Promoting Well-being and Mental Health in Schools

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Summary

Preface

Emotional and behavioral disorders are major contributors to health-related disability in children and youth, and are associated with premature mortality, including by suicide, and long-term negative social and economic consequences for individuals and society. **Prevention of emotional and behavioral disorders is therefore a global public health priority**. Schools have the unique opportunity to identify and support children who are experiencing emotional and behavioral difficulties.

Improving mental health literacy, which is the knowledge and beliefs about mental health and mental disorders, is now seen as critically important to establish the foundations of mental health and to promote well-being and socioemotional development, improve early recognition of mental disorders, and reduce of stigma.

To date, most mental health literacy programs have targeted adolescent teenagers (12–18-year-olds), while little attention has been paid to improve mental health literacy among primary school children aged 6-12 years. To address this limitation, **this book aims to provide training to teachers, administrators, and people involved in the education of primary school children (hereafter referred to as educators) about the implementation of mental health literacy into daily school life**.

Such knowledge, skills and attitudes will equip all levels of educators with key tools to support student mental health, manage difficult classroom behavior, and promote students' well-being and academic success.

How to use the handbook?

- As a **self-learning guide** for educators interested in increasing their knowledge about child mental health and its promotion. Educators can go through each section systematically or read a specific section to learn on a particular topic.
- As the **primary source of information for a tutor led virtual course** to train trainers on mental health literacy in primary schools via the PAHO Virtual Campus for Public Health. Those trained will be able to help schools to establish and operate mental health literacy programs.
- As a **training package** by mental health providers and others involved in education and used as educational materials in schools.
- As an **advocacy tool** containing information to increase awareness among educators and the public about mental health and well-being of children.

Acknowledgements

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We sincerely hope that the work and dedication of these and several other persons not mentioned here, leading up to this publication, will help inform the school mental health literacy.

What is mental health?

There is no health without mental health.

Health describes a positive state of complete physical, mental, and social well-being.

Helpful definitions

Educators: the entire educational community, from teachers and classroom assistants to administration and school management.

Learning environment: any place of education, in the country or in town, public or private, in person (like a traditional school) or virtual, that welcomes children on a regular basis during a school term to provide education.

Mental disorder: medical condition diagnosed by trained health professionals using internationally established diagnostic criteria. There are a variety of mental disorders, and all have a significant impact on the individual's ability to function in life.

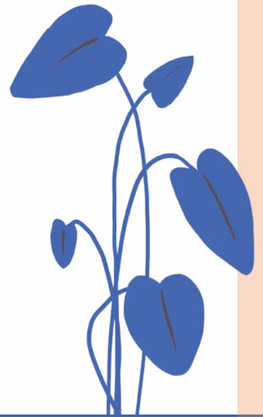
Mental distress (or stress): it is an internal signal that tells us that we must solve or overcome a new challenge, and is often a response to something in the environment. It is experienced by everyone and is a component of mental health.

Mental health problems: are the result of a significant stressful situation, such as the death of a loved one or facing a physical health problem. They may profoundly affect the way people feel and behave, and function.

Mental well-being: a state of mental functioning that results in productive activities, feeling good about oneself, enabling fulfilling relationships with family, friends, colleagues and the community at large.

Stigma: attitudes and beliefs that motivate people to fear, reject, avoid, and discriminate against other people.

Student: from kindergarten to graduate school, every student who attends school regularly and assiduously. In this handbook, we refer to elementary school children (6-12 years of age).



About the illustration

The purpose of this book is to give educators knowledge about mental health in children and the role they can play in promoting mental health in their classrooms. Having a book with surprising illustrations will help memorize key knowledge about mental health.

Characters are birds, to allow the reader to relate while maintaining some emotional distance, and to represent diversity without stigmatizing. Also, birds are universal and will allow this book to be read in schools all over the world.

Finally, some of these illustrations may be used by educators in their classroom, to illustrate important mental concept to their students.

The necessary promotion of

mental health

1/300

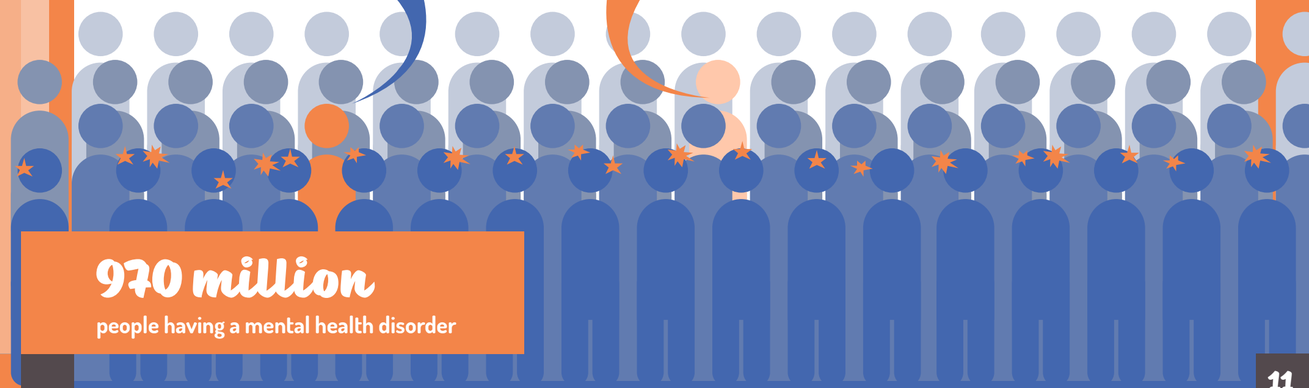
proportion of people with depression treated in high-income countries

1/5000

proportion of people with depression treated in low-income countries

50%

of mental health problems starting in childhood



970 million

people having a mental health disorder

“Mental health exists on a continuum that ranges from mental well-being to mental disorders.”

a doctor

Mental well-being

It refers to a state of successful mental functioning that results in productive activities, feeling good about oneself, enabling fulfilling relationships with family, friends, colleagues and the community at large.

It promotes the **ability to cope** and adapt to negative and positive life events.

“Through life, people encounter a variety of positive or adverse experiences that make them move up and down this continuum.”

a psychologist

Mental distress and mental health problems

Everyone experiences periods of mental distress (or stress) in their life.

When a person is exposed to a major stressful situation, mental health problems may arise. Situations such as the death of a loved one or facing a physical health problem are examples of situations that may profoundly affect that way we feel, behave, and function. Coping with mental health problems may be very challenging.

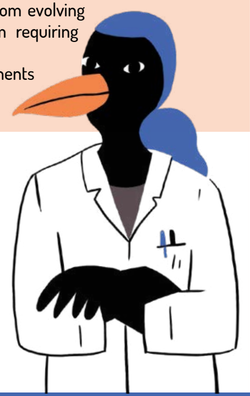
Distress is the internal signal telling us that there is a challenge or stress to overcome. It usually comes as a response to something in our living environment.

Mild distress does not require specific treatment. But persons experiencing moderate or high levels of distress may benefit from different supportive interventions helping them to cope with the situation. This often prevents the distress from evolving into a prolonged or serious mental health problem requiring specialized care.

Distress signals have several different components that can be experienced as positive or negative.

“Focus on building resilience can mitigate some of the negative impacts of mental distress on child development. Techniques for maintaining good general health, such as exercise, quality sleep, a balanced diet, can also aid in managing mental distress.”

a pediatrician



Take the example of a student experiencing conflict with a friend. The conflict can bring several types of distress:

- **emotional**: the student may worry about his/her social standing and sense of belonging. This can manifest as irritability, anger, or detachment/aloofness.
- **cognitive**: the student may interpret the conflict, negatively – («no one likes me», «I can't find anyone to be my friend») – or positively – («I need to find a solution», "I should ask my teacher for advice").
- **behavioral**: the student may use their interpersonal skills to respond to the situation. More maladaptive responses can manifest as avoidant or even aggressive behaviors. More adapted responses can result in appropriately looking for advice or support, or initiate discussions to solve the problem.
- **physical**: the student might experience physical symptoms such as headaches, muscle fatigue, or even restlessness.

Each person's stress response will differ based on their abilities to cope.

Through trial and error and support from others, children develop stress management skills and increase their ability to cope with mental distress.

“During a class, in front of 30 students, how can you tell the difference between normal stress reactions and the signs of a mental disorder?”

a professor

Mental disorder

It is a medical condition diagnosed by trained health professionals using internationally established diagnostic criteria.

A mental health disorder usually has a significant impact on the individual's ability to function (in the personal, familial, and social-occupational spheres of life).

Mental disorders arise because of **a complex interplay between a person's environment, and genetic susceptibilities**, that bring about changes in typical brain function.

This can lead to changes in thoughts, feelings, and behaviors of varying durations.

A person with a mental health disorder is **best helped by working with a trained mental health professional**.

Indeed, a young person with a mental disorder requires additional care above and beyond that which may be provided for mental distress; self-management strategies are usually not sufficient.

As with most health conditions, the trajectory for short and long-term outcomes improves with early access to effective treatment.

The importance of well-being and mental health in school

Schools are uniquely positioned to promote overall emotional well-being and socioemotional development, and to identify and support students who are experiencing emotional and behavioral difficulties.

Learning mental health literacy will help educators to:

- Understand how to optimize and maintain good mental health
- Understand mental disorders and their treatments
- Decrease stigma
- Enhance help-seeking efficacy by:
  - Knowing when and where to get help
  - Having the necessary skills to promote self-care
  - Understand how to obtain relevant care

What can educators do?

"I love my job as an educator, the transmission of knowledge to my students. On the ground, I am sometimes confronted with difficult situations related to mental health issues that confuse me as I do not feel equipped to deal with it. How can I better recognize, help, and maybe even prevent some of these difficulties?"

