

Staff Guide for Working With Problem Behaviors

25 Problem Behaviors & their Related Mental Health Issues:

***Choosing Solutions to Match
the Needs and Abilities of
Each Individual Youth***



**A Project of the
Juvenile Justice Advisory Council
Mental Health Issues Committee**

Produced by

JJMMI
JUVENILE JUSTICE MEDIATING MENTAL ILLNESS

**University of Iowa Hospital and Clinics
Department of Child & Adolescent Psychiatry**

Funded by

**Juvenile Justice and Delinquency Prevention Act – Title II
Office of Juvenile Justice and Delinquency Prevention**



<http://www.state.ia.us/government/dhr/cjip/index.html>

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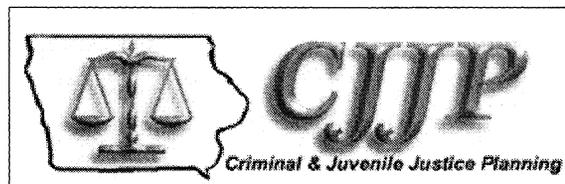
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Des Moines & Iowa City

2006

About this Publication

Recent years have seen the judicial placement of many young people with mental health disorders in Detention and Shelter facilities. These are staffed by youth workers whose requirements for the job have not included training about mental disorders or how to respond helpfully to youths who suffer from them. In 2001, the Juvenile Justice Advisory Committee of the Iowa Division of Criminal & Juvenile Justice Planning (CJJP), recognizing the need for sharper focus on the problem, formed the Mental Health Issue Committee. Members representing Youth Shelters and Detention Centers throughout Iowa as well as resource people from CJJP and elsewhere met regularly. Among their activities were collecting data on diagnoses and psychoactive medications used in facilities statewide; disseminating books and videotapes; and disseminating information about screening tools.

A major goal of this project was to create materials that could be used to train youth workers to appreciate the severity and complexity of the mental health problems of youths they were likely to encounter on the job. Staff members from Shelter and Detention facilities submitted lists of the behaviors they found most difficult to deal with in their settings. Educators from the Child & Adolescent Psychiatry Service prepared the *Staff Guide* itself. This required visits to youth facilities to learn about these problems in their everyday context. Content was reviewed with psychiatrists, nurses, and social workers at the University of Iowa's Department of Child & Adolescent Psychiatry to be certain that suggestions made were suitable. Finally, topics were distributed to Mental Health Issue Committee members to try out with their staffs for feedback. This collaboration was essential to the development of the Guide.

Members of the Mental Health Issue Committee

Eric Sage, *chairman*, Louie Cox, Richard Davenport, Robert Eppler, Mike Fritz, Cathrine Gerdes, Deb Hanus, Doug Harrold, Scott Hobart, Glen Holt, Cindy Laughead, Alan Michael, Scott Musel, Polly Nichols, Tony Reed, Carl Smith, & Scott Thomas

Members of the University of Iowa Child & Adolescent Psychiatry Service

JJMMI

Juvenile Justice Mediating Mental Illness Project

Polly Nichols, PhD, *author* • Gretchen Holt, LLD, *project director* • Sharon Roknich, BA & Cathy Willoughby, MSN • *primary assistants*; Mary Eileen Hogan, MA • Al Marshall, PhD • Nancy Millice, MA • Deb Rudish, MA • & Myra Wagehoft, MA • *contributors*.

Laura Macrowski, *illustrator*

Staff Guide for Working with Problem Behaviors

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NOTE: The suggestions related to psychiatric/psychological symptoms, diagnoses, and treatments are not professional recommendations for specific persons and are not to be acted on as such. They are intended only to build awareness in staff members charged with the care of youths in residential and corrective facilities of the implications of problem behaviors from the psychiatric perspective; to provide ideas for surface management; and to alert them to the possible need for consultation with the mental health professionals available to their facilities.

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How and why to use this Staff Guide

The first step in solving all 25 of these problems is to say, "*It all depends.*"

There is no single solution for any problem.

The right solution all depends upon the personal thoughts, needs, & feelings of the people who are struggling with or creating the problem:

- who they are, genetically & by their history,
- what environment they've grown in,
- their strengths & abilities, their weaknesses & disabilities,
- how they perceive the problem situation,
- their beliefs, long-held & at that moment,
- the health of their brains, bodies, & their communities,
- & what they wanted this particular action to achieve, the function it served in their lives.

Every problem described in this Guide is followed by *several* reasons why it might occur. **Each solution suggested depends on different thoughts, feelings, & experiences of youths, on their purposes for acting the way they did.**

Shelter and Detention Centers are *not* mental health institutions although overall, 60 to 70 percent of incarcerated boys & girls have a diagnosable mental disorder. **And the juvenile justice system is not under obligation to treat them all—it is just to “treat cases in which symptoms of disorder seriously impair functioning in a way that matters for overall rehabilitative objectives,”** according to Thomas Grisso.*

In what way would symptoms of disorder *not* matter?

We judge the seriousness of anyone's mental illness by how well or poorly that person functions in the real world.

Our young clients have *flunked* real world, maybe for the long term! **Their prospects for a good life are dim enough without leaving them also to struggle with untreated mental illnesses.**

We know what the costs of that to society will be—

more crime, more job- & homelessness, more violence & sorrow.

A year ago, a nationwide survey of over 9,000 adults with mental illness** showed that **nearly half of all adults' chronic mental illnesses had their onset by age 14. Most went untreated for a up to a decade. The result? More serious illness & bad life experiences, & a much greater chance of adding on more "co-morbid" disorders, the sure signs of failed treatment.**

Grisso calls for the integration of the mental health & juvenile justice systems to serve seriously disturbed youth.

That is the best idea — but what can do we do until then?

Learn, Listen, Advocate, Act.

There will *never be* enough money or mental health professionals to give our young people as much help as they need to recover from their disorders & their lives. Resources will go first to the “more deserving.”

Make this a human rights issue in your community.

Speak up and speak knowledgeably.

Enlist the help of service groups, family advocates, mental health and juvenile justice professionals.

Call on parents to help—they have long been blamed silent, but they need to speak. No families are immune from mental illness and trouble in our troubled world. Their stories can make wet eyes out of dry topics & turn “those damned kids” into *our* children.

#1—INDIVIDUAL PROBLEM SOLVING

Finding the best solution for a problem requires analytical thought. **Think about it. Read about it. Talk about it** with someone who knows more about kids' brains, behaviors, and emotions than you do. Someone who has paid close attention to the youth whose problem is a big concern needs to share in planning solutions. **Be that person.** The more practice you have in figuring out the **functions of the youth's misdeeds (the purposes they serve in his or her life instead of just the grief they cause in ours)**, the more effective your solutions will be. *Staff Guide* materials are all available on the Internet without copyright restrictions. Single pages or the entire *Guide* can be a keystroke away or downloaded and copied. That way *everyone* who will help solve the problem can be literally on the same page with the same core information.

#2—TEAM PROBLEM SOLVING

Staff Guide pages are useful in staffings or with problem-solving teams. At the Northeast Iowa Detention Center, Director Lou Cox copies and distributes *Staff Guide* pages about the disorders and problems that pertain to youths who are newly admitted to their facility. **By staffing time, everyone is familiar with the mental health issues . And Guide pages make good parent handouts.**

#3—STAFF DEVELOPMENT

Use the Staff Guide as a springboard for learning rather than as a cookbook for following. In the Reference Section, at least one good website that goes into each topic in detail is linked to the pdf copy of the *Staff Guide* on the CJJP web page. (The web address is on the title page.) A good way to familiarize an entire staff with the contents of the *Staff Guide* is to use pages from it regularly in staff meetings. **A discussion of a problem or a disorder that fits a real-life problem can be scheduled; staff persons could use one as a basis for a short talk about a topic of interest; or differing viewpoints about the purposes for a behavior could be argued, always a lively way to learn.**

**Double Jeopardy: Adolescent Offenders with Mental Disorders*, U. of Chicago Press, 2004, p.147.

***Mental illness exacts heavy toll, beginning in youth*, NIMH Press Release, 6/6/2005.
<http://www.nimh.nih.gov/press/mentalhealthstats.cfm>

Part One:
25 Problem Behaviors

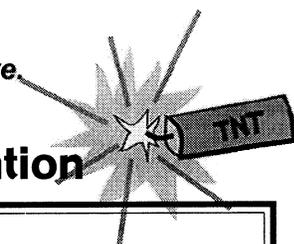
Anger outbursts— Emotional loss of control in which behavior is agitated, loud, and at times aggressive.

Anger is contagious—*inoculate yourself.* As staff members, we are almost sure to feel anger toward youths at times, especially when they are threatening, foul-mouthed, or defiant. Even when we feel scared, disgusted, disempowered, or furious, we still have to respond for the youth's best interest. We need to use and model stress management techniques. (See the *Resources Section*.) We need to take a deep, calming breath and say to ourselves: "That young person has a bad emotional habit of letting his uncontrolled anger burst out. That's the youth's problem, and he'd handle it better if he could. Now I have to handle my problems—dealing with this angry youth and with my own anger."

Skills for de-fusing anger outbursts

- **Move close to the youth. Speak as privately as you can.** When we bark out public commands, we raise the ante. Don't glare—that may send a message that breeds more defiance. Use just short moments of eye contact.
- **Acknowledge the youth's feelings.** "JD, you look really angry." "Juan, you seem very frustrated." "Jess, I can tell you think this rule is unfair." "Ty, are you getting angry, or are you just really disappointed."
- **Acknowledge what is true. Agree that the youth has personal power.** "You do have a point." "Yes, you are much bigger than I am." "I know I can't change your mind. Only you can do that."
- **Use respectful words.** "Please, Jackie, take a Cool-Down." "I'd like for you to go over there, please." "Stop and think—Thank you!" "May I say something?" "Thanks for letting me speak."
- **Refuse to argue.** Instead of trying to refute the argument points, just say the same thing over and over again, quietly and calmly, like a broken record, (We never win on the basis on logic, even though we're right!) "I hear you, JD. Nevertheless, the rule is... Yes, nevertheless, now the rule is... Yes, I hear you — nevertheless, the rule is..."
- **Make a plan to solve the problem later.** "We can talk about it when we have both calmed down." "I will talk about it with you after school. **There is no rule that says we have to solve everything NOW!** We need time and the help of colleagues. Our anger arousal systems may also have been set off by the outburst—we also need time to settle down, consider the other person's perspective, and start doing our best alternative thinking. Neither young people nor adults do first-rate jobs of problem solving when they are still pumped up full of stress chemicals.

Cool-Down plans to avoid physical intervention



The Cool-Down

- A *Cool-Down* is a period of time in a removed place—the hall, the youth's own room, a special Cool-Down room, a corner or staircase, depending on supervision requirements.
- A *Cool-Down* is **not** punishment for an anger outburst, and a punitive space should not be used.
- The purpose of a *Cool-Down* is for the youth to settle down physically from the effects of anger arousal and to get ready to re-enter the regular routine without continuing problems.
- When the youth feels ready to leave the *Cool-Down* area, a plan to avoid the trouble that caused the problem for the rest of the day should be stated verbally, in writing, or on a simple form for that purpose.
- The *Cool-Down* is only a short-term coping mechanism — it signals the need for long-term training in anger control and problem solving.
- A *Cool-Down* is an option we teach young people as a better choice than losing control. If they choose it, they avoid the consequences of serious misbehaviors that would follow verbal or physical assault, fighting, etc.
- A *Cool-Down* instead of a blow-up is a choice to teach youths to make to lead their lives successfully

Seven Steps for using a Cool-Down

Step 1. Be prepared. Plan ahead. The best predictor of behavior is past behavior. Be ready with a plan your facility has worked out to manage anger problems with violent youths. Write *Cool-Down* plans* down so you can explain them as part of your self-management or levels plans. During admissions orientation, walk youths through a typical plan and *teach* stress-reduction* techniques regularly. More focused work on these techniques will be required for some, but an environment in which stress management is taught to *all* clients and modeled by *all* staff is the best possible one. It reduces the number of total outbursts and strengthens *everyone's* self-control.

Step 2. Be alert for agitation. Once a youth who is known to have a hot temper starts to show agitation, do not "wait to see what will happen." That just gives a spark of anger time to smolder, ignite, and explode. Move in close. Try to change the environment—who is sitting where, the activity, the location. Try to distract the people involved with positive attention, humor, or getting them started on a task that needs to be done.

*(See *Cool-Down Plans* and *Stress Management* in the *Resource Section*.)

Step 3. Offer a Cool-Down. If the behavior is heating up to the point of threatening words, posturing, glares or gestures, offer the angry youth/s the option of a *Cool-Down*. "*Pat, you seem angry. Please take a Cool-Down and avoid trouble. We can talk about the problem later.*"

Step 4. Decide what will happen during the Cool-Down. Is the youth to practice taking calming breaths or relaxing? Is s/he to discuss the problem with someone and figure out how to become calm enough to re-enter the regular activity? Is there school work to be completed? **What you do not want is for the youth to storm around becoming angrier and angrier.** Your choice of activity will depend on the youth, your setting, and the supervision available. Your goal is to have the youth calm down as soon as possible with whatever help is needed. Then s/he should be able to **explain a simple plan to avoid trouble for the rest of the day** with the same person or situation that was part of the outburst. You can take dictation, or it can be written on out by the youth later—the point is that s/he *explain a simple re-entry plan for now.*

Step 5. Re-engage the youth in regular activity. The effects of anger arousal may not completely leave the body for from *two to 48 hours!*

Don't demand apologies right after a Cool-Down or outburst. Apologies and problem solving *demanded* at that time are likely to be done resentfully and to cause more anger than true remorse. It can wait until you have met later and worked it out.

Step 6. Process the incident with the youth later. At the end of the *Cool-Down*, be sure to set a time to meet and talk about the problem later. This delay provides time for you to plan the best approach with other staff, if you need to. It also works as an "anticipatory consequence," giving the youth time to think about what she or he did wrong and to wonder what the result might be. This will be a good time for more formal problem-solving about the core problem and alternative solutions. Then you can work on anger-control strategies and encourage the youth to continue efforts at self-control..

Step 7. Make sure that youths who choose the Cool-Down (or who successfully calm themselves before full-blown outbursts in other ways) receive positive recognition. It is easy for staff to overlook the value of the *absence* of a negative behavior. Adding *Used a Cool-Down* or *Avoided Anger Outburst* to a levels plan is a good formal reward. Staffs' immediate congratulations in private and in front of a group are often even more powerful encouragers. Have successful anger-managers teach and model the way they do it to other temper-prone youths. They are the most believable experts for other young people. When they teach what they think and do, they also strengthen their own self-control skills.

Anger Outbursts That May Be Associated with Mental Health Disorders

 **Antisocial disorders.** Youths diagnosed with Conduct Disorder or young adults over 18 with Antisocial Personality Disorder feel justified in attacking anyone they feel "has it coming" or is disrespectful of them or their rights as they see them. They show little care about the feelings and sufferings of others. They have almost surely been traumatized by physical and/or emotional abuse themselves and to have seen others close to them suffer it. In the process, violent family members or peers may have taught them that violence is their right and gives them power. **They live dangerously and are constantly on guard against other people's giving offense.** They are at high risk for suicide, accidents, or homicide.

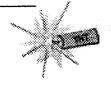
(See *Conduct Disorder*)

 **Occasional explosive outbursts.** Certain mental or neurological disorders can cause violent outbursts on occasion. Some are: the manic phase of Bipolar Disorder; rare episodes of Schizophrenia or other psychotic disorders; substance use disorders; Posttraumatic Stress Disorder; some impulse control disorders, or traumatic brain injuries. **These outbursts occur mostly at times of high stress or are driven by irrational beliefs.** People with these problems typically feel remorseful later.

(See *Bipolar Disorder, PTST, and Psychotic Disorders*.)

 **Rigid or limited thinking patterns.** Youths who cannot make sense of what is expected of them and are pressured to perform beyond their capabilities may respond with anger outbursts. People with Obsessive Compulsive Disorder may have anger problems if forced to stop their compulsive behaviors. Youths with neurological disorders such as Asperger's Disorder or high-functioning Autism are very rigid thinkers who cannot readily adjust to other's rules. **These youths may become hard to manage if forced to do things that their thinking cannot accept as right.**

(See *Autism/Asperger's Disorder* and *Anxiety Disorders*.)

 **Emotional self-control problems.** Some mental health problems are known for the trouble they cause regulating emotional intensity. Young people with ADHD frequently have this problem. **If something triggers their anger, they have a hard time controlling their feelings and the actions they spark.** Another mental health problem that is known for the trouble it causes handling powerful emotions is called Borderline Personality or Emotional Regulation Disorder. Young people with this problem frequently have intense anger upsets in their relationships.

(See *ADHD and Borderline Personality Disorder*.)

Attention-seeking behaviors— from tantrums, to endless questions, to suicidal

Calling a youth's behavior *attention-seeking* is like calling it *manipulative*. Those are both negative labels for what we guess to be the *motivations* for behaviors, not labels for distinct actions. When a youth behaves in a way that we think is motivated by a desire for attention, we must first figure out if that is true. If so, we need to find out whose attention the youth seeks and how s/he can gain it and keep it in a more reasonable way. That done, we try to help the young person replace out-of-bounds behaviors with more acceptable, less annoying ways to meet his or her needs.

Step 1: Think, "Whose attention is the youth seeking?"

If it is yours, as soon as you pay attention, the attention-seeking behavior will stop for as long as the youth keeps your full attention. It may start up again when you turn your attention elsewhere. If it is peers' attention that the youth really wants, the behavior will continue, perhaps more subtly, until a peer or group of peers pays attention. **Once attention-seekers have the attention of those they desire, their behavior usually changes to take advantage of it.**

Step 2: Think: attention-*needing* instead of attention-seeking.

Human beings are social creatures—we need to belong, to know that we have influence with people we hold in esteem. **Think of each person as having an attention tank that must be kept full.¹ Different people have different-sized attention tanks for reasons that go back to their temperaments, how they were cared for as babies and toddlers, and to all their social experiences ever since. To be comfortable, people do what they can to keep their tanks filled.** Loners with truly small attention tanks isolate themselves, and we may see that as a problem. Socially inept youths with large attention tanks may seek attention from people in ways that cause them harm or rejection. Bold or impulsive ones may do it in dangerous ways, or they may seek their attention from gangs where they feel accepted.

Step 3: Think, "Can this young person's need for attention be filled in a more acceptable way?"

Does she have low self-esteem and **need huge amounts of attention from the group to feel accepted?** Does he seem to **need to show power over the group** by controlling their attention? Does she ask a thousand questions because she **needs staff reassurance about a confusing environment?** Is he an easily bored person who **needs excitement and change, for better or for worse?** Is she a person who **needs to feel superior to peers or to retaliate against them** by acting like junior staff and reporting their every misdeed? Has he been from moved one foster home to another so often that he seeks **closer, more frequent attention from adult women than is society's norm?**

gestures, to just clowning around . . .

Attention-seeking behaviors that infringe on the rights of others to personal boundaries, safety, and an orderly environment need to be covered by clear rules. **Spell out the basic rules of civil behavior that must be followed wherever one is—at home, school, on the job, in the community.**

Just because we set rules, however, we cannot assume that everyone will know how to follow them. What we call "attention seeking behaviors" are often the immature and unskilled behaviors of youths who are too mentally delayed and/or who have grown up too distanced from the rules of civil behavior to know, appreciate, and follow them.



for instance . . .

What we call attention-seeking behavior may be unskilled attempts at making friends. **Some youths are socially awkward and frequently rejected. Coaching them in friendship skills that are appropriate for their age can help.**

Youths who talk to staff too often or for too long need **direct feedback coupled with non-contingent attention.** That is, they need to receive feedback about unwanted attention and also to receive attention when they did *not* earn, ask for, or demand it. "*Sol, when you stop me to ask so many questions, it wears me down. I need quiet time now. I'll check in with you later. Okay?*" Be sure to do it! If the youth interrupts you for an ill-timed conversation, just **hold up your hand, avoid eye-contact, and be busy. Then, as soon as you conveniently can, approach the youth and start a conversation.** Do this often at first and fade to less often.

The girl who has to check out every detail of the day's routine may **reduce her need for constant reassurance by having a written or picture schedule to check off. Disabled youths need closer attention to fit into a strange environment, and they may not know how to seek it properly.**

Youths who dominate the group and control its attention may have leadership abilities as well as needs to show their power. Try giving them **opportunities to be in charge of groups or activities in a positive way.** Discuss their leadership skills and successes with them.

Giving attention-seeking youths **jobs as helpers** in some capacity can turn their need to feel influential into something helpful.

Recognize that some conspicuous behaviors can be **signs of long-lasting patterns of behavior or of mental disorders** that will require intensive treatment. Consult with mental health professionals if they seem truly excessive.

Also recognize that attention-needing behaviors may simply be just that, nothing more or less. Then what we need to do is to listen and pay close attention to young people who are in a rough spot in their lives and crave our focus and care.

The Mediation Essay²

This negative consequence for seeking attention by crossing other people's boundaries has the advantage of *teaching* rather than simply *punishing*.

With the guidance of an adult, the youth thinks through the answers to the questions that follow. The adult writes down the answers and creates from them a very short essay. The essay contains the thoughts that the young person needs to say to him- or herself *before* doing things that interfere with the rights of others for personal space, safety, and order.

What did I do wrong?

What happened because of what I did?

What were the payoffs?

What were the costs?

Why wasn't that civil? Why was it wrong?

What should I do next time?

How will that make things better?

A form to guide the discussion of the questions

When: Mr. E was making announcements.

What I did that got me in trouble: I burped real loud right in Fred's face.

The payoffs (the good things I expected) were: The look on Fred's face. People around us laughed.

The costs (the bad things that happened) were: Fred hit me and lost points. He's mad at me. I had to miss free time to do this. Kids say I act like a gross little kid.

This was not civil behavior because: I was in Fred's personal space. It was insulting to Fred and Mr. E. Cool people don't burp or fart so loud in public places that people can tell. *

What should I do next time? Think about it, but DON'T DO IT. Wait and hold it in or hide it the best I can like cool people do.

How will that make things better? I won't get in trouble. People won't think I'm disgusting. I'll get more respect.

* Elicit this answer by asking the youth to imagine peers or famous people he or she is likely to admire and asking if they would be likely to do such a thing..

This discussion is essential. It gives us the words for the thoughts that we want the youth to use to *mediate* (modify, or change) his or her immediate response to an impulse. **As far as possible, the essay must be in the youth's own words to be effective. But we want to be the ones to put those words into an essay—the youth does not yet know how to use those thoughts to mediate his actions.**

The adult writes a short "essay" based on these answers.

ACTING GROSS TO MAKE PEOPLE LAUGH

What did I do wrong? I do things like burp in someone's face or cut a loud fart in public. Payoff for me? It feels good. It always makes people look around and somebody laugh. I like the attention.

Costs for me? The bad things that happen are that some kids get mad. They say I'm a gross hog. If they dis me and I hit back, we both get in trouble. Even if I don't hit, I have to copy this essay.

Why was it wrong to do? Acting gross is NOT OK in public because it disgusts too many people. I get into people's space with the noise and bad air. Kids say I stink and make them puke. They don't want me to sit or be near them.

What should I do? Next time I feel like burping or farting out loud in public, I will think about it, but I WILL NOT DO IT. I will hold it in or hide it. What will happen then? I won't get in fights. People won't think I'm a hog and grunt at me and laugh. I'll act cool and get more respect.

Signed _____ date _____

The next time the youth shows the same kind of attention-seeking behavior, s/he copies this out neatly, both questions and answers,

If that is too hard because of learning problems, the essay can be done in a fill-in-the-blanks format or read into a tape recorder. **The point is to have the youth review and practice these questions and answers about a true problem situation in his or her own words. The next time such a thing is tempting, the mediating thought will come to mind to be acted on.** This is different from having a student write "*I will not be rude*" 100 times as a penalty.

Use the same essay every time that youth has the same kind of problem. If s/he is volatile and likely to tear up the original essay, cover it in adhesive-backed plastic. Sometimes it helps to ask that the essay be copied twice, but with a provision that if it is copied once *very neatly*, that will be enough.

Mediation essays can be developed for other problems of the kind where you want a brief teaching consequence for a fairly frequent, straightforward kind of misbehavior. Keep good records to see if copying the essay is needed less and less often. Talk with the youth often about the progress s/he's making. If there has been too little progress, encourage suggestions. Your goal is to use this teaching consequence so that you don't have to use penalties such as taking away points. **You want youths to share in the solutions to their problems. to learn to use their own good thoughts to solve them.**

Crying, hopelessness, low mood

Young people who find themselves in a Shelter or Detention facility are in crisis. They may experience powerful emotions. Sadness, fear, shame, loneliness, anger, regret, and depression take many forms in different people.

Some youths cry a great deal; others silently shut down, withdraw from others' company, and show no emotions or changes in facial expression; still others stay in contact but do it irritably and fretfully. Some may find relief in talking about their problems to whomever will listen; many will suffer alone.

These low moods may be due to sadness over events that have brought the youth to your facility, to missing significant people, or to pain that the youth has caused or has suffered. Or it could be related to drugs or to withdrawal from them. Some of these symptoms will eventually ease on their own, but some could be the signs of the onset of a long-lasting emotional problem.

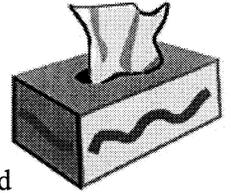
A myth exists that if we bring up emotional troubles with young people, they will just use them as excuses to avoid the hard work of facing up to what they need to do. But Major Depressive Disorder and Posttraumatic Stress Disorder, to name two pervasive, serious emotional disorders in Shelter and Detention populations, are painfully real. They are illnesses that rob people of the ability to get through the day, let alone that hard "facing-up" work. They destroy concentration, drain physical energy, and leave youths unable to tolerate thoughts of a future.

Although Shelter and Detention staff cannot offer the kinds of long-term assistance that will help youths who are emotionally hurting the most, we can—

- 1) validate their feelings;
- 2) listen and respond helpfully;
- 3) change things that we can change to meet their emotional needs;
- 4) emphasize planning for the future;
- 5) make psychological and psychiatric consultations available; and
- 6) monitor for potential suicide. Its occurrence is highest among depressed, incarcerated, and alienated youths.

1) Recognize the validity of the youth's upset feelings.

Many young people are confused about their feelings. They may have constantly been told such things as, "You have *no right* to feel bad about that," or "Stop feeling sorry for yourself. Just get over it." Feelings are not something one chooses to have or not have—they are as basic a part of us as breathing is. Many youths come to believe that strong people don't have "weak" feelings and should be able to "tough it out."



Denied and concealed feelings don't disappear—they only become more powerfully compressed. They are never opened to the fresh air of other people's ideas and reactions. Youths who have not had their feelings taken seriously do not know how to seek emotional support. Instead of asking for help, they demonstrate their depressed feelings through moodiness, isolation, and self-harm.

The first step to helping these youths feel better is to teach them to *name* their feelings. Let them know that we won't tell them that they *shouldn't* or *don't really* feel like that.

2) Listen and respond helpfully.

Emotions just *are*. They're an inborn feature of our brain's basic survival system, and talking logic to someone who is upset won't erase them. It is better to acknowledge feelings and offer support.

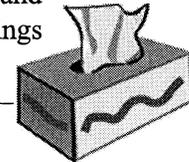
- Instead of, "You shouldn't feel bad about that," say, "It looks like you're really unhappy about that. I'm sure it's rough."
- Instead of, "There's no point feeling bad over what you can't help," say, "I'm sorry you're feeling bad. What could we do right now that will help?"
- Buck-up advice like, "Whoever said life was fair? Just try to stop thinking about it," does not help. If they could follow that advice, they would, but they cannot, so it makes the hopelessness worse. Instead, say, "It looks like you're feeling pretty low. Can you tell me about it?"
- Instead of empathizing by saying, "I know just how you feel," realize that each person believes his or her feelings are unique. Instead, say, "I can imagine how bad you might be feeling, and I feel for you. What can we do to help you now?"

Accept the fact that offers of help by talking about what is wrong may be rejected. The help they want will probably be in fixing problems outside our control. Young people do not necessarily trust us, and many will not have learned how talking about feelings can help. Putting depressed feelings into words weakens the power of negative emotions. Feelings become more ordinary and accessible to self-healing and help from others, and the depressed young people will have the energy to begin planning how to get their lives back on track. But if we *force* well-meaning advice on them, they will back away. Trained counselors can help by focusing on family systems, interpersonal issues, and thinking skills—and by helping youths find their own solutions to problems.

Make the here-and-now meaningful and active.

Depressed youths need to stay involved in the **active routines of daily life**. Keep them with their scheduled groups throughout the day. Clearly a youth who cannot stop crying will need to be temporarily on the sidelines or, if truly out of control, with a counselor, but only until s/he is calm. Similarly, although isolated and withdrawn youths cannot be forced to be socially involved, they need to be around others. The day's schedule needs to include **exercise, regular meals, and hygiene**. These need to be checked to see

that showers are taken and clothes changed—miserable people are likely to let these basics slide. It is important to schedule into each day's activities' **something that the youth finds pleasurable to do**. This may be a challenge, but building in something to look forward to every day is important. Most importantly, work on **making plans**—short-term plans, workable plans. Teaching the skill and habit of making a plan about what to do next when things go wrong is a powerful antidote for hopelessness.



Offer alternative ways to express feelings.

Many young people find it helpful to express feelings through **drawing, music, or writing**. Offer these activities and ask that they talk about their work with you, a counselor, or another trusted adult. The point of these activities is to provide a creative avenue for release of feel-

ings and to find a confidante whom the youth will share them with. Only a licensed art or music therapist would be qualified to use these techniques in therapy sessions over time, but they can often be the start of helpful adult-youth relationships.

Be alert for signs of clinical depression.

Begin to worry if crying and extreme withdrawal continues into a third day after admission. Keep records on the physical signs of a depressive illness — sleeping, eating, and psychomotor problems. Keep notes on whether the youth requires too much sleep or has insomnia at bedtime, in the morning, or in the middle of the night. Is s/he eating too much or too little? Are his or her activity pat-

terns agitated or lethargic? This information is important to report. A young person with these problems needs to be seen for a psychological evaluation to rule out a major depressive disorder. He or she might require medicine as well as counseling and planning to help resolve real-life problems. *Always monitor for potential suicide.*

(Refer to your institutional guidelines for specific suicide prevention, precautions, and response information. See also *Suicidal Ideation and Depression—Major Depressive Disorder and Other Mood Disorders*)

Defecating in the wrong places – Smearing feces

First Response: Name the behavior and say what must happen next. Use a calm, matter-of-fact voice: "You left stool in/on the _____. You'll need to clean it up. I'll get you the clean-up bucket." (Say *poop* or *shit*, as needed, to make yourself understood.) Have a bucket ready with gloves, scraper, disinfectant, rags, and disposal bags inside and step-by-step directions on the side. Whatever the reason behind the youth's behavior, s/he is the one who has to clean up the mess—*clean up after yourself* is a routine standard of behavior

everywhere with consequences for following or not following rules already in place. The most probable cause is *Encopresis*, a medical term for uncontrolled passing of stool. Depositing or smearing stool improperly can also be a symptom of **neurological impairment**, a **psychotic disorder**, or a **disruptive disorder**—acting furious or disgusted will not help. No matter what you think the cause is, make **as little fuss about it as you possibly can.**



Encopresis, or fecal overflow incontinence, affects up to 3% of children and youths

Encopresis is loss of bowel control through a severe form of constipation. For some reason, a person begins to hold back stool. As this continues, the bowel builds up a very large, solid mass of fecal matter. Passing stool becomes more and more difficult and painful. The rectum enlarges to hold the greater mass of stool. As it does so, the normal nerve messages that signal the brain to send the urgent need to "go" are deadened. **When the solid matter has built into a hard mass higher in the bowel, the new and softer stool seeps around its edges and escapes without any advance warning — thus the term "overflow incontinence."** The normal muscle tone that controls the whole process of elimination is lost, so the ability to control the escape of this soft stool is lost. **The encopretic youth has so little warning that he soils his clothes or defecates wherever he can in a hurry.** Over time, the youth may become insensitive even to the odors of his soiled clothing and not realize how unacceptable he has become to others. Isolation or defiant retaliation to being excluded or ridiculed may result. Encopresis is 6.5 times more common in boys than in girls. About one percent of adults continue to soil.

What causes it? Something as trivial as a child's passing several large stools that hurt and becoming fearful of having more may trigger the problem, or it may have no clear beginning. **Children with anxiety, depression, or other emotional difficulties are more likely to be affected than those with acting-out behavior problems.** Some studies have shown that male sexual abuse victims are more likely to develop encopresis than others.

How is it treated? Treatment has two main components: **1) laxatives and enemas to clean the bowel out** and keep it that way; and **2) a routine of scheduled pot-sitting to train the bowel** to function at a regular time. The treatment usually takes about a year and sometimes has to start with hospitalization.

Helping responses. Youths with bowel problems are likely to be unhappy. **Serious family discord and low self-esteem are common results of their problem.** Many parents are frustrated or angered by their child's soiling even if they do know it is a medical problem. The treatment of encopresis requires medical/psychological follow-up and the purchase of laxatives and stool softeners for a long time. Some families and children refuse to continue treatment they find expensive and unpleasant. **If a young person in your facility has hidden soiled pants or has defecated somewhere and tried to hide it, ask if he has a problem with sometimes needing suddenly to go and sometimes not being able to go. Say that this is a fairly common medical problem you would like to see him get help with. Seek medical help and knowledgeable counseling.** You could put a big problem within reach of an ultimate solution.

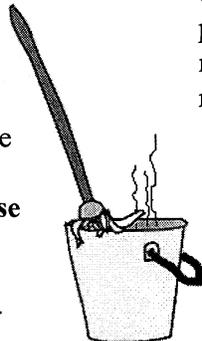
Psychiatric and neurological causes

What are they? People with psychiatric disorders such as **schizophrenia or severe bipolar disorder** may smear their feces on the walls or themselves, throw or eat them. Persons with **neurological disorders such as severe autism or brain injury** or those with **severe mental retardation** may also handle their fecal matter.

What causes it? It is hard to understand what causes people with these severe disorders to do these things. One person may have been commanded to do it by voices; another may simply want to feel the way she did as a baby; a third may mean to show how angry he is; a fourth may do so for sensory stimulation. **We are certain that in most cases, whatever their problems, people are more likely to handle their feces if they are stressed, angry, or have nothing more interesting or useful to do.**

How is it treated? Individuals with mental illness need to have their **psychiatric status and medications checked**. Neurologically impaired and mentally disabled youths should be seen by a **behavior specialist** who can analyze what they are gaining from fecal handling and how to **replace that with more suitable behaviors**.

Helping responses. These young people require close staff attention to see that they are always doing or watching something useful or interesting. **Avoid solitary down time.** Imagine the stress these disturbed young brains are under in your strange new place. **Ease stress for the best defense against a mess.**



Defiant Messes with Feces

What are they? There is no substance that more clearly symbolizes total disrespect or loathing than human excrement. Leaving it in someone's area or smearing it on someone's possessions literally says "**Sh__ on you.**" It may be the most troubling, if not the most expensive, act of vandalism there is. In that case, it is a secret act of defiance, and staff may or may not learn who did it. In settings where disturbed people receive overwhelming negative consequences and confinements, these behaviors may occur very openly. They serve as a bottom line of defiance that cannot be stopped. One thing that other people *cannot* keep us from doing, even by tying us down flat in restraints or chaining us to a wall, is releasing our bowels.

What causes it? Defiance does not necessarily travel alone. This level of vandalism could be a symptom of Conduct Disorder or it could be due to a psychotic disorder. Likewise, an encopretic youth who also has Conduct Disorder and/or a severe emotional disturbance may act out anger and defiance. It might even be just a nasty behavior that a youth got talked into, unconnected to any mental health disorder of his own.

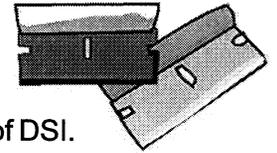
Helping responses. If you catch the youth in the act, have him or her clean it up. Follow your guidelines for handling destruction of property. Be sure the youth makes restitution for whatever needs cleaning or replacement. An over-correction technique of requiring clean-up above and beyond the mess itself can be an appropriate consequence. It serves as a positive pay-back to the community for defiling its space. In the more likely event that you do not know who did it, still make the clean-up inconspicuous. Try to minimize peers' chances of giving the culprit any positive reinforcement by limiting their gross-out reactions to the misdeed. Act and speak about it as the infantile behavior of a childish person. Go about your usual procedures to identify the responsible person.

Whatever you believe to be the cause of the fecal messing, it is important still to respond more clinically than angrily to the defecation or smearing. This helps take the power out of the act. *Keep in mind that an encopretic youth may prefer to be thought defiant than to be known to have a bowel disorder.* Assure privacy during conversations about bowel problems. Make inconspicuous arrangements for scheduled pot-sitting times and clothing changes. If the youth feels truly supported, s/he may make real progress in controlling this difficult problem with the help of your facility's nurse or medical providers.

Deliberate Self-Injury (DSI)—cutting, head-banging, burning . . .

Deliberate self injury (DSI) can be a dramatic act done in full view of others or, more often, a private act done secretly. DSI includes burning, scratching, slicing, gouging, banging or slamming so that body tissue is damaged. Injury is done with foreign objects or with the person's own nails, teeth, or

force. Not included here is the self-injurious behavior (SIB) of the severely developmentally disabled or brain injured. Also not included are self-applied body piercings and tattoos, though they may have elements of DSI.



General guidelines for dealing with DSI. Deal with deliberate self-injury calmly, kindly, and confidently.

Quietly and firmly tell the youth to stop. *"We don't want you hurting yourself here by [describe the exact behavior in as neutral terms as you can]."* Interrupt the behavior by having the youth change location, activity, or, if others are around, closeness to peers. If there is injury that needs attention, calmly say, *"I'll take*

you where you can get that cleaned up." See to it that there is as little commotion and drama as possible resulting from the injury itself. Treat the youth as someone with a problem that can be dealt with competently and without much fuss. Keep medical attention low key and to the minimum needed.

Consider two general sources of Deliberate Self-Injury

Group 1. Stress and anxiety elements

What might the youth gain by DSI?

- *Relief of pent up feelings of stress and depression.*
- *Relief of disgust at themselves by punishing their bodies.*
- *Feeling a chemical "high" while inflicting pain.*
- *Relief of tension from inability to meet social or perfectionistic expectations.*
- *Feeling relief from depersonalization, a result of abuse, trauma, or PTSD.*

These are neurochemical reactions to acts of self-injury that self-injurers become dependant on to relieve intense psychological discomfort when under stress. DSI actually causes measurable changes in endorphins and other brain chemicals. Once relied on as a coping mechanism, it is very difficult to give up. Breaking the habit requires many of the same techniques used to change such behaviors as drinking or compulsive gambling.

When assessing a youth's DSI, remember: it might contain both stress and behavioral elements.

Group 2. Social problems and behavior elements

What might the youth gain by DSI?

- *Attention and sympathy* from peers or staff.
- *Social connection* with a group that includes or admires self-injurers.
- *A way to express personal feelings* such as fear or sadness or anxiety by youths who cannot put feelings into words.
- *A way to express aggressive feelings* by youths who are frustrated, angry, bored and feel a strong need for stimulation and acting out.
- *Hope for a special outcome* such as medical attention or transfer.
- *Physical contact and control over staff* time and actions in settings where staff are required to physically restrain clients to prevent DSI.

These are behavioral outcomes to acts of self-injury that may be extremely important to the youth. That will make DSI highly reinforcing and hard to quit.

DSI as a mental health problem

Deliberate self-injury (DSI) is an unnatural act—that signals to us how seriously we need to take it as an indicator of mental health problems. But we need to help the self-injuring youth by not over-reacting to each incident, unless it involves a serious wound. Our message needs to be, *"I can see that you hurt and that you have needs. But hurting your body doesn't fix what's wrong in your life."* Acknowledge that DSI is a way that some people cope with problems, but insist, *"This is an unhealthy way to manage stress, and part of my job here is to keep you healthy."*

As staff, we need to recognize that trying to forbid or absolutely prevent self-injurious behavior is likely to fail. Certainly we need to take all reasonable precautions. At the same time, **we need to recognize that youths intent on DSI will find some way to harm themselves.** They can use their own nails and teeth

or even rub themselves raw against a mechanical restraint. Restraining holds by staff members cannot be maintained forever and expose youths to high risk of both emotional and physical damage. Chemical restraints are given only by doctors' orders.

Is DSI due to a serious mental health disorder? It *may* be. DSI is primarily a method of *coping* with life's stresses, not of working up to committing suicide. Still, a majority of suicide victims had engaged in some self-destructive behavior in the past, so we cannot dismiss that possibility. Also, DSI is a symptom observed in some people who have Bipolar Disorder, Posttraumatic Stress Disorder, certain Psychotic and Personality Disorders, and severe Depression. Deliberate Self-Injury or Self-Mutilation is not, *in itself*, a mental health disorder, but it is a *symptom* of several.

Helpful responses. Check all the pre-admission records available about the youth's mental health history as well as the family's. Also red-flag accounts of abuse, neglect, major illnesses, and substance use. Then consult your mental health provider.

Try to understand what Deliberate Self-Injury means in the lives of youths who do it.

It hurts. It's unnatural. So what is the purpose of DSI? What is the goal of the behavior for each young person that does it? Even though self-injury causes pain, the youth is inflicting the injury because it makes something about his or her life better. If we understand what, we have a clue on how to how to intervene.



Does DSI help the youth cope with emotional intensity? Some young people experience poor emotional self-regulation. Their moods swing between intense highs and lows, and they have a hard time regaining their balance to levels they can tolerate. In extreme periods, they may engage in DSI.

Helpful responses. Teach stress relieving techniques to replace DSI. Emotional self-regulation can be taught and practiced using the SUDSmeter activity. Stress management training includes ways to teach youths to recognize the physical signs of stress in their bodies. They can use them to cue coping skills to calm themselves. The more youths understand how stress works, they better they can control it without resorting to DSI. (See *The SUDs Meter* and *Stress Management* in the *Resource Section*)



Does DSI provide relief from negative feelings about oneself? Excessive guilt, disgust over one's body or failures, or self-hatred may make a youth experience mounting tension and an irresistible desire to hurt him- or herself. Some want the punishment of feeling pain. Others actually feel no pain at all but may find relief in seeing the flow of their own blood. Afterwards, the tension is drained away, and mood returns to baseline. This relief is powerful, and relying on it becomes a hard habit to break.

Helpful responses. Work on the youth's issues of personal autonomy, self-worth, and plans for the future. If DSI wounds are discovered that the youth has tried to conceal, be sensitive to possible fears that s/he might be "crazy." These add to feelings of stress and self-loathing.



Is the act of DSI a substitute for expressing feelings in words? Youths who mutilate themselves tend to be action-oriented. They believe that when something is wrong, they have to *do* something about it. If they are angry or upset with someone, they have to *show* them just how badly they have been hurt by hurting themselves. They have not learned to communicate feelings with words.

Helpful responses. Most young people have very poor vocabularies of feeling words and need a lot of practice identifying and expressing their emotions verbally. Youths who hurt themselves to send messages to others about their distress need help learning to *say* what they mean instead of *acting out* what they mean. Teaching youths to say or write "I messages," having them write letters about their feelings, and assertiveness training are all good activities to help them learn to express themselves directly.



Is DSI an attempt to gain nurturing relationships? In the drama of relationships, behaviors that gain a lot of attention or cause distress, guilt, or anxiety in others are valuable social currency. DSI may be resorted to out of distress, not out of deliberate manipulation, but if it results in what the needy youth so desires—attention, care, and focus—DSI may be repeated again and again.

Helpful responses. Denying attention to the attention-needing adolescent is futile --s/he will just seek it more, just as a thirsty person denied water seeks it more eagerly. Our goal is to find ways to give a lot of attention to the youth for positive attributes and actions, or for no good reason at all! And if there is an incident of DSI, we give little eye contact and provide care as coolly and mechanically as possible.



Is DSI the result of group contagion? Youths, usually girls, who engage in DSI are likely to have major problems with peer relationships. In residential settings, they gather in groups, a natural stage for acting out the drama of stormy relationships. There, DSI tends to be accepted, flagrant, or even competitive. Such groups see themselves as highly tolerant of personality and physical flaws, as counter-cultural and perhaps deviant.¹ Young people who may have always been socially on the margins find acceptance into such a group a welcome place.

Helpful responses. Affirming the strengths of individuals outside the context of the group is as essential in this instance as it is in dealing with gang membership. Stress management is essential as well. Involve such groups of girls in consciousness-raising activities about their value as young women in today's world.



Is DSI due to a serious mental health disorder? Most youths who engage in DSI are not making suicide gestures. DSI is primarily a method of *coping* with life's stresses, not of giving up on life. It is still important to consider the possibility that DSI is a symptom of a more serious disorder that requires psychiatric treatment. The youth may need a complete mental health evaluation to assess for Major Depressive Disorder, Bipolar Disorder, Posttraumatic Stress Disorder, a Psychotic Disorder, Personality Disorder, or other serious problems.

Helpful responses. Check all the pre-admission information available about the youth for information about diagnoses, medications, and admissions to mental health facilities. Then consult your mental health provider.

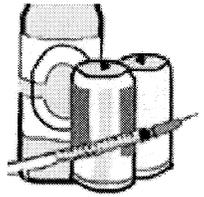
In general, who engages in DSI?

Studies of adolescents who deliberately injure themselves show that they are significantly more likely than others to have **backgrounds that include sexual and physical abuse, substance abuse and divorce in the family, multiple out-of-home placements, and major illnesses and surgeries.** Problems that **co-exist in adolescence with DSI are sexual and physical abuse, substance abuse, relationship problems, eating disorders, and sexual and gender identity problems.**² Notice how many of these problems involve the physical body—the body is the victim and the victimizer in the lives of these troubled young people.

Drug or Alcohol Withdrawal—sobering up, coming down, getting clean

General precautions. When young people are admitted to your Shelter or Detention Facility impaired because of taking alcohol, drugs, or both, they need special care. **It is impossible to know for certain what they might have taken, so take full precautions to assure their safety.** Some youth may be experimenters or binge users. Others may have been abusing regularly, and their admission will be day one of their withdrawal from physical

dependency. A few may be poisoned or heavily addicted and need to go to the hospital for emergency care or detoxification. **Do not allow sleep without checking to see that the youth is fully conscious and not close to an overdose. If a youth is pale, has blue lips, is passed out or barely responsive, call 911.**



Withdrawal and detoxification *Withdrawal* is the term for the body's reaction to the sudden absence of a substance to which it has adapted. **If someone with an addiction stops a drug suddenly, the "cold turkey" experience can make them ill. Youths who are admitted when they are impaired may go through that process during their stay in our facilities.** *Detoxification* or "*detox*" is for people with addictions so severe that they need to go to treatment centers to get medical help with the process of withdrawal. They receive drugs to wean their bodies more gradually from full dependence on the drug. Substance abuse counselors may seek inpatient referrals for youth, but most are treated on an outpatient basis. Some may require prescription drugs; consult your medical provider.

Handling violent behavior Try quietly to reassure the youth. Give simple, matter-of-fact directions about what he needs to do next. If you must use physical restraint, the danger is that the person drunk on **alcohol** might vomit, inhale it, and choke. Be careful not to compress the chest and abdomen. **Never leave the youth lying down.** Both coordination and the ability to think will be poor. Watch for flailing limbs and protect the head. Those high on **stimulants such as meth** do not have the problems with coordination that drinkers have. In fact, physical agility may be heightened. Be alert. They may be hostile and powerful. They will have no inhibitions and can behave dangerously. **Impaired youth must not be left alone once they are settled; they require continual monitoring and assistance.**

Alcohol *When the youth arrives drunk:* keep the youth who appears drunk sitting up and talking to be sure that s/he is functioning. **Be certain of the difference between sleep and unconsciousness.** (At a blood alcohol level of .30, many lose consciousness; at .40 most do and some die; at .50, breathing stops and many die.) Neither walking around nor cold showers will sober anyone up, and both increase the chance of falls. **Do not offer or allow coffee or any other remedies to be drunk**—they won't help and will increase the chance of vomiting. When vomiting seems to have fully subsided, let the youth lie down to sleep on her side with knees drawn up in the fetal position. Wedge pillows in so she can't roll over into a position to choke on more vomit. **Check every 30 minutes** for the following: 1) warm, dry skin; 2) regular breathing (at least 10 breaths a minute, and no more than 8 seconds between breaths); 3) no vomit in the mouth; 4) positioning so she won't choke if vomiting does start again. We must keep checking because vomiting could start later, for instance after a stimulant she has also taken wears off. **Withdrawal symptoms: common ones include aggressiveness, poor memory and concentration, nervousness, sleeplessness, and depression.** The most serious withdrawal symptom is delirium tremens (d.t.'s) which is marked by hallucinations and convulsions. It almost never occurs among youths.

