Mindful
Continuing Education

Affect and Mood Disorders in Children

Overview

Affect and mood related to school aged youth covers a broad range of concerns. This Introductory Packet provides frameworks related to affect and mood for

- defining and describing,
- understanding causes of problems,
- Promoting health and positive development,
- Responding to the first signs of problems,
- interventions for serious problems.

Resources are provided for more in depth information.

I. What Do We Mean When We Talk About Affect and Mood?

AA. Defining Affect and Mood

Affect

From: Gale Encyclopedia of Childhood and Adolescence

The expressions of emotion or feelings to others include facial expressions, gestures, tone of voice, and other signs of emotion such as laughter or tears. As a child grows and develops, environmental factors, such as peer pressure , and internal factors, such as self-consciousness, help to shape the affect.

What is considered a normal range of affect--display of emotion--varies from family to family, from situation to situation, and from culture to culture. Even within a culture, a wide variation in affective display can be considered normal. Certain individuals may gesture prolifically while talking, and display dramatic facial expressions in reaction to social situations or other stimuli. Others may show little outward response to social environments, expressing only a narrow range of affect to the outside world.

When psychologists describe abnormalities in a child's affect, they use specific terminology. The normal affect--which is different for each child and changes with each stage of childhood--is termed broad affect, to describe the range of expression of emotion that is considered typical. Persons with psychological disorders may display variations in their affect. A constricted affect refers to a mild restriction in the range or intensity of display of feelings; as the display of emotion becomes more severely limited, the term blunted affect may be applied. The absence of any exhibition of emotions is described as flat affect; in this case, the voice is monotone, the face is expressionless, and the body is immobile. Extreme variations in expressions of feelings is termed labile affect. When the outward display of emotion is inappropriate for the situation, such as laughter while describing pain or sadness, the affect is described as inappropriate. Labile affect, also called lability, is used to describe emotional instability or dramatic mood swings.

Mood

From: Gale Encyclopedia of Psychology

A mood, while relatively pervasive, is typically neither highly intense nor sustained over an extended period of time. Examples of mood include happiness, sadness, contemplativeness, and irritability. The definitions of phrases to describe moods-such as good mood and bad mood-are imprecise. In addition, the range of what is regarded as a normal or appropriate mood varies considerably from individual to individual and from culture to culture.

The ups and downs of adolescence

Excerpted from: Raising Children Network, with the Centre for Adolescent Health

Did you know?

> Many people think that adolescence is always a difficult time, and that all teenagers experience bad moods and exhibit challenging behaviours. In fact, only 5-15% of teenagers go through extreme emotional turmoil, become rebellious, or have major conflicts with their parents.

Ups and downs are a normal part of everyone's lives, teenagers included. Teenagers have a lot going on – physically, emotionally and socially – which helps to explain why your child might be having more moods than before.

Teen moods: what you need to know

Some days your child might be cheerful and excited, and other times he might seem down, flat, low or sad. This is a normal part of life for young people in the same way it's normal for adults.

You might notice your child feeling more ups and downs than she used to, or her moods might be more extreme. This could be for many reasons – physical, emotional, social and psychological – and not for any one reason in particular. Often you can't pin down the causes of adolescent ups and downs.

You might also notice that your relationship with your child is changing, as well as how he shares her emotional world with you. Privacy might be very important to him.

When your teenager wants more time on her own or more private headspace, it's not necessarily that she's being 'moody' – it's actually a sign that your child is maturing and becoming more independent. This can be a healthy part of adolescence, although your child still needs your supervision and support.

These changes in feelings, behaviour and thinking are normal and will last for longer than moods. It's a time for you and your teenage child to learn new ways of communicating with each other.

Why the ups and downs?

Physical factors
Young people go through lots of physical changes during adolescence. They need to adjust to their changing bodies, which might make them self-conscious or embarrassed – or just make them want more privacy and time to themselves. Children whose development seems to be taking a long time compared with friends might seem frustrated by or emotional about these physical delays.

Another physical factor is your child's need for sleep. It's thought that teenagers need more sleep than they did when they were younger – about 9¼ hours each night, in fact. So the amount of sleep teenagers get is likely to affect their moods.

Regular, nutritious meals and enough physical activity are good for your child's physical health and can help your child feel good emotionally too.

Brain factors
Young people's brains keep developing into their early 20s. The section of the brain that's the last to develop, the prefrontal cortex, is closely connected to the areas responsible for regulating and controlling emotions.

This means young people can find it harder to keep a lid on some of their more powerful

emotions, and it might seem that they react more emotionally to situations than they used to. They're also still learning to process and express those emotions in a grown-up way.

Social and emotional factors

New thoughts, new emotions, new friends and new responsibilities – these all affect how your child is feeling.

Your child is learning how to solve more problems on his own as he moves towards independence. He's also living in his own head more than he used to, and is busy thinking about challenges such as friendships, school and family relationships.

Stressful family situations can impact on your child's mood too.

MOST TEEN MOOD SWINGS DECLINE WITH AGE

Dominique F. Maciejewski et al. A 5-Year Longitudinal Study on Mood Variability Across Adolescence Using Daily Diaries. *Child Development, October 2015* DOI: 10.1111/cdev.12420

Adolescence is typically regarded as a period of heightened emotionality, and an important time for youth to learn to regulate their emotions. This longitudinal study looked at the development of teens' emotional stability. It found that mood swings gradually decline as teens age. Additionally, the study identifies when instability could require intervention. All this is seen as reassurance for parents concerned about their moody teens, while also helping identify when instability is considered risky and requires intervention.

I. What Do We Mean When We Talk About Affect and Mood?

B. Broad Continuum

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1. *Developmental Variations*: Behaviors within the Range of Expected Behaviors for That Age Group*

DEVELOPMENTAL VARIATION	COMMON DEVELOPMENTAL PRESENTATIONS
Sadness Variation Transient depressive responses or mood changes to stress are normal in otherwise healthy populations.	**Infancy** The infant shows brief expressions of sadness, which normally first appear in the last quarter of the first year of life, manifest by crying, brief withdrawal, and transient anger. **Early Childhood** The child may have transient withdrawal and sad affect that may occur over losses and usually experiences bereavement due to the death of a parent or the loss of a pet or treasured object. **Middle Childhood** The child feels transient loss of self-esteem aver experiencing failure and feels sadness with losses as in early childhood. **Adolescence** The adolescent's developmental presentations are similar to those of middle childhood but may also include fleeting thoughts of death. Bereavement includes loss of a boyfriend or girlfriend, friend, or best friend.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics.

I. What Do We Mean When We Talk About Affect and Mood?

B. Broad Continuum

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22. *Problems*--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria

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PROBLEM

Sadness Problem

Sadness or irritability that begins to include some symptoms of major depressive disorders in mild form.

- depressed/irritable mood
- diminished interest or pleasure
- weight loss/gain, or failure to make expected weight gains
- insomnia/hypersomnia
- psychomotor agitation/retardation
- fatigue or energy loss
- feelings of worthlessness or excessive or inappropriate guilt
- diminished ability to think/concentrate

However, the behaviors are not sufficiently intense to qualify for a depressive disorder.

These symptoms should be more than transient and have a mild impact on the child's functioning. Bereavement that continues beyond 2 months may also be a problem.

Adapted from The Classification of Child and Adolescent Mental Diagnoses in primary Care. (1996) American Academy of Pediatrics

Notes: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant may experience some developmental regressions, fearfulness, anorexia, failure to thrive, sleep disturbances, social withdrawal, irritability, and increased dependency, which are responsive to extra efforts at soothing and engagement by primary caretakers.

Early Childhood
The child may experience similar symptoms as in infancy, but sad affect may be more apparent. In addition, temper tantrums may increase in number and severity, and physical symptoms such as constipation, secondary enuresis (...), encopresis (...), and nightmares may be present.

Middle Childhood
The child may experience some sadness that results in brief suicidal ideation with no clear plan of suicide, some apathy, boredom, low self-esteem, and unexplained physical symptoms such as headaches and abdominal pain (...).

Adolescence
Some disinterest in school work, decrease in motivation, and day-dreaming in class may begin to lead to deterioration of school work. Hesitancy in attending school, apathy, and boredom may occur.

SPECIAL INFORMATION

Sadness is experienced by some children beyond the level of a normal developmental variation when the emotional or physiologic symptoms begin to interfere with effective social interactions, family functioning, or school performance. These periods of sadness may be brief or prolonged depending on the precipitating event and temperament of the child. Reassurance and monitoring is often needed at this level. If the sad behaviors are more severe, consider major depressive disorders.

The potential for suicide in grieving children is higher. Evaluation of suicidal risk should be part of a grief workup for all patients expressing profound sadness or confusion or demonstrating destructive behaviors toward themselves or others.

Behavioral symptoms resulting from bereavement that persist beyond 2 months after the loss require evaluation and intervention. Depressed parents or a strong family history of depression or alcoholism (...) puts youth at very high risk for depressive problems and disorders. Family and marital discord, ... exacerbates risk. Suicidal ideation should be assessed (see Suicidal Thoughts or Behaviors cluster).

Lying, stealing, suicidal thoughts (see Suicidal Thoughts or Behaviors cluster), and promiscuity may be present. Physical symptoms may include recurrent headaches, chronic fatigue, and abdominal pain (...).

AAbout Suicidal Ideation and Attempts --

from *The Classification of Child andAdolescent Mental Diagnoses in Primary Care**

DISORDER

Suicidal Ideation and Attempts

The child has thoughts about causing intentional self-harm acts that cause intentional self-harm or death.

This code represents an unspecified mental disorder. It is to be used when no other condition is identified.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Unable to assess.

Early Childhood
The child expresses a wish and intent to die either verbally or by actions.

Middle Childhood
The child plans and enacts self-injurious acts with a variety of potentially lethal methods.

Adolescence
The adolescent frequently shows a strong wish to die and may carefully plan and carry out a suicide.

SPECIAL INFORMATION

A youngster's understanding that death is final is not an essential ingredient in considering a child or adolescent to be suicidal. How-ever, very young children, such as preschoolers who do not appreciate the finality of death, can be considered to be suicidal if they wish to carry out a self-destructive act with the goal of causing death. Such behavior in preschoolers is often associated with physical or sexual abuse (...).

Prepubertal children may be protected against suicide by their cognitive immaturity and limited access to more lethal methods that may prevent them from planning and executing a lethal suicide attempt despite suicidal impulses.

The suicide rate and rate of attempted suicide increase with age and with the presence of alcohol and other drug use. Psychotic symptoms, including hallucinations, increase risk as well.

Because of societal pressures, some homosexual youth are at increased risk for suicide attempts (...).

In cases of attempted suicide that are carefully planned, adolescents may leave a note, choose a clearly lethal method, and state their intent prior to the actual suicide. In contrast, most suicide attempts in adolescence are impulsive, sometimes with little threat to the patient's life. The motivation for most attempts appears to be a wish to gain attention and/or help, escape a difficult situation, or express anger or love. However, irrespective of motivation, all suicide attempts require careful evaluation and all patients with active intent to harm themselves should have a thorough psychiatric evaluation.

Although suicidal ideation and attempts is not a disorder diagnosis, more extensive evaluation may identify other mental conditions (e.g., major depressive disorder).

Note:Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

3. Disorders

Depressive Disorders

SECTION QUICK LINKS
- Disruptive Mood Dysregulation Disorder –
  http://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm04#BCFBGAGG
- Major Depressive Disorder –
  http://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm04#BCFJBIIA
- Persistent Depressive Disorder (Dysthymia) –
  http://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm04#BCFHGBJG
- Premenstrual Dysphoric Disorder –
  http://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm04#BCFIEGFF
- Substance/Medication-Induced Depressive Disorder –
  http://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm04#BCFDAIBA
- Depressive Disorder Due to Another Medical Condition –
  http://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm04#BCFEJHED
- Other Specified Depressive Disorder –
  http://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm04#BCFHDJJH
- Unspecified Depressive Disorder –
  http://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm04#BCFDHFGE
- Specifiers for Depressive Disorders –
http://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm04#x16916.2610425

Depressive disorders include disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder. Unlike in DSM-IV, this chapter ""Depressive Disorders"" has been separated from the previous chapter ""Bipolar and Related Disorders."" The common feature of all of these disorders is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual''s capacity to function. What differs among them are issues of duration, timing, or presumed etiology.

In order to address concerns about the potential for the overdiagnosis of and treatment for bipolar disorder in children, a new diagnosis, disruptive mood dysregulation disorder, referring to the presentation of children with persistent irritability and frequent episodes of extreme behavioral dyscontrol, is added to the depressive disorders for children up to 12 years of age. Its placement in this chapter reflects the finding that children with this symptom pattern typically develop unipolar depressive disorders or anxiety disorders, rather than bipolar disorders, as they mature into adolescence and adulthood.

DISRUPTIVE MOOD DYSREGULATION DISORDER

Finding a Home in DSM

The road to mental health begins with an accurate diagnosis. Consider a recent Wall Street Journal article describing nearly a decade of suffering for an 11-year-old boy who, although diagnosed with bipolar disorder at age 4, has never been successfully treated for his extreme, explosive rages. Too many severely impaired children like this are falling through the cracks because they suffer from a disorder that has not yet been defined. A new diagnosis in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) aims to give these children a diagnostic home and ensure they get the care they need.

Characteristics of the Disorder

This disorder is called Disruptive Mood Dysregulation Disorder (DMDD), and its symptoms go beyond describing temperamental children to those with a severe impairment that requires clinical attention. Far beyond temper tantrums, DMDD is characterized by severe and recurrent temper outbursts that are grossly out of proportion in intensity or duration to the situation. These occur, on average, three or more times each week for one year or more.

Between outbursts, children with DMDD display a persistently irritable or angry mood, most of the day and nearly every day, that is observable by parents, teachers, or peers. A diagnosis requires the above symptoms to be present in at least two settings (at home, at school, or with peers) for 12 or more months, and symptoms must be severe in at least one of these settings. During this period, the child must not have gone three or more consecutive months without symptoms.

The onset of symptoms must be before age 10, and a DMDD diagnosis should not be made for the first time before age 6 or after age 18.

Process for New Diagnosis

A new *DSM* diagnosis is included only after a comprehensive review of the scientific literature; full discussion by Work Group members; review by the *DSM-5* Task Force, Scientific Review Committee, Clinical and Public Health Committee; and, finally, approval by the American Psychiatric Association's Board of Trustees.

The DMDD diagnosis, like every other new disorder, also received review and feedback from other mental health clinicians and advocacy organizations during three open-comment periods facilitated through the *DSM-5* website, www.DSM5.org.

Throughout this rigorous process, considerable discussion about DMDD focused on the need for developmentally appropriate diagnostic criteria for severe irritability in children and adolescents. *DSM-IV* provided no guidance on an appropriate diagnosis for children with such severely impairing symptoms.

Improving Diagnosis and Care

While *DSM* does include two diagnoses with related symptoms to DMDD, oppositional defiant disorder (ODD) and Bipolar Disorder (BD), the symptoms described in DMDD are significantly different than these two diagnoses.

ODD is an ongoing pattern of anger-guided disobedience, hostilely defiant behavior toward authority figures that goes beyond the bounds of normal childhood behavior. While some of its symptoms may overlap with the criteria for DMDD, the symptom threshold for DMDD is higher since the condition is considered more severe. To avoid any artificial comorbidity of the two disorders, it is recommended that children who meet criteria for both ODD and DMDD should only be diagnosed with DMDD.

BD also has similar symptoms. And while clinicians may have been assigning a BD diagnosis to these severely irritable youth to ensure their access to treatment resources and services, these children's behaviors may not present in an episodic way as is the case with BD. In an effort to address this issue, research was conducted comparing youth with severe non-episodic symptoms to those with the classic presentations of BD as defined in *DSM-IV*.

Results of that extensive research showed that children diagnosed with BD who experience constant, rather than episodic, irritability often are at risk for major depressive disorder or generalized anxiety disorder later in life, but not life-long BD. This finding pointed to the need for a new diagnosis for children suffering from constant, debilitating irritability. The hope is that by defining this condition more accurately, clinicians will be able to improve diagnosis and care.

Defining this disorder as a distinct condition will likely have a considerable impact on clinical practice and thus treatment. For example, the medication and psychotherapy treatment recommended for BD is entirely different from that of other disorders, such as depressive and anxiety disorders.

The unique features of DMDD necessitated a new diagnosis to ensure that children affected by this disorder get the clinical help they need.

DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish *DSM-5* in 2013, culminating a 14-year revision process. For more information, go to www.*DSM5*.org.

APA is a national medical specialty society whose more than 36,000 physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org and www.healthyminds.org.

II. Understanding the Causes of Problems Related to Affect and Mood

A. Keeping The Environment in Perspective as a Cause of Commonly Identified Psychosocial Problems.

A large number of students are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters have trouble behaving in classrooms; only a small percent have attention deficit or a conduct disorder. In some schools, large numbers of students have problems learning; only a few have learning disabilities. Individuals suffering from true internal pathology represent a relatively small segment of the population. A caring society tries to provide the best services for such individuals; doing so includes taking great care not to misdiagnose others whose "symptoms" may be similar, but are caused by factors other than internal pathology. Such misdiagnoses lead to policies and practices that exhaust available resources in ineffective ways. A better understanding of how the environment might cause problems and how focusing on changing the environment might prevent problems is essential.

Labeling Troubled and Troubling Youth: The Name Game

She's depressed.

> *That kid's got an attention deficit hyperactivity disorder.*

He's learning disabled.

What's in a name? Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" -- making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as ADHD, depression, and LD. This happens despite the fact that the problems of most youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

Diagnosing Behavioral, Emotional, and Learning Problems

The thinking of those who study behavioral, emotional, and learning problems has long been dominated by models stressing *person* pathology. This is evident in discussions of cause, diagnosis, and intervention strategies. Because so much discussion focuses on person pathology, diagnostic systems have not been developed in ways that adequately account for psychosocial problems.

Many practitioners who use prevailing diagnostic labels understand that most problems in human functioning result from the interplay of person and environment. To counter nature *versus* nurture biases in thinking about problems, it helps to approach all diagnosis guided by a broad perspective of what determines human behavior.

A Broad View of Human Functioning

Before the 1920's, dominant thinking saw human behavior as determined primarily by person variables, especially inborn characteristics. As behaviorism gained in influence, a strong competing view arose. Behavior was seen as shaped by environmental influences, particularly the stimuli and reinforcers one encounters.

Today, human functioning is viewed in *transactional* terms -- as the product of a reciprocal interplay between person and environment (Bandura, 1978). However, prevailing approaches to labeling and addressing human problems still create the impression that problems are determined by *either* person or environment variables. This is both unfortunate and unnecessary -- unfortunate because such a view limits progress with respect to research and practice, unnecessary because a transactional view encompasses the position that problems may be caused by person, environment, or both. This broad paradigm encourages a comprehensive perspective of cause and correction.

Toward a Broad Framework

A broad framework offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid over-diagnosing internal pathology. Such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems caused by the environment are placed at one end of the continuum (referred to as Type I problems). At the other end are problems caused primarily by pathology within the person (Type III problems). In the middle are problems stemming from a relatively equal contribution of environmental and person sources (Type II problems).

Diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, person variables account for more of the problem (thus e<--->P).

