HEARTS AND MINDS

Mental Health Support for Schools

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The University of Southern Queensland acknowledges the traditional custodians of the lands and waterways where the University is located. Further, we acknowledge the cultural diversity of Aboriginal and Torres Strait Islander peoples and pay respect to Elders past, present and future.

We celebrate the continuous living cultures of First Nations Australians and acknowledge the important contributions Aboriginal and Torres Strait Islander people have and continue to make in Australian society.

The University respects and acknowledges our Aboriginal and Torres Strait Islander students, staff, Elders and visitors who come from many nations.

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INTRODUCTION

Hearts and Hands: Mental Health Support for Schools

Welcome to Hearts and Minds: Mental Health Support for schools – a contribution by UniSQ's Master of Guidance and Counselling students. The collection presented here aims to be a comprehensive overview of current mental health concerns in schools with gold standard interventions included. The foundation of this venture is based on focus group feedback from teachers, deputy principals, support staff, and school guidance counsellors. This from one participant: ***I would like to have a deeper understanding of these conditions and their impact on children, to be able to help staff improve their understanding, along with sharing effective strategies to support the students and families.***

Mental health and wellbeing is at the forefront of support and intervention for schools with current indicators of wellbeing reaching significant levels of concern. As such, Guidance and Counselling students at UniSQ are mentored and equipped with skills and knowledge to be highly effective practitioners in the field. The outcomes of their endeavours are collated here.

Each category of mental health is structured within a concentric framework of the individual, school, family, and society at large. Impacts on the individual and community as well as cognitive, behavioural, and physical indicators of the mental health concern are identified for specific developmental age groups. With this in mind, it is hoped that the in-depth empirical information presented in each of the mental health categories of Anxiety, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, Depression, Post-Traumatic Stress Disorder and Suicidal Ideation inform the support and intervention for students, staff, and families.

ABBREVIATIONS

ADHD	Attention Deficit Hyperactivity Disorder
APA	American Psychiatric Association
ASD	Autism Spectrum Disorder
AD	Anxiety Disorder
CBT	Cognitive Behaviour Therapy
GAD	Generalised Anxiety Disorder
IBSP	Individual Behaviour Support Plan
IEP	Individual Education Plan
GC	Guidance Counsellor
GO	Guidance Officer
ISP	Individual Support Plan
OECD	Organisation for Economic Cooperation and Development
PLP	Personal Learning Plan
PTSD	Post Traumatic Stress Disorder
REBT	Rational Emotional Behaviour Therapy
WHO	World Health Organisation

PART I

ANXIETY

1.

ADOLESCENCE

Kim Rohde

Adolescence

Early and mid-adolescence is the age bracket between approximately 11 and 18 years (Gilmore & Meersand, 2014) which is universally characterised by major biological, cognitive, social, and contextual changes (Larson & Sheeber, 2009) thus, adolescence is a highly active time of development for young people. As the adolescent brain and body develops and changes, so too does their interaction with those within their immediate and extended environment. These factors combine to create a myriad of never before experienced challenges (Gilmore & Meersand, 2013) that vary enormously in duration and intensity across individuals (Arnett, 1999). Adolescents begin seeking autonomy from their parents while investing concerted effort into their peer group and romantic relationships which may result in conflict with parents (Gilmore & Meersand, 2013). Similarly, in their pursuit of self-identity and individuation, adolescents may experiment through sexual encounters, hair and fashion styles and challenging previously held beliefs (Kinsman, 2014). Cognitive development sees the emergence of executive function, complex decision-making, and self-regulation in the adolescent (Kinsman, 2014). As mastery of these newly acquired skills is evolving, youth still grapple with the competence to negotiate unknown circumstances with ease (Larson & Sheeber, 2009).

Anxiety

While the *Diagnostic and Statistical Manual 5* identifies multiple anxiety disorders affecting adolescents (American Psychiatric Association, 2015), it is beyond the scope of this report to discuss these conditions individually. Instead, adolescent anxiety will be addressed generally.

Anxiety is a disorder that affects approximately 10% of the adolescent population, making this mental health condition the most common among this age group (Kinsman, 2014). Anxiety can be defined as the physical and emotional preparedness that occurs in anticipation of a situation perceived as dangerous (Pine & Klein, 2015). It is when the intensity, duration and frequency of anxiety is serious and misaligns with the individual's development that further assessment for possible intervention should be prioritised to avoid immediate or longer-term negative outcomes (Huberty, 2012).

Huberty (2012) describes several attributes common to young people who experience anxiety. Firstly,

youth who experience anxiety are known to feel more deeply worried about a broad range of circumstances that appear unremarkable to their peers. In a school environment, these students may be referred to as "drama queens" by their same age peers and at home as "my little worrier" by parents (Kinsman, 2014). Secondly, repetitious thoughts invade the cognitive space required to concentrate and perform learning tasks resulting in a student who appears distracted or lacking effort. Thirdly, anxious adolescents anticipate negative outcomes which serves to perpetuate the anxiety cycle. Finally, a "threat attributional bias" (p. 30) means adolescents who are anxious assign threat to more situations than would their non-anxious peers.

Evidence of Symptoms

Anxiety causes significant difficulty with concentration, memory, problem-solving and attention to tasks (Huberty, 2012). These problems are known as cognitive distortions and cognitive deficiencies (Kendall, 1992, as cited in Huberty, 2012). Distortions occur when incoming information is interpreted incorrectly through the lens of the anxious youth resulting in skewed thinking (Huberty, 2012). According to Read et al. (2013), three kinds of cognitive distortions are evident in youth with anxiety, (1) catastrophising is evident when anxious young people assign calamitous consequences to a potential situation that their non-anxious peers would not; (2) overgeneralising becomes obvious when adolescents expect poor results across other situations, and (3) personalising occurs when a young person takes responsibility for undesirable outcomes when blame cannot be attributed to them. Equally, deficiencies result from impairment in academic functioning as anxiety impedes the ability of the adolescent to process information (Huberty, 2012). A student's decreased capacity for attention to tasks and instructions mean they are unable to discern relevant material and cues (Pine, 2011) that is vital for the synthesis of information and application of higher order thinking skills. Reduced concentration impairs the individual's ability to formulate a correct response to teacher questions (Kinsman, 2014) which may lead teachers to describe these students as day dreamers when they consistently appear off-task and unresponsive (Huberty, 2012). Not surprisingly, extended and persistent periods of trouble engaging with many elements of learning tasks lead to further perpetuation of anxious thoughts reinforcing their own school failure (Huberty, 2012).

The most common behavioural indicators of adolescent anxiety are easily observable by parents, teachers, and clinicians (Huberty, 2012). These can be categorised as voluntary and involuntary and are deliberately or unavoidably undertaken by adolescents, respectively (Huberty, 2012). It is not unusual for an anxious adolescent to avoid, retreat or withdraw from activities or events where they anticipate a negative outcome, just as it is reasonable that hyperarousal may cause unintentional movement (Huberty, 2012). Both result in behaviours that may be misinterpreted as disinterested, lazy, or present as though they lack regulatory skills (Huberty, 2012).

Adolescents with anxiety frequently identify social situations as potentially distressing. Research has empirically proven the value of peer socialisation to healthy adolescent development (Steinberg & Morris, 2001) yet some teens fear this interaction and proactively work to avoid it. Consequently, these adolescents raise their risk of poor social outcomes as avoidance preventing opportunities to build confidence which

in turn increases the chance of social rejection by peers (Ollendick & Ishikawa, 2013). In complex school social environments requiring small group interactions and assessment performances, anxious children are interpreted as being "socially inept, incapable or disinterested" (Huberty, 2012, p. 45). Moreover, this school dynamic has implications for learning outcomes where anxious students avoid leading groups and difficult tasks and instead seek easier options where they avoid volunteering or asserting themselves appropriately (Huberty, 2012).

Educators are warned not to dismiss the physiological symptoms of anxiety in adolescents (Kinsman, 2014) as they are an indicator of the high level of distress currently being experienced (Huberty, 2012). Flushed skin, while a sign of increasing anxiety, is likely to be a source of embarrassment (Huberty, 2012). In addition, headaches, stomach pain, high pulse rate and muscle tension may result in further medical investigation (Huberty, 2012).

Impact on the the Individual and their Interactions

Adolescents who experience anxiety are subjected to short, and potentially long-term detrimental impacts of the condition which highlight the need for prompt identification, assessment, and intervention. The immediate effects may include irritability, erratic behaviour, rapid speech, perfectionism, withdrawal, oversensitivity, and a failure to complete tasks (Huberty, 2008, as cited in Huberty, 2012). These characteristics significantly limit opportunities for productive interactions with peers which are essential in developing friendships at this age leading to acceptance by peers (Ollendick & Ishikawa, 2013). This is supported by the finding that anxious teens identify as lonelier and present with a deficit in social skills in comparison to their non-anxious peers (Strauss et al., 1989) as well as enduring social isolation from their cohort (Strauss et al., 1989). Likewise, parents and other significant adults in an adolescent's life have a role to play in responding to the needs of an anxious youth. If parents or teachers react negatively to these behaviours, it only serves to further perpetuate the already distorted beliefs of the teen (Ollendick & Ishikawa, 2013).

The long-term effects of experiencing anxiety as an adolescent are concerning. When compared to their non-anxious peers, adults who were diagnosed as anxious during their youth are less likely to live independently or access further education (Woodward & Fergusson, 2001). Moreover, it was identified that anxiety in adolescence reduced the likelihood of attending university while raising the chance of parenthood at a young age (Woodward & Fergusson, 2001). Studies have demonstrated that an anxiety diagnosis increases workplace absenteeism with 35% of participants identifying the disorder as a significant contributor for being unable to attend their place of employment (Wittchen et al., 1998).

Suggested Interventions

Schools are perfectly positioned to deliver whole school programs that target the specific needs of the

student population. Evidence supports the use of a tiered system of intervention as it is structured to address potential issues in a proactive manner through to unique challenges experienced by individuals (Shores, 2009). For those universal programs at Tier I accessible to all students (Shores, 2009), the Guidance Officer is integral in planning for the school-wide delivery of this intervention. Social-emotional development in children should be a priority for schools with the implementation of interventions that promote social-emotional learning among students (Iizuka et al., 2013). The FRIENDS for Life program (Australia Institute of Family Studies, n.d.) is an example of one evidence-based program that has been developed from an individual student strength-based perspective that promotes resilience when teaching about interactions between contexts by "actively involving students, families, teachers and schools in the intervention process" (Iizuka et al., 2013, p. 522).

Tier II supports are for approximately 15% of the student body who continue to experience mild or moderate difficulties or have been identified as at risk, despite the implementation of Tier I programs (Shores, 2009). For youth with anxiety, the efficacy of Computer-based Cognitive Behavioural Therapy (CCBT) has demonstrated results on a par with clinician delivered therapy (Wuthrich et al., 2013). This style of therapy is advantageous as it is easily accessible to adolescents, reduces treatment cost and stigma, and can free up guidance time, however users are cautioned that it may threaten the strength of the therapeutic alliance and limits custom responses to individual need (Wuthrich et al., 2013). In this instance, the Guidance Officer would investigate all options and proceed only with an empirically proven and well-evaluated support.

For approximately 5% of students, further intensive intervention is required at the Tier III level. The Guidance Officer may be nominated as the case manager and will be instrumental in developing a student plan in accordance with the Supporting students' mental health and wellbeing procedure (Department of Education, 2021b). If specialist treatment is required through a clinical care provider, (Department of Education, 2021b) the Guidance Officer will work collaboratively with this specialist and the school team to develop a cohesive approach to intervention for the student.

2.

ADOLESCENCE

Jaymie Parish

Adolescence

Adolescence is the stage in a young person's life between childhood and adulthood where a child moves developmentally from dependency to independence, while becoming more autonomous within their thinking and actions (Geldard et al., 2019). Adolescence is a period of many developmental challenges, including biological, cognitive, psychological and social that may be related to a young person's personality traits or their surrounding environments (Geldard et al., 2019). For example, adolescents may experience difficulty with aggression, violence, social acceptance and their sexuality (Wise, 2004). In addition, some adolescents may find it difficult to deal with these challenges successfully, leading to an increase in behavioural or emotional consequences (Geldard et al., 2019). As a result, a young person may be susceptible to an increased change in their moods, resulting in some young people experiencing mental health conditions such as anxiety (Wise, 2004).

Anxiety

Anxiety is characterised by feelings of tension, worried thoughts and physical changes (American Psychological Association [APA], 2013b). It is a common neurobiological disorder that affects close to 14% of the population (Beyond Blue, 2022a), with individuals that experience anxiety usually having recurring intrusive thoughts, feelings and concerns (APA, 2013b). In adolescence, anxiety can include the anticipation of real or imagined threats to themselves and the term can be used interchangeably with fear (Fonseca et al., 2011). An individual with anxiety may experience one of four main types of the disorder, including generalised anxiety disorder, social phobia, specific phobia or obsessive-compulsive disorder (Geldard et al., 2019), all having specific impacts on a young person's relationships (Rapee, 2015).

A young person that has anxiety may experience changes to their behaviour, cognitive responses or physiological responses (Fonseca et al., 2011). Common behaviours can include nervousness, restlessness, poor concentration, irritable moods and fatigue (Geldard et al., 2019). Furthermore, behaviours such as avoiding situations, irrational fears or obsessively concerned about unpleasant and intrusive thoughts may be present in an adolescent with an anxiety disorder (Geldard et al., 2019). These behaviours can have multiple impacts on a young person's life, including educational outcomes and social situations (Rapee, 2015).

Anxiety can impact an adolescent's life in many ways. As argued by Ameringen et al. (2003), anxiety can have negative consequences on a broad range of psychosocial variables such as academic performance and social functioning. In addition, anxiety can also lead to school refusal, educational underachievement and difficulty forming appropriate relationships (Ameringen et al., 2003). These behaviours within an adolescent can then lead to problems adjusting to adulthood and successfully functioning outside their environments (Rapee, 2015).

Evidence of Symptoms

Various symptoms contribute to the development of anxiety in adolescents. Symptoms of anxiety are argued to be the most common psychiatric problem among adolescents, causing significant negative impacts on the daily functioning and quality of life of young people (Weeks et al., 2016). Maladaptive cognitive patterns have been examined to contribute to the development and maintenance of anxiety in adolescents, specifically the way a young person processes threatening information or dangerous situations (Weeks et al., 2016). Furthermore, cognitive interpretation of emotional situations can cause excessive catastrophizing, over generalising and personalising of stressful situations in which an adolescent has difficulty processing (Legerstee et al., 2011). In addition, self-blame and rumination have been argued to be positively associated with symptoms of anxiety in adolescents (Legerstee et al., 2011). As such, it can be argued that negative cognitive contexts are observed to be a factor in the presence of anxiety in young people.

Behaviourally, there are various symptoms that can be argued to be observed in adolescents with an anxiety disorder. Inhibited temperaments such as irritability, shyness and fear of unknown situations are behavioural patterns that can be argued to be present in adolescents with an anxiety disorder (Muris et al., 2001). Moreover, interaction with negative environmental influences, such as stressful life experiences, also impacts a teenager's susceptibility in developing an anxiety disorder (Muris et al., 2001). In addition, a young person's environment has significant impacts on the presence of anxiety throughout adolescence (Geldard et al., 2019). This is due to factors such as parental expectations, peer acceptance and academic pressure (Rapee, 2015). This connection between the behavioural and social contexts of a young person's life is argued to be major risk factors in individuals with anxiety (Geldard et al., 2019).

Anxiety disorders in adolescence are associated with impaired academic, financial, social, and health functioning and can lead to significant risk for developing an anxiety disorder (Reardon et al., 2018). When identifying an adolescent with an anxiety disorder, multiple assessments are utilised to accurately ascertain the level and type of symptoms present. Typically, assessment of adolescents requires multiple approaches including multiple measures, multiple informants, multiple settings and multiple time periods (Huberty & Reed, 2012). Furthermore, developmental and family history, interviews, with family and teachers, diagnostic tools and observations are all frequently used to monitor symptoms of anxiety in adolescents (Huberty & Reed, 2012).

Questionnaires, interviews and psychometric data are used as diagnostic tools for identifying anxiety disorders in adolescents (Geldard et al., 2019). One of the most common ways of assessing a young person for an anxiety disorder is the use of questionnaires such as the Spence Children's Anxiety Scale (SCAS), Revised Children's Anxiety and Depression Scale (RCADS), Screen for Child Anxiety Related Disorders (SCARED) and the Multidimensional Anxiety Scale for Children (MASC-2; Reardon et al., 2018). These questionaries measure for accuracy, consistency and validity in diagnosing an adolescent with an anxiety disorder. Although arguments demonstrate that these diagnostic tools are ineffective due to time constraints, specificity and the difficulty distinguishing between anxiety and other psychiatric disorders, they are overall effective at identifying a mental health disorder in adolescents (Reardon et al., 2018).

Impact on the Individual and Interactions

Anxiety in an adolescent can be disabling and more pervasive than the anxiety experienced in normal life (Geldard et al., 2019). It can affect a young person's ability to cope with everyday stressors, and can lead to varying consequences across an individual's social, environmental and educational lives. Poor academic performance due to the inability to concentrate or excessive fear of failure are associated with anxiety disorders in adolescents (Weeks et al., 2016). In addition, this poor academic performance can then lead to school refusal, impacting their educational and social outcomes (Ameringen et al., 2003). Furthermore, an adolescent with anxiety may also find it difficult to form appropriate relationships, choosing to isolate themselves away from unfamiliar social situations due to their excessive intrusive thoughts (Rapee, 2015). These negative interactions can impact a young person's ability to cope, leading to problems in adulthood.

Suggested Interventions

The high prevalence and significance of anxiety disorders on individuals highlight the importance of effective early intervention. Educational strategies allow young people to gain control over their behaviours and develop the knowledge to adequately deal with the stressors of life When providing interventions for students with an anxiety disorder, the focus should be on aspects of an individual's socio-emotional development (Huberty & Reed, 2012). Furthermore, interventions help to build the capacity of school staff to address the barriers to learning and promote the development of students that are affected by a mental health disorder (Huberty & Reed, 2012). Interventions such as Individual Support Plans are necessary to meet the educational and emotional needs of students with an anxiety disorder (Huberty & Reed, 2012).

Within schools, Individual Support Plans should be developed in order to intervene as early as possible after the onset of behaviour, learning and emotional problems within a classroom setting (Huberty & Reed, 2012). These plans help classroom teachers to monitor for symptoms of anxiety, while providing differentiated interventions within a classroom that help an adolescent to feel connected to their learning (Huberty & Reed, 2012). Furthermore, an Individual Support Plan may help a Guidance Officer to

adequately provide the necessary information to classroom teachers to help a student successfully complete set tasks and assessments (Huberty & Reed, 2012). They also enable classroom teachers to monitor for signs of anxiety that a student may have, allowing them to appropriately intervene where necessary (Huberty & Reed, 2012). Therefore, it can be argued that Individual Support Plans are beneficial interventions for students with an anxiety disorder as they help monitor and provide alternate methods of teaching and learning, enabling students to succeed with their educational outcomes (Huberty & Reed, 2012).

3.

ADOLESCENCE

Waneka Jannusch

Adolescence

The World Health Organisation (2022a) defines adolescence as a developmental period that extends from the age of 10 through to 19 years. Other researchers consider that adolescence lasts much longer, until approximately 25 years, at which time the body and the brain have completed their structural development (Siegel, 2014). Regardless of the varying specifications of exact ages, what remains undisputed is that adolescence is a transitional stage defined by significant cognitive, physical and socioemotional development with a view to achieving independence into adulthood (Chulani & Gordon, 2014).

As a result of the rapid changes that occur throughout adolescence, developmental challenges are commonplace across cognitive, social, behavioural and environmental domains. For example, as the adolescent brain develops, their reward circuitry becomes hypersensitive and the limbic system oversensitive. This is further exacerbated by an underdeveloped executive functioning region (Casey & Caudle, 2013; Galván, 2013). This results in an adolescent brain that emotively seeks out rewards without the balance of executive functions such as logic and reason (Sandor & Gürvit, 2019). This can lead to disrupted moods and risky behaviours, such as shoplifting; experimentation with drugs and alcohol; vandalism; unsafe use of vehicles and unsafe sex (Ahmed et al., 2020). These behavioural challenges are further impacted by the adolescent drive for social connection with peers and an elevation of peer opinion above that of caregivers (Blakemore, 2018). Throughout this period of connection-seeking and experimentation, adolescents are simultaneously developing their personal and social identity within the changing landscape of transitioning from primary to high school and for some, making their way into the workforce for the first time (Crocetti et al., 2018). All this occurs while physical changes are taking place, which for adolescents who enter puberty either early or late, can cause additional distress (Seligman & Gahr, 2013). The combination of these ongoing stressors throughout this lengthy developmental stage can lead adolescents to experience feelings of psychological distress which, for some adolescents, can develop into psychopathology.

Anxiety Disorder

Anxiety Disorder (AD) is one of the most commonly reported mental health issues in adolescence (Australian Institute of Health and Welfare, 2021b). AD is an internalising disorder characterised by

holding a future-oriented outlook that provokes feelings of unpredictability and uncontrollability that results in maladaptive responses to perceived dangers that negatively impact an individual's life (Wicks-Nelson & Israel, 2015). According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association [APA], 2013a), AD includes Separation Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, Specific Phobia, Selective Mutism, Agoraphobia and Generalised Anxiety Disorder. While recognising that there are nuanced and specific variations within the AD umbrella depending upon the focus of the adolescent's anxiety, this report considers AD in general. AD can be present from childhood through to adulthood (APA, 2013). It has a median onset age of 11 years, prevalence rates estimated between five and 18 per cent and a relapse rate of approximately 30 per cent when shifting from adolescence into adulthood (Seligman & Gahr, 2013; Zavos et al., 2013).

AD can have deleterious impacts on everyday functioning resulting from its characteristic social withdrawal, which hinders the development of important adolescent social connections (Allen et al., 2018). Avoidance behaviours that originate in AD can impact on school attendance and involvement in extracurricular activities, such as sports. In turn, this can reduce the amount of physical activity an adolescent undertakes, which diminishes the protective factor that physical activity offers for mental wellbeing to combat mental ill-health, such as depression (Biddle et al., 2019). This is noteworthy as there is significant comorbidity between anxiety and depression (Zavos et al., 2013). Additionally, reduced physical activity can result in undesired changes to the adolescent's physical development, impacting upon their body image. This is problematic because impaired self-image is commonly associated with adolescent AD (Di Blasi et al., 2015). Self-image not only incorporates body image, but includes social emotional aspects of perception of educational goals and relationships with friends and family (Di Blasi et al., 2015). In the presence of AD, these factors combine to have negative flow-on effects that become evident across life domains.

Evidence of Symptoms

The symptomatic evidence of AD can be seen across behavioural, cognitive and social contexts. Observed behaviours of anxiety include physiological symptoms such as headache, stomach ache, sweating, heart palpitations and shortness of breath (Beesdo et al., 2009). Sleep disturbance is also common (Zavos et al., 2013), which exacerbates the distractibility, irritability and excessive worrying that is characteristic of AD (Wicks-Nelson & Israel, 2015). Social withdrawal is often observed in adolescent AD (Ollendick & Ishikawa, 2013). This is further complicated by the incongruence of social withdrawal with the innate adolescent desire for social connection with peers. The implications become more far-reaching if school refusal or school dropout ensues (Aqeel & Rehna, 2020). Withdrawal, combined with avoidance behaviours leave ample scope for rumination, which can lead to further maladaptive responses such as self-harm (Stanford et al., 2017) and in some instances, suicidal ideation (Teismann & Forkmann, 2017).

As anxiety is an internalising disorder that originates in maladaptive client perceptions, it is recommended that data collection techniques used to assist in identifying AD should include informants from multiple domains, including the adolescent, their primary caregivers, teachers and clinicians (Creswell et al., 2021). Discrepancies are often found between reporters, in particular variances between the adolescent and primary caregiver report (Clementi & Alfano, 2013). Dillon-Naftolin (2016) attributes this to the varying emphases reporters have; such as adolescents more commonly reporting somatic symptoms and parents reporting behavioural symptoms. The Adaptive Behaviour Assessment System, Third Edition (ABAS-3) (Achenbach, 2013) is an assessment instrument that allows for multi-informant data gathering and is well-accepted as a comprehensive instrument that is aligned with DSM-5. While it is not within the parameters of a school Guidance Officer's (GO) role to diagnose, the ABAS-3 is nominated as an approved psychoeducational test for Queensland Education GO administration under appropriate supervision (Department of Education, 2021a).

Impact on the Individual and Interactions

AD can have negative impacts on an individual that diminish their connection with peers, family and the broader community; may lead to reduced academic engagement; and, result in ongoing psychopathology into adulthood. The social withdrawal that is characteristic of AD can have significant consequences because adolescence is a key phase for building lifelong social competence, in tandem with the broadening of adolescent cognitive skills (de Lijster et al., 2018). Adolescents with AD report higher levels of interpersonal issues across life domains, including friendships, romantic partners, caregivers and teachers (Brumariu et al., 2012). While Neal et al. (2016) find that the transition from primary to high school can be a trigger for social withdrawal, Barzeva et al. (2020) find that for some adolescents with AD, this key transition can present as an opportunity for social reinvention. Therefore, transitions are a critical time of impact for adolescents with AD.

As children transition into adolescence, it becomes more common for adolescents to experiment with substances (Berge et al., 2016). However, male adolescents with AD are at a higher risk of substance misuse (Alfano, 2012). Interestingly, Rieselbach et al. (2022) find that AD in adolescent females is evidenced to serve as a protective factor for substance misuse; however, upon entering adulthood, AD increases the risk of substance misuse in adult females. An emerging field of research around other areas of misuse in adolescence investigates the links between mobile phone addiction and anxiety (Soni et al., 2017). While Akhther and Sopory (2022) find that technology can positively assist socially withdrawn adolescents to remain connected to peers, Yang et al. (2019) find a positive correlation between mobile phone addiction and anxiety. Overuse of technology can also result in insufficient sleep (Lemola et al., 2014). Roberts and Duong (2016) find that insufficient sleep during adolescence significantly increases the risk of AD onset. Therefore it is apparent that overuse of mobile phones may trigger AD.

While Jarrett et al. (2015) report that adolescent AD is associated with lower academic performance, de Lijster et al. (2018) find that academic results are not impacted. This discrepancy may be mediated by

the perfectionistic tendencies of some adolescents with AD (Lyman & Luthar, 2014). Thus, in spite of increased school absenteeism that often results from somatic complaints of headache and stomach ache, adolescents with AD strive to achieve academically (Allen et al., 2018). Regardless of the debate around the immediate impact on academic results, Seligman and Gahr (2013) report links between increased prevalence of AD in mid-adolescence with a significantly reduced likelihood of entering tertiary education. In turn, this can impact on important life domains into adulthood, such as employability (Creswell et al., 2021). Thus it is evident that if left untreated, AD can cause negative impacts on immediate daily functioning as well as having long-term implications on mental health and employability.

Suggested Interventions

Given the far-reaching implications of untreated anxiety, the development of an Individual Support Plan (ISP) that promotes an integrated support approach across the various domains of an adolescent's life is beneficial. An ISP may include strategies for parents, such as encouraging healthy sleep hygiene in the home (McMakin et al., 2019); teachers, such as celebrating effort over achievement to alleviate perfectionistic tendencies (Schleider & Weisz, 2018); and strategies for the adolescent, which could include active participation in anxiety-focused Cognitive Behaviour Therapy (CBT). Anxiety-focused CBT is well-established as an effective evidenced-based intervention for AD (Bennett et al., 2016; Sburlati, 2014). CBT addresses the maladaptive thought patterns characteristic of AD through cognitive restructuring, recognising affect, relaxation techniques and psychoeducation (Baourda et al., 2021; Silfvernagel et al., 2015). By targeting these key areas, the impacts of AD, including social withdrawal, poor social development, disturbed sleep, perfectionism and substance abuse can be mediated. Recognising and treating adolescent AD is critical to help adolescents build a toolkit of strategies that they can draw on to maintain mental health throughout their significant transition into adulthood.

4.

ADOLESCENCE

Courtney Paolucci

Adolescence

Adolescence is the time period between childhood and adulthood where individuals undergo a unique phase of development. This stage is commonly recognised as being a time of rapid change with significant physical and psychological progress occurring. Cognitive, behavioural and social challenges often arise as a result of these transformative developments. Cognitive development during adolescence allows individuals to perceive the world in new ways through improvements in critical thinking skills. This ability, alongside a new capability of exploring multiple perspectives, can prove challenging as an understanding of the complexity of the world is formed. Social growth occurs and an increased importance on peer relations grows, resulting in potential challenges with friendship dynamics and romantic relationships. Teenagers today have increasingly complex lives with pressure arising from multiple directions. Stress is further compounded by anxieties about school work and decision making about further education and career options. Significant physical changes also occur during adolescence with increases in height, weight and strength (Raising Children Network, 2021b). Changes to skin, sexual organs, hair and sweatiness also transpire (Raising Children Network, 2021b). Individuals develop at different rates, which can be a stressor for adolescents as they may feel different to their peers depending on when these changes occur for them. Additionally, physical changes can result in fatigue and mood disruptions due to hormonal fluctuations. While these challenges are common to the majority of adolescents, further obstacles can occur depending on the risk and protective factors relevant to each individual. Contextual factors, such as socio-economic standing, neighbourhood characteristics, family cohesion and health, can have further implications for adolescent wellbeing and development.

Anxiety

Anxiety is a mental health disorder characterised by excessive anxiety and worry (American Psychiatric Association [APA], 2013a). This disorder involves a strong negative response to threatening situations, though these situations may sometimes be imagined (Essau & Ollendick, 2013). Additionally, people with anxiety find it difficult to control their worry and it subsequently can be impairing to their lives (APA, 2013a). A 2015 survey conducted by the Australian Government Department of Health revealed that 6.9%

of all children and adolescents suffer from some form of anxiety disorder (Lawrence et al., 2015). To be diagnosed with an anxiety order, undue anxiety must be present more days than not within a six-month time period (APA, 2013a). Anxiety disorders fall into several categories including social phobia, separation anxiety disorder, generalised anxiety disorder and obsessive-compulsive disorder.

Experiencing some anxiety in life is a normal part of the human condition. However, when the anxiety is outside of normal parameters it can impact development and be detrimental to various areas of an individual's life. An indicator that a mental health disorder is present is when the duration and magnitude of a person's anxiety does not correlate to the real threat of a situation (Essau & Ollendick, 2013). Additionally, there is reason for concern when anxiety arises in average everyday situations or when it lasts for long periods of time (Essau & Ollendick, 2013). Intervention may be required to help individuals overcome anxiety. Interventions are particularly important when children and adolescents are suffering from anxiety as the disorder can lead to lasting negative developmental consequences (McKay & Storch, 2011).

Depending on the type of anxiety, the worry can be caused by a variety factors. One of the common triggers for anxiety is the fear of social situations where embarrassment might occur. This is particularly pertinent for adolescents in the school environment. Teenagers are especially sensitive to how they believe they are being perceived by others and can often feel overly scrutinised. Elkin (1967) described this phenomenon as adolescents conceptualising an 'imaginary audience' that judges their every move. A result of social anxiety may be school refusal and withdrawal from social activities. Another root of anxiety can be excessive worry concerning particular events or activities. Anxiety has implications on physical health and can lead to fatigue and irritability. Adolescent anxiety can have repercussions not only on an individual's development, but can also lead to stressful relationships within the home context.

Evidence of Symptoms

Anxiety can be identified in an adolescent through several different notable symptoms in cognitive, physical and behavioural functioning. Diagnosing anxiety is beyond the scope of a Guidance Officer (GO), though they may collect anecdotal reports from the individual, parents and teachers in order to refer a student to a General Practitioner. Additionally, a GO might conduct a Conners (CBRS) assessment, which gives insight into behavioural, social and academic issues (Conners, 2008). This assessment is useful in gathering information to assist in the diagnosis process.

One of the cognitive indicators of anxiety is excessive worrying in relation to activities or events that don't typically warrant such a response. Worry is defined as thoughts and beliefs about potential difficulties that may occur in the future (Barlow, 2002). Furthermore, feeling anxious for long periods of time, or chronically, is another cognitive symptom of anxiety disorders. People with anxiety are often afraid of the

uncertainty that the future holds. Additionally, they worry that they will not be able to cope in situations. During moments of fear or panic, cognitive capability is diminished and a strong physiological response can occur (Essau & Ollendick, 2013).

While anxiety stems from cognitive patterns it can also have physical and behavioural ramifications. Individuals who suffer from anxiety often feel easily fatigued. Insomnia is a common implication of anxiety, which further exacerbates exhaustion (Abrahams, 2021). Tiredness can also be a result of a post-anxiety crash, where the adrenaline from the body's fight or flight response runs out (Abrahams, 2021). On the other hand, another physical symptom of anxiety is restlessness or feeling constantly on edge (APA, 2013a). Physical symptoms can also include headaches, feeling weak, stomach aches and nausea (Mayo Clinic, 2018). In fear invoking instances, individuals with anxiety can experience sweaty palms, increased heart rate and rapid breathing (Essau & Ollendick, 2013). Anxiety can be identified in adolescents through behavioural presentation. The most common behavioural symptom of anxiety is avoiding the fearful stimuli or situation (Essau & Ollendick, 2013). For adolescents, this avoidance can correlate to school refusal. Irritability, angry outbursts and reduced interest in previously pleasurable activities are also behavioural symptoms of anxiety.

Impact on the Individual and Interactions

The presentation of anxiety can have clear developmental consequences for children and adolescents if left untreated (McKay & Storch, 2011). Social anxiety often occurs in adolescents as identity development and the desire for peer acceptance are significant life concerns. School refusal is a common repercussion that stems from anxiety and this avoidance behaviour is detrimental to academic and social growth. Anxiety may prevent a young person from adequate socialisation and limit opportunities to establish age appropriate behaviours and emotional development. Furthermore, anxiety disorders have been linked to low self-esteem and an increased likelihood of depression (Maldonado et al., 2013). Additionally, studies have shown that adolescents with anxiety are more likely to be lonely and have poor social skills (Essau & Ollendick, 2013). Anxiety during adolescence is also a predictor of post-school unemployment and indicates a decreased likelihood of pursuing tertiary education (Essau & Ollendick, 2013).

Suggested Interventions

An Individual Support Plan (ISP) is a useful intervention for adolescents suffering from anxiety, particularly if school refusal is involved. An ISP outlines a student's educational goals alongside strategies and resources required to achieve these goals (Queensland Government, 2018). A common strategy for

students with high anxiety around attending school is to implement a flexible arrangement where the student only attends part days or certain days of the week. Increasing an individual's exposure to situations that evoke anxiety in short amounts has been shown to decrease anxiety in the long term as the person realises that the fear is unwarranted (Essau & Ollendick, 2013). Academic progress is also monitored through the ISP to ensure that the student's anxiety is not interfering with educational outcomes. The ISP will also notify teachers that flexible learning modes may be required, such as access to content online. It may also outline issues for teachers to be aware of, for example to avoid calling on the student in front of their peers to reduce anxiety inducing situations.

Participating in The Brave Program (The Brave Program, 2020), an online psychological program for adolescents who experience anxiety, is another beneficial intervention. The program's foundations are in Cognitive Behaviour Therapy and results indicate that 80% of children are free from their anxiety by the completion of the course (The Brave Program, 2020). CBT involves altering how a person thinks about their fear and works towards increasing exposure and learning relaxation and coping strategies to counter it (McCarthy, 2019). The course involves one online session each week for the duration of ten weeks, which is a simple and flexible mode of delivery for anxious teens. BRAVE also includes parent sessions to educate families on how to best support their child, which results in an added protective factor for the individual.

5.

ADOLESCENCE

Leticia Pujol

Adolescence

The development stage of adolescence is known for the changes in cognitive processes in the brain. During puberty the impact of serotonin and dopamine on the cerebrum and additional stress hormones impact the body's responses, processing ability and behavioural functionality. According to Eysenck et al. (2007), cognitive processing begins to become impaired when anxiety affects the perceptive and reasoning areas of the brain, beginning to distort working memory. These distortions affect the regularity of general processing when recall, retention, and storage components are applied. The cognitive-developmental processing parts of the brain are still developing from the ages of ten years to young adult, making this time frame accurately reflect the four stages of adolescent development than previously estimated. According to Sanci et al. (2018), the four stages of development are biological and sexual maturation, personal identity formation, engagement in intimate sexual relationships with an appropriate peer, and establishment of social independence and autonomy. According to the Department of Health (2017), around 8.8% of adolescents aged 12 to17 years and 28.2% of young adults aged 18–24 years reported illicit drugs in cannabis, methamphetamines, ecstasy, and cocaine. These alter brain functionality, altering perception and the regulation of behaviour. According to the Centres for Disease Control and Prevention (CDC, 2021a), the prevalence of certain sexually transmitted infections is highest, especially among adolescents and young adults, with chlamydia, gonorrhoea, and young adolescent females infected with the HPV virus. All these stressors are due to adolescents being at an age where risk-taking activities of unprotected sex and substance use are all impacted by changes within the body, altering brain functionality and distorting the individual's perception of self and notion of reality.

Anxiety

Anxiety is an aversive emotional and motivational state occurring in dire circumstances (Eysenck et al., 2007). It is a debilitating condition that manifests in several forms. Some Anxiety disorders are more common than others, while some are triggered by a trauma or a situation that creates the manifestation due to conditions within the individual. The individual has an overwhelming, uncontrollable fear and dread about every aspect of their life. Anxiety impedes the individual's mental health capacity to function; it affects the individual work-life or finances and disturbs the family dynamics. The repetitive negative self-talk and elements of paranoia where internalisation, self-focus are intensified, debilitating the individual,

mentally, physically and socially, leading to depression if left untreated. According to Health Direct (2019), Generalized anxiety disorder (GAD) is an extreme and overwhelming worry about mundane daily life. According to Beyond Blue (2019), generalized anxiety disorder (GAD) is when an individual is constantly experiencing anxious emotions, not in specific stressful situations but continuously affecting all aspects of daily life. The constant cyclic fears in all aspects of everyday life, from health, family, and work. Every slight daily aspect of their lives becomes a focal point of the attention within the anxiety, from being late to an appointment to simple household chores; these can spiral an individual with a generalized anxiety disorder to overwhelming emotion that something dreadful will transpire, a form of predictive catastrophe.

Social anxiety disorder (SAD), also known as social phobia disorder, is an incapacitating condition that causes individuals to circumvent social situations of fear of being ridiculed or rejected. According to Brook and Schmidt (2008), it is a chronic illness categorized as the constant dread of social situations. Its prevalence is 7% to 13%, with the last two decades depicting a rapid increase as social media and technology become staples and extensions of society. Panic disorder is another disorder under the anxiety umbrella. An individual must have had two panic attacks to be diagnosed with panic disorder. A panic attack manifests as an unexpected intense occurrence of illogical fear, shortness of breath, dizziness and other physical symptoms. Individuals have described it as an internal separation of senses as though the internal body was speeding at high velocity. However, the outside appeared to move in a painfully slow motion. According to Richmond (2003), one in 10 individuals between the ages of 15 and 25 usually begin with panic attacks. About 3% of adults have it, and it is more common in women than in men.

