

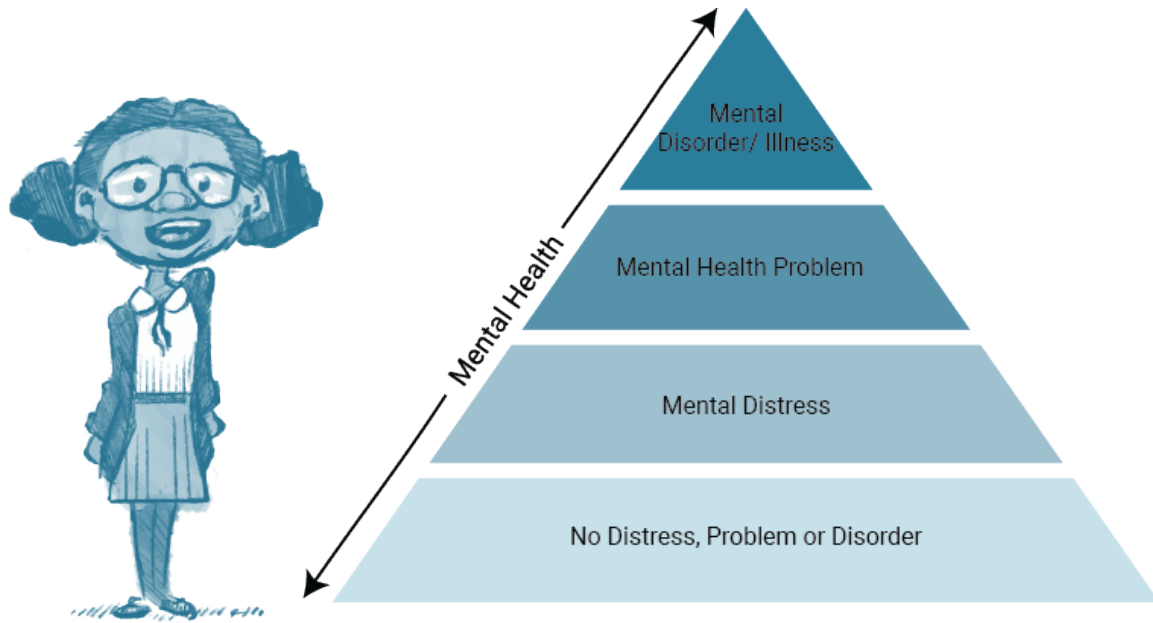
## Module 4:

# Common Mental / Neurodevelopmental Disorders

- All mental disorders reflect difficulties in thoughts, emotions, daily activities, physical health, behaviours and signalling
- The sooner people receive proper treatment and support, the better the outcome
- It is important to distinguish between expected life challenges and having a mental/neurodevelopment disorder.



# Common Mental / Neurodevelopmental Disorders



**M**ental disorders are common medical conditions that often emerge during childhood and adolescence. Approximately 50% of all mental disorders have an onset by age 14, making childhood a critical time to promote mental health, reduce stigma against mental disorders and enhance access to mental health services for young people. In Module 3, we learned that the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-5-TR) defines mental disorders as dysregulation of mood, thoughts, and / or behaviours. Mental / neurodevelopmental disorders are diagnosed by licensed clinicians who use internationally agreed upon criteria, such as the DSM-5-TR or International Classification of Diseases 11 (ICD-11). Treating<sup>1</sup> these disorders requires the best available evidence-based interventions planned and coordinated by properly qualified healthcare professionals. Note that treatment is most successful when multiple stakeholders such as teachers, doctors and family members work together to support the treatment plan of a young person living with one or more mental disorders.

<sup>1</sup> Information regarding the following disorders is primarily based on the DSM-5-TR. All statistics, such as prevalence rates or inheritability index are quoted from DSM-5.