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the the person (P)

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        E              (E<--->p)        E<--->P        (e<--->P)            P
        |---------------------------------------------|---------------------------------------------|
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Type I	Type II	Type III
problems	problems	problems

•caused primarily by environments and systems that are deficient and/or hostile

•caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)

•caused primarily by person factors of a pathological nature

•problems are mild to moderately severe and narrow to moderately pervasive

•problems are mild to moderately severe andpervasive

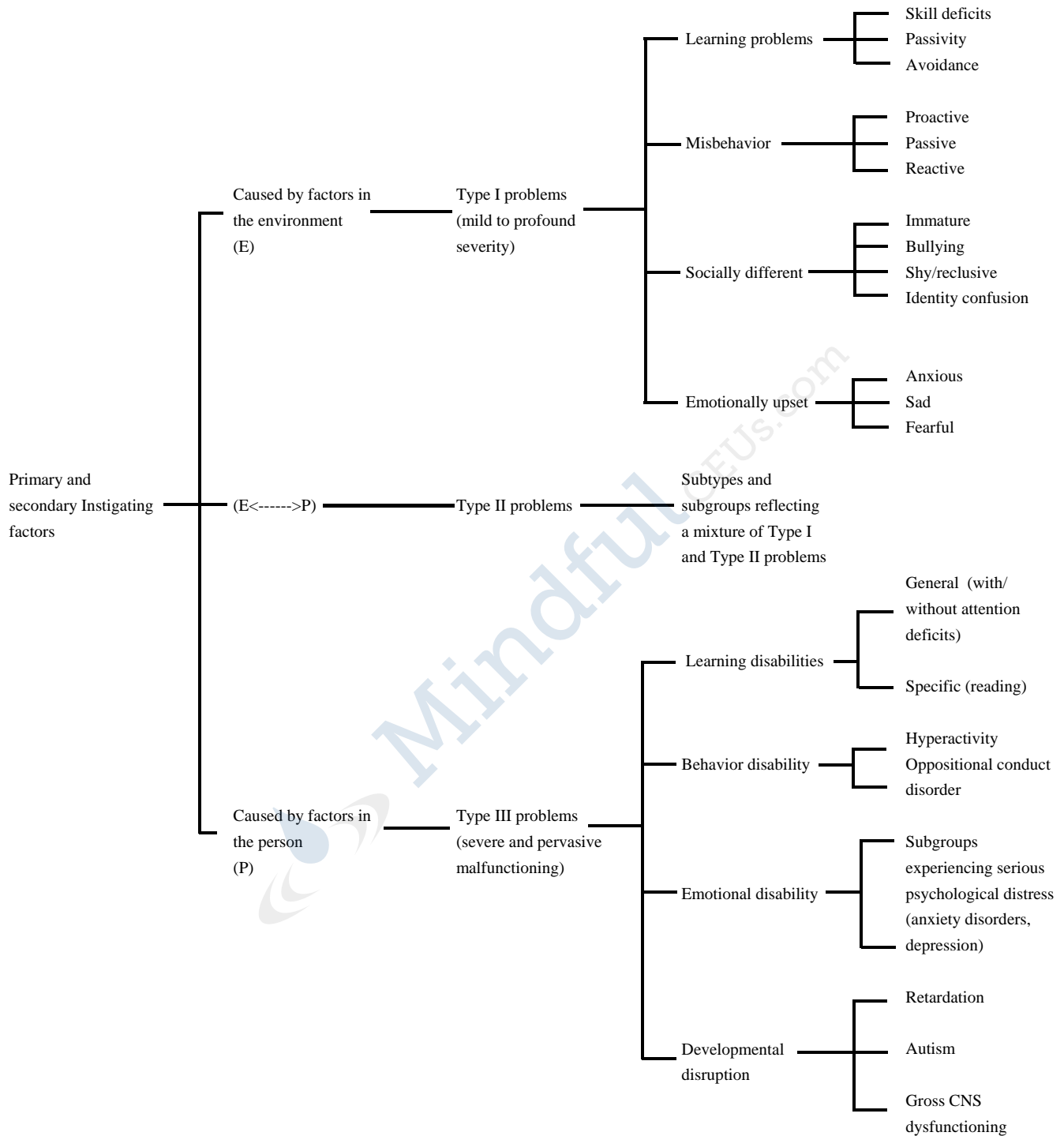•problems are moderate to profoundly severe and moderate to broadly pervasive

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Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. However, the above conceptual scheme shows the value of starting with a broad model of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward blaming the victim (Ryan, 1971). It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

There is a substantial community-serving component in policies and procedures for classifying and labeling exceptional children and in the various kinds of institutional arrangements made to take care of them. "To take care of them" can and should be read with two meanings: to give children help and to exclude them from the community.
Nicholas Hobbs

After the general groupings are identified, it becomes relevant to consider the value of differentiating subgroups or subtypes within each major type of problem. For example, subtypes for the Type III category might first differentiate behavioral, emotional, or learning problems arising from serious internal pathology (e.g., structural and functional malfunctioning within the person that causes disorders and disabilities and disrupts development). Then subtypes might be differentiated within each of these categories. For illustrative purposes: The figure on the next page presents some ideas for subgrouping Type I and III problems.

Categorization of Type I, II, and III Problems

Primary and secondary Instigating factors

Caused by factors in the environment (E)

→ Type I problems (mild to profound severity)

- Learning problems
  - Skill deficits
  - Passivity
  - Avoidance
- Misbehavior
  - Proactive
  - Passive
  - Reactive
- Socially different
  - Immature
  - Bullying
  - Shy/reclusive
  - Identity confusion
- Emotionally upset
  - Anxious
  - Sad
  - Fearful

(E<------>P) → Type II problems → Subtypes and subgroups reflecting a mixture of Type I and Type II problems

Caused by factors in the person (P) → Type III problems (severe and pervasive malfunctioning)

- Learning disabilities
  - General (with/without attention deficits)
  - Specific (reading)
- Behavior disability
  - Hyperactivity
  - Oppositional conduct disorder
- Emotional disability
  - Subgroups experiencing serious psychological distress (anxiety disorders, depression)
- Developmental disruption
  - Retardation
  - Autism
  - Gross CNS dysfunctioning

II. Understanding the Causes of Problems Related to Affect and Mood

B. Environmental Situations and Potentially Stressful Events and Common Behavioral Responses

The American Academy of Pediatrics has prepared a guide on mental health for primary care providers. The guide suggests that commonly occurring stressful events in a youngsters life can lead to common behavioral responses. Below are portions of Tables that give an overview of such events and responses.

Environmental Situations and Potentially Stressful Events Checklist

Challenges to Primary Support Group
- Challenges to Attachment Relationship
- Death of a Parent or Other Family Member
- Marital Discord
- Divorce
- Domestic Violence
- Other Family Relationship Problems
- Parent-Child Separation

Changes in Caregiving
- Foster Care/Adoption/Institutional Care
- Substance-Abusing Parents
- Physical Abuse
- Sexual Abuse
- Quality of Nurture Problem
- Neglect
- Mental Disorder of Parent
- Physical Illness of Parent
- Physical Illness of Sibling
- Mental or Behavioral disorder of Sibling

Other Functional Change in Family
- Addition of Sibling
- Change in Parental Caregiver

Community of Social Challenges
- Acculturation
- Social Discrimination and/or Family Isolation

Educational Challenges
- Illiteracy of Parent
- Inadequate School Facilities
- Discord with Peers/Teachers

Parent or Adolescent Occupational Challenges
- Unemployment
- Loss of Job
- Adverse Effect of Work Environment

Housing Challenges
- Homelessness
- Inadequate Housing
- Unsafe Neighborhood
- Dislocation

Economic Challenges
- Poverty
- Inadequate Financial Status

Legal System or Crime Problems

Other Environmental Situations
- Natural Disaster
- Witness of Violence

Health-Related Situations
- Chronic Health Conditions
- Acute Health Conditions

Common Behavioral Responses to Environmental Situations and Potentially Stressful Events

INFANCY-TODDLERHOOD (0-2Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
   N/A
Emotions and Moods
   Change in crying
   Change in mood
   Sullen, withdrawn
Impulsive/Hyperactive or Inattentive Behaviors
   Increased activity
Negative/Antisocial Behaviors
   Aversive behaviors, i.e., temper tantrum, angry outburst
Feeding, Eating, Elimination Behaviors
Change in eating
   Self-induced vomiting
   Nonspecific diarrhea, vomiting
Somatic and Sleep Behaviors
   Change in sleep
Developmental Competency
   Regression or delay in developmental attainments
   Inability to engage in/sustain play
Sexual Behaviors
   Arousal behaviors
Relationship Behaviors
   Extreme distress with separation
   Absence of distress with separation
   Indiscriminate social interactions
   Excessive clinging
   Gaze avoidance, hypervigilance

MIDDLE CHILDHOOD (6-12Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
   Transient physical complaints
Emotions and Moods
   Sadness
   Anxiety, Changes in mood
   Preoccupation with stressful situations
   Self -destructive
   Fear of specific situations
   Decreased self-esteem
Impulsive/Hyperactive or Inattentive Behaviors
   Inattention, High activity level, Impulsivity
Negative/Antisocial Behaviors
   Aggression
   Noncompliant
   Negativistic
Feeding, Eating, Elimination Behaviors
Change in eating
   Transient enuresis, encopresis
Somatic and Sleep Behaviors
   Change in sleep
Developmental Competency
   Decrease in academic performance
Sexual Behaviors
   Preoccupation with sexual issues
Relationship Behaviors
   Change in school activities
   Change in social interaction such as withdrawal
   Separation fear/ Fear being alone
Substance Use/Abuse...

EARLY CHILDHOOD (3-5Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
   N/A
Emotions and Moods
   Generally sad
   Self-destructive behaviors
Impulsive/Hyperactive or Inattentive Behaviors
   Inattention
   High activity level
Negative/Antisocial Behaviors
   Tantrums
   Negativism
   Aggression
   Uncontrolled, noncompliant
Feeding, Eating, Elimination Behaviors
   Change in eating
   Fecal soiling
   Bedwetting
Somatic and Sleep Behaviors
   Change in sleep
Developmental Competency
   Regression or delay in developmental attainments
Sexual Behaviors
   Preoccupation with sexual issues
Relationship Behaviors
   Ambivalence toward independence
   Socially withdrawn, isolated
   Excessive clinging
   Separation fears
   Fear of being alone

ADOLESCENCE (13-21Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
   Transient physical complaints
Emotions and Moods
   Sadness, Self-destructive
   Anxiety
   Preoccupation with stress
   Decreased self-esteem
   Change in mood
Impulsive/Hyperactive or Inattentive Behaviors
   Inattention, impulsivity
   High activity level
Negative/Antisocial Behaviors
   Aggression
   Antisocial behavior
Feeding, Eating, Elimination Behaviors
   Change in appetite
   Inadequate eating habits
Somatic and Sleep Behaviors
   Inadequate sleeping habits
   Oversleeping
Developmental Competency
   Decrease in academic achievement
Sexual Behaviors
   Preoccupation with sexual issues
Relationship Behaviors
   Change in school activities
   School absences
   Change in social interaction such as withdrawal
Substance Use/Abuse...

* Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics

II. Understanding the Causes of Problems Related to Affect and Mood

C. Overview of Protective and Risk Factors

Protective Factors for Populations Served by the Administration on Children, Youth, and Families:
A Literature Review and Theoretical Framework (2103)

Excerpt from the Executive Summary
http://www.dsgonline.com/acyf/DSG%20Protective%20Factors%20Literature%20Review%202013%20Exec%20Summary.pdf

A growing body of evidence from research and practice show that many children and youth, even those who have experienced trauma or other adversity, are able to avoid or mitigate negative outcomes more readily than others. These characteristics strongly associated with improved outcomes, or protective factors, can be assessed as interim results to help determine the
effectiveness of investments in services and supports. Thus, a protective factor framework offers a promising tool to enhance and develop new interventions and to improve the well-being of children and youth.
...

Key Findings

Empirical evidence for protective factors is found at the individual, relationship, and community levels of influence for all five populations. Table 1 shows the protective factors present among children and youth in each population, as well as the strength of the evidence for each factor and population. Protective factors often occur as individual attributes of children or youth (agency, self-regulation, and problem-solving skills), or as adult caregiver characteristics and skills (parenting competencies, caring adults). In addition, evidence increasingly indicates that community protective factors play an important role in the lives of at-risk or troubled children and youth. Positive school and community environments and economic opportunities and resources were identified as protective factors in several focus populations.

Ten protective factors were identified with highest levels of evidence across the in-risk populations. Reviewing the evidence across populations identified a subset of protective factors that had the most empirical support. An analysis based on evidence and programmatic considerations resulted in a subset of protective factors with the most empirical support across populations.
...
Evidence of protective factors for in-risk populations is strongest for the developmental period of adolescence. The scope and number of studies in this review did not provide sufficient evidence to draw conclusions about the salience of protective factors for all developmental stages. One exception to this trend, however, was for adolescent populations. A majority of studies examined protective factors among children and youth over the age of 12.

Still a growing body of literature suggests that developmental stage is an important consideration for which protective factors are most salient or most responsive. Recent evidence of neurological and cognitive factors is concentrated on infancy and early childhood. Many social and behavioral theories state that family protective factors are particularly important during early and middle childhood. Community level factors reflected by the stability of children's living situations are important during infancy and early childhood. The availability of economic resources and opportunities are most salient for adolescent and young adult populations.
...

Top 10 **Protective Factors Across ACYF Populations**

Individual level

Relational skills: Relational skills encompass two main components: 1) a youth's ability to form positive bonds and connections (e.g., social competence, being caring, forming positive attachments and prosocial relationships); and 2) interpersonal skills such as communication skills, conflict resolution skills, and self-efficacy in conflict situations.

Self-regulation skills: Self-regulation skills refer to a youth's ability to manage or control emotions and behaviors. This skill set can include self-mastery, anger management, character, long-term self-control, and emotional intelligence.

Problem-solving skills: Includes general problem-solving skills, self-efficacy in conflict situations, higher daily living scores, decision-making skills, planning skills, adaptive functioning skills and task-oriented coping skills.

Involvement in positive activities: Refers to engagement in and/or achievement in school, extra-curricular activities, employment, training, apprenticeships or military.

Relationship level

Parenting competencies: Parenting competencies refers to two broad categories of parenting: 1) parenting skills (e.g., parental monitoring and discipline, prenatal care, setting clear standards and developmentally appropriate limits) and 2) positive parent-child interactions (e.g., close relationship between parent and child, sensitive parenting, support, caring).

Positive peers: Refers to friendships with peers, support from friends, or positive peer norms.

Caring adult(s): This factor most often refers to caring adults beyond the nuclear family, such as mentors, home visitors (especially for pregnant and parenting teens), older extended family members, or individuals in the community.

Community level

Positive community environment: Positive community environment refers to neighborhood advantage or quality, religious service attendance, living in a safe and higher quality environment, a caring community, social cohesion, and positive community norms.

Positive school environment: A positive school environment primarily is defined as the existence of supportive programming in schools.

Economic opportunities: Refers to household income and socioecomic status; a youth's self-perceived resources; employment, apprenticeship, coursework and/or military involvement; and placement in a foster care setting (from a poor setting).

Risk and protective factors for depression that adolescents can modify:
A systematic review and meta-analysis of longitudinal studies
by K.E. Cairns, M.B.H. Yap, P.D. Pilkington, & A.F. Jorm (2014).
Journal of Affective Disorders, 169, 61–75.

Excerpts from the Abstract

Adolescence is a peak time for the onset of depression, but little is known about what adolescents can do to reduce their own level of risk. To fill this gap, a review was carried out to identify risk and protective factors for depression during adolescence that are modifiable by the young person.

We identified 113 publications which met the inclusion criteria. Putative risk factors implicated in the development of depression for which there is a sound evidence base, and which are potentially modifiable during adolescence without professional intervention, are: substance use (alcohol, tobacco, cannabis, other illicit drugs, and polydrug use); dieting; negative coping strategies; and weight. Modifiable protective factors with a sound evidence base are healthy diet and sleep.

Findings from this review suggest that future health education campaigns or self-help prevention interventions targeting adolescent depression should aim to reduce substance use (alcohol, tobacco, cannabis, other illicit drugs, and polydrug use); dieting; and negative coping strategies; and promote healthy weight; diet; and sleep patterns.

A. The Prevention of Mental Disorders in School-Aged Children: State of the Field

Excerpts from Greenberg, Domitrovich, & Bumbarger (2001). *Prevention & Treatment*, 4(1)

The Role of Risk and Protective Factors in Preventive Interventions

Public health models have long based their interventions on reducing the risk factors for disease or disorder as well as promoting processes that buffer or protect against risk. Community-wide programs have focused on reducing both environmental and individual behavioral risks for both heart and lung disease and have demonstrated positive effects on health behaviors as well as reductions in smoking (Farquhar et al., 1990; Jacobs et al., 1986; Pushka, Tuomilehto, Nissinen, & Korhonen, 1989).

Risk factors and their operation. During the past decades, a number of risk factors have been identified that place children at increased risk for psychopathology. Coie et al. (1993, p. 1022) grouped empirically derived, generic risk factors into the following seven individual and environmental domains:

1. *Constitutional handicaps*: perinatal complications, neurochemical imbalance, organic handicaps, and sensory disabilities;

2. *Skill development delays*: low intelligence, social incompetence, attentional deficits, reading disabilities, and poor work skills and habits;

3. *Emotional difficulties*: apathy or emotional blunting, emotional immaturity, low self-esteem, and emotional dysregulation;

4. *Family circumstances*: low social class, mental illness in the family, large family size, child abuse, stressful life events, family disorganization, communication deviance, family conflict, and poor bonding to parents;

5. *Interpersonal problems*: peer rejection, alienation, and isolation;

6. *School problems*: scholastic demoralization and school failure;

7. *Ecological risks*: neighborhood disorganization, extreme poverty, racial injustice, and unemployment.

Theory and research support a number of observations about the operation of these risk factors and the development of behavioral maladaptation. First, development is complex and it is unlikely that there is a single cause of, or risk factor for, any disorder. It is doubtful that most childhood social and behavioral disorders can be eliminated by only treating causes that are purported to reside in the child alone (Rutter, 1982). Furthermore, there are multiple pathways to most psychological disorders. That is, different combinations of risk factors may lead to the same disorder and no single cause may be sufficient to produce a specific negative outcome (Greenberg, Speltz, & DeKlyen, 1993). In addition, risk factors occur not only at individual or family levels, but at all levels within the ecological model (Kellam, 1990)...

Protective factors and their operation.   Protective factors are variables that reduce the likelihood of maladaptive outcomes under conditions of risk. Although less is known about protective factors and their operation (Kazdin, 1991; Luthar, 1993; Rutter, 1985), at least three broad domains of protective factors have been identified. The first domain includes characteristics of the individual such as cognitive skills, social-cognitive skills, temperamental characteristics, and social skills (Luthar & Zigler, 1992). The quality of the child's interactions with the environment comprise the second domain. These interactions include secure attachments to parents (Morissett, Barnard, Greenberg, Booth, & Spieker, 1990) and attachments to peers or other adults who engage in positive health behaviors and have prosocial values (Hawkins & Catalano, 1992). A third protective domain involves aspects of the mesosystem and exosystem, such as school-home relations, quality schools, and regulatory activities. Similar to risk factors, some protective factors may be more malleable and thus, more effective targets for prevention...