A key role to recognize symptoms and provide guidance

Educators can support students' mental health by recognizing the symptoms of mental health difficulties at an early stage. To do so, it is helpful to understand typical child development. Educators may be sensitized to differentiate between expected behaviors to:

- Identify a need for more attention or assistance
- Provide information and guidance to help their students navigate mental health concerns
- Adapt their behavior and the environment to promote the mental well-being of their students
- Minimize the negative impact of mental health problems on their student's development

A key role to reduce stigma and stigmatizing attitudes

Stigma refers to those attitudes and beliefs that motivate the people to fear, reject, avoid, and discriminate against other people.

Stigma can occur in many different contexts, including when people are confronted with diversity or difference in terms simply of unexpected behavior, or of more identity positions as gender identity, culture, and sexual preference. Certainly, negative attitudes and beliefs toward people who have a mental disorder are also common and have wide implications for the victim. Stigma significantly adds to the burden of those with mental disorders. Many people with mental disorders say that stigma is harder to manage than the disease itself. Stigma also acts as a barrier to seeking professional help.

Often, stigma results from misinformation and lack of information about mental health and mental disorders. Different factors may promote stigma, including poor understanding of the causes. Certainly, attributing religious, moral, or supernatural causes to mental disorders, make it more likely for the unwell person to be judged or feared; such views go against a medical model and often against a belief that treatments exist. The irrational link sometimes made with infectious diseases can bring equally irrational fears of "contagion".

"As an educator, I promote better understanding of the causes of mental health conditions, I try to break the link with moral judgement. I promote education and I encourage access to effective treatment in order to decrease stigma."

Why developing mental health literacy?

Share key knowledge

Key knowledge includes:

- Mental disorders and symptoms
- The importance of promoting mental health and well-being
- The importance of family and community support

With this knowledge, educators are more equipped to promote students' mental well-being, as well as to understand and support children (and possibly their families) with mental health problems.

They may also make students with mental health problems and their families more aware that symptoms can explain difficulties, rather than resorting to sometimes inappropriate interventions like punishment for symptoms. The right kind of support from educators or school counselors will promote a climate conducive to resolving problems and moving forward.

Gain ability to better recognize

Educators are confronted with changed behaviors or complaints that reflect something going on in their students, and affect them as educators, and even be a burden to them.

Sensitivity to this, paired with greater literacy, should lead to recognizing mental health problems, and perhaps even disorders. This is key to acknowledging that a child may have specific needs for which attention is appropriate, and care may be required.

Early support and treatment of mental health conditions decrease potential adverse consequences. For children, recognition can also help to enhance self-awareness and promote well-being.

Mental health symptoms may be mistaken for other issues, such as physical illness, personality traits, or learning difficulties. The lack of recognition may also lead to stigma when behaviors may be mistakenly labeled.

Build an ability to change attitudes

Attitude refers to a person's tendency to evaluate a person or event in certain inflexible ways. We carry with us a set of emotions and beliefs that influence the way we behave. For educators, developing mental health literacy can be an effective way to widen one's views and develop awareness about our implicit attitudes towards children's behaviors to include notions of mental health and well-being. Developing awareness is the first step to changing attitudes that are helpful, supportive, and conducive to promoting child mental health.

Educators provide **essential life skills to students** (such as emotional regulation, dealing with conflict, modeling moral and ethical characteristics), enabling them to choose healthy ways of living.

Every student who comes into a classroom should be able to choose their **path in life**. Educators equip them to do so, ensuring their intellectual development, self-esteem, and social well-being.

Understanding of child development

Educators can support students' mental health by recognizing the symptoms of typical mental health problems at an early stage. A basic understanding of developmental stages is therefore necessary.

The complex processes of child development tend to be essentially continuous, rapid and dynamic across multiple domains.

The school years as a crucial period in children development

Children develop competencies and mature from being fully dependent on their caregivers to being self-sufficient and autonomous. School-aged children are constantly developing across multiple domains: cognitive, emotional, social, and biological.

Keep in mind

It is useful to look at child development in **stages**, with development enabling the passage from one stage to the next.

In this context, recognizing **normal age-appropriate behavior and developmental** processes provides a template of what can be expected. These represent "average" development and there can be variations. But significant deviations from normal developmental stages can represent a mental health problem.

However, child development is often **not so linear and different stages are often not clear-cut**. For instance, growth in some domains may outpace others, and transitions from one stage to another can occur at different paces for each child.

Under stress, children can be expected to even **regress** from their developmental stage to a previous one, for example in illness, with losses or disasters.

Nevertheless, each stage lays the foundations for the next, and failure to develop adequately at one stage can seriously affect further development.

Key factors influencing child development

Risk and protective factors

Several factors experienced during the early years of life can have a profound effect on children's cognitive and socioemotional development, with long-lasting effects in adolescence and adulthood. Prolonged exposure to adversity may increase a child's vulnerability to mental health disorders. Factors that may compromise a child's development and mental health include:

- Sexual, physical, or psychological abuse and neglect
- Family history of mental disorders
- Adverse socioeconomic conditions
- Parental unemployment or low education

On the other hand, several factors may protect children's development, even buffering the negative effects of adverse environments. These include:

- Having positive and supportive relationships in some spheres of life (family, school)
- Receive nurturing care via supporting parenting
- Safety, security, and healthy attachment
- Concrete support for parents

Cultural differences

The beliefs, values, customs, social circumstances, and technology change over time and contribute to a child's development. Because of their rapid development, younger children are more impacted by sociocultural factors than older children and adults.

As children mature, they also gain more control over their environment: they develop specific interests and relationships, which in turn shape their further development.

Sex differences

Boys and girls show slightly different developmental timetables. Girls tend to develop social skills earlier than boys, while the opposite is true for motor skills. Girls also demonstrate an advantage over boys in their cognitive development, although most differences disappear by late childhood and adolescence. Similarly, verbal and non-verbal abilities develop earlier in girls than boys, but by age 10–12 boys outperform girls in non-verbal abilities, and differences are no longer noticed in the long-term. Puberty also starts sooner in girls than boys. Genes and hormones are important in explaining such sex differences, but they do not fully account for them. Experience also plays a fundamental role.

Concerning mental health, overall, boys disproportionately suffer from more developmental disorders than girls, including language and learning disorders, dyslexia, attention-deficit disorder, intellectual disabilities, and autism spectrum disorders. Boys are also more vulnerable than girls to the adverse effects of environmental risk factors and stressors, such as parental neglect.

Multiple domains of child development

Prenatal development

The fetus is immersed in an **abundance of sensory information** in the womb. Sight, touch, taste, smell, and hearing are all stimulated within the prenatal environment. The fetus' experience in the womb can lead to preferences that persist long after birth, such as taste and even language.

A **healthy pregnancy** includes minimal exposure to stress, illness, and toxins, including alcohol, tobacco, or non-vital medications.

Prenatal maternal stress may contribute to postnatal behavior problems in early childhood and beyond.

Brain development

The brain is a **complex organ**, which is far to be fully understood. Its development contributes to all aspects of human experience — thought, memory, emotion, imagination, personality. Healthy brain development is therefore the basis for developing and maintaining a good mental health.

Brain development is uneven throughout childhood and into early adulthood, where nature and nurture play a role and often interact. The parts of the brain associated with more basic functions (the sensory and motor areas) mature earlier than the areas involved in higher processes (attention, executive functioning). Notably, the brain's frontal area, which is involved in executive functioning, decision-making, and self-control, does not fully mature until early adulthood.

Problems with specific areas of the brain can impact the development of specific functions that in turn may influence classroom behavior. For example, a child might have deficits in the brain related to language, speech, and sensory analysis. This could impact its ability to share information through speech or perceive things in their environment. In this case, the student may require additional help to communicate non-verbally.

Impairments in brain functions can also occur over time via **brain injury or exposure to highly stressful situations**. Such events can alter child behavior, although the changes may only be temporary.

Motor development

Children are born with an **innate desire to explore, perceive and experience the world**, this fuels their motivation for movement.

As the child gets more mobility, develops muscle strength, posture control, balance, and perceptual skills, he/she develops a range of strategies to explore, interact with more objects and cope with environmental challenges.

Their judgments of relative size, slope, and their motor skill level become **more accurate and finer with time and practice**.

Motor development milestones can vary substantially amongst children and across cultures and lifestyles, but the **milestones' order is consistent**.

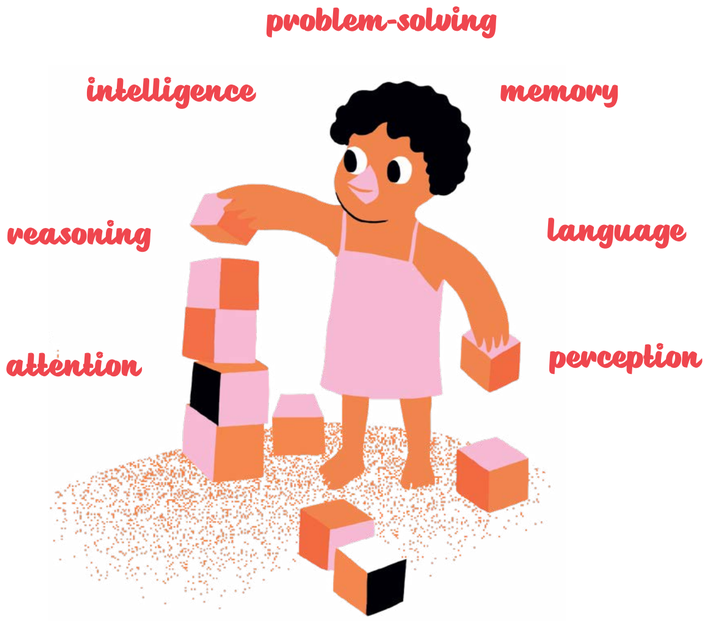
Main milestones

Birth – 2 years	• Able to move oneself around and eventually walk independently • Developing the ability to walk on uneven and sloped surfaces
2 – 6 years	• Learning to use the toilet • Learning about sexual differences and behaviors
6 – 12 years	• Learning the physical skills necessary for games (throwing, kicking, catching)
> 12 years	• Accepting one's physical strength and using the body effectively

Cognitive development

Children's cognitive capacity **develops gradually and continuously**, in small increments at different ages. These changes are linked to memory development, which is progressively enhanced through adopting new strategies to acquire knowledge as they grow.

