autism and other forms of PDD is based on observation of a child's behavior, communication, and developmental level. According to the Autism Society of America, development may appear normal in some children until age 24-30 months; in others, development is more unusual from early infancy. Delays may be seen in the following areas: ▪ **Communication:** Language develops slowly or not at all. Children use gestures instead of words or use words inappropriately. Parents may also notice a short attention span. ▪ **Social Interaction:** Children prefer to be alone and show little interest in making friends. They are less responsive to social cues such as eye contact. ▪ **Sensory Impairment:** Children may be overly sensitive or under-responsive to touch, pain, sight, smell, hearing, or taste and show unusual reactions to these physical sensations. ▪ **Play:** Children do not create pretend games, initiate others, or engage in spontaneous or imaginative play. ▪ **Behavior:** Children may exhibit repetitious such as rocking back and forth or head banging. They may be very passive or overactive; lack of common sense and upsets over small changes in the environment or daily routine are common. Some children are aggressive and self-injurious. Some are severely delayed in areas such as understanding personal safety. A child who is suspected to have autistic disorder should be evaluated	Each child's behavior is unique. Parents and professionals who are familiar with the student are the best source of information. In general, children with autism usually appear to be in their own world and seem oblivious to classroom materials, people, or events. But a child's attention to you or the material you are presenting may be quite high, despite appearances. Teaching must be direct and personalized in all areas. This includes social skills, communication, and academic subject matter as well as routines like standing in line. Patience, firmness, consistency, and refusing to take behaviors personally are the keys to success. **Resources:** Autism Research Institute: www.autism.com/ari Autism Society of America: www.autism-society.org	▪ Use a team approach to curriculum development and classroom adaptations. Occupational therapists and speech/language pathologists can be of enormous help, and evaluations for assistive/augmentative technology should be done early and often. ▪ To teach basic skills, use materials that are age-appropriate, positive, and relevant to student's lives. ▪ Maintain a consistent classroom routine. Objects, pictures, or words can be used as appropriate to make sequences clear and help students learn independence. ▪ Avoid long strings of verbal instruction. Use written checklists, picture charts, or object schedules instead. If necessary, give instructions a step at a time. ▪ Minimize visual and auditory distractions. Modify the environment to meet the student's sensory integration needs; some stimuli may actually be painful to a student. An occupational therapist can help identify sensory problems and suggest needed modifications. ▪ Help students develop functional learning skills through direct teaching. For example, teach them to work left to right and top to bottom. ▪ Help students develop social skills and play skills through direct teaching. For example, teach them to understand social language, feelings, words, facial expressions and body language. ▪ Many children with autism are good at drawing, art, and computer programming. Encourage these areas of talent. ▪ Students who get fixated on a subject can be motivated by having "their" topic be the content for lessons of reading, science, math, and other subjects. ▪ If the student avoids eye contact or looking directly at a lesson, allow them to use peripheral vision to avoid the intense stimulus of a direct gaze. Teach students to watch the forehead of a speaker rather than the eyes if necessary. ▪ Some autistic children do not understand that words are used to communicate with someone who has a "separate" brain. Respond to the words that are said and teach techniques for repairing "broken" communication. Consult your school's speech language pathologist for more information about your student's communication. ▪ Help students learn to apply their learning in different situations through close coordination with parents and other professionals who work with the student. *This fact sheet must not be used for the purpose of making a diagnosis. It is to be used only as a reference for your own understanding and to provide information about different kinds of behaviors and mental health issues you may encounter in the classroom.*

		by a multidisciplinary team. This team may be comprised of a neurologist, psychiatrist, developmental pediatrician, speech/language therapist, and learning specialist familiar with autism spectrum disorders. Early intervention is important because the brain is more easily influenced in early childhood. Children with autism respond well to highly structured, specialized education and behavior modification programs tailored to their individual needs. Schools need to seek the assistance of trained professionals in developing a curriculum that will meet the child's specific needs. Good collaboration and communication between school personnel and parents is very important and can lead to increased success.		