Preventive Intervention: Definition of Levels

The Institute of Medicine (1994) report clarified the placement of preventive intervention within the broader mental health intervention framework by differentiating it from treatment (i.e., case identification; standard treatment for known disorders) and maintenance (i.e., compliance with long-term treatment to reduce relapse; after-care, including rehabilitation). Based, in part, on Gordon's (1983, 1987) proposal to replace the terms primary, secondary, and tertiary prevention, the IOM Report defined three forms of preventive intervention: universal, selective, and indicated. Notwithstanding the recent redefinition of prevention by NIMH (Greenberg & Weissberg, in press; National Institute of Mental Health, 1998), we retain the distinctions as defined by the IOM report as well as the recent Surgeon General's report (U.S. Department of Health and Human Services, 1999).

Universal preventive interventions target the general public or a whole population group that has not been identified on the basis of individual risk. Exemplars include prenatal care, childhood immunization, and school-based competence enhancement programs. Because universal programs are positive, proactive, and provided independent of risk status, their potential for stigmatizing participants is minimized and they may be more readily accepted and adopted. Selective interventions target

individuals or a subgroups (based on biological or social risk factors) whose risk of developing mental disorders is significantly higher than average. Examples of selective intervention programs include: home visitation and infant day care for low-birth weight children, preschool programs for all children from poor neighborhoods, and support groups for children who have suffered losses/traumas. Indicated preventive interventions target individuals who are identified as having prodromal signs or symptoms or biological markers related to mental disorders, but who do not yet meet diagnostic criteria. Providing social skills or parent-child interaction training for children who have early behavioral problems are examples of indicated interventions...

Effective Preventive Interventions: Universal Programs

Fourteen universal programs were identified as meeting our criteria for inclusion based on study design and positive outcomes related to psychopathology. For ease of discussion, they can be classified into 4 categories: violence prevention programs; more generic social/cognitive skill-building programs, programs focused on changing the school ecology, and multi-component, multi-domain programs. Although we will use this typology for discussion purposes, in actuality the programs do not fall along a linear continuum and may include characteristics of more than one of the above categories. This typology is useful however in that it is somewhat representative of the recent progress of prevention science, as the field continues to move in the direction of comprehensive, multi-system programs that target multiple risk factors across both individual and ecological domains...

B. AAnnotated "lists" of Empirically Suported/ Evidence-Based Interventions for School-Aged Children and Adolescents

*T*he following table provides a list of lists, with indications of what each list covers, how it was developed, what it contains, and how to access it.

I. Universal Focus on Promoting Healthy Development

A. *Safe and Sound. An Educational Leader's Guide to Evidence-Based Social & Emotional Learning Programs* (2002). The Collaborative for Academic, Social, and Emotional Learning (CASEL).

1. *How it was developed:* Contacts with researchers and literature search yielded 250 programs for screening; 81 programs were identified that met the criteria of being a multiyear program with at least 8 lessons in one program year, designed for regular ed classrooms, and nationally available.

2. *What the list contains:* Descriptions (purpose, features, results) of the 81 programs.

3. *How to access:* CASEL (http://www.casel.org)

B. *Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs (2004).* Social Develop. Res. Group, Univ. of Wash.

1. *How it was developed:* 77 programs that sought to achieve positive youth development objectives were reviewed. Criteria used: research designs employed control or comparison group and had measured youth behavior outcomes.

2. *What the list contains:* 25 programs designated as effective based on available evidence.

3. *How to access:* (http://ann.sagepub.com/content/591/1/98.abstract)

II. Prevention of Problems; Promotion of Protective Factors

A. *Blueprints for Violence Prevention* (2004). Center for the Study and Prevention of Violence, Institute of Behavioral Science, University Colorado, Boulder.

1. *How it was developed:* Review of over 600 delinquency, drug, and violence prevention programs based on a criteria of a strong research design, evidence of significant deterrence effects, multiple site replication, sustained effects.

2. *What the list contains: 11* model programs and 21 promising programs.

3. *How to access:* Center for the Study and Prevention of Violence (http://www.colorado.edu/cspv/blueprints/modelprograms.html)

B. *Exemplary Substance Abuse and Mental Health Programs* (SAMHSA).

1. *How it was developed:* These science-based programs underwent an expert consensus review of published and unpublished materials on 18 criteria (e.g., theory, fidelity, evaluation, sampling, attrition, outcome measures, missing data, outcome data, analysis, threats to validity, integrity, utility, replications, dissemination, cultural/age appropriateness.) The reviews have grouped programs as "models," "effective," and "promising" programs .

2. *What the list contains*: Prevention programs that may be adapted and replicated by communities.

3. *How to access:* SAMHSA's National Registry of Evidence-based Programs and Practices (http://nrepp.samhsa.gov)

C. *Preventing Drug Use Among Children & Adolescents. Research Based Guide* (1997). National Institute on Drug Abuse (NIDA).

   1. *How it was developed:* NIDA and the scientists who conducted the research developed research protocols. Each was tested in a family/school/community setting for a reasonable period with positive results.

   2. *What the list contains:* 10 programs that are universal, selective, or indicated.

   3. *How to access:* NIDA (http://www.nida.nih.gov/prevention/prevopen.html)

D. *Safe, Disciplined, and Drug-Free Schools Expert Panel Exemplary Programs* (2001). U.S. Dept. of Educ. Safe & Drug Free Schools

   1. *How it was developed:* Review of *132* programs submitted to the panel. Each program reviewed in terms of quality, usefulness to others, and educational significance.

   2. *What the list contains:* 9 exemplary and *33* promising programs focusing on violence, alcohol, tobacco, and drug prevention.

   3. *How to access*: U.S. Dept. of Education – (http://www2.ed.gov/admins/lead/safety/exemplary01/panel.html)

III. Early Intervention: Targeted Focus on Specific Problems or at Risk Groups

A. *The Prevention of Mental Disorders in School-Aged Children:* A Review of the Effectiveness of Prevention Programs (2001). Prevention Research Center for the Promotion of Human Development, Pennsylvania State U.

   1. *How it was developed:* Review of scores of primary prevention programs to identify those with quasi-experimental or random-ized trials and been found to reduce symptoms of psychopathology or factors commonly associated with an increased risk for later mental disorders.

   2. *What the list contains:* 34 universal and targeted interventions that have demonstrated positive outcomes under rigorous evaluation and the common characteristics of these programs.

   3. *How to access:* (http://prevention.psu.edu/pubs/documents/mentaldisordersfullreport.pdf)

IV. Treatment for Problems

A. American Psychological Association's Society for Clinical Child and Adolescent Psychology, Committee on Evidence-Based Practice List

   1. *How it was developed:* Committee reviews outcome studies to determine how well a study conforms to the guidelines of the Task Force on Promotion and Dissemination of Psychological Procedures (1996).

   2. *What it contains:* Reviews of the following:

   >*Depression (dysthymia):* Analyses indicate only one practice meets criteria for "well-established treatment"(best supported) and two practices meet criteria for "probably efficacious"(promising)
   >*Conduct/oppositional problems:* Two meet criteria for well established treatments: videotape modeling parent training programs (Webster-Stratton) and parent training program based on Living with Children (Patterson and Guillion). Ten practices identified as probably efficacious.
   >*ADHD:* Behavioral parent training, behavioral interventions in the classroom, and stimulant medication meet criteria for well established treatments. Two others meet criteria for probably efficacious.
   >*Anxiety disorders*: For phobias participant modeling and reinforced practice are well established; filmed modeling, live modeling, and cognitive behavioral interventions that use self instruction training are probably efficacious. For anxiety disorders, cognitive-behavioral procedures with and without family anxiety management, modeling, in vivo exposure, relaxation training, and reinforced practice are listed as probably efficacious.

   Caution: Reviewers stress the importance of (a) devising developmentally and culturally sensitive interventions targeted to the unique needs of each child; (b) a need for research informed by clinical practice.

   3. *How it can be accessed*: http://www.effectivechildtherapy.com

V. Review/Consensus Statements/ Compendia of Evidence Based Treatments

A. *School-Based Prevention Programs for Children & Adolescents* (1995). J.A. Durlak. Sage: Thousand Oaks, CA. Reports results from 130 controlled outcome studies that support "a secondary prevention model emphasizing timely intervention for subclinical problems detected early.... In general, best results are obtained for cognitive-behavioral and behavioral treatments & interventions targeting externalizing problems."

B. *Mental Health and Mass Violence:* Evidence-based early psychological intervention for victims/ survivors of mass violence. A workshop to reach consensus on best practices (U.S. Departments of HHS, Defense, Veterans Affairs, Justice, and American Red Cross). Access at: (http://www.nimh.nih.gov/health/publications/massviolence_34410.pdf)

C. *Society of Pediatric Psychology,* Division 54, American Psychological Association, *Journal of Pediatric Psychology.* Articles on empirically supported treatments in pediatric psychology related to obesity, feeding problems, headaches, pain, bedtime refusal, enuresis, encopresis, and symptoms of asthma, diabetes, and cancer.

D. *Preventing Crime: What works, what doesn't, what's promising. A Report to the United States Congress* (1997) by L.W. Sherman, Denise Gottfredson, et al. Washington, DC: U.S. Dept. of Justice. Reviews programs funded by the OJP for crime, delinquency and substance use. (https://www.ncjrs.gov/pdffiles/171676.pdf). Also see Denise Gottfredson's book: *Schools and delinquency* (2001). New York: Cambridge Press.

E. **School Violence Prevention Initiative Matrix of Evidence-Based Prevention Interventions** (1999). Center for Mental Health Services SAMHSA. Provides a synthesis of several lists cited above to highlight examples of programs which meet some criteria for a designation of evidence based for violence prevention and substance abuse prevention. (i.e., Synthesizes lists from the Center for the Study and Prevention of Violence, Center for Substance Abuse Prevention, Communities that Care, Dept. of Education, Department of Justice, Health Resources and Services Administration, National Assoc. of School Psychologists)

F. The *What Works Clearinghouse* (WWC). Collects, screens, and identifies studies of effectiveness of educational interventions (programs, products, practices, and policies). (http://ies.ed.gov/ncee/wwc/)

Also see the Center's Online Clearinghouse Quick Find on *Empirically-Supported/Evidence-Based Interventions* – http://smhp.psych.ucla.edu/qf/ests.htm

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BUT KEEP IN MIND THAT THE NEEDS OF SCHOOLS ARE MORE COMPLEX!

Currently, there are about 91,000 public schools in about 15,000 districts. Over the years, most (but obviously not all) schools have instituted programs designed with a range of behavior, emotional, and learning, problems in mind. School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. Some programs are provided throughout a district, others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at risk." The activities may be implemented in regular or special education classrooms or as "pull out" programs and may be designed for an entire class, groups, or individuals. There also may be a focus on primary prevention and enhancement of healthy development through use of health education, health services, guidance, and so forth – though relatively few resources usually are allocated for such activity.

There is a large body of research supporting the promise of specific facets of this activity. However, no one has yet designed a study to evaluate the impact of the type of comprehensive, multifaceted approach needed to deal with the complex range of problems confronting schools.

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It is either naive or irresponsible to ignore the connection between children's performance in school and their experiences with malnutrition, homelessness, lack of medical care, inadequate housing, racial and cultural discrimination, and other burdens . . . .

Harold Howe II

****

. . . consider the American penchant for ignoring the structural causes of problems. We prefer the simplicity and satisfaction of holding individuals responsible for whatever happens: crime, poverty, school failure, what have you. Thus, even when one high school crisis is followed by another, we concentrate on the particular people involved – their values, their character, their personal failings – rather than asking whether something about the system in which these students find themselves might also need to be addressed.

Alfie Kohn, 1999

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What the best and wisest parent wants for (her)/his own child that must the community want for all of its children. Any other idea . . . is narrow and unlovely.

John Dewey

****

C. Preventing Depression in Youth

The Prevention of Adolescent Depression
by T.R.G. Gladstone, W.R. Beardslee, & E.E. O'Connor (2011).
Psychiatr Clin North Am., 34, 35–52.
http://www.sciencedirect.com/science/article/pii/S0193953X10001073

This article provides a conceptual framework for research on the prevention of depression in youth and reviews the recent literature on prevention efforts targeting children and adolescents. Prevention efforts should target both specific and non-specific risk factors, enhance protective factors, use a developmental approach, and target selective and/or indicated samples. In general, a review of the literature indicates that prevention programs utilizing cognitive behavioral and/or interpersonal approaches, and family-based prevention strategies, are most helpful. Overall, it appears that there is reason for hope regarding the role of interventions in preventing depressive disorders in youth. Several new directions for future research on the prevention of depression in youth were outlined.

D. About Positive Psychology

Psychotherapy has for some time focused on an individual's troubles with a view to helping the person deal with weaknesses. In general, too little attention has been given to the idea that increasing an individual's strengths with a view to helping the person find happiness may be beneficial. (The emphasis on happiness stresses more than just feeling good. Happiness is associated with well-being – health, success, extroversion.) This focus is a major concern of positive psychology.

What is Positive Psychology?

Positive psychology is devoted to the study of positive emotions, positive character traits, and positive enabling institutions. The term represents an effort to unite "scattered and disparate lines of theory and research about what makes life most worth living." The goal is to supplement "what is known about human suffering, weakness, and disorder." "The intent is to have a more complete and balanced scientific understanding of the human experience – the peaks, the valleys, and everything in between." With a view to application, there is a focus on creating evidence-based practices for "making people lastingly happier."

Classifying Character Strengths and Virtues

As an essential step in delineating well-being, Seligman and his colleagues (2004) have generated a classification schema for character strengths and values and published a handbook* designed "to do for psychological well-being what the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* ... does for psychological disorders...."

The schema encompasses six overarching virtues expressed in most cultures around the world: (1) wisdom & knowledge, (2) courage, (3) humanity, (4) justice, (5) temperance, and (6) transcendence. A total of 24 strengths of character are grouped under these virtues.

*Peterson, C. & Seligman, M. (2004). *Character strengths and virtues: A handbook and classification.* Washington, DC: Amer. Psychological Association.

Efficacy of Interventions to Increase Individual Happiness

Seligman et al. stress that "the word *happiness* is a scientifically unwieldy term and that its serious study involves dissolving the term into at least three distinct and better-defined routes to 'happiness'" – "(a) positive emotion and pleasure (the pleasant life); (b) engagement (the engaged life); and (c) meaning (the meaningful life)." Thus, their use of the term "happiness" is atheoretical – designed to stress the overall aim of positive psychology and to refer jointly to positive emotion, engagement, and meaning. They stress that the ability to integrate all three aspects is seen as more likely to be personally satisfying.

Instead of studying interventions focused on reducing suffering, their emphasis is on ways to enhance happiness. This is seen as leading to a form of psychotherapy where an individual goes not just to discuss weaknesses, but also strengths.

In studying interventions, they have identified a large set of practices that make claims about enhancing happiness, and they are pursuing randomized control trials to study them. They report some early findings and conclude that specific interventions can make people lastingly happier and that the findings have implications "for the future of positive interventions and perhaps for clinical interventions."

A Few Implications for Mental Health in Schools

An understanding of positive psychology is consistent with the efforts of schools to

- avoid a deficit view of students and emphasize strengths, assets, resilience, protective buffers

- develop a supportive, nurturing, and caring climate in classrooms and school-wide

- enhance student self-regulation

- promote social and emotional learning

Positive Mood is 'Contagious' in Teens, Depression Is Not

Nancy A. Melville

September 16, 2015

http://www.medscape.com/viewarticle/851073

Positive, healthy, mood states can be '"contagious" and are associated with a reduced risk for, and recovery from, depression in adolescents. However, depressive mood does not appear to have the same influence, new research shows.

"Having sufficient friends with healthy mood can halve the probability of developing, or double the probability of recovering from, depression over a 6- to 12-month period on an adolescent social network," the authors, led by Thomas House, PhD, a senior lecturer in applied mathematics at the University of Manchester, in the United Kingdom, write.

"Our results suggest that promotion of friendship between adolescents can reduce both incidence and prevalence of depression," the investigators add.

The study was published online August 19, 2015 in the Proceedings of the Royal Society of London Series B. (See "Spreading of healthy mood in adolescent social networks" by E.M. Hill, F.E. Griffiths, & T. House http://rspb.royalsocietypublishing.org/content/282/1813/20151180/)

Unconscious Mimicry

Using a nonlinear, complex mathematical contagion model based on models used in assessing the spread of infectious disease, the researchers evaluated data on 3084 adolescents enrolled in US high schools from the in-home survey of the Add Health study, which assessed respondents' in-school friends.

Participants' mood states were further assessed according to Center for Epidemiologic Studies Depression Scale scores.

The data, taken from two time points 6 to 12 months apart, showed statistical significance in the transmission of healthy moods for participants who were surrounded by enough friends with a positive mindset, but a similar trend was not found with regard to depressive moods.

"Our complex contagion model suggests that adolescents with 5 or more healthy friends have half the probability of becoming depressed over a 6-12 month period compared to adolescents with no healthy friends, and that adolescents with 10 healthy friends have double the probability of recovering from depressive symptoms over a 6 to 12 month period compared to adolescents with 3 healthy friends," the authors write.

"If such an effect were demonstrated in an intervention study, this would massively outperform existing interventions," they add.

The authors also note that the data rule out the potential confounding issue of homophily, or the effect of people to be friends with others like themselves, which has been a controversial issue in similar research.

IV. Responding to the First Signs of Problems

A. Internalizing Problems

Excerpts from: *What Works to Prevent or Reduce Internalizing Problems or Socio-emotional Difficulties in Adolescents: Lessons from Experimental Evaluations of Social Interventions* M.A. Terzian, K. Hamilton, & S. Ericson (2011)

Left untreated, internalizing problems, such as a depressive or anxious mood, negative self-perceptions, and emotional distress, can undermine one's ability to succeed in school, live a healthy lifestyle, form and maintain close relationships with others, and, in general, accomplish life goals.
...
This synthesis presents lessons learned from 37 random-assignment social intervention programs for adolescents that are designed to prevent or treat internalizing problems.[i] Programs were identified by searching LINKS (Lifecourse Interventions to Nurture Kids Successfully),[ii] Child Trends' online database of rigorously-evaluated social interventions for children and youth. All interventions included in LINKS are social interventions evaluated using random assignment, intent-to-treat evaluations.

Findings from this literature review suggest that social interventions to address internalizing problems are most effective when they teach adolescents how to cope with negative thoughts and emotions, solve problems, and interact effectively with others. Therapeutic approaches, such as family therapy, group therapy, individual therapy, and treatment-focused, school-based approaches appear to be effective.[iii] Mixed results were found for programs including activities to increase self-esteem and programs directed at non-clinical populations of youth.

IV. Responding to the First Signs of Problems

B. Loneliness in Children

The Role of Loneliness in The Relationship Between Anxiety And Depression in Clinical And School-based Youth

C. Ebesutani, M. Fierstein, A.G. Viana, L. Trent, & J. Young (2015).
Psychology in the Schools, 52, 223-234.

Abstract

Identifying mechanisms that explain the relationship between anxiety and depression are needed. The Tripartite Model is one model that has been proposed to help explain the association between these two problems, positing a shared component called negative affect. The objective of the present study was to examine the role of loneliness in relation to anxiety and depression. A total of 10,891 school-based youth (Grades 2–12) and 254 clinical children and adolescents receiving residential treatment (Grades 2–12) completed measures of loneliness, anxiety, depression, and negative affect. The relationships among loneliness, anxiety, depression, and negative affect were examined, including whether loneliness was a significant intervening variable. Various mediational tests converged showing that loneliness was a significant mediator in the relationship between anxiety and depression. This effect was found across children (Grades 2–6) and adolescent (Grades 7–12) school-based youth. In the clinical sample, loneliness was found to be a significant mediator between anxiety and depression, even after introducing negative affect based on the Tripartite Model. Results supported loneliness as a significant risk factor in youths' lives that may result from anxiety and place youth at risk for subsequent depression. Implications related to intervention and prevention in school settings are also discussed.