Mental / neurodevelopmental disorders involve disturbances of usual brain function. As described in Module 3, the brain has six key functions: thinking, perception, emotion, signalling, physical movements, and behaviour. A mental disorder may occur when one or more of these brain functions work differently than they should. To date, there are no independent biological markers that appear on diagnostic tests (such as blood tests or brain scans) to indicate the onset or presence of a mental disorder. Instead, diagnoses are assigned on the basis of signs (what an independent observer can see) and symptoms (what the person experiences). Mental health professionals identify signs and symptoms that occur together in 'clusters,' which informs diagnosis and treatment.

In previous modules we have learned to identify different emotional states and how to use appropriate language to distinguish between them.

In this module, we will teach students how to distinguish between 'normal stress' arising from everyday life challenges and mental / neurodevelopmental disorders. We will focus on Generalised Anxiety Disorder, Autism Spectrum Disorder, Attention-Deficit / Hyperactivity Disorder, Major Depressive Disorder, Specific Learning Disorder, Specific Phobia and Obsessive-Compulsive Disorder based on information from the DSM-5-TR. Teachers play a crucial role teaching mental health in the classroom and providing support for students in need of help.

**As teachers, do not diagnose! Instead describe concerning behaviour, offer support and link to clinical professionals.**

However, the teachers' role is NOT to diagnose or treat, but rather to recognize potential mental health problems or disorders, refer students to appropriate services, and collaborate with other professionals (e.g. school-based mental health professionals, school counsellors, community mental health clinicians) to support children and adolescents identified as having a mental health problem or disorder.



## Anxiety Disorders

Anxiety Disorders are some of the most common mental illnesses among children. This class of disorders refers to a number of specific conditions, including but not limited to Separation Anxiety Disorder, Generalised Anxiety Disorder, Panic Disorder, Social Anxiety Disorder and Specific Phobia.

Anxious feelings are usual and expected human emotions that everyone experiences from time to time. People may feel anxious when facing problems, challenges, changes, or difficult decisions. Additionally, it is common for children and adolescents to have some fears throughout their development. For example, many young children are afraid of the dark, monsters, or separation from their parents. Children and youth often have more fears than adults; this is expected as they try to make sense of their world. Most childhood fears will diminish over time.

It is also important to remember that an Anxiety Disorder is not the same as the stress response, which is the brain-body signal that alerts us to an environmental challenge we need to address. Furthermore, Anxiety should not be confused with shyness or a 'slow-to-warm up' temperament.

Anxiety Disorders are characterised by disproportionate responses (e.g. increased frequency, intensity or duration) to a situation that causes severe distress and interferes with someone's ability to function.

In this resource, we will focus on Separation Anxiety Disorder, Specific Phobias, Panic Disorder, Social Anxiety Disorder and Generalised Anxiety Disorder.



**Feeling nervous and apprehensive is not the same as having an Anxiety Disorder**

## Separation Anxiety Disorder

Separation Anxiety Disorder is the most prevalent Anxiety Disorder in children younger than 12 years of age. It is characterised by developmentally inappropriate and intense fears related to separation from one's home, parents or other attachment figures. In any given year it is estimated that about 4% of children would qualify for the disorder. Separation Anxiety Disorder decreases in prevalence from childhood through adolescence and adulthood.



The following animated video on Separation Anxiety Disorder is available to share with students  
<https://youtu.be/jEkFp0Ux40Q>

Children with Separation Anxiety Disorder may experience:

- Persistent and excessive worries that something bad might happen to a caregiver (e.g. illness, injury, death)
- Refusal to leave home, go to school or elsewhere
- Excessive distress (e.g. throwing tantrums) when anticipating or experiencing separation from home or from major attachment figures
- Fear that they may be kidnapped or otherwise taken away from their caregiver
- Refusal to be alone or go to bed at night
- Refusal to sleep away (e.g. sleepovers)
- Nightmares about separation
- Physical symptoms (e.g. nausea, headache, stomach aches) in response to separation

These symptoms may indicate the presence of a Separation Anxiety Disorder if they are pervasive, severe and last for at least four consecutive weeks. Both genetic and environmental factors contribute to the risk of developing Separation Anxiety Disorder. The genetic basis of Separation Anxiety Disorder can be demonstrated by the heritability index, which is approximately 70%, and even higher in girls (DSM-5-TR). Exposure to certain stressful or negative life events in early childhood may increase the risk of developing Separation Anxiety Disorder, along with how adults around the child respond to anxious behaviours.

