

Definitions



Mental Health Disorders

The following are descriptions of some of the most commonly diagnosed mental health disorders.

The Anxiety Disorders

Anxiety disorders fall into several categories, as listed below. These disorders may have a biological basis or be triggered by environmental causes, such as the stress from coping with a learning disability. They are usually treated with psychiatric medications and a variety of therapies, such as social skills training, behavior management, and in some cases, a specialized school setting.

Panic Disorder

Panic attacks are instances of extreme fear, usually with a sense of looming danger and the strong desire to escape. Youth with this disorder may experience unrealistic worry, self-consciousness, or tension. Attacks can be spontaneous, or triggered by specific situations, and usually start suddenly. Physical symptoms include: pounding heart, shortness of breath, chest pain, nausea, dizziness, shaking, sweating, numbness, or tingling sensations.

Phobia

A phobia is an intense, irrational, and disabling fear of something that poses little or no actual threat. The fear leads to avoidance of objects or situations and can cause extreme feelings of terror, dread, and panic. The actual presence of the feared object or situation nearly always provokes an immediate anxiety response.

“Specific” phobias center around particular objects (e.g., certain animals) or situations (e.g., heights or enclosed spaces). These fears can substantially restrict a youth’s life. Some common phobias in youth include fears of: leaving home, boarding a bus, entering a classroom, attending a movie, taking tests, or responding to questions.

Except for very young children, youths with phobias usually recognize their fear is excessive or unreasonable but find themselves powerless to control their reactions.

Social Phobia

Children and adolescents with “social” phobia have an unreasonable expectation that they will fail in social settings with their peers.* They often feel hypersensitive to criticism, cave in easily to peer pressure, and suffer from low self-esteem. The youth fears he will humiliate himself.

Exposure to the feared social situation provokes anxiety and is avoided if possible. When a social situation is impossible to avoid, the youth may endure it with intense anxiety and distress or may succumb to a panic attack. The stress and subsequent avoidance behaviors interfere significantly with the youth’s normal routine, ability to work, academic functioning, social activities, and relationships.

*Youths with social phobia may relate to adults in an appropriate way, without phobic behaviors.

Post-traumatic Stress Disorder (PTSD)

PTSD is an anxiety disorder that can occur when a youth has been exposed to a traumatic event. The youth reacts with intense fear or helplessness to experiencing, witnessing, or learning of event(s) involving serious injury to self or others, such as suffering from domestic abuse or viewing the televised terrorist attacks on 9/11/2001.

Symptoms of PTSD vary widely, but generally fall into three categories: re-experience, avoidance, and irritability.

A youth with PTSD may re-experience traumatic events in the form of recurrent and intrusive thoughts or nightmares. He/she may experience flashbacks or hallucinations. In a younger child repetitive play may occur in which aspects of the trauma are expressed or reenacted.

A youth with PTSD may show phobic avoidance of anything that reminds him/her of the trauma, and may even be unable to recall details about it. He/she may show disinterest in formerly important activities, places or people, and feel depressed, detached, emotionally numb, or hopeless.



A youth with PTSD may show a number of forms of irritability, including insomnia, anger outbursts, impaired concentration, or a jittery condition. This may be expressed by disorganized, agitated or hostile behaviors.

PTSD causes significant distress and impairment in social, academic, or other important functioning. Youths who suffer from PTSD frequently use alcohol or other drugs to “self-medicate” in an attempt to dull painful memories or psychological torment.

Youths with this disorder are known to have high instances of attempted suicide.

Obsessive-compulsive Disorder (OCD)

This disorder is characterized by repetitive, intrusive, and unwanted thoughts (obsessions) and/or rituals (compulsions) that seem impossible to control. Adolescents may realize their symptoms don't make sense and are excessive, but younger children may be distressed only when they are prevented from carrying out their compulsive habits.