Children **learn well in social contexts**, with the support of educators and the interaction with peers. To support a child's cognitive development, adults should provide a framework to help children think and problem-solve at a higher level until they develop sufficient skills to act independently. Such social scaffolding can include demonstrating a task, explaining the goal, and assisting with the most challenging tasks.



Main milestones

Birth – 2 years	• Knows the world through their sense perceptions and motor activity (e.g. they learn what dogs look like and what petting them feels like) • Begins to understand that an item still exists when it is out of view • Able to categorize items, distinguish people from objects and animals • Develops a sense of relative location based on their body's location and of time
2 –7 years	• Acquires the ability to think about the world through language, mental imagery, and thoughts • Enjoys playing pretend - their thinking is based on impressions rather than reality • Develops an understanding of invisible processes, such as growth, illness, and healing • Show an interest in living things, such as animals and plants • Begins to see the world from other people's perspectives • Able to understand that goals, desires, and beliefs motivate actions, and cause-effect relations
7 – 12 years	• Able to think logically, not just intuitively • Able to reason concretely but have trouble with abstract and hypothetical thinking • Can understand that multiple factors, not just one, influence events • Develops fundamental skills in reading, writing and arithmetic • Developing the ability to make decisions, exercise self-control, solve problems, adapt to situational changes • Starts seeing the point of view of others more clearly and frequently
> 12 years	• Develops systematic thinking that considers the interaction of several factors • Able to test their assumptions through reasoning and experimentation • Able to reason based on generalizations and abstractions

Social development

Simply by **observing other people's behavior**, children acquire social information that helps them develop skills in emotional regulation, learn about appropriate social behaviors, and the perspectives, feelings, and motives of others.

School environment facilitates the learning of prosocial behavior and considering the other people's view. For example, aggressive behaviors are frequent in children of age 2-4, but their frequency progressive declines across middle childhood and adolescence owing to the child's acquisition of alternative ways to express himself and resolve conflicts.

Understanding of others' mental states (including their beliefs, desires, and knowledge), and the ability to comprehend that these may differ from our own, play a key role in children's social development.

Temperament and personality play a significant role in shaping children's own development by choosing their interests, seeking out experiences, and engaging with their peers.

Individual perception plays a role in social development. For instance, whether children attribute failures to their lack of effort or ability can dramatically influence subsequent motivation.

The adequate resolution of psychosocial challenges provides a firm foundation for future growth, whereas the inability to resolve such challenges will lead to developmental setbacks.

Main milestones

2 – 6 years	• Self-conscious emotions (e.g. guilt, shame, empathy, pride, and jealousy) emerge • Interested in new experiences • Exhibits social skills, including turn-taking. cooperation with other children • Increasingly inventive in fantasy and pretend play • Idolizes parents and caregivers • Begins to set goals and attempts to achieve them
6 – 8 years	• Able to pursue personal, social, and academic goals • Develops skills to maintain harmonious social relationships including conflict resolution • Often prefers same-sex friends from the same neighborhood • May focus on others' perceptions of them by enhancing their appearance, skill sets, and possessions • Continues to develop skills in decision-making and self-control
9 – 12 years	• Building self-esteem and a wholesome attitude towards one's body • Learning to get along with peers and cooperates towards common goals • Learning appropriate masculine or feminine social roles • Developing an understanding of appropriate and inappropriate social behaviors • Achieving personal independence and autonomy • Engages in self-directed goals and behaviors • Sensitive to negative feedback and may struggle with failure • Developing skills to communicate personal experiences, feelings, and needs to others
12 – 18 years	• Tries on various forms of self-expression and develops a social identity • Achieving new and more mature relations with peers of both sexes • Achieving a masculine or feminine social role • Shows a heightened level of self-consciousness, autonomy, emotional independence from parents • Tend to test the limits of established boundaries and challenge authority

Language development

Children develop a **basic understanding of what others are saying** before they can communicate with words. Pitch, intonation, and facial expressions all help infants acquire language.

Language is **developed within a community**. Adult responses can help children to practice speaking, recognize words, and establish conversation-like routines. Thus, the presence of attentive caretakers and educators plays a significant role in promoting children's language development.

Main milestones

Birth - 2 year	• Progressively acquires the ability to interact and communicate with others, and begin to produce words • Tend to speak in single words to represent a whole idea
2 – 4 years	• Develops a more extensive vocabulary and begins using short sentences • Beginning to acquire grammar and syntax rules • Continues to use words in broader contexts than is appropriate • Learning language concepts to describe social and physical reality • May require help and scaffolding to produce coherent thoughts and sentences
4 – 6 years	• Developing the ability to talk about past events • Acquiring the ability to form novel and semantically correct sentences • Developing readiness for reading • Beginning to consider non-verbal cues to interpret meaning • Learning about different uses of language to understand meaning, such as irony and sarcasm • Distinguishes between drawing and writing
6 –12 years	• Beginning to identify meaning and the rhetorical use of language • May take an interest in the multiple meanings of words, such as in riddles, puns, and jokes • Developing fundamental skills in reading, writing, and arithmetic

Moral development

Perception of right and wrong changes as children gain new cognitive abilities, evolve in their self-conception, and engage in perspective-taking. **Morality develops slowly** over time and is influenced by factors that span from societal and cultural norms, temperament, genetics to children's relationship with parents. Children refer to their understanding of morality **to make tough decisions and guide their social behavior**.

Negotiating the responsibility of care towards the self and others and changing perceptions of justice and fairness are central to moral development. **There is no precise age progression** through the proposed stages.

Importantly, behaviors that are considered moral, social-conventional, or personal judgments **vary somewhat across cultures**.

Main milestones

> 6 years	• Learns to distinguish right and wrong and a sense of conscience • Sees morality as clearly divided between good and evil • Sees rules as absolute and unbreakable • Begins to shift from avoiding punishment to maximizing self-benefit • Follows the rules to avoid penalty and gain reward
6 –12 years	• Internalizes the values and perspectives of an adult figure or a particular group and thrives on living to these standards • Measures morality by the ability to uphold the rules and expectations of a chosen person or group • Focuses on securing social approval and acceptance • Orients towards loyalty and social belonging • Transitions from focusing on personal needs to prioritizing the needs of others • May adopt a self-sacrificing orientation towards morality • Struggles to negotiate with others and tends to concede to other's needs
> 12 years	• Acquiring a set of values, ethics, or ideologies as a guide to behavior. • Developing socially responsible behavior • Exhibit a "justice" orientation and becomes cause-oriented • Sees morality as abstract ethical principles about right and wrong • May view oneself as able to make a significant change and aims to persuade others to adopt the same values and perspectives • Begins to see rules as negotiable and often start to challenge authority • Begins to consider both individual needs and the needs of others

Influences on child development

Children's development and mental health are shaped by biology as well as exposure to experiences in several spheres of influence.

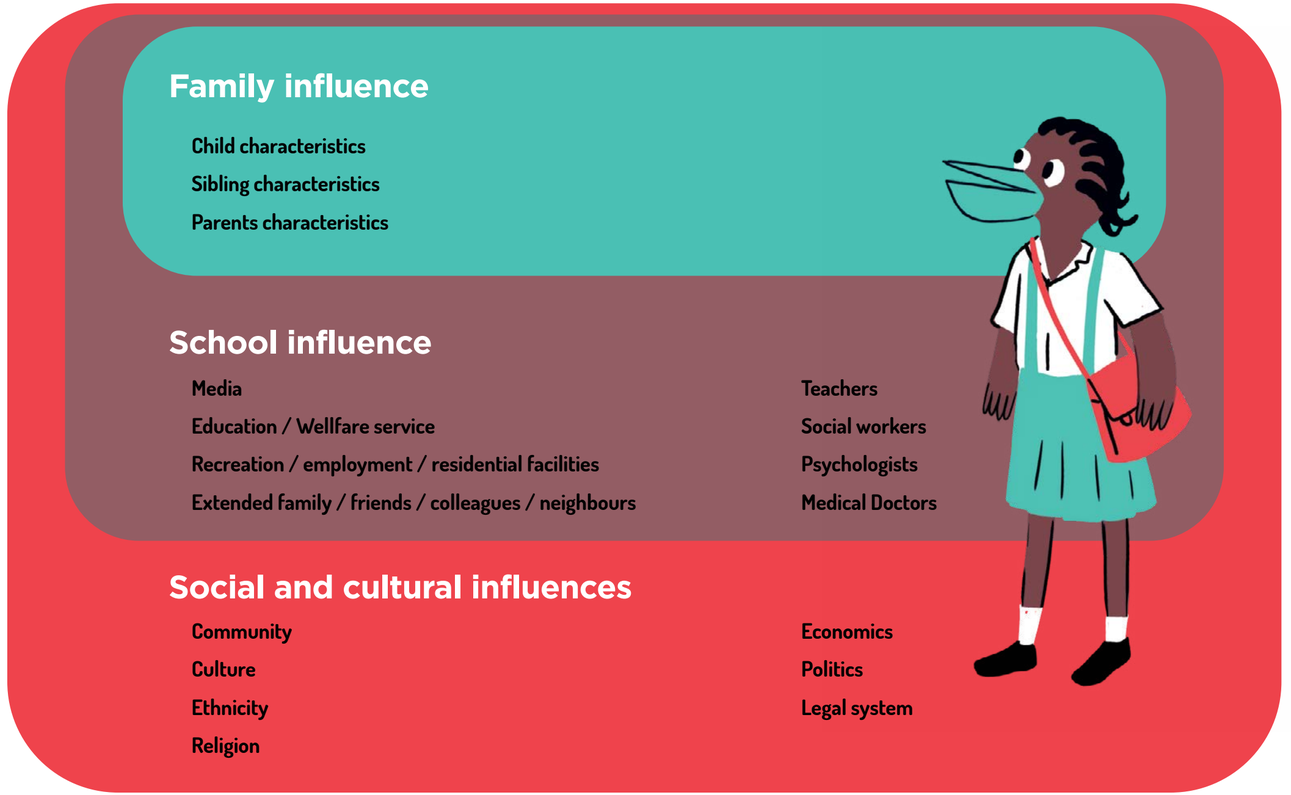
Understanding how these spheres of influence children's development and mental health is key in identifying where to target effective prevention and treatment interventions.