Disorder	**Symptoms or Behaviors**	**About the Disorder**	**Educational Implications**	**Instructional Strategies and Classroom Accommodations**
Post-Traumatic Stress Disorder (PTSD) **Resources:** National Center for PTSD www.ncptsd.org PTSD Alliance www.ptsdalliance.org SAMHSA"S National Mental Health Information Center-*Center for Mental Health Services* www.mentalhealth.samhsa.gov National Institute of Mental Health (NIMH) www.nimh.nih.gov	▪ Flashbacks, hallucinations, nightmares, recollect-ions, re-enactment, or repetitive play referencing the event ▪ Emotional distress from reminders of the event ▪ Physical reactions from reminders of the event, including headache, stomachache, dizziness, or discomfort in another part of the body ▪ Fear of certain places, things, or situations that remind them of the event ▪ Denial of the event or inability to recall an important aspect of it ▪ A sense of a foreshortened future ▪ Difficulty concentrating and easily startled ▪ Self-destructive behavior ▪ Irritability ▪ Impulsiveness ▪ Anger and hostility ▪ Depression and overwhelming sadness or hopeless-ness	Children who are involved in or who witness a traumatic event that involved intense fear, helplessness, or horror are at risk for developing PTSD. The event is usually a situation where someone's life has been threatened or severe injury has occurred, such as a serious accident, abuse, violence, or a natural disaster. In some cases, the "event" may be a re-occurring trauma, such as continuing domestic violence. After the event, children may initially be agitated or confused. Eventually this develops into denial, fear, and even anger. They may withdraw and become unresponsive, detached, and depressed. Often they become emotionally numb, especially if they have been subjected to repeated trauma. They may lose interest in things they used to enjoy. Students with PTSD often have persistent frightening thoughts and memories of the experience. They may re-experience the trauma through flashbacks or nightmares. These occur particularly on the anniversary of the event or when a child is reminded of it by an object, place, or situation. During a flashback, the child may actually lose touch with reality and reenact the event. PTSD is diagnosed if the symptoms last more than 1 month. Symptoms usually begin within 3 months of the trauma, but occasionally not until years after; they may last from a few months to years. Early intervention is essential, ideally immediately following the trauma. If the trauma is not known, then treatment should begin when symptoms of PTSD are first noticed. Some studies show that when children receive treatment soon after the trauma, symptoms of PTSD are reduced. A combination of treatment approaches is often used for PTSD. Various forms of psychotherapy have been shown effective, including cognitive-behavioral, family, and group therapies. To help children express their feelings, play therapy and art therapy can be useful. Exposure therapy is a method where the child is guided to repeatedly re-live the experience under controlled conditions and to eventually work through and cope with their trauma. Medication may also be helpful in reducing agitation, anxiety, depression or sleep disturbances. Support from family, school, friends, and peers can be an important part of recovery for children with PTSD. With sensitivity, support, and help from mental health professionals, a child can learn to cope with their trauma and go on to lead a healthy and productive life.	The severity and persistence of symptoms vary greatly among children affected by PTSD. Their symptoms may come and go for no apparent reason, and their mood may change drastically. Such variability can create a perception that there are no explanations for behavior or that they are unpredictable, making it difficult for teachers to respond with helpful interventions. Children with PTSD will often regress. They may act younger than their age, which can result in increased emotional and behavioral problems. They may become clingy, whiny, impatient, impulsive, and/ aggressive. They may be unable to perform previously acquired skills, even basic functions like speech. Their capacity for learning may be decreased. They often have difficulty concentrating, are preoccupied, and become easily confused. They may lose interest in activities, become quiet and/or sad, and avoid interaction with other children.	