Loneliness in Children and Adolescents:
What Do Schools and Teachers Need to Know and How Can They Help?

by Pamela Qualter (2003). Pastoral Care in Education, 21, 10-18.

Brief review of the research. Highlights long-term outcomes, especially in relation to the utility of intervening. Advocates an approach based on increasing social competence, developing mutual friendships and overcoming self-defeating thought patterns. Concludes that all components of loneliness should be addressed, not merely the lack of social skills. States that since the long-term outcomes of loneliness are as yet unknown, there is no practical and ethical justification for focusing interventions on an individual. Interventions that involve the whole-school or whole-class are theoretically capable of alleviating loneliness in childhood.

How to Help Your High-Schooler With Loneliness
By Kate Kelly (2014)

Some kids with learning and attention issues find that they're less lonely once they start high school. Their world gets bigger, with more kids and more opportunities. Still, loneliness may continue to be problem for some kids. The good news: Parents can help these teens make the most of the new options that are out there for them. Here are six ways to help.

Make your child aware of all that's available.

Most high schools have a lot of extracurricular opportunities. There's a good chance there's a club or volunteer activity that may interest your teen. Churches, town sports leagues, the local youth orchestra and even an afterschool job can be good places for teens to make friends. Check out clubs and meetings in your area that might be a good fit in case your child misses something. Then you can mention what you find in a low-key way.

Tap into the faculty.

High school teachers often have passions that they like to share with their students. If your child has a specific interest or skill, ask around. There may be a small group of kids who have the same passion and a teacher who shares that interest.

Monitor new friendships.

Sometimes teens who are lonely fall in with a group that's not committed to academics or high school culture in general. If you don't think your teen's new friends are a good influence, have a candid discussion about your concerns. You don't have to forbid him from seeing these teens (unless he's at high risk). But you can encourage him to get involved with groups outside school that are better suited to his interests.

Get outside help if necessary.

Teens who are lonely may self-medicate by taking drugs, drinking or engaging in other risky behaviors. If you see signs that your child might be going down this path or if he seems depressed, he needs help. Your pediatrician or your child's school may have suggestions about professionals in your area.

Encourage him to volunteer.

Helping others can be beneficial for your child. It can make him feel needed, and help him feel a part of something. Where to look? If you're connected to a faith-based organization, that would be a good place to start. Other possibilities include animal shelters, senior centers or local political offices and civic organizations.

Help him envision his future.

As kids with learning and attention issues make their way through high school, the thought of what's next can make them feel very alone. Their peers may be planning for college while they're less sure they'll get in or even want to go.

If your child has an IEP, start transition planning early in high school. This can help him feel more in control and part of a team that's thoughtfully helping him plan for life after high school. If your child doesn't have an IEP, you can still work with him to plan for life after high school.

High school students have many more opportunities to become involved and be a part of the action. This can help them feel less isolated and more connected. An important role for parents is helping their teens with learning and attention issues identify these opportunities and develop the confidence to try them. Learn more about how you can support your teen and help him build relationships.

IV. Responding to the First Signs of Problems

C. Depression in School

Depression in School: A Student's Trial

DDepression Community -- HealthyPlace.com

Teachers are trained to handle students who lack discipline, the slow learners, the extremely bright, and even kids faced with ADHD. What I've discovered, though, is that they aren't prepared to teach the students suffering from depression. Just like anyone else, teachers are very perceptive when it comes to identifying disturbed, possibly depressed students in their class, yet they often seem incapable of and uninterested in helping that student.

When I was depressed my sophomore and junior years in high school, the academic world was the last place I wanted to be. Like anyone suffering from depression, I wasn't deliberately trying to disrespect the teacher's efforts to conduct a class, but the depression overwhelmed me so that I could only see things in the broad spectrum, as opposed to concentrating on one situation at a time, such as a single class.

I found that the majority of my teachers dealt with me in one of two ways. The solution easiest for them was to ignore the fact that I wasn't absorbing any of the information being taught and simply assume that the apathy they were perceiving was typical of high schoolers. The other path was that of talking to me on a personal level. I think we are all aware of the very well defined student-teacher line; therefore, for teachers to ask the student to discuss their problems puts them in a very awkward position. Teachers are different from other adults because they hold a position of superiority over students that is especially apparent when discussing something of a personal matter.

Teachers can help to lighten a depressed student's load by creating a comfortable classroom where the student knows he/she is cared for and where the student doesn't have a time limit to suddenly cheer up. Depression takes a lot of time to get over, and school does not have to be a negative place of responsibility. If I had had a teacher that did at least one of the following things during the period of time I was depressed, I might have turned my act around a little sooner, or I might have had a more positive outcome in school.

Three tips for dealing with students who are depressed in the classroom:

1. Don't ignore depressed students. It shows that you don't care and invites the students to give up, guaranteeing their failure. Draw them out in class discussion and do whatever it takes to stimulate their minds so that they don't, in turn, learn to ignore you.

2. Let them know that you care, but without getting too personal. Help them to update any missing assignments, or set up extra study time - whether they accept your efforts or not all depends upon the severity of the depression . The fact that you've proven you care can make all the difference in the world.

3. Never give up on the student - regardless of how long they haven't wanted to put forth any effort in your class. Students can tell when a teacher no longer believes in them and expects them to fail, and it only ends up making the situation worse than necessary.

D. Adolescent Depression

Helping Depressed Teens

Mental Health America

It's not unusual for young people to experience "the blues" or feel "down in the dumps" occasionally. Adolescence is always an unsettling time, with the many physical, emotional, psychological and social changes that accompany this stage of life.

Unrealistic academic, social, or family expectations can create a strong sense of rejection and can lead to deep disappointment. When things go wrong at school or at home, teens often overreact. Many young people feel that life is not fair or that things "never go their way." They feel "stressed out" and confused. To make matters worse, teens are bombarded by conflicting messages from parents, friends and society. Today's teens see more of what life has to offer —— both good and bad —— on television, at school, in magazines and on the Internet. They are also forced to learn about the threat of AIDS, even if they are not sexually active or using drugs.

Teens need adult guidance more than ever to understand all the emotional and physical changes they are experiencing. When teens'' moods disrupt their ability to function on a day-to-day basis, it may indicate a serious emotional or mental disorder that needs attention —— adolescent depression. Parents or caregivers must take action.

Dealing With Adolescent Pressures
When teens feel down, there are ways they can cope with these feelings to avoid serious depression. All of these suggestions help develop a sense of acceptance and belonging that is so important to adolescents.

- **Try to make new friends.** Healthy relationships with peers are central to teens'' self-esteem and provide an important social outlet.

- **Participate in sports, job, school activities or hobbies.** Staying busy helps teens focus on positive activities rather than negative feelings or behaviors.

- **Join organizations that offer programs for young people.** Special programs geared to the needs of adolescents help develop additional interests.

- **Ask a trusted adult for help.** When problems are too much to handle alone, teens should not be afraid to ask for help.

But sometimes, despite everyone''s best efforts, teens become depressed. Many factors can contribute to depression. Studies show that some depressed people have too much or too little of certain brain chemicals. Also, a family history of depression may increase the risk for developing depression. Other factors that can contribute to depression are difficult life events (such as death or divorce), side-effects from some medications and negative thought patterns.

Recognizing Adolescent Depression

Adolescent depression is increasing at an alarming rate. Recent surveys indicate that as many as one in five teens suffers from clinical depression. This is a serious problem that calls for prompt, appropriate treatment. Depression can take several forms, including bipolar disorder (formally called manic-depression), which is a condition that alternates between periods of euphoria and depression.

Depression can be difficult to diagnose in teens because adults may expect teens to act moody. Also, adolescents do not always understand or express their feelings very well. They may not be aware of the symptoms of depression and may not seek help.

These symptoms may indicate depression, particularly when they last for more than two weeks:

- Poor performance in school

- Withdrawal from friends and activities

- Sadness and hopelessness

- Lack of enthusiasm, energy or motivation

- Anger and rage

- Overreaction to criticism

- Feelings of being unable to satisfy ideals

- Poor self-esteem or guilt

- Indecision, lack of concentration or forgetfulness

- Restlessness and agitation

- Changes in eating or sleeping patterns

- Substance abuse

- Problems with authority

- Suicidal thoughts or actions

Teens may experiment with drugs or alcohol or become sexually promiscuous to avoid feelings of depression. Teens also may express their depression through hostile, aggressive, risk-taking behavior. But such behaviors only lead to new problems, deeper levels of depression and destroyed relationships with friends, family, law enforcement or school officials.

Treating Adolescent Depression

It is extremely important that depressed teens receive prompt, professional treatment. Depression is serious and, if left untreated, can worsen to the point of becoming life-threatening. If depressed teens refuse treatment, it may be necessary for family members or other concerned adults to seek professional advice.

Therapy can help teens understand why they are depressed and learn how to cope with stressful situations. Depending on the situation, treatment may consist of individual, group or family counseling. Medications that can be prescribed by a psychiatrist may be necessary to help teens feel better.

Some of the most common and effective ways to treat depression in adolescents are:

- Psychotherapy provides teens an opportunity to explore events and feelings that are painful or troubling to them. Psychotherapy also teaches them coping skills.

- Cognitive-behavioral therapy helps teens change negative patterns of thinking and behaving.

- Interpersonal therapy focuses on how to develop healthier relationships at home and at school.

- Medication relieves some symptoms of depression and is often prescribed along with therapy.

When depressed adolescents recognize the need for help, they have taken a major step toward recovery. However, remember that few adolescents seek help on their own. They may need encouragement from their friends and support from concerned adults to seek help and follow treatment recommendations.

Facing The Danger Of Teen Suicide
Sometimes teens feel so depressed that they consider ending their lives. Each year, almost 5,000 young people, ages 15 to 24, kill themselves. The rate of suicide for this age group has nearly tripled since 1960, making it the third leading cause of death in adolescents and the second leading cause of death among college-age youth.

Studies show that suicide attempts among young people may be based on long-standing problems triggered by a specific event. Suicidal adolescents may view a temporary situation as a permanent condition. Feelings of anger and resentment combined with exaggerated guilt can lead to impulsive, self-destructive acts.

Recognizing The Warning Signs
Four out of five teens who attempt suicide have given clear warnings. Pay attention to these warning signs:

- Suicide threats, direct and indirect
- Obsession with death
- Poems, essays and drawings that refer to death
- Dramatic change in personality or appearance
- Irrational, bizarre behavior

- Overwhelming sense of guilt, shame or rejection
- Changed eating or sleeping patterns
- Severe drop in school performance
- Giving away belongings

REMEMBER!!! These warning signs should be taken seriously. Obtain help immediately. Caring and support can save a young life.

Helping Suicidal Teens

- **Offer help and listen.** Encourage depressed teens to talk about their feelings. Listen, don''t lecture.

- **Trust your instincts.** If it seems that the situation may be serious, seek prompt help. Break a confidence if necessary, in order to save a life.

- **Pay attention to talk about suicide.** Ask direct questions and don''t be afraid of frank discussions. Silence is deadly!

- **Seek professional help.** It is essential to seek expert advice from a mental health professional who has experience helping depressed teens. Also, alert key adults in the teen''s life —— family, friends and teachers.

Looking To The Future

When adolescents are depressed, they have a tough time believing that their outlook can improve. But professional treatment can have a dramatic impact on their lives. It can put them back on track and bring them hope for the future.

If you or someone you know is contemplating suicide, call 1-800-273-TALK (1-800-273-8255).

Other Resources

The Boys Town National Hotline. (800)-448-3000.

American Academy for Child and Adolescent Psychiatry
3615 Wisconsin Avenue NW
Washington, DC 20016-3007
Phone 202/966-7300 Email Address: clinical   aacap.org
www.aacap.org

American Association of Suicidology
4201 Connecticut Avenue NW; Suite 408
Washington, DC 20008
Phone: 202-237-2280
www.suicidology.org

Suicide Awareness/Voices of Prevention
http://www.save.org/index.cfm?fuseaction=home.viewPage&page_id=7049F2F1-C9C4-C392-588484F7906539D6
06539D6
The Jed Foundation. Suicide prevention for college students.
http://www.jedfoundation.org/

The Nine Line. (800) 999-9999. Covenant Hous crisis counseling for homeless and at-risk children.

E. Children and Depression

Accommodations to Reduce Affect and Mood Problems

by Janzen, HJ & Saklofske, DH

National Association of School Psychologists

»Background

Depressed mood is a common and universal part of human experience that can occur at any age and has various causes. Over time, many children report or give the appearance of feeling unhappy, sad, dejected, irritable, "down" or "blue" but most of them quickly and spontaneously recover from these brief and normal moods or emotional states. However, for others, the depression can be severe and long lasting, and interfere with all aspects of daily life from school achievement to social relationships.

The incidence of more severe depression in children is probably less than 10% although exact figures are not known. Girls are more likely than boys to develop mood disorders. The associated risk of suicide increases significantly during adolescence.

»Development

Recognizing and diagnosing childhood depression is not always an easy task. The onset of depression can be gradual or sudden, it may be a brief or long term episode, and may be associated with other disorders such as anxiety. The presence of one or two symptoms is not sufficient evidence of a depressive disorder. It is when a group of such symptoms occur together over time that a more serious mood disorder should be considered. The DSM-III- R manual published by the American Psychiatric Association classified depression according to severity, duration and type.

The definition of major depression requires the presence of five or more of the following symptoms for at least two weeks. One or both of the essential features of depressed or limitable mood, and loss of interest or pleasure in almost all activities must be observed. Other symptoms include appetite disturbance and significant weight loss or gain, sleep difficulties or too much sleep, slow or agitated and restless behavior (many depressed children become overly aggressive), decreased energy or fatigue, feeling of worthlessness or self-blame and guilt, concentration and thinking difficulties, and thoughts of death or suicide.

Less severe forms of depression include dysthymia (moderately depressed mood over one year) and adjustment disorder with depressed mood caused by some known stress and lasting less than 6 months. Depressive features will vary in relation to the age and developmental level of the child. For example, physical complaints, agitation, anxiety and fears are more often seen in younger children while adolescents are more likely to engage in antisocial behavior or become sulky, overly emotional, and withdrawn.

There are a number of suggested causes of childhood depression. Biological explanations of depression have examined the roles of hereditary, biochemical, hormonal, and brain factors. More recently, the amount of light associated with seasonal changes has been suspected to affect mood.

Psychological descriptions have linked depression to the loss of loved ones, disturbances in parent-child relationships, and threats to self-esteem. Attention has also been focused on the way children interpret and structure everyday experiences and the belief they have about their ability to control and shape their world. Any of a number of psychological stressors may be able to significantly affect the mood of some children.

Given the various kinds and causes of childhood depression, there are different treatments that may

be required. The "treatment" for the disappointment that follows the loss of a ball game may be a visit to

the local hamburger restaurant, or the feelings of failure and irritability caused by a poor school mark could signal the need to improve study habits and pay

closer attention in school. When the signs of depression described above occur and persist, the professional assistance of a psychologist or psychiatrist should be obtained. Antidepressant (tricyclics and MAO inhibitors) and antianxiety medications are very beneficial in the treatment of severe depression. Several effective forms of psychological treatment include behavioral, cognitive-behavioral, and interpersonal (IPT) therapy. Combined medication and psychotherapy programs are frequently employed in the treatment of depression.

»What can I do as a parent?

The list of suggestions follows the most frequently cited symptoms of childhood depression.

—Self-esteem and self-critical tendencies: give frequent and genuine praise; accentuate the positive; supportively challenge self-criticism; point out negative thinking.

—Family stability: maintain routine and minimize changes in family matters; discuss changes beforehand and reduce worry.

—Helplessness and hopelessness: have the child write or tell immediate feelings and any pleasant aspects 3 or 4 times a day to increase pleasant thoughts over 4-6 weeks.

—Mood elevation: arrange one interesting activity a day; plan for special events to come; discuss enjoyable topics.

—Appetite and weight problems: don't force eating; prepare favorite foods; make meal-time a pleasant occasion.

—Sleep difficulties: keep regular bed-time hours; do relaxing and calming activities one hour before bed-time such as reading or listening to soft music; end the day on a "positive note."

—Agitation and restlessness: change activities causing agitation; teach the child to relax; massage may help; encourage physical exercise and recreation activities.

—Excessive fears: minimize anxiety-causing situations and uncertainty; be supportive and reassuring; planning may reduce uncertainty; relaxation exercises might help.

—Aggression and anger: convey a kind but firm unacceptance of destructive behavior; encourage the child to his angry feelings; do not react with anger.

—Concentration and thinking difficulties: encourage increased participation in games, activities, discussions; work with the teachers and school psychologist to promote learning.

—Suicidal thoughts: be aware of the warning signs of suicide; immediately seek professional help.

—if depression persists: consult your family doctor for a complete medical exam; seek a referral to a psychologist or psychiatrist.

V. Interventions for Serious Problems

A. Depression

1. Understanding the Problem

Normal teenage behaviour vs. early warning signs of mental illness
By Jaimie Byrne

Excerpt:

It is not uncommon for parents to wonder whether their child is acting like a normal teenager or behaving differently due to mental illness, drug use or behavioural difficulties. Normal teenagers are often moody due to hormonal and physical changes that happen during puberty. However, when mental illness is involved, it may be difficult to differentiate "normal teenage behaviour" from the symptoms of depression, anxiety and other emotional difficulties.

Teenagers may be short-tempered and get angry easily, especially when they begin to naturally separate from the family and feel they do not have enough distance or privacy. The natural process of separation begins in early adolescence; this is when parents see that their child begins to be embarrassed by them and spends increasing amounts of time with friends and very little time with the family. You may be worried that your teenager spends hours on end on the computer or locked in his or her room chatting on the phone and gets defensive when asked what he or she is doing or who he or she is talking to. This type of behaviour is normal. Teenagers need to naturally separate in order to gain their independence in early adulthood and often react defensively in order to attain this goal. During this time, you should be able to see that even though your teenager may cringe at spending quality time with the family, he or she is still able to enjoy time with friends and engage in healthy social and extracurricular activities outside of the home. If you see that your teen is not engaging in other activities or with friends and is chronically disconnected, angry and sad, this is when the behaviour becomes abnormal and requires intervention.

V. Interventions for Serious Problems

   A. Depression
      1. Understanding the Problem

Depression in Children and Adolescents

Only in the past two decades has depression in children been taken very seriously. The depressed child may pretend to be sick, refuse to go to school, cling to a parent, or worry that the parent may die. Older children may sulk, get into trouble at school, be negative, grouchy, and feel misunderstood.

Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child is just going through a temporary "phase" or is suffering from depression. Sometimes the parents become worried about how the child's behavior has changed, or a teacher mentions that "your child doesn't seem to be himself." In such a case, if a visit to the child's pediatrician rules out physical symptoms, the doctor will probably suggest that the child be evaluated, preferably by a psychiatrist who specializes in the treatment of children.