Stimulants—Cocaine, Amphetamines and their derivatives (methamphetamine, crack, ice, ecstasy, etc.)
When the youth arrives high: unfortunately, there is no known way to hurry the return to sobriety from these drugs. They come in a variety of types and potencies. The most powerful ones are inhaled by smoking (freebasing). They can be active for as long as 8 to 24 hours. Four to 8 hours is more typical for most. The youth will be in overdrive—sleepless, without appetite, in "flight or fright" readiness. **Youths admitted while high on stimulants will require very close supervision until the drug has left the blood stream.** They will have high blood pressure, dilated pupils, and an elevated heart rate. They will feel keen, energized, powerful. With the stronger drugs, they may be aggressive. In high doses, euphoria and confusion can lead to psychotic paranoia, hallucinations, and delusions. **Withdrawal symptoms.** The depression that follows the highs from these drugs may be so severe that **suicide precautions must be taken.** Severe anxiety and agitation are common. Other withdrawal symptoms include disorientation, confusion, irritability, apathy, and itchiness. After long periods of sleeplessness and little food, the youth may be extremely hungry and have an intense desire to sleep.

Withdrawal from other drugs

Analgesics (heroin, codeine, prescription pain killers, DMX in cough syrup) *Withdrawal symptoms:* stopping suddenly after several weeks of high doses causes very severe flu-like symptoms with nausea, vomiting, sweating, and muscle aches. Doctors typically prescribe medication to ease the misery of heroin withdrawal.

Depressants which include **a) benzodiazepines** (antianxiety drugs or tranquilizers such as Valium, Xanax) and **b) volatile substances that are sniffable** (solvents, glues, aerosols, gases)

Withdrawal symptoms: withdrawal from group **a)** may cause anxiety, restlessness, irritability, confusion, and seizures. No specific withdrawal symptoms are known for the many agents in group **b)**. **Note: Alcohol is also a depressant.** See the preceding page.

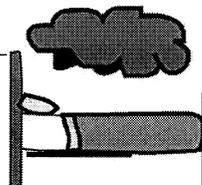
Hallucinogens (LSD, marijuana, mushrooms)—*Withdrawal symptoms:* no physical withdrawal symptoms are associated with these substances. Some youths may experience continuing flashbacks and perceptual abnormalities.

Mixtures of drugs—*Withdrawal symptoms:* the results of mixing substances are unpredictable and can be very dangerous. The most serious problems are caused by analgesics and depressants in any combination. They can lead quickly to coma and death. **Alcohol is a depressant**, so if a youth were drunk and also huffed a solvent or took a prescription pill, he could be in serious trouble. If he took speed that temporarily overrode the depressing effects of a drug, trouble might not appear until later. **We must keep substance-impaired youth under close observation.**



Check heavy sleepers every 30 minutes regardless of what substance/s we believe they have used. Combinations can be deadly. For instance, a stimulant can easily mask alcohol symptoms. Many meth users go through periods of “tweaking” where they deal with the bad feelings of coming down from from their amphetamine highs by drinking.

Emotional upset, anxiety, or sleeplessness at bedtime



Our First Response: Listen. Recognize the problem as real without opening up the youth to ridicule. *"This is tough for lots of kids."* Listen for fears about any immediate danger at home. Does s/he fear abuse or retaliation from someone? Is s/he revealing reportable abuse to herself or others that must be acted on? These require immediate action, but other problems should wait for full discussion until the next day. *"That's a big problem. You need a plan to work on that, and we'll make one tomorrow. But right now, you need your rest."*

Offer choices. Make such options available as • sleeping with the door open or a light on; • listening to a relaxation tape; • moving to a place to sleep within eyesight of staff.

Teach skills for settling into sleep. • See the back of this page for a go-to-sleep technique. • Use stress management strategies from the *Resource Section*. • Avoid stimulating horseplay or TV at bedtime. • Plan with colleagues how to respond to the youth's sleep problems.

Immature thoughts and fears

What is the purpose of the upset?

To express sadness and homesickness; to protest changes in routine.

Helping responses. It is important to think developmentally about all youths. Many young people in detention and shelter facilities have poor thinking skills. Some, despite having grown-up bodies, are very immature thinkers. Others are neurologically damaged or retarded; still others have such disorders as Asperger's Disorder (a kind of high-skills autism), or Schizophrenia. Whatever the reason, if a youth has problems with abstract thinking and has a brain that responds to change and to being away from familiar routines at home with great upset, we can expect difficult bedtimes. It helps to **make every part of the routine crystal clear ahead of time. Short, simple directions, advance practice and warnings, and written schedules help.** Making the routine resemble the ones the youth is used to will provide comfort and reduce fear and resistance.

Post-Traumatic Stress Disorder

What is the purpose of the upset?

To avoid sleep and nightmares; unintentional responses to mental images of sexual, emotional or physical abuse, either recent or from earlier times.

Helping responses. The circumstances that brought a youth to a shelter or detention facility may in themselves have brought on symptoms of PTSD, or trauma may have been long-standing. Estimates are that 53% of youths in detention centers have PTSD symptoms. They are likely to be in emotion turmoil. During flashbacks and nightmares, the person is actually *re-experiencing* the traumatic incident, not just seeing it in his or her mind's eye. All the physical upset returns, not just the memory. **The reassuring presence of a safe adult is important and needs to be available. Teaching soothing sleep skills is helpful; discussing the trauma at bedtime is not.** That mostly needs to take place at scheduled times with consistent, trained people.

Disruptive Disorders

What is the purpose of the upset?

For opposition or attention, to defy rules set about bedtime, or to gain peer attention for doing so; for power, to gain a desired outcome such as being given a desired sleeping arrangement; to express true emotional upset.

Disruptive youths also have emotional problems they truly need help with.

Helping responses. It is possible that a young person is putting on emotional upset to gain something s/he wants. It is also possible that an oppositional or conduct-disordered youth is genuinely emotionally upset. The first time this bedtime behavior occurs, follow the **First Response** guidelines above. Always note and plan with colleagues so you can compare notes and modify the youth's behavioral plan. If you agree s/he's conning, make a plan to change rooms, devise a point plan for good bedtimes, or add a goal to his or her level plan. **See that you don't create lots of extra benefits for the emotional upset. If problems continue into a third night, consult your mental health consultant.**

Anxiety & Depression

What is the purpose of the upset?

In Anxiety Disorder, the brain's goal is constant vigilance and worry. Sleeplessness is one of the key symptoms that may also play a part in Major Depressive Disorder.

Helping responses. The Anxiety Disorders include Panic Disorder where the racing heart and other features of panic are so powerful that a person feels like s/he is dying. Most anxieties are far less extreme, but they are persistent and hard to turn off. Depressed thinking may involve endlessly going over everything that has gone wrong and seeing nothing but hopelessness as an outcome. This is especially dangerous because it can lead to suicidal thinking. **Staff can help by being kind, calm, and reassuring and by encouraging the use of relaxation and stress management.** Take note of wakefulness in the night and early morning as well as at bedtime to report to the youth's mental health provider.

Worrisome events such as court dates or family visits trigger bedtime upsets in many young people. A youth who has problems getting to sleep that are unrelated to clear trigger events and that last for more than two or three nights should be seen by a health professional.

5,4,3,2,1...an activity for helping someone fall asleep

First, the youth gets comfortable in bed.

Then, the youth picks five things that s/he sees in the room – lights, pillow, walls, etc.

Next, the youth picks five things that s/he hears in the room— squeaking bed, humming light, air conditioner, etc.

Then, the youth picks five things that s/he feels by touch in the room – pillow on head, air on cheek, ring on finger, etc.

Next, the young person repeats the cycle. This time s/he picks...

Four new things s/he sees in the room,

Four things s/he hears in the room, and

Four things s/he feels by touch in the room.

In the next cycle, s/he picks...

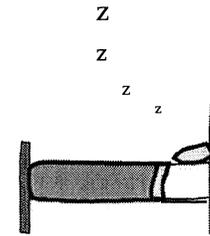
Three new things s/he sees in the room,

Three things s/he hears in the room, and

Three things s/he feels by touch in the room.

Continue cycles two, and one, and...

By cycle three, if the youth has an open mind to the technique,
he or she has usually been able to relax completely and fall asleep.



A note about this activity: It was devised by Milton Erickson, a revolutionary psychiatrist and therapist who died in 1980. He is known for having made hypnosis into a legitimate therapeutic tool. He was very focused on using the mind and the senses to overcome the problems people face without having to relive the past entirely in order to gain insight into it. This relaxation activity is an example of this idea. Erickson himself suffered from two bouts of polio and many physical disabilities, so he honed his techniques of mind over matter from his own experiences.

Thanks to Polk County Juvenile Detention Center for contributing this activity which they use successfully in their facility.
It is a fine example of a stress management technique. See others in the *Resource Section*.

Hallucinations & Delusions

Hallucinations are sensations of seeing, hearing, feeling, smelling, or being touched by things that do not truly exist. **Delusions** are complex patterns of belief with no basis in truth. Examples are “knowing” that other people can hear your thoughts or that someone who is dead is really alive. **Paranoid delusions** are false beliefs about other people persecuting you. Random events are believed to be parts of schemes carried out by evil people who want to harm or kill you. Hallucinations and delusions are the hallmarks of **Schizophrenia**, but they can also be experienced in **Major Depressive Disorder, Bipolar Disorder, Personality Disorders, Posttraumatic Stress Disorder, and Substance Use Disorders**. Some people even experience them when they are not mentally ill but are undergoing **extreme stress**.



GUIDELINES FOR HELPING: Our reaction when the youth first complains of a hallucination or having a delusional thought must be to

- a) Listen
- b) Show empathy
- c) Explore what the youth tells you:
"Tell me about what you see . . . hear . . . believe."
- d) Reassure that s/he is safe, and
- e) Re-engage him or her in activities

Record the incident and discuss it in a staff meeting so that the problem can be carefully evaluated. See that any psychoactive medications are being given as prescribed. Check with referring agencies or families for medical and social histories.

What will the youth gain by the behavior? Some may have learned to use pretending to see and hear things as a way to gain attention. **But there is nothing to be gained if the experiences are real — they range from unpleasant to disturbing to terrifying.** Adolescence is the time when Schizophrenia is likely to first make its appearance. Some youths may find themselves in shelter or detention facilities without ever before having been identified as mentally ill. They will be certain that what they see, hear, and believe is *true*. **Their brains perceive these “imaginary” sights, sounds, and feelings as being as real as what we see and hear in our actual surroundings.** The voices they hear are often so loud that they drown out all other noises. Their messages may be cruel taunts or demands about what the suffering person must do — all the way up to killing themselves or others. Some people believe that they have godly powers or will go to hell if they do not follow orders.

Will you know if s/he's *really* hallucinating?

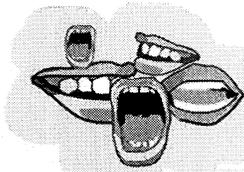
You won't for sure, but still follow the guidelines above. It is difficult to know if accounts are of genuine psychotic symptoms or are story-telling for attention or to dramatize scary or bad feelings. Many people try to conceal or deny that they have these symptoms, and the most far-out accounts of them may or may not be true. **We can't ignore any accounts, however.** They all tell us something about the youths in our care. To give a mental health professional added information, observe the youth when he or she is unaware. See if s/he appears to be attending to voices, looking intently at something going on, etc., If a youth tells you s/he hears voices or sees worrisome things, check out a few details — *Could you tell who was saying those things?*

Do you see them at a certain time of the day or night? Just when you're falling asleep? How often? How long has this been going on? Then explain that you are not an expert, but you will pass the information along to someone who knows more about it. Doing so will help that person know if the youth's accounts have been consistent.



What else could cause a youth to report these sensations?

Does he or she come from a family that dramatizes wrong in terms of evil spirits, monsters, or the devil? Is there a history of telling grandiose tales? Is s/he confusing those odd *hypnagogic* sensations many people have just as they fall asleep with hallucinations? Is there serious mental illness in the family? Might talking about them be a learned behavior?



Co-occurring mental health and substance abuse disorders are a serious problem. For example, people may develop extreme paranoid delusions after heavy methamphetamine use. **Symptoms of the onset of Schizophrenia may look like the signs of heavy drug use**, for instance major changes in social habits, confusion, odd speech, hallucinations. Psychotic symptoms will subside more rapidly in drug reactions, however, than they will in Bipolar Disorder or Schizophrenia. Sometimes, a youth may have started taking street drugs to deal with the onset of a mental disorder, so now *both* problems must be treated.

Helping responses. Young people who are mentally ill must receive psychiatric help as soon as possible. Encourage them to keep you informed of what is happening to them. Psychotic people are at risk for suicide. **Our role is to keep stress as low as possible and to keep them stable.** Antipsychotic drugs provide relief for most people, but they require close monitoring. Even so, some symptoms may remain. Youths experiencing these problems need security, support, and as little upset as possible to maintain control. When these elements are missing, they may start to lose their ability to hold things together.

What to do if you're pretty sure the youth is making it all up.

No one can ever be perfectly sure what is going on in another person's brain. A mental health professional may evaluate a youth and decide that s/he is probably *not* experiencing true hallucinations and delusions. The youth may react by dropping all talk about them or may continue insisting that s/he knows what s/he saw, heard, or believes to be true. **Whether the youth is or is not really experiencing a psychotic symptom is not something to argue about. Still follow the guidelines and make note of all incidents.** Pay attention less obviously and ask fewer or no questions. **Try not to excuse the youth from responsibilities because of delusions and hallucinations, whether they are true experiences or not.** That is how the real world works. If the youth is taking a psychoactive drug to relieve psychotic symptoms, data must be kept so the doctor can tell how well the medicine is working. Keep careful data even if the youth has no diagnosis or meds. You will need it to see if the behavior drops out or continues when it gains less adult attention, and you will want accurate counts and descriptions to report for a psychiatric evaluation if one is scheduled. Make note of things going on in your setting such as excited reactions to the youth's behavior. They may be so reinforcing to an attention-needing youth that they keep made-up delusions and hallucinations going. **The staff person who works most closely with the youth should be the person to talk with him or her about how, if, and why or why not s/he might stop or control these behaviors**—other staff should mainly observe and keep data.



It is never wise to discount youths' accounts of symptoms of mental illness entirely, no matter what the official word. Adolescents are notoriously difficult for psychiatrists to diagnose. Sometimes behaviors that look like symptoms disappear—very often diagnoses come, go, and change several times as children grow to adulthood. In 2005, researchers at the National Institute of Mental Health (NIMH)¹ reported in a series of studies that **half of all lifetime cases of mental illness begin by age 14.** They also reported that **1) long delays between the first signs of illness and people's receiving treatment were usual, and that 2) an untreated mental disorder can lead to a more severe, more difficult-to-treat illness and to co-occurring mental illnesses.** No one can fake psychotic symptoms forever, and we certainly do not want to overlook a serious illness. That is especially true now that we know the big difference that early intervention can make in treating psychotic disorders successfully.

See pages on *Psychotic Disorders, Bipolar Disorder, Major Depression, & Borderline Personality Disorder.*

Homicidal Ideation – thoughts, drawings, gestures, talk, & threats

A youth says, “I want to kill . . .” or, “I am going to kill . . .” We cannot just ignore these words as wild claims. We have to decide how likely the youth is to act on these ideas. If it *could* happen, we must take steps 1) to stop the

youth and 2) protect the victim. If it is *not likely*, we help him or her find better ways to deal with negative emotions, social challenges, or impulsivity.



Assessing the seriousness of homicidal risk

It is as important to judge the seriousness of homicidal risk as it is of suicidal risk. The questions to ask are much the same. Follow up a youth’s speaking of thoughts, plans, or desires to kill someone with questions that will help you learn about these risk elements:

Risk Elements — of Harm from Homicidal Ideation

- **Homicidal ideation** — How intense is this thinking? Is it just an occasional fleeting thought, spoken impulsively? Is it a part of a general negative, aggressive view of how the world works? Or is it a focused idea centered on certain people?
- **Plan** — Does the youth have a plan for how s/he would commit the homicide? Is the plan a fantasy, or does it show reasonable thought? Is it a true, do-able plan?
- **Means** — Does the youth have the means to carry out the plan? Will s/he be able to carry it out now? Once discharged from your facility?
- **Cultural history** — Is there a history of homicide in the youth’s family? Or has the youth been a witness to a murder attempt or connected to one in the neighborhood or school environment? How much is violence a part of his/her culture?
- **Personal history** — How impulsive is the youth? Has s/he shown lack of insight and judgment? How involved in group violence? How physically or sexually aggressive has s/he been to others? Has s/he been assaulted or victimized?
- **Mental health history** — Has the youth been affected by delusional thinking? Does s/he have paranoia or believe that voices are commanding him/her to kill?
- **Substance abuse** — How likely is the youth to use substances? To the point of increasing the risk of uncontrolled or dangerous behaviors?
- **Support system** — How strong a support system will be available for the young person after discharge? How safe will s/he be from dangers of victimization, abuse, and neglect or from being driven to homicidal activity?

Responding to risk

The higher the risk, the more we must do to change the youth’s homicidal thinking and to protect the victim. If the youth has a plan to harm an in-house victim, constant in-sight supervision is necessary. If we learn of a plan to kill someone after discharge, full disclosure to community agencies must be part of discharge planning. Even when there appears to be little risk of harm, discourage killing talk: “*Stop. When you say [use the exact words], I have to take that literally. It’s a threat, threats are against the law., and that means trouble.*”

Who may think about killing and why

Youths with no mental health diagnoses

In our violent world, we speak easily of who is going to kill whom over what. War, media violence, school and domestic violence — killing or its threat touches the everyday existence of all young people. **Deadly, violent thinking may become contagious wherever troubled youths, often raised in violence, find themselves.** We must recognize *low-risk* homicidal ideation as well as high-risk and think of its meanings, too. It reminds us that we need to find ways to bring hope into our settings, building positive beliefs and goals for the future.

Youths with Conduct Disorder (CD)

What do they hope to gain by homicidal thought and talk?

Feelings of having power or showing dominance over others; Support & admiration from other antisocials; Revenge against enemies.

Youths with early-onset Conduct Disorder have brains that have been wired, most likely from combinations of genes and early experience, to feel little empathy with victims of their harmful acts. Instead, they are constantly on the lookout for people ready to do *them* harm. They are primed to fight—some to the point of killing. They may develop a belief system that convinces them that killing is “necessary” if they are to thrive and have respect.

Youths with adolescent-onset Conduct Disorder are more likely to have learned their delinquent behaviors from their peers than to have it so basic a part of their hard-wiring. They are less likely to think of killing as a solution to personal problems, but they are quick to get involved with gang activity that leads to it.

Helping responses We won’t reach youths with CD by urging them to feel empathy for their victims. They are unable to understand their own feelings, let alone the feelings of others. Instead, work on these youths’ self-interest, their desire to make smart decisions to get ahead. Stress the fact that even *threats* to kill are illegal and that killing is likely to get them killed. Work on *Problem Solving* and *Cost/Payoff* activities to teach the long-term consequences of actions that they believe will solve their problems of the moment. Plan protection into your social environment. Keep threateners away from victims and the social reinforcement of peers, especially gang members.

(See Conduct Disorder pages and Cost/Payoff and Problem-Solving in the Resource Section.)

Youths with psychotic symptoms (e.g., of PTSD, severe Depression or Bipolar Disorder, Schizophrenia)

What do they hope to gain by homicidal thought and talk?

*Obedience to orders from beings perceived to be in control.
Revenge for or safety from imagined plots against them.*

Adolescence is when severe psychotic disorders may first appear. Ideas of killing people arrive in the conscious minds of preteens and teenagers from unconscious mental processes. The voices may *command* them to kill. They may be familiar or strange voices, evil or godly, soft or loud. They will sound as real to young people suffering from these disorders as our voices do. They may be so loud that they literally drown us out, and the youth may actually see someone speaking. Almost harder for them to disbelieve are paranoid delusions, unshakable beliefs that enter the minds of mentally ill persons and convince them that there are complex, devious plots against them. These false realities that the brain manufactures are very convincing, and their demands are difficult to resist. They actually cause few murders, however.

Helping responses Most psychotic symptoms can be relieved effectively by psychoactive medications. Read the *Hallucinations and Delusions* pages for ideas on what to listen for in your talks with youths who might have these problems. Refer them for psychiatric evaluations. *Follow medication regimens carefully.*

Youths with poor emotional self-regulation

What do they hope to gain by homicidal thought and talk?

Making a major impact on a school or public place; Scaring someone they are angry with; Release of angry or upset feelings.

Youths may be sent to Detention Centers for threats made at school.

Since Columbine and other high-profile school killings, communities may seek to have students who carry weapons to school hospitalized or incarcerated. In a typical case, a boy sent e-mail threats to kill two high-school teachers because he was angry with one of them who wouldn't let him make up a missing assignment. His parents had just been divorced, he lived with dad, and he couldn't reach his mom who had changed her cell phone number. He had no previous aggression problems, though he had been charged with vandalism and stealing a neighbor's golf clubs. His defense attorney said he was upset and lashed out but wouldn't kill anybody. Nevertheless, he was expelled and sentenced to five months in a juvenile correctional facility.

Helping responses The young person who has made a threat of this kind is more likely to be an unpopular outsider than an accepted member of an antisocial group. Often described as a "loner," he or she may have difficulties with peers in your setting. This will give you an opportunity to work on interpersonal problem solving. Work on the *SUDs* activity for emotional self-regulation and on the *Problem-Solving* sheet. Watch closely for signs of mental health problems—psychological autopsies of high-profile school-shooters show most of them to have been severely mentally ill. Seek mental health professionals' advice as needed.

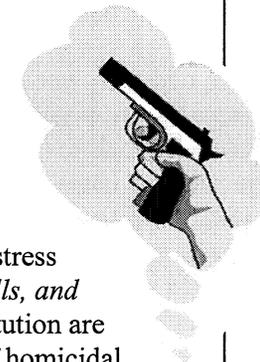
Youths with ADHD, developmental disorders, or problems with social immaturity

What do they hope to gain by homicidal thought and talk?

*An end to feelings of powerlessness, frustration, and incompetence;
Respect from other youths; Release of angry or vengeful feelings.*

Youths who have ADHD have trouble with social relationships. Others may have similar problems—those with developmental disorders as well as many who have suffered **Traumatic Brain Injury**. They may speak out impulsively about whatever enters their minds. They also may act impulsively on these thoughts. They think only of Now with little thought to future consequences of what they say or do. They are often unpopular with people their own age and so may say and do extreme things to try to win respect or power.

Helping responses. See the ADHD section for general ideas. Just as you do for Conduct Disordered youths, stress the fact that threats to kill people are illegal and will get them in trouble. Work on *Problem Solving*, *Thinking Skills*, and *Cost/Payoff* activities to teach the long-term consequences of and alternatives to violent acts. Apologies and restitution are important activities to drive home the point that threats of harming people cause *them* trouble. The seriousness of homicidal ideas must be made graphically clear. At the same time, we need to help these young people find other solutions to problems that lead to thoughts of killing. Watch for signs of depression and despair. Teach them better responses to feelings of social frustration. Help them find ways to gain respect in prosocial ways.



(See *Cost/Payoff*, *SUDs*, *Thinking Skills*, and *Problem-Solving* in the Resource Section.)

Hyperactive behavior — excessive or constant movement

Hyperactivity is ADHD's middle name

Youths with Attention-Deficit/Hyperactivity Disorder (ADHD) have problems in their brains' motor control systems. These are just the most obvious signs of the problems they have regulating many aspects of their behavior and emotions. Just as they have poor emotional self-control and poor problem-solving skills, so about two-thirds of youths with this disorder cannot control their motor systems well. Being active is characteristic of the young, but these young people are *beyond* active. They are described as being driven by a motor, *constantly* moving, twitchy, squirmy, unable to settle down. Their “hyper” activity may also include noise-making such as humming or odd vocalizations and abrupt, impulsive actions that annoy or distract other people.

ADHD and its hyperactivity are often partners with other mental health problems such as Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), Anxiety, and Depression. It may be the feature of ADHD that is most noticeable. It should signal to you that this young person is also likely to have trouble with attention, following directions, and making good decisions as well as problems with emotional and behavioral control.

How can we help hyperactive youths?

Provide reasonable outlets for energy. Accept and plan for their high activity levels as part of who they are! Adequate space and time for exercise and energy release are important for all youths. They are essential for those with hyperactivity. Walking, running, sports, and exercise are a big help and keep spirits up.

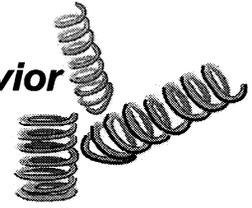
Make limits clear. Roughhousing, chasing, and bothersome interactive behaviors should not be allowed. They infringe on other people's boundaries. Living in a group setting may be a big challenge for the youth with ADHD. They must have rules made simple and direct. Post rules clearly as reminders—Hands OFF!

Check that hyperactive youths follow sleeping and eating routines. ADHD symptoms are made worse by sleep deprivation and hunger. Schedule an every-night routine before bedtime that avoids stimulation and lets everybody wind down. This is essential for letting the hyperactive young person settle down enough so that he is able to “shut down his motor” and fall asleep once s/he is in bed. Try to see that s/he starts every school day with a big breakfast and doesn't forget to eat during the day.

Think ahead to avoid over-stimulating or troublesome situations. Keep your antennae up for chances to head-off trouble by deciding who sits, stands, and goes where, when, and next to whom.

Stimulant medications help. If they have been prescribed, see that they are taken and that the youth discusses their effectiveness with his medical provider.

Other causes of overactive behavior



Too much sugar? Surprisingly, no! — not according to all the carefully controlled studies that scientists have done trying to prove what many of us believe we have observed. What might be going on is that sugar is often mixed with caffeine in soda pop and chocolate which can cause problems; or sugar fills kids up instead of more complete foods eaten at the dinner table; or sugar is eaten or drunk after school when kids are wilder anyhow. About 5% of hyperactive reactions, however, may be wholly or partially due to food-related substances including sugars, dyes, and additives.¹ It does make sense to limit junk.

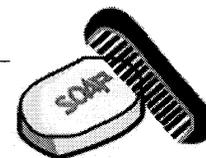
Stimulant abuse Youths who are high on crack, cocaine, methamphetamine or other stimulant drugs may be very active, feel very powerful and energized. They might also be aggressive and goal-driven in their overactive behavior. These behaviors are time-limited and seem much less random than the behaviors that we see typically associated with ADHD. (See *Alcohol & Drug Withdrawal*)

Bipolar Disorder Youths who are in the manic phase of a manic-depressive illness may go to behavioral extremes that include hyperactive behavior. They may be restless and physically very active, unable to sleep. They tend to talk endlessly and loudly and to come up with one grand idea after another. They feel compelled to act on these. (See *Bipolar Disorder* .)

Tourette's Disorder and other tic disorders Tics are bodily movements and vocal sounds that a person may be able to suppress for a while but not fully control. Tics can be mild, or they can be complex and occur so often and involve so much of the body that they appear to be random hyperactivity. TD often goes along with ADHD which makes it hard to distinguish from it. Its symptoms get much worse in stressful situations. (See *Tourette's Disorder* .)

Agitation Restlessness, pacing, inability to settle down, and hand-wringing coupled with irritability or fretfulness are signs of agitation. Some young people may feel severe anxiety due to their placement in your facility or to a mental disorder and may show it by restless, agitated activity. Think of agitation as a signal that you need to pay close attention and help the youth deal with stress before a full emotional meltdown occurs.

Hygiene & personal cleanliness



Basic rules for personal care are included in the guidelines youths receive when they enter Shelters and Detention Centers. Routines of bathing and laundering clothes are structured into their routine. But refusal to shower, shampoo, or clean teeth, nails, or clothing and failure to take care of odors of toileting, sweat, or menstruation are personal decisions. **Think about the meaning or purpose of poor personal care in the life of each youth whose personal hygiene**

need to improve. Your strategies will depend on the function that poor self-care serves, (the need that it fills), in the life of that youth. Maybe avoiding

showing just meets Albert's need to watch TV longer since no one in his family showers much anyway. But maybe Lily believes that male staff have hidden cameras in the shower room and refuses for that reason.

Possible reasons for poor hygiene

Youths may be asserting a right *to do as they choose with their own bodies*. Then they will have to recognize the rights of others to avoid them.

Do a Cost/Payoff exercise with them. Other reasons include:

Refusal to bathe. A youth may be . . .

- deeply **apathetic and care too little** about herself or himself to care whether s/he is clean or not. This is true of depressed people and can be a warning sign of potential suicide.
- **unaccustomed to regular bathing** in a poor or neglectful home and believe it is unnecessary.
- (male) **afraid of having his genitals seen** by others if he has been teased in the school locker room or has an abnormality (for instance, an undescended testicle or Klinefelter's syndrome of undeveloped male genitalia).
- (female) **afraid of displaying her body** if she is obese or sees herself as ugly or having under- or over-developed breasts
- **very anxious** and excessively modest about undressing in a strange place.
- **obsessively afraid of germs** in the shower room.
- **afraid of homosexual contact** or (males) of sexually responding to other males in a group shower.
- **avoiding a flashback** of a previous bad shower room experience.
- **seriously mentally ill** and displaying the deadened interest in appearance and hygiene that is a symptom of severe disorders.
- having the same reaction due to drugs.

Refusal to care for hair. A youth may be . . .

- **wanting to deceive staff by getting hair wet without washing** it with shampoo.
- **suffering from dandruff** (seborrheic dermatitis) that requires special shampoo and unwilling to use a substitute.
- **unwilling to wash out hair coloring** or treatments that have been added for style.
- **unaware how offensive** the look and odor of unwashed hair is to some people.

Refusal to clean teeth. A youth may be . . .

- **ignorant of dental hygiene** because his whole family is not in the habit of brushing.
- **afraid to brush because of bleeding gums or sensitive teeth** due to poor nutrition and/or lack of dental care.
- **unused to the toothpaste provided** and refusing to brush with an unfamiliar products.

Refusal to keep one's body smelling clean. A youth may be . . .

- **poor or young** and not accustomed to using deodorant.
- **a believer in natural odors** as the way people are supposed to smell.
- **encopretic**, i.e. someone who cannot help soiling his pants. (*See Defecating in the wrong places*) Many people with this problem grow **immune to their own odors** and are not aware of how offensive they are to others. More frequent in boys than girls, this requires medical treatment.
- **incontinent**, i.e. someone who cannot help wetting her pants. (Called daytime or diurnal enuresis.) As is true with the problem above, the odor this causes may not be as noticeable to the girl herself as to others. More girls suffer daytime enuresis, while more boys have nocturnal or nighttime enuresis into their teens. (*See Bedwetting*)
- **poorly instructed on sexual hygiene**. The importance of cleanliness, especially during menstruation, concerns raised by discharges from penis or vagina, and knowing when to seek medical advice may be missing information.
- **afflicted with athlete's foot or other fungi** that never clear up in dirty socks and shoes and that cause smelly feet.
- **attached to clothing** that s/he feels looks good and wears repeatedly despite its smelling bad.

Refusal to care for skin. A youth may be . . .

- **suffering from acne** and not knowing how or having the means to care for it.
- **applying cover-up products** inexpertly or not cleansing skin after use.

And then there is the matter of products. A youth may be . . .

- **genuinely allergic** to the products available in your facility
- **strongly opinionated** about what s/he can and cannot stand to use, what will make skin break out, rashes appear, and what odors will make him or her sick. These are not trivial concerns for some people! (*Tip — Preferred products make great reinforcers!*)

(See the Cost/Payoff activity in the Resource Section.)

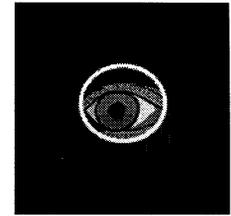
Isolation—avoiding being with or talking to others

A youth's isolating him- or herself may make sense.

Being sent to a Shelter or Detention Center is stressful. The situations young people have been thrust into may be too much for them to handle. Instead of seeking people out for friendship or help, some will withdraw into themselves.

They may be depressed or too worried to feel sociable. They may need time alone to gain emotional control. They may be basically shy.

Be concerned about isolation if it continues for more than the first few days or is accompanied by a low mood or agitation.



GUIDELINES FOR DEALING WITH ISOLATIVE BEHAVIOR. Shelter and Detention settings are organized around group living, so “loners” are a tough fit.

First, think about what *function* isolation has in the youth's life right now, the *purpose* it serves that boy or girl.

Second, find out these things: Is **this typical behavior**? Did this young person isolate herself at home and school? Is this a basic temperamental factor, or is it a new behavior that began when she came to your setting?.

Third, check it out with the youth: “*I notice you stay by yourself as much as you can. Can you tell me something about that?*”

Then, decide what to do. We need to **respect youths' personal preferences not to be socially involved with others**. That does not mean we excuse them from taking part in group activities that are part of the scheduled routine. At mealtimes, youths *do* have to sit at the table with others, eat with acceptable manners, and pass the food when asked to. They *do not have to* make eye contact, smile, or take part in conversations.

This is most important: Never give up on or forget about the isolative youth. Check in regularly to offer quiet support.

Some purposes or functions of isolation to consider— AVOIDANCE:

- of specific people who have known the youths or their families in the past who they are afraid may reveal things about them;
- of peers in your setting who harass them when staff is not around and threaten harm if they tell;
- of sexual approaches;
- of plots contrived by others to do harm.
- of people in a more dominant racial or cultural group in your setting;
- of anyone who is “stupid enough” to be there in a place like yours;
- of people in general;

GAIN FROM OTHERS' CONCERN:

- to act miserable so that it will be reported to those at home and make them feel sorry or worried;
- to pretend to be depressed to solicit special concern from staff, or to signal the need for a mental health evaluation.

FOCUS ON INTERNAL STIMULI:

- to be left alone to be totally preoccupied by one's own thoughts or imaginings;
- to be able to focus on the commands and comments of voices and sights in hallucinations;
- to be left alone to focus on one's own feelings and thoughts—feeling upset or sick or absorbed by ideas and memories of outside people and situations.

Helping responses—

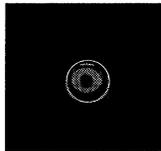
When we have identified a probable function of the isolative behavior, ideas of how to deal with it will become clearer:

- How much we *can* do depends on the purpose of the isolation. Is it to avoid something that **can be changed**? Or is it to avoid something that is **only illusionary**? Or do you think it is all an **act**? Or is it the sign of an **isolative personality** or a **serious mental illness**?
- If the youth reveals s/he is fearful about peers or staff, **work directly to address those specific problems**. This may be a matter of offering adequate protection while the youth is in your setting and/or of negotiating conflict resolution.
- If the youth is socially inadequate and generally at odds with peers, **coaching in needed social skills may be helpful. Identify the skills the youth lacks and teach them**. Provide opportunities for individual practice and give clear feedback.
- If the youth is immature and awkward, **teach age-appropriate things to say or do so s/he can socialize with same-age peers without embarrassment**.
- Youths who really dislike social contact may increase group interactions if they have incentives to work for on their behavior plans. **Earning reasonable periods of time alone can be a powerful reinforcer for times spent socializing**.
- Provide the youth who does not interact with people **other ways to communicate ideas and feelings with others such as by writing and art**. Help him or her develop a relationship with at least one person for sharing these expressions.

Isolation from the mental health perspective

Human beings are social creatures. When a person isolates him- or herself from others much of the time, we see that as a problem. Withdrawing from contact with other people is a feature of a number of psychiatric and neurological disorders.

- **Depression** may cause young people to stop wanting to be with their usual friends. They do not have the energy or interest to seek out new ones in an unfamiliar setting.
- **Anxiety disorders** include such problems as Social Anxiety and Generalized Anxiety that can make teenagers very fearful of social contact.
- **Psychotic disorders** may cause youths to feel no need or desire at all to socialize with others. Medications and structured daily activities will help.
- **Autism** really means “I-ism,” and people with neurological disorders on the autism spectrum, including **Asperger’s Disorder**, will have little to no interest or skill in dealing with others. They may do well following a structured routine, especially if it includes brief “rest periods” they can look forward to for spending time alone each day. (See the pages on these disorders.)

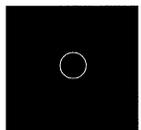
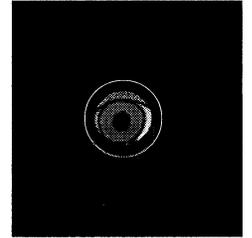


Think about isolation as a consequence for behavior.

- Is isolation (in a control room, time-out, quiet room, the youth’s own room) used in your facility as a negative consequence for behaviors you want a youth to stop doing?
- The basic rules of behavior management tells us to *reward* behaviors we want to have the youth do more often; *ignore or punish* behaviors we want done less often or less intensely.
- Consider the disorders and personality traits on this page. Imagine a youth with each one of them. Do you think that he or she would be *rewarded or punished* by spending time alone in your control or time-out room?
- Has any of your clients ever done things wrong purposely to be *rewarded* by isolation? Did that make his or her behavior better or worse?
- How could you use brief periods of time alone as a *positive consequence* for doing the right thing?

Human beings differ. Some are very social, some very isolative, most somewhere in between. Extreme isolation that interferes with normal life can be understood and treated as a personality disorder.

- When **adults** seek help for these extremes and they are not found to have a psychiatric disorder, they may be given a **Personality Disorder** diagnosis. **Antisocial Personality Disorder** and **Borderline Personality** are examples that Shelter and Detention personnel may recognize.
- **The DSM-IV definition of a Personality Disorder** is: “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.”
- **Personality Traits** are: “enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. “Only when personality traits are inflexible and maladaptive and cause significant impairment or subjective distress do they constitute Personality Disorders.” (Emphasis added. We may speak of *traits*, but we should never assume a youth in our care has a personality disorder even if s/he seems to meet the criteria. **Personality Disorders are diagnoses for adults. Adolescents may have all the symptoms in times of stress without their ever becoming permanent patterns of behavior.**)
- **Labels for traits and patterns of isolative behavior** in the DSM-IV are:
 - **schizoid**: detachment from relationships, coldness, preference for being alone, little pleasure in activities, no close friends, indifference to praise;
 - **schizotypal**: as above, but with eccentric behavior and distorted ideas or perceptions, paranoid ideas or suspiciousness, odd beliefs in the supernatural, bizarre fantasies or preoccupations, unusual speech, fear of social contact;
 - **avoidant**: deep feelings of inadequacy, hypersensitivity to negative evaluation, fear of rejection, refusal to do or try anything new because of certain failure, preoccupation with social rejection.



Lying

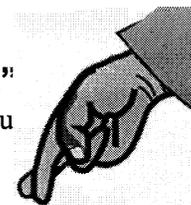
The dictionary defines the verb “to lie” by its two purposes—to deceive and to mislead:

“1) to make an untrue statement with the intent to deceive,”

This kind of lie is **underhanded**. The purpose of lying is to trick people into believing something that will be to the liar’s advantage. This kind of lie usually has a victim. Deceitful lies include *blaming* someone else for your wrong-doing, *spreading false rumors*, *grooming* people to lure them into sexual activities, or *conning victims* for money or services.

“2) to create a false or misleading impression.”

This kind of lie is created on purpose to make people believe you have traits or have had experiences that are untrue. People may not always *intend* harm by telling this kind of lie but do so to appear cool or powerful in the minds of listeners. There are victims, however—the people who rely on the liars to have been telling the truth.



A general rule for dealing with a lie. When we only *suspect* that someone is lying, we often let it go—we don’t have proof of the lie. That is a mistake. It does not give the youth who lies the feedback s/he needs to correct the behavior. Instead, we need to say, “*I find that hard to believe, Marty. I’m going to check it out, and we’ll talk about it later.*” Don’t sound as though you are making an

angry accusation, but say it calmly, as a statement of fact. **Youths who lie to deceive or mislead need to know they were not believed.** If they lied, they need to lose privileges and make restitution for the harm they did. If it turns out that they were telling the truth, say so and apologize sincerely for mistrusting them. If you cannot check out the facts, say so, but tell them why it sounded to you like a lie.

Deceitful lies. We all probably say things that are not true. Why? To be tactful is one reason. Instead of saying, “*That haircut looks hideous on you,*” we might say, “*That haircut is right in style.*” Or to avoid embarrassment, “*I’m sorry I’m late meeting you—my bus was late.*” The first untruth is an *evasion*, and the second is a *fib* (“*a trivial or childish lie*”), but neither one was truly *underhanded* and meant to *deceive* someone. In neither case was there a *victim* or an attempt to *escape the law*. So they were not true lies.

Lying is included as a symptom in only two DSM-IV psychiatric diagnoses: **Conduct Disorder** for children and youths and **Antisocial Personality Disorder** for adults over 18. Other disorders have symptoms that include saying things that are untrue, but they are not called *lies*; lying **means doing something distinctly and knowingly dishonest**. It is important to make this point to young people. When they are accused of lying, they may be quick to point out other people’s untrue statements as lies. They need to know that **what is wrong about a real lie is that it can do harm and that many of them are illegal**. Give examples of perjury, withholding evidence, lying to protect a witness, fraud, etc.

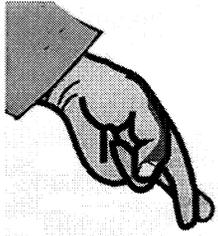
When youths are caught lying about what they or peers did, be sure that they know that their lies have been uncovered and that *for that reason*, a privilege has been lost. **Young people need to understand that lying has negative consequences.** When they tell lies, they think only of the many payoffs the lies will have for them—avoiding trouble, getting over on people, etc. They need practice thinking about the *problems* their lies can cause for others and for themselves. **They lose people’s trust; they lose privileges; they risk angry pay-backs; they risk trouble with the law.**

Misleading lies. These are intended to deceive others in a way that will make the liars look other than they truly are to their listeners.

Reason—To make a social impression. Youths newly admitted to Shelters or Detention Centers may publicly tell tales of exploits that they believe will establish their reputations as notable persons to be taken seriously by peers and adults. These stories may be wholly or partially false and are sometimes wildly exaggerated. The purpose in telling them may vary from winning friends to scaring people off. **To handle the problem, discourage the open telling of wild “war stories” in general, true or not.** They glorify antisocial behavior and encourage just such lying. Simply say, “*No personal history stories, please. Everyone’s past is confidential—the past is just what’s over. Think about today and the days after you leave.*” Talk with the youth privately about the story and what about it was true and not true.

Reason—To create a false impression. Here the goal is to convince others that you are great at doing something when, in fact, you are not. Most kids will at some time brag and be unable to live up to their claims. Among young people with risky behaviors, this is most dangerous when the claims have been about crime, sex, drugs or weapons, and they are expected to make good on what they have said. Misleading lies become legal problems when they involve truancy, forgery, identity theft, or fraud.

There is no easy way to handle the problem of lying. It becomes a habit. **At the moment of telling a lie, the probability of that single lie’s being successful is greater than the probably of its being caught.** **Work on showing youths the legal, social, and monetary costs of lies** using the Cost-Payoff activity. Use examples from movies, articles from the newspaper, and stories on TV to make the point. (*See the Cost/Payoff sheet in the Resource Section.*)



Not all untrue statements are lies.

That is not clear to all young people, especially when they are upset by something they hoped for that failed to happen. If Dad said he would come visit on Sunday, but there was a huge ice storm Saturday night that closed the roads, he had not *lied* when he promised to come. **Define lies as false stories *meant* to deceive or mislead.** Dad did not mean to do either of those things. He wasn't a fortune-teller—he did not know it would snow. **This kind of mistake shows that the youth is not really sure about what a lie is and what is wrong about telling one. He believes Dad *lied* just because what Dad said didn't turn out to be *true*. For him, anything that turns out to be untrue is a lie; he has a poor ethical concept of what it is to tell a lie.** Distinctions of this kind are hard for many young people to make, especially if they have not learned to value truth and when strong feelings are involved. That may be a part of what happens when a youth lies about being to blame for doing something wrong that we have actually seen him or her do. Defensive feelings overwhelm rational thought, and more rather than less trouble is the result.

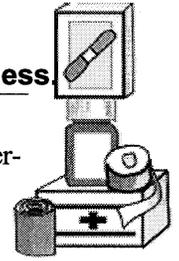
Talk with youths about truth, lies, and all that fall in between. Teach a group what “to lie” means as defined here — **to deceive or mislead *on purpose*.** **Emphasize the damage that is caused by a lie, not just the fact that what was said is untrue.** Make a list of D words under the heading **Lies = Deceit**. Have the group think of other D words that lies can lead to— damage, distrust, divorce, death. What is a “white lie?” Do friends ever lie? Enemies? Adults? What is perjury? Rent the movie *Liar, Liar* and talk about it. What is a fair way of dealing with someone who has told a lie about you? About a friend? What is an oath to tell the truth? Whom can you count on to tell the truth? Does it take more courage to lie or to tell the truth?

Reasonable goals for these activities are to have youths understand that:

- 1) telling a lie is a deliberate, underhanded act for the purpose of deceiving others into believing what is not true;
- 2) telling a lie usually damages victims by betraying their trust, casting blame on them, cheating them, or leading them into trouble;
- 3) telling lies has severe, long-term social and legal consequences for the liar that are not worth their short-term benefits.

Hypochondria, Somatization, & Malingering—“Sick body” problems

There are words for feeling and acting sicker than a doctor might agree a person really is. But they don't all mean *faking* sickness.



• **Hypochondria—genuine worry that one has a serious disease when one does not.** Normal bodily functions such as heartbeats or stomach growls, small problems such as sores or coughs or headaches, or vague symptoms such as “weak arteries” are misunderstood to be the symptoms of a serious disease. This belief is usually based on having a little knowledge about an illness and may be so strong that even a doctor’s reassurance cannot shake it. **Hypochondria often starts in the teenage years. It can last a long time and interfere with normal life.** Youths who had a severe illness when they were very young or who have experienced it in someone close to them are vulnerable. Some get over-anxious about their health just by seeing medical shows on TV. **They may ask to be seen by a doctor constantly, though some are so afraid of what they will find out that they refuse to be examined.**

• **Somatization—real, multiple, but vague and exaggerated physical problems.** People who somaticize have recurring physical problems in many body systems. The problems are clinically significant. That means they do result in medical treatment and interfere with normal life functioning. Somatization disorder tends to be a lifelong health and mental health problem. Like Hypochondria, it typically begins in adolescence. Symptoms include pain in various parts of the body; nausea, bloating, or other stomach or intestinal problems; difficult menstrual periods for girls; and pseudo-neurological symptoms such as double vision, amnesia, and pseudo-seizures. (These are not faked, but neither do they show up on such measures as EEG readings.) These health problems appear over several years and cause constant discomfort regardless of changes in mood or life circumstances. **People who somaticize seek almost constant doctoring and tend to discuss their medical problems freely. Somatization often goes along with depression, substance abuse, and personality disorders.**

• **Malingering—deliberately faking sickness to gain or avoid something.** Drinking salt water to throw up and miss school or faking whiplash to make an insurance claim is malingering. But there is a rare kind of faking that is due to a true mental disturbance—**Factitious Disorder. That is pretending to be sick because of a need to be treated as a sick person.** The person does not exaggerate true symptoms, though he (mostly males) may produce symptoms by self-injury or by ingesting something to make himself sick. He is a skilled actor who knows medical terminology, even talking doctors into unneeded surgeries. This disorder has its onset in early adulthood. As a rule, children and teens have a partner in the illness, a parent with an irrational need for his or her child to be sick. An older name for this disorder is *Munchausen by Proxy Syndrome*.

How can staff know for sure how sick is too sick?

