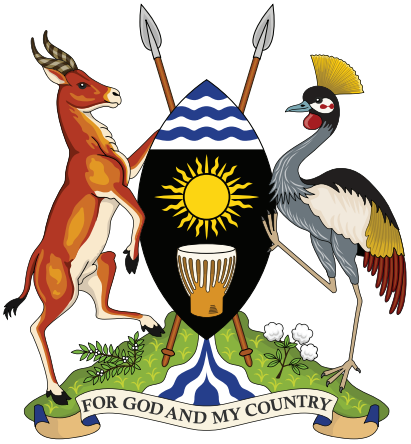
THE REPUBLIC OF UGANDA

Department of Guidance & Counselling

MINISTRY OF EDUCATION AND SPORTS

THE MENTAL HEALTH RESOURCE BOOK FOR EDUCATIONAL INSTITUTIONS IN UGANDA



THE REPUBLIC OF UGANDA

MINISTRY OF EDUCATION AND SPORTS

THE MENTAL HEALTH RESOURCE BOOK FOR EDUCATIONAL INSTITUTIONS IN UGANDA

Table of Contents

Introduction

The Mental Health Resource Book has been developed in recognition of the need to address the mental health of young people in Uganda by providing teacher and student-friendly school-based resources.

This resource book is designed to assist teachers and learners to;

- Promote learners' awareness of mental health issues and reduce the stigma.
- Provide a safe and supportive environment in which all learners can maximise their learning
- Remain accessible and responsive to learners' needs
- Help learners develop their abilities to cope with challenges and stress.
- Identify those learners in particular need of assistance or support.

The resource book aims at assisting learners explore the language of mental health and mental illness and learn about the causes, symptoms and approaches for dealing with different mental illness.

Learners will also learn about seeking help and providing peer support and meaningful recovery from mental illness, as well as the importance of positive mental health for all.

Why use the Resource Book?

Stigma, fear and lack of information about mental health problems have been identified as reasons why mental health and mental illness have not been adequately addressed in many schools in Uganda. This Resource Book has been developed to help overcome some of these barriers. By providing accurate, peer reviewed information on mental health and mental illness.

The Mental Health Resource Book is intended to achieve the following outcomes:

1. To provide teachers in Uganda with consistent, reliable and easy-to-use information to help promote the basic understanding of mental health and mental illness
2. To provide learners with a basic introduction to normal brain functioning to help them better understand mental health and mental illness
3. To help learners understand the various factors that can contribute to mental illness and the biological component which makes mental illnesses not that different from other illnesses
4. To equip youths with the knowledge they need in order to identify when they, a friend or family member is experiencing mental health problems or mental illness
5. To reduce the stigma associated with mental illness by providing clear, factual information about mental illness, its causes, ways to address it and recovery
6. To help young people understand that seeking help to mental health problems is very important and to suggest strategies for seeking help

7. To reinforce the importance of positive mental health and effective ways of coping with stress
8. To provide information about recovery from mental illness and the factors which help keep people well.

Mental disorders affect approximately 15-20 percent of youths worldwide and about 70% of these disorders begin prior to age 25 years. It is therefore likely that educators will be faced with having to deal with young people who are experiencing or living with mental illness. In order to assist educators in their work, the following unit was specifically developed to help inform educators about some of the common mental disorders found in young people.

Mental health problems affect around one in six young people. They include depression, anxiety and conduct disorder (a type of behavioural problem) and are often a direct response to what is happening in their lives.

Alarmingly, however, 75% of young people who experience a mental health problem aren't getting the help they need.

Young people emotional wellbeing is just as important as their physical health. Good mental health helps develop the resilience to cope with whatever life throws at them and grow into well-rounded, healthy adults.

WHAT ARE MENTAL DISORDERS?

Here is what we know about mental disorders:

- Disturbances of emotion, thinking, and / or behaviour
- May occur spontaneously (without a precipitant)
- Severe (problematic to the individual and others)
- Lead to functional impairment (interpersonal, social)
- Prolonged
- Often require professional intervention
- Derive from brain dysfunctions – brain disorder
- Is rarely, if ever, caused by stress alone

Mental Disorder behaviours are NOT:

- Not the consequences of poor parenting or bad behaviour
- Not the result of personal weakness or deficits in personality
- Not the manifestation of the malevolent spiritual intent
- Only in exceptional cases; it is caused by nutritional factors
- Not caused by poverty

How is the Brain Involved?

- The brain is made up of: cells, connection amongst the cells and various neurochemical
- The neurochemicals provide a means of the different parts of the brain to communicate
- Different parts of the brain are primarily responsible for doing different things (e.g. Movement)
- Most things a brain does depends on many different parts of the brain working together in a network.

What Happens Inside The Brain When It Gets Sick?

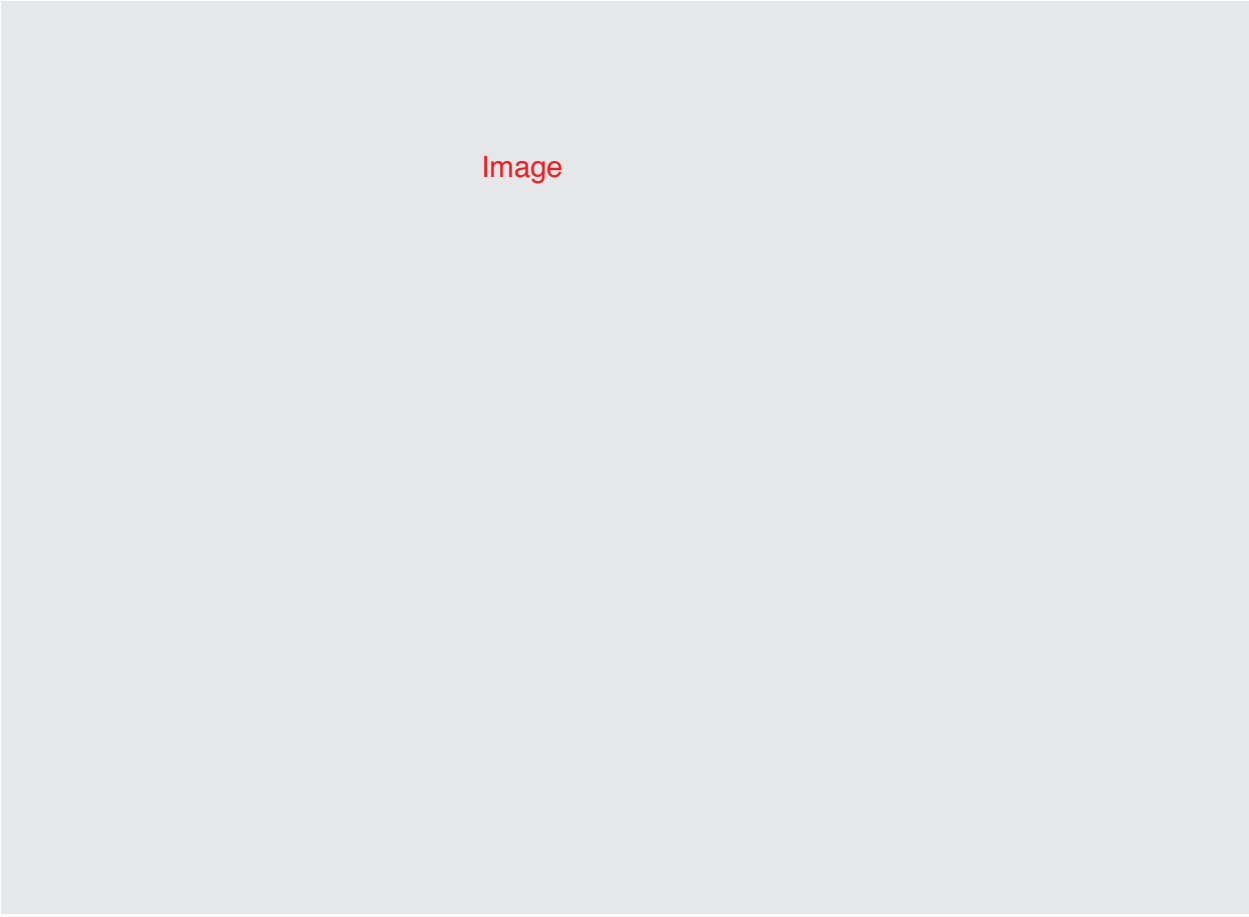
- A specific part of the brain that needs to be working on a specific task is not working well
- A specific part of the brain that needs to be working on a specific task is working in the wrong way
- Neurochemical messengers that help different parts of the brain communicate are not working properly.

How Does The Brain Show Its Not Working Well?

If the brain is not working properly, one or more of its functions will be disturbed

- Disturbed functions that a person directly experiences (such as sadness, sleep problems, etc.) are called SYMPTOMS
- Disturbed functions that another person sees (such as over activity, withdrawal, etc.) are called SIGNS
- BOTH signs and symptoms can be used to determine if the brain may not be working
- The person's usual life or degree of functioning is also disrupted because of the signs and symptoms.

Mental disorders are associated with disturbances in six primary domains of brain functions:



When the brain is not functioning properly in one or more of its domains, and personal experience that interfere with his or her life in a significant way, they may have a mental disorder.

BUT

Not all disturbances of the brain functioning are mental disorders. Some can be normal or expected responses to the environment-for example: grief when somebody dies or acute worry, sleep problems and emotional tension when faced with a natural disaster such as earthquakes.

What's the difference between mental distress and mental disorders?

Distress		Disorders:
Common; caused by problem or event; usually not severe (may be severe); usually short lasting; professional help not usually needed; (professional help can be useful **– DIAGNOSIS NOT NEEDED**	**VS.**	Less Common; May happen without any stress; often with high severity usually long lasting; professional help usually needed **– NEEDS TO BE DIAGNOSED**

What causes mental illness?

A variety of different insults to the brain can lead to mental illness. Basically, there are two major causes that can be independent or can interact:

GENETICS (The effect of genes on brain function) and

ENVIRONMENT (The effect of things outside the brain – such as infection; malnutrition; severe stress, etc.).

Classification of Mental Health Disorders:

Functions of the Brain

Image

WHAT ARE PSYCHOTIC DISORDERS?

Psychotic disorders are a group of illnesses characterised by severe disturbances in the capacity to distinguish between what is real and what is not real. The person with psychosis exhibits major problems in thinking and behaviour. These include symptoms such as delusions and hallucinations. These result in much impairment and significantly interfere with the capacity to meet ordinary demands of life. Schizophrenia is an example of a psychotic disorder that affects about 1% of the population.

Who is at risk of developing Schizophrenia?

Schizophrenia (SCZ) often begins in adolescence and there often may be a genetic component although not always. A family history of SCZ, a history of birth trauma and a history of fatal damage in utero increases the risk of SCZ. Significant marijuana use may bring on SCZ in young people who are at higher risk for the illness.

What does Schizophrenia look like?

Delusions are erroneous beliefs that may involve misinterpretation of experiences or perceptions. One common type of delusion is persecutory (also commonly called paranoid) in which the person thinks that he or she is being harmed in some way by another person, force or entity (such as God, the police, spirits, etc.). Strongly held minority religious or cultural beliefs are not delusions.

Hallucinations are perceptions (such as hearing sounds or voices, smelling scents, etc.) that may occur in any sensory modality in the times of extreme stress or in sleep like states. Occasionally, they can occur spontaneously (such as a person hearing their name called out loud) but these do not cause problems with everyday life and are not persistent.

