

AFRICAN SCHOOL MENTAL HEALTH CURRICULUM

UNDERSTANDING MENTAL HEALTH AND MENTAL ILLNESS



**Guidance, Counselling &
Youth Development
Centre for Africa**



teen mental health
www.TeenMentalHealth.org



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Part 1 Introduction

March 2013

Thank you for acquiring a copy of the African School Mental Health Curriculum. This curriculum was first adapted from the Canadian Mental Health & High School Curriculum Guide (2012), courtesy of Teen Mental Health. The Teen Mental Health website has materials that can be used as support files and these can be accessed on:

<http://teenmentalhealth.org/curriculum/support-materials>

The username is: **resource_user**

The password is: **t33nh3alth**

Thank you for joining us as we continue to try new ways to connect with teachers and students.



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Background

About GCYDCA

The Guidance, Counselling and Youth Development Centre for Africa (GCYDCA) is a Regional Institution for Ministers of Education in Africa. Established in 1999 as a Diplomatic Mission, the GCYDCA was as a result of a key resolution made during the Pan African Conference which recognised the value and importance of Guidance and Counselling. The GCYDCA was established with the aim of building capacity of programme implementers and the youth in issues affecting boys and girls in Africa such as mental health problems, HIV & AIDS, adolescent sexual reproductive health, alcohol and drug abuse, communication and technology, enterprise education and youth leadership. The GCYDCA has 32 member countries from the French, English and Portuguese speaking countries across Africa. The French speaking countries are Mali, Burkina Faso, Burundi, Cameroon, Cote d'Ivoire, Guinea Conakry, Niger, Senegal, Chad and Rwanda. The English speaking countries are Botswana, Gambia, Ghana, Kenya, Lesotho, Malawi, Mauritius, South Africa, Namibia, Nigeria, Seychelles, Swaziland, Tanzania, Uganda, Sierra Leone, Zambia and Zimbabwe. Portuguese speaking countries are Mozambique, Angola, Guinea Bissau, Sao Tome & Principe, and Cape Verde.

Through its Mental Health Integrated Innovation Programme, the GCYDCA developed this Curriculum in order to promote the mental health of the youth in Africa and support the resilience and recovery of youth experiencing mental illness. The GCYDCA accomplishes this mission through advocacy, education, research and service.

Our Mental Health Integrated Innovation Programme focuses on combating mental health problems and emotional disorders. Our tools include research and information services, training workshops, advocacy meetings, youth peer mental health clubs, and promotional materials such as fliers.

Through its Mental Health Integrated Innovation Programme, the GCYDCA acts as a social advocate to encourage public action and commitment to strengthening school and community mental health services and policies affecting services. This programme is based on the principles of empowerment, peer support, community support, and youth participation and involvement.

GCYDCA
P.O. Box 30058
Lilongwe 3 - Malawi

Tel: (+265) 1 713 181/2
Fax: (+265) 1 759 024
www.gcydca.com

Educating young people about mental health and mental illness

Having access to reliable information on positive mental health and mental illness is crucial for both in-school youth for a number of reasons. Mental and emotional problems are common among in-school youth and need to be addressed, just like students' physical health problems.

Even if students have not experienced mental illness, it is very likely that they know someone who has. Consider the following statistics to get an idea of just how widespread the effects of mental illness are in society, among young people in particular.

- 1) Mental illness is second only to heart disease as the leading cause of disability worldwide (Global Burden of Disease – World Health Organization, World Bank, Harvard University, 1990).
- 2) Mental health problems affect one in every five young people worldwide.
- 3) Mental disorders are the single largest health problem affecting young people globally, and nationally.
- 4) The first symptoms of severe, chronic forms of mental illness (such as schizophrenia, bipolar disorder, Depression and anxiety disorders) generally appear between the ages of 15 and 24 (Canadian Mental Health Association, 2003).
- 5) An estimated 2/3 of all young people with mental health problems are not receiving the help they need.
- 6) At least 90% of young people aged 15-24 who commit suicide have a diagnosable mental illness. Learning about mental illness and the importance of seeking treatment can serve lives.
- 7) Fear of stigma and the resulting discrimination discourages individuals and their families from getting the help they need (Canadian Mental Health Association, 2012).

The role of schools

Schools provide an ideal environment and natural opportunities to address issues of mental health and illness. Schools are well positioned to be at the vanguard of public health strategies designed to prevent and detect mental health disorders among young people. Educators can play an important role by delivering accurate, comprehensive information and by challenging the stereotypes about mental illness held by the general community.

The **African School Mental Health Curriculum** programme encourages schools to actively promote the message that seeking help is a sensible and supportive act rather than a sign of weakness. Therefore, in addition to providing information and education about mental health and mental illness, this material actively promotes discussion about when, how and where to seek help.

Brief History of the African Mental Health Curriculum and the Mental Health Integrated Innovation

In 2012, with funding from the Grand Challenges, Canada, we developed tools for students, their teachers and community-based youth peer mental health clubs to help them deal with mental health problems in schools and communities, under the leadership of the lead Knowledge Consultant, Prof. Dixie Maluwa-Banda (Malawi) and with continued leadership support from Dr. Stan Kutcher (Teen Mental Health, Canada). We also benefited quite a lot from the professional eye of our implementing partners in the Mental Health programme namely Farm Radio International and Farm Radio Malawi. This Curriculum is a result of all these efforts.

It has been a privilege for me, as the Executive Director for the GCYDCA to see the completion of this African School Mental Health Curriculum Guide. I hope the Curriculum will make a difference for students, teachers, parents and community as a whole across the countries where the Curriculum will be implemented.

My sincere thanks should go to the following GCYDCA staff who invested much of their energy to the success of the material development phase of the programme.

Prof. Kenneth Hamwaka, PhD, FCASSON, FG&C
Executive Director, GCYDCA

Introduction

Part 1

V

This Curriculum Guide has been developed to accompany other resources namely; Peer Mental Health Facilitator Guide and the Training Manual for Peer Mental Health Education in African Schools and Communities.

The African School Mental Health Curriculum Guide

This section provides general information on the Curriculum Guide and ways that it can be used in the classroom. You will find specific suggestions in the instructions provided with each module.

The **African School Mental Health Curriculum** materials have been developed in recognition of the need to address the mental health of young people in Africa by providing teacher and student-friendly classroom-based resources.

The tools in this package (including the Curriculum Guide, PowerPoint presentations and videos) are designed to help teachers and other members of staff to:

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

By using the activities in the Curriculum Guide, teachers and students will explore the language of mental health and mental illness and learn about the causes, symptoms and approaches for dealing with different mental illnesses such as mood, anxiety, eating and psychotic disorders. Through the audiovisual materials, students will hear directly from other young people about their experiences with mental illness and the impact of stigma on their personal struggles and at the community and societal level.

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

Why use the guide?

Stigma, fear and lack of information about mental health problems have been identified as reasons why mental health and mental illness have not been adequately addressed in many schools. The **African School Mental Health Curriculum** materials have been developed to help overcome some of these barriers. By providing accurate, peer reviewed information on mental health and mental illness, and a range of interactive activities, the Curriculum Guide can help teachers deliver crucial information in a way that encourages and challenges the youth.

Many of the curriculum guidelines in Health and Physical Education for schools in Africa contain explicit requirements for mental health education. The **African School Mental Health Curriculum** Guide provides teachers with a user and student-friendly way of meeting the learning outcomes and curriculum requirements.

Learning Outcomes:

The **African School Mental Health Curriculum** Guide has several learning outcomes:

- To provide school staff across Africa with consistent, reliable and easy-to-use information to help promote the basic understanding of mental health and mental illness in the classroom
- To provide students with a basic introduction to normal brain functioning to help them better understand mental health and mental illness
- To help students understand the various factors that can contribute to mental illness, and the biological component which makes mental illnesses not that different from other illnesses
- To equip youths with the knowledge they need in order to identify when they, a friend, or family member is experiencing mental health problems or mental illness
- To reduce the stigma associated with mental illness by providing clear, factual information about mental illness its causes, ways to address it and recovery
- To help young people understand that seeking help for mental health problems is very important, and to suggest strategies for seeking help
- To reinforce the importance of positive mental health and effective ways of coping with stress
- To provide information about recovery from mental illness and the factors which help keep people well.

Part 1

Where does the material fit into the school curriculum?

Each country in Africa has its distinct curriculum framework, including specific subjects, content standards and learning expectations. This Curriculum Guide however, has been designed to be general enough to meet many of the different criteria for Health and Physical Education subjects in all countries across Africa. This guide is designed for use in schools in Africa. Although the material is intended for use in Health and Physical Education for the senior primary school section and secondary level, it may also fit well with a number of other learning areas across the curriculum, including: Biology, Social Studies, Life Skills Education, and Home Economics. The material may also fit well in college and university courses such as Family and Community, Psychology and Sociology.

Educational approach

The **African School Mental Health Curriculum** Guide uses activities and other strategies which engage young people in their learning, and challenge them to explore the issues.

The modules in this Curriculum Guide are comprehensive, easy to implement and fun. The interactive teaching strategies used in the activities provide opportunities for building students' skills in participation, communication, relationship-building, teamwork, and critical thinking. Many of the activities in the modules are designed to be completed by teams of students working together.

The activities address a range of learning styles by incorporating both experiential and reflective elements, and using guided discussion to assist students to process and share new experiences and information.

The modules include print-based classroom activities and are designed to fit into 40 minutes of classroom time. Each module is written in the form of lesson plans that can easily be implemented by teachers without additional training.

Teacher tips are provided to highlight the sensitive aspects of certain modules, and offer suggestions about strategies that are designed to teach about mental health.

Teachers can integrate their assessment of students' learning through this resource with their assessment plan for the subject with which they are using this material.

Part 1

Implementing the curriculum guide

- 1) Before implementing the curriculum guide, it is strongly recommended that teachers review the teacher training unit and complete the self-test (self-test is also available online at teenmentalhealth.org/curriculum)
- 2) Before teaching the modules, students should be given the students' questionnaire which will be given after the modules are taught as a sort of pre and post-test evaluation.

The six modules are designed to stand alone or to be taught in sequence so that students progress from: 1) understanding mental health and mental illness, to 2) the stigma and discrimination of mental illness, to 3) information on specific mental illnesses, to 4) a real life look at young people's experiences of mental illness, to 5) the importance of services and ongoing support for those living with mental illness, to 6) the importance of positive mental health, to 7) counselling treatment for Depression and mental illness.

Module	Major Concepts
Module 1: Understanding Mental Health and Mental illness	<ul style="list-style-type: none">• Everyone has mental health regardless of whether or not they have mental illness• The brain controls our feelings, thoughts and behaviours• A mental illness is a health condition that changes a person's thinking, feelings or behaviour (or all three) and that causes that person distress and difficulty in functioning• Mental illnesses have complex causes that include a biological basis and are therefore not that different from other illnesses or diseases. As with all serious illnesses, the sooner people get help and effective treatment for mental illness, the better their long and short term outcomes
Module 2: The stigma and discrimination of mental illness	<ul style="list-style-type: none">• Stigma acts as a barrier to people seeking help for mental health concerns• Learning the facts about mental illness can help dispel misconceptions and stigma• People's attitudes about mental illness can be positively influenced by exposure to accurate information• We all have a responsibility to fight the stigma and discrimination associated with mental illness
Module 3: Information on specific mental illnesses	<ul style="list-style-type: none">• Mental illness describes a range of mental and emotional conditions. The type, intensity, and duration of symptoms vary• The exact cause of mental disorders is not known, but most experts believe that a combination of factors – biological, psychological and social - are

	<p>involved</p> <ul style="list-style-type: none"> • Like illnesses that affect other parts of the body, mental illnesses are treatable and the sooner people get proper treatment and support, the better the outcomes
Module 4: Experiences of mental illness	<ul style="list-style-type: none"> • Mental illnesses are diseases that affect many aspects of a person's life • Mental illnesses are usually episodic. With appropriate support and treatment, most people can function effectively in everyday life • Getting help early increases the chances that a person will make a full recovery from mental illness • Mental illnesses, like physical illnesses, can be effectively treated
Module 5: Seeking help and finding support	<ul style="list-style-type: none"> • There are many ways of seeking help for mental health problems and mental illnesses, and resources are available within schools and within broader community • Knowing the signs and symptoms of mental illness helps people know how to distinguish the normal ups and downs of life from something more serious • Recovery from mental illness is possible when a range of support, beyond formal treatment, are available • Everyone has mental health that can be supported and promoted, regardless of whether or not they also have mental illness
Module 6: The importance of positive mental health	<ul style="list-style-type: none"> • Positive coping strategies can help everyone maintain and enhance their mental health
Module 7: Counselling treatment for Depression and mental illness	<ul style="list-style-type: none"> • A person with mental illness can be associated as a desperate person in search of one's needs, a sufferer in search of help or a patient in need of treatment • Counsellors should understand each individual client's world if they are to practice accurate empathy, positive regard and genuineness to clients. • Counselling helps people with mental illness to manage their problems, live more productively, and develop unused or underused opportunities more fully • A trusting and open relationship can facilitate sharing of important information necessary to identifying and solving problems that are interfering with the quality of life of a person who is in Depression or has a mental illness • Peer counselling is an affective support strategy for counselling the youth who are depressed or those with mental illness as it enhances empowerment in the youth and reinforces learning through on-going contact with peers who are in close proximity and those that are hard to reach • Dealing with your Depression can seem overwhelming at first but with the understanding and support of a good counsellor, you can overcome the feelings of helplessness and despair and once again gain control of your life • During counselling, identifying links that trigger Depression or finding positive motivators to encourage individuals is part of the process of moving through and out of the depression

Part 2 Teacher Training

Introduction

Mental disorders affect approximately 15-20 percent of youth worldwide and about 70% of these disorders begin prior to age 25 years. It is therefore likely that educators will be faced with having to deal with young people who are experiencing or living with mental illness. In order to assist educators in their work, the following unit was specifically developed to help inform educators about some of the common mental disorders found in young people. This unit is meant to be used in conjunction with the **African School Mental Health Curriculum** Guide for teachers to review or upgrade their knowledge about mental disorders. It can also be used as a resource for classroom if so desired.

Activities:

- Activity 1: Self-evaluation (before reviewing material)
- Activity 2: View PowerPoint presentation: Teacher Training
- Activity 3: Read Mental Health Training for Teachers Booklet
- Activity 4: Self-evaluation (after reviewing materials)
- Activity 5: Correction of self-evaluations and comparisons

Activity 1: Self-evaluation (before reviewing material)

1. Take the self-evaluation questionnaire (30 questions) and answer each question either true or false (note: make a copy of this quiz or write your answers elsewhere as you will do this quiz two times).
2. Put the questionnaire aside until you have finished reviewing the teacher training materials.

Activity 2: View PowerPoint presentation: Teacher Training

1. View the PowerPoint presentation as Supplementary Resources (96 slides in total)
2. Take as much or as little time you need or want.

Activity 3: Read Mental Health Training for Teachers Booklet

1. Read through the booklet which is designed to be used as a reference in the classroom. There is some overlapping material from the PowerPoint, but this is presented in an entirely different way.

Activity4: Self-evaluation (after reviewing materials)

1. Take the self-evaluation questionnaire (30 questions) again and answer each question either true or false. Do not look at your first questionnaire answers.

Activity 5: Correction of self-evaluations and comparisons

1. Use the answer key and correct your questionnaire
2. Compare the two results. Hopefully you did better in the second round.

Self-evaluation for teachers

Activity 1: Before reviewing material

Activity4: After reviewing materials

1. A phobia is an intense fear about something that might be harmful (such as height, snakes).
a. true b. false
2. Useful interventions for adolescent mental disorders include BOTH psychological and pharmacological treatment.
a. true b. false
3. Mental distress can occur in someone who has a mental disorder.
a. true b. false
4. Stigma against the mentally ill is uncommon in this country.
a. true b. false
5. Substance abuse is commonly found together with a mental disorder.
a. true b. false
6. The most common mental disorders in teenage girls are eating disorders.
a. true b. false
7. The stresses of being a teenager are a major factor leading to adolescent suicide.
a. true b. false
8. Three of the strongest risk factors for teen suicide are: romantic breakup, conflict with parents, and school failure.
a. true b. false
9. Schizophrenia is a split personality.
a. true b. false
10. A depressed mood that lasts for a month or longer in a teenager is very common and should not be confused with a clinical Depression that may require professional help.
a. true b. false
11. Teen suicide rates have decreased over the last decade worldwide.
a. true b. false
12. Diet, exercise and establishing a regular sleep cycle are all effective treatments for many mental disorders in teenagers.
a. true b. false
13. Anorexia Nervosa is very common in teenage girls.
a. true b. false
14. Bipolar disorder is another form of manic depressive illness.
a. true b. false
15. Many clinical Depressions that develop in teenagers come 'out of the blue'.

- a. true b. false
16. Obsessions are thoughts that are unwanted and known not to be correct.
a. true b. false
17. Serotonin is a liver chemical that helps control appetite.
a. true b. false
18. Mental disorders may affect between 15-20 percent of the people worldwide.
a. true b. false
19. Most people with panic disorder do not get well with treatment.
a. true b. false
20. Depression affects about 2% of people worldwide.
a. true b. false
21. A psychiatrist is a medical doctor who specialises in treating people who have a mental illness.
a. true b. false
22. Attention Deficit Hyperactivity Disorder (ADHD) is equally common in boys and girls.
a. true b. false
23. A hallucination is defined as a sound that comes from nowhere.
a. true b. false
24. Panic disorder is a type of anxiety disorder.
a. true b. false
25. Medications called 'anti psychotics' are helpful to treat the symptoms of schizophrenia.
a. true b. false
26. A delusion is defined as seeing something that is not real.
a. true b. false
27. Lack of pleasure, hopelessness and fatigue can all be symptoms of a clinical Depression.
a. true b. false
28. Nobody with schizophrenia ever recovers.
a. true b. false
29. People with mania may experience strange feelings of grandiosity.
a. true b. false
30. Mental disorders are psychological problems caused by poor nutrition.
a. true b. false

Teacher self-evaluation answer key

- | | |
|-----------|-----------|
| 1. True | 16. True |
| 2. True | 17. False |
| 3. True | 18. True |
| 4. False | 19. False |
| 5. True | 20. False |
| 6. False | 21. True |
| 7. False | 22. False |
| 8. False | 23. False |
| 9. False | 24. True |
| 10. False | 25. True |
| 11. True | 26. False |
| 12. False | 27. True |
| 13. False | 28. False |
| 14. True | 29. True |
| 15. True | 30. False |

Mental Health Training

For teachers



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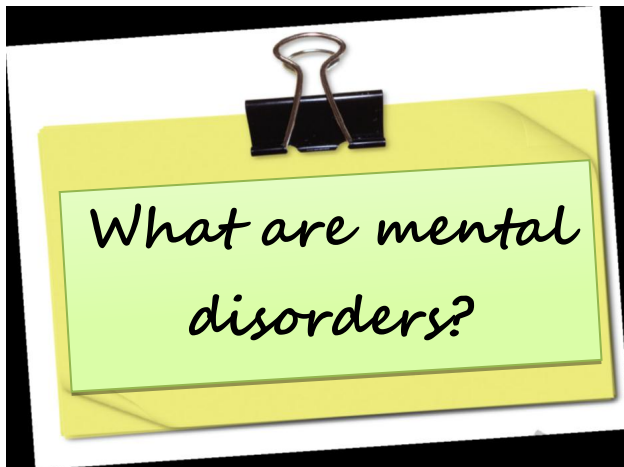
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Here's what we know about Mental Disorder

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

Mental Disorder behaviours are NOT:

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

How is the brain involved?

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

WHAT HAPPENS INSIDE THE BRAIN WHEN IT GETS SICK?

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

HOW DOES THE BRAIN SHOW IT'S NOT WORKING WELL?

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

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



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

BUT

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

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

Distress:
Common; caused by problem or event;
usually not severe (may be severe);
usually short lasting; professional help
not usually needed; [professional help can
be useful -
DIAGNOSIS NOT NEEDED

VS.

Disorders:
Less common; May happen without
any stress; often with high severity
usually long lasting; professional help
usually needed - NEEDS TO BE
DIAGNOSED

What causes mental illness?

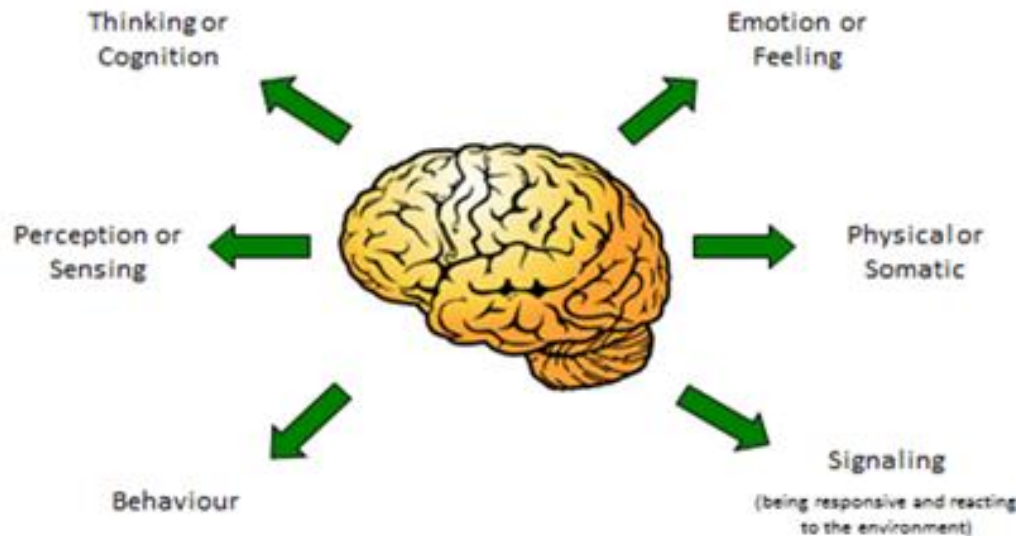
A variety of different insults to the brain can lead to mental illness. Basically there are two major causes that can be independent or can interact:

GENETICS (The effect of genes on brain function) and

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

Classification of Mental Disorders:

Functions of the Brain



Mental Disorder of thinking and Cognition: (Psychotic disorder)

WHAT ARE PSYCHOTIC DISORDERS?

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

Who is at risk for developing Schizophrenia?

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

What does Schizophrenia look like?

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

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

Thinking is disorganized in form and in content. For example, the pattern of speaking may not make sense to others or what is being said may not make sense or be an expression of delusional ideas.

Behavior can be disturbed. This can range from behaviour that is mildly socially inappropriate to very disruptive and even threatening behaviors that may be responses to hallucination or part of a delusion. Self-grooming and self-care may be also compromised.

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

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

What are the criteria for the diagnosis Schizophrenia?

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

What can I do if it is SCZ?

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

What do I need to watch out for?