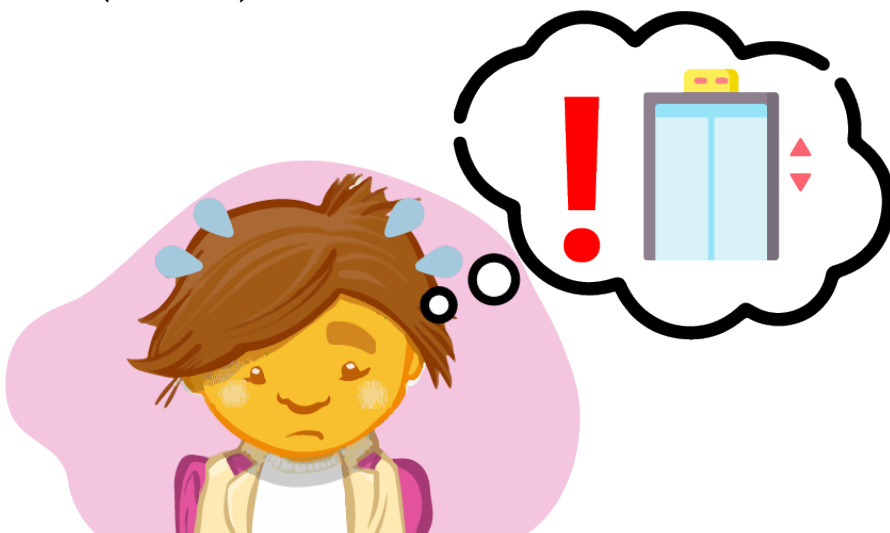
## Specific Phobias

Everyone has some mild, irrational fears, however phobias are intense fears about particular objects or situations, such as heights, animals, seeing blood, and enclosed spaces. People with Specific Phobias avoid these objects or situations to an extent that interferes with daily living. Most Specific Phobias develop in childhood, with the majority of cases developing prior to age ten.

Children with a phobia may experience the following:

- Extreme fear or anxiety about a specific object or situation
- The phobic object or situation almost always provokes immediate fear or anxiety
- The phobic object or situation is actively avoided or endured with intense fear or anxiety
- The fear or anxiety is proportionally greater than the actual danger posed by the specific object or situation given an individual's sociocultural context
- The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more
- The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Approximately 5% of children and 16% of 13 to 17 year olds meet the criteria for having at least one Specific Phobia. Roughly 75% of individuals with Specific Phobia fear more than one situation or object. Phobias develop as the result of the interaction of genetic (inherited) and environmental factors.



## Panic Disorder

A panic attack is a period of extreme fear or discomfort that develops abruptly and reaches a peak within a few minutes. Symptoms include intense physical sensations and catastrophic thoughts. Sometimes there is a clear trigger for a panic attack (e.g. an exam), however, sometimes panic attacks seem to occur randomly.



During a panic attack, four (or more) of the following symptoms occur:

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feelings of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, light headed, or faint
- Chills or heat sensations
- Numbness or tingling sensations
- Feelings of unreality or being detached from oneself
- Fear of losing control or 'going crazy'
- Fear of dying

Panic attacks are essentially the body's fight-flight-freeze response gone awry. Episodes can be triggered, especially with conditions like Specific Phobias, or occur repeatedly and randomly, which is called Panic Disorder. The frequency and severity of panic attacks can vary greatly among individuals. To be diagnosed with a Panic Disorder, a person must experience recurrent, unexpected panic attacks, followed by more than a 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
- Agoraphobia (fear of being in places where escape is difficult)
- Panic attacks that are not due to substance abuse, medications or a general medical condition
- Panic attacks that are not better accounted for by another mental disorder

Although panic attacks occur in children, the overall prevalence of Panic Disorder is low before the age of 14 (<0.4%). While Panic Disorder is very rare in childhood, the development of Panic Disorder can often be traced back to 'fearful spells' first experienced during childhood. Both genetic and environmental factors (often in combination) can lead to Panic Disorder. Studies of children, families, and twins indicate that the heritability of panic disorder is around 43%.