Your health provider will establish the guidelines for giving over-the-counter medicines and going to the doctor. **All staff members must be alerted when a youth is admitted with special health issues such as diabetes or heart problems.** Special rules will apply to them. In general, however, activity guidelines for sick adolescents are fairly simple. If the youth does not have visible signs of illness (such as vomiting, diarrhea, a rash, a cough that is producing yellow sputum) and/or a temperature over 100 degrees, he or she is probably well enough to attend school and other routine activities. If the youth does have symptoms of an illness, your sick-day protocol needs to go into effect.

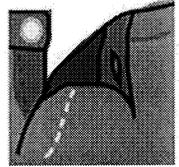
What should the sick-day protocol include and not include?

If someone is too sick to follow your routine schedule, s/he needs bed rest. That continues until bedtime—a **sick day is a sick 24-hour day, not one that lasts just until friends return from their school day.** Drawing, writing, and reading are good bed-rest activities. No television, video games, or socializing for the first 48 hours of an illness. (Young people who have to be isolated from the group for longer periods of time may have more activities as time goes on.) Obviously, these restrictions are meant to meet two goals — providing rest and also seeing that being sick is a non-rewarding event.

How do we deal with the youth who complains a lot about feeling sick, but who never is sick enough to miss the daily routine?

Since we can never know for certain what is real and not real, at some point a decision will be made for the youth to see a doctor. No one in an institution wants to risk missing a genuine health problem. **Even if we believe that the problem is “mostly in his head,” however, we never act sarcastic or deny that the youth really does hurt or feel unwell. Remember that in Hypochondria and Somatization, the problems are real to the person who has them.** We can take a girl’s temperature and say no, she cannot miss school, but add, *“I’m sorry—it’s no fun to go to school when you’re not feeling good. I don’t like coming to work when my stomach aches, either;”* or to a boy, *“I know it hurts, but this way, at least you won’t be in bed when school’s out. Maybe by then you’ll feel good enough for basketball practice.”* We don’t let youths miss activities because of mild or exaggerated health problems, and we don’t reward being sick. **The protocol’s structure provides all the firmness needed. That way, we can be kind and pleasant in our interactions with the young people themselves.**

Masturbating in view of others



GUIDELINE FOR BEHAVIOR IN PUBLIC PLACES: First, using a quiet, firm voice, stop the youth's behavior by giving a direction to change activity, location, or proximity to staff: "*Chris, please put your hands on the desktop,*" or "*TJ, come stand next to me,*" or "*Please bring that waste can over here.*" If the youth refuses to stop, move him or her out of the view of others. Be accurate and matter-of-fact. "*Rubbing yourself against... putting your hand down your*

pants and . . . is sexual behavior. The rule for everybody is, "No Sexual Behavior in Public Places." If s/he does not stop, direct the youth to a private place. Ask about soreness or itchiness. Perhaps a urinary tract or genital infection is prompting the behavior and needs checking. What developmental, health, or social needs does open masturbation meet for the youth?

<u>Mental Retardation</u>	<u>Posttraumatic Stress Disorder</u>	<u>Conduct Disorder</u>	<u>Sexual Offenses</u>
<p>What is gained by the behavior? <i>Physical satisfaction, pleasure; Relief of tension.</i></p> <p>Helping responses The greater the degree of retardation, the more difficult it may be to limit masturbation, especially when the person is stressed. The simplest way to limit the toughest problems is to limit access by seeing that jeans are securely fastened with a belt and perhaps covered with a zip-up jacket. No sweat pants. Have activities available to keep hands busy.</p> <p>Observe the youth for those times and places when s/he is most likely to masturbate. When s/he is lonely and bored? Over or under stimulated? In a certain time and place in the day-room? See that staff spend time then and there.</p> <p>The availability of private space and adequate time for using it for private masturbation will require an individualized plan and some sex education. Set up a simple system for rewarding a shift without problems with a high-five or a coke for a Good Public-Place Behavior shift.</p>	<p>What is gained by the behavior? <i>Response to images of sexual abuse or trauma, maybe from an earlier age; Relief of stress.</i></p> <p>Helping responses When you have taken the youth aside, discuss alternative methods for tension release—relaxation and deep breathing, for instance. Inquire about anything that may have triggered these sexual behaviors. Remind him or her of the value of talking about feelings instead of acting them out.</p> <p>The youth may need quiet time and support. Public masturbation is unusual in a normally functioning adolescent; refer for psychological evaluation or counseling if concerns continue.</p> <p>Observe the youth for those times and places when s/he masturbates. PTSD can involve panic, hallucinations, and suicide, and your observations should be carefully recorded. The counselor working on these problems needs to be trained in trauma counseling. Our role is to be that of a source of guiding adult support who will see that the youth is kept free from further harm.</p>	<p>What is gained by the behavior? <i>In these cases, the purpose for the behaviors may be closer to exhibitionism than to true masturbation. Attention, either negative adult attention for its shock value or positive peer attention for daring to flaunt sexuality; Power, to assert control over an individual or group by sexual authority.</i></p> <p>Helping responses When you deal with this behavior, be sure your words and actions are low-key. The more outraged the adult, the bigger the payoff for the disruptive youth. During your talk, don't argue about denials and about what was going on. Just say, "<i>Nevertheless, it appeared you were _____, and the rule of public behavior is, No Sexual Behavior in Public Places.</i>" Your request has been that s/he stop, so follow that up.</p> <p>Later, when the heat is out of the situation, ask the youth what was going on. Say you were taken aback by what s/he was doing, and you needed to check it out. Be alert for sexual harassment or sexual mastery issues associated with conduct disorder. (Talk about sex with another adult present.)</p>	<p>What is gained by the behavior? Try to tell if the act is a) more for self-gratification or b) to gain others' attention.</p> <p>A) Satisfaction of a compulsive urge to masturbate. A strong preoccupation with sex in adolescence can be a predictor of adult problems;</p> <p>B) Eliciting another's sexual response. Power, gaining control, often over a younger peer.</p> <p>Helping responses If the youth is in Detention because of a sexual offense, the behavior needs to be stopped, of course, and then evaluated in that context. If s/he is actively involved in a sexual offenders' program, report masturbation to that therapist. Then recommendations can be made that will fit both the history of sexual offenses and present treatment.</p> <p>Many people caught sexually offending are low functioning and impulsive. These limitations must also be kept in mind when treatment plans are made. <i>(See Sexual Acting Out)</i></p>

If the behavior is way out of bounds, the youth may be in a manic phase from Bipolar Disorder or reacting to drugs. S/he may need medical attention.

Mood swings – Wide or sudden shifts from high or elated moods with laughter or silliness, through flat moods, to negative moods of anger, fear, or depression.



What is the basic cause of mood swings?

Adolescent brains lack full capacity for emotional self-control. Powerful hormonal changes mark the start of adolescence. Around age 13 is when their direct influence is greatest. The remaining teen years are filled with intense interpersonal, physical, and social change, all affecting brain development. **Throughout their teens, youths have limits in their ability to control their moods and the reactions that moods trigger.** Modern neuroscience has shown us that **the brain's emotional control centers are not fully developed until about 25 years of age.** (Declaring legal adulthood to start at age 21 was pretty good common sense!) Until then the pre-frontal cortex, the part of the brain behind the forehead that controls the brain's executive functioning, is not fully developed.¹ That means that young people do not yet have the brakes fully installed that will allow them to slow their emotions down. A strong emotion creates chemical changes throughout the body that readies it for action—fight, flight, making love or war. **Youths do not have the ability to override these emotions, reduce their power, and put off acting on them to the degree that adults can.** This is especially hard for those who also have mental disorders or who are under extreme stress. Weeping, storming, sulking—these “bad moods” are under limited control.

In general, what are good helping responses?

#1—To help with mood upsets, give more empathy than advice.

Avoid labeling the mood swings or pointing them out critically—*“Now you're yelling at everybody, and just ten minutes ago you were on top of the world!”* This will not make the present problem go away and is likely to make the youth feel more upset. **It is pointless to advise people about what they should and should not feel. Emotions just are.** Offer an empathic observation that will let the youth see that you are trying to understand. *“You seemed very upset just now. What's up?”* *“It looks like you're really mad about something.”* If s/he does not want to talk about it, that's okay. Just give the youth space enough to regain emotional self-control. **Offer a cool-down.** Take him or her aside to **reduce stress. Demonstrate adult emotional control** by modeling it yourself. *“I don't like being shouted at. But I figured you were having a hard time and needed some quiet space, so I brought you here.”*

#2—Teach what emotions really are and how to express them in words.

This is the key skill to teaching people to help themselves gain emotional self-control. Young people often feel that they are controlled by powerful emotions. Once they understand that emotions are natural reactions of their

brains and bodies to internal and external pressures and events, they can begin to control *them*. Many young people have not learned the language of emotional self-control. They need to learn to recognize their feelings so that they can *name them* and *talk about them* instead of *acting them out*.

Help that process by encouraging youths to think about and express their feelings instead of simply releasing them in emotional outbursts. *“You seemed very riled when . . . What were you feeling about that? Emotions are built into our brains to help us survive. But we have to name them and talk about them, or they can make us feel bad. So think about how you were feeling when you got so upset. Were you angry? Frustrated? Think—how does “frustrating” feel?”* Then help the youth practice saying, *“I am frustrated...I feel sad.”* Recognizing, labeling, and expressing emotions in words are the key skills needed for calming down one's own level of emotional intensity and gaining control.

Special considerations

Attention-Deficit/Hyperactivity Disorder (ADHD). Young people with this disorder have an especially hard time keeping their emotions under control. **Problems with emotional self-regulation are a central characteristic of ADHD.** Youths who have ADHD have a hard time keeping themselves from acting on the emotional impulses that strike them. The degree of upset they experience over an incident may seem far beyond what is reasonable for their age. Some might seem emotionally very young, giddy and then pouty and then angry. These episodes feel less like full mood swings than quick, impulsive shifts in mood, but they can get a youth into a world of trouble. Work on teaching them to **Use Your Words to Express Your Feelings.** Show them that *words* (*I'm sad, I'm disappointed, I'm frustrated*) work better than *actions* (getting back at someone or tearing things up). They get their feelings out; they get in less trouble; problems can be solved. Teach stress management skills to help the ADHD youth manage strong feelings.

(See ADHD pages and, in the Resources Section, Stress Management and Expressing feelings in words.)

Substance use/withdrawal. Methamphetamine withdrawal is known for mood swings between irritability, depression, anxiety, and paranoia. Keep withdrawal from alcohol and drugs always in mind when we see youths in emotional trouble. Seek advice from a substance abuse counselor or doctor.

(See Drug and Alcohol Withdrawal.)

Mood Swings: special considerations, continued

Premenstrual tension. Up to 88 percent of adolescent girls experience discomfort for up to two weeks before the start of their period. Symptoms can include weepiness, irritability, mood swings, depression, and aggressive reactions in addition to poor judgment, concentration problems and physical discomfort. These problems are more common in older than in younger girls. Basically, they are due to imbalances of progesterone, serotonin, and nutrients. Many girls will be familiar with their own symptoms and prefer certain over-the-counter remedies for backache or water retention. See that your medical provider orders suitable ones to be kept on hand. **Be sure that girls are not belittled as being “on the rag” because of their emotionality.** This may be especially important in corrections settings that are oriented toward boys’ culture and needs. Young girls may not have good understanding of their moods’ relationships to their reproductive systems. Boys also have hormone-driven mood swings in adolescence. They are not cyclical, and so they are not recognized as being hormonal. **All youths need to have their emotions respected and to be supported in learning to express and manage them.**

Emotional Regulation Disorder traits. Some young people are described as having a cluster of behaviors that is named for mood instability: *Emotional Regulation Disorder* is what **Borderline Personality Disorder** is more accurately called in Europe.² Most of the people who have this disorder are young women, age 18 and over. (When we see the problem in younger people, we speak of their having those *traits*.) They have bouts of intense anger, depression, and anxiety. They may emerge on and off for an hour or last for most of a day. Intense problems with relationships that switch from positive to negative may trigger some episodes. **It is important not to be drawn directly into these emotional issues.** This can easily happen, as these young people may be very needy for close emotional relationships and seek to rely on us too heavily. The relationships may then become unstable and conflict-ridden. Staff in shelter and detention settings can be supportive and helpful at an emotionally safe distance by respecting young people’s feelings and helping them understand and express them. These principles are the heart of the treatment that research has shown to be most effective for people with this disorder, Dialectical Behavior Therapy (DBT).³ While that requires many sessions over time, we can teach **1) that these young people’s feelings are valued, and 2) that they can express feelings through words instead of acting them out.**

(See *Borderline Personality Disorder*.)



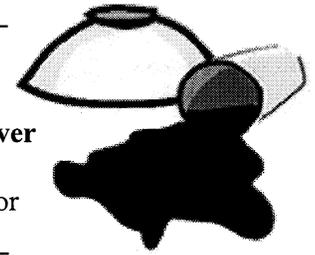
Posttraumatic Stress Disorder (PTSD). PTSD is the reaction of the body and the mind to overwhelming stress. Many youths in our shelters and detention centers are there because of what have been, to them, extremely stressful events. They tend to re-experience the trauma with the same emotional intensity as when it originally happened. This can lead to major mood swings or even sudden rage outbursts. Others may have experienced sexual or physical abuse in the more distant past and still experience flashbacks. These take the form of visual or verbal recall of that event. Sudden startle responses, fearfulness, and avoiding anything that reminds them of the trauma are other hallmarks of PTSD. The youth may seem to be having a panic attack and having a hard time breathing. **These kinds of extreme mood reactions are best helped by calm reassurance and an offer of some space and quiet. Most PTSD sufferers prefer not to be touched but welcome a calm, matter-of-fact reminder of the reality of present time, place, and safety.** It may help to prompt the youth to take a calming breath. (See *Posttraumatic Stress Disorder* and , in the *Resource Section, Stress Management*.)

Bipolar Disorder. Mood swings related to this serious mood disorder have a different feel to them than the mood swings that are part of general adolescent moodiness. The youth with bipolar disorder goes to emotional extremes, from periods of depression to periods of mania. Most adults stay at one extreme “pole” or the other for weeks or months with some normal time in between. Some adults and young people who have this illness experience “rapid cycling” and switch from one extreme to another daily or several times within a day. What characterizes bipolar mood swings is their irrationality. They are way out of proportion and totally unrelated to things that are going on. **Appeals to logic and setting up consequences are unlikely to change the youth’s behaviors.** They are signs of a medical problem and require a doctor’s treatment. **The youth with these problems needs to be given clear, simple directions and guided to behave safely.** (See *Bipolar Disorder*.)

Head injury. People who have suffered traumatic brain injuries may have what is called *emotional lability*. That means that their emotional reactions are sometimes driven by random neurological impulses. They may break down in tears or in laughter or in anger without meaning to. They may change rapidly from one mood to another or go way too far expressing an emotion. This may happen when it doesn’t make any sense to themselves or to anyone else. It is likely to be very disturbing and embarrassing to the persons themselves. **Help the youth calm down. Encourage him or her to take some calming breaths. Model calm behavior and offer reassurance that you understand.** (See *Cognitive Disorders*)

Refusal to eat

Ideally, we want the young people we care for to enjoy their meals. Your facility will have rules for orderly mealtimes—but food preferences are very personal. **It is best not to have rules about minimum amounts or varieties of food that must be eaten.** The more attention adults pay to refusals to eat, the stronger the refusals are likely to grow. **Eating can quickly become a power struggle over who owns the youth's body,** and that is a struggle the youth must win. Clinical reasons for refusals to eat are listed on the back of this page. They are useful to think about because of what they tell us about the young people in our care. Rarely, however, would Detention or Shelter staff attempt to treat a true eating disorder in their facilities, and if they did, it would be by following a clinician's directions.



Refusals to eat can be due to personal, short-term decisions. Youths may go without meals to prove a point, to lose a few pounds while with you, or to follow the example of someone who has an eating disorder. Picky eating of small amounts may be due to homesickness, unhappiness, worry, or dislike of the food. **Ask one time, acknowledge the reason politely, (Oh, I see—that's too bad), and drop the subject.**

Guideline # 1

Do not assume that all refusals to eat are due to eating problems and disorders listed on the next page. They could also be due to **gastro-intestinal problems** such as colitis, or to **neurological disease, infections, or cancer.** They could be due to other **psychiatric disorders.** Loss of appetite is a key symptom of **Major Depressive Disorder.**

Guideline # 4

Downplaying eating behaviors does not mean staff should ignore the possibility of eating disorders. They are very serious and can be fatal. They may co-exist with anxiety, depression, deliberate self-injury, and other problems that are less visible. Young people who refuse to eat and appear emaciated need to be checked by health providers familiar with these disorders. The regimen of supervised calorie intake, weigh-ins, and therapies to restore healthy thinking will exceed many Shelter and Detention Centers' ability to provide.

Guideline # 7

When a youth has refused liquids for two days or food for three, say that you are concerned. You need to arrange a medical checkup. What are you concerned about? That s/he is getting dehydrated, that with so little nutrition, blood pressure could be low, and electrolytes could be off. A blood draw may be needed. **Keep the focus on physical health, not on the non-eating.**

Guideline # 2

If a client has a stimulant medication prescribed, (e.g., Ritalin, Dexadrine, Adderall), be sure not to give it before meals. These drugs can cut appetite almost immediately. Wait until the last few minutes of the meal or later. Youths taking these medicines may be very hungry by evening. Then they should be able to eat all they want of nutritious snacks.

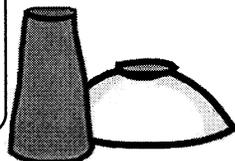
Guideline # 5

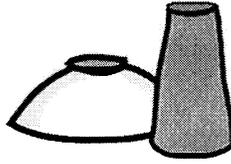
Do not speak of poor eating as an Eating Disorder. It is better not to quiz youths about their weight or focus on their reasons for leaving food. Be off-hand about it. Eating refusals quickly grow into issues of control. Our urging is likely to make control problems worse. **Observe and keep track of problems. Talk them over talk with staff or directly with health providers.**

Guideline # 3

Remember that we cannot command or punish away a mental health disorder. If someone steals food for bingeing or throws up after meals, try to manage the environment rather than confront the youth. For instance, have everyone use bathrooms to toilet and wash their hands *before* meals. Supervise bathrooms and then close them for an hour *after* meals. Offer lock-up cupboards for clients' treats sent from home.

Guideline # 6





EATING PROBLEMS

Medical eating clinics have labels for Eating Problems:

- **Selective Eating**—means that only a few foods are willingly eaten. This problem usually starts at around age 8 and gradually lessens. The youth who will eat nothing but spaghetti with ketchup, corn dogs, frosted corn flakes, and pie (or who will eat nothing but burgers and fries!) is a selective eater.
- **Restrictive Eating**—is the term for having a poor appetite for *all* food. Restrictive eaters eat a normal range of foods but in very small quantities. They are often thinner than average for their age and height, but not necessarily unhealthy.
- **Food Phobia**—is literally being “made sick” by certain foods. Some youths may choke and gag and complain that it actually hurts to eat some foods, especially if they are foods that are new or especially disliked. Or there may be a connection to a certain incident or to a smell or feeling in the mouth that reminds them of something bad that happened and causes fear or disgust.
- **Food Refusal**—is a problem seen fairly often in out-of-home placement centers. The food refuser might eat normally at home but not at school or not in front of other people. This problem is due more to worry or unhappiness in a certain environment than to any qualities of the food itself. Sometimes, the refusal to eat is mainly oppositional, one of many refusals to take part in setting routines. This is *not* one to focus on—ignore it to end it sooner.

EATING DISORDERS

Mental health professionals diagnose Eating Disorders:

- **Anorexia Nervosa**—a disorder that includes: body weight being *significantly* less than that expected for height and age; a great fear of being heavy, even when one is very skinny; a distorted view of oneself as being fat even when that is clearly untrue and denial of the seriousness of being too thin; in girls who have begun having periods, the stopping of menstruation.
 - **Bulimia Nervosa**—a similar disorder in terms of thinking all the time about body weight and shape; eating huge amounts in a short time period, such as two hours, at least twice a week for three months; feeling a lack of control while bingeing; making up for bingeing by vomiting or sometimes by fasting, laxatives, or excessive exercise. Some people with Anorexia also binge and purge—the difference is that in Bulimia, weight range and menstruation are normal.
 - **Binge-eating Disorder**—a similar disorder to Bulimia except that the person *doesn't* get rid of what s/he has binged on and so is usually heavy. Feelings of guilt and worthlessness are strong.
- Rarely are these disorders labeled purely and simply. They occur mostly in girls, but more and more often in boys where the excess is more likely to be exercise than restricting food. Starving, bingeing, and purging behaviors and ideas of worthlessness based on body size are very common even among young people who do not fully qualify for a diagnosis.

TREATMENT

Treatment for these eating problems and disorders requires that people learn to think differently about food and about themselves. They may have attached all kinds of beliefs to eating that keeps them from eating—*I can't eat in front of other people; I get sick if I eat vegetables; I can't stand to feel that in my mouth.* If poor eating becomes a serious problem, feeding clinics provide medical and psychological treatment. Eating Disorders are psychiatric problems. Irrational beliefs are the heart of the problem, for instance — *no one can like me unless I'm thin; I feel like a disgusting cow when I'm full; I don't need food to be healthy.* Eating disordered people spend most of their time thinking compulsively about food and body size. Their brains become as under-nourished as their bodies. They can no longer think sensibly about themselves, other people, schoolwork, jobs, or the future. Their treatment requires nutrition to restore their health and caring but firm limits to keep them from cheating on eating routines until their thinking improves. Treatment also includes a lot of work on self-image and relationships. Medicine often helps.

People who have eating disorders may have other mental health problems such as depression, anxiety, or severe stress disorders. If you are concerned about problem eating, stay alert for signs of other emotional disorders that may need more direct attention.

Refusal to follow directions

Rules make up the structure of conduct that organizes any group or setting. They need to be few, short, and simple. *Hands to yourself. Lights out at ten.* **Rules are made to apply equally to all persons in the same time and place.** That way, everyone can count on the results of following or not following the rules.

Rationales and respect. Give a brief reason along with your directions. We give directions for many reasons: for keeping everyone safe; for treating people fairly; or just for common sense. **If young people see directions as having some kind of connection to real circumstances, they view staff as being more reasonable in making them.** Rationales can be explained when directions are given: ("*Stop, Teri. You will hurt her,*" "*Please move to the next table, Ross. You're doing a good job so far in avoiding trouble*") Try to emphasize the *payoffs*, the good things that will happen when the direction is followed instead of only threatening the *costs* or negative consequences of not following the direction. ("*Antwan, please change seats with Carlos. That way you will both finish your work in time for rec.*") Directions given this way communicate *respect*, a key ingredient of successful interactions with young people. When we show we have good reasons for directing young people to behave in certain ways, it also builds respect for *our* good judgment.

Refuse to argue. When a youth refuses to follow a rule or direction, *one* rationale statement is enough. **If you are sure that the youth has heard and understood the direction and its rationale, do not give lots more reasons in response to complaints.** Then it will change from a direction into pleading for compliance or into an argument. Do you know any adults who have won arguments with teenagers over following a direction? Even with their undoubtedly better adult logic and wealth of experience? Probably not! So refuse to get trapped in arguments. Once you have given your respectful rationale, simply and calmly repeat it saying, "*Nevertheless, the rule is . . .*" or "*Even so, the direction is . . .*" or if the refusal is in the form of a personal attack on you, "*Nevertheless, it's my job to see that this place runs smoothly, so your choice are . . .*" Don't make other responses, just the same one again and again in a calm, matter-of-fact voice. (See other suggestions on the *Oppositional Defiant Disorder* pages.)

Directions are different—they are individual requests for action. A direction is an order or set of instructions for doing a specific thing. A *rule* may be to follow staff directions, but directions will be more specific. For instance, the rule might be *Hands to yourself*, but a direction might be, "*Leave Tyisha's hair alone and sit over here.*"



Give choices. Practice in recognizing and making choices should be a main theme of our work with our young clients who have probably made many poor decisions. **When staff give a direction, the youth can always make the choice to refuse. It is impossible to force someone to follow a direction unless we are physically much larger and stronger than the person.** If the direction must be followed "*or else,*" know in your mind what the *or else* really is. When working with a young person who is often non-compliant, think of two possible ways that each direction could be followed. "*Sam, please move away from Damon now so there's no trouble. You can come sit down by these guys or go over to the TV.*" The *or else* might be a room restriction, a loss of points for failing to follow a direction, or worse if trouble broke out. **Those negative consequences might ultimately need to be spelled out—but then the choice becomes more a threat than a true choice between two acceptable ways of handling a problem. That is what young people need to learn.**

Consider options. Most people, including ourselves, find it unpleasant to stop what they are doing and follow a direction the *instant* it is given. **Teach young people that a civil response to a direction may earn a reasonable delay.** Consider the cause of the refusal and the time-frame in which the direction must be followed. Maybe you or the youth could suggest following the direction in a slightly different way or doing the thing requested after finishing something else. Young people need to learn that *polite* responses and *civil* negotiation may be as welcome as blind obedience. **It is the habit of automatic defiance that will wreck their chances to succeed in school, job, and the community.** To reduce constant confrontations with a non-compliant youth, plan a strategy with the team who works regularly with him or her. Model and teach acceptable ways to ask adults for a change or delay in the direction to be followed. *Show* that you appreciate the youth's following your directions.



NO!

Some mental health **Why's** behind

Youths who have serious emotional disorders (e.g. Bipolar Disorder, Major Depressive Disorder (MDD), Posttraumatic Stress Disorder (PTSD), Schizophrenia, severe Obsessive Compulsive Disorder (OCD)

Following staff directions may not be very important to youths with these severe disorders. The boy with **Bipolar Disorder** who is in a manic state may be too super-charged with energy and too convinced that he is in charge of everyone else to heed directions from mere staff. The girl suffering from **MDD** may not have the energy to follow directions to get out of bed to start her day. She may not care about the consequences. The young person with **PTSD** having a flashback may not even hear directions or may fear following them if they are reminiscent of past dangers. The **schizophrenic** youth may hear voices commanding him *not* to obey or may be too lethargic to do so. People who have **OCD** feel compelled to follow odd rituals to ease their obsessive thoughts. They may become extremely upset, even violent, when someone directs them to stop.

Youths who have Oppositional Defiant Disorder (ODD).

Here is where the difference between stating rules and giving individual directions can make a big difference. Youths with ODD are, by definition, set to defy adult authority. They have a particularly hard time with one-to-one demands. **The more we can rely on pre-established rules rather than on personal directions the better.** We get better results from calmly saying, "*The rule says do such-and-so*" than from saying, "*I want you to do such-and-so.*" When general agreements about the rules of civil behavior are made clear, we need to give fewer individual directions. Then youths with ODD are less likely to be irritable, argumentative, and set to retaliate. The more demanding we are, the more oppositional youths push back, even when they know they will lose the battle and suffer negative consequences. Our win is only short-lived, however. They will *not* have "learned their lesson," and a power struggle will start soon again over another issue. (See the ODD pages.)

Youths who have Asperger's Disorder or Autism. One central feature of these disorders is mental rigidity. On the one hand, young people affected by them may be very rigidly bound by rules. Once they have a set of rules or guidelines in their heads for how things should happen in a certain time and place, they will follow those rules to the letter. If requests don't fit into their own set of rules, however, **they are sure that *their way is the right way.*** They may become very upset if forced to follow another person's directions. This upset may build to a point of extreme distress or aggression. What is confusing to staff is that people with Asperger's may be extremely bright in certain narrow areas. This may also be true of autistic people who don't have the mental retardation that typically goes along with Autism. This streak of genius makes it seem that they should be perfectly able to understand that they must follow ordinary directions. But they are more confused and upset by new rules and routines than someone who arrived here from a faraway culture or century. **Youths with these limitations need to have their new sets of rules patiently explained, written out, and practiced.** They do not generalize from one situation to another and may not understand what rules apply where. Make those differences very clear. They handle transitions poorly, so give advanced warnings about any shifts in rules or routines.

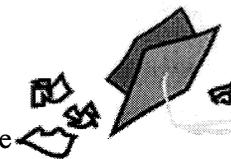
(See the Autism and Asperger's Disorder pages.)

Youths who have Attention Deficit Hyperactivity Disorder (ADHD).

To make it more likely that youths with ADHD will follow directions, we need to do these things: **1) Get the youth's full attention;** **2) Give the direction—one step at a time, if possible;** **3) Use simple, direct words;** **4) Have the young person indicate that s/he got it; and** **5) Acknowledge a good job.** People who have ADHD truly cannot hold a complex set of directions in mind. We need to adjust the directions to fit the way their brains and bodies work. It is *our* job to make it possible for them to do *their* jobs. (See the ADHD pages.)

School refusal or truancy

School refusal usually refers to **students' feeling such high anxiety about going to school that they will not go.** This can be a short-lived problem due to a specific fear about a person or situation. When it becomes an ongoing problem, it is a disability in which a student has severe problems coping with irrational fears that are as much about leaving home as about school. The DSM-IV name for this is *Separation Anxiety Disorder*.



Truancy usually refers to **students' skipping school because they would prefer to be anywhere else.** It is illegal behavior with various consequences such as fines or jail sentences for parents and detention sentences and loss of drivers' licenses for youths. Truancy deprives youths of learning crucial academic, social, and coping skills. It accustoms them to ducking responsibilities. It gives them free time to spend committing crimes. Recent statistics show that 89% of prison inmates have histories of truancy from school and 80% of all prisoners cannot read beyond a fourth grade level.¹ A Dade County Juvenile Court study reported that truancy was one of the three traits that their most serious juvenile offenders had in common. The others were academic failure and a history of aggressive/disruptive behavior.²

Reclaiming resistant learners

When a youth tells you s/he won't go to school from your Shelter or Detention, try to understand why. Think: *Is this School Refusal? Or is it Truancy?* Even *before* you state your rules that demand that everyone must go to school, say . . . "*It sounds like you're concerned about school. What kind of problem is it for you?*"

• **First, listen closely.** Some youths will have *worries* to talk about — people they are afraid of, knowing they can't pass out of their grade, not wanting to show how stupid they are. Other youths will say there's nothing to worry about—they just *hate school and don't want to go.* They have better things to do, schools don't teach what they like, and so on.

• **Respond to what you hear.** There are three common staff response types that are *not* useful at this point:

- "If you don't go to school, you'll never get a decent job."
- "I don't care if you hate it. School is the rule—not a choice."
- "I always hated school, too. It's a drag, but you've got to go."

Instead, as staff, we want youths to see that we take their feelings about school seriously. There is one basic right response to every complaint you listen to— "*That sounds like a problem. Tell me more about it. Maybe this school can figure out how to make things better.*" They *do* have to go, and we try to do what we can to help them succeed.

• **How can your staff help?** Collaborate on planning with teachers. Make certain that your Shelter or Detention becomes a true learning center during study hours every evening. Staff oversees homework time, offers help when it is needed, and supervises group study projects. Reward hard work and school successes. Model the personal value of school skills by having staff read during spare monitoring moments. Work hard to make this school experience one that re-engages resistant learners—in school, a GED program, or other educational training.

Challenge: Persistent academic failure

Nearly 40% of America's Juvenile Offenders in the 10th grade read below the 4th grade level. And many of these 10th graders have already been held back twice and are years older than their classmates. Many labels can be attached to youths with this problem: Learning Disabled, Mentally Retarded, Developmentally Disabled, and Brain Injured are a few. The majority of delinquents come from poor backgrounds, so add to these formal diagnoses the disadvantages of poverty. Other problems are frequent family moves, transfers from one poor school to another, cultural and language differences.

Shouldn't these students have qualified for special education services? Yes, probably so. Very often, their poor academics have been blamed on family or behavior problems, not on true academic needs. Once students get in trouble with the law, schools may not worry so much about their absences. Some schools resist offering special education because then students are harder to suspend or expel under the Individuals with Disabilities Education Act (IDEA).

Think. If the job you went to every day meant you had to show your bosses and all your co-workers that you lacked the basic know-how to do the work, how would you feel about going back day after day, year after year?

Helping Responses

Does a school-refusing youth lack basic reading, writing, and math skills? Check it out for yourself. Then ask his or her teachers. They can access public school records without release-of-information forms, but your agency cannot. **Try hard to have parents or guardians sign releases so that school can share information with you.** Families are naturally guarded about having details of their children's social problems end up in school files—the form can specifically disallow that. Explain that signing releases will improve their sons' or daughters' chances by letting you *work directly with the school* to plan for greater success. **Talk positively with families and youths about students' strengths as well as their needs..**

Challenge: Sharing responsibilities—school and living-unit staff

It is common practice for Shelter or Detention classrooms to be operated on their grounds but not by their employees. Teachers are chosen, hired, and paid by school districts or educational agencies. During school hours, staff in living units are not assigned work hours because youths are supposed to be in school. Teachers often feel in a world apart from their students' "homes" though they may be just down a hallway or in the next building.

Problems arise when someone is disruptive at school and is suspended to "home" for the rest of the day or longer. If teachers feel that they are hired to teach and not to deal with bad behavior, and if unit staff believes that school should deal with problems on their own, resentments grow. **The shared planning that it will take for the youth to do better in school does not happen.**

Think about it. The youth has probably been suspended a dozen times before. It didn't fix him then—it won't fix him now. It certainly won't make him value learning more highly.

Helping Responses

Each youth we care for is likely to have been involved in many systems—health, mental health, welfare, education, the courts. **For such "deep end" youths, the research evidence is clear—it takes coordinated care across systems to make a difference. In the Shelter or Detention Center setting, that means that the school and youth-care staffs need to make time for joint planning and problem-solving.** A youth-care staff person may need to come to school to assist a non-reader with a special reading program. A teacher may need to spend time on the living unit teaching a special technique to use during evening study hours. Together with the youth, staff from both may design a special incentive contract to cover the *entire* day. The directors of the Shelter or Detention Center and the School could establish guidelines for volunteers from community service clubs to be school-time or evening tutors.

Challenge: Serious mental health problems

Mental health disorders that affect feelings or perceptions make going to school very tough. Mood disorders such as **Depression** or **Bipolar Disorder** destroy concentration and motivation so much that schoolwork becomes impossible. The worry, stress, and fear of some **Anxiety Disorders (PTSD, Panic Disorder, Social Phobia)** make it almost unbearable for some young people to leave home. A psychiatrist may diagnose refusal to go to school for six months as an **Adjustment Disorder**. **Psychotic Disorders** such as **Schizophrenia** bring on scary hallucinations and delusions that take over the youth's thoughts altogether. The thinking of people with **Asperger's Disorder** is so rigid that they cannot stand for anyone to break one of their strict "rules." Some with **Obsessive Compulsive Disorder (OCD)** cannot tolerate being stopped from following rigid compulsions that they believe they must follow to be keep safe. These rigid thinkers can be violent if crossed. These **severe emotional disturbances (SED's)** as they are termed in the IDEA) often go **hand-in-hand with other disorders** such as **ADHD, Conduct Disorder, or Substance Abuse.**

Think about what surveys tell us. Two-thirds of adolescents with serious emotional disturbances (SED's) also are juvenile delinquents. Two-thirds of delinquents who have been in the system two years or longer have serious emotional disturbances.⁴

Helping Responses

Youths with these problems who come from poor or criminal backgrounds are least likely to have been noticed and helped. Adults in those surroundings, including teachers and probation officers, may overlook the significance of changes in their moods and behaviors. Your Shelter or Detention setting may be exactly the right time and place for considering these possibilities. **Between your facility's staff and the school, you have around-the-clock chances to observe and take note of unusual behaviors.** Can his or her family help you learn the history and meaning of learning and school-attendance problems? Does this youth need a mental health evaluation to help set the right course? **How can you help him or her find hope and meaning for life ahead through education and training?**

Challenge:

• Truants are at greater risk for becoming involved with gangs, drugs, alcohol, or violence. • 67% of truants tested positive for drugs at the time they were detained. • In one California county, 60% of juvenile crimes occurred between 8 a.m. and 3 p.m. on weekdays. • 57 percent of violent crimes committed by juveniles occur on school days.

Gangs, drugs, alcohol, violence, and crime offer risk but also immediate reward.

Education's big payoffs are long-lasting but far off. The challenge is to tailor school well enough to students' needs *now* that they find immediate satisfaction there—instead of wanting to escape school, they would rather go. **All students need work at the academic and interest levels where they can be successful;** group projects for display or use by others; cooking and building and hands-on learning; chances to overcome past learning failures. Refusal to come to school is better dealt with by consideration and counseling than by confrontation.

Think: They have already experienced confrontation, and it has not worked!

Will your facility turn the youth into a lover of school? Maybe not, but it could be a first step onto a successful path. And if discharge includes plans for new steps into a new kind of educational program, they might prove to be the steps that make a critical difference.

Sexual acting out



GENERAL FOUR-STEP GUIDELINE:

STEP 1. Stop the behavior before you talk about it. Say "Stop," change the situation, or have people move apart or away, as needed.

STEP 2. Describe the unacceptable behavior quietly and accurately. "You were rubbing yourself against Chris's buttocks in line," or "Your pants are unzipped and your penis is showing," or "You are describing a pornographic movie." Direct, un-shocked feedback gives needed information, maintains staff's professional role, and is not mistaken as kidding around.

STEP 3. State the rules for sexual behavior: If the behavior is against the rules of the facility, "No sexual talk or physical contact here." Or, if the behavior would be unacceptable in any school or workplace, "No sexual harassment (or exhibiting yourself or stalking). It is against the law."

STEP 4. Apply the consequence for breaking the rule and/or redirect the behavior. After following these steps, consider *other* needs of the youth.

WHERE DO WE DRAW THE LINE?

Right at the door. Sexual expression is natural, but we cannot allow it in residential settings. Significant numbers of our clients are court ordered into care because of sexual offenses, and most have witnessed or been involved in sexual abuse or harassment. They need to know they will be kept safe from other youths and adults and from their own behaviors. **Think of their stay as a time-out from sexual pressures, a learning time.** Frame rules in the context of the rules of legal public behavior. Post the rules of the Equal Employment Opportunity Commission for Sexual Harassment in schools and workplaces that are included on the next page. We are not just arbitrary sex-police; we are adults who model non-sexual caring for colleagues and youths in our workplace and concern for their well-being. **Adults must take care never to be alone with sexually acting-out, precocious, or reactive youths.**

Youths who offend against children

The victims of these youths are only slightly more likely to be girls than boys. Up to 40 percent are siblings or other relatives.¹ These young offenders more commonly use guile, tricks, or bribery than force. Juveniles account for up to half of all child molestation cases each year. They are likely to have been socially isolated in their home towns and to show signs of being depressed.

- **Deficits in social skills** are common. A group setting provides many opportunities for teaching socially inadequate youths how to interact in socially acceptable ways with others their age.
- **Build self-confidence** by teaching skills with social value such as bowling or a craft that they can feel good about and enjoy with others.
- **Teach thinking skills.** Teach these youthful offenders to think ahead to consequences by using the Cost/Payoff sheet. They also need to practice **expressing feelings and ideas in words** and **resolving conflicts**.
- **Reinforce Sexual Abuse Treatment:** empathy training, correcting thinking errors, and impulse and anger management are key components.

Youths who offend against peers or adults

The victims of these youths are mainly females, either strangers or acquaintances. These assaults are likely to be committed in public areas or in connection with other criminal acts. Weapons and violence are often used, causing injury to their victims. Juveniles account for up to one-fifth of all rapes each year.

- **These youths have histories of antisocial behavior.** In one study² of juveniles who had raped or attempted to rape adult women, 75% were diagnosed with Conduct Disorder, mostly the socialized or adolescent-onset type. Anxiety and depressive symptoms were also common. So were impulse control problems and substance abuse. The influences of cruel treatment, exposure to crime, pornography, and violent mentoring by peers and adults are severe in this group. That suggests the importance of **adult mentoring, counseling, positive role-modeling, and substance abuse and aggression replacement programs.** Collaborative mental health and juvenile justice Sexual Abuse Treatment programs generally report low recidivism rates.³

Offenders with cognitive, language, and learning problems

Sexually offending youths have high rates of learning disabilities and academic problems (30 to 60%). One study of 85 offenders found that 89% had failed a grade in school.⁴ Mentally challenged youths are more likely to expose themselves, masturbate publicly, and sexually approach people of both sexes and any age than are those with normal functioning. Some become violent if frustrated.

- **Recognize the social frustration of failing to "get it."** The isolation and angry frustration that can fuel sexual incidents may come from failing to understand and being left out. These youths are often the butt of jokers and bullies. Teach them to recognize when trouble is coming and to avoid it.
- **Keep language simple.** Follow the directions for using easily understood language from the ADHD section. Use illustrations or draw simple pictures to make meaning clearer.
- **Make sure that group classes and activities will fit the learning abilities of all members** of the group, including those with learning problems. Individualize and check for understanding.

Sexual behavior that is way out of bounds could be due to the manic phase of Bipolar Disorder and require psychiatric attention.

SEXUAL HARASSMENT: *Legal Definition — US Equal Employment Opportunity Commission*

“Unwelcome sexual advances, unwelcome requests for sexual favors, or other unwelcome conduct of a sexual nature which makes a person feel offended, humiliated or intimidated, where a reasonable person would anticipate that reaction in the circumstances.”

Examples of sexually harassing behavior include:

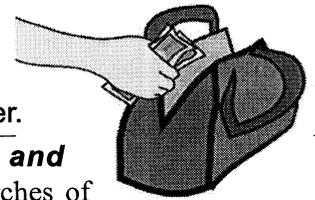
- **Requests for sex;**
- **Staring or leering;**
- **Insults or taunts based on sex;**
- **Inappropriate physical exposure;**
- **Sexually explicit pictures or posters;**
- **Sexually suggestive or obscene gestures;**
- **Sexually explicit notes, e-mails, or other messages;**
- **Unwelcome attempted or actual kissing or fondling;**
- **Unwelcome touching, patting, tickling, pinching, etc.;**
- **Intrusive questions about a person’s private life or body;**
- **Sexually suggestive, insulting sounds such as whistling or barking;**
- **Jokes about men or women that denigrate their gender as a whole; and**
- **Unnecessary familiarity, such as deliberately brushing up against a person.**

Teach this poster. This language is much too complex for general use in Shelters and Detention Centers. It measures at a 12.0 grade readability level. But it is important to translate our rules into real-world rules, and these are the words our youths will run into at school and on the job. Give each student a copy of the definition and examples. First, explain that your setting is like a public place, and the rules in your facility stand in for what would “a reasonable person” would be expected to find offensive, humiliating or intimidating. The rules stand, whether the object of the sexual attention actually feels that bad or not! Then discuss the rest of the quoted rule, word by word.

Have group members number the list of examples. Draw numbers to see who will read which one. Go over unfamiliar words before each reader starts so embarrassing or hard words are easily read. ***It is important that youths know what is and is not okay.*** If the group gets overstimulated and rowdy, *stop* the discussion after *one* warning. *“We’ll come back to this later when you guys can handle it.”* Note comparisons to the rules in effect in your facility. Discuss victims’ feelings. Then discuss severe consequences— job loss, stalking charges, restraining orders, and sexual offense charges. Consult Sexual Offender Treatment staff about this activity and individuals’ treatment plans.

Stealing – taking something without its owner's clearly stated consent

Be clear about this definition, and accept no others. If someone says that s/he was only borrowing something or that s/he meant to replace it later, it is still stealing—unless the owner *clearly stated* that it could be borrowed or replaced later.



Stealing is called the gateway crime. It is the crime that youths in detention settings are most likely to have been picked up for at the youngest age. It leads to the most additional charges, including assault.¹ Almost 90% of incarcerated delinquents' records include theft, and about a third of non-delinquent teens also report that they have stolen something of value.

Stealing precautions will differ between Shelter and Detention settings. Closer monitoring and routine searches of clothing, rooms, and possessions are the norm where delinquents are housed, but consequences for stealing are the same. **Youths who steal must return what was stolen, apologize, and compensate victims for any financial costs of the stolen items and for the disrespect of their rights and feelings.**

Think of reasons why a youth might steal

1. Super-optimism. Stealing works pretty well. The thief gets things of value and has a fairly good chance of getting away with it any one time. From this viewpoint, stealing is logical. In some places, only one in 47 complaints about car thefts results in a conviction. Shoplifters are caught an average of only once in 49 times. But here is the long-term probability that these youths do *not* consider: virtually all thieves *do* end up paying negative consequences for stealing, including doing prison time.

2. Frustration and boredom with life. A word for this lack of purpose or ideals is *anomie*. These youths steal because they see no very good reason not to. They have no positive relationships with adults in authority, no positive experiences in school, and no real hope that things will be better. Anomie may be due to an inability to reach goals because of limited opportunities, poverty, and no vision of escape, but it may also affect youths of every socio-economic status. Depression is common.

3. Feelings of entitlement. If you cannot buy what you want, steal it. Why not? After all, *you should* have it.

Ways to help the youth who steals

1. Teach about costs. A thinking skill that many youths lack is Consequential Thinking. Teach them to think automatically of the full range of consequences for the things they are tempted to do—not only the payoffs, but the costs as well. Use the *Cost-Payoff* activity to teach how to **weigh the value of the payoffs you get now for stealing something against the costs that will come later. Point out legal consequences, of course, but also social and emotional consequences that will follow.** The same youths who are poor consequential thinkers are also likely to be poor at the thinking skill called Perspective-Taking. That means they have a hard time see things from another person's point of view. They do not even think of the people from whom they have stolen things as victims unless they were *physically* harmed. Act out role-reversals of thefts to help youths empathize with victims. List their feelings—upset, loss, terror, etc. Consider also what the thief loses in terms of other people's trust and respect. (See *Cost/Payoff* and *Thinking Skills*)

2. Create hope and a positive climate. Adding meaning to youths' lives when they are in a Detention Center or a Shelter is a challenge that depends much on the ethos, the guiding beliefs and positive character of the institution. **Research has shown repeatedly that to change clients' behaviors, staff must provide them with four positive responses for every one critical or negative response.** This four-to-one balance of positive-to-negative responses is necessary in order to create a climate where positive change will happen. (Smiles and pleasant comments count, not just direct positives such as points or "good job" statements.) The power of positive behavioral support is huge. Even angry and discouraged youths will be better able to form relationships with adults and to risk making hopeful plans for themselves. Those who need treatment for a Depressive Disorder must have that care as well. (See *Major Depression and other Mood Disorders*)

3. Separate wants from needs. These feelings are often thought of as belonging only to rich kids who learn from spoiling parents that rules only apply to those who cannot afford to ignore them. In truth, **feelings of entitlement are often more closely related to histories of deprivation.** When people have had too little security or affection or material comfort, they may not develop a balanced sense of what *enough* . .

3. Feelings of entitlement, continued. . .

. . . truly is. Some develop a need to own things in order to deal with feelings of inadequacy or to make up for the chaos in their lives. They become arrogant and controlling and feel entitled to own everything they think would be theirs “if the world were fair.” **This can become a fixed personality disorder of grandiosity that has a name —Narcissism. When feelings of entitlement are part of general disregard for the law as well as for the feelings or rights of others, that is a sign of Antisocial Personality Disorder.** Hold group discussions on the differences between wants and needs and the rights that people do and do not have. Group discussions bring the ideas of other youths into the picture. Peers are good at giving real-world feedback about statements of special entitlement.

4. Feelings of rivalry, power, or revenge. Stealing can be a way of getting back at someone. A youth steals a parent’s and a peer’s favorite possessions to hurt them. A vengeful group steals a mascot or objects of no value to themselves from a school, church, or rival gang to show they can.

4. Teach assertiveness and independence. Youths who do hostile things in secret need to learn to use words to express their negative feelings directly.

Assertiveness and problem solving training may help. They also need to look at the cost and payoffs of their stealing, both for their victim and for themselves—which one is now in Detention? Stealing for revenge won’t improve their situation and runs the risk of making life worse in the long run. **Gang or peer-group driven robbery requires the full measure of interventions aimed at breaking gang involvement.**

5. Stealing to meet a true need. Some youths may steal because they truly need food or shoes. Youths who are addicted to drugs steal to be able to buy them.

5. Address the need. In these cases, look first at the need, then at the act of stealing. Impoverished youths may lack opportunities to earn money to buy what they and their families need. **Youths in poverty need a safety net first. Youths addicted to drugs need treatment first.** Then they all need help with thinking and planning: consequential thinking; perspective-taking about their victims; and means-end thinking about making plans to reach a goal.

6. Impulsive stealing. Some stealing is as thoughtless as seeing something unguarded, taking and concealing it to keep. Or stealing may be done only because the people one hangs out with do it.