Specific phobias are among the most common anxiety disorders as most of the population has a couple, to a culmination of very specific phobias. According to the Mayo Clinic (2016), Specific Phobia is not seen as a problem unless it becomes an impediment to the individual's way of life. Specific phobias are illogical fears targeting one area, such as a fear of people, places, animals, or insects. Common fears generally are Acrophobia, the fear of heights, Claustrophobia, the fear of confined spaces, Coulrophobia is the fear of clowns and Arachnophobia, the fear of spiders. For example, if an individual were to see a spider, they would become highly anxious, and their body would start to show signs of becoming highly stressed.

Characterized by obsessions and compulsions, obsessive-compulsive disorder (OCD) is the undesirable feelings, compulsions, and fixations that cause a habitual compulsion to repeatedly repeat a routine, action, or behaviour to soothe the anxious feeling of dread. According to Better Health (2012b), individuals with obsessive-compulsive disorder are acutely embarrassed by their repetitive, routine behaviours and compulsions. In addition, the condition and ritualistic elements of the illness retain them housebound and isolated.

Post-traumatic stress disorder (PTSD) is a disorder of reliving fear or trauma in individuals who have experienced or witnessed a traumatic life event. According to the National Institute of Mental Health (2019), an individual with post-traumatic stress disorder cannot deal with or move past the circumstances of that situation or traumatic incident. Instead, they are stuck in a loop and relive that moment and situation, and anything can trigger or instigate the recall of that experience and trauma. Post-traumatic

stress disorder according to Health Direct (2019), manifests in reliving the traumatic memories in the form of flashbacks, nightmares affecting sleeping and general daily life.

Evidence of Symptoms

Anxiety is a multifaceted mental health condition that affects all levels of society. There is a notion that biology and genetics influence the condition and their response mechanisms. It begs to consider how previously generations in the past managed the world and coped with the additional contributing factors of human resilience. According to Lukasik et al. (2019), Anxiety and trauma produced by severe life-changing events like emotional, physical and mental distress and stressors have revealed the detrimental effects and deterioration of cognitive development within the working memory. Cognitive performance affects numerous elements, including the non-cognitive emotional state. According to Wang et al. (2015), their study on anxiety strongly demonstrated that Generalized anxiety disorder is related to cognitive deficiency and impairment, specifically in the attention and working memory area. When ranked in order of cognitive debilitation, anxiety disorders, according to Nyberg et al. (2021), ranked second among all mental disorders. The complexity and severity of range within the condition and the impact the disorder has on executive functions and working memory, independently of comorbid major depression and cognitive function.

According to Volel et al. (2018), anxiety disorders' high prevalence and significance within the community are essential due to the negative impact on the quality of life and the associated physical symptoms and neurological impairments present in the patients. The cognitive and social development during puberty affects the behaviour response during anxiety episodes. According to Blaker (2019), anxiety disorder has common symptoms. However, the less common symptom experienced by adolescents can go undiagnosed until it becomes severe and diagnosed. Some of the unusual anxiety symptoms are indigestion, heartburn, nausea, and any stomach related symptom. Another is phantom ringing in the ear, from buzzing or humming. Symptoms of burning on the skin, lips, mouth, and eyes, to prickly sensation on the skin, or sharp shooting pain over the body.

Anxiety disorder has been associated with palpitations, but heart irregularities are also an undiagnosed part of the condition, with misdiagnosis due to the difficulty to distinguish between heart irregularities caused by anxiety versus a heart attack (Blaker, 2019). Other symptoms are phantom smells, tremors, eye problems, physical numbness and tingling, excessive yawning, globus hystericus, a lump in the throat and derealisation, the sensation of not experiencing reality, to a feeling of losing touch with reality.

Impact on the Individual and Interactions

Adolescents' perception and processing of stress conditions outside their comfort zone is demonstrated as fight, flight, or freeze response mode. According to the American Academy of Child and Adolescent

Psychiatry (2019), teenagers develop an overload of stress leading to manifesting neuroticism when exposed to stressful conditions. They exhibit and display forms of anxiety, mood irregularity, aggression, irrationality in behaviour, and physical illness and can turn to substance abuse as coping mechanisms. Stress factors take the form of difficult or painful changes in the adolescent mind and the body begins to prepare for the response to danger. The physical symptoms manifest as fast racing heart, rapid breathing, increased blood to muscles in the arms and legs, becoming physically cold or rise in body temperature with clammy hands and feet, sensations of upset stomach including nausea and a sense of dread and panic. According to Headspace (2021a), adolescents fear the future and the impact of their place within the environment. The worry and anxiety referred to as 'climate anxiety' being that it is a new concept affecting adolescence and youth culture generation. The increased level of anxiety based on a future generation that will be most affected by climate change affects the psyche of adolescents today. Therefore, the sense of urgency to create direct change for future generations adds to the stress and non-compliance from older generations. All these factors and perceptions create additional anxiety for the current generation, who feel that they must cope and deal with a resistance of outdated ideologies and mindsets.

Suggested Interventions

The following suggested intervention allows for the development of cognitive restructuring and cognitive executive functioning skills to manage anxiety and modify the development of depression as a secondary condition. Moodgym is an interactive program introduced in 2001 that has applications to assess emotions like anxiety and depression. It allows individuals to reformulate their thinking from negative tendencies into positive thought patterns. It retrains the individual to consider how thoughts can alter perception, mindsets and emotions. It aims to develop the individual the learning skills to manage and work through these emotions. According to Moodgym (2021), several research trials globally have been performed within settings from schools, workplaces, crisis support services, and mental health care services. As a result, diverse individuals have used the program (especially adolescents), with students able to access it at their own pace with and without therapist guidance.

Moodgym requires the individual to register and is a free service. However, it has proven to have various secondary benefits. According to Powell et al. (2012), studies demonstrated that moodgym was an effective tool in improving wellbeing. It allowed the individual to be aware of the automatic tendency of thought patterns and behaviours and tools to modify negative responses by illustrating options of considerations. Moodgym models and simulates examples and activities with a pre-test that is a prerequisite at the start before starting the modules. This gauges the individual's mindset and depressive, anxious or other sever thought patterns. In addition, studies suggested that moodgym was the feasible choice for individuals who could not access face-to-face therapy and treatment due to distance, location, or other circumstances. It was also available to reexplore once the program was completed and individuals could practice key activities, explore the characters, modules and activities again for further practice and enforcement of learnt skills.

6.

MIDDLE CHILDHOOD

Suzannah Fullerton

Middle Childhood

Middle childhood occurs between approximately ages 6 and 12, primary school age, and is a time when children face new cognition and experiences. Significant cognitive skills in, for instance, logical thinking, complex reasoning, self-regulation, executive functioning and problem solving develop (Carr, 2015; Collins, 1984; DelGuidice, 2018; Feldman, 2005). During middle childhood, children gain access to new settings where they learn to master these new skills. Exposure to wider social environments, such as school, increase children's interpersonal relationships. Children are expected to gain independence and autonomy to self-regulate their emotions and interact successfully with a range of adults and peers (Carr, 2015).

The process of socialisation, integration into society and forming a personal identity are all important aspects of middle childhood. Children become more independent from the family and friendships increase in importance – more complex friendships form, with pressure from peers increasing. Alongside these challenges is an individual's growing awareness of their body as puberty approaches. Children can become very conscious of body image and often become self-critical (Centres for Disease Control and Prevention, 2021c & d).

In middle childhood, the ability to self-evaluate and compare oneself to others increases. Aspects of appearance, academic ability, athleticism and social performance all become attributes to self-evaluate and compare. Some children will gain a sense of competence and self-efficacy while others may develop a sense of inferiority, influencing self-esteem and anxiety levels (Carr, 2015). A major challenge for children during this phase is the need to find their place in society and to fit in. This proves more challenging for some than others. During this journey of self-discovery and development of autonomy, some children become more difficult to manage, less respectful and preoccupied with their own interests – they can be egocentric (Geldard et al., 2019; Wicks-Nelson & Israel, 2015). Some children, during middle childhood, experience intense emotional responses which can impact daily functioning, leading to both internalising and externalising disorders (Carr, 2015; Wicks-Nelson & Israel, 2015).

General Anxiety Disorder

Anxiety is a future-oriented emotion, characterised by an elevated level of apprehension and lack of control,

and involves a range of complex behaviour, cognitive and physiological responses when something is perceived as risky, frightening or worrying (Barlow, 2002; Carr, 2015; Wicks-Nelson & Israel, 2015). It is a basic human emotion and is part of the normal developmental process (Carr, 2015; Headspace, 2022b; Wicks-Nelson & Israel, 2015). As Be You state, "feeling anxious is a survival response to situations where there are dangers or threats, however, some people react more intensely to such situations" (2022c, p. 1). Anxious feelings can become problematic when very intense, when they are persistent, impact everyday functioning or are developmentally inappropriate. Such feelings may lead to mental illness, a longer-lasting mental health problem, such as an anxiety disorder and require clinical attention (Carr, 2015; Wicks-Nelson & Israel, 2015).

Anxiety disorders are the most common mental health condition in Australia (Barrett & May, 2007; Be You, 2022a), and are among the most common disorders experienced by children (Wicks-Nelson & Israel, 2015). According to the Australian Institute of Health and Welfare (AIHW; 2020a, p. 85), "[i]n 2013-14, an estimated 314,000 children aged 4-11 (almost 14%) experienced a mental disorder." AIHW goes on to state that, "[a]nxiety disorders were the second most common disorders among all children (6.9%), and the most common among girls (6.1%)".

Anxiety is a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed; DSM -5; American Psychiatric Association [APA], 2013b), The DSM-5 (2013b) defines a number of anxiety related disorders, such as Separation Anxiety Disorder, Specific Phobia, Social Anxiety disorder (Social Phobia), Selective Mutism, Panic Disorder, Agoraphobia, and Generalised Anxiety Disorder (GAD) (APA, 2013b; Wicks-Nelson & Israel, 2015). GAD can impact an individual's interpersonal relationships, social competence, and ability to adjust in school (Barrett, 1998; Barrett & May, 2007).

Evidence of Symptoms

Generalised Anxiety Disorder (GAD) is the experience of excessive, disproportionate anxiety and worry occurring the majority of days for at least 6 months (APA, 2013a). These feelings of apprehension can be about a number of events or activities. The child finds it difficult to control the worry. The anxiety or worry is not restricted to a particular situation or resulting from recent stress (APA, 2013a; Carr, 2015; Wicks-Nelson & Israel, 2015).

In the case of children, the anxiety and worry are associated with at least one of the following symptoms: restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension and/or sleep disturbance. These symptoms result in clinically significant impairment in various areas of functioning and are not explained by another mental disorder (APA, 2013b; Wicks-Nelson & Israel, 2015). As Wicks-Nelson and Israel (2015, p. 120) state, children with GAD "seem excessively concerned with their competence and performance in a number of areas" – academics, peer relations, sports – setting high expectations for themselves, seeking approval and constant reassurance. Children within middle childhood may also worry about wider aspects of life such as natural disasters and

fears of climate change (Carr, 2015; Wicks-Nelson & Israel, 2015). Average age of onset is approximately age 10, with the number and intensity of symptoms increasing with age (Wicks-Nelson & Israel, 2015). Children who meet the diagnostic criteria for GAD are likely to meet the diagnostic criteria for additional disorders. For example, younger children, those in the earlier stage of middle childhood, are likely to receive a concurrent diagnosis of separation anxiety disorder, whereas those in the later stage, moving into adolescence, may receive a concurrent diagnosis of depression or social anxiety disorder (Wicks-Nelson & Israel, 2015).

Impact on the Individual and Interactions

Generalised Anxiety Disorder (GAD) can impact individuals in the middle childhood phase in a number of ways. In general, children who experience GAD within middle childhood face behavioural inhibition, negative affectivity (neuroticism) and harm avoidance – leading to quite debilitating implications for an individual's functioning within various settings, if undiagnosed and symptoms not addressed (APA, 2013b). Persistent and excessive anxiety and worry about various realms in life impairs an individual's capacity to do things efficiently and causes a range of physical symptoms: muscle tension, headaches, nervous feelings, restlessness, frustration, irritability, difficulty concentrating and sleep disturbance (APA, 2013; Wicks-Nelson & Israel, 2015). All these symptoms can impact a child's ability to confidently function and cope with everyday activities within various settings such as home and school. Tension and conflict can arise, as well as social withdrawal and avoidance of situations (APA, 2013b; Barrett and May, 2007; Wicks-Nelson & Israel, 2015).

Suggested Interventions

The phase of childhood presents great opportunity for intervention to address GAD – anxiety prevention should start early (Barrett & May, 2007). A Guidance Officer (GO) cannot diagnose GAD but they can work alongside the student, teachers and parents to gather information and, through observation and anecdotal notes, identify potential indicators towards a case of anxiety within a student of concern. This data will assist in assessing whether a referral to an external specialist is required and to assess what intervention and support is required in the classroom (Wicks-Nelson & Israel, 2015).

In the school context, a GO can work alongside a student to develop their skills and abilities to cope with challenges. Much research suggests that Cognitive-Behavioural Treatment (CBT), that includes a range of potential behavioural and cognitive-behavioural strategies, is effective for anxiety disorders (Silverman et al., 2008; Wicks-Nelson & Israel, 2015). CBT targets changing behaviour and positively influences emotional feelings (Geldard et al., 2019). Example of therapeutic strategies, cited by Wicks-Nelson and Israel, include: "education about anxiety and emotions", "teaching awareness of bodily reactions and physical symptoms", relaxation techniques, "recognition and modification of anxious self-talk and anxious cognitions", "role playing and contingent reward procedures", "teaching problem-solving models", "use of coping models",

"exposure to anxiety-provoking situations" and "practice in using newly acquired skills" (2015, p. 137; Kendall, 2012)

One example of a program that a GO could implement, either as a universal program across certain year levels, or as more targeted tier 2, small group intervention is the FRIENDS program (Barret & May, 2007). Barrett and May, describe this as an effective and sustainable, cognitive-behavioural evidence-based intervention program addressing "cognitive, psychological and behavioural processes that are seen to interact in the development, maintenance and experience of anxiety" (2007, p. 4). The program is designed to be implemented as both a treatment and a school-based universal prevention program targeted at ages 10-12 and age 15-16 years. It aims to teach children how to cope with, and manage, anxiety both now and later in life. Both a GO or teacher can implement this in a group setting following a one-day training session. According to Wicks-Nelson and Israel, the goal is to teach the child to: "recognise the signs of anxious arousal, identify the cognitive processes associated with anxious arousal, and employ strategies and skills for managing anxiety" (2015, p. 136). In severe cases, a child diagnosed with GAD, through an external specialist, such as a child psychologist, may be prescribed pharmacological treatment. Psychological treatments that address coping skills may be implemented alongside pharmacological intervention (Wicks-Nelson & Israel, 2015).

7.

MIDDLE CHILDHOOD

Deborah Shaw

Middle Childhood

Middle childhood, the stage of development from age 6 years to 12 years is typically characterised by issues of self-esteem or emotional well-being, and bullying (Magro et al., 2019). Self-esteem or emotional well-being is a dynamic construct that grows and diminishes across the ages and is of particular importance at this stage of development. Self-esteem is characterised by instability and formation particularly during middle childhood (Magro et al., 2019). It is important at this stage to understand how self-esteem impacts a child given the correlation between healthy self-esteem in the middle years, and positive psychological development in adulthood. A correlation between positive peer support, a sense of belonging and positive family environment influences a child's self-esteem trajectory.

Bullying impacts a child's self-esteem significantly. Bullying is an intentional act of causing fear, distress or harm to someone with unequal power and is widespread across this stage of development with prevalence rates ranging from 9% to 54% (Craig et al., 2009; Nansel et al., 2004, as cited in Wicks-Nelson & Israel, 2019). Victims of bullying are typically anxious, insecure, cautious, sensitive, quiet, nonaggressive and experience low self-esteem more than other children. Typically, victims of bullying do not have one single protective friend in their class resulting in a greater risk of depression, loneliness and suicide. Additional affects of bullying relate to fear, insecurity and anxiety.

Anxiety

Anxiety generally is a future-focussed emotion and is not unusual for children in the middle years in stressful situations such as school. Anxiety disorders on the other hand, is characterised by excessive and persistent fear or worry affecting day-to-day functioning. Anxiety disorders in middle childhood are pervasive, manifesting learning and social difficulties resulting in significant impairment to a child's academic, social and family functioning. As cited in Gouze et al. (2021), prevalence rates of children experiencing some form of anxiety including General Anxiety Disorder, Social Anxiety (SA), Agoraphobia, Separation Anxiety Disorder (SAD) and specific phobias vary considerably with rates estimated at 2.5 % to 5% (Rapee et al., 2009); 12% to 25% (Franz et al., 2013; Lavigne et al., 2009), and as high as 41.2% (Cartwright-Hatton et al., 2006; Costello et al., 1996, as cited in Affrunti & Woodruff-Borden, 2015). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013b) does not refer

to one specific anxiety syndrome rather various anxiety disorders classified within a broad category of internalising disorders. Severity varies from mild to severe, often with high rates of comorbidity.

Children with persistent anxiety, commonly display internalised behaviours such as withdrawal, sadness, fear, and a lack of self-confidence. Additionally, sleep problems, reduced ability to concentrate, poor school performance, diminished emotional awareness and augmented emotional inhibitions are characteristic of anxiety disorder, thus impacting social interactions with peers, teachers and family members. In the case of SAD, due to fear of leaving a significant attachment the following morning, children can experience difficulties with getting to sleep or disturbed sleep throughout the night thus affecting school attendance and the natural development of peer relationships. Due to avoidant behaviours experienced by children with SAD, the establishment and longevity of meaningful friendships and the attendance of family events can be problematic. Excessive worry and intrusive thoughts along with sleep deprivation experienced by children with anxiety, affects focus and concentration thus impacting academic performance, peer relationships and family relationships. Despite little understanding of the cause of anxiety disorders, genetic, environmental, psychological and developmental factors are believed to be key factors that play a role in the development of anxiety in the middle childhood years (APA, 2020a).

Research indicates a small gender difference with girls presenting with higher rates of anxiety than boys (Kadam, 2014). Anxiety typically co-exists with other problems leading to comorbidity resulting in later drug use, peer conflict and poor social relationships, poorer academic grades, and suicidal ideation. It is not uncommon for a child who experiences anxiety disorder to go unnoticed in a school setting due to the limited understanding by teachers and parents. Additionally, children often lack the emotional intelligence and language to express extreme feelings of apprehension and worry (Kadam, 2014). SAD is found to be of most pervasive for this age group and debilitating for a child who is required to attend school on a daily basis

Evidence of Symptoms

Anxiety is a multifaceted experience for children and can be difficult to recognise because anxiety typically affects a child's thoughts and feelings. Anxiety is easy to overlook due to a level of anxiety being somewhat normal in middle childhood, and due to high rates of comorbidity (Aschenbrand et al., 2005). In addition, children can present as happy at the same time as feeling anxious. Children with anxiety present with somatic, cognitive and emotional symptoms. When a child experiences anxiety three types of reactions occur: (1) overt physical behavioural responses such as running away, shaking, crying, trembling voice and eyes closing, (2) cognitive responses such as thoughts of being scared, disapproving thoughts of the self and images of bodily harm, and intrusive and repetitive worrying thoughts about what might happen which can incur cognitions resulting in avoidant behaviours; which in turn results in more fear, and so a cycle continues (3) physiological responses including rapid heart rate and decreased respiration, muscle tension and stomach pains, nausea and increased perspiration. It is also noted in the DSM-5 that children may express anxiety by crying, exhibiting tantrums, freezing or clinging behaviours.

Symptoms often begin around six years of age, although this can vary. Anxiety can be seen in terms of inhibited emotional expression, shyness, and withdrawal in social situations. Some children come across as perfectionists; based on their own opinion of what perfect is and therefore things need to be 'just right'. In such cases it is often the pressure the individual places on themselves that causes anxiety thus affecting school performance or resulting in performance anxiety even in extra-curricular activities. Anxiety typically impacts a child's self-esteem and social skills; impacting friendship development and feelings of being alone or isolated.

In the school setting, a comprehensive, culturally sensitive, age appropriate assessment must be carried out (Wicks-Nelson & Israel, 2015). While diagnosis is not the role of a Guidance Officer (GO), gathering information can help decision making processes, academic planning and intervention. Observations, structured Diagnostic Interviews, self-reported questionnaires including the Revised Child Anxiety and Depression Scale, and Functional Behaviour Analysis can be carried out by multiple key stakeholders including the teacher, specialist teachers, and parent/s to help gather relevant information; acting as a foundation to direct intervention and possible referral options. Assessing the interplay between the individual child and their environment is key to comprehensive assessment. Diagnosis at some stage by the appropriate professional is an important part of supporting a child with any type of anxiety disorder as research suggests that untreated anxiety disorders in childhood can lead to chronic mental health conditions in early adulthood (Pauschardt et al., 2010, as cited in Van Meter et al., 2014).

Impact on the Individual and Interactions

Anxiety is pervasive and debilitating, and without treatment can lead to chronic mental health. It can affect a child's self-esteem, social development and academic progress. School refusal, and avoidance of situations or events deem as a threat by the individual can result. Avoidant behaviours typically occur for those children with specific phobias. In such a case the individual may have thoughts of catastrophic events occurring should they be exposed to a particular feared situation or event. In the case of social anxiety disorder, cognitively, children experience fear of embarrassment or are excessively worried about what others think of them. Often thoughts relate to how they perceive themselves typically focusing on their negative attributes which is related to the level of social-cognitive maturity at this stage of development (Wicks-Nelson & Israel, 2015). Children with anxiety are typically unaware that their reaction or behaviours as a result of anxiety are disproportionate to the event or situation. Peer and family relationships can be jeopardised due to avoidant and extreme behavioural challenges expressed by the individual child. Maladaptive avoidant strategies to counteract anxiety can restrict both the child's activities such as school, parties and local community events. Family members can also be impacted as avoidance of family events with unfamiliar people or an uncertainty of what to expect is also common.

Suggested Interventions

Assessment and early intervention are key to supporting a child with anxiety (Nabors, 2020). When considering the development of an Individual Support Plan, the role of collaborative practice ensuring key stakeholders are considered particularly during the assessment phase is of utmost importance. Establishing and maintaining an open, trusting professional relationship with key stakeholders and sharing relevant information adds to a holistic assessment and treatment plan (Bryce, 2017).

In addition, the attributes of the Guidance Officer (GO) such as congruence, unconditional positive regard, and empathy, self-reflection, building a trusting therapeutic relationship and understanding of child development are key components essential to providing emotional support to children with anxiety. Children have difficulty with verbal communication skills particularly when it comes to articulating and expressing thoughts and emotions. Therefore, appropriate use of media activities such as imaginative play or miniature animals, dolls or Lego are best used to engage a child; thus, providing them with a safe space to share their story. Cognitive behavioural therapy (CBT; Geldard et al., 2017) is an effective evidence-based approach to treating child anxiety and offers successful outcomes for many children as it directly addresses thoughts and behaviours. CBT helps the child to change unhelpful beliefs, attitudes, thoughts and ideas bringing relief of cognitive dissonance brought on by emotional distress (Geldard et al., 2019). Components of psychoeducation, relaxation and stress managements skills, affective expression and modulation along with cognitive coping and processing skills are ways in which a GO can provide intervention for a student. Working from an ecological perspective utilising a strength-based approach, a GO could focus on building capacity with the child, parents and school community.

8.

ADOLESCENCE

Hamish Robb

Adolescence

The developmental period of adolescence is characterised by many cognitive, behavioural, social and environmental transformations simultaneously occurring (Geldard et al., 2019). Puberty, and the biological changes that ensue, typically initiate the onset of adolescence. Such radical hormonal and physical changes can be challenging as each individual matures differently. These changes are often coupled with greater introspection and may lead to heightened sensitivity regarding self image. At the same time, sexual maturation is occurring, causing increased interest in sexual identity, orientation and behaviour.

As the body, mind and identity of each adolescent transforms, so to do the social structures that they interact with and which surrounds them. Changes in friendship groups, the desire to individualise outside of the family, independent participation of interests, and identity exploration all contribute to new and challenging situations that require resilience, emotional strength, help seeking skills and adaptive coping behaviours from the adolescent.

During adolescence, the young person's brain undergoes a transformation, resulting in many new thinking skills. During this transformation, brain plasticity may result in heightened impulsivity, risky behaviour, emotional turbulence, increased responsiveness to rewards / stress and a rise in perceived 'boredom' (Geldard et al., 2019; Romeo, 2013). Dangerous driving, drinking, smoking, substance experimentation, and sexual exploration all become significant challenges that may face adolescents during this stage.

Major social challenges also arise at this developmental point. Power struggles between parents and adolescents can occur as young people seek to individualise. Peer pressure becomes a strong factor in decision making and egocentric thinking tends to make adolescents overly aware of their self image and the perceptions of others. These challenges are exacerbated by conflicting environmental attitudes between their parents, themselves and the new environments they exist within.

Anxiety

Anxiety is a growing problem among Australian adolescents. In 2015, the prevalence rate for anxiety disorders in adolescents aged 12 to 17 was 7% (Lawrence et al., 2015). There are however, a wide range of disorders that fit under the 'anxiety' umbrella. The *Diagnostic and Statistical Manual of Mental Disorders*

(5th ed.; DSM-5; APA, 2013b) recently created 3 anxiety categories: anxiety disorders, obsessive compulsive disorders, and trauma and stressor related disorders (APA, 2013b). The first category alone includes seven distinct disorders. Each anxiety disorder may have differing observable behaviours, symptoms, triggers, impacts, risk factors, protective factors, interventions and/or support strategies (APA, 2013b). The following report is focussed on social phobia in adolescence, otherwise known as social anxiety disorder (SAD).

For a diagnosis of SAD, the DSM-5 requires key symptoms to be present and ongoing. Symptoms must significantly alter either the adolescent's normal routine functioning, academic functioning or social functioning. In children and adolescents, the anxiety must also occur in peer settings.

Box 1

Diagnosing Criteria for Social Anxiety Disorder (APA, 2013b)

Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others.
The social situations almost always provoke fear or anxiety.
The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.
The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance or another medical condition.
The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.

Barlow (2002) describes anxiety as an emotion orientated toward the future, where the attention is focused on potentially aversive events, or one's response to such events. Such thoughts and feelings are normal, however if this thinking/feeling disrupts functioning it becomes problematic (Wicks-Nelson & Israel, 2015). In the case of adolescents, this fear may result in avoidance of settings that involve social interactions such as those at school, in public, or social events. Home settings tend to be more predictable and less of an issue (Aderka et al., 2012). Weeks et al. (2014) describe common physiological symptoms such as: stomach aches, blushing, breathlessness, nausea, elevated hearth rate and restlessness are also common. Feigned illness may also start to appear in response to potential social interactions.

Evidence of Symptoms

There are a range of factors that contribute to SAD manifestation in adolescence. Many determining anxiety-related traits have biological aetiology, however environmental influences also play a large role in the development of SAD (Wicks-Nelson & Israel, 2015). Insecure attachments in infancy, authoritarian/

over demanding parenting styles, victimization, cyberbullying, significant adverse social interactions/ experiences and childhood trauma are all significant risk factors for SAD (Ruscio et al., 2008; Shapira et al., 2003). Peer or romantic rejection, cyberbullying, teasing and victimisation by peers can all trigger the development of SAD, and all are significant challenges during the adolescent period (Kashdan & Herbert, 2001).

Adolescence is typically a period dominated by social interactions with peers (Geldard et al., 2019). Young people with SAD however, tend to resist such interactions. Feelings of anticipated confrontation / negative evaluation can effect their ability to make and maintain friendships (Wicks-Nelson & Israel, 2015). They may have few friends and are at risk of developing low quality friendships. This may be noticeable in their behaviour at school, preferring to find spaces where they are 'isolated' from others, choose to eat / use public toilets when areas are empty. Adolescents with SAD can appear 'invisible' to school staff and peers (Kashdan & Herbert, 2001). They may suffer emotional distress, loneliness, sadness, have low self-confidence and often hold distorted cognitions about their impression on others. They may experience and disclose feelings of rejection or anticipated rejection, of failure and have a fear of making mistakes. This lack of social self-esteem can lead to a reliance on internet based identities/activities as compensation (Steinfield et al., 2008). SAD has a high comorbidity with other anxiety diagnoses: generalised anxiety disorder and separation anxiety disorder (Wicks-Nelson & Israel, 2015). Other aspects of life can be affected by SAD, which can reinforce SAD symptoms. Reduced participation in physical activity, poor diet and unhealthy sleeping patterns are examples of this. In such instances, adolescents are at high risk of developing comorbidities such as depression, alcohol related problems, substance use, and suicide (Ruscio et al., 2008).

Recent findings have documented significantly increased SAD prevalence among gender and sexual minorities relative to peers. Targeted screening of these groups would be beneficial as self reporting of SAD is commonly very low (Parodi et al., 2022; Wehry et al., 2015)

Schools are well placed to identify and contribute to the assessment process. Education professionals spend significant amounts of time observing student interactions with their peers and other adults, where symptoms may become apparent (Masia-Warner et al., 2005). Data collection, observations and anecdotal records regarding behaviours can add to the identification of youth at risk. Screening tools from multiple sources, the adolescent, parents and teachers, is an effective initial assessment process (Wehry et al., 2015). An example is The Adaptive Behaviour Assessment System, Third Edition, (Harrison & Oakland, 2015). This should be followed up by interviews of the child and parent by the relevant professional who is trained in such processes (psychologist, paediatrician, or guidance counsellor).

Impact on the the Individual and Interactions

The individual may experience rapid and unexpected mood swings in anticipation of potential social situations (Wicks-Nelson & Israel, 2015). In the family setting, somatic complaints and/or panic attacks

may occur at the thought of attending a certain social experience, and attendance in any such activities tends to drop or stop completely. On a school level, academic achievement/output may drop as adolescents with social anxiety disorder may try to avoid scrutiny and negative evaluations of themselves and their work in speaking, reading, performing or even writing. They tend to avoid any adult confrontations and may withdraw from recreational events and friendship groups. If left untreated this can lead to impaired educational attainment and/or employment attainment. Individuals with SAD are less likely to complete senior schooling (Nagata et al., 2015).

Suggested Intervention

Common intervention programs for SAD often include psychotherapy and/or pharmacological intervention (Wehry et al., 2015). Approximately 50-60% of youth with SAD are diagnosed with a comorbid disorder. Cognitive Behaviour Therapy (CBT) for adolescents has been found to remain effective in treating anxiety alongside comorbid disorders (Seligman & Ollendick, 2011). Further evidence suggests CBT alongside serotonin reuptake inhibitors results in the greatest improvements of SAD in adolescents (Wehry et al., 2015).

Within the school context, a Guidance Counsellor who has relevant training could undertake a form of CBT such as Cognitive Behaviour Group Therapy for Adolescents (CBGT-A: Masia-Warner et al., 2005). Ellis (2008) recommends that younger clients benefit from group therapy as well as individual therapy. Individual CBT would also need to occur simultaneously if time constraints allow. The CBGT-A program utilises cognitive restructuring to identify and challenge anxiety-provoking thoughts. Parents and adolescent are educated on SAD and its dimensions. Specific triggers and physiological indicators are identified and training in management skills in response to such occasions is undertaken. Throughout the sixteen 90 minute sessions, the adolescent is given opportunities to practice problem solving and coping strategies in response to anticipated anxiety-provoking challenges with like peers. Gradual exposure to feared social stimuli and/or situations is done systematically alongside the counsellor (simulated, imaginal and real life situations), with the goal of eventual independent exposure and desensitisation to social fears (Masia-Warner et al., 2005; Wehry et al., 2015). Creating a realistic personal growth plan with the individual regarding this progress and possible relapse would allow for independent and visual monitoring of progress. Aspects of this plan could be incorporated on Individual Support Plans that are shared with the adolescent's teachers and family.

9.

ADOLESCENCE

Susan Holmes

Adolescence

Different life stages present differing personal challenges and the adolescent stage is no exception. Adolescence is the multi-dimensional and culturally influenced stage of life when an individual moves from childhood into adulthood, typically taking place from the age of 11 until 18 years of age (Geldard et al., 2019). It is often characterised by emotional reactivity, a decreased ability to tolerate change and disruptive emotions (Geldard et al., 2019). It is a transitional period, biologically, psychologically, socially and economically with remarkable changes happening cognitively and sexually with the individual becoming more self-aware, independent and future-oriented (Steinberg, 2014). An adolescent can experience a decrease in their level of self-control and an increase in their sensitivity. The World Health Organisation (2021a) highlights that mental health conditions, emotional disorders, behavioural disorders, eating disorders, psychosis, suicide and self-harm and risk-taking behaviours begin in the adolescent years due to physical, emotional and social changes and challenges.

Anxiety

Anxiety is an internalising disorder. Barlow (2002) characterises anxiety as a future-oriented emotion with feelings that events are potentially uncontrollable, unpredictable, dangerous or adverse and the response is unknown. Often the terms fear (a reaction to a threat) and worry (intrusive negative outcome thoughts) are used synonymously with anxiety, and it is only when these common emotions become persistent, intense, inappropriate and interfere with functioning that intervention is required (Geldard et al., 2019).

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (5th ed; DSM-5; APA, 2013) includes separation anxiety disorder, specific phobia, social anxiety disorder, selective mutism, panic disorder, agoraphobia and generalised anxiety disorder under the anxiety disorders diagnosis. Related disorders such as obsessive-compulsive disorder, posttraumatic stress disorder, acute stress disorder, reactive attachment disorder and disinhibited social engagement disorder are included in a separate section, however, it is suggested that adolescents can display various symptoms occurring together and are likely to meet the criteria for more than one disorder (Geldard et al., 2019). Miller (2022b) explains that some adolescents who present with anxiety struggle with anxiety-related problems for years prior, others develop symptoms in their teenage years citing social anxiety and panic attacks as the main disorders experienced.

Geldard et al. (2019) state generalised anxiety disorder, social phobia, specific phobia and obsessive-compulsive disorder as common types young people experience.

Experiencing anxiety is typical when it is consistent with the requirements of a situation and may help increase awareness and performance, however, if the anxiety level is too high and the situation does not require such a level, anxiety can be debilitating (Geldard et al., 2019). Observed behaviours include agitation, insomnia, panic attacks, obsessions, compulsions, excessive worry and rumination (Mansberg & Lamble, 2021). The impact on daily functioning can include school refusal due to attempting to avoid anxious feelings which can result in reduced academic performance and involvement in extracurricular activities and self-esteem issues (American Academy of Adolescent Child and Psychiatry [AACAP], 2022). The individual may be reluctant to leave home and struggle to attend activities, sports, social or family events; may seek excessive reassurance about identity and ability; possibly engage in self-destructive behaviours like turning to alcohol and drugs to self-medicate or develop rituals in an effort to reduce or prevent anxiety (AACAP, 2022).

Evidence of Symptoms

Behaviourally, symptoms such as nervousness, restlessness, sleep problems, irritable and depressed mood, muscular tension and fatigue could be observed especially if generalised anxiety disorder is present (Geldard et al., 2019). Cognitively, poor concentration, unpleasant and intrusive thoughts and irrational and persistent fear could be observed in adolescents suffering from obsessive-compulsive disorder and specific phobia, with avoidance behaviours in social or performance situations evident in social phobia cases (Geldard et al., 2019). Physical behaviours that may be observed include breathing difficulties, chest pains, perspiration, accelerated heart rate and feeling separated from reality during panic attacks and repetitive actions and compulsions in individuals with obsessive-compulsive disorder (Mansberg & Lamble, 2021). Sleep problems may be observed due to melatonin, the hormone that induces sleep, being released up to two hours later than it is in children and adults, which delays sleepiness in adolescents and with early morning rises for school, sleep deprivation can cause anxiety and exacerbate the condition if it already exists (Young, 2022). School refusal is often a symptom as trying to avoid negative thoughts and feelings is sometimes the anxiety-related reason (Mansberg & Lamble, 2021). Being unable to relax, feeling annoyed or irritated by others or events, avoiding people or places and withdrawing from family and friends are symptoms visible in social contexts (Headspace, 2021b).

There is a wide variety of self-tests or self-report questionnaires available for the individual or parent to complete, many are on-line and freely available from websites such as Black Dog Institute (www.blackdoginstitute.org.au), Mind Spot (www.mindspot.org.au), Beyond Blue (www.beyondblue.org.au) and Headspace (headspace.org.au). Screening and assessment tools such as the Beck's Anxiety Inventory (Beck et al., 1988), the Depression Anxiety Stress Scales (Lovibond & Lovibond, 1995), the Hamilton Anxiety Scale (Hamilton, 1959), and the Yale-Brown Obsessive Compulsive Scale (Goodman et al., 1989; Heninger et al., 1989) assist with identifying when a more detailed assessment is

necessary (Headspace, n.d.). A doctor is required for a formal diagnosis of the type of anxiety disorder based on recognised criteria such as those listed in the DSM-5 (Healthdirect, 2020a).

Impact on the Individual and Interactions

The impact on an adolescent with anxiety can be debilitating. Dealing with physical responses such as a racing heart, breathlessness, tense feelings with aches and pains especially in the neck, shoulders and back, perspiring and feeling dizzy, shaky and nauseous can cause an individual to become withdrawn and isolated trying to avoid these symptoms (Headspace, 2021b). Isolating and withdrawing limits family, social and educational interaction. An adolescent with a mental health problem can pose challenges for parents, siblings, relatives and family friends. It can breed resentment as they can be seen as being manipulative and attention seeking, particularly to siblings, if the adolescent is receiving more consideration than others (Mansberg & Lamble, 2021). Family relationships can become strained and may affect the family's connection with relatives and their social network, isolating the family from potential support sources (Youth.gov, n.d.). Alternatively, it could bring the family closer as they work together to support their child and seek interventions and help.

Throughout adolescence, greater importance is placed on peer and social interaction and with a still developing brain comes increased vulnerability to misinterpreting social cues, emotions or intentions of others, and poses the potential for conflict, exclusion, or broken friendships fuelling anxiety (Young, 2022). The fear of missing out (FOMO) and fear of being left out (FOBLO) are modern day worries and triggers derived from social media use. Comparing attractiveness, lifestyles, materialistic possessions and friends can leave many adolescents with low self-esteem. Recent studies have shown the longer the amount of time spent on social media connects with a higher risk of anxiety and depression including social anxiety, issues with eating and sleep problems (Mansberg & Lamble, 2021). Anxiety is also more common in adolescents who identify as LGBTQIA+, pansexual or asexual and appear to be worse for those from rural or suburban areas (Mansberg & Lamble, 2021).

Suggested Interventions

Anxiety interventions and support depends on individual circumstances and the type of anxiety disorder present. Lifestyle changes such as regular physical exercise and adequate sleep and nutrition may help mild anxiety sufferers, whereas more severe cases may require medication, intensive therapy or both (Healthdirect, 2020a). A Guidance Officer in a school setting can develop an Individual Support Plan for an adolescent with anxiety and details will depend on the severity of symptoms, available health services, other presenting health issues, the support network including family, friends and school supports and the individual's preference for a particular treatment approach (Headspace, n.d.).

The support plan could include the guidance officer offering counselling sessions that promote a

therapeutic alliance and collaboration on the approach, skill development, stress management and the use of cognitive behavioural therapy (CBT). CBT is the most researched treatment for anxiety in young people and has been found to reduce symptoms of anxiety, post-traumatic stress disorder and obsessive-compulsive disorder in adolescents (Headspace, n.d.). In CBT, patterns of thinking and behaviour that are prone to cause anxiety are recognised and changes are devised to replace the patterns with ones that help reduce feelings of anxiousness and enhance coping (Reavley et al., 2019).