Thinking is disorganised in form and in content. For example, the pattern of speaking may not make sense to others or what is being said may not make sense or be an expression of delusional ideas. Behaviour can be disturbed. This can range from behaviour that is mildly socially inappropriate to very disruptive and even threatening behaviours that may be responses to hallucinations or part of a delusion. Self-grooming and self-care may be also compromised.

A youth person with schizophrenia will also demonstrate a variety of cognitive problems ranging from difficulties with concentration to “higher orders” difficulties such as with abstract reasoning and problem solving. Most people with schizophrenia will also exhibit what are called “negative symptoms” which include flattening of mood; decreased speech; lack of will.

A person with schizophrenia may exhibit delusions, hallucinations and disordered thinking (also called “positive symptoms”) as well as negative symptoms at different times during the illness.

What are the criteria for the diagnosis Schizophrenia?

1. Positive symptoms as described above (delusions, hallucinations, disorganised thinking)
2. Negative symptoms as described above
3. Behavioural disturbances as described above
4. Significant dysfunction in one or more areas of daily life (social, family, interpersonal, school/work, etc.)
5. These features must last for at least 6 months during which time there must be at least one month of positive symptoms.

What can I do if it is SCZ?

A young person with SCZ will require immediate effective treatment – usually in a specialty mental health programme (first inset psychosis programme). If an educator suspects SCZ a referral to the most appropriate health provider should be made following discussion with the parents about the concerns.

What do I need to watch out for?

Many people with SCZ will demonstrate a slow and gradual onset of the illness – often over the period of 6 - 9 months or more. Early signs include: social withdrawal, odd behaviours, lack of attention to personal hygiene, excessive preoccupation with religious or philosophical constructs, etc. Occasionally the young person suffering SCZ may exhibit very unusual behaviours – often in response to a delusion or hallucinations. Sometimes, it may be difficult to distinguish the onset of SCZ (also called a “prodromal’) from mental disorders – such as Depression or social anxiety disorder. Young people suffering from SCZ may also begin abusing substances – particularly alcohol and marijuana and develop a substance disorder concurrently. Occasionally, the young person may share bizarre ideas or may complain about being persecuted by others or may appear to be responding to internal voices. Rarely these delusions or hallucinations may be accompanied by unexpected violent acts.

Mental Disorders of Emotion and Feeling; (Mood disorders)

DEPRESSION

Not to be confused with the word “depression” which is commonly used to describe emotional distress, sadness; depression means CLINIAL DEPRESSION which is a mental disorder.

What are the different types of Depression?

There are two common kinds of depression, Major Depression disorder (MDD) and Dysthymic Disorder (DD). Both can significantly and negatively impact on people’s lives. They can lead to social, personal and family difficulties as well as poor vocational/educational performance and even premature death due to suicide. Additionally, patients with other illnesses such as heart diseases and diabetes have an increased risk of death if they are also diagnosed with depression. This is thought to be due to the physiologic effects that depression has on your body as well as lifestyle effects such as poor self-care, increased smocking and alcohol consumption. Individuals but in mild cases may experience substantial improvement with strong social supports and personal counselling.

What do MDD AND DD look like?

MDD is usually a life-long disorder beginning in adolescence or early adulthood; is characterised by periods (lasting months to years) of depressive episodes that are really self-limiting. The episodes may be separated by periods (lasting months to years) of relative mood stability. Sometimes, the depressive episodes may be triggered by a negative event (such as the loss of a loved one; severe and persistent stress such as economic difficulties, conflicts) but often, the episodes may occur spontaneously. Often there is a family history of clinical depression, alcoholism, anxiety disorder or bipolar (Manic-depressive) disorder. DD is low grade depression that lasts for many years. It is less common than MDD.

What is a depressive episode?

A depressive episode is characterised by three symptoms clusters: 1) Mood 2) Thinking (often called cognitive) 3) Body sensations (often called somatic). MDD may present differently in different cultures, particularly in the somatic problems that people present with. Symptoms:

- Must be severe enough to cause functional impairment (stop the person from doing what he or she would otherwise be doing, or decrease the quality of what they are doing)
- Must be continuously present every day, most of the day for at least two weeks
- Cannot be due to a substance or medicine or medical illness and must be different from the person’s usual state.

These symptoms are:

Mood:

- Feeling “depressed”; “sad”; “unhappy” (or whatever the cultural equivalent of these descriptors is)
- Feeling a loss of pleasure or a marked disinterest in all activities
- Feelings of worthlessness, hopeless or excessive and inappropriate guilt

Thinking:

- Diminished ability to think or concentrate or substantial indecisiveness
- Suicidal thoughts/plans or preoccupation with death and dying

Body sensation:

- Excessive fatigue or loss of energy
- Significant sleep problems (difficulty falling asleep or sleeping excessively)
- Physical slowness or in some cases excessive restlessness
- Significant decrease in appetite that may lead to noticeable weight loss.

Criteria:

Five of the above symptoms must be present EVERY DAY for MOST OF THE DAY during the same two weeks period; ONE of the FIVE symptoms MUST BE either depressed mood or loss of interest or pleasure.

Things to look for:	What can I do if it is Depression?
People with Depression are at an increased risk of attempting suicide. Every person with depression should be monitored for suicide thoughts and plans. As a teacher, you need to be aware that a depressed student who begins to talk about suicide needs to be referred to his/her health provider immediately.	You can identify the disorder and counsel the person with the disorder (including the education of the person and family) if it is mild and if you are trained in counselling. If the disorder is more intense or the person is suicidal, you should immediately refer the person to the health professional best suited to treat depression. Ideally, this should be done in collaboration and with the active support of the school guidance counsellor or identified school based mental health provider. Once an intervention occurs and the young person is back at school, it is important that you be part of the on-going treatment team and help develop and address learning needs. You may also need to continue to provide realistic emotional support

Questions to ask:

Have you lost interest or pleasure in the things that you usually like to do? Have you felt sad, low, down or hopeless? Are you feeling like ending it all? If the student answers yes to either these, further assessment of all of the symptoms should be directed to the appropriate health care sector.

BIPOLAR DISORDER

- Illness is characterised by cycles (episodes) of Depression and mania
- Cycles can be frequent (daily) or infrequent (many years apart)
- During depressive or manic episodes, the person may become psychotic
- Suicide rates are high in people with bipolar mood disorder

In bipolar disorder how is 'mania' different from feeling extremely happy?

- Mood is mostly elevated or irritable
- Many behavioural, physical and thinking problems
- Significant problems in daily life because of the mood
- Mood may often not reflect the reality of the environment
- Is not caused by a life problem or life event

Bipolar - what to look for:

- History of at least one depressive episode and at least one manic episode
- Rapid mood changes include irritably and anger outbursts
- Self-destructive of self-harmful behaviours – including spending sprees, violence towards others; sexual indiscretions; etc.
- Psychotic symptoms including: hallucinations and delusions.

Mental Disorder of signalling: (The Anxiety Disorders)

WHAT IS GENERALISED ANXIETY DISORDER?

GAD is described as excessive anxiety and worry occurring for an extended period of time about several different things. The persistent apprehension, worry and anxiety, causes distress and leads to physical symptoms.

Who is at risk for developing GAD?

Gad often begins in childhood or adolescence and there is also a genetic or familiar component. Once GAD is present, the severity can fluctuate and exacerbations often occur during times of stress. Other psychiatric disorders are also risk factors for GAD such as depression, panic disorder and agoraphobia.

What does Generalised Anxiety Disorder look like?

Generalised Anxiety Disorder (GAD) is characterised by excessive anxiety and worry about many different things. The worry is out of proportion to the concern or event. This anxiety and worry must be noticeably greater than the usual socio-cultural norms. Youth with GAD often do not present with panic attacks as in panic disorder. Often, they present with physical complaints such as headaches, fatigue, muscle aches and upset stomach.

How do you Differentiate GAD from normal worrying?

Anxiety can be broken into four categories:

1. Emotions – i.e. feeling fearful, worried, tense or on guard.
2. Body Response – anxiety can cause many different responses of the body including increased heart rate, sweating and shakiness, shortness of breath, muscle tension and stomach upset.
3. Thoughts – when experiencing anxiety, people are more likely to think about things related to a real or potential sources of danger and may have difficulty concentrating on anything else.
4. Behaviours – people may engage in activities that can potentially eliminate the source of the danger, examples include avoiding feared situations, people or places and self-medicating with drugs or alcohol

When does anxiety become a disorder?

These physical emotional and behavioural responses to perceived danger are normal reactions and that we experience them every day. Many times, this ‘anxiety response’ is automatic, and every creature has these automatic responses as a way of protecting themselves from danger. However, anxiety becomes a problem when:

- It is greater intensity and/or duration then typically expected given a context
- It leads to impairment or disability in work, school or social environments
- It leads to avoidance of daily activities in an attempt to lessen the anxiety

What are the criteria for the diagnosis of GAD?

1. Excessive anxiety and worry occurring for at least 6 months about several things
2. Difficulty controlling the worry
3. The anxiety and worry are associated with 3 or more of the following
4. Restlessness or feeling on edge, fatigued, difficulty concentrating, muscle tension or sleep disturbance
5. The anxiety and worry are not due to substance abuse, a medical condition or a mental disorder
6. The anxiety and physical symptoms cause marked distress and significant impairment in daily functioning.

What can I do if it is Generalised Anxiety Disorder?

The first thing is to identify the problem for the young person and elicit assistance from a helper knowledgeable about the problem. Some people with GAD will experience improvements in their anxiety and functioning with supportive cognitive based counselling. Others may require medication. Referral to an appropriate health professional for medical attention could be considered if the GAD is severe and if the functional impairment is excessive. For some, merely knowing that they have GAD and receiving supportive counselling may be helpful enough.

Things to look for:	Questions to ask:
Some people with GAD may go on to develop a clinical Depression. Some people may begin to use substances, such as alcohol to help control their anxiety. If this occurs, they may be at risk of developing a substance abuse of substance dependence problem.	Can you tell me about your worries? Do you or others see you as someone who worries much more than most people do? Do you have trouble 'letting go of the worries'? Do you sometimes feel sick with worry – in what way? What things that you enjoy doing or would like to do or made less enjoyable are avoided because of the worries? What if anything do you find makes the worries better – is this for a short or a long time?

SOCIAL PHOBIA

What is social phobia?

Social Phobia, also known as Social Anxiety Disorder, is characterised by the presence of an intense fear of scrutiny by others, which may result in embarrassment or humiliation.

What does Social Phobia look like?

Young people with social phobia fear doing something humiliating in front of others or of offending others. They fear that others will judge everything they do in a negative way. They believe they may be considered to be a flawed or worthless if any sign of a poor performance is detected. They may cope by trying to do everything perfect; limiting what they are doing in front of others and gradually withdraw from contact with others. Youth with social phobia often experience panic symptoms in social situations. As a result, they tend to avoid social situations such as parties or school events. Some may have a difficult time attending class and many avoid going to school altogether. Although young people with social phobia recognise that their fears are excessive and irrational, they are unable to control it and therefore avoid situations that trigger their anxiety. The presentations of social phobia may vary across cultures and although it may occur in children, it usually onsets in the adolescent years. It must not be confused with shyness and the strength of the fears may wax away over time.

What are the criteria for diagnosis of Social Phobia?

The following must be present for someone to have a social phobia?