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

may appear to be responding to internal voices. Rarely these delusions or hallucinations may be accompanied by unexpected violent acts.

Questions to ask

Can you tell me what you are concerned about? Do you feel comfortable in school (your class)? Are you having any problems thinking? Are you hearing or seeing that others may be hearing or seeing?

Mental Disorders of Emotion and Feeling; (Mood disorders)

There are two types of mood disorders which include unipolar mood disorders. Unipolar disorder is a major depression, whereas bipolar disorder is when a person experiences cycles of depression and mania.

DEPRESSION

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

What are the different types of Depression?

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

What do MDD and DD look like?

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



What is a depressive episode?

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

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



These symptoms are:

Mood:

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

Thinking:

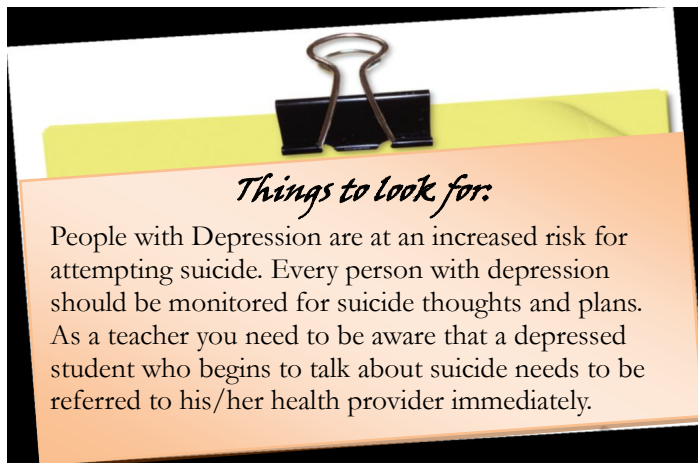
- Diminished ability to think or concentrate or substantial indecisiveness
- Suicidal thoughts/plans or preoccupation with death and dying

Body sensation:

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

Criteria:

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



Things to look for:

People with Depression are at an increased risk for attempting suicide. Every person with depression should be monitored for suicide thoughts and plans. As a teacher you need to be aware that a depressed student who begins to talk about suicide needs to be referred to his/her health provider immediately.

What can I do if it is Depression?

You can identify the disorder and counsel the person with the disorder (including the education of the person and family) if it is mild and if you are trained counseling. If the disorder is more intense or the person is suicidal you should immediately refer the person to the health professional best suited to treat depression. Ideally this should be done in collaboration and with the active support of the school guidance counselor or identified school based mental health provider. Once an intervention

occurs and the young person is back at school it is important that you be part of the ongoing treatment team and helps develop and address learning needs. You may also need to continue to provide realistic emotional support.

Questions to ask:

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

BOPOLAR DISORDER

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

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

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

Bipolar-what to look for:

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

Mental Disorder of signaling: (The Anxiety Disorders)

WHAT IS GENERALIZED ANXIETY DISORDER?

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

Who is at risk for developing GAD?

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

What does Generalized Anxiety Disorder look like?

Generalized Anxiety Disorder (GAD) is characterized by excessive anxiety and worry about many different things. The worry is out of proportion to the concern or event. This anxiety and worry must be noticeably greater than the usual socio-cultural norms. Youth with GAD often do not present with panic attacks as in panic disorder. Often they present with physical complaints such as headaches, fatigue, muscle aches and upset stomach. These symptoms tend to be chronic and young people may miss school or social activities because of these physical symptoms.

How do you Differentiate GAD from normal worrying?

Anxiety can be broken into four categories:

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

When does anxiety become a disorder?

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

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

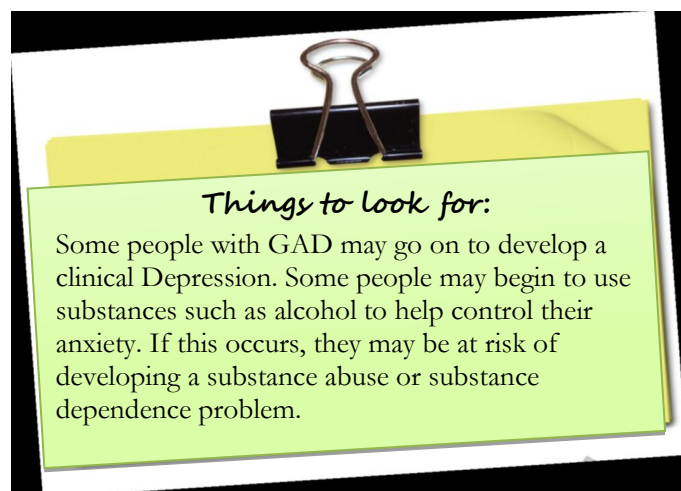
What are the criteria for the diagnosis of GAD?

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

What can I do if it is Generalized Anxiety Disorder?

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

Questions to ask?



Can you tell me about your worries? Do you or others see you as someone who worries much more than he/she should? Do you or others consider you to be someone who worries much more than most people do? Do you have trouble 'letting go of the worries'? do you sometimes feel sick with worry- in what way? What things that you enjoy doing or would like to do or made less enjoyable are avoided because of the worries? What if anything do you find makes the worries better- is this for a short or a long time?

SOCIAL PHOBIA

What is social phobia?

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

What does Social Phobia look like?

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

What are the criteria for diagnosis of Social Phobia?

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

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

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

What can I do if it is Social Phobia?

The first step is the identification of the problem. Often, people with Social Phobia will have suffered for many years without knowing the reasons for their difficulties. Sometimes just informing and educating them about the problem can be very helpful, particularly in mild cases. Treatment is not indicated unless the problem is causing significant functional impairment but counselling using

cognitive behavioral techniques and exposure to the anxiety provoking situation in the company of a counselor may help the person better deal with their difficulties. If the disorder is severe referral to an appropriate health care provider is indicated, and the counselor can provide ongoing support. A teacher may be able to assist in behavioral modification programs (such as getting used to a classroom situation). If you think a student may have social phobia it is important not to draw attention publically to their difficulties but speak with them in private about what you notice - be supportive.

What do I need to watch out for?

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

Questions to ask?

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

WHAT IS PANIC DISORDER?

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

Who is at risk for developing Panic Disorder?

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

What does Panic Disorder look like?

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

What are the components of a panic attack?

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

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

What are the criteria for panic Disorder?

Assessing panic disorder involves evaluating 5 areas:

1. Panic attacks
2. Anticipatory anxiety
3. Panic related phobia avoidance
4. Overall illness severity
5. Psychosocial disability

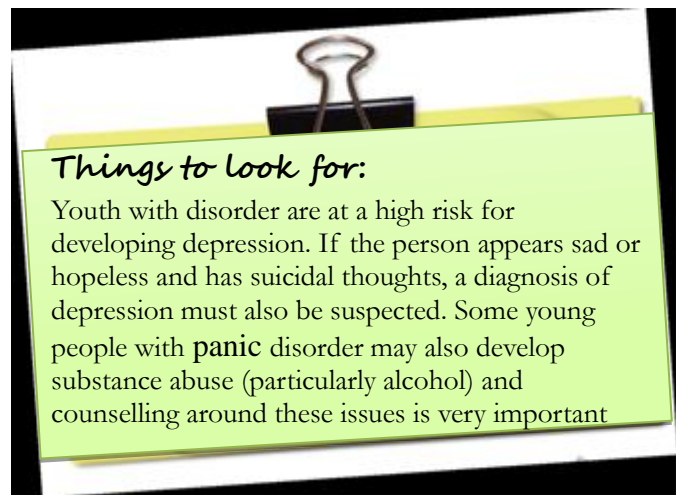
For diagnosis of panic disorder, a patient must have:

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

What can I do if it is Panic Disorder?

The first thing is to identify the panic attack and provide a calm and supportive environment until the attack passes. Education about panic attacks and panic disorder is often very helpful and should ideally be provided by a professional with good knowledge in this area. Counselling using cognitive behavioral methods may be of help and medications can be used as well. The teacher's role in help-

ing a young person suffering from a panic disorder can also involve assisting them in dealing with their anxieties about having another attack and also helping them with strategies to combat avoidance of social situations. Therefore it is a good idea for a teacher to be part of the treatment planning and treatment monitoring for a youth with panic disorders.



Questions to ask?

Can you describe in your own words what happens when you have one of these episodes (some people will refer to them as “spells”)? How many of these episodes have you had in the last week, in the last month? What do these episodes mean to you? What do these episodes stop you from doing that you would otherwise usually do? What do you do when these episodes occur? Do you ever feel that you would like to be dead or think that your problem is so great that you should kill yourself? How do your family, friends, loved ones, etc react to these episodes? What do they say is the problem?

OBSESSIVE COMPULSIVE DISORDER

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

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

Who is at risk for developing OCD?

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

What does OCD look like?

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

Obsession:

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

Compulsions

- Repetitive behaviours (such as checking washing, ordering) or mental acts such as counting, praying, repeating words silently) that a person feels driven to perform in response to an obsession or according to rigid rules.
- These behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation BUT are not realistically connected to the obsessions they are meant to neutralize.

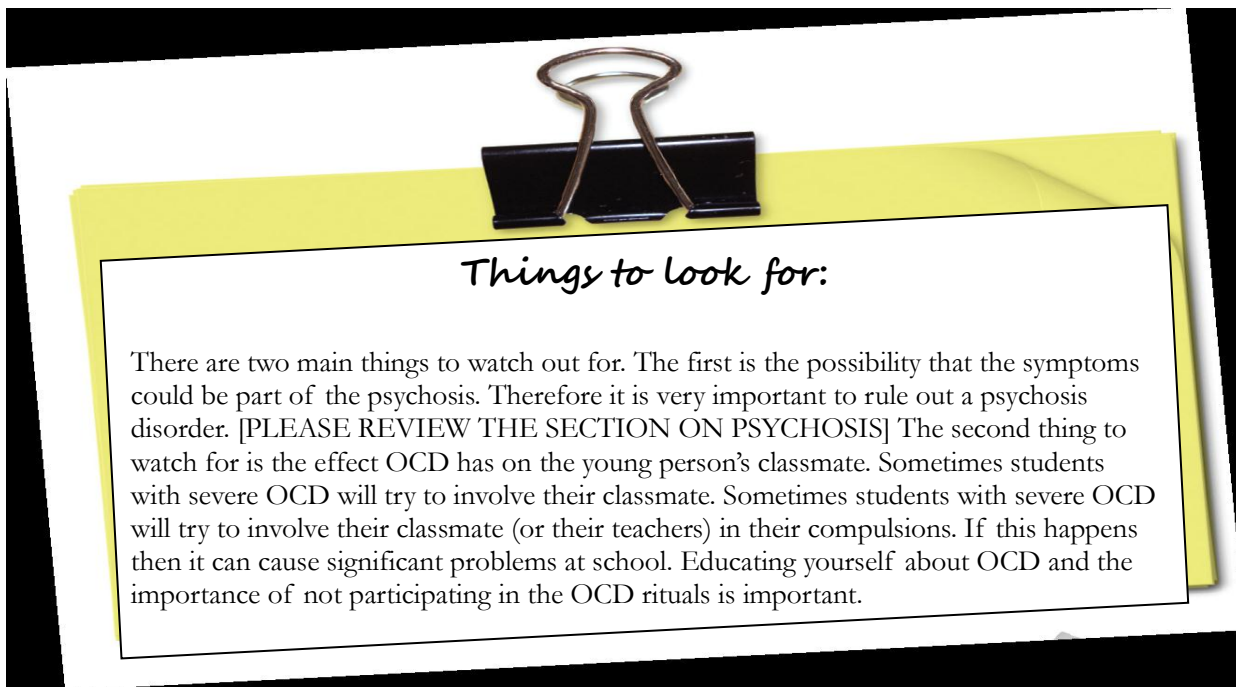


How do you differentiate between OCD and Psychosis?

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

What Can I do if it is OCD?

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



Things to look for:

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

Questions to Ask

As you are having thoughts that are coming into your mind that you do not want to be there? Can you tell me what those thoughts are? Do those thoughts cause you to feel uncomfortable or anxious or upset? Do you think that those thoughts are true? Where do you think those thoughts are coming from? How are you trying to deal with or stop the thoughts from coming? What do thoughts stop you from doing that you would otherwise be doing? How much time are those thoughts on your mind?

Please describe the things that you are doing that are causing distress to you or other people. Can you tell why you are doing those things? What do those things you are doing stop you from doing that you would otherwise be doing? How much time do you spend doing those rituals?

WHAT IS THE POST TRAUMATIC DISORDER?



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

Who is at risk for developing PTSD?

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

What does PTSD look like?

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

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

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

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

What are the criteria for the diagnosis of PTSD?

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

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

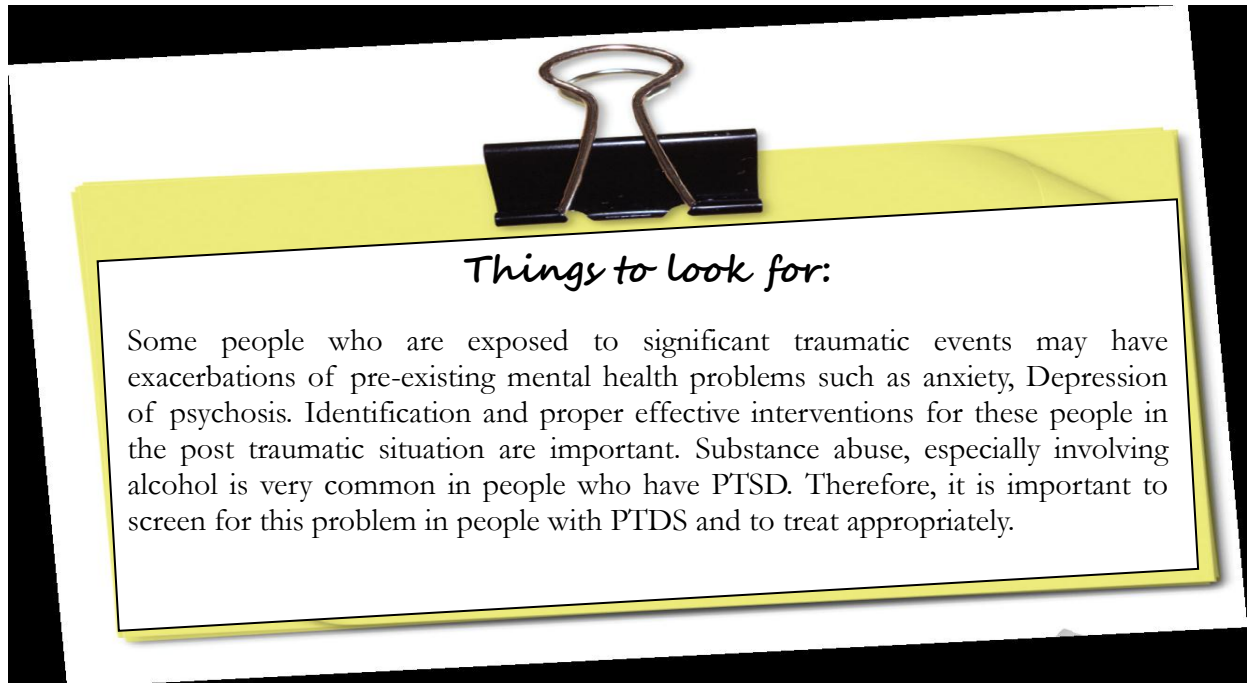
How does PTSD differ from Acute Stress Disorder or normal grieving?

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

What can I do if it PTSD

The first thing is to identify the young person with PTSD and help them find a knowledgeable helper who can provide education to them about what the problem is and how it can be treated. It is important not to confuse PTSD with normal responses to traumatic events or with ASD. Do not create pathology where it

does not exist! For people with PTSD, supportive counselling using cognitive therapy methods may be of help. If the disorder is causing significant distress and impairment, referral to an appropriate health care provider is indicated, as medication may be needed.



What question can I ask?

Are you bothered with memories or thoughts of a very upsetting event that has happened to you? Make sure you ask about frequency and persistence of the symptoms and include clear evidence to functional impairment before considering PTSD.



Mental Disorder of Physical: (Eating disorders)

WHAT IS AN EATING DISORDER?

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

Who is at risk for developing an eating disorder?

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

What does Anorexia Nervosa look like?

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

What does Bulimia Nervosa look like?

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



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

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

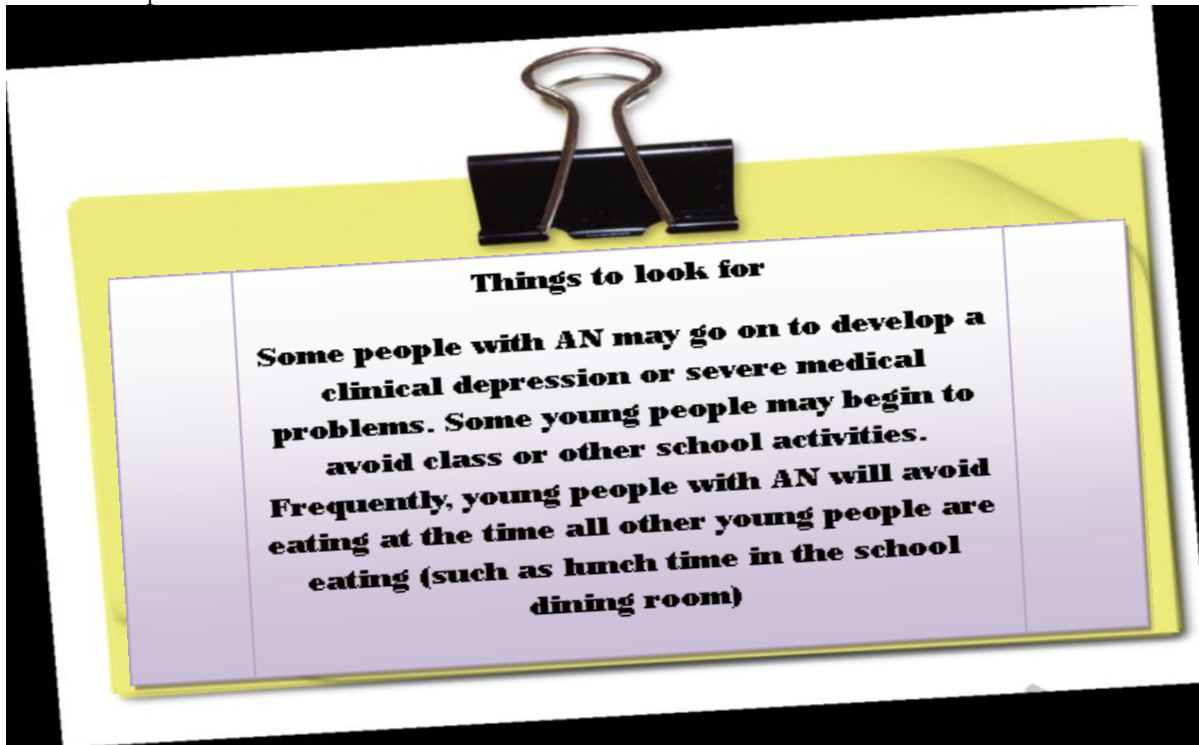
What are the criteria for the diagnosis of AN?

- 1- Refusal to maintain body weight at or above a minimally normal weight for age and height resulting in a body weight less than 85% of that expected.
- 2- Intense fear of gaining weight or becoming fat while underweight.
- 3- Substantial disturbances in body image (considers self to be fat even though is underweight) or denial of seriousness of current low body weight.
- 4- Loss of menstrual periods in post pubertal girls.

The prevalence of AN is about 0.2 to 0.5 percent.

What can I do if it is AN?

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



What are the criteria for the diagnosis of BN?

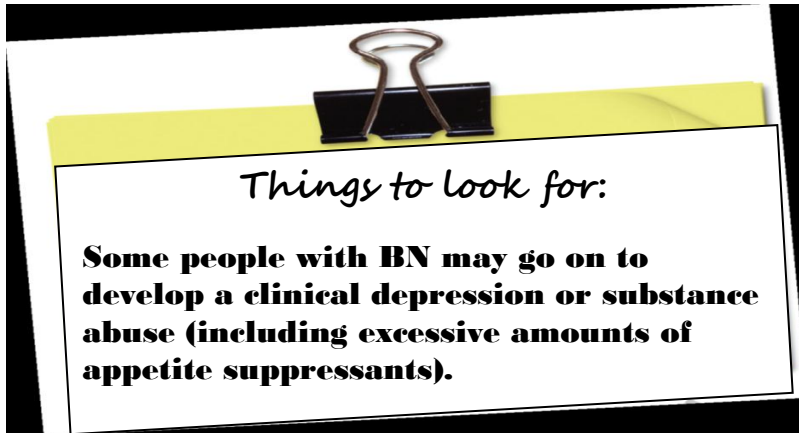
- 1- Recurrent episodes of binge eating where both of the following are present: a)- eating large amounts of food in a short period of time; b)- feeling that eating is out of control.
- 2- Recurrent inappropriate behaviours in order of control weight (such as: self-induced vomiting; misuse of laxative.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

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

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

What can I do if it is BN?

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



Questions to ask?

How do you feel about yourself? Has anyone asked you were having problems with your eating? Do you sometimes feel that your eating may be out of control?

Mental Disorders of Behaviours: (ADHD), Substance Abuse, Conduct Disorder)

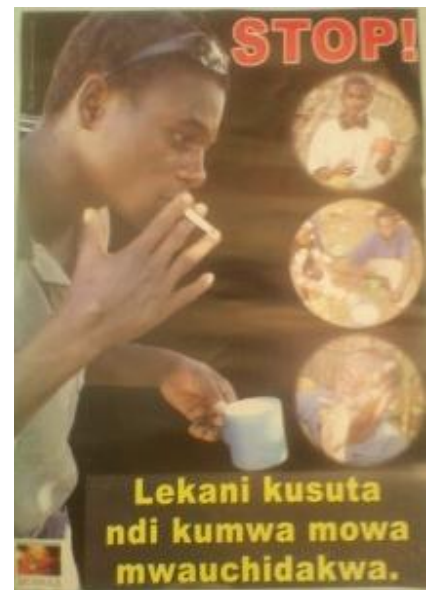
SUBSTANCE DEPENDANCE AND ABUSE

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

What is Substance Abuse?

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

- 1- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g. repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household)
- 2- Recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by substance use)
- 3- Recurrent substance-related legal problems (e.g. arrests for substance-related disorderly conduct)



- 4- Continued substance use despite having persistent or recurrent social interpersonal problems caused or exacerbated by the effects of the substance arguments with spouse about consequences of intoxication, physical fights.

What is Substance Dependence?