**Experiencing a panic  
attack does not mean  
you have a  
mental disorder**





**It is always important to consider the unique context for each child**

## **Social Anxiety Disorder (Social Phobia)**

People with Social Anxiety Disorder experience significant fear or anxiety about social situations where they might be judged negatively by others. Examples of situations that can trigger Social Anxiety include:

- Having a conversation (e.G. Talking to classmates and adults)
- Going to social events (e.G. Going to birthday parties or school dances)
- Meeting unfamiliar people
- Being observed (e.G. Eating or drinking)
- Performing in front of others (e.g. giving a speech).

Individuals with Social Anxiety Disorder tend to be intensely fearful of judgement and humiliation or of acting in ways that could lead to rejection. They may also be fearful of showing signs of anxiety, such as blushing, trembling, sweating, stumbling over one's words, or staring. Individuals experiencing Social Anxiety Disorder greatly overestimate the threat of social situations, often second guess or replay their performance after the fact or avoid potentially triggering situations altogether (e.g. school avoidance). These symptoms are persistent, lasting a minimum of 6 months, and often intensify over time.

Children with Social Anxiety Disorder may present very differently than adults; they may cry, have tantrums, freeze, cling or hide, lash out or become temporarily mute. It is always important to consider the unique context for each child before considering if the patterns of behaviour may be the product of Social Anxiety Disorder or another mental disorder.

In any given year around 4% of youth ages 14 to 25 will meet the criteria for Social Anxiety Disorder. About 75% of individuals who are eventually diagnosed experienced the onset of their symptoms between the age of 8 and 15 years of age. Genetics in combination with environmental factors can put an individual at higher risk of developing Social Anxiety Disorder. For example, an individual has a two to six times greater risk of developing Social Anxiety Disorder if a first degree relative has the condition.

## Generalised Anxiety Disorder (GAD)

At times, we all feel anxious about challenges in our daily life and figure out ways to deal with these feelings. However, Generalised Anxiety Disorder (GAD) is characterised by persistent and excessive worry across multiple domains of life (such as work or school performance) that the individual finds difficult to control. In any given year, 0.4% to 3.6% of people will meet the criteria for GAD globally. Females are twice as likely as males to experience Generalised Anxiety Disorder. Children and youth with GAD tend to have excessive worries and anxiety that span multiple topics and life areas (for more days than not for at least 6 months). Examples include:

- School performance
- Doing tasks perfectly
- What people think of them
- Bad events happening (disaster, environmental concerns, disease, war, robbery, accidents)
- Health or illness (fearing a cold or flu may be a more serious illness)
- Safety and well being of loved ones (family, friends, pets)
- Everyday stressors (being on time, what to wear, where to go, family finances).

GAD also can impact mood and the functioning of the body, resulting in symptoms such as:

- Restlessness or feeling on edge
- Being easily fatigued
- Difficulty concentrating or mind going blank
- Irritability
- Muscle tension, increased heart rate, sweating and shakiness or shortness of breath
- Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).



People with GAD are often preoccupied with thoughts about real or potential sources of danger. They tend to ask a lot of 'what if...' questions and seek constant reassurance from others. To be diagnosed with GAD, the intensity and frequency of anxious feelings, worry, and physical symptoms needs to cause significant suffering and impairment that cannot be better attributed to other causes like substance use, a medical condition, or another mental disorder.