- Marked and persistent fear of social or performance situations in which the person is exposed to unfamiliar people; fear of embarrassment or humiliation
- Exposure to the feared situation almost always provokes marked anxiety or panic
- The person recognises that the fear is excessive or inappropriate
- The avoidance of fear causes significant impairment in functioning and distress
- The feared social or performance situations are avoided or else endured with intense anxiety or distress
- The symptoms are not due to a substance, medicine or general medical condition.

In children, social phobia may be expressed by crying, tantrums and a variety of clingy behaviours. Other psychiatric diagnoses that social phobia must be differentiated from include: Panic Disorder, Pervasive Developmental Disorder' Schizoid Personality Disorder.

What can I do if it is Social Phobia?

The first step is the identification of the problem. Often, people with Social Phobia will have suffered for many years without knowing the reasons for their difficulties. Sometimes just informing and educating them about the problem can be very helpful, particularly in mid cases. Treatment is not indicated unless the problem is causing significant functional impairment but counselling using cognitive behavioural techniques and exposure to the anxiety provoking situation in the company of a counsellor may help the person better deal with their difficulties. If the disorder is severe, referral to an appropriate health care provider is indicated, and the counsellor can provide ongoing support. A teacher may be able to assist in behavioural modification programs (such as getting used to a classroom situation). If you think a student may have social phobia, it is important not to draw attention publically to their difficulties but speak with them in private about what you notice – be supportive.

What do I need to watch out for?

Some young people with social phobia will use excessive amounts of alcohol to help decrease their anxiety in social situations. In some cases, Social Phobia can be a risk factor for the abuse of alcohol or other substances. In young children, it is important to differentiate Social Phobia from Persuasive Developmental Disorders such as Autism. Children with autism, in contrast to the children with social phobia, will not demonstrate age-appropriate social relationships with family member or other familiar people.

Questions to ask:

Do situations that are new or associated with unfamiliar people cause you to feel anxious, distressed or panicky? When you are in unfamiliar social situations, are you afraid of feeling embarrassed? What kinds of situations cause you feel that way? Do these feelings of embarrassment, anxiety, distress or panic stop you from doing things that you would otherwise do? What have you not been able to do as well as you would like to do because of these difficulties.

WHAT IS PANIC DISORDER?

Panic Disorder is characterised by recurrent, unexpected, anxiety (panic) attacks that involve triggering a number of frightening physical reactions. The frequency and severity of panic attacks can vary greatly and can lead to agoraphobia (fear of being in places in which escape is difficult).

Who is at risk of developing Panic Disorders?

The onset of panic disorder is commonly between the ages 15 – 25. People who have first-degree relatives with panic disorder have an 8x higher risk of also developing panic disorder themselves. Panic Disorder is associated with an area of the brain that regulates alertness. Disturbances in this area of the brain is one explanation why panic attacks occur.

What does Panic Disorder look like?

Young people with panic disorder experience recurrent, unexpected panic attacks and they greatly fear having another attack. They persistently worry about having a panic attack. Some may fear they are 'losing their mind' or feel they are going to die. Often, they will change their behaviour to avoid places or situations that they fear might trigger a panic attack. In time, the person may come to avoid so many situations, that they become bound to their home.

What are the components of a panic attack?

The person has four or more of the following symptoms which peak within 10 minutes.

1. Palpitations, pounding heart or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensations of shortness of breath or smothering
5. Feeling of choking
6. Chest pain or discomfort
7. Nausea or abdominal pain
8. Feeling dizzy, unsteady, lightheaded or faint
9. Feeling of unreality or being detached from oneself
10. Fear of losing control or going crazy
11. Fear of dying
12. Numbness or tingling in the body
13. Chills or hot flashes

What are the criteria for Panic Disorder?

Assessing panic disorder involves evaluating 5 areas:

1. Panic attacks
2. Anticipatory anxiety

3. Panic related phobia avoidance
4. Overall illness severity
5. Psychosocial disability

For diagnosis of panic disorder, a patient must have:

1. Recurrent unexpected panic attacks
2. One or more of the attacks has been followed by more than 1 month of:
    - Persistent concern of having additional attacks
    - Worry about the implications of the attack or its consequences
    - A significant change in behaviour as a result of the attacks
3. Can be _+ agoraphobia
4. Panic attacks are not due to substance abuse, medications or a general condition
5. Panic attacks are not better accounted for by mental disorder

What can I do if it is Panic Disorder?

The first thing is to identify the panic attack and provide a calm and supportive environment until the attack passes. Education about panic attacks and panic disorder is often very helpful and should ideally be provided by a professional with good knowledge in this area. Counselling using cognitive behavioural methods may be of help and medications can be used as well. The teacher's role in helping a young person suffering from a panic disorder can also involve assisting them in dealing with their anxieties about having another attack and also helping them with strategies to combat avoidance of social situations. Therefore, it is a good idea for a teacher to be part of the treatment planning and treatment monitoring for a youth with panic disorders.

Things to look for:	Questions to ask?
Youth with disorders are at high risk of developing depression. If the person appears sad or hopeless and has suicidal thoughts, a diagnosis of depression must also be suspected. Some young people with **panic disorder** may also develop substance abuse (particularly alcohol) and counselling around these issues is very important.	Can you describe in your own words what happens when you have one of these episodes (some people will refer to them as "spells")? How many of these episodes have you had in the last week, in the last month? What do these episodes mean to you? What do these episodes stop you from doing that you would otherwise usually do? What do you do when these episodes occur? Do you ever feel that you would like to be dead or think that your problem is so great that you should kill yourself? How do your family, friends, loved ones, etc. react to these episodes? What do they say is the problem?

OBSESSIVE COMPULSIVE DISORDER

Obsessive Compulsive Disorder (OCD) is an anxiety disorder characterised by obsessions and/or compulsions. Obsessions are persistent, intrusive, unwanted thoughts, images or impulses that the person recognises as irrational, senseless, intrusive or inappropriate but is unable to control.

Compulsions are repetitive behaviours, which the person performs in order to reduce anxiety associated with an obsession. Examples of these are counting, touching, washing and checking. Both can be of such intensity that they cause a great deal of distress and significantly interfere with the persons daily functioning. Obsessions are different from psychotic thoughts because the person knows that they are their own thoughts (not put inside their head by some external force). Compulsions are different from psychotic behaviours because the person knows why he/she is doing the activity and can usually say why they are doing them.

Who is at risk of developing OCD?

OCD often begins in adolescence or early adulthood, although it can start in childhood. It is quite common and affects both men and women. First-degree relatives of people with OCD are more likely to develop OCD. It is important to note that people with OCD are at a higher risk of developing Depression and other anxiety disorders.

What does OCD look like?

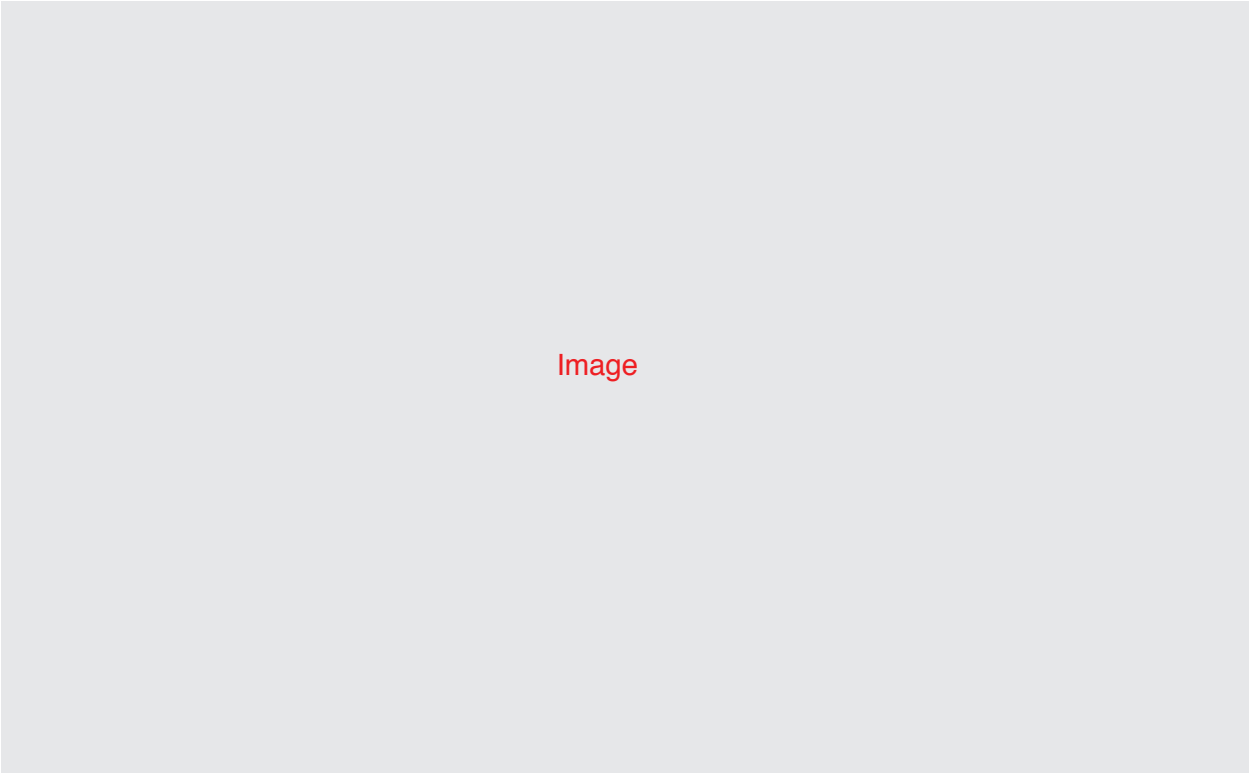
OCD should not be confused with superstitious or those repetitive checking behaviours that are common in everyday life. They are not simply excessive worries about real life issues. A person with OCD will have significant symptoms of either obsession or compulsions or both. These symptoms will be severe enough to cause marked distress, are time consuming (take up more than one hour per day) and significantly interfere with a person's normal activities (work, school, family, etc.).

Obsessions:

- Recurrent and persistent thoughts, impulses or images that are experienced as intrusive and not appropriate and cause significant distress or anxiety
- These symptoms cannot be simply excessive worries about everyday life
- The person with these symptoms suppresses or ignores them. The person may try to neutralise, decrease or suppress the thoughts with some other thought or action. The person knows that the thoughts are coming from his mind.

Compulsions:

- Repetitive behaviours (such as checking, washing, ordering) or mental acts such as counting, praying, repeating words silently) that a person feels driven to perform in response to an obsession or according to rigid rules.



- These behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation BUT are not realistically connected to the obsessions they are meant to neutralise.

How do you differentiate between OCD and Psychosis?

This is a very important step to take if you suspect someone has OCD. In general, patients with OCD have insight into the senselessness of their thoughts and actions and often try to hide their symptoms. This distinguishes OCD from psychotic orders such as Schizophrenia because those patients lack any insight into the senseless nature of their symptoms.

What can I do if it is OCD?

