Mental Health Issues in a School Setting

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Objectives

1. Understand the relation between mental illness and stigma.
2. Understand the role of therapeutic communication in developing a relationship with children with mental health issues.
3. Identify symptoms and risk factors for depression.
4. Recognize the need to identify children at risk for suicide and how to talk to them.
5. Identify different anxiety disorders and interventions.
6. Recognize that eating disorders are a mental illness with serious medical complications.

Mental Illness And Stigma

- What comes to mind when you think of mental illness?
- How many people in the room know someone who has been diagnosed with a mental illness?
- Why is it important to talk about?
- FICTION: Children aren’t diagnosed with mental illness.
- FACT: Millions of children are affected by depression, anxiety and other mental illnesses. As a matter of fact, 1 in 10 children live with a diagnosable mental illness. Getting treatment is essential.
Mental Illness and Stigma

- https://www.youtube.com/watch?v=Kos6rPlw0

Therapeutic Communication

"The human language, as precise as it is with its thousands of words, can still be so wonderfully vague."

— Garth Stein (The Art of Racing in the Rain)

Begin with Self Awareness

- Understand — one’s belief, thoughts, motivations, biases, and limitations and how they affect others.
- Build relationships — via successful therapeutic communication —
- Therapeutic communication is the ongoing process of interaction through which meaning emerges.
### Empathy vs. Sympathy

<table>
<thead>
<tr>
<th>Empathy</th>
<th>Sympathy</th>
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</thead>
<tbody>
<tr>
<td>An appreciation and awareness of the patient’s point of view from their experience - understanding the point of view of the patient.</td>
<td>Feeling for a patient from the point of view of your experience</td>
</tr>
</tbody>
</table>

### The Art of Listening

"Here’s why I will be a good person. Because I listen. I cannot talk, so I listen very well…. Learn to listen! I beg of you. Pretend you are a dog like me and listen to other people rather than steal their stories."

— Garth Stein *(The Art of Racing in the Rain)*

### Therapeutic Communication Skills

- Silence and listening
- Facilitative questions and statements
- Reflection
- Restatement
- Focusing
- Clarifying
- Conveying information
- Providing feedback
- Stating observations
- Connecting islands of information
- Confrontation
- Summarizing
- Silence
- Humor
Barriers to Therapeutic Communication

- Giving advice
- Giving false reassurance
- Changing the subject
- Being judgmental
- Giving directions
- Excessive questioning
- Using emotionally charged words
- Challenging
- Making stereotypical comments
- Self-focusing behavior

Non-Verbal Communication

“So much of language is unspoken. So much of language is compromised of looks and gestures and sounds that are not words. People are ignorant of the vast complexity of their own communication.”

— Garth Stein (The Art of Racing in the Rain)

Discussion

- Think of time when you struggled with what to say to someone struggling with a mental illness.
- Have you ever avoided talking to patient about their sadness because you were afraid of making things worse?
- Why is it important to listen?
Major Depression

Depression

- Major Depression differs from the ‘blues’
- A diagnosis of depression should be considered when a physically healthy child exhibits depressed mood or anhedonia, multiple somatic complaints, or behavioral changes, such as bullying, aggression, and social withdrawal.
- Risk factors for depression include childhood trauma, genetic susceptibility, and environmental stressors.

2015 National Survey on Drug Use and Health

- In 2015, an estimated 3 million adolescents aged 12 to 17 in the United States had at least one major depressive episode in the past year. This number represented 12.5% of the U.S. population aged 12 to 17.
How is depression different in kids?

- Irritable or angry mood
- Physical complaints
- Extreme sensitivity to criticism
- Withdrawing from some but not all people

What Are the Risks Associated with Major Depression

- Increase in suicide risk
- Risk for substance use disorders
- Risk for failing grades
- Risk for legal involvement

Suicide
Definition of Common Terms

- **Suicide**: The voluntary act of killing oneself. Also called Suicide Completion
- **Para Suicide**: The voluntary, failed attempt to kill oneself. Also called Attempted Suicide
- **Suicidal Ideation**: Thinking about and planning one’s own death. Includes excessive and unreasoned worrying about losing a significant other
- **Lethality**: Probability of successful completion of suicide attempt, determined by seriousness of intent and efficacy of plan
- **Hopelessness**: State of despair characterized by feelings of inadequacy, isolation, and inability to act on one’s own behalf, connected with belief that situation is unlikely to improve.