6. Teach impulse-control. There are many strategies for young people *who are motivated* to learn to gain better control over their own behaviors and avoid trouble. A simple but effective one is **S.T.A.R.** Youths practice in their imagination telling themselves to **Stop** when they recognize a temptation; to **Think** of words they have practiced to remind themselves of what to do and not do; to **Act** the right way; and to **Reward** themselves by feeling proud or by allowing themselves a small treat.

7. Kleptomania. This impulse control disorder involves a person’s feeling more and more nervous excitability before stealing and a kind of high rush or release at the time of the theft. The stolen object is usually of no use to the thief who knows it is wrong to take it and feels bad about it. S/he may even try to return it. Kleptomania causes people social and financial embarrassment. It is an uncommon disorder, and it is treatable.

7. Refer for treatment. This may be more often used as an excuse to duck personal responsibility for stealing than it exists as an actual fact. If the stolen items just happen to be clothes that fit or are other things appealing to the thief, be skeptical. **People who have this problem feel bad about it and welcome treatment because their lives and relationships can be so disturbed by their stealing.** Treatment is much like helping people with addictive problems. It is provided by a mental health provider and may include medicine.

Suicidal Ideation—threats, drawings, writings, gestures

Assessing the seriousness of suicidal risk

When a youth speaks or writes of killing him- or herself, say quietly and very clearly, “*When you say/write/do* [describe the specific words or actions], *I am concerned that you might really mean to end your life.*” The questions that follow are asked to gain a complete picture of a person’s suicidal ideation. **You would not fire these questions one-by-one at a youth.** Many of the answers would be impossible to know without taking a complete social history in a formal interview with youth and family. **But you can have your antennae up for these topics as you interact with young people in your care. Make notes of any comments you hear that are related to them.**

Questions to help you think about risk—

The more risk elements that exist, the more specific the plan.

The easier the access to a means of suicide, the greater the risk.

- **Nature of the suicidal ideation**—Does the youth talk about suicide or death excessively? How intense is this thinking? Is it a part of a general pessimistic, hopeless view of the world and of the future? Is it focused on the idea of making certain people sorry, or of showing others how badly s/he has been hurt? Is it a desire to join someone who is dead or to escape pain? Hopelessness, anger, revenge, and escape are all motivations. (*Don’t suggest them—just listen for them.*)
- **Plan**—Does the youth have a plan for how, where, and when s/he would commit suicide? Is it a specific plan that shows logical thought?
- **Means**—Does the youth have access to a way to carry out the plan? Would s/he be able to carry it out now? Could s/he when discharged from your facility?
- **Cultural history**—Is there a history of suicide in the youth’s family, school, or friendship group? Has the youth been acquainted with death through accident or murder or suicide in his or her neighborhood, family, or social circle? How emotionally affected has s/he been by community violence or war?
- **Personal history**—How impulsive is the youth? Has s/he shown lack of insight and judgment? Has s/he attempted suicide in the past? How effectively? By what means? Has s/he been humiliated, neglected, assaulted, or victimized? Has s/he recently suffered personal defeats and losses in status or relationships? How traumatic were the circumstances of his or her admission to your care?
- **Mental health history**—Has the youth been depressed, agitated, or psychotic? Does s/he believe that voices are demanding the suicide? Has s/he tried before?
- **Support system**—How strong a support system will be available for the young person after discharge? How safe will s/he be from dangers of victimization, abuse, and neglect? How carefully monitored for suicide potential?

90% of suicide victims have one or more mental disorder, including substance abuse.¹

Depression, alone or with other severe emotional disorders— anxiety disorders, PTSD, psychotic disorders

What does the youth hope to gain by suicide?

An end to troubles and problems; a solution to hopelessness.

An idyllic afterlife; being with a loved one in heaven.

Proving worthlessness; acting on the belief that one is useless and unneeded.

What does the youth hope to gain by suicidal talk and behavior?

Clearly anyone who is *expressing* thoughts of suicide to another has **some level of desire to share those ideas.** That may be in hopes of someone having a solution to their problems—it is an opportunity that must be grasped. Our attempts to convince severely depressed youths about their strengths and future possibilities are not likely to cheer them up, however. Concentration and ability to solve problems they have now and see for the future are poor. It may be helpful to tackle small problems that will make their daily lives brighter. A youth with an emotional disorder is at a high risk for suicide and requires medical treatment.

Helping responses

Pep talks won’t help, but there are important things we *can* say. *Remain calm and supportive. Give one-to-one attention. To assess how focused the suicidal thinking is, check for a plan.* Here are some things to say:

“I can see you are really discouraged. Tell me what’s going on.”

“I can’t read your mind. Could it be you’re distressed over (your hearing, breaking up, your mom’s visit...)? or just feeling sad in general?”

“On a scale of 1-10, how upset are you feeling?”

“You say you’d like to kill yourself. Do you have a plan? What is it?”

“This is serious talk. I am concerned about you. Let’s make a plan to keep you safe. And then we can talk more about those problems.”

Don’t avoid the topic.

Say that suicide is a terrible idea, that you can’t let it happen and will find help so that it won’t. Record all such talk carefully. Also ask about physical symptoms of depression—sleep or eating disturbance, feelings of agitation or lethargy. The young person who has expressed ideas of suicide must be watched closely. Refer for a mental health evaluation if the youth has a plan or if suicidal behaviors continue. Be mindful that people intent on accomplishing suicide may skillfully hide their plans. Their mood may brighten once their decision is firm and a firm plan is in place. Once identified as at risk for suicide, a youth needs *always* to be under close supervision



Emotional regulation disorders

Borderline Personality Disorder or Cluster B Personality Traits

What does the youth hope to gain by suicidal talk and behavior?

Demonstration of powerful feelings by those who don't know how to talk about them openly

Attention, either negative attention for its shock and fear value or positive attention to gain sympathy.

Power, to gain emotional control over an individual or group

Helping responses

Youths with problems with emotional self-regulation may use suicidal threats and gestures as a way to express their anger, frustration with relationships, or need for attention. The cluster of symptoms that, in adults, is labeled Borderline Personality Disorder includes suicidal behavior and deliberate self-injury. Some adolescents in Shelter and Detention Centers have symptoms of this disorder. Many are likely to have had histories of emotional, sexual, and physical abuse. They may have been in many out-of-home placements in their childhood and adolescent years. In this group, the function of suicidal talk and gestures is different from other emotional disorders.

Instead of suicidal behaviors meaning to end life, they are usually attempts to cope with life's difficulties.

Their deliberate self injury actually serves as a release of tension as these youths try to make life work better for themselves..

A major problem these young people may have is that they have not learned to express powerful emotions except through actions. They cannot effectively express feelings in words. Instead, they *show* anger or despair and *do* things to show people how much they're hurting or to pay them back. They may use suicidal threats to make staff see how upset they are at being in our care, to try and influence outcomes, or even just for our attention. Help them learn to explain in reasonable words what they need when feeling hurt or disrespected or angry. Help by focusing more on solving the problems that cause self-defeating feelings than on the suicide threat itself. But our rule is the same: ***In our settings, we can never ignore suicidal behavior.*** Remain calm and supportive. To assess how focused the suicidal thinking is, check for a plan. **Eventually, 10 percent of people with Borderline Personality Disorder die of suicide.**² Whether or not some may just miscalculate a gesture or carry an act of self injury too far is unknown, but it is certain that many suffer severe depression and take their own lives.

Disruptive disorders and/or substance abuse³

Youths with conduct disorder or substance abuse problems may display the symptoms of those problems so openly that their emotional issues are masked or overlooked. Their suicidal talk or gestures may be to gain *attention* and *power*; or they may be expressions of true hopelessness and despair. **Roughly half of teen suicides are committed by youths who have histories of aggression, are socially left out, and academically failing.** The too-frequent news stories of teens killing themselves in jail lock-ups bear witness to the fact that teenagers in trouble with the law are at serious risk. Impulsivity and substance use are factors in a high proportion of successful youth suicides. **Staff must have their antennae raised as high for suicidal ideation in conversations with and observations of disruptive youths as for those who look downcast and withdrawn.**



Two keys to survival: Always consider suicide a real possibility; Follow your facility's *Suicide Prevention / Intervention Plan.*

Threats of harm to peers or staff

GUIDELINE FOR SAFE BEHAVIOR: Step back, cool off, de-escalate the emotions of anger and fear that automatically rise in *us* when someone makes a violent threat. The youth says, "I'm going to kill you!" or "Just wait. I'll make you hurt for that!" or "I know where your kids go to school, and they're going to pay." • Think: this is irrational talk — s/he cannot do that here and now. • Put your body in a non-threatening position. • Use *non-glaring* eye contact. • Say in a calm, matter-of-fact voice, "Stop. That's a threat, and making threats is not OK here. It's a good time to take a Cool-Down." (See *Anger Outbursts for Cool-Down directions*)

The *first* time a youth makes a threat:

- 1) **name the behavior a threat and have him or her take a Cool-Down;**
- 2) **talk with the youth about reasons** for the threatening behavior (but not until emotions have cooled down!);
- 3) **explain that from now on, threats will be treated as serious problems of aggression** because they are dangerous in themselves. They will lead to major trouble in school, with the law, and with hostile people.
- 4) **with the youth's treatment team, analyze what happened** in terms of the possible causes listed below, and
- 5) **make a plan to reduce threatening behavior .**



What's behind the threat?

Realistic fears. Some youths may know others from the outside who are **rival gangs members** or who have given them trouble. Others may be **targeted as victims** for reasons having to do with their personal characteristics or reputations. They may use threats to ward off harm.

Helpful responses. It is important always to understand the reasoning behind threats. Perhaps the threatener truly needs protection. Or perhaps the youth who was threatened does. You don't want to be an arbitrator in outside conflicts. You *do* want to stop youths' threats of aggression, and understanding their rationale will help you know how.

What's behind the threat?

Personal vengeance. Some severely aggressive youths with severe **Conduct Disorder** are vengeful and have never developed adequate consciences. For that reason, society has laws mandating that staff who hear serious threats against others are obligated to inform those persons so they can take precautions needed for their safety.

Helpful responses. Personal threats must be taken seriously. Steps must be taken to repair the relationship or end contact between those involved. Ideally, the youth should make restitution to the victim for the threatening behavior.

What's behind the threat?

Social pressure for power. If the threats appear to have been made as much for the **approval of others** as to threaten an individual, the point may have been to demonstrate power to those peers. Displaying power by scorning authority is a big motivator for some adolescents.

Helpful responses. The best way to avoid helping youths build power by threats is for us to refuse to get hooked into their power plays. When they argue, refuse to argue back. Get quieter instead or louder, keep your wind out of their sails! Model being cool instead of hot, briefly repeat the rules of your setting, and make a date to talk later.

What's behind the threat?

Powerful survival emotions. Adrenaline and similar brain chemicals may remain active in the body 24 to 48 hours after a stressful event. Anger emotions are triggered readily in reactive youths with **severe Conduct Disorder and with histories of abuse and trauma.** Their brains become patterned to see insult and aggression everywhere, and they are always primed to fight. Threats may be automatic reactions to defend themselves against what they see as threats by others, even against neutral acts intending no harm.

Helpful responses. Teach consequential thinking, that threats lead to more, not less trouble. Teach anger control which includes Stress Management.

What's behind the threat?

Poor impulse control. Some young people who are often in trouble cannot inhibit the urge to make threats. They have poor judgment and poorer emotional self-control. Many of them have been diagnosed with **Attention Deficit / Hyperactivity Disorder (ADHD)** with or without the Disruptive Disorders that often go with it. Their angry feelings may be no stronger than others', but whatever jumps into their heads comes out of their mouths without their weighing the consequences.

Helpful responses. Use the techniques suggested on the *Thinking Skills* and *ADHD* pages.

What's behind the threat?

Delusions and irrational fears. Some youths react with threats and aggression because they are responding to dangers that seem real to them even though they are actually caused by psychotic thinking. Adolescence is when **Schizophrenia** commonly makes its first appearance, and delusions and hallucinations are hallmarks of this illness. Young people suffering from **Bipolar (Manic Depressive) Disorder** and **Post-Traumatic Stress Disorder (PTSD)** may also experience frighteningly real thought distortions.

Helpful responses. Reassure, but reasoning with youths suffering in these ways may not be helpful. Mental health assistance will be needed.

Youths with mental health problems make threats for all the reasons listed on the preceding page — **they're mad, they're scared, they're impulsive—or they could be intent on doing real harm.** Their threats may be only emotional imagination and rants, or they may be well thought out, explicit plans. The latter are dangerous and must be listened to and acted on by mental health and legal professionals. **But at least the threats themselves don't really hurt anybody — right? WRONG!** In case young people don't see it that way—

TEACH WHAT'S WRONG WITH THREATS.

Threats victimize other people. Discuss how people feel when they're threatened, how it feels to be scared, what it does to *our* lives when we are living under a threat. (Youths with under-developed consciences may not really "get" empathy, but it is important to expose them to these ideas.) Talk about how people's lives are changed when they feel threatened—maybe they can't go to work or school, or maybe they *never* feel safe. These are the reasons that threats are against the law and why you take them seriously in your Detention Center or Shelter. Do a *Cost/Payoff* activity on making threats. Threats may make you feel powerful now, but they can cause big trouble in later.

Threats put the people who make them in danger—

- **from school.** You can get suspended or expelled for threatening to do harm.
- **from retaliation from the ones who have been threatened.** You can get beat up or make enemies, some of them powerful enemies.
- **from the law. It is wrong and illegal to threaten, intimidate, or harass other people regardless of whether those threats are delivered in person, on the phone, via the mail, or over the Internet.** You can be especially harmed by delivering such threats in a public area such as a web site, chat room, or bulletin board. Adults go to jail, juveniles to detention centers.

You have made it clear that threats are not OK and why. Your facility may already provide negative consequences for making threats. Build *No Threats* into individual behavior management plans. **Give positive points for shifts when a youth has successfully resisted the impulse to make threats.**



(See *Anger Outbursts, Stress Management, Thinking Skills, & Cost/Payoff*.)

Refusal to take medications

GENERAL RULE: Medications are typically passed out in a fairly public routine. If a youth refuses to get into line for meds or to take them when they are passed, be supportive. Simply say pleasantly, “OK. We’ll talk about it in a little while.” Public warnings or disagreements will only make refusals stronger.

Medication refusals are not battles that can be won by threat of punishment or loss of privileges. Most doctors will not urge continuation of a psychoactive medication for behavioral problems if a youth will not comply with treatment. **Most medicines should be tapered off gradually instead of being stopped suddenly. Seek youth’s cooperation and check with your medical advisor.**

MEDICAL PRECAUTIONS:

When a youth refuses medication, seek information. Check admission records and daily charting.

A. Is this drug for a critical physical problem such as diabetes, a seizure disorder, or a heart condition? If so, it is essential that the youth take the medicine. If he or she will not cooperate, deal with it as a *medical emergency*. Still handle it privately, however, “in a little while.”

Take special precautions with diabetic youths. Depression may take the form of refusing to follow dietary restrictions or check blood sugar levels and inject needed insulin. Managing chronic health problems can become complicated in adolescence and requires close medical and psychological care.

B. Is this a psychoactive medication that the youth has been taking for a period of time? Missing one dose will not be a major problem—everyone forgets and misses one every now and then. But stopping psychoactive drugs altogether can cause serious problems. If medications are completely stopped all at once, emotional and behavior problems can result. Symptoms such as depression and suicidality or agitation and violence can “rebound” and become severe again. Stopping some medications may result in severe physical problems. These may include changes in blood pressure, tremors, hallucinations, and seizures.

Stopping most medications that the body has become used to requires a tapering-off process that a doctor specifies. This is not necessary for the stimulant drugs taken for ADHD but is true for most antidepressants, anti-psychotics, and drugs taken for anxiety and mood control. **For concerns about a specific youth, consult his or her doctor if available to you. If not, call your facility’s medical provider.** For general information, refer to the *Stopping Medications Suddenly* page and to the medication booklet in your Iowa Youth Shelter or Detention Center.

Please look ahead to
**Stopping Medications Suddenly:
Possible Negative Effects, p. P-46,**
to read specific information on
stopping psychoactive drugs.



HANDLING THE REFUSAL:

When a youth refuses to take meds, check with him or her privately to see what the problem is.

A. Have a one-to-one conversation.

Taking medications, especially psychoactive ones, is a matter of confidentiality in the real world. Youths must be able to discuss their issues about taking them in private with a trusted adult. **There is nothing bad or silly about having any of the concerns that are discussed on the next page. Thoughtful adults object to taking psychoactive drugs for many of the same reasons.** We want young people to take personal responsibility for the drugs they put into their bodies—after all, we expect them to think responsibly about street drugs.

B. Involve the youth in problem solving.

Answers to questions. Seek agreement from refusing youths that they will give reasons for refusing to take medicine and will talk about them with a doctor, nurse, or counselor. The drug was prescribed to help them think, feel, and do better, and that is what we really want for them. Help them write a list of questions they want answered so they would be more comfortable taking the medicine. Ask them to continue to take it while you find a way to get those answers to them. The drug information booklet in your facility is helpful, but a direct conversation with a doctor or nurse practitioner who has actually prescribed the medications is ideal. They can explain their chemistry and describe other people’s experiences with them.

Youth involvement. Encourage the youth to keep track of positive feelings as well as side-effects. Is it easier to concentrate in school? To avoid losing your temper? To let go of troubling thoughts? What side-effects do you notice? When do they occur? Make a simple chart or log the youth can fill out and use to discuss the medicine’s effects with your medical provider.

Recognize that we cannot force medical treatment on people. Millions of dollars a year are wasted in prisons and in hospitals nationwide by people who seem to comply with taking their medicine and who actually “cheek” their pills or otherwise get rid of them. Only in cases of certain medical emergency can we force people to take medicine. In those cases (threat of insulin shock, proven need for anti-psychotic medication, danger of sudden withdrawal symptoms), giving the drug in a shot or hospitalization might be necessary.

REFUSALS DUE TO ATTITUDES AND BELIEFS

Control issues. Youths locked up in secure settings may turn their resentment over their loss of freedom into demands for power over what they *can* control—their own bodies. **Refusal to swallow a pill may be a last line of defense over personal boundaries.** (Having a chance to express those feelings may make them less demanding. Work on the *Power Light* activity with young people to help them understand the many areas of life they *can* influence and control. That includes their own feelings and behavior. They can control them by *deciding* to do so and practicing use of their personal power for self control. Taking medicine that slightly changes their own brain chemistry can make that control much easier.)

Social issues. Youths may be influenced by the opinions of peers or staff about taking meds for psychiatric problems. (These opinions may be real or imagined.) **They may fear the stigma of being labeled “mental, crazy, or psycho.”** They may believe that by taking medication they are seen as being weak and needing a “chemical crutch.” (Offering to give the medicine privately may be much more agreeable than passing it out in front of everyone.)

Cultural issues. There is widespread belief in minority groups, especially in the African-American community, that drugs are prescribed more often for troubled children and youth of color than for whites. **They see this as an effort by the establishment to control their behavior and make them more docile and “acceptable.”** (You can try to refute this statistically. More than twice as many white suburban elementary school kids are prescribed stimulants for ADHD than are black kids. But the total ratio by comparison to the total population is still disproportionate. Considering reasons why this might be true leads to meaningful conversations.)

Personal issues. Some youths experience tremendous stress due to their reasons for being in a shelter or detention center. They may have strong feelings of shame or anger or be blaming other people or circumstances beyond their control. **These emotions can be so powerful that they make the idea of taking psychoactive drugs to affect feelings and behavior seem pointless.** If a youth has been on a medication, severe stress may override its effectiveness. The drug may be judged not to have worked, as “not worth it anyway.” (Deal with this is a sign that the youth may feel depressed and hopeless. Suggest that if depression caused him or her to need medication, stopping it might make those feelings worse.)

See the *Information on Psychoactive Medications for Iowa Shelter and Detention Staff Members* booklet in your facility.



REFUSALS DUE TO MEDICATION-RELATED CONCERNS

Concerns about side-effects. Young people may have heard exaggerated accounts of **side-effects—addiction, memory loss, zombie-like behavior—that have scared them.** (Make sure the possible side-effects of whatever medicines they take are explained to them, and assure them that any such problems will be reported to your medical provider.)

Actual side effects. All drugs have side-effects, and individual reactions to them vary widely. They may be particularly troublesome as a medication is being started or changed. They typically include such problems as **headache, dizziness, upset stomach, constipation or diarrhea, or drowsiness** that are unpleasant or scary. (Take complaints seriously and reassure youths that most side-effects lessen or disappear as bodies adjust to medicines. If the problem is very troublesome, your medical provider should be able to provide relief by changing the med, the dosage, or the times it is taken.)

Lack of information about reasons for taking medicine. Diagnosis and medication teaching is essential for adolescents—after all, we *want* them to question what drugs they take into their bodies! This teaching is complex and needs to happen more than once. Even intelligent adults cannot take in all that is told to them about a diagnosis and medical treatment in one doctor’s appointment. **Teens may not really understand the purpose for taking drugs, the good effects they may expect, and how long they might expect to take them.** They may never have had a chance to ask their own questions, or they may have received answers they haven’t fully understood. (You can find out information to help them in the booklet referred to below.)

Effects of illness. Youths who have serious psychiatric disorders that alter their thinking such as Bipolar Disorder or Schizophrenia **may reject taking medicine because of the effects of the disorders themselves.** A person in a manic phase may feel on top of the world and believe s/he no longer needs meds. A person who has paranoid delusions may be convinced that the drug contains poison. (If a youth has one of these disorders and refuses medication, get medical help soon.)

Reasonable reasons. There may be a reason that makes sense for a youth choosing to skip a dose of a prescribed medication. Maybe s/he feels nauseated or is experiencing a worrisome side-effect. Some athletes feel they can’t perform when medicated and gain their doctors’ permission to skip a dose before competitions. **Medicine is one of those body-based topics about which it is far better to be understanding-listeners than consistency-enforcers. Power-struggles can do harm.**

Stopping Medications Suddenly – Possible Negative Effects

Drug Category	Common brand names:	Withdrawal symptoms that may result
Antianxiety: Benzodiazepines	Ativan, Klonopin, Librium, Valium, Xanax	Anxiety, irritability, shaking, sweating, aches and pains, muscle cramps, vomiting, trouble sleeping. If large doses stopped suddenly, seizures, hallucinations, and out-of-control behavior may result.
Anticonvulsants	Tegretol, Depakene, Depakote, Klonopin, Lamictal, Neurontin, Topamax	Stopping Tegretol or Depakene (valproic acid) suddenly causes uncomfortable withdrawal symptoms. When used for seizure control, stopping these drugs could result in fits or convulsions.
Beta-Blockers	Inderal, Corgard, Tenormin, Visken	Fast or irregular heartbeat, high blood pressure, or severe emotional problems.
Catapres (Clonidine) and Tenex (Guanfacine)	Catapres (Clonidine) and Tenex (Guanfacine)	Very high blood pressure, worsening of tics or behavioral problems, nervousness or anxiety, rapid or irregular heartbeat, chest pain, headache, stomach cramps, nausea, vomiting, trouble sleeping.
Lithium	Eskalith or Lithotabs	No medical withdrawal effects of suddenly withdrawing lithium occur, but some bipolar patients become manic more often and more difficult to handle.
Neuroleptics	Clozaril, Geodon, Haldol, Loxitane, Mellaril, Moban, Navane, Orap, Prolixin, Risperdal, Serentil, Seroquel, Stelazine, Thorazine, Trilafon, Zyprexa	Involuntary movements, “withdrawal dyskinesias,” may appear within one to four weeks of lowering the dose or stopping the medicine. Usually these go away, but they may last for days or months. Other problems may include emotional disturbance such as irritability, nervousness, moodiness, oppositional behavior; physical problems such as stomachache, loss of appetite, nausea, vomiting, diarrhea, sweating, indigestion, trouble sleeping, trembling, or shaking.
Selective Serotonin Reuptake Inhibitors (SSRIs)	Celexa, Luvox, Paxil, Prozac, Zoloft	No serious withdrawal effects, but there may be uncomfortable feelings such as trouble sleeping, nervousness, flu-like symptoms, or even seeing things that are not there, especially with Paxil.
Stimulants	Ritalin, Ritalin-SR, Metadate, Methylin, Concerta, Focalin, Dexedrine, Adderall, Cylert,	No medical withdrawal effects occur if stimulants are stopped suddenly, but there may be uncomfortable feelings of irritability, trouble sleeping, or increased hyperactivity, especially if the medication has been taken for a long time and at high doses.
Wellbutrin(Bupropion)	Wellbutrin (Bupropion)	No medical withdrawal effects occur if Wellbutrin is stopped suddenly, but some people experience headaches.
Tricyclic Antidepressants	Anafranil (clomipramine), Elavil (amitriptyline), Norpramin(desipramine), Pamelor or Avenyl (nortriptyline), Tofranil (imipramine)	Stopping the medicine suddenly or skipping a dose is not dangerous but may make a person very uncomfortable with flu-like symptoms —headache, stomachache, nausea, and muscle aches. Sadness, nervousness, trouble sleeping, and behavior problems may also occur.

Refusal to take some medications could represent serious risk to a youth in your care. Follow your facility’s guidelines and seek medical advice.

General information taken from Dulcan MK, Lizarralde C (editors): *Helping Parents, Youth, and Teachers Understand Medications for Behavioral and Emotional Problems: A Resource Book of Medication Information Handouts, Second Edition.* Washington, DC: American Psychiatric Publishing, 2003.

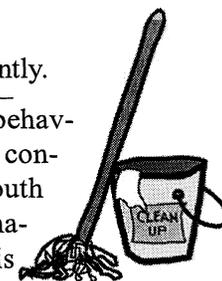
Urinating in the wrong places

Urinating during waking hours in bedrooms, on carpets or beds, in quiet rooms, or in any place other than a toilet, either secretly or defiantly.

Our First Response:

Acknowledge the behavior and state the consequence in a calm, matter-of-fact voice: "You urinated on/in the _____. You'll need to clean that up. I'll get you the clean-up bucket." Have a bucket ready with gloves, disinfectant, and rags inside and step-by-step directions on the outside. Even if the behavior was due to some psychological or physical problem, cleaning up is still

required. We make that clear as just a routine rule of civil behavior. *Clean Up After Yourself* should be a posted rule with consequences already in place for noncompliance. If the youth was expressing anger and defiance, seeing that this immature behavior did not irritate you is the best response. It is the one least likely to cause the behavior to happen again.



Physical/Psychological Problems

What is the goal of the behavior?

To relieve one's bladder when physically desperate and too embarrassed, troubled, or inhibited to use public or group toilet facilities.

Helping responses It is always good practice to check with a youth on the possibility that a reasonable purpose lies behind what we see as unreasonable behavior.

There are many reasons for daytime wetting (diurnal enuresis), among them: anxiety; bladder infection (frequent in girls); sexually transmitted diseases (both genders); small bladder capacity and high bladder muscle tone (especially in boys); anatomical abnormalities; and psychotic symptoms. Check with youths who urinate improperly about problems. Schedule medical appointments as needed.

Consider the possibility that a young person is scared to go to the bathroom because of fear of peers. Make sure they feel safe from teasing, bullying, or sexual harassment. Young people with PTSD may dread using public bathrooms if they trigger flashbacks of a past assault. Youths who are restricted to their bedrooms may experience real discomfort and finally relieve themselves however they can, usually in an inconspicuous place such as a drawer or closet. Make certain that no one is restricted from close and timely access to toilet facilities.

Controlling Behaviors

What is the goal of the behavior?

As a threat in an argument — to show who is control of a situation.

Helping response When children and adolescents are kept from doing what they want by being restricted to their rooms or another kind of space without a built-in toilet, a ploy that they may use is to insist that they have to go to the bathroom. They have this right. But if told that they just went, they may prove their point by urinating. Then the response is as stated above — "You urinated on the floor. I'll get you the clean-up bucket (and dry clothes.) But that doesn't count toward your time away from the group. Make sure to clean up quickly and well so I don't have to add on too many more minutes."

It is always reasonable for people to clean up after themselves, even if wetting was an accident. But just in case it was an accident produced for its effect, give the youth a urinal or bedpan in the room to avoid further accidents. Do this without anger or sarcasm. Your goal is to take the power out of using urination as a tool. If the bedpan or urinal is avoided or spilled, then the cleanup will take longer and the restriction will last longer—the clean-up simply a logical consequence. Skillfully handled, the use of urination as a ploy can be diminished.

Defiant Behaviors

What is the goal of the behavior?

To express personal disdain for the institution or people in it; to express one's ability to be beyond others' control.

Helping response Most people have control over their bladders and bowels even in times of great difficulty. The youth who urinates on things deliberately to mark or spoil them or to say "_____ on you" to staff or peers is making a bold statement and probably expects some kind of reprisal. Clearly s/he has to be guided to clean up the mess and to restore damaged objects to proper condition for other people's use. If an object is ruined, extra chores should be assigned to earn replacement money for restitution. **Again, our rule needs to be — No sarcasm, belittling, or angry display. Just insist on clean-up and pay-back for the mess.** If the culprit is unknown, then *everybody* has to help. The group's negative response to this is likely to make an impact on the one who truly did it and who will now also have to help make restitution. Truth is likely to emerge. The less we are outraged by this behavior — the more we handle it as the immature act of an upset child — the less the youth gains from it as a method of alarming or controlling others. That makes it less likely to happen again.

See also *Bedwetting or Nocturnal Enuresis*.

Part Two
Mental Health Disorders

Note: The topics in this Disorders (D) Section are grouped in their diagnostic clusters rather than presented alphabetically as in the Problems (P) Section.

Overview of diagnoses for children and adolescents

The standard rule-book used in the United States for classifying mental disorders is the ***Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)***. This fourth edition was published by the American Psychiatric Association in 1994, and there is currently a **DSM-IV-TR** (for *Text Revision*) in print that was published in 2000. New editions are published only after years of research, debate, disagreement, and compromise. While improvements are made, **the manual remains best suited for describing adult disorders. It is far from a perfect fit for young people's mental health problems.** People working with adolescents need to bear in mind that **behaviors described as symptoms of adult mental disorders in DSM-IV may not have that significance in young people. They may be merely developmental behaviors that are part of an adolescent phase that is common to many normal teens.** That is why we laypersons must rely on people who are trained in making diagnoses to do so instead of just counting up the DSM criteria

CLASSIFICATION CATEGORIES OF MENTAL DISORDERS

Disorders with their own pages in the ***Disorders*** section are grouped under their categories so you can see how they relate to one another.

Disorders in the same categories that are mentioned in the ***Problems*** section are also listed with their page numbers.

I. Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

Disruptive Behavior Disorders

Attention-Deficit / Hyperactivity Disorder [ADHD]; Oppositional Defiant Disorder [ODD]; Conduct Disorder [CD]

Pervasive Developmental Disorders

Autism & Asperger's Disorders; Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS);

Rhett's Disorder; Childhood Integrative Disorder

Feeding and Eating, Tic, and Elimination Disorders

Tourette's Disorder; Nocturnal Enuresis—Bedwetting;

Defecating in the wrong places (Encopresis, p.8);

Urinating in the wrong places (Diurnal Enuresis, p. 52);

Refusal to Eat (Eating Disorders, p.36)

Mental Retardation & Learning, Motor, & Communication Disorders

Cognitive Deficits—Mental Retardation, Fetal Alcohol Syndrome,

Traumatic Brain Injuries

Childhood Anxiety Disorders

Separation Anxiety Disorder (p. 86 & School Refusal, p. 40)

Selective Mutism (p. 86)

for a certain disorder and declaring the diagnosis on our own. **Making a "differential diagnosis" between two or three possible disorders (or between one and none!) is a complex business that affects all kinds of important decisions down the road.**

DSM-IV descriptions and criteria are what are referred to in this Staff Guide except where noted. The reason is that **everyone referring to a youth as having ADHD or Schizophrenia must speak of the same cluster of observable, countable symptoms. Then treatment can be prescribed and its outcome reliably predicted based on research done on people with the same characteristics.** Because of that diagnostic standardization, we now know that mental disorders are treatable and that recovery from them is as promising as recovery from disorders of the rest of the body. **The research on children and adolescents, however, still lags far behind that on adults.** Everyone can keep up to date with new developments by checking reliable sites on the Internet such as those referred to in the *References* section, pp.121-128.

II. Disorders With Few if Any Age Designations

Mood Disorders

Major Depressive Disorder [MDD] & Other Mood Disorders—Adjustment Disorder with Depressed Mood, Dysthymia, Premenstrual Dysphoric Disorder Bipolar Disorder

Anxiety Disorders

Anxiety Disorders—Simple Phobias, Social Phobia, Obsessive Compulsive Disorder (OCD), Generalized Anxiety Disorder, Separation Anxiety Posttraumatic Stress Disorder [PTSD] Disorders of Extreme Stress Not Otherwise Specified [DESNOS]

Personality Disorders

Borderline Personality Disorder—plus Paranoid, Schizoid, Schizotypal, Histrionic, Narcissistic, Antisocial, Avoidant, Dependant, and Obsessive-Compulsive Personality Disorders

Psychotic Disorders

Psychotic Disorders—Schizophrenia—Delusional Disorder Hallucinations & Delusions, (p.22)

Somatoform (Body-Related) Disorders

Hypochondria, Somatization, & Malingering, (p.32)

Substance-Related Disorders

Drug or Alcohol Withdrawal (p.18)

Impulse Control Disorders

Stealing (Kleptomania, p. 44)

Mental Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

DISRUPTIVE BEHAVIOR DISORDERS OR EXTERNALIZING DISORDERS

Attention-Deficit / Hyperactivity Disorder • Oppositional Defiant Disorder • Conduct Disorder
ADHD • ODD • CD

These three common disorders are grouped together as the **Disruptive Behavior Disorders**. They are also referred to as **Externalizing Disorders** because of the overt, “acting out” behaviors they are named for. If they are not directed against another person, they are at least noisy and bothersome enough to disturb those around them. It is very common for youths to have more than one of these disorders sequentially or at the same time. **Together, the Disruptive Behavior Disorders account for much higher rates of aggression than do any other diagnostic clusters. For that reason, they are particular interest to staff members of facilities serving delinquent youth.**

- **80 to 90 percent of youths with CD had ODD when they were younger.** More than two-thirds of those with CD also have ADHD, and roughly the same proportion will have criminal records when they are adults.
- **Only about 25 percent of youths who have ODD go on to be diagnosed as having CD.** Most do not cross the line from mouthy belligerence into physical aggression and law violation.
- **About 40 percent of youths diagnosed as having ADHD go on to be diagnosed as having CD later.** That is about the same proportion of youth with ADHD who do *not* have another disruptive disorder. **The long-range outlook of having both CD and ADHD, especially if ODD was also a problem earlier in childhood, is discouraging.** Such youths have a higher delinquency rate and commit more harmful acts against others than occurs with other groups during adolescence, and their aggression and criminal behavior continue as they become adults. **The majority are not, however, arrested for violent crimes in adulthood.**



Attention-Deficit/ Hyperactivity Disorder-ADHD

Understanding the many characteristics of ADHD has always been a puzzle. According to well-known expert R. A.

Barkley's¹ current line of thought, **they are all caused by faulty self-regulation systems in the brain.** That involves:

A. Problems Inhibiting Impulses. This means that it is hard for the ADHD brain to put on the brakes—to stop a behavior, to wait, to delay a response, to keep its owner from following through on whatever urge strikes.

B. Problems Organizing Thoughts. Youths with ADHD do not recognize how rules that fit one situation need to be changed for another. Therefore, they do not retain lessons learned from past experiences to make better plans for the future. Their thinking is disorganized, and they do not solve problems effectively. These skills, called the brain's *executive functions*, are what we use for advanced thinking and decision-making. Youths with ADHD develop them slowly—some never do.

C. Problems Controlling Emotions. This causes negative problems such as lack of self-motivation as well as emotional outbursts when upset or angry.

D. Problems Controlling and Inhibiting Movement. Problems with motor control involve the inability to *continue* working on a task, to *stop* doing something interesting, or to *stick with* an activity in spite of distractions. The youth with ADHD may truly intend to do those things but be unable to find the motivation to push on to something hard or to put the brakes on what s/he is already absorbed in.

How do youths with ADHD behave?

Youths with ADHD **lose things** and are **disorganized**. They have **trouble paying attention** to an activity for long unless it is very novel or stimulates intense interest. They are **impulsive** and **distractible**. They will lose track of more than one-step, immediate instructions. They **avoid tasks that require complex thought**. Sometimes these youths seem as though they are not listening to staff. They **forget things they were told** to remember or do. Those that are hyperactive **can't stay still**—they move around, fidget, feel constantly restless. In group instruction situations, they **cannot be quiet**. They **interrupt others** or call out answers before the leader finishes the question. They find it **hard to wait their turn** at an activity or play quietly—they are **always on the go**. ADHD causes **social problems**. Young people with ADHD tend to be unpopular with others, many being the **butt of teasing** or **without close friends**. About half of them grow up having serious **problems with interpersonal relationships**.

People who have ADHD are handicapped by having a flawed sense of time, by always living and responding in this very moment. They have been called *Now* people. They have major problems waiting. Thoughts of consequences that lie ahead are not clear enough in their minds to influence their decisions of the moment. Because of this, people with ADHD have more automobile accidents, poorer ability to manage money, and more sexually transmitted diseases and pregnancies than those who do not. They are more likely to suffer substance abuse and to have less job and relationship security on into adulthood. This very serious disorder is increasing in our population. Estimates of the proportion of youths in detention facilities who have ADHD are as high as 76%. **It works best to tailor all our rules and protocols to fit ADHD youths—simple directions, immediate feedback, and short-term consequences will be effective for most of our clients.**

Is there a difference between youths who truly have ADHD and others who seem "hyper" or impulsive?

Yes. Most youths have trouble paying attention or following directions at one time or another, but a youth with ADHD has trouble most of the time. Sometimes, hyperactivity or inattention in a non-ADHD youth may be due to another mental health disorder, traumatic experiences, anxiety, or substance abuse. To be accurately diagnosed, a youth's entire behavior history, tests, and interviews are necessary. ADHD occurs because of the ways the youth's brain developed from before birth.

What other disorders co-exist with ADHD?

Oppositional Defiant Disorder affects 40 to 67% of youths who have ADHD; 20 to 56% may develop **Conduct Disorder**. **Anxiety Disorders and Mood Disorders**, both Depression and Bipolar Disorder, co-occur with about 18% of ADHD cases overall, much more among delinquents. So do **mental retardation, learning and communication disorders**, and, later on, **substance abuse**.

Can ADHD . . .

...be genetic? **Yes.** ADHD runs in families. If one child has ADHD, siblings are at two to three times the risk of having it as well. The odds are even higher for twins. The ratio of boys to girls with ADHD is four to one.

...be biological? **Yes.** Youths with ADHD have brain circuit abnormalities that scientists can see in brain scans. There is less activity in the orbital-frontal area of the brain in ADHD youths. This area governs how we inhibit our behavior as well as regulate our emotions. It also controls the executive functions of the brain, the formation of future goals and following of rules.

...be environmental? **No.** Poor parenting does not *cause* ADHD. Stress or parental problems may come from raising ADHD children but do not cause them to become ADHD in the first place. Sound parenting, good schooling, and pro-social after-school activities help lessen the effects of the disorder.

What helps youths who have ADHD?

Environmental interventions:

1. Create lists of the basic rules that guide civil behavior. These should be the four to six main rules such as *Respect Personal Space*, or *Respect Personal Property*, that all staff members have agreed to. **Make sure they are clear, direct, and say what they mean.** (If your rule is *No Physical Contact*, for instance, what will that mean in a basketball game?) **Make rules clear for each different setting in advance.** When the young person with ADHD needs to be corrected, **hearing the same words helps keep the rule in memory.** It also takes some of the argument out of the correction. It isn't you, the staff, telling the youth to stop—it's the *rule*. This impersonal approach is an important strategy to use with all oppositional youths.

2. Post laminated to-do lists for all rules and routines in visible places—for instance, step-by-step chore routines in the kitchen or day room and daily grooming routines in bathrooms. **Use positive words whenever possible.** (*Towels In Basket* instead of *No Towels On Floor*.)

3. For group activities, seat youths with ADHD near a leader and not near others with the same problems. The same guideline applies to study time. Study carrels are only useful if a young person truly wants a distraction-free space. Otherwise, they just serve to screen youths from adults' eyes.

4. Include books and videos on ADHD in your facility. Make sure books are at several reading levels. Excellent materials are available through catalogs from the A.D.D. Warehouse (addwarehouse.com), Childsworld/Childsplay (www.childsworld.com), Free Spirit Publishing (www.freespirit.com), to name a few. Youths who have ADHD may gain self-knowledge and a sense of direction for life after discharge from learning all about ADHD and the successes of others who have the disorder. They will also provide staff with activities and ideas.

Counseling: Counseling needs to be very practical and centered on **life skills and careers.** **Substance abuse** should be covered, because many youths with ADHD are attracted to drugs and may self-medicate or recreate with them. In this area as in others, **they need practice making connections between present actions and long-term consequences well enough to make good decisions.** Youths with ADHD have trouble getting and keeping jobs when they are on their own—delinquent youths will be doubly challenged. Every effort must be made to locate **transition services** for youths aging out of the system. Many will continue to have lifelong problems with ADHD. They need all the help we can arrange for them as they start out.

Thinking of ADHD as a disability: Children and teens with ADHD are impaired in thinking of *what* to do, in doing it *right*, and in *stopping* themselves from doing it wrong. **They can't help it.** Adults have ADHD as well, but now we know that no one's prefrontal cortex (the executive part of the brain where decisions and judgments are made) matures fully until the late teens or twenties.³ By then, at least the think-ahead-and-plan functions of the ADHD brain will probably have improved. Youths with ADHD cannot put the brakes on their thoughts, emotions, or actions. **Medications will help, but they also need for us to show them understanding.** Rising frustrations may be problems both for staff and ADHD youths. **We must rise above ours. Speak calmly. Move calmly. Be positive—we try to find four or five positive things to say for every correction.** Those don't have to be compliments—simple greetings or pleasant comments count, too. If we know a youth has ADHD, we help him or her talk about how that feels and get information about living with the problem.⁴

Medical management: Doctors will do a full evaluation, including a history of behavior from home, school, and current staff. Stimulants are usually prescribed. Ritalin, Adderall, and Concerta are common ones. A non-stimulant drug for ADHD that some find helpful is Strattera. Other medicines are used that also have other treatment purposes. **Medicines are very helpful to most people who have ADHD. Stimulants, the most widely used, act to stimulate the brain centers that are causing problems because they are inefficient and underactive.** There are problems associated with using stimulant medications with adolescents. They have value as street drugs, so their use has to be monitored by a responsible adult. Many youths resist taking medications, either because of embarrassment or because they see drugs as lessening their self-control. They must have the disorder and medicine thoroughly explained to them if they are to fully take part in treatment. Along with good medicine, they also need to receive help in working on their own self-control skills.

ADHD – continued

Language Levels: Young people with ADHD are action oriented. They are not reflective, skilled language users. They do not learn from our talking to them at length, especially when they are emotionally upset. Because teenagers want to appear cool and mature, they learn to use more grown-up words through hearing and mimicking than they really process on their own. That makes people think they are also capable of thinking and acting like adults—they are *not*.

1. Speak clearly, honestly, and in a straightforward way. Vocabulary needs to be simple. Humor is fine. Sarcasm is confusing and cruel.

2. Practice what is certain to be hard. Get ready for hearings, for instance, or for difficult meetings with the family or probation officer. Even though we say ADHD youths won't learn from the past, practice does help. **Sometimes, adults have to step in and help the youth work out exactly what to say and do.** Then write down phrases or draw diagrams on cue cards for the youth to take along in a pocket that will remind him/her of how to handle the situation. Practice will build confidence and skill. (See *ADHD Cue Card* on the *Examples* page in the *Resources* Section.)

Corrections and Confrontations:

1. Intervene immediately in a situation with a youth who has ADHD rather than letting things build and hoping the problem will fix itself. Here's how . . .

2. If the rule s/he has broken is posted on a list, simply say in a firm voice just loud enough to get the youth's attention, "Chris, . . ." and point to the rule. If Chris does not immediately stop the behavior, then state what the correct behavior is in a calm, unemotional voice: "*Hands to yourself.*"

3. Correct privately, or separate the person from the group. If more correction is needed, private talk is understood and complied with far better than public reprimand. The quieter and more neutral our voice tone the better, especially when a person with ADHD is escalating toward upset. Public punishment is likely to result in an outburst as the youth with ADHD is unable to hold back the impulse to argue or strike back.

4. Avoid sensory overload with persons who have ADHD. They are likely to be over-sensitive to touch and made much more upset by it. Some may lose control when handled physically. They are also likely to be over-sensitive to noise. They often believe we are yelling at them when we are not.

5. With an angry person, give some space, keep your voice calm, and give a choice between two acceptable options. "*Stop, Pat. Avoid trouble and make a choice. Either hand it to me or put it on my shelf.*" Give the youth a few seconds to do so. ("*Give it to me now or go to time-out,*" is an ultimatum, not a choice!)

Giving Directions: Give them clearly to save the time it takes to correct mistakes.

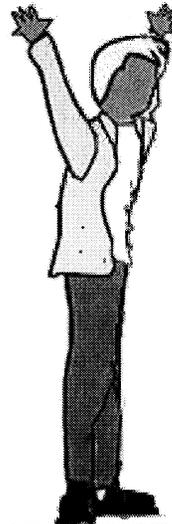
1. Get youths' attention before you give directions. "*Chris, listen up.*"

2. Say exactly what they are to do, giving no more than two steps at a time—Not "*Get the cleaning cart out and start work first in the day room before you do the hall.*" Instead, "*Get the cleaning cart from the janitor's closet and bring it here. Then I'll show you where to start.*"

3. Give new directions twice—say them once, then again a different way. Check for understanding. "*So, cart from the closet first, then here. OK?*"

4. Post written lists of rules and routines. Go over them and refer to them.

5. Provide encouraging feedback. People with ADHD learn best by feedback. Say what is done well or not. "*OK! That's clean!*" or "*Please re-do that part.*"



Behavior Management Plans: Behavior improvement systems (levels plans, point systems, etc.) *with long-term payoffs* may work less well with youths who have ADHD than they may do with others. It is hard to for them to learn lessons from past consequences or to think ahead to ones very far in the future. **Plan short-term goals and payoffs along the way.**

Decide on a key behavior or two to target. Make a chart that names those behaviors positively and have the youth carry it in a pocket, handing it off to the supervisor of each block of the day. That teacher, youth worker, cafeteria worker, etc. **rates the youth's behavior with a 0 (unsuccessful) or 1 (successful) for that time and initials the chart.** At the end of the day, a counselor or other meaningful person tallies the points. A successful day (the criterion will depend on the behavior — 100% for *Hands To Self*, maybe 80% for *On Time*) will earn the youth a small food treat or privilege. As most days have many more successful hours in them than unsuccessful ones, the result should be an increase in positive behavior. **The important point is that these positive points also earn a reasonable equivalent toward whatever longer-range levels plan is in effect in the institution.**

This kind of individualized plan meets several criteria for truly changing behavior: **a) immediate feedback on behavior** (the ratings at the end of each activity period— best if preceded by positive comments like "*Nice going.*"); **b) frequent payoffs for positive behaviors** (daily tallying and talk with counselor about the day, plus small daily treats earned for successful days); and **c) a four-to-one ratio of positive to negative responses** (the ratio that research has repeatedly proven necessary to *change* behavior); and **d) increased chances to move up on the overall levels plan** or other general reinforcement system with other youths in the facility.

Non-behavioral therapies do not help youths with ADHD.