The various influences on child development

The development of a child can be seen as part of a systemic "bioecological" model, resulting from the intersection of influences encompassing levels of proximity from the intimate context of the child's home (the microsystem) all the way to the cultural climate in which the family lives (the macrosystem).

These levels change over time, hence the use of the term "chronosystem" to describe the changes that occur over time in beliefs, values, customs, technologies, societal and cultural factors.

Although many environmental factors are beyond the child's control, the child is nevertheless playing a significant and active role in interacting with these and actively contributing to his or her own development.



Child development at the center of three interactive systems - Bronfenbrenner's model

Family influence

An important part of a child's development occurs within the family unit. There is a continual interplay between the child, the family and the social environment, which changes over time.

Taking family factors into account provides a better understanding of a child's thoughts, feelings and behaviors:

A child's mental health problems can often be linked to problems in the family system

Interventions at the family level are likely to have more impact than those at the individual level, because the individual resides within a family structure and is part of a complex system.

School influence

Relationships with people outside the family - such as peers, teachers and the school culture - all help shape children's behavior and mental health trajectories and become increasingly important as the child grows up.

When mental health problems manifest in the school environment, parents often turn to educators as the first point of contact to assist their children's difficulties.

Social and cultural influences

The macrosystem has a major impact on the interactions of all other layers. It consists of larger structural factors such as economics, politics, the legal system, societal culture, and religion. It refers to the attitudes, beliefs, values, and ideologies that are apparent in a particular society.

Some environmental factors may increase the risk of mental health problems, while others may play a protective role against them. As the number of risk factors accumulates, more protective factors are needed to offset their negative effects.

Family influence is central on the child's development

Ideally, family interactions will provide the child with a sense of belonging, material and emotional support, encouragement toward autonomy. They also provide an environment within which children understand boundaries and communication.

The importance of parenting and attachment

Children form strong emotional attachments to their primary caregiver(s). These are usually the parents but may include other family members, extended family, depending on circumstances. These emotional attachments provide comfort and stability, as well as a secure base to foster the child's interests, curiosity, and learning. Another vital benefit is in promoting the child's emotional resilience and regulation, well-being, and ability to recover from difficult experiences later in life.

The impact of parental mental disorder

Children of mentally ill parents are at a higher risk for developing mental health problems themselves. First, mental health problems run in families. Second, parental mental illness can have an influence on the family environment and on parenting practices and be associated with other determinants of poor general emotional or developmental difficulties and adverse childhood events.

Taking stock of these realities often helps be less judgmental of cumulative or persistent mental health problems.

Other characteristics of a family

The characteristics of each family – number of people in the family, cultural background, socioeconomic status, health status, parenting style, and ethics and ideologies - play a significant role in the development and socialization of the child. The range of children's needs that can be fostered within the family environment is wide and can go beyond emotional, interpersonal and safety (economic, physical) factors, to include wider social, educational, and vocational opportunities and skills. Reciprocally, the developmental changes of a child affect the family and bring it to progress through various family life stages, requiring that family members adjust to each other as they each progress through their lives.

The bioecological model helps avoid placing blame only on the family (or on the individual for that matter), and to remember that while the family is foundational and fundamental, it is only one aspect of the many levels of influence.

Children can develop well in many different environments, under incredible levels of duress at times, and the bioecological model helps look for all the possible sources of protection and resiliency for any given child.

The consequences of family separation and conflicts

Parental separation and conflicts are often experienced as stressful events that can have short and long-term consequences for the child. Children at different ages display marked differences in their responses to parental separation, with less detrimental effects in older children.

Pre-schoolers may deny separation, become very upset, develop separation anxiety, and regress to a state of lesser autonomy. This can manifest in dressing, feeding, or toileting.

Primary school children tend to feel guilty or anxious, often feeling responsible somehow for the separation. There can be fear of being punished or abandoned. They may also become highly emotional, whether sad or despondent, or irritable or aggressive.

Other behaviors associated with parental separation include restlessness, withdrawal, concentration problems, loss of self-esteem, peer relationship difficulties, deterioration in academic achievement/

Educators cannot become or replace parents but are in a privileged position to be a source of support for children experiencing such difficulties in the family environment.

Schools: an appropriate setting to address mental health

Since children spend a significant amount of time at school, their existing relationships and direct contact with educators make schools an essential setting to promote mental health and well-being. School administrators also play a determining role in mental health promotion through actions such as devising well thought-out codes of conduct and integrating proper time frames and spaces.

School ethos as a foundation

Schools that promote mental wellness are thought to be successful because of:

- A committed and engaged senior management team
- A school culture based on trust, integrity, equality of opportunity, and mutual respect
- Clear school-wide policies and procedures for behavioral and mental health concerns, agreed-upon and successfully implemented

Effective school-based mental health prevention and awareness measures require multi-level participation. Educators are encouraged to foster a culture of mutual respect, participation and mentoring to facilitate mental wellness. Senior management can advantageously provide additional training for educators, or envision how to make the school a calm place for students to do their homework, for example.

Collaborating with parents is key

When there are deeper concerns for a student's well-being, it is empowering to understand when and how to refer the students to more appropriate mental health and social services.

In such circumstances, parents and children should understand and be part of the referral process. Usually the problem needs to be clearly explained, in a non-judgemental manner. Such partnering of different levels of the "bioecological" model is key in successfully addressing children's mental health problems.

School can also be source of distress – Bullying and victimization

Bullying is defined as repeated and persistent behavior that is intended to cause fear, emotional distress, self-doubt, or intended to damage the victim's feelings, body image, self-esteem, or reputation. It can also be physically damaging and cause injury. It is often intentional and occurs when there is a perceived power imbalance. On the bullying continuum, name-calling may be at one end and assault at the other.

Bullying has a negative impact on social development, education, physical health, and mental health, persisting into adulthood.

Socially, bullying often aims to lower self-confidence, and can lead to difficulty making friends and withdrawal.

Academically, the anxiety and isolation associated with bullying can distract students and compromise their schoolwork, attendance, and participation.

In terms of **mental health**, the most common problems are sleep disorders, eating disorders, phobias, depression, suicidal thoughts, and behavior, and even acute or post-traumatic stress.

Physical well-being is affected, as children who are bullied are much more likely to have enuresis (wetting the bed), headaches or abdominal pain ("stomach aches"), loose appetite and stop eating.

Other noticeable signs that may point to bullying include:

- Signs of physical injury
- Unwillingness to attend school, withdrawal
- Decrease in quality of schoolwork
- Having personal items destroyed or missing

Mental health is also shaped by social and cultural factors

Social and cultural factors influence a family's perceptions towards mental health, and ability to meet the needs of their children. Considering the interactions within and between different ecological systems can inform initiatives for mental health prevention.

Parental education and socioeconomic status: cascading impacts on development

Poverty decreases the chances to have access to education, life opportunities, and even health care. Conversely, children more exposed to reading will develop a stronger vocabulary compared to those less exposed who can start school less prepared. Socioeconomic disadvantage tends to be associated with stressors like precarious employment, relationship conflicts, health or mental health concerns. The lesser access to costly resources and support adds a burden on parents who can adopt less patient behaviors toward their children. Children from lower-income households have higher chances of being exposed to cramped or insalubrious environments, and environments lacking social infrastructure and safety. At the extreme, exposure to excessive **violent activity in one's community** can be traumatic, and can lead to eventual involvement in gangs or other dangerous activities.

Children directly or indirectly submitted to **discriminatory attitudes** - based for example on religious affiliations, skin colour, ethnic background, body type, disability, gender, sexual orientation, socioeconomic status... - can be negatively impacted in terms of school performance, self-esteem, and mental health. This can manifest itself in symptoms of poor sleep, loneliness, depression, anxiety, or other behavioral problems.

Humanitarian crises and climate change introduce new stressors

Humanitarian crises, including natural or human-caused disasters, war, displacement and disease, disrupt routines, introduce intense new stressors, and exacerbate existing ones. All children around the world are also cognizant of being negatively impacted by the gloomy information surrounding the dangers of climate change. This often leads to anxiety, distress, and uncertainty about the future.

Moreover, the actual frequency and severity of extreme weather events (heatwaves, drought, floods, wildfires, etc.) often damages infrastructures, health systems, healthy lifestyles, and economic stability. These levels of hardships cascade and amplify each other in certain circumstances. Economic and social consequences are also substantial. Even before birth, severe weather events can stress pregnant mothers physically and mentally, thus triggering the vulnerability of the unborn child to develop mental health problems later in life.

Resiliency can be fostered and reinforced.

A child's age, genetic vulnerability, developmental stage, availability of emotional support, as well as the nature of the crisis all play a role in the mental health impacts of such events. Remarkably, some children develop resilience following stressful events while others develop various degrees and duration of distress.

Internet, social media and the impact on mental health

The use of digital technologies is becoming an important part of students' educational experience. Understanding of the impact of the Internet and social media on child development and mental health is still emerging.

Many educational resources available on the Internet can **enhance and facilitate academic success**. Quality and age-appropriate content improves the social and language skills of children, especially those living in poverty or otherwise disadvantaged. This use of the Internet can be powerfully prosocial, helping children develop anti-violence attitudes, empathy, tolerance, and respect.
Students can also benefit from **instant communication and support** with family and friends and connect with peers and support groups around the world.