▪ Try to establish a feeling of safety and acceptance within the classroom. Greet the child warmly each day, make eye contact, and let the child know that he/she is valued and that you care. You can make a tremendous impact on a child by what you say (or don't say); a child's self-perception often comes from the action of others. ▪ Don't hesitate to interrupt activities and avoid circumstances that are upsetting or retraumatizing for the child. Watch for increased symptoms during or following certain situations, and try to prevent these situations from being repeated. ▪ Provide a consistent, predictable routine through each day as much as possible. A regular pattern will help re-establish and maintain a sense of normalcy and security in the child's life. If the schedule does change, try to explain beforehand what will be different and why. Consistency shows children that you have control of the situation; they may become anxious if they sense that you are disorganized or confused. However, allow children choices within this pattern wherever possible. This will give them some sense of control and help to build self-confidence. ▪ Try to eliminate stressful situations from your classroom and routines; make sure your room arrangement is simple and easy to move through; create a balance of noisy versus quiet activity areas and clearly define them; and plan your day or class period so that alternates between active and quiet activities (being forced to maintain the same level of activity for too long may cause the child to become restless and anxious). ▪ Do not tell a child to forget about the incident. PTSD symptoms may a result of trying to do just that. This request also minimizes the importance of the trauma, and children may feel a sense of failure if they can't forget. ▪ Reassure children that their symptoms and behaviors are a common response to a trauma and they are not "crazy" or bad. ▪ Incorporate large muscle activities into the day. Short breaks involving skipping; jumping, stretching, or other simple exercises can help relieve anxiety and restlessness. For young children, you can also use games like London Bridge or Ring Around the Rosy.

Disorder	Symptoms or Behaviors	About the Disorder	Educational Implications	Instructional Strategies and Classroom Accommodations
Reactive Attachment Disorder (RAD) **Resources:** Association for Treatment and Training in the Attachment of Children (ATTACh) www.attach.org Families by Design/ Nancy Thomas Parenting www.attachment.org **www.RADKID.org**	▪ Destructive to self and others ▪ Absence of guilt or remorse ▪ Refusal to answer simple questions ▪ Denial of accountability—always ▪ Blaming others ▪ Poor eye contact ▪ Extreme defiance and control issues ▪ Stealing ▪ Lack of cause and effect thinking ▪ Mood swings ▪ False abuse allegations ▪ Sexual acting out ▪ Inappropriately demanding or clingy ▪ Poor peer relationships ▪ Abnormal eating patterns ▪ Preoccupied with gore, fire ▪ Toileting issues ▪ No impulse control ▪ Chronic nonsensical lying ▪ Unusual speech patterns or problems ▪ Bossy—needs to be in control ▪ Manipulative—superficially charming and engaging	The essential feature of reactive attachment disorder (RAD) is a markedly disturbed and developmentally inappropriate social relatedness with peers and adults in most contexts. RAD begins before age 5 and is associated with grossly inadequate or pathological care that disregards the child's basic emotional and physical needs. In some cases, it is associated with repeated changes of a primary caregiver. The term "attachment" is used to describe the process of bonding that takes place between infants and caregivers in the first 2 years of life, and most important, the first 9 months of life. When a caregiver fails to respond to a baby's emotional and physical needs, responds inconsistently, or is abusive, the child loses the ability to form meaningful relationships and the ability to trust. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) describes two types of RAD: "inhibited" and "disinhibited." Inhibited RAD is the persistent failure to initiate and respond to most social interactions in a developmentally appropriate way. Disinhibited RAD is the display of indiscriminate sociability or a lack of selectivity in the choice of attachment figures (excessive familiarity with relative strangers by making requests and displaying affection). Aggression, either related to a lack of empathy or poor impulse control, is a serious problem with these students. They have difficulty understanding how their behavior affects others. They often feel compelled to lash out and hurt others, including animals, smaller children, peers, and siblings. This aggression is frequently accompanied by a lack of emotion or remorse. Children with RAD may show a wide range of emotional problems such as depressive and anxiety symptoms or safety seeking behaviors. To feel safe these children may seek any attachments—they may hug virtual strangers, telling them, "I love you." At the same time, they have an inability to be genuinely affectionate with others or develop deep emotional bonds. Students may display "soothing behaviors" such as rocking and head banging, or biting, scratching, or cutting themselves. These symptoms will increase during times of stress or threat.	