Depression Information from NIMH – http://www.nimh.nih.gov/health/topics/depression/index.shtml

Additional information on depression, not specific to children and adolescents, including details on signs and symptoms, treatment options, research, and where to go for help. more>>

Related Information (for links to the following, see
http://www.nimh.nih.gov/health/topics/depression/depression-in-children-and-adolescents.shtml)

Treatment Treatment of Children with Mental Disorders --
Combination treatment most effective – TADS trial –
Child and Adolescent Bipolar Disorder: An Update from NIMH –
Children and Violence --
Child and Adolescent Mental Health –
Antidepressant Medications for Children/Adolescents: Information for Parents and Caregivers–
Clinical Trials --
Information about medications –
Depression Information and Organizations from NLM's MedlinePlus --
(en Español) –
Some mental illnesses also carry an increased risk for suicide –
Science News about Depression

V. Interventions for Serious Problems
    A. Depression
        1. Understanding the Problem

THE DEPRESSED CHILD

American Academy of Child & Adolescent Psychiatry

Not only adults become depressed. Children and teenagers also may have depression, which is a treatable illness. Depression is defined as an illness when the feelings of depression persist and interfere with a child or adolescent''s ability to function.

About 5 percent of children and adolescents in the general population suffer from depression at any given point in time. Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. Depression also tends to run in families.

The behavior of depressed children and teenagers may differ from the behavior of depressed adults. Child and adolescent psychiatrists advise parents to be aware of signs of depression in their youngsters.

If one or more of these signs of depression persist, parents should seek help:

- Frequent sadness, tearfulness, crying

- Hopelessness

- Decreased interest in activities; or inability to enjoy previously favorite activities

- Persistent boredom; low energy

- Social isolation, poor communication

- Low self esteem and guilt

- Extreme sensitivity to rejection or failure

- Increased irritability, anger, or hostility

- Difficulty with relationships

- Frequent complaints of physical illnesses such as headaches and stomachaches

- Frequent absences from school or poor performance in school

- Poor concentration

- A major change in eating and/or sleeping patterns

- Talk of or efforts to run away from home

- Thoughts or expressions of suicide or self destructive behavior

A child who used to play often with friends may now spend most of the time alone and without interests. Things that were once fun now bring little joy to the depressed child. Children and adolescents who are depressed may say they want to be dead or may talk about suicide. Depressed children and adolescents are at increased risk for committing suicide. Depressed adolescents may abuse alcohol or other drugs as a way to feel better.

Children and adolescents who cause trouble at home or at school may actually be depressed but not know it. Because the youngster may not always seem sad, parents and teachers may not realize that troublesome behavior is a sign of depression. When asked directly, these children can sometimes state they are unhappy or sad.

Early diagnosis and medical treatment are essential for depressed children. This is a real illness that requires professional help. Comprehensive treatment often includes both individual and family therapy. It may also include the use of antidepressant medication. For help, parents should ask their physician to refer them to a child and adolescent psychiatrist, who can diagnose and treat depression in children and teenagers. Also see the following Facts for Families:#8 Children and Grief, #10 Teen Suicide, #21 Psychiatric Medication for Children, and #38 Manic-Depressive Illness in Teens.

V. Interventions for Serious Problems
    A. Depression
        2. Assessing the Problem

Assessment of depression in children and adolescents.

by Gray, L.B., Dubin-Rhodin, A., Weller, R.A., & Weller, E.B. (2009).
Curr Psychiatry Rep., 11, 106-13.

Abstract

Depression assessment instruments are valuable tools in the treatment of children and adolescents. Available instruments include diagnostic interviews, self-administered rating scales, and observer-rated scales. To select an appropriate instrument, the user must define the goal of the assessment and then identify instruments with the properties that match this goal. This article discusses how to choose an assessment instrument and gives an overview of currently available depression assessment instruments. Important considerations include how and by whom an instrument is administered, what kind of data are obtained by the instrument, and the validity and reliability of the instrument. Standardized instruments can greatly improve the assessment process, but the user must not overinterpret or misinterpret the results.

V. Interventions for Serious Problems
    A. Depression
        2. Assessing the Problem (cont.)

Children's Depression Inventory 2 – CDI 2
Maria Kovacs, Ph.D.

Brief description of this copyrighted instrument:

The CDI 2 is a revision of the Children''s Depression Inventory (CDI™). The CDI 2 can be used in both educational and clinical settings to evaluate depressive symptoms in children and adolescents. Authored by Dr. Maria Kovacs, an internationally recognized researcher of childhood and adolescent depressive disorders, the CDI 2 retains many of the essential features of its predecessor, while introducing a number of important refinements. Such refinements include: new items that focus on the core aspects of childhood depression, revised scales, and new norms that are representative of the U.S. population.

The CDI 2 is a comprehensive multi-rater assessment of depressive symptoms in youth aged 7 to 17 years. When results from the CDI 2 are combined with other sources of verified information, the CDI 2 can aid in the early identification of depressive symptoms, the diagnosis of depression and related disorders, as well as, the monitoring of treatment effectiveness.

The CDI 2 quantifies depressive symptomatology using reports from children/adolescents (full-length and short); teachers, and parents (or alternative caregivers). It can be administered and scored using paper-and-pencil format with MHS Quikscore™ forms, or online through the MHS Online Assessment Center. The CDI 2 can also be scored using scoring software.

The CDI 2 is available in paper-and-pencil, online, and software formats.

All CDI 2 forms can be administered and scored using the MHS QuikScore™ format. The rater writes on the external layers of the form, and the results transfer through to a hidden scoring grid within the internal layers. The assessor then uses the internal layers for tabulating results. Each QuikScore form includes conversion tables, which are used to convert raw scores to T-scores. For individuals who wish to use software or online scoring, CDI 2 items are also available as Response/E-Paper forms that do not include the scoring pages.

Online Administration and Scoring
The CDI 2 can be completed and automatically scored online wherever an internet connection is available. Online administration allows the assessor the flexibility to send a link to each respondent to complete the assessment at a location convenient to the respondent (e.g., child care center, school). It also significantly reduces administration and data entry time. Assessors using online scoring have the option of printing E-Paper forms that can be scored online by entering responses from the paper-and-pencil administration into the online program.

Software Scoring
The CDI 2 can be scored using the scoring software by entering responses from a completed paper-and-pencil administration into the software program.

Scales: Functional Problems, Emotional Problems
  Subscales: Negative Mood, Negative Self-Esteem, Ineffectiveness, Interpersonal Problems

Forms:
>CDI 2: Self-Report (CDI 2:SR), a 28-item assessment that yields a Total Score, two scale scores (Emotional Problems and Functional Problems), and four subscale scores.

>CDI 2: Self-Report (Short) version (CDI 2:SR[S]), 12 items and takes about half the time of the full-length version (5–10 minutes). Yields a Total Score that is generally very comparable to the one produced by the full-length version.

>CDI: Teacher (CDI:T) and CDI: Parent (CDI:P)

Ten-year review of rating scales II: scales for internalizing disorders

(Research Update Review).

Author: Kathleen Myers

Journal of the American Academy of Child and Adolescent Psychiatry

Excerpt:

SUMMARY AND CONCLUSIONS

Depression-rating scales and anxiety-rating scales offer great utility for elucidating youths' internalizing psychopathology treatment planning, following treatment course, and assuring accountability in practice. However, they cannot be used casually. The potential user must consider a particular scale in relation to the problem to be assessed, characteristics of the sample, properties of the scale, and the goals of assessment. All of the reviewed scales have strengths and weaknesses. Depression-rating scales suffer predominantly from the lack of clear construct validity. Furthermore, several depression scales are waning in popularity, thereby reducing the number of available depression-rating scales and ongoing examination of their functioning. On the other hand, the most popular scales provide a wealth of information on their functioning.

Furthermore, these scales have parallel parent-report forms for collateral information and short forms to facilitate repeated evaluation. Older anxiety-rating scales also suffer from the lack of construct clarity and developmental relevance. However, newer scales appear to enjoy good construct validity and suitability for youths but have not been used long enough to draw conclusions regarding their overall appropriateness and validity. Most also have parallel parent forms and short screening forms. Their biggest challenge, and their greatest promise, is their ability to discriminate anxiety disorders from depressive disorders. In any event, no one scale is likely to provide all of the information desired. In general, more than one scale should be used to evaluate a specific internalizing construct, thereby assuring a more robust assessment of a youth's problem (Myers and Winters, 2002). This is especially important for scales assessing mood and anxiety disorders because they tend to overlap in their construct s and symptom profiles. Within these guidelines, rating scales for internalizing disorders can facilitate research and augment clinical practice.

3. Treating the Problem

Empirically Supported Treatments

In an effort to improve the quality of treatment, the mental health field is promoting the use of empirically supported interventions. The following pages contain *excerpts* from a 2008 report, which appears in the *Journal of Clinical Child Psychology.*

Evidence-Based Psychosocial Treatments
for Child and Adolescent Depression

The evidence-base of psychosocial treatment outcome studies for depressed youth conducted since 1998 is examined. All studies for depressed children meet Nathan and Gorman's (2002) criteria for Type 2 studies whereas the adolescent protocols meet criteria for both Type 1 and Type 2 studies. Based on the Task Force on the Promotion and Dissemination of Psychological Procedures guidelines, the cognitive-behavioral therapy (CBT) based specific programs of Penn Prevention Program, Self-Control Therapy, and Coping with Depression-Adolescent are probably efficacious. Interpersonal Therapy-Adolescent, which falls under the theoretical category of interpersonal therapy (IPT), also is a probably efficacious treatment. CBT provided through the modalities of child group only and child group plus parent components are well-established intervention approaches for depressed children. For adolescents, two modalities are well-established (CBT adolescent only group, IPT individual), and three are probably efficacious (CBT adolescent group plus parent component, CBT individual, CBT individual plus parent/family component). From the broad theoretical level, CBT has well-established efficacy and behavior therapy meets criteria for a probably efficacious intervention for childhood depression. For adolescent depression, both CBT and IPT have well-established efficacy. Future research directions and best practices are offered.

Recommendations for Best Practice

This review identifies a number of specific treatment programs and theoretical and modality approaches that are efficacious in the treatment of depressed youth. However, no single intervention has emerged as the most beneficial, and effectiveness trials and examinations of mediators and moderators of treatment are only beginning to emerge. CBT for children and CBT and IPT for adolescents appear to be the most promising to base an intervention on, but this review also reveals that other treatments may be effective and deserve consideration. To identify the most appropriate approach for a specific youth and his or her family and to establish the youth's baseline level of functioning to help monitor treatment progress, treatment should begin with a thorough evaluation of a youth's functioning. The evaluation should include information from multiple informants; provide a comprehensive

view of the patient's strengths and weaknesses; and incorporate assessment tools appropriate for the youth's developmental stage and, if possible, gender and cultural background.

Strengths and deficit areas identified by the evaluation will help determine the most appropriate treatment approach. For instance, if a depressed youth is found to have dysfunctional thinking patterns, a therapist would begin with a CBT intervention that teaches the patient to identify negative beliefs, evaluate the evidence for them, and generate more realistic alternatives. At the conclusion of the CBT course of treatment, a re-evaluation of the youth's functioning would determine whether treatment can be terminated, whether a repeated course or a booster session of the CBT-based intervention is needed, or whether another deficit area (e.g., interpersonal) is present that should be addressed through a different intervention activity (e.g., IPT-based improved communication intervention). Interventions should be applied sequentially and re-evaluation of the patient's needs should be done at each stage of treatment. In the selection of intervention components, therapists should consider how to capitalize on a youth's interests and areas of strength to support and enhance treatment impact and increase the likelihood of engagement. For instance, a youth with strong language and reading skills may find the use of a journal and readings that supplement session by session CBT exercises appealing and beneficial. Because depressed youth may benefit from antidepressant medication, either alone or when provided in combination with psychosocial treatments (TADS Team, 2004), the possible benefit and role of medication should be part of the initial and ongoing evaluation of progress. Medications should be considered in cases of moderate or severe depression (National Institute for Health and Clinical Excellence, 2005). If medications are provided, monitoring of functioning in accord with FDA recommendations is necessary.

At each stage of intervention, therapists should maintain the integrity of the treatment manual of the evidence-based intervention they selected. However, because of the reality of individual differences, therapists need to tailor the approach (e.g., frequency of sessions, speed/intensity of session) to the needs and treatment progress of the child, family, or group. Also, the modality that an intervention is conducted (e.g., group vs. individual, inclusion of parent component) would depend on a number of factors (e.g., age of the patient, treatment setting). Parental and/or entire family involvement may be essential to support the generalization of treatment effects for young people and to effectively treat depressed youth with particular cultural backgrounds (Tharp, 1991) even if not part of the original intervention protocol. Sensitivity to such issues may occur at simply the assessment phase (Rossello & Bernal, 1996, 1999) or be integrated into specific treatment approaches (Yu & Seligman, 2002). Unfortunately, any of these modifications may negatively impact the demonstrated efficacy of the intervention, and research is limited with regard to how to implement programs found to be efficacious with fidelity to support the generalization of positive outcomes to a new treatment group or setting. Therapists should consult recommendations presented by a number of researchers and clinicians regarding making such adjustments (Bernal & Scharron-del-Rio, 2001; Nagayama-Hall & Okazaki, 2002; Tharp, 1991). As the development and evaluation of psychosocial treatments for depressed youth progress forward, attention must be given to how evidence-based interventions can be implemented successfully while allowing for variations in service delivery processes, level of therapist training, contextual factors, and individual needs of patients (Fagan & Mihalic, 2003; Filene, Lutzker, Hecht, & Silovsky, 2005).

EFFECTIVE CHILD THERAPY
Evidence-based mental health treatment for children and adolescents

Last Updated on : 09th Apr, 2013

Depression & Related Disorders

Sadness, hopelessness, and depression are among the most common symptoms of child and adolescent depression and related disorders. Please refer to the sections below (as well as to the left menu box) for more information about these difficulties and to learn about the best-supported treatment options.

What is Depression?

Although it is common for most children and teenagers to feel down or sad sometimes, a smaller number of youth experience a more severe phenomenon known as depression. Such young people, who are often described as "clinically" depressed, feel sad, hopeless, or irritable for weeks or even months at a time. They may lose interest in activities that they used to enjoy (e.g., playing with friends), their sleeping and eating habits often change (i.e., they may eat or sleep either more or less than usual), and they may have trouble thinking or paying attention, even to TV programs or games.

Of particular concern, youths who are clinically depressed may think or talk a lot about death and some depressed children have more specific thoughts about hurting or killing themselves. Often children and teenagers may have similar symptoms when they are grieving the loss of someone close to them. In clinical depression, however, these thoughts and feelings tend to appear even when the child has not experienced a loss or a sad event. To learn more about various forms of depression, please use the quick links on the left to learn more.

As can be seen below, **cognitive behavioral therapy (CBT)** currently has the most research evidence for the treatment of depression in children, and **CBT** and **interpersonal psychotherapy (IPT)** are preferred therapies for adolescent depression. Treatments can be administered in a variety of different formats, each of which has varying levels of research support.

Children

Works Well What does this mean?	• CBT group, child only • CBT child group, plus parent component
Works What does this mean?	• Behavior Therapy
Might Work What does this mean?	N/A
Unknown/Untested What does this mean?	• Child group psychoeducation, plus parent intervention • Family Therapy

Adolescents

Works Well What does this mean?	• CBT group, adolescent only • Individual Interpersonal Psychotherapy (IPT)
Works What does this mean?	• Adolescent CBT group, plus parent component • Individual CBT • Individual CBT, plus parent/family component
Might Work What does this mean?	N/A
Unknown/Untested What does this mean?	• Self-directed bibliotherapy • IPT group, adolescent only • Nondirected support group, adolescent only • Family Therapy

Source: David-Ferndon, C., Kaslow, N. J. (2008). Evidence-based psychosocial treatments for child and adolescent depression. *Journal of Clinical Child & Adolescent Psychology, 37,* 62-104.

V. Interventions for Serious Problems
    A. Depression
        4. Suicide

Guidelines for School Based Suicide Prevention Programs

National Strategy for Suicide Prevention Objectives Addressed:
Objective 5.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.*

Developed by the Prevention Division of the American Association of Suicidology, the topics addressed by these Guidelines include:
- The conceptual basis for prevention programs
- Requirements for effective suicide prevention programs
- Requirements for effective program implementation
- Requirements for institutionalization and sustainability of suicide prevention programs
- Components of comprehensive school-based suicide prevention programs

An outline of a four-lesson sample student curriculum is provided, as is a selected bibliography of suicide prevention and crisis intervention literature.

Program Objectives:

Users of the Guidelines should have:
1. Increased knowledge of the conceptual and theoretical underpinnings of effective school-based suicide prevention programs.
2. Increased understanding of universal, selective, and indicated approaches to suicide prevention.
3. Increased knowledge of effective program implementation and sustainability strategies.
4. Increased knowledge of the multiple components of a comprehensive school-based suicide prevention program.

Website: www.suicidology.org

The Guidelines are available from the SPRC library without charge (http://www.sprc.org/sites/sprc.org/files/library/aasguide_school.pdf).

*The content of programs listed in Section II (Expert and Consensus Statements) of the SPRC/AFSP Best Practices Registry address specific goals of the National Strategy for Suicide Prevention and have been reviewed by a panel of three suicide prevention experts and found to meet standards of importance, likelihood of meeting objectives, accuracy, safety, congruence with prevailing knowledge, and appropriateness of development process. Programs were not reviewed for evidence of effectiveness. Additional information about the Best Practices Registry can be found at www.sprc.org.

V. Interventions for Serious Problems
  A. Depression
    4. Suicide

Behavioral Management: Suicide Crisis

I n developing our Center's Resource Aid Packet on *Responding to Crisis at a School,* we were impressed by the good work being done by so many people around the country. The unfortunate fact that so many students feel despair and consider suicide has resulted in important common practices at school sites.

Changing systems in schools to support students and reduce unnecessary stress is the first line of defense. However, when concerns arise about a specific student, school staff must be ready to respond. The suicide assessment and follow-through checklists in the next section are a compilation of best practices and offer tools to guide intervention.

When a Student Talks of Suicide . . .

You must assess the situation and reduce the crisis state (see Suicidal Assessment Checklist in section V). The following are some specific suggestions.

What to do:

- Send someone for help; you'll need back-up.
- Remain calm; remember the student is overwhelmed and confused as well as ambivalent.
- Get vital statistics, including student's name, address, home phone number and parent's work number.
- Encourage the student to talk. Listen! Listen! Listen! And when you respond, reflect back what you hear the student saying. Clarify, and help him or her to define the problem, if you can.

Consider that the student is planning suicide. How does the student plan to do it, and how long has s/he been planning and thinking about it? What events motivated the student to take this step?

- Clarify some immediate options (e.g., school and/or community people who can help).
- If feasible, get an agreement to no-suicide ("No matter what happens, I will not kill myself.")
- Involve parents for decision making and follow-through and provide for ongoing support and management of care (including checking regularly with parents and teachers).

What to avoid:

- Don't leave the student alone and don't send the student away
- Don't minimize the student's concerns or make light of the threat
- Don't worry about silences; both you and the student need time to think
- Don't fall into the trap of thinking that all the student needs is reassurance
- Don't lose patience
- Don't promise confidentiality -- promise help and privacy
- Don't argue whether suicide is right or wrong

When a Student Attempts Suicide . . .

A student may make statements about suicide (in writing assignments, drawing, or indirect verbal expression). Another may make an actual attempt using any of a variety of means. In such situations, you must act promptly and decisively.