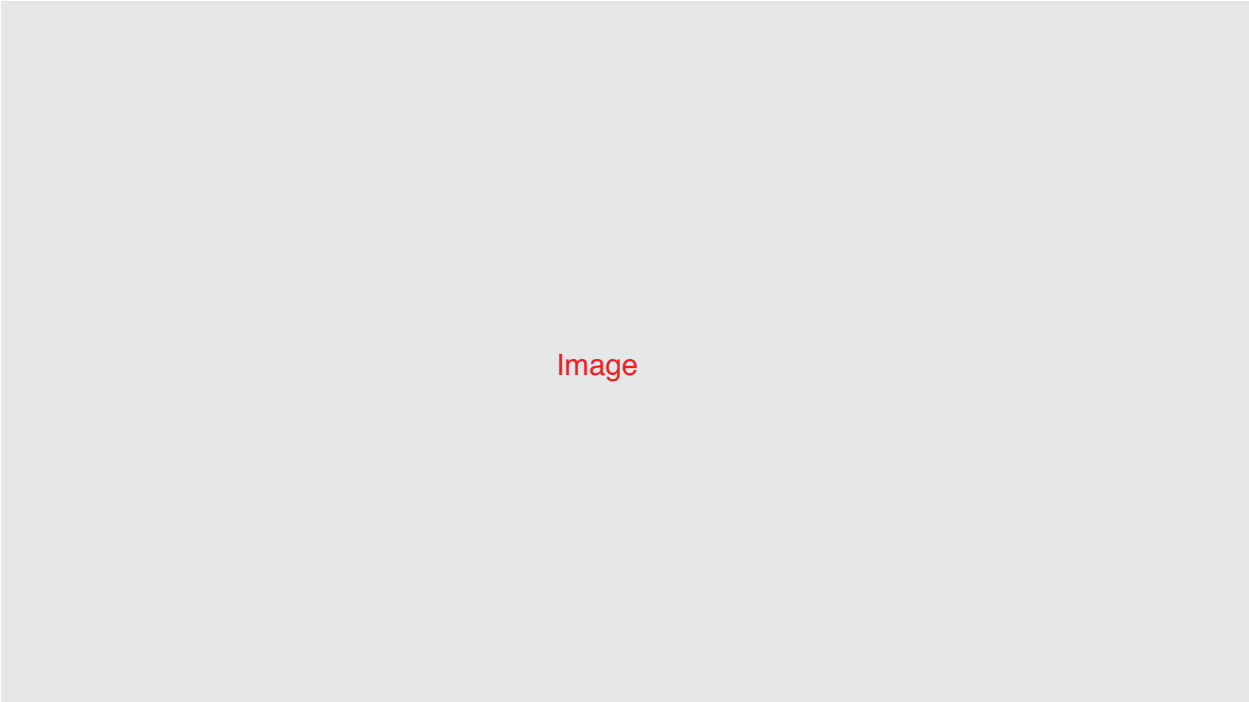
You can educate the student about OCD and how it is treated. If the symptoms are associated with impairment (social or academic) you should send the student to the school guidance or health professional who can then refer the person to the professional best suited to provide treatment and you can continue to provide education and support to the student if that is mutually agreed to. Often young people will be treated with cognitive behavioural therapy (CBT). Sometimes, this may require a teacher's input. It is important to know if any academic modifications need to be made to enhance learning opportunities for young people with OCD so; including the teacher treatment planning and treatment monitoring is usually necessary.

Things to look for:

There are two main things to watch out for. The first is the possibility that the symptoms could be part of the psychosis. Therefore, it is very important to rule out a psychosis disorder. (PLEASE REVIEW THE SECTION OF PSYCHOSIS). The second thing to watch for, is the effect OCD has on the young person's classmates. Sometimes students with severe OCD will try to involve their classmates (or their teachers) in their compulsions. If this happens, then it can cause significant problems at school. Educating yourself about OCD and the importance of not participating in the OCD rituals is important.

WHAT IS THE POST TRAUMATIC STRESS DISORDER?

Post-Traumatic Stress disorder (PTSD) develops after a trauma occurs that was either experienced or witnessed by the patient. It involves the development of psychological reactions related to the experience such as recurrent, intrusive and distressing recollections of the event. These may be in the form of nightmares, flash backs and/or hallucinations.



Who is at risk for developing PSTD?

Not all people who have experienced a traumatic event will develop PTSD. Indeed, most will not. Risk factors including personal or family history of depression or anxiety, severity of the trauma and early separation from parents.

What does PSTD look like?

The symptoms of the PSTD develop within 6 months following the traumatic event and are organised into three categories.

Re-experiencing Symptoms - Recurrent, intrusive, distressing recollections or memories of the event in the form of memories, dreams, or flash backs in which the individual perceives himself/herself to be reliving the event as though it was actually happening again in the present.

Avoidance and Numbing Symptoms- Avoidance of anything-people, places, topics of conversation, food, drink, weather conditions, clothing, activities, situations, thoughts, feelings – that are associated with or are reminders of a traumatic event. In addition, the person may experience a general numbing of emotions, a loss of interest in a sense of hopelessness about the future.

Hyperarousal Symptoms- Sleep problems (difficulties falling asleep or staying asleep), irritability, angry outbursts, hyper vigilance, exaggerated startle response, and difficulty concentrating.

What are criteria for the diagnosis of PTSD?

1. The person has been exposed to a traumatic event in which both of the following were present;
    a. The person felt their life was in danger or witnessed someone else's life put in danger
    b. The person experienced extreme fear, helplessness or horror
2. The traumatic event is re-experienced, including one or more of;
    a. Recurrent, intrusive memories, dreams or nightmares reliving the event which causes psychological distress.
3. Avoidance of things associated with the event including 3 or more of:
    a. Avoid thoughts, feelings or conversations; avoid activities, places or people, inability to recall aspect of the trauma, decreased interest or participation in activities, feeling detached or estranged from others, restricted range of affect, sense of foreshortened future.
4. Persistent symptoms of increase arousal including two or more of:
    a. Difficulty falling or staying asleep, irritability, difficulty concentrating, hypervigilance, exaggerated startle response.
5. Duration of symptoms greater than 1 month

    Severity of symptoms causes marked distress and impairment in daily functioning.

How does PSTD differ from Acute Stress Disorder or normal grieving?

PSTD must be distinguished from normal responses (such as grief, distress) to such situations and from Acute Stress Disorder (ASD) which has similar symptoms to PSTD but which ends or diminishes greatly usually without formal treatment within four weeks of the traumatic event. Duration and severity of the PSTD symptoms may vary over time with complete recovery within half a year or less in half or more cases.

What can I do if it is PSTD?

The first thing is to identify the young person with PTSD and help them find a knowledgeable helper who can provide education to them about what the problem is and how it can be treated. It is important not confuse PSTD with normal response to traumatic events of with ASD. Do not create pathology where it does not exist! For people with PSTD, supportive counselling using cognitive therapy methods may be of help. If the disorder is causing significant distress and impairment, referral to an appropriate health care provider is indicated, as medication may be needed

Things to look for:

Some people who are exposed to significant traumatic events may have exacerbations of pre-existing mental health problems such as anxiety, Depression or Psychosis. Identification and proper effective interventions for these people in the post traumatic situation are important. Substance abuse, especially involving alcohol is very common in people who have PTSD. Therefore, it is important to screen for this problem in people with PTDS and to treat appropriately.

Mental Disorder of Physical: (Eating Disorders)

WHAT IS AN EATING DISORDER?

There are two main types of eating disorders anorexia nervosa and bulimia nervosa. While there may be some overlapping in symptoms between the two, they are likely to have different causes and the treatments of them differ.

Who is at risk of developing an eating disorder?

Eating disorders usually begin in adolescence and may continue into adulthood. Girls are much more commonly affected than boys.

What does Anorexia Nervosa look like?

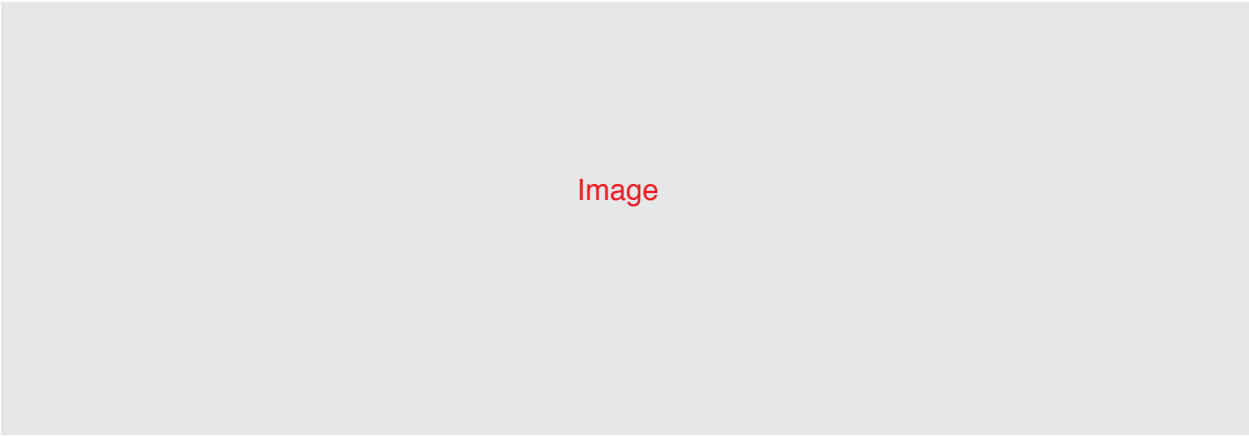
Anorexia Nervosa (AN) is characterised by excessive preoccupation with body weight control, a disturbed body image, an intense fear of gaining weight and refusal to maintain a minimally normal weight. Post pubertal girls also experience a loss of menstrual periods. There are two subtypes of AN – a restricting subtype (in which the young person does not regularly binge or abuse laxative or self-induce vomiting) and a binge-eating/purging subtype (in which the young person regularly binges and abuses laxatives or self-induces vomiting).

What does Bulimia Nervosa look like?

Bulimia Nervosa (BN) is characterised by regular and recurrent binge eating (large amounts of food over a short time accompanied by lack of control over the eating during the episode) and by frequent and appropriate behaviours designed to prevent weight gain (including but not limited to: Self-induced vomiting, use of laxatives, enemas, excessive exercises.

How do you differentiate an eating disorder from normal teenage eating?

Eating patterns in young people can be very erratic. Food fads are common as are periods of dieting and food restriction (often in response to concerns about weight). Adolescence is also a period in which some young people experiment with food types and eating experiments that may differ substantially from those common to their families or communities. These are not eating disorders.



What are the criteria for the diagnosis of AN?

Refusal to maintain body weight at or above a minimally normal weight for age and height resulting in a body weight less than 80% of that expected.

1. Intense fear of gaining weight or becoming fat while underweight.
2. Substantial disturbances in body image (consider self to be fat even though is underweight) or denial of seriousness of current low body weight.
3. Loss of menstrual periods in post pubertal girls.

The prevalence of AN is about 0.2 to 0.5 percent.

What can I do if it is AN?

Young people with AN do not complain about having AN; most deny that they have a problem with being underweight. Usually a friend, teacher or family member will notice the severe weight loss. An educator who is concerned that a student may have AN should gently and supportively discuss the issue with the young person and if after that discussion, it seems as if a possibility of AN, the young person should be referred to the appropriate support person or health provider in the school for further assessment and intervention. Suggestions that the young person eat more or negative comments on the youth's weight are counterproductive.

Things to look for

Some people with AN may go on to develop a clinical depression or severe medical problems. Some young people may begin to avoid class or other school activities. Frequently, young people with AN will avoid eating at the time all other young people are eating (such as lunch time in the school dining room).