Many of these students will have developmental delays in several domains. The caregiver-child relationship provides the vehicle for developing physically, emotionally, and cognitively. In this relationship the child learns language, social behaviors, and other important behaviors and skills. The lack of these experiences can result in delays in motor, language, social, and cognitive development. The student may have difficulty completing homework. They often fail to remember assignments and/or have difficulty understanding assignments with multiple steps. They may have problems with comprehension, especially long passages of text. Fluctuations in energy and motivation may be evident, and they may often have difficulty concentrating. The student with RAD often feels a need to be in control and may exhibit bossy, argumentative, and/or defiant behavior, which may result in frequent classroom disruptions and power struggles with teachers.	▪ Consider a Functional Behavioral Assessment (FBA). Understanding the purpose or function of the student's behaviors will help you respond with effective interventions. For example, a punitive approach or punishment may increase the student's sense of insecurity and distress and consequently increase the undesired behavior. ▪ Be predictable, consistent, and repetitive. Students with RAD are very sensitive to changes in schedules, transitions, surprises, and chaotic social situations. Being predictable and consistent will help the student to feel safe and secure, which in turn will reduce anxiety and fear. ▪ Model and teach appropriate social behaviors. One of the best ways to teach these students social skills is to model the behavior and then narrate for the child what you are doing and why. ▪ Avoid power struggles. When intervening, present yourself in a light and matter of fact style. This reduces the student's desire to control the situation. When possible use humor. If students can get an emotional response from you, they will feel as though they have hooked you into the struggle for power and they are winning. ▪ Address comprehension difficulties by breaking assigned reading into manageable segments. Monitor progress by periodically checking if the student is understanding the material. ▪ Break assignments into manageable steps to help clarify complex, multi-step directions. ▪ Identify a place for the student to go to regain composure during times of frustration and anxiety. Do this only if the student is capable of using this technique and there is an appropriate supervised location. *This fact sheet must not be used for the purpose of making a diagnosis. It is to be used only as a reference for your own understanding and to provide information about different kinds of behaviors and mental health issues you may encounter in the classroom.*

Disorder	Symptoms or Behaviors	About the Disorder	Educational Implications	Instructional Strategies and Classroom Accommodations
Schizophrenia *This fact sheet must not be used for the purpose of making a diagnosis. It is to be used only as a reference for your own understanding and to provide information about different kinds of behaviors and mental health issues you may encounter in the classroom.*	▪ Confused thinking (for example, confusing what happens on television with reality) ▪ Vivid and bizarre thoughts and ideas ▪ Hallucinations ▪ Hearing, seeing, feeling, or smelling things that are not real or present ▪ Delusions ▪ Having beliefs that are fixed and false (i.e., believing that aliens are out to kill them because of information that they have) ▪ Severe anxiety and fearfulness ▪ Extreme moodiness ▪ Severe problems in making and keeping friends ▪ Feelings that people are hostile and "out to get them" ▪ Odd behavior, including behavior resembling that of a younger child ▪ Disorganized speech ▪ Lack of motivation	Schizophrenia is a medical illness that causes a person to think and act strangely. It is rare in children less than 10 years of age and has its peak age of onset between the ages of 16 and 25. This disorder affects about 1 percent of the population, and thus middle and high school teachers will likely see children who are in the early stages of the illness. Schizophrenia can be difficult to recognize in its early phases, and the symptoms often are blurred with other psychiatric disorders. Schizophrenia usually comes on gradually in what is known as the prodrome, and teachers are often the first to notice the early signs. The early signs are usually non-specific. For example, students who once enjoyed friendships with classmates may seem to withdraw into a world of their own. They may say things that don't make sense and talk about strange fears and ideas. Students may also show a gradual decline in their cognitive abilities and struggle more with their academic work. Since the disorder can come on quite gradually, it