In the Latin American and Caribbean regions:

- **> 50%** of children and youth < 25 years old have an Internet connection at home
- All secondary schools are equipped with a **computer lab** in the Caribbean
- **Internet and social media** use is increasing every year, especially in urbanized areas

Uncontrolled social media and internet use can pose potential risks. For example:

- **Excessive screen time** and prolonged Internet use may negatively impact daily habits such as sleep and physical exercise, social relationships, and school performance.
- **Exposure to violent and age-inappropriate online content** may negatively impact well-being and emotional development. Youth with mental health problems may be even more vulnerable to these negative effects.
- **Social media can promote disinformation and unhealthy habits** and can be a platform for bullying and psychological abuse.

Educators may rely on the following measures:

- Engage students, parents, and school staff in discussions about the benefits and potential harms of Internet use, and implement controls to increase online safety (e.g. adapt the use of the Internet age of the participants, encourage responsible use, including about sharing personal information, raise awareness ot the need to limit screen time before bedtime to promote good sleep hygiene, etc.)
- Identify situations where Internet use becomes a coping mechanism to divert attention from underlying concerns, such as anxiety or loneliness
- Implement guidelines for student use of smartphones

Prohibiting physical punishment to preserve child development

The United Nations Committee on the Rights of the Child defines corporal punishment as "any punishment in which physical force is used to cause some degree of pain or discomfort, however slight."

This includes hitting (slapping, spanking) children with the hand or an instrument (a whip, stick, belt, shoe), but also anything that causes physical pain or discomfort, such as shaking, pinching, and forced ingestion (of soap or hot spices).

Why is physical punishment used in schools?
It appears to be used with the intention of stopping undesirable behavior, discouraging imitation, and to enhance more desired behavior.

Is corporal punishment an effective classroom management method?
No, it is not an effective classroom management method.

Why is it not?
Corporal punishment makes students more aggressive, mimicking punitive behaviors . It also:

- encourages students to reflexively conform to authority figures, while doubting those same authority figures
- decreases students' attendance and focus on learning
- prevents true cooperation and mutual understanding in the classroom, resulting in student withdrawal and disinterest in school activities
- punishment of a behavior in a given situation does not indicates what the correct behavior in this situation would have been

Does corporal punishment have any negative consequences?
It has negative consequences on multiple areas of child development:

- It increases risk of mental health problems such as anxiety, depression, behavioral problems
- it produces changes in areas of the brain, especially for more severe forms of violence such as physical and sexual abuse
- it creates delays in spheres of child development such as language, motor, emotional, and moral development

What are the possible alternative approaches for educators?
Research indicates that educators can be much more effective in applying alternative approaches to modifying problematic classroom behaviors without resorting to corporal punishment:

- Establish a school-wide consistent policy on nonviolent disciplinary methods, with clear guidelines and expectations for acceptable disciplinary methods
- Lead by example through clear communication and emotional management skills (e.g. maintain a calm and approachable tone when speaking to students).
- Promote a positive classroom environment to encourage positive behavior, including using role modeling.
- Address the social, emotional, and psychological needs that cause students to misbehave.
- Consider whether external stressors (e.g., economic stress or violence in the home) or developmental delays may be impacting students' ability to participate and perform.
- Have students write essays about the effects of an undesirable behavior and the benefits of a preferred behavior.
- Ask students to make amends whenever possible, such as by apologizing to the person they offended.

There may be local experience that teachers can contribute to effective non-violent, supportive interventions for classroom and behavioral difficulties.

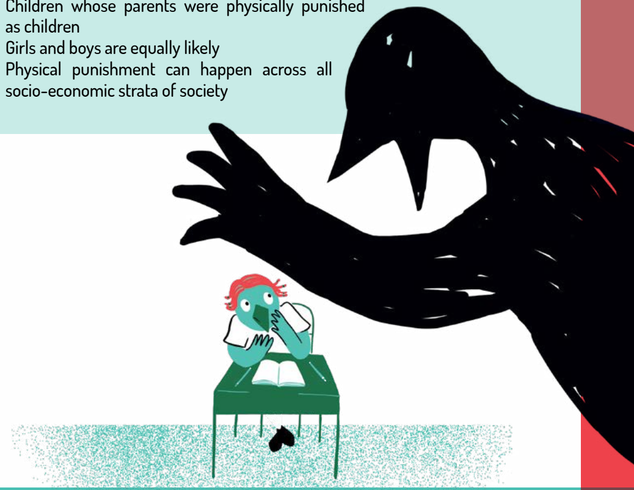
What are the benefits of using this kind of alternative disciplinary measures?
These alternative disciplinary measures can allow children to develop self-discipline without physical pain or undue fear. Their introduction into early childhood institutions and schools require teachers and administrators to act as mentors and role models to support students' self-reflection, self-respect, and willing cooperation.

Worldwide, approximately 60% of children between the ages of 2 and 14 are subjected to recurrent or regular physical punishment.

- In the Caribbean:
- Corporal punishment of students in schools **is legally restricted in several but not all Carribean countries**.
- Corporal punishment **at home** ranges from 89% in Jamaica to 77% in Trinidad and Tobago
- Corporal punishment **in schools** in Central America is over 70%.
- **17% of children** have experienced severe corporal punishment (hitting the head, face, or ears with force and repeatedly), with some contexts exceeding 40%.

Who is more likely to be physically punished?

- Young children aged 2 to 4 years
- Children with disabilities
- Children whose parents were physically punished as children
- Girls and boys are equally likely
- Physical punishment can happen across all socio-economic strata of society



Countering adverse childhood experiences in schools

Children are often limited in their ability to understand the situation, verbalize their experiences, and effectively manage negative emotions. Often, children will believe that they are somehow responsible for the adverse event(s), or that they have the potential to bring about a better outcome. This could lead to unrealistic expectations and excessive emotional burdens for children.

Child abuse and neglect

Child maltreatment is defined as intentional abuse or neglect that endangers the well-being of anyone under 18 years old. Exposure to domestic violence, neglect, physical abuse, sexual abuse, and emotional abuse are amongst the most common adverse childhood experiences. Abuse and neglect often co-occur and are under-reported, and often happen within the family.

Maltreated children often develop a heightened response to anger cues, leading them to be more sensitive to potential signs of hostility. This helps children notice potential signs of danger in a threatening home environment. However, it often results in withdrawal or aggressive behaviors, which hinders peer relationships.

Bereavement

Several factors influence a child's ability to process the loss of a loved one: child's age, relationship with the deceased, personality, previous experience with death, available social support, and the circumstances of death.

Parents play a major role in a child's response to bereavement. Some parents may try to protect children from the realities of death and the complex and painful feelings associated with grieving. They may avoid the topic and exclude children from funerals. Parents may also not know how to support a grieving child and be struggling themselves during bereavement. This can cause them to overlook their children's needs. In turn, children may pretend to be fine to avoid burdening their parents. This can lead children to become confused, distressed, and unable to properly move through the grieving process.

An **adverse childhood experience** is a single or multiple events, or a set of circumstances experienced by an individual as physically and emotionally harmful or threatening, and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well being. These are often persistent, frequent, and intense sources of stress that children may encounter either in the home environment, school, or community.

School-based support can take a multi-layered approach of:

- School-wide awareness and prevention
- Student-based emotional response and resilience building
- Individualized psychological support

School-based initiatives to meet the needs of students experiencing adverse events have the potential to reap profound mental health benefits. This is especially true in socioeconomically disadvantaged communities, where children are more likely to be exposed to adverse events yet are less likely to have access to mental health services.

Main emotional and behavioral disorders

At the classroom level, teachers may identify mental health problems, and liaison with parents and specialized mental health professionals.

Anxiety disorders

Anxiety disorders are some of the most common mental health problems in children and adolescents.

Anxiety, fear, and panic are highly interrelated emotional states and natural parts of growing up.

Each can influence physiological, emotional, cognitive, and behavioural states.

Panic responses occur when alarm reactions happen in the absence of a clear threat or danger, or they are disproportionate with respect to the actual threat.

Fear is an immediate emotional reaction to danger, characterized by a sense of alarm and a urge to flee. An adaptive fear response is proportional to the threat and subsides when the threat has passed. It also leads to developing appropriate coping behaviors. Fear becomes anxiety when it persists after the threat has subsided. Such responses are excessive, debilitating, and inhibits daily functioning and enjoyment of life.

Over time, children with anxiety disorders may delay social, emotional, and cognitive development. Anxious children may become withdrawn in school settings and with peers.

AGE-APPROPRIATE FEARS AND ANXIETIES IN CHILDREN AND ADOLESCENTS

Young Children (age 2-5)

Fear of storms, fire, water, darkness, nightmares, and animals

Middle Childhood (age 6-12)

Anxiety about school or about performing in front of others

Adolescents (age 13-18)

Fear of rejection by peers, performing in front of others, physical illness, medical procedures, catastrophes (e.g. war, terrorist attack, disasters)

age when generally phobias are materialized

Children may be diagnosed with **SEVERAL** anxiety disorder

Anxiety disorders can **COEXIST** with other mental disorders

FEMALES show a higher prevalence rate than males

5% of children and adolescent between 13 and 18 years old develop anxiety disorders

What can educators do?

Building a trusting relationship with students facilitates a supportive classroom environment.

Watching for **indicators** that the student may be becoming more anxious, such as:

- missing class
- frequently going to the washroom
- not finishing tasks and assignments

Identifying, with behavioural cues, situations producing most anxiety for students.

Adopting the following strategies to support students with anxiety disorders:

- Help the student accept and prepare for setbacks
- Develop realistic goals with students to avoid unrealistic self-expectations
- each positive self-talk by choosing positive words and phrases
- Adjust assignments according to the student's level of distress, such as chunk work into smaller sections or allow extra time for exams and assignments
- Give advanced notice when there will be a change in the schedule or routine (e.g., school assembly).
- Try to approach the student from the front in order to reduce a startle response
- Introduce emotion-regulation techniques for reducing anxiety, such as physical exercise, distractions, relocating to a quiet place, and focusing on sensory input

Social Anxiety Disorder

As a Student

- I will be negatively judged and scrutinized in social settings
- I am easily embarrassed and I experience anxiety in social and performance situations
- I withdraw from social situations or I attempt to perform perfectly and be socially appropriate in my interactions

How to act as an Educator?

