A guide for working with children with unique attributes

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A guide for working with children with unique attributes

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Each summer, hundreds of thousands of parents entrust the care of their children to college-aged summer camp counselors and other childcare organization employees. In most cases, summer camp counselors are well-equipped to care for these children. Many summer camps require their staff members to participate in rigorous training. Staff members are often CPR and first aid certified, and they may receive training about appropriate lifting techniques for campers with mobility restraints. Staffers who facilitate high ropes or archery will meet various standards to ensure they can safely guide campers through these activities. Waterfront directors may hold lifeguarding certifications and boating licenses. The camp nurse may be certified as a registered nurse or emergency medical technician, and a nature director may even hold some form of ecological certification! Entire staffs will receive emergency preparedness training and review and practice emergency action plans. Most of these organizations take training their staff and making sure they are prepared to provide quality care and instruction to their campers seriously.

However, room for improvement remains. Despite these efforts to train staff in many areas and increases in societal mental health awareness, many summer camp staff members and other childcare employees do not possess much knowledge about working with children with various mental disorders and developmental disabilities. In hopes of improving this deficiency, this guide aims to provide an overview of some disorders that childcare staff may encounter. It should be noted that this guide is not comprehensive. Nor is it a complex analysis of various mental disorders and disabilities. Rather, it was compiled in hopes of increasing awareness and exposure so that staff members may provide somewhat better care to the children under their watch. Please note this guide is not intended for use as a resource in providing treatment or as a diagnostic tool. Additionally, the content discussed here is not exhaustive, as its purpose is
merely to increase awareness in hopes of helping summer camps expose their staffs to various
mental disorders. Anyone with concern about their own or someone else’s mental health or
development should consult a physician or licensed therapist. Again, the hope is this guide may
be used to help childcare organizations better prepare their staffs to care for the needs of all
children.

Overview

This guide contains information about various topics in abnormal psychology. Additionally, some
general information concerning self-harming behaviors and other related topics is included at the end. Should you wish to obtain more information about any of the topics discussed, consult the included list of references.

Anxiety Disorders

Anxiety is the vague sense of being in danger (APA, 2013). Feelings of anxiety can be
warning signs for our bodies, alerting us when danger looms. It prepares our bodies for “fight or
flight”—to face the danger or escape it. Given this, anxiety is not inherently unhealthy. However,
when anxiety levels become too high, they can impair daily functioning. The Yerkes-Dodson
Law suggests an optimal level of arousal leads to the best performance (Starr et al., 2014). For
instance, some anxiety about an upcoming test compels a student to study. Studying will help the
student perform well on the exam. When anxiety levels are too low, the student will not be
concerned about the test and will forgo studying, leading to poor performance. If anxiety levels
are too high, the effects of anxiety will prevent the student from studying well, also leading to
poor performance. Anxiety can be a false alarm within the body, and it can be debilitating. It
causes reactions within the body’s nervous system, leading to real responses by the body.
When anxiety is produced under normal conditions, it is a reaction to a stressor, protective, time-limited, occasional, and expected (APA, 2013). When it is abnormal, it is irrational, debilitating, extended, frequent, and maladaptive (APA, 2013). Anxiety carries a high co-morbidity with depression, and as much as 30% of the population will have an anxiety disorder at some point (Starr et al., 2014). It is the most common mental health problem. Fortunately, it is easily diagnosed and effective treatment options exist.

**General causes of anxiety disorders**

Researchers have found genetic links to anxiety disorders (Schienle et al., 2011). Studies indicate relatives of individuals with anxiety disorders are more likely to develop an anxiety disorder than other members of the population (Bergado-Acosta et al., 2014). The closer the genetic likelihood to someone with an anxiety disorder, the more likely it is the person will also develop an anxiety disorder. Biochemical factors in the brain have also been linked to anxiety disorders. GABA deficiencies or GABA receptor problems are tied to anxiety (Salari et al., 2015). GABA is the brain’s primary inhibitory neurotransmitter. Thus, GABA can inhibit the processes within the brain caused by anxiety. When GABA processes are not working properly, it is more difficult for the body to inhibit anxiety processes.

Some individuals may be more likely to develop anxiety disorders on account of their personalities. People who respond to external stimuli more excitedly may be more affected by external events (Bandura & Rosenthal, 1966). This can lead to the development of an anxiety disorder. The sum of one’s life experiences may also play a role. When constantly faced with stressful stimuli, an individual may develop strong coping skills that cause them to seem unfazed by scenarios that would affect most people. Alternatively, they may become more sensitive to stressful stimuli and produce an increased stress response, leading to an anxiety disorder.
We will consider a variety of anxiety-linked disorders.

Generalized Anxiety Disorder

Individuals with generalized anxiety disorder (GAD) struggle with unfocused, chronic, and excessive worry (APA, 2013). They may experience anxiety about nearly anything they encounter. To be diagnosed with GAD, an individual must display at least three of the following symptoms: restlessness, fatigue, trouble concentrating, irritableness, muscle tension, and trouble sleeping (Wang et al., 2005). Additionally, the anxiety experienced much create distress or impair the individual’s life. The symptoms cannot be due to medical problems or drug use, but drug use can worsen symptoms. Individuals with generalized anxiety disorder are often thought to always be worrying by their peers (Ritter et al., 2010).

**Contributing factors to generalized anxiety disorder.** Life experiences can lead to increased risk for developing this disorder. It is thought that 6 percent of Americans will experience generalized anxiety disorder at some point during their lives (Wang et al., 2005).

**Treatment of generalized anxiety disorder.** Drug therapy to address GABA inefficiencies has been found to be helpful when addressing generalized anxiety disorder (Chollet et al., 2013). Additionally, relaxation training is a popular technique. During relaxation training, therapists work to help the patient gain physical relaxation with hopes that this will induce psychological relaxation (Bourne et al., 2004). The development of coping techniques to better handle feelings of anxiety and controlled exposure to events that may be the most problematic for the patient have also been used with a great deal of success.

Phobias

Phobias are persistent, irrational fears of specific objects or situations (APA, 2013). People with phobias experience anxiety when exposed to these particular objects or situations.
While people with phobias generally recognize their fears as excessive or unreasonable, they still respond in a way that impairs their lives (Hopko et al., 2008). Phobia-linked anxiety can be associated with avoidance, anticipation, and worry about the object of the phobia, in addition to actual encounter of the phobia-inducing item or event (Hopko et al., 2008). It is estimated that around 14 percent of Americans will have a phobia at some point during their lives (Stein & Williams, 2010).

Phobias can hinder one’s work performance and affect one’s life overall. The anxiety response to a phobia can lead to other complications, including weight gain or loss, sleep problems, and more. As with all disorders and mental disturbances, individuals can receive treatment for phobias. Treatment is especially needed when the phobia affects other aspects of life.

Many phobias exist. Perhaps the most common phobia is agoraphobia, a phobia affecting two percent of adults (APA, 2013). This phobia is characterized by an intense fear of open spaces where help may be difficult to obtain. Individuals with this phobia may struggle with isolation and depression, and they may experience panic attacks when in public spaces. Arachnophobia and claustrophobia are two other well-known phobias.

**Contributing factors to phobias.** Phobias may develop through conditioning (APA, 2013). An individual may associate some traumatic experience with a specific thing, leading to the development of a phobia. A lack of education about something, such as snakes, can also lead to phobias. Furthermore, stimulus generalization may contribute to phobias. For instance, an individual who experiences a traumatic event related to running water may develop an irrational fear to all liquids, making maintaining hydration and bathing difficult for the individual (Gamble et al., 2010).
Treatment of phobias. As with other anxiety-related disorders, careful exposure treatments are often used to treat phobias (Gordon et al., 2013). Additionally, therapists will seek to treat patients using systematic desensitization, which is a technique that teaches patients to employ relaxation techniques while encountering anxiety-inducing situations (Wolpe, 1987). Oftentimes, this process is gradual. The first step may only involve discussing the anxiety-inducing event and using relaxation techniques during that. Eventually, the goal will be for the patient to be able to fully face the source of their phobia while employing coping mechanisms and not responding maladaptively.

Anxiolytics and antidepressant medications may also be used to help promote emotional and mental stability.

Social Anxiety Disorder

Social anxiety disorder is defined by an intense fear of social situations (APA, 2013). It can affect many aspects of everyday life, including eating in public, using public facilities such as bathrooms, receiving public recognition, asking questions in class, and calling people on the phone (Heimberg et al., 2014). People with social anxiety disorder often grade their performance on public tasks as lower than others would consider their showings (Cooper, Hildebrandt, & Gerlach, 2014). Social anxiety disorder used to be referred to as social phobia. However, due to its wide scope, it is now accepted as its own disorder. To be diagnosed with this disorder, a variety of symptoms may be present: regular anxiety about social situations lasting at least six months, fear of negative evaluation by others, anxiety induced by social situations, avoidance of anxiety-causing situations, and notable distress or impairment due to one’s symptoms (APA, 2013). Social anxiety disorder can cause people to avoid leaving their homes or trying new things for fear of public embarrassment.
Contributing factors to social anxiety disorder. Many things can contribute to the development of social anxiety disorder. Individuals who hold high social standards for themselves may be more susceptible to social anxiety disorder (Iza et al., 2014). Feelings of inadequacy and unattractiveness in a social context are also tied to social anxiety disorder (Heimberg et al., 2010). Many of the attributes associated with social anxiety disorder stem from a lack of faith in one’s ability to conduct one’s self appropriately in a social setting.

Treatment of social anxiety disorder. Treatment of social anxiety disorder often surrounds social skills training (Sarver et al., 2014). Therapists may work to help patients improve social skills so they will be more confident in public settings. Additionally, controlled exposure to social fears combined with the development of relaxation techniques may also be helpful. Antidepressants and anxiolytics can be used to address some of the symptoms of the disorder.

Panic Disorder

Panic disorder is characterized by panic attacks. Panic attacks are brief periods of panic that occur without warning and usually last a few minutes (APA, 2013). At least four symptoms must be present to be considered a panic attack: a pounding heart, sweating, shaking, shortness of breath, chills or hot flashes, feeling of throat constriction, chest pain, nausea, dizziness, fear of helplessness, and numbness or tingling (APA, 2013). More than 25% of Americans will experience at least one panic attack (Kessler et al., 2010). However, when these attacks become common, and the individual begins to carry a persistent worry about the onset of the next attack, a panic disorder may be diagnosed (Sareen et al., 2011).

There are three categories of panic disorders: unexpected, situationally-bound, and situationally-predisposed (Levine et al., 2013). An individual who experiences seemingly
random panic attacks is diagnosed with the unexpected designation of panic disorders. An individual who has panic attacks only in a specific situation, but does not always have a panic attack in the situation, will be diagnosed with situationally-bound panic disorder. When an individual only has panic attacks in a specific situation, and they always have a panic attack in the specific situation, they are considered to have a situationally-predisposed panic disorder.

**Contributing factors to panic disorders.** In general, psychologists believe panic disorders operate on a cycle (APA, 2013). People will feel scared or anxious, experience symptoms, develop intense fear due to their symptoms, have a panic attack, fear future panic attacks, and, finally, misinterpret body sensations as panic attacks. This will cause them to feel scared and anxious and renew the cycle (Bourin et al., 1995). Therapists seek to break the cycle of panic attacks in hopes of their clients being able to enjoy lives not defined by their panic attacks.

**Treatment of panic disorders.** Antidepressant drugs and anxiolytics have been found to be helpful in treating panic disorders (Stein et al., 2010). They can help reduce the severity and occurrence of panic attacks, making the disorder more manageable. Additionally, some therapists intentionally will induce symptoms of a panic attack in their clients and help them develop coping techniques to respond to the symptoms (Nardi et al., 2001). While this does not help prevent panic attacks, many individuals live with unpredictable panic attacks, so addressing the symptoms may be more beneficial than trying to prevent the attacks altogether. Moreover, therapists will work to help patients more accurately interpret bodily sensations in hopes of lessening the onset of panic attacks when possible (Clark & Beck, 2012). If a patient can accurately recognize a bodily sensation, they may be able to avoid panic attacks resulting from misinterpretation.
Observing-Compulsive Disorder (OCD)

OCD should not be confused with obsessive-compulsive personality disorder. To learn a little about the differences between the two, visit the obsessive-compulsive personality disorder section of this guide. OCD is not considered to be an anxiety disorder. OCD is included with anxiety disorders because anxiety plays a pivotal role in the disorder.

OCD is characterized by obsessions followed by compulsions. Obsessions are recurring, anxiety-producing thoughts or impulses that are undesirable, inappropriate, or overwhelming (APA, 2013). To address obsessions, individuals result to compulsions. Compulsions are ritualized behaviors or mental procedures employed by a person to reduce anxiety stemming from obsessions (APA, 2013). Oftentimes, people with OCD will fear something terrible will happen if they do not complete the compulsions. It is estimated that 3 percent of Americans will have OCD at some point during their lives (Kessler et al., 1999).