The therapy involves helping individuals to recognise anxious feelings and somatic reactions, clarify thoughts in triggering situations, develop coping skills and evaluate outcomes (James et al., 2015). Modelling, reality exposure, role playing and relaxation training can be offered as behavioural strategies and are based on the premise that fear and anxiety are learnt responses and can be reversed (James et al., 2015). Cognitive strategies such as self-control approaches can be taught and include a step by step process such as first identifying when anxious feelings occur, identify associated thoughts, modify or restructure feelings by creating alternative coping thoughts or behaviours and finally, rewarding and praising for confronting fears (James et al., 2015). CBT can be adapted to include parents and family and can involve identifying ways to assist and respond to their child's behaviours and even help parents to manage their own anxiety (James et al., 2015).

As in all cases, if attempts at the school and home level do not succeed then further help is required. Referrals to medical and psychological professionals should occur with relevant authorities, such as child safety, being alerted if the family are not responding with the help and support required and the adolescent is suffering.

10.

ADOLESCENCE

Tracey Sidoti

Adolescence

Adolescence is traditionally known as the developmental time between childhood and adulthood (Millstein et al., 1994). The period of adolescence can be an influential one when an individual gains physical, emotional, cognitive and social abilities that culminate and provide a foundation for their future (Beyond Blue, 2022c). This period is when young people go through biological changes reaching both physical and sexual maturity. These changes along with both cognitive and psychosocial changes enable adolescents to either make risks or alternatively lead to healthy lifestyle choices (Millstein et al., 1994). Due to the uniqueness of each individual, the adolescent period can be quite varied with some young people moving through this period quicker than others. Additionally, this time period may be more tumultuous for some compared to others who may have better coping mechanisms (Geldard et al., 2019).

Anxiety

Anxiety is a mental health condition that involves a person's future-oriented emotion which is defined by an increased level of apprehension and lack of control. Anxiety can occur in many forms such as social anxiety disorder, separation anxiety, generalised anxiety disorder, panic disorder, agoraphobia and obsessive-compulsive disorder control (Wicks-Nelson & Israel, 2015). When a person experiences anxiety they experience anxious symptoms in reaction to situations they perceive as a threat to them, rather than actual danger (Wicks-Nelson & Israel, 2015). Considering there are several types of anxiety disorders, they vary amongst teenagers. Anxiety during the adolescent period can typically be based on the way their body is changing throughout the period of puberty, how their body is looking and feeling. It can also centre on being accepted by peers and conflicts they are experiencing about independence (American Academy of Child & Adolescent Psychiatry, 2022).

The impact on a young person's daily functioning can be significant and varies according to the form of anxiety disorder they have. Adolescents who experience social anxiety disorder experience significant anxiety when exposed to social situations and subsequently this leads to avoidance behaviours with peers and the school environment (Geldard et al., 2019). Additionally, young people with generalised anxiety disorder, experience long periods of persistent worry, with the source quite often unknown. Their symptoms can often impact their ability to concentrate which again impacts their ability to engage in

required school work (Geldard et al., 2019). Adolescents who experience obsessive-compulsive disorder often experience intrusive thoughts which are difficult to manage. These thoughts often lead to repetitive rituals which can be isolating when socialising with peers as well as providing a strain on family members in the home environment (Geldard et al., 2019). Overall the avoidance behaviours displayed by young people experiencing anxiety can impair relationships and can increase the likelihood of further mental health problems such as depression (Geldard et al., 2019). According to studies, this can impact a young person's physical, psychosocial and cognitive functioning (Herbert et al., 2009).

Evidence of symptoms

Young people during the adolescent developmental period experience not only biological changes but also cognitive changes. This occurs during the process of changing from more concrete thinking experienced during childhood to dealing with more abstract ideas enabling them to make independent decisions (Geldard et al., 2019). Additionally, during this period egocentric thinking traits develop, which can have a direct impact on the cognitive thought process of a young person experiencing anxiety. The individual differences this person identifies with such as physiological symptoms of social anxiety disorder include excessive blushing, sweating and stomach aches. These symptoms can prove to be isolating as the adolescent believes that no-one else is capable of understanding them (Geldard et al., 2019; Wicks-Nelson & Israel, 2015).

As a young person starts to form their personal identity during aolescence, anxiety disorder can take its toll on their cognitive functioning. Anxiety symptoms such as excessive fear of a perceived threat, catastrophising or obsessive thinking which is commonplace for obsessive compulsive disorder can affect the formation process of identity which is a central characteristic of this period (Beyond Blue, 2022a; Geldard et al., 2019). Overall these challenges can affect the quality of day-to-day functioning of an adolescent.

Impact on the Individual and Interactions

Behavioural and social implications of anxiety can be profound for young people. Behaviours that are commonplace for generalised anxiety disorder include excessively worrying about their competence in certain areas which leads to perfectionist behaviours, displaying nervous habits, restlessness and sleep deprivation (Wicks-Nelson & Israel, 2015). Additionally, youths who experience anxiety can suffer from physiological symptoms such as rapid heart rate, shaking, quick breathing, fear of losing control and even fear of dying (Beyond Blue, 2022c; Wicks-Nelson & Israel, 2015). These dramatic behavioural symptoms can impact a young person's ability to maintain friendships during a period when closeness to friends remains a high priority, more so than to their parents (Millstein et al., 1994). Youths who experience social anxiety disorder often make mention of feelings of loneliness and lesser self-worth, leading them to avoid everyday activities such as attending school or eating in public places (Wicks-Nelson & Israel, 2015).

According to the DSM-5 (APA, 2013) a variety of assessment tools to assist in the identification of anxiety include self-report instruments, taking part in direct observations of the young person in question and interviews (Wicks-Nelson & Israel, 2015). The most favoured assessment tool is the self-report instrument as it provides accurate reports assessing behavioural, physiological and cognitive anxiety traits (Wicks-Nelson & Israel, 2015).

Suggested Interventions

Cognitive behaviour therapy (CBT) is known as one of the most widely used therapies to treat young people experiencing anxiety. There are many different approaches to CBT but all of them share similar characteristics which include attributes, such as: collaborative relationships between counsellor and client; the knowledge that the clients' issues stem from cognitive processes; a plan to change cognitions in order to change behaviour and affect; and an active and direct approach lead by the counsellor (Corey, 2021). CBT involves exposing a young person to a feared situation in which they perceive is dangerous and through this changing their process of cognition through modifying their thinking patterns and avoidant behaviours (Gordon et al., 2014).

11.

ADOLESCENCE

Crystal Steger

Adolescence

Currently adolescents make up 16 per cent of the world's population. That equates to 1.3 billion adolescents worldwide (UNICEF, 2022a). Adolescence is the developmental growth between childhood and adulthood (Csikszentmihalyi, 2021). It is defined as anyone aged between 10 and 19 years of age (Csikszentmihalyi, 2021). During the transition from childhood to adolescence, teenagers experience puberty, producing hormonal changes effecting emotional, physical, social and psychological growth (Raising Children Network, 2021b). They are beginning to find independence, develop their own identity and form new relationships (CDC, 2021e). With adolescence comes exploration and risk taking. Teens experiment with alcohol and drugs, becoming sexually active, experiencing mood and metal health disruptions, questioning authority and disengaging from school (ReachOut, 2022a). In today's society, anxiety is a frequently diagnosed mental health factor among teens.

According to the National Institutes of Health, nearly 1 in 3 of all adolescents ages 13 to 18 will experience an anxiety disorder (McCarthy, 2019). These numbers have been rising steadily; between 2007 and 2012, anxiety disorders in children and teens went up 20% (McCarthy, 2019).

Anxiety

Anxiety triggers the fight or flight response when individuals are faced with challenging, stressful and intimidating situations (Lyness, 2022). The body is overwhelmed by tense feelings of dread, a person's heart begins to race and they may find it difficult to physically, emotionally, psychologically and cognitively manage the situation (Health Direct, 2020a). Anxiety can have an adverse effect on the development of teenagers schooling, socialisation and ability to function in everyday life (Healthdirect, 2020b). Anxiety underpins many disorders such as phobias, separation, social panic, Obsessive Compulsive Disorder (OCD), Post traumatic stress disorder (PTSD) and Generalised Anxiety Disorder (Healthline, 2018). Each disorder involves similar symptoms, apprehension and avoidant behaviours (Wicks-Nelson & Israel, 2015).

Phobia is the fear of something that may pose little or no threat (Lewis, 2020). Phobias include but are not limited to, the fear of heights, animals, blood and flying (MentalHealth.gov, 2022). Separation anxiety disorder is one type of anxiety disorder. This form of anxiety is described as a feeling of extreme distress

when a child is away from their parent or guardian. There are two kinds of separation, normal separation and separation disorder. Separation disorder is more intense with the child unable to participate in normal activities, becoming anxious at just the thought of being away from their parent and becoming physically sick, often missing school (Helpguide, 2022). Social anxiety is the fear of being judged or scrutinised negatively for doing or saying things, and acting anxious in social settings such as public speaking, meeting and engaging with new people, going out in public, speaking to adults and being placed in new situations or environments (Kids Helpline, 2022). This fear can play a negative factor in building relationships, participating in educational learning and future employment and careers (Kids Helpline, 2022).

Panic attacks produce strange and unknown feelings and thoughts. Teenagers struggle to manage this disorder and suffer from symptoms such as shortness of breath, disorientation, chest pain, racing heart, sweating and shaking. Teens who experience panic attacks will begin to avoid people, places and situations, therefore disengaging in life (Star & Lockhart, 2021). OCD is pattern based obsessive-compulsive behaviours based on anxiousness and fears (Mayo Clinic Staff, 2020). Its repetitive cycled actions cause further distress and anguish. OCD interferes with normal functioning and daily life (Mayo Clinic Staff, 2020). People who witness or experience a stressful or traumatic situation can develop PTSD (Torres, 2020b). PTSD causes intrusive thoughts such as flash backs, avoidance, mood alterations and the inability to regulate emotions and outbursts. (Torres, 2020b). PTSD can negatively affect a person's whole way of life from everyday activities, family engagement, to functioning in today's society (Torres, 2020b). General anxiety is known as having no set or specific type of diagnoses (Wicks-Nelson & Israel, 2015). Like the other forms of anxiety, it is linked to excessive fear, worry and apprehension. Individuals with anxiety are perfectionists who set high standards, seek constant reassurance and display nervousness in almost all new, social and unstructured situations (Wicks-Nelson & Israel, 2015).

Evidence of Symptoms

Risk factors associated with teenage anxiety disorders include, physical, mental and emotional abuse, witnessing or experiencing trauma, long term serious health conditions, excessive worrying (family, school and home life), mental health disorders (depression), misuse of drugs and alcohol and genetics (Mayo Clinic, 2018). Anxiety, stress and excessive worrying have a negative impact on the adolescents working memory and their cognitive abilities (Rapgay, 2019). Working memory assists in making decisions, learning new tasks and setting goals. Cognitive processes such as being focused, attentive, shifting from one task to another and updating information relies heavily on the working memory (Rapgay, 2019). Research shows that anxiety damages the adolescent's cognitive processes and memory leading to adverse effects (Rapgay, 2019). Anxiety limits the person's ability to separate responsibility and threats therefore they are unable to complete everyday tasks (Rapgay, 2019). Cognitively they struggle to concentrate, are irrational, always think the worst and lose the ability to make competent decisions (Valley Behavioural Health, 2022).

Social anxiety is common in the adolescent years. Teens who have family history of anxiety, suffer bullying,

family trauma or abuse, are shy, or have the added pressure of social awkwardness associated with a mental health condition such as Autism (Autism Spectrum Australia, 2022), can find it difficult to function socially, emotionally and physically in daily life (Mayo Clinic Staff, 2021). Socially teenagers feel they are negatively being judged, become oversensitive, embarrass easily, struggle to engage in conversations and overthink the social situation or event leading to heightened physical and emotional responses (Mayo Clinic Staff, 2021). Physically and emotionally they experience hyperventilation, racing heart, nightmares, fatigue, headaches, insomnia and the constant feelings of being sick (nausea) (Mayo Clinic Staff, 2021). Teenagers are unable to regulate their thoughts formulating an intense dislike to socialisation, relationship building and interaction's altogether (Mayo Clinic Staff, 2021). Behaviourally, teenagers become disengaged, irritable, heightened and turn to substance use to control unwanted thoughts. They begin to show signs of avoidance, refusal, oppositional and aggressive behaviours. These are inbuilt coping mechanisms controlling the teen's situation and undesirable thoughts and feelings (Miller, 2022a). They are overwhelmed and consumed by stress, fear and panic, and therefore retaliate in order to escape.

When undertaking anxiety assessments and diagnoses we are guided by the tripartite theory. The tripartite theory identifies the comorbidity within the symptoms addressing behaviour, cognitive and physiological responses (Buckby et al., 2008). Assessment must be developmentally appropriate, culturally sensitive and environmental factors taken into consideration when assessing (Wicks-Nelson & Israel, 2015). Data can be untaken via clinical interviews (Structured interview), Self-reporting Instruments (MASQ Multidimensional Anxiety Scale for Children), direct observation (behavioural and environmental issues) and Physiological Recordings (e.g. heart rate, blood pressure) (Wicks-Nelson & Israel, 2015).

Impact on the Individual and Interactions

Anxiety impacts socialisation, relationships, schooling and home life. Adolescents who suffer anxiety live in a world of constant fear, worry and obsessive thoughts (AACAP, 2022). These symptoms become overwhelming and can lead to further mental health problems, substance abuse, self-harm and suicidal feelings (AACAP, 2022). As noted before, anxiety has many different forms but produce many of the same symptoms. Symptoms include panic, flashbacks, trouble sleeping, inability to self-regulate, shortness of breath and nausea (Cleveland Clinic medical professional, 2020). These symptoms are triggered by stress, environmental factors and genetics (Cleveland Clinic medical professional, 2020). Anxiety impacts teenager's ability to form relationships, engage in school and actively participate in family life (AACAP, 2022). Anxiety develops risky behaviours, mood disruption and questioning of adult authority (AACAP, 2022). Teenagers begin to withdraw, turn to substance abuse, aggression and undesirable behaviours to overcome the storm and stress of adolescent anxiety (AACAP, 2022). This behaviour has a negative knock on effect in schooling (truant, disengaged), social interaction (fear of separation, judgement, withdrawn) and family (self-harm, moodiness) (Epstein et al. 2020). Some factors that trigger anxiety at school and home are negative socialisation (bullying) the pressure of doing well academically, separation (home/

parents), sleep disorders, learning disabilities, trauma, abuse, divorce in the family, substance abuse and the hormonal changes of puberty (Klein & Geng, 2021).

Suggested Intervention

Cognitive Behavioural Therapy (CBT) is a common and effective form of treatment when treating anxiety disorders in adolescents (Raising Children Network, 2021a). CBT guides teenagers to develop an understanding of their condition and challenges their anxious behaviours (Raising Children Network, 2021a). Guidance officers, counsellors and psychologists use CBT to help teenagers overcome fears, establish coping strategies and understand how to regulate their feelings and emotions during heightened situations (Wicks-Nelson & Israel, 2015). CBT provides adolescents with the cognitive ability to identify their symptoms and signs of anxiety, plan and overcome situations and self-reflect (Wicks-Nelson & Israel, 2015). The therapy is constructed using strategies such as to role playing, exposure therapy (faced with fear) and begin to form relaxation techniques (breathing) to instil the different skills needed when successfully functioning in everyday life (Wicks-Nelson & Israel, 2015).

12.

ADOLESCENCE

Suzanna Jacovou

Adolescence

Adolescence is a critical developmental stage that involves various challenges and experiences. The large age range between approximately 11 to 21 years involves more prominent challenges in the different stages of adolescence than others. Research suggests adolescence is the most challenging developmental lifespan period providing the physiological, biological, psychological changes endured. Childhood experiences also play a key role in shaping the transition to adolescence, and consequently the transition to adulthood, therefore the challenges associated with this key developmental period and their impacts should be considered. Stereotypical adolescent behavioural challenges involve impulsivity, conflict with peers and parents, emotional turbulence, norm-breaking, risk-taking, recklessness, and anti-social behaviour (Geldard et al., 2019). Although not all research suggests this is the case for all adolescents, their natural desire for independence and autonomy (Smith, 2015) can lead to potential behaviour challenges. Secondly, significant challenges can arise through adolescents' social development and experiences as their sense of identity, security, values are often questioned, increasing their overall sensitivity, reactivity and vulnerability (Silverberg, 2020). Social media can also provide grounds for further insecurity through challenges such as bullying, unhealthy comparison, warped reality and addiction (Smith 2015), all closely associated with psychological problems. Most significantly, adolescents experience considerable cognitive challenges due to higher levels of abstract reasoning, and distorted perceptions of themselves, others and situations (Smith, 2015). Mental health problems such as anxiety, are considered to be continually rising for this demographic and present more in adolescents comparatively with other life stages (Helseth et al., 2016). This may be attributed to these stress-inducing cognitive and environmental changes.

Anxiety

Anxiety is considered one of the most common and prevalent psychological disorders in childhood and adolescence (Kim-Cohen et al., 2003), affecting up to one in five youth (Butterfield et al., 2021). Studies show that that anxiety is a serious problem that when experienced through key developmental periods such as adolescence, can have significant impacts on social and academic functioning, and longer-term consequences (Cartwright-Hatton, 2006). Furthermore, adults with anxiety disorders report the onset of their disorder in childhood or adolescence (Kim-Cohen et al., 2003) suggesting it is a mental health issue that can last into adulthood. Although anxiety is a feeling all individuals experience at times, it becomes

a disorder when the frequency and severity interferes with daily functioning, such as concentration, socialising or finding enjoyment (Department of Health, 2020). The various types of anxiety adolescents may experience are social anxiety, phobias, panic disorder, agoraphobia or separation anxiety. These may present in different ways such as restlessness, physical symptoms, heightened self-consciousness and sensitivity, irrational negative thoughts, pre-empting unrealistic negative outcomes, avoidance, withdrawal, lack of concentration and sleep difficulties (Department of Health, 2020). The impacts of some of these symptoms can be detrimental to the wellbeing and development of teenagers, as they can severely impact on their daily functioning, relationships and perception of self (Silverberg, 2020). Within the school environment, a decrease in concentration, motivation and enjoyment, in conjunction with hyper-sensitivity and negativity, can significantly affect academic performance and relationships with teachers and peers. Within a home environment, depending on the type of anxiety experienced, family attachments can be impacted through increased conflict, withdrawal and negative thought patterns (Silverberg, 2020).

Evidence of Symptoms

Anxiety is one of the most prevalent psychological disorders amongst youth (Butterfield et al., 2021). However, dependent on the type of anxiety experienced by an adolescent and the individual themselves, evidence of anxiety can present differently. From a cognitive perspective, anxiety disorders are broadly associated with neural hypersensitivity and a heightened response to negative stimuli in the brain networks that impact emotional responses and processing (Butterfield et al., 2021). Studies have shown that adolescents suffering with anxiety demonstrate excessive emotional reactivity which can further lead to poor psychosocial functioning (Butterfield et al., 2021). Individuals within this age bracket experience biological changes impacting on cognition and therefore typically possess higher levels of abstract reasoning, affecting their perception of situations, themselves and others. Consequently, stimulating negative thought patterns of critical questioning of their role in society, their personal beliefs and self-esteem, adolescence is considered a risk period for anxiety (Butterfield et al., 2021).

Throughout this developmental lifespan period, youth experience emotional vulnerability whilst navigating new social challenges, more complex peer and romantic relationships and often conflict with family members (Silverberg, 2020). These challenges are paired with adolescents maturing, increasing awareness of social evaluation, and heightening self-consciousness. Therefore, if young people are not provided with support and protective factors to enhance emotional resilience and more logical thought patterns, unhealthy mental cognitions can manifest contributing to an anxiety disorder. Traditionally from a cognitive view, anxiety has been related to hypervigilance and attention bias; either towards or avoidance of perceived threat, and therefore impacting on how an individual may behave. Avoidance or overanalysing of negative stimuli may increase the way an adolescent internalises negative thoughts, presenting as anti-social behaviours or withdrawal (Butterfield et al., 2021). This can appear as absent-mindedness, lacking concentration, ignoring or avoiding interactions due to re-occurring negative thoughts about themselves, their environment, the past or future, or other individuals. According to Di Blasi et al. (2015), impaired

self-image has been closely associated with high levels of social anxiety. However, this may not be the case for all types of anxiety or for all individuals and can often present in externalising behaviours. Hall's (1904) Storm and Stress Theory (Casey et al., 2010) suggests that adolescents experiencing significant emotional turbulence and mental health issues may engage in risky and reckless behaviour, displaying impulsivity, rebellion, norm-breaking, and potentially harmful behaviour (Geldard et al., 2019). Maintaining their innate desire for autonomy (Smith, 2015) and search for identity (Sullivan, 2003), adolescents can also present with anxiety through externalised overt behaviours, creating more conflict with peers, parents, and society, and consequently further impacting on development and wellbeing. As a result of these various behaviours, negative social and academic impacts can present for adolescents. Peer aggression and social phobia can present in youth suffering anxiety which are both behaviours closely linked to social impairment, poor academic achievement, substance misuse, and increased risk of depression (Storch et al., 2005).

Professionals such as psychologists and Guidance Counsellors must not only understand these complex mental health issues from varied perspectives but be able to identify these signs and symptoms in young people in order to provide support and intervention. Data collection is one key method involved in this process. There are common methods of data collection used in schools and clinics such as observations, interviews or consultation with involved stakeholders, individual or family counselling, and conducting formal assessments, scales and reports. Functional Behaviour Assessments (FBA) are commonly used within schools as an initial data collection method. Psychometric assessment tools may be utilised such as the Severity Measure for Social Anxiety Disorder (Craske et al., 2013), the Social Experience Questionnaire (Crick & Grotpeter, 1996), the Social Anxiety Scale for Adolescents (La Greca et al., 1988) , and The Generalised Anxiety Disorder 7 item scale (Spence, 2017). Personality inventories and assessments may also be useful in identifying risk factors and the likelihood of anxiety in adolescents. A combination of data collection methods would be beneficial for professionals to accurately assess an individual's circumstances, behaviours, and cognitions in order to provide adequate support and intervention strategies.

Impact on the Individual and Interactions

As adolescence is broadly considered a challenging time for any individual, anxiety can create additional negative impacts on a teenager, in all aspects of their life. For an individual suffering with anxiety, daily experiences, emotions and cognitions can be further heightened causing hypersensitive reactions to perceived negativity (Butterfield et al., 2021). Stereotypical adolescent experiences such as peer or parent conflict, challenges at school (Geldard et al., 2019) along with biological factors heightening self-consciousness and social awareness (Silverberg, 2020), can be exacerbated to unhealthy emotional responses and cognitions due to anxiety. Something that may occur to both a non-anxiety suffering adolescent and an individual with anxiety could result in vastly different reactions, externally and internally. An individual displaying resilience, healthy cognitions, effective communication skills and processing, pro-social behaviour (Fu et al., 2017) and positive self-image has the ability to endure adversities and further

develop through adolescence into adulthood. However extreme poor self-image, lack of confidence or autonomy, and internalising behaviours can result in clinical anxiety (Di Blasi et al., 2015) impacting on an individual's emotional regulation, academic performance and key relationships that all negatively affect development (Tariq et al., 2021).

Suggested Interventions

Guidance Counsellors can provide many strategies and intervention methods to address anxiety and the impact it has on adolescents through this life stage and beyond (Queensland Guidance Counselling Association, 2019). In order to do so effectively, thorough awareness of key signs, symptoms and impacts is required. Possible interventions may include counselling, parental support, CBT methods such as mindfulness, or whole-school wellbeing programs. Strength-based parenting directly relates to reduced impacts of anxiety and increased school engagement (Cartwright-Hatton, 2006) therefore family involvement is beneficial. However, as there are many forms of anxiety and ways young people may respond to stimuli (Healthdirect, 2020b), development of an Individualised Support Plan would enhance the level of support for an individual adolescent. This allows for personalised support and intervention, considering the uniqueness of their personality, cognitions, behaviours, family, environment, cultural background, and specific circumstances. Evidence suggests that robust social networks enhance quality of life (Rice et al., 1993), increasing academic success and future employment prospects (Smith, 2015), therefore intervention with peers such as group counselling or school-wide mental health programs is advised. As adolescents place high value on peer relationships, it is recommended to use an individual's social network as the commencement point for intervention. Furthermore, harnessing group-driven engagement (Rice et al., 1993) offers potential for more sustainable, long-term positive impacts (Smith, 2015) for the individual and their peers. This is also highly beneficial for Guidance Counsellors to make further observations of the adolescent, witnessing peer interactions and monitoring progress, to ensure adequate intervention is provided.

13.

ADOLESCENCE

Christina Deans

Adolescence

Adolescence is described by Geldard et al. (2019) as the development period between childhood and adulthood. During adolescence individuals are faced with multiple challenges including biological, cognitive, psychological and social which can contribute to increasing feelings of anxiety.

Anxiety

Anxiety is a basic human emotion, however when it becomes prolonged, with heightened levels of discomfort and impacts normal daily functioning it becomes a mental health concern (APA, 2015; Wicks-Nelson & Israel, 2015). While anxiety can occur over the lifespan of an individual, it is the most commonly reported disorder experienced by adolescents (Wicks-Nelson & Israel, 2015) with the median age of onset being teens to twenties. The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013a) lists 11 anxiety disorders:

- Separation anxiety disorder,
- Selective mutism,
- Specific phobia,
- Social anxiety disorder (social phobia),
- Panic disorder,
- Agoraphobia,
- Generalized anxiety disorder,
- Substance/medication-induced anxiety disorder,
- Anxiety disorder due to another medical condition,
- Other specified anxiety disorder, Unspecified anxiety disorder.

Each of the 11 anxiety disorders has specific diagnostic criteria. However, commonly observed behaviours are avoidance, distress, physiological indicators such as blushing, sweating, shaking. The degree to which the behaviours are demonstrated impact the severity on how the individual can function. For example, in the school setting, social anxiety may present as a student avoiding eye contact in a group setting and remaining on the periphery with limited verbal engagement, or it may present as panic attacks at the school

gate, creating severe distress, somatic pains such as stomach ache and school refusal impacting their own education and family routines. In the home situation, separation anxiety disorder may range from a child who seeks constant proximal closeness or frequent eye contact with a parent, to a child who cannot sleep in their own room and frequently has nightmares about being separated, lost or searching for their parent disturbing their own and the families sleep patterns. Each anxiety disorder has unique criteria, however, comorbidity is common (APA, 2013a).

Internationally, anxiety is the most prevalent psychiatric condition with 10 to15% of patients diagnosed with an anxiety disorder and 40% of new clinical referrals related to anxiety (APA, 2015). In Australia, between 2017 and 2018 a reported 3.2 million individuals had an anxiety related condition representing 13.1% of the population (Australian Bureau of Statistics, 2018). Concerningly, individuals diagnosed with one of more anxiety disorders have a heightened risk of suicide attempt or suicide ideation (APA, 2015). Many anxiety disorders developed in childhood persist into adolescence and beyond if not treated (APA, 2015).

Evidence of Symptoms

Adolescence has already been outlined as a period of development where behavioural changes, thought processes and social challenges can be observed in individuals. The delimitation between what may be considered atypical 'storm and stress' responses and indicators of anxiety disorders requires observation and data collection over an extended period of time and multiple settings.

Thought processes include, but are not limited to, a pre-occupation of excessive worry, trouble concentrating, feelings of impending danger, worrying excessively or irrationally about key people in their lives, mind going blank or worry about catastrophic events such as nuclear war, earthquake (APA, 2015).

Observable indicators include appearing nervous, restless or tense, irritable and distressed, potentially sweating, shaking, and breathing rapidly. Somatic stomach-aches, dizziness and headaches may also present. Seeking perfectionism in tasks or becoming increasingly withdrawn may become evident in observations (APA, 2015; Wicks-Nelson & Israel, 2012).

Avoidance of people or situations that trigger feelings of anxiety (American Academy of Child and Adolescent Psychiatry, 2022). This may present as being absent from school during assessment periods, or eating alone in the library to avoid peer group conversations. In the home setting it may look like the adolescent withdrawing from everyone, refusing to engage with peers, hobbies or even family.

Data collection will support case conceptualisation and begin to differentiate between anxiety symptomology and typical adolescent challenges. Collecting pre-existing data from Queensland schools system, OneSchool, can give background information and potentially identify an overall pattern of behaviour, attendance and academic achievement. Previous reports or records of social emotional interventions can provide valuable information and a timeline for consideration. Reviewing records of

contact may provide an indicator of the mesosystem relationship and any potential life changes in family settings. Interviews with the adolescent and/or close significant family members can provide information on the level of impact across various contexts and, importantly, how long feelings of anxiety have been present (essential for anxiety diagnosis). Potentially the use of a norm-referenced test for anxiety screening, such as the Spence Children's Anxiety Scale (Spence, 1998), suitable for adolescents up to the age of 16. Caution must be taken using anxiety screeners as most assess frequency of symptomology and neglect to assess the functional impact on life over an extended period of time (Krygsman & Vaillancourt, 2022).

Impact on the Individual and Interactions

Feelings of anxiety, particularly social anxiety which is the most prevalent anxiety disorder diagnosed during the adolescence (Krygsman & Vaillancourt, 2022) impact the extent to which the individual socialises and integrates with peers, family and society. Avoidance and withdrawal is a common symptom of social anxiety and can be pervasive impacting all aspects of the adolescent life, the impact of which is discussed next.

Withdrawing from social interactions may result in feelings of isolation, loneliness and exacerbate cognitive egocentric thinking beliefs that no one understands what they are going through (Geldard et al., 2019). Social anxiety is linked to lowering of self-esteem, poor self-concept and future depressive episodes (American Academy of Child and Adolescent Psychiatry, 2022; Krygsman & Vaillancourt, 2022). Complete withdrawal may include school refusal impacting academic performance. Social media comparison may act as a trigger for the adolescent who is becoming more self-reflective and awareness of physical changes. Physiological symptoms, or the thought of displaying symptoms such as sweating or blushing may also trigger anxiety.

Avoidance of social settings and peers, including school and extra-curricular activities may result in a diminished circle of friends. Worry around what peers think of how they look, how they behave may become all-consuming and lead to further withdrawal. Alternatively, risk taking behaviour in the form of substance abuse, to lower inhibitions and become more relaxed to interact with peers may occur where the adolescent becomes boisterous or adopting clowning behaviour to cover anxiety (Krygsman & Vaillancourt, 2022). Triggers for anxiety may include situations where attention may be on the individual such as group assessments at school where they as required to contribute or social parties where the egocentric thinking natural in this development period leads them to believe everyone's attention is on them.

The family unit may become temporarily dysfunctional as parents and caregivers adapt to the adolescent's behaviours, emotions, and moods. A permissive parenting style may perpetuate or heighten feelings of anxiety. Caregivers may need to adapt practises such as speaking on behalf of the child, providing special meals away from the family and facilitating school refusal which have been shown to prolong social anxiety (Norman et al., 2015).

Complete withdrawal may lead to agoraphobia, or fear of open spaces limiting the individual's opportunities to engage in the wider community. This may limit exposure to social norms, experiences and adolescent adaptation.

Suggested Interventions

An initial treatment phase of Rational Emotional Behaviour Therapy (REBT) may be recommended for the adolescent experiencing anxiety disorders. This therapy centres around the presupposition that thoughts, perceptions and beliefs create the emotional state rather than external stimulus (Corey, 2016). To effect change therefore, REBT relies on challenging, disputing and thinking differently around perspectives. The timing of this approach for adolescents is particularly relevant as their cognitive development shifts to a more abstract level of thinking allowing them to explore other people's perspectives.

The Guidance Officer and adolescent adopt a collaborative approach exploring self-defeating beliefs, irrational thinking and self-constructed truths. Collaboration is imperative for the adolescent whose egocentric thinking may make them feel unique and like no-one understands them (Geldard et al., 2019). REBT promotes the power of choice over emotional response therefore facilitating autonomy as part of the individuation process (Dobson, 2009).

REBT may require several sessions and typically involve homework such as listing self-defeating thoughts, identifying frequency of anxiety, duration and self-rating levels of anxiety providing a further degree of autonomy. Self-identification of antecedents to feelings of anxiety across multiple systems – home, peer and school may also provide distinguishing factors for specific anxiety disorders (Dobson, 2009).

14.

ADOLESCENCE

Megan Fogelis

Adolescence

Adolescence is a time of massive change. Everyone progresses through this developmental stage at different rates but all young people experience physical, cognitive, social and emotional changes (Kelly et al., 2017). One of the challenges facing health professionals and educators is that some of the changes and behaviours that develop in adolescence may be mistaken for mental illness and the symptoms of mental illness may be masked by the changes that occur during this stage of development (Kelly et al., 2017). Therefore, counsellors must understand the key changes and challenges that occur during adolescence to ascertain the best intervention for the young person they are supporting.

Physical Changes

Puberty causes significant changes to occur in a young person's body. Kelly et al. (2017) states the following facts relating to physical changes:

- in Australia, the typical age of onset is 11-15years
- both male and females increase in height and weight
- the voice deepens
- growth of facial and body hair
- many young people have difficulties with pimples or acne
- increase in testosterone in males
- increase in estrogen in females
- start of menstruation for females
- increase in sexual thoughts and feelings which may lead to sexual experimentation

With all these changes it is understandable that an increased concern about personal appearance occurs. A young person may feel embarrassed and self-conscious if they are developing at a different rate to their peers (Geldard et al., 2019).

Cognitive Changes

The way an adolescent thinks about themselves, others and the world changes during adolescence. Kelly et al. (2017) highlights the following cognitive changes:

- movement from concrete ways of thinking to more abstract, analytical and critical ways of thinking
- brain is undergoing dramatic changes and part of the brain that is responsible for decisions making can take the whole of adolescence to develop
- use more reasoning and logic to solve problems
- analyse and critique things they see and hear
- formulate beliefs about what is right and wrong
- make long term plans
- think about the meaning of life
- develop spiritual and religious beliefs
- devise ethics and justice ideas
- question authority, rules and norms
- become passionate about causes (world poverty/animal cruelty)
- debate topics of interest
- sometimes intolerant of others
- take risks and make poor decisions

The reader can appreciate the volume of change occurring can result in positive and negative thought processes.

Social Changes

The biggest social change to occur during adolescence is the movement away from family and parents to an orientation toward friends. Kelly et al. (2017) proposes the following social developmental challenges during adolescence:

- learning to resolve conflict harmoniously
- manage pressure from peers
- thinking about future adult roles
- devise career identity
- experiment with looks and styles
- what young people find normal can be frustrating for parents
- finding which identity suit them best
- experimentation with romantic relationships
- gender identity experimentation

Emotional Changes

Many emotional changes occur during adolescents. Kelly et al. (2017) outlines the emotional challenges as:

- greater intensity of emotional states
- quicker emotional reactions
- an argument with a friend can quickly lead to a screaming match
- make emotionally charged statements such as vowing to never to speak again to a friend
- romantic attractions can quickly become infatuation
- emotional functions of the brain react quickly which contributes to poor decision making

The result of these emotional changes can mean that an adolescent is more likely to take risks, be impulsive and look for ways of having fun without thinking through the consequences (Kelly et al., 2017).

After considering the physical, cognitive, social and emotional challenges it is evident that processes need to occur if these challenges are to be handled with success. Unfortunately, the onset of mental illness peaks during adolescence which means that as well as being a time of psychological maturity it is also a time of psychological susceptibility (Kelly et al., 2017). The following will detail the impacts of adolescent anxiety and suggest an intervention.

Anxiety

Anxiety disorders are among the most common disorders faced by adolescents (Wicks-Nelson & Israel, 2015). To a certain degree it is normal to worry and feel anxious at times. Anxiety can motivate an individual and help get energy to combat challenges. However, when excess anxiety isn't connected to a challenge and is getting in the way of day-to-day activities, the quality of a person's life gets affected (Reachout, 2022a). This is when an adolescent or the people in their life would seek assistance.

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; APA, 2013b) defines seven anxiety disorders seen in adolescence: generalized anxiety, social anxiety, separation anxiety, panic disorder, agoraphobia, specific phobia and selective mutism (Garcia & O'Neil, 2021). According to Garcia and O'Neil (2021) the three most common adolescent anxiety disorders are generalized anxiety disorder (GAD), social anxiety disorder (SAD) and separation anxiety. This research states that these disorders can be comorbid with each other and with other disorders such as eating disorders, depression, and attention deficit/hyperactivity disorders. General information relating to anxiety disorders retrieved from the DSM-5 is described next.

Evidence of Symptoms

Anxiety disorders include disorders that share features of persistent and excessive worrying that last more than six months and interferes with daily activities such as school. According to the DSM-5 (APA, 2013b) the situation that induces the anxiety may be different but some of the behaviours can be similar. These are feeling restless or on edge, fatigue easily, irritability, difficulty concentrating, pervasive avoidance behaviours, panic attacks and overestimating danger. Anxiety can impact on daily functioning.

Anxiety affects an adolescent's cognition. Kelly et al. (2017) describe cognitive symptoms as a person's mind going blank or racing, reduced concentration and memory, indecisiveness, confusion and vivid dreams. As a result this would impact not only day to day living but classroom learning, behaviour and assessment.

Anxiety may cause an adolescent to behave differently. For example, avoidance of situations, compulsive or obsessive behaviour, social situations become stressful, disturbed sleep and increased alcohol or drug use. These maladaptive behaviours can lead to isolation, loneliness and secondary health issues.

Anxiety affects the social aspects of an adolescent's life. An adolescent may avoid situations that make them feel anxious such as travelling on public transport, going to school and meeting new people (Reachout, 2022b). As a result, school performance and friendship circles can be negatively impacted. For people who are unfamiliar with symptoms of anxiety, they may seem strange and as a result some behaviours may cause school disciplinary action or stigmatising attitudes from others. These consequences are not helpful to a young person with anxiety.

The most widely used method of assessing anxiety in adolescence is self-report instruments (Wicks-Nelson & Israel, 2015). A guidance officer can administer the Achenbach System of Empirically Based Assessment to assess competencies, strengths, adaptive functioning, behavioural, emotional and social problems (Achenbach System of Empirically Based Assessment, 2022). This data could then be forwarded to mental health professionals to be used to better understand and diagnose disorders. Severe cases require clinical interviews and direct observations by mental health doctors.

Impact on the Individual and Interactions

An adolescent can find it difficult to control the worry and to keep worrisome thoughts from hindering everyday tasks (APA, 2013a). This can have impacts on their home, school and peer interactions. The home environment could be the first place that anxiety symptoms are noticed. At home a teen may:

- complain about physical symptoms to avoid going to school
- be tearful in the morning not wanting to attend school
- express concern that homework is never done well enough

- want continual reassurance from parents
- be irritable or touchy when interacting with parents
- spend lots of time getting ready for social occasions to decide at the last minute not to attend

These impacts at home can cause conflict within family relationships and worry for parents.

Impacts within the school environment have implications for an anxious adolescent. Here Kelly et al. (2017) describes that an anxious young person may:

- be shy, well-behaved and fearful of asking questions
- require extra teacher time and need a great deal of reassurance
- failure to hand in work and assessment due to perfectionism
- complain of a sudden onset of headaches or stomach ache if required to do oral presentations or exams

All these descriptions impact school achievement and school attendance.