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

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

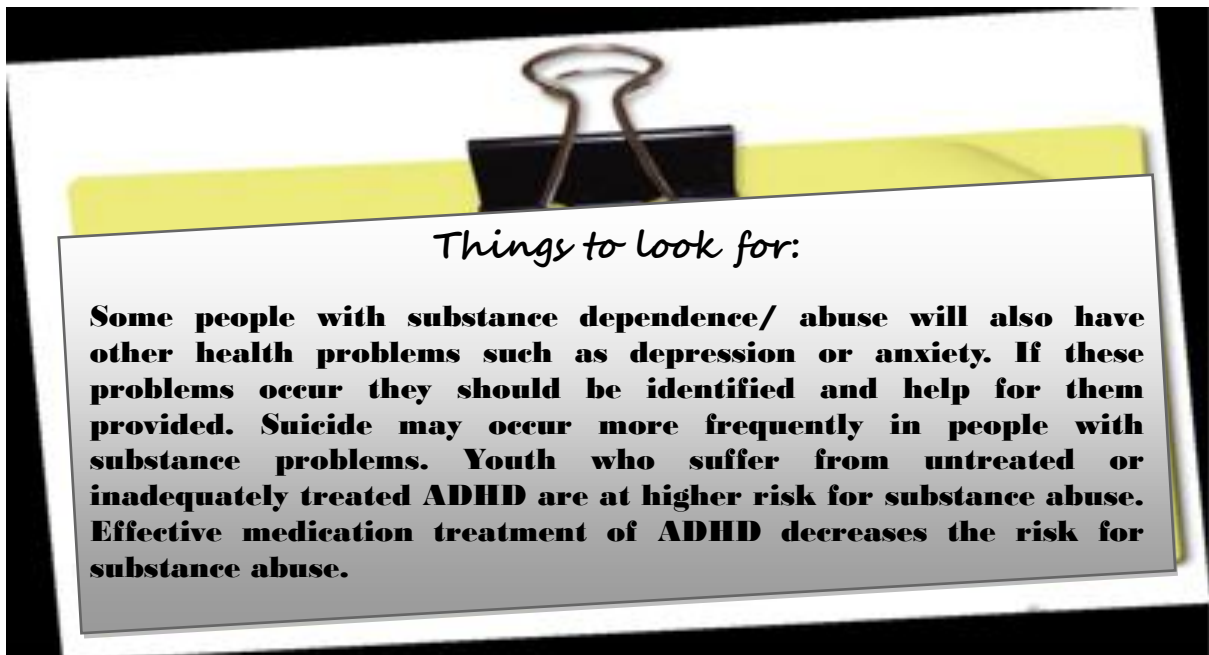
What are types of substances that can be abused?

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

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

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

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



Questions to ask?

Try to determine the amounts of the substance used- remember that use can be continuous (for example "daily) or the binge patterns (large amounts used sporadically)- such as every three to five days). Determine if the young person's problems are due in the whole or in the part to excessive use of substances. One particularly important question is - "How does taking (name of substance here) help you or hinder you in your school and social life.

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

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

What is attention deficit hyperactivity disorder?

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

Who is at risk for ADHD?

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

What does ADHD look like?

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

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

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

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

What are the criteria for diagnosis of ADHD?

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

Inattention (at least six of the following)

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

Hyperactivity

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

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

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

What can I do if it is ADHD?

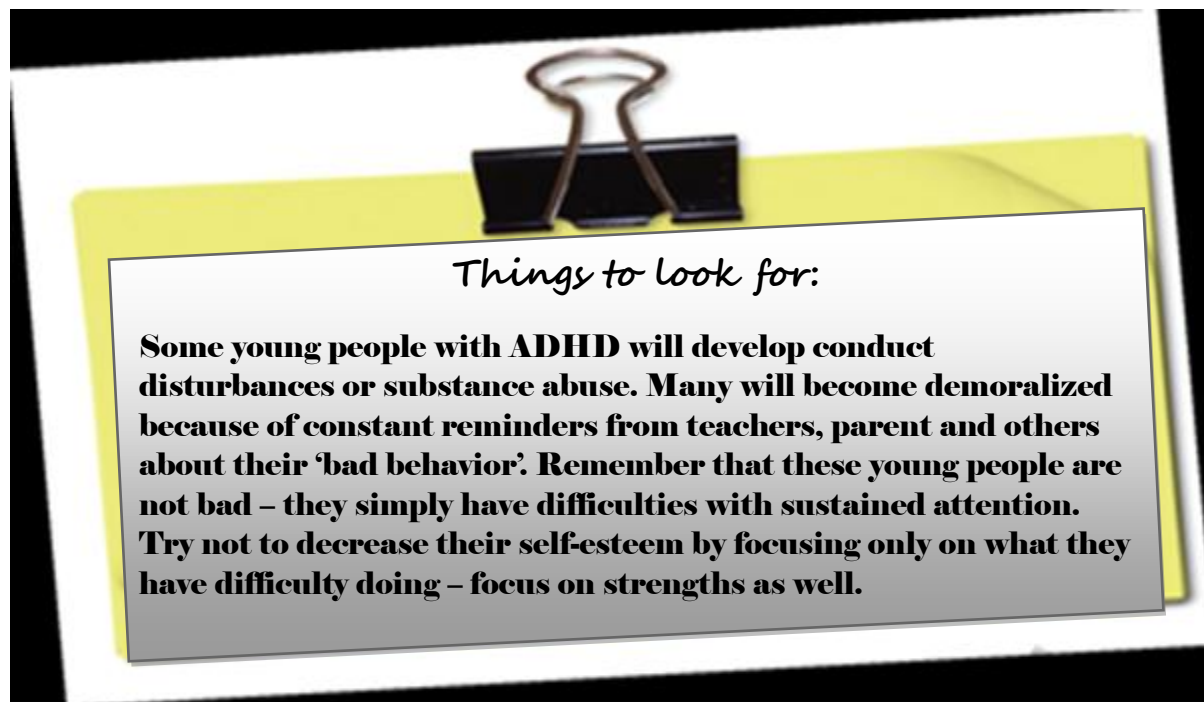
ADHD can be treated with a combination of medications and other assistance – such as social skills training and cognitive behavior therapy. The most effective treatment for symptoms is medication. Because learning difficulties are common, young people with ADHD should undergo educational testing to determine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

What can I do if it is ADHD?

Some young people with ADHD will develop conduct disturbances abuse. Many will become demoralized because of constant reminders from teachers, parents and others about their 'bad behavior'. Remember that these young people are not bad- they simply have difficulties with sustained attention. Try not to decrease their self-esteem by focusing only on what they have difficulty doing- focus on their strengths as well.

Questions to ask?

Are you having difficulties focusing on your schoolwork? It is hard for you to finish your work if there are noises or distractions. Do your parents or your teachers seem to be nagging all the time to do your work of sit still?



What is suicide?

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

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

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

What does suicide look like?

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

Suicidal behavior has three components: ideation; intent, plans.

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

What can I do if it is suicide?

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

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

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

What are risk factors for suicide?

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

- Sex(male)
- Depression or other mental disorder
- Previous suicide attempt
- Family history of suicide
- Excessive alcohol or drug abuse
- Impulsivity or juvenile justice history

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

Questions to ask?

Ask about ideation: “Have you been thinking about dying, harming yourself or suicide?”

Ask about intent: “Have you decided that you would be better off dead or that you should kill yourself?”

Ask about plans: “What plans have you made to kill yourself (and obtain the details)?”

What should I do?

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

Student Questionnaire –

What do you think?

Part 3

Activity 1:

Purpose:

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

How to:

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

Questionnaire: What do you think?

Today's date _____ Birth date: _____ Gender: _____

Write two or three sentences to answer each of the following:

- 1) What is mental health?
- 2) What is mental illness?
- 3) Name some mental illnesses that you have heard about?
- 4) How would a person with mental illness look or act?
- 5) If you learned that a new student at school has a mental illness, how would you act toward him or her? How would you feel about her?
- 6) What causes someone to be mentally ill?

Student Question –

What do you think?

Part 3

Activity 2:

(15 mins.)

What do you think about mental illness now?

Purpose:

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

How to:

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

GCYDCA

P.O. Box 30058

Lilongwe 3 - Malawi

Tel: (265)1 713 181/2

Fax: (265)1 759 024

Note: at least some of the students’ answers should be different now that they have learned more about mental illness. Even if some students’ attitudes have not changed within the span of this Unit, the knowledge they have gained may influence their opinions about how people who have mental illness should be treated. Notice that the discussion questions above do not ask students to divulge their answers. Because of the potentially sensitive nature of the questions, students may be uncomfortable sharing what they wrote. Use your judgement in discussing responses to specific questions. The discussion will need to be handled with sensitivity because students may bring up personal experiences or stories. You might want to ask the School Counsellor or Mental Health Facilitator to be present or to help facilitate the discussion.

Questionnaire: What do you think?

Today's date _____ Birth date: _____ Gender: _____

Write two or three sentences to answer each of the following:

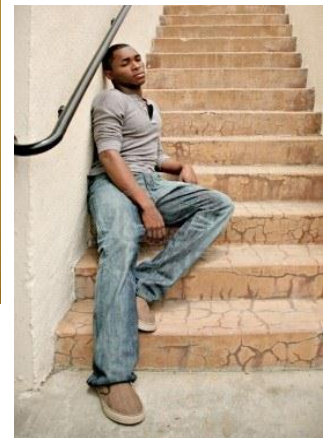
- 1) What is mental health?
- 2) What is mental illness?
- 3) Name some mental illnesses that you have heard about?
- 4) How would a person with mental illness look or act?
- 5) If you learned that a new student at school has a mental illness, how would you act toward him or her? How would you feel about her?
- 6) What causes someone to be mentally ill?

AFRICAN SCHOOL MENTAL HEALTH CURRICULUM

PART 4

MODULES

- Module 1:** Understanding Mental Health and Mental illness
- Module 2:** The stigma and discrimination of mental illness
- Module 3:** Information on specific mental illnesses
- Module 4:** Experiences of mental illness
- Module 5:** Seeking help and finding support
- Module 6:** The importance of positive mental health
- Module 7:** Counselling treatment for Depression and mental illness



MODULE 1

Preparation

Module 1: Understanding Mental Health and Mental illness

Overview

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

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

Learning Outcomes

In this lesson students will learn:

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

Major concepts addressed

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

MODULE 1

Preparation

Activities

- Activity 1: Language Brainstorm (20 mins.)
- Activity 2: PowerPoint Presentation (25 mins.)

Teacher Background:

- Read through the activities and definitions provides
- Preview Part 1 of the PowerPoint Presentation:
Mental Health and Mental Illness: The Common Basis

In advance:

Set up computers or projector to show PowerPoint presentation
Photocopy handouts for Activity 1, one for each student

Material Required:

- Handout Activity 1 Definitions
- Flip chart paper, markers and tape

MODULE 1

Activity 1:

(20 mins.)

Language Brainstorm

Purpose:

- To provide an icebreaker that encourages students to participate in an open discussion about a topic not often addressed in the classroom
- To get an idea of students' knowledge about mental health and illness and what their fears and misconceptions might be
- To highlight the ways we tend to conceptualize mental illness
- To set the stage for introducing information on mental health and mental illness in the next activity

How to:

1. Divide the class into 4 groups
2. Give each group a piece of flip chart paper with one of four terms written at the top: physical health / mental health / physical illness / mental illness
3. Give the group five minutes to brainstorm all the words that come to mind when they see their term
4. After five minutes, ask groups to tape their sheets up on the wall for all groups to see
5. Ask one student from each group to read out their list for the whole class
6. Ask students what they notice about the type of words used on each
7. Discuss the similarities and differences in students' responses to mental and physical aspects of people's health
8. Ask students to suggest some reasons for these differences
9. Give students handouts of definitions of mental health and mental illness and lead a brief discussion on the definition

Is important to emphasise that there are no wrong answers in a brainstorm. This exercise is all about opening up a discussion. Tell students that don't have to agree with or believe in the ideas or names they offer.

Definitions

Mental Health

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

Who’s got mental health?

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

Mental Illness

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

Mental Health Problems

Mental health problems refer to the more common struggles and adjustment difficulties that affect everybody from time to time. These problems tend to happen when people are going through difficult times in life, such as a relationship ending, the death of someone close, conflict in relations with family or friends, or stresses at home, school or work. Feeling stressed or having the blues is a normal response to the psychological or social challenges most people encounter at some time or another. Mental health problems are usually short-term reactions to a particular stressor, such as a loss, painful event, or illness. (*Mental Illness Foundation, 2003*).

MODULE 1

Activity 2:

(25 mins.)

PowerPoint Presentation -

Mental Health and Mental Illness: The Common Basics

Purpose:

- To provide an introduction to basis brain functioning for students to help them understand that the brain controls out thoughts, feelings and behaviours
- To illustrate that mental health and mental illness are related to each other but that they are not mutually exclusive
- To show that some changes in the brain function cause changes in thoughts, feelings and behavior that last a short or a long time

How to:

- Use the web version of the presentation by logging on to <http://teenmentalhealth.org.curriculum/support-materials/>
The username is: resource_user
The password is: t33nh3alth

See Module 2/Activity 2: mental Health and Mental Illness: The common Basis

- Play the presentation, pause if needed.

MODULE 2

Preparation

Module 2: The stigma and discrimination of mental illness

Overview

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

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

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

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

Learning Outcomes

In this module students will:

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

Major concepts addressed

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

Teacher background and preparation:

Read through the activities and preview video component before class. To prepare for module 1, students need to survey five to ten people about their attitudes towards mental health problems and people with mental illness.

How to:

Hand out a copy of the Community Attitude survey and request that students survey a minimum of five and a maximum of ten people from the school, their household or the broader community. Remind students to bring their results in for the lesson.

Note to teachers:

Discuss with the students the sensitive nature of the questionnaire and warn them that some people they approach might not want to answer it.

In advance:

- Make photocopies of the Activity Handouts one per students
- Set up web-based video component of Video Session 1: Living with Stigma

The support materials are located on:

<http://teenmentalhealth.org.curriculum/support-materials/>

The user name is : resource_user

The password is : t33nh3alth

Activities:

- Activity 1: Defining stigma and discrimination
- Activity 2: Exploring attitudes – survey
- Activity 3: Video – Courageous not Crazy Part 1: Living with Stigma
- Activity 4: Reducing Stigma and Discrimination– What works?

Materials required

Handouts from Activities 1, 2 and 4

Courageous Not Crazy video Part 1: Living with Stigma

Note to teachers:

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

The following is some general information about Malawian community attitudes towards mental illness and effective ways of addressing mental health problems. You can use this information to compare and contrast with students findings.

The results of a 2012 situation analysis on the mental health literacy in Malawian schools conducted by the Guidance, Counselling and Youth Development Centre for Africa revealed that most Malawians:

- Are not aware of information about mental illness such as symptoms and signs of mental disorders
- Do not know that Depression is treatable
- Do not know how to deal with people with mental illness
- Are aware of the stigma and discrimination that people with mental illness face in communities
- Are not aware of communities' involvement to overcome mental illness
- Are not aware that mental illness can be genetically transmitted
- Are not involved in slowing down or elimination of stigma on people with mental illness
- Are not involved in mobilizing community members in helping people with Depression and mental illness
- Are not involved in providing information on the causes of Depression and mental illness
- Are not involved in early identification of mental illness and Depression
- Are not involved in the provision of referral services to people in Depression.

According to a 2007 Report on Mental health Literacy in Canada prepared by the Canadian Alliance on mental Health and Mental Illness, most Canadians:

- Have difficulties recognizing and correctly identifying mental disorders
- Prefer psychosocial of mental disorders over biomedical ones, e.g. prefer to think that depression is caused by stress then a chemical imbalance or other problems that are happening in the brain
- Do not know how to deal with people with mental disorders
- Do not consider common mental health problems (anxiety/mild to moderate depression) as mental illness, and have relatively benign attitudes towards these disorders
- Associate mental illness with psychotic disorders and are fearful of those labeled “mentally ill”
- Are often reluctant to seek professional help
- Have negative attitudes towards psychiatric medications
- Are often reluctant to disclose mental disorders for fear of stigma and discrimination

Additionally

- A significant minority of Canadians hold stigmatizing attitudes towards mental illness, and many believe that others subscribe to these views
- Serious mental illness, especially psychosis is more feared and stigmatized than common mental health problems
- People remain concerned about disclosing common mental health problems, particularly in the workplace, for fear of discrimination

Activity 1: (10 mins.)

Defining stigma and discrimination

Purpose:

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

How to:

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

Questions to guide discussion:

- What are some of the negative things you have heard about people with mental illness? (responses may include things like: link to violence etc)
- What are some of the positive things you have heard about mental illness (responses may include things like: link to creativity). While this may be seen as positive, remind students that generalizing can also be a form of stereotype
- Why do you think people with mental illness are stigmatized? (Possible answers include: they are seen as being different. People don't really know the facts about mental illness)
- Can you think of any other health conditions or social issues that have been stigmatized throughout history (possible answers include: homosexuality, leprosy, AIDS, unwed motherhood, divorce)
- What kinds of factors have contributed to changing public attitudes around some of these conditions or issues? (possible answers include: education, public policy, open dialog, scientific research, changing social mores)
- What do you think influences perceptions about mental illness? (possible answers include: the media – films, news newspaper headlines and stories that associate people with mental illness, the fact that people with mental illness sometimes behave differently and people are afraid of what they don't understand).
- How do you think stigma affects the lives of people with mental illness? (possible answers include: people decide not to get help or treatment even though they would benefit from it, it makes them unhappy, they may not be able to get a job or find housing, it may cause them to lose their friends, it puts stress on the whole family)

MODULE 2

Activity Handout

Defining Stigma

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

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

- *The Concise Oxford Dictionary, 1990*

An attribute which is deeply discrediting.

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

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

- *The Shorter Oxford Dictionary, Fourth Edition, 1993* ”

The stigma of mental illness

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

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

Terms related to Stigma

Stereotype:

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

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

Prejudice:

“A preconceived opinion”

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

Discrimination:

“unfavourable treatment based on prejudice”

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

- *The Concise Oxford Dictionary, 1990*

ACTIVITY 2: (20 mins.)

Examining Community Attitudes- Analyzing survey results

Purpose:

- To collate the results of the survey completed by students and examine and analyze the results with the class
- To compare their results with the Community Attitudes Survey Best answers and draw conclusions about the community's awareness of mental health and illness in relation to broader Malawian and Canadian attitudes

How to:

- 1) In groups of four or five, students share survey responses to get a better picture of attitudes of the larger sample. If time permits (or as a possible follow up project for those who are interested), students could use the computer to collate and graph the survey results.
- 2) Ask students to come up with general conclusions from the grouped survey findings to share with the rest of the class, for example:
 - Our sample was not well informed about illness because X% responded....
 - The women in our sample were not tolerant about mental illness than the men
 - Only half the people surveyed agreed that they would have someone with a mental illness as a close friend
- 3) Facilitate a class-wide discussion about the survey results, highlighting ways in which the results inform us about people's attitude about mental illness. Refer to the Community Attitude Survey Best answers, to ground the discussion and answer any questions that students might have. Use the sample questions below as a guide for discussion.

Sample questions:

- What do the responses tell you about the level of awareness about mental illness in the community?
- What role do you think the media plays in shaping peoples' attitudes?
- Do you think your results reflect the Canadian as well as the Malawian community attitudes more generally? Why or why not?
- Do you think it's possible to change community attitudes toward mental illness?
- How might this be done?

(* This activity has been adapted from "Talking About Mental Illness, CAMH 2001)

Activity 2 SURVEY

Community Attitudes Survey

Check the most appropriate answer:	Agree	Disagree	Not sure
1) People should work out their own mental health problems			
2) Once you have a mental illness, you have it for life			
3) Females are more likely to have a mental illness than males			
4) Medication is the best treatment for mental illness			
5) People with a mental illness are generally violent and dangerous			
6) Adults are more likely than teenagers to have a mental illness			
7) You can tell by looking at someone whether they have a mental illness			
8) People with a mental illness are generally shy and quiet			
9) Mental illness can happen to anybody			
10) You would be willing to have a person with a mental illness at your school or at your work			
11) You would be happy to have a person with mental illness become a close friend			

Respondent	M/F	Under 19	20-29	30-39	40-49	50 and up
#1						
#2						
#3						
#4						
#5						
#6						
#7						
#8						
#9						
#10						

*Adapted from *Mind Matters: Understanding Mental Illness*, pg 57

MODULE 2

Activity 2 Handout

Community attitude Survey: Best Answers

1) People should work out their own mental health problems.

Not true. When people have a physical health concern, they generally take some action, and often go to the doctor or seek some other kind of help for their problem. Mental illness is associated with disturbances with brain functioning and usually requires professional assistance. Because of the stigma surrounding mental illness, many people have been reluctant to seek help.

2) Once you have a mental illness, you have it for life.

While it's true that most mental illnesses are lifelong, they are often episodic, which means that the symptoms are not always present. Just like people who live with chronic physical illnesses like arthritis and asthma, people with mental illnesses can, when their illness is managed, live positive and productive lives.

3) Females are more likely to have a mental illness than males

Men and women are both equally affected by mental illnesses in general, but there may be higher rates among women of specific illnesses such as eating disorders. There may sometimes be higher rates in women for other disorders such as Depression. Men have higher rates for some disorders such as alcoholism and ADHD. Some illnesses are relatively equally shared by both men and women (e.g. bipolar disorder).

Women are more likely to seek help for mental and emotional difficulties and to share their concerns with friends compared to men. Females are more willing to let friends know if they are receiving counselling. In practice, 62% of women would probably or definitely want their friends to know compared to 45% of men. *(Canadian Mental Health Survey COMPAS Inc. Multi-Audience Research Ottawa and Toronto April 20, 2001)*
http://www.cmha.ca/bins/content_page.asp?cid=5-34-212-213#_Toc512618127

4) Medication is the best treatment for mental illness

Medication can be a very effective part of managing a mental illness, but it is by no means the only type of treatment or support that helps people recover. A wide range of appropriate interventions, including medication, counselling, social, vocational and housing-related supports, as well as self-help and generic resources for all community members (such as groups, clubs, and religious institutions) are also important in helping people recover and stay well.

It is helpful to think of medications as necessary but not sufficient treatments for many mental disorders. The best approach is to have a combination of strategies that have been proven effective.

5) People with a mental illness are generally violent and dangerous

People with mental illness are generally not more violent than the rest of the population. Mental illness plays

no part in the majority of violent crimes committed in our society. The assumption that any and every mental illness carries with it an almost certain potential for violence has been proven wrong in many studies.

6) Adults are more likely than teenagers to have a mental illness.

Many of the major mental illnesses begin to appear during adolescence and early adulthood.

7) You can tell by looking at someone whether they have a mental illness.

Generally, you can't tell if a person has a mental illness based on their appearance. Sometimes, when people are experiencing an acute episode of their illness, their behavior may be bizarre, especially if they are experiencing an episode of psychosis.

8) People with a mental illness are generally shy and quiet.

There is no strong causal relationship between personality characteristics and tendency to develop mental illness. Some mental disorders such as depression and anxiety can lead people to avoid or limit social contact.

9) Mental illness can happen to anybody.