Suicide Facts

- Suicide is the second leading cause of death in youth ages 15-19y. Third leading cause of death ages 14-21.
- Every year approximately 157,000 youths between the ages of 10 and 24 receive medical care for self inflicted injuries at emergency departments across the United States.
- A 2015 nationwide study of youths in 9-12th grade found that 17.7% of students reported seriously considering suicide, 14.6% reported creating a plan and 8.6% reported trying to take their own lives in the 12 months preceding the survey.
**Risk Factors**

- Previous suicide attempt
- Close family member who has committed suicide
- Past psychiatric hospitalization
- Recent losses
- Social isolation and or hopelessness
- Co-occurring mental and alcohol or substance abuse disorders
- Impulsive and/or aggressive tendencies
- Exposure to violence in the home or social environment
- Handguns in the home, especially if loaded
- Parental psychopathology
- Psychiatric disorders such as mood disorders.
- Chronic physical illness

**Tips to Identify a Child at Risk**

- Change in eating habits
- Withdrawal from friends, family and regular activities
- Violent actions, rebellious behavior, or running away
- Drug and alcohol use
- Unusual neglect of personal appearance
- Marked personality change
- Persistent boredom, difficulty concentrating, or decline in quality of schoolwork
- Frequent complaints of physical symptoms often associated to emotions
- Loss of interest in fun activities
- Not tolerating praise or reward

**Common Warning Signs**

- Talking about suicide
- Seeking out lethal means
- Preoccupation with death
- No hope for the future
- Self-loathing, self-hatred
- Getting affairs in order
- Saying goodbye
- Withdrawing from others
- Self destructive behavior
- Sudden sense of calm
Common Misconceptions

- People who talk about suicide won’t really do it.
- Anyone who tries to kill him/herself must be crazy
- If a person is determined to kill him/herself, nothing is going to stop them
- People who commit suicide are people who are unwilling to seek help.
- Talking about suicide may give some one the idea.

Ask the questions

- Incorporate the safety questions into your health assessment.
- Has there ever been a time when you have thought about wishing you were dead?
- Have you ever thought about a specific way to end your life?
- What is the child’s access to the means?
- Have you ever tried to end your life?
- What has prevented you from following through with these thoughts?

When talking to a suicidal person:

- Do:
  - Be yourself. Let them know they are not alone
  - Listen
  - Be sympathetic, non-judgmental, patient, and calm
  - Offer hope. Reassure the person that help is available
- Don’t:
  - Argue with a suicidal person
  - Act shocked, lecture on the value of life
  - Promise confidentiality
  - Offer ways to fix the problem, or give advice
  - Blame yourself.
In 2015, the Georgia General Assembly passed House Bill 198, also known as the “Jason Flatt Act – Georgia”. The Jason Flatt Act – Georgia requires local school systems to provide annual suicide prevention education training to all certificated school system personnel and to adopt a policy on student suicide prevention.

https://www.gadoe.org/External-Affairs-and-Policy/Policy/Pages/Suicide-Prevention.aspx

**Georgia Suicide Statistics: GBI Child Fatality Unit**

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<thead>
<tr>
<th>Year</th>
<th>Deaths</th>
<th>Death Rate</th>
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<td>30</td>
<td>1.6</td>
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<tr>
<td>Georgia 2015, 5-17 Years of Age</td>
<td>51</td>
<td>2.8</td>
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<tr>
<td>Georgia 2014, 5-9 Years of Age</td>
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</tr>
<tr>
<td>Georgia 2015, 5-9 Years of Age</td>
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<tr>
<td>Georgia 2014, 10-14 Years of Age</td>
<td>12</td>
<td>1.7</td>
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<tr>
<td>Georgia 2015, 10-14 Years of Age</td>
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<tr>
<td>Georgia 2014, 15-17 Years of Age</td>
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</tr>
<tr>
<td>Georgia 2015, 15-17 Years of Age</td>
<td>35</td>
<td>8.3</td>
</tr>
</tbody>
</table>

**Resources**

- National Suicide Prevention Lifeline: 1-800-273-TALK
- National Hopeline Network: 1-800-SUICIDE
- Georgia Crisis and Access Line: 1-800-715-4225
Anxiety Disorders

- Generalized Anxiety Disorder
- Social Phobia
- Separation Anxiety Disorder
- Panic Disorder vs Panic Attack

Prevalence

![Graph of Generalized Anxiety Disorder Prevalence](image-url)
What does this mean for the school nurse?

- Children presenting with physical complaints
- Children with multiple absences due to anxiety
- Children presenting with symptoms of panic

What Can I do to Help?

- Teach relaxation breathing
- Teach guided imagery
- Provide a safe and calming environment
- Collaborate with family, teachers and school counselors to help teacher remain in school.