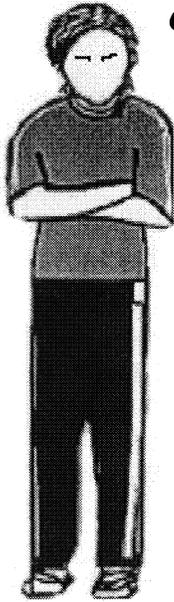
Cognitive interventions are helping methods that work directly with what goes on in people's minds—their ideas, emotions, and perceptions. Used well, they are effective for many kinds of emotional disorders—but **these activities are too abstract for most youths with ADHD.** These young people have problems organizing their thoughts, grasping complex ideas, and holding lessons learned in their memory. **The only way they can is if those brain activities are paired with physical activity and are of intense interest to them. Otherwise, cognitive interventions, like other insight-oriented therapies, are ineffective for ADHD.**⁵ A cognitive technique commonly used in detention centers is one in which delinquent youths are taught to recognize their supposedly inborn criminal thinking errors. Youths with ADHD would not be expected to profit from these lessons, and indeed, research has not shown them to reduce recidivism in detention centers.^{6,7}

Interventions that work directly on here-and-now behaviors can help youths with ADHD do things differently. For instance, anger management teaches safe responses to events that trigger anger outbursts. We have the youth role-play and rehearse them. Finally we reinforce the youth every time we *see* him or her use a safe response to avoid an anger melt-down in everyday life in our setting. **One big problem remains, however. It is hard to get these new behaviors to transfer to other settings.**⁸ The youth with ADHD needs to think about all the places back home where s/he will need the skill and then role play using the skill there, step by step. **It is best if a key person from the youth's real home environment comes to your setting to learn and work on these steps with the youth before discharge.** He or she can then be the link to bringing new behaviors home. Unless the skills we teach ADHD youths fit their unique learning and living problems, they will have been wasted time spent away from where life is really lived.

Personal interventions: Help youths experience success while they are with you.

A controlled setting with a structured behavior management system offers some youths a chance to experience the benefits of good behavior for the first time ever. Provide them with needed prompts. Break big steps down into clearer, smaller steps that will be followed closely by positive feedback. **A can of pop or a vending machine treat works better with Now kids than long-term contracts for large, far-off rewards.** Even simple check marks are rewarding when staff shows pride or approval for them. Extra service work for the institution or for others is an excellent way for all young people to boost feelings of self worth. **Adult pleasure and recognition for helping others are meaningful to young people who have received more criticism than honor during their lives so far.**

Oppositional Defiant Disorder—ODD



ODD is, along with Conduct Disorder (CD), one of the Disruptive Behavior Disorders. But ODD is not just a mild version of CD. . .

ODD is a disorder that begins in childhood or adolescence. It is a repeated pattern of negative, hostile, and disobedient behaviors that do not seriously violate the rules of society or the rights of others.

These behaviors include: frequent loss of temper • arguing with adults • annoying people on purpose • acting touchy or easily annoyed by others • blaming others for personal mistakes or misbehaviors • refusing to obey adults' rules or requests • seeking revenge • and doing things deliberately to irritate or frustrate people. **They do not include major physical aggression and destruction, law-breaking, cruelty, conning, and major theft that make up Conduct Disorder (CD).** Up to half of youths with CD start out by having ODD—but two-thirds of children who have ODD do *not* end up with Conduct Disorder.

Almost all children behave some of these ways sometimes. Those with ODD behave most of these ways so often that it seriously disrupts their lives for at least six months. Youths with ODD have their greatest problems with authority figures, especially those at home. That soon spreads to adults in school and the community. Their unhappiness is described in DSM-III: "The most striking feature [of ODD] is the persistence of the oppositional attitude even when it is destructive to [their] interest or well-being . . . the behavior may, in fact, deprive the individual of productive activity and pleasurable relationships."

We need to think of ODD as a disability. Because youths with ODD are often in staff persons' faces acting disrespectful or obnoxious, it is hard to think of how to help them. They are blind to their own disability and see everything as the fault of us in authority. We work on breaking through their defiance with a combination of structure, quiet responses, and friendly concern.

How does ODD develop?

ODD most often begins in the preschool years when it affects boys much more often than girls. For some children, symptoms build up over childhood. By adolescence, as many girls have ODD as boys. There are thought to be four major factors in a child's developing ODD². They are:

1) Discipline practices. Researchers have identified four types of problem discipline practices that contribute to ODD and CD: *a. inconsistent discipline,*

being harsh one time and giving in the next; *b. irritable, explosive discipline,* handing out many commands with constant yelling and threats; *c. little supervision or involvement,* indifference to the child even when she or he is in trouble; and *d. rigid discipline,* a fixed set of punishments used with no attention paid to differences in situations, the seriousness of the problem, or the child's understanding of it.

2) Parent-child incompatibility. This viewpoint includes the characteristics of the parent *and* child as factors causing ODD. For instance, nervous, anxious parents with a need for routine and order could raise a mellow baby who makes few demands very well. The temperament of a restless, fussy baby, however, could start the same parents down a rocky path to raising a child with ODD.

3) Individual child characteristics that contribute to development of ODD. Most ODD behaviors may be viewed as *reactive* acts, impulsive responses to things that happen. They are not usually *proactive* acts. Those are planned acts, calculated deliberately to hurt someone or get something from him. As with Conduct Disorder, that happens more often with older youths. **Reactive aggressive acts are thought to be driven by poor emotional self-regulation and poor impulse control. These are the same problems with behavior inhibition that are at the heart of ADHD, and ODD frequently goes along with ADHD.** ODD problems may also co-exist with **Anxiety Disorders**; uncontrollable worry is also due to faulty self-regulation of the emotions. ODD also co-exists with **obsessive-compulsive thinking and behavior.** That is when we see the young person getting stuck on an oppositional viewpoint, unable to let go of it even when it will clearly do him harm.

4) Behavior learned from others. The later ODD behaviors surface, the more likely they are to have been learned at school or in the neighborhood. That may be one big reason for as many girls as boys having the disorder by adolescence.

Can ODD . . .

...be genetic? We don't know enough about ODD apart from CD and ADHD to be sure. At least one parent is likely to have a history of mood disorders, disruptive disorders, or substance abuse. In some families, only one child has ODD while the others are not affected. The fact that more boys than girls are diagnosed early also suggests that a genetic factor may be involved.

...be biological? Scientists are not certain at this point.

...be environmental? Yes. ODD is more common in families in which there has been a series of different caregivers instead of steady parenting. It is more common in families where there is neglect or serious marital discord. Low socioeconomic status is *not* disproportionately high among the families of children with ODD.

What helps youths who have ODD?

Behavior Strategies

The best way to make progress with youths who have ODD is this: **1) find ways to represent authority clearly without expressing it personally face-to-face.** It is up-close-and personal interactions with adults in authority roles that set off their most vigorous acts of defiance. That requires making rules and structure very clear at the outset so that as staff persons, *we* are not the ones making youths do this or that—the *rules* are. The less personal our interactions with oppositional youths, the less likely we are to set off their opposition. When youths with ODD are forced to bow to direct adult authority, they are flooded with hostile feelings. Their faulty belief systems tell them that they are being victimized. **Instead of “breaking their will” and teaching them to be less defiant, confrontation makes them worse.** The less emotional we are, the less defiant the youth feels he or she must be.

2) Write down the rules that must be followed in advance. First, there will be the **general list or handbook of rules for your setting.** Explain rules that are non-negotiable, and lay out the consequences both for following them (positive) and for breaking them (negative) as you do for everyone. Then, as individual issues come up, **post written notice of any special rules that apply to that situation.** Close loopholes and make it clear that these rules also must be followed. **Rules rule.** Do this in a businesslike and respectful way to set boundaries for *all* youths in your setting, not only those with ODD.

3) When you must direct or correct, refer to the rule you have already gone over. Post short rule lists and routines close to where they need to be followed. This way, staff can keep words to a minimum and just point or refer to “*Rule four.*”

Relationships

4) Refuse to argue. It takes two to argue, and you will never win! What the youth with ODD really wants is to defy us, not to be declared the winner on the basis of debating points, so s/he will never stop the argument! **A good way to avoid arguing is to use the word *Nevertheless.*** The youth insists on what s/he wants, and we calmly say, “*I understand. Nevertheless, the rule is . . .*,” and s/he goes on and on, and we say, “*Nevertheless, the rule is . . .*,” and act on it. Talking logic to a defiant youth only sparks anger. Does that mean we never discuss problems or explain why rules exist? Certainly not. We say, “*We’ll talk later when your voice is as calm as mine.*” Keep that promise, and talk later when the heat is down.

5) Remember this—The power to say NO is absolute.³ Adults are not forced

to solve problems to youths’ satisfaction. Likewise, no one can force adolescents to do anything against their will—not walk, learn, believe, behave, or agree. We could four-man carry, restrain, or incarcerate them; we could plead, offer treats, or befriend them. But the power to oppose and defy is absolute.

What we do have in our power are our choices and consequences—positive, negative, mild, and severe. We do have power to influence them.* For instance, try this: **oppositional youths know they can say NO, so disarm them by acknowledging it.** “*You’re right, Chris. I cannot make you do that. You are in charge of what you decide to do next. I have a job, and it says I am to do _____ if you do it. Or, I am to do _____ if you don’t. So we both have choices. But yours comes first, to do this or not.*” It is the job of all adolescents to seek their own personal power. It is fair, smart, and meaningful for us to acknowledge that.

6) Give them space. Youths with ODD tend to be made irritable by close adult contact. Touch is usually intolerable. **When they back off from us, it is best that we back off, too.** We lower our voices and do not insist on any more direct answers, eye contact, or personal involvement than the minimum required. **It is hard for them even to tolerate an adult’s positive comments.** This presents a big challenge, as they need feedback for what they do right in order to improve their behavior. They can handle praise if it is not public and does not require admitting that they like it. Try a private word, a quick thumbs-up, or a short written note on a work-sheet.

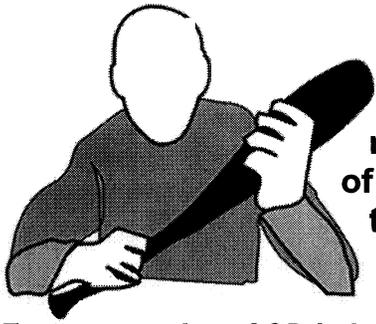
7) Counsel. A problem with ODD is that it cuts youths off from mentoring relationships with adults. They need them, and as these youths may be verbal and full of ideas, counseling relationships can help them tremendously. Here is what helps an adult become a confidante: **the self-confidence to tolerate some degree of disrespect; a good sense of humor; the humility to admit one’s own mistakes; and the ability to listen to shocking statements and quickly re-frame them.** Such counseling can have a profound effect in our facilities. The bottom line of bad behavior has become very clear, and the youth is far from the emotional triggers of home.

Medical Management

No medicines directly target the symptoms of Oppositional Defiant Disorder. The best candidates are usually stimulants for ADHD or drugs that help with anxiety, depression, or compulsive thoughts.

About Structured Behavior Modification Plans

Behavior management systems that rely on symbols (token economies, point systems, etc.) are not likely to work well with youths who have ODD. If the system includes lots of directions and reminders about earning and losing points, youths with ODD may see it as a power game that gives them just that many more chances to defy the system. **They will be oppositional and lose the points even if it means the loss of major privileges.** On the other hand, plans or contracts that are straightforward and based on logical consequences that make sense in real-life terms can be effective. **When the youth has a say in the planning, behavior changes we want are much more likely to happen.**



Conduct Disorder—CD

Conduct Disorder (CD) is a repetitive and persistent pattern of behavior in which a person violates the rights of others or the rules of society.

Four categories of CD behaviors are:

- 1) Behaviors that cause or threaten harm.** These include fighting, bullying, using weapons, forcing sexual acts, and stealing while threatening people — and cruelty to animals, too;
- 2) Deliberate destruction of property or fire-setting**—intended to destroy things or harm people;
- 3) Deceitfulness or theft** such as breaking and entering, major shoplifting, forgery, or “conning” people to get things from them;
- 4) Serious violation of rules** such as running away from home or staying out all night or truancy *before age 13*, says DSM-IV-TR.¹ After 13, some seems to be expected.

Ages of onset and types of Conduct Disorder:

Age 10 is the dividing point between *Childhood-Onset* and *Adolescent-Onset Conduct Disorder*. CD may also be classified as *Mild*, *Moderate*, or *Severe*. The earlier the disorder becomes apparent (as early as 4 or 5), the more severe and long-lasting its course will probably be.

There are important differences between early-onset and late-onset Conduct Disorder. **Aggressive behavior that starts early in young children is likely to be reactive rather than proactive.** *Reactive* means it is driven more by impulsive reactions to environmental triggers than to planning beforehand. Early-onset CD is likely to co-occur with ADHD and low frustration tolerance. When CD begins in the teens, it seems to be less “wired-in” to the basic temperament of the youth. Dangerous, law-breaking behaviors have probably been learned from neighborhood and school friends. Many more boys than girls have the early-onset type. By adolescence, girls have narrowed the CD gap between the sexes, though boys still lead. **As antisocial behavior that starts in adolescence is less impulsive and spontaneous than the early-onset kind, it is usually more successfully treated.**

At age 18 (and not before), if Conduct Disorder behaviors last, the youth may receive the adult diagnosis of *Antisocial Personality Disorder*. Roughly one-third of children with disruptive behavior disorders (CD, ODD, and ADHD) go on to have serious problems as adults. Another third have some symptoms but get along fairly well. A final third do well and go on to lead successful lives.

Is there a difference between non-conduct disordered juvenile offenders and those who have CD? Yes. Conduct Disorder is a brain disorder. Even though they may be very intelligent, youths with CD do not truly grasp simple human interactions properly. They feel unrealistically threatened by other people and strike out. A normal youth may do a criminal act in reaction to a stressor or temptation, be caught, punished, feel shame or remorse, and not repeat the misdeed. A conduct-disordered youth will do many harmful things over time—*persistently and repeatedly*—even though most are punished again and again. They hold on to the same self-justifying beliefs, feel the same negative emotions, and follow the same antisocial patterns of behavior.

Can Conduct Disorder . . .

...be genetic? Yes. Recent twin studies have shown that genes may account for 40 to 70 percent of CD. Two genes have been identified as having the strongest association with CD. One was for a gene on chromosome 2—in an area strongly linked to alcohol dependence.² This is interesting given the frequent co-occurrence of CD with alcohol abuse.

...be biological? Yes. Some children with ADHD have been found to have brain abnormalities.³ These are in the frontal lobe, an area that affects the ability to plan, to avoid harm, and to learn from negative consequences. This may be the result of chemical exposure to toxins, to emotional trauma, or to genetic predisposition. Also, many of these violent youths have experienced birth complications or abusive injuries to the head or face. Another biological difference is that some youths with CD have lower heart rates and slower nerve impulses than normal.⁴ These differences may account for their being less emotional, less moved by feelings for others, and less afraid of risks.

...be environmental? Yes. Poverty, lack of a stable developmental environment, emotional trauma, as well as parental mental illness and substance abuse can all be factors.⁵ Children who experience violence, whether to themselves or by being exposed to its terror, are highly at risk.

...be a combination of these? Definitely—by an interaction of a genes, physical conditions, and life experiences. In New Zealand, for instance, researchers⁶ identified a gene they called MAOA in 85% of a group of men who had been mistreated as children—rejected by their mothers, physically or sexually abused, or subjected to many changes in primary caregiver. On 30-year follow-up, some men with the MAOA gene were found to have been involved in violent behavior, including crime. Other men also had the gene, *but only those who were abused or neglected as children became violent.* The gene produces an enzyme that breaks down serotonin, norepinephrine, and dopamine, brain chemicals that are essential for mental health.

What helps youths who have Conduct Disorder?

The dangerous behaviors of conduct-disordered youths demand attention, so other serious and more treatable problems that these youths have may be overlooked. If that is so, it is critical that they be evaluated. That treatment could also have a positive effect on conduct problems.

- Many have **lower intelligence, learning disabilities, and/or ADHD** that result in school failures. These make success in adulthood harder to achieve, so it is important to focus on **special education** and **transition planning**. The school in your facility has a crucial part to play in preparing the youth and the school he or she will return to for the best outcomes upon discharge.

- A high proportion of youths with CD have **language disorders**. While they may talk like normal teenagers, **they do not process spoken language well and they do not keep up with abstract ideas.**⁷ Our own language must be simple and direct. It is especially important that we go over important events like court appearances in advance. That way, the boy or girl will fully understand what will be said and has a chance to practice how to respond. This can make a critical difference in the way legal cases are decided.

(See ADHD example in the Resource Section.)

- **Depression and related mood disorders** are significant problems with many conduct-disordered youths. Working with a counselor on their beliefs about themselves and the future can be an important avenue of help. We need to keep their **high risk for suicide** always in mind. **Anxiety** is a problem for many, though some kinds of anxiety are protective since anxious youths are generally less risk-taking than others. As many as 85% of youths in Detention Centers have symptoms of **Posttraumatic Stress Disorder**. Studies have shown delinquents raised in our urban “war zone” neighborhoods suffer PTSD symptoms identical to those of traumatized Vietnam veterans.⁸

(See Disorders of Extreme Stress, Depression, & Violence.)

- **Substance abuse** is a very common partner of Conduct Disorder, increasing its danger to the youth. Work hard to have treatment gains made during placement.

Making plans

Plans for Safety. One rule of behavior planning is this: *the best predictor of behavior is past behavior*. So a plan must be *in place* for managing a seriously aggressive act based on the worst that you can expect from past behavior. Every staff member needs to know that plan so s/he is ready to handle dangerous behavior safely and with minimum disruption for others. The conduct-disordered youth needs to know the plan so s/he knows what will happen when deciding how to behave. Tell the youth—not in a threatening way, but in a calm, businesslike tone.

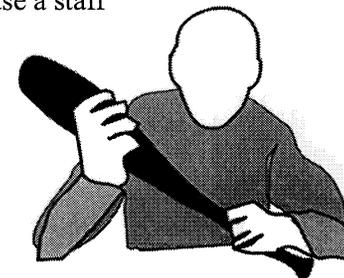
Plans for Success. Assure the young person that you do not expect to need the safety plan. Explain the behavior improvement plan for your setting. Some youths require extra supervision because of a history of sexual misbehavior or

unprovoked aggression. In that case, work extra hard to create an individualized plan so that **each young person experiences more successes for positive things than restrictions and punishments for negative ones**. Otherwise, we will have lost the chance to change the course of the disorder even a little. For some, this may mean creating an earning system with short-term credits toward a desired treat like an extra phone call. Others may scorn that but find success in earning a good grade, learning a trade skill, or doing activities with a favorite adult.

Interacting with conduct-disordered youths

Respectfully. We might ask, *why?* Young people who have this disorder lack respect for the personal well-being, possessions, feelings, and rights of others. So why should we respect them? **Whether the respect we show is heartfelt or is a learned technique, it is best to act respectful—because it works best.** People new to working with CD youths tend to think that if they had been severely disciplined when they first showed their antisocial behaviors, they would know how to behave. The best way to fix that, they believe, is to provide the strictness that they missed by confronting them sternly and punishing them severely if they do wrong now. *We know the opposite to be true.* The histories of the worst criminals show most of them to have been cruelly though inconsistently punished as children. They also have witnessed the abuse of others. This process kills their feelings and thwarts the growth of normal conscience.⁹ When we raise our voices, confront, threaten, and have to resort to physical management, it is just more of the same to most youths with CD. When we avoid that and **deal with them in an adult, matter-of-fact, respectful way—as a coach, mentor, or job foreman might—it disarms them. They are much more likely to cooperate. Even if they do not, they will experience a respectful model of adult disapproval and fair, consistent consequences for breaking rules. That is important.** The best outcome for a youth with Conduct Disorder is to establish a strong counseling relationship with a positive adult that can last over time.

Watchfully. That said, it is just as important to be watchful as it is to be respectful. **Boundaries are essential for the safety and security of youths and staff.** Some youths with Conduct Disorder are very sophisticated at taking advantage of relationships. They may deliberately use a staff person’s friendship or a lapse in supervision to gain advantage—to steal or run away, for instance. The rules and restrictions of the setting are staff’s allies, and bending them to befriend youths with CD leaves us vulnerable. **Respect and relationships are the keys to helping them change, but they must fit within rigid keyholes to work.**



Mental Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

Pervasive Developmental Disorders (PDD's)

Autism • Asperger's Disorder • PDD–Not Otherwise Specified (PDD–NOS)

These three disorders make up what is often referred to as *the Autism Spectrum*. They are *developmental* disorders which means that they showed their first symptoms early in the children's lives. These unique symptoms are inborn neurological characteristics, not problems caused by injury or poor parenting. And the symptoms are *pervasive* which means that they run through and pervade major aspects of these people's lives for as long as they live.

Symptoms experienced by people on the Autism Spectrum:

- Their **senses** perceive the world around them as too bright or too loud or disturbing or distorted;
- their **body movements** might be self-stimulating such as rocking, twirling in circles, making odd shapes with their hands to filter the light, or they might just be awkward or clumsy;
- their **learning abilities** range from very low to streaks of brilliance in narrow areas;
- their **abilities to communicate** also range widely from none, to repetitive and nonsensical, to adequate but still a bit odd in content or tone;
- their **emotions** may be flat or so explosive that they are hard for others to understand or help them control;
- their **need for order and resistance to change** —in rules, in schedules, in where they sit or what they eat —looks like sheer stubbornness and causes serious problems in some settings;
- finally, and most characteristic of all, **their lack of social awareness or understanding of others** locks them into their own isolated selves. They are unable to connect with other people, even truly to look at them. Severely affected people may not care very much, but many more able people have a sense of their own oddness and inability to fit in. They may become hostile or very depressed.

People with full Autism are likely to appear the most disabled. Those with Asperger's disorder have fairly normal speech as their diagnostic marker and so may seem close to normal. But they also have other problems that emerge to cause serious trouble and unhappiness. Those given the PDD-NOS diagnosis have many but not all of the characteristics of the other two disorders on the spectrum.

Or they may have shown the symptoms less clearly or for too short a time to merit the full diagnosis.

(Two other PDD's are Rett's Disorder, which only girls have, and Childhood Integrative Disorder.

They both involve children's *losing* normal abilities at an early age and then becoming autistic.

These children will not live long enough to be seen in a Shelter or Detention Center.)



Autism & Asperger's Disorder ¹

These disorders are closely related. They are both **Pervasive Developmental Disorders (PDD's)**.

People with Developmental Disorders are seven times more likely than others to come into contact with the police.² Their reactions often get them in trouble.

Developmental Disorders are disabilities that interrupt normal development in childhood. They may affect a single area of development (Specific Developmental Disorders) or several (Pervasive DD's). **Pervasive** means that problems have taken over many aspects of a youth's development—in the case of Autism and Asperger's, language, the senses, coordination, behavior, but especially *social relationships*. We speak of people with one of these disorders or with characteristics similar to them as being on the **Autism Spectrum**.

There are many differences across the full Autism Spectrum, but for all of the disorders, it is their *self-ism* that is especially limiting—the word *autism* means *self-ism* or *I-ism*. Those with a PDD cannot relate normally or effectively with others or the world outside themselves. The ways they respond to encounters with the law, therefore, are socially off-kilter. Running away, unsteadiness, impulsive actions, or refusals to respond, for instance, can lead to serious trouble with police.

People with Autism or Asperger's Disorder cannot fully understand other people's ideas, needs, or emotions. They view the world from their own here-and-now perspective in a very literal way. That makes them the objects of jokes, easy victims of teasing or bullying. When their usual routines are not followed, or when our rules do not fit with the structure they have in their minds, these youths become upset and even aggressive. Reasoning with them then is pointless, especially in situations that also overload their senses.

People with Autism who are low-functioning (most are) will be more easily recognized as handicapped than will be those with normal or higher IQ and Asperger's Disorder. People tend to view Autism as a genuine disability. Youths with Asperger's appear more normal and have no major speech problems. Good language is the basic difference between the two: youths with Autism may echo what they hear instead of conversing, and some cannot communicate at all; those with Asperger's may talk like "little professors." Sometimes they tire people with endless talk about trains or maps or statistics. They may act superior to "dumber" kids and behave like junior staff, annoying both adults and peers. Caretakers think that if they are that smart, they should be able to understand what simple rules mean.

Their inability to "get it" can just seem stubborn.

What disorders co-exist with Autism Spectrum Disorders?³

Sometimes, it turns out that by treating one of these, a person is relieved of symptoms that had been thought to be part of the PDD. 1) **Tic Disorder**. Autism involves what are called "*stereotypic movements*." These are odd movements done repeatedly. It is possible that they could be partially due to a tic disorder such as Tourette's. 2) **Attention Deficit**. ADHD may be partially responsible for attention and learning problems, and stimulant medications can help. 3) **OCD or Obsessive Compulsive Disorder**. For some youths, the insistence on routine that is typical of Autism and Asperger's may become so excessive that it becomes **OCD-like** and can be treated. 4) **Anxiety disorders** co-exist very commonly with autism spectrum disorders causing worries, fears, and physical stress symptoms. 5) **Major Depression** and **Bipolar Disorder** are serious mental illnesses once thought impossible for people with autism spectrum disorders to have. They are now recognized as co-existing with them and may start in the teens. 6) Finally, **Seizure Disorders**. Some autistic persons develop seizures. Medicine and the regular guidelines for your facility will be adequate for handling them.

Can Autism and Asperger's Disorder . . .

...be genetic? Yes. Autism clearly runs in families.⁴ Autism affects an estimated 1 to 2 per 1,000 people. The chances of someone with one autistic child having a second one with the disorder are 1 in 15. The odds of heritability are less clear for Asperger's Disorder but are still well above what one would normally expect.

...be biological? Yes. Recent research has shown that the brain's white matter, made up of nerve cables that connect various brain parts so they can work together, is deficient in autistic brains. This leads to **underconnectivity theory**,⁵ the idea that **autism is a system-wide brain disorder that limits the ability of different parts of the brain to work in coordination**. For instance, the word-calling part of the brain (Wernicke's) has been shown to work overtime, but the comprehension part (Broca's) is sluggish. This theory helps explain one curious aspect of Autism: some autistic people have superior skills in some areas while other, more useful areas of thought are disordered.

...be environmental? No and Maybe. No, these brain disorders are definitely *not* caused by bad parenting as was once believed. Scientists are, however, exploring evidence that some children develop Autism from environmental poisons such as mercury in fish eaten by their pregnant mothers.

...be treated? Yes. Despite frequent claims that a cure has been found, none has proved to be worthwhile for more than a small number of children. Intensive **behavioral training is very valuable, however, when begun early in life while the brain is most malleable**. Medicines relieve many symptoms.

Ways to help

- **Recognize that youths on the autism spectrum are rigid thinkers.**

Once they have rules or procedures fixed in their minds to apply to certain situations, they will rely on them absolutely. But they cannot think with flexibly enough to apply the same rules to similar-but-different situations. If a schedule calls for lunch at 12:10 and it is delayed until 12:30, an autistic youth may become very upset. If the rule is never to touch anything on the teacher's desk, and the principal walks in and picks up her lesson plan book, s/he may fly into a rage. **Use a standard phrase to prepare them for any changes in rules or routines that you can predict. "Today will be different. . ."**

If the youth has language, write the change down on a written schedule so s/he can anticipate it during the day. Use simple drawings and words to make things clear for those with language problems.

(See the Extra Supports for Youths with Asperger's or Autism Disorders in the Resource Section.)

- **Youths on the autism spectrum may have rage attacks or "meltdowns."** Try to recognize the first signs of agitation. Remember, these youths are concrete thinkers; **verbal reasoning strategies will not help when they are already upset.** Quietly approach the youth from the front, not from the side or back. Avoid touching him or her, especially around the head or neck. If s/he knows some stress management techniques such as taking a cleansing breath or relaxing, try cuing these. Melt-downs are likely to be triggered by confusion and sensory overload in the environment, so do what you can to reduce them. **Your goal is to keep the youth from harming him- or herself or others.** Remain calm and non-judgmental as you maneuver the youth away from others to a non-stimulating place.

Severely limited youths with Autism

- **About half of this population is non-verbal.** Autistic youths may use gestures, pointing, or a few signs or words. They may repeat your question back to you or say the same thing over and over. **Resist getting louder—just get simpler.** Try using very short phrases that you can act out with gestures. Communicate with pictures from a phrase book or make one from magazines.
- **Recognize their lack of awareness of other people's needs and feelings.** They may invade your space or ask personal questions over and over again. Or they may stare right through you, refuse eye contact, and misunderstand your facial expressions or gestures. Recognize these as odd behaviors they cannot help and **model using social language and gestures that are socially correct for the person's true age.** Smile and say, "Good morning, Elisha," or "How are you, Ellen," as you would to a normal peer. **People with autism are people first, and we respect that.**

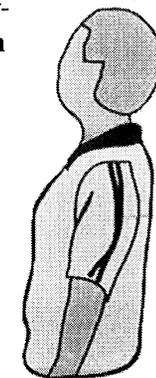
- **Protect youths on the autism spectrum from being victimized by teasing or bullying.** At the same time, attempt to teach them how to seek out safety for themselves. In our controlled Shelter and Detention environments, the first of these goals is more easily achieved than the second. It requires too much understanding of the subtleties of language and relationships to try to teach these young people the differences between kidding and malicious teasing. If they try to make clever comebacks or assertive responses, they are likely to be teased or bullied even more. Instead, teach them to walk away and "*go to a safe place.*" List all the safe places there could possibly be—next to a parent, teacher or official, into a classroom, office or store, or perhaps just off by themselves.

- **When a youth on the autism spectrum does or says something out-of-line, stop the behavior. Then plan how you will teach the youth the right way to handle the situation the next time.** For instance, social/sexual development is difficult for youths with Asperger's. Their sexual feelings are not matched by age-appropriate social skills. They want to belong, but they behave in frank and naive ways that don't fit in with social custom. Although they may not understand another person's feelings, they feel their own rejection keenly. They need to learn scripts of what is and is not okay to say to someone of the opposite sex whom one is attracted to. They need to know the rules of girlfriends and boyfriends, that you don't just get to have whomever you choose. For their own safety, they need to practice and role-play tough situations. Autistic youths, on the other hand, rarely have any real interest in relationships of this or any kind.

Intelligent youths with Asperger's Disorder

- **These youths will all have had normal communication skills; it is one of the criteria for the AD diagnosis.** Some, however, have oddly formal or sing-song speech mannerisms that may make them sound like "little professors." Do not be misled by adult-like talk—just as with their lower-functioning cohorts, **use clear, simple language, and make certain that your meaning is understood.**

- It is difficult to distract youths with Asperger's Disorder from focusing on the very narrow areas of interest that absorb all their attention long enough to listen to you. Give a time warning— "*In one minute it will be my turn to talk, your turn to listen.*" Then make sure you have the youth's attention. Put up your hand and say "*My turn. Pay attention,*" and wait until you have eyes in your general direction. Then say what needs saying clearly and simply. Ask the youth to tell you what was said.



Mental Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

FEEDING & EATING, TIC, & ELIMINATION DISORDERS Tourette's Disorder • Nocturnal Enuresis–Bedwetting

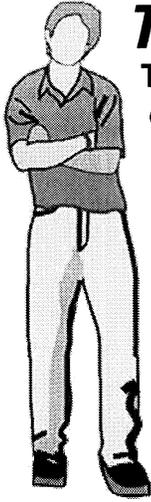
AND SEE ALSO

- Diurnal Enuresis (*Urinating in the wrong places, P-47*)
- Encopresis (*Defecating in the wrong places, P-8*)
- Eating Disorders (*Refusing to eat, P-30*)*

One thing this group has in common is that the disorders are all *developmental*—they are almost always established well before adulthood. What they affect are young people's most basic body functions: controlling their muscle movements so they can do things; ingesting food to nourish their bodies; and eliminating the wastes that would clog up and sicken their bodies.

So why are what sound like *physical* disorders in a diagnostic manual of *mental* disorders? Because when these systems are out of order, they cause strong reactions in the *emotional* systems of both the young people themselves and of their worried, stressed, or angry care-givers. Furthermore, the symptoms of all the disorders are made worse by emotional stress. Finally, most of these disorders have psychological problems inherent in them that must be addressed as carefully as the physical problems they appear to be. Many people who have Tourette's motor and vocal tics also have the tic-like recurrent thoughts of the obsessive thinker as well as ADHD. Those with elimination disorders experience shame and in many cases, suffer harsh punishment or alienation from their parents. Eating disorders diagnoses include symptoms of obsessive thinking about food and body size. Youths have delusional thoughts about their own body images, seeing themselves as fat when they are in fact nearly starved.

*Anorexia and Bulimia are included on this page, and they frequently do have Child or Adolescent onset. They have their own Eating Disorders category, however, among the Age Non-Restricted disorders. In this category are other feeding problems of young children.



Tourette's Disorder

Tourette's Disorder is a neurological disorder that causes a person to have *both* motor and vocal tics.

Simple motor tics are meaningless, involuntary actions such as eye-twitches or shrugs. **Complex tics** involve whole sets of muscles in such actions as deep knee bends or twirling. **Vocal tics** vary from a simple cough or yelp to a very complex tic, coprolalia. Coprolalia means shouting out the very filthiest words you know and know you shouldn't say. This affects fewer than 10 percent of people with Tourette's.

How do youths with Tourette's Disorder act?

There is a wide range of severity of tic problems. About one out of every four children has a tic for a while without ever developing Tourette's—it just fades away. On the other end of the severity scale, a small proportion of young people's tics quickly become very forceful, frequent, and noticeable. **They may bark, spit, shake and grunt, shout, or yell out obscene words. Tics this severe can cause them to be socially stigmatized and very anxious.** Tics interfere with speaking, writing, and learning in general. Jerks and falling can cause serious damage to their bodies. What we cannot see is the obsessive thinking that may go along with the obvious motor and vocal tics.

Age 7 is a frequent age for Tourette's Disorder to first appear, but it can wait until adolescence to show up. The kinds of tics people have can change over time, particularly while they are young. They tend to become less frequent and to stay in established patterns in adulthood. They may even disappear by then. At least twice as many males as females have Tourette's.

What does it feel like to have Tourette's Disorder?

That varies. Tourette's is a disorder that waxes and wanes. There will be hours, a day, weeks, or, maybe later in life, years when a person is free of tics. Some people have such mild cases that they do not even know it, or if they do, they don't even bother treating it. For others, it is very severe. Imagine having continually to suppress a sneeze or ignore an itch in a private part of your body. You can deal with that urge only so long before you have to respond to it. Having tics feels something like that. **Embarrassment, stigma, rejection, or open hostility are the worst problems for people with severe cases.**

Tics are a problem of disinhibition. That means that the **motor parts of the brain tell the muscles to do things that the thinking brain cannot stop them from doing.** Sometimes vocal or motor muscles can be held in check

for a while, but they must be released later, often in a great burst. People with Tourette's try to disguise their tics so they seem more normal. They may turn a growl into frequent throat clearing or a jaw-stretching grimace into yawns.

Stress makes tics worse. The more a person has it in mind to avoid a tic, the more it can become an obsessive thought, and the more likely the tic is to recur. This leads to serious social trouble for adolescents whose tics include calling out sexual words or grabbing their genitals. At their developmental stage, sexual thoughts often come to mind and prompt tics with sexual terms and gestures. Tourette's can cause some people to blurt out racial or dirty words or strike at people. These complex tics can quickly lead to fights or beatings.

What co-exists with Tourette's Disorder?

1) **ADHD is Tourette's closest partner.**¹ Attention problems are often noticed before tics even start. When they team up, the young person is likely to be to **disruptive, impulsive, and socially immature. These features of the attention deficit are far more damaging than the tic disorder alone.** This is complicated by treatment of ADHD with stimulant medications that may worsen the tic symptoms in many, though not all, individuals. The other disruptive behavior disorders, **ODD and CD**, are not uncommon. 2) **Obsessive-Compulsive Disorder (OCD) is another close companion to Tourette's Disorder.**² Boys usually have this combination. It is unique enough that it may qualify as a special subtype of OCD with more aggressive symptoms, fewer obsessions about cleanliness and hoarding, and an earlier age of onset. **Think of these three disorders as all sharing *disinhibition*, the inability to keep one's attention, thoughts, and/or movements under one's own conscious control.**

3) **Depression** can also become a problem for sufferers of Tourette's Disorder.

Can Tourette's Disorder. . .

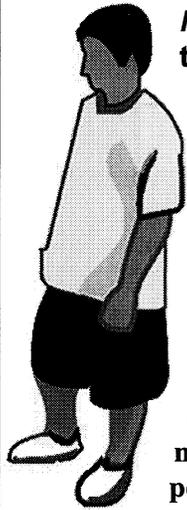
...be genetic?² **Yes.** Tourette's Disorder, simple tics, and OCD sometimes run in the same families. Estimates are that 85 to 90 percent of the risk of having Tourette's is genetic. Those who have Tourette's also have higher risk for ADHD.

...be biological? **Possibly.** From 10 to 15 percent of people with Tourette's do not acquire the disorder genetically. Biological factors may also play a part.

...be environmental? **Probably.** Researchers have pointed to stressful events during the prenatal or early life periods that threaten the fetus growing in its mother's womb. These could include exposure to drugs or other toxins.

...be treated? **Yes.** There is no cure, but young people whose tics are severe enough to interfere with their leading full lives can usually be helped with medicines. **The medical provider chooses from many that are used successfully to find the best balance between control of tics and side effects.**

Nocturnal Enuresis—Bedwetting



Nocturnal Enuresis is the involuntary loss of urine that occurs only at night.

The key word here is *involuntary*—people who wet the bed do not do it on purpose.

How many young people have this problem?

It is a common **developmental** problem—not an illness, but a disorder related to the process of developing into maturity. Among all children starting kindergarten, almost one-fourth have **never been consistently dry at night**. That is called **Primary Nocturnal Enuresis**. By the time they are 12 years old, 8% of boys and 4% of girls still wet the bed. **By mid-teens, the general percentages have dropped from 3 to 1%, males always having the greater problem. One or two percent of adults wet the bed.**

Among young people in Detention Centers, these percentages are probably higher. **Enuresis often co-occurs with ADHD, and youths with ADHD are over-represented among juvenile delinquents.** The rate of co-occurrence researchers have found between the two is 15 to 23%. Among all bedwetters, those with *both* problems are among those most likely to continue wetting the longest.¹ Given the high proportions of youths in youth facilities who have ADHD, it is possible that as many as 10% could still wet the bed.

Some youths might have **Secondary Nocturnal Enuresis**. That is a bedwetting problem that begins after six months of nighttime dryness. It is **due to an underlying emotional or medical problem such as PTSD, sexual abuse, or urinary track infection**. Secondary enuresis occurring at night is much less common than in the daytime, however, and it happens most often with younger children.

(See *Urinating in the Wrong Places*)

What causes and cures bedwetting?

We naturally produce an **anti-diuretic hormone** that regulates the amounts of urine we produce through the cycles of day and night. Some people naturally produce too little of it. When a chemical that acts the same way, **desmopressin**, is taken in tablets or nose drops, it brings it up to normal levels. It is expensive, however, and as soon as it is stopped, almost all users go back to bedwetting. The anti-depressant medicine **imipramine (Tofranil)** also works with good results though for less clear reasons. It also has a high relapse rate when stopped.²

Many believe that the main cause of nocturnal enuresis is a kind of **sleep disturbance**. Some children and youths sleep too heavily to be awakened by

their bodies' own alarm signals when their bladders are full. (This reminds parents of the kind of deep sleep their ADHD children are in when they try to wake them up in the morning, a possible connection.) A **bedwetting alarm** is the most effective treatment for Nocturnal Enuresis overall. The first drops of urine set off an alarm under the sheet so that the person wakes up to go to the toilet. It is 75% effective with only a 41% relapse rate—for those who stick with the 15 weeks of treatment.³ Many families find it too hard or too unpleasant and stop.

In the past, most people thought of bedwetting as a psychological issue. Now we realize that **emotional problems are more likely to be the result of nocturnal enuresis than its cause**. The National Kidney Foundation estimates that 35% of parents still use punishment as their main method of dealing with bedwetting.⁴ Punishment results in more rather than fewer incidents. **Positive reinforcement systems**, on the other hand, can improve motivation to make any treatment work a little better. **Responsibility training**, having youths strip sheets from the bed, launder, and replace them, also has a place in treatment plans for older children and teens.

What are common co-existing disorders?

ADHD is the most common partner of enuresis.⁵ **Encopresis** also co-occurs. Some youths who hold back their stool also hold back their urine. They hardly go all day and finally urinate when asleep. Enuresis often co-occurs with **Oppositional Defiant Disorder** and **Conduct Disorder**. Youths who have been harshly punished for bedwetting may have layers of hostile motivations added to their developmental enuresis. (See *Defecating in the Wrong Places*)

Can Nocturnal Enuresis . . .

...be genetic? Definitely. The child of two parents who were enuretic has a 70% risk of having the same problem, and the child of one has a 40% risk. The child with neither parent having been affected still has a 15% chance of wetting the bed.⁶

...be biological? Yes. There are no differences in anatomy to account for enuresis, though high muscle tone may keep some normal-sized bladders from filling as fully as others. Small capacity leads to more frequent urination, day and night. The lack of enough anti-diuretic hormone is a biological factor.

...be environmental? In a way. When enuretic children were compared to a control group of children who had urinary control, those who wet their beds also had significantly more mental health disorders. They had more internalizing disorders (e.g., depression and anxiety), more externalizing disorders (e.g., ODD and Conduct Disorder), and more ADHD. But when socioeconomic variables were controlled for in the analysis, the differences between wet and dry children disappeared.⁷ Enuresis is just one of a set of problems among poor kids.

Ways to Help

Some people with Tourette's learn to **explain the reasons for obvious vocal and motor tics assertively and right away.** " *Please try to ignore my shouts. I have Tourette's, and it happens sometimes.*" " *Excuse all this jerking. I have Tourette's Syndrome, and my nervous system acts up.*" (Tourette's Disorder is the official name, but some people like to use the original word *Syndrome* better.) If you see tic-like behaviors and a youth does not mention them, check out the possibility that s/he may have Tourette's Disorder.

- **If you learn about the problem in advance, bring it up at admission.** When first coming into a new setting, a youth with tics may work successfully to suppress them. Eventually, though, the tics *must* be released, sometimes in a great storm. See that the youth knows where s/he can go to release them in private. Let the youth know that staff members understand Tourette's Disorder. Ask how you can help. Make it clear that if peers have questions or comments on the tics, you will be available to help explain that Tourette's is a neurological problem beyond a person's control.
- **If you think you notice tics but they are not mentioned, check the medications list from intake.** See if s/he is taking such drugs as Haldol (haloperidol), Orap (pimozide), Clonidine (guanafacine), Risperdal (Risperidone), or Abilify (Aripiprazole). These are some of the medicines prescribed to reduce tics.³ This knowledge could give you some idea if the youth is currently being treated for Tourette's Disorder. **Their primary use is to treat psychotic disorders which Tourette's is not**, so a youth could be taking them for Tourette's or for another reason. Notice also if the youth is taking a stimulant medication. These would include Ritalin (methylphenidate), Adderall (amphetamine/dextroamphetamine), Dexedrine (d-amphetamine), and Concerta (methylphenidate time-released). **Stimulants are prescribed for ADHD and can cause tics in some persons or make Tourette's tics worse.**
- **For some youths, having tics may be a new experience, an old problem that has become more noticeable, or one for which they were once diagnosed but have chosen not to take medicine.** Some people find that the sedating and other side effects of the drugs used to treat Tourette's are bigger problems than the tics themselves.
- **Listen to what the youth thinks and feels about your observation of possible tics or about knowing s/he has Tourette's Disorder.** Many well-adjusted people can lead fully normal lives despite very noticeable tics. Others, especially those who also have symptoms of ADHD and OCD, have a rough time. **Feelings of lack of self-control, frustration, and social rejection may explode into major anger episodes.** Your facility's treatment team may decide that unless a medical/psychological evaluation has been done recently, one should be scheduled now.
- **The best defenses against hurtful comments for those with Tourette's Disorder are assertiveness and shared, accurate understanding of the problem.** Some severely affected people make up little cards with a brief explanation of Tourette's printed on them that they can hand to curious people. Composing these and printing them on a computer can be a satisfying activity and build confidence even if the actual cards are rarely handed out. Showing a good videotape, sharing printouts from the Internet about the disorder, and having a discussion with staff and peers can build everyone's understanding and empathy.



Ways to be helpful to enuretic youths

1. Be prepared to meet their needs. Most residential facilities have moisture-proof coverings on all their mattresses. If yours does not, see that you have enough waterproof mattress pads and pillow covers on hand as well as other linens to allow for frequent laundering. **Prepare an Enuresis Protocol for waking up with a wet bed.** The ideal arrangement would be for the youth who wakes up in the morning with a wet bed to get up, rinse off in the shower, dress, strip the bed, and put the wet linens into a special hamper until s/he can put them through the washer and dryer. More realistically, if it is nighttime, the least disruptive routine will be for the youth to wash off, put on fresh pants, put a towel or a waterproof mattress overlay over the wet place, and wait until morning for the full routine. **Privacy, nearness to the bathroom, the institution's general morning routine—these are variables that you will have to fit to the specifics of your facility.** (For instance, in places that cannot change sheets daily, a wet bed should be left open to the air to dry at least until noon.)

3. Hold a private planning conversation. As part of settling in, **go over the Enuresis Protocol with the youth.** Show him or her where supplies are and ask if s/he needs any help. Some will say that they like to be **awakened at night so they can get up and go to the toilet.** That is a reasonable request to make of night staff. Add in a couple of practice imagery elements for the youth:

- 1) **Drink only a tiny amount of fluid during the 2 hours before bedtime;**
- 2) **Empty your bladder at bedtime;**
- 3) **While you are lying in bed going to sleep, practice this imaginary routine in your head:** *Pretend that your bladder is full and telling you, **WAKE UP BEFORE IT'S TOO LATE.** Then imagine hurrying to the bathroom, emptying your bladder, and getting back into a nice, dry bed.*
- 4) **Imagine it over and over again.**

Enuretic youths are often very hard to wake up. Some may refuse to budge. If that happens and it results in a wet bed, the young person can negotiate a change in the procedure, or you can add in a little bonus for a dry bed. **Do not make a big deal of it, however, so that the youth feels it has been another failure if the bedwetting continues.** Settle pleasantly for the youth's coping with wet sheets and showers as a personal hygiene matter.

2. Assess for Nocturnal Enuresis at admission.

Assume in your written or verbal interview questions that it is among the possible health problems that any youth coming into your facility might have:

Do you urinate in your sleep (wet the bed)?

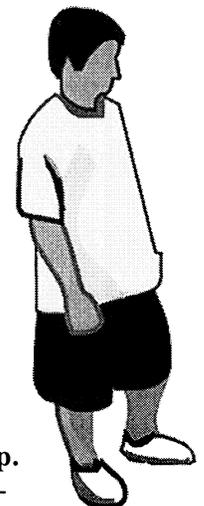
Y_____N_____

About how often?

nightly___weekly___monthly___other_____

Make sure your words are clear so the youth does not think you are referring to nocturnal *emissions* or wet dreams. Substitute *pee* if you have any doubt. Ask if the youth has ever seen a doctor for the problem or taken medication.

4. Special problems. By the time an enuretic child becomes a teenager, bedwetting may have become a huge source of trouble. At some point, bedwetters all feel a degree of shame. Even the most gently raised child whose parents have hardly so much as sighed about their wet beds know that they are failing at something all kids should be able to do. As they get older, they are afraid to have sleepovers with friends, and when older still, they fear becoming sexually active. **A problem for young people living in poverty is keeping themselves and their clothes clean.** Families that have few clothes, few or no sheets on their beds or couches, and no washers of their own cannot keep an enuretic child or teen smelling fresh. As the smell of urine permeates everything around them, the young people themselves become so accustomed to its odor that they may not realize why people are turned off by them. They may respond to rules or suggestions about showers and laundry defiantly and resist help. **Then your written Enuresis Protocol will have to depersonalize the problem and become just the set of rules to be followed with the resulting costs and payoffs in effect in your levels system.** But always keep the door open for true communication about this problem and the youth's feelings about it. **Simply seeing that bedwetting is a common enough problem that it doesn't freak out the adults in your facility can be a help.**



Mental Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

MENTAL RETARDATION & LEARNING, MOTOR, & COMMUNICATION DISORDERS **COGNITIVE DISORDERS**

Mental Retardation (MR) or Developmental Disabilities (DD)

Fetal Alcohol Syndrome (FAS)¹ & other substance-caused problems

Traumatic Brain Injury² (TBI)

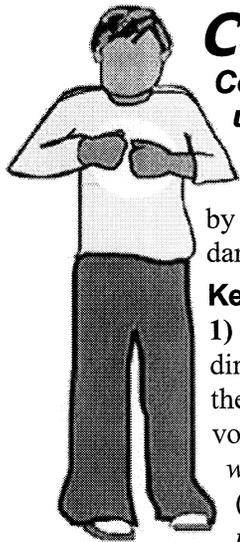
Mental Disorders are brain disorders.