Compulsive behaviors may include, but are not limited to, activities such as: counting and recounting, repeated rearranging or aligning of objects, tapping and knocking, turning lights on and off, locking and unlocking doors and windows and excessive hand washing. The obsessions or compulsions cause significant distress once the youth recognizes the excessive and unreasonable nature of the activities. The activities are very time consuming (at least one hour a day) and significantly interfere with the youth's normal routine, academic functioning or social activities and relationships.

Generalized Anxiety Disorder

Generalized Anxiety Disorder and Over-Anxious Disorder of Childhood are characterized by excessive anxiety and exaggerated worry about a number of events or activities (such as school work), that occurs a majority of days. The youth finds it difficult to control the worry and experiences one or more of these symptoms: feeling restless or edgy, difficulty concentrating, easily fatigued or mind going blank, irritability, muscle tension, sleep disturbance (difficulty falling or staying asleep or restless, dissatisfying sleep). Youths with this disorder usually anticipate the worst and often complain of fatigue, tension, headaches, and upset stomach.

Bipolar Disorder

Bipolar disorder, also known as manic depressive illness, is a serious but highly treatable brain disorder. A bipolar youth experiences highs and lows: periods of mania and depression with normal moods in between.

A younger child's symptoms often differ from those seen in adolescents. The younger child generally has periods of extreme irritability, agitation, or hostility during a manic phase, while an older child often shows more adult patterns of mood swings.

During manic phases a youth may exhibit a number of “hyper” characteristics that may include: extreme irritability and

distractibility, euphoria, increased energy, restlessness, racing thoughts or rapid talking, disrupted sleep, delusions of grandeur, very poor judgment, impulsiveness, reckless sexual encounters, abuse of drugs or alcohol, obnoxious, provocative or intrusive behaviors, and denial that anything is wrong. This unpredictable and intense behavior can make it difficult to maintain friendships. Isolation from their peers increases the youth's level of anxiety, adding to the risk of self-destructive behaviors.

Law enforcement officers may encounter bipolar youth more often than those with other mental health disorders. Attention seeking behavior can sometimes become disorderly or aggressive. The youth may fall in with “the wrong crowd” or self-medicate (experiment with alcohol and drugs) since they are often unable to determine the consequences of their actions.

Bipolar disorder is most effectively treated with a combination of counseling and medication. A youth with bipolar illness will often refuse medication once their symptoms are controlled, believing they no longer need medication. However, once interrupted, medications may be less effective if resumed and higher doses may be needed to obtain the same level of symptom control.

Please see the following description of depression.

Depression/Major Depression

Clinical depression goes well beyond sadness, and is much more than having a bad day or coping with a major loss. Youth who suffer with depression cannot “snap-out-of-it” by trying hard. Depression affects the way a youth feels, thinks, and acts. Symptoms include persistent sadness and hopelessness, withdrawal from friends or activities, and poor school attendance or declining academic performance. The youth may experience a distressing level of indecision, an inability to concentrate, excessive sleep, a change in eating habits, a feeling of numbed emotions, and frequent physical complaints. A youth who is attempting to escape their depression may try to self-medicate with street drugs or alcohol. There may be thoughts of death or suicide.

Any attempt at suicide, even an apparently small gesture, should receive professional intervention, since they often represent “the tip of the iceberg”. Treatment usually includes a combination of counseling and anti-depressant medications. Supportive relationships with caring adults and the development of the youth's strengths and abilities are two important factors in successful treatment. Activities that provide the youth personal attention from a mentoring adult and supervised peer socialization in small groups are ideal. Useful activities include team sports, scouting, faith-based youth groups, volunteering with the very young, the elderly, or animals, and expressive arts like drama, painting, and music.

Youth who experience a loss or who have attentional, learning, or conduct disorders are at a higher risk for depression.

For more information about the Idaho System of Care and services and support available in your area, call the Idaho CareLine by dialing 211 or 1-800-926-2588.