Adolescents value their friendships and the connection it brings. However, Kelly et al. (2017) explains that peers of a young person with anxiety may witness them:

- only spending time with a few close friends and avoid socialising in groups
- using alcohol or drugs at parties to make it easier to mix
- leaving social occasions early
- not speaking up due to embarrassment

All these presentations make it hard for the young person to be assertive and thus they may get taken advantage of or go along with risk-taking behaviour suggested by peers. With all these impacts on the individual, symptoms would start to be noticed and communicated to support networks such as doctors and school counsellors. One support strategy that could be implemented will be discussed below.

Suggested Intervention

The first-option in the treatment for adolescent anxiety is psychotherapy (Garcia & O'Neil, 2021). One type of psychotherapy is cognitive-behavioural treatment (CBT). Some of the CBT therapeutic strategies have been proven successful in treating anxiety disorders (Wicks-Nelson & Israel, 2015). CBT strategies would be useful for a guidance officer to teach an anxious student.

Developing an Individual Support Plan (ISP) would be a priority task for a Guidance Officer working with a student with anxiety. This plan is jointly constructed with the student and parents. It would be

documented as a support provision for the student. The ISP could contain goals and strategies based around cognitive-behavioural skills suggested by Lusk and Melnyk (2013). These are:

- self-awareness – identifying the thoughts, behaviours and feelings when anxious
- self-esteem and positive self-talk
- goal setting and problem-solving strategies
- stress and coping
- emotional and behavioural regulation
- effective communication, personality and communication styles
- barriers to achieving goals
- healthy lifestyle plan – food groups, physical activity, influences of feelings on eating
- identifying people and places that are emotionally supportive when in crisis
- identifying professional help outside of school who can help such as Kids Helpline, Beyond Blue and Headspace

The student would select a small manageable set of goals and strategies to implement and at the next ISP review session new goals would be set. The Guidance Officer would case manage the ISP prioritising regular check-ins with the student, parents and relevant outside agencies (General Practitioner, mental health professionals and social workers) to keep up with progress and current states.

15.

ADOLESCENCE

Liam Callaghan

Adolescence

Adolescence is the time of great development between childhood and adulthood (Call et al., 2002). Although the World Health Organisation describes adolescence as being between ten and nineteen years old, many agree that adolescent development continues in to the mid-twenties (Arnett, 2000; World Health Organisation, 2021a). The proportion and number of adolescents present in each country differs due to cultural demographics (Petersen et al., 1992). Globally however, the proportion of adolescents is rising as young people are provided more time and opportunity to develop skills necessary to perform their new adult role in industrialised society (Patton, 2018). Children must adaptively progress through a number of physical, psychological and social changes during this maturation process (Call et al., 2002). Those who are not able to adaptively navigate these changes are at higher risk of developing mental health problems (World Health Organisation, 2021a).

Anxiety

Anxiety is the most common mental heath issue in Australia and it is seen in many forms (Beyond Blue, 2022a). People with a generalised anxiety disorder suffer from a persistent sense of worry across most situations (Beyond Blue, 2002b). This has a great impact on daily life as there is no specific source or trigger for this form of anxiety (Beyond Blue, 2022a). As small issues which are encountered in safe environments can become the focus of anxiety, greater issues in larger contexts can become even more overwhelming (Beyond Blue, 2022a). Within the context of adolescence, anxiety disorders can affect normal daily functioning in a number of ways. Commonly identifiable symptoms include irritability, tiredness, restlessness, tension and difficulty sleeping and concentrating (Beyond Blue, 2022a). These physical symptoms make it difficult for adolescents to perform in a number of settings, affecting their ability to work, study and socialise (Beyond Blue, 2022a). This increases the likelihood of school avoidance which can make the situation worse (Carsley et al., 2017). As individuation is a social process, anxiety disorders can therefore have a negative effect on adolescent development.

Anxiety can also surface in a number of other presentations. People may have specific phobias which affect their ability to perform in specific situations (Beyond Blue, 2022a). Social anxiety is also common,

where people have an intense fear of negative social consequences (Beyond Blue, 2022b). Anxiety can also physically materialise in the form of panic attacks (Beyond Blue, 2022a).

Evidence of Symptoms

A number of cognitive, behavioural and social factors are implicated in the development and continuance of a generalised anxiety disorder (Hazlett-Stevens, 2008). The underlining view held by those with a generalised anxiety orders is that the world is dangerous and that they do not have the physical, social or emotional skills necessary to adaptively navigate it (Hazlett-Stevens, 2008). Worrying then becomes the primary strategy used to cope with an increased sense of threat (Hazlett-Stevens, 2008). People with underdeveloped emotional regulatory skills therefore avoid situations that cause an increased sense of worry (Hazlett-Stevens, 2008). As perceived threats are catastrophised, those suffering from a generalised anxiety disorder can live in a state of hypervigilance (Hazlett-Stevens, 2008). If not corrected this hypervigilance contributes to the development of muscle tension, restlessness, fatigue, irritability, sleep disturbances and difficulties concentrating (Nutt et al., 2002). When the aforementioned symptoms are experienced for a significant period or time or cause functional impairment a generalised anxiety disorder is diagnosed (Nutt et al., 2002).

As brain size and function improves markedly during adolescence, so does the adolescent's ability to think critically and abstractly (Steinberg, 2005). This increase in cognitive ability is necessary for individuation, as the adolescent must self-construct an individual identity necessary to assume a role in adult society (Steinberg, 2005). Adolescents that do not meet cognitive milestones in line with their peers may therefore experience stress (Luna et al., 2004). Adolescents that do not possess the cognitive and social skills necessary to address this stress may develop avoidance strategies (Hazlett-Stevens, 2008). Although stress avoidant strategies may reduce the immediate stress experienced by the adolescent, social withdrawal can consolidate social dysfunctional and reduce the opportunity for the adolescent to build protective cognitive, social and behavioural skills (Steinberg, 2005).

Impact on the Individual and Interactions

Generalised anxiety disorders are chronic and prevalent (Wittchen & Hoyer, 2001). Individuals who suffer from a generalised anxiety disorder are very likely to develop other functional impairments on top of their social dysfunction (Wittchen & Hoyer, 2001). For example, adolescents that are diagnosed with a generalised anxiety disorder are up to five times more likely to develop a drug or alcohol abuse problem (Stewart & Conrod, 2007). In addition to negative health outcomes, adolescent anxiety is also associated with poor peer and family relationships (Bögels & Brechman-Toussaint, 2006; Vernberg et al.,1992).

Anxiety disorders are also associated with an early school dropout (Van Ameringen et al., 2003). One study investigating the reasons for students leaving school prematurely determined that anxiety was the primary

concern for twenty-four percent of students (Van Ameringen et al., 2003). It was also determined that those adolescents who left school prematurely were more likely to have a life time diagnosis of anxiety and likely to develop extra maladaptive coping strategies such as alcohol and drug abuse.

On a societal level, workers with anxiety disorders often exhibit reduced performance levels and are more prone to accidents (Haslam et al., 2005). Also, as there is a stigma attached to mental health disorders, workers are less likely to disclose their condition which reduces their ability to seek help and increases the likelihood company performance levels reducing (Haslam et al., 2005).

Suggested Interventions

There are a number of different intervention strategies that can be implemented to address generalised anxiety disorders. A variety of drug therapies have been determined effective and may be appropriate depending on an individual's specific context (Fisher, 2006). Applied relaxation, cognitive therapy and cognitive behaviour therapies however have been identified as the most effective treatment options for generalised anxiety disorder (Fisher, 2006).

Within the school context Guidance Officers should focus on developing relaxation strategies with students with anxiety so that they have the skills necessary to self-regulate and continue social engagement (Jerath et al., 2015). Specific breathing techniques, grounding strategies and mindfulness activities can assist adolescents to refocus and self-regulate (Jerath et al., 2015). Guidance Officers should also co-develop an action plan with anxious adolescents that builds upon their protective strengths and mitigates risk factors. Anxious adolescents should be supported in approaching previously anxiety inducing situations in a manner that restories anxiety induced narratives (Jonas et al. 2014).

As generalised anxiety disorders increase the likelihood of further functional impairments, early identification and treatment is vital for community health (Wittchen & Hoyer, 2001). Due to this Guidance Officers should advocate for, develop and implement preventative measures within their school contexts (Seligman et al., 1999).

PART II

AUTISM SPECTRUM DISORDERS (ASD)

16.

MIDDLE CHILDHOOD

Susan Wilkinson

Middle Childhood

Middle childhood is the period between early childhood and adolescence, the approximate age range of six to twelve years old, but dependent on the onset of puberty and adolescence. This coincides with the primary school phase of education. In this time the child begins to distance from the family physically and emotionally and establish important relationships with peers and other adults outside of the family unit (Slentz & Krogh, 2001). Children are faced with the challenges of navigating the complexities of school life such as the structured environment of academic learning, classroom/school processes, relationships and increasing independence (Slentz & Krogh, 2001). Peer relationships become more important to the child and necessitate more sophisticated social skills (Slentz & Krogh, 2001). Externalised and internalised behaviours may develop or become problematic in nature (Carr, 2015). Normal cognitive development is a critical factor in all these areas, thus children with executive dysfunction may potentially become increasingly challenged during the middle childhood phase (Carr, 2015).

Autism Spectrum Disorder

Autism Spectrum Disorder (ASD) is described in the American Psychiatric Association's (2013b) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) as a condition in which the individual exhibits multiple deficits in the two core domains of social communication and restricted, repetitive sensory-motor behaviour (Lord et al., 2018; Sharma et al., 2018). It is a broad category which has drawn together developmental disorders with significant differences in presentation and severity of symptomology into one diagnostic grouping that is identified as a spectrum (Sharma et al., 2018). The onset of these traits is in the early developmental phase; however, the behavioural characteristics may not be identified until the child enters the school environment and has difficulty managing the routine changes and peer relationships (Volkmar et al., 2014). The child may exhibit behaviours such as restricted, repetitive body movements or interests, deficits in social interaction including lack of eye contact, little variation in facial expression or inability to engage in reciprocal conversation, an inability to recognise another person's emotions, high anxiety levels and inability to cope with change (Sharma et al., 2018). This list is not definitive, but some of the common and recognisable behaviours. Woodbury-Smith and Scherer (2018) identified a prevalence rate for autism as 1% of the population, with a high rate of co-occurrence for other neurodevelopmental and psychiatric disorders. Males are four times more likely to be diagnosed

with ASD than females (Woodbury-Smith & Scherer, 2018). While there are biological alterations to brain development and neurological organisation, the diagnosis of ASD is made based on exhibited social and sensory-motor behaviours (Lord et al., 2018).

Evidence of Symptoms

ASD presents through a variety of cognitive, behavioural and social symptoms with varying degrees of severity and impact on the ability to function. While these symptoms are typically identified in early development, it is possible for some children to progress normally, and then display signs of regression such as in Rett syndrome (Volkmar et al., 2014). Cognitive symptoms have a significant impact on the skills of the child in social communication and social interactions. The executive functioning of the brain is impaired, resulting in a child having difficulty with multi-tasking type behaviours, such as ability to listen to the teacher and complete a task (Volkmar et al., 2014). This impairment impacts on the ability to engage in theory of mind, thus an ASD child will demonstrate a lack of empathy and inability to recognise another's perspective, and may exhibit inappropriate emotional responses (Volkmar et al., 2014). A child with ASD can display skill deficits and/or a lack of interest in establishing relationships with peers and engaging in social play. They have difficulties adjusting to different social contexts, do not understand imaginative play or the skills associated with friendship (Lord et al., 2018; Volkmar et al., 2014). The child may have a very limited understanding and use of non-verbal communication skills, with limited or no eye contact, restricted facial expressions and unusual body posture (Sharma et al., 2018).

In 50% of ASD diagnoses, there is an associative diagnosis of intellectual disability (Woodbury-Smith & Scherer, 2018). Language development delays are a common symptom of ASD, with some children being mute (Sharma et al., 2018). Poor expressive language is also common, with children having difficulty initiating or sustaining conversation, and/or with repetitive language patterns evident (Volkmar et al., 2014). Children with the ASD subtype previously referred to as Asperger's Disorder may present with exceptional language skills for their age; however, it is often very formal and pedantic in its structure, with the child highly focused on favoured topics (Volkmar et al., 2014). Gross motor skills are often poorly developed (Carr, 2015).

Repetitive body movements or activity (such as lining up toys, fiddling with an object) which can also serve as self-stimulating behaviours are a typical pattern of behaviour (Lord et al., 2018; Sharma et al., 2018). Inflexibility in routines, transitions and difficulty coping with change can lead to tantrums, tics and displays of aggression or withdrawal (Lord et al., 2018; Sharma et al., 2018). Children may experience atypical reactions to sensory stimulus in the environment, such as intolerance of sounds or textures in food or clothes, inability to experience pain or identify temperature changes (Lord et al., 2018).

Assessment of a child presenting with ASD type behaviours would involve discussions with the parents and teaching staff working with the child to identify if the child has symptoms typical of ASD and gain some background knowledge. The Autism Spectrum Rating Scale (ASRS; Goldstein & Naglieri, 2010;

Department of Education, 2021) would be an appropriate assessment administered by the ASRS trained school Guidance Officer, under the direct supervision of the Senior Guidance Officer to collate relevant information for ASD to present to the treating paediatrician for diagnosis. This instrument was reviewed by Goldstein and Naglieri (2011) for effectiveness in identifying ASD in children between the ages of 2 and 18 according to the DSM-5, with the reliability and validity of the ASRS scores verified as accurately distinguishing ASD cases from other neuropsychological disorders and the general population. This test is administered to teachers and parents, providing a holistic perspective of the child's symptoms.

Impact on the Individual and Interactions

The impact of ASD is dependent on the type and level of social, behavioural and cognitive dysfunction experienced by the child, their position on the autism spectrum. For children on the acute end of the spectrum, who may have severe cognitive impairment, there is a requirement for highly specialised fulltime care to assist them in everyday living. For the individual there will be a level of frustration resulting from their inability to be independent, a substantial emotional and economic burden on the family as carers and significant cost to the community in supporting the child physically and educationally (Lord et al., 2018). At the other end of the spectrum is the high functioning child with ASD who can learn the skills and rules of social interactions through interventions and observation of other children to participate competently and completely in all educational and social settings with minimal to no support. Along the continuum between these two extremes are most children with ASD who exhibit a range of behaviours that will impact on themselves and those around them. An ASD child may have difficulty coping with new and changing environments, such as school and childcare as it involves dealing with large numbers of adults and children who have patterns of behaviour with which they are not familiar and are highly variable. This experience can create anxiety, which may lead to an increase in self-stimulating, repetitive behaviours or they may act out with aggression, tantrums or withdraw (Smith & Iadarola, 2015). High levels of anxiety are common in the ASD child, however the rates of anxiety and depression in ASD teenagers increase significantly (Volkmar et al., 2014). Engagement in peer relationships can be hindered by the child's social deficits, language delay and their own preference for solitude (Sharma et al., 2018). In the school setting, the child's peers may find it difficult to relate to the child and be hesitant to engage due to the unpredictability of their behaviours. For the family there is significant stress associated with managing the child's behaviours daily and securing the child's future on a long-term basis. Identifying appropriate interventions that will help the child can create financial burden on the family (Smith & Iadarola, 2015).

Suggested Interventions

Research suggests early intervention for an ASD child provides the most successful outcomes, particularly for behavioural interventions (Volkmar et al., 2014). In the circumstance that a child is unable to engage due to maladaptive behaviours, it will be necessary to complete a Functional Behaviour Analysis (FBA) to

identify triggers, the purpose of the behaviours and a plan to modify them to be more socially appropriate. Intervention for an ASD child will be multifaceted, dependent on the child's identified strengths and vulnerabilities, which will be identified through the paediatric assessment and the ASRS. This will guide the involvement of external support agencies and inform the Individual Support Plan (ISP) developed in the school. The ISP provides school staff with information specific to the needs of the child and details the goals and strategies to support the child's development, in the areas of verbal and non-verbal communication, social and motor skills, academic and behaviour capabilities (Volkmar et al., 2014). The plan is constructed with the parents and inclusive of external services working with the child to ensure there is consistency and compatibility for the child in the language, and strategies used by all adults. Establishing a productive relationship with the parents is crucial and aided through regular reviews of the ISP to ensure it is meeting the changing needs of the child.

17.

ADOLESCENCE

Megan Hunt

Adolescence

Adolescence is the period of life between childhood and adulthood when individuals must learn skills to become independent, autonomous, and mature (Geldard et al.,2019). During this time, several cognitive and physiological changes to the body have a significant impact on development, with key areas being cognition, behaviour, and social engagement in several contexts.

Typically, adolescents undertake an individuation process in which they move away from their family unit toward their peers. This can present inconsistency between the various environments adolescents belong to, as expectations and behaviours differ between the home, school, and social settings. Bronfenbrenner's Ecological Systems Theory (1979) recognises the interactions between individuals and these various systems that may increase stress (risk factors) or decrease stress (protective factors).

Autism Spectrum Disorder

Autism Spectrum Disorder (ASD) is categorised by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013b) as a deficit in social communication, and demonstration of restricted, repetitive and/or sensory behaviours or interests. This diagnosis adds a greater level of complexity for adolescents over their neurotypical peers as they navigate cognitive, behavioural, social, and environmental challenges.

While all individuals diagnosed with ASD share core characteristics, these symptoms are manifested in a vast array of severity from low-level high functioning to more acute effects resulting in high dependence on parents and carers. This gamut of attributes is reflected in cognitive functioning, with intellect varying from superior results on conventional IQ tests, to some intellectual impairments requiring highly individualised support and interventions (Phetrasuwan et al., 2009). An ASD diagnosis can be made as early as 18-24 months, with males demonstrating higher prevalence rates. In addition to this, social determinants include demographic, racial and socioeconomic considerations (Zeidan et al., 2022). According to Van 't Hof et al. (2020), the mean age of an ASD diagnosis is 60.48 months (approximately five years of age), with a range of 30.9-234.57 months. This indicates that most ASD adolescents have been diagnosed earlier in life, with opportunities to develop skills for socialisation. Despite this, adolescents with

ASD have a greater likelihood of mental health condition comorbidity. Zaboski and Storch (2018) state that anxiety appears in 40% of ASD cases, consequently adding strain to family relationships and increasing parental stress.

Evidence of Symptoms

Common symptoms of adolescents with ASD include rigidity to change in routines, restricted interests, hypo or hyper-reactivity to sensory input, language, and communication difficulties, eating pathology, restricted and repetitive behaviours, including narrow interests (Gal & Yirmiya, 2021).

Adolescents naturally move away from their families and toward their peers during a process of individuation (Geldard et al., 2019). For young people with ASD, this process may be difficult due to a lack of social awareness and ability to communicate with others. Social communication is one of the most pervasive barriers for individuals with ASD, due to their perceptions of difficulties communicating, challenging feelings about their communication experiences, and their perspectives about the support required for developing communication skills (Kelly et al., 2018). Kelly et al. (2018) further report that adolescents with ASD are at increased risk of social isolation, depression, and developing a positive social identity.

Socially, ASD individuals may find it difficult to assimilate with their peers due to unique interests and abilities. Furthermore, interactions may have little meaning to others as conversations are often narrow, with a lack of awareness of how these topics are being received. These experiences contribute to a lack of ability to assimilate, and in some cases attract negative attention from their peers resulting in a higher risk of bullying victimisation (Chou et al., 2020).

Research has demonstrated a link between ASD adolescents and aggression, resulting in increased severity of social anxiety and behavioural consequences, specifically in a school setting. Ambler et al. (2015) reported that adolescents are more likely to be suspended from school than their typically developing peers, due to their reactive anger and lack of self-control and regulation strategies. Bronsard et al. (2010) further researched aggression by ASD adolescents in different environments as reported by parents, caregivers, and mental health professionals. They stated that in stressful situations, ASD individuals were more likely to release their anxiety through a wide range of aggressive behaviours, including slapping, pinching, throwing objects, and pitching into others with their heads. It was noted, however, that the role of the environment impacts the degree to which these behaviours are displayed, as individuals can modulate their behaviour according to the expectations and structure of the environment. This study highlights the impact of supportive environments for individuals with ASD, as well as the relationships built by regular interactions which determine consistent observations, data collection and anecdotal information used for intervention.

Impact on the the Individual and Interactions

Due to difficulties in socialisation, individuals with ASD may struggle with friendships. Bernardin et al. (2021) report the detrimental effects of ASD adolescents who 'camouflage' to fit in by hiding their autistic traits. This practice has been found particularly true for ASD females, with mental health links to depression, anxiety, and stress. Adolescents with ASD reportedly spend less time socialising with peers, have smaller peer groups and are less likely to have reciprocal friendships as compared to their neurotypical counterparts (Dean et al., 2020).

Poor communication and socialisation may impact an ASD adolescent's ability to access individual milestones such as getting a part-time job or learning to drive. Activities such as these are contributors to the individuation process in which young people move toward adulthood. ASD adolescents may demonstrate a similar deficit of adaptive behaviours to those with an Intellectual Disability (ID), resulting in a variance in daily living skills. This is supported by Baker et al. (2021) who report that both ASD and ID individuals have an increased likelihood of demonstrating externalising problem behaviour.

For families, raising ASD adolescents can be challenging, in some cases affecting parents' mental health and parenting experience. Schiltz et al. (2017) studied the impact on these families, stating that there is a correlation between challenging ASD adolescent behaviours and parental stress. Guidotti et al. (2020) further report that siblings of ASD adolescents may have strong psychological and emotional impacts, with negative emotions evident due to annoyance, shame, and embarrassment.

Suggested Interventions

Supporting ASD adolescents' social development is integral to their successful integration into school and the wider community. Within a school setting, there are several support staff who work together to ensure that ASD students are given opportunities to succeed, including Special Education Teachers, Classroom Teachers, School Chaplains, and Guidance Officers. Ensuring all support staff are working together to provide adjustments and opportunities for ASD adolescents is integral to their success at school.

Research suggests that the inclusion of individuals with ASD in general education is most beneficial, particularly in social skill interventions. Dean et al. (2020) uncovered that social skill lessons that incorporate typically developing peers are more effective than groups of only ASD individuals due to peer mentoring, with joint engagement decreasing the levels of solitary engagement. Providing a range of extra-curricular interest groups to enhance social engagement is also a support strategy that Guidance Counsellors may use to increase inclusive socialisation.

Meeting the needs of each ASD student can be complicated, due to the complexities and variance of this mental health condition. One way to ensure individualised support is to complete a Functional Behavioural Assessment (FBA), accessible through the Autism Hub (Queensland Government, 2022).

This tool is designed to assist educators to understand behaviour and effectively respond to prevent frequent minor behaviours.

There is a range of reasons students with ASD may behave in a particular way, such as attempting to escape or avoid stimulation, sensation, items or activities, as well as obtain stimulation, sensation, items, or activities. When the function of the behaviour is understood, support can be put into place to meet the need of that student in a more desirable and socially acceptable way. FBAs often inform Individual Support Plans (ISPs) for ASD students by highlighting strengths and challenges in a school environment. ISPs are used as a formal reference for all stakeholders, endorsed by parents, of all the supports in place to enable full participation by that student.

It is the role of all educational stakeholders to make reasonable adjustments for students. The *Disability Standards for Education* (2005) states that all students with disabilities have the right to be treated on the same basis as students without disabilities. Ensuring that ASD students have access to tools and resources to support their learning, including the use of digital technologies, is an example of a reasonable adjustment. Frameworks such as Universal Design for Learning (CAST, 2021) demonstrate pedagogy that supports access to the curriculum in highly individualised ways, without singling out individual students due to academic or social abilities.

18.

MIDDLE CHILDHOOD

Jillian Stansfield

Middle Childhood

Middle Childhood (6 to 12 years of age) are the first years of formal schooling. For some children it is a time for particular vulnerability due to a number of factors as they develop socially, culturally, cognitively, emotionally and physically (Charlesworth et al., 2011). Examples of development in this population include developing fine and gross motor skills advance (physical); ability to solve problems using logical strategies (cognitive); viewing themselves as belonging to a category (cultural); identify and articulate emotions (emotional); develop peer groups (social) (Charlesworth et al., 2011). However, there are numerous challenges children may experience during middle childhood that can affect their development socially, culturally, cognitively, emotionally and physically. These include family conflict, poverty, chronic health problems, family violence, disability, and diagnoses that were not identified in early childhood (Charlesworth et al., 2011). In addition, challenges from early childhood such as poor birth weight may affect a child's development in later years, particularly if issues are not identified prior to beginning school (Charlesworth et al., 2011).

Autism Spectrum Disorder

Teachers are a key person in these children's lives so it is not unexpected that they are often the ones who identify issues with a student's development whether it is cognitive or behavioural. Teachers work with children with different abilities and have also studied child development, which is why if an issue is not picked up in early childhood, it will often be identified when formal schooling begins, which is sometimes as early as four years of age in the preparatory year. One condition that is often overlooked, particularly for girls, is autism spectrum disorder (ASD), with more males identified in the earlier stages of childhood (Hull et al., 2020). Children who are diagnosed with an autism spectrum disorder have deficits in key areas of social communication and interaction and restricted, repetitive behaviours (Geldard et al., 2019). The *Diagnostical and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013b) is the main guide that health professionals such as paediatricians, psychologists and psychiatrists use for determining whether a person presenting with a specific cluster of autism traits meets the ASD criteria. As there is no definitive biological test for determining autism, a process is followed that involves a number of tests and observations by multiple stakeholders, such as parents, teachers, speech therapists and occupational therapists, to assist medical professionals with making a diagnosis (Stansfield, 2020). A diagnosis of ASD is now assigned a

severity specifier of level 1, 2 or 3, depending on the support required; however, this does not align with the severity of social communication difficulties or repetitive behaviours but to the amount of support an individual requires (APA, 2013b).

There are many autism assessment tools available to clinicians, which is why Australian guidelines were developed to improve consistency of the diagnostic process of ASD in Australia (Whitehouse et al., 2018). The journey to a diagnosis involves a holistic process and at the middle childhood level where children are in their first formal years of school, teachers, Guidance Officers and other school staff are an integral part of the diagnostic process (Stansfield, 2020).

Evidence of Symptoms

Due to pathologising traits and stigmatism, today's knowledge and understanding of autism is still in its infancy and appears some way off from understanding and acceptance of this different way of thinking (Stansfield, 2020). As there is no definitive biological test for determining autism, a process is followed that involves a number of tests and observations by multiple stakeholders, including guidance officers, parents, teachers, speech therapists and occupational therapists, to assist medical professionals with making an accurate diagnosis (Stansfield, 2020). It is common for individuals diagnosed with ASD to also have one or more co-morbidities such as anxiety and depression, which may add complexities to the diagnostic proccess (Geldard et al., 2019).

Prior to a diagnosis, it is a common occurrence for a teacher in the lower primary school years who realises when they need to have potentially a difficult conversation with the parent about their child when they observe known autism traits (Stansfield, 2020). The teacher would have observed the student during classtime and play time and noted that the student's development is different to their peers. There are numerous checklists available that may assist teachers in documenting behaviours in class. Table 1 displays the common traits of autism that may be observed in lower primary school in the target population. A child will not have all of the traits but these are traits that may identify the need for a referral.

Table 1

Common observable traits of autism in 6 -12 year old children at school

Traits	
Behavioural	Social communication
Narrow interests, focused on one subject, which may change over time	Difficulty taking turns in a conversation or may dominate a conversation
Thrives on routine	Focus on one subject of interest
Sensory issues	Miss social cues
Unusual vocal noises e.g. echolalia	Prefer to hang around adults or one child
Unique walking patterns e.g. tiptoeing	Rigid with following rules
School refusal due to anxiety and/or overwhelm	Difficulty with eye contact
Poor sleep patterns	Limited facial expression
	Limited spatial awareness

Note. Adapted from The Spectrum (2022)

The cluster of deficit-based traits for ASD identified in the DSM-5 are oriented toward males (Ranson & Byrne, 2014), leaving girls undiagnosed or misdiagnosed when their collective autistic traits are misinterpreted and categorised under a mental illness rather than autism (Carpenter et al., 2019). Table 2 displays traits from personal and lived experiences, rather than formal diagnostic tools such as the DSM-5 manual (Craft, 2012; The Little Black Duck, 2018; Marshall, 2013; Hayden, 2020). Many of these traits in Table 2, males can also exhibit.

Table 2

Autism traits pertaining to female students

Trait	Notes/examples
Narrow interests (Behavioural)	Animals, dolls, celebrities
Meltdowns (Behavioural)	Happen more often at home, after school
High intelligence (Cognitive)	Capability may not be evident even though a high IQ
Intense emotions (Cognitive)	Can stem from hypersensitivity and negative emotions
Rituals and routines (Behavioural)	Prefer predictability
Anxiety (Behavioural)	Often a trigger for meltdowns
Masking (Behavioural)	To assist in fitting in friendship groups
Sensory issues (Behavioural)	Bright lights, noisy classrooms and hallways
Friendships (Social communication)	Difficulty understanding social rules

It is imperative for teachers, particularly in lower primary school to have up to date professional

development on autism and its presenting traits to fast-track the referral process for an earlier diagnosis (Stansfield, 2020). An earlier diagnosis means earlier intervention leading to better student outcomes.

Impact on the Individual and Interactions

There are a number of ways that autism impact a young student's daily life. These include and are not limited to anxiety, resistance to change, difficulty forming friends, transitioning between classrooms or tasks, and bullying (Autism Tasmania, 2022)

Anxiety and stress, particularly from academic, social and environmental factors, impact the school experiences of autistic children (Adams et al., 2019). This anxiety about school can lead to school refusal. Familiar environments are also preferred, which is why a predictable routine often found at school, is helpful when transitioning between classes and tasks (Autism Tasmania, 2022). Changes, particularly at short notice can increase anxiety leading to meltdowns (Stansfield, 2020). Playing independently either on one's own or parallel playing often means there is little opportunity to develop social skills to form friendships. Playing on one's own also increases the likelihood of being bullied, however, in lower primary school, this may not be noticed due to misunderstanding social cues (Stansfield, 2020).

Challenging behaviours and the added pressure on parents around a child's diagnosis contributes to higher rates of separation and divorce rates (Hartley et al., 2010). A study in the Unites States by Freedman et al. (2012) showed that autistic children are at higher risk of parents divorcing compared to their peers. The added stress of intervention and understanding a child who is 'different' does add a layer of stress to the parenting role.

Suggested Interventions

There are interventions that can take place both at school and externally to the school. When a Guidance Officer (GO) receives a referral and the student is suspected as having many autistic traits but does not have a diagnosis on file, reports from observations and testing can be used to assist the GO to decide on the appropriate testing tool to utilise dependent on the presenting behaviours. Although a GO cannot diagnose, their reporting is an important part of the autism diagnostic journey by gathering information for the paediatrician. These assessment results can also assist the teacher in the classroom for not only curriculum implementation but also how the learning will occur.

When a student already has an autism diagnosis, GOs can interpret the reports and assist teachers in implementing strategies suggested in reports such as an Occupational Therapy report. GOs can support the families and teacher by working through the assessment results, the report findings and choosing appropriate teaching and learning strategies for the autistic student. This may involve sitting in with

parents and teachers at Individual Education Plan (IEP) meetings and assisting with goal setting and interpretation of assessment results. This collaborative approach can be helpful for the follow up process.

Although the diagnostic process is deficit based to receive an ASD diagnosis, it is imperative that school staff such as the classroom and GO also take a strengths-based approach to the intervention (Stansfield, 2021). Teachers need ongoing PD on autism to understand how autistic students, particularly girls, present in the classroom and recognise the need for a referral so that these students receive support and intervention in the early years (Stansfield, 2020).

PART III

ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER (ADHD)

19.

MIDDLE CHILDHOOD

Angela Mitchell

Middle Childhood

Middle childhood has unique developmental challenges and difficulties. Whilst some variance in age ranges occurs in the literature, it is usually defined as between ages 6 to12. This coincides with the most significant change during the period, the attendance at primary school. This new environment offers a range of new learning experiences and social situations that are rewarding and challenging. Some key developmental challenges include requirements of being a participant in a rule-governed environment, and the increased cognitive changes with advanced academic rigour (Wicks-Nelson & Israel, 2015). In addition, an expanded social focus from parents to peers and teachers leads to greater self-awareness leading to self-perception and self-esteem concerns (Hutchison, 2008). Middle childhood difficulties are linked to social and academic challenges at school; the ability to apply coping strategies may determine adaptive or maladaptive pathways (Sotardi, 2017; Wilmshurst, 2014). Whilst there are many biopsychosocial difficulties that can occur throughout this period, in Australia, one mental health disorder is by far the most prevalent, attention-deficit hyperactivity disorder (ADHD; Goodsell et al., 2017).

Attention Deficit Hyperactivity Disorder

According to Gibbs (2021) 8.2% of all Australian school children have ADHD. Categorised as a neurological disorder and defined by inattention and/or hyperactivity, it is characterised by an inability to stay-on-task, clumsy or less precise motor skills and disorganisation; the effects are pervasive (APA, 2013c).

In schools, the inattention/disorganised facets of ADHD appear as the child appearing not to listen, being unorganised, often losing materials or being unprepared; the hyperactivity/impulsivity facets show as fidgeting, impatience, inability to sit still or stay seated and the intrusion into other people's activities or personal space (APA, 2013c). These deficits have impacts on cognitive, social, and emotional domains across the home and other environments.

In adulthood, symptom severity tends to decline, particularly regarding hyperactive/impulsive behaviours (Young et al., 2020); however, symptoms can still impair academic, social and occupational functioning (APA, 2013c).

Many students with ADHD also have a specific learning disorder; and it is frequently comorbid with

autism spectrum disorder and the externalising disorders of oppositional defiant disorder and conduct disorder (APA, 2013c).

Evidence of Symptoms

The DSM-5 outlines specific symptoms required for the diagnosis of ADHD across two subdomains: inattention and hyperactivity/impulsivity. Those under 17 years need to demonstrate at least six symptoms from each subdomain; for those over 17 years, five symptoms are required (APA, 2013c). Symptoms need to be present prior to age 12, exist across two or more settings, be limiting to social, academic or occupational functioning and must not be a result of another disorder or difficulty (APA, 2013c). Based on the number of symptoms, diagnosticians determine if the diagnosis meets standards for combined presentation, predominately inattentive presentation or predominately hyperactive/impulsive presentation; additionally, severity is judged as mild, moderate, severe or in partial remission (APA, 2013c).

ADHD symptoms and impairment varies by age, domain, and subdomain (Zoromski et al., 2015). Inattentive behaviours include difficulties sustaining attention, ignoring details, making careless errors and being easily distracted by extraneous stimuli (APA, 2013c). Often the child can appear as if they are not listening; they may not finish tasks or can avoid or are reluctant to participate in tasks that require sustained mental effort (APA, 2013c).

Students with ADHD perform poorly on measures of working memory, processing speed, inhibition and shifting (Moura et al., 2019). In addition, mild delays in language can often co-occur with ADHD, and individuals may exhibit cognitive difficulties on tests of attention, executive function or memory (APA, 2013c).

Hyperactivity and impulsivity behaviours are usually obvious. Talking incessantly, fidgeting, tapping feet, squirming, general on-the-go behaviour and reluctance or inability to engage in quiet leisure activities are all examples (APA, 2013; Carr, 2015), as is impatience, difficulty waiting in line, blurting out answers or completing people's sentences (APA, 2013c). These behaviours can often intrude on others; examples include butting in on conversations and taking things without permission (APA, 2013c).

There is no medical test for ADHD; it is diagnosed by observing behavioural symptoms. While some hypothesise that ADHD results from dysfunction in the pre-frontal-striatal circuitry resulting in deficits in executive function (Moura et al., 2019), to date, no biological marker is apparent (APA, 2013c). Current theories suggest that the aetiology of ADHD involves biological, environmental and cultural influences (Young et al., 2020).

In Australia, diagnosis is completed by a paediatrician, psychologist or child psychiatrist, and school staff are often required to assist in the collection and collation of data. Whilst their use should be only for data collection purposes, guidance officers can administer approved psychoeducational tests such as the Conners 3, a multi-informant assessment aligned to the ADHD DSM-5 criteria, which shows functioning

across settings and identifies specific challenge areas (Conners, 2008). Behaviour and functioning checklists such as the National Initiative for Children's Healthcare Quality (NICHQ) Vanderbilt Assessment Scales (NICHQ, 2002), can also be used, and functional behaviour assessments and observations can be conducted. The Wechsler Intelligence Scale for Children (WISC) provides information regarding cognitive strengths and weaknesses (Moura et al., 2019).

Reviewing existing school data and conducting interviews with parents and class teachers can determine academic levels, concerns, behaviours, and symptoms across different settings, it may provide a valuable medical history and will develop positive home/school connections. Parents with ADHD are more likely to have children with ADHD (Young et al., 2020). Employing a systems-based framework that considers personal maintaining and protective factors along with personal and contextual predisposing factors will ensure a thorough picture is gained (Carr, 2015).

Throughout these processes, teachers and guidance officers need to be aware of gender bias. Some evidence suggests that the ratio of male to female diagnoses is 2:1 (APA, 2013c), which is likely due to the lack of recognition of females' symptoms, and therefore referrals (Young et al., 2020). Whilst behavioural problems may be present in girls, they are less common. Social problems may be particularly impairing, emotional dysregulation and general impairments in intellectual function may be common (Young et al., 2020). Girls are more likely to present with primarily inattentive behaviours (APA, 2013c). In addition, compensatory and coping strategies may mask symptoms and result in a delayed or non-referral (Young et al., 2020).

Impact on the Individual and Interactions

Individuals with ADHD are significantly more likely to develop a conduct disorder in later years, potentially increasing the risk of substance abuse (APA, 2013c). ADHD is associated with reduced behavioural inhibition, constraint, and novelty-seeking behaviours, which may account for increased traffic accidents and violations.

ADHD also has an impact on other people in the student's life. Communication is a fundamental aspect of social participation and socially, ADHD influences the building and maintaining of relationships. Primary deficits of ADHD can cause impairments in social communication and ensures functional limitations of social participation (APA, 2013c). Hyperactivity and impulsivity behaviours are often disruptive. In research identifying teacher-reported symptoms most associated with impairment, 'often leaves seat' had the strongest link with impairment of relationships with peers and teachers (Zoromski et al., 2015).

The family domain is where the most significant impact on functioning occurs with17.3% of children reporting a severe impact within the family environment, including issues such as communication, planning within the family, conflict, and emotional and practical support levels (Goodsell et al., 2017). Whilst not causal, there is a strong relationship between the level of family functioning and the prevalence

of ADHD. In families where functioning is reported to be dysfunctional, more than one-fifth of children have ADHD (Lawrence et al., 2016).

ADHD attracts controversy in the community. Some believe that it is over-diagnosed, and Australia has become a 'medication nation'; others that diagnoses are the medicalisation of normal life and that the thresholds are too low (Price-Robertson, 2018). One Queensland study found that 78.3% of participants thought that too many children are diagnosed who do not have it (Price-Robertson, 2018). Regardless of opinion, the financial impact of ADHD is massive. The average health care cost per child with ADHD is $1170 per year; this incorporates the highest contribution per person of any mental health disorder to the Pharmaceutical Benefits Scheme for medication totalling $16.25 million a year (Le et al., 2021).

ADHD behaviours have a significant impact on the school environment. It is associated with reduced academic attainment and academic functioning, social rejection and elevated personal conflict; individuals with ADHD obtain less schooling and have poorer occupational achievement (APA, 2013c). Hyperactivity/impulsivity is a stronger predictor of classroom functioning at the pre-school level; however, this changes during MC, when inattention becomes a more significant and a stronger predictor of classroom functioning (Zoromski et al., 2015). In addition, ADHD students' difficulty in organising becomes a significant predictor of academic impairment (Zoromski et al., 2015).