Although there have been few investigations into the disorder's heritability, a summary of available family and twin studies suggests that genetic factors play a moderate role in the development of GAD. Genetic heritability may account for as much as 30% of one's risk of experiencing Generalised Anxiety Disorder. The most carefully studied treatment that demonstrates effectiveness with all Anxiety Disorders is Cognitive Behavioural Therapy (CBT). This helps people change the way they think about and respond to situations that cause symptoms, which in turn lowers the anxiety they feel and impairment they experience. For moderate to severe cases of Anxiety Disorders, medication may be used in combination with CBT. The most effective class of medications used in youth for anxiety disorders are Selective Serotonin Reuptake Inhibitors (SSRIs).

Teachers may be involved in supporting behavioural interventions. Avoidance of treatment or support can be common in individuals experiencing GAD. It is important for teachers to understand that struggling students who appear avoidant may be preoccupied, overwhelmed, or not quite ready to accept support for their GAD. Building mutually trusting relationships with students is a great first step to reducing avoidant behaviours. While persistent avoidance may exacerbate GAD over time, it is crucial that teachers build relationships to deter avoidance rather than simply confronting students.



## Autism Spectrum Disorder (ASD)

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder that affects a person's social skills, communication / interaction and behaviour. It affects about 1% of the population and the diagnosis is usually made in the first 2 to 5 years of life.

Children with ASD may exhibit challenges related to social communication and interactions, including:

- Difficulties understanding that others may think, feel and perceive the world differently from them
- Lack of awareness of social norms (e.g. Responding less to their own name)
- Deficits in non-verbal communication (e.g. Limited eye contact, unusual facial expressions, limited use of gestures)
- Absent, delayed or unusual use of verbal language (e.g. Seemingly meaningless repetition of other people's spoken words, repeating words from tv, movies, commercials, stories)
- Difficulties following the 'rules' of typical back-and-forth conversation (e.g. Not taking turns speaking, focusing on own interests, trouble sharing interests, thoughts and feelings with others)
- Difficulties forming and sustaining age-typical relationships.

Children with ASD also commonly exhibit unusual or restricted patterns of behaviour which may include:

- Repetitive movements, such as hand flapping or body rocking
- An insistence on sameness and extreme resistance or distress to even minor changes in routine
- Highly restricted interests that are unusual in their intensity, depth, or focus
- Being more sensitive or less sensitive than others to sensory experiences (pain, temperature, texture, smell, taste, lights or sound)
- Self-injury (e.g. Skin picking, hand biting, head banging).

**The best outcomes in Autism Spectrum Disorder occur through early interventions when the brain is more plastic and changeable**



These signs and symptoms must be present in the early developmental period; cause significant impairment; and are not better explained by intellectual disability. While specific causes of ASD have yet to be found, many risk factors have been identified in the research literature that may contribute to its development. These risk factors include genetics and environmental factors (e.g. a sibling with ASD, very low birth weight, and older parents). ASD has a genetic basis involving many different genes, but the exact pattern or patterns of heritability has not yet been fully established. Heritability estimates for Autism Spectrum Disorder have ranged from 37% to higher than 90%, based on twin concordance rates.

The best outcomes in ASD occur through early interventions when the brain is more plastic and changeable. These may include programs to assist with communication, social skills, and sensory processing. It is also important to recognize and nurture the unique strengths of youth with ASD, which may include exceptional memory or an aptitude for creative expression (e.g. art, music). Specialised ASD diagnostic and treatment centres (usually associated with paediatric hospitals and universities) are available in most Canadian provinces.

Classroom strategies for students with ASD need to be developed based on the needs, capabilities and strengths of each individual child. Information about teaching tips and strategies have been developed by many credible educational organisations and are easily found online. An example is one hosted by the Ontario Teachers Federation, which can be found at:

<http://teachspeced.ca/teaching-strategies-students-special-needs>.



## Attention-Deficit/Hyperactivity Disorder (ADHD)

Children are naturally active and inquisitive – some more so than others. One of the main differences between a normally active child and one with ADHD is that the disorder significantly interferes with a child's ability to function and thrive in school and social situations.