It should be noted that there is a difference between OCD and feeling the need to wash your hands after using the bathroom or working in the yard. People often suggest they have OCD when they like to organize or collect things in a systematic way. Usually, this is not indicative of OCD. Additionally, meticulous, ritualistic behavior does not necessarily signify OCD. Attention to detail and meticulous practice may be due to a desire to hone one’s craft, to do things in a specific way out of respect for tradition, or some other motivation. People are diagnosed with OCD when their obsessions and compulsions generate distress and impair their daily activities (McNeil, 1967). When an individual washes their hands over 200 times per day for fear of contamination, or someone checks the lock on their car doors multiple times after already checking if it is locked and having not touched the car keys since doing so, they may be diagnosed with OCD. In situations like this, individuals are obsessing over various doubts, such
as doubting they are clean or that their car doors are locked. To address these doubts, they feel they must do some action, such as wash their hands repeatedly or check their car doors. These compulsions alleviate some of the anxiety produced by the obsessions.

**Contributing factors to OCD.** Similarly to panic disorders, OCD operates on a cycle. An individual experiences obsessions, which increases their anxiety. Their increased anxiety leads to compulsory behaviors to reduce the anxiety. This reduced anxiety is then met by obsessions, where the individual doubts they have actually addressed a problem satisfactorily. Thus, the cycle is renewed.

A number of OCD related disorders exist, including excoriation (skin-picking), trichotillomania (hair-pulling), body dysmorphic disorder, and hoarding. While the others are self-explanatory, body dysmorphic disorder stems from a pervasive belief that the individual’s body has some serious flaw (Fang & Wilhem, 2015).

Researchers have found that people with OCD tend to have incredibly high standards of moral and ethical behavior (Whitton et al., 2014). It is believed that these high standards may contribute to the development of OCD. Additionally, low serotonin levels has been linked to OCD, making antidepressants an effective treatment method (Bokor & Anderson, 2014).

**Treatment of OCD.** Treatment of OCD is similar to treatment for anxiety disorders. Therapists may try to employ exposure and response prevention (Meyer, 1966). In this treatment, therapists will expose a patient to the source of their obsessions while trying to help them resist their compulsory behaviors. People with OCD often blame themselves for their disorder, which can complicate treatment. Therapists will aim to neutralize the self-blame thought processes behind obsessions in hopes of encouraging more sound reasoning from their patients (Jacob et al., 2014).
Anxiolytic drugs can be used to help address the feelings of anxiety associated with OCD. This can lessen the severity of the obsessions, which in turn will sometimes lessen the severity of the compulsions (Bokor & Anderson, 2014). While the drugs show some benefits, patients tend to relapse after stopping use of the drug if no other therapy is provided.

**Interacting with children with anxiety disorders and OCD**

As always, it is important that you are understanding of the child. While it may seem trivial to you, remember that the source of their anxiety matters to them. Acting like it is not a big deal could cause the child to lose faith in you. Do your best to comfort the child and ask them what you can do to help them. If they are able to sense the onset of a panic attack or anxiety attack, ask them to give you a warning so you can help them get into a more comfortable and private area. It can be embarrassing for a child to have a panic attack in front of lots of people, and it can cause a commotion when others do not understand and support the child as much as you might.

Panic attacks and anxiety attacks can strike at unexpected times. I was teaching a 16-year-old girl how to swim in a 4-foot deep pool when she experienced a bout of anxiety. She was over five feet tall and was at no risk of drowning, but she was scared to put her face underwater. When I asked her to put her face under water and then bring her head back out of the water, she refused and started crying. I encouraged her to go get some water and breathe a little bit. When she did not return after a couple of minutes, I went looking for her, and I found her in the bathroom having an attack. Sometimes, things you do can contribute to the child’s anxiety or panic attack. It can be upsetting to realize you caused so much discomfort to a child, but it is important you apologize, offer support, and explain you were not aware that would happen.
Moreover, I worked with a young woman who has trichotillomania. She would experience bouts of crippling anxiety, and her primary coping mechanism was pulling on her hair. This young woman had experienced abuse as a child, and she blamed herself for some of her experiences. When she would discuss her past, she would proceed to pull on her hair to the point of pulling it out at times. There is almost always a deeper story behind the behavior. Remember that and respond with compassion and empathy.

**Depressive and Bipolar Disorders**

It is normal and expected for people to experience varying moods. Few people remain happy or sad all the time. Life events and occurrences will affect people’s moods. However, when these moods last a long time and affect people’s normal functioning, they may be considered maladaptive. Depression and mania can adversely affect people’s lives. Depression is considered to be a period of sadness where an individual feels life is overwhelming and dark (APA, 2013). In a way, mania is the opposite of depression. Mania is recognized as periods of high energy, where people hold the euphoric belief they are on top of the world (APA, 2013). Depression and bipolar disorders are distinguished by the presence or absence of manic episodes. Depression is unipolar, meaning it only consists of depressive episodes. Bipolar disorder consists of both depressive episodes and manic episodes.

A depressive episode will include a variety of symptoms: depressed mood, decreased interest, weight loss or gain, insomnia or hypersomnia, restlessness or lethargy, fatigue, feelings of worthlessness, trouble concentrating, and thoughts of suicide (APA, 2013). To be classified as a depressive episode, at least five of the symptoms of a depressive episode must be present for at least two weeks. A consistent depressed mood or a loss of interest in nearly all activities must be present (Kessler et al. 2012).
A manic episode includes elevated self-esteem, decreased need for sleep, excessive speech, high distractibility, elevated goal orientation, excessive pursuit of pleasure, and higher risk-taking (APA, 2013). To be classified as a manic episode, a period of elevated mood must last at least one week with at least three of the symptoms, including significantly impaired functioning or psychotic features (Sareen et al., 2011).

Several mood disorders based on the presence of depressive and bipolar episodes are identified in the DSM-V. They include major depressive disorder, dysthymic disorder, disruptive mood dysregulation disorder, premenstrual dysphoric disorder, bipolar I disorder, bipolar II disorder, and cyclothymic disorder (APA, 2013). We will focus on major depressive disorder and bipolar disorder.

**Depression**

Studies suggest about 18 percent of adults experience unipolar depression at least once during their lives (Sareen et al., 2011). About 85 percent of adults who experience unipolar depression recover, and about 40 percent of those who recover will have depression again later in their lives (Monroe, 2010). To be diagnosed with major depressive disorder, an individual must experience at least one depressive episode while reporting no previous manic episodes (Astbury, 2010). The symptoms and severity of depression can vary depending on the person. Individuals with depression tend to lack motivational drive and report emotional emptiness (APA, 2013). They are often less active and may remain in bed or spend time alone most of the day (Behrman, 2014). Oftentimes, people with depression feel inadequate and inferior compared to others (Lopez Molina et al., 2014). They may blame themselves for things that go wrong and defer credit when they succeed. They also may struggle with confusion and memory problems, although some psychologists believe this reflects motivational rather than cognitive problems.
There are several forms of depressive disorder in addition to major depressive disorder. Persistent depressive disorder is when the depressive episode is especially long-lasting. Dysthymic disorder is when the depressive episodes are less severe but the person has been depressed for at least two years. In this case, an individual can function, but they feel sad, tired, and pessimistic (APA, 2013).

**Contributing factors to depression.** Genetic studies indicate individuals inherit a disposition to depression from their parents (McGuffin, 2014). Family members of individuals with depression may be three times more likely to develop depression than the general population. Of course, similar living conditions and other factors that could contribute to the onset of depression should be considered, too. Low levels of norepinephrine and serotonin have been linked to the onset of depression (Ayd, 1956). However, more recent research suggests low levels of these neurotransmitters alone does not cause depression. Rather, the relationship between these neurotransmitters and other brain neurotransmitters may lead to the onset of depression (Goldstein et al., 2011). These findings led researchers to believe endocrine functions may influence depression, particularly high levels of cortisol produced during stressful events.

Unsurprisingly, traumatic events and stressful situations can lead to the onset of depression (Gilman, 2013). The loss of a loved one or other severe grief may lead to depression, particularly in children. Furthermore, high amounts of punishment with little reward can contribute to depression (Lewinsohn et al., 1990). Moreover, abuse and other experiences that diminish one’s self-worth may contribute to depression as well. Learned helplessness, or the perception that they cannot control their own lives and are responsible for their inability to control their lives, is often tied to depression (Dygdon & Dienes, 2013). For these individuals, failure to address learned helplessness will render most depression treatments ineffective.
Treatment of depression. Arguably, the most popular treatment for depression is the use of antidepressant drugs (Fink, 2014). This may be apparent from the quantity of advertisements for antidepressant drugs seen on television. Three types of antidepressant drugs are used: monoamine oxidase inhibitors, tricyclics, and second-generation antidepressants. The second-generation antidepressants are the newest drugs used to combat depression, and they are primarily known as selective-serotonin reuptake inhibitors (Advokat et al., 2014). Serotonin, a neurotransmitter associated with feelings of happiness and satisfaction, can be artificially elevated by preventing its reuptake in the brain. These drugs, such as Zoloft and Prozac, aim to prevent serotonin’s reuptake to elevate moods (Advokat et al., 2014). Tricyclic drugs and monoamine oxidase inhibitors target other neurological processes associated with depression. While antidepressants are popular, they do not always work. Some estimates suggest antidepressants benefit patients only 65 percent of the time (Hegerl et al., 2012). Additionally, discontinuing use of the drug can lead to symptoms returning. It is important to use other treatment methods, too.

Electroconvulsive therapy, albeit controversial, has been used to treat patients with severe depression (Fink, 2014). Deliberate shocks to the patient’s brain has led to lessening of depressive symptoms in some cases. Other nerve stimulation methods, such as nerve stimulation through the use of magnets, has also been used with similar effects (Mayberg et al., 2005). This practice, known as deep brain stimulation, is producing promising results in early stages of research. Traditional counseling methods can also be used to treat patients with depression.

Interacting with children with depression. Make yourself available to discuss feelings, but try to avoid forcing yourself into the child’s feelings. Rather, be gentle and try to understand them. Show empathy. It may take time, but if you are consistently caring for the child, it is likely
that they will eventually make themselves more available to you. Always suggest coping mechanisms other than self-harm if thoughts of self-harm or suicide are expressed. Remember, you need to communicate such matters to your supervisor.

**Bipolar Disorder**

Individuals with bipolar disorder experience depressive episodes and manic episodes (APA, 2013). An individual with bipolar disorder may view their life as an emotional rollercoaster, and this can negatively affect both them and their peers (APA, 2013). Bipolar disorder is divided into two main designations, bipolar I and bipolar II. People diagnosed with bipolar I disorder experience a normal mood disrupted by manic episodes and depressive episodes. Generally, the episodes alternate, with a period of depression followed by a period of normalcy and then a period of bipolar, forming a cycle of sorts. Gone untreated, bipolar I disorder often worsens over time (APA, 2013). Bipolar II disorder is characterized by hypomanic disorders and depressive episodes. These follow the same general alternating pattern as bipolar I disorder, but the hypomanic episodes are less severe than the manic episodes. Hypomanic episode symptoms include an elevated, non-depressed mood, lower levels of fatigue, increased social initiative, and no social or occupational impairment (Sareen et al., 2011). Individuals with bipolar II disorder are more likely to recover than individuals with bipolar I disorder. When individuals experience alternating hypomanic episodes and mild depressive episodes for more than two years, they may be diagnosed with cyclothymic disorder (Zeschel et al., 2015). This disorder can worsen over time. Oftentimes, people with cyclothymic disorder seem to display a mostly normal affect, but they have more severe mood swings than most people. As many as 50% of cyclothymic disorder cases will become bipolar I or II disorders (Goto et al., 2011). 5-15 percent of people with bipolar II disorder will develop bipolar I disorder. It is believed that
between 1 and 2.6 percent of the population suffers from some bipolar disorder (Kessler et al., 2012).

It should be noted that some therapists believe the diagnosis of bipolar disorder has been overused among children (APA, 2013). The latest version of the DSM includes a new disorder referred to as disruptive mood dysregulation disorder. This disorder is characterized by patterns of extreme rage. Psychologists expect more children to receive this diagnosis, leading to lower numbers of bipolar disorder diagnoses (Toteja et al., 2014). This may help limit the number of children taking adult bipolar medications, which have not been tested on children to the same extent that they have been tested for adults (Chang et al., 2010).

Some features of disruptive mood dysregulation disorder include extreme anger outbursts for at least one year, the occurrence of these outbursts at least three times per week in at least two settings, regular irritable mood outside of outburst, and diagnosis between the ages of 6 and 18 years.