This is correct. In fact, it is very likely that you, a family member or someone you're close to will experience a mental illness at some point in their lives.

10) You would be willing to have a person with a mental illness at your school or at your work

11) You would be happy to have a person with mental illness become a close friend

Questions 10 and 11 both address the issue of "social distance", that is, the willingness to engage in relationships of varying intimacy with a person. Social distance is an indicator of public attitudes toward people with mental illness.

Social distance is a complex concept influenced by a number of factors, including age, gender, socioeconomic and cultural factors, but also by the respondent's general attitude toward mental health issues.

Contact, or social inclusion of people with mental illness with the rest of the population, is the factor that usually leads to a decrease in stigma by bringing about significant changes in attitudes and behavior that are maintained over time. This can happen when people find out that a coworker, neighbour or friend is struggling with mental illness, and despite it, is living on their own, working and being a part of the community.

MODULE 2

Activity 3: (20 mins.)

Video- Courageous Not Crazy: Living with stigma and discrimination

Purpose:

- To provide students with an opportunity to learn about the impact of stigma on young people's lives
- To help students develop an understanding of the living with stigma
-the social consequences that are part of living with mental illness

How –to:

- 1) Set up a DVD if showing the video to the class as a whole or arrange small groups at computers to view Courageous not Crazy Part 2: Living with Stigma to watch.

The support materials are located on:

<http://teenmentalhealth.org/curriculum/support-materials/>

The username is: resource_user

The password is: t33nh3alth

This section of the video addresses the experience of living with the stigma of mental illness, and how stigma has impacted on the lives of the young people interviewed.

- 2) At the end of the video, lead a brief discussion of students' impressions of the video, and distribute photocopies of activity 4 Hand out Reducing Stigma: What works.

MODULE 2

Activity 4: (10mins)

Handout: Reducing Stigma and Discrimination- What Works?

Purpose:

- To provide students with ideas about what they can do to reduce the stigma and discrimination of mental illness in their everyday life

How to:

- 1) Distribute the handout and encourage students to apply the strategies for reducing stigma in the school, at home, and in the community.
- 2) Remind students that despite the fact that mental illness and Depression are treatable, there are still many examples of how people living with mental illness are portrayed as violent as well as ridiculed in the media and popular culture. Have students think about topical stories from the news and/or movies and TV shows.
- 3) Let the students debate on the pros and cons of talking openly about one's mental illness and Depression to a group of friends.



MODULE 2

Activity 4 Handout

Reducing Stigma – What works?

There is no simple or single strategy to eliminate the stigma and discrimination associated with mental illness, but some positive steps can be taken. Research is showing that negative perceptions about severe mental illness can be changed by:

- **Providing information based on reliable research** that refutes the mistaken association between violence and severe mental illness (*Penn & Martin, 1998*).
- **Effective advocacy and public education programs** can help to shift attitudes and contribute to the reduction of stigma (*Surgeon General Report on Mental Health, 1999*).
- **Proximity or direct contact with people with mental illness** tends to reduce negative stereotypes (*Corrigan & Penn, 1999*).
- **Programs that help people to become better integrated in the community** through school, work, integrated housing, or interest-based social groups not only serve to promote the individual's mental health by reducing exclusion, but also can play a part in gradually shifting commonly-held negative attitudes.
- **Treatments and supports** that work to help people recover.

MODULE 2

Activity 4 Handout

Reducing Stigma – What works (cont.)

LEARN MORE ABOUT MENTAL ILLNESS

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

LISTEN TO PEOPLE WHO HAVE EXPERIENCED MENTAL ILLNESS

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

WATCH YOUR LANGUAGE

Most of us, even mental health professionals and people who have mental illness, use terms and expressions related to mental illness that may perpetuate stigma.

RESPOND TO STIGMATIZING MATERIAL IN THE MEDIA

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

SPEAK UP ABOUT STIGMA

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

TALK OPENLY ABOUT MENTAL ILLNESS

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

PROVIDE SUPPORT FOR ORGANIZATIONS THAT FIGHT STIGMA

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

Adapted from: *Telling is Risky Business: Mental Health Consumers Confront Stigma*. By: Otto Wahl (Rutgers University Press)

MODULE 3

Module 3: Information on specific mental illnesses

Overview

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

Learning Outcomes

In this module, students will

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

Major Concepts addressed

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

Teacher background and preparation

- Read through the information sheets for activity 2 on mental illnesses prior to the class
- Preview the PowerPoint presentation

MODULE 3

Preparation

Activities

- Activity 1: PowerPoint Presentation Part 2: (25 mins)
What Happens When the Brain Gets Sick? The Road to Recovery
- Activity 2: Specialist groups – Learning about specific mental illnesses (15 mins)
- Activity 3: Sharing the pieces (10 mins)

In advance

- Preview the PowerPoint presentation:

Part 2: What Happens When the Brain Gets Sick? The Road to Recovery
- Photocopy Activity 2 handouts and information sheets on specific mental illnesses (there are 6 illnesses covered) one per student in six different groups e.g. if the class has 24 students, then photocopy 4 of each sheet

Materials required

- PowerPoint presentation Part 2: What happen when the brain gets sick: The road to recovery
- Handouts: Activity 2 Activity sheets

MODULE 3

Activity I:

(25 mins.)

PowerPoint Presentation Part 2:

What Happens When the Brain Gets Sick? The Road to recovery

Purpose:

-
- To provide an overview of the major mental illnesses that affect adolescents

Group 1	Understanding Anxiety disorders
Group2	Understanding ADHD
Group 3	Understanding Bipolar Mood Disorder
Group 4	Understanding depression
Group 5	Understanding Eating Disorders
Group 6	Understanding Schizophrenia
- To continue exploring the idea of stigma and examine the impact it can have on the lives of people with mental illness
- To show that there are effective treatments for mental illness and that with appropriate supports, most people recover and lead fulfilling lives

How to:

- Use the web version of the presentation by logging on to:
<http://teenmentalhealth.org/curriculum/support-materials/>

The username is: resource_user

The password is: t33nh3alth

and Module 3/Activity 1: What Happens When the Brain Gets Sick? The Road to Recovery

Play the presentation, pausing if needed

MODULE 3

Activity 12

(15 mins.)

Specialist groups

Purpose

- To focus on some of the specific symptoms, treatments and supports for the major mental illnesses which affects adolescents
- To have students share information about the different disorders with other members of their class

How to:

- 1) Explain to students that a jigsaw puzzle activity will be used during this lesson. This means that students will work in small groups and will become “experts” about one mental illness (one piece of the jigsaw). After completing the handout on their specific illness together, they will break up into mixed groups to share their information and learn more about other illnesses from other members of the group.
- 2) Give the six groups a few minutes to scan the information sheets. When they have finished reviewing, ask each group to discuss the nature of the mental illness they were assigned.
- 3) Have each group complete the handouts to share with others during the next activity. Remind them that they will each need to complete the activity sheets, as they will switch groups in the next activity.

MODULE 3

Activity 2 HANDOUT

Group 1: Anxiety Disorders

What is anxiety?

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

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

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

What are anxiety disorders?

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

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

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

Anxiety disorders are common and may a good number of the population.



not

MODULE 3

Activity 2 HANDOUT

Anxiety Disorders: What are the main types of anxiety disorders?

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

Generalized anxiety disorder

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

Agoraphobia

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

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

People experiencing agoraphobia may find comfort in the company of a safe person or object. This may be a spouse, friend, pet or medicine carried with them.

The onset of agoraphobia is common between the ages of 15 and 20, and is often associated with panic disorder or social phobia.

Panic disorder

(with or without agoraphobia)

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

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

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

Specific phobias

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

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

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

Social phobia (also called Social anxiety disorder)

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

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

Obsessive compulsive disorder

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

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

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

Post-traumatic stress disorder

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

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

What causes anxiety disorders?

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

Personality

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

Learnt response

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

Heredity

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

Biochemical processes

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

How can anxiety disorders be addressed?

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

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

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

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

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

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

MODULE 3

Activity 2

ACTIVITY SHEET

Group 1: Understanding Anxiety Disorders

What are anxiety disorders?

Who gets anxiety disorders and how common are they?

Describe some of the symptoms of anxiety disorders:

List and briefly explain some of the main types of anxiety disorders:

What type of treatment is available for people experiencing anxiety disorders?

What other kinds of support can help people with anxiety disorders recover?

MODULE 3

Activity 2 HANDOUT

Group 2: Attention Deficit Hyperactivity Disorder (ADHD)

What is Attention deficit hyperactivity disorder (ADHD)?

Attention Deficit Hyperactivity Disorder is the most commonly diagnosed behavioural disorder of childhood.

In any six-month period, ADHD affects an estimated 4 -6 % of young people between the ages of 9 and 17 at the global level. Boys are two to three times more likely than girls to develop ADHD. Although ADHD is usually associated with children, the disorder can persist into adulthood. Children and adults with ADHD are easily distracted by sights and sounds and other features of their environment, cannot concentrate for long periods of time, are restless and impulsive, or have a tendency to daydream and be slow to complete tasks.

Symptoms

The three predominant symptoms of ADHD are

- 1) inability to regulate activity level (hyperactivity); 2) inability to attend to tasks (inattention); and
- 3) impulsivity, or inability to inhibit behaviour.

Common symptoms include varying degrees of the following. All must occur with greater frequency and intensity than “normal” and must lead to functional impairment as a result of the symptoms in order to be considered ADHD:

- Poor concentration and brief attention span
- Increased activity - always on the go
- Poor coordination
- Normal or high intelligence but under-performing
- Fearless and takes undue risks
- Sleep problems
- Social and relationship problems at school
- Impulsive-doesn't stop to think

What causes ADHD?

While no one really knows what causes ADHD, it is generally agreed by the medical and scientific community that ADHD is due to problems in the brain's control of systems that regulate concentration, motivation and attention.

Much of today's research suggests that genetics plays a major role in ADHD. The possibility of a genetic cause to ADHD is supported by the fact that ADHD runs in families. Between 10 and 35 percent of children with ADHD have a first-degree relative with past or present ADHD. Approximately half of parents who have been diagnosed with ADHD themselves, will have a child with the disorder.

It has been generally considered that approximately 50% of ADHD cases can be explained by genetics. It is obvious that not every case of ADHD can be explained by genetics; it would seem that there are other causes.

Researchers have suggested that some of the following could also be responsible for ADHD symptoms:

- exposure to toxins (such as lead)
- injuries to the brain
- delayed brain maturation

However, all of these possibilities need further research.

MODULE 3

Activity 2 HANDOUT

Group 2: Attention Deficit Hyperactivity Disorder (ADHD)

Myths, misunderstandings and facts

According to the National Institutes of Mental Health, ADHD is not caused by:

- Too much TV
- Sugar
- Caffeine
- Food colourings
- Poor home life
- Poor schools
- Damage to the brain from complications during birth
- Food allergies

How can ADHD be addressed?

A variety of medications and behavioural interventions are used to treat ADHD. The most effective treatments are medications. The most widely used medications are stimulants such as Ritalin. Nine out of ten children improve when taking one of these medications. When used as prescribed by qualified physicians, these medications are considered quite safe. Some common side effects are decreased appetite and insomnia. These side effects generally occur early in treatment and often decrease over time. Some studies have shown that the stimulants used to treat ADHD slow growth rate, but ultimate height is not affected.

Interventions used to help treat ADHD include several forms of psychotherapy, such as cognitive-behavioural therapy, social skills training, support groups, and parent and educator skills training. A combination of medication and psychotherapy may be more effective than medication treatment alone in improving social skills, parent-child relations, reading achievement and aggressive symptoms.

MODULE 3

Activity 2

ACTIVITY SHEET

Group 2: Understanding Attention Deficit Hyperactivity Disorder (ADHD)

What is ADHD?

Who gets ADHD and how common is it?

Describe some of the symptoms of ADHD:

What type of treatment is available for people experiencing ADHD?

What other kinds of support can help people with ADHD recover?

Group 3: Bipolar Mood Disorder

Bipolar mood disorder is the new name for what was called manic depressive illness. The new name is used as it better describes the extreme mood swings - from depression and sadness to elation and excitement – that people with this illness experience.

People with bipolar mood disorder experience recurrent episodes of depressed and elated (overjoyed) moods. Both can be mild to severe.

The term ‘mania’ is used to describe elation and overactivity.

Some people with bipolar disorder only have episodes of elation and excitement.

What are the symptoms of bipolar mood disorder?

Mania - Common symptoms include varying degrees of the following:

- **Elevated mood** – The person feels extremely high, happy and full of energy. The experience is often described as feeling on top of the world and being invincible.
- **Increased energy and overactivity**
- **Reduced need for sleep**
- **Irritability** – The person may easily and frequently get angry and irritable with people who disagree or dismiss their sometimes unrealistic plans of ideas.
- **Rapid thinking and speech** – Thoughts are more rapid than usual. This can lead to the person speaking quickly and jumping from subject to subject.
- **Lack of inhibitions** – This can be the result of the person’s reduced ability to foresee the consequences of their actions, for example, spending large amounts of money buying things they don’t really need.
- **Grandiose plans and beliefs** – It is common for people experiencing mania to believe that they are unusually talented or gifted or are kings, movie stars or political leaders. It is common for religious beliefs to intensify or for people with this illness to believe they are an important religious figure.
- **Lack of insight** – A person experiencing mania may understand that other people see their ideas and actions as inappropriate, reckless or irrational. However, they are unlikely to recognize the behaviour as inappropriate in themselves.
- **Psychosis** – Some people with mania or depression experience psychotic symptoms such as hallucinations and delusions.



Depression

- Many people with bipolar mood disorder experience depressive episodes. This type of depression can be triggered by a stressful event, but more commonly occurs without obvious cause.
- The person loses interest and pleasure in activities they previously enjoyed. They may withdraw and stop seeing friends, avoid social activities and cease simple tasks such as shopping and showering.
- They may become overwhelmed by a deep depression, lose their appetite, lose weight, become unable to concentrate, and may experience feelings of guilt or hopelessness.
- Some attempt suicide because they believe life has become meaningless or they feel too guilty to go on.
- Others develop false beliefs (delusions) of persecution or guilt, or think that they are evil.
- For more information on depression and its treatment, please see the information sheets called “What is depression?”

Normal moods

Most people who have episodes of mania and depression experience normal moods in between. They are able to live productive lives, manage household and business commitments and hold down a job.

Everyone experiences mood swings from time to time. It is when these moods become extreme and lead to a failure to cope with life that medical attention is necessary.

What causes bipolar mood disorder?

Bipolar mood disorder affects both men and women. It usually appears when people are in their twenties, but often begins in the teen years.

It is believed that bipolar mood disorder is caused by a combination of factors including genetics, biochemistry, stress and its onset may even be related to the seasons.

Genetic factors

Studies on close relations, identical twins and adopted children whose natural parents have bipolar mood disorder strongly suggest that the illness may be genetically transmitted, and that children of parents with bipolar mood disorder have a greater risk of developing the disorder.

Biochemical factors

Mania, like major depression, is believed to be associated with chemical changes or other problems in the brain which can often be corrected with medication.

Stress

Stress may play an important role in triggering symptoms, but not always. Sometimes the illness itself may cause the stressful event (such as divorce or a failed business), which may then be blamed for causing the illness. Drugs or other physical stressors (such as jet lag) may bring on an episode.

Seasons

Mania is more common in the spring, and depression in the early winter. The reason for this is not clear, but it is thought to be associated with the light/dark cycle.

How can bipolar disorder be addressed?

- Effective treatments are available for depressive and manic episodes of bipolar mood disorder. Medications called thymoleptics (such as lithium) are an essential treatment for the entire course of the illness.
- For the depressive phase of the illness, antidepressant medications are effective. Bright light therapy and some psychological treatments may also help.
- Antidepressants are not addictive. They slowly return the balance of neurotransmitters in the brain, taking one to four weeks to achieve their positive effects.
- Medication should be adjusted only under medical supervision, as some people may experience a switch to a manic phase if given an antidepressant.
- During acute or severe attacks of mania, several different medications may be used. Some are specifically used to calm the person's manic excitement: others are used to help stabilize the person's mood. Medications such as lithium are also used as preventive measures, as they help to control mood swings and reduce the frequency and severity of both depressive and manic phases.
- It may be necessary to admit a person with severe depression or mania to a hospital for a time.
- When people are in a manic phase, it can often be difficult to persuade them that they need treatment.
- Psychotherapy and counseling are used with medication to help the person understand the illness and better manage its effects on their life.
- With access to appropriate treatment and support, most people with bipolar mood disorder lead full and productive lives.

MODULE 3

Activity 2

ACTIVITY SHEET

Group 3: Understanding Bipolar Mood Disorder

What is bipolar mood disorder?

Who gets bipolar mood disorder?

Describe some of the symptoms of bipolar mood disorder:

What combination of factors is believed to cause bipolar mood disorder?

What type of treatment is available for people experiencing bipolar mood disorder?

What other kinds of support can help a person with bipolar mood disorder recover?

MODULE 3

Activity 2

HANDOUT

Group 4: Depression

What is depression?

The word depression is often used to describe the feelings of sadness which all of us experience at some times in our lives. It is also a term used to describe a form of mental illness called clinical depression. Clinical depression is not sadness.

Because depression is so common, it is important to understand the difference between unhappiness or sadness in daily life and the symptoms of clinical depression.

When faced with stress, such as the loss of a loved one, relationship breakdown or great disappointment or frustration, most people will feel unhappy or sad. These are emotional reactions which are appropriate to the situation and will usually last only a limited time. These reactions are not a clinical depression, but are a part of everyday life.

The term clinical depression describes not just one illness, but a group of illnesses characterized by excessive or long-term depressed mood which affects the person's life. Clinical depression is often accompanied by feelings of anxiety. Whatever the symptoms and causes of clinical depression, there are many therapeutic interventions which are effective.



What are the main types of depressive illness?

Adjustment disorders with depressed mood

People with this problem are reacting to distressing situations in their lives (for example, the failure of a close relationship or loss of a job) but to a greater degree than usual.

This depression is more intense than the unhappiness experienced in daily life. It lasts longer and the symptoms often include anxiety, poor sleep and a loss of appetite. This form of depression may last longer than a few weeks.

It usually goes away when the cause is removed or the person finds a new way to cope with the stress. Occasionally people require professional help to overcome this type of depression.

“Baby Blues” and postpartum depression

The so-called “baby blues” affect about half of all new mothers. They feel mildly depressed, anxious, tense or unwell, and may have difficulty sleeping even though they are tired and lethargic most of the time. These feelings may last only hours or a few days, then disappear. Professional help is not usually needed.

However, in up to ten percent of mothers this feeling of sadness develops into a serious disorder called postpartum depression. Mothers with this illness find it increasingly difficult to cope with the demands of

everyday life.

They can experience anxiety, fear, despondency and sadness. Some mothers may have panic attacks or become tense and irritable. There may be a change in appetite and sleep patterns. Because of these symptoms they may have difficulties in their daily lives, including trouble in caring for their child.

A severe, but rare form of postpartum depression is called puerperal psychosis. The woman is unable to cope with her everyday life and is disturbed in her thinking and behaviour. Professional help is needed for both postpartum depression and puerperal psychosis.

Major depressive disorder

This is the most common form of clinical depression. It can come on without apparent cause, although in some cases a severely distressing event might trigger the condition.

The cause is not well understood but is believed to be associated with a chemical imbalance or other problem in the parts of the brain that control mood. Genetic predisposition is common.

A depressive episode can develop in people who have coped well with life, who are good at their work, and happy in family and social relationships.

For no apparent reason, they can become low-spirited, lose their enjoyment of life and suffer disturbed sleep patterns. People experiencing a depressive episode lose their appetite, lack concentration and energy, and may lose weight. Feelings of guilt, hopelessness and loss of pleasure are also common.

Sometimes the feelings of hopelessness and despair can lead to thoughts of suicide. Suicide is a tragic outcome of depression in some people.

The most serious form of this type of depression is called psychotic depression. During this illness, the person loses touch with reality, may stop eating and drinking and may hear voices saying they are wicked or worthless or deserve to be punished.

Others develop false beliefs (delusions) that they have committed bad deeds in the past and deserve to be punished, or falsely believe that they have a terminal illness such as cancer, despite there being no medical evidence.

A depressive episode or psychotic depression are serious illnesses which present risks to the person's life and well-being. Professional assessment and treatment is always necessary and, in severe cases, hospitalization may be required for a period of time.

Bipolar mood disorder (previously called Manic Depression)

A person with bipolar mood disorder experiences depressive episodes (as described above) with periods of mania which involve extreme happiness, overactivity, rapid speech, a lack of inhibition and in more serious instances, psychotic symptoms including hearing voices and delusions of grandeur (having a feeling of greatness beyond what you are).

Sometimes only periods of mania occur, without depressive episodes, but this is rare. More information about this mood disorder is found in the section called "What is bipolar mood disorder?"

What causes depression?

Often there are many interrelated factors associated with depression.

Heredity: It is well established that the tendency to develop depression runs in families. This is similar to a predisposition to other illnesses, such as heart disease and high blood pressure.

Biochemical imbalance: Depressive episodes are thought to be due in part to a chemical imbalance or other problems in the brain. This can be corrected with anti-depressant medication or with psychotherapy.

Stress: Depression may also be associated with stress after personal tragedies or disasters. It is more common at certain stages of life, such as at childbirth. It may also occur with some physical illnesses.

Personality: People with certain personality characteristics may be more prone to depression. Some people have a low grade depressive disorder called dysthymia which may become difficult to distinguish from their personality.

How can depression be addressed?

People experiencing symptoms of depression which have persisted for a long time, or which are affecting their life to a great extent, should contact their family doctor or community health centre. Modern methods for dealing with depression can help the person return to more normal feelings and to enjoy life. The approach depends on each person's symptoms and circumstances, but will generally take one or more of the following forms:

- Psychological interventions help individuals understand their thoughts, behaviours and interpersonal relationships.
- Antidepressant medications relieve depressed feelings, restore normal sleep patterns and appetite, and reduce anxiety. Antidepressant medications are not addictive. They slowly return the balance of neurotransmitters in the brain, taking one to four weeks to achieve their positive effects.
- Specific medications help to manage mood swings for people with bipolar illness.
- General supportive counseling assists people in sorting out practical problems and conflicts, and helps them understand how to cope with their depression.
- Lifestyle changes such as physical exercise may help people who suffer from depression.
- For some severe forms of depression, electroconvulsive therapy (ECT) is a safe and effective treatment. While it is still considered by some to be controversial, it may be lifesaving for people who are psychotic, at high risk of suicide, or who, because of the severity of their illness, have stopped eating or drinking and may die as a result.

MODULE 3

Activity 2

ACTIVITY SHEET

Group 4: Understanding Depression

What is depression?

Who gets depression and how common is it?

Describe some of the symptoms of depression:

List and briefly describe some of the main types of depression:

What type of treatment is available for people experiencing depression?

What other kinds of support can help a person with depression recover?