What to do:

- Be directive. Tell the student, "Don't do that; stand there and talk with me." "Put that down." "Hand me that." "I'm listening."
- Mobilize someone to inform an administrator and call 911; get others to help you; you'll need back-up.
- Clear the scene of those who are not needed. An "administrator" should contact parents to advise them of the situation and that someone will call back immediately to direct the parent where to meet the youngster.
- Look at the student directly. Speak in a calm, low voice tone. Buy time. Get the student to talk. Listen. Acknowledge his or her feelings "You are really angry." "You must be feeling really hurt."
- Secure any weapon or pills; record the time any drugs were taken to provide this information to the emergency medical staff or police.
- Get the student's name, address and phone.
- Stay with the pupil; provide comfort.
- As soon as feasible, secure any suicidal note, record when the incident occurred, what the pupil said and did, etc.
- Ask for a debriefing session as part of taking care of yourself after the event.

What to avoid:

- Don't moralize ("You're young, you have everything to live for.")
- Don't leave the student alone (even if the student has to go to the bathroom).
- Don't move the student.

In all cases, show concern and ask questions in a straightforward and calm manner. Show you are willing to discuss suicide and that you aren't appalled or disgusted by it. Open lines of communication. Get care for the student.

SUICIDAL ASSESSMENT -- CHECKLIST*

Student's Name:_____ Date:_____ Interviewer: _____

(Suggested points to cover with student/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH
Does the individual have frequent suicidal thoughts?   Y   N
Have there been suicide attempts by the student or significant   Y   N
others in his or her life?

Does the student have a detailed, feasible plan?   Y   N

Has s/he made special arrangements as giving away prized possessions?   Y   N

Does the student fantasize about suicide as a way to make others   Y   N
feel guilty or as a way to get to a happier afterlife?

(2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress?   Y   N

Have there been major changes in recent behavior along with   Y   N
negative feelings and thoughts?

(Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant other to help the student survive?   Y   N

Does the student feel alienated?   Y   N

(4) HISTORY OF RISK-TAKING BEHAVIOR

Does the student take life-threatening risks or display poor impulse control?   Y   N

*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk also is associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time, and a location where it is unlikely the act would be disrupted. Further high risk indicators include the student having made final arrangements and information about a critical, recent loss. Because of the informal nature of this type assessment, it should not be filed as part of a student's regular school records.

FOLLOW-THROUGH STEPS AFTER ASSESSING SUICIDAL RISK -- CHECKLIST

____(1)   As part of the process of assessment, efforts will have been made to discuss the problem openly and nonjudgmentally with the student. (Keep in mind how seriously devalued a suicidal student feels. Thus, avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.) If the student has resisted talking about the matter, it is worth a further effort because the more the student shares, the better off one is in trying to engage the student in problem solving.

___(2)   Explain to the student the importance of and your responsibility for breaking confidentiality in the case of suicidal risk. Explore whether the student would prefer taking the lead or at least be present during the process of informing parents and other concerned parties.

___(3)   If not, be certain the student is in a supportive and understanding environment (not left alone/isolated) while you set about informing others and arranging for help.

___(4)   Try to contact parents by phone to

       a)   inform about concern
       b)   gather additional information to assess risk
       c)   provide information about problem and available resources
       d)   offer help in connecting with appropriate resources

       Note: if parents are uncooperative, it may be necessary to report child endangerment after taking the following steps.

____(5)   If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help. In high risk cases, if parents are unavailable (or uncooperative) and no one else is available to help, it becomes necessary to contact local public agencies (e.g., children's services, services for emergency hospitalization, local law enforcement). Agencies will want the following information:

       *student's name/address/birthdate/social security number
       *data indicating student is a danger to self (see Suicide Assessment -- Checklist)
       *stage of parent notification
       *language spoken by parent/student
       *health coverage plan if there is one
       *where student is to be found

____(6)   Follow-up with student and parents to determine what steps have been taken to minimize risk.

____(7)   Document all steps taken and outcomes. Plan for aftermath intervention and support.

____(8)   Report child endangerment if necessary.

V. Interventions for Serious Problems

A. Depression

5. *Affect regulation of repetitive self-injury*

Affect regulation and addictive aspects of repetitive self-injury in hospitalized adolescents

Journal of the American Academy of Child and Adolescent Psychiatry

by M.K. Nixon, P.F. Cloutier, & S. Aggarwal

Excerpt:

The association of SIB with stressful events and the endorsement of self-injury as a means to cope with dysphoric affect or express frustration, anger, or revenge support the affect regulation model as the primary function of SIB in hospitalized adolescents. The only other studies examining reasons for self-injury that we are aware of are those of Briere and Gil (1998), which examined a sample of self-referred, primarily abused women, and Herpertz (1995), who studied a psychiatric inpatient population of mostly women. The former gave self-punishment as the most commonly reported reason to self-injure, with affect regulatory being secondary, whereas the latter study, with a broader clinical sample, endorsed SIB'S tension-relieving effect in response to overwhelming affect. SIB as a means to regulate affect may be more predominant among those with psychiatric disorders. Zlotnick et al. (1997) noted that suicidal behavior in adolescent inpatients appeared related to a reduced capacity to manage internal states, with the suggestion that suicide attempts were a means to reduce intolerable emotional states. Whereas learning to modulate affect adaptively should lead to appropriate self-soothing strategies as the individual matures, the failure to regulate affect, due to either genetic or environmental factors, has been suggested as being central to the development of psychopathology (Bradley, 2000). Overall, much of our sample did not experience anger chronically, nor did a large proportion invest a great deal of energy in monitoring or preventing the experience or expression of anger. The equal distribution of those with clinically elevated internalizing anger and externalizing anger indicates that repetitive SIB is nor exclusive to those who primarily suppress their anger. Nevertheless, adolescents with elevated internalized anger scores appear to have greater morbidity, with higher levels of both depression and self-reported rates of ever having had an eating disorder. SIB served most highly as a means to express frustration, in addition to being a means for expressing anger and revenge, releasing unbearable tension, and coping with feelings of depression...

V. Interventions for Serious Problems
B. Bipolar Disorder
(1) Child and Adolescent Bipolar Disorder

Excerpt from the National Institute of Mental Health
http://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-adolescents/index.shtml

Introduction

All parents can relate to the many changes their kids go through as they grow up. But sometimes it's hard to tell if a child is just going through a "phase," or showing signs of something more serious.

In the last decade, the number of children receiving the diagnosis of bipolar disorder, sometimes, called manic-depressive illness, has grown substantially.[1] But what does the diagnosis really mean for a child?

This booklet discusses bipolar disorder in children and teens. For information on bipolar disorder in adults, see the National Institute of Mental Health (NIMH) booklet Bipolar Disorder in Adults.

What is bipolar disorder?

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, and activity levels. It can also make it hard to carry out day-to-day tasks, such as going to school or hanging out with friends. Symptoms of bipolar disorder can be severe. They are different from the normal ups and downs that everyone goes through from time to time. Bipolar disorder symptoms can result in damaged relationships, poor school performance, and even suicide. But bipolar disorder can be treated, and many people with this illness can lead full and productive lives.

Symptoms of bipolar disorder often develop in the late teens or early adult years, but some people have their first symptoms during childhood. At least half of all cases start before age 25.[2]

Bipolar disorder tends to run in families. Children with a parent or sibling who has bipolar disorder are up to six times more likely to develop the illness, compared with children who do not have a family history of bipolar disorder.[3] However, most children with a family history of bipolar disorder will not develop the illness.

This presentation goes on to discuss the signs, symptoms, assessment, and treatment (and its side effects) of bipolar disorder in children and adolescents and emphasizes that it's normal for almost every child or teen to show some of the behaviors at times and that these passing changes should not be confused with bipolar disorder.

Note on Misdiagnosis: Rapidly Shifting Moods and High Energy

Findings from the NIMH-funded Longitudinal Assessment of Manic Symptoms (LAMS) study suggest that most young children with rapid mood swings and extremely high energy levels do not actually have bipolar disorder. However, these symptoms do cause significant problems at home, school, or with peers.

V. Interventions for Serious Problems
B. Bipolar Disorder
(2) Bipolar Disorder in Teens

Fact Sheet from: The American Academy of Child and Adolescent Psychiatry (AACAP)

Bipolar Disorder In Children And Teens (updated 2015)

Bipolar disorder (formerly called manic depressive illness) is an illness of the brain that causes extreme changes in a person's mood, energy, thinking, and behavior. Children with bipolar disorder have periods (or episodes) of mania and depression.

Manic Episodes: An episode of mania includes a period where someone's mood has changed and it is elevated (overly happy), expansive, or very irritable and the person also has increased energy at the same time.

Other manic symptoms may include:
>Unrealistic highs in self-esteem - for example, a child or adolescent who feels all-powerful or like a superhero with special powers
>Great increase in energy
>Decreased need for sleep such as being able to go with little or no sleep for days without feeling tired
>Increase in talking - when the child or adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted
>Distractibility - the child's attention moves constantly from one thing to the next
>Thinking more quickly - for example, thoughts are on "fast forward"
>Repeated high risk-taking behavior, such as abusing alcohol and drugs, reckless driving, or sexual promiscuity

Depressive Episodes: People who have bipolar disorder may also experience periods of depression. An episode of depression includes low, depressed, or irritable mood.

Other symptoms of a depressive episode may include:
>Decreased enjoyment in favorite activities
>Low energy level or fatigue
>Major changes in sleeping patterns, such as oversleeping or difficulty falling asleep
>Poor concentration
>Complaints of boredom
>Major change in eating habits such as decreased appetite, failure to gain weight or overeating
>Frequent complaints of physical illnesses such as headaches or stomach aches
>Thoughts of death or suicide

Some of these signs are similar to those that occur in children and adolescents with other problems such as drug abuse, attention-deficit hyperactivity disorder, major depressive disorder, disruptive mood dysregulation disorder, or even schizophrenia.

Bipolar disorder can begin in childhood or during the teenage years. The illness can affect anyone. However, if one or both parents have bipolar disorder, the chances are greater that their children may develop the disorder.

The diagnosis of bipolar disorder in children and teens is complex and involves careful observation over an extended period of time. A comprehensive evaluation by a child and adolescent psychiatrist or trained mental health professional can help identify bipolar disorder and is the first step to starting treatment. Children and teenagers with bipolar disorder can be effectively treated. Treatment for bipolar disorder usually includes education of the patient and the family about the illness, mood stabilizing medications such as lithium, or atypical antipsychotics, and psychotherapy. Medications often reduce the number and severity of manic episodes, and may also help to prevent depression. Psychotherapy helps the child understand himself or herself, adapt to stresses, rebuild self-esteem, and improve relationships.

V. Interventions for Serious Problems
B. Bipolar Disorder
(3) Sample Goals for Special Ed Students

Sample Goals for Individualized Educational Program
(from : NAMI – the National Alliance for the Mentally Ill

Excerpt:

While preparing their book, The Bipolar Child, authors Janice and Demitri Papolos sent a description of "Elan," a hypothetical student with bipolar disorder and special education needs, Elan is a personable individual who shows good attention and task orientation for very short periods of time. Elan has been diagnosed with bipolar disorder. His emotions and his academic availability are variable and quite unpredictable. Physical complaints are often present both in and out of school. Presently, Elan has a difficult time getting up in the morning, and he is often late, or does not come to school at all. He can appear tired, bored, irritable, and explosive, and he has poor judgment and decision-making skills. Other times, Elan can be extremely energetic and need to move around quite a bit. He can be talkative, distractible, and extremely impulsive.

Elan has *difficulty expressing his feelings and frustrations*, and he often has negative and hopeless thoughts. When unable to do something others might consider simple, he feels a sense of failure. He does not have good problem-solving skills or stress-management techniques. He often resorts to self-inflicted wounds and talks of suicide.

Elan's *concentration and ability to focus can be extremely impaired* because of his limited alertness and attendance difficulties. His lack of interpersonal skills causes peer difficulties and limits his ability to establish healthy relationships with peers and adults.

At other times-usually when he has high energy levels and is becoming more manic-he feels his understanding is superior to that of his classmates and that this negates his need to complete assignments. During these times, he can be disrespectful to adults, oppositional, and provoking to his peers.

Currently, Elan is very compliant about taking his medications, and he has the desire to do what it takes to manage his disorder.

Consistent positive understanding and intervention is necessary for improving Elan's self-esteem and allowing him to be accepted through his good and bad times. Staying calm and speaking to him in a reassuring tone is a must.

Elan is in need of a smaller, very structured setting that would be sensitive to his psychosocial needs. He presently does not do well with change or too much environmental stimulation. Counseling and support services, such as a safe place and/or a person to go to when he feels overwhelmed or is having negative thoughts, is necessary. A support group with similar peers would be ideal, if available. Flexibility in this plan is a must.

Goal #1:Elan will learn and apply strategies to independently divert bad thoughts.

  Objectives:

- Elan will go to the school counselor/psychologist twice a week (more frequently as needed).

- Elan will explore negative thoughts with the counselor and develop strategies for diverting them independently.

- Elan will tell an appropriate adult when he has negative feelings he cannot manage.

- Elan will use a variety of learned strategies and document results in a journal at least two times weekly.

Goal #2:Elan will develop other techniques to relieve anxiety rather than resort to harmful behaviors.

  Objectives:

- When faced with a stressful situation, Elan will explore options with a counselor.

- Elan will address anxiety-causing topics, which may be suggested by staff, in a journal at least one time per week.

- Elan will talk to an adult when feeling explosive or becoming out of control. He will remove himself to a safe place/person before harming himself or others.

- Elan will identify triggers that contribute to harmful behaviors and problem-solve alternatives with a counselor.

Goal #3:Elan will increase his time on task with only one redirective from 2-3 minutes to 10-15 minutes.

  Objectives:

- Elan will comply with all redirection (such as non-verbal cues) the first time.

- Elan will increase the number of daily assignments he completes within a specified amount of time, determined by the teacher and his ability for that day.

- Elan will stay focused for 10-15 minutes-or longer-on any given subject.

- Elan will use problem-solving strategies when needing a break to refresh and refocus.

Goal #4: Elan will increase his communication skills in a variety of settings.

Objectives:

- Elan will seek assistance with problem-solving from appropriate adults.

- Elan will practice communication skills at least one time per week with staff and in his journal.

- Elan will ask an adult when he needs to move around and/or go to a safe place.

- Elan will tell an adult when he feels he may be getting out of control.

- Elan will converse positively with a peer three times a week. He will note any positive changes he notices as a result of these interactions.

Goal #5: Elan will achieve grade-level work with a success ratio of four out of five assignments completed in all classes.

Objectives:

- When given an assignment, Elan will complete four out of five of them, accurately, legibly, and on time.

- Elan will ask for extended time, modified work, etc. when he feels overwhelmed. (Parent will have to do this initially.)

- Elan will accept redirection cues from the teacher when off task.

- Elan will use a homework notebook daily to record all assignments. Teachers will check for accuracy and sign. Parent will sign to verify homework is completed.

Modifications Necessary at This Time:

- Breaking down assignments into manageable parts with clear and simple directions, given one at a time.
- Preparing for transitions.
- Ensuring clarity of understanding and alertness.
- Allowing most difficult subjects to be taken in the afternoon when he is most alert.
- Granting extra time for tests, class work, and homework.
- Allowing for unpredictable mood swings and skill functioning.
- Training all staff involved with Elan on bipolar disorder.
- Ensuring awareness of potential victimization from other students.
- Providing positive praise and redirection.
- Reporting any suicidal comments to counselor/psychologist immediately.
- Providing home instruction to help him keep up with schoolwork if there are times when Elan's mood disorder makes it impossible for him to attend school for an extended period of time.
- Placing an aide in Elan's classroom to ensure his well-being and to assist the teacher with all the students who also need help.
- Having the aide accompany Elan as a buddy without drawing undue attention to him if he does not do well with unstructured times, such as lunch and recess.

Behavior Plan

<u>Goal # 6</u>: **Elan will decrease explosive outbursts.**

Objectives:

- Elan will seek adult assistance before lashing out with aggressive behaviors.

- Elan will remove himself and seek time out and/or a safe place when feeling explosive.

- Elan will learn and apply strategies for anger control.

- Elan will postpone making important decisions during a depressive state.

- Elan will recognize possible early signs of an impending manic or depressive cycle and talk about them to his psychiatrist.

Elan will earn points for all of the above. Points can be accumulated toward a day without homework or something special that will motivate this child.

Source: The Bipolar Child **by Demitri Papolos, M.D., and Janice Papolos (Broadway Books, January 2000). Reprinted with permission of Broadway Books. Ms. Faustini will be making a presentation on IEP development at the NAMI Convention, June 14-18, 2000 in San Diego**

V. Interventions for Serious Problems
B. Bipolar Disorder
(4) Educator's Guide To Receiving Bipolar Students After Hospitalization

by Tracey Trudeau.

Tracey Trudeau is a Child & Adolescent Specialist at the Mood Disorders Association of Manitoba, Canada.

1. Erratic school attendance makes it difficult to assess academic potential or impairment, therefore awareness of lack of opportunity to learn as opposed to the inability to learn is important. Students require flexibility in their academic programming, including those capable of learning core subjects when well and stable. This ultimately becomes an attendance issue rather than a problem defined by a deficit in potential.

2. Premorbid cognitive assessment data provide a good baseline measure for illness-related changes, particularly when qualitative analyses of subtests are employed.

3. A strong supportive partnership between the disciplines of psychiatry and education where there is some common understanding of each other's roles, needs, and language is a prerequisite of successful transitioning. Information sharing that is full of discipline-related jargon confounds the end purpose - student well-being.

4. A special effort should be made by inpatient facilities to connect with rural school districts to minimize any feelings of geographical disconnection by receiving school staff or perception of diminished support.

5. Inpatient staff roles should include finding a supportive school and a primary liaison for the student, providing initial teacher education, program planning assistance, and post-placement support to the receiving school.

6. Predictable and consistent daily routines are ideal for recovering students - the idea of one room, one teacher, might be explored with appropriate students. Gradual or partial re-integration is usually recommended rather than returning with a full academic load.

7. Importance of finding a student's optimum learning style is stressed (i.e. auditory, visual, kinesthetic), as is the willingness of teachers to allow flexibility of the format of work product that would best represent the student's understanding of concepts.

8. Medication and treatment non-adherence difficulties are often timed around school and holiday transitions. Is there a role here for the school counselor in proactively seeking out the student and checking in?

9. Some students will struggle with learning in two languages after recovery despite excelling previously in bilingual education. Careful evaluation of student ability to continue in a demanding bilingual program will ensure that possible pressure to please parents or teachers does not sabotage the total academic program.

10. Students have a strong desire to return to community schooling. This is complicated by worry of ostracism or harassment by peers. These concerns should be raised proactively by parents, therapists, and school staff. Instances of bullying or ridicule about psychiatric hospitalization or diagnosis should be dealt with swiftly and seriously in a manner consistent with racial or sexual harassment.

11. Mental health units should be taught in the upper grades in the context of regular biology or health courses. It is important to begin to demystify these illnesses to the general public and to peers of recovering students rather than solely directing this information to educators, service providers and other helpers.

12. Hospital staff is encouraged to develop a personalized checklist for cues of illness relapse (such as particular symptom emergence) based upon an individual student's past history and current presentation. The student should collaborate in the creation of the checklist and know the steps a school staff member will take on his/her behalf. The use of a contract in the event of acute illness onset facilitates more efficiently timed emergency psychiatric services. Emergence of psychotic symptoms in school should be handled (if possible) discretely.

13. Medication education (especially the side effect profile and level of efficacy in controlling symptoms) should be provided to teachers. Evaluation of work product and performance must consider the limitations of residual illness symptoms and medication side effects: Poor penmanship due to hand tremor, awkward gait or rapid weight gain in physical education, dry mouth and increased fluid intake necessitating frequent bathroom trips, heightened sensitivity to noise and light, are all common in students treated with psychotropic medications.