What are the criteria for the diagnosis of BN?

1. Recurrent episodes of binge eating where both of the following are present: a)-eating large amounts of food in a short period of time: b)-feeling that eating is out of control.
2. Recurrent inappropriate behaviours in order to control weight (such as: self-induced vomiting; misuse of laxatives, diuretics, enemas or other medications, fasting or excessive exercises).
3. The above must occur an average of at least twice a week for a period of 3 months.
4. Self-perspective is overly influenced by body shape and weight.
5. The above does not occur exclusively during AN.

There are two subtypes of BN – the purging type; characterised by self-induced vomiting or misuse of laxative, diuretics, enemas, etc.); the nonpurging type (no use of the above).

Note: The prevalence of BN in Canada is about 1-3 percent. However, worldwide statistics are similar/close.

What can I do if it is BN?

Young people with BN do not complain about having BN and most deny that they have a problem with eating. BN is often hidden. Classroom discussion about BN and other eating problems should be undertaken with sensitivity that there may be a young person with unknown or unrecognised BN in the group.

Things to look for:
Some people with BN may go on to develop a clinical depression or substance abuse (including excessive amounts of appetite suppressants).

SUBSTANCE DEPENDANCE AND ABUSE

There is a spectrum of harm that can develop from various substances; along this spectrum of harm is abuse and dependence.

What is Substance Abuse?

The abuse of substance is a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring with a 12 months period;

1. Recurrent substance use resulting in a failure to fulfil major roles, obligations at work, school or home (e.g. repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household)
2. Recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by substance use).
3. Recurrent substance-related legal problems (e.g. arrests for substance-related disorderly conduct).
4. Continued substance use despite having persistent or recurrent social interpersonal problems caused or exacerbated by the effects of the substance arguments with spouse about consequences of intoxication, physical fights.

What is Substance Dependence?

Substance dependence is a maladaptive pattern of substance use, leading to clinically significant impairments or distress. As manifested by three (or more) of the following; occurring at any time in the same 12 months period.

1. Tolerance, as defined by either or the following:
    a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect
    b. Markedly diminished effect with continued use of the same amount of substance.
2. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome of the substance
    b. The same (or a closely related) substance is taken to relieve or avoid withdraw symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities to obtain the substance, use the substance, or recover from its effects.
6. Important social, occupational or recreational activities are given up or reduced because of substance use.
7. The substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have caused or exacerbated by the substance (e.g. continued drinking despite recognition that an ulcer was made worse by alcohol consumption.

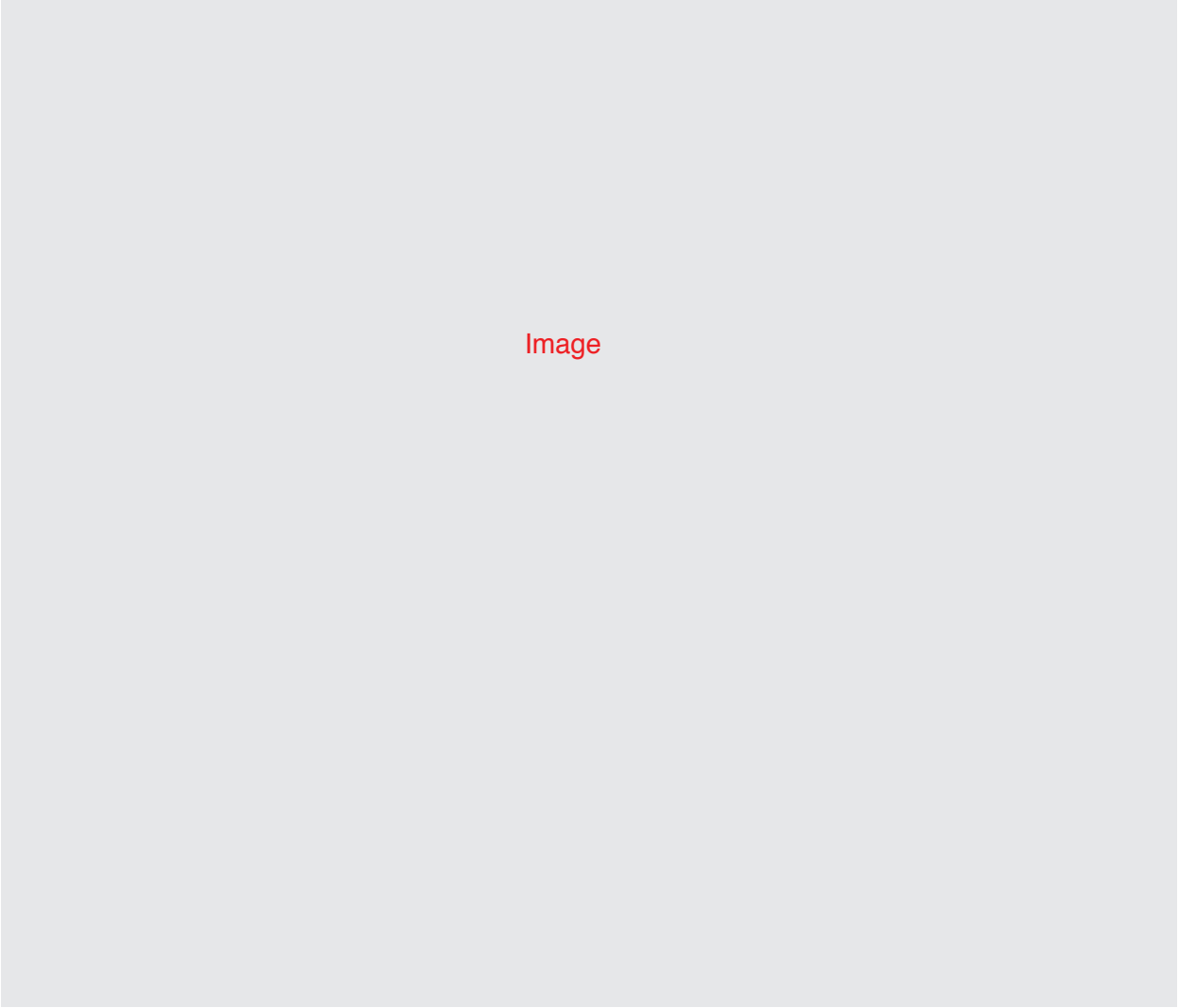
What are types of Substances that can be abused?

The abuse of substance includes those that are legal and illegal. The definition of the drug as legal or illegal substance does not determine if the substance can induce dependence or abuse. Substances include such things as alcohol, nicotine, cannabis, amphetamines, cocaine, inhalants, opioids, hypnotic and others.

A variety of substance can be safely used in modernisation by most people as social modifiers (for example; beer or other alcohol taken with meals or in social situations). Substances which may be abused in some situations can be therapeutic in others-for example heroin or cocaine can be used to treat pain under medical supervision but are also well known to be addictive substances when used for non-medical purposes.

What can I do if it is Substance Abuse/Dependence?

First, it is important to identify the problem. In some situations, cultural, social or economic factors may impede the identification of the substance problem. The person with a problem will often deny the problem exists and sometimes the person's family or loved ones will also deny that the problem exists. Young people often proceed through a path of substance misuse for a long time (years) before some of them go on to abuse. Most young people who misuse substances likely do not go on to abuse them-therefore, substance misuse, although a risk factor for substance abuse, is not necessarily predictive of substance abuse. Academic and social problems characterise the young person who suffers from substance abuse – failing grades, missing classes, Monday morning absences, aggressiveness, etc.



Things to look for:

Some people with substance dependence/abuse will also have other health problems such as depression or anxiety. If these problems occur, they should be identified and help for them provided. Suicide may occur more frequently in people with substance problems. Youth who suffer from untreated or inadequately treated ADHD are at higher risk for substance abuse. Effective medication treatment of ADHD decreases the risk for substance abuse.

Substance abuse/dependence in young people usually requires professional interventions. Issues such as confidentiality will often arise so it's important that teachers understand what the expectations and limits to confidentially regarding substance abuse/dependence and in their setting.

Often the advice of a teacher or a coach is an important step towards treatment for a young person abusing substances. Non-judgemental but realistic advice from a teacher can sometimes lead them to the realisation that they need help. Some young people traffic in the substances that they use. The teacher therefore, needs to know the school policy on drugs and abide by it.

What is attention deficit hyperactivity disorder?

Attention Deficit Hyperactivity Disorder (ADHD) is characterised by persistent pattern of hyperactivity, impulsivity and substantial difficulties with sustained attention that is outside the population norm and is associated with substantial functional impairments at school, home and with peers. This disorder begins before age seven and continues into adolescence or for some people, even into adulthood.

Who is at risk of ADHD?

ADHD has a genetic component and runs in families and is more common in boys than girls. Girls who have ADHD often do not have similar problems with hyperactivity although; they have similar problems with sustaining attention. Young people who have learning disabilities and youth with Tourette's syndrome have higher rates of ADHD. Young people with conduct disorder may have ADHD which has not been recognised or treated and which may contribute to their social and legal difficulties.

What does ADHD look like?

Problems with sustaining attention may result in substantial difficulties in or task behaviours. Young people with ADHD frequently make multiple careless errors, do not complete their academic or house tasks, and may start numerous activities. They are easily destructed by stimuli in their environment (such as noises) and often will begin to avoid tasks that require significant sustained attention (such as homework). Young people with ADHD will often rush into things such as games or other activities without taking the time to learn the rules or determine what they should do.

Hyperactivity is often manifested by difficulties staying still in one place – such as sitting at a desk or in a group. Young children may run around the room or climb on furniture, etc. instead of focusing on group activities. Most young people with ADHD have trouble sitting still and are very active - often they will fidget, talk excessively, make noises during quiet activity and generally seem 'wound up" or driven.

Impulsivity is often shown as impatience or low frustration tolerance. Young people with ADHD will often interrupt others, fail to listen to instructions, rush into novel situations without thinking about consequences, etc. This type of behaviour may lead to accidents. Many youths with ADHD also do not seem to learn from negative experiences; it is as if the impulsivity overrides learning about dangers.

These difficulties can be less pronounced in activities that require a great deal of physical participation and are constantly engaging. Sometimes young people with ADHD, seem less distracted when they are playing games that they like – especially games that do not require sustained attention (such as video games). Symptoms are more likely to be noticed when the young person is in a group setting in which sustained and quiet attention is needed or when he/she is working in an environment in which there are many distractions.

What are the criteria for diagnosis of ADHD?

There must be a number of symptoms from each of the following categories: inattention, hyperactivity, impulsivity PLUS a duration of at least six months to a degree that the person demonstrates maladaptive behaviours and trouble functioning that is consistent with their level of development.

Inattention (at least six of the following)

1. Failure to give close attention or many careless errors in work requiring sustained attention (such as school work)
2. Difficulty sustaining attention in tasks or play
3. Does not listen when spoken to directly
4. Does not follow through on instructions
5. Has difficulty organising tasks and activities
6. Avoid tasks that require sustained attention (homework)
7. Loses things needed for tasks and activities
8. Easily destructed by the environment
9. Forgetful in daily activities

Hyperactivity

1. Fidgets or squirms while seated
2. Leaves seat in a classroom or when is supposed to be seated
3. Runs about or climbs excessively when not appropriate
4. Has difficult in solitary play or quiet activities
5. Is usually on the go, as if motor driven
6. Often talks excessively

Impulsivity (are included in the number of symptoms of hyperactivity)

7. Blurts out waiting comments or answers to questions before he/she should
8. Has difficulty for her turn
9. Often interrupts or intrudes on others.