ADHD is a neurodevelopmental disorder characterised by substantial and persistent difficulties sustaining attention for non-preferred activities. Many, but not all, youth with ADHD also struggle with levels of hyperactivity and impulsivity that are beyond what is typical for people their age. This can interfere with normal functioning at school, home and with peers. ADHD begins early in life, affects about 3 to 7% of school-aged children and continues into adolescence and potentially into adulthood. The incidence is about three times higher in boys than in girls.

ADHD has two core areas of signs and symptoms. People living with ADHD may struggle predominantly with inattention or hyperactivity / impulsivity or some combination of both. The signs and symptoms must be present for at least 6 months and to a much greater degree than others of the same age.

You may notice the student:

- Making numerous errors and overlooking or missing details
- Having trouble sustaining attention (unless something is highly stimulating, such as video games or social media)
- Failing to listen when spoken to directly as their mind is often elsewhere (e.g. Daydreaming)
- Being easily sidetracked and struggling to finish tasks
- Procrastinating or avoiding activities requiring sustained mental effort
- Struggles with disorganisation, messiness and time management often losing, forgetting or misplacing belongings
- Being easily distracted
- Being forgetful for day-to-day activities (e.g. Keeping appointments, doing chores)
- Struggles with estimating time accurately.

Typical signs and symptoms of Hyperactivity and Impulsivity may include:

- Fidgeting or squirming
- Having difficulties staying seated or frequently finding reasons to get up and move around
- Running or climbing in situations where it is inappropriate
- An inability to play or engage in leisure activities quietly
- Seeming to be always 'on the go', or needing to do something
- Excessive talkativeness
- Blurting out an answer before a question has been completed or speaking over others in conversations
- Impatience when waiting their turn.





As is the case with many psychiatric disorders, most researchers agree that an interaction between genetic and environmental factors can lead to ADHD. Genetics determine about 75% of all ADHD cases. Environmental factors also play an important role, such as exposure to cigarette smoke, recreational drugs, alcohol or other toxins in utero or premature delivery with very low birth weight.

The most effective and commonly used treatment is stimulant medication, which helps increase the student's ability to pay attention and focus and decreases their impulsivity and hyperactivity. Stimulants are safe, effective and fast acting for most people but side effects may be problematic for some. In this case a healthcare provider may prescribe a different medication.

Psychosocial interventions can be a helpful addition to medication. Behaviour Therapy can help improve the student's academic and social functioning. Parental Behaviour Training can help parents better understand how to understand and support their child. Classroom interventions can help adapt the classroom and learning environment to suit a student with ADHD.

Classroom strategies should be developmentally appropriate and teachers can often participate in assessing the impact of medication interventions. Specific classroom interventions need to be tailored to the needs of the student. Here are some examples:

- ADHD in the classroom | CDC: <https://www.cdc.gov/ncbddd/adhd/school-success.html>
- ADHD General Information | CADDAC: <https://caddac.ca/about-adhd/in-general/>
- ADHD Symptoms, Impairments and Accommodations in the Elementary School Environment | CADDAC: <https://caddac.ca/wp-content/uploads/Elementary-Impairment-Accommodations-chart-with-check-boxes-FINAL-1.pdf>



**Neurodivergent learners benefit from clear, kind and consistent interventions tailored to their specific needs**





**Emotional states  
(sad, unhappy,  
disappointed, dismayed,  
demoralized, and  
disenchanted) are not the  
same as Depression**

## Depressive Disorders

Occasionally feeling sad or hopeless is a normal part of life for both children and adults. Specific diagnostic criteria separate Depressive Disorders from feelings and behaviours that are expected and age appropriate. Children experiencing a Clinical Depression may exhibit a low mood that lasts for more than a few weeks and makes it difficult for them to function at school, with friends, or in their daily lives (e.g. sleeping, studying, eating, and enjoying pleasurable activities).