14. Public school reintegration should be gradual (starting with half days) and working gradually towards a full load if the student is capable. Curriculums should be flexible and the preferred learning methods are co-operative learning and a module format. Mastery learning through module format will ensure that cognitive instability has not interfered with concepts previously taught. A module format may be helpful where a student can work at his or her own pace, or perhaps come back to the module after a hospitalization. Emphasis on mastery learning may be appropriate for students who have lost previous academic achievements/gains. Learning gaps (including concurrent high competencies and clear deficits) are common in bipolar students.

15. A peer mentor (ideally one grade older) may be assigned to the student at a new school. Conversely, a recovering bipolar student wishing to mentor younger peers may be important in developing self-competency. A peer mentor from a self-help or advocacy group may be one important step in understanding that it is possible to grow beyond persistent psychiatric illness, or conversely, share the realistic experiences of being treatment non-adherent and self-destructive.

16. Teachers and other staff should encourage a self-help philosophy with students through advocating for a life-management perspective. Such a philosophy includes self-challenge, self-acceptance, honesty, and especially humor. Typical classroom behavior management strategies are appropriate to use when the student is stable and in remission - they do not work when the student is becoming ill or is still in recovery. For example, during the depressive phase of the illness, bipolar students experience phenomena called 'anhedonia' or flat affect - the inability to experience pleasure or happiness. Consequently, the student has lost the reinforcement of satisfaction which comes from learning something new, so being praised and encouraged by teachers and parents may be ineffectual for behavioral reinforcement.

17. Special education staff are encouraged to design IEPs for students with bipolar disorder that allow for equal time to develop strengths and to follow creative projects as is given for addressing identified academic shortcomings. Students who see themselves as spending more time 'making up' and less time 'getting ahead'

may not develop an area of perceived competence. For example, these students show decline in math performance when comparing work pre- and post-illness. Remedial work in math is necessary, however bipolar disorder also increases the tendency of creative excellence in the visual and written arts. These strengths must be developed and even become a primary focus in an IEP.

18. Below average adaptive behavior skills (communication, daily living skills, socialization, motor skills) as measured by tools like the Vineland Adaptive Behavior Scale may identify target areas missed in more 'intellect-based' assessments (Shole-Martin & Alessi, 1988). Many students who are hospitalized frequently or for extended periods with serious psychiatric illnesses show significant to serious deficits in adaptive behavior skills. Consulting with an occupational therapist may identify problems which parents and/or teachers have attributed to 'motivational' factors.

19. If a student is capable or doing all academic work, but at a slower pace, or, in chunks due to regular and protracted school absences, an IEP that realistically plans for 1.5 academic years to complete each grade might be more helpful than a plan that 'hopes' the student will complete the work if he or she would just remain stable. This also brings forth the serious question of mandatory grade promotion. If the student can understand the work but simply requires the time to complete it, are educators creating ever-increasing cumulative deficits and setting these bipolar students up for later failure? Promoting these students just so that they may remain with their peers may not be a) what the student wants, b) an academically sound decision, or c) the best way to ensure that the student is given a chance to learn to his or her potential.

20. Inpatient staff must ask themselves if parents are making 'informed' decisions regarding educational and health concerns for their children. Parents must know, however hard it may be, the full extent of current and future impairment given what is know about the student's course of illness and history. This is neither the time to 'understate' the case nor to protect the student and the family from the expectation that relapse is not only likely but highly probable. The goal is to frankly communicate the serious nature of the disorder while ensuring that some optimism may be maintained. Contingency planning helps reduce the anxiety of impending relapse.

21. The most important goal for an educator of a bipolar student is to keep that student interested in learning and feeling welcome at school. This is even more important that teaching a prescribed number of concepts by June or in a manner that does not appear to 'bend the rules' too much for a particular child. If the primary measure of success in educating these students is how well they have been molded into the routine and rules of the school, then it is likely that the student's best interests have come second. This illness will go on far longer than the years spent in school. If the student leaves school loving to learn, (s)he will come back to it throughout the lifespan when well enough.

22. Remember that the student did not choose to have bipolar disorder any more than a child chooses to have Down's syndrome or profound deafness. The transition planning process and educational programming should be governed by compassion.

1. Controlling Anger -- Before It Controls You

We all know what anger is, and we've all felt it: whether as a fleeting annoyance or as full-fledged rage. Anger is a completely normal, usually healthy, human emotion. But when it gets out of control and turns destructive, it can lead to problems——problems at work, in your personal relationships, and in the overall quality of your life. And it can make you feel as though you're at the mercy of an unpredictable and powerful emotion. This brochure is meant to help you understand and control anger.

What is Anger?

The Nature of Anger

Anger is "an emotional state that varies in intensity from mild irritation to intense fury and rage," according to Charles Spielberger, PhD, a psychologist who specializes in the study of anger. Like other emotions, it is accompanied by physiological and biological changes; when you get angry, your heart rate and blood pressure go up, as do the levels of your energy hormones, adrenaline, and noradrenaline.

Anger can be caused by both external and internal events. You could be angry at a specific person (Such as a coworker or supervisor) or event (a traffic jam, a canceled flight), or your anger could be caused by worrying or brooding about your personal problems. Memories of traumatic or enraging events can also trigger angry feelings.

Expressing Anger

The instinctive, natural way to express anger is to respond aggressively. Anger is a natural, adaptive response to threats; it inspires powerful, often aggressive, feelings and behaviors, which allow us to fight and to defend ourselves when we are attacked. A certain amount of anger, therefore, is necessary to our survival.

On the other hand, we can't physically lash out at every person or object that irritates or annoys us; laws, social norms, and common sense place limits on how far our anger can take us.

People use a variety of both conscious and unconscious processes to deal with their angry feelings. The three main approaches are expressing, suppressing, and calming. Expressing your angry feelings in an assertive——not aggressive——manner is the healthiest way to express anger. To do this, you have to learn how to make clear what your needs are, and how to get them met, without hurting others. Being assertive doesn't mean being pushy or demanding; it means being respectful of yourself and others.

Anger can be suppressed, and then converted or redirected. This happens when you hold in your anger, stop thinking about it, and focus on something positive. The aim is to inhibit or suppress your anger and convert it into more constructive behavior. The danger in this type of response is that if it isn't allowed outward expression, your anger can turn inward——on yourself. Anger turned inward may cause hypertension, high blood pressure, or depression.

Unexpressed anger can create other problems. It can lead to pathological expressions of anger, such as passive-aggressive behavior (getting back at people indirectly, without telling them why, rather than confronting them head-on) or a personality that seems perpetually cynical and hostile. People who are constantly putting others down, criticizing everything, and making cynical comments haven't learned how to constructively express their anger. Not surprisingly, they aren't likely to have many successful relationships.

Finally, you can calm down inside. This means not just controlling your outward behavior, but also controlling your internal responses, taking steps to lower your heart rate, calm yourself down, and let the feelings subside...

Anger Management

The goal of anger management is to reduce both your emotional feelings and the physiological arousal that anger causes. You can't get rid of, or avoid, the things or the people that enrage you, nor can you change them, but you can learn to control your reactions.

Are You Too Angry?

There are psychological tests that measure the intensity of angry feelings, how prone to anger you are, and how well you handle it. But chances are good that if you do have a problem with anger, you already know it. If you find yourself acting in ways that seem out of control and frightening, you might need help finding better ways to deal with this emotion.

Why Are Some People More Angry Than Others?

According to Jerry Deffenbacher, PhD, a psychologist who specializes in anger management, some people really are more "hotheaded" than others are; they get angry more easily and more intensely than the average person does. There are also those who don't show their anger in loud spectacular ways but are chronically irritable and grumpy. Easily angered people don't always curse and throw things; sometimes they withdraw socially, sulk, or get physically ill.

People who are easily angered generally have what some psychologists call a low tolerance for frustration, meaning simply that they feel that they should not have to be subjected to frustration, inconvenience, or annoyance. They can't take things in stride, and they're particularly infuriated if the situation seems somehow unjust: for example, being corrected for a minor mistake.

What makes these people this way? A number of things. One cause may be genetic or physiological: There is evidence that some children are born irritable, touchy, and easily angered, and that these signs are present from a very early age. Another may be sociocultural. Anger is often regarded as negative; we're taught that

it's all right to express anxiety, depression, or other emotions but not to express anger. As a result, we don't learn how to handle it or channel it constructively.

Research has also found that family background plays a role. Typically, people who are easily angered come from families that are disruptive, chaotic, and not skilled at emotional communications.

Is It Good To "Let it All Hang Out?"

Psychologists now say that this is a dangerous myth. Some people use this theory as a license to hurt others. Research has found that "letting it rip" with anger actually escalates anger and aggression and does nothing to help you (or the person you're angry with) resolve the situation.

It's best to find out what it is that triggers your anger, and then to develop strategies to keep those triggers from tipping you over the edge.

Strategies To Keep Anger At Bay

Relaxation

Simple relaxation tools, such as deep breathing and relaxing imagery, can help calm down angry feelings. There are books and courses that can teach you relaxation techniques, and once you learn the techniques, you can call upon them in any situation. If you are involved in a relationship where both partners are hot-tempered, it might be a good idea for both of you to learn these techniques.

Some simple steps you can try:

- Breathe deeply, from your diaphragm; breathing from your chest won't relax you. Picture your breath coming up from your "gut."

- Slowly repeat a calm word or phrase such as "relax," "take it easy." Repeat it to yourself while breathing deeply.

- Use imagery; visualize a relaxing experience, from either your memory or your imagination.

- Nonstrenuous, slow yoga-like exercises can relax your muscles and make you feel much calmer.

Practice these techniques daily. Learn to use them automatically when you're in a tense situation.

Cognitive Restructuring

Simply put, this means changing the way you think. Angry people tend to curse, swear, or speak in highly colorful terms that reflect their inner thoughts. When you're angry, your thinking can get very exaggerated and overly dramatic. Try replacing these thoughts with more rational ones. For instance, instead of telling yourself, "oh, it's awful, it's terrible, everything's ruined," tell yourself, "it's frustrating, and it's understandable that I'm upset about it, but it's not the end of the world and getting angry is not going to fix it anyhow."

Be careful of words like "never" or "always" when talking about yourself or someone else. "This !&*%@ machine never works," or "you're always forgetting things" are not just inaccurate, they also serve to make you feel that your anger is justified and that there's no way to solve the problem. They also alienate and humiliate people who might otherwise be willing to work with you on a solution.

Remind yourself that getting angry is not going to fix anything, that it won't make you feel better (and may actually make you feel worse).

Logic defeats anger, because anger, even when it's justified, can quickly become irrational. So use cold hard logic on yourself. Remind yourself that the world is "not out to get you," you're just experiencing some of the rough spots of daily life. Do this each time you feel anger getting the best of you, and it'll help you get a more balanced perspective. Angry people tend to demand things: fairness, appreciation, agreement, willingness to do things their way. Everyone wants these things, and we are all hurt and disappointed when we don't get them, but angry people demand them, and when their demands aren't met, their disappointment becomes anger. As part of their cognitive restructuring, angry people need to become aware of their demanding nature and translate their expectations into desires. In other words, saying, "I would like" something is healthier than saying, "I demand" or "I must have" something. When you're unable to get what you want, you will experience the normal reactions——frustration, disappointment, hurt——but not anger. Some angry people use this anger as a way to avoid feeling hurt, but that doesn't mean the hurt goes away.

Problem Solving

Sometimes, our anger and frustration are caused by very real and inescapable problems in our lives. Not all anger is misplaced, and often it's a healthy, natural response to these difficulties. There is also a cultural belief that every problem has a solution, and it adds to our frustration to find out that this isn't always the case. The best attitude to bring to such a situation, then, is not to focus on finding the solution, but rather on how you handle and face the problem.

Make a plan, and check your progress along the way. Resolve to give it your best, but also not to punish yourself if an answer doesn't come right away. If you can approach it with your best intentions and efforts and make a serious attempt to face it head-on, you will be less likely to lose patience and fall into all-or-nothing thinking, even if the problem does not get solved right away.

Better Communication

Angry people tend to jump to——and act on——conclusions, and some of those conclusions can be very inaccurate. The first thing to do if you're in a heated discussion is slow down and think through your responses. Don't say the first thing that comes into your head, but slow down and think carefully about what you want to say. At the same time, listen carefully to what the other person is saying and take your time before answering.

Listen, too, to what is underlying the anger. For instance, you like a certain amount of freedom and personal space, and your "significant other" wants more connection and closeness. If he or she starts complaining about your activities, don't retaliate by painting your partner as a jailer, a warden, or an albatross around your neck.

It's natural to get defensive when you're criticized, but don't fight back. Instead, listen to what's underlying the words: the message that this person might feel neglected and unloved. It may take a lot of patient questioning on your part, and it may require some breathing space, but don't let your anger——or a partner's——let a discussion spin out of control. Keeping your cool can keep the situation from becoming a disastrous one.

Using Humor

"Silly humor" can help defuse rage in a number of ways. For one thing, it can help you get a more balanced perspective. When you get angry and call someone a name or refer to them in some imaginative phrase, stop and picture what that word would literally look like. If you're at work and you think of a coworker as a "dirtbag" or a "single-cell life form," for example, picture a large bag full of dirt (or an amoeba) sitting at your colleague's desk, talking on the phone, going to meetings. Do this whenever a name comes into your head about another person. If you can, draw a picture of what the actual thing might look like. This will take a lot of the edge off your fury; and humor can always be relied on to help unknot a tense situation.

The underlying message of highly angry people, Dr. Deffenbacher says, is "things oughta go my way!" Angry people tend to feel that they are morally right, that any blocking or changing of their plans is an unbearable indignity and that they should NOT have to suffer this way. Maybe other people do, but not them!

When you feel that urge, he suggests, picture yourself as a god or goddess, a supreme ruler, who owns the streets and stores and office space, striding alone and having your way in all situations while others defer to you. The more detail you can get into your imaginary scenes, the more chances you have to realize that maybe you are being unreasonable; you'll also realize how unimportant the things you're angry about really are. There are two cautions in using humor. First, don't try to just "laugh off" your problems; rather, use humor to help yourself face them more constructively. Second, don't give in to harsh, sarcastic humor; that's just another form of unhealthy anger expression.

What these techniques have in common is a refusal to take yourself too seriously. Anger is a serious emotion, but it's often accompanied by ideas that, if examined, can make you laugh.

Changing Your Environment

Sometimes it's our immediate surroundings that give us cause for irritation and fury. Problems and responsibilities can weigh on you and make you feel angry at the "trap" you seem to have fallen into and all the people and things that form that trap.

Give yourself a break. Make sure you have some "personal time" scheduled for times of the day that you know are particularly stressful. One example is the working mother who has a standing rule that when she comes home from work, for the first 15 minutes "nobody talks to Mom unless the house is on fire." After this brief quiet time, she feels better prepared to handle demands from her kids without blowing up at them.

Some Other Tips for Easing Up on Yourself

Timing: If you and your spouse tend to fight when you discuss things at night——perhaps you're tired, or distracted, or maybe it's just habit——try changing the times when you talk about important matters so these talks don't turn into arguments.

Avoidance: If your child's chaotic room makes you furious every time you walk by it, shut the door. Don't make yourself look at what infuriates you. Don't say, "well, my child should clean up the room so I won't have to be angry!" That's not the point. The point is to keep yourself calm.

Finding alternatives: If your daily commute through traffic leaves you in a state of rage and frustration, give yourself a project——learn or map out a different route, one that's less congested or more scenic. Or find another alternative, such as a bus or commuter train.

Do You Need Counseling?

If you feel that your anger is really out of control, if it is having an impact on your relationships and on important parts of your life, you might consider counseling to learn how to handle it better. A psychologist or other licensed mental health professional can work with you in developing a range of techniques for changing your thinking and your behavior.

When you talk to a prospective therapist, tell her or him that you have problems with anger that you want to work on, and ask about his or her approach to anger management. Make sure this isn't only a course of action designed to "put you in touch with your feelings and express them"——that may be precisely what your problem is. With counseling, psychologists say, a highly angry person can move closer to a middle range of anger in about 8 to 10 weeks, depending on the circumstances and the techniques used.

What About Assertiveness Training?

It's true that angry people need to learn to become assertive (rather than aggressive), but most books and courses on developing assertiveness are aimed at people who don't feel enough anger. These people are more passive and acquiescent than the average person; they tend to let others walk all over them. That isn't something that most angry people do. Still, these books can contain some useful tactics to use in frustrating situations.

Remember, you can't eliminate anger——and it wouldn't be a good idea if you could. In spite of all your efforts, things will happen that will cause you anger; and sometimes it will be justifiable anger. Life will be filled with frustration, pain, loss, and the unpredictable actions of others. You can't change that; but you can change the way you let such events affect you. Controlling your angry responses can keep them from making you even more unhappy in the long run.

2. Helping Young Children Deal with Anger

by Marian Marion, PhD

Children's anger presents challenges to teachers committed to constructive, ethical, and effective child guidance. This Digest explores what we know about the components of children's anger, factors contributing to understanding and managing anger, and the ways teachers can guide children's expressions of anger.

THREE COMPONENTS OF ANGER

Anger is believed to have three components:

THE EMOTIONAL STATE OF ANGER. The first component is the emotion itself, defined as an affective or arousal state, or a feeling experienced when a goal is blocked or needs are frustrated. Fabes and Eisenberg describe several types of stress-producing anger provocations that young children face daily in classroom interactions:

- * Conflict over possessions, which involves someone taking children's property or invading their space.

- * Physical assault, which involves one child doing something to another child, such as pushing or hitting.

- * Verbal conflict, for example, a tease or a taunt.

- * Rejection, which involves a child being ignored or not allowed to play with peers.

- * Issues of compliance, which often involve asking or insisting that children do something that they do not want to do--for instance, wash their hands.

EXPRESSION OF ANGER. The second component of anger is its expression. Some children vent or express anger through facial expressions, crying, sulking, or talking, but do little to try to solve a problem or confront the provocateur. Others actively resist by physically or verbally defending their positions, self-esteem, or possessions in nonaggressive ways. Still other children express anger with aggressive revenge by physically or verbally retaliating against the provocateur. Some children express dislike by telling the offender that he or she cannot play or is not liked. Other children express anger through avoidance or attempts to escape from or evade the provocateur. And some children use adult seeking, looking for comfort or solutions from a teacher, or telling the teacher about an incident.

Teachers can use child guidance strategies to help children express angry feelings in socially constructive ways. Children develop ideas about how to express emotions primarily through social interaction in their families and later by watching television or movies, playing video games, and reading books. Some children have learned a negative, aggressive approach to expressing anger (Cummings, 1987; Hennessy et al., 1994) and, when confronted with everyday anger conflicts, resort to using aggression in the classroom. A major challenge for early childhood teachers is to encourage children to acknowledge angry feelings and to help them learn to express anger in positive and effective ways.

AN UNDERSTANDING OF ANGER. The third component of the anger experience is understanding--interpreting and evaluating--the emotion. Because the ability to regulate the expression of anger is linked to an understanding of the emotion, and because children's ability to reflect on their anger is somewhat limited, children need guidance from teachers and parents in understanding and managing their feelings of anger.

UNDERSTANDING AND MANAGING ANGER

The development of basic cognitive processes undergirds children's gradual development of the understanding of anger.