**Contributing factors to bipolar disorders.** Researchers believe high activity levels of norepinephrine can contribute to manic episodes (Post et al., 1980). This would suggest norepinephrine levels fluctuate greatly in the brains of people with bipolar disorder, as low norepinephrine levels are associated with depression. Low serotonin levels may be linked to mania, and it is also linked to depression (Nugent et al., 2013). Most researchers think some relationship between norepinephrine and serotonin leads to the disorder. Additionally, other biochemical factors such as ion concentrations may contribute to bipolar disorder (Manji & Zarate, 2011). A number of theorists suggest parents can bestow a predisposition to bipolar disorder upon their children (Wiste et al., 2014). Twin studies and pedigree studies support this theory.
Unexpected loss, extreme grief, and negative life events may all contribute to the onset of bipolar disorder, as well. Like depression, learned helplessness and overall low self-esteem are tied to the manifestation of the disorder. Addressing these are important steps in a patient’s treatment (Nugent et al., 2013).

**Treatment of bipolar disorder.** Mood stabilizers are often employed to help address the drastic mood swings associated with bipolar disorder (APA, 2013). These may include lithium and other antibipolar drugs. Antidepressants may also be used. As with depression, electroconvulsive therapy or other forms of brain stimulation may be employed (Fink, 2014).

Like with most disorders, traditional forms of therapy may also be successful.

**Interacting with children with bipolar disorder.** As with depression, make yourself available to discuss feelings. Try to be gentle and understanding. Show empathy.

Be understanding if manic episodes arise. If a child cannot sleep through the night during a manic episode, take steps to ensure they will be safe during the night and will not prevent others from sleeping. If you need to stay awake to watch the camper, take turns with other counselors so you can all rest. Communicate expectations to the child, such as “You may not leave the cabin until we all do in the morning.” Maybe offer them a puzzle, pencil and paper, a crossword, or some other task to help them pass the time.

Again, always suggest coping mechanisms other than self-harm if thoughts of self-harm or suicide are expressed. Remember, you need to communicate such matters to your supervisor.

**Stress and Trauma Disorders**

Traumatic experiences and stress can dramatically affect people’s lives long after the event passes. Stress and trauma can alter people’s careers, family interactions, personalities, and more. Stress can be considered as the body’s subjective reaction to something in the environment
(Spielberger, 1985). Stress can result from either physical or psychological events. People respond to stress differently, and not everyone is stressed by the same things. A series of networks within the body handles the stress response. The autonomic nervous system and the endocrine system are two important body systems that respond to stress. While the effects of stress can be maladaptive, it is normal to encounter stress in daily life. For instance, a student may feel psychologically stressed while preparing for an upcoming exam. A runner may experience physical stress while running a race. In such situations, stress is normal and expected.

Some people may struggle with stress events that are negative, uncontrollable, and ambiguous. In these cases, stress may be maladaptive. Ultimately, the individual’s stress response, or how they cope with the stress, will determine how maladaptive the stress can be. Poor stress management is linked to the onset of mental illness and interferes with everyday life.

Some people can be confused by the difference between trauma and stress. Trauma is produced by stress events. Traumatic events are basically events that produce more stress than an average person is accustomed to facing (Kagan, 2003). Some stress events produce intense fear, feelings of helplessness, terror, dissociation, and agitated behavior (Schwartz et al., 2015). In these cases, these events may be labeled as traumatic events. While most people would consider a house fire or an assault to be traumatic, some people may not show signs of trauma after such events. Generally, traumatic events have either caused or threatened injury or death.

While there is much to discuss concerning the psychological effects of stress, we will focus on two primary kinds of stress disorders: acute stress disorder and posttraumatic stress disorder.

**Posttraumatic Stress Disorder**
Posttraumatic stress disorder (PTSD) has gained lots of media attention in recent years as doctors and psychologists learn more about the effects of long-term military deployments on American soldiers. After exposure to a traumatic event, some of the following symptoms are associated with PTSD: distressing memories, repeated and traumatic dreams, dissociative experiences, distress when exposed to triggers associated with the traumatic event, and physical response after a reminder of the event (APA, 2013). A person with PTSD may avoid stimuli associated with the event, and they may display mood changes associated with the trauma. Changes in alertness and sleep patterns are also common. Finally, these symptoms must last for more than a month, or they must begin more than one month after the event (Worthen et al., 2014). PTSD can be debilitating because individuals with PTSD continually re-experience the trauma and maintain high levels of alertness and sleep disturbances (Kessler et al., 2012). While much of the media coverage of PTSD focuses on military service members, it is important to recognize people can develop PTSD from other events, such as abuse and car accidents.

**Acute Stress Disorder**

Individuals with acute stress disorder will display a lot of the same symptoms as those with PTSD (APA, 2013). If symptoms arise less than a month after the traumatic event and are resolved in less than a month, the individual may be diagnosed with acute stress disorder. It can be considered to be a shorter-term response to a traumatic event than PTSD.

**Treatment of Stress Disorders**

Depression, anxiety, and substance abuse are often linked to stress disorders (Church, 2014). This requires therapists to address much more than simply the traumatic event. Anxiolytics and antidepressants may be used to address some symptoms and side effects of stress.
disorders (APA, 2013). At the least, they may help calm responses to triggers associated with the traumatic event.

Counseling can be helpful when treating stress disorders. Psychological debriefing, where the individual discusses their feelings and experiences at great lengths shortly after a traumatic event, has been used with some success (Mitchell, 2003). However, some therapists oppose this method because it asks patients to continually relive their experiences. They fear forcing their clients to recall painful memories shortly after the event may lead to worsening of symptoms. Other therapists may try other approaches, such as exposing patients to stimuli that trigger feelings of anxiety and encouraging relaxation and coping mechanisms (Delahanty, 2011). Still others choose to never address the traumatic stressor and instead only address symptoms.

The majority of stress disorders are resolved through treatment within six months (Asnis et al., 2004). Despite these encouraging statistics, only two-thirds of people with these disorders acquire care (Asnis et al., 2004). Various social pressures, as well as a lack of awareness about stress disorders, may contribute to this. For instance, gender norms make some men avoid addressing their emotional well-being, and some people assume their symptoms are normal because they think they should be upset and expect it to improve on its own with time. Therapy may benefit all people, regardless of gender. As far as expecting to be upset, it is normal for individuals to experience negative emotions following a stressful event. However, when it begins to hinder a person’s functioning and daily living, it may be time to consider seeking help.

**Interacting with children with stress disorders**

Working with children with PTSD or an acute stress disorder can present some challenges. Be aware of possible things that may cause anxiety or discomfort in the child, and try to avoid those things. Avoiding known triggers can help avoid re-traumatization while the child
is under your care. Be careful not to blame the child for their symptoms. Remember, it is unlikely the child wants to have a stress disorder. Pay extra attention to high-risk children who may be suicidal or trying self-harm due to the anxiety produced from their stress disorder. As with any child struggling with things of this nature, do your best to keep them safe in a compassionate way.

I have worked with a lot of children who have PTSD. Most of them experience PTSD due to histories of physical or sexual abuse. Others struggle with PTSD from watching assaults, murders, and other traumatic events. I even worked with a child who had PTSD due to watching tornado coverage on his television. While he was never in danger, the stress of knowing some of his friends in the county were at risk was overwhelming for him. Following the event, he avoided going outside and standing near windows on cloudy days, and he always wanted to know my plan if a storm should approach, no matter the forecast. Stress disorders can arise from a variety of events. Show empathy about the child’s particular situation and do your best to make them more comfortable during their time at camp.

**Personality Disorders**

A personality disorder is defined as an enduring pattern of inner experience and behavior that strays from one’s cultural expectations (APA, 2013). Most often, it is pervasive, inflexible, has an onset in adolescence or early adulthood, and contributes to distress and impairment (Mayo Clinic, 2015). In other words, individuals with personality disorders have more malfunctional and severe personality traits than other members of their culture. This contributes to psychological distress for themselves or others (Grant et al., 2004).

The symptoms of a personality disorder must be present for one year to be diagnosed. According to data released by the National Institute of Mental Health, it is estimated that 9.1% of
Americans above the age of 18 currently have some personality disorder (2017). While statistics
about the prevalence of personality disorders in children are less readily available, many
individuals with personality disorders display symptoms of their disorders prior to reaching
adulthood. As the National Institute of Mental Health notes, personality disorders are most often
diagnosed in adulthood because they describe long-standing and enduring patterns of behavior
(2017). Children experience a great deal of change in their personality and maturation throughout
development, but much of it can be attributed to natural processes of development. Many
behaviors exhibited by adolescent youth may resemble symptoms associated with various
personality disorders, but they often do not last at least a year. Moreover, these behaviors are
often the result of chemical changes within the body as the child matures, and behaviors
generally return to more typical representations within a relatively short period of time.

**The clusters of personality disorders**

The current DSM-V representation of personality disorders includes ten types of
personality disorders (2013). It employs a categorical approach to list the ten personality
disorders.

Cluster A: The “odd” disorders

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder

Cluster B: The “dramatic” disorders

- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
Cluster C: The “anxious” disorders

- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder

Cluster A Personality Disorders

The “odd” personality disorders are the paranoid, schizoid, and schizotypal personality disorders. Individuals with these disorders may exhibit eccentric behaviors similar to those displayed by an individual with schizophrenia. However, the behaviors are usually less severe than those associated with schizophrenia (APA, 2013).

Paranoid Personality Disorder

Children exhibiting paranoid personality disorder distrust others and are suspicious of their actions. This disorder begins by early adulthood and centers around an individual’s suspiciousness and distrustfulness of others in some form (APA, 2013). Common features attributed to the disorder may include aggressiveness, rigidity, hypervigilance, sensitivity to others’ opinions, and an extreme desire for independence (Vyas & Khan, 2016). It is common for individuals with paranoid personality disorder to believe others want to hurt them. While they distrust others, they also place great faith in their own ideas and skills. Typically, an individual with paranoid personality disorder will appear guarded and emotionally withdrawn.

It is believed that between 2.3% and 4.4% of American adults live with paranoid personality disorder (Lenzenweger et al., 2004). The disorder often becomes apparent during adolescence. Poor peer relationships, social anxiety, eccentric thoughts, and fantasies all may indicate paranoid personality disorder in youths (APA, 2013).
Contributing factors to paranoid personality disorder. Some research suggests genetic factors play a role in paranoid personality disorder. Individuals whose relatives have schizophrenia may be more likely to develop paranoid personality disorder (APA, 2013). Additionally, theorists believe individuals may develop paranoid personality disorder because of controlling, yet distant, parents (Caligor & Clarkin, 2010). Physical abuse may also lead to paranoid personality disorder. Physical abuse deflates a child’s self-worth and violates the child’s trust, and it can lead children to believe all individuals seek to harm them (Beck & Weishaar, 2014). The development of distrust towards others can lead to feelings of anxiety when interacting with other people (Kellett & Hardy, 2014). The coping mechanisms used by a person dealing with this anxiety may manifest as paranoid personality disorder.

Treatment of paranoid personality disorder. Many individuals with paranoid personality disorder do not view their behavior as maladaptive (Millon, 2011). Thus, they do not consider themselves in need of help. This can make providing therapy to an individual with paranoid personality disorder more difficult. Individuals with paranoid personality disorder may also distrust their therapist’s intentions and feel disrespected if labeled as a patient (Kellett & Hardy, 2014).

Due to the nature of the disorder, individual psychotherapy is often largely unbeficial. However, therapists may see some success in attempts to improve the patient’s social skills and improve the patient’s ability to manage anxious feelings towards others. (Kellett & Hardy, 2014). The development of a more realistic interpretation of others’ words and actions through cognitive-behavioral therapy may lead to some improvement. Poor empathic skills and difficulty interpreting the behaviors of others is associated with paranoid personality disorder. This makes group therapy less successful.
Antipsychotic drug therapy may be helpful in some cases (Birkeland, 2013). However, most psychoactive medications have shown little benefit (APA, 2013). Additionally, many individuals will avoid taking drugs and supplements, citing the need to remain on constant alert of their surroundings (APA, 2013). After all, paranoid behavior is why the disorder is so named.

**Interacting with children with paranoid personality disorder.** Interacting with children displaying paranoid personality disorder can be difficult because they may question the motives behind your behavior. It is important to gain the child’s trust. Consistent behavior can help with this. Additionally, remaining compassionate, listening to the child, and paying attention to how they respond to your actions can help. If the opportunity arises, try to help the child view their surrounding environment more accurately by helping the child interpret the actions of others. Offer gentle correction when they appear to inaccurately interpret the actions of others, and explain how you arrived at your conclusions. Finally, help the camper meet other people. If the child trusts you, it can be helpful when introducing the child to a new person to communicate to the child you feel safe around the new individual.