- Facilitate a supporrive classroom environment
- Identifying situations producing most anxiety for students and give advanced notice
- Introduce emotion-regulation techniques for reducing anxiety
- Teach positive self-talk by choosing positive words and phrases

Going Further

Youth with social anxiety disorder recognize that their fears are exaggerated and irrational. However, they often lack the ability or skills to self-regulate it.

The onset of SOC usually occurs at the end of middle childhood/beginning of adolescence. It should not be confused with shyness or age-appropriate social development that improves over time.

Main Symptoms

Emotional

- Fear and avoidance of social and performance situations
- Fear or worry of being judged or scrutinized negatively by other people
- Shame, fear of negative evaluation, or rejection

Physiological responses

- Heightened stress response that exceeds the actual threat

Behavioural

- Avoids social situations such as parties or school events
- Avoids performance situations and situations where others observe them (in stores, movie theatres, public speaking, and social events)
- When social avoidance is unsuccessful, crying, freezing, and other forms of outbursts or withdrawal may occur

> ***"I could see that asking one of my students to speak in public was extremely difficult. Having his anxiety symptoms noticed by his peers was putting him even more in distress!***
>
> ***As a teacher, I was wondering how to act?"***

Separation Anxiety Disorder

As a Student

- I feel distressed when when my parents drop me off to school, and I cannot stop thinking about it during the whole day
- I refuse to leave home to go to school, or I refuse to stay home alone
- I have stomach aches thinking about the next one-week school outing

> ***"In a writing exercise, one child answered the question "What are you afraid of?" with "that something bad can happen to me if I'm not with my parents". This made me understand why it was so difficult for him to concentrate in the classroom."***

How to act as an Educator?

- Acknowledge both child's and parent's feelings
- Set up a routine that is calm and quiet at the arrival at school and minimize rush
- Prepare a visual schedule with the activities for the day, so student can better anticipate the activities

Going Further

When separation anxiety becomes intense, prolonged, or interferes with daily activities, it could be separation anxiety disorder.

Risk factors for this disorder can be environmental (e.g., death of a loved one, parental divorce) or biological (e.g., relative with anxiety disorder, imbalance of norepinephrine and serotonin chemicals in the brain).

Common co-occurring disorders include other anxiety disorders, and depression. Without therapeutic or pharmaceutical treatment, separation anxiety disorder can continue from childhood into adulthood.

Main Symptoms

For a diagnosis to be made in a child under age 18, three of the following symptoms must be present for at least four weeks and must cause significant impairments with family, social life, or school:

- Recurrent and excessive distress about being away from or anticipating being away from home or loved ones
- Constant, excessive worry about losing a loved one
- Continuous fear of separation from loved ones such as through kidnapping or being lost
- Refusal to leave home
- Refusal to be home alone
- Reluctance or refusal to sleep away from home without a loved one nearby
- Recurrent nightmares about separation from loved ones
- Frequent complaints of headaches, stomach aches, or other symptoms when anticipating separation from a loved one

Specific phobias

As a Student

- I know it is unreasonable, but I cannot refrain from crying when I see spiders
- Impossible for me to climb a mountain: spiders can be everywhere, under the stones, falling from trees, ...

Going Further

Phobias are a type of anxiety disorder characterized by excessive and immediate fear or anxiety towards a specific object or situation. The fear response is out of proportion to the actual danger and occurs every time the trigger is present. For a person to be diagnosed with a specific phobia, the symptoms must occur for at least six months and cause significant impairments with family, social life, or school.

Most phobias develop around a negative experience or panic attack, or simply just hearing negative information on the topic. The development of phobias are strongly influenced by individual differences in genetics and brain functionning.

Phobias can occur at any point in life but generally materialize by age 10. With adequate treatment, symptoms can significantly improve and even disappear entirely.

Main Symptoms

Main phobias

Most common phobias are:

- Arachnophobia: fear of spiders
- Cynophobia: fear of dogs
- Acrophobia: fear of heights
- Astraphobia: fear of storms
- Astraphobia: fear of needles
- Hemophobia: fear of blood

Other type

- Emetophobia: fear of vomiting
- Nosophobia: fear of getting an illness (different from someone with hypochondria who believes they currently have an illness)
- Agoraphobia: fear of having a panic attack in a space where leaving would be embarrassing or difficult (ex. public transport, busy store, crowds, highways)
- Claustrophobia: fear of enclosed spaces

How to act as an Educator?

Strategies to help manage the anxiety outside of therapy:

- Mindfulness and meditation exercises
- Relaxation techniques (deep breathing, yoga)
- Physical activity

“ I witnessed a panic attack in the lunchroom: suddenly, a young boy was terrified of not being able to leave, and lost control, having physical reactions such as sweating, shortness of breath and nausea. ”

Obsessive Compulsive Disorder

As a Student

- I have obsessions: intrusive, recurrent, and distressing thoughts, images, or urges
- I have compulsions: over-repetitive behaviors, or mental rituals such as counting
- Those are time-consuming: I can spend hours each day cleaning, repeating, hoarding, and checking, or having more aggressive obsessions

How to act as an Educator?

- Provide extra time and flexibility during transitions and for completing assignments
- Provide students with a quiet location with few distractions and extra time during tests
- Develop a class strategy to help classmates respond appropriately to unusual behaviors
- Being aware of triggering events
- Encourage and help students to develop their own strategies for managing OCD symptoms

Going Further

Obsessive Compulsive Disorder (OCD) affects approximately 1 to 3% of youth. It is more common in males than females. Compulsive behaviors are often a way to reduce mental distress or avoid an undesirable event or situation.

A person with OCD will recognize that their obsessions are their own and can give reasons for their compulsive behaviors. However, they may not realize that those are excessive or unreasonable.

OCD is different from superstitions or everyday life repetitive checking behaviors.OCD should not be confused with the typical phase of children's development with minorobsessions like avoiding cracks in the pavement

when walking.

Main Symptoms

Emotional

- Mental distress or anxiety, caused by impulses or mental images or compulsive behaviors
- Fear and avoidance of social situations
- Shame, fear of negative evaluation, and rejection

Cognitive

- Most common obsessions: somatic, contamination, aggressive, symmetry,
- Religious, and sexual obsessions
- Intrusive and inappropriate recurrent and persistent thoughts
- May use other thoughts to suppress or neutralize their obsessive thoughts

Behavioral

- Repetitive behaviors: checking, washing, ordering, etc.
- Repetitive mental acts: counting, praying, repeating words silently, etc.
- Behavior that follows rigid rules to reduce or prevent mental distress or a dreaded
- Situation that is unrelated to the repetitive behavior

“ One student in my class was asking me to go to the bathroom very frequently and was very distressed when I asked to wait. Talking to him, I discovered that he felt the need to continuously wash his hands and pencils. ”

Post-Traumatic Stress Disorder

As a Student

- I saw a volcanic eruption and had to evacuate my house. Since then, I have nightmares and can't concentrate in class. I overreact to loud sounds.
- It impairs my relationships because all my friends are telling me that I am afraid of everything

How to act as an Educator?

- Provide a predictable and supportive routine to establish a sense of familiarity and safety
- Introduce emotional regulation strategies for all students, sustainable friendships, and healthy behaviours
- Review school practices with educators and parents to create a calm and more supportive learning environment

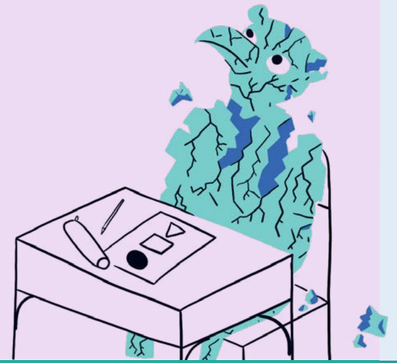
"I am careful to distinguish "traumatic experience", reserved for severe, substantial, and significant (often life-threatening) events from common stress-provoking challenges of life, like failing a test or addressing an argument between students."

Going Further

Post-traumatic stress disorder (PTSD) can develop after witnessing or experiencing a life-threatening event. Potentially traumatic events are characterized by intense fear, terror, and helplessness. Such events include a car accident, a sexual assault, witnessing a murder, exposure to domestic abuse, or surviving a natural disaster.

Repeated or extreme indirect exposure to such events may also become traumatic.

Depression and anxiety may be apparent in the first six months, whereas the symptoms of PTSD may occur within the first three months or may not be evident until years after the event. This delayed effect also contributes to a lack of identification.



Main Symptoms

- Recurrent, intrusive, distressing recollections or memories of the event
- May occur in the form of memories, dreams, or flashbacks in which the individual perceives themself to be re-living the event
- Avoidance of situations, people, thoughts, feelings, topics of conversation, weather conditions, and/or things that are associated with the traumatic event
- General sadness, numbing of emotions, having a limited range of emotions
- A loss of interest in previously enjoyed activities
- Feeling detached or estranged from family and friends
- Hopelessness about the future or a sense of foreshortened future
- Inability to recall aspect(s) of the traumatic event
- Hyperarousal
- Sleep problems
- Irritability, aggression, angry outbursts, and exaggerated startle response
- Hypervigilance, extreme fear, helplessness, or horror
- Difficulty concentrating

Mood disorders

Mood disorders describe a group of severe conditions characterized by an extreme or long-term alteration in mood, and significantly influence the person's daily functioning and well-being.

Mood disorders are **long-term and pervasive**, they are not restricted to a transient reaction in response to a stressful event.

The cause of mood disorders is not well understood. There is often a family history of mood disorder, alcohol-related problems, anxiety disorder, or bipolar disorder. Biological and psychosocial factors, along with interpersonal stressors or early adverse life events, can all contribute to the onset of mood disorders.