What can I do if it is ADHD?

ADHD can be treated with a combination of medications and other assistance – such as social skills training and cognitive behaviour therapy. The most effective treatment for symptoms is medication. Because learning difficulties are common, young people with ADHD should undergo educational testing to determine if their learning disability is present. Sometimes, youth with ADHD will benefit from medications to their learning environments such as having quieter places in which to work or having homework done in small amounts over long periods of time.

What can I do if it is ADHD?

Some young people with ADHD will develop conduct disturbances abuse. Many will become demoralised because of constant reminders from teacher, parents and others about their “bad

behaviour". Remember that these young people are not bad-they simply have difficulties with sustained attention. Try not to decrease their self-esteem by focusing only on what they have difficult doing-focus on their strengths as well.

Things to look for:
Some young people with ADHD will develop conduct disturbances or substance abuse. Many will become demoralised because of constant reminders from teachers, parents and others about "bad behaviour". Remember that these young people are not bad-they simply have difficulties with sustained attention. Try not to decrease their self-esteem by focusing only on what they have difficult doing-focus on their strengths as well.

What is suicide?

Suicide is the act of ending one's life. Suicide itself is not a mental disorder, but one of the most important causes of suicide is mental illness – most often depression, bipolar disorder (manic depression) schizophrenia, and other substance abuses.

Suicide is found in every culture and may be the result of complex social, religious and socio-economic factors in addition to mental disorders. The reasons for suicide may vary from region to region because these factors. It is therefore important to know what the most common reasons for suicide are in this region in which you are working. This may be difficult to determine accurately because of the "taboos" and stigma around suicide.

The preferred methods of completing suicide may vary from location to location – ranging from firearms to fertiliser poisoning to self -burning to overdosing on pills. Therefore, it is also important to know the most common methods suicide in the region in which you are working.

What does Suicide look like?

Not all self-harm behaviours are attempts to die by suicide. There may be many reasons for self-harm behaviours besides suicide. These include a person attempting to cry for help, for example from a person who is stuck in a harmful situation that they cannot escape such as on-going sexual abuse. Certain types of personal disorders commonly perform self-harm behaviours. A suicide is distinguished from a self-harm behaviour by the person intent to die.

Suicidal behaviour has three components: ideation, intent, plans

1. Suicide ideation includes ideas about death or dying, wishing that he/she were dead, or ideas about committing suicide. These ideas are not persistent. These ideas can be fairly common in people with mental disorders or in people who are in difficult life circumstances. Most people with suicide ideation do not go on to commit suicide but the suicidal ideation is a risk factor for suicide.
2. The second component is suicidal intent. With suicidal intent, the idea or committing suicide is better formed and more consistently held than in suicidal ideation. A person with suicidal intent may think about committing suicide most of the time, imaging what life would be for friends and family without him/her, etc. The strongest intent occurs when the person decides that he/she will commit suicide.
3. The third component is suicide plan. This is a clear plan of how the act of suicide will occur. Vague plans (such "someday, I will jump off a bridge") are considered as part of intent. In a suicide plan, the means of committing suicide will be identified and obtained (such as gun, poison, etc.), the place and time will be chosen. The presence of a suicide plan constitutes psychiatric emergency.

What can I do if it is suicide?

The first thing is to identify the presence of suicide ideation, intent and plans. Suicide ideation and intent may benefit from supportive cognitive based on counselling. The presence of suicide plan should lead to placement of the person in a situation in which he/she can be safe and secure. The situation should be therapeutic and not punitive and should be accompanied by supportive and cognitive counselling. The family or loved ones may require support and help as well. Non-judgmental supportive counselling may be of assistance in such a situation. If a suicide has happened, the family or loved ones may benefit from non-judgemental supportive bereavement counselling.

If a teacher is faced with a student who is talking about or writing about suicide, then it is important to include an educator from guidance or health to assess the situation. Generally, it is better to err on the side of caution and take the young person to a location in which they can be safe. Schools should have policies about how to deal a suicidal youth – know your school's policy. If there is no policy bring this issue to the attention of the principal.

If a person suicides, there can be negative repercussions amongst peers, classmates and teachers. It is important not to force students or others into relieving or analysing the event. Traditional critical incident stress debriefing interventions have not shown to be helpful and may even cause harm. A supportive space for those students who wish to use it should be provided after school hours and a teacher or guidance counsellor known to the students should ideally be available for those who wish to talk. Each community should have its own traditions for dealing with this kind of event and it is not necessary to create highly effective response to a suicide in the school setting.

What are risk factors of suicide?

The following are the commonest (and strongest) risk factors for suicide in young people. Remember that a risk factor does not mean something that causes an event to happen, rather is something that is related to an event that happens.

- Sex (male)
- Depression or other mental disorders
- Previous suicide attempts
- Family history of suicide
- Excess alcohol or drug abuse
- Impulsivity or juvenile justice history

Suicide risk is high in people with mental disorders, in particular: depression (of all kinds), and bipolar (manic depression), schizophrenia, substance abuse. If a young person talks to you about suicide, take them seriously - it is a myth that people who talk about suicide will not attempt suicide.

What should I do?

1. If you suspect that a young person may be having mental disorder, it is necessary to refer them to the designed mental health professional (guidance counsellor, psychologist, social worker) in the school.
2. If you suspect that a young person may be suicidal, immediate contact with your school designed coordinator or principal is necessary.

STUDENTS QUESTIONNAIRE:

What do you think?

Activity 1:

Purpose:

- To have students reflect on their understanding and attitudes towards mental health and mental illness
- To provide a baseline snapshot of students' ideas of mental illness that can be re-examined at end of modules taught so that students and teachers can see the impact of the material on their learning.

How to:

1. Give each student a copy of the "what do you think" Questionnaire. Ask students to take 10 minutes on their own to complete the questionnaire.
2. Ask students to fold their completed copies of the questionnaire in half. Have them write their names on the outside and staple the papers closed.
   At this time, do not provide answers or make judgements about students' responses, inform them that no one will look at their answers until they do so themselves at the end of the module.
3. Collect the students' papers and save them until after all modules have been taught

Questionnaire: What do you think?

Today's date:…….....Birth date:…….....Gender:…….....
Write two or three sentences to answer each of the following:

1) What is mental health?

2) What is mental illness?

3) Name some mental illnesses that you have heard about?

4) How would a person with mental illness look or act?

5) If you learned that a new student at school has a mental illness, how would you act towards him/her? How would feel about her/him?

6) What causes someone to be mentally ill?

STUDENT QUESTION:

What do you think?

Activity 2:

What do you think about mental illness now?

Purpose:

- To provide students with an opportunity to reflect on the changes in their knowledge and attitude about mental illness from their module.

How to:

1. Hand out a copy of “what do you think” questionnaire to each learner and have them answer the question
2. After learners have answered the questions, give each learner their copy of the questionnaire that they completed in module 2. Ask learners to compare the answers they just wrote with the answers they wrote in the earlier module. Give students a few minutes to compare their responses, reminding them that they should only be looking at their own answers. Ask learners whether their answers are different today, and if so how they are different.
3. Conduct a brief group discussion around students’ responses. Use the following questions as guide:
    - If your answers were different today, why do you think they were different?
    - Does learning about mental health make a difference? Why?
    - Do you think, you should react differently now to someone who has a mental illness compared to your reaction before you completed this unit

Understanding Mental Health and Mental Illness

Overview

Many young people do not know basic facts about mental health and mental illness. In fact, many confuse the terms: Mental Health and Mental Illness. Before thinking about the problems, that occur in the brain when someone has a mental illness, it is helpful to think about how the brain functions normally.

In this module, students will be introduced to the basics of the brain functions, and will learn that the brain processes and reacts to everything we experience. Its activities initiate and control movement, thinking, perception, and involuntary, physiological processes, as well emotions. Students will learn that the brain functions determine both mental health and mental illness and that the two are not mutually exclusive.

Learning Outcomes

In this lesson students will learn;

- Some of the basic concept involved in normal brain function, and the role the brain plays in determining our thoughts, feelings and behaviours.
- That mental health and mental illness both include wide range of states
- That having mental health problems is not the same thing as having mental illness
- Some of the language of mental health and mental illness

Major Concepts addressed

- Everyone has mental health regardless of whether or not they have mental illness
- The brain is responsible for our thoughts, actions and behaviour
- Changes in brain functions cause changes in thoughts, feelings and behaviours can last a short or long time
- A mental illness affects a person's thinking, feelings or behaviours (or all three) and that causes that person distress and difficult in functioning
- Mental illnesses have complex causes including biological basis and therefore, not that different from other illnesses or diseases. As with all serious illnesses, the sooner people get help and treatment for mental illness, the better their long and short-term outcomes
- Many of the major mental illnesses begin to emerge during adolescence.

DEFINITIONS

Mental Health

"Mental Health is the emotional and spiritual resilience that enables us to enjoy life and survive pain, disappointment, and sadness. It is a positive sense of wellbeing and an underlying belief in our own and other's self-worth." (Health Education Authority, UK, 1997)

Who's got Mental Health?

Everyone – we all have mental health just like we all have physical health. People with mental illness also have mental health, just as people with illness also have a physical well-being.

Mental Illness

Mental illness is a term that describes a variety of psychiatric (emotional, thinking and behavioral) problems that vary in intensity and duration, and may recur from time to time. Major mental illness includes Anxiety, Mood, Eating, and Psychotic Disorders. Mental illness are diagnosable conditions that require medical treatment as well as other supports (www.cmba.ca)

Mental Health Problems

Mental Health problems refer to the more common struggles and adjustment difficulties that affect everybody from time to time. These problems tend to happen when people are going through difficult times in life, such as a relationship ending, the death of someone close, conflict in relations with family or friends, or stresses at home, school or work. Feeling stressed or having the blues is a normal response to the psychological or social challenges most people encounter at some time or another. Mental health problems are usually short-term reactions to a particular stressor, such as a loss, painful event, or illness *(Mental Illness Foundation, 200230.*

The Stigma and Discrimination of Mental Illness

Overview

Many people with mental illness say the stigma and discrimination that surrounds mental illness is harder to live with than the disease itself.

In the context of the curriculum guide, stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid and discriminate against people with mental illness. Stigma is not just a matter using the wrong word or action. Stigma is about disrespect. It is the use of negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma and the resulting discrimination discourages individuals and their families from getting the help they need (SAMHSA, 2004).

In the United States, the Surgeon general's report on Mental Health (1999) cites studies showing that nearly two-thirds of all people with diagnosable mental disorder do not seek treatment (Regier et al., 1993; Kessler et al., 1996). While the reasons for this varied, we know stigma surrounding to receipt of mental health services is a significant barrier that discourages people from seeking treatment, and that stigma may be growing instead of declining over time (Sussman et al, Cooper-Patrick et al., 1997).

The activities in this session will explore the nature of stigma, its impact on the lives of people with mental illness, and effective ways of combating stigma.

Learning Outcomes

In this Chapter students will:

- Understand the stigma surrounding mental health problems and impact of stigma and discrimination on help-seeking behaviour.
- Explore the difference between the myths and realities of mental illness
- Investigate the attitudes of people in the school community about mental illness
- Learn ways of overcoming stigma and promoting a realistic and positive understanding of mental illness.