**Schizoid Personality Disorder**

Children displaying schizoid personality disorder often seem unemotional and tend to be loners, passive, and indifferent (APA, 2013). The primary feature of the disorder is a detachment from social connections and limited emotional expression (APA, 2013).

Similar to individuals with paranoid personality disorder, individuals with schizoid personality disorder lack close connections with others. However, they lack these tight relationships because they have developed a preference to be alone, rather than due to a distrust of others.
People with schizoid personality disorder can seem indifferent towards intimate relationships, and they often pursue careers that limit contact with others. Symptoms of schizoid personality disorder may appear in childhood or adolescence (APA, 2013). During this time, it is often recognized through a lack of peer relationships and a favoring of self-isolation. This disorder is estimated to be seen in 3.1 percent of the adult population (Sansone & Sansone, 2011).

**Contributing factors to schizoid personality disorder.** Schizoid personality disorder seems to be more prevalent in relatives of individuals who have schizotypal personality disorder or schizophrenia, indicating there may be underlying genetic factors behind the disorder (APA, 2013).

A history of family abuse and neglect may lead to schizoid personality disorder (Caligor & Clarkin, 2010). Children may see abuse and neglect as a consequence of their neediness. This could cause the child to withdraw from social interactions. Over time, this social withdrawal may develop into schizoid personality disorder.

Meanwhile, many theorists believe the disorder can stem from an unmet desire for human connection. This could cause alienation and indifference towards emotional connections (APA, 2013). Additional research suggests the disorder can stem from learning deficiencies. A study found individuals with the disorder have more vague thoughts and weaker perceptual abilities, making it more difficult to recognize emotional stimuli in social settings (Kramer & Meystre, 2010). Rather than struggle to understand emotional stimuli, some individuals may choose to isolate themselves.

Interestingly, a study of survivors of the Chernobyl nuclear accident indicates the effects of radiation on neurological function may contribute to the development of schizophrenia.
spectrum disorders, including schizoid and schizotypal personality disorders (Loganovsky & Loganovskaja, 2000). Limited research exists about the subject, as intentionally exposing humans to radiation to evaluate this hypothesis is unethical and inhumane.

**Treatment of schizoid personality disorder.** Social withdrawal may keep some people with this disorder from obtaining treatment. Therapy often produces negligible signs of improvement because of a lack of emotional investment in the treatment by the patients (Colli et al., 2014). Cognitive-behavioral therapy may be successful. This therapy aims to encourage more positive emotions and more fulfilling social relationships (Mayo Clinic). The therapist may encourage the patient to focus their thoughts on positive memories in hopes of inducing a more positive affect. Many therapists consider group therapy to be the most beneficial form of therapy because it creates a safe arena for observed social interaction (Mayo Clinic). Role play and other exercises may be used during group therapy. Similar to paranoid personality disorder, antipsychotic drug therapy can be used with limited benefit (Colli et al., 2014).

**Interacting with children with schizoid personality disorder.** Connecting with a child who has schizoid personality disorder can prove difficult due to their desire to avoid social interaction. Physical closeness can be uncomfortable for them. While it is ideal for the child to foster peer relationships, sometimes it can be easier to help the child foster relationships with other staff members, as you may find staff more supportive than other children of the child. When introducing the child to someone else, it can be helpful to show the child you already have a relationship with the individual. If the child trusts you, they may feel more comfortable meeting someone they see you trust.

**Schizotypal Personality Disorder**
The symptoms of schizotypal personality disorder tend to center around interpersonal problems. Individuals with the disorder often feel uncomfortable in close relationships, have odd thoughts and perceptual patterns, and display eccentric behavior (APA, 2013). People displaying schizotypal personality disorder may seem socially awkward, anxious around others and suspicious of their motives. Symptoms may include “ideas of reference”—the idea that unrelated events relate to them—and “bodily illusions”—such as feeling an external presence (Millon, 2011). Many individuals with schizotypal personality disorder believe they have some amount of power over the actions of others (APA, 2013).

Individuals tend to be unproductive and pursue careers that limit social interaction. Like schizoid personality disorder, symptoms may resemble schizophrenia, but are generally less severe. Prevalence of schizotypal personality disorder is estimated to be between 1% and 4% in adults (Lenzenweger et al., 2007). Interestingly, schizotypal personality disorder carries a co-occurrence with major depressive disorder of 30-50% (APA, 2013).

**Contributing factors to schizotypal personality disorder.** A tendency to schizotypal personality disorder seems to be tied to genetic traits. Notably, individuals with the disorder may be predisposed to abnormal neurological functions. (APA, 2013). Some examples of this include high dopamine activity, enlarged brain ventricles, smaller temporal lobes, and the loss of gray matter in the brain (Lener et al., 2015). Family conflict, isolated up-bringing, and severe-long-term abuse have all been linked to the expression of schizotypal personality disorder (Rosell et al., 2015). Attention deficits and short-term memory have also been tied to the disorder (APA, 2013).

**Treatment of schizotypal personality disorder.** Most therapists believe clients need to reconnect with the world and recognize where their thoughts end and others begin (Sperry,
Talk therapy is an important part of treatment. Improving social skills can help people feel more comfortable during social interactions.

Antipsychotic drugs have been shown to reduce some thought problems in individuals with schizotypal personality disorder (Rosenbluth & Sinyor, 2012). Like the schizoid and paranoid personality disorders, drug therapy produces limited benefits.

**Interacting with children displaying schizotypal personality disorder.** Attempt to empathize with the child’s feelings. Try to understand what factors are affecting the child emotionally, and attempt to relate. Focus on present problems. It is difficult to address things you cannot see.

When speaking, if the child begins to stray off topic, it can be helpful to ask the child to summarize what they want to say. Set an example of appropriate social interaction and provide feedback about their social interaction.

**Cluster B Personality Disorders**

The “dramatic” personality disorders are the antisocial, borderline, histrionic, and narcissistic personality disorders. The behavior of individuals with “dramatic” personality disorders is often considered dramatic, emotional, or erratic (APA, 2013). It can make it difficult for these individuals to develop satisfying relationships with others. This group of personality disorders is the most often diagnosed (APA, 2013).

**Antisocial Personality Disorder**

Individuals living with antisocial personality disorder regularly neglect others’ rights and show a lack of remorse, at times receiving the label “psychopaths” (APA, 2013). Of course, it should be noted referring to someone with the disorder as a “psychopath” is inappropriate and disrespectful. Individuals displaying antisocial personality disorder tend to be deceitful,
impulsive, and aggressive. While the DSM-V requires an individual to be 18 years of age to receive this diagnosis, the individual usually shows conduct similar to antisocial personality disorder before the age of 15 (APA, 2013). Research suggests people with antisocial personality disorder may be more likely to engage in criminal behavior (Maghsoodloo, 2012). Additionally, studies suggest individuals with the disorder are also more likely to struggle with alcohol and substance abuse (Reese et al., 2010). It is believed between .2% and 3.3% of American adults live with antisocial personality disorder (Goldstein et al., 2007).

**Contributing factors to antisocial personality disorder.** Genetic factors appear to play a role in the development of antisocial personality disorder, as immediate relatives of an individual with antisocial personality disorder are more likely to also have the disorder than members of the general population (Meloy & Yakeley, 2010).

Physiologically, individuals who are impulsive and aggressive, two factors associated with the disorder, tend to have lower serotonin activity in their brains (Meloy & Yakeley, 2010). They may also show lower functioning in their frontal lobes (Liu et al., 2014). People with antisocial personality disorder may feel less anxiety, making them less likely to learn from negative experiences or others’ emotional cues. The lack of social learning may cause them to behave in abnormal ways. Conversely, some theorists believe individuals may develop antisocial personality disorder by watching others display the symptoms (Gaynor & Baird, 2007).

**Treatment of antisocial personality disorder.** Treatment of antisocial personality disorder is generally ineffective (Black, 2015). The individuals’ limited conscience, trouble recognizing a need for change, and a general disrespect for therapy contributes to this.
Attempts to encourage the patient to consider moral issues and others’ needs can show limited benefit (Beck & Weishaar., 2011). The primary benefit of these attempts is to help cause the patients to develop better responsibility toward others.

It is becoming more common for psychiatrists to prescribe antipsychotic medications to address symptoms of antisocial personality disorder such as aggression, but the benefit of the medications are not yet known (Thompson et al., 2014). Oftentimes, the medications are tranquilizers to combat the patients’ aggressiveness.

Finally, deficits in parental compassion in early childhood, family violence, child abuse, and poverty are all linked to the disorder (Kumari et al., 2014).

**Interacting with children with antisocial personality disorder.** Individuals must be eighteen years of age to be diagnosed with antisocial personality disorder.

**Borderline Personality Disorder**

People with borderline personality disorder tend to display instability in mood, self-image, and impulsivity (APA, 2013). They may be volatile, impulsive, self-destructive, and emotionally intense. Due these attributes, it can be difficult for people with borderline personality disorder to form healthy relationships with others. People with borderline disorder can experience mood swings lasting as long as a few days (APA, 2013). These mood swings can lead to severe, depressive moods. This may contribute to a study’s findings that around 75 percent of people with borderline personality disorder attempt suicide at least once during their lives (Amore et al., 2014). At times, they can feel rejected in a relationship if their partner does not seem to match their effort, and this can lead to domestic violence. They may threaten to harm themselves to prevent a partner from leaving. Statistics suggest close to 6% of American adults have borderline personality disorder (Sansone & Sansone, 2011).
Contributing factors to borderline personality disorder. A 2005 study found orbitofrontal cortex abnormalities may contribute to impulsive behaviors associated with borderline personality disorder (Berlin et al., 2005). Abnormal neurological development may lead to the changes in the orbitofrontal cortex.

Sexual abuse, physical abuse, and verbal abuse have all been tied to this disorder. Strains in early parental relationships may also contribute to this disorder, and parental strain is often linked to parental abuse. Inconsistent attachment to parents can cause decreased self-esteem, decreased independence, and difficulty handling separation (Caligor & Clarkin, 2010).

As with other disorders, many researchers agree some combination of biological and environmental factors likely contributes to the manifestation of this disorder (APA, 2013).

Treatment of borderline personality disorder. Treatment of borderline personality disorder can be challenging. The emotional instability of the patient can make it more difficult for therapists to connect emotionally with the patient.

Dialectical behavior therapy, a practice developed by Marsha Linehan, seems to be one of the better options. The process involves modeling by the therapist, teaching of social skills, goal setting, and collaboration between the client and therapist (Linehan et al., 2015). One favorable outcome of this method of treatment is the forging of a relationship between the therapist and the patient. This can help encourage the patient to remain in treatment for its duration. In addition to being more likely to remain in treatment, patients receiving this form of treatment may be more likely to limit drug use, increase work performance, and tolerate stress than those in other treatments.
Antidepressant, antibipolar, antianxiety, and antipsychotic drugs have all been used to address some of the emotional feelings and aggressive actions of individuals with borderline personality disorder (Bridler et al., 2015; Gunderson, 2011).

The use of psychotherapeutic drugs may help address some of the more severe behavioral tendencies of individuals with borderline personality disorder. Some control of this may allow counseling therapy to be more effective.

**Interacting with children with borderline personality disorder.** As with most of the other personality disorders, consistent behavior is important. Show you are attentive and care for the child. Encourage appropriate emotional regulation in the child. Provide gentle correlation if the child seems to overreact to something.

If the child is acting aggressively towards others, try to encourage redirection of those actions to a healthier and safer outlet. For example, throw some rocks at a tree (away from other people), break sticks into small pieces, or draw emotions on papers. Awareness is always important in childcare, and you need to protect others and yourself. I worked with a young man with borderline personality disorder who, when angry, would pick up large rocks and cinderblocks with the intention of dropping them on the heads of people who upset him. As always, intending to harm others is unacceptable and should be treated as such.

**Histrionic Personality Disorder**

Histrionic personality disorder was formerly known as hysterical personality disorder. Individuals displaying histrionic personality disorder tend to be extremely emotional and wish to be regarded as the center of attention (APA, 2013). An individual with histrionic personality disorder is often uncomfortable not being the focus of others’ attention, and the individual may use physical attributes to attract attention (Grant et al., 2004). Feelings of inadequacy and
diminished self-worth contribute to the manifestation of this disorder. Exaggerated moods and neediness of an individual with histrionic personality disorder can make social interaction more difficult. Individuals with the disorder often rely on others to provide direction and help them, and it is common for people with histrionic personality disorder to seduce others to manipulate them for help. Others often assume people with histrionic personality disorder are superficial (Anderson et al., 2001). This may be seen in individuals with this disorder often claiming to be best friends with others when their counterparts might say they are casual acquaintances. Recent surveys indicate 1.8 percent of American adults may live with histrionic personality disorder (APA, 2013).