Suggested Interventions

As with most educational support, early intervention is vital. Individual interventions should be based on the data collected for that individual, their presentation subdomain, and be evidence-based. Any individual support plan should be strengths based and individualised. The strengths possessed by students with ADHD can offer certain advantages, in a recent survey, 73% of teachers believe that the strongest strength of students with ADHD can be very knowledgeable on specific topics (Gibbs, 2021).

Whilst a majority of Australian teachers believe that they have knowledge of ADHD and can recognise children in their class with symptoms, they also believe that they are unsure or do not know how to support students with ADHD (Gibbs, 2021). Providing professional development on strategies to support teachers is an area in which A Guidance Officer (GO) could assist at a whole-school level.

Programs or interventions that are collaborative have been shown to be more effective (Carr, 2015). Collaborative Life Skills is a 12-week psychosocial program consisting of behaviour targets that could be introduced by a GO individually or in a small skills group, then supported in classroom interventions and parent training groups; terminology is reinforced across all settings and results have shown statistically and clinically significant improvements in the severity of organisational, academic, and social impairments (Pfiffner et al., 2016). Implementing a program like this could have benefits for the teacher, the parents, and the child.

20.

ADOLESCENCE

Bianca Hyslop

Adolescence

Adolescence is a key transition period in an individual's life. An estimated 2.93 million adolescents aged 15 to 19 lived in Australia in June 2021. This consisted of 761,029 thousand male, 720,644 female and 1,481,673 peoples. Together, young people aged 15 to19 made up 13% of the total population (Australian Bureau of Statistics [ABS], 2022b). While most people experience good health and wellbeing, approximately 26.4% of persons aged 16 to 24 reported having long-term mental disorders that have lasted for more than 12 months (ABS, 2008, 2022a). It is most commonly reported that mental and behavioural problems were mood and anxiety related with the onset occurring during childhood or adolescence. For example, the adolescent may experience frequent risk-taking behaviour, conflict with adults and mood disruption. All these stressors can impact self-identity, physical changes and maladaptive coping strategies into adulthood and as a result require long term intervention.

Attention Deficit Hyperactivity Disorder

Attention Deficity Hyperactivity Disorder (ADHD) is a disorder that is characterised by difficulty maintaining attention and impulsive and excessive activity (Geldard et al., 2020) which can persist throughout adolescence. ADHD is recognised as lacking persistence and moving frequently between activities and interferes on daily life. It is a chronic debilitating disorder which may impact upon academic outcomes, social skills problems and strained parent child relationships. Therefore, individuals continue to show significant symptoms of the disorder into adulthood. Children are at greater risk of longer-term negative effects such as lower educational outcomes and employment attainment. The core difficulties in executive function seen in ADHD may result in inappropriate functioning in adulthood, depending on the demands made on the individual by their environment. Research suggests that there is a propensity associated with ADHD that key stages occur during the development lifespan, which get increasingly more complex and manifest in severe disruptions if left untreated or undiagnosed (Kewley, 1999). Adolescents with ADHD can experience either/or both inattention, hyperactivity and impulsivity. When compared to their peers this often creates issues in motor skills, intelligence, executive function, adaptive, behaviours, social and family relationships.

Evidence of Symptoms

Diagnosis of ADHD prescribes that several symptoms must be present before the age of 12 and be ongoing for at least 6 months. This neurodevelopmental disturbance has lifelong implications therefore being listed in the *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013) as impacting cognitive, behavioural and social domains (Wicks-Nelson & Israel, 2015).

Adolescents experiencing ADHD have difficulties in executive function. Whereby, "planning, organisation, working memory, verbal regulation, inhibition of behaviour and motor control are impacted compared to their peers" (APA, 2013). During adolescence this may be observed by parents and teachers as laziness, disobedience and decreased academic results.

ADHD tends to typically appear during childhood into adolescence, whereby adolescents engage in behaviour more immature than their peers. Everyday skills may not be achievable, due to the general intelligence level of not being able to regulate goal directed behaviour. Ten to forty percent of teens with ADHD experience some form of anxiety characterised by excessive worry including panic attacks without the ability to control such. Sleep disturbance is also characterised as common in adolescents with ADHD, whereby normal sleep cycles may change, further impacting on daily functions (Children and Adults with Attention-Deficit/Hyperactivity Disorder [CHADD], 2022a).

Social difficulties occur when adolescents with ADHD show excessive activity, inappropriate talkativeness and interrupting others. The other is an aggressive negative style of social interaction displayed by physical and verbal aggression, rule breaking and hostile controlling behaviour. Also, inattention can be exhibited as being distracted, not listening with a tendency towards anxiety, shyness and withdrawal. During adolescence, ADHD may see the onset of risk-taking behaviour, substance abuse, mood changes and changes in peer groups.

Impact on the Individual and Interactions

Due to the characteristics of ADHD namely: Inattention, Hyperactivity and Impulsivity they have significant impacts on an adolescent. Adolescence is already a stage of considerable change and transition from childhood to adulthood. Therefore, a person experiencing the symptoms of ADHD may by more likely to have extreme presentations in already heightened behaviours and emotions. Individually it may present as emotional dysregulation such as unusual crying, extreme sadness and trouble sleeping. With peers' adolescents may seek out dangerous behaviours with the essence of impulsivity appearing as not holding back or being able to control behaviours that are dangerous. It is noted that during adolescence those with ADHD can experience conduct disorders in which careless and irresponsible getting in trouble with the law may start occurring. This then will have considerable impact on the family dynamic whereby altercations around expectations and responsibilities are not being met. Within the school setting it would be possible that teacher student relationships are strained due to the disruptive nature and expectation to

deliver content while a student is constantly moving or losing their equipment while disturbing others. Redirection might work during childhood but during adolescent it is known that students respect peer thoughts more than adults. Therefore, truancy and no attendance may start occurring for those repeatedly getting in trouble for what might be undiagnosed ADHD.

Suggested Interventions

Approximately 3 to 7% of school age children are likely to experience ADHD. Boys are more likely to be diagnosed displaying hyperactivity/impulsivity. Research suggests for some children the primary features of ADHD continue into adolescence, but to a lesser degree into adulthood (CHADD, 2022a). Therefore, high school Guidance Officers have a unique opportunity to deliver strategies and commence referrals for intervention to lessen the effects of this disorder in adulthood.

Due to the unique behavioural or outward presentation of ADHD, Guidance Officers could recommend observations of the student in and out of the classroom environment. Combined with the collation of current school behaviour reports, past academic achievement records, previous school reports and any medical reports or professional referrals and recommendations could assist in the case management of a student with suspected ADHD. Guidance Officers would work with school staff including various teachers, Deputy Principal and use feedback obtained from previous schools to benefit the student. This would be with the view to assess the frequency, severity and types of behaviours / incidents occurring for the student, in a way that it is impacting on their ability to maintain appropriate social emotional and cognitive levels. Therefore, suggested use of two psychometric testing could assist in developing a hypothesis and validation of indicators for a specific disorder.

Firstly, according to DSM-5 intelligence and achievement testing and consideration of medical and social factors should be used when looking into ADHD. The Department of Education (2021a) provides approved Restricted Psychoeducational Tests that may be administered by Guidance Officers. Therefore, the use of Wechsler Intelligence Scale for Children – Fifth Edition (Pearson, 2022) would determine the impacts and ability of Intelligence and cognition for the student. This test would be preferred over the Preschool Primary age Wechsler due to the age range it considers. Also, the examples of subtests are based more on cognitive models such as vocabulary, block design, digit span and coding. The full IQ scale score is determined through four index scores namely: Verbal Comprehension, Perceptual Reasoning, Working Memory and Processing Speed.

Secondly, the Guidance Officer could implement the National Institute for Children's Health Quality Vanderbilt Assessment Scale (VAS) (NICHQ, 2022) used for diagnosing ADHD. Both parent and teacher complete initial assessment scales consisting of 2 components: symptom assessment and impairment in performance. On both the parent and teacher initial scales, the symptom assessment screens, for symptoms that meet criteria for both inattentive and hyperactive ADHD. According to the DSM-5 criteria a certain ratio of results must be recorded within the symptoms scale. The second scale has a set of performance

measures that provide a scale weighting the problematic impairment and not just symptoms. Although the name of the test is diagnosis, in the role of guidance counsellor they are not diagnosing, rather gathering sufficient evidence to provide a referral for paediatric and/or psychological assessment of possible ADHD in this case. Collett et al. (2003) and Kratochvil et al. (2009) suggest the VAS is easy to complete and score, is psychometrically sound, useful for collecting data from multiple sources and assessing academic and behaviour performance.

Inventory screeners assists educators to refer on for further evaluation. It is suggested that gathering what has happened over time, whether it be a gradual drop or sudden drop in behaviour and/or cognition, a case conceptualisation provides the groundwork for further investigation. Gathering assessment administered by previous Guidance Officers, or making a phone call to fill in any gaps or questions the file may have with previous Guidance Officer could be prudent. Having a transitionary meeting, if for example the student was coming from primary to high school could be an opportunity to discuss OneSchool or relevant school support records, regarding the student. Using the specialists' tabs that have more information about students will also provide further information regarding referrals that have been completed to external agencies, for example Headspace or Child Youth Mental Health Service in the past. Having this knowledge means Guidance Officers can support the student where they are rather than starting the process over, possibly wasting time or bringing further and unnecessary distress to the family. Furthermore, meeting with the parent to discuss their next steps, noting what are the current medications that paediatricians prescribe could be beneficial to ongoing support. This will enable the Guidance Officer to work with staff to prepare and make adjustments to workload, assessment and environment, all of which contribute to daily provisions allowable to support adolescent with ADHD.

21.

ADOLESCENCE

Louise Marshall

Adolescence

Adolescents are faced with many challenges inclusive but not limited to; cognitive, emotional, behavioural and environmental changes; all of which have the potential to cause significant impact upon healthy and stable transition to adulthood. Risk and protective factors that occur within this developmental stage additionally have the potential to cause either positive or negative (or a combination of the two) upon the life of an adolescent. Teenage years are notably difficult to navigate. When an adolescent has the added challenges and complexities of a diagnosed mental health condition, this can be detrimental to their academic and social achievement, if not managed and supported in the correct manner with the appropriate strategies and support teams.

Attention Deficit Hyperactivity Disorder

Attention Deficit and Hyperactivity Disorder (ADHD) is a complex neuro-developmental disorder (ADHD Australia, 2019) which is typically diagnosed in childhood, however, it affects children, adolescents and adults alike. It is estimated that, in Australia, ADHD affects 281,200 children and adolescents (aged 0-19) and 533,300 adults, aged 20. ADHD is recognised as a diagnostic category within the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA 2013b). There are three different sub-type categories of ADHD – predominantly inattentive type, hyperactive-impulsive type and combined type which is a combination of the two aforementioned types of ADHD (Better Health, 2019). This case study will aim to provide an in-depth description of the disorder, discuss the assessment and diagnosis process for ADHD, and describe and analyse interventions and support based strategies within an educational context.

Evidence of Symptoms

As aforementioned, ADHD is neuro-developmental disorder and as such, has significant impact on a person's executive functioning and this can be detrimental in all aspects of a person's life, if not treated accordingly. Each different sub-type of the disorder can be characterised differently, however much of the research available suggests that ADHD can potentially lead to adverse life outcomes. Some of the following

maladaptive behaviours have been recognised in people with ADHD; poor peer relationships, strained parental relationships, impaired academic performance, substance misuse, reduced job performance and increased emotional difficulties (Caye et al, 2018.) The inattentive sub-type of ADHD is characterised by forgetfulness, disorganisation, and an inability to focus for extended periods – particularly if the focus is an unpreferred task. The hyperactive sub-type is defined by running, climbing or leaving a seat at inappropriate times during teaching, interrupting during conversations and additionally includes difficulties with sleeping. The combined type is the most prevalent form of the disorder and people diagnosed experience a variety of symptoms from both aforementioned sub-types of ADHD (ADHD Australia, 2019).

In order to receive a diagnosis, children must present with six symptoms from either or both categories and adolescents and adults over 17 are required to present with 5 symptoms. Experiencing such a multitude of symptoms has the potential to cause significant deficits in both personal and academic (or professional) environments and as such can have a detrimental effect on development and functioning. ADHD is considered to be one of the most prevalent developmental and behaviour disorders amongst children and adolescents. As such, it is therefore notable that there is no current medical test that contributes to the diagnosis of ADHD. The disorder is diagnosed based on data provided from trusted adults and professionals that have a thorough knowledge and understanding of the presenting behaviours and limitations of the symptomatic person. There are suggestions that these diagnostic criteria lack diagnostic utility owing to the fact that the diagnostic tests are considered checklists to be completed. (Biermann et al., 2014.) Additionally, it has been identified that clinical assessment relies profoundly on accounts of behaviour in multiple settings as indicators for the disorder (Alloway et al., 2010). The DSM-5 (APA, 2013b) is the manual used by clinicians to diagnose and classify mental disorders. ADHD is now listed as a category within 'Neuro-developmental Disorders' and is characterised by inattention, hyperactivity, and impulsivity that are pervasive and affect social, academic and occupational parts of an individual's life.

Impact on the Individual and Interactions

ADHD can potentially cause a lifelong negative impact, it is imperative that children are correctly and intensively tested to ensure that they receive the correct course of treatment in order to become successful members of society in the future. Undiagnosed or untreated ADHD has the potential to cause significant ramifications in both the life of the person with ADHD and those around them. ADHD is a developmental disorder that typically begins in childhood and therefore, if not treated appropriately or with the best individualised supports and strategies implemented during the correct time periods, the disorder could result in maladaptive, dangerous and reckless behaviours. Impaired executive functioning has the potential to adversely affect a child with ADHD within an educational setting. The inability to self-regulate emotions, the limited capacity to focus and organise (both internally and externally) would cause a person with ADHD to seem careless, forgetful and disinterested in the classroom. In fact, the aforementioned symptoms of the disorder would impede the students' ability to successfully engage with

the learning program without intervention-based support. Academic impairment has been identified as one of the most difficult domains of impairment for adolescents with ADHD (Campez et al., 2016.), this would in turn cause undue stress upon a person and potentially damage relationships and future educational or employment opportunities.

Suggested Interventions

Within an educational context, classroom rules and expectations, social cues and norms and the structure of the school day are all factors that a student with ADHD could find difficult to navigate, owing to the fact that the symptoms of the disorder are misaligned with these factors and their executive functioning is limited. Difficulties with attention span, impulse control and capacity to remain in a designated space would significantly impact with curriculum delivery and learning of others. (Barkley et al., 2008; DuPaul & Stoner, 2003) It is imperative that Guidance Officers and caregivers work collaboratively to ensure that consistency of approach is executed to support the assessment and diagnosis of a child with ADHD. In the aforementioned information, it is identified that the assessment process for ADHD defines that the behaviours of concern are required to be observed in multiple settings. Therefore, it is paramount that caregivers and Guidance Officers that are present within these settings can work on a collaborative level to provide a holistic and valid interpretation of the behaviours, in order to gain an accurate diagnosis and treatment can begin.

From a classroom-based perspective, there is a level of expected professional practice from teachers, which includes knowing their students and how they learn (AITSL, 2018). There are a number of evidence-based practices and teacher mediated instruction strategies, that can be facilitated by a Guidance Officer, including; strengths-based approaches to learning, chunking of work, adjustment of tasks, scaffolding, explicit teaching of the use of graphic organisers and visual schedules, checking for understanding and importantly, environmental manipulations. These strategies can be applied as whole-classroom strategies and supplement the learning of all students, however it is acknowledged that teachers may not have the capability or the capacity to deliver individualised content for students with ADHD who require behavioural consultation intervention. As such, some school staff members may possess insufficient time to deliver the interventions (Campez et al., 2016). It has been noted by some that cognitive treatment studies have not demonstrated any treatment advancements (Abikoff, 1991). However, a multimodal treatment approach combined with a collaborative, holistic team facilitated by the Guidance Officer, would seem to provide the most beneficial outcomes for students with ADHD, particularly when implemented during early intervention.

22.

ADOLESCENCE

Bronwyn Cuffe

Adolescence

In addition to the universal stressors of life, adolescents also face specific mental health challenges. The significant number of life transitions and changes in physical, emotional and social contexts that occur in this life stage, make adolescence a particularly vulnerable period for the development of mental health problems. The World Health Organisation (2021a) contends that globally, an estimated 14 percent of adolescents aged 10-19 have experienced a mental health condition such as anxiety, depression or behavioural disorders. Adolescents with mental health challenges have a more complex and difficult developmental pathway than neurotypical individuals (Kaplan, 2004) which complicates the already complex task of navigating adolescence.

Attention Deficit Hyperactivity Disorder

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013b) conceptualises Attention Deficit Hyperactivity Disorder (ADHD) as a neurodevelopmental disorder that has its onset in early childhood. ADHD is the most common childhood neurodevelopmental disorder and while the prevalence of ADHD is difficult to precisely determine, current research suggests that between 1 and 7% of school aged children have the disorder (Thapar & Cooper, 2016; APA, 2013b; Wicks-Nelson & Israel, 2015). ADHD affects males and females of all intelligence levels and from every socioeconomic and cultural background (APA, 2013b). ADHD is a multifaceted, heterogeneous disorder that has widespread, pervasive effects on an individual's functioning and development. The primary features of ADHD are inattention and hyperactivity-impulsivity and are thought to be present from two years of age and continue into adolescence and to a lesser degree into adulthood. Behavioural symptoms resulting from hyperactivity include fidgeting, constant movement, incessant talking, tapping, and frustration with boredom or sitting still. Symptoms of impulsivity can manifest in behaviours such as interrupting conversations, risk-taking and acting without thinking of the consequences (Wicks-Nelson & Israel, 2015).

Evidence of Symptoms

ADHD is visible in cognitive, behavioural and social symptoms during adolescence, however, the

presentation of ADHD symptoms can change in severity and type when individuals reach adolescence. According to DSM-5 (APA, 2013b) the cognitive deficits of adolescents with ADHD are exemplified by a lack of academic achievement and inattentive symptoms such as poor listening skills, disorganisation, inability to filter out external or unimportant stimuli, poor memory, difficulty focussing on or completing mundane tasks and making careless errors. According to Wicks-Nelson and Israel (2015), the secondary features of ADHD include motor incoordination, poor academic achievement, sleep issues, poor executive function, adaptive behaviour deficits, and negative social interactions and typically continue into adolescence and across an individual's lifespan. Hyperactivity can present differently in high school. Adolescents with ADHD may present with less hypermobility but more anxiety or an inability to relax (Kaplan, 2004).

Impact on the Individual and Interactions

The impact of ADHD on an adolescent's functioning and development is profound. The pervasive nature of ADHD has potentially long-term and far-reaching impacts on an individual's entire lifespan including their health, education, occupation and interaction with the criminal justice system (Wicks-Nelson & Israel, 2015). Adolescents with ADHD face many academic difficulties in high school and many fail to master the developmental tasks of emotional and behavioural autonomy (Geldard et al., 2019). Research has established the link between poor academic performance and ADHD. Approximately two-thirds of primary school-aged children with ADHD also have a learning disability or another coexisting disorder (Cantwell, 1994). Up to 30% of adolescents with ADHD have repeated a grade and 40% have special education programs in place. 30% fail to finish high school or go on to tertiary education (Barkley & Murphy, 2006).

The behavioural functioning of adolescents with ADHD is often the first indication they are not tracking along a neurotypical developmental pathway (Wicks-Nelson & Israel, 2015). An adolescent with ADHD will display some or all of the following behaviours; not listening when spoken to, difficulty paying attention and completing tasks, making careless errors, daydreaming, disorganisation and avoiding activities requiring sustained mental effort. Adolescents with ADHD may appear more immature, take more risks, suffer more physical injuries and negative behavioural consequences at school because they lack the self-regulation skills of their same age peers. Deficits in adaptive behaviour may become more evident throughout high school and failure to learn everyday skills such as organisation of belongings and time management is an indication of the impacts of ADHD on an individual's development and functioning (Werner & Smith, 2001).

Cognitively, adolescents with ADHD score an average of nine points lower than their same aged peers on tests of intelligence (Barkley & Murphy, 2006; Frazier et al., 2004). It is estimated that 25–35% will have a coexisting learning or language problem (Pliszka et al., 1999), and approximately 10% have been reported to have reading disabilities (Shaywitz & Shaywitz, 1991). Adolescents with ADHD also have approximately 30% less executive functioning skills than is considered normal. Ultimately, by late adolescence individuals

with ADHD will only develop 75-80% of the executive functioning capacity of their neurotypical peers. This reduced cognitive functioning manifests as poor memory and processing abilities and requires that adolescents with ADHD be supported to plan and complete tasks at school. Studies found significant differences in academic performance of children with and without ADHD, particularly in problem solving, recall of facts and performance on normative assessments such as NAPLAN. Children with ADHD-I or predominantly inattentive symptoms can be overlooked. Too often ADHD is associated with child hyperactivity only and inadequate consideration is given to inattentiveness, cognitive impairment and emotional dysregulation.

Physiologically, ADHD brains are anatomically and functionally different. Individuals with ADHD have been found to have a greater number of general health problems such as asthma, physical injuries and sleep issues (Wicks-Nelson & Israel, 2015) resulting in long-term societal impacts such as, increased risk of obesity, diabetes, heart disease as well as anxiety and depression. Impulsive behaviours and motor incoordination also place adolescents at greater risk of accidental injury and lead to conflict with parents and disruption to family relationships (Barkley & Murphy, 2006).

The social-emotional impacts of ADHD are pervasive. Although not all adolescents with ADHD have social-emotional problems, research suggests that at least half of them do. At school, adolescents with ADHD suffer higher rates of peer rejection, bullying and social isolation than their neurotypical peers. Intrusive, overbearing behaviours of interrupting, aggression, incessant talking and hypermobility can alienate their peers. Inattentive symptoms such as social withdrawal and failure to listen to others may also cause them to be left out or ostracised. As a result of their poor social functioning, adolescents with ADHD may suffer low self-esteem, and are at increased risk of developing internalising and externalising disorders such as anxiety, depression and Oppositional Defiance Disorder (Rucklidge & Tannock, 2001). In the wider community context, adolescents with ADHD have been found to engage in more criminal behaviour and substance abuse than their neurotypical peers (Kaplan, 2004).

Suggested Intervention

The following mental health interventions for adolescents with ADHD have a pragmatic focus, are evidenced based and contextually relevant to a high school environment. The GRIP Framework (Commonwealth of Australia, 2007) and an ecosystems perspective requires the GO to gather data from multiple contexts and sources, such as the adolescent, their teachers, parents, and any allied health professionals they may have worked with in the past. Psychometric assessments assist the GO to determine an individual's overall IQ (WISC; Moura et al., 2019), ADHD symptoms (Conners, 2008 ASRS vi.i self-report and the SNAP-IV with parents and teachers) and comorbid depression and anxiety symptoms (Screen for Child Anxiety Related Emotional Disorders – SCARED; Muris et al., 1998) A search of school behaviour and academic records will offer a comprehensive picture of the adolescent's functioning in different contexts and their strengths and vulnerabilities. The GO may identify specific problems or compromised functioning in multiple domains, which would indicate possible psychopathology (APA,

2013b). In response, a referral to a doctor for assessment for ADHD is appropriate. A combination of stimulant medication and psychosocial interventions in multiple contexts yields the best outcomes for adolescents with the disorder (APA, 2013b). The presentation of ADHD symptoms and the cognitive and psychosocial strengths and weaknesses of people with ADHD vary widely, therefore the Student Support Plan should contain individualised strategies and interventions. Psychosocial interventions for adolescents with ADHD should focus on the core ADHD symptoms of inattention, hyperactivity and impulsivity and support executive functioning. Involvement of teaching staff and use of strategies such as visual timetables and concrete materials may free up working memory and allow adolescents to process information more efficiently and better understand tasks.

The Student Support Plan should include support strategies for adolescents with symptoms of inattention such as checklists to track task completion, preferential seating, allowing extra time to complete tasks and assessments, withdrawal to a quieter area for assessment, use of assistive technology to reduce written work, providing a copy of notes or audio recordings and assisting the student to underline, circle, or highlight key terms on reading material. Strategies to support disorganisation should be included such as study skills and time management strategies, assistance to create a daily routine and a school assignment calendar, check-ins with the teacher after doing the first few problems to ensure correct steps are followed, organisation skills to assist in prioritising assignment goals, organising desk and workspaces, sorting papers into coloured folders, using a daily assignment book and checking it before they leave for home. Strategies to support hyperactivity and impulsivity include movement breaks and using fidget toys such as stress balls when tempted to call out or walk around.

In conclusion, the mental health challenges of ADHD can cause adolescents to have trouble with mastering developmental tasks, and result in maladaptive behaviour. The interventions and supports provided by a Guidance Officer should aim to assist young people to find new and better ways to proceed adaptively along their developmental pathway and successfully deal with the demands of high school life.

23.

MIDDLE CHILDHOOD

Sabrina Grossman

Middle Childhood

Middle childhood, which is approximately the time between six to twelve years is when most children start formal schooling and thus, are exposed to academic, behavioural and social expectations. Therefore, this is also the age when most developmental and behavioural difficulties are identified (Carr, 2015). In this period, growth rates slow down and the average child gains about two and a half to four kilograms of weight and five centimetres of height per year. Children's torso usually grows longer which lets them appear slimmer than during early childhood. Muscles develop and the capacity of the lungs increases. Therefore, in middle childhood, youngsters have more endurance and can be active for longer (Papalia et al., 2009). Cognitively, children start to understand tangible aspects of the world around them, begin to categorise objects in various ways and grasp the concept of reciprocity (Papalia et al., 2009). In terms of social development, school-aged children continue to shape their sense of self, which is highly influenced by the diverse systems the child is surrounded by, such as family, peer group, class community and neighbourhood (Bronfenbrenner, 1979). With the start of schooling, children constantly learn new social skills, like communication, negotiation and problem-solving. They are immersed in society's rules as well as behaviour and language conventions (Henderson & Thompson, 2011). As a result, developmental challenges are likely to occur and identified during this period. Some key challenges primary school-aged children experience due to measuring processes are learning difficulties, such as dyslexia, dyscalculia and attention deficit hyperactivity disorder (ADHD). Conduct disorders and diagnosis of autism spectrum disorders are also likely due to the exposure to stricter rules and societal expectations in educational settings (Henderson & Thompson, 2011).

Attention Deficit Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder (ADHD) is a complex neurodevelopmental condition which is typically diagnosed during middle childhood and substantially impacts a child's personal, physical, social and academic functioning. Typical features include developmentally inappropriate inattention, hyperactivity and impulsivity. ADHD is the most prevalent mental health condition amongst school-aged children in Australia, with around five percent of children in this age group affected. ADHD, according to the current *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013b) appears in different forms: the inattentive type (ADHD-I), the hyperactive-impulsive type (ADHD-HI). However,

the disorder can occur with combined symptoms (ADHD-C). ADHD-C is the most diagnosed subtype, which however could be due to the high co-existence with externalising conditions, such as oppositional defiance disorder (ODD) and conduct disorder (CD) (APA, 2013b).

Key indicators for the inattentive form of ADHD include making thoughtless mistakes, having problems focusing on tasks for a sustained period of time, appearing to not listen when spoken to, inability to follow instructions and to finish chores or school-related activities, disorganisation, being distracted and unwilling to attempt tasks that require continuous effort. This type is the most common one, however, often not diagnosed, because children with inattentive symptoms are typically quiet and withdrawn. In girls this is the most common form of ADHD. The hyperactive impulsive type of ADHD shows through constant fidgeting, squirming, moving hands and feet, inappropriate climbing and running, difficulty to stay seated, excessive talking, interrupting others when they talk and not being able to wait for turns (APA, 2013b).

Evidence of Symptoms

ADHD affects executive functions. These are the mental processes which control self-regulation, control thoughts, speech, feelings and behaviour (Brown, 2019). Hence, executive functions are responsible for organisation, concentration and sustained attention, inhibition of responses, problem solving, intrinsic motivation, foreseeing consequences of actions, handling social interactions and aligning emotional responses with those expected by society (Brown, 2018). When these executive functions are impaired, as it is the case in children with ADHD, all mental tasks involve more effort than for children without the condition. As asserted by Barkley's model (1998, 2006; as cited in Wick-Nelson & Israel, 2012), hyperactive-impulsive behaviours are caused by misfunctioning response inhibition. This means, children with ADHD are unable to inhibit their responses to distractions. Additionally, four other key executive functions are affected. These are the working memory, speech internalisation, non-verbal regulation of feelings and emotions and reconstructing novel behaviours. Therefore, children with ADHD have problems regulating their own behaviour and adapting to new situations.

Furthermore, secondary features of ADHD impact on the child's life in various ways. Barkley (2015) claims that young people with ADHD seem clumsy and perform lower in sports that involve complex, progressive movements, like gymnastics and some ball sports. Self-help skills are also affected. According to Goldstein (2011), children with ADHD, although understanding societal expectations, fail to align their behaviour appropriately. Additional impacts include sleep disturbances and risky behaviours which entail a higher risk of accidents and injuries (Wicks-Nelson & Israel, 2012). Research, however, also reveals a variety of strengths in people with ADHD, such as the high capacity to focus on an activity or task of interest, high energy, creativity, inventiveness, curiosity, great imagination skills and the ability to think outside the box, (Parents for ADHD Advocacy Australia, 2019).

In Australia, ADHD can be diagnosed by paediatricians, psychiatrists as well as clinical psychologists. Paediatricians and psychiatrists can determine treatment and prescribe medication while clinical

psychologists can refer the child to a specialist but cannot prescribe medication (Thriving with ADHD, 2017). The process of assessment includes various components, like family interviews to attain a medical and developmental history, medical information about the parents, child-specific symptoms, strengths and level of social and academic impairments (Burdick, 2015). Current research suggests a combination of a semi-structured and standardised interview, like 'The Diagnostic Interview for Children and Adolescents', which allows for reliable multidimensional information. It involves questions about a variety of elements of the child's life, such as parent- child interactions, triggers for specific behaviours, trauma, socialisation and success at school (Burdick, 2015; Cooper & Thapar, 2016). Thereby, the child is included and observed in terms of speech, non-verbal interactions and appearance. Teacher interviews are another pivotal source of information, as these provide a different perspective (Mitsis et al., 2000). Standardised tests, as for example Conners Parent and Teacher Rating Scales are used to identify symptoms of ADHD and to identify co-occurring disorders, such as ODD and CD (Burdick, 2015). In addition to interviews and rating scales, direct observations in the child's natural settings, like home and school, can reveal invaluable information, since ADHD behaviours typically refer to specific situations. Such observations can also support the decision about treatment approaches (Wicks-Nelson & Israel, 2012).

Impact on the Individual and Interactions

The impacts of ADHD on executive functions cause behaviours, such as bullying and rule breaking, restlessness, interrupting others as well as verbal and physical aggression. These behaviours negatively impact on peer relations, family life and child-teacher relationships (Nijmeijer et al., 2008). Other children often reject or ignore individuals with ADHD, families are more stressed than control families and teachers tend to be more authoritarian with students living with ADHD (Mikami et al., 2010).

As educational settings expect particular behaviours and academic performances from children, the characteristics of ADHD, including impulsive outbursts, short attention spans, poor inhibition and low working memory have detrimental effects on the child's wellbeing at school. According to current studies, in comparison to their peers, children with ADHD perform lower in terms of academics (Birchwood & Daley, 2010; Young Minds Matter, 2017). Beside these academic shortages, young people's mental health and self-esteem are also immensely affected, particularly by peers' and educators' responses to their behaviour. According to Parents for ADHD Advocacy Australia (2019), teachers do not understand ADHD and its consequences for individuals enough to support students to achieve to their fullest potential. Considering the high number of children with ADHD, on an average basis, at least one student per class lives with the disorder and thus, needs specific help or an Individual Education Plan (IEP) with altered curriculum content and teaching strategies (Graham et al., 2018).

Suggested Interventions

The main goal of treating ADHD is to enhance self-regulation. The most commonly applied treatments

are stimulant medication and behavioural interventions or a mix of both (Cooper & Thapar, 2016). In educational settings, guidance counsellors play a crucial role to support teachers who have students with ADHD in their class and initiate processes, such as developing an IEP. This plan might include suggestions about a suitable classroom organisation and clearly defined procedures and routines as well as a calm and predictable teaching style. In addition, a focus on the reinforcement of positive behaviours is vital (DuPaul et al., 2014; Rief, 2016). As students with ADHD struggle with verbal instructions, auditory and visual cues, such as chimes, picture prompts, signing and visual timers, can be effective replacements for words (Poulton, 2019). Students with ADHD should be placed close to the front, where they are least distracted (OnLine Training Ltd., 2020). The IEP should include shortened instructions and assignments and strategies used by the educator to support the student to stay focused and provide feedback regularly throughout the task. Tactile resources and videos, music and colours must be used increase the attention span and focus level (Poulton, 2019).

Another valuable aspect of the IEP is the incorporation of regular movement and brain breaks within each lesson. These give students with ADHD with the chance to release excess energy (Rief, 2016). Regular dances and walks through the school yard, gardening and playing outdoor will benefit all students (DuPaul et al., 2014). Additionally, passing out books and worksheets, cleaning the board, delivering messages to administration, yoga and meditation are beneficial strategies to ensure children with ADHD get to release surplus energy. Besides supporting teachers and families with the development of an IEP, a guidance counsellor can refer families to specialists, link them with relevant parent groups and parenting programmes and provide all school staff with links and handouts.

24.

MIDDLE CHILDHOOD

Haylee Alice Holzworth

Middle childhood

Middle childhood is widely recognised as ages between 6-12 years and the developmental stage between early childhood and adolescence (Harold & Hay, 2005; Healthy People, 2020; National Research Council, 1984). Children in this period go through many physical, social, cognitive, emotional and behavioural changes which come with its many challenges. Developing cognitive abilities mean children can handle more complex intellectual problem solving and understand social relationships (Capital Health Network, 2020). Many of the challenges children in this age group face are in relation to social development and experiences. Peer acceptance and bullying is a significant issue as children are developing relationships with their peers and starting to spend less time with their parents. In these relationships children are making social comparisons that contribute to their emotional regulation and self-esteem. Social media also provides a platform for bullying online, especially as the usage is high. Ofcom (2022) found that children were more likely to be bullied online (84%) than in person (61%). Further significant difficulties for children in middle childhood are learning difficulties that interfere with their abilities to develop at the typical rate and the transition from primary school into high school.

Attention Deficit Hyperactivity Disorder

Attention deficit hyperactivity disorder (ADHD) is a developmental disorder that begins in early childhood, starting before 12 and sometimes noticeable as early as age 3 (Mayo Clinic, 2022). In 2013-14, ADHD was found to be the most common mental health disorders for children at 8.2%, and the most common with boys at 11% (Australian Institute of Health and Welfare, 2022). More than 3 in 4 children with ADHD will continue to experience symptoms into adulthood (Healthdirect, 2020c). There are 3 types of ADHD; Inattentive, Hyperactive-impulsive and combined (Healthdirect, 2020c; Mayo Clinic, 2022). Researchers acknowledge that ADHD affects the brain's executive functioning and the ability to self-regulate and practice self-control with thoughts, words, actions and emotions (Berk, 2012; Healthdirect, 2020c). Whilst ADHD does not cause other psychological or developmental problems, children are more likely to or often have other conditions with ADHD. These include mild delays in language, social development and motor skills, oppositional defiant disorder, conduct disorder, disruptive mood dysregulation disorder, learning disabilities, anxiety disorders, depression, autism and Tourette syndrome (Mayo Clinic, 2022). Children with ADHD tend to have low frustration tolerance, mood

swings and difficulties controlling their emotions (CHADD, 2017). The development of ADHD may be as a result of genetics, environmental factors, and problems with the central nervous system during fundamental stages of development.

Evidence of Symptoms

Generally, ADHD symptoms appear in early childhood. According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013b), before age 12, various symptoms are required to be present. It can be difficult to distinguish these symptoms, such as excessive motor activity during toddler years, as this is typical behaviour of children under four (CHADD, 2017). Under the DSM-5 criteria, clinicians can also diagnose the severity of the disorder as mild, moderate or severe.

Through observations at school and home, symptoms of ADHD can be identified. It is common for children to lose interest in activities, become inattentive and be full of energy at times, however, symptoms of ADHD are persistent and do not match up with where the child should be developmentally. Children with inattention may show the following signs: have trouble staying focused on tasks, fail to pay close attention to details and often make careless mistakes in schoolwork, appear not to listen even when spoken to directly, struggle to follow through with instructions, fail to finish tasks or chores, easily distracted, forget to do daily tasks, has difficulties organizing activities and tasks, and avoids tasks that require mental focus. Children with hyperactivity and impulsivity may have the following symptoms: difficulty staying seated in class and other situations, constantly on the go, fidgeting, tapping hands and feet or squirming in a chair, difficulty engaging in an activity quietly, talks excessively, interrupts people, and has difficulty waiting. Some children will show a combination of these symptoms (Healthdirect, 2020c; Mayo Clinic, 2022). In addition to this, children with ADHD may also struggle with self-esteem, have poor relationships and low achievement in schoolwork. Symptoms may lessen with age as individuals develop strategies to overcome these and have access to the appropriate medication.

Impact on the Individual and Interactions

Children with ADHD are at a greater risk of significant issues in adolescence and adulthood. This can include the impact it has on relationships with others, whether it be family, peers and the wider community. Children with ADHD tend to show more signs of depression than their peers and are at an increased risk of developing depression in adolescence and adulthood (Evans et al., 2019).

At school it can have an impact on developing friendships with others as they may get distracted easily when a peer is talking to them or talk over them. It can affect their relationships with teachers as they may be inattentive and do not follow instructions. Furthermore, the symptoms listed above can have a lasting effect on their learning if the suitable interventions are not implemented at school. Children in middle childhood with inattentive or combined ADHD demonstrate lower achievement than their peers (Evans

et al., 2019). Research shows that these children do poorly on tasks requiring sustained attention, fail to manage frustration and intense emotion, find it hard to ignore irrelevant information and have difficulty with memory, planning, reasoning and problem solving in academic and social situations (Berk, 2012). Disruptive behaviours, such as, being unable to play quietly and independently, struggling to wait for a turn during conversation or activity and difficulty sitting still, also affect a student's social, emotional and academic development and functioning. According to Dunn and Bennett (2002), children with ADHD may not process and receive sensory information correctly and therefore have issues with responding appropriately at home, school and social settings. Additionally, this disorder may impact functional and motor achievement, behavioural development and their ability to learn (Shimizu et al., 2014).

Suggested Interventions

As ADHD is present in childhood, guidance counsellors have the opportunity and responsibility to support these children and develop methods to manage their symptoms at school and provide parents with education and strategies to support them outside of school and into adulthood. Before implementing the relevant interventions, it is crucial for a guidance counsellor or educator to understand what skills need developing for the child coping with ADHD as children exhibit different symptoms. Developing an Individual Support Plan (ISP) through assessments, is a useful way to gather information on a student concerning their individual preferences, goals, needs and abilities. For the best results, guidance counsellors should work directly with parents to practice consistency and routine to best support the child.