**In this category are gathered disorders that limit
the brain's ability to guide its owner to function effectively in the world.**

Mental Retardation diminishes the ability to understand how and why things happen and how to solve problems. **Learning Disorders** interfere with the ability to learn to read, write, or work with numbers, skills necessary to participate in the modern world. **Motor Disorders** interfere with physical coordination and prevent fully active involvement in work or play.

Communication Disorders interfere with normal abilities to express what one means, understand what others mean, or hear or speak clearly enough to share conversation.

Many of these conditions have been wired in since birth and belong exclusively in this group of disorders “usually first diagnosed in infancy, childhood, or adolescence. **Traumatic Brain Injury**, on the other hand, can cause such problems at any age.



Cognitive Disorders

Cognitive is a word that refers to what we understand, what we know.

These disorders have in common problems with mental abilities and abilities to get along in the world. Some of these deficits are caused by genes, some by substances absorbed *before* birth, some by damage to the brain *after* birth.

Keys to working with youths with cognitive deficits:

1) **Watch Your Language!** We say what we mean simply and directly in plain talk that still sounds respectful and right for the person's age. We use fewer words in our regular tone of voice. No complicated questions (*What made you think you wouldn't be held responsible?*); no four-syllable words (*appropriate, consequences*); no sarcasm (*Now that was real smart!*).

2) **Use short-term costs and payoffs to change behavior.** Their memory for long-term ones is likely to be too poor to be of real use. 3) **Use visuals**—signs, drawings, calendars, and schedules—to help with changes and to avoid confusion. Images help even when their language is good. 4) **Plan for “the worst that could happen” on the basis of reported past history.** Then, any emotional or aggressive crisis can be handled with as little uproar and as much understanding as possible.

Mental Retardation (MR) or Developmental Disabilities (DD)

These terms are wrongly used interchangeably. Many people prefer to use *Developmentally Disabled* for both categories. This is because *Retarded* has been shortened to “*Ree-tard*” and chanted to hurt people's feelings. No matter what the labels are, they end up being used to make people feel inferior.

MR refers primarily to intellectual problems but also to the resulting problems it causes in functioning at home, school, and in the community. DD is defined as a disability due to a mental or physical impairment that starts in early childhood and results in three or more problem areas.

Autism, for instance, is a Developmental Disability that *may* include intellectual, social, language, sensory, and motor problems. Some autistic people, however, are very bright. MR and DD are both observable in very early childhood.

The psychiatric manual DSM-IV still uses scores from individually administered IQ tests as criteria for levels of retardation. Many, perhaps most schools no longer do. In the past, those with Mild Mental Retardation (IQ about 55-70) were taught in Educable classes. That meant they could do academic work up to about a sixth grade level. Students with Moderate MR

(IQ about 35 to 50) were taught basic functional skills in Trainable classes that prepared them for sheltered workshops. The intellectually lowest were placed in Severe (IQ about 20-35) and Profound (IQ below 20) classes or settings where they might learn a few self-help skills. Even those in the Borderline range (IQ about 70-85) could count on extra help. **Now, IQ tests are rarely given. Young people with borderline, mild, and even moderate degrees of retardation are likely to be fully included in general education classes.** Work is usually made easier for them, and they may receive extra help from trained special educators by being labelled as Eligible Individuals (EI) instead of the Trainable MR, etc.

Shelter and Detention staff members will need to consult with School staff to get an accurate idea of true functioning levels of new clients. **Some young people have better social functioning and language skills than they have ability to understand and use ideas. They give the impression that they are smarter and better able to think on their own than they truly are.** This is especially important to know as we plan such essentials as substance abuse or sexual abuse classes. **Never rely on class responses or quiz scores alone to judge what youths really know. Talk with them one-to-one about the important things you want to be sure they understand. Re-teach key points over and over again in a variety of interesting ways to be sure that they will stick.**

Fetal Alcohol Syndrome (FAS)¹ & other substance-caused problems

Children born to women who drank alcohol during pregnancy may have low IQ's and poor communication, problem solving, social, and memory skills. If they also have certain facial deformities (such as small, wide-set eyes, a thin upper lip, low-set ears, a small head), they may have the full FAS syndrome. Others may look more normal but have similar learning, social, and behavior problems. We used to say they had Fetal Alcohol Effects (FAE), but now we more accurately call them **Alcohol Related Neuro-developmental Disabilities (ARND).** **Disruptive behaviors (hyperactivity, impulsivity), conduct problems (lying, stealing, etc.) and stubborn, oppositional behaviors are common. These problems are different from those found in most other forms of mental retardation.**

Poor social/emotional functioning is probably these youths' greatest problem area. They do not think ahead to the consequences of their actions or respond well to social cues. They can't share in the give and take of friendships, so they withdraw socially or turn to bullying or teasing. They are naive and easily led by more powerful peers. They are subject to mood swings, periods of high anxiety, and unhappiness. Suicide is a risk. Because they don't learn well from experience, punishment has no lasting effect. Many have been in foster or institutional care due to their mothers' substance abuse. **They require a closely supervised, positive, structured environment where staff has the patience to teach and re-teach each step of what needs doing.**

Other substances. Other drugs can cause cognitive and physical problems for fetuses, but their effects are less clear. Alcohol is the worst drug in terms of the effects it has on the central nervous system and the problems it can cause in brain development throughout the entire pregnancy. **But babies born addicted to cocaine, heroine, or methamphetamine are also off to a very poor start. Many newborns have low birth weight, in itself a high risk factor for problems.** Some infants born to heavy users are born dead. Many people who use meth also use alcohol to come down from the over-stimulating effects of the drug, doubling the danger for their unborn infants. Prescription drugs can also be dangerous, some in ways that are not apparent until later.

Traumatic Brain Injury² (TBI)

Brain injuries happen frequently to adolescents because of motor vehicle accidents, fights, sports, and risk-taking behaviors. The two highest risk age groups for TBI, in fact, are 0 to 4 year-olds and 15 to 19 year-olds. Early injuries may actually end up doing more lasting harm than later ones, as younger brains and skulls are much more fragile than older ones.

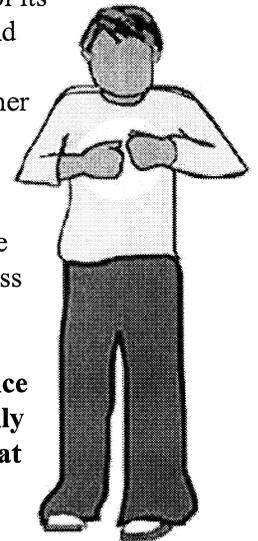
Closed head injuries; concussions. The most common types of brain injuries occur when the head is thrown forward and back as when a baby is shaken or a head is thrown forward into a windshield during a collision. In these concussions, or closed head injuries, the soft brain is slammed first into the front of the bony skull, then into the back of it, then again into its front. **Damage to the frontal lobes of the brain affects its executive functions. Those are its abilities to make judgments and decisions, to choose the right course of action, to deal with abstract thought. Some of the changes caused by this brain trauma wait to show their full effect until the late teens and early 20's. That is when the frontal lobes normally develop to do their work and should be ready to take decision-making control.**

TBI victims usually do not appear to have lost any intellectual ability. Rote learning skills may remain as good as ever. This misleads people into believing that these young people have regained *all* of their former mental skills and need no special help. In fact, just when they need to think in more complex, adult ways, youths who have suffered even mild TBI may find that they are less able to think well enough to solve everyday problems. They have trouble organizing their thoughts. Abstract ideas are confusing. **Under stress, the parts of their brains that control emotions (limbic center) take over when their brains' executive center (frontal cortex) cannot perform.** The brain-damaged youth who expects to be able to handle problems as well as ever becomes easily riled, upset, and even more obviously incapable of doing so.

Other head injuries and brain damage. Traumatic Brain Injury refers not only to closed-head injuries like concussions but also to open head injuries. Brain damage is also caused by **poisons and lack of oxygen.** Anoxia or lack of oxygen in the brain causes brain cells to die. That's what happens in a stroke. Depending on where and how many cells die, people lose the skills controlled by the parts of the brain affected. If the brain goes too many minutes without oxygen, it stops functioning together, and medical science considers the person dead even if the heart is still pumping blood through the body. Young people rarely have the same kinds of strokes as the elderly do, but they **overdose on drugs or starve their brains of oxygen in other ways.** Alcohol and opiates such as heroin and barbiturates slow breathing down to a point where the lungs cannot supply the brain with enough oxygen to survive. Methamphetamine, ecstasy, cocaine, and their cousins send the heart into spasms which sends blood pressure shooting up, causing strokes and brain damage. **Inhaling vomit and motor vehicle accidents** add to the toll.

People who have had to be hospitalized because of brain damage find these still to be difficult challenges after coming home:³

- **problems with learning and memory.** Memory for old things may be good, but it may be harder for the youth to learn new material and easier to lose things;
- **problems managing stress and emotional self control.** The executive thinking centers of the brain may remain less able to control its emotional centers. Low frustration tolerance, irritability, and anger outbursts can become tough problems to deal with.
- **problems with attention and concentration.** One's former ability to stay focused and get work done or even to keep track of conversations may be missing.
- **problems with information processing, speed, and capacity.** Youths' ability to think and react in a normal time frame may be impaired. This may make them noticeably less sharp at school, work, athletic or social activities.



Head-injury patients also have a better than 50/50 chance of having seizures and mental health problems, especially mood and anxiety disorders.⁴ There is a good chance that these will last for decades into their adult lives.

These must all be taken into account when we plan present and future accommodations for these young people. Taking medicines to control seizures or to level out extremes of mood can definitely help. We must see that they are made available to the young people in our care.

Mental disorder categories with few if any age designations

MOOD DISORDERS

- Major Depressive Disorder (MDD) & Other Mood Disorders
- Bipolar Disorder

ANXIETY DISORDERS

- Anxiety Disorders
- PTSD–Posttraumatic Stress Disorder
- Disorders of Extreme Stress–DESNOS

The disorders in these two categories combined are referred to as the

EMOTIONAL DISORDERS

Emotional Disorders is not an official DSM-IV Category.

It is the term often used, however, for a group of problems that involve emotional distress rather than behavioral excesses.

Emotional Disorders are seen as being the opposites of *Disruptive Disorders*.

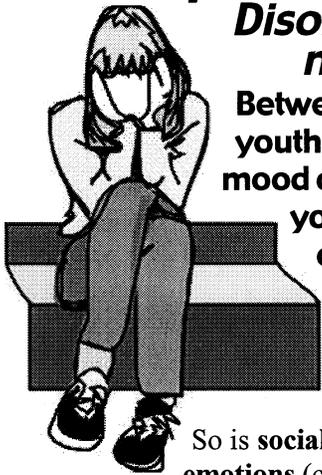
They also are the cluster of diagnoses called the *Internalizing Disorders* because sad and anxious feelings are said to be kept hidden inside instead of openly displayed for all to see. This sets them in contrast to the *Externalizing Disorders*, the disruptive disorders that

are known for acting-out behaviors and for making a general ruckus. (“*What is it they are acting out,*” we ask, “*if it isn’t their emotions?*”)

For a long time childhood phobias such as fear of the dark or of dogs were about the only ones of these diagnoses given to children. There was a belief that young people never suffered from real depression, and so the diagnosis was never even considered.

That has changed now, and we know that Externalizing Disorders often team up with Internalizing Disorders to put youths’ mental health in double jeopardy.

Depression—Major Depressive Disorder (MDD) & other mood disorders



Between 32 and 88 percent of incarcerated youths have been found to suffer from a mood disorder. Runaway and homeless youths are three times more likely than others to have a major depression.

Range of behaviors. The ones we expect are **sadness, crying,** or expressing feelings of **hopelessness. Lack of interest in activities** the person would usually think are fun is another.

So is **social withdrawal** or just seeming to be **empty of emotions** (called having a *flat affect*). These are called the

melancholic symptoms, but the most common symptom in children is **irritability**. Depressed youths are often **touchy, easily annoyed, and short tempered**. They may **strike out** when they want to be left alone and someone intrudes on them or forces them into activities they cannot tolerate.

Major Depressive Disorder (MDD) is a brain disorder that causes imbalances in brain chemicals (*neurotransmitters*). These result in **severe mood problems** as well as an **inability to concentrate or make decisions**. These become obvious in the inability to keep up with schoolwork. But MDD is an illness that also affects the rest of the body, and to receive the diagnosis, a person has to show problems in these basic body functions: **sleep problems**, insomnia most nights, usually in the middle of the night or early in the morning, or else needing sleep too much sleep (especially common in the teenage years); **fatigue or lack of energy; loss of appetite or problems overeating;** and either **restlessness and agitation** or being **physically slowed down** to a very noticeable degree. People become ill with MDD at any age, 4 to 94, most often in their mid- 20's. Many more girls than boys have teenage onset.

Other kinds of depression. The stressful facts of being sent to a Shelter or a Detention Center could cause some young people to have a depressed mood that lasts for days—but they would not receive an MDD diagnosis unless their symptoms met diagnostic standards **nearly every day for at least two weeks**. Also, they would have to represent a **change in mood and behavior from the past**. Major Depressive Disorder is classified, with Schizophrenia and Bipolar Disorder, as one of the *severe* emotional disorders.

(Bipolar Disorder or Manic-Depressive illness is a closely related disorder with its own pages.)

There are diagnostic labels for other depressive disorders: if someone's recent life has been filled with extreme grief and stress, emotional problems might be called **Adjustment Disorder with Depressed Mood**; for a chronically low mood for a year or two with only some symptoms of a *major* depression, the diagnostic term is **Dysthymia**. Some young women suffer **Premenstrual Dysphoric Disorder** causing depression and emotional mood swings the week before their periods. Severe episodes of depression often go hand-in-hand with **Substance Abuse**, both genetically and because alcohol is used for self-medication. Staff who observe depressive symptoms in a Shelter or Detention Center probably will not know enough about a youth's background to be certain how long these problems have lasted or whether or not they represent a change from usual behavior. They should still consider the possibility of depression and **consult parents or others who knew the youth before admission. Major Depressive Disorder is a severe illness with a high risk of suicide—it must not be overlooked.**

Can Depression . . .

...be genetic? Yes. In studies of twins, scientists look at the records of those hospitalized for MDD.¹ **If one of a pair of twins has MDD, it is highly likely that an identical twin will have it, too.** It is very likely, but *less* so, to affect a *fraternal* twin. That is how scientists decide if an illness is carried genetically. Depression is also associated with family histories of **alcohol abuse**.

...be biological? Yes. Between 40 and 60 percent of clinically depressed people have abnormal electrical brain activity measured by EEG readings when they sleep. The neurotransmitters, notably serotonin, norepinephrine, and dopamine, and sex hormones also responsible for depression are targeted in medications. Some **brain scans show increased blood flow to the emotional centers of the brain, and less to the executive centers in charge of concentration and decision-making**. None of these abnormalities is routine enough, however, that a doctor can draw some blood, test it, and know exactly what pill to give to cure someone's depression.

...be environmental? Yes. The effects of poverty, domestic and neighborhood violence, physical and sexual abuse, and/or serious problems with school, relationships, or the law can lead to genuine depression. **Science has shown us that trauma itself rewires the brain.**² But being born to a mother who is herself so ill from untreated depression that she cannot be positive with her baby can wire the child's brain to feel abandoned and hopeless from the start. **We cannot tell where heredity's influence leaves off and environment's begins.** One person born with the gene/s for MDD may not ever have it unless an environmental trigger sets it off. Another person with no family history of depression can suffer MDD after misery or stress. And a third person may cope with a badly damaged family and horrific life events with optimism and resilience. This is most likely when the child or youth is in an environment with adults who model solving problems with optimistic thinking.

Responding helpfully to depressed young people

- **Realize that no one can simply talk a youth who has MDD out of feeling depressed.** The depressed person's abnormally dejected feelings are a result of the changes in the brain's functioning. Ideas of being totally worthless, stupid, ugly, of having done nothing right, of having only a grim future, will be insisted on. They will ease up when the depressed person is recovering—brains recover from illness just as other body organs do. Respond to statements of self-hatred by saying such things as, "*I don't agree with you about that. . .*," "*It must be rough to feel that bad. . .*," or "*I wish I could help you feel better.*"

- **Be an optimistic person yourself, and focus on helping the youth find something to look forward to every day.** Planning a phone call or time to listen to music can help. This turns attention to something the youth can improve about the near future instead of dwelling on the past that cannot be changed.

- **Schedule regular physical activity.** Developing a habit of exercise is a great antidepressant strategy.

- **Avoid cheer-up statements, but validate the youth's feelings.** "*Buck up! Look on the bright side. If you think you've got it bad, let me tell you about this kid who _____*" or "*about the time I _____.*"

Depressed people hear these stories as our saying we aren't listening or don't care about them and *their* feelings. "*I know just what you're going through,*" is just as sure to be heard as unhelpful. We really *can't* exactly know. Young people believe themselves to be unique, so it's better to say, "*I'm so sorry that happened'*— *I'm trying to imagine how you must be feeling.*"

- **Recognize and face your own feelings about the severely depressed youth.** We might expect to find depressed young people much easier to get along with than youths with disruptive disorders. In fact, depressed adolescents are often unpopular with both their peers and the adults who work with them. Their depressed behaviors end up being called such things as *sullen, unmotivated, bored, touchy, or irritable*. Or perhaps they are called *over-emotional* or *attention-seeking*. When we offer help and get those kinds of responses, we may feel irritable or frustrated. Our best reaction is *not* to react to the off-putting behavior but to take a step sideways, stay available, pleasant, and open for conversation. Depressed people are quick to feel both rejection and intrusion—we would like them to gain trust.



- **Consider the purpose for behaviors that we see as signs of depression.** Try to decide: Is the goal of the behavior to be left alone? to cover up for inability to focus in on directions? to hide feelings of social awkwardness? of agitation? to prove how hopeless s/he really is? to be left alone to sleep? to ask for help? to trick you into thinking s/he needs hospitalization? to simply reflect just feeling awful? Find out how typical the behavior is of past behaviors. **Talk with someone who can describe if, when, and how long the young person has acted this way.** Is what you see a change? How was s/he getting along before arriving at your facility? **The history and context of a mood is as important as its appearance at the moment.**

- **Consult your mental health resources** if the results of checking with home, your observations, and team discussions suggest that depression could be a reason for the youth's problems. It is much better to err on the side of caution and make an unnecessary referral than to miss the chance to begin treatment of a depressive illness. **Depression is a life-changing, life-threatening illness that requires professional care.**

Depression is treatable, and medicine can help. In a 2004 nationwide study called TADS (Treatment for Adolescents with Depression Study)³, researchers looked at treatment with fluoxetine (generic name of Prozac, the only FDA-approved antidepressant for adolescents). They compared it in various combinations with Cognitive-Behavioral Therapy (CBT), the think-and-talk therapy that has the best evidence supporting it as

being effective. They found superior results when the two treatments were used in combination. Fluoxetine alone was more effective than CBT alone. **The combination of medicine and CBT was best both in relieving major depression and in reducing suicidal thinking.** There were no completed suicides, nor have any been reported in the US among adolescents or children taking this kind of medicine.

Depression hides beneath more obvious disorders. Watch for it *with* ADHD, PTSD, ODD, Conduct Disorder, Eating and Substance Abuse Disorders.



Bipolar Disorder (also called Manic-Depressive Disorder)

Bipolar means having two opposite extremes, just as the earth has a North and South Pole. People with Bipolar Disorder switch extremes of mood from feeling very high (mania) to very low (depression).

How does Mania look? It is “*an abnormally and persistently elevated, expansive, or irritable mood*” (DSM-IV).

People in a manic phase of Bipolar Disorder seem to **lose the need for sleep**. They feel as though their **minds are racing**. They become overactive due to **psychomotor agitation**, and they may speed through schoolwork or just pace non-stop. Their **speech may become loud, rapid, free flowing, and unstoppable**—too rushed and pressured to make complete sense. They may feel and act **grandiose** as though they are rock stars or other fabulous people.

Bipolar youths may have delusions and hallucinations. They may have deluded beliefs that they have super powers or are the sons of the President; they may hear saints’ voices or radio codes commanding them to do things. They might insist on talking intimately to everyone and could try to start relationships with unsuitable people. They can be **highly impulsive** and do things they would not normally do such as **steal, make sexual advances, or start fights with staff**. More often than not, especially in restrictive settings, bipolar youths are **extremely irritable** when they are manic. Their **inflated self-esteem** can take the form of **believing that rules do not apply to them**. Youths may demand special treatment. **Offering rewards and denying privileges as ways of changing their behavior are generally useless.**

Bipolar Disorder is classically described as a series of distinct episodes. It features **manic periods that last a week or longer followed by episodes of major depression**. Periods of normal mood may then follow and last months or years. Children and teens may present a different picture, however. Some have periods of what is called **rapid-cycling**. **Episodes of mania include severe and violent temper tantrums** that can go on for four hours or more. **Demanding, disruptive behaviors** often make it impossible for them to stay in their classrooms or activity areas with others young people. **Then their moods switch rapidly to depression.** These mood shifts happen often—every few days, or daily, or several times a day. Some adults also have this **rapid-cycling** type of Bipolar Disorder. Others, both adults and children, have **mixed episodes**. **That means that they are agitated, irritable, and depressed all at once.** This highly energized form of depression is very serious because it creates a **high risk of suicide**. **About half of all suicides in the US can be attributed to Bipolar Disorder.**¹

Mental health professionals disagree on whether youths with rapid-cycling or mixed symptoms really have Bipolar Disorder or not. Many believe in using the classic adult DSM-IV criteria only. **This is not an issue we can resolve.** **If the moods and behaviors of a youth in your care suggest mania and/or depression, discuss what you have observed with your mental health team or provider.** Unfortunately, many bipolar adults get their first diagnosis when they are in prison. That may be the first time their manic behaviors are seen out of the context of lawless acts and substance abuse. **Adolescence is a prime time for the onset of Bipolar Disorder. We need to have youths evaluated so that if they are given the Bipolar diagnosis, treatment can start as soon as possible. That will improve long-term outcomes.**

What co-exists with Bipolar Disorder?

People who have Bipolar Disorder can have other psychiatric disorders as well, most frequently **substance use disorders**. Children commonly have **ADHD**.

Can Bipolar Disorder? . . .

...be genetic? Yes. Genetic factors account for about 60% of cases. The genetics of Bipolar Disorder are the most closely studied of all psychiatric disorders. Scientists have linked its development to multiple genes on several chromosomes. Bipolar Disorder may share these genetic factors with other disorders— Schizophrenia, Epilepsy, Panic Disorder, and substance abuse.

...be biological? Yes. Researchers have found imbalances in a number of neurotransmitters that impair brain functioning. Biological factors include:

- **Over-secretion of cortisol**, a stress hormone, from the adrenal glands
- **Abnormal hyperactivity in parts of the brain** associated with emotion and movement coordination. (Think of psychomotor agitation.) Low activity in the parts regulating concentration, attention, inhibition, and judgment
- **A superfast “biologic clock”** Located in the center of the brain, it regulates sleeping-waking cycles. Bipolar people have major sleep problems and cannot deal with schedule changes such as rotating shifts.

...be environmental? Yes. Severely stressful events may influence the start of a major depression in those who are genetically vulnerable. Children who have lost a parent early in life also appear to be more likely to develop Bipolar Disorder when they become adults.

...be treated? Yes. Bipolar Disorder has a high rate of successful treatment, about 80 percent. Some people go long periods of time without episodes, but they are always aware that it can recur. It must be carefully managed throughout a person’s lifetime.

What helps youths who have Bipolar Disorder?

Crisis Planning. If, before or at the time of admission, you learn that a youth with Bipolar Disorder has had severe manic incidents, learn or imagine a scenario for the Worst That Could Happen. **Make team plans: 1) for avoiding that possibility; and 2) for handling it safely for the youth and others should it happen.**

Education. This is crucial, because many youths do not understand what happens to them when they go into the manic phase of Bipolar Disorder. Many enjoy the high or powerful feelings they experience. Since they feel on top of the world, they may refuse to take their medicine. Stopping meds is a source of trouble and tragedy for bipolar people of all ages. **It is vitally important to help young people gain insight into how this brain disorder affects them. They need to understand that their brain chemistry makes their emotions run to extremes, and that they must balance these extremes. To do that, they need to take chemicals to make up for their inborn chemical imbalances. These come in the form of pills, capsules, liquids, or shots.** They must learn to discuss with their doctors how their meds make them feel, ask them questions, and become smart consumers for their own health needs.

Training. Stress management* to combat irritation and isolation from others will help youths deal with the many mood changes they face. They will not take the place of medicine, but they will add self-control skills that they can use under their own personal power.

**(See the Stress Management sheet in the Resource Section.)*

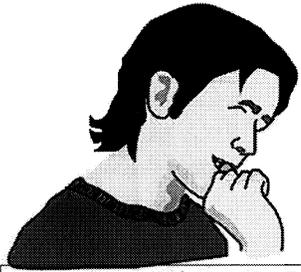
Medications. Usually, **mood stabilizers** are prescribed for Bipolar Disorder. **Anti-convulsants** are also used, and so are some of the **newer antipsychotic drugs**. Antidepressant medications are usually *not* effective with this particular mood disorder. They can actually make matters much worse. Typically, it takes a week for effects of a newly prescribed medicine to begin to be apparent to close observers. It can take up to three weeks or longer before the people with the disorder themselves feel that their mood has improved.

Transition Planning. It is essential to **coordinate services and education when youths leave your Shelter or Detention Center so that they will continue to get the medication they need.** Teachers, caregivers, and family members need full information so they can educate and support the youth at home.

Avoiding Recidivism. The manic behaviors of some bipolar people lead them to law violations. **The critical role that medications play in avoiding criminal involvement was shown in a 2005 Minneapolis study.** Researchers kept track of the numbers of days 31 bipolar adolescents stayed on their medications over a one-year period after their release from a county corrections treatment facility. They also tracked new violations and probation violations over the same time. **The result showed that the off-medication rate of offending was 4.8 times higher than that of the on-medication rate. When the youths were taking their meds, they committed 80% fewer offences than when they were not following their meds routines.** The teenagers stayed on their medications an average of 34% of the days in that year. Together, the 31 youths committed only four serious offenses during those four months. During the eight off-meds months, together they committed 39 felonies and serious misdemeanors. Probation violations showed a similar reduction when the youths took their medicines.

“The opinion that psychiatric treatment is ineffective, too expensive, or both appears unfounded in this population of serious juvenile offenders,” the researchers concluded.³





Anxiety Disorders

Anxiety Disorders are a group of disorders characterized by worry and stress severe enough to interfere with daily activities. They include:

- 1) Panic Disorder.** This disorder is named for repeated panic attacks—sudden periods of panic so intense that people feel that they’re going to die. Such symptoms as a pounding heart, shortness of breath, tremors, dizziness, and nausea are terrifying. People fear they are “going crazy” and go to great lengths to try to avoid these attacks. Panic attacks are part of other disorders as well.
- 2) Simple Phobias.** These are fears of specific things—animals, storms, rivers—or situations—being in a closed space or on an elevator—to the point of feeling intensely anxious or panicked. Most people realize these feelings are unreasonable but cannot help having them.
- 3) Social Phobia or Social Anxiety Disorder.** This problem centers on fears of being watched, criticized, or judged harshly by others. It usually emerges when a basically shy student has to speak or perform in school. Social Phobia may develop into a lifelong problem and cause youths to avoid all social contacts, drop out of school, and have a hard time seeking and keeping jobs.
- 4) Obsessive-Compulsive Disorder (OCD).** Obsessions are thoughts, impulses, or images that come to mind over and over again. They do not make sense, and they cause the youth huge anxiety and distress. To get the mind to stop producing the obsessions, the youth feels compelled to do certain mental or physical acts—compulsions—to neutralize them. These may be such odd things as washing one’s hands repeatedly, counting or praying silently, or putting a circle around every capital *I* in a book. The youth knows none of this makes sense but cannot stop without medical help.
- 5) Generalized Anxiety Disorder (GAD).** Youths with this problem worry uncontrollably until they literally worry themselves sick. They have physical problems such as restlessness, irritability, tension, and sleep problems. Their distress seems way out of proportion, and it lasts a long time.
- 6) Posttraumatic Stress Disorder (PTSD).** This most severe anxiety disorder is brought about by trauma experienced by youths in a horrible event such as rape or over time in a violent environment. It is of particular significance to those who care for homeless and delinquent youths.

Anxiety disorders are the most common mental health disorders of youth. In any year, about 13% of children and teens ages 9 to 17¹ can be expected to have one of the 15 listed in the DSM-IV.² (Only the nine most likely to affect youths in our care are mentioned here.) The symptoms typical of these disorders seem unlikely to lead to the kinds of problem behaviors that result in delinquency. To some extent, that has been proven true. Anxiety tends to be a protective factor against Disruptive Disorder behavior problems. Young people who are anxious and fearful generally are not risk-takers. Some, however, may be driven to aggression by the intensity of their anxious feelings.

Can Anxiety Disorders . . .

- ...be genetic?** Yes. First-degree relatives of people who have virtually any of the anxiety disorders are far more likely to have the same disorder or a very similar one than is a person picked at random from the general population.
- ...be biological?** Yes. There is a mind-body linkage with all anxiety disorders. It is not enough to worry—you must worry so much that you show physical symptoms. Panic attacks are terrifying physical attacks. The onset of one kind of OCD follows a certain kind of strep infection. Lab tests show that the physical reactivity of persons with OCD is truly reduced when they lower their anxiety by doing their compulsive rituals.
- ...be environmental?** Only to a degree. Stress can trigger a worsening of symptoms in all of the disorders, but only PTSD is caused by external stressors. Some people may be more vulnerable to these effects than others.
- ...be treated?** Yes. A combination of cognitive behavioral therapy and medicine can be very effective with most people. The drugs used either increase the amount of the soothing neurotransmitter serotonin in the brain or reduce the body’s tense responses to stress. Trained therapists teach people gradually to endure exposure to the things that cause their anxiety by using relaxation, breathing, and new thinking strategies. These techniques help them cope with problems, gain control over their crippling emotions, and live fuller lives.

7 & 8) Childhood Anxiety Disorders.³

Separation Anxiety Disorder (SAD) is the most common anxiety disorder among younger children. Its main characteristic is that it is a developmentally inappropriate fear of separation from home or a parent figure. This problem occurs among young teenagers as well. It used to be called *School Phobia*, but has a far wider reach than school alone. It usually predicts later anxiety problems.

Selective Mutism, or “consistent failure to speak in specific social situations despite speaking in other situations” is a kind of child’s social anxiety disorder. The child is too inhibited in the presence of others than family even to speak.

How can we help?

First, empathize with how anxiety makes the young people who experience it feel. Our respectful recognition that anxiety problems are serious will help. "I can see you're worried and upset about that. It's too bad you feel so uncomfortable." Second, offer practical help. If there is a reasonable way to lessen or remove whatever causes the anxiety, (such as finding a night-light for a boy who fears the dark, moving a girl to a table without boys), do it. Rarely are problems so easily solved. But you can provide help with stress management or offer a distraction such as listening to music.

Here is what will not help—our logical arguments to prove to the youth that his or her fears are just silly and that we have the evidence to prove it. We can tell a dozen stories of fears we ourselves overcame. We can present 100 scientific facts to prove that a fear is irrational. It won't make any difference—the youth's anxious beliefs and feelings will be much stronger than our logic. **If they believed us and accepted the fact that it is foolish**

How are Anxiety Disorders treated?

1) Panic Disorder. People who suffer what they think will be deadly attacks learn the methods others use to manage their physical symptoms. Then they **practice sitting through a pretend attack, using these new skills to endure it.** Sometimes they may fake their scariest symptoms so they can learn to cope with them—for instance, they might exercise hard to make their hearts pound or spin to feel dizzy. No one tries to convince them that panic attacks are all in their imagination, nothing to worry about. Instead, they **teach ways to minimize the attacks' effects on their lives.**

2) Phobias. The youth and therapist make up a **list of experiences of encountering the feared stimulus.** It goes in order from the easiest for the youth to handle without any anxiety all the way up to the worst that could happen. Then the youth learns how to do **deep muscle relaxation.** Twenty-minute sessions start with relaxation. Then the youth starts to imagine a scene from a point low enough on the list that the imagined scene does not bring on *any* anxiety. The **youth imagines the scene in great detail,** telling about it in terms of each of the senses. S/he keeps that scene in mind for 25 seconds **while totally relaxed. After a rest, s/he repeats it. After three successful trials, the youth tries the next, scarier scene up the list. Role-playing scenes for extra practice** or backing up a level helps assure complete confidence before **trying out real-life examples.**

3) Social Phobia or Social Anxiety Disorder. These problems center on **fears of negative social outcomes.** Youths are taught to check out the actual truth of their beliefs ("*Nobody wants me around,*" or

to worry about the things they do as much as they do, it would leave them with only one choice—to believe that they really are "crazy." People who have Panic Disorder, OCD, or PTSD tend to think so anyway. It makes matters worse to think that. Then they give up hope of ever being okay, and that leads to hopelessness, depression, even suicide. If a youth shows signs of an anxiety disorder to the extent that it interferes with his or her health or general ability to function, seek a mental health consultation.

Anxiety Disorders have a high rate of successful treatment.⁴

Successful treatments all have one thing in common—**exposure to whatever causes the anxiety.** This is done in **gradual steps that do not overwhelm** the youth with anxious feelings. Through those experiences, people become *desensitized to the stimuli that cause their emotional over-reactions,* which, in turn, make the heart pound, stomach heave, etc. At the same time, the therapist uses Cognitive Behavioral Therapy (CBT) methods to help the youth change fearful beliefs.



"I'm nothing but a loser). Then they take **gradual steps into facing the social interactions they fear least, working up to harder and harder ones** as above. Practicing them first with a small group is ideal for both receiving feedback and practicing how to share thoughts and feelings.

4) Obsessive-Compulsive Disorder (OCD). Treating OCD successfully usually involves taking medicine first, then working with Cognitive Behavioral Therapy. Learning to **endure exposure to whatever causes the fear or anxiety** is not enough alone. The youth also has to **resist the urge to follow the ritual that will neutralize the danger** that the feared object or event will cause. Young people usually cut down on compulsive behaviors gradually with goals of performing fewer rituals each day.

5) Generalized Anxiety Disorder (GAD). Worries do not present the clear targets for exposure and desensitization that specific fears do. They are more diffuse, more feelings than clearly defined thoughts. Treatment includes teaching youths to **recognize anxiety and the body sensations that go with it.** They learn **practical ways to judge if their worries make sense or not and to calm their bodies' stress reactions.**

6) Posttraumatic Stress Disorder (PTSD). Youths who have this disorder are highly sensitive to specific cues linked to the traumatic experiences that caused the disorder. **Systematic exposure and desensitization** work requires therapists who are skilled, experienced, and interested in this type of work.

(See *Stress Management in the Resource Section.*)

Posttraumatic Stress Disorder—PTSD

Trauma is an event that causes the youth to experience horror, fear, or pain, along with helplessness.¹ In Posttraumatic Stress Disorder, the person who survives the trauma has persistent, frightening thoughts and memories, or flashbacks, of the ordeal.



How does PTSD look and feel?

Symptoms unique to PTSD are the ones that are due to having experienced trauma. Many survivors jump or flinch or feel their hearts racing with **exaggerated startle responses**. They may have **flashbacks**, reliving the ordeal as vividly as if they were actually enduring the same

horrible events and emotions again. Some youths may be so removed from reality that the flashbacks qualify as psychotic episodes. They may be **tense and constantly on guard** when they are awake, always expecting trouble. They may fear sleep because **grim nightmares** wake them up sweating and screaming.

Many of the symptoms of PTSD, however, are less obviously connected to trauma. They are the same as the problem behaviors of other disorders—**poor concentration, depression, anxiety, anger and hostility, poor impulse control, aggression, sexually inappropriate behavior, and withdrawal**. Some behaviors associated with PTSD are the results of the mind trying to escape the memories of the trauma. Feeling **depersonalized**, as though they are cut off from their own bodies, is a severe stress reaction some people experience. They may feel numb and stare off as in a trance. This seems to be the brain's way of separating itself from the body that experienced the trauma, though it can be an unnerving experience in itself. **Deliberate self-injury** is common among those with histories of sexual and physical abuse and PTSD. One thing it does is prove to the person with problems of depersonalization that s/he really is in his or her body, grounded and surviving. The rate of **substance abuse** among people with PTSD is very high. Among incarcerated girls, it is even higher than it is among boys. This may also be attributed to their efforts to deal with the causes and symptoms of PTSD.

What kinds of trauma cause PTSD?

Rape is the most common cause of trauma among females. It accounts for about 40% of girls' PTSD cases and 3% of boys'.² **Other kinds of assault** have the next highest rates of causing PTSD. The assault doesn't even have to injure the person directly—**witnessing a mother, sibling, or friend be beaten or killed** is a major source of traumatic stress for children and adolescents.³ Some of the **greatest emotional damage of PTSD comes from feelings of being helpless to stop the horror**, especially if it is your parent who is doing the harm. Then

feelings of guilt and powerlessness mix with anger to cause painfully twisted feelings. Some youths come to Detention suffering the effects of PTSD from the violence they themselves have committed. And some acquire PTSD over time from living in urban "combat zones" where gang shootings and the deaths of family and friends are familiar, predictable horrors.⁴ Trauma rewires the brain.⁵ It changes the constantly growing networks of nerves that control the way people perceive and respond to the world. Brain and hormonal changes set survivors up to be **hyper-vigilant, pessimistic, and suspicious**. Some become violent people themselves. The kind of PTSD that comes from traumatic experiences that start in infancy and/or persist for years may be called *Complex PTSD* or *Disorder of Extreme Stress-Not Otherwise Specified (DESNOS)*.

What disorders co-exist with Posttraumatic Stress Disorder?

Major Depressive Disorder, Bipolar Disorder, and all other Anxiety Disorders including Panic Disorder and Separation Anxiety may be companion problems. Conduct Disorder and Substance Abuse are of special concern. PTSD sufferers are at high risk for suicide.

Can Posttraumatic Stress Disorder . . .

...be genetic? To a degree. Despite being named for the trauma that brings it on, PTSD does have a heritable component. Those with depression clustered among parents and siblings are more vulnerable to developing it.

...be biological? Yes. All Severe Emotional Disturbances (SED's) have biological components. Youths with PTSD will usually have sleep disturbances and increased physical arousal as measured by heart rate and sweat gland activity. They have more somatic complaints and general medical problems than average.

...be environmental? Definitely. What happens in the environment is the source of PTSD. Besides personal trauma of home and neighborhood, man-made or natural disasters such as fires, bombings, floods or tornados can bring it on.

...be treated? Yes. Cognitive Behavior Therapy is effective with PTSD patients. So are the newer antidepressant medicines that increase serotonin levels in the brain.

Clinical treatment for Posttraumatic Stress Disorder

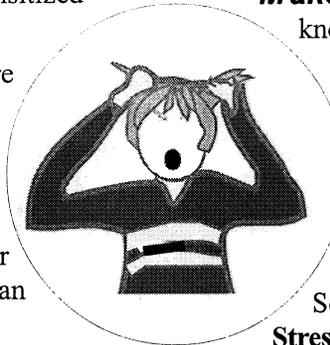
Cognitive Behavior Treatment for PTSD can be done individually or in a group. Groups are especially helpful if their members have all shared the same traumatizing event such as a school shooting.

Education is always the first step. Teaching that PTSD is a medical disorder that happens to normal people when they undergo extreme stress is essential. The survivor needs to learn what PTSD does to the brain and body and how it affects family, friends, and loved ones.

Exposure to the trauma itself is the next step. Through imagery, the traumatic event or events are re-experienced in a safe setting. There is a variety of ways this is done from flooding the survivor with powerful images all at once, to increasing their power very gradually, to distracting the survivor's vision while the images are experienced. The therapist helps the survivor look at reactions and beliefs connected to the event. The survivor gains experience dealing with the thing or things that happened and becomes less sensitized to fearful reactions from them.

Strong feelings are worked on. Anger, shame, and guilt are emotions the survivor may have buried under fear and panic. They need also to be uncovered and worked on.

Techniques for dealing with stress reactions are taught. Posttraumatic reactions and feelings can be so strong that they leave people overwhelmed and numb. The feelings may never entirely disappear. Survivors learn to master coping skills so they can manage them without falling apart.



How we can help youths with PTSD?

Be alert for the behaviors described on these pages — hyper-vigilance, unusual startle reactions, nightmares and sleeping problems, periods of acute upset when having a flashback. Perhaps the youth is experiencing them for the first time because of the incident that brought him or her to your facility. Reassure the youth that these are fairly common feelings for people who have been through way too much stress.

Be open to listening to details of trauma with it in mind that **you are a mandatory reporter of abuse.** Do not try to solve the youth's problems—just reflect that this much stress overloads the emotional circuits in people's brains and makes them so upset that sometimes they feel like they're losing their minds. Make an appointment for a **mental health evaluation. This is necessary.** **PTSD is a severe emotional disorder that must be treated. Both medicines and therapy can help.**

Make needed adjustments for the youth with PTSD. If you know that a youth already has been identified as having PTSD when s/he is admitted, **find out what you can from former caretakers about how to be most helpful.** If there are particular triggers in your facility that set off flashbacks, try to make changes to accommodate the survivor's needs. For instance, a youth who has been sexually abused might need to shower alone rather than with a group of boys. **Our best practice is to be aware of the pain of PTSD and support the young people who struggle with it.**

See also the suggestions for helping in **Disorders of Extreme Stress, Depression, & Violence, or DESNOS.**

The impact of PTSD on youth at risk for delinquency

The impact of trauma is enormous and too seldom recognized.

For instance, California researchers evaluated 131 boys who were in Juvenile Detention facilities for crimes against persons.⁶

They found that 32% of them met full criteria for PTSD, and another 20% met partial criteria.

Thus, over half of these violent boys had themselves been affected by severe trauma.

When incarcerated girls were evaluated,⁷ their rate of full PTSD was 49%.

Overall, as many as 65% of girls in some Detention Centers and in Shelters are reported to have PTSD.

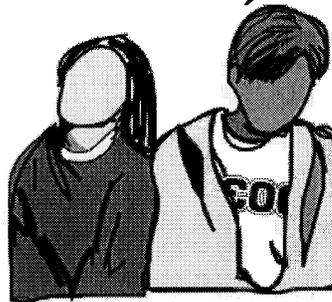
The long-term impact of youths' trauma on society—a cycle of violence

The odds that people who were maltreated as children will be arrested are 59 percent higher as juveniles, 28 percent as adults, and 30 percent higher for violent crimes. These were the results of a study⁸ comparing 908 adults with substantiated histories of childhood abuse and neglect with a group of non-maltreated adults matched for age, sex, race, and SES. All were interviewed, and 25 years of crime records were checked. A surprise finding was the fact that **neglect was nearly as powerful a predictor of violence as was childhood victimization.** The victims of neglect, however, were of lower intelligence and achievement than the victims of abuse due to factors of their childhood deprivation.

DISORDERS OF EXTREME STRESS, DEPRESSION, & VIOLENCE

Conduct Disorder plus Depression Overall, about 15 to 25 percent of youths with Conduct Disorder also have Depression.

**Depression + Conduct Disorder
= double grief & trouble**



- **Poor peer relationships.** Depression leads to social withdrawal, breaking off from old friendships and interests. Such youths are then at risk of being rejected by their pro-social groups. This leads to their **clustering together with other outcast peers in networks of antisocial youths.** This includes gang affiliation, one of the surest pathways to delinquency.
- **Weakened interest and ability in school and pro-social recreation such as sports and adult-organized activities.** Poor concentration and withdrawal of interest, key symptoms of Depression, weigh in heavily here. **Youth with Depression often come across as being sullen, lazy, bored, and irritable.** Instead of making us want to reach out to help them, depressed adolescents tend to turn adults away when we offer help.
- **Hopelessness about the future and indifference to their own safety.** If depressed young people assume that they have no future, then personal risk-taking behavior doesn't matter to them. They may do reckless things without thought of the danger to themselves or others, from drugs to crimes.
- **Feelings of worthlessness and personal unhappiness.** Think of this problem as having three parts: first, *the presence of negative feelings* such as stress and aggression; second, *the absence of constraints* such as lack of self-control or the lack of effort to avoid harm; and third, *the absence of positive feelings* such as personal worth, well-being, achievement, and social closeness. Conduct Disorder alone can cause both of the first two, negative feelings and absence of constraints. But even so, the youth with CD alone is likely to feel pretty good, even arrogant at times, about his or her personal and social worth. **It is the added Depression that destroys the youth's positive feelings about him- or herself and others.** These feelings of worthlessness and personal failure may be so strong that they lead to thoughts of suicide.¹

Problems Depression adds to Conduct Disorder in girls

Increases in the rate of girls' antisocial behavior now surpass that of boys.' These begin in adolescence, just when the incidence of Depression in girls sharply rises. *Researchers believe that many serious, chronic female offenders may have suffered Depression from the earliest years of their adolescence.*

Complex PTSD or DESNOS Disorders of Extreme Stress Not-Otherwise-Specified

A result of a high degree of chronic and severe interpersonal trauma

PTSD became an official *Diagnostic and Statistical Manual (DSM)* diagnosis in the 70's. It names symptoms that result

from living through short-term trauma, from one horrific incident to trauma lasting a brief period of time—as a fire, battle, wreck, rape, or hurricane. By the 90's, clinicians and researchers had found differences between what sudden events do to people and what long-term trauma does. **Constantly being the victim of another or others with more power, dealing with traumatic events that happen over and over again for years or even decades, and living in hateful, violent surroundings produce a special group of symptoms.** Researchers studied symptoms that clustered together and called them a unique syndrome. The first to study it called it *Disorders of Extreme Stress*; its second name was *Complex PTSD*; its latest is *Disorders of Extreme Stress Not Otherwise Specified or DESNOS*.² Now researchers are working on its inclusion in the next *Diagnostic and Statistical Manual (DSM)*.

Characteristics of DESNOS

DESNOS is most severe when the events that trigger it occur in childhood or adolescence—the earlier the onset, the greater the problems. Adults can acquire it in concentration and POW camps, as workers in brothels, or from long-term domestic violence. Children are more likely, however, to have **lifelong changes in basic personality and social development.** It is marked by:

- **Problems regulating emotions**—negative moods ranging from sad or anxious to hopeless or terrified; over-reactions to minor stress; self-destructiveness (self-abuse, drug use, eating disorders); suicidal thinking; sexual preoccupation or acting out; trouble expressing or controlling anger;
- **Problems with attention to reality**—totally forgetting traumatic time periods; dissociating or blanking out anything to do with trauma from everyday levels of consciousness; general forgetfulness or spaciness; “disowning” their own bodies because they are associated with trauma.
- **Problems in self-perception**—seeing themselves as damaged, helpless, guilty for the trauma; possessed of badness that makes them different from everyone else.

- **Problems with relationships**—distrust of others; isolation;

(Continued on column 2 of the next page.)

(Continued on column 1 of the next page.)

Heightened risk for substance abuse. Substance abuse among delinquent girls in detention centers is a far greater problem than for boys. Studying the problem shows it is the *combination* of CD and Depression that causes this increased abuse—not the effects of either alone. This is true of alcohol, nicotine, and drugs. **Experts say that we should consider substance abuse “normative” for all youths, boys and girls, with this combination of Conduct and Depressive Disorders.**³

Sexual issues. Girls who mature sexually at an early age are at higher risk for having both antisocial behavior and Depression than girls who mature on time or even late. They also have considerably higher rates of other mental health disorders, of sexual abuse, and of suicide. Research suggest that this may be due less to physical changes in and of themselves than to related risk factors of their attractiveness to males. Early maturation may lead to trouble when it occurs in girls who are from risky environments or are impulsive.⁴

Antisocial behavior. Depression itself leads to antisocial behaviors. Here are the differences in antisocial behaviors researchers report between adolescent girls in Chicago inner-city neighborhoods who did and did not have clinical Depression: a) 40% of all adolescent girls engaged in **property crimes**, but 68% of those who had Depression did; b) 42% had engaged in **crimes against persons**, compared to 82% of those with Depression who had; c) 13% of all girls were **highly aggressive**, compared to 57% of those with Depression who were. There were no racial or ethnic differences with respect to variations due to Depression. The differences held up even when socioeconomic status was controlled for.⁵

How can we help?