**Contributing factors to histrionic personality disorder.** Some researchers believe some people hold genetic dispositions towards histrionic personality disorder (Kenneth et al., 2008). While family members of individuals with histrionic personality disorder are more likely to also have the disorder than members of the general population, researchers disagree if the cause is because of genetic or environmental factors.

Insecure attachment during childhood and a lack of attention may contribute to the development of histrionic personality disorder (Bender et al., 2001). Cold and controlling parents may cause children to desire affection from others and wish for others to affirm their behaviors.

Some cognitive-behavioral researchers believe individuals develop histrionic personality disorder due to obsessive self-interest (APA, 2013). This leads to people with the disorder lacking sufficient knowledge about the world. Therefore, they must make assumptions about their surroundings and rely on others to direct them. This can lead to a learned helplessness of sorts.
Treatment of histrionic personality disorder. Research about treatment options for histrionic personality disorder is limited (Gabbard, 2010). Despite this, many therapists agree individuals with histrionic personality disorder often experience a great deal of emotional pain. This emotional pain causes people with this disorder to be more likely to seek treatment than individuals with other disorders (Tyler et al. 2003). However, this does not mean they are easy clients with which to work. Many individuals with histrionic personality disorder attempt to seduce their therapists, throw tantrums, and even show fake improvements to please the therapist (Gabbard, 2010).

Cognitive therapy may be most successful by aiming to alter the underlying beliefs and feelings that lead to the presence of symptoms. Cognitive therapists may address feelings of self-worth and seek to develop problem-solving skills to address learned helplessness (Gabbard, 2010). They aim to help patients recognize their excessive dependency, find inner satisfaction, and become more self-reliant.

Drug therapy is mostly unsuccessful, but antidepressants may be used to address depressive feelings (Grossman, 2004).

Interacting with children with histrionic personality disorder. Promote self-worth. Remind the child you think they are worth it, regardless of their own thoughts.

Seek to encourage the child to accomplish tasks for themselves. Tell them you believe in them, and push them to believe in themselves.

Remain objective. Be compassionate, but do not cater to outlandish desires and excessive attention. Avoid making a big deal about behaviors. If necessary, calmly encourage the child to calm down. Reacting excitedly to excessive behaviors may reinforce it, because you are giving extra attention to the behavior.
Narcissistic Personality Disorder

People with narcissistic disorder display a pervasive pattern of grandiosity (APA, 2013). They couple a need for praise to an absence of empathy towards others. People with this disorder often seem to display superficial self-admiration. They consider themselves superior to others, and they can be easily offended when people comment about personal matters. Criticism can push individuals with narcissistic personality disorder to feelings of rage and even depression. While many adolescents may display narcissistic thoughts, this usually does not indicate the development of narcissistic personality disorder unless it is severe (Sansone & Sansone, 2011). Narcissistic personality disorder’s prevalence is between 1 and 6 percent (Yeomans & Caligor, 2016). Studies suggest nearly ¾ of individuals with narcissistic personality disorder are male (Dhawan et al., 2010).

**Contributing factors to narcissistic personality disorder.** Some researchers believe parental rejection leads to narcissistic personality disorder (Celani, 2014). They believe individuals develop a grandiose self-image to convince themselves they are self-reliant. As with other personality disorders, a lack of affirmation from parents seems to carry serious consequences.

Meanwhile, other theorists believe too much positive affirmation from parents may lead to the development of narcissistic personality disorder (Sperry, 2003). In this case, the parents make the children feel superior to others due to excessive praise.

Sociocultural values seem to influence the development of narcissistic personality disorder. Family values and social ideas may cause entire generations of individuals to display materialistic and narcissistic values (Foster et al., 2003). Individuals living in the United States
are more likely to have the disorder than people in other nations. Perhaps the American focus on consumerism contributes to this.

**Treatment of narcissistic personality disorder.** It can be difficult to treat narcissistic personality disorder because individuals with the disorder usually do not recognize their weaknesses or the impact of their actions on others (Campbell & Miller, 2011). Instead, individuals with the disorder usually seek treatment for an effect of the disorder such as depressive moods. Additionally, individuals with the disorder may try to manipulate their therapist into supporting their feelings of superiority (APA, 2013). As Yeomans and Caligor noted in their 2016 paper, the forging of an alliance with a patient with this disorder requires perseverance and willingness to be devalued and even harassed over the course of treatment.

Cognitive therapy seems to benefit some patients. A cognitive therapist will encourage the patient to limit their self-centered thoughts while instead considering the feelings and thoughts of others (Beck & Weishaar, 2014). This can help increase empathy, but it is by no means a clear success.

**Interacting with children with narcissistic personality disorder.** Working with children with narcissistic personality disorder can be difficult when also trying to care for other children due to their self-centered actions. When the opportunity arises, encourage the child to increase their self-awareness. Additionally, help the child understand the thoughts and feelings of others. Share your empathic feelings with them.

**Cluster C Personality Disorders**

Cluster C personality disorders are considered the “anxious” personality disorders. They include avoidant personality disorder, dependent personality disorder, and obsessive-compulsive personality disorder. People with these disorders often display anxiety and fear (APA, 2013).
While these disorders may mirror some of the symptoms of anxiety and depressive disorders, researchers have yet to find direct links between this group and anxiety and depressive disorders (O’Donohue et al., 2007). Treatment for these personality disorders is generally more successful than treatment for personality disorders in the other two clusters.

**Avoidant Personality Disorder**

Individuals with avoidant personality disorder display a general pattern of social inhibition (APA, 2013). In short, the disorder can be likened to pathological shyness. Individuals with this disorder typically feel uncomfortable and inhibited in social situations. They fear rejection, so they avoid situations where rejection is possible. People with the disorder desire intimate relationships, but their fear of rejection prevents them from acting on this desire (Millon, 2011). Oftentimes, these individuals develop a fantasy world within their imagination where they develop strong social relationships and are confident (APA, 2013). Similarities such as a fear of humiliation and low confidence exist between this disorder and social anxiety disorder (Eikenaes et al., 2015). However, people with social anxiety disorder generally fear social circumstances, whereas people with avoidant personality disorder fear social relationships. A study from the early 2000s suggests 2.4% of adults live with avoidant personality disorder (Grant et al., 2004).

**Contributing factors to avoidant personality disorder.** A 2007 study found similar genetic vulnerability exists for avoidant personality disorder and social phobia, suggesting the two may be linked (Reichborn-Kjennerud, 2007).

Difficult childhood experiences involving extreme shame can lead to the onset of the disorder (Svartberg & McCullough, 2010). For example, a child who struggles with accidents
during their early years may experience a lot of embarrassment. This could cause them to wish to avoid social interactions to save themselves from embarrassment.

An overall negative self-image can also contribute to this disorder, as this makes children question their value in social situations (Lampe, 2015). This can lead them to discount positive feedback and focus on negative experiences.

The development of this disorder hinders social skills due to limiting social interaction. As one might imagine, this can cause the disorder to continue, as poor social skills will make social interaction more uncomfortable for the individual.

**Treatment of avoidant personality disorder.** Individuals with avoidant personality disorder often willingly attend therapy in hopes of finding acceptance and affection (Colli et al., 2014). It is important the therapist gains the patient’s trust. Otherwise, the patient may stop treatment because of feelings of rejection.

Therapy often mirrors treatment for individuals with social anxiety disorder. The psychodynamic approach focuses on patients understanding underlying conflicts that may be contributing to the disorder (Leichsenring & Salzer, 2014).

Behavioral therapy generally focuses on the development of social skills and encourages social interaction. Group therapy is often employed during behavioral therapy. Addressing social phobias may help improve the symptoms of avoidant personality disorder (Reichborn-Kjennerud, 2007).

Cognitive therapy tends to promote self-confidence and seeks to alter the feelings of inadequacy contributing to the disorder (Rees & Pritchard, 2015).
Antianxiety or antidepressant medications may be employed to address social anxiety caused by this disorder (Kantor, 2010). However, discontinuation of the medications often causes these symptoms to return.

**Interacting with children with avoidant personality disorder.** Be warm and accepting of the child.

Be patient and understand it may take time for the child to interact. Try not to force a connection. Let your actions show you are always open and happy to be supportive.

Introduce the child to others. Be mindful of situations that appear to cause the child to feel anxious. Try not to push the child to connect with others too much, as you may lose the child’s trust.

**Dependent Personality Disorder**

Individuals with dependent personality disorder display a disproportionate need to be cared for by others (APA, 2013). This need leads individuals with the disorder to display submissive behavior and fear separation from those they trust. Submissive behaviors can cause others to provide care to them. Some psychologists believe a self-belief of being unable to accomplish things without assistance is at the root of the disorder (Loas et al., 2015). This disorder can lead to high anxiety and discomfort initiating relationships. Sensitive to disapproval, individuals with this disorder tend to avoid disagreements for fear of being disliked (Grant et al., 2004). As one might imagine, the nature of the disorder can predispose individuals to depression, anxiety, eating disorders, and other stress-induced responses. The prevalence of this disorder is believed to be less than .5% in the American population (Grant et al., 2004).

**Contributing factors to dependent personality disorder.** Freudian theorists believe unresolved conflicts dating to the oral stage leads to dependent personality disorder (Bornstein,
2012). Essentially, if a child does not resolve these conflicts during the oral stage, they will depend on nurturance from others.

Parental loss, abuse, or rejection can lead to the development of dependent personality disorder (Caligor & Clarkin, 2010). These experiences may prevent the child from experiencing normal attachment and separation. Without this development, the child may fear abandonment.

Meanwhile, overprotective parents who do not allow their children to develop their independence can also contribute to the onset of dependent personality disorder (Bornstein, 2012).

Cognitive researchers believe feelings of inadequacy and need for a caregiver lead to the development of the disorder (Weishaar & Beck, 2006). The disorder prevents these feelings from dissipating.

**Treatment of dependent personality disorder.** Treatment of individuals with dependent personality disorder can be difficult. Many therapists believe patients need to assume responsibility for their well-being. Therapy for individuals with dependent personality disorder is complicated because they often place responsibility entirely on the therapist (Colli et al., 2014). Thus, one of the first tasks of the therapist may be to persuade the client to take responsibility for the treatment’s success.

Cognitive-behavioral therapy may help clients take control of their lives by challenging their feelings of incompetence and encouraging assertiveness (Svartberg & McCullough, 2010).

Antidepressant drug therapy may help patients whose disorder includes depressive moods (Beck et al., 2004).

Group therapy can be helpful, because it allows the individuals to support each other as they seek to become less dependent on others (Perry, 2005). Family therapy can also be
beneficial, since family members often serve as the caregivers for people with dependent personality disorder.

**Interacting with children with dependent personality disorder.** Avoid the care-taker role. Ensure the child’s safety, but try to avoid solving problems or handling tasks for them. With that being said, it is not worth traumatizing a camper to avoid taking the caretaker role. If they appear distressed, do your job and fill the role.

Encourage the child to take initiative for themselves.

Oftentimes, camps offer great opportunities for challenges in supervised environments. For example, many camps have climbing towers, archery ranges, obstacle courses, and other elements that present obvious challenges. Other parts of a camp, such as the craft room, swimming pool, and nature trails, may present opportunities to design challenges for the camper. Be creative and present challenges to the camper. Encourage them to use their mind and body to solve problems and take initiative for themselves.

If you work in a childcare facility that lacks the resources of a camp or outdoor center, be creative with what you have. How can you create challenges for the children to complete?

**Obsessive-Compulsive Personality Disorder**

Obsessive-compulsive personality disorder (OCPD) is highlighted by fixation on orderliness and perfectionism (APA, 2013). This fixation causes people with the disorder to be inflexible, closed, and inefficient. People with this disorder desire order, control, and organization; and this desire impairs their productivity. It also causes them to be rigid in their morals and values. People with obsessive-compulsive personality disorder can struggle to express affection and develop close relationships (Cain et al., 2015). This disorder primarily affects interpersonal relationships. The prevalence of obsessive-compulsive personality disorder
is estimated to be between 2.1% and 7.9% (Lenzenweger et al., 2007). The disorder may be twice as likely to be diagnosed in males as in females (APA, 2013).

While OCPD may sound similar to OCD, they are different. One primary difference is that people with OCD do not believe their obsessions are rational or reasonable, while individuals with OCPD find their thinking acceptable (APA, 2013). Moreover, OCD tends to affect all aspects of the person’s life, while OCPD tends to impact primarily interpersonal relationships (APA, 2013). Finally, individuals with OCD tend to recognize they need treatment, while people with OCPD often do not (APA, 2013).