You also can contact the Idaho Federation of Families, an Idaho-based support organization for families with children affected by SED, on the Web at www.idffcmh.org or by calling 1-800-905-3436.

Schizophrenia

Schizophrenia is a very serious mental illness that usually emerges in late adolescence or young adulthood. The symptoms of schizophrenia are characterized as either positive (characteristics they have) or negative (the absence of normal characteristics).

Positive symptoms include bizarre behavior and psychosis, which refers to hallucinations, delusions, thought disorders, and hearing voices. Negative symptoms include an emotionless expression, apathy, and withdrawal.

Thought disorders are the diminished ability to think clearly and logically. Language may sound garbled to them, or their own speech may be garbled. Delusions are false beliefs, such as thinking others can hear their thoughts. Paranoid delusions are false beliefs that an outside force threatens them. For example, they may believe that aliens or an enemy government are attempting to steal the thoughts from their head.

Hallucinations are false perceptions which may be heard, seen, or felt, and may be perceived as voices. The voices may warn of danger, tell the youth to take some action, or simply comment on life. Some youths hear multiple voices.

Schizophrenia differs from other mental health disorders in that it is rarely controlled without strong psychiatric medications. However, once the schizophrenic youth adheres to a program of regular medication and therapy, there is substantial hope for a normalized life, including education, employment, family and friends.

Borderline Personality Disorder (BPD)

Youths with BPD are impulsive and unstable in their moods, personal relationships, and self-image. They have dramatic mood swings with periods of depression, extreme irritability, anxiety, and uncontrolled anger.

Peer friendships, family relations, and especially romantic relationships are frequently of the “on again, off again” pattern. BPD youth often make extremely poor choices that have a high risk for self-harm. They may drive or spend recklessly, binge on food, alcohol or drugs, or engage in impulsive sexual activity. These youths often have very low self esteem and seek approval and acceptance from others, since they have little or no sense of self worth.

Some symptoms of BPD, such as anxiety or depression, can be treated with medication, but long-term counseling is usually necessary to correct harmful patterns of thinking and behaviors within relationships.

Dissociative Disorders

This group of disorders is believed to be a response to trauma, as the effected individual attempts to distance themselves from something too awful to include in their view of themselves. Dissociative symptoms, or a full-blown Dissociative Disorder, can occur within another diagnosis especially the Anxiety Disorders, such as PTSD. There are 4 main subtypes of this disorder.

Probably the more common forms are Depersonalization Disorder and Dissociative Amnesia. In Depersonalization Disorder, the youth may experience feelings of being detached from their own body, as if they were an outside observer. They may feel the world around them, or their own experiences, to be somehow unreal. In Dissociative Amnesia the youth may at times be unable to recall personal information, including their own name, due to associating this information with an emotional shock or stress.

Far more rare, but more sensationalized in the media, are Dissociative Identity Disorder (once referred to as multiple personality disorder) and Dissociative Fugue. In the former, the youth may have two or more distinct identities that can take control of their personality, each with separate memories and characteristics. The latter is very rare and involves sudden, often distant, travel away from home, work or school with the inability to recall information about personal identity or the past.

Treatment of these disorders is similar to that of other disorders stemming from abuse or trauma, and may include forms of talk therapy and antidepressant or anti-anxiety medication.

Oppositional Defiant Disorder (ODD)

ODD is a pattern of disobedient, hostile, and defiant rule breaking that lasts for an extended period and is longer than a typical child or adolescent “phase”. Many ODD youths also have co-occurring AD/HD, anxiety, depression, learning disabilities, or other mental health disorders. The negative behaviors interfere significantly with the youth’s ability to make and keep friends, do well academically, and behave appropriately in public. Some youth initially labeled with ODD may recover from ODD behaviors after careful evaluation and targeted treatment of co-occurring diagnoses. Many professionals believe ODD is the early form of Conduct Disorder.

ODD is treated in much the same way conduct disorder is treated, i.e.: psychotherapy, behavioral therapy, and psychiatric medications in a comprehensive treatment plan.