MODULE 3

Activity 2

HANDOUT

Group 5: Eating Disorders

What are Eating disorders?

Research on eating disorders is extremely rare in Africa. In addition to this, it is very uncommon to hear people in the African setting talk about eating disorders such as Anorexia nervosa (AN) and Bulimia nervosa (BN).

In a number of studies done in the West have indicated that Anorexia nervosa (AN) and Bulimia nervosa (BN) are the two most common serious eating disorders. Each illness involves a preoccupation with control over body weight, eating and food. Sometimes they occur together.

- People with anorexia are determined to control the amounts of food they eat
- People with bulimia tend to feel out of control about food

Anorexia nervosa is common and may affect up to one in every two hundred teenage girls, although the illness can be experienced earlier and later in life. Most people who have Anorexia nervosa are female, but males can also develop the disorder.

Bulimia nervosa may affect up to two in every hundred teenage girls. More females than males develop bulimia.

While these rates show that few people meet the criteria for eating disorders, it is far more common for people to have unrealistic attitudes about body size and shape. These attitudes may contribute to inappropriate eating or dieting practices, such as fad dieting, which is not the same as having an eating disorder.

Both illnesses can be overcome and it is important for the person to seek advice about treatment for either condition as early as possible.

What are the symptoms of Anorexia nervosa? (AN)

Anorexia nervosa is characterized by:

- A loss of at least 15% of body weight resulting from refusal to eat enough food
- Refusal to maintain minimally normal body weight
- An intense fear of becoming 'fat' even though the person is underweight
- Cessation of menstrual periods
- Misperception of body image, so that people see themselves as fat when they're really very thin
- A preoccupation with the preparation of food
- Unusual rituals and activities pertaining to food, such as making lists of 'good' and 'bad' food and hiding food.

Usually Anorexia nervosa begins with a weight loss, resulting from dieting. It is not known why some people go on to develop AN while others do not. As weight decreases, the person's ability to appropriately judge their body size and make proper decisions about their eating also decreases. About 40% of people with Anorexia nervosa will later develop Bulimia nervosa.

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What are the symptoms of Bulimia nervosa? (BN) Bulimia nervosa is characterized by:

- Eating binges, which involve consumption of large amounts of calorie-rich food, during which the person feels a loss of personal control and following which the person feels self-disgust
- Attempts to compensate for binges and to avoid weight gain by self-induced vomiting, and/or abuse of laxatives and diuretics
- Strong concerns about body shape and weight.

A person with BN is usually average or slightly above average weight for height, so it is often less recognizable than the person with AN.

BN often starts with rigid weight reduction dieting in an attempt to reach 'thinness'. Inadequate nutrition causes tiredness and the person develops powerful urges to binge eat.

Vomiting after a binge seems to bring a sense of relief, but this is temporary and soon turns to distress and guilt. Some people use laxatives, apparently unaware that laxatives do not reduce calorie or fat content, and serve only to eliminate nutritionally vital trace elements and to dehydrate the body.

The person can make frantic efforts to break from the pattern, but the vicious binge/purge/exercise cycle, and the feelings associated with it, may have become compulsive and uncontrollable.

A person with bulimia may experience chemical imbalances in the body which bring about lethargy,

depression and clouded thinking.

What causes Anorexia nervosa and Bulimia nervosa?

The causes of AN and BN remain unclear. Biological, psychological and social factors may be involved. While there are many hypotheses about various social and psychological factors involved in AN, there is no good scientific evidence which shows causality for one particular pathway.

What are the effects of Anorexia nervosa and Bulimia nervosa?

Physical effects

The physical effects can be serious, but are often reversible if the illnesses are tackled early. If left untreated, severe AN and BN can be life-threatening. Responding to early warning signs and obtaining early treatment is essential.

Both illnesses, when severe, can cause:

- harm to kidneys
- urinary tract infections and damage to the colon
- dehydration, constipation and diarrhea
- seizures, muscle spasms or cramps
- chronic indigestion
- loss of menstruation or irregular periods
- heart palpitations

Many of the effects of anorexia are related to malnutrition, including:

- absence of menstrual periods
- severe sensitivity to cold
- growth of down-like hair all over the body
- inability to think rationally and to concentrate

Severe bulimia is likely to cause:

- erosion of dental enamel from vomiting
- swollen salivary glands
- the possibility of a ruptured stomach
- chronic sore throat

Emotional and psychological effects:

These are likely to include

- Difficulty with activities which involve food
- Loneliness, due to self-imposed isolation and a reluctance to develop personal relationships

- Deceptive behaviours related to food
- Fear of the disapproval of others if the illness becomes known, mixed with the hope that family and friends might intervene and offer help
- Mood swings, changes in personality, emotional outbursts or depression

How can eating disorders be addressed?

Changes in eating behaviour may be caused by several illnesses other than AN or BN, so a thorough medical examination by a medical practitioner is the first step.

Once the illness has been diagnosed, a range of health practitioners can be involved in treatment, because the illness affects people both physically and mentally. Professionals involved in treatment may include psychiatrists, psychologists, physicians, dietitians, social workers, occupational therapists and nurses.

Outpatient treatment and attendance in special programs are the preferred method of treatment for people with AN. Hospitalization may be necessary for those who are severely malnourished.

Treatment can include medication to assist severe depression and to correct hormonal and chemical imbalances. BN may respond to specific antidepressant medications.

Dietary education assists with retraining in healthy eating habits.

Counselling and specific therapies such as (cognitive-behavioural therapy - CBT) are used to help change unhealthy thoughts about eating. The ongoing support of family and friends is essential.

MODULE 3

Activity 2

ACTIVITY SHEET

Group 5: Understanding Eating Disorders

What are eating disorders?

Who gets eating disorders and how common are they?

Describe some of the symptoms of Anorexia Nervosa (AN) and Bulimia Nervosa (BN):

What are the physical, emotional and psychological effects of AN and BN?

What type of treatment is available for people experiencing AN and BN?

What other kinds of support can help people with eating disorders recover?

MODULE 3

Activity 2

HANDOUT

Group 6: Understanding Schizophrenia

What is schizophrenia?

Schizophrenia is a mental illness which affects one person in every hundred. Schizophrenia interferes with a person's mental functioning and behaviour, and in the long term may cause changes to their personality.

The first onset of schizophrenia is usually in adolescence or early adulthood. Some people may experience only one or more brief episodes of psychosis in their lives, and it may not develop into schizophrenia. For others, it may remain a recurrent or life-long condition.

The onset of the illness may be rapid, with acute symptoms developing over several weeks, or more commonly, it may be slow, developing over months or even years.

During onset, the person often withdraws from others, gets depressed and anxious, and develops unusual fears or obsessions.

Schizophrenia is characterized by two different sets of symptoms. Positive symptoms refers to symptoms that appear - like delusions (thinking things that aren't true), or hallucinations (seeing or hearing things that aren't there).

Negative symptoms refer to things that are taken away by the illness, so that a person has less energy, less pleasure and interest in normal life activities, spending less time with friends, being less able to think clearly.

What are the symptoms of schizophrenia?

Positive symptoms of schizophrenia include:

Delusions – false beliefs of persecution, guilt or grandeur, or being under outside control. These beliefs will not change regardless of the evidence against them. People with schizophrenia may describe outside plots against them or think they have special powers or gifts. Sometimes they withdraw from people or hide to avoid imagined persecution.

Hallucinations – most commonly involving hearing voices. Other less common experiences can include seeing, feeling, tasting or smelling things, which to the person are real but which are not actually there.

Thought disorder – where the speech may be difficult to follow, for example, jumping from one subject to another with no logical connection. Thoughts and speech may be jumbled and disjointed. The person may think someone is interfering with their mind.

Other symptoms of schizophrenia include:

Loss of drive – when the ability to engage in everyday activities such as washing and cooking is lost. This lack of drive, initiative or motivation is part of the illness and is not laziness.

Blunted expression of emotions – where the ability to express emotion is greatly reduced and is often

accompanied by a lack of response or an inappropriate response to external events such as happy or sad occasions.

Social withdrawal – this may be caused by a number of factors including the fear that someone is going to harm them, or a fear of interacting with others because of a loss of social skills.

Lack of insight or awareness of other conditions – because some experiences such as delusions or hallucinations are so real, it is common for people with schizophrenia to be unaware they are ill. For this and other reasons, such as medication side-effects, they may refuse to accept treatment which could be essential for their wellbeing.

Thinking difficulties – a person's concentration, memory and ability to plan and organize may be affected, making it more difficult to reason, communicate, and complete daily tasks.

What causes schizophrenia?

No single cause has been identified, but several factors are believed to contribute to the onset of schizophrenia.

Genetic factors – A predisposition to schizophrenia can run in families. In the general population, only one percent of people develop it over their lifetime. If one parent suffers from schizophrenia, the children have a ten percent chance of developing the condition – and a ninety percent chance of not developing it.

Biochemical factors – Certain biochemical substances in the brain are involved in this condition, especially a neurotransmitter called dopamine. One likely cause of this chemical disturbance is the person's genetic predisposition to the illness.

Family relationships – No evidence has been found to support the suggestion that family relationships cause the illness. However, some people with schizophrenia are sensitive to family tensions which, for them, may be associated with relapses.

Environment – It is well-recognized that stressful incidents often precede the diagnosis of schizophrenia; they can act as precipitating events in vulnerable people. People with schizophrenia often become anxious, irritable and unable to concentrate before any acute symptoms are evident. This can cause relationships to deteriorate, possibly leading to divorce or unemployment. Often these factors are blamed for the onset of the illness when, in fact, the illness itself has caused the crisis. There is some evidence that environmental factors that damage brain development (such as a viral illness in utero) may lead to schizophrenia later in life.

Drug use – The use of some drugs, such as cannabis (marijuana), LSD, Crack and crystal meth is likely to cause a relapse in schizophrenia. Occasionally, severe drug use may lead to or “unmask” schizophrenia.

Myths, misunderstandings and facts

Myths, misunderstandings, negative stereotypes and attitudes surround the issue of mental illness in general, and in particular, schizophrenia. They result in stigma, discrimination and isolation.

Do people with schizophrenia have a split personality?

No. Schizophrenia refers to the change in the person's mental function, where the thoughts and perceptions become disordered.

Are people with schizophrenia intellectually disabled?

No. The illness is not an intellectual disability.

Are people with schizophrenia dangerous? No, people with schizophrenia are generally not dangerous when receiving appropriate treatment. However, a minority of people with the illness may become

aggressive when experiencing an untreated acute episode, or if they are taking illicit drugs. This is usually expressed to family and friends, rarely to strangers.

Is schizophrenia a life-long mental disorder? Like many mental illnesses, schizophrenia is usually lifelong. However, most people, with professional help and social support, learn to manage their symptoms and have a satisfactory quality of life. About 20-30 percent of people with schizophrenia have only one or two psychotic episodes in their lives.

How can schizophrenia and psychosis be addressed?

The most effective treatment for schizophrenia involves medication, psychological counseling and help with managing its impact on everyday life.

The sooner that schizophrenia is treated, the better the long- term prognosis or outcome. The opposite is also true: the longer schizophrenia is left untreated, and the more psychotic breaks are experienced by someone with the illness, the lower the level of eventual recovery. Early intervention is key to helping people recover.

The development of antipsychotic medications has revolutionized the treatment of schizophrenia. Now, most people can be treated and remain in the community instead of in hospital.

Antipsychotic medications work by correcting the brain chemistry associated with the illness. New but well-tested medications are emerging which may promote a more complete recovery with fewer side effects than the older versions.

Schizophrenia is an illness, like many physical illnesses. Just as insulin is a lifeline for people with diabetes, antipsychotic medications can be a lifeline for a person with schizophrenia.

Just as with diabetes, some people will need to take medication indefinitely to prevent a relapse and keep symptoms under control.

Though there is no known cure for schizophrenia, regular contact with a doctor or psychiatrist and other mental health professionals such as nurses, occupational therapists and psychologists can help a person with schizophrenia recover and get on with their lives. Informal supports such as self-help and social support are also very important to recovery. Meaningful activity or employment, and adequate housing and income are all essential to keeping people healthy.

Sometimes specific therapies directed toward symptoms such as delusions may also be useful.

Counselling and social support can help people with schizophrenia overcome problems with finances, housing, work, socializing and interpersonal relationships.

With effective treatment and support, most people with schizophrenia can lead fulfilling and productive lives.

MODULE 3

Activity 2

ACTIVITY SHEET

Group 6: Understanding Schizophrenia

What is schizophrenia?

Who gets schizophrenia and how common is it?

Describe some of the symptoms of schizophrenia:

List and briefly explain some of the factors that contribute to the onset of schizophrenia:

What type of treatment is available for people with schizophrenia?

What other kinds of support can help people with schizophrenia recover?

MODULE 3

Activity 3:

(10 mins.)

Sharing the pieces

Purpose:

In the activity, the “student experts” will share their new knowledge about their mental illness with others in the class. In this way, each student will gain an increased understanding of the mental illnesses covered in the unit.

How to:

- 1) Form new mixed groups which include at least one member from each of the illness-specific groups.
- 2) Give each student two minutes to report to the newly-formed group about their specific area of mental illness, highlighting important points about how common the illness is, symptoms and effective supports and treatments.

MODULE 4

Preparation

Module 4: Experiences of mental illness

Overview:

In this module students will hear directly from other young people about their personal experiences with mental illness. In their own words, a number of young people describe their symptoms, difficulties they went through as a result of their illnesses, and how the illness affect their lives at school, within their families, and in their friendships.

Students will work together in small groups to explore the impact of mental illnesses on the lives of the young people in the video.

Learning Outcomes:

- To recognize, on a more personal level, the way mental illnesses can impact on a person's life.
- To appreciate in the importance of getting help and proper treatment.

Major concepts addressed:

- Mental illnesses are diseases that affect many aspects of a person's life.
- While they are usually lifelong, mental illnesses are often episodic and with effective treatment, most people can function well in everyday life.

Teacher background and preparation

Teachers would preview part 2 of Courageous not Crazy: Experiences of mental illness, either the DVD or online video, before showing it to the class. Reviewing the video in advance will help you become familiar with the content so that you can help the students identify and keep track of the individual they are to focus on while watching the video.

The support materials are located on:

<http://teenmentalhealth.org/curriculum/support-materials/>

The username is: resource_user

The password is: t33nh3alth

MODULE 4

Preparation

In advance:

- Decide whether you will show the video to the class as a whole using the DVD, or whether you want smaller groups to view the video through the web-based format.
- Set up computer work stations or DVD equipment.
- Photocopy Activity 1 Video discussion sheet (1 copy of each per student).

Activities:

Activity 1: Experiences of mental illness video and activity sheet (40mins.)

Materials required:

- DVD or web-based video of Courageous Not Crazy part 2: experiences of mental illness
- Handout: Activity 1 Video discussion sheet.

Experiences of mental illness video and discussion sheet

Purpose:

- To explore the impact of mental illnesses on a group of young people
- To look specifically at the experience of each character in a video through small group work

How to:

- 1) Inform the class that the video they are about to see was created by young people who have experienced mental illness, and is about their experiences.

Before showing the video, divide the class into 5 groups and distribute the video activity sheet. Allocate each group one of the characters in the video (Chris, Tim, Sheila, Tyrone or Aaron).

Give the students a few minutes to read through the questions on the video discussion sheet. Explain that each group will focus specifically on one character and their particular diagnosis and experience, but that they will watch the complete video and hear the stories of all of the individuals.

- 2) Play *Courageous Not Crazy Part 2. Experiences of mental illness*. Remind each other about which individual they should be focusing while watching.
- 3) After viewing the video, ask the students to get together in their small groups and complete the group questions. Ask one member of the group to record the answers so that they can be shared with the whole class afterwards. Help students understand that the video may not include direct answers by each individual for each of the questions. But that they may make inferences from what the individual said. Circulate among the teams to listen as they discuss their answers, provide guidance if teams are confused about how to answer the questions.
- 4) Bring the groups back together and ask the member of each group to summarize the discussion from each of the small groups for the class.
- 5) Using the questions below, facilitate a discussion with the whole class
 - a) What specific illnesses were mentioned in the video?
 - b) Describe how some of the character appear to have lost touch with reality
 - c) What help or treatment did the characters receive?
 - d) Did the characters recover? What do you mean by “recover”?
 - e) Are there any other mental illnesses you have heard about? What mental illnesses are you aware of that were not mentioned in the video?
- 6) Conclude the activity by addressing any questions that the students may have after watching the video. Can students see any similarities among the individuals in the video, Even though they have different mental illnesses?

Activity 2:

(20 mins.)

Contextualising the experiences of mental illness video through discussion

Purpose:

- To relate the experiences of each character in the video to common experiences in the local communities
- To share information about interventions that are already being used in the local context

How to:

Using the questions below, facilitate a discussion with the whole class:

- a. How do you relate the experiences of each character in the video to common experiences in your community?
- b. What are some of the interventions being used in your country/ areas to address the following:
 - i. Anxiety disorder
 - ii. ADHD
 - iii. Bipolar modd disorder
 - iv. Depression
 - v. Eating disroders
 - vi. Schizophrenia.

MODULE 4

Activity I

DISCUSSION SHEET

Video Discussion Sheet

Name of your character:

What mental illness does the person have?

When did it start?

How did the illness affect the person's thoughts, feelings and behaviours?

Did the illness cause the person difficulty in his or her life? In what ways?

What kind of treatment did the individual get?

How has the individual's life changed since getting treatment?

What kinds of things have helped the person recover and stay well?

What other questions would you like to ask your character in order to better understand their illness?

MODULE 5

Preparation

Module 5: Seeking help and finding support

Overview

How do we decide that what a person is experiencing is outside the range of the normal ups and downs we all go through? When is it time to seek assistance from professionals?

Seeking help and finding support for mental health issues can be a tricky business. From the outside, it's often not clear when intervention is necessary, and people who are experiencing distress may themselves not always be aware of what's going on, and can be reluctant to come forward for fear of being labeled. When people know that they will not be discriminated against or harassed, they are much more likely to seek help. Early intervention is important and increases the chances of a quick recovery.

This lesson will address the issues around help seeking, as well as providing ideas about ways in which that help and support can be accessed, within the school and beyond.

Learning Outcomes

- To understand that people need support to deal with stressful life events and situations
- To learn to distinguish between “normal” responses to stress and difficulty, and those that may indicate a need for additional support from professionals.
- To get students to consider who they could talk to if they were worried about their own mental health, or that of a friend or relative.
- To identify support personnel in the school relevant to mental health
- To become familiar with the range of community-based healthcare services and groups available to support people who are experiencing mental illness and their families and friends.

Major concepts addressed

- Mental illnesses, like chronic, physical illnesses, can be effectively addressed
- Stigma acts as a barrier to people seeking help for mental health concerns
- Getting help early increases the chances that a person will make full recovery from the mental illness.
- Recovery from mental illness is possible, when a range of supports, beyond formal treatment, are available.

Teacher background and preparation

- Read through all activities and handouts before class
- Preview video Courageous Not Crazy part 3: Help and Support
- Compile list of community mental health resources for students

Activities

Activity 1: Video and activity sheet: Help and support- Youth Experiences (15mins.)

Activity 2: Getting help (15mins.)

Activity 3: Support strategies (10mins.)

In advance

- Fill out template of community mental health resources
- Preview video
- Set up computers or DVD to view video
- Photocopy handouts for activity 1 video activity sheets, Activity 2 what if...scenarios, checklists 1, 2 and 3, Activity 3 support strategies (one for each student)
- Cut activity 2: What if...scenario into cards

Materials required

- DVD or web –based video of courageous Not Crazy part3: Help and support
- Handouts: Activity 1 video activity sheets, Activity 2 What if...scenarios, checklists1,2 and 3, Activity 3 support strategies

Activity 1:**(30 mins.)****Community Mental Health Support Systems**

Let the students identify the support systems around their schools and the type of mental health support services being expected from one of them.

Template- **Community Mental HR Support Systems**

The following mental health related resources are available in many communities including youth oriented programmes. Find out the contact information for these resources in your community and distribute to students.

School resources:

- Guidance counsellor
- Social worker
- Nurse
- Peer support
- Mental Health Facilitators

Local community resources:

- Crisis/distress lines
 - Call the Doctor lines (airtel)
 - Operation *Ndakuona* (0800 990 997)
- Youth centres
 - Youth Network and Counselling (YONECO)
 - Counselling Adolescents and Youth Organization (CAYO)
- Mental health lines
 - YONECO Malawi Youth Support Helpline– This is a telephone counselling service for youth. It provides counselling directly to youth and also helps them to find the counselling services they need.
- Hospitals/clinics and Community health centres
 - Zomba Mental Hospital
 - Bwaila Hospital
 - Mulanje District Hospital
 - St. John of God Hospital
- Peer support groups
- Church
- Police
- Family
- CBOs
- FBOs
- NGOs

Mental health organizations (local):

- GCYDCA
- Mental Health Facilitators' Association
- Guidance and Counselling Association of Malawi (GCAM)
- Malawi Mental Health Association
- Association of African Counsellors (AAC)

Mental health organizations (international)

- Africa Mental Health Foundation (Kenya)
- Canadian Mental Health Association (www.cmha.ca)
- Centre for Addiction and Mental Health (www.cahm.net)
- Mood Disorders Society of Canada (www.mooddisorderscanada.ca)
- Schizophrenia Society of Canada (www.schizophrenias.ca)
- Anxiety Disorders Association of Canada ([www. Anzietycanada.ca](http://www.Anxietycanada.ca))

Video and activity sheet: Courageous Not Crazy part 3: Help and Support

Purpose:

- To learn more about young people's real life experiences getting help to deal with their mental health problems

How to:

- 1) Explain to the class that you will be watching a video made by youth from Laing House, which focuses on their experiences getting help and finding support to deal with their families.

Hand out the activity sheets and give the class a minute or two to read over the questions. Tell them that they are not expected to take notes while they are watching the video, but should keep the questions in mind as they watch, so that they can discuss the answers afterward.

- 2) Show the video and discuss the students' answers to the questions as a group.

Conclude the activity by addressing any questions that students may have after watching the video. Ask students if they can see any similarities among different individuals, even though they have different mental illnesses.

MODULE 5

Activity I

VIDEO ACTIVITY

Courageous Not Crazy Part 3: Help and Support

How did the youth in the video find help?

Did their friends and family notice there was something going on? What did they notice?

Did any of the youth talk to school staff like teachers or counsellors?

What does it mean to be supportive?

Did any of the youth attend a self-help or peer support group? If so, what was that like for them?

What kinds of supports/services seemed to help the most?

How can you help a friend?

MODULE 5

Activity 2:

(15 mins.)

Getting help

Purpose:

- To describe a range of scenarios in which it would be important to tell or refer a problem to an appropriate adult.