**Contributing factors to obsessive-compulsive personality disorder.** Some theorists explain the development of obsessive-compulsive personality disorder using Freudian concepts. They suggest people with this disorder are anal retentive. They argue harsh toilet training cause individuals to become fixated at the anal stage, making them orderly and restrained (Millon, 2011).

Cognitive theories suggest inconsistent thinking processes perpetuate the disorder, but they fail to explain how the disorder begins (Weishaar & Beck, 2006). All-or-nothing thinking is common for individuals with obsessive-compulsive personality disorder. This rigidity can be debilitating.

Struggles for control and independence with parents may also contribute to the development of the disorder.

**Treatment of obsessive-compulsive personality disorder.** Treatment can be difficult for people with obsessive-compulsive personality disorder, because they often do not consider their behavior to be unhealthy.
Individuals with this disorder are more likely to seek treatment for something stemming from the disorder, such as anxiety or depression, than for the disorder itself (Bartz et al., 2007).

Selective serotonin reuptake inhibitors have been used to address the depressive moods and anxiety resulting from this disorder with some success (Torgersen, 2009).

Psychodynamic and cognitive therapy have both been successful (Messer & Abbass, 2010). In psychodynamic therapy, therapists attempt to help the client acknowledge the insecurities behind their behavior. They also encourage their clients to take risks. In cognitive therapy, therapists attempt to alter their way of thinking (Pinto et al., 2008). Through this method, therapists hope to alter their clients’ desires for perfectionism, their indecisiveness, and their worrying.

**Interacting with children with obsessive-compulsive personality disorder.** Be flexible. Before challenges, remind the child they do not have to be perfect and making mistakes is expected.

Encourage the child to try new things even if failure is a possibility.

Employ a sense of humor when things do not go well. Remain patient.

**Eating Disorders**

Eating disorders are regarded as one of the deadliest psychological conditions in America (Alvarenga et al., 2014). As many as 20 percent of people with eating disorders will die from conditions stemming from the disorder. Additionally, high suicide rates exist among individuals with eating disorders. Of the more than 10 million Americans with eating disorders, fewer than 50 percent will completely recover (APA, 2013).

It is important to remember that many individuals wish to lose weight and may struggle with dieting or exercising without displaying an eating disorder. Body dissatisfaction may be a
primary contributor to all eating disorders. Some studies suggest mass media and marketing campaigns contribute to the development of body dissatisfaction and eating disorders. Other studies suggest ego deficiencies and perceptual disturbances stemming from poor mother-child interactions can cause the child to develop an eating disorder (Bruch, 2001). Additionally, if parents give a child food to calm them during an anxious episode, the child may be more likely to develop an eating disorder during adolescence (Bruch, 1973). Thus, depression and anxiety can lead to the development of eating disorders. The DSM-V identifies three eating disorders (APA, 2013). They include anorexia nervosa, bulimia nervosa, and binge eating disorder.

**Anorexia Nervosa**

Individuals with anorexia nervosa intentionally maintain a significantly low body weight. To be diagnosed with anorexia nervosa, an individual must be below 85% of their normal body weight. This eating disorder is characterized by an intense fear of gaining weight (APA, 2013). Distress concerning one’s body shape or a refusal to live with a standard body weight describe this disorder (Herzig, 2004). Distorted perceptions of true body size can also lead to this disorder. Some individuals living with this disorder at 80% of their body weight will still report considering themselves to be overweight. The maintenance of their low body weight is achieved through several methods, including excessive exercise, purging (self-induced vomiting or laxative use), and decreased food intake (Mann et al., 2014). These body weight maintenance methods are referred to as compensatory behaviors. Recognizing these methods, anorexia is divided into two types: restricting type and binge-eating/purging type. Restricting type involves food intake restriction only, while the binge-eating/purging type incorporates purging methods. Anorexia nervosa can pose serious health risks, including dehydration, anemia, electrolyte
imbalance, low blood pressure, permanent organ damage, decline in brain functioning, and reproductive problems (Raviv, 2010).

As many as 95 percent of individuals with anorexia nervosa are female, and it typically appears between the ages of 14 and 20 years (Stice et al., 2013). As many as 4 percent of American women will develop anorexia nervosa during their lifetimes (Stice et al., 2013).

Anorexia nervosa generally develops after a person who is normal weight or slightly overweight begins to diet (APA, 2013). The diet reaches extreme levels, and the individual becomes significantly underweight. A stressful event such as a failure, divorce, or other event generating instability can contribute to its onset (Wilson, 2005). Interestingly, a 2004 study indicates individuals with this disorder spend a significant amount of time planning their meals and thinking about food despite their limited food intake (Herzig).

**Bulimia Nervosa**

Bulimia nervosa is also known as binge-purge syndrome. It is characterized by recurring episodes of binge eating, where an individual consumes a large amount of food in a short period of time (APA, 2013). Individuals with bulimia often feel unable to stop eating, but they do not wish to gain weight. To compensate for overeating, individuals with bulimia employ compensatory behaviors and will take laxatives and diuretics, fast for extended periods of time, exercise excessively, or force themselves to vomit (APA, 2013). To qualify as bulimic, an individual must engage in these behaviors at least weekly for a span of 3 months (APA, 2013). Bulimia is often separated into 2 types: purging type and nonpurging type. The purging type is characterized by purging efforts to prevent weight gain. The nonpurging type is characterized by nonpurging methods to limit weight gain.
Like anorexia, 90-95 percent of individuals with bulimia are female (Sanftner & Tantillo, 2011). Bulimia often begins between the ages of 15 and 20 years and can last for many years (Stice et al., 2013). Despite purging behaviors and other efforts to prevent gaining weight, individuals with bulimia typically maintain a normal weight. However, if they become underweight to the point they are below 85% of their normal bodyweight, they can be diagnosed with anorexia (Ekern, 2014).

Individuals with bulimia will often conduct their binge-eating episodes secretively. Massive amounts of food may be consumed during these episodes, sometimes totaling as many as 10,000 calories (Fairburn et al., 2008). While the number of weekly binge-eating episodes varies on an individual basis, it typically ranges between 1 and 30 episodes. Binge eating can be due to anxiety and can also cause anxiety (Stewart & Williamson, 2008). Purging behaviors are often used to reduce anxiety generated by binge eating. Like anorexia, bulimia carries serious health risks. These can include teeth corrosion, dehydration, anemia, electrolyte imbalances, brain damage, muscle and bone damage, intestinal and reproductive system damage, and declines in brain functioning (Eifert et al., 2007).

**Binge-eating Disorder**

Like individuals with bulimia, individuals with binge-eating disorder experience recurring binge-eating episodes where they feel little or no control over the amount of food they consume (APA, 2013). However, the key difference between the two disorders is that individuals with binge-eating disorder do not participate in compensatory behaviors after episodes of binging (Brauhardt et al., 2014). They do not engage in excessive exercise, diet restriction, or purging behaviors. Since they do not employ compensatory behaviors, about two-thirds of people with binge-eating disorder are overweight or obese (Brauhardt et al., 2014). Many people with binge-
eating disorder are concerned about their bodyweight and appearance. They often binge-eat due to dissatisfaction with their appearance. Weight gain leads to increased dissatisfaction and even more binge-eating episodes. As one might expect, this can lead to depression and anxiety (Pearl et al., 2014). A study in 2015 suggests between 2 and 7 percent of Americans have binge-eating disorder (Brownley et al., 2015).

**Treatment of eating disorders**

To address an eating disorder, therapists aim to restore proper body weight and normal eating habits. In the case of anorexia, force feeding may be used if a patient refuses to eat (Rocks et al., 2014). However, this can cause the patient to distrust the therapist and make treatment largely unsuccessful. Nutritional counseling, encouragement, and motivational support have been shown to help patients who have eating disorders (Zerbe, 2010). Psychotropic drugs have helped with some depression and anxiety associated with eating disorders, but they seem to possess limited benefits (Starr & Kreipe, 2014). Overall, efforts to promote a healthy lifestyle through education and awareness as well as social and emotional support seem to serve as the best method of treatment for individuals with eating disorders. Furthermore, appropriate treatment for any underlying factors contributing to the manifestation of the eating disorders are also important to continued success. For example, ignoring depression that led to the development of binge-eating disorder will render any treatment designed for the binge-eating disorder mostly ineffective. Or, the patient may stop binge-eating in favor of another maladaptive behavior to address their depression.

**Interacting with children with eating disorders**

If you know a child has an eating disorder, special attention may be needed. It would be wise to observe the child at meal times. Determine if the child is eating excessively large
portions or barely eating at all. Also, be mindful of long trips to the bathroom, as this may indicate the child is purging food. If intervention is necessary, remember to be compassionate. Oftentimes, eating disorders cause children a great deal of distress or are the root of a great deal of distress, so please remember this is more than a child simply choosing to eat too much or not enough.

It should also be noted that you may notice a child overeating or undereating at meals for a reason unrelated to an eating disorder. I have worked with a lot of kids who live with food insecurity. I have seen kids try to eat as much food as possible because they are used to not knowing when they will eat again. This can become excessive, as I have seen children try to eat five or six plates of food. Alternatively, I have seen children stuff most of their meal into their pockets, as they plan to ration their meal for the same reasons. It can be helpful to explain to the child that they will always have as much food as they need while they are with you. Make snacks available as needed, and explain that they do not need to hoard food or overeat, as you will be eating again in a few hours. When a child is not accustomed to having enough to eat, ensuring they always have enough food while under your care is one of the easiest ways to gain their trust. For reasons such as this, I never take away food in disciplinary situations.

Other Disorders Common Among Children

Oppositional Defiant Disorder

Oppositional defiant disorder (ODD) can be one of the most difficult disorders in children for therapists to treat. ODD is characterized by consistent hostility and defiance of authority figures (APA, 2013). Individuals with ODD may be argumentative, defiant, irritable, and vindictive (APA, 2013). Children with ODD often ignore directions from adults and authority figures. They may argue with the adult, express anger towards them, and even
deliberately annoy other people (Wilkes & Nixon, 2015). Even trivial things can become major sources of discord between a child with ODD and an adult. For example, the adult may tell the child the wall is green. To differ from the adult, the child may claim the wall is orange. Although the wall is clearly green, the child will stand firm in their belief and argue the wall is orange to great extents.

ODD is diagnosed in children, typically between the ages of 7 and 15 years (Mash & Wolfe, 2015). It is estimated that between 2 and 16 percent of children in the population have ODD (Nock et al., 2006). ODD is more common in boys, and ODD can develop into conduct disorder. Ultimately, conduct disorder can become antisocial personality disorder in adults.

**Contributing factors to ODD.** ODD may be caused by both genetic and environmental factors (APA, 2013). Some psychologists believe a lack of exposure to guidance and structure can lead to the onset of the disorder (Kerekes et al., 2014). Additionally, abuse or neglect, as well as parental separation, can also contribute to the onset of the disorder.

**Treatment of ODD.** Treatment of ODD can be difficult because children with ODD often do not respect authority figures and adults. Stimulant drugs may be used to aid in limiting aggressive behaviors (Gorman et al., 2015). Additionally, anger management programs and other problem-solving skills development programs may lead to some improvement in children with ODD (Kazdin, 2015). Children with ODD may find themselves in juvenile detention facilities due to behavioral problems. However, many psychologists argue against the detention of children with ODD. Rather than leading to improved behavior, institutionalization has been found to cause more problems in children with ODD (Stahlberg et al., 2010).

**Interacting with children with oppositional defiant disorder.** Without formal training, it can be difficult to work with children with oppositional defiant disorder. In fact, working with
children with oppositional defiant disorder can be some of the most frustrating experiences a counselor will ever have at camp. I know of some camps and childcare organizations that do not accept campers who have ODD due to the unique challenges that may arise and the lack of formally trained staff. The child may display passive-aggressive or even physically aggressive behaviors towards you. If discipline is necessary, they often see themselves as victims and struggle to understand what they did that was wrong.

It is important to be consistent and follow through on things, because many children with oppositional defiant disorder will be watching for that. However, taking the position of enforcer or “sticking to your guns” can make your week much more difficult. Find ways to be consistent without coming off as a stickler who is there to tell the campers what to do. By all means, in an event concerning physical safety, do what is necessary to keep everyone safe. But if you approach an aggressive situation with aggressive behavior and “flex your muscles,” or act bigger than the camper, you may be making things much more difficult in the long run.

Do your best to avoid arguing with the camper, as this is most likely only going to worsen the problem and frustrate you. Children with ODD often will become more aggressive if they feel you are arguing with them. Make the child feel respected. I had success sitting down with a camper with ODD and talking “man to man,” when I needed him to change a behavior. I would ask him if we could talk as men, and he would agree. We would then talk about how I needed his help to make sure everyone else is safe. Since he wanted respect and liked feeling needed, this was helpful. I would tell him that while I enjoy seeing him do whatever behavior (such as jumping on top of his bunk bed) I needed him to change, as other kids might follow his lead and hurt themselves because they cannot jump on their beds as well as he does. Usually, this child would agree to change his behavior if he thought it was something I really needed him to
do in confidence for the good of the camp. While this will not work for all children with ODD, it could be worth trying.