Research suggests that a combination of medication and behavioural treatment has the best results for improved behaviour both at home and school over having just one treatment (CHADD 2017; The A.D.D. Resource Center, 2017). Behavioural interventions include the following strategies: positive reinforcement, being consistent, being taught problem-solving skills, self-advocacy skills and communication. Behavioural interventions can also include adjustments in the classroom/school environment depending on the symptoms of the child. This could be seating the child away from corridors or the like as they may be distracted, providing opportunity to take breaks or movement throughout the day, and breaking up long tasks into smaller segments (The A.D.D. Resource Center, 2017). Children should also be involved with planning. Guidance counsellors should work with parents and teachers to guide, support and teach strategies.

25.

CHILDHOOD

Amy Brushe

Childhood

The Australian Institute of Health and Welfare (AIHW, 2020a) estimated that 4.7 million children aged 0 to14 represented 19% of the Australian population. Despite using statistics describing childhood between birth and 14-years-old, the AIHW (2020a) consider the developmental period of childhood as occurring between birth and 12-years-old. Childhood is characterised by rapid physical, cognitive, emotional, and social development (Tully, 2020). The developmental changes that occur between birth and 12 years old are dramatic and extensive, and this can coincide with a range of developmental challenges. Childhood developmental challenges can be influenced by rate of development (e.g., when children develop at normatively different rates to their peers), the presence of distinct developmental differences and delays (e.g., related to a physical condition such as hearing loss, or neurodevelopmental disorder such as autism spectrum disorder [ASD]), or by the presence of mental health problems or disorders (e.g., depression or anxiety-related disorders; Kelly & Allen, 2015). Due to their developmental immaturity and dependence on others for care and support, children are also particularly vulnerable to environmental influences (e.g., parenting practices, teacher and peer relationships, exposure to health/welfare agencies, and/or physical environment; OECD, 2019). Childhood is therefore a critical period for health monitoring and intervention to promote positive outcomes into adulthood.

Attention Deficit Hyperactivity Disorder

Many mental health and neurodevelopmental disorders onset in childhood and can influence cognitive, emotional, and social developmental outcomes across the lifespan (Jones, 2013). The term "neurodevelopmental disorder" refers to a condition that onsets in the developmental period (i.e., infancy, childhood, or adolescence) and is characterised by stable neural deficits that impair an individual's functioning (APA, 2016; Morris-Rosendahl & Crocq, 2022).

Attention deficit/hyperactivity disorder (ADHD) is the most common neurodevelopmental disorder of childhood, affecting approximately 5 to 9% of children worldwide (Adler et al., 2015; APA, 2016). Deloitte (2019) reported prevalence rates of ADHD in Australia to be approximately 5.8% for boys and 2.3% for girls (aged 0 to14). Research suggests that ADHD is commonly underdiagnosed for girls, rather than simply occurring at lower rates for girls (Hinshaw et al., 2022). There are also associations between

risk factors for adverse childhood experiences (ACEs); e.g., parental psychopathology, low socioeconomic status) and the prevalence and severity of ADHD (Margari et al., 2013; Russell et al., 2014). Research suggests symptoms of traumatic stress can be misattributed to ADHD and this may also complicate diagnoses (Brown et al., 2017).

ADHD is characterised by inattention, hyperactivity and impulsivity that impacts with functioning and development (APA, 2016). To meet the diagnostic criteria for ADHD, several symptoms of inattention and/or hyperactivity must be present before the age of 12, persist for more than 6 months, present in more than one setting (e.g., school and home), and not be better explained by another condition (APA, 2016).

The cognitive impairments associated with ADHD surpass typical challenges associated with childhood development (Adler et al., 2015). Research suggests that ADHD cannot be reliably diagnosed in children younger than 4-years-old due to normal developmental variation in early childhood related to attentional control and increased motor activity (Felt et al., 2014). Thus, ADHD is often diagnosed in middle childhood (aged 6-12) when the cognitive and behavioural demands of school increase, and these demands begin to exceed the child's personal, social, and/or academic functioning (Adler et al., 2015; Felt et al., 2014).

Research indicates that many symptoms of ADHD (e.g., impaired attention and impulse control, increased distractibility and hyperactivity) involve dysfunction in the circuitry of the prefrontal cortex (Arnsten & Berridge, 2015). The prefrontal cortex guides many attention, action, emotion, and memory functions; it is also highly dependent on neurochemical state, and this explains how pharmacological treatments for ADHD can improve behavioural and cognitive symptoms (Arnsten & Berridge, 2015).

Evidence of Symptoms

The two patterns of behaviour associated with ADHD are inattention and hyperactivity or impulsivity (APA, 2016). Inattention may present in childhood as careless mistakes in academic work, appearing "off-task" or "absent", inability to follow multiple steps of a task, poor organisation of personal belongings (e.g., losing items), excessive distractibility, and/or forgetfulness in daily activities such as chores and school activities (APA, 2016). Hyperactivity or impulsivity may present in childhood as excessive fidgeting with hands or feet, difficulty remaining seated for extended periods, difficulty remaining quiet during activities, excessive talking, interrupting others in conversation, appearing to be constantly "on the go", and/or inability to wait their turn in an activity (APA, 2016).

These behavioural presentations are a result of underlying cognitive impairments in basic processes such as distractibility, and higher order functions of executive function, working memory (Butzbach et al., 2019; Kofler et al., 2016). Research indicates that underdeveloped working memory may interfere with "listen-and-wait" behaviours that are required for pro-social interactions (Kofler et al., 2016). Thus, cognitive

impairments associated with ADHD can contribute to behavioural symptoms such as interrupting others in conversation, and contribute to a corresponding social impairment (Bunford et al., 2015).

It is important to note that behavioural, cognitive, and social features may differ significantly between children diagnosed with ADHD (Kofler et al., 2016). Data collection techniques that can assist in identifying evidence of different symptoms and diagnosing ADHD in childhood include psychometric measures, such as the Conners 3rd Edition (C3; Stein et al., 2015). The C3 is an assessment tool designed to measure cognitive and behavioural issues associated with ADHD and common comorbid disorders. It includes rating scales to be completed by parents and teachers (for children aged 6-18 years) and a self-report scale for children aged 8-18 (Conners, 2008). Research suggests that parents and teachers often have different expectations, references, and samples of behaviour, and that interviewing both parties can identify if symptoms are present in different settings (Stein et al., 2015). Other psychometric measures include additional Conners indexes (e.g., Conners Early Childhood, Conners Comprehensive Behaviour Rating Scales) and the Achenbach System of Empirically Based Assessment (ASEBA; Stein et al., 2015). Functional behavioural assessments (Northup & Gulley, 2001) may also be a useful tool for data collection and analysis relating to ADHD-associated behaviours (Miller & Lee, 2013).

Impact on the Individual and Interactions

Individual differences in symptoms can vary the impact that ADHD has in childhood. Adaptive skills allow children to complete age-appropriate tasks, including communicating and learning, forming and maintaining friendships, regulating and managing emotions, behaviour, health, and personal safety (Weiss, 2015). ADHD is typically associated with deficits in one, many, or all of these skills; and this can result in functional impairment.

ADHD has high rates of comorbidity, and this can contribute to a substantial impact to childhood mental health. Research indicates that approximately 40 to 50% of children with ADHD also meet criteria for one or more mental health, sleep, or learning disorder (Adler et al., 2015). Many children with ADHD also have problems relating to emotional regulation (e.g., anxiety, oppositional defiant disorder, or conduct disorder) thought to be related to prefrontal cortex deficits and/or traumatic stress related to ACEs *(*Arnsten & Berridge, 2015**;** Brown et al., 2017). Research indicates that comorbid symptoms contribute to increased parental stress and mental health impairments, which can increase the risk of ACEs and negative outcomes for children with ADHD (Martin et al., 2019).

Research indicates that children with ADHD and those around them (e.g., their parents, families, teachers, and healthcare professionals) commonly hold negative perceptions towards ADHD behaviours (Bisset et al., 2022). ADHD has been associated with lower rates of school completion and academic achievement (e.g., reading and math standardised test scores), and increased rates of grade retention, detention, and expulsion (Weiss, 2015). However, research indicates that interventions (e.g., effective education

adjustments) can reduce the gap between academic performance, which may be impaired by ADHD symptoms, and a child's actual academic potential (Arnold et al., 2020; Weiss, 2015).

Suggested Interventions

Pharmacological and behavioural interventions have been shown to reduce symptoms and improve quality of life and family functioning for school-aged children aged 6 to12 years (Manos, 2015). Effective behavioural interventions can be applied across settings and include parent training, classroom management, and peer interventions (Felt et al., 2014). A key role of a Guidance Officer (GO) is to support student mental health and wellbeing in a school setting (Department of Education [DOE], 2021b). If a child with ADHD presents with behavioural challenges at school, a GO may take steps to develop an Individual Behaviour Support Plan (IBSP) in collaboration with teachers, parents, and the student (where possible; DOE, n. d.). The IBSP process begins with data collection (DOE, n.d.). This typically involves a Functional Behaviour Assessment. Suitably qualified GOs may also use a Conners index if they require further information about specific areas of functioning related to ADHD (DOE, 2021a**)**. The support team can then identify and implement long- and short-term goals, teaching strategies for alternative behaviours, antecedent and consequence strategies (DOE, n.d.). Specific strategies may include teacher-led adjustments to classroom routine and structure, use of a token economy to reinforce target behaviours, and/or daily "check-ins" to monitor progress and provide regular feedback to the child and members of their support team (Evans et al., 2013). The IBSP process includes regular data collection, monitoring, reviews, and adjustments as needed to ensure effective student support (DOE, n. d.).

26.

ADOLESCENCE

Dorani Magill-Connell

Adolescence

Attention-deficit/Hyperactivity Disorder (ADHD) is a world-wide, neurodevelopmental disorder manifesting itself during early development and its prevalence in adolescence is well documented (Adler et al., 2015; World Health Organization, 2022b). This disorder may not be easily detected during adolescence due to an individual's improved level of self-control (Wender, 2000). Neurodevelopmental disorders frequently co-exist with one another, and ADHD is often associated with Conduct Disorder and Oppositional Defiant Disorder during adolescence (Wender, 2000). It is estimated that 45% of adolescents with ADHD will have conduct disorder, with males more likely to be diagnosed (Renzoni, 2022). ADHD is present in 7.2% of children world-wide and this number diminishes somewhat during adolescence (APA, 2013b; Wender, 2000). Symptoms of ADHD are present in all individuals, but it is the intensity, persistence and patterns which differentiates it from the norm (Wender, 2000).

Attention Deficit Hyperactivity Disorder

Attention-deficit/Hyperactivity Disorder (ADHD) is caused by brain chemistry and genetics impacting upon the dopamine transporter gene and receptors causing varying reactions to stimuli (ADHD Support Australia, 2022; APA, 2013b). As described in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., DSM-5; APA, 2013b) ADHD is a condition which refers to those individuals who display inattention or hyperactivity and impulsivity or a combination of these. Individuals may present as a student with persistent and impaired difficulties in various areas including academic, motor skills, social and psychological domains (ADHD Support Australia, 2022; Rogers, 2021). However, these delays are not specific to ADHD (APA, 2013b). Often academic performance is below that of peers, whereas others may be identified as exceeding satisfactory outcomes, until tasks are completed under test conditions (ADHD Support Australia, 2022; APA, 2013b). Generally, a decrease in blood flow in the pre-frontal cortex is responsible for impaired executive functions, such as memory, planning and attention (ADHD Support Australia, 2022).

Individuals who have ADHD may present as distractible, restless, accident prone, hasty, attention seeking, poor coordination, emotional, appear immature or even overly domineering when interacting with others (Wender, 2000). Most importantly it should be recognised that ADHD is not outgrown but can be in

partial remission if some criteria is no longer experienced for over 6 months (APA, 2013b; Resnick, 2005). A key protective factor is a carer's parenting style and their interactions with their adolescent (Wender, 2000). A negative parenting style may be maternal, overprotective, controlling, rejecting, inconsistent, overly angry, lack involvement, critical, provide limited emotional support or intellectual stimulation which subsequently increases the likelihood of comorbidity (Wender, 2000).

Evidence of Symptoms

The DSM-5 explains that six or more of the following symptoms must be observable, but for adolescents, at least five should be present (APA, 2013b). Inattentive symptoms as listed include difficulty maintaining attention during various tasks, not paying close attention to detail, not listening; difficulty following instructions; trouble organising tasks, time, or things; reluctant completing activities that require concentration; easily distracted; often losing items; and poor retention (APA, 2013b). Whilst hyperactive and impulsivity behaviours include fidgeting; failure to remain seated; running or climbing at inappropriate times; difficulty being quiet; restless; talkative; turn-taking difficulties; and constantly interrupting others (APA, 2013b). To be diagnosed, some behaviours should be present before twelve years of age, appear in multiple settings, interfere with daily functioning and be present for 6 months or more. These characteristics can be mild, moderate, or severe and lean more towards either or both inattentive and hyperactive-impulsive behaviour. Often individuals with ADHD experience difficulties with regulating emotions, motivation and arousal, with a delayed development of internal dialogue concerning events, behaviours, and feelings (ADHD Foundation, 2022). The DSM-5 also states that the disorder is relatively stable throughout adolescence, but some individuals may display an increase in antisocial behaviour. Signs of hyperactivity are less common but persist (APA, 2013b).

Symptoms may include limited working memory, set shifting, reaction time, response inhibition, vigilance, and organisation. Parents may note an unusual amount of physical activity initially. A parent's over-reactivity or critical behaviours may be seen as rejection or overprotection by the adolescent (Brinksma et al., 2021). Parental warmth was found by Brinksma et al. (2021) to be a predictor of low levels of ADHD symptoms, and parental rejection a predictor of high levels of ADHD symptoms in later adolescence. Yet these symptoms may be dependent on genotype, whereby the genes of an individual influence their sensitivity to supportive or adverse environments (Brinksma et al., 2021). It is important to note that risk factors may include temperament, low birth weight, prenatal exposure to smoking or alcohol, diet reactions, exposure to toxins and infections but this is not conclusive (ADHD Foundation, 2022).

Impact on the Individual and Interactions

ADHD involves various characteristics that cluster together and tend to be less obvious with age. Consequently, for adolescents there is a need to delve into an adolescents' history, undertake interviews and utilise rating scales as there is no specific test which can be administered to diagnose or identify ADHD

(Wender, 2000). There are several rating scales available including Conners Comprehensive Behaviour Rating Scale (CBRS), Behaviour Rating Inventory of Executive Function Second Edition (BRIEF2), Vanderbilt Assessment Scale, and Vineland Adaptive Behavior Scale (Department of Education, 2021). There is also a need to rule out any other disorders before diagnosing as ADHD (APA, 2013b).

During adolescence the risk may be that more hostile behaviours develop after rejection by peers and persistent long-term academic difficulties (Wender, 2000). Therefore, rather than hyperactivity and lack of focus during childhood, antisocial problems come to the fore during adolescence (Wender, 2000). If left untreated, other issues such as risk-taking behaviour, anxiety, depression and angry outbursts may become more prevalent (Wender, 2000). There is a risk of suicidal thoughts later in life, poor occupational performance, unemployment, poor social interactions, trauma, accidents, obesity, hypertension and for the adolescent this would include family discord, poor school performance and attendance (ADHD Foundation, 2022). Overall, researchers have proven that ADHD is 74% hereditary and that effective parenting is the key factor in reducing these negative outcomes (APA, 2013b).

Suggested Interventions

ADHD can be managed in several ways and a multidisciplinary approach is necessary (ADHD Foundation, 2022). Options include medication, education, knowledge, training, psychotherapy, and a comprehensive behavioural, psychological, educational, and medical evaluation is required (ADHD Foundation, 2022). With evidence-based treatment, support, and appropriate adjustments it is possible to function with ADHD (ADHD Foundation, 2022).

Non-medication strategies include psychological therapies, occupational therapy, coaching and more (ADHD Foundation, 2022). Psychological treatments may be behaviour modification in the classroom and parent training in management methods, but ongoing treatment is required (ADHD Foundation, 2022). Adolescents with ADHD may benefit from social skills training or interoception programs to help individuals identify mood changes or self-regulate their body (ADHD Foundation, 2022; Department of Education, 2021b). Treatments with little evidence of effectiveness include dietary management, psychotherapy such as biofeedback, play therapy, chiropractic treatment or sensory-integration training (ADHD Foundation, 2022).

Medication prescribed by a psychiatrist or pediatrician can include stimulants or nonstimulants with the later taking time to have an effect (ADHD Foundation, 2022). Trialing is necessary to meet the needs of the client as the type or dosage can affect individuals in different ways (ADHD Foundation, 2022). Medication facilitates the electrical signal transmission within the brain improving cognitive function and reducing symptoms (ADHD Foundation, 2022).

Poulton (2019) highlights the fact that the DSM is symptom-based and descriptive and does not address the individual's experience of ADHD or cause. It is also difficult to separate it from other disorders

such as sensory processing disorder and even trauma which can produce similar symptoms (Poulton, 2019). Questioning an adolescent about their thoughts and functioning provides more insight. Poulton (2019) states that neuroscience or neuroimaging and neurocognitive testing can determine delay aversion, executive deficits such as reasoning, making good decisions, short term memory, attention span, listening, following instructions, and controlling impulsive behaviour but none are specifically able to diagnose ADHD.

To understand and implement adjustments within the classroom Poulton (2019) suggests we must consider that usually there is a cost or an amount of effort required to complete a task, followed by achievement or reward, culminating in a good mood. However, for an ADHD adolescent, the cost is greater due to executive functioning difficulties (Poulton, 2019). A reward deficiency causes maladaptive reward seeking behaviour to achieve a good feeling or mood (Poulton, 2019). Therefore, what is easy and satisfying for most students, requires unreasonable effort with little reward for those living with ADHD (Poulton, 2019). Consequently, screening questions should focus upon what percentage of time does an adolescent spend efficiently completing cognitive tasks (Poulton, 2019).

It is also important to undertake cognitive tests, scaled questionnaires and observations to identify behaviours, strengths and difficulties (Department of Education, 2021b; Poulton, 2019). This can provide the knowledge required to make reasonable adjustments in the areas of curriculum presentation and behaviour management (Department of Education, 2021b). Changes may need to be made within the school environment such as sound blocking headphones; or breaking tasks down into manageable parts; implementing strategies to suit energy levels such as regular movement breaks; completing difficult tasks early; working in one-to-one situations and utilising visual timetables (ADHD Foundation, 2022; Learning Connections, 2022; Wender, 2000).

A multidisciplinary approach is needed to incorporate advice and observations from doctors, specialists and others such as parents, teachers, advisors, speech language therapists, occupational therapists and physiotherapists to produce an appropriate action plan which caters for an individual's needs (Department of Education, 2021b). General health checks including vision, hearing, language, speech and movement, as well as developmental, learning, educational or IQ tests are important for identification (Raising Children Network, 2021c). A multimodal treatment is required so that information can be collated to develop strategies or adjustments to support those with ADHD (CHADD, 2022b).

27.

CHILDHOOD

Jennifer Entsch

Childhood

Table 1

Key developmental challenges faced by children aged 6 to12 years

Social	Environmental	Cognitive	Behavioural
– complex friendships – peer pressure – desire to be liked and accepted by peers – judgement based on populate cultural trends – struggle with social engagement – antisocial tendencies	– negative learning feedback at school – affected by poor parenting styles – limited social supports – limited community resources – compounding environment risk factors -physical isolation if living in rural areas	– academic challenges – fears about future – rapidly developing cognitive abilities – delayed abilities – internalising feelings and thoughts – negative perspectives if success is not experienced	– antisocial behaviour – negative attention seeking behaviours – conduct disorders – oppositional defiance disorders – impulse control – withdrawal and isolation as a result of negative experiences in other domains.

Note. The table lists key identified developmental challenges that may typically experience by primary school children aged 6 to12 year *(Halfon et al., 2018; Lesser & Pope, 2011)*.

Attention Deficit Hyperactivity Disorder

A child's inattention, impulsive or hyperactive behavioural characteristics maybe be indicators of attention deficit hyperactivity disorder (ADHD; APA, 2013b). ADHD is a behavioural disorder that is identifiable in primary children by their inability to concentrate due either to excessive activity or inability to act and maintain concentration. The APA (2013b) defines the two types as "inattentive" and "hyperactive-impulsivity." This can result in a failure to complete tasks as children are easily distracted or struggle to

wait, or both. At home, behaviour is similar and they may be easily overexcited, or seem quite and often daydream. In a child with ADHD the behaviours are more frequent and extreme than would be considered standard child developmental behaviours and as a result relationship and learning at school, at home and in other social settings can be adversely affected (Achenbach et al., 2012).

At school, ADHD affects a child's capacity to pay attention to instructions and learning content, and their ability to focus and put effort in to their school work (Achenbach et al., 2012). This negatively impacts learning outcomes and in turn the student's experience of academic success. Students are often restless, talkative and disruptive in class, and this affects their ability to establish, engage in and maintain healthy social relationships with peers and support and instructional relationships with teachers and other school support staff (APA, 2013b). Comorbidities such as Learning Disabilities, Conduct Disorder and Oppositional Defiance Disorder can also adversely affect relationships and the child's ability to participate in the school system (Achenbach et al., 2012; APA., 2013b). At home and in other social environments, children may struggle to share and take turns, often becoming bored and disengaging. They may not listen or respond to social cues, and struggle to control their emotions making engagement with others challenging (Achenbach et al., 2012).

When these frequently occurring behaviours are identified, scaled and supported by evidence, to be hampering the child's academic, social and occupational performance ADHD may be diagnosed by specialist health professionals (Becker et al., 2012).

Evidence of Symptoms

ADHD is the most prevalent neurodevelopmental disorder in Australia (ADHD Australia, 2019). Behaviourally, it is evidenced by persistent and frequent displays of "inattentive, impulsive, and sometimes hyperactive behaviour" and emotional regulation challenges present as well (ADHD Australia, 2019). Cognitively, these symptoms are the result of an inability to regulate and control attention, emotions and behaviours. Children are also unable to consistently recall information, self-monitor and reflect, problem solve or plan, and also to self-soothe (ADHD Australia, 2019; APA, 2013b). These neurological differences result in developmental delays that in turn impact the child's ability to self-control. This also has social implications, as children struggle to engage in a positive way at school, make friendships, achieve positive social currency and self-esteem, and can contribute to the development of significant adverse outcomes as they develop (ADHD Australia, 2019; van Stralen, 2016).

Following a model for the collection of evidence and data such as the GRIP Framework (Commonwealth of Australia., 2007), anecdotal and documented evidence from teachers and other key stakeholders, including parents and the child themselves, can be gathered and compared with existing information that may already be recorded on the student's file on OneSchool. Assessment records and report card comments can also provide insight into behaviour and academic performance. If the child has come from another school, they can be contacted to provide supporting information on prior referral and any support

strategies undertaken previously. A functional behavioural analysis (FBA) of behaviours observed and recorded both inside and outside the classroom may provide insight into contextual factors and triggers affecting the student's behaviour and wellbeing (Northup & Gulley, 2001). Psychometric tests such as the Vanderbilt ADHD Diagnostic Rating Scales are a screen tool that can be used to support the identification of ADHD in children between the ages of 6 and 12, and other comorbidities, such as Oppositional Defiant Disorder, conduct disorder, learning disabilities, anxiety and depression (Wolraich, 2003; Bard et al., 2013).

Impact on the Individual and Interactions

ADHD symptoms are identifiable in early childhood and usually need to appear before the child turns 12 to meet the requirements for an ADHD diagnosis. According to the *Diagnostic and Statistics Manual of Mental Disorders* (DSM-5; APA, 2013b), children with hyperactive-impulsive symptoms usually are fidgeting, restless and jiggle their legs or tap objects and generally move more frequently than their peers. They also tend to call out and interrupt their classmates and respond immediately, without thought for consequences.

At school, this may present as yelling out answers to questions directed at the whole class, or racing ahead in a task without waiting for instructions. However, it may also have more negative implications whereby children may swear or lash out at peers and teachers due to their lack of self-regulation resulting from issues with executive functioning (Garland, 2014). As a result, more often than not students are faced with negative consequences if identification goes unchecked, meaning early intervention and support are overlooked (Garland, 2014).

At home and in social contexts, children with ADHD may seem to frequently seek their parent's attention and seem impatient and persistent (Garland, 2014; van Stralen, 2016). This also extends to peers and extended family and community members. Boredom is a trigger and children resort to seeking stimulation, which can translate to unsafe risk-taking behaviours. These characteristics can vary in individuals and can evolve as the child develops. Emotions can escalate quickly into angry verbal or physical exchanges as the lack of self-control fosters psychological distress, compounding regulations issues (Garland, 2014; ADHD Australia, 2019).

Inattentive symptoms in students include struggling to concentrate and maintain focus during learning activities and completing tasks they adjudge as boring. They are also easily distracted and often miss teacher instructions or struggle to remember what they are meant to be doing. They make basic errors or fail to complete tasks. In the home environment, children frequently lose items, are reluctant to do chores, often leaving them incomplete or not done at all. They may struggle to remember, understand and complete homework, or to be ready to leave for school or other social activities. In some cases, both inattention and hyperactive impulsive symptoms can be present (Shaw et al., 2016).

Overall, individuals with ADHD struggle to regulate their emotions; this can be seen as rapid and intense

mood swings, ranging from high excitement to aggressive anger. Children may also focus on the negatives in a situation, and experience greater psychological issues as a result (Garland, 2014; ADHD Australia, 2019; Shaw et al., 2016). Unless diagnosed, supported and treated children experience learning difficulties, behavioural issues with disciplinary repercussions and will struggle socially. In turn, they develop poor self-esteem, anti-social tendencies and have an increased like hood of developing other comorbidities that continue into more risky, self-destructive behaviours as they continue to develop into adulthood (Shaw et al., 2016).

Suggested Interventions

The Zones of Regulation (Kuypers, 2011) is a validated, readily accessible support strategy for intervention that focuses on developing the child's self-awareness and self-control over their executive functioning that support their social capacity and ability to engage positive in the primary school environment (Kuypers, 2011; van Stralen, 2016). It can be implemented for the individual students, for a small group or as a whole-school wellbeing program. To provide equity and support inclusion, any adjustments for learning such as wellbeing strategies and support provision, can be noted in the student's personalised learning plan (PLP) on OneSchool (or equivalent) to ensure all school staff and parents understand the plan and better support the child as well. This information can then be referenced and developed as the student progresses.

PART IV

DEPRESSION

28.

ADOLESCENCE

Eden Bartlett

Adolescence

Adolescence is a dynamic maturation period in which an individual's life can rapidly pivot in both negative and positive directions (Dahl et al., 2018). Characterised by a number of developmental changes and associated biological, cognitive, psychological, and social challenges the purpose of adolescence is to achieve independence. Current research indicates that an age range of 10 to 25 years corresponds significantly to the developmental structures of the brain and patterns of behaviour seen during adolescence (Arnone, 2014; Sawyer et al., 2018; Wise 2018). The World Health Organisation (WHO; 2022a) estimates that there are approximately 1.2 billion adolescents globally making up one sixth of the population with numbers expected to rise through to 2050. Adolescence marks the peak onset of mental health conditions with global estimates indicating 14% of adolescents are experiencing mental health conditions (WHO, 2022b). Due to the developmental changes occurring at this time adolescents are increasingly vulnerable to societal stressors often resulting in risk taking or rebellious behaviours. These behaviours unfortunately increase the risk of poor mental health and the development of mental health conditions for which many are left untreated. Mental health literacies and promotion, prevention and early interventions should be integrated across educational and medical fields expending into the community in order to support adolescents as they transition to adulthood. In comparison to the general population individuals with mental health conditions have a decreased life expectancy of 10- 15 years, but with early interventions at the first onset, typically during adolescents can improve several outcomes (Solmi et al., 2021).

Depression

WHO (2022b) defines depression as a persistent sadness and lack of interest in previously enjoyable activities. A statistical review of literature highlights numerous findings associating adolescent depression with numerous negative psychosocial outcomes throughout adulthood (Clayborne et al., 2019). Racine et al.'s (2021) meta-analysis identifies that globally 25.2% of adolescents are displaying clinically elevated symptoms of depression. Bodden at al. (2018) further highlights global that prevalence rates in regards to adolescent depression in different countries, noting differences of between 1.3 to 18.2% with an estimated global prevalent rate indicating five percent of adolescents meeting diagnosis criteria in alignment to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013b). This aligns to national data, suggesting that 5% of Australian adolescents aged between twelve and seventeen experienced

major depressive disorder meeting DSM-5 diagnostic criteria (Lawrence et al., 2016). Lawrence et al. (2016) also indicates prevalence differences specific to gender identifying females (5.8%) were 1.5% higher than males (4.3%) in experiencing major depressive disorder. These findings corroborate with international studies identifying that prevalence rates are higher amongst females than males in regards to both subthreshold depression and major depressive disorders (Crockett et al., 2020).

Depression is a multi-factorial mood disorder that prevents people from reaching their full potential impeding on behavioural, cognitive, and social aspect of life (Bernard, 2018). The DSM-5 identifies three levels of depression mild, moderate, and severe affecting an individual's ability to function in different capacities. At mild levels of depression, daily tasks require some effort while moderate depression involves occupational and social impairments, with progressions including psychotic episodes in severe cases. Singh et al. (2019) systematic review highlighted two critical findings 1) that adolescents were poor at recognising the symptoms of depression, and 2) that adolescents tended to attach stigma to depression making them more inclined to seek help from informal sources. Therefore, in order to minimise lifelong impacts of adolescent depression, strategies to improve adolescent mental health literacies and remove associated help-seeking negative stigma. Depression is the leading cause of mental health related disease burden globally (Herrman et al., 2019) with the average onset being mid to late adolescence. Subthreshold depressive symptoms in adolescence poses a significant indicator of early adulthood depressive disorders, psychosocial impairments, and substance abuse (Aalto-Setälä, 2002). Concerningly, less than two-thirds of adolescents with mental health problems access professional help due to a number of factors including poor mental health literacies and understandings of depression, stigma associated with both mental health problems and help seeking behaviour and a lack of trust in regards to confidentiality (Radez et al., 2021).

Evidence of Symptoms

Depression is associated with broad deficits in cognitive functioning characterised by negative cognitive biases and maladaptive emotional regulation strategies evident by a lack of ability to plan, problem solve, as well as inhibiting the processing of information (LeMoult & Gotlib, 2019). In addition to this, depressed individuals fail to show positive cognitive biases and adaptive emotional regulation strategies that are likely to serve as protective factors (LeMoult & Gotlib, 2019). Within adolescents this can be observed as trouble concentrating and remembering information, disengagement in school and extra-curricular activities, extreme sensitivities and fixation with personal failures, low self-esteem, mood swings, and feelings of hopelessness. Adolescents who are depressed may not show obvious signs of depression but may begin to behave uncharacteristically engaging with a number of risk-taking behaviours such as drug and alcohol abuse, school refusal, inappropriate sexual involvements. Sleep and eating patterns may also drastically alter during this period characterised by constant fatigue and significant weight loss or gain (Beyond Blue, 2022f). Adolescents will typically begin withdrawing from close friends, family and activities they had previously found engaging with the effects of social isolation again impacting on negative cognitive bias and emotional regulation.

Impact on the Individual and Interactions

The prevalence, recurrence and incidence of depression in adolescents is substantial, impacting negatively not only the individual but the relationships they hold in their personal, social, and educational lives. Depression influences individuals' physical and mental wellbeing often leading adolescents to risk-taking behaviours and social isolation, which hold significant consequences on an adolescents' cognitive and social-emotional development. Depression impacts on daily life and although a mental health disorder impacts your physical health and wellbeing as individuals no longer find pleasure in a number of activities they generally revert to a sedentary lifestyle in which finding the motivation to shower daily can be difficult. Such behaviour may lead to: poor hygiene, insomnia, headaches, fatigue, chronic pain, weight loss or gain increasing the risk of heart disease. As a result of these conditions, social isolation from peers and family may occur over time consequently increasing feelings of emptiness and increase the adolescent's vulnerability to substance abuse and suicidal ideation (Butler et al., 2016). Depression often increases a student absence impacting on learning and when present at either school inhibits their ability to perform adequately (Johnston et al., 2019). This is of concern for a number of academic, social and emotional reasons as students enter a cycle of learning gaps which may lead to further feelings of failure and potentially bullying. Extended absenteeism from school or placement in an alternate setting due to mental health is also identified as a key risk factor in the for suicidal ideation and attempts, inappropriate sexual behaviour, teenage pregnancy, substance abuse and violence (Kearney, 2008).

Suggested Interventions

Guidance Counsellors (GC) have many responsibilities across the schooling section in providing prevention, intervention and postvention support to students, families and teachers in regards to an array of challenges that adolescents may face. Although GC do not diagnose mental health conditions such as depression, awareness of the symptoms and co-occurring conditions and behaviours allows for early identification of students with higher vulnerability to the condition for referral and to provide bases for initiation of school-based prevention and intervention programs (Evans et al., 2002). Due to the high prevalence rates of adolescents with depressive symptoms globally, interventions within a school context have been heavily reviewed due to their unique position to influence adolescent learning. It has been identified that universal strategies beginning with prevention and the expansion of mental health literacies are needed in reducing adolescent poor mental health. Prevention programs are associated with a number of advantages with research suggesting that it is possible to prevent 22% of new depression cases annually (Werner-Seidler et al., 2017). School based mental health promotion need to focus on adaptive coping skills, help seeking behaviours and related competencies which can be delivered through social and emotional learning and targeted areas of the health curriculum. Cognitive-behavioural therapy CBT are designed to teach the use of positive self-talk to regulate negative thoughts, emotions and behaviours (Caldwell et al., 2019). Programs such as SPARK Resilience (Boniwell & Ryan, 2009*)* have been effectively implemented as universal school preventions that builds on CBT with positive psychology concepts such

as resilience and post-traumatic growth to foster emotional resilience acting as a protective factor in adolescent mental health concerns.

For students who have been diagnosed or are experiencing symptoms of depression, individual and small group CBT interventions and daily check ins may be required (Paulus et al., 2016). The integration of CBT and mindfulness has also shown positive results for people with recurrent depression. Johnson et al. (2016) suggest that adolescents may receive particular benefits from mindfulness-based interventions in conjunction with CBT in providing support to students suffering from depression and anxiety. In providing interventions to students who are suffering from depressive symptoms there are a number of CBT and mindfulness-based approaches designed for school-based universal and targeted intervention. This is the responsibility of the GC to ensure appropriate facilitation of the delivery of these programs in best supporting students. For students experiencing diagnosed depression, it is in the best interest of the student that the school and their external adult support group work together in developing a holistic approach to intervention processes. The GC in this instance is available for support during the school day in alignment with the student's mental health plan which allows for closer monitoring of the student and their conditions progression or regression.

29.

YOUNG PEOPLE

Katelyn Jackson

Young People

The Australian Institute of Health and Welfare (AIHW, 2021a) defines a young person as someone aged between fifteen and twenty-four years old. Young people in Australia account for approximately 12% of the population or 3.2 million people (AIHW, 2021a). The proportion of the population that young people represent has been in decline due to low birth rate and a longer life expectancy the proportion has declined from 17% in 1971 to 12% in 2020 (AIHW, 2021a). Like all demographics young people face specific physical and psychological challenges these include ear infections, sexually transmitted diseases, ADHD, anxiety, depression, alcohol and substance abuse (Centers for Disease Control and Prevention, 2021b).

Depression

Depression is a common psychiatric disorder which is experienced widely across all demographics, depression can also be known as major depressive disorder or clinical depression. Depression is characterised by persistent symptoms of sadness, lack of enthusiasm and a lack of pleasure from activities which were previously rewarding. Depression can have long lasting impacts on a person's life and can reoccur throughout a lifetime (WHO, 2021b). The cause of depression is often an interplay of multiple factors impacting on a person's social, emotional, physical, spiritual and psychological wellbeing (WHO, 2021b).

A person suffering from depression may have several observable behaviours, but for these behaviours to be diagnosed as depression they must be persistent for two or more weeks. A person suffering from depression may experience some of the following symptoms; sad, anxious, or "empty" mood, feelings hopeless, pessimism, irritability, feeling guilty or worthless, loss of interest or pleasure in hobbies and activities, decreased energy, moving or talking more slowly, feeling restless, difficulty concentrating or remembering, indecisiveness, difficulty sleeping, rising early, or oversleeping, appetite and/or weight changes, thoughts of death or suicide, or suicide attempts, aches or pains without a clear cause. (NIMH, 2018). Depression is generally associated by a persistent low mood.

A young person with depression will often withdraw from friends and family, this may be observed both at home and at school, this is important for parents to note as teen withdrawal is often accepted as a normal

part of adolescence (Rubin et al., 2009). A change in sleep patterns could be observed by parents or self-reported by the teen, this may look like them staying up late, waking very early or oversleeping. Whilst it is considered normal for teens to need a greater amount of sleep than adults, approximately eight to ten hours a night, regularly exceeding this may be cause for concern (Hirshkowitz, et al., 2015; Italiya & Nakhat, 2019). A lack of sleep or poor-quality sleep can impact how a young person functions in their daily life, they may seem clouded, slow in speech and reactions, and lacking in motivation and energy (Richter, 2015). A lack of energy and motivation may see young people withdrawing from extracurricular activities which once brought them great enjoyment as well as difficulties getting to school and engaging with curriculum.

Evidence of Symptoms

Depression has observable symptoms which in isolation or observed on a rare occasion may be innocuous, however when there are multiple symptoms, or these symptoms are observed over a prolonged period these symptoms may need further investigation. Within a school setting there are several ways to gather data which may assist in understanding a young person better. The following will discuss cognitive, behavioural and social observable behaviour which teachers may report to the school Guidance Officer as well as how a Guidance Officer may gather data.

Whilst there are a large range of symptoms which may be present if a young person is depressed there are signs that teachers and the school community can look out for to help identify depression to ensure that a young person is referred to receive appropriate assistance as soon as possible. As teachers spend time with students on a regular basis across a large period, they are often able to observe changes in a student's temperament and motivation levels. A Guidance Officer may ask class teachers to complete a survey to report on the student's behaviour, motivation and achievement in class and give teachers the opportunity to note if they have observed any changes. In class teachers my observe a reduction in motivation and effort when completing tasks this may include a lack of effort or failure to submit tasks (Al-Qaisy, 2011). A change in a student's academic achievement and effort may be highlighted in school report cards. This data can be gathered from a source such as OneSchool which will give an indication of the student's academic achievement across their schooling history. If there is a noted drop in achievement this would be noted as evidence of change. Poor memory and recall may be observed through questioning or formative feedback in the classroom. Studies have shown that adolescents with depression are more likely to recall negative experiences and interactions and prioritise these memories over general memories (Oliver et al., 2019).

Teachers may also observe a change in student's social interactions. Students suffering from symptoms of depression may withdraw from their friends and peers (Rubin et al., 2009). When gathering data from teachers it is important to enquire about the student's social interactions, this may include observations in class and on playground duties, it would also be of benefit to speak to the teachers who run any extracurricular activities which the student may be involved in. Students with depression may also have an interpretation bias and interpret interactions with peers in a negative way which may cause them to report negative interactions with peers on a regular basis (Oliver et al., 2019). It may also be observed that students

try to avoid large crowds such as assemblies, this may be noticed by students arriving late on assembly days or being absent. Agoraphobia and social anxiety are often comorbid with depression; therefore, the avoidance of social interactions and large groups could be a sign of depression (Breier et al., 1984).