How –to:

- 1) Explain to students that they will be engaging in a problem solving lesson in which they can speculate about their possible actions they could take in a range of situations involving young people in distress. They will explore the scenarios using a game.
- 2) Ask students to arrange themselves into groups of four to six. Get them to sit in a circle- on the floor might be easiest.
- 3) Hand out the set of cards from the activity sheet. What if...scenarios. Ask each group to lay out their what if... cards in a circle with enough room inside the circle to spin a bottle or pen.
- 4) In turn each of the participants takes a spin and reads out the card the bottle points to. The person whose turn it is speculates first about what to do in such a situation, then others help out by adding their views, questions or challenges.
- 5) When they have finished discussing the scenarios, ask the class to come back together and pose the following questions:
 - Was there any disagreement in the groups about what was best to do?
 - Which was the scenario most likely to actually happen out of those you discussed?
 - Which do you think would be the hardest scenario to deal with if it happened to you or a friend or family member?
 - What sorts of fears or concerns would stop people from seeking help or telling someone else in these situations?
 - What kind of things would motivate someone to seek help or telling someone their concerns in the situations you discussed?
- 6) Distribute “something not quite right” checklists and read them through with the class.

MODULE 5

Activity 2

What if scenarios

1. Your friend seems really down and talks about dropping out of school.
2. A friend has been on a long diet, is getting really skinny and never seems to eat. She thinks she's really fat and will not wear shorts or a swimming costume.
3. Since your dad left, your brother/sister is spending almost all of their time smoking, drinking and watching TV, never wanting to do anything else. You have not told your friends about your parents splitting up.
4. There is a situation at school that is really stressing you out. Everyday when you wake up, you remember the situation and start to feel sick.
5. Your friend says s/he would be better off if s/he ran away. Your friend has already been sleeping over at your house a lot lately.
6. Someone in your class has started smoking marijuana before school everyday. The friends who smoke with this person only do it occasionally on the weekends. People are joking about how he/she is behaving – out of it and spacey. The person seems pretty down to you.
7. Your friend has started taking different kinds of pills at school, and is asking other people for pain-killers all the time.
8. Your friend isn't acting like his old self. He seems really down, and has been doing strange things like giving his favourite things away. He recently told you that he thought that people he knew would be better off without him around, and that he'd thought about killing himself. After he tells you, he asks you not to tell anyone else about what he's said.
9. A kid in your class often gets completely ignored and occasionally teased and even bullied. No one will ever be seen talking to this person. The teachers don't seem to notice, and no one does anything to this kid when teachers are around.
10. A friend has started skipping a lot of school and seems pretty down.
11. Your friend has a parent with mental illness. From time to time, when the parent isn't doing well, your friend has to do everything at home. None of your other friends know about the situation. Your friend doesn't even know that you know. Your mom found out through a neighbour.
12. A classmate who is not really your friend, but is not friends with anyone else either, has started acting really strangely. Other kids have been laughing and making fun, but underneath you think this is a bit scary, and maybe the person is not doing this on purpose.

Adapted from Lesson 4 of Coping – *MindMatters*

MODULE 5

Activity I

HANDOUT

Something is not quite right: getting help early for mental illness

You have a feeling that something is “not quite right” about the way someone close to you is behaving. You’re worried, but you’re not sure if it might be serious, or if moodiness, irritability and withdrawn behaviour is a stage they’ll grow out of. Could drugs be involved? Do you think you might need a professional opinion to help you decide if there is a serious problem?

Getting help early

The chances are that there is not a serious problem, and that time, reassurance and support are all that are needed. However, if a mental illness is developing, then getting help early is very important.

Being unwell for a shorter time means less time lost as school or work and more time for relationships, experiences and activities which help us stay emotionally healthy.

Checklist #1 Difficult behavior at home, at school or in the workplace:

Behaviour which is considered “normal”, although difficult:

People may be:

- | | | | | |
|-----------------------------------------|--------------------------------|--------------------------------------|------------------------------------|----------------------------------------|
| <input type="checkbox"/> rude | <input type="checkbox"/> weepy | <input type="checkbox"/> thoughtless | <input type="checkbox"/> irritable | <input type="checkbox"/> argumentative |
| <input type="checkbox"/> over-sensitive | <input type="checkbox"/> over- | <input type="checkbox"/> emotional | <input type="checkbox"/> lazy | <input type="checkbox"/> withdrawn |
| <input type="checkbox"/> rebellious | <input type="checkbox"/> shy | | | |

These behaviours may also occur as a normal, brief reaction to stressful events such as:

- | | | | |
|-----------------------------------------------|------------------------------------------------|---------------------------------------|----------------------------------------------|
| <input type="checkbox"/> breakup of a close | <input type="checkbox"/> relationship moving | <input type="checkbox"/> divorce | <input type="checkbox"/> other family crisis |
| <input type="checkbox"/> death of a loved one | <input type="checkbox"/> other personal crisis | <input type="checkbox"/> exam failure | <input type="checkbox"/> physical illness |

Probably no cause for serious concern, but...

It is often best to try not to over-react. Try to be as supportive as possible while waiting for the “bad patch” to pass. If the behaviour is too disruptive or is distressing to other people, or if the difficult behaviour lasts a long time, then you could seek professional counselling, help or advice. Talk it over with your family doctor, school counselor, community or mental health centre.

MODULE 5

Activity 2

HANDOUT

Checklist #2 -

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

Signs of Clinical Depression:

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

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

MODULE 5

Activity 2

HANDOUT

Checklist #3 – Behaviours which are considered ABNORMAL for that person, and may seriously affect other people

People may	
<ul style="list-style-type: none">❑ Withdraw completely from family, friends, and workmates❑ Be afraid to leave the house (particularly during daylight hours)❑ Sleep or eat poorly❑ Sleep by day and stay awake at night, often pacing restlessly❑ Be extremely occupied with a particular theme, for example, death, politics or religion❑ Uncharacteristically neglect household or parental responsibilities, or personal appearance or hygiene❑ Deteriorate in performance at school or work❑ Have difficulty concentrating, following conversation or remembering things❑ Talk about or write things that do not really make sense.❑ Panic, be extremely anxious, or significantly depressed and suicidal	<ul style="list-style-type: none">❑ Lose variation in mood – be “flat” – lack emotional expression, for example, humour or friendliness❑ Have marked changes in mood, from quiet to excited or agitated❑ Hear voices that no one else can hear❑ Believe, without reason, that others are plotting against, spying on, or following them, and be extremely angry or afraid of these people❑ Believe that they are being harmed or asked to do things against their will, by, for instance, television, radio, aliens, God or the devil❑ Believe they have special powers, for example, that they are important religious leaders, politicians or scientists❑ Believe that their thoughts are being interfered with or that they can influence the thoughts of others❑ Spend extravagant or unrealistic sums of money

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

MODULE 5

Activity 3:

(10 mins.)

Support strategies

Purpose:

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

How-to:

1. Begin a discussion about the role that young people often plays as supporters when they listen to their friends talk about their problems.

Ask students how they would like to be treated if they had a mental illness. Distribute photocopies of Activity 3 Support Strategies and Recovery: What works? to each student to facilitate further discussion. Read through the sheets with the class.

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

MODULE 5

Activity 3

HANDOUT

Support strategies

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

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

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



MODULE 5

Activity 3

HANDOUT

Recovery – What helps people with mental illness get (and stay) better?

Activity 4:

(25 mins.)

Purpose:

- To provide students with the opportunity to practice their roles and how they can refer their friends who have mental health problems or mental illness to required support services

How-to:

1. Divide the students into groups to role play on referral systems, with each role play depicting some of the following features:
 - Nature of the problem
 - Method used for support
 - Where they went to get support
 - How to hand over for consultation – preparations made, the process
 - Follow ups
2. Each role play should be followed by a discussion.

Recovery is an ongoing, slow process, and is different for each person. Research on recovery shows that there are a number of factors which people often mention are important:

- The presence of people who believe in and stand by the person who is in recovery.
- That person's ability to make their own choices about important things like treatment and housing.

Other factors that can support recovery include:

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

Deegan et. al., 2000, Canadian Mental Health Association, NS Division 1995

MODULE 6

Preparation

Module 6: The importance of positive mental health

Overview

What constitutes a mentally healthy person? Does everyone have mental health? In this module, students will explore these questions and will look at the impact of mental health on overall well-being. Through several group activities, students will also learn about the impact of stress, and will identify appropriate effective coping strategies to deal with stress.

Learning Outcomes:

- To describe the characteristics of an emotionally healthy person
- To demonstrate skills that enhance personal mental health, including stress management techniques

Major Concepts Addressed

- Everyone has mental health that can be supported, regardless of whether or not they also have a mental illness
- Positive coping strategies can help everyone maintain and enhance their mental health

Materials required

- Handouts: Activity 1 Taking care of your mental health, Activity 3 Coping cards
- Flip chart paper and pens

In Advance:

- Photocopy handouts for Activity 1 Taking Care of Your Mental Health (one copy for each student) and Activity 3 Coping Cards (only one copy)
- Cut out Coping Cards

Teacher Preparation:

Read through all activities before class

MODULE 6

Activity I:

(15 mins.)

What do you think about mental health?

Purpose:

- To explore students' growing understanding of mental health and its importance to each individual
- To brainstorm about the kinds of things that contribute to positive mental health

How to:

- 1) Ask students to brainstorm ideas of the kinds of things that keep people mentally healthy. Potential ideas are listed below:

- Think positively
- Organize your time
- Value yourself
- Eat right and exercise
- Try new things
- Get enough sleep
- Make plans
- Set realistic goals and work towards them
- Reward yourself
- Share concerns and worries with friends and family

Hand out photocopies of 'Taking care of your mental health' for students to keep.

MODULE 6

Activity I

HANDOUT

Taking care of your mental health:

Achieving mental health is about striking a balance in the social, physical, spiritual, economic and mental aspects of our lives. Reaching a balance is a learning process and it is ongoing. At times, we may tip the balance too much in one direction and have to find our footing again. Our personal balance is highly individual, and our challenge is to stay mentally healthy by finding and keeping that balance.

Mental health and mental illness each run along a continuum. When our personal balance is off, either repeatedly or for long periods, we may eventually find ourselves moving closer along the continuum towards mental illness. While some people experience a sudden onset of symptoms of a mental illness, many mental health problems

develop gradually. For example, you may hardly notice your anxiety turn to distress until, one day, you feel overwhelmed. To find out more about building healthy self-esteem, creating positive relationships, coping with change, and learning to manage stress, read the 10 tips below taken from the CMHA fact sheet Mental Health For Life, at www.ontario.cmha.ca/fact_sheets.asp?cID=3219

From nurturing relationships with family and friends, to identifying and dealing with situations that upset you – including stressful circumstances, such as the pressure of exams, a conflict at work, or a misunderstanding with a friend – you can take steps to improve and maintain your mental health throughout your life.

Tips for mental health:

1. Build a healthy self-esteem
2. Receive as well as give
3. Create positive parenting and family relationships
4. Make friends who count
5. Figure out your priorities
6. Get involved
7. Learn to manage stress effectively
8. Cope with changes that affect you
9. Deal with your emotions
10. Have a spirituality to call your own
11. Share feelings (a problem shared is half solved)
12. Take a break
13. Do something you are good at
14. Get enough sleep
15. Ask for help (if you want to run fast, go alone. If you want to go further, go as a team)
16. Do not procrastinate (better prepare than repair. The secret of getting ahead is getting started).



MODULE 6

Activity I HANDOUT

Taking care of your mental health

Consider these key characteristics when assessing your own mental health:

Ability to enjoy life – Can you live in the moment and appreciate the “now”? Are you able to learn from the past and plan for the future without dwelling on things you can’t change or predict?

Resilience – Are you able to bounce back from hard times? Can you manage the stress of a serious life event without losing your optimism and sense of perspective?

Balance – Are you able to juggle the many aspects of your life? Can you recognize when you might be devoting too much time to one aspect, at the expense of others? Are you able to make changes to restore balance when necessary?

Self-actualization – Do you recognize and develop your strengths so that you can reach your full potential?

Flexibility – Do you feel, and express, a range of emotions? When problems arise, can you change your expectations – of life, others, yourself – to solve the problem and feel better?

You can gauge your mental health by thinking about how you coped with a recent difficulty. Did you feel there was no way out of the problem and that life would never be normal again? Were you unable to carry on with work or school? With time, were you able to enjoy your life, family and friendships? Were you able to regain your balance and look forward to the future?

Taking the pulse of mental health brings different results for everyone; it's unique to each individual. By reflecting on these characteristics, you can recognize your strengths, and identify areas where your level of mental fitness could be improved



MODULE 6

Activity 2:

(15 mins.)

What do we mean by “Stress”?

Purpose:

- To identify different kinds of stress and the impact that stress can have on overall wellbeing
- To give examples of stressors commonly experienced by young people and explore different coping strategies and positive ways of dealing with stress

How to:

1. Ask students to imagine that they are about to explain the meaning of stress to someone who has never heard about it. Ask them to form pairs and talk with their partner and develop a definition e.g. “stress is when..” and write their own ideas down in point form
2. Ask each pair to share their definitions and write them on the board as they read them aloud
3. Ask students what they notice about what stress means to different people
4. Ask students to brainstorm about the different kinds of stressors. Use the list below as a guide to make sure all areas are mentioned. Write their responses on the board

Different kinds of stressors:

- Physical stressors (e.g. injury, illness, fatigue, hunger, lack of shelter)
 - Social stressors (e.g. arguments, rejection, embarrassment)
 - Intellectual stressors (e.g. mental fatigue, lack of understanding)
 - Emotional stressors (e.g. death of a close friend or family member)
 - Spiritual stressors (e.g. guilt, moral conflicts, lack of sense of purpose)
5. Divide the students into groups of four or five. Ask each group to brainstorm around the following question: “What are some of the stresses and challenges people around your age face?”

Circulate around the room as the students are brainstorming in their groups and use the probes below if they need help or direction:

- What sorts of stresses in the physical environment can directly affect how you feel either physically or emotionally
- What sorts of stresses or challenges can happen to relationships or between people?

- What kinds of happenings or events can cause stress (e.g. family breakup, transitions like leaving school or moving, illness end of a close relationship etc.
 - What are some of the fears, anxieties or thoughts that can get people feeling stressed?
6. As the groups report back, ask several students to record the brainstorm results on flip chart paper. Explain that this list will be used later in the next activity

Adapted from MindMatters, Coping, pg. 23

MODULE 6

Activity 3:

(15 mins.)

How do you cope?

Purpose:

- To describe a range of coping strategies to deal with stressful and challenging situations
- To identify some of students' own preferred coping strategies and examine the effectiveness of different strategies

How to:

1. Remind students that in the previous activity they identified the kinds of things people can feel stressed-out about and some of the thoughts and feelings they have when faced with challenging and stressful situations
2. Ask students to get into pairs or groups of three and ask them to share examples of things they like to do when they feel stressed or overworked. Ask a student in each group to write down at least one of the coping strategies discussed. To prepare for the next part of the activity, while students are busy in their groups, stick up one piece of paper in each corner of the room, with the words "Helpful", "Not much use", "Useless", and "Harmful", written on them.
3. Explain to the class that in this activity you'll be examining coping strategies, or things that people do in response to stress or challenge. Point out that there is a huge range of possible coping strategies, that it's different for each individual, varies in terms of a person's culture, religious background, gender, etc. and that there is no one right way of coping. Explain that people who cope effectively often have a whole range of different strategies that they use, and that people often learn about coping by watching what their friends and family do.
4. Have students come back together and arrange themselves in a circle. Ask those who recorded their group's coping strategies to put the paper on the floor in the middle of the circle and spread Coping Cards into the pile, face down. Ask each student to choose two cards or strategies offered by the students.
5. Ask students to choose one of the cards and hold it up at chest height so that it can be read by others.

6. Explain to the class that you will describe a situation of potential stress or challenge. Students will then be asked to move to a defined area of the room according to whether they think their coping strategy would be helpful, not much use, useless or harmful.
7. Describe the scenario, choosing either from the brainstormed list that the students came up with, or from the suggestions below:
 - Faced with a big exam
 - Dealing with separation of parents
 - Dealing with death of someone close
8. When the students have grouped, have them compare and comment on their choices. Ask them put their other coping card on top and regroup if they think this card belongs to a different category
9. Play a few rounds of the game to emphasize the point that different situations may call for different coping strategies. Remind students that there are no right or wrong answers, and that sometimes the most important coping strategy can involve getting help or support for yourself or someone else.

Adapted from MindMatters, Coping, pg. 34

MODULE 6

Activity I HANDOUT

Coping Cards

Withdraw – not mix with other people Think positive about how it will turn out

Play ball games

Worry

Visit a favourite person

See counsellor

Eat more

Eat less food

Quit (the job, the team...)

Sleep more

Avoid something you have to do

Ride a bicycle

Prioritize (put the most important things first)

Mix with friends (party/socialize)

Hide

Run away

Plan – figure out how to do it

Get sick

Start a fight

Blame someone else

Blame yourself

Smoke cigarettes

Ask for Help

Go out

Talk it up (do it)

Complain

Avoid eating food

Change direction

Take a bath

Sleep early

Drink alcohol

Exercise

Work harder

Stay out late

Meditate

Listen to music

Pretend it's OK

Call friends

Watch television/video

Write about it

Cook something

Sleep less

Do some garden work

Go to the market

Pray

Sing

Stay away from work/school

Do some cleaning/washing

Take risks

Make something

Problem-solve

Find new friends

Cry

Joke

Set goals

Laugh

MODULE 7

Preparation

Module 7: Counselling treatment for Depression and mental illness

The client and his/her world

My inner world

Each one of us is the star, producer, director and audience of our very own feature film in the theater of our mind. It's like living in our own parallel universe. There is the "real world" -- within which we all exist and interact with one another -- and then, within each of us, there occurs a creative interpretation of reality that may or may not bear any resemblance to objective reality or to the creative interpretation of others. Our ongoing emotional and ideological responses reflect who we think we are and what we think is going on. That creates our inner movie -- a diverted reflection of reality that serves as the foundation upon which we base our actions and reactions in our shared world. This is what is known as one's inner world; one's own world.

One's inner world is where you do and say what you want. A client is a human being but one's mental state may force the client to live in his/her own imaginary world. The implications of living in one's inner world are enormous. When one is in Depression or has a mental illness, there are some traces of incongruence in one's behaviour and in the way that person makes decisions.

A client who is in Depression or one who has mental illness becomes too insulated in their little inner world, making them lose contact with other people and lose sight of the importance of their wants and needs, hopes and dreams and their ability to contribute to the shared 'real' world. In such a state, it becomes life's greatest challenge to strike a balance between living in one's very own unique inner world and cohabitating in a shared world -- bearing responsibility for one's contribution. There is a separation of one's wishes from reality, resulting into a break-up of the connection between self and experience. This simply represents a fact that one's wishes and realities of life fail to meet.

A picture of a client in Depression or one who is mentally ill is therefore, summarised as a person who is;

- i. Continuously experiencing needs
- ii. Not always understanding or even recognising some of the needs
- iii. Seeking assistance whenever he/she cannot meet the needs.

As a result of the above mentioned points, we can associate a client as a desperate person in search of one's needs, a sufferer in search of help or a patient in need of treatment. In moments of tension, disappointments, dashed hopes and frustration, a client's world develops many dimensions. In an attempt to meet the needs, often without understanding what one wants, a client ends up making inadequate and irrelevant decisions.

Understanding their world

The client's inner world is where a counsellor should always begin from when offering a helping hand. A counsellor therefore, needs to learn how to appreciate, support, embrace and be kind to such clients because they are typically walking to the beat of a different drum. It is essential to consider that the inner worlds of the clients are worth taking into account when trying to get along and play nice in the processing of offering a helping hand. Counsellors should understand each individual client's world if they are to practice accurate empathy, positive regard and genuineness to clients. Counsellors need to appreciate that the world of a client is a complicated one and that someone should always be there to accompany the client in his/her journey from a state of confusion to a state of reality.

MODULE 7

The client and his/her world

Activity 1: You are your own mirror!

(60 min.)

1. *Make an assessment of your own inner world by writing down as many words as you can to describe your unique inner world. No need to share what you have written down with anyone if you feel it is too private to share.*

Make an individual reflection of how you think your inner reflects (or does not reflect) reality.

2. *Lead each participant to a private corner at a time (you may use a different room near the training room) to share their own feelings about their inner world and how it mirrors or does not mirror reality. At the end of the activity, allow the group to share their feelings about the activity.*

MODULE 7

What is helping?

Activity 2: The helping hand!

(20 min.)

Discuss how a person helping so many people at once manages to do so by brainstorming the conditions allowing the person to help the other people.

MODULE 7

Activity 2

HANDOUT

What is helping?

As the word suggests, this is actually to help clients manage their problems, live more productively, and develop unused or underused opportunities more fully. Helping facilitates the client to look at his/her general ability to manage problems and develop opportunities. This would result in the client becoming better at helping himself/herself in everyday life. For all helping to take place, the environment plays a central role. Usually the environment is the source of the problem and also the source of help. Its role can never be undermined.

The process of helping has several dimensions and each of them contributes to the definition of helping. In this training manual, we will classify the dimensions in three parts. The first dimension specifies the condition under which helping occurs. The second dimension specifies the pre conditions that influence one to seek help and the influencing factor for the other to accept to offer help. The third dimension is the one that deals with the result of the interaction.

1. For a helping process to commence there must be a help seeking person looking for a helper.
2. The second condition is that the client must show willingness to be helped and ready to participate fully in the helping relationship.
3. The third condition is that the helper if trained should be ready to utilize the counselling skills without reservations.
4. The fourth and last condition relates to the physical environment in which the help is offered. Conditions such as privacy, comfort, space in the room, and timing contribute to the success of the helping process.
5. Requirements of the psychological conditions such as empathy, unconditional positive self regard as necessary ingredients of help.

Person seeking help → Helper → Conducive physical and psychological conditions
→ Helping process = Helpee (client) feeling empowered

MODULE 7

Activity 3

HANDOUT

The environment as a source of help

The environment is a huge resource for help. All the people who can help are within the community and in most cases within our own immediate environment. These could be in our families, schools, hospitals, social welfare offices, religious institutions, youth organisations among other institutions. Below are elaborations of some of the people who can help us.

Non-Professionals:

Non-professional helpers have been in existence in traditional settings for a long time. These could be our friends, relatives and other elders within the community. But for our purpose in this chapter, emphasis will be placed on professional helpers in reference to their respective institution.

Professional Helpers

A professional helper is trained personnel in one or more counselling disciplines and the counsellor is actively involved in counselling. The following discussion will give an insight on various types of counsellors, their clients and nature of help they render. The following are singled out as major actors in the profession:

i. School Counsellors:

Education is dynamic and in its growth, authorities have found it fit to open up counselling units in Primary and Secondary Schools. In Primary Schools, counselling takes a large portion of their work on provision of individual counselling. Many pupils are largely affected by the economic situation and as a result children's mental position is affected. Some tend to be absent from class, some turn violent on others, some withdraw their class participation. Many negative results can still appear. In this regard, the school counsellor focuses on counselling pupils, parents and discuss with teachers over the approach to these particular pupils in the school.