Conduct Disorder

More research is needed to better understand youths with this disorder, a complicated group who persistently disregard rules and violate other’s rights. Inappropriate and socially unacceptable behaviors often cause these youths to be viewed as delinquent rather than mentally ill. Their expression of anger takes several forms including verbal and physical aggression. Common behaviors include: bullying, threatening or intimidating, stealing, running away, lying, fire setting, truancy, breaking and entering, vandalism, cruelty to animals, fighting, and confrontation. Explosive anger is the primary maladaptive behavior and causes significant interference in social, academic, and occupational functioning.

Treatment is especially challenging because these youths are uncooperative and do not trust adults. Psychotherapy, behavioral therapy and psychiatric medications are generally all incorporated into a comprehensive treatment plan. Conduct disordered youth often have additional challenges such as learning disabilities, depression or other mental health disorders.

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Attention Deficit Hyperactivity (AD/HD, ADD, ADHD)

Doctors believe that chemical differences in the brain cause AD/HD, the most commonly diagnosed behavior disorder in children. AD/HD youth find it hard to sit still, control their behavior, and pay attention. They may be disruptive, disorganized, have difficulty following instructions, and may “over-focus” on favorite activities. Youth with AD/HD often lack social skills and have trouble making and keeping friends. Law enforcement officers may encounter these youth when they act before they think, known as “impulsivity”. AD/HD youth have been known to run into traffic, reach into the kitchen blender, or climb too high, all without considering the consequences.

AD/HD can continue to be a problem in adolescence. Such youth, especially those who go untreated, may not develop the appropriate social, academic, and organizational skills they need to function successfully as adults. Even with treatment, repeated frustrations at school and with peers can some-times provoke a secondary anxiety disorder or depression.

Kids with AD/HD can be helped best with a team approach. Parents, teachers, and other involved adults should work with the child to develop consistent goals and strategies. Tools for success include developing time management skills, checklists, and following structured routines. Self-hypnosis has been used effectively by some youths, as well. In many cases parents and doctors will agree that stimulant medication (usually Ritalin, Adderall, or Concerta) should be part of the treatment plan. A youth who receives treatment can become more independent, and learn to successfully manage their illness.

Self-injuring Behaviors

Self-injuring behaviors are intentional, but non-life threatening, attempts to escape psychological pain by the self-infliction of physical pain. This is most often, but not exclusively, practiced by girls and is done solely for the self-injurer, not as an attempt to manipulate

others. Although the harm is deliberate, they often feel guilt and even revulsion at their own behaviors. “Cutting” is the most common form of self-injury, but burning, bone breaking and even severe eye injuring or sexual mutilation are known methods of intentional self-harm.

Although surprisingly common, families, friends, even counselors and doctors may be unaware that a patient is self-injuring. “Cutters” tend to make many shallow cuts on the upper arms, thighs or other hidden areas. Wearing long sleeves in hot weather may be a clue that a youth may be self-injuring.

Youths who practice intentional self-harm need professional intervention and support and understanding from family and friends. Psychiatric medications may help with co-occurring symptoms of depression or anxiety.

Eating Disorders

The 3 main categories of eating disorders include compulsive overeating, anorexia, and bulimia. Until recently eating disorders had been seen primarily in girls; but increasingly, boys are identified.

Anorexia is the refusal to maintain body weight at a normal level through self-inflicted starvation, as a result of a distorted body-image. Although underweight, the anorexic youth has an intense fear of gaining weight or becoming fat.

Bulimia is a process of binge eating followed by self-induced vomiting, abuse of laxatives, diuretics, enemas, or other medications. Fasting and excessive exercise are also commonly used methods to induce rapid weight reduction.

Eating disorders are treated with counseling and sometimes with psychiatric medications to address co-occurring depression or anxiety.



BUILDING ON EACH OTHER'S STRENGTHS.

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