By taking Depression as seriously as we do Conduct Disorder and seeking treatment for it. Youths with symptoms of Depression should be referred for a mental health evaluation. **Depression is treatable, both with medications and cognitive behavioral therapy. Substance abuse treatment is also critical, but it alone will not be enough if Depression is the core of the problem.** We can help young people avoid becoming overwhelmed by depressive thoughts by teaching them to recognize and break negative thinking habits. These are the self-defeating beliefs they repeat over and over in their minds until they lower their bodies’ abilities to withstand the mental, physical, and relational stressors in their lives. We can reduce learned helplessness by teaching problem solving and stress management.



constant searching for a rescuer; inability to pick up danger cues; easily falling into the role of learned helplessness; or victimization of others that mirrors what happened to them.

• **Problems with physical disorders**—hard-to-pin-down illnesses such as headaches, pseudo-seizures, irritable bowel syndrome; much higher numbers than average of diagnosed digestive, heart-lung, and urinary-genital system problems; over-production of stress hormones and nervous-system chemicals (*e.g.* adrenaline)—these problems are difficult in themselves and may also throw off the immune system and general body functioning.⁶

How can we help?

First, refer the youth with these characteristics for an evaluation.

There are three phases of treatment of this kind of extreme stress, whatever its diagnostic label.⁷ We help with Phase 1.

Phase 1, stabilization, will begin as soon as you recognize that a youth is experiencing extreme stress. You may have learned that from admission information, or you may have learned of it from observation, screening data, and/or evaluation results.

a) **It is important that the youth feel safe.** Some fears may seem foolish, but we never belittle them. Explain that you understand how minds can hold on to powerful feelings. Make arrangements to lessen exposure to the fear.

b) **Recognize that self-harm, suicidal gestures, and “out-of-control” behavior** are, for youths with a DESNOS, frantic attempts to control the way they feel. Be as calm as possible about them and explain that there are better ways to cope with miserable feelings.

c) **Teach self-soothing techniques that the youth can use instead.** These can include relaxation, deep breathing, putting a warm blanket around the shoulders, listening to music or to a guided-imagery tape through headphones, rocking, drawing, writing, and so on. Experiment until some seem helpful. Then have the youth make a list of Soothers to carry and refer to.

d) **Help the youth express feelings in words.** That ability will become crucial as therapy progresses into dealing with the actual trauma she or he experienced.

Phase 2) processing and grieving traumatic memories. Shelter and Detention staff probably *won't* have had the training to begin the work of phase 2 which focuses intensely on clients’ personal history. It requires a licence in trauma counseling as well as long enough time to build a trust relationship.

Phase 3) re-connection and re-integration with the everyday world. Work on phase 3 activities is critical but may be limited to making **discharge plans.**

The relationship between abusive environments and violent behavior

Why are violent youths often the sons of violent fathers who had abused them?

Lonnie Athens is a criminologist whose father cruelly abused his wife, sons, and daughter. He grew up rough but smart, not impaired by ADHD and its related problems, and he was successful in school. His abuse stopped when he grew bigger than his dad. He left home, went into the service, and earned his PhD in

criminology on the GI bill. Because of his background, Athens had enough credibility with life-term and death-row convicts to interview scores of them in Iowa and California prisons. They told stories of growing from abused boys into violent men and then into heinous criminals. All of their journeys

followed the same basic pattern of developmental steps. They told not only of the physical pain they suffered growing up, but also of their emotional pain. Athens tells us what happened and, in the criminals' own words, the thoughts, beliefs, and feelings they experienced at each stage along the way.⁸

The Creation of Dangerous Violent Criminals—Lonnie Athens

Pretend that you are someone tracing these steps. This is what happens between you and your primary group, be that your family or your gang.

• **Stage I: Brutalization** There are three components of Brutalization:

IA. Violent Subjugation. You are beaten until you obey an order or comply with a demand of some kind. As a victim, you feel pain and fear, then relief when the pain stops, and then hatred for the abuser. You fantasize revenge. Another form of violent subjugation is **retaliation**. This is even worse because there is no end point to it. You are beaten for some *past* wrong. Even if you promise never to do it again, it continues until your abuser feels like stopping. Your wish for revenge turns into long-lasting fantasies of hitting or killing your tormentor.

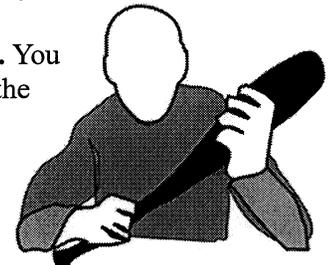
IB. Personal Horrification is a second major ingredient of brutalization. You yourself are not hurt, but **you see or hear another person you care about being beaten or made to suffer**. Hearing that person's distress and being unable to stop it traumatizes you. Your impulse to help the victim is stopped by fear of either the victim or yourself being hurt *more* if you do. So you do not act. Then you are flooded with anguish and intense feelings of shame. **This extreme empathy is killed only when the pain of horrification is hardened by later stages.** Right now, your feelings are a mixture of shame for being a coward, hatred for the aggressor, and helplessness. **Females most often stop their progress through the stages at this stage.** (Athens' sister did.) **It is enough to cause PTSD. Males are more likely to experience the stages that follow due to their size and gender.**

IC. Violent Coaching is a third component of brutalization. Someone in your primary group, often an older sibling, cousin, or uncle, views it as **his or her job to teach you what to do if people provoke you: don't walk away or try to calm them down—just hit them hard.** This advice is backed up with many tales of violent and powerful actions taken by people in your family or circle. They are held up as examples. If you don't live up to them, you are scorned. **This code of aggression may even be beaten into you if you act like a weakling, a "faggot."** By the end of this brutalization phase, **you are deeply disturbed and wondering why you have been singled out to live such a horrible life.**

• **Stage II. Belligerency** You have learned to be **constantly on guard against pain and danger** from violent subjugation. You feel powerless and unworthy from your experiences of personal horrification. Now the lessons of violent coaching really sink in—you decide that **the only way you really can handle these disturbing feelings is to resort to violence yourself. You decide that you will attack people—but only if they really provoke you.** Then you will be ready to assault them to the point of badly injuring or even killing them. **That resolution marks a major turning point.**

• **Stage III. Violent Performances** **Actually turning belligerent thoughts into violent action is another major step. Now a provocation is likely to trigger your aggression. What happens next depends on the outcome.** If you are badly defeated, you might give up and go back to the vengeful, hateful feelings of Stage I. Or, if defeated, your belligerency could grow, and you could resort to more lethal violence. If you win and no great notice is taken of it, your winning will have no great impact. But if you win and it is a very big deal to your family or gang and to school officials, the police, and the papers, you may get a reputation for being violent. **You could become notorious and cause fear in your circle and beyond. This feeling can be very soothing and bring relief from both the fear of violent oppression by others and the feelings of helplessness and shame.** You may feel better emotionally than you have since the days before you were first brutalized.

• **Stage IV. Virulence** Finally, you become firmly **resolved to attack people with the serious intent of harming or even killing them for little or no reason.** You are a dangerous, violent criminal, willing to brutalize the weak. Fortunately, only a small proportion of people complete all of these steps. **The most brutal serial killers are among them; PTSD can be a part of the picture at any point along the way.**



Screening for trauma & depression

We can divide most young people's psychiatric problems into two categories, **Externalizing and Internalizing**. Externalizing includes Conduct Disorder, Oppositional Defiant Disorder, and Attention Deficit/Hyperactivity Disorder. It focuses on behaviors that make a negative impact on other people. **A Detention Center's first responsibility is to keep everyone safe from delinquents' dangerous externalizing behaviors—the physical environment and rules are set up to do that. Its other key responsibility is to rehabilitate the youths in order to reduce the chances of their re-offending.**⁹ To do this, we must understand and know how to handle problems with the Internalizing disorders as well—Depression, Anxiety, and Stress Disorders.

Some states (Texas, Connecticut, Colorado, Massachusetts) routinely screen all youths for mental health and substance abuse problems when they enter the Juvenile Justice or Corrections system. In others, including Iowa, youths are typically admitted to Detention Centers with no such information available.

It is important to screen youths, therefore, for trauma and suicide risk, as well as for other mental health/behavior problems, when they arrive.

Young people in crisis are at great risk. We need to know how to respond to them both for the sake of safety and to make a smart start at rehabilitation.

An appropriate and easy-to-use screening tool is the *Massachusetts Youth Screening Instrument–2*.¹⁰ It is a valid and reliable, 53-item, true-false questionnaire. Written for and standardized on youths in the juvenile justice system, it has been used in 46 states. It gives **subscale scores on Depression and Anxiety, Anger Problems, Thought Disturbance, Somatic Complaints, Alcohol and Drug Use, Suicide Risk, and Traumatic Experiences**. Although the MAYSI-2 includes only six items directly about trauma, it produced screening information comparable to that gained on a much more thorough, clinical measure of traumatic experience.

In 2004-2005, Chapman and Ford, researchers from Connecticut's judicial branch and its state university¹¹ studied 1,393 teenagers consecutively admitted to detention centers. Their interest was in the connections between trauma and posttraumatic stress as risk factors for suicide and other mental disorders. They noted that reliable research has consistently shown that 65% of incarcerated youths have mental health disorders and concluded,

“We have found that providing juvenile justice facility administrators and staff with education and training concerning the relevance of trauma and PTSD risk reduction (including suicidality) and behavior management has enabled them to integrate trauma and PTSD screening into standard detention admission screening procedures with high levels of “buy-in” and no documented instances of adverse effects.”¹²

“Screening may thus be seen as a moral and ethical responsibility in juvenile justice settings, as well as a means to potentially reducing future delinquent behavior and enhancing the safety of the child and staff.”¹³

For information on how trauma affects the brain, including on-line courses that may be taken free or for credit, go to www.childtraumaacademy.com

For information on procuring the MAYSI-2, go the web site for the National Youth Screening Assistance Project at the University of Massachusetts Medical School at www.umassmed.edu/nysap/MAYSI2/

Mental disorder categories with few if any age designations

PERSONALITY DISORDERS

These are described in DSM-IV-TR as being **long-lasting patterns of inner experience and behavior that are very different from what is expected in the general culture**. These patterns do not change over time, and **people who truly are set in them lead lives of distress and impairment**. We are warned against giving the diagnosis to adolescents because the disorders are described as being **“pervasive and inflexible,”** too severe for young people who still have the capacity to change and grow.

There are three groups or clusters of Personality Disorders.

CLUSTER A disordered people are **odd or eccentric** with **Paranoid, Schizoid, or Schizotypal Personality Disorders**.

CLUSTER B Disorders are rather like the personality equivalents of the children’s category **Externalizing or Disruptive Disorders**. People with these disorders will be **dramatic, erratic, and sometimes aggressive**. **Antisocial Personality Disorder is the one Personality Disorder that may not be given to anyone under 18. It predicts lifelong criminal behavior**. Cluster B also includes **Histrionic, Narcissistic, and Borderline Personality Disorders**, the only one given commonly enough to adolescents to be included here.

CLUSTER C disorders could be called the **Internalizing Personality Disorders** as people with these problems—**Avoidant, Dependant, and Obsessive-Compulsive Personality Disorders**—are beset with fears and anxieties¹.

PSYCHOTIC DISORDERS

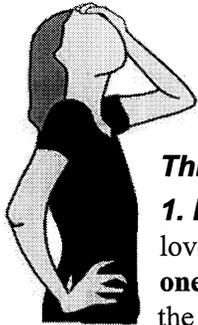
These most serious psychiatric disorders are known for the severe and peculiar symptoms they have in common—delusions and hallucinations. Schizophrenia is the best known. Other psychotic disorders have less bizarre symptoms. Delusional Disorder, for instance, involves a firm belief in something far from true—you are related to a god or some famous person idolizes you, for instance—but involves no hallucinations and doesn’t badly disrupt everyday functioning. Schizophrenia, on the other hand, has a number of subtypes itself as well as a number of companion disorders that are differentiated because of how long they last or because of a unique symptom.

The three distinct characteristics of Schizophrenia are:

- **psychotic symptoms,**
- **disorganization of thought, speech, and behavior, and**
- **negative symptoms or the restriction of emotions, thinking, and motivation.**

People who have Bipolar Disorder, Borderline Personality Disorder, Depression, or even severe stress may sometimes have **psychotic symptoms**, but the term *Psychotic Disorder* is reserved for illnesses most similar to Schizophrenia.

Borderline Personality Disorder or Emotional Intensity Disorder or Emotional Regulation Disorder or Cluster B Traits*



Borderline Personality Disorder (BPD) is a serious mental illness² that affects about two percent of adults, more women than men. One-fifth of hospitalized patients are there for this illness.

This disorder affects:

1. Relationships. These young people often have intense love/hate relationships. They **switch from idealizing someone one day to being furiously disappointed** by the same person the next day. They have **great fears of abandonment** that make

them see any small lack of attention from someone they value as a sign that they are hated or bad. If a favorite staff member sends a substitute to a meeting, for instance, the person with BPD may react with panic or bitter fury, believing that s/he has been abandoned. Youths with this problem can seem **very needy and demand much staff attention**. They can be empathic with others so long as those others are “there” for them whenever they want them to be. As stormy as relationships with same- or opposite-sex friends are, the **youth with BPD dreads isolation and may feel overwhelmed by loneliness**.

2. Self-image. One of the DSM-IV criteria for this disorder reads, “**identity disturbance: markedly and persistently unstable self-image or sense of self.**” Examples given are of shifting goals, values, career plans, types of friends, and sexual identity. Since adolescence is the time when these changes may naturally occur, we cannot judge whether or not this is going to persist to the point of instability. What is not normal is the **poor self-image of being bad or evil, or of depersonalization, not really existing at all**. These can be overwhelming to the point of being delusional.

3. Emotions. Here is the key element of BPD. **Intense and swiftly changing moods are signs of poor emotional control**. These extremes have been described as **raging torrents of emotions**. The youth may be highly irritable or anxious or angry for hours or a day and then be over it. **Deliberate self-injury** is common. So are **suicidal threats and gestures**. Eventually, 10 percent of people with BPD do kill themselves.

4. Behaviors. Problems involving **impulsive behaviors** may be what brought the youth with BPD to your facility. Problem areas include **gambling, spending, risky sex, substance abuse, reckless driving, binge eating**—things that involve failing to put the brakes on behavior. The youth may have explosive anger outbursts and frequently get into fights.

* **About all these names:** This cluster of problems was named *Borderline Personality Disorder* long ago because it seemed to fall on the borderline between neurosis and psychosis. The word *Borderline* stuck even though it has no clear meaning today. Newer names refer to the disorder’s true central features—problems with *Emotional Regulation and Intensity*. *Cluster B Traits* is a term used to avoid the naming problem. It refers to the group of disorders with similar symptoms to which this one belongs without calling it a *Personality Disorder*. The DSM-IV definition of personality disorders includes such words as *enduring, pervasive, and stable over time*.¹ That leads some to believe that *Borderline Personality Disorder (BPD)* involves basic character flaws and is nearly impossible to treat. For that reason, **and because many teenagers do outgrow these symptoms, mental health providers do not like to give young ones the BPD label. They may use Cluster B Traits instead.** Most favor a name change to one of the other alternatives listed above. But for now, *Borderline Personality Disorder* is, at least in the US, its official name.

What disorders co-exist with Borderline Personality Disorder?

BPD often co-occurs with a depressive or an anxiety disorder, especially PTSD. It may be confused with Bipolar Disorder. Substance Abuse and Eating Disorders are common companion disorders.

Can Borderline Personality Disorder . . .

...be genetic? Yes. BPD is about **five times more likely to be found among parents and siblings** than among people in general.

...be biological? Yes. Brain images show that the **emotional centers of some people’s brains are especially vulnerable to spiking fear and anger arousal responses**. The thinking brain (frontal cortex) is unable to suppress these negative emotions completely.

...be environmental? Definitely. **Physical, sexual, and emotional abuse** are common in the histories of those with BPD. As many as **71 percent have suffered sexual abuse**, usually by a non-caregiver. Neglect, loss of one or both **parents through death or separation**, and **hostile family conflicts** are common.³

...be treated? Yes. **Group and individual therapy** using special methods developed just for this disorder have helped people tremendously. **Medicines may be used to target particularly troublesome symptoms.**

Helping Youths with Borderline Personality Disorder/Cluster B Traits

Providing real help to young people with these problems requires years of training and experience. We can, however, use a few of the main principles of a therapy that was developed specially to treat BPD. It was developed by **Marsha Linehan of the University of Washington and is called Dialectical Behavior Therapy or DBT⁴**. DBT is a treatment that has been **research-proven to bring about lasting improvements**

in the lives of people who have this serious disorder. Dialectical means working with words and ideas until logic arises out of contradictions. For us it means genuinely accepting these often contrary people while at the same time trying hard to help them think logically. It will help if you read and understand more about the disorder, because they need that understanding, too. Following are some of the basic DBT principles staff can use.

1) Acceptance is the key helping skill. As Linehan sees it, **young people with borderline traits have grown up in “invalidating settings”** where their feelings, thoughts, and reactions have been dismissed as being silly or worthless. **Listening, reflecting back what the youth has said, and confirming that their thoughts and feelings matter and have been heard are helpful responses.** Even when they are wrong-headed and their ideas and emotions will lead to trouble, we listen respectfully to understand where so much anger is coming from—at the same time that we work hard to bring about change.

4) The SUDs (Subjective Units of Distress) Scale⁵ teaches that you can **mediate feeling levels.** Instead of having either to feel either 100% angry (*killing mad*) on the anger SUDs scale or 1% (*irked*), you can feel about 25% angry (*annoyed*) or even 75% (*P.O.ed*) and still avoid trouble. Black-or-white thinking is a major problem for youths with Cluster B thoughts and emotions, and this teaches them to think in proportions and shades of gray.

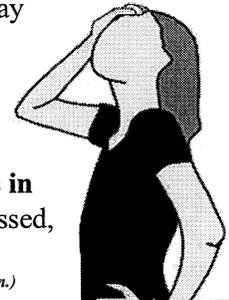
(See directions for teaching the SUDSmeter in the Resource Section.)

2) Stress management skills to reduce the body’s responses to intense emotional arousal can provide direct, soothing relief. Probably of equal value is their giving the youth a sense of regulating his or her own emotions.

(See directions for Stress Management in the Resource Section.)

3) Learning to say how you feel with words instead of acting it out or bottling it up inside is a vital skill. The words don’t always have to be said to the person involved in a conflict that is upsetting the youth. Just learning to put the worry into words and speak them clearly to another person helps. When the youth can say what s/he feels and know that s/he has been heard, it won’t be so necessary to act it out with weeping or raging. **Learning the words for a full range of emotions gives people tools for being more skilled in moderating their own feelings. It also lets others in on them.** When other people hear feelings well expressed, they are more likely to validate them.

(See the Feeling Words sheet in the Resource Section.)



Staff relationships

Young people with this disorder are likely to have **abandonment issues** that can cause placement in a Youth Shelter or Detention Center to be truly traumatic. Some will probably have a hard time with relationships, feeling **needy and demanding much attention from favored staff. Clear and reasonable boundaries are important for this attention-needing phase.** At some point, these same young people are almost certain to **switch and become hostile with the very people whose attention they have most valued.** Here, too, is where clear and reasonable boundaries are essential. The more clearly they are framed as institutional rules, the better. Structure keeps these young people at a healthy distance when they are up and down, but we

can always **remain accepting.** The clearer the rules, the more this is possible. Let the youth know that you understand that s/he has lost emotional control and needs help to regain it. If you have helped to teach and practice stress management skills, remind the youth to use them. **Sometimes young people who are extremely upset may become violent or self-abusive.** Your facility will have strict rules about seclusion and restraint to meet today’s safety guidelines. Be aware that using **holds and restraints runs a high risk of re-traumatizing youths who have been physically and sexually abused.** Your warm acceptance of the person coupled with emotionally even-keeled limit-setting will be the bigger help.

(See the introduction to Personality Disorders on page D-41.)

Psychotic disorders

A Psychosis is a disorder of perception. The ways one sees, hears, and understands the world are distorted by a **brain that is broken.** The brain reacts exactly as though it were truly registering these sights and sounds, as though the world were really capable of such strange happenings. Psychotic symptoms can be divided into two groups, **hallucinations** and **thought disorders/delusions.** The first are distortions of the senses, the second of thinking and beliefs.

HALLUCINATIONS

Auditory: voices or other sounds; soft to ear-splitting, pleasant to hateful; often the voice of God or the devil; voices may demand harm, but more often to oneself than to others.

Visual: colors, whirling shapes, creatures, people; pleasant or terrifying; often bizarre, gory, or threatening; less than half as frequent as auditory hallucinations.

Kinesthetic: hallucinations of touch or physical experience; odd smells to excruciating pain to the feeling of things crawling on the skin or inside the body.

THOUGHT DISORDERS/DELUSIONS

Thought insertion: the belief that someone else is inserting thoughts into your brain in order to control you. You do as those thoughts tell you because you think have no choice.

Thought broadcasting: The belief that others can literally hear what you are thinking, even your most secret thoughts. Some people do not even bother talking because they are so sure that other people can already hear what they think.

Ideas of reference. The belief that random happenings, sights, and conversations all refer to you and are part of a complicated plot to harm you. It is all evidence for **paranoid delusions.** If all references are to how superior you are instead, they will feed **delusions of grandeur.**

Derealization. The belief that you or your environment are somehow unreal, set apart from real existence. This is similar to **Depersonalization,** the belief that you are not your “true self.” These are very distressing perceptions to experience.



The disorders

Schizophrenia is the primary psychotic disorder. Males' age of onset is usually 16 to 20; females', 20 to 30. Early warning signs are listed on the back of this page—the most common are “**unusual behavior**” and “**noticeable social withdrawal.**” It is the most severe of all mental illnesses and is never entirely cured. With good medical treatment and a strong support system, however, people with Schizophrenia can lead comfortable lives. The disease tends to wax and wane. **Positive** (or active) **symptoms** are those described above—drugs help to manage them best. Between active periods (and at all times for some), **negative symptoms** may occur. **These are losses**—of interest, pleasure, emotions, ability to talk, socialize, and function intellectually. People may become unable even to eat or care for themselves. Negative symptoms are much harder to treat than the more flagrant, positive ones.

Psychotic disorders similar to schizophrenia are named for their shorter duration or other characteristics. **Schizoaffective Disorder** is the name given to psychosis that appears combined with the depression and mania of Bipolar Disorder. It is a more hopeful diagnosis because people are more likely to get well than from Schizophrenia if they stick with good treatment. Some scientists believe that Schizophrenic, Schizoaffective, Major Depressive and Bipolar Disorders are all different faces of the same illness. They become almost indistinguishable from one another in their most severe psychotic phases. By contrast, a person can experience psychosis and *not* have a serious disorder. Stress can bring on a **Brief Psychotic Disorder** that lasts only from one day to one month.

Can Psychotic Disorders . . .

...be genetic? Yes. Schizophrenia is carried by a number of genes. If one of your parents has it, your risk of becoming schizophrenic is 6%. If your sibling does, it is 9%, If your identical twin does, it is 48%. Genetic studies of psychotic depression show similar results. As research continues, genes may be what finally tell scientists if these are different types of the same illness or truly different disorders.

...be biological? Yes. Imbalances of brain chemicals, low frontal lobe activity, and brain ventricles that are twice normal size are all measurable. (The frontal lobe is where executive decisions are made; enlarged brain ventricles mean that the hollow places in the center of each half of our brains have doubled in size as millions of brain cells have died off.)

...be environmental? Yes. A person may have the genes for psychosis and never become ill, or someone with no known family history of mental illness may develop a psychosis. Environmental stressors cannot cause it, but they can trigger its onset. Researchers report, **“Psychosis is, of all diagnostic categories, the most strongly correlated with child abuse.”**^{2,3} Of 100 inpatients, 77 percent of those who had been sexually abused were diagnosed psychotic, compared with 10 percent of those who had not been abused.⁴ In a review of 15 studies, 44 percent of psychotic boys and girls reported physical abuse. About one-half to one-third fewer boys than girls reported sexual abuse.⁵ Incarcerated boys who did suffer depression equal to girls' as a result.⁶

Early Warning Signs of Schizophrenia

- Deterioration of personal hygiene
- Depression
- Bizarre behaviour
- Irrational statements
- Sleeping excessively or inability to sleep
- Social withdrawal, isolation, and reclusiveness
- Shift in basic personality
- Unexpected hostility
- Deterioration of social relationships
- Hyperactivity or inactivity – or alternating between the two
- Inability to concentrate or to cope with minor problems
- Extreme preoccupation with religion or with the occult
- Excessive writing without meaning
- Indifference
- Dropping out of activities – or out of life in general
- Decline in academic or athletic interests
- Forgetting things
- Losing possessions
- Extreme reactions to criticism
- Inability to express joy
- Inability to cry, or excessive crying
- Inappropriate laughter
- Unusual sensitivity to stimuli (noise, light, colours, textures)
- Attempts to escape through frequent moves or hitchhiking trips
- Drug or alcohol abuse
- Fainting
- Strange posturing
- Refusal to touch persons or objects; wearing gloves, etc.
- Shaving head or body hair
- Cutting oneself; threats of self-mutilation
- Staring without blinking – or blinking incessantly
- Flat, reptile-like gaze
- Rigid stubbornness
- Peculiar use of words or odd language structure
- Sensitivity and irritability when touched by others.



Responding to Warning Signs

As you look over this list, notice that many of these behaviors could be signs of a young person's becoming involved with drugs or with an alienated or antisocial peer group. You won't have known this young client long enough to know how great a change what you see now is from a year or six months ago. Find out:

- *Did s/he come in with psychoactive medications? What kind and what for?*
- *Did s/he come in high on something? Psychotic people self-medicate that way.*
 - *Has s/he ever been hospitalized for psychiatric problems? Ask the family.*
 - *Is the family disconnected or unavailable? Seek DHS help.*
 - *In your setting, does the youth seem socially withdrawn?*
 - *Does s/he display strange mannerisms or seem to talk or listen to unseen persons, or say peculiar things with odd use of language?*

The Catch 22 of Diagnosing Schizophrenia

No one is eager for young persons to receive this diagnosis, the most devastating for anyone to hear. So some may give them other, less scary labels or just hold off dealing with the problem until it becomes impossible to deny the fact of Schizophrenia any longer.

Now we know that this is a cruel kindness. Scientists have learned that Schizophrenia's greatest damage to the brain seems to be done during the first psychotic episode.⁸ It helps to begin treatment as soon as problems first show up. That is in what is called the prodromal or preliminary stage, before the person becomes seriously ill, immediately at the onset of the illness. The earlier one of the new medicines such as Clozaril or Abilify is started, the better the chances are that the person will escape the full, chronic course of Schizophrenia.

In Shelter or Detention settings, we have the chance to watch youths closely when they are completely off drugs or alcohol and in a stable environment.

Placement out of home is difficult for all children and youth— for one vulnerable to psychosis, the stress could be overwhelming. You may be able to see clearer warning signs of disorder than were ever before possible.

This is a situation in which we must be sure to intervene, even at the risk of ordering an evaluation when it turns out that the youth was not psychotic after all.

Help now could make a lifelong difference.

This list is from *Basic Facts About Schizophrenia*, a brochure published by the British Columbia Schizophrenia Society that is available online.⁷

Part Three

Resource Section

These pages contain activities and accommodations to help youths learn and practice new ways of thinking and managing their emotions.

Resource Pages

- 102 • **STRESS MANAGEMENT**
- 103 • **MY BODY'S REACTION TO STRESS**
- 104 • **SUDSMETER—SUBJECTIVE UNITS OF DISTRESS SCALE**
- 106 • **EXPRESSING FEELINGS IN WORDS**
- 107 • **THINKING SKILLS**
- 108 • **TEACH CONSEQUENTIAL THINKING**
- 109 • **COST / PAYOFF**
- 110 • **PROBLEM SOLVING WITH THINKING SKILLS**
- 112 • **POWER LIGHTS—AN ACTIVITY TO CHANGE FEELINGS OF HOPELESSNESS**
- 114 • **COOL-DOWNS—TEACHING CONTROL OF ANGER OUTBURSTS**
- 116 • **RELAXATION TRAINING**
- 117 • **EXTRA SUPPORTS FOR YOUTHS WITH AUTISM OR ASPERGER'S DISORDER**
- 118 • **EXTRA SUPPORTS FOR YOUTHS WITH ADHD**

Resource Pages elsewhere in the Guide

- 11 • **THE MEDIATION ESSAY**
- 21 • **5,4,3,2,1...AN ACTIVITY FOR HELPING SOMEONE FALL ASLEEP**
- 43 • **SEXUAL HARASSMENT**

Body Works

IT'S A TOUGH WORLD! THE HUMAN BRAIN AND BODY NEED AN AUTOMATIC SURVIVAL SYSTEM.

SPEED UP

Alarm! The brain triggers active defense to fight off danger and protect the body:

- edgy • jumpy • ready for anything • pacing • trembling • punching • kicking • yelling • crying • how you might feel if a MUGGER jumped out and started chasing you.

STOP

Freeze! The brain halts the body's risky behavior and buys time to decide what to do next:

- blank expression • rigid muscles • stuttering • "cat's got your tongue" • how you might feel if you were climbing a HIGH LADDER that began to wobble.

SHUT DOWN

Collapse. The brain deactivates the body's motor system to withdraw it from danger:

- getting dizzy • blacking out • fainting • passing out • how you might feel if you had to watch an OPERATION to save a life.

SENSES

- NOISES SEEM LOUD, IRRITATING
- SEE RED • SEE BLACK
- JUMPY WHEN TOUCHED
- FOOD TASTELESS

RESPIRATORY SYSTEM

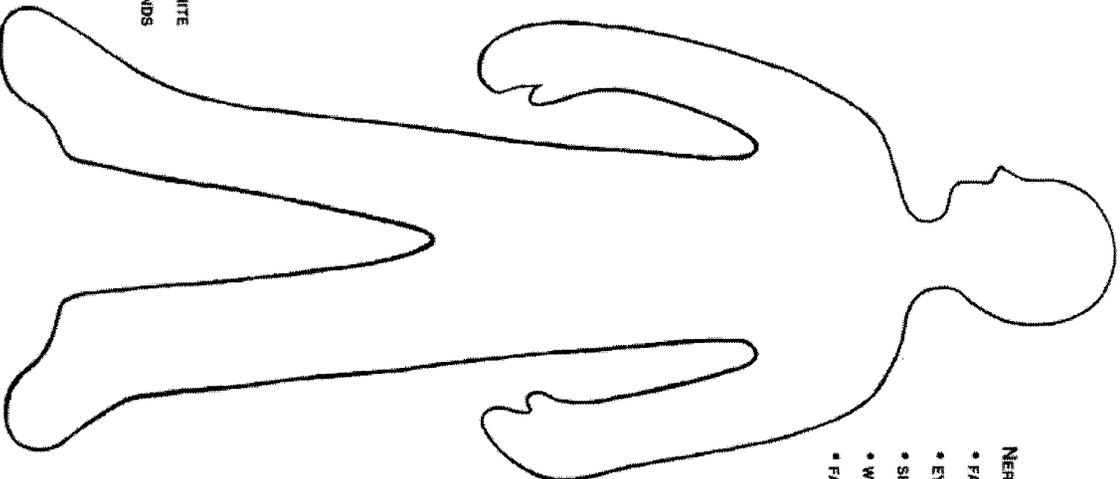
- BREATHE FAST
- SHORT OF BREATH
- FEEL LIKE CHOKING

URINARY TRACT

- FEEL PRESSURE
- GO FREQUENTLY

SKIN

- FACE BLUSHES • FACE TURNS WHITE
- SWEATY ALL OVER • SWEATY HANDS



NERVES AND MUSCLES

- FASTER REFLEXES • STARTLE EASILY
- EYELIDS TWITCH • HARD TO SLEEP • FIDGETY
- SHAKY • TENSE • RIGID • FEEL WEAK
- WOBBLY LEGS • CLUMSY • CLENCHED FISTS
- FACE TINGLES

CIRCULATORY SYSTEM

- HEART BEATS FAST
- HEART SKIPS A BEAT
- HEARTY RACES
- BLOOD PRESSURE GOES UP OR DOWN
- BLOOD PULSES BACK FROM CAPILLARIES — TURN PALE & COLD
- BLOOD RUSHES TO CAPILLARIES — TURN RED & HOT

DIGESTIVE SYSTEM

- LOSS OF APPETITE
- FEEL LIKE THROWING UP
- STOMACH CRAMPS
- CRAMPS IN THE GUT
- DIARRHEA
- GAS

Different people have these feelings for different reactions, Alarm!, Freeze!, or Collapse. If these feelings come at the right time, they help you survive, protect your life or health. But if these feelings get too strong for any use or turn on at the wrong times, they lead to trouble instead of survival.

My body's reactions to stress

Use this worksheet to teach stress management.

Stress is a word for what goes on in the body when people face demands they see as too big to handle, and where failure to do so will have serious consequences. This worksheet summarizes the stress responses that occur in each body system. Across the top are descriptions of the three types of autonomic (unconscious) nervous system response to stressors. Help youths identify how their bodies react to powerful emotions such as fear or anger. They can use the body outline to draw in cartoon images of where their bodies react to stress. The point is for them to be more aware of stress feelings and use them as cues to start stress-reducing techniques such as relaxation, taking a calming breath, or calming self-talk..

SUDSmeter—Subjective Units of Distress Scale¹

People who have emotional self-control problems tend to see things in extremes. They feel either *OK* or *horrible*; *people are nice* or *awful*. Young people can learn to keep things in proportion by visualizing a scale inside their brains that has a control on it. When they decide to make themselves feel less distressed, they literally picture themselves turning down their SUDS control from 100 closer to 0. How? By instead of telling themselves they feel *horrible* or *awful*, words that push their SUDSmeter² pointer into the danger zone, they find milder and more exact words to describe how they feel. Explain it this way:

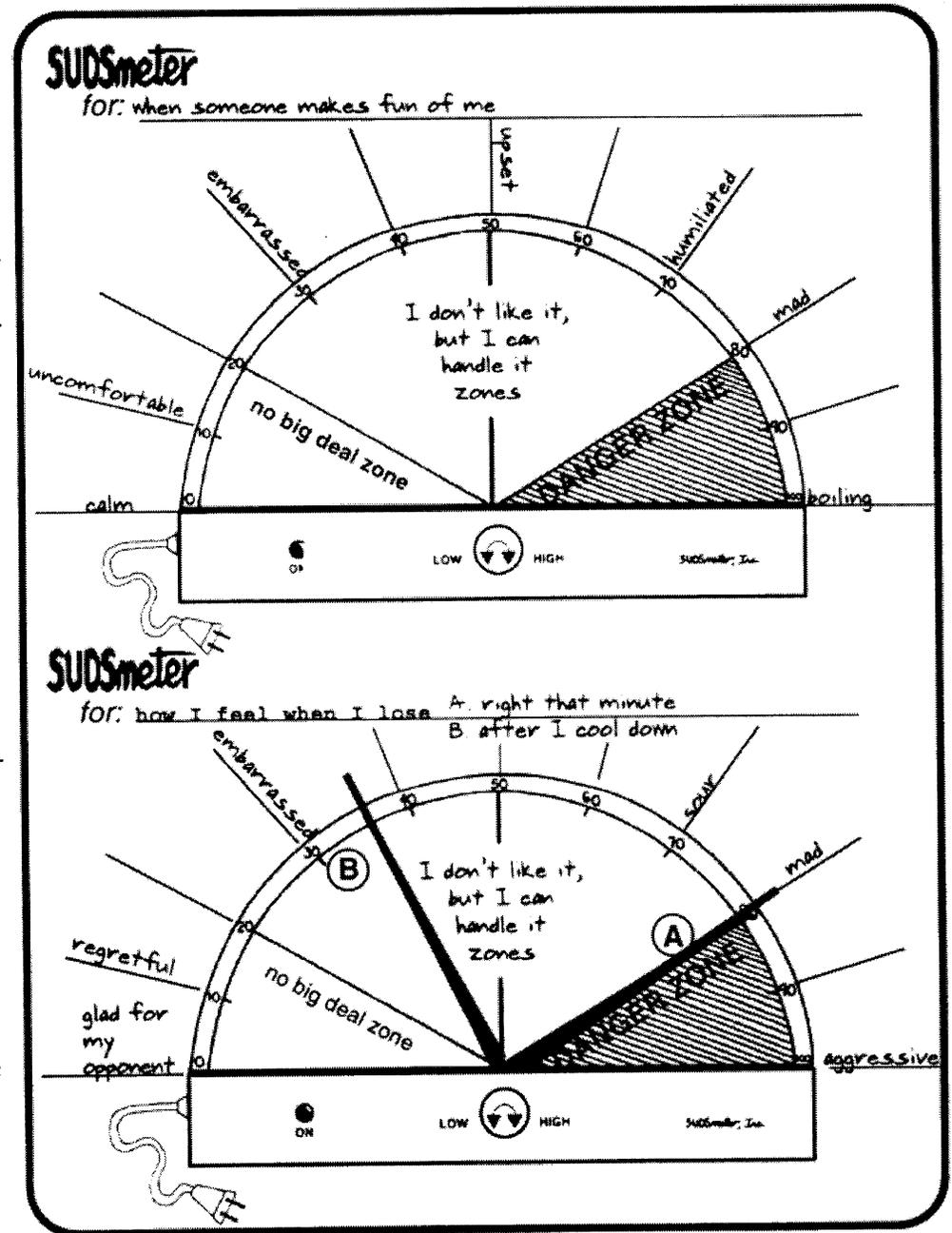
"The SUDSmeter measures the power of disturbing emotions from 0 to 100. It gives you power to control them with your mind.¹ Since we think in words, we can label the meter with words that fit the power points on our own scales.

"What is a word for the angriest you can ever feel? (Use *Expressing Feelings in Words*, page R-5, for ideas.) Write it next to 100 on the scale. What is one for 80, the low edge of the Danger Zone? In between is the area on the meter that shows where this emotion is likely to get you in trouble with yourself or others. Now think of words for the No-Big-Deal zone, 0 to 20. Here is where you still feel the emotion just a little bit—nobody has pulled your plug—but you don't let it bother you much at all. In between, 21-79, are various levels of the emotion you can handle, even though you still don't like it. Put down some words for them.

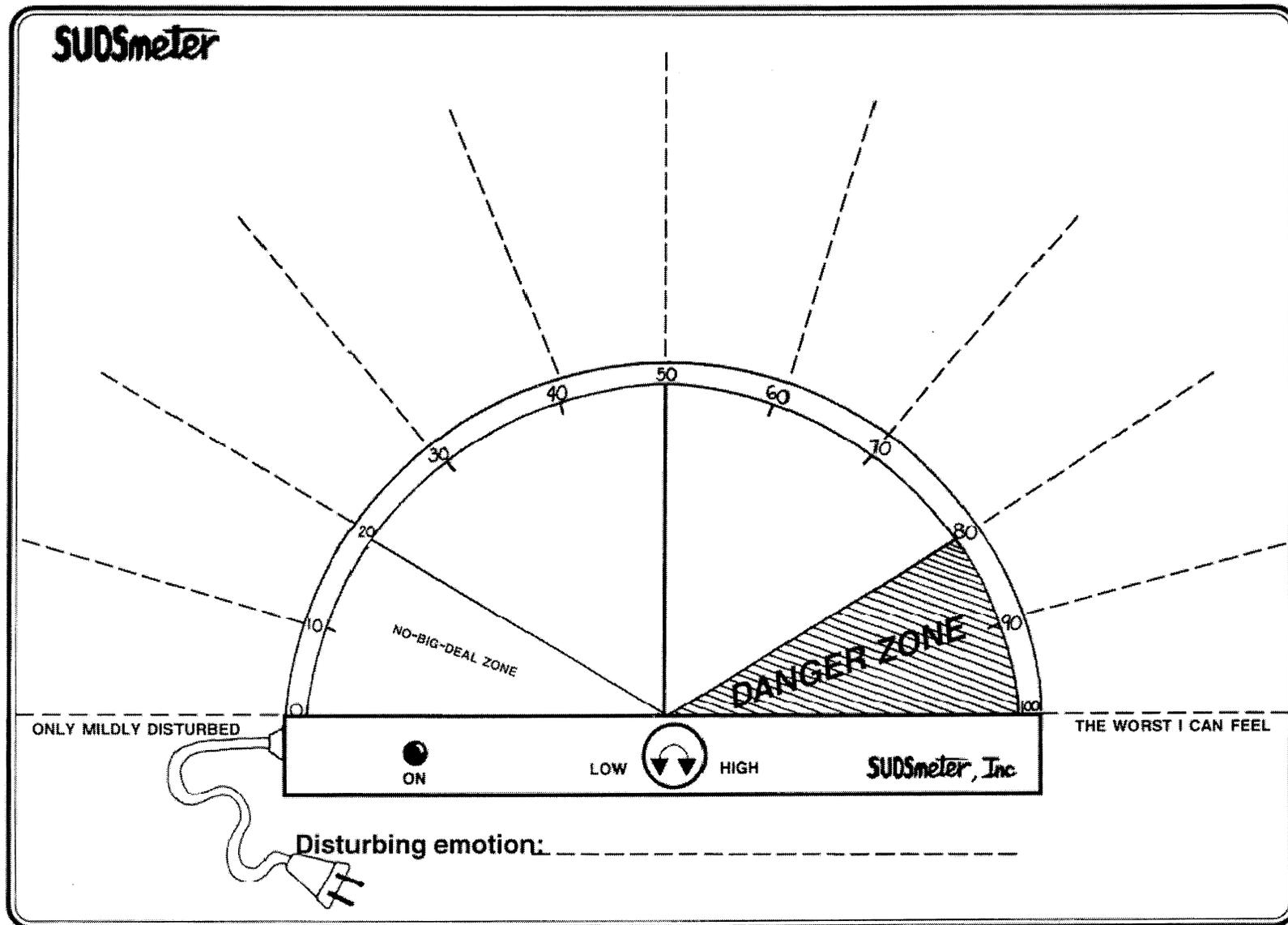
"Pretend you are dealing with a bad situation—something that made you lose control. It automatically made you feel ...what? mad? disgusted? Now think about the same situation, but think about yourself keeping your cool and handling the problem with no bad outcomes for you or for anyone else. What feelings did you feel then? Choose those words to put at key spots around your SUDSmeter. If you practice lowering your SUDS level in your imagination, you'll find you can do it in real life, too. You need real words to aim for.

"Most of us have an automatic SUDS level—some people have high emotions that jump to the danger zone over things that don't bother others so much. If your SUDS level jumps automatically to the danger zone, take a calming breath. Think while you do so of turning the control lower. The pointer on the dial glides down to a manageable feeling word, one at a level you can handle. Then YOU will be in charge of your emotions instead of other people being able to trigger your loss of self-control."

Make copies of the SUDSmeter sheet on the next page. A list of feeling words follows on R-5. Youths can draw in their pointers with pencils. If you have a white board and draw a SUDSmeter on it with washable transparency markers, you can use erasable white-board markers for words and pointers. They will erase as youths change words and pointers, and you can wash the SUDSmeter off when you are done.



(See another sample on the *Stress Management* page, R-4)



Using words and images for emotional self-control

Young people in today's media world are almost as likely to use visual imagers for brain pictures of thoughts as they are to use words. Using accurate and non-inflammatory words to *express* emotions is important, but another powerful way to think about and control them is by using pictures. Here is how the SUDSmeter³ picture can be used in that way. After looking at the drawing and discussing its details, you say, "Close your eyes. Now think about that time you were so upset. See a picture of the SUDSmeter in your mind's eye. Look at it as you

take a Calming Breath . . . and hold it for three seconds. . . Now slowly exhale, and imagine turning down your central SUDS control from HIGH to LOW. Watch the needle slowly glide down from the Danger Zone to the place and the word you've picked to be in control. Feel how cool and settled your mind feels when your emotions are the middle zone where you can think and avoid trouble. Practice this any time—like a muscle, it gets stronger with regular exercise. Then **USE IT FOR REAL** the next time your feelings are heading you into the danger zone."

Expressing feelings in words¹

The ability to express feelings in words is an essential tool for emotional self-control for two reasons:

- 1) the need to *act out* is reduced when you use words to *say* how you feel when your emotions are high. We know, for instance, that a reason for suicidal acts and deliberate self injury is that some people feel they need to use actions instead of words to tell others of powerful feelings.²
- 2) the bad feelings that can remain for days, months, or even years after a relationship problem occurs are drained away when those feelings are talked about openly with the other person.

Gender research shows this to be particularly difficult for males in the US and many other countries. Boys are traditionally raised to see the expression of feelings as a feminine trait.³

Because we think it words, knowing words that *exactly* describe feelings gives us more self-knowledge. Think of the differences between feeling *frustrated* or *humiliated* or *disappointed* or *vengeful*, for instance, and being just plain *mad*. *Mad* means 1) *roused to anger*, 2) *affected with insanity*, 3) *marked by uncontrolled emotion*, or 4) *very foolish*. The other four words carry more exact mean-

**"When such-and-such happens —
"When I think such-and-such —**

<p>"Angry . . ." annoyed burned up furious indignant irate irritated mad offended outraged p.o.ed quick-tempered short-fused sore ticked off up in arms"</p>	<p>"Upset . . ." bummed bugged distressed flustered frantic freaked out knocked for a loop overwhelmed shaken up tormented unhinged undone up tight wounded"</p>	<p>"I feel . . ."</p>	<p>"Un cared-for . . ." abandoned alone cut off deceived hated hurt humiliated ignored injured insulted left-out lonely misunderstood put down rejected threatened teased unheard used victimized"</p>
<p>"Doubtful . . ." anxious bewildered cautious confused distrustful</p>	<p>"Sad . . ." blue choked up depressed down gloomy grief-stricken joyless low melancholy mourningful sorrowful spiritless unhappy"</p>	<p>"Joyful . . ." carefree cheerful delighted ecstatic enthusiastic elated excited giddy glad invigorated lighthearted lively merry playful silly</p>	<p>"Alert . . ." aware eager energized smart on the ball on top of things refreshed with it"</p>
<p>"Just awful . . ." aching ashamed bitter</p>	<p>"Fearless . . ." bold brave courageous daring gutsy tough unafraid"</p>	<p>"Valued . . ." accepted admired appreciated cared for heard loved respected supported understood wanted"</p>	<p>"Peaceful . . ." accepting at ease calm cool-headed comfortable composed contented easy-going even-tempered fulfilled gentle mellow quiet relaxed satisfied serene unmuffled"</p>
<p>"Just fine . . ." amused bright capable competent encouraged fascinated generous grateful hopeful liberated optimistic pleased proud tolerant reassured safe self-confident"</p>	<p>"Interested . . ." absorbed curious enthusiastic fascinated focused inquisitive intrigued involved inquisitive motivated thoughtful"</p>	<p>"Sparkling . . ." sparkling spirted sunny super thrilled up"</p>	<p>"Giving . . ." giving loving nurturing open-hearted passionate sympathetic tender warm"</p>

ing. Use this word list to suggest many more precise feeling words.

Teach youths to express feeling words in I-statements:⁴
"When you do such-and-such, I feel _____," practiced over and over again. No blaming words allowed—Not, *"When you act like a jerk . . ."* Just a neutral description of the other person's actions—*"When you tell her she's dumb, I feel . . ."* Then words for one's own feelings—*"furious. . . sorry for her . . . embarrassed to be with you."* This main feeling statement can be followed by a request: *"So I wish that you would keep that kind of opinion to yourself."*

Thinking skills

All persons have to use certain basic *thinking skills* in order to solve problems effectively.