A counsellor at Secondary School does all that a Primary School counsellor does. Addition responsibilities are that of providing career counselling. In this area, a counsellor provides pupils with college information, study skills, personality growth and tactics of living with others. These counselling sessions can either be done individually or in a group for not more than thirty minutes.

ii. Community Setting Counsellors:

Trained Community Social Workers take the role of community counsellors. Such counsellors include Family Planning Counsellors, Psycho Social Counsellors and Mental Health Counsellors. Their clients include children, adolescents, adults, couples, families and the elderly.

iii. Religious Counsellors:

Religious counsellors are often associated with a particular denomination. Many religious counsellors believe that human problems must be examined and changes introduced within a context of religious beliefs and

values. Most of them emphasise on improving moral and specialisation in marriage and family therapy.

iv. Health Counsellors:

Health institutions are obvious places where counsellors are needed. Their main role is to reduce tensions in patients and comfort those looking after the sick. Other roles of these counsellors are to establish personal relationships with various patients, learn more about their problems and later discuss with medical practitioners on specific information which can in turn help the client. The main clients for these counsellors are patients.

Points to Remember:

- Helping is a process.
- The person to be helped must be willing to engage in a helping process.
- The helping environment must be conducive.
- The environment is the resource base for professional helpers.

MODULE 7

Activity 3: The helping hand!

(60 min.)

Work in small groups to do the following:

- 1. Define 'helping' as it relates to Counselling (using your own words)**
- 2. Develop a mind mapping of a helping relationship using the following discussion points:**
 - a. Why is the environment important when we consider helping someone?**
 - b. What do you think could be barriers to helping a person?**
 - c. How can these barriers be overcome?**

MODULE 7

Activity 3

HANDOUT

Characteristics of a helping hand

Positive counselling outcomes are also largely dependent upon a healthy relationship. A helping relationship is like a journey. In this journey the helper is to provide the conditions necessary for the client to feel confident, to open up and develop trust towards the helper. This is a crucial ingredient to a successful relationship.

A trusting and open relationship can facilitate sharing of important information necessary to identifying and solving problems that are interfering with the quality of life of a client. It is therefore imperative to create an environment that is safe, accepting, caring, open, and objective.

The following are some of the characteristics of a quality helping relationship:

i. Meaningfulness

Counselling is meaningful because both counsellor and the client concentrate on the process and value it is personal and intimate, relevant, anxiety-evoking and it involves mutual self-commitment. Indeed there is no neck pulling in the helping relationship but all that is needed is a voluntary commitment to the process by both counsellor and client.

ii. Collaborative effort

As a helping relationship, the client and the counsellor must feel free to talk about the problem at hand. They must be open and honest with their feelings about the problem.

iii. Effect

This is evident through self-revelation of personal emotions, feelings and values. During self-disclosure, the counsellor watches the emotional expressions of the client and respects such observations because effect reactions help to learn the extent the client is affected by the problem.

iv. Approachable and secure

The helper in the relationship is approachable and this helps the client to feel at ease and welcome with a strong hope that a solution will be found.

v. Integrity

The helper and the client remain honest to one another in the relationship in order to maintain trust and confidence in one another. They look at each other as human beings of worth value with intellectual capacity to remain in, and gain from the relationship.

vi. Empathetic

Empathy is an important characteristic to maintaining a good relationship. People come to therapy with all sorts of emotional and mental problems. Simply nodding or saying, "I understand" can put a client at ease and on the road to recovery.

vii. Meticulous

Always pay attention to details. This affords the counsellor not to miss any tell tales from the client.

viii. Acceptance

Being able to suspend judgement and criticism, listen by giving complete attention so that the client feels valued for himself.

All these characteristics are crucial and every counsellor should strive to develop these where they feel they may be lacking.

MODULE 7

Activity 4:

(20 min.)

Work in small groups to discuss how a good helping relationship facilitates positive counselling outcome.

MODULE 7

What counselling is and what it is not

Activity 5:

(15 min.)

In small groups, look at the statements said about counselling from the illustration below and identify what you think is not counselling. Give reasons for your opinions and report during plenary.



MODULE 7

Activity 5

HANDOUT

What counselling is and what it is not

Counselling is a profession just like nursing, teaching, engineering, and many others. Trained and certified counsellors become professionals and can offer services to both groups and individuals. Support services by peers sensitised on counselling skills and management are referred to as peer counsellors such as those found in peer clubs.

MODULE 7

The benefits of counselling

Activity 6:

(60 min.)

Work in groups to prepare for a gallery walk poster addressing the following questions.

- **What are the advantages of having a teacher counsellor available to offer services of counselling to fellow teachers in the same school or community?**
- **What are the advantages of having a young peer counsellor available to offer peer counselling in the same school or community?**
- **Do you think parents also need counselling?**

Share your responses with the large group.

MODULE 7

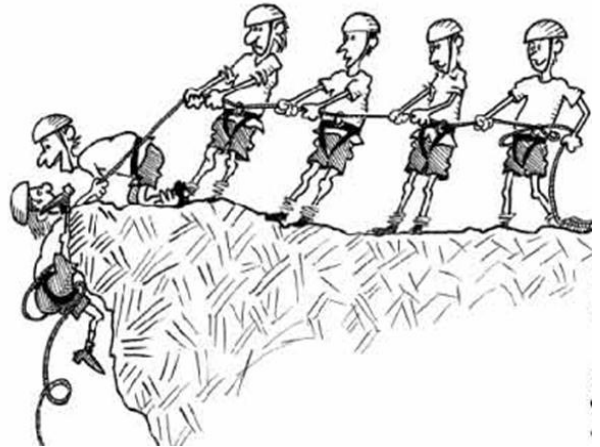
Activity 6

HANDOUT

The benefits of counselling

The following are some of its benefits of counselling.

1. Peers identify and relate with peers
2. Peers can reinforce learning through on-going contact
3. Peers are close in proximity and are thus able to connect with those who are hard to reach
4. Peer counselling utilizes an already established means of information
5. Peer counselling enhances empowerment in youth
6. Peer counsellors also serve as role models to their peers.



MODULE 7

What a Counsellor should always be aware of

Activity 7:

(20 min.)

In small groups, discuss potential dangers and concerns in a counselling relationship. Further, how can these be prevented?

After discussion, share your ideas with the large group.

10 Peer counselling commandments

1. A helping relationship has a purpose and need not be viewed as a permanent concern by both parties.
2. Avoid intimate relationships within the peer counselling groups.
3. Do not promise what you cannot fulfil.
4. Appreciate your limitations and make relevant referrals.
5. Limit the levels of self-revealing in a peer counselling relationship as this may show weakness on the side of the counsellor.
6. Avoid conducting counselling in non-authorised premises or during odd hours.
7. Do not busy yourself creating imaginary problems on the peers and solving them. Not having a client is not a weakness on your part.
8. Your fellow youth's problem that you are attempting to help to resolve should never be viewed as your personal problem. A peer counsellor is just there to help peers find their own solutions.
9. Observe arms-length distance during sessions. Proximity can build or destroy a peer counselling relationship.
10. When additional crises emerge during a session, do not lose sight of the original intention (*When putting out fire, concentrate on the log and not on the sparks*).

MODULE 7

Activity 7

HANDOUT

Effective counselling relationship

Discovering the helper!

Have you ever found yourself in a situation where you faced a problem and did not know what to do? It could have been that something valuable was stolen from you or that your close friend was persuading you to do something very bad like taking drugs.

How did you get out of the situation? Sometimes we are faced with problems that we cannot manage to handle on our own. We need other people to help us. The outcome of that helping, among other factors, depends on the qualities of the helper, who in this case is a Counsellor.

The connection between client and counsellor

Depression is often a product of the environment. The environment which consists of human beings and other elements must be responsible in fighting it. The depressed (client) often seeks solace from the helper (Counsellor). Their engagement is purposeful and therefore will require building of a helping relationship between the two, called a counselling relationship.

MODULE 7

Activity 8: Let's build a relationship

(20 min.)

In small groups, fill in the following table and share the results during plenary

Quality	How it helps build effective relationships.	How it can negatively affect relationship
Patience		
Confidentiality		
Approachability		
Good conduct		
Trustworthiness		
Endurance		
meaningfulness		
Collaborative effort		
Honesty		
Respect		
Non judgmental		

MODULE 7

Activity 8

HANDOUT

Let's build a relationship

Unit of purpose brings about quality relationship that can produce positive outcomes. Here are brief personality profiles that can enhance counselling relationships.

i. Patience:

The peer counsellor need to be patient as the client narrates his story. Rushing clients results in some valuable information being left out. Rushing clients will make them realize that the Counsellor is disinterested.

ii. Honesty:

This facilitates trust between the client and the Counsellor.

iii. Non-judgmental:

This boosts the relationship because the client feels accepted and not guilty. Judging makes clients feel guilty and may not turn up for other sessions.

iv. Good Conduct:

Counsellors who believe in do as I say not as I do may not maintain a good relationship with clients. Good conduct builds confidence in clients. To modify behaviour the Counsellor himself/herself must be of positive conduct. A Counsellor cannot embark on anti-alcohol promotion when he/she abuses alcohol.

v. Confidentiality:

An effective Counsellor does not divulge what transpires in a counselling session. This may actually destroy any relationship.

vi. Meaningfulness:

Counselling is meaningful because both Counsellor and the client concentrate on the process and value it as personal and intimate, relevant, anxiety-evoking and it involves mutual self-commitment. Indeed there is no neck pulling in the helping relationship but all that is needed is a voluntary commitment to the process by both Counsellor and client.

vii. Collaborative efforts:

As a helping relationship, the client and the Counsellor must feel free to talk about the problem at hand. They must be open and honest with their feelings about the problem.

viii. Approachability:

The Counsellor in the counselling relationship is approachable and this helps the client to feel at ease and welcome the counselling sessions with a strong hope that a solution will be found.

ix. Honesty:

The Counsellor and the client remain honest to one another in the relationship in order to maintain trust and confidence in one another. They look at each other as human beings of worth value with intellectual capacity to remain in, and gain from the relationship.

x. Respect:

The Counsellor must show appropriate esteem to others and their understanding of themselves.

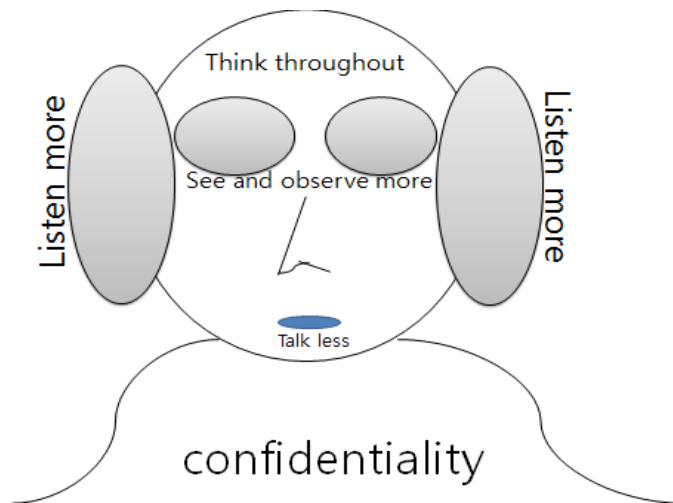
MODULE 7

Being a good Counsellor

Activity 9:

(5 min.)

Look at the following picture and complete the statements below:



I want to be a good peer counsellor

SO! I should

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____

MODULE 7

Activity 9

HANDOUT

Being a good Counsellor

i. Effective listening:

Listen to the client with all your senses and at all times, considering what you hear, what you see, and how you feel the client perceives themselves. Communicate in line with what you listen to. When you listen to and acknowledge your friend's feelings, it sends your friend the message that you care. Knowing that you have people who care about you is an important part of recovering from Depression.

ii. Build trust in relationships:

Be empathetic (being able to walk in another person's shoes) and trustworthy in order to win the confidence of the client.

iii. Alertness:

Always observe the client's behaviour, emotions, gestures and possibilities of other emerging issues during the session.

iv. Recognize the role of other service providers:

When necessary, make referrals to other service providers. It is advisable to have a register of a variety of service providers and orient yourself to their specialties.

MODULE 7

Qualities of a good Counsellor

Activity 10:

(60 min.)

Materials: Flash cards, markers, stones/pebbles/seeds

Process:

1. Invite the participants to sit in a circle.
2. Explain that a Counsellor must have or must develop qualities that allow him/her to work with people. This exercise will enable the group to discuss and list the essential qualities for a good Counsellor.
3. Ask each participant to take a flash card and a marker.
4. Ask them to close their eyes. You might want to play some soft music on a tape recorder. Let everyone think of a person they love and can talk with.
5. After 5 minutes, ask them to open their eyes, and write the one quality they like the most in the person they just thought of.
6. When they finish writing, ask them to place their cards on the floor.
7. Invite the participants to read the cards and group the cards that are similar.
8. Ask them to arrange the cards in a vertical line on the floor.
9. Ask each participant to take as many stones/seeds/leaves (marker) as there are cards. For example, there may be 6 cards on the floor so every participant must have 6 markers.
10. Start at the top of the vertical line. Ask the participant to think for a moment and place one marker in front of the card if they feel that they possess that quality. If someone feels that he/she does not possess that quality, they should not place their marker against it.
11. Finish marking all the qualities in this manner.

When all the qualities are marked, do the following:

1. Invite the participants to sit in a circle around the display, and facilitate a discussion based on what you observe. For example, card number one may have as many stones as there are participants. This means that everyone thinks they have the quality written on that card. Ask how this quality can help them in their own lives and how they can help Counsellors in their helping relationship. Cover all the cards in this manner.

2. Sum up the discussion and the results of the exercise, by emphasizing the importance of those qualities for a Counsellor.

This exercise is fairly simple and it allows you to determine the qualities that a Counsellor should have. You can use this exercise to focus on the qualities that need to be developed by a Counsellor. You can take this exercise a step further by asking the participants to list the manner in which these qualities can be developed. You could also undertake a similar exercise to determine the skills and knowledge required by a Counsellor.

Qualities of a good Counsellor

Traits + competency = effective Counsellor

An effective Counsellor should have qualities in order to offer help skilfully to desperate solution seeking clients. The following are some qualities worthy for an effective Counsellor:

Traits

a) Patience

Resolving complex depression requires endurance, resilience and ability to show interest in helping the client. Avoid hurrying the client but if they drag on make empathetic reflective statement to help them think through their statements and feelings

b) Honesty

Counsellors should not hide their feelings and knowledge that can benefit the client. Clients deserve honest direction and guidance on how they are proceeding with the helping process and what should be done to enhance recovery. The Counsellor should take note of his or her limitations and propose for a referral with an honest justification when necessary.

d) Empathetic

Counsellors should attempt to see things the way the client does, visualise the way the client feels without necessarily expressing too much sympathy. A common statement by the Counsellor could be, "I know how you feel right now..."

e) Pragmatic

The counsellor should structure the session that leads to the empowerment of the client coming up with practical and workable solutions.

f) Spontaneous/Immediacy

A Counsellor should be aware that counselling is fluidal and that it can change direction any time. In this regard, a Counsellor should use his/her skills to adapt to any situation where necessary.

g) Non-judgmental

A Counsellor is not a judge and should not interrogate the client but listen carefully to what the client is saying about the depressing moments. Special care should particularly be taken when counselling a youth who is depressed and disabled at the same time by not focusing on the impairment during counselling as this would constitute judgement.

h) Good conduct

Do as I do not do as I say should be the fundamental principle of a Counsellor. A Counsellor is the light of the community.

i) Communication

Clear communication between counsellor and the depressed client is most likely to yield quick and sustainable recovery from depression.

Competences

a) Cultural sensitivity

- Be aware of the existing cultural values, beliefs, norms and perceptions about depression and depressed people in the society.
- Recognise the importance of family, social networks and community systems in the treatment of depression and mental illnesses

b) Ethical Consideration

- Demonstrates the ability to apply and adhere to ethical and legal standards in counselling.
- Demonstrates the ability to recognize one's own limitations as a Counsellor and to seek supervision or refer clients when appropriate.

Counselling Treatment for Depression

How do I get help?

Depression is now one of the leading causes of disability worldwide. With a large percentage of youth experiencing some form of the condition, it is imperative that they seek treatment as soon as symptoms are recognized. Many people don't realize that depression is a treatable medical condition. Often times, we feel there is a certain stigma attached to any kind of emotional or psychological problem so we don't talk to family, friends, or even our family doctor until things have gotten out of control. Depression is not something to be ashamed of and you are not weak or broken because you experience it. For the most part, the onset of feelings of hopelessness and emptiness is beyond your control. But with medical intervention and values-based counselling, you can usually see marked results in a very short time. Dealing with your depression can seem overwhelming at first but with the understanding and support of a good counsellor or therapist, you can overcome the feelings of helplessness and despair and once again gain control of your life.

Counselling treatment for Depression

We all feel a little down at times. After all, life isn't always easy. But for people suffering from depression, these times of feeling sad or "blue" are much more intense and last much longer. They may feel lost, and hopeless, lacking value to themselves or to others, feeling that living itself is not worth it. Depressed people can look at their lives and say, "What is the point?". This deep sadness doesn't seem to go away but instead it persists, completely overwhelming the individual.

People who are depressed may feel increasingly irritable, experience a sense of emptiness and hopelessness, and they often feel completely overwhelmed, losing interest in activities they once enjoyed. Real depression is also commonly accompanied by a variety of physical symptoms including lack of energy, problems with sleeping, pronounced weight changes, and eventually, even serious illness

Counselling for depression often begins with an assessment to determine if the onset of symptoms can be linked to an event or series of events in the individual's life. In the case where this is determination, the counsellor works to help resolve the implications of the events and the emotional consequences of the situation. In some situations, acceptance of life changes may be necessary as the events cannot be resolved and management of the depression by dealing with the emotions may be the only viable option. Counselling seeks to help individuals find ways to regain control and direction in their life, finding purpose and meaning to motivate them during "low" periods.

Identifying links that trigger depression or finding positive motivators to encourage individuals is part of the process of moving through and out of the depression. In many cases, depression is maintained due to a childhood or previous life experience that subconsciously reminds the individual of a sad or depressing mood. Counselling aims to identify these links and resolve the underlying issue to free the individual of this

burden.

In order to have a systematic counselling the following schedule may assist the counselling.

1. ANALYSIS: **GET TO KNOW**

Collecting as much information as possible on what could be triggering depression through careful interaction with the depressed. Master most of the information and avoid being busy writing notes and taking telephone calls.

2. SYNTHESIS: **WHICH IS WHICH?**

Summarizing issues according to levels of intensity and organize the information collected to determine the client's strengths and weaknesses in the fight against depression.

3. DIAGNOSIS: **AHA!!!! LET'S DEAL WITH IT TOGETHER**

Counsellor's conclusion about the depressing situation, how it has affected the life of the client and starts to empathize with the client.

4. PROGNOSIS: **WHERE THERE IS A WILL THERE IS A WAY**

This refers to the counsellor's prediction of the client's future developments or the implications of the diagnosis. It's time to inform the client that he or she should be actively involved in fighting depression by following advice and change habits of life. It's important to remind the client that recovery is not a one way journey but may experience backward steps at times. When this happens it not a sign that things are not getting better. Client should be reminded that counselling will require feeling free to express the depressing moment exactly the way it is without over or under stating it.

5. COUNSELLING: **TAKE MY HAND**

Application of techniques to resolve the problems identified. The counsellor uses any method that can bring about adjustment of behaviour or reduce depression. Remember to give the client much time to express themselves. If they cry during the process please give them chance to do so for a short while.

6. FOLLOW UP: **I AM STILL WITH YOU**

It's better to remain in touch after counselling in order to access progress .Don't expect recovered hours after your counselling. At times it takes time and with your support recovery can be speeded up. Constant follow up may add confidence in the counsellor and improve the relationship between the two.

MODULE 7

Activity 11:

(60 min.)

Counselling treatment for Depression

Let's practice it!!

After three counselling sessions, a client has returned to the counsellor to report positive results of recovery in terms of feeling guilty and improved sleeping habits. The counsellor appreciates the role the client played in the recovery, warns the client against re-elapses, and finally tells the client that the sessions have been terminated but open for future interaction.

Specific counselling techniques for Depression

Counselling techniques may be a personal innovation, personal in the sense that they work for particular individuals at a specific time depending on the level of complexity of the problem. Techniques are determined early in the session. However, regardless of training, counsellors are prone to develop a style of counselling for some time.

In order to determine the choice of a technique, it is vital to measure through observations the nature and extent of the problem. The final act is a choice between an active or a passive technique.

ACTIVE TECHNIQUE

This is a situation where the counsellor is highly active to ensure that the counselling process is beneficial to both the client and the counsellor. During this approach, the client is at the receiving end and much of the talking is done by the counsellor. Clients presented in this approach manifest half or more of the following characteristics;

- Display maladjustment as a result of inability to use one's intellectual resources
- Fail to respond to social learning principles such as reinforcements
- Have severe mental illness
- Too young to think logically
- Have a lot of incongruences due to irrational thinking
- Display neurotic behaviour
- Lost self-perception and value of his being
- Feel lonely and views the universe as unfriendly.

Specific techniques used in active approach include the following techniques;

a) Forcing conformity

This is a situation where the counsellor may help the client through direct advice, persuasion or suggestion to the client in order for the client to adjust and follow expectations of society.

b) Changing places

It is hoped that changing places goes a long way in the modification of the client's behaviour.

c) Learning the needed skills

Where Depression is as a result of lack of skills or being idle, the client is advised to learn the needed skills.

PASSIVE TECHNIQUES

This is an approach where the counsellor is passive while the client is highly active. The role of the

counsellor is to facilitate the discussion through activation, suggestions and the use of leads. Clients suitable for this technique fall under the following characteristics:

- manifest few problems
- are psychologically balanced
- can communicate effectively
- usually they are self-referrals.

Some of the helpful techniques suitable for passive approach are

a) Assertive Responses

Depressed people who feel lonely and fear to mix with others benefit from this method. The client is helped to overcome the problem by breaking down the process into parts. For example, a client can be encouraged to meet members of his/her family, later he/her is encouraged to greet the neighbours and lastly he/her may be accompanied to a market to mix with many people. In such a way, the client will recover from his/her fear of mixing.

b) Sexual Responses

Those affected by serious sexual desires which result into behaviour problems may be encouraged to take part in a number of games.

c) Relaxation Responses

This is giving patients (clients) intensive training in the practice of relaxation to enable them relax their muscles. While relaxing, clients are encouraged to imagine less but relax more.

d) Respiration Responses

A very useful tool for those suffering pervasive anxiety. The client is asked to empty and fill the lungs. In this process gas composition is 70% carbon dioxide and 30% oxygen.

e) Systematic Desensitisation Responses

The client is asked to list the problems according to how pressing they are starting with the most disturbing on the top and the least disturbing at the bottom. The client is instructed to relax and told to imagine the bottom problem which is the weakest, he/she responds positively, he/she is encouraged to go to the next problem until he handles the most worrying problem.