Children with depression disorders usually experience deep feelings of hopelessness and worthlessness, along with a lack of interest or motivation. Cognitively, children often have difficulty thinking logically, concentrating, remembering, and making decisions. They often believe that they are inadequate and worry excessively, which often prevents them from seeking help. Even small tasks may appear effortful and can negatively impact school attendance and performance.

Depression presents differently amongst children's age group and developmental stages:

- In infancy, depression tends to be associated with sleep disturbances, failure to gain weight, developmental delays, and clingy behaviours
- In school-age, children may present an argumentative and irritable mood
- Adolescents often experience mood changes, mainly centered around guilt and hopelessness

Suicidal thoughts and self-harm behaviors

As a Student

- I'm feeling like my life is not worth living
- I'm feeling trapped the problems that I cannot solve
- I don't have hope that my situation will change
- Sometimes my emotions are so intense that is difficult to retain a clear state of mind
- I sometimes think that if I disappeared, nobody would notice my absence
- I feel like a burden for other people
- I sometimes feel that family conflicts are my fault, and I deserve to be punished

From the age of 8 years on, most children understand that death is inevitable and irreversible, and represents the final stage of life. Children may begin to understand some of these aspects even earlier, around ages 4-6, especially those exposed to life events like the death of a grandparent or depressed children.

Most preadolescents understand the concept of 'killing oneself', despite suicide is uncommon before adolescence:

- 6-10% of children under age 12 reports some form of suicidal thoughts, although for only 2% these though have the form of clear suicidal plan.
- Suicidal behaviors are rarer, with 1.4% of children reporting self-harm behavior in the general population.
- Self-harm behaviors that have no suicidal intent (Non-Suicidal Self-Injuries) are more frequently reported (6 to 52%) and can take many forms such as hitting the head in the wall, stabbing the skin with a sharp object, burning the skin, severely scratch or pinch the skin with fingernails, or strongly biting oneself.

Most often children engage in Non-Suicidal Self-Injuries as a way to cope with intense emotions by using physical pain to reduce their intensity. These intense emotions can result from interpersonal conflicts, including bullying, or negative feeling towards themselves. However, **exactly determining whether children who self-harm have an intent to die is difficult and requires the evaluation of a mental health specialist.**

Although suicidal thoughts and self-harm behaviors are significantly more prevalent in teenager than young children, preadolescent children may think about suicide and even engage in suicidal behaviors. It is important to know that children might not disclose to their parents and/or caregivers about their suicidal thoughts and self-harm behavior and might therefore not receive adequate and appropriate professional support. Therefore, **it is important that professionals ask the children directly and not only rely on the family members' account.** Studies in teenagers and adults suggest that directly asking whether someone is thinking about suicide does not increase suicide risk or distress.

How to act as an Educator?

- Suicidal thoughts in young children signal serious and profound distress
- They need the attention of educators and family
- Educators should contact the family and encourage them to go to professionals to determine the best type of support needed

What can educators do?

Educators would develop an awareness and sensitivity to the nature of childhood depression, support their students through encouragement to re-engage with school activities and help develop depressed students' self-esteem and self-understanding.

It includes following strategies:

- Address the specific symptoms that can undermine school performance
- Teach the class about identifying emotions and emotional management (positive self-talk, mindfulness practices)
- Focus on student's strengths, interests, and areas of need
- Provide small, measurable, and attainable goals rather than large, vague ones
- Provide a safe, predictable classroom, with clear rules and routines
- Promote a learning environment that fosters proactivity and a sense of personal control
- Be aware that test scores of students with depression may not reflect the student's true ability
- Incorporate relaxation techniques into classroom routines to help reduce symptoms of depression
- Promote physical activity

2:1

gender gap between females and males - females showing a greater risk for depression beginning in their teens and persisting across the lifespan. Ratio of depression in males and females is similar in pre-pubertal children.

SOCIALLY WITHDRAWN

likely behavior of students with depressive disorders

AGGRESSIVE

commonly exhibited of students with depression disorders

Depressive Disorder

As a Student

I've lost interest in school or sports, I'm tired all the time, and I feel like my brain is slowing down. I no longer enjoyed playing my favourite games and spend more time by myself.

Going Further

Major Depressive Disorder is the most common form of depression, and one of the most under-diagnosed disorders in children and adolescents. Symptoms should not be only the result of an event such as a loss or bereavement. Dysthymia is a form of depression with often less severe symptoms but that is more persistent than major depression (symptoms are present for at least 1 year).

"Last year I had a student usually very quiet who started spending more time alone, being unable to concentrate, and being short-tempered with the other children. I though he was having problems with other school mates, but is only after talking with her parents that I understood that she was suffering from depression."

How to act as an Educator?

- Help students with depression feel welcome and included. Let them know you're available to help. Encourage their strengths and their interests.
- Look for opportunities for student succeed in the classroom and acknowledge their efforts
- Make physical activities a part of your daily classroom routine. This can help ease mild depression symptoms and enhance energy
- Make brief mindfulness practices a part of everyday instruction. At random or scheduled times, invite your class, "Let's all pause and take a few slow, calm breaths."

Main Symptoms

They are wide-ranging and may present cultural differences, particularly in the physical problems identified.

Emotional
- Poor self-esteem, rejection sensitivity, and feelings of worthlessness
- Loss of pleasure or interest in most or all activities
- Hopelessness, excessive and inappropriate guilt
- Feeling sad or more irritable

Physiological responses
- Excessive fatigue, loss of energy, and physical slowness
- Difficulties falling asleep or sleeping excessively
- Observable agitation, restlessness, and feeling on edge
- Significant change in appetite or weight
- Unexplained physical symptoms such as headaches and stomach-aches

Cognitive
- Reduced concentration and diminished ability to think rationally
- Displaying substantial indecisiveness
- Heightened risk for suicidal thoughts/plans or preoccupation with thoughts of death

Disruptive Mood Dysregulation Disorder

As a Student

- It is very difficult to regulate my emotions, and I feel like I'm constantly on the edge
- I often feel intense anger outburst and I loose control very easily
- It is not easy to make friends

How to act as an Educator?

- Teach children how to recognize moods and how to monitor the changes in their moods
- Grant permission to leave the classroom: The student needs to go to a "safe place" to go to calm down or stay with a "safe person" previously identified by the student. A discreet signal should be also planned
- Minimize stress in the classroom environment, as stress triggers outbursts
- Use positive reinforcement to tell children how proud they are when they control their anger
- Act empathetically and do not contribute to the escalation of temper tantrum episodes

Going Further

Disruptive mood dysregulation disorder (DMDD) is a type of childhood mood disorder that describes non-episodic emotional and behavioral problems. Children and adolescents with DMDD exhibit persistent, severe, and chronic irritability that are developmentally inappropriate.

It is important to distinguish DMDD form pediatric bipolar disorder (a disorder characterized by periods of elevated mood) as irritability is a key symptoms in both disorders.

Main Symptoms

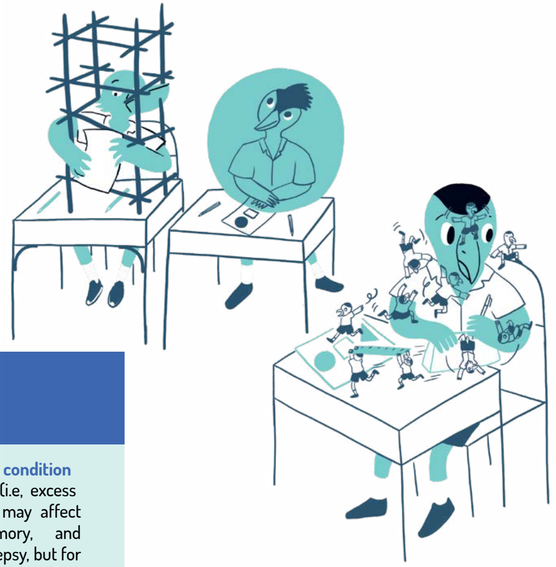
The main symptoms are:
- Chronic, severe, and persistent irritability
- Hyperarousal
- Frequent temper tantrums and outbursts
- Present for most of the day, nearly every day

These characteristics must:
- Appear before the child is ten years old
- Continue for at least one year
- Cannot be diagnosed before six years of age

"Sam is a very difficult student. He reacts strongly when contradicted, is constantly on edge and has temper tantrums. We agreed that when he feels that the situation is getting out of control, he can have some alone time out of the classroom to calm down"

Neurodevelopmental disorders

Neurodevelopmental disorders result **when complex genetic and environmental factors come together to change brain development**. In some cases, we know what those genetic and environmental factors are. In many cases, we do not. Neurodevelopmental disorders tend to run in families.



The specific case of epilepsy

Epilepsy is a **common neurological condition that causes a child to have seizures** (i.e, excess of electrical activity in the brain that may affect consciousness, responsiveness, memory, and movement). Some children outgrow epilepsy, but for others it is a lifelong condition.

Epilepsy can affect a child's quality of life and functioning, and lead to isolation and loss of self esteem. **Epilepsy will not be extensively described in this book**.

3/1000

proportion of school age children having Tourette's disorder

4x

Males have consistently outnumbered females in the diagnosis of autism

1/54

recent numbers of autism rate for children

4-8%

estimated % of children affected by ADHD. Most diagnosed behavioural disorder.

Attention-Deficit/Hyperactivity Disorder (ADHD)

As a Student

- I'm always active, have trouble sitting stil
- I often interrupt others and fail to listen to instructions
- I rush into novel situations without thinking about the consequences
- I am slow to learn from negative experiences, which make me accident-prone
- But those difficulties are less pronounced in physical or enjoyed activities

Going Further

There are three types of ADHD: predominantly hyperactive-impulsive, predominantly inattentive, and a combination of both. ADHD is often diagnosed in later elementary or early high school when the demands for independence and organized tasks increase, and quiet attention is needed.