Major concepts addressed

- Stigma results in discriminatory behaviour and treatment towards people with mental illness
- The fear of stigma prevents people from seeking help and treatment for mental illness
- Stigma is perpetuated through mistaken beliefs about mental illness and can be seen in people's attitudes, in public policy, in the media etc.
- Stigma and discrimination can be reduced by providing accurate information about mental illness and its treatment.

Notes to teachers

Our society often attaches a variety of labels to mental illness – psycho, mad, demon-possessed, imbeciles, crazy, foolish, dangerous, violent and so on. These terms reinforce the stigma associated with mental illness. In the classroom, it's more appropriate to use the term "person with mental illness".

DEFINING STIGMA AND DISCRIMINATION

Purpose:

To explore the meaning of the term stigma and the relationship between attitudes (beliefs) and discriminatory treatment (behaviour and actions) towards people with mental illness.

How to:

1. Ask students if they know what the words “stigma” and discrimination mean. Lead a whole class discussion of the definitions of stigma and discrimination and the relationship between stigma, stereotype and discrimination.

Questions to guide discussion:

- What are some of the negative things you have heard about people with mental illness? (responses may include things like: link to violence, etc.)

- What are some of the positive things you have heard about mental illness (responses may include things like: link to creativity). While this may be seen as positive, remind students that generalizing can also be a form of stereotype.
- Why do you think people with mental illness are stigmatized? (Possible answers include they are seen as being different. People do not really know the facts about mental illness)

- Ca you think of any other health conditions or social issues that have been stigmatized throughout history (possible answers include: homosexuality, leprosy, AIDS, unwed motherhood, divorce)

- What kinds of factors have contributed to changing public attitudes around some of these conditions or issues? (possible answers include: education, public policy, open dialog, scientific research, changing social mores).

- What do you think influences perceptions about mental illness? (possible answers include: the media –films, news, newspapers headlines and stories that associate people with mental illness, the fact that people with mental illness sometimes behave differently and people are afraid of what they do not understand).

- How do you think stigma affect the lives of people with mental illness? (possible answers include: people deicide not get help or treatment even thought they would benefit from it, it makes them unhappy, they may not be able to get a job or find housing, it may cause to lose their friends, it puts stress on the whole family).

DEFINING STIGMA

The following are definitions of “Stigma” taken from different sources and from different historical periods.

“A mark or sign of disgrace or discredit; a visible sign or characteristic of disease.

- *The Concise Oxford Dictionary, 1990*

An attribute which is deeply discrediting.

- *Goffman, E. Stigma: The Management of Spoiled Identity, 1963*

A distinguishing mark or characteristic of a bad or objectionable kind; a sign of some specific disorder, as hysteria; mark made upon the skin by burning with a hot iron, as a token of infamy or subjection; a brand; a mark of disgrace or infamy, a sign of severe censure or condemnation, regarded as impressed on a person or thing”.

- *The Shorter Oxford Dictionary Fourth Edition, 1993*

The Stigma of Mental Illness

“Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid and discriminate against people with mental illnesses. Stigma is not just a matter of using the wrong word or action.

Stigma is about disrespect. It is the negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma and the resulting discrimination discourages individuals and their families from getting the help they need.” *(SAMHSA 2004)*

Terms related to Stigma

Stereotype:

“a person or thing that conforms to an unjustly fixed impression or attitude”

Stereotypes are the attitudes about a group of people, e.g. “All people with mental illness are dangerous”.

Prejudice:

“A preconceived opinion”

Prejudice is agreeing with the stereotypes e.g. “I think people with mental illness are dangerous.”

Discrimination:

“Unfavourable treatment based on prejudice”

Discrimination is the behaviour that results: (I don’t want people with mental illness around me, therefore I discriminate against them by not hiring them, not being friends with them, etc.

- The Concise Oxford Dictionary, 1990

REDUCING STIGMA- WHAT WORKS

Learn More About Mental Illness

If you are well informed about mental illness, you will be better able to evaluate and resist the inaccurate negative stereotypes that you come across.

Listen To People Who Have Experienced Mental Illness

These individuals can describe what they find stigmatizing, how stigma affects their lives and how they would like to be viewed and treated.

Watch Your Language

Keep your eyes peeled for media that stigmatizes mental illness and report to any number of organizations. Get in touch with the people – authors, newspaper editors, movie producers, advertisers – responsible for the material. Write, call or email them yourself, expressing your concerns and providing more accurate information that they can use.

Speak Out About Stigma

When someone you know misuses a psychiatric term (such as schizophrenia), let them know and educate them about the correct meaning. When someone says something negative about a person with mental illness, tells a joke that ridicules mental illness, or makes disrespectful comments about mental illness, let them know that it is hurtful and you find such comments offensive and unacceptable.

Talk Openly About Mental Illness

Do not be afraid to let others know of your mental illness or the mental illness of a loved one. The more mental illness remains hidden; the more people continue to believe that it is shameful thing that needs to be kept hidden.

Provide Support For Organisations That Fight Stigma

Join, volunteer, donate money: The influence and effectiveness of organizations fighting the stigma surrounding mental illness depend to large extent on the efforts of volunteers and on donations. You can make a contribution by getting involved.

Information of Specific Mental Illnesses

Overview

In this chapter, students will learn more about the most common forms of mental illness, paying special attention to those that generally affect adolescents.

Learning Outcomes

In this topic, students will:

- Recognize that mental illnesses are associated with differences in brain activity.
- Gain a better understanding of the symptoms, causes, treatments and other supports specific to mental illnesses that are common among adolescents

Major Concepts addressed

- A mental illness changes a person's thinking, feelings or behavior (or all the three and causes that person distress and difficulty in functioning
- Mental illness describes a broad range of conditions. The type, intensity and duration of symptoms vary from person-to-person
- Like illnesses that affect other parts of the body, mental illnesses are treatable and the sooner people get proper treatment and supports, the better the outcome.
- With variety of supports, most people with mental illness recover and go on to lead fulfilling and productive lives.

ANXIETY DISORDERS

What is anxiety?

Anxiety is term which describes a normal feeling people experience when faced with threat or danger, or when stressed.

When people become anxious, they typically feel upset, uncomfortable and tense and my experience many physical symptoms such as stomach upset, shaking and headaches.

Feelings of anxiety are caused by experiences of life such as a new relationship, a new job or school, illness or an accident. Feeling anxious is appropriate in these situations and usually we feel anxious for only a limited time. These feelings are not regarded as clinical anxiety, but are part of everyday life.

What are Anxiety Disorders?

The anxiety disorders are a group of illnesses, each characterized by persistent feelings of intense anxiety. There are feelings of continual or extreme discomfort and tension, and may include panic attacks.

People are likely to be diagnosed with an anxiety disorder when their level of anxiety and feelings of panic are so extreme that they significantly interfere with daily life and stop them from doing what they want to do. This is what characterizes an anxiety disorder as more than normal feelings of anxiety.

Anxiety disorders affect the way the person thinks, feels and behaves and, if untreated, cause considerable suffering and distress. They often begin in adolescent or early adulthood and may sometimes be triggered by significant stress.

Anxiety Disorders are common and **may be in a good** number of the population.

Image

ANXIETY DISORDERS: WHAT ARE THE MAIN TYPES OF ANXIETY DISORDERS?

All anxiety disorders are characterized by heightened anxiety or panic as well as significant problems in everyday life.

Generalized Anxiety Disorder

People with this disorder worry constantly about themselves or their loved ones, financial disaster, their health, work or personal relationships. These people experience continual apprehension and often suffer from many physical symptoms such as headache, diarrhea, stomach pains and heart palpitations.

Agoraphobia

Agoraphobia is fear of being in places or situations from which it may be difficult or embarrassing to get away, or a fear that help might be unavailable in the event of having a panic attack or panic symptoms.

People with agoraphobia most commonly experience fear in a cluster of situations: in supermarkets and department stores, crowded places of all kinds, confined spaces, public transport, elevators, highways and heights.

People experiencing agoraphobia may find comfort in the company of a safe person or object. This may be disorder or social phobia.

Panic Disorder

(with or without agoraphobia)

People with this disorder experience panic attacks in situations where most people would not be afraid such as: at home, walking in the park or going to a movie. These attaches occur spontaneously, come on rapidly (over a few minutes) and go away slowly. Usually, they last about 10-15 minutes.

The attacks are accompanied by all of the pleasant physical symptoms of anxiety, with a fear that the attack may lead to death or a total loss of control.

It is because of this that some people start to experience a fear of going to places where panic attacks may occur and being in places where help is not at hand. I addition to panic attacks and agoraphobia symptoms, people with panic disorders also worry about having another panic attack.

Specific Phobias

Everyone has some mild irrational fears, but phobias are intense fears about particular objects or situations which interfere with our lives. These might include fear of heights, water, dogs, closed spaces, snakes or spiders.

Someone with a specific phobia is fine when the feared object is not present. However, when faced with the feared object or situation, the person can become highly anxious and experience a panic attack.

People affected by phobias can go to great lengths to avoid situations which would force them to confront the object or situation which they fear.

Social Phobia (also called Social Anxiety Disorder)

Every person experiences social phobia at some point in their lifetime. People with social phobia fear that others will judge everything they do in a negative way they feel easily embarrassed in most social situations. They believe they may be considered to be flawed or worthless if any sign of poor performance is detected.

They cope by either trying to do everything perfectly, limiting what they are doing in front of others, specially eating, drinking, speaking or writing, or withdrawing gradually from contact with others. They will often experience panic symptoms in social situations and will avoid many situations where they feel observed by others (such as in stores, movie theatres, public speaking and social events).

Obsessive Compulsive Disorder

This disorder involves intrusive unwanted thoughts (obsessions) and the performance of elaborate rituals (compulsions) in an attempt to control or banish the persistent thoughts or to avoid feelings of unease.

The rituals are usually time consuming and seriously interfere with everyday life. For example, people may be constantly driven to wash their hands or continually return home to check that the door is locked or that the oven is turned off.

People with this disorder are often acutely embarrassed about their difficulties and keep it a secret, even from their families.

Post-traumatic stress disorder

Some people who have experienced major traumas such as war, torture, hurricanes, earthquakes, accidents or personal violence may continue to feel terror long after the event is over.

They may experience nightmares or flashbacks for year. The flashbacks are often brought about by triggers relates to the experience.

What causes Anxiety Disorders?

The causes of each disorder may vary, and is not always easy to determine the causes in every case. All anxiety disorders are associated with abnormalities in the brain signalling mechanisms that are involved in the creation and expression of “normal” anxiety.

Personality

People with certain personality characteristics may be more prone to anxiety disorders. Those who are easily upset, and are very sensitive, emotional or avoidant of other may be more likely to develop anxiety disorders, such as social phobia.

Learnt response

Some people exposed to situation, people or objects that ate upsetting or anxiety-producing may develop an anxiety response when faced with the same situation, person or object again, or become anxious when thinking about the situation, person or object.

Heredity

The tendency to develop anxiety disorders runs in families and seems to have a genetic basis.

Biochemical Processes

All anxiety disorders arise from disturbances in the different brain areas or processes that control anxiety.

How can Anxiety Disorder be addressed?

Anxiety Disorders, if they are not effectively treated, may interfere significantly with a person's thinking and behaviour, causing considerable suffering and distress. Some anxiety disorders may precede depression or substance abuse and, in such cases, treatment may help to prevent these problems.