Children with Major Depressive Disorder may:

- Feel or appear numb, bored, tired, empty or irritable
- Feel unhappy even when good events happen
- Be very sensitive to rejection or failure
- Not enjoy their interests as much as they used to
- Spend less time with friends, family, or in after school activities
- Be absent from school often or not perform to their potential
- Have difficulty concentrating and making decisions
- Feel hopeless and pessimistic about the future
- Feel helpless and think that everything is unfair
- Feel like everything is their fault or they are not good at anything
- Think negatively about most things
- Have thoughts of suicide or want to die
- Sleep more or less than usual
- Have changes in appetite and / or weight
- Have frequent headaches or stomach aches.

For a mental health clinician to diagnose Major Depressive Disorder, the symptoms must be substantial and different from the emotional, cognitive and physical challenges of everyday life. Symptoms should not be attributable to the physiological effects of a substance or to another medical condition.

Depressive Disorders are among the most common mental illnesses due to a combination of factors. Certain people's genetics (including personality traits) may make them more susceptible to developing a mood disorder following major life stressors. Depression also runs in families, making it more likely that someone will develop Major Depressive Disorder if a first-degree relative (parent or sibling) also has the same disorder, even in the absence of a major life stressor. Heritability index for Clinical Depression is approximately 40%. Adverse childhood experiences (e.g. neglect, abuse, poverty, or violence) and stressful life events may also contribute to the occurrence of Major Depressive Disorder.



There are several effective treatments for Major Depressive Disorder. These include psychotherapy (e.g. cognitive behavioural therapy); interpersonal psychotherapy (IPT); and a class of antidepressant medication called Serotonin-Specific Reuptake Inhibitors (SSRIs). These treatments may be combined in some cases.

If you are concerned that your student may have Clinical Depression, it is necessary to discuss this with the most appropriate mental health provider in your school (e.g. counsellor or psychologist). The school-based health provider can provide counselling and support (including suggestions for self-help strategies). If the disorder is more intense or the person is suicidal, the school counsellor should immediately refer the person to the health professional best suited to treat the disorder. In acute situations this may include the emergency department or urgent care centre. Once an intervention occurs and the student is back at school, it is important that the teacher be part of the ongoing treatment team and help develop and address learning needs. You may also need to collaborate with school-based and non school-based professionals to provide emotional support and positive experiences for the student.



**If you're concerned that  
your student may have  
Clinical Depression, it  
is necessary to discuss  
this with the most  
appropriate mental  
health provider in your  
school**

## Specific Learning Disorder (SLD)

Many children struggle with reading, writing or mathematics, but some students may experience profound difficulty acquiring and refining specific educational skill sets. A Specific Learning Disorder (SLD) is a neurodevelopmental disorder diagnosed when there are specific deficits in an individual's ability to perceive or process information efficiently and accurately. An SLD is characterised by persistent and impairing difficulties with learning foundational academic skills in reading, writing, and / or mathematics, that is not due to sensory issues, a lack of learning opportunities, or intellectual impairment. Types of Learning Disorders include difficulties in reading (e.g. dyslexia), mathematics (e.g. dyscalculia), and writing (e.g. dysgraphia). The prevalence of specific SLD across the academic domains of reading, writing, and mathematics is 5% to 15% among school-age children across different languages and cultures.

A person with SLD may present at least one of the following symptoms that have persisted for at least 6 months, despite the provision of interventions that target those difficulties:

- Inaccurate or slow and effortful word reading (e.g. reads single words aloud incorrectly or slowly and hesitantly, frequently guesses words, has difficulty sounding out words)
- Difficulty understanding the meaning of what is read (e.g. may read text accurately but not understand the sequence, relationships, inferences, or deeper meaning of text)
- Difficulties with spelling (e.g. may add, omit, or substitute vowels or consonants)
- Difficulties with written expression (e.g. makes multiple grammatical or punctuation errors within sentences; employs poor paragraph organisation.
- Difficulties mastering number sense, number facts, or calculation (e.g. has poor understanding of numbers, their magnitude, and relationships; counts on fingers to add single-digit numbers instead of recalling the math fact as peers do)
- Difficulties with mathematical reasoning (e.g. has severe difficulty applying mathematical concepts, facts, or procedures to solve quantitative problems).