Along the same lines, my best suggestion when it comes to working with children with ODD is to make them believe they are doing you a favor when you need them to do something. If the camper is moving slowly to get dressed for breakfast, consider telling them you need their help once they finish dressing. Find something they can accomplish after dressing, such as straightening the chairs or setting the table. However, participate in the task with them. Otherwise, it may seem like you are giving them orders. If the child is young enough, you may be able to pose tasks you need to accomplish as secret missions or some other scene. I have seen counselors pretend the camper and themselves are spies and they have to tie their shoes and dress quickly so they are not exposed to the bad guys who are watching them. Then, they continue this scene by running from activity to activity so as not to spend too much time exposed to the bad guys. Be creative. However, remember that if you flex your muscles or try to impose your will on the camper, they may not play these games with you. Be careful.

**Conduct Disorder**

Like ODD, conduct disorder in children can be difficult to address. Conduct disorder is considered more severe than ODD, and many children with ODD will be diagnosed with conduct disorder if their behaviors do not improve. Conduct disorder is characterized by repeated violations of others’ rights (APA, 2013). Children with conduct disorder may be aggressive towards people and animals, destructive of property, deceitful, and prone to commit serious violations of rules (APA, 2013). At times, they may destroy the belongings of others, steal valuables, and intentionally hurt others.
Children with conduct disorder may develop antisocial personality disorder later in life (Mash & Wolfe, 2015). It is estimated that between 2 and 10% of the population has conduct disorder (Nock et al., 2006).

**Contributing factors to conduct disorder.** Conduct disorder may be caused by genetic factors and neurobiological irregularities (Kerekes et al., 2014). Additionally, drug abuse, poverty, traumatic events, and exposure to violence have also been linked to the disorder (Wymbs et al., 2014). Inattentive parents or parents who reject or abuse children are more likely to see their children develop conduct disorder (Advokat et al., 2014).

**Treatment of conduct disorder.** Treatment of conduct disorder is most effective when the child is younger than 13 years (APA, 2013). This is primarily because aggressive behaviors become more frequent during adolescence. Most of the same therapeutic practices listed for ODD are used for conduct disorder. Psychotropic medications such as stimulants are used to treat conduct disorder with some success (Gorman et al., 2015). Problem-solving skills training and anger management programs are often used. Like ODD, institutionalization usually leads to a worsening of symptoms (Stahlberg et al., 2010). These disorders can pose significant treatment challenges to even the best therapists.

**Interacting with children with conduct disorder.** Similarly to their policies concerning ODD, I know of many camps and childcare organizations that will not accept children with conduct disorders. Awareness is important when working with children. It is vital when working with children with conduct disorders. The safety of yourself and other campers may depend on it. It is important that you pay attention to their actions and warning signs. If they tell you they are going to do something, do not dismiss their comments. Much of the suggestions listed for working with children with ODD apply here, too.
Some kids “blow smoke” and talk about how they are going to fight someone. I encourage you to not tolerate that kind of language. While you will know some kids will say things like that and you can expect them to never do something, others may try to follow through on their statements. It can become messy when you only take certain children’s threats seriously, so I encourage you to not tolerate any of it. Plus, even the most peaceful kids have breaking points. If they make threats back and forth all week or are being consistently frustrated all week, they may find their breaking point and you may find yourself with a physical altercation that was likely preventable.

Most counselors secure valuables such as their wallets and phones at all times when working. If you do not already, it is wise to do so when working with kids with conduct disorders. One of my positions at camp required me to carry my driver’s license, boating license, and cellphone at times. I remember setting my phone on the kitchen counter one day in the lodge while campers were changing after a day at the lake. I walked down a hallway to my bedroom to change, and my phone was gone when I returned. A small mistake by me in leaving my valuables exposed led to an uncomfortable process of asking the campers to return my phone and ultimately having to check a camper’s bag to find it. I will say that a tendency to steal does not mean a child has a conduct disorder. I know plenty of children who tend to take what is not theirs who do not really have any disorder at all. Paying attention to your belongings and removing temptations may help you avoid problems like this.

**Attention Deficit/Hyperactivity Disorder**

Attention-deficit/hyperactivity disorder (ADHD) is likely one of the best known disorders in America. Many people grew up hearing of both ADHD and attention deficit disorder (ADD). ADD is not considered to be a diagnosis anymore. Rather, four types of ADHD exist (APA,
ADHD is a developmental disorder of inattention and hyperactivity. Children with ADHD often struggle to focus on tasks, can behave impulsively, and usually display high levels of activity (APA, 2013). Many children with ADHD may also have difficulty learning or communicating (Mash & Wolfe, 2015). Some will perform poorly in school due to their trouble focusing, and many will misbehave and struggle to interact with others (Goldstein, 2011).

Symptoms of ADHD are arguably well-known by most people. They include disorganization, avoidance of mentally taxing tasks, high distractibility, inability to pay attention, failure to follow directions, tendency to fidget, tendency to wander, running or climbing in inappropriate settings, difficulty playing quietly, restlessness, and tendency to interrupt others (APA, 2013). At least some of the symptoms are almost always displayed before the age of 12 years. Furthermore, children must display the symptoms in more than one setting and their function must be impaired due to their symptoms (APA, 2013).

Diagnosis of ADHD is often made by discussing the child’s experiences and collecting reports from parents and teachers about the child’s activity. Around five percent of American children are believed to have ADHD at present, and about 70 percent of them are boys (Merikangas et al., 2011). Despite the gender disparity in its diagnosis, many psychologists now believe more even numbers of girls and boys have ADHD. Recent studies report that girls may display less severe and different symptoms than boys, making girls less likely to be diagnosed with ADHD (Millichap, 2010). Many psychologists also believe ADHD is overly diagnosed in America. Some are concerned children are being diagnosed with ADHD when their behaviors are the result of some other factor (Millichap, 2010). For example, physical abuse or an empty stomach can cause children to be inattentive in the classroom and display symptoms associated with hyperactivity. Or, if a child only displays symptoms in one setting, perhaps the root of the
problem is stemming from something in that particular setting. If doctors do not consider other factors that may be causing ADHD, they may medicate a child unnecessarily. More importantly, they may also miss an opportunity to make sure the child is receiving the care they deserve.

**Contributing factors to ADHD.** Abnormal activity of dopamine, a neurotransmitter, is linked to the development of ADHD (Advokat, 2014). Additionally, the disorder has been tied to high stress levels and disorder in the family setting (Rapport et al., 2008). Some therapists believe the diagnosis of ADHD can be a self-fulfilling prophecy. Essentially, telling the child they have ADHD can lead to a worsening of symptoms (Martin, 2014). It also may lead others to view them negatively.

**Treatment of ADHD.** Drug therapy is arguably the most popular form of treatment for ADHD (Sibley et al., 2014). Popular ADHD drugs such as Ritalin and Focalin may be prescribed to help children focus and calm their hyperactivity. In many cases, these drugs will lead to improved academic performance and fewer behavioral problems. Behavioral therapy is also used with some success. Therapists will reward children for attentiveness and self-control, leading to operant conditioning of the desired behavior (Coates et al., 2015). Combining both drug and behavioral therapies has been shown to allow for lower doses of medication, which helps reduce the risk of negative side effects (Hoza et al., 2008). It is not out of the ordinary for individuals to take ADHD medication for much of their adult lives.

**Interacting with children with ADHD.** During the summer months, many parents choose to not give their children their ADHD medications out of concern for the long-term effects of taking the medications. While I understand the motive behind this, it can complicate a camp counselor’s job. In these cases, it may be helpful to offer positive reinforcement for attentiveness and self-control. This may be in the form of fist bumps or playing a game together.
or some other reward you find works. Be prepared to repeat instructions to a child with ADHD and provide extra attention to ensure they are staying on task. Try to remember most children are not intentionally straying from the current task. It can be helpful to provide step-by-step instructions, rather than telling the child everything they need to do at once. For example, you may want to break down the tasks associated with getting ready in the morning. You could wake the child up and ask them to get dressed, make their bed, brush their teeth, and line up at the door all in one breath. Or, you could take one task at a time. After waking the child up, you could ask them to get dressed. Once they are dressed, you could ask them to make their bed. Then, ask them to brush their teeth, and so on. This may lead to more success with handling tasks.

**Autism Spectrum Disorder**

Autism spectrum disorder is characterized by unresponsiveness to others, communication deficits, and rigid and repetitive behaviors and interests (APA, 2013). The symptoms of autism spectrum disorder usually are apparent by three years of age, and around 1 in 68 children have this disorder (CDC, 2015). Recently, there has been an increase in the number of children diagnosed with this disorder (CDC, 2015). Some doctors believe the increase in diagnosis numbers is due to increased awareness. A faulty research study used insufficient data to suggest vaccines cause autism. This has led to some parents electing not to vaccinate their children. Since the faulty research study was published, numerous studies have been published indicating no link between vaccines and autism exists. Doctors warn against forgoing vaccinating your children, as this puts them and members of the population who are not healthy enough to be vaccinated at greater risk of contracting deadly illnesses.

Since autism exists on a spectrum, symptoms can vary in severity and form (Aman & Farmer, 2011). Additionally, individuals with autism can range in levels of functioning
depending on the severity of the disorder. Some symptoms of autism include deficiencies in social-emotional reciprocity, nonverbal communication, and relationship development (APA, 2013). Additionally, children with autism may display exaggerated and repeated speech patterns or movement, inflexibility in daily activities, overly intense interests, and overreaction or underreaction to sensory information (APA, 2013). To be diagnosed with autism spectrum disorder, the child must display symptoms by early childhood, and the symptoms must cause significant impairment to the child's life.

**Contributing factors to autism spectrum disorder.** Recent studies indicate autism spectrum disorder is caused by genetic and biological factors (Risch et al., 2014). While a complete explanation has yet to materialize, researchers feel confident biological factors are the source of the disorder. Studies indicate family members of individuals with autism are significantly more likely to be diagnosed with autism as well (Risch et al., 2014). While psychological and sociocultural factors may lead to a worsening of symptoms, researchers do not believe these factors cause the manifestation of autism spectrum disorder (Kimhi et al., 2014). There are currently many ongoing studies concerning autism, and researchers hope they will have a better understanding of the disorder within the next few years.

**Treatment of autism spectrum disorder.** Treatment of autism spectrum disorder can vary greatly depending on the individual’s level of functioning and the severity of the disorder. Behavioral therapy involving the modeling of behavior and operant conditioning to encourage the implementation of the modeled behaviors has been found to benefit some children with autism (Lovaas, 2003). Children with autism may visit a speech therapist in hopes of improving communication difficulties resulting from the disorder (Lerna et al., 2014). Some individuals
with more severe autism may be mostly nonverbal. Drug therapy may be used to address some behavioral problems or other complications arising from autism, but this is on a limited basis.

**Interacting with children with autism spectrum disorder.** Like working with any children, working with children with autism can be a fun and rewarding experience. As mentioned earlier, many children with autism have particular interests. Since they focus so much on particular things, they may become exceptional at them. I have seen some great artists come to camp who happen to have autism. Their disorder contributes to their attention to detail and meticulous work on their art. Celebrate that. At the same time, encourage them to branch out and try some new things. They may feel more nervous than most campers about trying new things, so provide additional support as needed. As with ADHD, it may be helpful to provide instructions on a step-by-step basis.

One key thing to remember is that many children with autism struggle with metaphors and figurative language. They tend to take things literally. For example, a camper with autism and I were working on a list of his favorite kinds of trees. When he thought of an idea, I told him to “put it down,” meaning that he should write his idea on the list. Instead, the camper put his pencil down. Remember that children with autism may interpret things differently than most people would. Be prepared to rephrase things and try to discuss things using a literal context.

**Intellectual Disabilities**

An intellectual disability is a disorder that arises during development that affects intellectual and adaptive functioning (APA, 2013). Due to an intellectual disability, individuals may need more time to talk, walk, and handle tasks such as eating and dressing. An IQ test is required, as a score below 70 is needed to be diagnosed with an intellectual disability.
Intellectual disabilities are the most common developmental disabilities in America, with 2.5 percent of the population believed to have an intellectual disability (APA, 2013).

An intellectual disability is characterized by complications in making judgements, planning, abstract thinking, academic learning, experiential learning, and reasoning (APA, 2013). Additionally, adaptive functioning deficits must also be present. These may include deficits in social involvement, communication skills, and independence. These adaptive limitations may necessitate support from others (APA, 2013).