Eating Disorders
What are Eating Disorders?

• Eating disorders:
  – are a group of serious mental illnesses associated with significant medical impact
  – can present in children and adolescents as abnormal growth or delayed or interrupted puberty
  – have medical consequences that often go unrecognized but can compromise every organ system in the body
• Best outcomes for patients with eating disorders hinge upon:
  – Early recognition
  – Early intervention
  – Weight restoration

Remember that Eating Disorders

• Can affect boys as well as girls
• Can be present in younger and older patients than previously thought
• Can affect people of all ethnicities and backgrounds
• Can be present in people at normal weight

Epidemiology

• Anorexia Nervosa (AN) affects an estimated 0.5% of adolescent girls in the U.S.
• Bulimia Nervosa (BN) affects an estimated 1% to 2% of adolescent girls in the U.S.
• Males comprise 5% to 10% of all eating disorders patients
• Other eating disorders affect an estimated 14% of the population
• Median age of onset is 12 to 13 years old
• Younger patients comprise an increasing portion of patients with eating disorders
2013 DSM-5 Eating Disorder Classifications

- Anorexia Nervosa
- Bulimia Nervosa
- Avoidant/Restrictive Food Intake Disorder (ARFID)
- Binge-Eating Disorder (BED)
- Pica
- Rumination Disorder
- Other Specified Feeding or Eating Disorder (OSFED)
  - Atypical Anorexia Nervosa
  - Bulimia Nervosa (of low frequency and/or limited duration)
  - Binge-Eating disorder (of low frequency and/or limited duration)
  - Purging disorder
- Unspecified Feeding or Eating Disorder (UFED)

Anorexia Nervosa DSM-5 Diagnosis

- Significantly low body weight
- Intense fear of gaining weight
- Distorted body image
- Subtype (required for ICD-10-CM):
  - Restricting type
  - Binge eating/purging type
- DSM-5 also requires defining:
  - Remission: Partial or Full
  - Current level of severity: Mild, Moderate, Severe, Extreme
- Criterion from DSM-IV TR removed:
  - Less than 85% of expected weight for height
  - Intense fear of food
  - In females, loss of three consecutive menstrual periods

Bulimia Nervosa DSM-5 Diagnosis

- Repeated episodes of binge eating:
- Inappropriate compensatory behaviors to prevent weight gain:
- Self-evaluation is unduly influenced by weight and shape
- Binge eating and inappropriate compensatory behaviors occur at least once a week for 3 months
- Disturbance does not occur exclusively during episodes of anorexia nervosa
- DSM-5 also requires defining:
  - Remission: Partial or Full
  - Current severity: Mild, Moderate, Severe, or Extreme
AAP Medical Criteria for Hospitalization

Anorexia Nervosa
- <75% ideal body weight
- Refusal to eat
- Ongoing weight loss despite intensive outpatient therapy
- Heart rate <50 bpm daytime, <45 bpm nighttime
- Systolic blood pressure <90
- Orthostatic changes
- Hypothermia (<95 degrees F)
- Arrhythmia
- Electrolyte abnormalities
- Suicidality

Bulimia Nervosa
- Syncope
- Electrolyte disturbances:
  - Serum potassium < 3.2 mmol/L
  - Serum chloride < 88 mmol/L
- Esophageal tears
- Cardiac arrhythmias including prolonged QTc
- Hypothermia
- Intractable vomiting
- Hematemesis
- Suicidality

New AAP Message

- Discourage dieting- encourage healthy eating and physical activity behaviors
- Promote positive body image – do not encourage body dissatisfaction
- Encourage more frequent family meals
- Encourage families not to talk about weight – encourage talk about healthy eating and being active to stay healthy
- Inquire about a history of mistreatment or bullying in overweight and obese teenagers - address this issue if present
- Carefully monitor weight loss in an adolescent who needs to lose weight - ensure the patient does not develop the medical complications of starvation

Local Resources

- Outpatient Facilities
  - Atlanta Center for Eating Disorders (ACE) (males and females, age 10+)
  - Ridgeview Institute (females only, age 18+)
  - Renfrew Treatment Center (females only, age 15+)

- Acute Psychiatric Inpatient Facilities
  - Ridgeview Institute (females only, age 18+)

- Long-Term Residential Facilities
  - Veritas Collaborative (Durham, NC) (ages 10+)
  - Eating Recovery Center (Denver, CO) (ages 10+)
  - Coming 2018– Veritas Collaborative Atlanta (ages 10+)
References


Questions?