may be difficult to appreciate this decline in cognition without a longitudinal perspective over several academic years. The typical prodromal period lasts about 2 to 3 years. Some children show difficulties with attention, motor function, and social skills very early in life, before the prodrome, whereas others have no problems at all before the illness sets in. The symptoms of schizophrenia include hallucinations (hearing and seeing things that are not there), delusions (fixed false beliefs); and difficulties in organizing their thoughts. A student may talk and say little of substance or the child may have ideas or fears that are odd and unusual (beyond developmental norms). Many, but not all individuals with schizophrenia may show a decline in their personal hygiene, develop a severe lack of motivation, or they may become apathetic or isolative. During adolescence the illness is not fully developed, and thus it is at times difficult to differentiate schizophrenia from a severe depression, substance abuse disorder, or bipolar affective disorder. Students who show signs of schizophrenia need a good mental health assessment. Early diagnosis and treatment of schizophrenia is important. About 50 percent of people with schizophrenia will attempt suicide; 10 to 15 percent will succeed. Young people with this disease are usually treated with a combination of medication and individual and family therapy. They may also participate in specialized programs. Medications can be very helpful for treating the hallucinations, delusions, and difficulties in organizing thoughts. Unfortunately, the difficulties with motivation, personal hygiene, apathy, and social skills are often the least responsive to medications. The cause of schizophrenia is not known, although it is believed to be a combination of genetic and environmental factors. The exact environmental factors that contribute to the development of schizophrenia are also not known.	Students with schizophrenia can have educational problems such as difficulty concentrating or paying attention. Their behavior and performance may fluctuate from day to day. These students are likely to exhibit thought problems or physical complaints; or they may act out or become withdrawn. Sometimes they may show little or no emotional reaction; at other times, their emotional responses may be inappropriate for the situation. NAMI (National Alliance for the Mentally Ill) www.nami.org National Association for Research on Schizophrenia and Depression (NARSAD) www.narsad.org info@narsad.org *Research updates and fact sheets* National Mental Health Association www.nmha.org	▪ Reduce stress by going slowly when introducing new situations. ▪ Help students set realistic goals for academic achievement and extra-curricular activities ▪ Obtaining educational and cognitive testing can be helpful in determining if the student has specific strengths that can be capitalized upon to enhance learning. ▪ Establish regular meetings with the family for feedback on health and progress. ▪ Because the disorder is so complex and often debilitating, it will be necessary to meet with the family, with mental health providers, and with the medical professionals who are treating the student. These individuals can provide the information you will need to understand the student's behaviors, the effects of the psychotropic medication and how to develop a learning environment. ▪ Often it is helpful to have a "Team Meeting" to discuss the various aspects of the child's education and development. ▪ Encourage other students to be kind and to extend their friendship *—From "Schizophrenia: Youth's Greatest Disabler," produced by the British Columbia Schizophrenia Society, available at www.mentalhealth.com/book/p40-sc02.html*

Disorder	Symptoms or Behaviors	About the Disorder	Educational Implications	Instructional Strategies and Classroom Accommodations
Tourette's Disorder Resources: Tourette's Syndrome Association, Inc. www.tsa-usa.org www.tourettesyndrome.net Developed by Dr. Leslie E. Packer This website covers Tourette's Syndrome and related disorders	▪ •Throat clearing ▪ •Barking ▪ •Snorting ▪ •Hopping ▪ •Vocal outbursts ▪ •Mimicking of other people ▪ •Shoulder shrugging ▪ •Facial grimaces ▪ •Facial twitches ▪ •Blinking ▪ •Arm or leg jerking ▪ •Finger flexing ▪ •Fist clenching ▪ •Lip licking ▪ •Easily frustrated ▪ •Sudden rage attacks	Tourette's disorder is a neurological disorder that has dramatic consequences for some 200,000 Americans and affects an approximate additional 2 million to some degree. Boys identified with Tourette's disorder outnumber girls 3 to 1; the disorder affects all races and ethnic groups. Researchers have traced the condition to a single abnormal gene that predisposes the individual to abnormal production or function of dopamine and other neurotransmitter in the brain. Although Tourette's