While the causes of Specific Learning Disorders are not well understood, some potential contributing risk factors include heredity and environmental factors. Heritability estimate values are greater than 60% for reading disabilities (Dyslexia) and the risk of Specific Learning Disorder in mathematics is about 5 to 10 times higher in first-degree relatives of individuals (e.g. parents and siblings) with these learning difficulties compared with those without them. Environmental factors, such as premature birth, very low birth weight, prenatal exposure to nicotine or alcohol, head injuries, malnutrition, or toxic exposure may also increase the risk for a Specific Learning Disorder.

Individuals with Learning Disorders face unique challenges that may persist throughout their lives. Depending on the type and severity of their disorder, interventions may be used to help the individual learn strategies to foster future success. School psychologists and other qualified professionals often help design and manage such interventions. Social support may also improve learning for students with Learning Disorders.



## Obsessive-Compulsive Disorder (OCD)

Occasional intrusive thoughts or repetitive behaviours are common in the general population (e.g. double-checking that a door is locked). Everyone has unwanted or recurring thoughts at times. Similarly, lots of people have idiosyncrasies and preferred ways to do tasks (e.g. routines, superstitious habits) however OCD is far more than that. It is a mental illness that leaves people feeling trapped in a cycle of distressing thoughts and / or behaviours that become so extreme they get in the way of daily life, consume large amounts of time (e.g. more than one hour a day) and attention, or result in significant suffering.

Obsessions are recurrent and persistent thoughts, urges, or mental images that are intrusive and unwanted.

Common obsessions may include:

- Concerns about cleanliness or contamination
- Bad events happening (e.g. violence, horrible scenes, or being attacked)
- Doubts about whether an action was performed
- Possessions or actions having to be in a specific order (e.g. symmetry and order).



Compulsions (or 'rituals') are repetitive behaviours or mental acts to reduce distressing feelings associated with an obsession; the person feels driven to perform according to extremely rigid rules. However, these behaviours or mental acts only work for a short time so they need to be continuously repeated, thereby interfering with daily life. They are time consuming (e.g. more than 1 hour per day) or cause clinically significant distress or impairment. Common compulsions may include:

- Repetitive behaviours (e.g. washing hands; tapping a desk; repeatedly checking to make sure a task has been completed)
- Placing items in a specific order or requiring symmetry
- Asking for reassurance pertaining to their compulsions
- Mental acts (e.g. counting items, repeating words silently).



Children with OCD may avoid friends, quit sports they like, experience rejection from peers, struggle to concentrate at school, argue or have conflict with family members, spend more time on tasks than others, and have trouble enjoying hobbies and life in general. The prevalence of OCD is 1.1% to 1.8% in any given year. Genetic factors (e.g. a concordance rate of 57% for identical twins) contribute to the development of OCD. People with immediate family members with OCD are twice as likely to have OCD, and ten times as likely if they developed OCD as a child or adolescent.



**Liking a tidy desk is  
not the same as OCD**

OCD is treated with psychotherapy, psychoeducation and / or medication. Exposure and response prevention (a type of CBT) helps people face the obsession without giving in to the compulsion in a safe and supported environment. Medications are also an important part of treatment for some people with OCD, with SSRIs being the most commonly prescribed.

If you are concerned that a student may have OCD, refer the student to the school counsellor or school-based health professional who can then refer the student to a professional best suited to provide treatment. As a teacher, continue to provide emotional and learning support to the student as part of their 'circle of care'. It is important to know if any academic modifications need to be made to enhance learning opportunities for young people with OCD, so including the teacher in treatment planning and monitoring is usually necessary.

#### **Sources:**

- Mental Health & High School Curriculum Guide:  
<http://teachmentalhealth.org>
- Kelty Mental Health Resource Centre:  
<http://keltymentalhealth.ca/>
- National Institute of Mental Health:  
<https://www.nimh.nih.gov/health/topics/>
- American Academy of Child and Adolescent Psychiatry:  
<http://aacap.org/>