**Contributing factors to intellectual disabilities.** There are many causes of intellectual disabilities. Biological and genetic factors are the primary causes of intellectual disabilities (Fletcher, 2011). For example, Down syndrome is an intellectual disability caused by an abnormality of the 21st chromosome (Powell et al., 2014). Metabolic disorders such as phenylketonuria and Tay-Sachs disease may also lead to intellectual disabilities (Waisbren, 2011).

Moreover, events during pregnancy and delivery may also lead to intellectual disabilities. For example, alcohol consumption by the mother while carrying the child can lead to fetal alcohol syndrome, which causes a range of problems including intellectual disabilities (Hart & Ksir, 2014). A lack of oxygen during or after birth may also affect the brain and cause an intellectual disability. Throughout development, traumatic brain injuries due to accidents or abuse, exposure to toxins, malnutrition, and other factors can hinder neurological development and lead to intellectual disabilities (Durkin et al., 2000). The brain is incredibly complex, and many factors can lead to intellectual disabilities. This list is not all inclusive.

**Treatment of intellectual disabilities.** No cure exists for intellectual disabilities. However, efforts can be made to improve the quality of life of an individual with an intellectual
disability. Support services can help an individual with an intellectual disability attain more inclusion in society, particularly in education, recreation, and employment (Merrick et al., 2014). Special education programs in schools often seek to teach course material at a more personalized pace for each student, while also exposing students to basic life skills that help them function in life (Hardman et al., 2002). These life skills include tasks such as cooking, doing laundry, making one’s bed, and more. The school may even help older children receive training to prepare them for an occupation. For example, a high school in my hometown worked with a local grocery store to train students with intellectual disabilities who wanted jobs as check-out clerks and greeters at the store.

**Interacting with children with intellectual disabilities.** Be prepared to slow down and take your time. Try to remember that it is not the child’s fault that they may require more time to prepare or travel. Be understanding when you need to rephrase something or remind your camper about something. As with campers with ADHD and autism, it can be helpful to present step-by-step instructions to campers with intellectual disabilities. Do your best to include your camper in all activities and help them participate fully, but be prepared to make modifications as needed.

**General Comments**

**Therapy**

Put simply, if you are not trained to deliver therapy, do not try to do it. Licensed therapists spend years of their lives training to do their work. You may have the best intentions, but do not try to do something you are not prepared to do.

Besides, lots of kids I have met hate the word “therapy.” They equate it to a miserable time where they are required to talk about their feelings with people who do not seem to really care about them. Some of my campers refused to join small-group discussions and Bible studies
because they thought someone was going to try to treat them. In a lot of cases, you are probably better off not trying to equate yourself to therapy. Remember to encourage, support, and empower the children with whom you work. While camp is a lot of things, it is not designed therapy if the staff lacks formal training. Camp still presents great opportunities for discussion, discovery, and growth. Use them.

**Signs of Abuse, Neglect, and Self-Harm**

It is important to familiarize yourself with the signs of possible abuse and neglect so you can help ensure the safety of the children you meet. You may be the only person who sees warning signs of unsafe living conditions for a child.

Still, please remember these warning signs do not necessarily mean a child is in danger. A bump and bruise are normal injuries.

**Signs of abuse.** This list is compiled with help from the Tennessee Department of Children’s Services. It is not all-inclusive.

- Bruises, welts, or burns the child cannot explain.
- Unusual bruise shapes or locations, such as injuries to areas that generally avoid injury like the back of the legs or neck.
- Attempts to hide signs of injury.
- Withdrawn, fearful, or extreme behavior.
- Talking about someone hitting them and other verbal cues.

**Signs of neglect.** This list is also compiled with the assistance of the Tennessee Department of Children’s Services. Again, it is not all-inclusive.

- Frequent absences from school.
- Drastic changes in actions or performance.
• Severe body odor or uncleanliness.
• Lack of adequate apparel.
• Underfed.
• Discussion of doing all the cooking, cleaning, and other household tasks for self and younger siblings.

Comments. It should be noted that the presence of these or other warning signs does not always mean a child is being abused or neglected. Remember, there can be other explanations for what you see. However, if you believe something is awry, report it to someone who has the training and jurisdiction to investigate.

Reporting Abuse, Neglect, and Mental Crises.

Mandatory Reporting. If you have found something you believe is putting the child’s health or safety at risk through abuse or neglect, you need to report it. The four categories of reportable offenses in Tennessee include child abuse, neglect, sexual abuse, and psychological harm.

In the state of Tennessee, everyone is considered a mandatory reporter. This means anyone who suspects child abuse or neglect must report it to the police or the Tennessee Department of Children’s Services. Failing to report abuse or neglect can carry legal consequences, including up to three months imprisonment. If you suspect abuse and report it, you will not be liable if an investigation finds no abuse has occurred. However, knowingly submitting false reports is illegal.

If a situation is life-threatening for any person involved, you need to call 911 immediately. If you are unsure if a situation is an immediate emergency, you should call Tennessee’s Child Abuse Hotline: 1-877-237-004. Otherwise, you may submit a report online at
the Tennessee Department of Children’s Services’ website or by calling the child abuse hotline. While this guide is written with Tennessee in mind, similar laws exist in other states. A simple web search of child incident reporting in your state should provide information about where to report abuse in your state.

At the start of a week of camp, I like to tell campers I will respect their confidentiality except for three outcomes: they are trying to hurt someone, someone is trying to hurt them, or they are trying to hurt themselves. In those situations, I explain I will not share it with everyone, but I will need to discuss the situation with my supervisor and potentially with Children’s Services. When a child shares something I believe may lead to a report, I try to stop them and remind them I will have to tell someone if I think someone is in danger. While it is difficult when a child refuses to share something because they know I may report it, I think they deserve the respect of me being honest. I remind the camper I only report things because I love them and want them to be safe. Still, campers will sometimes refuse to discuss the topic further, and I have to accept that.

**Details to include in a report.** If you will be reporting something, it is helpful to jot down notes right after your conversation with a child or after observing something on their body so you will remember more information for the report. It is important to only report information shared. Do not try to lead the child to say something that might not be true so you may report it. Do not exaggerate, assume, or provide false information. When collecting information for a report, pay attention for this information:

- Child’s name, age, address, race, school, and other demographic information
• The name(s), address(es), and phone number(s) of parents/guardians/caretakers.

• An explanation of the harm or events necessitating the report

• Dates of said events, descriptions of injuries resulting from said events

• Name of the perpetrator

• Any witnesses

• Information about the current situation. Does the abuser still have access to the child?

• How you learned the information and whether the child is at risk of further harm.

• Any other comments from the child.

Avoid judgment and blame in the report. Rather, listen to the child and address comments that concern you. Reassure the child and be patient while they share with you. Remember, they are probably sharing something personal and closely guarded. Give them the respect they deserve for choosing to discuss this with you.

Next steps. If you correctly follow the steps of incident reporting, you may wonder what happens after you submit it. After submitting a report, you may receive a few follow-up phone calls if you provide your phone number. In other cases, you may never hear the outcome of your report. I have submitted a number of reports in Kentucky and Tennessee, and I have not heard from anyone connected to many of the cases, including the child, since receiving an email confirming receipt of the report. Reporting child abuse can be emotionally trying, and it is difficult not knowing the outcome. However, you must trust you followed the appropriate course of action and take care of yourself. Allowing this to consume you could prevent you from
noticing warning signs present in another child’s life. It would be heartbreaking to miss warning signs in one child because you are upset about another child’s case.

**Self-injurious Behavior**

There are several warning signs indicating a child may be engaging in self-injurious behaviors.

- Increased alcohol or drug consumption.
- Self-critical behavior.
- Signs of depression, or an inability to cope with signs of stress.
- Inconsistent mood and behavior.
- Cuts, bruises, burns, and bald patches (where hair has been pulled).
- Always wearing long sleeves, even on the hottest days of the year.
- Noticeable scarring on wrists, thighs, etc.
- Long trips to the bathroom or some other private area.

While self-injurious (self-harming) behavior on the part of a child is not abuse, it could be the sign of neglect or psychological harm. Abuse could also lead the child to engage in self-injurious behavior. If you suspect it to be induced by a reportable offense, you should report it. Additionally, if a child is displaying suicidal behavior and you believe the child is in danger, you need to call 911 or report it to your local authorities immediately. In the event of discovering non-suicidal, self-injurious behavior (such as cutting), it is a good idea to share this information with someone who can help the child with this, such as the child’s case worker or counselor.

As with nearly everything discussed in this guide, remember the presence of warning signs associated with a behavior or disorder does not always indicate its presence. For example, wearing a child may wear long sleeves in the heat of summer to cover scars from cutting their
arms. Meanwhile, a young man with whom I worked always wore a jacket zipped-up to his neck and long pants, even when the temperature exceeded 95 degrees. While this could indicate a desire to cover up scars, his apparel decisions stemmed from a traumatic experience from early childhood. His past caused him to experience anxiety in public settings. The weight of the clothes made him feel covered and more comfortable in public settings.

It is a good idea to remove items that can be used to self-harm if your camper has a history of self-harm. These items can include lighters, scissors, knives, toothpicks, and razors. This is something to approach carefully. While a child may have a history of self-harm, they also may have brought a razor to shave their legs or face while at camp. Taking this away can suggest to the child a lack of trust. Unless the child is currently self-harming, I prefer to let them keep their razors with the understanding we may take them if a problem arises. If something happens where I am concerned they may try to harm themselves, I usually will talk to them and take the razors. Sometimes, I have had campers where I have held onto the razors except for when they are showering. Obviously, if I were to see signs of distress in a camper, I would not let them have their razors. This is a sensitive subject and can be difficult to navigate. It is best to tread carefully.

Working with a child who is actively self-harming at camp is one of the most difficult experiences I faced during my time at camp. One of the beautiful things about summer camp is that it can provide a safe place where a kid can feel loved for a week. They can feel like they are enough. When one of my campers self-harmed at camp, I felt like I had failed her. Even in the camp setting, she felt led to hurt herself. While her felt need to harm herself was not really my fault, it was still hard for me to swallow. Regardless, it was my job to remove items she could use for self-harm from the environment and talk to her about it. These can be incredibly difficult
situations to face. But remember, the child who is self-harming is likely facing much more challenging battles within their minds and at home than you are.

**Suicidal Behavior**

Non-suicidal, self-injurious behavior can be emotionally tough to see. Working with children who have attempted suicide or wish to attempt suicide can be even more difficult. If working with at-risk youth, there is a high probability at least one of the campers has considered or attempted suicide. According to [www.dosomething.org](http://www.dosomething.org), suicide is the third leading cause of death for 15 to 24-year-olds.

Per the New York State Department of Health, there are many factors that can increase the risk of a suicide attempt. It should be noted the presence of these factors does not mean a suicide attempt will occur.

- Depression, substance-use disorder, or other mental disorder
- Feelings of hopelessness
- Previous suicide attempts
- Social detachment and isolation
- Family history of mental disorders
- Family history of physical violence, including abuse
- Access to weapons
- Knowing someone else who has tried to commit suicide
- Coping with something for which they feel unsupported.

Some signs a child may be preparing a plan for a suicide attempt are also provided by the New York State Department of Health.

- Threatening self-harm or talking about wanting to kill themselves.
• Writing suicide notes
• Expressing troubling thoughts.
• Displaying a dramatic change in personality.
• Giving away important possessions.
• Talking about leaving or not being there in the future.
• Obtaining weapons, drugs, or other potentially lethal materials.

**What you should do.** If you believe someone is displaying these warning signs, you need to do something. Ignoring warning signs could lead to one of the most heartbreaking memories imaginable. Talk with the child and express your support and love. Tell them you are concerned about their behavior and want better for them. As soon as possible, tell your supervisor so they can take appropriate action. Other individuals who might be able to provide assistance will need to be notified as well, such as parents and case workers.

Do not leave the youth alone if you know they are actively considering suicide. Remove objects that can be used for self-harm. These include knives, scissors, medications, and cleaning supplies. As a general rule, the camp where I worked did not allow campers access to these materials to help prevent their use in fights and self-harm. When doing crafts, a certain number of scissors were provided, and inventory was taken at the end of the activity.

Many suicide hotlines exist where trained suicide prevention specialists are ready to talk on the phone with an individual struggling with thoughts of suicide. Some options that you may contact if needed:

• Crisis Text Line: Text “start” to 741-741
• National Suicide Prevention Lifeline: Call 1-800-273-8255
• The Trevor Helpline (focusing on suicide prevention among gays and lesbians): 1-800-850-8078

Closing

While this guide hopefully contains a lot of helpful information, it is by no means comprehensive. Should you wish to collect more information, please consult the list of references included. For additional information requests or other inquiries, please contact Jeremy McDuffie via email, jmcduff5@vols.utk.edu.

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