MEMORY. Memory improves substantially during early childhood, enabling young children to better remember aspects of anger-arousing interactions. Children who have developed unhelpful ideas of how to express anger may retrieve the early unhelpful strategy even after teachers help them gain a more helpful perspective. This finding implies that teachers may have to remind some children, sometimes more than once or twice, about the less aggressive ways of expressing anger.

LANGUAGE. Talking about emotions helps young children understand their feelings. The understanding of emotion in preschool children is predicted by overall language ability. Teachers can expect individual differences in the ability to identify and label angry feelings because children's families model a variety of approaches in talking about emotions.

SELF-REFERENTIAL AND SELF-REGULATORY BEHAVIORS.

Self-referential behaviors include viewing the self as separate from others and as an active, independent, causal agent. Self-regulation refers to controlling impulses, tolerating frustration, and postponing immediate gratification. Initial self-regulation in young children provides a base for early childhood teachers who can develop strategies to nurture children's emerging ability to regulate the expression of anger.

GUIDING CHILDREN'S EXPRESSIONS OF ANGER

Teachers can help children deal with anger by guiding their understanding and management of this emotion. The practices described here can help children understand and manage angry feelings in a direct and nonaggressive way.

CREATE A SAFE EMOTIONAL CLIMATE. A healthy early childhood setting permits children to acknowledge all feelings, pleasant and unpleasant, and does not shame anger. Healthy classroom systems have clear, firm, and flexible boundaries.

MODEL RESPONSIBLE ANGER MANAGEMENT. Children have an impaired ability to understand emotion when adults show a lot of anger. Adults who are most effective in helping children manage anger model responsible management by acknowledging, accepting, and taking responsibility for their own angry feelings and by expressing anger in direct and nonaggressive ways.

HELP CHILDREN DEVELOP SELF-REGULATORY SKILLS. Teachers of infants and toddlers do a lot of self-regulation "work," realizing that the children in their care have a very limited ability to regulate their own emotions. As children get older, adults can gradually transfer control of the self to children, so that they can develop self-regulatory skills.

ENCOURAGE CHILDREN TO LABEL FEELINGS OF ANGER. Teachers and parents can help young children produce a label for their anger by teaching them that they are having a feeling and that they can use a word to describe their angry feeling. A permanent record (a book or chart) can be made of lists of labels for anger (e.g., mad, irritated, annoyed), and the class can refer to it when discussing angry feelings.

ENCOURAGE CHILDREN TO TALK ABOUT ANGER-AROUSING INTERACTIONS. Preschool children better understand anger andother emotions when adults explain emotions. When children are embroiled in an anger-arousinginteraction, teachers can help by listening without judging,evaluating, or ordering them to feel differently.

USE BOOKS AND STORIES ABOUT ANGER TO HELP CHILDREN.

UNDERSTAND AND MANAGE ANGER. Well-presented stories about anger and other emotions validate children's feelings and give information about anger. It is important to preview all books about anger because some stories teach irresponsible anger management.

COMMUNICATE WITH PARENTS. Some of the same strategies employed to talk with parents about other areas of the curriculum can be used to enlist their assistance in helping children learn to express emotions. For example, articles about learning to use words to label anger can be included in a newsletter to parents.

Children guided toward responsible anger management are more likely to understand and manage angry feelings directly and nonaggressively and to avoid the stress often accompanying poor anger management. Teachers can take some of the bumps out of understanding and managing anger by adopting positive guidance strategies.

V. Interventions for Serious Problems
C. Anger
(3) Helping the Child Who is ExpressingAnger

Except from: Anger Management for Young Children

What is anger and why does it need to be managed?

Anger is a normal human emotion. Uncontrolled anger, however, can lead to aggression. This can cause physiological problems and lead to harmful behaviour.

Aggression first begins in the toddler years. This is when children are naturally more aggressive than any other age group. A toddler's inability to talk may be one reason why aggression starts at this age.

Toddlers and young children need to learn how to control their emotions. Otherwise, frequent aggression over time can cause problems in school, at home and with their friends and family. One study found that 1 in 7 children who had aggression early in life that increased as they aged were at a higher risk of:

- school failure
- adult unemployment
- physical violence
- mental illness

Anger management helps a child develop better ways to cope with angry feelings.

Managing anger

The goal of anger management is to reduce negative feelings. This can help reduce the negative physiological changes caused by anger. Like other emotions, anger can cause physiological changes such as a rise in blood pressure, and an increase in your energy hormones like adrenaline.

There are three main ways your child can deal with angry feelings:

- expressing anger
- suppressing anger
- calming anger

Expressing anger, understanding emotions

The more a child expresses anger, the less likely he will have an angry outburst. Expressing anger requires him to communicate. He needs to be able to start sentences with phrases like, "I'm mad because…" or "I'm feeling angry because…". Children need to express what their needs are. They need to express how their needs can be met without hurting others. Parents can help their children understand their emotions by asking them how they are feeling when they are calm and happy. Then can ask how their children feel when they are mad. It may also help to point out other people's emotions or feelings, such as "that man on TV looks angry."

Suppressing anger: accept and redirect

Anger can be suppressed and converted into another emotion. This can occur if your child focuses on something else that is positive. This is a good technique for older children or teenagers.

The technique here is to help your child recognize his anger, and then convert the anger into something positive and constructive. You could ask your young child to draw pictures how he is feeling. An older child may write a note. He may confront whatever is causing the anger by offering an alternative solution to the problem.

There is a danger to this technique. If your child does not convert the anger, the unexpressed anger can harm his health. Unexpressed anger may cause high blood pressure or depression.

You should not be so afraid of suppressing your child's anger that you begin to allow unacceptable behaviours. Children who are 'rewarded' for temper tantrums will continue to have them. Unacceptable outbursts should calmly be met with natural and logical consequences. For example, if they break a toy in a fit of rage, that toy should not be replaced. If they break a family members' object, they should pay for it through their allowance or by doing additional chores.

Calming down, taking time out

Every child needs to learn how to calm their emotions. This helps them to control their outward behaviour. Helpful exercises include:

- taking deep breaths
- walking outdoors
- spending time alone
- doing yoga, martial arts, or other forms of exercise

Excerpts from: ## Help for Parents of Troubled Teens

Dealing with Anger, Violence, Delinquency, and Other Teen Behavior Problems

Parenting a teenager is never easy, but when your teen is violent, depressed, abusing alcohol or drugs, or engaging in other reckless behaviors, it can seem overwhelming. You may feel exhausted from lying awake at night worrying about where your child is, who he or she is with, and what they're doing. You may despair over failed attempts to communicate, the endless fights, and the open defiance. Or you may live in fear of your teen's violent mood swings and explosive anger. While parenting a troubled teen can often seem like an impossible task, there are steps you can take to ease the chaos at home and help your teen transition into a happy, successful young adult.

Normal teen vs. troubled teen behavior

As teenagers begin to assert their independence and find their own identity, many experience behavioral changes that can seem bizarre and unpredictable to parents. Your sweet, obedient child who once couldn't bear to be separated from you now won't be seen within 20 yards of you, and greets everything you say with a roll of the eyes or the slam of a door. These, unfortunately, are the actions of a normal teenager.

As the parent of a troubled teen, you're faced with even greater challenges. A troubled teen faces behavioral, emotional, or learning problems beyond the normal teenage issues. They may repeatedly practice at-risk behaviors such as violence, skipping school, drinking, drug use, sex, self-harming, shoplifting, or other criminal acts. Or they may exhibit symptoms of mental health problems like depression, anxiety, or eating disorders. While any negative behavior repeated over and over can be a sign of underlying trouble, it's important for parents to understand which behaviors are normal during adolescent development, and which can point to more serious problems.

When Typical Teen Behavior Becomes Troubled Teen Behavior	
Typical Teen Behavior	**Warning Signs of a Troubled Teen**
Changing appearance. Keeping up with fashion is important to teens. That may mean wearing provocative or attention-seeking clothing or dyeing hair. Unless your teen wants tattoos, avoid criticizing and save your protests for the bigger issues. Fashions change, and so will your teen.	Changing appearance can be a red flag if it's accompanied by problems at school or other negative changes in behavior, or if there's evidence of cutting and self-harm or extreme weight loss or weight gain.
Increased arguments and rebellious behavior. As teens begin seeking independence, you will frequently butt heads and argue.	Constant escalation of arguments, violence at home, skipping school, getting in fights, and run-ins with the law are all red flag behaviors that go beyond the norm of teenage rebellion.
Mood swings. Hormones and developmental changes often mean that your teen will experience mood swings, irritable behavior, and struggle to manage his or her emotions.	Rapid changes in personality, falling grades, persistent sadness, anxiety, or sleep problems could indicate depression, bullying, or another emotional health issue. Take *any* talk about suicide seriously.
Experimenting with alcohol or drugs. Most teens will try alcohol and smoke a cigarette at some point. Many will even try marijuana. Talking to your kids frankly and openly about drugs and alcohol is one way to ensure it doesn't progress further.	When alcohol or drug use becomes habitual, especially when it's accompanied by problems at school or home, it may indicate a substance abuse issue or other underlying problems.

When Typical Teen Behavior Becomes Troubled Teen Behavior	
More influenced by friends than parents.Friends become extremely important to teens and can have a great influence on their choices. As teens focus more on their peers, that inevitably means they withdraw from you. It may leave you feeling hurt, but it doesn't mean your teen doesn't still need your love.	Red flags include a sudden change in peer group (especially if the new friends encourage negative behavior), refusing to comply with reasonable rules and boundaries, or avoiding the consequences of bad behavior by lying. Your teen spending too much time alone can also indicate problems.

Seeking professional help for a troubled teen

If you identify red flag behaviors in your teen, consult a doctor, counselor, therapist, or other mental health professional for help finding appropriate treatment.

Even when you seek professional help for your teen, though, that doesn't mean that your job is done. As detailed below, there are many things you can do at home to help your teen and improve the relationship between you. And you don't need to wait for a diagnosis to start putting them into practice.

All teens need to feel loved

Teenagers are individuals with unique personalities and their own likes and dislikes. Some things about them are universal, though. No matter how much your teen seems to withdraw from you emotionally, no matter how independent your teen appears, or how troubled your teen becomes, he or she still needs your attention and to feel loved by you.

Understanding teen development

No, your teen is not an alien being from a distant planet, but he or she *is* wired differently. A teenager's brain is still actively developing, processing information differently than a mature adult's brain. The frontal cortex—the part of the brain used to manage emotions, make decisions, reason, and control inhibitions—is restructured during the teenage years, forming new synapses at an incredible rate, while the whole brain does not reach full maturity until about the mid-20's.

Your teen may be taller than you and seem mature in some respects, but often he or she is simply unable to think things through at an adult level. Hormones produced during the physical changes of adolescence can further complicate things. Now, these biological differences don't excuse teens' poor behavior or absolve them from accountability for their actions, but they may help explain why teens behave so impulsively or frustrate parents and teachers with their poor decisions, social anxiety, and rebelliousness. Understanding adolescent development can help you find ways to stay connected to your teen and overcome problems together.

V. Interventions for Serious Problems

C. Anger

5. Model Programs

Aggressors, Victims, and Bystanders: Thinking and Acting to Prevent Violence, for middle schools, is a demonstrated curriculum for high-risk students. The curriculum is composed of 12 classroom sessions that deal with violence among peers and the separate but interrelated roles of aggressors, victims, and bystanders that youth play in potentially violent situations. The backbone of this curriculum is the four-step Think-First Model of Conflict Resolution. The model helps students to pause and keep cool, understand what is going on before jumping to conclusions, define their problems and goals in ways that will not lead to fights, and generate positive solutions. The curriculum has been tested in urban, suburban, and small-city school districts and has made students more supportive of resolving conflicts without aggression.

Contact: Christine Blaber Education Development Center, Inc., 55 Chapel Street, Suite 25, Newton, MA 02458, 800-225-4276 ext. 2364, E-mail: Cblaber@edc.org

To order the curriculum: Education Development Center, Inc., P.O. Box 1020, Sewickley, PA 15143-1020, 800-793- 5076, Fax: 412-741-0609, & Email: mcc@edc.org/mcc.

The Anger Coping Program, for middle schools, is a demonstrated model for selected male students. The program consists of 18 weekly small group sessions led by a school counselor and a mental health counselor during the school day. The lessons emphasize self-management and self-monitoring, perspective taking, and social problem solving skills. Aggressive boys who have been through the Anger Coping Program have been found to have lower rates of drug and alcohol involvement and higher levels of self-esteem and problem-solving skills than those who have not.

Contact: John E. Lochman, Professor and Saxon Chair of Clinical Psychology, Department of Psychology, Box 870348, The University of Alabama, Tuscaloosa, AL 35487, 205-348-5083, Fax: 205-348-8648, E-mail: jlochman@GP.AS.UA.EDU

BASIS, for middle schools, is a demonstrated model that focuses on procedures for discipline. Clarifying and consistently enforcing the school rules, improving classroom management and organization, tracking student behaviors (good and bad), reinforcing positive behaviors, and increasing the frequency of communication with parents about student behavior are emphasized. A multi-year, multi-site study found that classroom disruption decreased and attention to academic work increased significantly in the schools in which the program was well implemented.

Contact: Denise Gottfredson, University of Maryland, Department of Criminology, Lefrak Hall, Room 2220, College Park, MD 20742, 301-405-4717, Fax: 301-405-4733, E-mail: dgottfredson@crim.umd.edu

Conflict Resolution: A Curriculum for Youth Providers, for secondary schools, is a demonstrated model. Key elements include helping students define conflict, teaching three types of conflict resolution, and reviewing basic communications behavior. Each session contains at least one skills-building exercise and lasts from 15 to 50 minutes. This program has reduced violence and the frequency of fights resulting in injuries that require medical treatment.

Contact: National Resource Center for Youth Services, College of Continuing Education, University of Oklahoma, 4502 E 41st Street Building 4 West, Tulsa, OK 74135-2512, Phone: 918/660-3700, Fax: 918/660-3737, Web site: www.nrcys.ou.edu

Positive Adolescent Choices Training (PACT), for middle and high schools, is a demonstrated model for high-risk African American youth and other high-risk youth selected by teachers for conduct problems or histories of victimization. Using videotaped vignettes and role playing, students learn social skills such as giving positive and negative feedback, accepting feedback, negotiation, problem-solving, and resisting peer pressure in small groups of 10-12. Students who have been through PACT have exhibited 50 percent less physical aggression at school and more than 50 percent fewer violence-related juvenile court charges than a comparable group who did not receive PACT.

Contact: Betty R. Yung, Ph.D., Director, Center for Child and Adolescent Violence Prevention, Wright State University, School of Professional Psychology, Ellis Human Development Institute, 9 North Edwin C. Moses Boulevard, Dayton, OH 45407, 937-775-4300, Fax: 937-775-4323, E-mail: betty.yung@right.edu

Promoting Alternative Thinking Strategies (PATHS), for grades K-5, is a demonstrated model designed to promote emotional competence through expression, understanding, and regulation of emotions. Cognitive problem-solving skills are also taught. The main objectives are for students to learn new skills and be able to apply those skills in daily life. Improvements have been found in students' hyperactivity, peer aggression, and conduct problems.

Contact: Dan Chadrow, Developmental Research and Programs, 800-736-2630, Web site: www.drp.org, E-mail: moreinfo@drp.org.   (Developer) Mark Greenberg, Ph.D., Prevention Research Center, S110 Henderson Building, Pennsylvania State University, University Park, PA 16802, 814-863-0112 Fax: 814-865-2530, Email: mxg47@psu.edu

Peace Builders®, for grades K-5, is a demonstrated model for students of mixed ethnicity that has been tested in urban and suburban elementary schools. Peace Builders should be viewed as a way of life rather than a program because it attempts to change the characteristics of the school setting that trigger aggressive, hostile behavior. This program seeks to increase the availability of pro-social models to enhance social competence and decrease the frequency and intensity of aggressive behaviors. Researchers found that this program improved students' social competence (especially if students had two years of exposure to the program) and buffered expected increases in their aggressive behavior.

Contact: Jane Gulibon, Heartsprings,, Inc., P.O. Box 12158, Tucson, AZ 85732, 800-368-9356, Web site: www.peacebuilders.com, E-mail: custrel@heartsprings.org

Second Step, for pre-K through middle schools, is a demonstrated curriculum designed to insert skills-based training into existing school curriculums and encourage the transfer of skills to behavior at school and at home. The pre-K through grade 5 versions of Second Step also have a 6-week parent education component. The elementary program teaches empathy, impulse control, and anger management. The middle school program covers understanding the violence problem, empathy, anger management, problem solving, and applying skills to everyday situations. A study showed that physical aggression decreased from autumn to spring among students who were in the program but increased among students who were in a comparison group.

Contact: Committee for Children, 2203 Airport Way South, Suite 500, Seattle, WA 98134, or 172 20th Avenue, Seattle, WA 98122, 800-634-4449 ext 6223, Fax: 206-438-6765, Web site: www.cfchildren.org

The School Safety Program, for high schools, is a demonstrated model for identifying violence problems and devising effective responses. The program's main component is a curriculum integrated into a required 11th grade social studies course that trains students to be problem solvers, engages students in solving their school's problems, identifies problem students through reviews by teachers and police, and sponsors regular meetings among school teachers, school administrators, and the police. An evaluation found a 50 percent reduction in incidents requiring calls to the police (mainly assault-related behaviors) at an intervention school but only a small reduction at a comparison school. In addition, threats to teachers decreased 17 percent in an intervention school but increased by five percent in a comparison school.

B. A Few Agencies and Online Resources Relevant to Affect and Mood Problems*

American Association of Suicidology – http://www.suicidology.org

D/ART: Depression/Awareness, Recognition and Treatment – http://www.nimh.nih.gov/

MDSG-NY (Mood Disorders Support Group, Inc.) -- http://www.mdsg.org

Mental Health Net (MHN) -- http://www.mentalhelp.net

Depressive and Bipolar Support Alliance – http://www.dbsalliance.org/

The Samaritans – http://www.samaritans.org.uk/

SA\VE: Suicide Awareness \ Voices of Education – http://www.save.org

Suicide Prevention Resource Center – http://www.sprc.org/

*See other agencies cited throughout this document.

C. A Few Center Resources

The Center's Quick Find Online Clearinghouse offers a fast and convenient way to access Centert resources and to link to resources from others. http://smhp.psych.ucla.edu/quicksearch.htm

TOPIC: *Anger Management* http://smhp.psych.ucla.edu/qf/p2108_06.htm

TOPIC: *Childhood and Adolescent Depression* http://smhp.psych.ucla.edu/qf/depression.htm

School Interventions to Prevent and Respond to Affect and Mood

Periodically, windows of opportunities arise for providing inservice at schools about mental health and psychosocial concerns, When such opportunities appear, it may be helpful to access one of more of our Center's *Quick Training Aids*.

Each of these offer a brief set of resources to guide those providing an inservice session. (They also are a form of quick self-tutorial and group discussion.)

Most encompass

- key talking points for a short training session
- a brief overview of the topic
- facts sheets
- tools
- a sampling of other related information and resources

In compiling resource material, the Center tries to identify those that represent "best practice" standards, If you know of better material, please **let us know** *so that we can make improvements.*

Suicide Prevention

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- key talking points for a short training session

- a brief overview of the topic

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- a sampling of other related information and resources

In compiling resource material, the Center tries to identify those that represent "best practice" standards. If you know of better material, please **let us know** *so that we can make improvements.*

"This course was developed from the public domain document: Affect and Mood Related to School Aged Youth (2015) – Center for Mental health in Schools at UCLA."