disorder is classified as a mental health disorder, it is usually treated by a neurologist as well as a psychiatrist. The disorder is still poorly recognized by health professionals. About 80 percent of people with Tourette's disorder diagnose themselves or are diagnosed by family members after learning about the disorder in the media. Many people have symptoms mild enough that they never seek help; many others find their symptoms subside after they reach adulthood. Indicators of Tourette's disorder include: ▪ The presence of multiple motor and vocal tics, although not necessarily simultaneously ▪ Multiple bouts of tics every day or intermittently for more than a year ▪ Changes in the frequency, number, and kind of tics and in their severity ▪ Marked distress or significant impairment in social, occupational, or other areas of functioning, especially under stressful conditions ▪ Onset before age 18 An estimated 25 percent of students in the U. S. have a tic at some time in their life. Not all students with tics have Tourette's disorder, although they may have a related "tic disorder." Tics may be simple (for example, eye blinking, head jerking, coughing, snorting) or complex (for example, jumping, swinging objects, mimicking other people's gestures or speech, rapid repetitions of a word or phrase). In fact, the range of tics exhibited by people with Tourette's disorder is so broad that family members, teachers, and friends may find it hard to believe that these actions or vocalizations are not deliberate. Like someone compelled to cough or sneeze, people with Tourette's disorder may feel an irresistible urge to carry out their tics. Others may not be aware of the fact they are ticking. Some people can suppress their tics for hours at a time, but this leads to stronger outbursts of tics later on. Often, children "save up" their tics during school hours and release them when they return home and feel safe from harassment or teasing. Somewhere between 50 to 70 percent of students with Tourette's disorder have related learning disabilities, attention-deficit/hyperactivity disorder (AD/HD), obsessive-compulsive disorder or difficulties with impulse control. Sensory integration problems may explain some behaviors. Depression and anxiety may underlie more visible symptoms.	Tics, such as eye blinking or shoulder shrugging, can make it difficult for students to concentrate. But suppressing tics is exhausting and takes energy away from learning. Tics may also be disruptive or offensive to teachers and classmates. Peers may ridicule the child with Tourette's disorder or repeatedly "trigger" an outburst of tics to harass. Tension and fatigue generally increase tics. *Please note: Most students with Tourette's disorder do not qualify for special education services under the emotional or behavioral disorders (EBD) classification, unless the coexisting conditions are severe. Some may qualify for services under the category of Other Health Disability (OHD) or Specific Learning Disability (SLD). Others who do not qualify under either the EBD, OHD, or SLD categories may do well in a general education classroom with accommodations (504 plans).*	▪ Educate other students about Tourette's disorder, encourage the student to provide his own explanations, and encourage peers to ignore tics whenever possible. ▪ Be careful not to urge the student to "stop that" or "stay quiet." Remember, it's not that your student "won't stop," they simply can't stop. ▪ Do not impose disciplinary action for tic behaviors. ▪ To promote order and provide a diversion for escalating behavior, provide adult supervision in the hallways, during assemblies, in the cafeteria, when returning from recess, and at other high-stress times. ▪ Refer to the school occupational therapist for an evaluation of sensory difficulties and modify the environment to control stimuli such as light, noise, or unexpected touch. ▪ Help the student to recognize fatigue and the internal and external stimuli that signal the onset of tics. Pre-arrange a signal and a safe place for the student to go to relax or rest. ▪ Provide a private, quiet place for test taking. Remove time limits when possible. ▪ Reduce handwriting tasks and note taking. Provide note takers or photocopies of overheads during lectures and encourage computer use for composition tasks. ▪ Give students with Tourette's disorder special responsibilities that they can do well. ▪ Encourage them to show their skills in sports, music, art, or other areas. ▪ Provide structured, predictable scheduling to reduce stress and ensure adult supervision in group settings. *This fact sheet must not be used for the purpose of making a diagnosis. It is to be used only as a reference for your own understanding and to provide information about different kinds of behaviors and mental health issues you may encounter in the classroom.*