Those who did not learn the skills naturally in their homes will have lifelong problems, especially interpersonal problems. Those of us who did learn them naturally don't even think of them as skills at all—we assume everybody can think that way. Researchers Spivak and Shure¹ have

shown us that a) **these are specific skills**, b) that **the skills can be taught** if they were not learned naturally, and c) that once taught, the **skills result in more effective, less aggressive problem-solving over time**, for months and years.¹

Four Interpersonal Cognitive Problem Solving (ICPS) Skills

Notice that these skills require learners to 1) **lengthen their views of time** from here-and-now into the future, or to 2) **widen their views of what is possible** by thinking of several solutions to problems, or to 3) **to broaden their views of the importance of other people** by considering their thoughts and feelings. It will require a lot of practice for some young people to hypothesize about the future and about what others *might* think or do. These skills will be particularly challenging for youths with severe ADHD or who are very concrete thinkers.

Consequential Thinking

is routinely thinking ahead to what might happen as a result of an action you decide to take. Some consequences could be good (pay-offs), and others could be bad (costs). Consequential thinking is a necessary part of making decisions so that the results have the best possible outcomes.

To teach it:

a) Practice using the Cost/Payoff sheet often. Use it first for practice happenings of no true importance, and work up to using it to help make major decisions. Use it after a major disciplinary incident to see how it could have been avoided.

b) Compare Cost/Payoff sheets done by several youths to judge which solution would work out best if you were deciding between several options.

(See the Teach Consequential Thinking page in the Resource Section.)

Alternative Thinking

is considering many solutions to problems instead of doing the same unsuccessful or dangerous thing over and over again. It is the opposite of “one-shot thinking²” which is coming up with the same solution to every problem. For some, that could be *fight* (hitting); for others, *flight* (running away to cry).

To teach it:

a) Set up a problem and have youths brainstorm as many solutions as they can, both serious and not. The rule of brainstorming is that no one judges how good or bad an idea is until all ideas are written down. What you are after is getting young minds to think beyond their one-shot limits. (See the Problem-Solving page for ways to judge them.)

b) Make “What’s another way you could solve that problem?” a routine question.

Means-End Thinking

is understanding that it takes many steps to reach a goal, even though many of the steps may seem meaningless in themselves. Understanding the reverse, that great accomplishments have taken many steps to achieve, is also part of means-end thinking. Notice the *lack of means-end thinking* when you talk with youths who have goals of being rich professionals but who are failing school subjects because they do not complete work or attend class.

To teach it:

a) Emphasize Making a Plan whenever possible. Write plans, discuss plans, follow plans. Planning is essential.

b) List the steps it has taken celebrities who are admired by the youths in your care to achieve their fame. Focus on those who overcame problems. (Google their biographies.)

Perspective Taking

is the ability to see a problem from other people’s points of view and realize that what others do makes sense when seen from their perspectives. This skill is the most critical one to learn in order to become a good negotiator or problem-solver. We assume that even little children have it—“*How do you think she feels when you do that?*” In fact, it isn’t until adolescence that the skill weighs in heavily on whether or not a person is socially competent. After that, it gains in importance every year.

To teach it:

a) Make up stories about common conflict situations—the cop writing a ticket, the teacher lecturing about cutting class. Help youths role play *both* parts, saying their thoughts out loud. **Then use real conflict examples.**

Consequential, Alternative, and Means-End Thinking are the ICPS Thinking Skills that research has shown carry the most weight in the difference between well-adjusted elementary age students (average age 10), and poorly adjusted ones. This is true *after* IQ’s were corrected for, so having these skills is not just a matter of being smart. The importance of Perspective Taking emerged in studies done with teens and adults.

Consequential thinking¹

If we could teach every one of our young clients to think ahead to the near and far consequences of what they do *automatically*, before they do it, we would rejoice. Teaching the Cost/Payoff² sheet is a good beginning, and you may be surprised at how hard it is for many youths to get it straight. It is a simple format that you would like to get solidly implanted in youths' brains so that the chart comes immediately to mind. Images are often easier to connect ideas to than are verbal explanations. Start by using some made-up but realistic examples like the one in the sample.

The Basics of Cost/Payoff

Don't use the word consequences very often—most people think it means only bad outcomes, and we want youths to of both positive and negative ones.

Payoffs are desirable results of actions. They can be **concrete payoffs**—money, grades, cigarettes, pets, cars; **social payoffs**—invitations, influence, caresses; or **emotional payoffs**—love, trust, pride, superiority.

Costs are undesirable results of actions. They too can be **concrete or tangible**—debt, jail time, car wreck, gambling loss; **social**—rejection, embarrassment, loneliness, pain from beatings; or **emotional**—hatred, loss of trust, grief, anger.

There are three time columns:

Now means during the exact minutes the action would be taking place. It is for the catching any impulsive thoughts that led to the action. Start filling in the chart with the *Payoffs Now* square. Explain how **it is human nature to go for the payoffs we can enjoy right this minute, even though we know that it won't be good for us in the long run.** Smoking now is not worth lung cancer much later; eating this second dessert now is not worth bulging out of my clothes much later. When we were babies, all humans thought alike— *"I want what I want when I want it."* It's harder for some people to learn to think ahead and wait than for others.

When you fill in the *Costs Now* square with the negative things that could happen right at that minute, they might not seem so bad. The person might get caught, or might not. It's a gamble, and the *PAYOFF NOW* is a surer bet.

Later is for later that day or the next day. This requires even more hypothesizing, hard for some young people to do but absolutely necessary for thinking ahead to long-term consequences. What are the good things that could still be

Costs / Payoffs

Happening		My mom gets on my case again. I can't stand it, so I yell back at her louder.		
	NOW <i>right this minute</i>	LATER <i>today or tomorrow</i>	MUCH LATER <i>next week, month, year, 5 years, 10</i>	
C O S T S	She gets louder still and says I can't use the car for week.	I'd counted on the car, so now I'm real mad. She won't give in. We fight more.	She's mad all the time and never gives me a break. I hate being home. Stress!	
P A Y O F F S	I get my anger out.	I show her I won't take it anymore.	NONE	

happening because of what was done yesterday? Perhaps some social attention, bragging rights, revenge, something gained that was wanted? Then check in about the *Costs*. Any losses? jealousy? retaliation? penalties?

Much Later is for the undetermined long time from now. In the *Costs* square is where the jail sentences, divorces, and many other unhappy endings are recorded. To get any entries other than tangibles in the *Payoffs* square will probably take some prompting—*"So, do you think he'll be happy or not?"*

The Bottom Line. Most *Cost/Payoff* charts end up filled with many entries in most of the charts' cells. Then you show how you have to weigh the *Costs* and *Payoffs* to figure out what to do. You can use poker chips as tokens—red ones for costs, blues for payoffs, and literally count or weigh them to see which side has more. Then you can begin to greater assign greater value to some. If a ride home from school is worth one chip, how many chips is lending you a car for the weekend worth? If being called a name cost one chip, how many would being kicked out of your group cost?

Costs / Payoffs

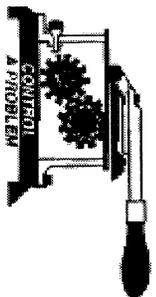
Happening

	NOW <i>right this minute</i>	LATER <i>today or tomorrow</i>	MUCH LATER <i>next week, month, year, 5 years, 10 years</i>
 C O S T S			
 P A Y O F F S			

Cost/Payoff work You are likely to find that delinquent youths make very harsh predictions about outcomes for the distant future, at least about made-up situations involving others besides themselves. This shows a basic understanding of right and wrong and of respect for the law. It is also a sign of these youths' lack of understanding of the principles

of equity and fairness, that the severity of punishment should have a relationship to the severity of wrongdoing. This thinking is typical of very young children. Their expectations for long-term payoffs may also be concrete and naive. They seem to have had too few opportunities to gain these cognitive developmental skills naturally as they grew up.

Problem Solving with Thinking Skills



Getting a problem under control . . .

Name the problem:

Ask: "What do I want that I don't have now?"

Think: "If I want something, I have to do something." Consider the possibilities:

-
-
-
-
-
-
-

Circle a choice. Predict its consequences . . .

	NOW <i>right this minute</i>	LATER <i>today or tomorrow</i>	MUCH LATER <i>next week, month, year . . .</i>
C O S T			
P A Y O F F			

So, is it likely to make things better? Yes ___ No ___ Is it honorable? Yes ___ No ___ Safe? Yes ___ No ___
If I did my choice, what's the worst that could happen?

How likely: how many chances out of 100 that the worst that could happen would happen? _____ /100
What would I do then?

What's the best that could happen? How likely?

So, is it worth a try? Yes ___ I'll make a plan and do it. No ___ I'll make a choice with longer, stronger payoff

Problem Solving with Thinking Skills¹

This worksheet is a tool for teaching a thinking process for solving problems. Pose made-up problems or deal with real ones and go through these steps with individuals or small groups of youths. Your goal will be to plant these routines and phrases in their minds for their own use later on. That takes repetition and practice using the same cues in many situations—not just in group or counseling time, but also throughout the day.

Name the problem. Instead of just being riled up and dissatisfied with how things are, the youth needs to find exact words for the problem. That will help him or her think because remember, "*Thoughts are just what we say to ourselves.*"

Ask: What do I want that I don't have now? This is the most concrete way to describe a problem, and it makes it very clear what the goal of problem solving is—a later bedtime, a better relationship, reassurance that Dad still cares for me, greater popularity.

Think: If I want something, I have to do something. This is an important reminder that problems don't solve themselves. If the problem isn't something you can do something about, maybe it isn't a problem but just a complaint. Doing something can include asking for help from others. Doing something requires a plan,

Consider the possibilities. This is where the need for **Alternative Thinking** comes in. There are 12 dots on the sheet—challenge youths to fill in a different action for each one. If they are stuck, you come up with a silly one just to jar their thinking loose. *Want to avoid summer school? Call the FBI and say you're joining a terrorist cell instead.*

Circle a choice. Predict its consequences. Here you have a chance to practice more than one skill, both **Consequential Thinking** and **Means-End Thinking**, as you predict what the long-range outcome of a decision will be weeks, months or years from now. You may not agree with the youths' choice. Say at the outset

that you might need to try out two or three **Cost/Payoff** sheets to see which is really the best.

Next comes a set of questions.

So, Is it likely to make things better? . . . Is it honorable? . . . Safe? This trio of questions establishes three basic standards for judging the merits of a solution—effectiveness, fairness, and safety. Remind

new find this self-challenge very helpful. Fear of the vast, unlabeled unknown is much worse than fear of something specific and clearly imagined. Expect the question to be answered. Don't shy away from the answers, no matter how gruesome or unlikely they seem.

How likely: how many chances out of a hundred that the worst that could happen really would happen?

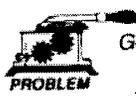
_____/100. Here is where you teach youths to think like their own personal scientists, calculating probability. As you do with the **SUDSmeter** activity, teach the youth to think proportionally instead in terms of all-or-nothing. Instead of scaring herself about some nameless, enormously awful thing, you help her pin "the worst" down to a named danger with a defined likelihood of happening or not.

What would I do then? Here is the third part of this powerful anxiety-reducer. **Planning what to do even if the worst that could happen did happen.** This is the step that people with severe anxiety disorders never get to. They stop at the point where they imagine the panic and horror of the *worst* that could happen. They never project their thinking far enough to plan what they could actually *do* in that case.

What's the best that could happen? . . . How likely? These questions provide a chance for reviewing the plan from a positive perspective.

So, is it worth a try? Yes ___ I'll make a plan and do it. No ___ I'll make a choice with longer, stronger payoffs. If you work through a poor choice first, the fact that it is likely to turn out badly will be clear as youths answer these questions. When a chosen solution seems likely to be successful, the next step it is to follow up right away with a step-by-step plan.

What about Perspective Taking? Throughout the activity, it is necessary to take the perspective of others. Doing a Cost/Payoff sheet, for instance, requires that the youth think of how others will react to his actions now, later, and much later. This would be a teachable moment: "*Why do you think your dad would act so mad when he heard that his son had cheated? What do you think he would be feeling?*"



Getting a problem under control . . .

Name the problem:

This guy at work has a sewer mouth . . .

Ask: "What do I want that I don't have now?"

I want to do my work and feel comfortable . . .

I want something, I have to do something. Consider the possibilities:

- tell the supervisor
- ignore it
- quit my job
- call the police
- tell him to cut to cut
- laugh at him
- file a complaint
- ask for a transfer
- threaten to file one
- get a few guys to
- bring a weapon to work
- make him stop

Circle a choice. Predict its consequences . . .

	NOW	LATER	MUCH LATER
C O S T S	I'm still grossed out, mad I still feel my face get red.	He might like seeing me get mad. He could try harder, up the ante, act grosser.	He could get more determined, do it more. He could make contact after work.
P A Y O F F S	I avoid hassles. If he doesn't get any reaction, he might get bored.	He could just give up or go bother someone else.	He could get the picture, do his job, and stop acting like a jerk.

So, is it likely to make things better? ? Is it honorable? Y Safe? N

If I did my choice, what's the worst that could happen? He's weird. He could get mad about being ignored, come after me.

How likely: how many chances out of 100? 5/100

What would I do then? run & scream for help

What's the best that could happen? He'd leave me alone. How likely? 25/100

So, is it worth a try? No. Too little chance that he'll really stop.

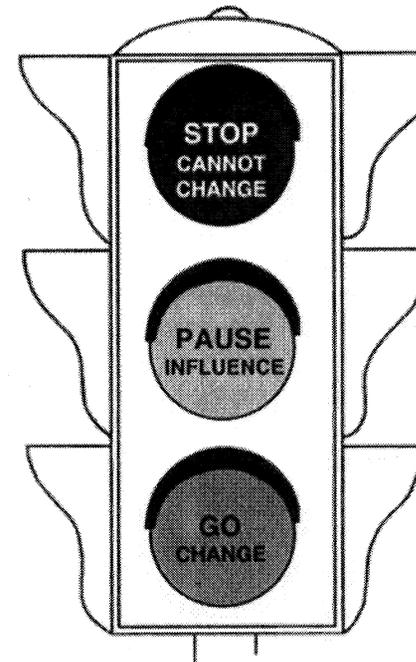
Yes ___ I'll make a plan and do it. No X I'll make a choice with stronger payoffs -- I'll file a complaint.

youths that safe can mean emotional and legal safety as well as physical safety. Talk about what is fair and honorable. **If I did my choice, what's the worst that could happen?** This is a very useful question to get youths to ask themselves often. People who are anxious or fearful about taking a risk by trying to do something

Power Lights¹—an activity to change feelings of hopelessness

Think of a traffic light as a **power light** that tells you when you can use your personal power:

- **RED LIGHT — “STOP” — NO POWER**
There are some things we have **no** power over. They are the **givens**.
- **YELLOW LIGHT — “PAUSE & PLAN” — SOME POWER**
There are some things we have to pause and plan to make happen. We do not have direct authority over them, but we can **influence** how they’ll turn out.
- **GREEN LIGHT — “GO” — COMPLETE POWER**
There are some things we have **complete** power over. We **decide** what’s to happen, then we go ahead and do it.



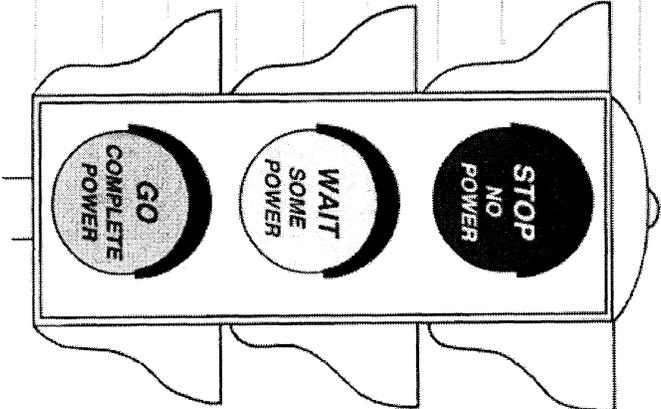
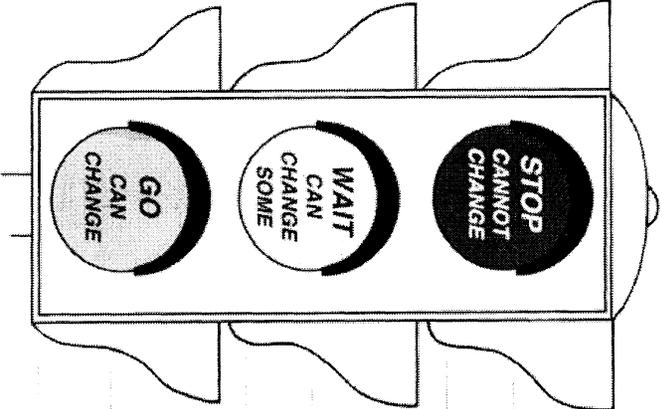
Teach the Power Lights to resolve the conflict between adolescents’ need for power on the one hand and feelings of powerlessness on the other. Many young people feel there is no way that things will ever change for them. **Working on ideas of what one does have the power to change now and in the future is a good antidote for hopelessness.** Recognizing what one simply cannot change and has to accept is a good reality check. This is a good activity to do with a group. Have each youth make his or her own list of red light, green light, and yellow light things about himself. Then share them next to a big stoplight drawn on a black-or-white board. Expect a lively discussion!

The most useful discussions of all are talks about the yellow light, what one can influence or change at least a little bit. You say, *“No one has absolute power to change what somebody else thinks or believes. No one can make somebody else change. But people have great power to influence what other people think and do and how things turn out. How do they do it? Adults at school, the police, and staff in this Shel-*

ter/Detention Center have more of one kind of influence than you do—the power of the law. In what other ways can adults influence kids to do or not do things? What adult has the most influence over you? Why? Do family members have special influence? How about teenagers—how do they influence others their own age? Their families? Authority figures? What do they say and do?

“You can plan to accept the red-lights in your life that you have no power to change; change the green-lights that you can easily change by deciding to and just doing it; and figure out what it will take to influence the yellow-lights. It takes making a plan. Sometimes you will have to stop, and the light will stay red for a long time. But sometimes you will find that planning and influencing is easier than you think. Lights do turn green eventually!”

Hang a poster of a Power Light somewhere in your place—it’s a good reminder about truth, hope, and plans to make your future the way you want it to be.

Topic	Power Lights
I have no power over . . .	
I have some power over . . .	
I have complete power to control . . .	
Topic	
I have no power over . . .	
I can influence . . .	
I have personal power to control . . .	

Each youth personalizes his or her own Power Lights

If you can, teach the basic Power Lights¹ ideas to several young people at a time. It's good to get a discussion going. When someone is off-track, asking the group if anyone has another idea. That's a more encouraging response than making a correction. When you are reasonably certain that the basic ideas are clear, have each youth use

this form to make his or her own Power Lights statements. These ideas are important, so talk them over with all young person you work with. If there are things you think they could change and should, make suggestions. If they list things as changeable that are good ideas, help them make step-by-step plans to follow through.

Cool-Downs—teaching control of anger outbursts

MAKING A COOL-DOWN PLAN¹

When do you need a Cool-Down?

- When you are: Arguing? Feeling threatened? Starting to think about pushing or hitting peers or staff? At other irritating or dangerous feeling moments?
- You may recognize when you need a Cool-Down, but sometimes you may not. Staff may have to let you know it's time to move away from the group before there is trouble.
- Go to the nearest Cool-Down area right away. Most of our cool-down areas are clearly marked. A staff person might remind you where the nearest one is.

Remember—this is not a punishment.

You may not want to talk to staff about the problem, and that is OK. Just say in a quiet voice, *"I need a Cool-Down. I don't want to talk about it now,"* and go quietly.

While you are taking your Cool-Down,

Soothe yourself:

- If you have learned conscious relaxation or want to relax your body using the tense-relax method, use your Cool-Down for a relaxation break.
- Take some cleansing breaths. Try closing your eyes while you breathe. Breathe in through your nose, out through your mouth.

- Think about a place that you dream of as being calm and safe. Focus on how it makes you feel to think about being there.

Distract yourself:

- If you like math, try counting as high as you can, or counting by prime numbers. Do the times-table in your head.
- Like puzzles? List countries or cities that begin with a certain letter of the alphabet.
- Think about your favorite video game or movie or TV show. Try to remember the words to a favorite song.

Practice Staying Cool:

- Think about what you are going to do when you leave the Cool-Down. Think about an activity you are looking forward to later. Imagine yourself doing it.
- When you think you are ready to rejoin the group, alert a staff person. S/he will help you check your progress and see if you are ready. If the staff person thinks you need a little more time, just say *OK* and wait a while. Following directions and sitting quietly will show that you are right. You can set a time to talk about it later. That way, you won't miss any more of the activity and you will have still more time to cool off.

Later on the same day.

A Conversation about the Cool-Down later

- The staff person says, *"Good for you for using a Cool-Down and avoiding trouble(or fighting, loss of privileges, whatever else.) You're learning the value of cooling down on your own. Cooling down emotional heat puts you in charge, not somebody else who knows s/he can get you riled up. You'll be the one to keep a job, keep your friends, and make a success of your life."*
 - Is there unfinished business that needs to be cleared up from the problem that triggered your need for the Cool-Down? The old saying, "Never let the sun go down upon your wrath" is good advice. Take care of any apologies or negotiations that need making before you sleep so problems don't have time to grow bigger!
- Think about your triggers—be ready:**
- The more you think about getting ready to cool down about the things that really make you hot, the less upset they will make you. Instead of thinking "Things are so terrible that I can't stand it," you will think, "Things are pretty bad, but I know I can cool down and deal with them."

This page is designed to help staff members teach youths how to use Cool-Downs. That is important, because **the Cool-Down is very helpful as a positive alternative to Time-Out or Seclusion for disruptive behavior.** It also teaches essential first steps of self-control and anger management. At first, it requires *staff's* alertness to trouble *before* it begins while the youth can still exercise choice and self control. By having the youths who use it make out Cool-Down plans for themselves (*see the next page*), **we transfer that alertness to them so that they can ask for Cool-Downs on their own.**

Teaching a youth to take a Cool-Down is a first step along the way to teaching full anger control. Anger-control training assumes that both actors stay in the scene until it ends peacefully without a blowup. Here, we are teaching the angry youth to withdraw from the scene and resolve the problem later. A staff member will need to help plan or oversee the resolution by apology or negotiation later. In Shelter and Detention Settings, group management is the norm, and the **Cool-Down is useful to remove a potentially upset or disruptive youth. Staff follow-up of the incident is crucial.**

* A feedback form such as this will structure the conversation between a youth who has used a Cool-Down and the staff member who makes it into a true anger control lesson later.

* They need to work on it together—the youth will need help thinking through most of the answers, and it will be enough for him or her to talk while we write brief notes.

* Most of these questions make up a plan — how the youth will apply what s/he learned from today's Cool-Down to use the next time something upsetting happens.

* At the very end, the youth gives today's effort a rating. The completed form is a good thing to keep as an ongoing reference.

* On the back of the form, we write down a short list of the plans for “whatever work or apologies” are to be done.

Cool-Down Plan & Self-Rating

When _____
_____ happens

I start to feel _____
feeling word *description*

In the past, when I felt that way, I _____
action that led to trouble

That led to trouble _____
what kind of trouble?

Now, before I risk that, I will go _____ and
where?

take a Cool-Down for _____
for about how long?

While I am there, I will use these strategies to help myself cool down:

- Soothing myself _____
how?
- Distracting myself _____
by what?
- Telling myself “ _____
self-talk thoughts

When I have cooled down enough to go back, I congratulate myself for having used my personal power to avoid trouble. I'll make up whatever work or apologies I owe for the time I was gone before the end of the day.

Today, ____/____/____, I give myself — ____ out of 10 for the Cool-Down I took. *date*

signature

* It is important to have youths understand that they will have to make up the time they spend in Cool-Downs if it is time removed from class, work chores, or any scheduled activity with a designated program.

* Occasionally, this becomes a tricky issue when a youth declares the needs for Cool-Downs only during an activity s/he especially dislikes. To deal with it, we run the risk of making the whole Cool-Down process more and more punitive.

* A youth's taking too many Cool-Downs needs to lead to a conference between him or her, the staff person primarily involved with the youth, and other concerned adults to work out a reasonable plan for both cooling anger and meeting responsibilities.

*** Special recognition should be given to reluctant users who use Cool-Downs 1) more and more often to replace anger outbursts; and to over-users who use them 2) less and less often and still do not have unmanageable anger outbursts.**

*** Different strokes for different folks! It's what individualized planning is all about.**

Relaxation training¹

Teaching people to relax when they choose to helps for two reasons:

- 1) So that as they learn to tense their muscles, they grow to recognize the feelings of tension and use them as a cue to relax;
- 2) So that as they relax their muscles, they learn to let tension flow out of their minds as it flows out of their bodies.

A full relaxation session takes between 15 and 20 minutes. Young people sit in straight-backed chairs with their feet flat on the floor and hands on their thighs. The room needs to be quiet with lights turned low. Explain that you will be the coach, giving relaxation directions and moving around to lay a hand on a shoulder if a youth needs a reminder to still a body part that is tense or moving.

Start the session by having everyone take a **Calming Breath**. (See the *Stress Management* page.) Then ask the trainees to shut their eyes and begin. The script will suggest changes in voice volume for variety.

You are going to learn how to relax your muscles deeply by first tensing them. I want you to listen to what I tell you to do. There will be times when you will actually be doing what I am describing to you. (Moderate voice tone.)

Ready . . . I want you to take both of your hands and make a fist. (Moderate voice tone.)

Hold those fists tight, tighter, tighter. . . (Strong voice tone.)

That's good. Now let those fists go and relax. (Soft voice tone.)

Let your fingers open up and your fingers straighten out naturally . . . nice.

(Moderate voice tone.)

REPEAT hand-tightening script again.

You are ready to go on. Now I want you to turn your focus to your feet. Point the toes on both feet, tensing your foot and leg muscles.

(Moderate voice tone.)

Tense those muscles tight, tighter, tighter. . .

(Strong voice tone.)

That's good. Now let those foot and leg muscles go, let them relax. (Soft voice tone.)

Allow the warm feeling of relaxation to flow into your legs and feet. (Moderate voice tone.)

REPEAT the feet and leg tightening script again.

Now focus your attention on your chest and stomach area. Relax while I explain what you are going to do to your chest and stomach areas in order to tense them. You will take a deep breath, sucking in your stomach at the same time. In your mind, visualize your stomach

being sucked toward your backbone. At the same time, your chest will rise higher and higher. OK, ready to practice? (Moderate voice tone.)

Take a deep breath, tensing your chest and stomach tighter and tighter.

(Moderate voice tone.)

Hold your breath, pulling your stomach in toward your back, let your chest rise higher and higher.

(Strong voice tone.)

Relax and let your breath out; let the tension flow from your stomach and chest. (Soft voice tone.)

REPEAT the stomach and chest script again.

Turn your attention to your shoulders and neck.

Just listen to my voice as I describe to you what I am going to have you do. Remember, just listen.

When I cue you, I want you to raise your shoulders up as high as you can. Try to touch your shoulders to your ears. Then you will relax and let your shoulders fall. (Moderate voice tone.)

Ready, raise you shoulders up to your ears. Higher and higher, hold it. Feel the tension.

(Strong voice tone.)

Now relax, let your shoulders fall, feel the warm relaxation flow into your shoulders and neck.

(Soft voice tone.)

REPEAT the shoulder and neck script again.

Listen to my voice as I describe to you the last exercise we will do. When I tell you to, I want you to press your tongue up against the roof of your mouth as hard as you can. Then I will ask you to relax and let your tongue go back to its natural position." (Moderate voice tone.)

Ready, press your tongue up against the roof of your mouth. Press harder and harder. Feel the tension in your mouth and throat."

(Strong voice tone.)

Now relax, let your tongue fall gently back to its natural position. (Soft voice tone.)

REPEAT the mouth script again.

You have tensed and relaxed all of your body. (Moderate voice tone.)

Take a moment, and in your mind's eye scan your body for any pockets of tension that may remain there.. (Soft voice tone.)

We will take one last calming breath and exhale that tension away. Ready? (Moderate voice tone.)

Breathe in. Gather all last remaining signs of tension. (Strong voice tone.)

Now exhale, letting all remaining tension flow out with your breath. . . Good. (Moderate voice tone.)

Feel that relaxation flow through your body from the top of your head to the ends of your toes.

Take a moment and enjoy the wonderful feeling relaxation gives you.

(Soft voice tone, pausing for a moment.)

I want you to remember what we have practiced today. Any time you become tense, you will now notice that tension. Remember how it feels to tighten those muscles. Then relax them and feel the tension drain away. Take a calming breath. Any time you start to feel tense, angry, or scared, breathe deeply and relax. You will be calm, in control, and able to think clearly.

It is ideal if relaxation sessions can be scheduled daily. If that isn't possible, weekly sessions may still be valuable. New clients will need coaching; accomplished relaxers can listen to a relaxation tape or CD with just monitoring. Schedule sessions for a time when the soothing, settling effects of relaxation will help you manage your environment. But be aware that truly wound-up kids don't relax easily or instantly!

Extra supports for youths with Autism or Asperger's Disorders

- **Youths with autism spectrum disorders need special help when experience stress.**¹ Stress may cause them to become suddenly aggressive or self-abusive, to have temper tantrums, or to soothe themselves with unusual self-stimulatory behaviors such as rocking or odd gestures. Teach the Calming Breathe and the Cool-Down. Remove the youth from the action to a quiet place.

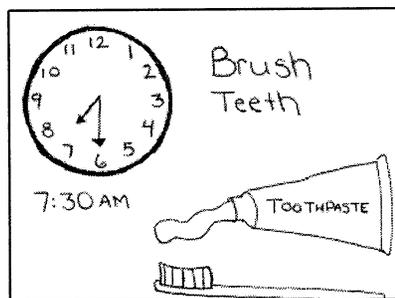
- **Always model positive social behaviors**—youths on the autism spectrum do not understand others' needs very well, but you can show them how to act by direct modeling.

- **When talking, use hand signals to emphasize your directions:** "Stop—" (hand up, palm facing forward). "It's Tom's turn to pick out a magazine. "It will be your turn next." (Keep hand up until Tom has picked. Then beckon.)

- **Youths with these disorders do not like to give direct eye contact.**² Do not force them to look you straight in the eye, but only request that they look in your direction.

- **Give the youth a one-step direction and ask that it be repeated** back to you. If the youth cannot tell you what needs to be done, repeat your direction. For youths with very limited or no verbal skills, you may have to act out what you want them to do, (brush teeth for example).

- **For youths who can read, simple schedules will help** them feel comfortable about what comes next. Cutting pictures out of magazines or drawing simple ones on cards can help make a schedule easy to follow. Add clock faces or digital-type numbers if they understand time.



Youths with normal or high intelligence are rigid about rules³ and schedules just as lower functioning youths with Autism are. A written daily schedule helps, with any particular shifts in the normal routine carefully written in. Variations, such as there are on weekends and holidays, must be carefully explained and written out in advance—even a ten minute wait for an anticipated activity can cause a blow up. Here is an example of this type of schedule:

7:30-8:45 AM Morning Routine

- Shower and brush your teeth. Staff will come to your door and tell you when it is your turn.
- Return to your room and get dressed.
- Breakfast for your group is at 8:00. You are in Group A.
- Make your bed. Straighten your room.
- Morning Free Time. Staff will tell you when it is time to begin. Come to the Day Room. Choose a magazine or puzzle book. Look at it quietly.

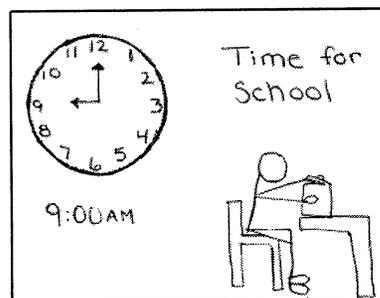
8:45 AM: School.

- Get your books and homework folder from your room. Do not bring anything else to school.

- Line up at the unit door for pick-up. ~~Tony will~~

~~take you to school.~~

Wed. Wait in the cottage. See Mr. K. in his office at 8:45. School at 9:05.



Extra Support for ADHD

Make individualized behavior plans to help the youth fit into the big picture.

Decide on one key behavior to target first.

When the youth is successful with that, you may want to add a second behavior. Tell the young person what is expected of her in order to receive a successful score: "Amy, the behavior you need to work on is following directions. This means that when staff asks you to do something, you start doing it right away. (Right away means before you could count six seconds in your head.) This will get you a "1" on your chart for that block. Here are some examples." (Write down an **example of exactly what the youth should do**. Make the non-example exactly like the kind of behavior that has been a problem.)

Example: Lon says, "Amy, pick up your tray and put it on the rack."

You say to the girl next to you, "Excuse me. I've got to put this tray on the rack. I'll be right back."

You pick up your tray and put it on the rack and return to talk with your friend.

Lon puts a "1" on your chart at the end of the lunch block.

Non-example: Lon says, "Amy, pick up your tray and put it on the rack."

You don't pay attention to him.

He gives the same direction again, loudly.

You say to Lon, "Can't you see I'm talking to somebody? I'll do it when we're done."

You go on talking and ignore Lon.

He puts a "0" on your chart after lunch.

Later that day: "Now let's practice that the right way a couple of times. I'll be me, and you be talking to Traci at the end of lunch. I go . . ."

Make the card small enough to be folded into the youth's pocket. This will keep it from getting lost. Make sure to remind the youth to put it back in her pocket right away. **Tell her that she will only get one card each day and that a lost or unreadable card will not earn anything.** A blank square on the chart counts the same as a 0.

Decide what percentage of compliance you can expect the youth to achieve. Working on a high-rate, habitual behavior (a sneering voice tone when speaking with adults) needs to start at a lower daily expectation than low-rate behaviors (being late to meals), for instance.

ADHD Sample Behavior Point Plan

Behavior Plan for Amy Jones

Goal 1—starting to follow staff directions within 6 seconds of the first time they are given.

Goal 2—_____

"1" is a successful behavior for that time period.
"0" is an unsuccessful behavior for that time period.

Amy will be asked for the chart after each block by the staff member responsible for giving points. He or she will score the behavior 1 (successful) or 0 (not).

At the end of the day, if Amy has 1's in 90% of her squares for following directions right away,

And _____% of her squares for _____,

s/he will be able to earn her choice of soda out of the vending machine

For each day of this plan, a new chart will be started. An unreadable or stolen card will not earn any points.

Tell the youth how many 1's are needed.

"Amy, this is day one for the plan. Today you need to get 70% on your card for 'following directions right away' in order to earn a treat. That means you need 1's in 7 out of the 10 blocks today. So, if you earn seven 1's, you'll have earned your treat.

That will go up to eight in a few days and then to nine when you get really good at this." Youths may earn a small treat, (soda or snack) or a small privilege, (phone call, quiet time alone)—whatever is appropriate for your facility and your youth's preference.

The positive points should count toward the longer-range point goals for the levels plan or other behavior management system used in your facility. Earning these points may be the way the youth on a special plan earns the positive points on the overall plan. This is a way of breaking down more general goals such as Acceptable Behavior so that young people with particular behavioral challenges can achieve them. **Feedback is frequent and immediate**—ten times a day in this example, twice that many if staff members give the youth a smile and word of encouragement as record their ratings.

Behaviors that make good targets include:

- Pleasant Voice Tone
- Hands to self
- Hands in sight
- On time following schedule
- Follows directions
- Willing worker
- Walks away from trouble
- Shows tolerance of others
- Uses civil language

A sample behavior rating chart

Copied on both sides of an index card, this simple chart has room for two behavior goals over a 10-activity day.

Name/	1	2	3	4	5
"A" Behavior	Rating	Rating	Rating	Rating	Rating
	Initials	Initials	Initials	Initials	Initials
"B" Behavior	Rating	Rating	Rating	Rating	Rating
	Initials	Initials	Initials	Initials	Initials
Total "A" _____ %		Total "B" _____ %			

Work together with the school serving your facility to arrange behavior plans with similar formats. That way, School and Living Unit staff members collaborate to support youths' achieving the same goals. Count points from all parts of the day toward their overall levels plans or other behavior improvement plans.'

Readying the youth with ADHD for appearing in court— cue cards and practice

Alex was a 14 year-old youth with ADHD. He was brought to the Pine Center for a four-week evaluation prior to his court date. A judge would decide if he should be formally charged with assault. He lived with his mother and 9 year-old brother Michael. Alex had never before been arrested, although he had been in trouble at school and at home for fighting.

According to the police report, Alex had spun out of control that evening. He had recently acquired an old TV set and enjoyed having it in his room. The thing that would make it perfect, in his mind, would be to hook up the Playstation 2 to it so he could play video games in bed. He went to ask his mother who was in the living room reading to Michael. When he

asked her to let him move the game system into his room, **he said no**, because it belonged to both him and his brother and needed to stay in a shared space. **He began to argue, his voice rising in anger.** His mother would not back down and turned away to continue reading to Michael. **Alex began to scream obscenities. Then, without warning, he lunged at his mother, kicking, yelling, and pulling her hair.** When he saw out of the corner of his eye that his brother was trying to inch out of the room, he let go of his mother, **grabbed some of Michael's toys and threw them against the wall nearest the younger boy, screaming and swearing.** As Alex smashed toy after toy, his mother, alone in the house with the two boys, was able to slip out of the room and call the police.

During Alex's first days at Maplewood, Jim, one of the staff, was assigned to pay close attention to him. He saw that although **Alex had a hard time sitting still and following through with directions, he was eager to please and enjoyed playing basketball with Jim.** He preferred spending free time playing Horse and talking with him to activities with other boys.

Jim watched Alex's attempts to interact with peers, and he could see why he had trouble interacting with people his age. **Sometimes he blurted out critical or cruel comments. It seemed as though whatever popped into his head came out of his mouth.** This caused misunderstandings and hurt feelings, and the **other boys either stayed away from him or threatened him.** That made Alex feel lonely and confused. At times when he was playing Horse, he would wander away from the game when he finished his turn to see what else was going on. Annoyed peers would yell for him to go back to his own game. Sometimes, without warning, he darted into another group's game and snatched away their basketball, laughing as he ran. **When the others caught up to him, not sharing his idea of a joke, he would lash out verbally or start a fight.**

As Alex's court date came closer and closer, Jim realized that there was **good reason to worry that Alex might not make a good impression in court.** He and Alex spent time talking over what things could happen and how he needed to behave to show the judge that he could be a

responsible person. Before Jim sat down with Alex, he had read the pages on Attention Deficit/Hyperactivity Disorder and realized how **many of the characteristics that got Alex into trouble were due to his ADHD.** He was impulsive, had a hard time sitting still, and was very distractible. He was disinhibited, saying anything that popped into his head. Anger issues were a big problem; he was easily provoked into losing control. **Although Alex was now receiving medicine that would help, he needed to learn what to say and do in stressful situations. He had no social skills in influencing people but struck out, instead, like a very young child.** When he worked with Alex, Jim kept these things in mind.

Jim taught Alex how to **behave in ways that influence rather than aggravate other people.** Alex made cue cards on the computer as reminders of the most important things for court. He printed lots of copies and stuck them around his room and in his books and pockets to cue himself to use a survival skill instead of acting goofy or mad around other people. Alex learned a lot about ADHD and why it made things difficult for him. He did want to have friends and avoid trouble—he was motivated to try.

To get ready for his court date, Alex taped four of his cue cards to one sheet of paper so he wouldn't fiddle with a handful of index cards when he took it to court.

THINGS-TO-DO
 Apologize
 Sit still
 Use a pleasant tone of voice
Stop and think before speaking.

THINGS-NOT-TO SAY
"It was someone else's fault."
"No, I can't do that."
"Nobody can make me."
No swearing, no dirty words.

PLEDGES TO MAKE & KEEP
"I'm sorry for hurting my mom and wrecking my brother's stuff."
"I want help learning to control my temper."
"I will stay in school and out of trouble."
"I want to fix the trouble I caused."

GET OTHERS TO WANT TO HELP
*"Bad opinion? Think it—
 but don't say it."*
*"Mad emotion? Feel it—
 but don't act on it."*
**Use personal power to
 INFLUENCE people instead.**

These cues were to remind Alex of what he must say and also of words he should definitely squelch. He could look at them to remind himself of what he wanted to tell the judge.

Jim taught Alex to practice these lines of self-talk over and over again:

"Think it—but don't say it."

It is the basic rule Alex needed to learn in order to stop turning people off with his negative comments. Its companion is:

"Feel it—but don't act it out."

That's what he needed to practice in order to put the brakes on his angry feelings so his temper did not explode. Alex also practiced other stress management techniques and things to say and do instead of blowing up.

After the cue sheet was ready, Jim and Alex practiced various scenarios.

Sometimes Judge Jim would say things Alex wanted to hear; sometimes he would say things that made him angry. When Alex was stuck or acting the wrong way for court, Jim would tap his finger lightly on the table to remind him to take a calming breath and check his sheet. After a time, Alex was able to remind himself to check the sheet before speaking. For a "final exam," Jim asked the school principal to play the judge. After many practice sessions, **Alex felt more self-confident. He had skills that would help him come across as someone who could safely go home to continue this progress.**

Teaching and coaching cognitive-behavioral skills can help youths who have ADHD. But it will not be helpful past this one occasion—unless someone continues to teach and coach. Fail-

ure to generalize newly learned strategies from one time and place to another is a special problem for youths with ADHD. See that someone is prepared and committed to continue your good work.

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Depression—Major Depressive Disorder (MDD) & other mood disorders

* **Depression and Bipolar Support Alliance:** <http://www.dbsalliance.org>

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Disorders of Extreme Stress, Depression, & Violence: Conduct Disorder plus Depression; Complex PTSD, or DESNOS

* **Department of Veterans Affairs National Center for PTSD:** <http://www.ncptsd.va.gov>

* **Gift From Within:** <http://www.giftfromwithin.org>

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- * Greene, A. (2003). Bed Wetting. *Dr. Greene: Caring for the next generation.* Retrieved in November, 2004, from http://www.drgreene.com/21_1082.html
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* See also reference for Conduct Disorder.

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PTSD—Posttraumatic Stress Disorder

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Psychotic Disorders

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Tourette's Disorder

- * **Tourette Syndrome Information and Support Site:** <http://www.tourettes-disorder.com>
- * **Tourette Spectrum Disorder Association:** <http://www.tourettesyndrome.org>
1. Soliman, E., (2005). **Tourette Syndrome.** In J. S. Berg, F. Talavera, E. Dunayevich, H. Harsch, and S. Soreff (Eds.) *eMedicine.* Retrieved in August, 2005, from <http://www.emedicine.com/med/topic3107.htm>
 2. **National Institute of Neurological Disorders and Stroke (2005). Tourette Syndrome Fact Sheet (2005).** Retrieved in April, 2005. from: http://www.ninds.nih.gov/disorders/tourette/detail_tourette.htm#32103231
 3. Coffey, B., Berlin, C. & Naarden, A. (n.d.) **Medications and Tourette's: Combined pharmacology and drug interactions.** Retrieved in April, 2005, from <http://www.tsa-usa.org> [✓ MEDICAL & TREATMENT, scroll down 12 titles.]

Section 3: Resource Section

Cool-Downs—Teaching control of anger outbursts

*1. Use this resource in conjunction with the first problem behavior pages, *Anger Outbursts*. The anger reduction techniques are described on the Stress Management page in this Resource Section.

Expressing feelings in words

*1. Nichols, P. □ (1999) *Clear thinking: Talking back to whispering shadows, a psychoeducational program for preteens, teens, & young adults*. Iowa City, IA: River Lights, p. 17. <http://www.riverlights.com> (The “I feel” list provides ideas for precise or expressive words for positive as well as negative emotions.)

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4. Tucker-Ladd, C. E. (1996-2000). “I” messages. In Chapter 13, Methods for developing skills, of *Psychological self-help*. Retrieved in February, 2006, from mentalhelp.net/psychhelp/chap13/chap13g.htm

Extra supports for youths with Autism or Asperger’s Disorders

* Samet, D. (2002). *Asperger’s Syndrome: Emotional and social implications*. Waltham, MA: University of Massachusetts Medical School. Retrieved as a mini-course in February, 2006 from The Aperger’s C-o-n-n-e-c-t-i-o-n at <http://www.ddleadership.org/aspergers/courses/esimplications/index.html>

(The references in this resource page are to one of the nine short chapters that make up this very readable and complete explanation of the behaviors typical of Asperger’s and Autism Disorders.)

1. Samet, D. (2002). *Op. cit.*, Lesson five: Additional characteristics sometimes present. Retrieved in February, 2006, from http://www.ddleadership.org/aspergers/courses/esimplications/additional_characteristics.html
2. Samet, D. (2002). *Op. cit.*, Lesson two: Impairment in social interaction. Retrieved in February, 2006, from http://www.ddleadership.org/aspergers/courses/esimplications/social_impairment.html
3. Samet, D. (2002). *Op. cit.*, Lesson four: Restricted and/or repetitive patterns of behavior, interest and activities Retrieved in February, 2006, from http://www.ddleadership.org/aspergers/courses/esimplications/behavior_patterns.html

Extra Supports for youths with ADHD

* CHADD: Children and Adults with Attention-Deficit/Hyperactivity Disorder—<http://www.chadd.org> (This support organization has over 20,000 members nationwide and has been a powerful voice advocating for persons with ADHD of all ages. If you have questions about the disorder, treatment, or legal issues related to it, look here first.)

Power Lights

*1. Nichols, P. □ (1999) *Clear thinking: Talking back to whispering shadows, a psychoeducational program for preteens, teens, & young adults*. Iowa City, IA: River Lights, Publishers.
Nichols, P., & Shaw, M. (1999). *Whispering shadows: Think clearly and claim your personal power*. Iowa City, IA: River Lights, Publishers. www.riverlights.com (Together, these comprise the Clear Thinking program.)

Problem Solving with Thinking Skills

*1. Nichols, P., & Shaw, M. (1999). *Op. cit.* (*Whispering Shadows* is the student worktext of the Clear Thinking program.)

Relaxation training

*1. Rudish, D. (2000) *Relaxation training. Handout from Circle of Courage School*. Iowa City, IA: Child & Adolescent Psychiatry Service, University of Iowa hospitals and Clinics.

2. American Psychological Association (2006). Problem solving program teaches kids to use their heads instead of their fists. *Psychology Matters*. Retrieved in February, 2006, from <http://www.psychologymatters.org/shure.html>
3. Whimby, A. with Whimby, L. S. (1975). *Intelligence can be taught*. New York: E. P. Dutton.

Stress management

*1. Nichols, P. □ (1999) *Op. cit.* (This is the teaching guide for the Clear Thinking program. Many of the cognitive-behavioral activities included in this Resource Section are from this program. They were developed through use with inpatients at the Child and Adolescent Psychiatry Service at the University of Iowa Hospitals & Clinics. The Clear Thinking program is used by therapists and educators in schools, clinics, and residential settings including corrections and shelter facilities.)

2. Wilson, R. (n.d.). Step 3: Breathe! *The Anxiety Site*. Retrieved in January, 2006, from www.healthplace.com/Communities/Anxiety/anxieties/7flying/step3.htm
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NOTE: References for SUDs appear below in this Reference Section.

SUDSmeter—Subjective Units of Distress Scale

*1. Wolpe, J. □ (1969) *The practice of behavior therapy*. Oxford: Pergamon Press. (This method of having people rate the degree of anxiety they experience is commonly used by clinicians and researchers. A drawing of a thermometer is commonly used, however, instead of a scale with a dial, pointer, and control.)

2. Nichols, P., & Shaw, M. (1999). *Op. cit.*, p. 49.

Teach Consequential Thinking

*1. Gardner, J. (2003). Interpersonal cognitive problem solving. *Cognitive behavior.com: The cognitive behavior management reference*. Retrieved in August, 2005., from <http://www.cognitivebehavior.com> [✓ Training; go to Practice; Interpersonal cognitive problem solving.] (This power point presentation is a good overview of Shure’s thinking skills and how to teach them to children and adolescents.)

2. Jones, V. F. (1980.) Teaching the adolescent with behavior problems: Strategies for teaching, counseling, and parent involvement. Boston: Allyn & Bacon. The Cost-Payoff chart and its uses are modifications of a counseling technique outlined by Jones.)

Thinking skills

*1. Spivak, M. S. & Shure, M. B. (1982). The cognition of social adjustment: Interpersonal cognitive problem-solving thinking. In B.B. Lahey & A.E. Kazdin (Eds.), *Advances in clinical child psychology* (pp. 323-372). New York: Plenum Press.

2. American Psychological Association (2006). Problem solving program teaches kids to use their heads instead of their fists. *Psychology Matters*. Retrieved in February, 2006, from <http://www.psychologymatters.org/shure.html>
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