MODULE 7

Activity 12, 13&14

HANDOUT

Other techniques of counselling

The purpose of counselling is to aid the counselling process through listening, understanding, empathy and assistance by someone who has similar experiences. Other techniques used in counselling are:

i. Active listening

One of the most important techniques for a Counsellor is to listen. Simply listening may allow the client an opportunity to honestly express his/her feelings. This can be very important when the client feels that family members and friends will judge, give opinions or provide advice rather than listen. When sharing feelings, the client has the opportunity to process the situation and to make decisions about whether a change is necessary.

When the Counsellor listens with a non-judgmental attitude and allows the client to express feelings openly and honestly, trust can build and grow. The client may be open to receiving help once the trust is secure. Through listening, the Counsellor also empowers the client to make his/her own decisions.

ii. Review and Restate (Repeating Information Through Questions)

When working with their clients, Counsellors have to be careful not to push their clients away by combating them over every issue. Instead, you can repeat information that sounds irrational and unreasonable back to a client in the form of a question. For example, a client might say, "I don't care that I get teased every day." Instead of saying, "Of course you care," and pushing the client away, a Counsellor could respond by asking, "So it doesn't bother you that your friends make fun of you on a daily basis? How does it make you feel?" When put into a question, the clients immediately thinks about the statement they just made and it sounds different, and possibly irrational, coming from someone else. In this case, you're not objecting to what the client said. Instead, you're asking following up questions.

Through review and restate, the Counsellor restates what the client said in his/her own words. This affirms to the client that the Counsellor is listening and allows him/her to correct any errors in what the Counsellor understands. The other purpose of this technique is to let the client hear what he/she is really saying.

iii. Teaching

Peer counselling is helpful in teaching techniques and information on a less formal basis outside the realm of classroom education. Substance abuse programmes advocate peer counselling for individuals well along in recovery who can assist those who are just beginning.

iv. Questioning

The peer counsellor can ask deep, open-ended questions to help the client move through the counselling process. Questions that require only a yes or no answer are less effective than questions that require an explanation or a narrative. Questions that begin with how, what or when will elicit detailed answers.

v. Silence (sit and wait)

There is no need to fill all of the counselling time with words. When you ask a question, sit and wait quietly for the client to consider and answer the question. Restate the question only if the client requests it.

vi. Replacing negative self-perception, ideas and self-talk

Depression in the youth is the most worrying issue in the modern world as nations aim at meeting the national development goals. One area of concern is often the way they think. When the thinking is correct and valuable it is called rational. When it is destructive and illogical it is called irrational. Irrational ideas are more likely to bring about depression among youth.

vii. Group Counselling

Another technique peer counsellors can use is encouraging their clients to try out group counselling. This technique makes the peers realize that they aren't alone in their Depression. Members of the group often feel free to share ideas and their feelings about Depression because the discussions are wider and not personalized.

MODULE 7

Techniques of counselling: Active listening

Activity 12:

(10 min.)

Let's whisper down the line / broken telephone!

Let one participant whisper a message to another, which is passed through a line of all the participants until the last person announces the message to the entire group.

Compare the two messages (the first person's and the last person's message).

MODULE 7

Techniques of counselling: Replacing negative self-perception, ideas and self-talk

Activity 13:

(30 min.)



Let's get it right together!

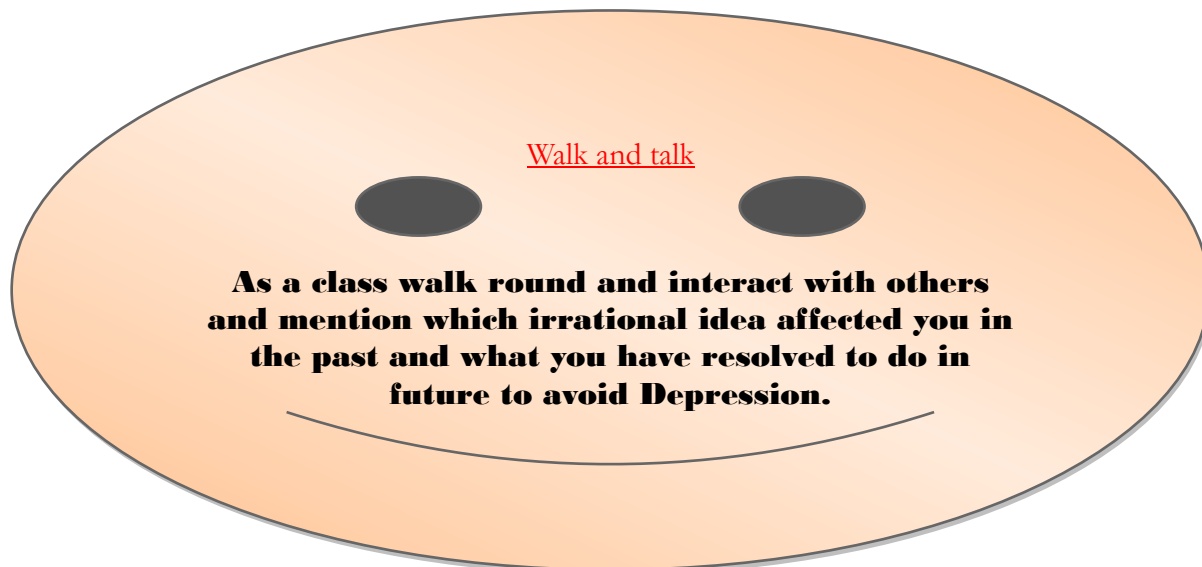
	IRRATIONAL IDEA	RATIONAL IDEA
1	Be loved by everybody in society and that this is a dire need in life.	
2	Be competent in his/her operations if he/she is to be approved as a skilled person.	
3	Bad people should be punished and blamed severely for their sins.	
4	It is better to correct others when they go wrong than wish them for punished.	
5	It is awful and catastrophic when things are not the way one wishes them to be.	
6	Human unhappiness is externally caused and that people have little or nothing to do to control the sorrows and disturbances.	
7	Something may be dangerous or fearsome and that we should be concerned about it and should keep dwelling on to the possibility of it occurring again.	
8	it is easier to avoid a problem than to face	
9	One should be dependent on others who are intellectually or financially stronger than them.	
10	The past history is all important determiner of one's present behaviour.	
11	One should be quite upset over other people's problems and disturbances.	
12	Life is not worthwhile if perfect solutions to human problems are not found.	

MODULE 7

Techniques of counselling: Replacing negative self-perception, ideas and self-talk

Activity 14:

(10 min.)



MODULE 7

Activity 15

HANDOUT

Taking care of self as a Counsellor

You are a facilitator in helping the clients find solutions to their own problems. Never personalise what you receive from your clients as you are a completely different individual. Take time off to do the following:

- i. Know it's not your fault. Remember that it's not your fault that he/she has Depression; no one can "make" another person depressed.
- ii. Put yourself first. In a bus, there is an emergency window and whenever there is an accident help yourself first before helping others. When you are safe on the ground, help others to safety exit as well. If you don't rescue yourself first, you won't be able to help anyone. It's absolutely okay (and *so important*) to take time away to take care of yourself.
- iii. Educate yourself. Understanding what Depression is and how it affects the person you care about will help you to be a less frustrated and more supportive friend.
- iv. Be patient. Sometimes it can be frustrating when your client doesn't seem to want to hang out or do anything they used to like to do. Take a deep breath and remember that Depression is making your client feel this way. He/she can't just "snap out of it." Getting impatient will only make the situation worse. Stay positive and be patient. Encourage your client to participate in social events. He/she may feel like it's too much work or effort, but will probably feel better afterwards.
- v. Don't try to change your client. You don't have to solve all of your client's problems or turn him/her into a different kind of person. Just be present and supportive.
- vi. Be positive. Positive moods are contagious! It's really easy for someone with Depression to focus only on the negative aspects of his/her life. Sharing your positive mood may help your client see things from a different perspective.
- vii. Create space for yourself by encouraging your client to seek further help. Having a Counsellor he/she can trust, like you, is so important. But most people need more help than from just one person. Encourage your client to see his/her doctor or other School Counsellors or Mental Health Facilitators to get the help he/she needs. Even if the problems don't seem that bad yet, seeking help early can prevent mental health problems from worsening and turning into mental disorders.
- viii. Have fun! You and your client individually need to have fun, relax, and laugh with you. These are all important parts of your client's mental health (and yours!).
- ix. Be aware of suicide. If your client talks about death or suicide, don't ignore it or keep it a secret because it will remain in your thoughts, which is not a healthy situation. Talk to a responsible adult who your client also trusts (e.g. parent, teacher, coach, other Counsellor or Mental Health Facilitator). Let your client know that you care about him/her and his/her life. If your client is talking about suicide, you must take it seriously.

MODULE 7

Taking care of self as a Counsellor

Activity 15:

(60 min.)

In small groups, discuss and fill in the following Table. Resent your work in a gallery walk.

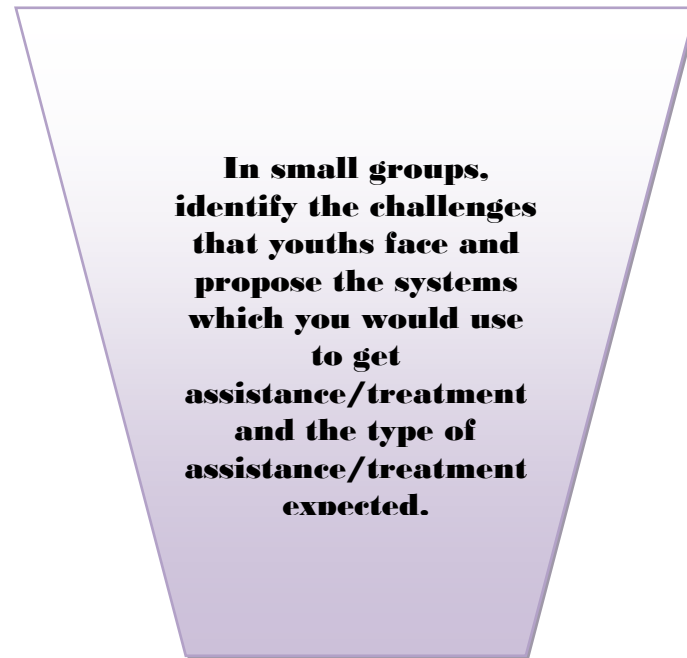
What to be aware of	What would happen if we are not aware of
Knowing it's not your fault	
Put yourself first	
Educate yourself	
Be patient	
Don't try to change your friend	
Be positive	
Create space for yourself by encouraging your friend to seek further help	
Have fun!	
Be aware of suicide	

MODULE 7

Other sources of help

Activity 16:

(40 min.)



MODULE 7

Activity I6

HANDOUT

Other sources of help

REFERRED FROM	REFERRED TO	NATURE OF PROBLEM
Counsellor/Social Officer	Hospital	Health matters
Hospital	Counsellor	Psychosocial problems
Counsellor	Social Department	Social problem/Financial matters
Counsellor	Parents	Home background information
Parents	Counsellor	Home background information
Counsellor/Parent/Hospital	Psychiatrist	Mental illness
Counsellor/Parent/Hospital	Police	Security matters
Counsellor	Church Leader	Moral support
Counsellor/Parents	Speech therapist	Speech problems
Counsellor/Parents	Teachers	Academic matters
Counsellor	Lawyer	Legal matters

The choice of where a referral should be made is a responsibility of both the client and the Counsellor. An agreement should be reached before a referral is made. If possible, a Counsellor should contact the new helper in person before a client goes to present himself/herself.

OPTIONAL ACTIVITY

Optional Activity:

(15 mins.)

What do you think about mental illness now?

Purpose:

- To provide students with an opportunity to reflect on the challenges in their knowledge and attitudes about mental health from the first module.

How to:

1. Hand out a copy of the “What do you think” questionnaire to each student and give them 5 minutes to answer the questions
2. After students have answered the questions, give each student their copy of the questionnaire that they completed in Module 2. Ask students to compare the answers they just wrote with the answers they wrote in the earlier module. Give students a few minutes to compare their responses, reminding them that they should only be looking at their own answers. Ask students whether their answers are different today from when they answered the questions in Module 2, and if so how they are different
3. Conduct a brief group discussion around students’ responses. Use the following questions as a guide:
 - If your answers were different today, why do you think they were different
 - Does learning about mental illness make a difference? Why?
 - Do you think you would react differently now to someone who has mental illness compared to your reaction before you completed this unit?

PART 5 Appendices: Other activities & Resources

Appendix A: Glossary

Acute	Refers to an illness or condition that has a rapid onset, marked intensity and short duration.
Acute stress disorder (ASD)	Persistence of substantial stress induced symptoms beyond usually expected levels and time.
Antidepressant	A medication used to treat Depression.
Anorexia Nervosa (AN)	Is characterised by excessive pre-occupation with body weight control, a disturbed body image, and intense fear of gaining weight and a refusal to maintain a minimally normal weight.
Anxiety	An abnormal sense of fear, nervousness and apprehension about something that might happen in the future.
Anxiety disorder	A group of illnesses that fill people's lives with overwhelming anxieties and fears that are chronic and unremitting. Anxiety disorders include panic disorder, obsessive compulsive disorder, post-traumatic stress disorder, phobias and generalised anxiety disorder.
Attention Deficit Hyperactivity Disorder (ADHD)	A mental illness characterised by an impaired ability to regulate activity level (hyperactivity), attend to tasks (inattention) and inhibit behaviour (impulsivity). For a diagnosis of ADHD, the behaviours must appear before an individual reaches the age of 7, continue for at least 6 months, be more frequent than in other children of the same age, and cause impairment in at least two areas of life (school, home, work, or social functioning).
Bipolar disorder	A mood disorder in which a person alternates between episodes of major Depression and mania (periods of abnormally and persistently elevated mood). Also referred to as mania Depression.
Bulimia Nervosa (BN)	Is characterised by regular and recurrent binge eating, and by frequent and inappropriate behaviours designed to prevent weight gain.
Chronic	Refers to an illness, disorder, or condition that persists over a long period of time.

Cognition	Conscious mental activity that informs a person about his or her environment. Cognitive actions include: perceiving, thinking, reasoning, judging, problem solving and remembering.
Cognitive behaviour therapy (CBT)	Psychological treatment that includes changing how people think about their past, present and future.
Delusion	A false belief that persists even when a person has evidence that the belief is not true.
Depression (depressive disorders)	A group of diseases including major depressive disorder (commonly referred to as depression), dysthymia and bipolar disorder (manic depression). See bipolar disorder and major depressive disorder.
Disorder	An abnormality in mental or physical health. In this guide, it is used as a synonym for illness.
Dysthymia (also referred to as Dysthymic Disorder (DD)	A depressive disorder that is less severe than major depressive disorder but is more persistent. In children and adolescents, dysthymia lasts for an average of four years.
Electroconvulsive therapy (ETC)	An effective treatment for severe depression that is used only when people do not respond medications and psychotherapy. ETC involves passing a low-voltage electric current through the brain. The person is under anesthesia at the time of treatment. ECT is not commonly used in children and adolescents.
General anxiety disorder (GAD)	Excessive anxiety and worry occurring for an extended period of time about several different things. This persistent apprehension, worry and anxiety causes substantial emotional distress and physical symptoms and leads to functional impairment.
Hallucination	The perception of something, such as a sound or visual image, that is not actually present other than in the mind.
Major depressive disorder (MDD)	A mood disorder commonly referred to as depression. Depression is more than simply being sad; to be diagnosed with depression, a person must have five or more characteristics symptoms nearly every day for a two-week period.
Mania	Feelings of intense mental and physical hyperactivity, elevated mood and agitation.
Manic depression	See bipolar disorder.
Mental illness	A brain health condition that changes a person's thinking, feelings or behaviour (or all three) and that causes the person substantial distress and difficulty in functioning.

Obsessive compulsive disorder (OCD)	An anxiety disorder in which a person experiences recurrent unwanted thoughts or rituals that the individual cannot control. A person who has OCD may be plagued by persistent, unwelcome thoughts or images or by the urgent need to engage in certain rituals such as hand washing or checking.
Panic disorder (PD)	An anxiety disorder in which people have feelings of terror, rapid heartbeat and rapid breathing that strike suddenly and repeatedly with no warning. A person who has panic disorder cannot predict when an attack will occur and may develop intense anxiety between episodes, worrying when and where the next one will strike.
Phobia	An intense fear of something that poses little or no actual danger. Examples of phobias include fear of closed-in-places, heights, escalators, tunnels, highway driving, water, flying, spiders and dogs.
Post traumatic disorder (PTSD)	Develops after a trauma occurs that was either experienced or witnessed. It involves the development of psychological/physical reactions related to the experience such as recurrent, intrusive and distressing recollection of the event.
Psychiatrist	A medical doctor (M.D) who specializes in treating mental diseases. A psychiatrist evaluates a person's mental health along with his or her physical health and prescribes medications.
Psychiatry	The branch of medicine that deals with identifying, studying and treating mental, emotional and behavioural disorders.
Psychologist	A mental health professional who has received specialized training in the study of the mind and emotions. A psychologist usually has an advanced degree such as a PHD.
Psychosis	A serious mental disorder in which a person loses contact with reality and experiences hallucinations and /or delusions.
Recovery	Recovery from mental illness refers to a person's improved capacity to lead a fulfilled life that is not dominated by illness and treatment. Recovery does not always mean that symptoms go away completely, or that people no longer need medication or supportive services. Recovery is defined differently for each individual, but most often means that a person has the capacity to find purpose and enjoyment in their life despite their illness.
Relapse	The recurrence of symptoms of an illness.
Schizophrenia (SCZ)	A psychotic disorder characterized in the active phase by hallucinations, delusions, disorganized thoughts/speech, disorganized or catatonic behaviour and apathy. Schizophrenia is an extremely complex medical mental disorder; in fact it is probably many illness masquerading as one. A bio-medical imbalance is believed to cause symptoms, which usually develop in the late teens or early twenties.

Serotonin	A neurotransmitter that regulates many functions, including mood, appetite and sensory perception.
Stigma	Stigma is the use of negative labels to identify a person living with mental illness.
Symptom	Something which indicates the presence of an illness.

Appendix B: Sample Template

Template - Community Mental Health Resources

The following mental health related resources are available in many communities. Find out the contact information for these resources in your community and distribute to students.

Malawi National Help Line 80001234

This is a Malawi Government Project National Helpline which was launched in Malawi through the roll out of the Youth Net and Counselling's Tithandizane helpline – 80001234. The helpline provide accurate information on issues that affect the youth and children such as information on sexual reproductive health, sexuality and relationships, HIV and AIDS, human rights and child abuse through online and face to face counselling to youths and children. The toll free line is open from 6:00am to 10:00pm Monday to Sunday. After 10:00pm calls are rerouted to specific members of staff who ably respond and provide necessary counsel.

The Helpline is currently coordinated by Youth Net and Counselling as a secretariat on behalf of the Malawi Government. Malawi Government, through its Child Affairs Section provides policy direction. Other partners in this initiative include Centre for Youth and Children's Affairs (CEYCA) and Youth Watch Society (YOWSO) in Mzuzu. The helpline is accessible from two telephone lines one a mobile and the other one a fixed line. These are Malawi Telecommunications Limited (MTL) and Telekom Networks Malawi (TNM). Since the establishment of the helpline, over 100,000 youth and children have accessed the helpline.

Parents, teachers and any other concerned adults are welcome to call for information and referral services at any time.

Call a Doctor Airtel Line 59090

This is a national clinical counselling and consultation line.

Operation Ndakuona (+265) 800 990 997

Ndakuona Toll Free to call the police to contain rising insecurity in the country, with an aim of reporting crime and related issues in the community. People tip-off the police whenever they notice suspected criminal activity or criminal suspects.

Local Mental Health Organizations _____

Local community Mental Health Clinic _____

Local Community Health Centre _____

Local Hospital _____

Appendix C Further Resources and Information

For more information

Websites and other resources for teachers-

Further information on mental health problems and mental illness

Canadian Mental Health Association

www.cmha.ca

CMHA National has a comprehensive range of information available to download from their website, including a complete series of pamphlets with vital information on mental health and mental illness.

Additionally, you will find many resources pertaining to mental health and schools - for teachers, parents and students at www.cmha.ca/high school.

American Academy of Child and Adolescent Psychiatry

<http://www.aacap.org/>

The AACAP Website contains a wide range of information on childhood and adolescent mental health and illness geared towards different audiences, including educators and parents.

Parents and Teachers as Allies

<http://www.nami.org/ContentGroups/Youth/Parents and Teachers as Allies. Htm>

By Joyce Burland, PHD., National Director, NAMI Education, Training and Peer Support Centre, Second Edition, 2003. Available through NAMI, c/o Lynne Saunders, Colonial Place Three, 2017 Wilson Blvd. Suite 300. Arlington, VA 22202-3042 or by fax (&) #) 524-9094. (\$1.00 per copy)

A useful guide that can help parents and teachers identify the key warning signs of early-onset mental illness among children and adolescents. It focuses on specific, age-related symptoms of mental illness in young people, which may differ from adult criteria for diagnosis.

National Institute for Mental Health (NIMH)

[http://www. Nih.gov/](http://www.Nih.gov/)

The NIMH website contains up-to date and reliable information about a wide range of issues relating to mental health and illness across the lifespan.

Classroom Resources

When Something's Wrong: Ideas for Teachers with Troubled Students

http://www.cprf.ca/publication/wsw_order.pdf

A quick reference source of useful classroom strategies to help elementary and secondary school teachers and administrators understand and assist students with mood behaviour or thinking disorders. Available from the Canadian Psychiatric Foundation (\$10 including shipping and handling).

<http://allmentalhealth.samhsa.gov/schools.html>

Eliminating barriers for learning is a packages continuing education programme for secondary schools in promoting and protecting the social and emotional well-being of members of school communities.

Reaching Out

<http://cms.schizophrenia.ca/reachingout/>

A complete, easy to teach, bilingual educational program especially created for Canadian youth. The program includes classroom activities and a video which provide information on psychosis and schizophrenia.

The science of Mental Illness- National Institute on Mental Health Curriculum Supplement Series

<http://www.science-education.nih.gov/customers.nsf/MSMental>

In this supplement designed to address science curriculum for grade 6-8, students gain insights into the biological basis on mental illness and how scientific evidence and research can help us understand its causes and lead to treatments and, ultimately, cures.

Information geared to young people

Psychosis Sucks

<http://www.psychosissucks.ca/epi/>

This site contains valuable information for youth in the importance of early intervention in psychosis. It includes information on warning signs and how to get help, along with personal stories and accounts of recovery.

Mind your Mind

<http://www.mindyourmind.ca/>

Mindyourmind.ca is an award winning site for youth by youth. This is a place where youth can get information, resources and the tools to help manage stress, crisis and mental health problems.

NOTES