There may be noted changes in behaviour depending on the symptoms of the individual. Students may appear sadder and more irritable than usual (NIMH, 2018). Students suffering from depression may also have difficulties concentrating in class this may be perceived as the student being unmotivated or noncompliant. A sudden or sharp rise in behaviour records for a student may indicate that they are facing some difficulties, this data may be gathered from the school's behaviour specialist or from a data report such as behaviour history on OneSchool. Students with depression may have difficulties sleeping (Short et al., 2013). Students may arrive to school late and seem very tired or complain that they have not been sleeping properly, this can also be observed in an increased number of days absent. A students attendance record will tell a story of late arrivals and days absent; this could be valuable data when gathering information about a student and a possible psychopathology.

Impact on the Individual and Interactions

Depression can impact on young people's everyday life both whilst suffering from depression and potentially later in life. Secondary schooling is a time in person's life when many skills are developed and refined (Geldard et al., 2019). A young person will develop social skills during their adolescence, however those with depression will often avoid social situations and withdraw from peers, this can have a lasting impact as they may continue feeling anxious about social interactions (Elmer & Stadtfeld, 2020). If a young person is depressed interactions may change, there can be an increase of conflicts within the family, however parents can look to be supportive model problem solving for their teen to assist them in building resilience (Sheeber et al., 2001). A student's willingness to engage with school during periods of depression can influence future outcomes such as academic achievement and future employment. Schools must be aware of how they can best support their students.

Suggested Interventions

When suspected that a student may be depressed, or the school has received information that a student is receiving care for depression the *Supporting students' mental health and wellbeing* procedure (Department of Education, 2021b) would need to be followed to put appropriate supports in place. If a staff member raises concerns about a student, this will be investigated. This can be done by surveying teachers, analysing behaviour and attendance data, speaking with the student and their parents. If there is cause, a complex case management process will begin with a case management team assigned (Department of Education, 2021b). Parents will be contacted and it is recommended that during this initial contact discussions are had around concerns that have been raised, what has been observed to validate these concerns and what the rest of the process may entail. When contacting the parent, it would be advisable to discuss the Supporting

Students Mental Health Form 1 and Form 2 with the parent to gain consent to communicate with health care providers about the students need and condition (Department of Education, 2021b). In an Education Queensland school, these support provisions would need to be recorded in OneSchool. When creating a complex case record the presenting conditions must be documented, this is where the gathered evidence can be recorded in one place (Department of Education, 2020). When working with the student and their parents, if they are not already seeking external support, the Guidance Officer may refer the student to an external agency such as Child Youth Mental Health Services. This external referral would also be recorded in the complex case record (Department of Education, 2020). Within the school there are also adjustments which could be made to support the student depending on the stressors such as an adjusted timetable, regular counselling with the Guidance Officer, referral to the school nurse, adjusted assessment conditions, inclusion in school-based support groups, and connection with a case manager. All adjustments would need to be recorded as well as communicated appropriately with staff and approved by the principal.

30.

ADOLESCENCE

Heather Loxton

Adolescence

Adolescence is the period in a young person's life when they go through many changes. The period of adolescence happens between childhood and adulthood. It is most commonly referred to as the teenage years in one's life. During adolescence young people struggle with many changes such as emotional, physical, social and environmental changes (O'Donnell et al., 2015). Often young people will struggle with their self-esteem, confidence, identity, emotions and social integration difficulties. These challenges can cause mental health problems such as depression due to the lack of confidence, feelings of isolation and their struggle to discover their identity and place in society (Geldard et al., 2019). Many of these problems come from direct and indirect influences, such as pressure from their peer group, their struggle with authority figures, mass media, their educational environment and expectation, as well as their social economic and community influence (Geldard et al., 2019). These problems during adolescences can cause young people to seek out risky and harmful behaviour, such as underage drinking, smoking, vandalism, shoplifting, reckless driving, unhealthy weight loss, anorexia and substance abuse (Costello et al., 2008; Geldard et al., 2019).

Depression

There are numerous ways of defining depression, however it is most commonly defined as a mood disorder that causes significant loss of interest and causes the constant feeling of sadness. It not only affects the way one feels but affects their motivation and ability to complete tasks and socially interact with others. Depression in adolescence affects one in seven young people between the ages of 10 and 19 years old (World Health Organisation, 2021b). While for most people depression is only experienced from time to time, there are still many people who experience a major depressive episode. Adolescents make up approximately 14% of the global number of depression cases within the mental health statistics, within the same age group (World Health Organisation, 2021a). Depression in adolescence often affects a young person's behaviour. They will experience sudden outbursts of emotions when they get worked up, such as yelling, throwing things, crying and storming off (Geldard et al., 2019). Sometimes their behaviour may seem reserved with parents describing them as having lowered self-esteem, being unmotivated, socially withdrawn, lack of concentration, poor grades and school and unhappy, with more serious signs being thoughts of death or harmful behaviour (Geldard et al., 2019). Depression in adolescence can cause alterations in biological

functions such as an excessive sleep and a change in the eating habits. Adolescent episodes of depression have an appreciable period of time, and for some young people it may present a recurring problem (Wicks-Nelson & Israel, 2015). Many current views of depression in adolescent young people hold that there are multiple determinants that cause depression in young people (Geldard et al., 2019).

Evidence of Symptoms

Research on depression in adolescents suggests that there a genetic component to depression and that there are also considerable environmental influences that affect depression. The biochemistry in the brain affects the neurons in the hippocampus part of the brain, which can cause the hippocampus to shrink causing memory loss and difficulties with concentration (Nestler et al., 2002). Dealing with a lack of concentration and memory loss for young people during adolescence can increase the feelings of stress, particularly at school due to the effect that it can have on their academic results (O'Donnell et al., 2015). This effect on the brain can also make completing familiar and simple tasks feel difficult, which can lead to feelings of guilt, anxiety and hopelessness. There are many different causes for depression.

Cognitive and behavioural theories present the idea that there are more than multiple contributing factors to depression, such as interpersonal and cognitive functioning aspects (Wicks-Nelson & Israel, 2015). Separation and loss or a learned perception of helplessness can invoke the feeling of having a lack of control in a young person's life, which can lead to outbursts, dominating behaviour and toxic relationships with others (Wicks-Nelson & Israel, 2015). Interpersonal relationships can have a significant impact on the development of depression during adolescence (Wicks-Nelson & Israel, 2015). Relationships with a young person's peers or family can slowly be impacted by depression due to a young person's social influences and egocentric development. Negative social influences can cause the feelings of isolation and loneliness in a young person, with their egocentric development potentially developing feelings that nobody understands them or their difficulties, which can cause a young person to retreat into themselves and isolate themselves from their friends (Geldard et al., 2019).

There are multiple tools that can be used for identifying depression in young people going through adolescence. In order to assess for depression, it is important to gather and obtain information through a variety of measures. These assessment strategies include structured interviews, which can be used to narrow down the symptoms of depression (Wicks-Nelson & Israel, 2015). One of the most common tools used in diagnosing depression is self-reporting, this is due the broad spectrum of possible depressive symptoms (Wicks-Nelson & Israel, 2015). Self-reporting tools focus on the young person's feelings such as worthlessness and sadness. Another strategy includes systematic observations of how a depressed young person interacts with others in a controlled environment (Wicks-Nelson & Israel, 2015). This is done to get an understanding of how a depressed young person is coping with social integration and their social behaviour (Wicks-Nelson & Israel, 2015). These techniques provide vital information for a counsellor so that they may know of the best counselling strategies and areas that a young person needs support with.

Impact on the Individual and Interactions

Depression has a significant impact on a young person going through adolescence. There are numerous situations which can cause a young person to experience depression, such as parental separation, death of a loved one, receiving very little positive reinforcement, living in an abusive or harmful environment or even moving schools or houses and leaving trust friends and family behind (Geldard et al., 2019). Young people going through adolescence respond to depression in many different ways. Adolescent boys tend to display feelings more openly, even when depressed, they may act out aggressively or storm off during an argument (Wicks-Nelson & Israel, 2015). However, girls tend in internalise their emotions in order to hide how they are feeling. They may show their depression by withdrawing themselves, worrying or getting anxious (Wicks-Nelson & Israel, 2015). Depression also causes a loss of motivation which can impact a young person education and add more negative feelings such as disappointment and stress (O'Donnell et al., 2015). Depression leaves a young person vulnerable to many risk factors, especially if left untreated. A young person may begin to engage in risky behaviour, such as underage drinking, smoking, vandalism, shoplifting, reckless driving and substance abuse (Costello et al., 2008; Geldard et al., 2019).

Suggested Interventions

There are multiple forms of treatment for depression, with the two most widely used methods being medication and cognitive-behavioural therapy (Wicks-Nelson & Israel, 2015). Cognitive-behavioural treatments are designed to confront and alter a young person's behaviour (Wicks-Nelson & Israel, 2015). In order to alter a young person's behaviour, the root of the young person's depression needs to be identified (Ivey et al., 2016). From there small goals can be made with the young person and the help of the counsellor. For example, if a young person is struggling with their self-esteem and views themselves as worthless, unhappy and useless – then small goals that focus on increasing enjoyment in life, relationship building, social interaction and coping skills, will be set to slowly help the young person to find enjoyment and coping skills that they can use to help them through their depression (Wicks-Nelson & Israel, 2015). Another example of this is, if a young person finds they cannot identify why they are feeling sad, then a coping skill can be used to help them deal with this (Wicks-Nelson & Israel, 2015). If they begin to struggle with negative thoughts, then they can use a strategy to alter their thoughts (Wicks-Nelson & Israel, 2015). If a young person finds themselves in a situation that makes them feel sad, then they can use a problem-solving strategy to change the situation (Wicks-Nelson & Israel, 2015). These strategies may include, talking to a counsellor about how the young person is feeling, which then may lead the young person to a mental health plan that could include setting small goals that focus on increasing positive thoughts and identifying the problems in different situations that make the young person feel sad. Programs like Cognitive Behavioural Therapy (CBT) are beneficial forms of therapy for people that struggle with depression as it provides guided therapy sessions that help emphasis and provide an understand of the importance of thinking and feeling. By developing a plan with a counsellor, a young

person will be able to slowly figure out strategies to help them deal with the challenges of adolescence and their integration into adulthood.

31.

ADOLESCENCE

Lynele Thompson

Adolescence

Adolescence is defined as the stage between childhood and adulthood in which the young person moves from dependency to independence (Geldard et al., 2019). During this stage of development, many challenges are presented. Biological challenges occur as the adolescent goes through puberty where physiological and sexual changes take place. The increased hormone levels impact on the adolescent's emotional state when impacted with social relationship changes (Geldard et al., 2019). Difficulties at school may arise as adolescents develop self – image concerns, partake in risk-taking behaviours and as conflicts occur. With all these changes happening, the adolescent is at increased risk of developing mental illnesses.

The World Health Organisation (WHO, 2021b) states people ages 10 to 19 years of age make up one in six of the population and globally. One in seven or 13% experience a mental disorder such as depression (WHO, 2021b). It is important adolescents are supported socially and emotionally by their family and friends, within the school environment and by the wider community. By protecting adolescents from adversity, promoting socio-emotional well-being and with access to mental health care, improvements with young people experiencing depression can be made as they progress through to adulthood (WHO, 2021b).

Depression

According to Black Dog Institute (2022) depression has high prevalence in Australia as one of the most common illnesses. Depression can be defined as having feelings of sadness and irritability lasting longer than two weeks and impacting daily life and participation in enjoyable activities (Headspace, 2022d). It can be difficult to distinguish depression from adolescent turmoil as it is common for young people to have mood swings and become irritable at times. However, having a reduced interest and enjoyment in participating in events or activities the adolescent used to enjoy doing, is what sets depression apart from just being adolescent turmoil (Black Dog Institute, 2022; Headspace, 2022d). From their interactions together, family and friends of the adolescent may notice other signs that depression is developing for the young person.

The obvious signs of depression may not always be evident as the young person's independence grows. Lower self-esteem, emotion regulation difficulties, sleep patterns and diet changes, low energy and social

withdrawal are signs that depression could be affecting the adolescent (Black Dog Institute, 2022; Be you, 2022b). Events or issues may have occurred that impacted greatly on the young person's feelings, thoughts and behaviours. They may have experienced symptoms of depression in response to stressful events (Headspace, 2022d). These symptoms can vary in severity and frequency for adolescents.

Depression can be categorised into two main types of major and mild depression. Major depression involves the young person experiencing 'episodes' with symptoms building up over a period of time and lasting for a few weeks or longer. The low mood and loss of interest in activities may cause difficulties for young persons to complete their school work, go to work and even with getting out of bed (Headspace, 2022d). A young person who has mild depression has longer lasting symptoms but can participate in most daily activities. However, they require more effort and the activities are often less enjoyable for them.

Evidence of Symptoms

Depression in adolescents is caused by a variety of events and experiences that trigger the young person into developing symptoms. Cognitive–interpersonal theories relating to depression highlight young people seek negative information about themselves as they believe they are unworthy of positive social attention, instead having negative expectations of interpersonal situations (Rudolph & Clark, 2001). These cognitive changes influence how they critically think of others. It also impacts on how young people interact with others, particularly their peers.

Adolescence involves growth biologically and cognitively which impacts on their interactions and self-belief systems. As young people develop their cognitive skills, their new-found confidence is likely to be tried out in unfamiliar situations, which are not always successful (Geldard et al., 2019). Negative events or influences combining with other triggers or may be the trigger itself, can result in depression developing. This has further implications for the adolescent with added cognitive challenges occurring.

Cognitive changes occur as the adolescent grows and also as they develop depression. Major depression can cause impaired cognitive function including memory loss, inattention and reduced executive function (Wen et al., 2021). This impacts the young person's ability to make decisions while developing a low self-esteem with possibly suicidal thoughts occurring. The influences on their emotions may mean the adolescent will have difficulties self-regulating their feelings and responses. This in turn impacts greatly on their behavioural and social choices.

Depression impacts how adolescents behave and interact with others. During adolescence, peers are spending more time together with the quality of their interactions changing. A greater reliance on each other for social support is occurring with social stress from maladaptive behavioural patterns leading to the development of depressive behaviours (Burke et al., 2017). The adolescent may engage in risk taking behaviours with their peers or withdraw away from them and their family. Their self-care may deteriorate

and they lose interest in activities that were particularly important to them (Headspace, 2022d). As they are disengaging from their family and friends, impacts are inevitable.

Impact on the Individual and Interactions

Depression impacts the individual and the interactions they have with others. An impaired functioning is linked to depression as the adolescent demonstrates diminished competence in completing daily living tasks, maintaining family and friend relationships, and their ability in school and work environments (McDermott, 2010). As their mood and behaviours change, experiences they had enjoyed previously do not have the same impact when depressed. Their depressed behaviours negatively impact relationships at home and at school while having significant consequences for their mental health and wellbeing.

Having depression is a significant risk factor for suicidal thoughts or actions. Depression is linked to suicide by being one of its strongest risk factors with suicide accounting for one-fifth of all deaths of young people in 2005 (McDermott, 2010). Not only does this have significant impacts on the individual, the effects are also experienced by interactions with their family, friends and into their schooling and the wider community. Support services are required to be put into place to support the individual as well as their family and friends.

Suggested Interventions

Prompt support through the use of a school guidance officer (GO) can be provided to adolescents showing symptoms of having depression or developing this mental illness. To assist in addressing the wellbeing needs of these students, cognitive behaviour therapy (CBT) can be utilised. CBT is a thoroughly researched psychotherapy that is considered to be one of the most effective treatments for young people who have depression (Hetrick, 2015). The GO can assist adolescents in exploring their current negative thinking and modifying their thoughts. There is a focus on changing the young person's behaviours which in turn will trigger changes in their thoughts and emotions (Hetrick, 2015). CBT is considered for reducing symptoms in the short-term for young persons who do not meet the diagnostic criteria for having a major depressive disorder (McDermott, 2010). For those adolescents who are showing symptoms of major depression, expertise clinical care is required which a guidance officer does not have the skill set or qualifications to do.

A clinical interview can be used to identify depression in adolescents. It involves a general practitioner or psychiatrist assisting the young person to make sense of their feelings and reactions, as well as identifying symptoms or severity of a disorder. The HEADSS tool (Home, Education, Activities, Drugs, Sexuality and Suicide and Depression) is a psychosocial assessment used by health professionals in a clinical encounter with young people (McDermott, 2010). Engagement is promoted by addressing confidentiality and through the structuring of questions. The assessment is in a slowly escalating level beginning with relatively 'safe' issues to more sensitive ones (McDermott, 2010). The information gathered from the assessment can

be used to inform a care plan for the adolescent. This care plan may be shared with the school so they can put further supports in place.

The school in which the adolescent who has a diagnosis of depression attends, should have an individual support plan for the student. Schools have a duty of care which includes maintaining student wellbeing and engaging in learning safely by enabling the health support needs of their students (Department of Education, 2022). Any suggestions from the care plan created by the adolescent's clinical care support team should be added to the student's individual support plan at school. This school's plan would contain current interventions such as regular counselling sessions incorporating CBT. The guidance officer will provide this intervention to further assist the adolescent with managing their mental illness of depression.

32.

ADOLESCENCE

Robyn McConochie

Adolescence

The adolescent population in Australia increased to 3.2 million in 2020, with statistics predicting that by 2066, the proportion of young people in the community will reach 5.1 million (Australian Institute of Health and Welfare, 2022). Developmentally, the goal of adolescence is to transition from childhood to adulthood; leaving behind a life of dependence, arriving at adulthood as mature, autonomous and independent individuals, with a refined sense of identity and purpose (Gerald et al., 2019). As a result, this stage of life is undisputedly an influential period of time in a young person's life; multifaceted and complex in nature and demarcated with changes that extend across the biological, psychological, cognitive, physical and behavioural developmental domains (Gerald et al., 2019; Quas, 2014). Changes in these areas of functioning impact how young people feel, interact, look, think and make decisions about their future (Torres, 2020a). Therefore, adolescence can be described as a particularly vulnerable and risky stage of life, with developmental challenges more likely to occur at this lifespan stage. For example, adolescents may experience mood disruptions; conflict with adults and authority; episodes of risk-taking behaviour; peer pressure; difficulties with abstract and egocentric thinking; challenges with parental and community expectations, self-image, as well as, ethnic, sexual, career, self and spiritual identity, and physical illness (Gerald et al., 2019). These stressors collectively or alone, have the capacity to perpetuate the onset of more serious mental health illnesses, such as social phobias, anxiety, panic disorders and depression which may result in teens requiring professional support and intervention (Black Dog Institute, 2022; Bowyer, 2022).

Depression

Depression is a mental health disorder that affects the way people think, feel and act (Torres, 2020a). It is characterised by overwhelming sadness, impaired mood, loss of interest in once enjoyable activities and can result in emotional and physical problems that impact an individual's ability to function within their home, school, work and community environments (Black Dog Institute, 2022; Healthdirect, 2020d; Torres, 2020a; WHO, 2022b; Youth.gov, n.d.). Globally, depression is one of the leading causes of disability, affecting 6.7% of people each year (Torres, 2020a; WHO, 2022b). The onset of depression can occur at any lifespan phase, however, it typically presents during the period of adolescence and may characteristically be the combined result of childhood adversity, poverty, grief, unemployment, genetics, biochemical factors, illness, gender, stress and/or personality type (Black Dog Institute, 2022; Krans &

Faris, 2021; WHO, 2022b). Depression ranges in severity and can be mild, moderate or severe depending on the duration, persistence and degree of symptoms, with women statistically more likely than men to experience a depressive episode (Krans & Faris, 2021; WHO, 2022b). An individual with mild depression may experience low mood, energy and self-esteem; poor concentration, memory, diet and sleep; guilt; anger; mood swings (irritability, despair, inadequacy) and withdrawal from social activities (Gerald et al., 2019). These symptoms often interfere with one's ability to perform daily tasks and consequently, can reduce their capacity to function within their home, work and social settings (Gerald et al., 2019). Depression in its severest form can involve symptoms of psychosis, hallucinations, delusions, thoughts of death and suicidal ideation and behaviours (Krans & Faris, 2021). However, with the correct diagnosis and treatment, the prognosis for depression sufferers is positive, with 80-90% of people going on to experience relief of their symptoms, making depression one of the most curable mental health disorders (Torres, 2020a).

Evidence of Symptoms

Depression in adolescence is synonymous with depression in adults, with statistics highlighting that more than half of all adult mental health disorders begin during the period of adolescence (Bowyer, 2022; Klein, 2021; Krans & Faris, 2021). Nevertheless, depression during this stage of life remains serious, with youth suicide identified as the leading cause of death among young people (Black Dog Institute, 2022; Healthdirect, 2020d). Various factors contribute to the cause of depression in young people and include differences in brain structure, genetics, learned patterns of behaviour, substance misuse, stress of puberty and adverse childhood trauma (Black Dog Institute 2022a; Klein, 2021; Krans & Faris, 2021; WHO, 2022b). The risk of developing depression is amplified when adolescents become exposed to family crisis, domestic violence, bullying, harassment, illness and social exclusion (Klein, 2021; Krans & Faris, 2021). Subsequently, the signs and symptoms of depression among teens often manifest differently to adults due to the cognitive, social, behavioural and environmental changes and challenges they are exposed to, making depression difficult for parents and caregivers to identify; with warning signs often confused with stereotypical adolescent behaviour (Black Dog Institute, 2022; Klein, 2021; Krans & Faris, 2021).

Symptomatically, adolescents with depression tend to have problems with declining academic performance, concentration, memory and are likely to disengage from school and work (Black Dog Institute, 2022; Klein, 2021; Krans & Faris, 2021). Socially, they may withdraw from peer groups and activities that were once pleasurable and become irritable and/or melancholic most of the time (Black Dog Institute, 2022; Klein, 2021; Torres, 2020a). The once active teen may also become uncharacteristically lethargic, lacking in energy and adopt an apathetic attitude towards the world around them, choosing to sit and internalise feelings of worthlessness, inadequacy and helplessness over opportunities to connect and engage with others (Black Dog Institute, 2022; Klein, 2021; Krans & Faris, 2021; Torres, 2020a). Physically, depressed teens may lose their appetite, refuse to eat and perform necessary hygiene routines; and experience prolonged episodes of insomnia which can result in physical ailments such as unexplained

aches, pains and illnesses (Healthdirect, 2020d). Teens who develop depression may also start to experiment with illicit substances, sexual promiscuity and engage in other risk-taking behaviours like irresponsible driving and property misconduct (Krans & Faris, 2021; Youth.gov, n.d.). Additionally, youths suffering from a severe depression episode may engage in self-harm behaviours, think deeply about death and develop suicide ideation behaviours and devastatingly, in some cases attempt suicide with success (Youth.gov, n.d).

Distinguishing between typical adolescent broodiness and depression can be challenging, however, when these signs and symptoms persist beyond 2 weeks, increase in frequency and intensity, negatively impact the daily functioning of the young person and present as uncharacteristic changes in behaviour it is recommended that they are supported to seek help (Healthdirect, 2020d; Torres, 2020a). The first step to seeking support for adolescents involves visiting a general practitioner who may assess the young person, which may include a physical examination, lab tests and psychological evaluation using interview techniques, questionnaires and basic facts template (Black Dog Institute, 2022; Healthdirect, 2020; Klein, 2021; Torres, 2020a). Based on the analysis and interpretation of the assessment, the practitioner may suggest lifestyle changes and/or refer the teen to a psychologist or psychiatrist who specialises in young people (Gerald et al., 2019; Healthdirect, 2020d). They may also contact and recommend that the adolescent reaches out to the school guidance counsellor and/or community health services to access support contextualised to their surrounding environments (Healthdirect, 2020; Klein, 2021). Unfortunately, some young people refuse offers of assistance, however, they should be encouraged and supported to access reading materials and websites to learn more about depression and its prevalence, to fully understand that help can be and is available (Black Dog Institute, 2022; Gerald et al., 2019; Healthdirect 2020d). However, when help is declined and a young person becomes suicidal, it is imperative that an adult act protectively and immediately access mental health support on behalf of the adolescent (Black Dog Institute, 2022).

Impact on the Individual and Interactions

Depression can significantly impact all aspects of an adolescent's life, with difficulties that extend beyond the individual and transcend into their home, school and community environments (Krans & Faris, 2021). Depressed teens typically withdraw and isolate themselves away from family and friends and choose to engage in various behaviours that can pose many challenges for the them and those around them (Krans & Faris, 2021). As a result of these behaviours, it is common for family members to feel helpless, which can lead to strained relationships within the home that mirror sibling, parent and marital conflict (Bowyer, 2022; Youth.gov, n.d.). Fractured family relationships are often blamed on mentally unwell teens, and affect how families connects with relatives and members of the wider community; which may isolate the individual and family from community support and/or place them all at risk of social isolation (Youth.gov, n.d).

Teens suffering from depression also find it challenging to engage in the school setting successfully.

Young people with mental health illnesses are more likely to engage in school refusal, experience poor academic success and consequently drop out, or engage in risky, anti-social behaviours that may sever peer relationships and potentially lead to increased levels of school disciplinary absences (Youth.gov, n.d.). These same behaviours also place them at risk of peer isolation, bullying and harassment, which when combined, can negatively impact their future life trajectory with later life challenges such as career and tertiary study opportunities (Youth.gov, n.d.).

Suggested Interventions

Of all mental health disorders, depression is one of the most treatable, however, it is vital for this common mental health disorder to be identified and diagnosed early (Black Dog Institute, 2022; Torres, 2020a). Medication, psychotherapy and self-help coping strategies are all outlined as effective treatment options for adolescent depression sufferers (Klein, 2021; Krans & Faris, 2021; Torres, 2020a). However, as part of a young person's treatment plan, a young person's doctor, psychologist, psychiatrist or social worker may reach out to or recommended that they seek the support of the school guidance counsellor, as they too can provide a range of psycho-educational strategies to teens that may be beneficial to overcoming mental illness (Black Dog Institute, 2022; Gerald et al., 2019). One strategy that may be effective is the *Problem-Solving Framework*, a strategy used to support self-discovery, whilst helping young people make decisions and change behaviours (Gerald et al., 2019). This strategy recognises that teens are at a stage of development that involves a new-found level of independence, that requires them to make decisions for themselves. The problem-solving framework encourages counsellors to work with teens to; identify the problem; list all the possible solutions; made a list of pros and cons; decide on the best solution; outline the steps they will take to achieve the result and revise their progress to inform future decisions and outcomes (Gerald et al., 2019). As a strategy, it can guide and support teens to understand the root cause of their depressive behaviours and look to find solutions to these problems, with emphasis on changing patterns of behaviour that may be perpetuating depression symptoms (Gerald et al., 2019). Based on the outcomes and success of the solutions explored in the framework, depressed teens and school counsellors may then work together to develop and document an individual support plan that includes effective self-help and coping strategies experienced as part of the problem-solving framework.

33.

ADOLESCENCE

Ashleigh Morris

Adolescence

Adolescence is a significant developmental period that extends beyond the linear progression of change from childhood to adulthood (Wicks-Nelson & Israel, 2015). It encompasses the dynamic change to physiological, psychological, emotional, behavioural and cognitive development (Golombek et al., 1977; Crosnoe & Johnson, 2011). Along with these changes comes many challenges and risks, threatening each layer of environment, having significant impact well into adulthood. Adolescents have a higher rate of mental health issues, risk-taking behaviours, loss in self-worth and self-esteem, and self-isolating behaviours which all have significant adverse effects on the individual during an already tumultuous time of identity formation, search for autonomy and finding a place within society (Geldard et al., 2016). Each of these factors of adolescence can result in complexities during their current developmental period and later in life.

Depression

Depression, according to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013b) is a mood disorder which affects feelings of worthlessness or guilt, behavioural symptoms, cognitive functions and physical functions (Wicks-Nelson & Israel, 2015). This mental health disorder is common among adolescents, with rates between 0.4 to 8.3%, and poses as a major risk factor for suicide and social and educational impairments (Wicks-Nelson & Israel, 2015; Thapar et al., 2012). There are three different classifications of adolescent depression. First, depressed mood being periods of sadness either in response to a situation or failure. Second, depressive symptoms, being a collection of behaviours and emotions whether anxious or depressive and third, clinical depression being the categorisation of mental disorders (Petersen et al., 1992).

Symptoms of depression are consistent among children, adolescents and adults, consisting of depressed or irritable mood, loss of interest or pleasure, change in weight or appetite, insomnia, agitation, fatigue, feelings of worthlessness or guilt, cognitive difficulty or suicidal ideation (Wicks-Nelson & Israel, 2015). Wicks-Nelson & Israel (2015) states that factors such as low socio-economic status has a significant relationship with higher rates of depression in adolescents, due to family stressors of income, limited parental education, family disruption, environmental adversities and racial or ethnic discrimination (Wicks-Nelson & Israel, 2015). The DSM-5 (APA, 2013b) states that in order to assess for depression,

information from parents, family and social environments as well as a clinical interview accompanied with an assessment instrument, such as the Child Behaviour Checklist is required (Wicks-Nelson & Israel, 2015). Depression in adolescence manifests in a similar way to that of children, however, during adolescent development and the shift in cognitive, social and biological factors, symptoms of depression begin to resemble that of their adult counterparts (Wicks-Nelson & Israel, 2015). Nevertheless, adolescent depression is often missed in comparison to adults due to the already prominent behaviours of mood reactivity and irritability that occurs during the adolescent time period (Thapar et al., 2012). During an already tumultuous time where adolescents are searching for their place in the world, this poses a significant threat.

Evidence of Symptoms

Determining the cause of adolescent depression is challenging due to the range of family, social and individual risk factors that can occur (Thapar et al., 2012). Inherited factors and adversity early in life can impact the structure and functioning of the brain, increasing the risk of depression symptoms. Additionally, research into genetics suggest that parents who have depression are three to four times more likely to have children with depression (Thapar et al., 2012). Beyond inherited factors, psychosocial risk factors should be considered when assessing cause. Environmental factors such as exposure to stressful events, chronic adversity and severe stressors on relationships such as, family discord, bullying by peers, poverty, illness and negative family relationships can each add to the compounding risk for adolescents who have already genetic predisposition to depression (Thapar et al., 2012).

Depression in adolescence can appear in many forms ranging from periods of sadness, inability to problem solve, feelings of hopelessness, disengagement from school and from social settings to reoccurring feelings of worthlessness and suicidal ideation (Wicks-Nelson & Israel, 2015). In order to best assess depression in adolescents it is important to involve a number of strategies and gather as much information, from as many stakeholders as possible (Wicks-Nelson & Israel, 2015). As depression can manifest in a number of ways, such as declines in academic outcomes, behavioural problems and withdrawal from peers and family (Wicks-Nelson & Israel, 2015). Collecting information from parents, teachers, guidance officers and social environments are all effective avenues for assessing the presence of depression. However, among the most commonly used practices is self-reported measures, in particular the Children's Depression Inventory which asks the adolescent a series of questions that best describes them for two weeks prior (Wicks-Nelson & Israel, 2015). This inventory tool is then rephrased to be used by parents and other stakeholders in order to assess different aspects of the adolescent's behaviour (Wicks-Nelson & Israel, 2015).

Impact on the Individual and Interactions

Adolescence is already a stressful period and poses great risks to an individual's physical, cognitive and psychological state. The added complexity of depression in adolescence increases these risks immensely

in regards to negative outcomes for education, family and social aspects. The increase in an adolescent feeling less self-worth, feeling displaced and disengaged, feeling chronic sadness and fatigue and at worst case, suicidal ideation, is detrimental to their health, wellbeing and future success. Within and beyond the educational context this can have lasting impacts well into adulthood which ultimately could exacerbate the individual's mental health, unless support and intervention is provided at many levels.

Suggested Interventions

Identifying mental health issues and providing support and intervention is essential when considering individuals of all ages. However, it is more detrimental when working with adolescents. Both self-reported assessment, information gathering from parents, family, environment and educational contexts, in conjunction with clinical assessment are recommended for best outcomes of interventions and support. In an educational context it is important for adolescents to be linked with the appropriate support services in order to provide appropriate support. Guidance officers are vital to first level assessment, where students engage on a daily basis. Furthermore, guidance officers have direct access to extra information from teachers and parents which can help aid in developing such things as an individual support plan. Adolescents that are dealing with depression require many levels of support. Firstly, depending on the depressive symptoms, adolescents may require a safety plan as well as an individual support plan, which is to be implemented in classroom contexts and within the overall school environment to ensure that teachers are aware of required support. However, considerations should be made when developing these methods of support. Knowledge of the students' background, past adversities, home life and current risk and protective factors are necessary for the most effective support and intervention when dealing with adolescent depression (Petersen, et al., 1992).

34.

ADOLESCENCE

Katlego Maizon

Adolescence

According to Kevey (2022), adolescents makeup the largest part of the world's population, they are estimated to be about 1.8 billion which is almost a third of the world population. Adolescence is a developmental stage characterised by rapid physical, intellectual and social changes from childhood into adulthood (Centre for Disease Control [CDC], 2019). Individuals reach this stage differently but it generally starts with the onset of puberty around the age of 10 years, and ends with the acquisition of adult roles and responsibilities at the age of 19 years (CDC, 2019). It is a period of challenges for many brought forth by accelerated changes in: physical appearance due to onset of puberty, psychological changes due to seeking independence and autonomy, cognitive changes signified by shifting from concrete to abstract way of thinking, emotional moodiness and social changes as they experience knew life influences (New South Wales Government NSW Health, 2019).

At this stage, adolescents are trying to discover their identities and build new relationships, their bodies and brain development changes so rapidly resulting in mood swings and impulsiveness (Backes & Bonnie, 2019). Due to these major shifts in their biological and social environment, adolescents are vulnerable to mental health problems such anxiety and depression (Australian Institute of Health and Welfare [AIHW], 2018). In 2021, WHO (2021a) estimated the prevalence of mental health problems among adolescents as 14% worldwide, with depression, anxiety and behavioural disorders among the leading disabilities.

Depression

Depression is one of the most common mental health problems in the world, it is characterised by an ongoing sadness and lack of interest in things which were previously enjoyable, leading to behavioural and physical challenges which affect one's functionality (Cieza et al., 2020). The four common categories of depressive disorders include: major depressive disorder also known as 'depression', persistent depressive disorder, bipolar disorder, and seasonal affective disorder, with major depressive disorder being the most common of all (Harvard Health Publishing, 2018). According to The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; APA, 2013b), all of the depressive disorders are characterised by sadness, emptiness, or irritability, together with somatic and cognitive changes that are significant enough to interfere with an individual life, the only difference is the time and length of suffering. Depression

is usually comorbid with other mental health disorders such as anxiety and drug dependence leading to increased negative outcomes in an individual's life such as self-harm and suicide if not treated (Harvard Health Publishing, 2018).

To be diagnosed with depression, an adolescent has to experience five or more of the following symptoms for at least 2 weeks, inclusive of either depressed mood or loss of pleasure: unexplained weight loss or gain, insomnia or hypersomnia, fatigue, clouded thinking, worthlessness or guilt, suicidal thoughts, extreme distress and no physiological explanation of the symptoms (APA, 2013b).According to the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) 2019, depression is one of the most disabling psychopathological disorders and ranked third of burden of all diseases both worldwide and in Australia with 13% prevalence (AIHW, 2018).

Depression is common in adolescence especially girls, with an increasing prevalence after puberty, exceeding 4% rate per year (Cieza et al., 2020). During the year 2013 to 2014, 20% of Australian adolescents aged 11 to 17 years had depression:13% and 6.6%, respectively (AIHW, 2018). Depression often remains undiagnosed among adolescents, one of the reasons is that it is challenging to differentiate adolescent mood-swings from depressive illness and therefore leading to lack of diagnosis or misdiagnosis (AIHW, 2018). Besides the physical decline in health, depression also affect adolescent's social wellbeing, manifesting through social withdrawal as the individual loses interest in things, lower academic achievement at school due to lack of motivation, involvement in risky and antisocial behaviours as a way of masking the depression and consequently becoming even more alienated due to their behaviours (Thapar et al., 2012).

Evidence of Symptoms

Several different factors: biological, physiological and environmental may lead to depression in adolescents. When considering biological and physiological factors, blood samples have been used to measure hormonal levels in a patient's body. For example, a study by Kraus et al. (2017) linked serotonin deficiency with the prevalence of depression, Serotonin is responsible for brain functions including mood and neural activities hence its deficiency increases the likelihood of depression in adolescents. The presence of endocrine dysfunction such as decreased growth hormone and hormonal shifts due to puberty in adolescents have been linked to depression (Clarke & Currie, 2009: Reinecke & Simons, 2005). Evidence gathered from high performance liquid chromatography showing defective and increased neurotransmitters from adolescents' brains have been associated with major depressive disorders (Reinecke & Simons, 2005).

Cognition and emotion are related processes originating from the interaction within the brain neurons, and a dysfunction of these interactions leads to failure to regulate one's mood and diminished cognition (Clarke & Currie, 2009). Evidence from reports of diminished executive functions such as planning, and executive control have been documented in adolescents with depression, and they also experience difficulties in memory retention which directly impacts their academic performance (Kraus et al., 2017).

Taking into consideration some environmental factors, an experience of traumatic childhood events such as neglect and abuse has been linked to depression in adolescence (APA, 2013b). Other genetic factors include family history of depression, heritability of neuroticism trait which increases the risk of developing depression during stressful events is approximately 40% (APA, 2013b), hence adolescents with family history of depression have higher prevalence.

There are several identified behavioural and social changes that may indicate that the adolescent has depression, these include: irritability-adolescents with depression tend to be more irritable and full of outbursts more than others age groups, they spend less time with their social groups as compared to those without depression (Reinecke & Simons, 2005). These behaviours also impact them at school, more often they are socially withdrawn which limits their interaction with others and exacerbating their loneliness (Reinecke & Simons, 2005).

Impact on the Individual and Interactions

Depression interferes with different aspects of an individual's life. It affects their emotions, self-perception, way of thinking, relationships, functionality and overall happiness (Clarke & Currie, 2009). At an individual level, depression does not only manifest cognitively with diminished functionality which leads to low academic achievement or psychologically as lack of interest, low self-worth and self-mutilation, it can cause physical challenges such as headaches, lack of sleep and appetite, fatigue and general body weakness, and the most detrimental of all is suicide (Kraus et al., 2017).

Depression has a ripple effect, affecting not only the individual, but also their surrounding: peers, family and school. It disrupts family routines, create conflict within the family and peers because of the moodiness and outbursts (Victoria Government; Better Health Channel, 2012). If not isolating themselves, adolescents with depression may disrupt lessons or get into physical altercation at school in order to mask the depression, this negatively impact their academic performance peer relationships (Victoria Government; Better Health Channel, 2012). They have higher prevalence of school dropout and involvement in drugs, smoking and alcohol use, which put them at a higher risk of other long-term diseases such as heart disease, diabetes and lung cancer, impacting the community's economy in the long run due to medical expenses (Better Health, 2012a).

Suggested Interventions

There are several evidence-based psychotherapeutic such as cognitive behaviour therapy (CBT) and pharmacological treatments proven to improve the symptoms of depression (Thapar et.al., 2012). A study of 439 American adolescents with depressive symptoms aged between 12-17 years on whether evidenced-based psychotherapeutic treatment or pharmacological treatment was more effective showed no difference between results of individual programmes but more efficacy on combined treatment: 73% combined, 62%

pharmacological and 61% CBT (Spirito et al., 2011). Adolescents with depression face many challenges including stigma, and this usually impedes them from seeking help (Thapar et.al., 2012). It is the responsibility of the Guidance Officer (GO), administration staff and teachers as they are the secondary carers, to devise a whole school approach as an initial intervention to teach about depression and target stigma associated with it hence encouraging students and families to seek help more (Thapar et.al., 2012).