Many professionals such as family doctors, psychologists, social workers, counsellors or psychiatrists can help people deal with anxiety disorders.

Treatment will often include education and specific types of psychotherapy 9such as cognitive behavioural therapy) to help the person understand their thoughts, emotions and behaviour. People develop new ways of thinking about their anxiety and how to deal more effectively with feelings of anxiety.

Medication is sometimes used to help the person control their high anxiety levels, panic attacks or depression.

The benzodiazepines (like diazepam or Valium) are used for the temporary relied of anxiety, but care has to be taken as these medications may occasionally cause dependence in some people.

Antidepressants play an important role in the treatment of some anxiety disorders, as well as associated or underlying depression. Contrary to common belief, antidepressants are not addictive.

What is Attention Deficit Hyperactivity Disorder (ADHD)?	What causes ADHD?
Attention Deficit Hyperactivity Disorder is the most commonly diagnosed behavioural disorder of childhood In any six-month period, ADHD affects an estimated 4-6 % of young people between the ages of 9 and 17 at the global level. Boys at two to three times more likely than girls to develop ADHD. Although ADHD is usually associated with children, the disorder can persist into childhood. Children and adults with ADHD are easily distracted by sights and sounds and other features of their environment, cannot concentrate for long periods of time, are restless and impulsive, or have a tendency to day dream and be slow to complete tasks. **Symptoms** The three predominant symptoms of ADHD are i) Inability to regulate activity level (hyperactivity); ii) Inability to attend to tasks (inattention); and iii) Impulsivity, or inability to inhibit behaviour	While no one really knows what causes ADHD, it is generally agreed by the medical and scientific community that ADHD is due to problems in the brain's control of systems that regulate concentration, motivation and attention. Much of today's research suggests that genetics plays a major role in ADHD. The possibility of genetic cause to ADHD is supported by the fact that ADD runs in families. Between 10 and 35 percent of children with ADHD have a first degree relative with past or present ADHD. Approximately half of parents who have been diagnosed with ADHD themselves, will have a child with the disorder. It has been generally considered that approximately 50% of ADHD cases can be explained by genetics. It is obvious that every case of ADHD can be explained by genetics; it would seem that there are other causes.
Common symptoms include varying degrees of the following. All must occur with greater frequency and intensity than "normal" and must lead to functional impairment as a result of the symptoms in order to be considered ADHD: • Poor concentration and brief attention span • Increased activity – always on the go • Poor coordination • Normal or high intelligence but under performing • Fearless and takes undue risks • Sleep problems • Social and relationship problems at school • Impulsive – does not stop to think	Researchers have suggested that some of the following could also be responsible for ADHD symptoms: • Exposure to toxins (such as lead) • injuries to the brain • delayed brain maturation However, all of these possibilities need further research.

What is the difference between just having a bad day and something potentially more serious?

Signs of Clinical Depression:

- Feeling miserable for at least 2 weeks
- Feeling like crying a lot of the time
- Not wanting to do anything, go anywhere, see anyone
- Having trouble concentrating or getting things done
- Feeling like you're operating in slow-motion
- Having trouble sleeping
- Feeling tired and lacking energy – being unable to get out of bed even after night's sleep
- Having a change in appetite
- Feeling like there's a "glass wall" between you and the rest of the world
- Feeling hopeless or thinking of suicide
- Always putting yourself down and thinking you're no good

If you often experience a number of these things, you may be depressed. Remember that you don't have to be alone with these feelings, and that depression is treatable!

Behaviours which are considered ABNORMAL for that person, and may seriously affect other people

People may	
• Withdraw completely from family, friends, and workmates	• Lose variation in mood – be "flat" – lack emotional expression, for example, humour or friendliness
• Be afraid to leave the house (particularly during daylight hours)	• Have marked changes in mood, from quiet to excited or agitated
• Sleep or eat poorly	• Hear voices that no one else can hear
• Sleep by day and stay awake at night, often pacing restlessly	• Believe, without reason, that others are plotting against their will, by, for instance, television, radio, aliens, God or the devil
• Be extremely occupied with a particular theme, for example, death, politics or religion	• Believe they have special powers, for example, that they are important religious leaders, politicians or scientists
• Uncharacteristically neglect household or parental responsibilities, or personal appearance or hygiene	• Believe that their thoughts are being interfered with or that they can influence the thoughts of others
• Deteriorate in performance at school or work	• Spend extravagant or unrealistic sums of money
• Have difficulty concentrating, following conversation or remembering things	
• Talk about or write things that do not really make sense	
• Panic, be extremely anxious, or significantly depressed and suicidal	

Seek medical assessment as soon as possible. These types of behaviours are much clearer signs that someone needs to be checked out, particularly if they have been present for several weeks. They may be only a minor disturbance, but a mental illness such as a psychotic disorder may be developing.

Support strategies

Purpose:

- To provide students with strategies for supporting friends and others who are having trouble coping because of mental health problems or mental illness

How-to:

1. Begin a discussion about the role that young people often play as supporters when they listen to their friends talk about their problems.
   Ask students how they would like to be treated if they had a mental illness. Distribute photocopies of the Activity 3 Support Strategies and Recovery: What works? To each student to facilitate further discussion. Read through the sheets with the class.

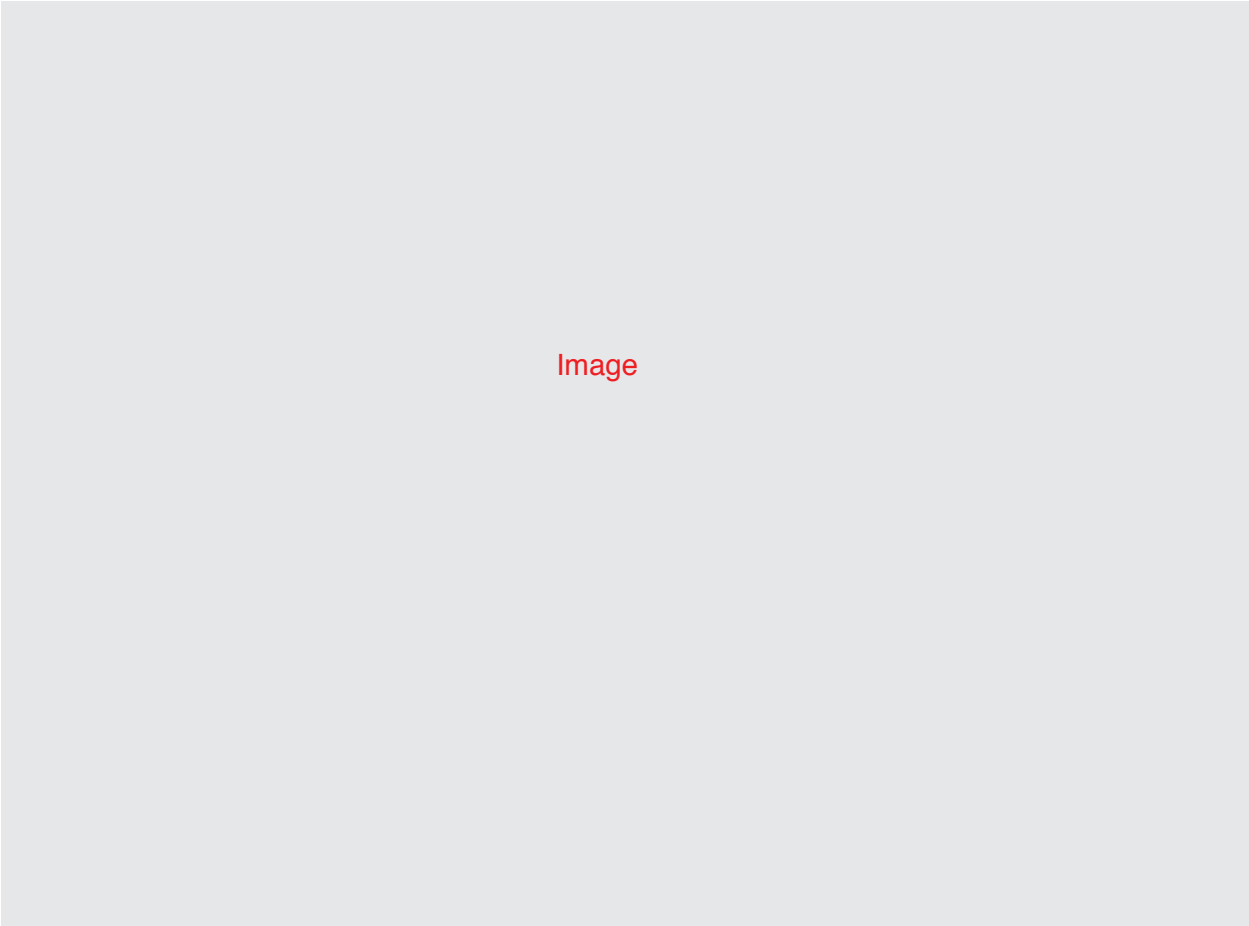
Note: Make sure to emphasize that everyone has a personal responsibility to take action if a friend mentions thoughts of suicide. Young people should always share this information with a trusted adult – like teacher, guidance counsellor, relative or parent – and never promise to keep the information secret.

Support strategies

Here are strategies for supporting someone with a mental health problem/illness:

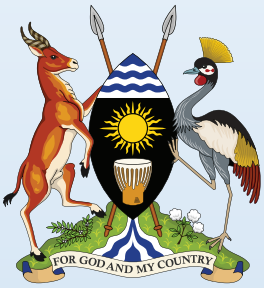
- Be supportive and understanding.
- Spend time with the person. Listen to him or her.
- Never underestimate the person's capacity to recover.
- Encourage the person to follow his or her treatment plan and seek out support services. Offer to accompany them to appointments.
- Become informed about mental illness.
- Remember that even though your friend may be going through a hard time, they will recover. Stand by them.
- If you're planning an outing to the community centre, remember to ask your friend along. Keeping busy and staying in touch with friends will help your friend feel better, when they're ready.
- If you are a close friend or family member of someone who has a mental illness, make sure you get support as well. Crisis training, self-help and/or individual counselling will help you become a better support person.
- Put the person's life before your friendship. If you think the person needs help, especially if he or she mentions thoughts of suicide, don't keep it a secret – even if the person asked you to.

If a friend mentions thoughts of suicide or self-harm, you NEED to tell his or her parents, a teacher, guidance counsellor or someone else who can help. It's better to have a friend who angry with you for a while than to keep secret and live with knowing you could have helped, but remained quiet when your friend was in trouble.



Other factors that can support recovery include:

- Mutual support (self-help groups)
- Social opportunities (church groups; drop-in centres, volunteer work, participating in community life)
- Positive relationships (accepting and being accepted, family and friends and communicating with them in a positive way)
- Meaningful daily activity – Being able to work, go to school
- Medication (sticking with a treatment plan, working with doctors to find the best medications with the fewest side effects)
- Spiritually (involvement in a faith community or individual spiritual practice)
- Inner healing capacity and inner peace (finding a sense of meaning and purpose, even in suffering)
- Personal growth and development (hobbies, self-education, taking control of one's life, exercise, personal goal setting)
- Self-awareness (self-monitoring, recognizing when to seek help, recognizing one's accomplishments and accepting and/or learning from one's failures)



THE REPUBLIC OF UGANDA

Ministry of Education and Sports

Department of Guidance & Counselling
P.O. Box 7063, Kampala -UGANDA.

www.education.go.ug/guidance & Counselling