"I had a child with ADHD. He could sometimes disturb the class. To avoid stigma, I took the time to remind classmates that some children may have a hard time controlling their impulses and focus on a task, and that his behaviors were not representative of laziness or character flaws."

How to act as an Educator?

- Give clear, brief directions and reduce environmental distractions (e.g., seat students away from windows or doors)
- Give visual, written, as well as oral directions
- through checklists, graphic organizers, visual referents and examples
- Break tasks and assignments into short, easy-to-manage steps.
- Provide each step separately and give feedback along the way.
- Encourage students to delay their responses to provide time for processing and reflection ("stop, think and listen") before responding, acting or making a choice
- Provide opportunities for movement such as working while standing, fidget toys, or short breaks

Main Symptoms

Inattention

- Easily distracted. Failure to sustain attention for long periods
- Difficulty listening when spoken to directly
- Difficulty following instructions; organizing tasks; does not take time to learn the rule of a game or activity
- Difficulty with short-term memory and recall; forgetful in daily activities

Hyperactivity / Impulsivity

- Acting without planning or thinking first; blurts out comments or answers
- Has difficulty waiting their turn; often interrupts or intrudes on others
- Excessive talking, restlessness, squirming
- Leaves their seat in the classroom when they are supposed to be seated
- Takes undue risks; runs about or climbs excessively when not appropriate
- Has difficulty in solitary play or quiet activities
- Difficulty managing frustrations, emotions, and transitions
- Social and relationship problems
- Average or high intelligence but underperforming at school

Autism Spectrum Disorder

As a Student

- I cannot respond easily to social interactions, and I have limited reciprocity with language
- have an hard time understanding understand social cues and how I am supposed to act within a group

> ***"Parents know their children well and can offer insights on how to maintain the social and emotional well-being of ASD children. Thus, communication with the student's parents is a necessary first step to supporting ASD children in education."***

Going Further

Autism Spectrum Disorder is a developmental disorder associated with impairments or delays related to central nervous system. It impacts how a person perceives and socializes with others.

Its onset is usually before the age of two.

The symptoms can be categorized into two types: difficulties in social emotional reciprocity, and restricted or repetitive patterns of behaviour.

ASD may have several different manifestations, and be associate with different level of impairment, and social functionning.

How to act as an Educator?

- Provide information in visual ways
- Give clear instructions and ample time for school tasks
- Break large tasks into smaller and reinforce each step
- Whenever possible, provide hands-on activities
- Provide clear expectations, consistency, structure, and routine for the entire class
- Use a consistent, agreed-upon response to manage disruptive behaviours
- Teach and practice social skills, such as how to read body language and facial expressions

Main Symptoms

Social-Communication deficits

- Few or no attempts to socialize with others, which are often poorly coordinated
- Few or no attempts to imitate others
- Little to no understanding of social cues, especially in conversations
- Little to no attempt to seek comfort or support from others
- Little to no interest in sharing with others – whether hobbies, ideas, or items
- If at all, attempts to socialize and engage with others are often awkward and unconventional
- If at all, interactions with others are often one-sided and lack back-and-forth conversation

Restricted or repetitive patterns of behaviour

- Facial expressions are often independent of social context
- Abnormal or lack of eye contact when spoken to directly
- Minimal, uncoordinated, or absent body language and gesturing
- Little to no integration of verbal and nonverbal communication methods
- Difficulty with joint attention, where attention and focus are shared with another person
- Little to no speed intonation

Intellectual Disability

As a Student

- I have limited cognitive ability and intellectual functioning
- I can present some deficits in self-care, home living, social and interpersonal skills, self-direction, academic skills, work, leisure, and safety.

Going Further

Intellectual disability, formally known as mental retardation, is a life-long condition of arrested or incomplete development of the mind that significantly limits the overall level of intelligence and impairs adaptive behavioral and practical skills.

Nearly 40% of cases have no specific cause. Genetic vulnerability and environmental factors play a significant role.

> ***"Academic underachievement in students can reflect intellectual disability but also learning disorders (difficulties in acquiring academic skills such as reading, writing, and arithmetic), or only reflects barriers to learning within the school. It is important to be helped to make a diagnosis."***

Main Symptoms

Limitations in cognitive functioning resulting in an Intelligence Quotient of (IQ) of 70 or below with different degrees of severity (from mild to profound disability). Main symptoms include:

- Delayed language development and difficulties speaking and expressing
- Slow reaction and perception of environmental stimuli, visual or audio
- Problems distinguishing slight differences in shape, size, and color
- Impaired capacity for reasoning, calculating, and abstract thinking
- Low and narrow ability to concentrate
- Difficulties recalling, often with inaccurate memories
- Naive and immature emotions that may improve with age
- Lack of coordination
- Behavior problems, including self-injury

How to act as an Educator?

With the support of specialized professionals, the educator can advise students on skills training, addressing challenging behaviors, psychoeducation, and education planning.

Behavioral disorders

Behavioral disorders involve a pattern of disruptive behaviors that cause problems in school, at home, with peers, and in social situations.

While all children sometimes are aggressive, act defiant around adult, and have temper tantrums, behavioral disorders last for at least 6 months and are more serious.

age before which the disruptive behavior usually materializes

2-11 %

estimated school age children diagnosed with disruptive behavior

3.3 %

average prevalence of conduct disorder

What can educators do?

Tips for managing students with behavioral disorders in the classroom include:

- Praising positive behaviours in detail and sometimes offering a reward, so the student knows exactly what they have done right and has an incentive to repeat it
- Supporting the student if they decide they need a break to calm down
- Actively ignoring bad behaviour unless it poses a safety hazard
- Discussing bad behaviour privately once the student has calmed down by acknowledging their emotions but reaffirming expectations and boundaries
- Keeping clear, consistent and fair in rules and discipline
- Giving the student choices, when possible, to help them maintain a feeling of control
- Connecting with the student one on one to set goals and maintain a positive bond

Oppositional Defiant Disorder

As a Student

- I have a hard time complying with authority of adults
- I don't follow rules, I'm disobedient
- I'm very argumentative and refuse to do as I am asked in the classroom

How to act as an Educator?

Establish a positive environment by praising students often for positive behaviours, provide a warm and nurturing environment with role models to learn how to have good interpersonal relationships, use a reward system as positive reinforcement instead of punishment

Set clear classroom rules and explain children why rule are important and what are the consequences of breaking them

Talk with students about feelings and help them manage their emotions (e.g., relaxation)

Going Further

It is common for children's emotions to get the best of them, but for children with Oppositional Defiant Disorder (ODD), there is a pattern of excessive anger, irritability, vindictiveness, and argumentative or defiant behaviour. For a child to be diagnosed, this behaviour must last at least six months and cause significant impairments with family, social life, or school.

Currently, a clear cause of ODD is unknown, but both biological factors and social factors can play a role. Symptoms of ODD can be significantly improved with therapy, and behaviour usually improves with age. Persons with a history of ODD have a 90% chance of being diagnosed with another mental illness. Therefore, early detection is crucial in preventing poor school performance, antisocial behaviour, impulse control problems, substance abuse, and suicide.

Main Symptoms

The disorder can range from mild to severe depending on how many settings the symptoms occur in. Symptoms include:

- Often losing temper
- Being physical with others
- Easily annoyed
- Often angry and resentful
- Arguing with authority figures
- Defying or refusing to comply with requests or rules
- Deliberately annoying others
- Blaming others for their own mistakes or bad behaviour
- Being spiteful or vindictive

ODD materializes differently in boys and girls:

- boys are more likely to be diagnosed with the disorder before adolescence begins
- boys display more aggressive tendencies and suffer from ADHD; they have a more challenging time in school
- girls are more likely to internalize their symptoms and are at a greater risk for anxiety and depression ; any efforts to build self-esteem are beneficial

> ***"While interacting with a child with ODD, I remember that their bad behavior is not an active choice, but a symptom of a mental disorder"***

Conduct Disorder

As a Student

- I have deviant behaviors including aggression, destruction of property, theft, deceitfulness, or other serious violations of rules
- I am irritable and reckless and lack empathy, guilt and emotional depth
- I struggle with forming relationships and often have poor self-esteem

How to act as an Educator?

- Seating them somewhere that will maximize focus but not isolate them
- Maximize their interaction with other children with good prosocial skills
- Using 'start' and 'do' requests rather than 'stop' or 'don't' requests
- Giving the child choices, when possible, to help them maintain a feeling of control
- Describing desired behaviours in detail and avoid an argument about them
- Teaching classmates to walk away from confrontations and get help when necessary
- Building on life skills, especially anger management

> ***"I realized that this student with conduct disorder had a very difficult family history and had violenced himself. That would not excuse all behaviors but it would help me having empathy and trying to give him warmth."***

Going Further

Early onset of conduct disorder occurs before the age of 10, and onset after age 16 is rare. Males are more likely to suffer from conduct disorders than females.

Common coexisting disorders are ADHD, ODD, depression, and anxiety. It is important to identify and treat any coexisting conditions as they can increase the likelihood of worse behaviours.

In early childhood, the symptoms of conduct disorder may look a lot like oppositional defiant disorder, but as older ages, behaviors typically become more severe. For this reason, early detection and treatment using psychosocial interventions are crucial.

Main Symptoms

Aggression to people and animals

- Bullies, threatens or intimidates others
- Initiates physical fights
- Used a weapon
- Been physically cruel to other people and/or animals
- Stolen while confronting a victim (e.g., mugging, extortion)
- Forced someone into sexual activity
- Serious violations of rules
- Stays out after curfew beginning before age 13
- Has run away from home overnight at least twice, or once without returning for a lengthy period
- Often truant from school beginning before age 13
- Deceitfulness or theft
- Broken into others' car, building or house
- Lies to obtain goods or favours or to avoid obligations
- Stolen without confronting a victim (e.g., shoplifting, forgery)
- Destruction of property
- Set a fire with the intention to cause damage
- Deliberately destroyed others' property

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