For adolescents who have depressive symptom, the school guidance officer should adapt the use of Cognitive Behaviour Therapy (CBT), which has been proven to alleviate symptoms of depression in adolescents (Spirito et al., 2011). CBT is an evidence-based therapy which involves mood monitoring, social skills, relaxation training, thinking and problem-solving techniques which are needed for emotion regulation and interpersonal relations, for adolescents, the involvement of parents is critical as primary carers to enhance the support system (Spirito et al., 2011).

Telman et al. (2020) suggest a more individualised program which targets the individual's personnel needs and strength. As the GO is limited when considering pharmacological treatment, they cannot use it as their intervention plan. Unless the adolescent is already on medication, it is advisable to consider a combination of CBT with Interpersonal Psychotherapy for Depressed Adolescents (IPT-A). IPT-A is described as a short-term therapy aimed at focusing on the individual's current functioning challenges in order to reduce symptoms of depression by enhancing their interpersonal relationships (Mufson et al., 2004). It is focused on five main areas associated with depression: grief, conflicts, role changes, empathy and parental component. The aim of IPT-A is to identify interpersonal relationship challenges within the five areas above and focus on them treat the depression. Studies have shown that both CBT and IPT-A are beneficial towards adolescence depression (Telman et al., 2020: Mufson et al., 2004), with IPT being more efficacious than CBT (Mufson et al., 2004), and therefore it is reasonable to combine them as they target different areas of life.

35.

ADOLESCENCE

Kylie Bilsen-Neville

Adolescence

Adolescents make up almost 15% of the Australian population (Australian Institute of Health and Welfare [AIHW], 2020b). This is over 3.2 million young people, up from 2.3 million in 1971 (AIHW, 2021a). The proportion of adolescents in relation to the Australian population is expected to remain the same for the next 45 years, resulting in well over 5 million adolescents in 2066 (AIHW, 2021a).

Adolescence is a time for significant growth and development. The body grows in size, the brain rewires, the sexual and reproductive organs mature. Simultaneously, adolescents develop advanced reasoning skills and a stronger sense of self as they seek to create their own identities through forming attachments with people other than their parents (Lumen, n.d.). Within all these developmental changes the importance of good health, both mentally and physically is imperative. When adolescents have good overall health, they achieve better academic outcomes, transition successfully to full time employment, develop healthy adult lifestyles and engage in fewer adverse risky behaviours (AIHW, 2020c; Institute of Medicine (US) et al., 2011).

Fewer risky behaviours could reduce the injuries and deaths amongst adolescents as there is a significant increase of injury related deaths between ages 10 to 14 and 15 to 24 years (AIHW, 2020c). Additionally, mental health disorders of adolescents are on the rise with approximately one third of Australian youth reporting high to very high levels of psychological distress (AIHW, 2021b). Poor mental health is associated with suicidal ideation. Self-inflicted injury and suicide were the leading cause of burden of disease for people aged 15 to 24 in 2015 followed by anxiety and depression (AIHW, 2021b). One key challenge that adolescents face is the diagnoses of depression as typical adolescent behaviour is often indicated by increased irritability, mood negativity and instability which can mask depressive symptoms (Dietvorst et al., 2021)

Depression

Depression is a persistent state of sadness, loss of interest in pleasurable things and a general feeling of hopelessness that can interfere with relationships and one's ability to participate in daily activities (Nelson & Kjos, 2008). The World Health Organisation (WHO) classifies depression into three categories; mild,

moderate and severe and although many people may experience depression at some time major depressive episodes are distinguished by their severity, persistence and duration (Geldard et al., 2019). One out of every seven Australians will experience depression in their lifetime and globally approximately 5% of adults suffer from depression (Beyond Blue, 2021; WHO, 2021a). Adolescents who become depressed and suffer depressive symptoms are at higher risk of developing depressive disorders as adults.

The predominant symptoms of depression are sadness, emptiness, feeling hopeless and having a negative focus on problems. People may also experience weight loss or gain, suffer from insomnia or hypersomnia, experience headaches and stomach problems, feel exhausted, drained of energy and sluggish (Nelson & Kjos, 2008). Depression can leave a person feeling tired, empty, angry, sad and irritable. They experience poor concentration, feelings of guilt, low self-worth and have suicidal thoughts. These symptoms often interfere with their everyday activities of work, school and family/social interactions.

The most severe outcome of depression is suicide, which is the leading cause of death in Australian adolescents (Healthdirect, 2018). Suicidal ideation and parasuicide becomes most common at approximately 15 years of age and should be taken very seriously, serving as a warning that an adolescent's emotions are overwhelming (Lumen, 2012). When an adolescent descends into major depression their thinking becomes distorted and all normal, regular activities are disrupted as their thoughts become increasingly pessimistic, sad and hopeless (Nelson & Kjos, 2008).

There is no one cause for depression. Genetics and adverse childhood experiences, puberty, lack of self-esteem, lack of connection with others and unstable family environments may all contribute to depressive disorders.

Evidence of Symptoms

Many adolescents experience some types of depressive moods with studies indicating that higher negative moods are shown in early adolescence and then growing out of them towards later adolescence (Dietvorst et al., 2021). However, this is not indicative of all adolescents with some negative moods escalating through to problematic depressive disorders affecting wellbeing. Adolescents displaying depressive symptoms experience persistent patterns of lower positive moods.

Adolescents who experience depression may also engage in high risk behaviours, such as unsafe sex, substance abuse, self-harm and aggression towards others (Geldard et al., 2019; Nelson & Kjos, 2008). Conflict with parents is also prevalent to adolescents with depression, consequently, they may run away from home to avoid confrontation and pressures. These adolescent behaviours often mask the depressive symptoms and can be a way for the adolescent to self-medicate and alleviate the pain of their depressive thoughts.

Additionally, adolescents may lack concentration and focus, have failing grades at school, be irritable, have feelings of guilt and self-hatred (Nelson & Kjos, 2008). Due to the depressive symptoms of sadness,

disruption in sleeping patterns, loss of interest in regular activities, isolation and anger are characterised as typical adolescent behaviours, depression can often be undiagnosed or go unnoticed. However, when an adolescent begins to isolate themselves and is displaying self-destructive behaviours further investigation and testing must be done to uncover their state of mind and motivation.

Due to adolescents trying to mask their feelings parents are often unaware of their self-damaging behaviour and thought patterns of loneliness, fear, shame, self-loathing and despair. It is a positive sign if an adolescent informs a parent or adult about their depressive symptoms as this shows they have a belief that others can help. Unfortunately, the most self-destructive and damaging behaviours are kept private by the adolescent believing that others would not help and they are not worthy of help anyway (Wise, 2004).

As acknowledged, identifying depression in adolescents can be difficult unless they present themselves and request help. Symptoms can often be masked as delinquent behaviours or mistaken as a typical moody adolescent. It has been recognised that completing real-life or context-mood questionnaires could assist in detecting adolescents who are at risk of developing depressive disorders (Wise, 2004).

Impact on the Individual and Interactions

Depressed adolescents risk problems in varied aspects of their lives. Even though adolescents often report feeling happier and having a more positive mood when around their friends they may begin to withdraw from social situations such as school as they have the inability to adapt their moods to different contexts (Dietvorst et al., 2021). Thus, poor school attendance results in poor academic results perpetuating the isolation of an adolescent as they refuse to attend due to failing as well as their depressive mood. This can lead to further at-risk situations such as unemployment as an adult.

Literature confirms that parents and adolescents rarely discuss the personal issues of adolescence thus many parents are unaware that their child may be suffering (Wise, 2004). Additionally, they may not recognise signs and symptoms specific to a depressive disorder and dismiss their adolescent child's emotions as moody, telling them to 'snap out of it'. These types of statements and beliefs can reinforce the adolescent's negative feelings and further distance them for seeking support within the family.

Adverse childhood trauma, family hardships and parental psychopathology contribute to the troubled social, behavioural and emotional behaviours displayed during adolescence. Adolescents who have not learned successful socialisation skills such as conflict resolution, communication and problem-solving techniques are at risk of developing stress in their friendships and selecting maladaptive social contexts (Lumen, 2012). This can generate a scenario of depressed adolescents congregating together exacerbating negative social and depressive contexts and feelings within one another leading to more sinister individualised and internalised depressive thoughts

Suggested Interventions

Depression is a complex condition with such varied symptoms and reasons to why one would become depressed. Although there are medications used to treat some people with depression they are not the preferred option as many antidepressant medications do have adverse side effects. Psychological treatments are a more favourable option when treating depression. In Queensland, the government supports those in need to obtain a mental health plan. By visiting a local GP, a mental health plan can be created assisting access and affordability to allied health professionals. To assist in diagnosing anxiety and depression a K10 checklist can be used and when a student presents with persistent depressive symptoms the Guidance Officer (GO) will refer the adolescent to their GP for a mental health plan so they have further assistance and more protective factors on offer.

Additional to the GP referral a GO can work with the adolescent in the school environment and offer support. Modified cognitive behavioural therapy (CBT) can be useful for assisting adolescents with depression. Rather than allowing the adolescent to continually reflect on their feelings (as this can be counter-productive) GO's can reflect back their beliefs, support them in becoming aware of their self-talk, assist them to set short term goals, encourage activity and use a priming approach to help them understand that others have different responses and beliefs (Geldard & Geldard, 2012; Scanlan & Francey, 2017). Similarly, to children, adolescents like things to be fun; GO's can tap into this part of the adolescent by being playful and creative with their CBT techniques including using games, role-plays, simple and relatable language such as metaphors, cartoons and props. These things can help the adolescent make sense of what is going on for them and remember the session. There are also a range of outside agencies that work with schools, such as Headspace, that can assist adolescents to deal with their feelings and connect with clinicians.

36.

ADOLESCENCE

Karen Stirling

Adolescence

The adolescent years are a critical time for brain development, with the brain reaching its biggest size in early adolescence, undergoing significant changes and remodelling during this crucial time. The adolescent brain works differently to that of an adult when making decisions and solving problems. Adolescent actions are guided more by emotions and the reactive amygdala, and less by the thoughtful, logical frontal cortex, which does not fully develop until a person is approximately twenty-five years of age (Casey et al., 2008). The neurotransmitters in the adolescent brain such as serotonin, acetylcholine and norepinephrine are central to the study of the biochemistry of depression, and it was found that low neurotransmitter levels respond effectively to antidepressant medications. Antidepressants work by increasing levels of neurotransmitters in the brain, which help to raise and regulate the mood and emotion in the teenager. However, side effects can be quite debilitating and may include agitation, dizziness, headaches, and stomach aches (Wicks-Nelson & Israel, 2015).

During the adolescent years young people begin to develop their sense of self and develop their identity. The complex interplay of the internal and the external factors that impact on identity development involve all aspects of social, psychological, and environmental factors, which impact on how an adolescent will feel, think, and interact with others around them (Wicks-Nelson & Israel, 2015). It is a developmental period which is often characterised by poor decision making that give rise to violence, alcohol and drug abuse, early sexual relations, teenage pregnancy, self-harm, and suicidality (Wright & Kutcher, 2016). Teenagers around the world are currently experiencing high levels of mental ill-health, and suicide is now the leading cause of death of teenagers. Data suggests that although adolescents as a group are considered high risk takers, some teenagers will be more prone than others to engage in risky behaviours, depending on the ecological and biological factors (Black Dog Institute, 2020). Recent data indicate suicidality, eating disorders, self-harm, anxiety, and depression are at an all-time high, and depression has now become the third leading cause of death among teenagers. Mental illness during the vulnerable adolescent stage has an adverse effect on adolescent brain development as well as mental health and wellbeing (Cavioni et al., 2020).

Depression

Depression, is labelled in the *Diagnostic and Statistical Manual of Mental Disorders*, (APA, 2013b)

as clinical depression or major depressive disorder and described as being a serious mood disorder. Adolescents who suffer from depression experience ongoing feelings of hopelessness, sadness and have lost an interest in life itself. Teenagers can also present with physical symptoms such as digestive issues and chronic pain when depression is present. In order to be diagnosed with depression, a person must, for the duration of a two-week period experience five of the following eight symptoms. Read the list of signs and symptoms of depression at Beyond Blue's website.

In order to be diagnosed with depression, at least five of symptoms must cause the young person significant distress or impairment in school, social, occupational, or other important areas of functioning. The symptoms must not be a result of substance abuse or any other medical condition (APA, 2013b).

Evidence of Symptoms

Depression is characterised by an obvious decline and impairment of mood in the adolescent's mental health and wellness. The early stages of depression may not initially cause any concern to those closest to them, as depression can often be misinterpreted as the stereotypical view that the teenager is in the storm and stress period of their life (Astalis, 2005). This misrepresentation may lead many adults to minimise the serious nature of depression and assume it is just the teenage phase they are going through (Geldard et al., 2019). It can be difficult to distinguish depressive illness from adolescent turmoil, especially when the teenager is attempting to forge new roles within the family, is struggling with independence and at the crucial stage of having to make vocational and career decisions (Berk, 2010).

There are a number of symptoms a young person will display through their cognition, social skills, and their behaviour. Early-onset depression is associated with low self-esteem, an increased risk of suicidal behaviours, substance abuse, recurring depression as well as other significant emotional and mental health concerns that often carry on into adulthood (Hodes & Gau, 2016).

Teenagers with depression often struggle cognitively with their concentration and to remember even the most basic things, describing the feeling as having brain fog. Young people with depression report their sleep patterns are affected either with an inability to sleep, they may be sleeping excessively, or they are waking multiple times throughout the night. There are significant changes in their appetite and weight, either losing or gaining a substantial amount of weight in a short period of time. Young people suffering with depression often have a reduced pain tolerance for minor aches and pains and their sex drive will either reduce or disappear completely (Nolen-Hoeksema, 2013).

There is often an inability to control emotions such as guilt, anger, irritability, and anxiety and they may find they have a myriad of emotions throughout the day. They may feel worse first thing in the morning and begin to feel better as the day progresses. It is very common for young people with depression to have a reduced capacity to experience pleasure, an inability to enjoy the here and now, and they often do not look

forward to any activities, hobbies, or upcoming events. Motivation to carry out even the most menial of tasks is difficult and they describe themselves as having very low energy levels (Black Dog Institute, 2020).

Impact on the Individual and Interactions

As depression begins to worsen, it often leads the adolescent to isolate from friends and family and they will almost always seem to appear gloomy, downcast, and alone. There is very little social interaction or communication from the teenager with their family, spending large amounts of time in their room, which is usually darkened by closed blinds or curtains. They very often lose contact with their closest friends and will make no effort to return calls or initiate contact with them (Berk, 2010). Depression will impact significantly on school performance, which will create a downward spiral effect on later study or career options. It is well documented that an adolescent with depression will achieve much lower academic attainment than their non depressed peers due to a number of factors, which may include working memory, sleep deprivation, school absenteeism, which may lead to an increased risk of school dropout, further exacerbating their already low self-esteem (Quiroga et al., 2013). They have very little regard for their life, therefore will engage in risk taking behaviours such as inappropriate sexual involvements, reckless driving, drug and alcohol abuse, vandalism, shoplifting, self-harm, join gangs, and engage in serious criminal activities (Geldard et al., 2020).

Suggested Interventions

School staff are gatekeepers for depressed and suicidal teenagers, therefore ensuring all staff are trained to recognise depression in an adolescent is key to early identification and intervention (Mo et al., 2018). Cognitive Behaviour Therapy to support the behavioural, social, and emotional needs of teenagers to prevent, as well as treat depression is an excellent strategy to redirect a student's negative thought pattern (Forman & Barakat, 2011). Cognitive Behaviour Therapy is designed to firstly confront, then modify an adolescent's maladaptive cognition. The adolescent is taught self-control, challenge their self-destructive belief systems such as replacing the following statement: 'I never succeed in anything', with, 'sometimes I succeed and sometimes I fail. I'm human and I'm ok'. Instigating a strong focus on future goals such as improved social, communication, and coping skills as well as a focus on a student's academic, future career and vocational pathways are strategies that can be implemented by the school guidance counsellor (Wicks-Nelson & Israel, 2015). The school guidance counsellor is in a position to provide ongoing Cognitive Behaviour Therapy and support to individual students as well as implement group therapy for students struggling with depression (Education Queensland, 2019).

PART V

POSTTRAUMATIC STRESS DISORDER (PTSD)

37.

CHILDHOOD

Melissa Elliot

Childhood

During childhood the key developmental challenges experienced include sleep, toileting, intellectual, learning and communication difficulties, conduct disorder, developmental disorders such as Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiance Disorder (ODD), fear and anxiety disorders, Post traumatic Stress Disorder (PTSD), depression, bipolar disorder, and Autism Spectrum Disorder (ASD) (Carr, 2015).

Post-traumatic Stress Disorder

Common behaviours displayed by children when they are stressed include crying, becoming aggressive, talking back or becoming irritable. Other children may behave well but become nervous, fearful, or panicky. Emotional and behavioural reactions to a traumatic event are normal, and at times these reactions can be quite strong. Experiencing such things as fear, loss of interest in activities, emotional upheaval, difficulty concentrating and paying attention is a normal human reaction to trauma. (Peterson, 2022), However, when these symptoms of stress continue for longer than a month, are upsetting or interfere with their relationships and activities, a child may be diagnosed with PTSD (Centers For Disease Control and Prevention, 2022).

PTSD can develop as a consequence of experiencing or witnessing a traumatic event, learning about the death or threatened death that has occurred to a close family member or friend (Centers For Disease Control and Prevention, 2022), repeatedly being exposed to traumatic events through media or conversations overheard by adults (Cobham et al., 2016).

Some of the causes of PTSD can include disasters both natural and man-made, family events such as domestic violence, abuse (physical or sexual), or extensive injuries gained from accidents, for example, a car crash. The type of event and the severity of exposure impact the degree to which PTSD is experienced (Hamblen & Barnett., 2022). Regardless of whether the child was a victim or a witness, the symptoms of PTSD can impact the daily functioning of a child (Trickey et al., 2012).

Behaviours can be observed in a variety of settings including the home, school and other environments. Some behaviours seen at home may include developmental regression, bedwetting, nightmares or sleep

disturbance. Young children may show unusual clinginess to the carer, have an exaggerated startle response (Peterson, 2022). They may avoid places or people associated with the event, become irritable or experience angry outbursts, they may relive the event over and over in thought and this can be observed in their play (Centers For Disease Control and Prevention, 2022).

At school there may be a decrease in academic performance. A child's capacity for self-regulation, organisation, comprehension, and memorisation can be severely impacted due to trauma, affecting students academically and socially throughout their school experiences (Thommas et al., 2019). A child may display a lack of positive emotions or may experience feelings of intense ongoing fear or sadness. Constantly looking for possible threats or becoming easily startled, becoming very upset when something causes memories of the event especially if the event occurred at school. The child may even pretend that the event never even occurred (Centers For Disease Control and Prevention, 2022). A child may stop talking and refuse to communicate with those around them.

Evidence of Symptoms

The brain recognises the situation as dangerous or threatening, feelings of apprehension, tenseness and uneasiness would most likely be experienced and then an automatic arousal occurs to prepare the child for the appropriate response to the danger, fight or flight. In the case of extreme danger, they may freeze. The resulting behaviour whether aggressive or avoidant is dependent on the context in which it occurs. This context usually would involve parents, siblings, school teachers and peers (Carr, 2015).

Many people go through traumatic events but not all people develop PTSD. It has been found that when certain risk factors are present then there is a higher likelihood of the condition occurring. Apart from the level of exposure, other risk factors include female gender, previous trauma exposure, pre-existing psychiatric disorders, parental psychopathology and low social support (Peterson, 2022), poor family functioning and the type of communication between parents and their children (Cobham et al., 2016). Protective factors include parental support and lower levels of parental PTSD have been found to predict lower levels of PTSD in children (Peterson, 2022).

Children may experience time skews which refers to a child mis-sequencing trauma-related events when recalling the memory and 'omen formation' which is the belief that there were warning signs that predicted the trauma. As a result, children often believe that if they are alert enough, they will recognise warning signs and avoid future traumas. A child may re-enact the trauma in play, drawings, or verbalisations, they child may compulsively repeat some aspect of the trauma, and this type of play does not tend to relieve anxiety (Hamblen & Barnett, 2022).

A functional behaviour analysis (FBA) would be most beneficial to determine the causes of behaviours to determine if the behaviours being exhibited are indeed PTSD and not something else. This involves collecting data from a review of the child's school records, interviews with school staff and parents/carers,

structured rating scales, a collection of direct observation data, identification of any health and wellbeing concerns or issues and consideration of environmental conditions that may impact behaviours of concern (State of Victoria Department of Education and Training, 2020).

If PTSD is suspected then child should be referred to a health care provider trained in psychotherapy in which the child can speak, draw, play, or write about the stressful event (Centers For Disease Control and Prevention, 2022).

Impact on the Individual and Interactions

At times the behaviour of children with PTSD can be mistaken for the behaviour problems associated with oppositional defiance disorder and conduct disorder (Peterson, 2022), or attention deficit hyperactivity disorder (ADHD) as children may seem restless, fidgety, or have trouble paying attention and staying organized (Centers For Disease Control and Prevention, 2022). Children with PTSD have also been found to experience problems with fear, anxiety, separation anxiety, panic disorder, depression, anger and hostility, aggression, sexually inappropriate behaviour, self-destructive behaviour, feelings of isolation and stigma, poor self-esteem and difficulty in trusting others (Peterson, 2022).

Children with PTSD may find it difficult to communicate with peers or family members due to the stigma attached to the trauma. Further, PTSD in children can damage the child's relationship with parents and other caregiving adults, siblings, and peers, especially if abuse is the cause of the trauma (Peterson, 2022). In this case attending a family event, where the abuser may be present may trigger the behaviour, or attending school where a child has experienced severe bullying. Travelling in a vehicle after witnessing or being involved in a car accident.

Suggested Interventions

Because of the very nature of PTSD, it is usually treated by professional psychotherapists through play-based therapy or Cognitive Behaviour Therapy. The school guidance counsellor may have training in these areas and therefore would be able to use these methods in the treatment of children suffering from PTSD. However, for those who are not trained, working with students with a trauma informed practice would be highly beneficial (Thommas et al., 2019). Kezelman (2014) states that Trauma Informed Practice is a strengths-based framework which is founded on five core principles – safety, trustworthiness, choice, collaboration and empowerment as well as respect for diversity.

The guidance counsellor could help with building self-esteem, employing positive coping strategies, developing a healthy self-image and learning how to manage stress. Using the information gathered with an FBA, the school team could implement school wide strategies to assist all students in these skills. Because of the multiple behaviours that can be displayed by children suffering from PTSD a child's Individual

Support Plan would need to be structured specifically to the types of trauma reaction displayed (Thommas et al., 2019).

38.

ADOLESCENCE

Judith A. Symonds

Adolescence

The chosen population for this report is the formal operational adolescence stage from ages 12 and up according to Piaget's Cognitive Development Theory (Hugar et al., 2017). During this stage students begin to think in abstract terms, having abstract reasoning and are beginning to be able to use deductive logic.

Post Traumatic Stress Disorder

The diagnosis of PTSD has been extended to children and adolescents since 1987 (referred to as youth) (Hawkins & Radcliffe, 2006). The symptoms of PTSD are variable because the extent of damage differs depending on developmental stage. The most common symptoms of PTSD include nightmares, fear, and general distress reactions. However, symptoms can extend to re-enactment of the event, regressed behaviour, separation anxiety, and specific forms of behaviour, academic, and somatic problems (Hawkins & Radcliffe, 2006).

Youth have been found to experience PTSD from many types of events where the severity of condition is related to the level of exposure and number of exposures to the experience. There is also a clear association between childhood medical illness such as cancer or trauma due to an accident and post-traumatic stress symptoms in both children and parents. Between 25 and 87% of youth report experiencing at least one traumatic event before age 20, with girls reporting more episodes (Hawkins & Radcliffe 2006).

Evidence of Symptoms

PTSD is detected through youth and parent interviews and youth self-report PTSD/PSS measures exist (Hawkins & Radcliffe 2006). The Impact of Events Scale–Revised may be useful as a self-report measure to assess intrusive and avoidant reactions associated with a particular event (Hawkins & Radcliffe, 2006) and could highlight triggers. Another possible instrument is the Child Post-Traumatic Stress Disorder Reaction Index (CPTSD-RI) which is often used as a self-report measure (Hawkins & Radcliffe, 2006) and would highlight levels of distress. A very useful instrument for Guidance Officers is the Trauma Symptom

Checklist for Children (TSCC) which is a self-report measure that can assess a range of symptoms in children (Hawkins & Radcliffe, 2006) and could be used to check whether PTSD is a possibility before investigating more thoroughly.

Impact on the Individual and Interactions

Children's brains naturally respond to environmental signals to satisfy needs and develop strategies over time. For example, if a child is malnourished, the child will develop strategies to ensure that a meal can be found and the child can survive (Libertin, 2019). However, if a child faces repetitive starvation, their brain develops strategies to remain alert and reactive and other parts of the brain controlling logic and thinking do not develop. For example, researchers have found that PTSD in early childhood abuse cases is associated with deficits in verbal declarative memory which suggests changes to the hippocampus (Caffo et al., 2005). Eventually researchers have found that the teen's brain develops neural pathways for fear as coping mechanisms to survive trauma that are triggered by emotions that are uncontrollable and unexpected.

PTSD triggers are certain smells, sights, situations and feelings that activate a strong emotional response from a person. Reactions to triggers are uncontrollable by the individual once they escalate past a certain point.

Suggested Interventions

Overall, interventions to PTSD outbursts must be carefully and creatively built to build connected relationships. Research by Libertin (2019) warns adults to steer clear of punishments that involve confiscation of digital devices and time-outs as these only exacerbate the problem. Instead, interventions can be family or group activities such as social sport, bushwalks or other group activities that give the teen a chance to connect and share. If connection is enabled, some teens experience post-traumatic growth where teens experience inflated perception of self, better interpersonal relationships, and positive changes to life priorities (Caffo et al., 2005).

The main treatment approaches used in the interventions for PTSD are Cognitive Behavioural Therapy (CBT), Play/Art, Eye Movement Desensitization and Reprocessing and Mind-Body Skills and multiple forms of treatment utilised in several studies (Rolfsnes & Idsoe, 2011). In the first instance, researchers agree that trauma-focused CBT should be used in all children over seven years (Caffo et al., 2005; Brent et al., 2022). For children who do not respond to trauma-focused CBT there may be trauma reoccurring or triggers causing relapse. Research suggests that in these cases trauma reminders should be minimised or avoided (Brent et al., 2022). Medication may also be considered (Brent et al., 2022).

Another possible scientifically backed intervention for PTSD in adolescents is the Brief Relaxation,

Education and Trauma Healing (BREATHE) intervention. Although developed for primary care hospital settings, the intervention has been shown to be feasible and sustainable (Srivastava et al., 2022). Predominantly made up of breathing techniques and mind-body relaxation skills, BREATHE have scientifically been shown to increase a sense of control and decrease anxiety (Kobayashi-Suzuki, 2014). Research suggests that BREATHE suits older children better than younger children although there is no research to suggest age-appropriate modification of the BREATHE approach.

39.

CHILDHOOD

Kay Dillon

Childhood

Childhood is a time of significant development. Children's language skills, executive functioning, and self-regulation are developed actively through positive interactions (Center on the Developing Child, 2007). The associated skills that they develop contribute to academic, social, and emotional functioning. Delayed or disrupted development can result in difficulty sustaining attention, following instructions, retaining new information, and establishing positive relationships with peers. As development progresses, evidence of neurodiversity may become apparent. For example, inability to maintain focus, careless behaviour, and excessive talking may be indicators of Attention-Deficit Hyperactivity Disorder (ADHD) and delayed language and communication skills, challenges with social interactions and sensory difficulties are some indicators of Autism Spectrum Disorder (ASD; Wicks-Nelson & Israel, 2015). As they develop, children also experience significant integration of neurological and physical skills through proprioception development; this is interconnected with cognitive development and affects areas like handwriting, gross motor skills, and self-regulation (Raising Children Network, 2022).

Children are vulnerable and dependant on their parents/caregivers. The relationship that children experience with their parents is a central component of their development (Center on the Developing Child, 2015). It is a source of protection but can be also a major risk factor. This relationship, known as attachment, is established in a child's formative years and can be classified as either secure, ambivalent, avoidant or disorganised (Cherry, 2019). The patterns of attachment formed with parents also affects the attachment style the child may use in other relationships thus contributing either to positive development or developmental challenges (Bowlby, 1982). Ambivalent, avoidant, and disorganised attachment styles are indicators of possible exposure to neglect, abuse and/or trauma. These suboptimal attachment styles then further increase a child's vulnerability to abuse and trauma, both of which have a major impact on all areas of their development (Bowlby, 1982; Cherry, 2019; Davidson & Davidson, 2007).

Posttraumatic Stress Disorder

Both the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013b) and the International Classification of Diseases 11th Revision (ICD-11; World Health Organisation, 2019a) recognise Posttraumatic stress disorder (PTSD) as a psychiatric disorder that develops in response to

the person experiencing or witnessing a stressful or traumatic event or events. Examples of stressful or traumatic events include war, natural disaster, terrorism, serious accident, personal attack (including rape or sexual violence), and bereavement (The National Child Traumatic Stress Network, n.d.). There are some variations though between definitions and related conditions. This Mental Health Case Report will be referring to the DSM-5 definition of PTSD that applies to adults, adolescents, and children as young as six years old.

While data relating to incidence of trauma in Australia is limited, international research estimates between 62 to 68% of young people have had exposure to at least one traumatic event by 17 years of age (Australian Institute of Health and Welfare, 2020e). PTSD is experienced by up to 16% of children (Phoenix Australia, 2021). Symptoms of PTSD are organised into four categories and can vary in severity (Wicks-Nelson & Israel, 2015). These categories are intrusion, avoidance, alterations in cognition and mood, and alterations in arousal and reactivity. Intrusion can be explained as re-experiencing the event with intrusive thoughts, and avoidance includes conscious and unconscious efforts to evade association with the event. Alterations in cognition and mood are characterised by negative thoughts and negative emotional state, including distorted thinking. Altered arousal and reactivity is typified by anger, irritability, and variation in engagement from hypervigilance to poor concentration (Rothbaum, 2021). Experiencing these symptoms is a normal response to trauma. Symptoms become a sign of PTSD when they are present for more than a month and affect daily functioning. Three months post-experience is when many develop symptoms but in some instances it is later. The duration of PTSD can also vary, from months to years, and be experienced in conjunction with other psychopathology and disorders including depression, anxiety, behavioural, substance abuse, and developmental delays (APA, 2020b; Wicks-Nelson & Israel, 2015). Related conditions include acute stress disorder, adjustment disorder, disinhibited social engagement disorder, and reactive attachment disorder.

Evidence of symptoms

Symptoms that are the observable behaviours and experiences of a person with PTSD can be classified in the four categories of avoidance, intrusion, negative cognitions and mood, and alterations in arousal (Phoenix Australia, 2021; Wicks-Nelson & Israel, 2015). Observable behaviours and experiences associated with intrusion include recurring nightmares, vivid memories, flashbacks, intense emotional distress, and physiological reactions (Rothbaum, 2021). In children this may present as sleep problems resulting in fatigue and affecting their ability to engage in learning when at school (Phoenix Australia, 2021). Children may recreate their experiences of trauma in their play or repeatedly retell the story and events associated with their traumatic event. Children may experience a racing heartbeat or trouble breathing when reminded of the trauma.

Experiences in the category of avoidance include avoiding discussing or thinking about the trauma, and avoiding external reminders including people, places, and activities (Phoenix Australia, 2021). Depending on where the trauma was experienced will impact on a child's ability to feel safe. Avoidance may result in

school or activity refusal, or difficulty being with certain peers or school staff. Children may also experience increased separation anxiety.

Negative alterations in mood and cognition include memory lapses of the event, and pervasive negative thoughts and feelings leading to distorted beliefs about themselves or others (APA, 2020b; Phoenix Australia, 2021). Mood and cognition alterations may also include inaccurate thoughts about the cause and consequences of the event and associated feelings of guilt and shame, inability to experience positive emotions, and withdrawal from regular activities where enjoyment had previously been experienced. Children may experience a new realisation of their own mortality, feel anxious or depressed, and have difficulty concentrating and remembering.

Alterations in arousal and reactivity may result in feelings of anger and irritability, or uncontrolled behaviour (Phoenix Australia, 2021). Children may exhibit tantrums, oppositional behaviour, show skill regression in previous areas of mastery and may also develop new fears. Feelings of hypervigilance may also be present affecting a child's ability to feel safe and engage in learning.

Impact on the Individual and Interactions

A sentiment felt by those who have experience PTSD, is that rather than focusing on what is wrong with them and trying to fix it, they want those around them to acknowledge and understand what they have experienced (Ford, 2015; Llewellyn, 2015). PTSD can range in intensity and duration with one third of children with PTSD experiencing natural recovery with a year, one third achieving positive outcomes from direct interventions, although the remainder of children experience prolonged effects (Phoenix Australia, 2021). A major consideration is the vulnerability of children and their reliance on parents/caregivers. It is essential for adults who are in a support role to children, to receive assistance with their experiences of trauma first or concurrently as their experiences of PTSD can affect the parent-child attachment relationship (Phoenix Australia, 2013).

After incidents like the recent flooding, pandemic, drought, and bushfire events whole communities may be experiencing symptoms of PTSD. Coordinated responses of support may be required between schools and multiple government or other external agencies. Triggers may be readily experienced with seemingly simple events like rain and schools need to have response plans in place to minimise the recurrence of stress, especially if children are in a hypervigilant state. Peer interaction may increase anxiety and further traumatisation if left unchecked and a formal strategy is not in place. Recommendations for responses include information dissemination, emotional support, and assistance of a practical nature, but avoiding psychological debriefing (Phoenix Australia, 2021).

Suggested Interventions

It is important that treatment is provided as soon as possible by a skilled counsellor who specialises in trauma and PTSD (Geldard et al., 2019) to avoid grave consequences. Guidance officers (GO) may play

a significant role in identifying initial symptoms and then refer a student on to receive the appropriate treatment. In the instance of counselling and psychological intervention being required, the *Australian guidelines for the prevention and treatment of acute stress disorder, posttraumatic stress disorder and Complex PTSD* (Phoenix Australia, 2021) recommends trauma-focussed Cognitive Behaviour Therapy (TF-CBT) for both the child, and the child and caregiver together, post incidents of trauma. TF-CBT is effective and strongly recommended because it supports individuals to develop skills to process memories and come to terms with their trauma experience (Phoenix Australia, 2021). Delivered by a skilled professional, TF-CBT generally involves 6 to 12 sessions, or more if required. It is tailored to the individual according to their age and parental/caregiver involvement is encouraged to support skill and strategy mastery. TF-CBT is a psychoeducational approach that aims to develop conscious understanding of cognitions, reactions and emotions, and skills to process these including self-regulation strategies.

Research has also identified that children who have experienced trauma benefit from sand play and play-based therapy with other media as it is developmentally appropriate and fosters feelings of safety (Geldard et al., 2019). Geldard et al. (2019) cite multiple studies to illustrate that therapies using media and play-based approaches have a vastly positive effect on children who have experienced abuse, neglect, and/or witnessed domestic violence. These positive results not only include reduced negative symptoms of anxiety, depression and anger but increased positive results, including collaboration and self-regulation.

There is consensus across treatment guides that family and relational involvement in treatment is important (Barrett & Ollendick, 2003; Ford, 2015; Phoenix Australia, 2021). What does this mean though for the intervention or support strategies a GO might apply? The GO plays a key role in providing not only onsite support to students individually or in group sessions but also educating staff in how to best create an environment that is supportive and promotes recovery. A key intervention for a GO is the provision of professional development about trauma-informed and resilience promoting practices. Building staff understanding of the significance of their relationship with children and their caregivers and how this contributes to children feeling safe is paramount. Staff must be cognisant that for a child to be able to engage in learning, they must first feel safe. When students do not feel safe, negative behaviours that are detrimental to the student's learning, social connections, and overall safety emerge (Delahooke, 2019). Examples of these behaviours include refusal to participate, avoidance, or aggression. Some simple and practical steps staff can take to support students to feel safe include establishing strong relationships with the student and their family, considerations to the classroom's physical environment, awareness of proximity, conscious use of an even facial expression, using a prosodic vocal tone, and calming music (Phoenix Australia, 2021).

40.

MIDDLE CHILDHOOD

Nicole Giaquinto

Middle Childhood

Middle childhood is considered to cover the years of 6 to 12 and is a key transition stage between early childhood and adolescence. In this stage of development children begin and complete primary education. It is also a period critical for the development of important psychosocial functions such as cognitive skill acquisition, social relationship formation and self-concept consolidation. It is a time when children gain the building blocks of education, social skills and motivation to become productive adults, and failure to gain these building blocks can lead to long-term negative consequences in the future (Penela et al., 2015). Cognitively, in middle childhood, the ability to problem solve, reason and think logically is developed. Additionally, the building blocks of literacy, numeracy and scientific learning are gained. These building blocks have an impact on future academic success. It is also a time of social development. Peers become more important, and children have greater contact with adults external to their family (Eccles,1999). It is during this time that social and emotional regulation is learnt, communication skills developed, and a sense of self and confidence is gained (Bishop, 1995). It can be a time when comparison to peers causes inferiority and self-doubt however, protective factors like a close relationship with a teacher and a supportive family can mitigate these risks. Children become able to identify differences in social functioning and compare and contrast this functioning between social situations. Children in this stage of develop a sense of self pride as they expand their social and peer groups, they strive for achievement (Cherry, 2020). Emotional adjustment and development is a key area for change in middle childhood, they forge a personal identity, a self-concept, and an orientation toward achievement that will play a significant role in shaping their success in school, work, and life.

Post Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) can result from a singular trauma or as a result of prolonged, repeated or multiple traumas. The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013b) sets specific criteria for the diagnosis of PTSD as exposure to an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature. Examples include child abuse and neglect, disasters, serious accidents, violence, a sudden death of a loved one or a life-threatening illness. Following the traumatic event the experience of the following 3 core elements lasting for several weeks:

1. Re-experiencing the traumatic event in the present, in which the event(s) is not just remembered but is experienced as occurring again in the here and now, typically in the form of vivid intrusive memories or flashbacks or repetitive dreams and nightmares (Carr, 2004).
2. Avoiding, reminders of the event in a deliberate way to reduce re-experiencing the traumatic event, avoidance can be active internal avoidance of thoughts and memories related to the event(s), or external avoidance of people, conversations, activities, or situations reminiscent of the event(s) (Carr, 2004).
3. Persistent perceptions of heightened current threat, for example hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises (Carr, 2004).

Further to the above 3 elements, consideration is given to the disturbance or significant impairment in personal, family, social, educational, occupational or other important areas of functioning (Carr, 2004).

Evidence of Symptoms

In Middle childhood, PTSD often manifests behaviourally, for example in trauma-specific re-enactments during play, in drawings, frightening dreams or impulsivity not previously a characteristic of the child behaviour (Kenardy et al., 2011). There may be no distress evident when children are talking about the trauma or acting it out in play despite the traumata actually having impact on functional development. There may be changes in behaviour such as hypervigilance that occurs in the form of temper tantrums with increased frequency and intensity. A child may regress in their behaviour and experience separation anxiety, age-appropriate fears may be overexaggerated, or they may cry excessively (Kenard et al., 2011). A child's behaviour may also become disinhibited or more inhibited when compared to past behaviour. Avoidance of thinking about or talking about the trauma may be evident through the observation of new acting out behaviours, protective strategies not seen before, reluctance to engage in new activities and require excessive reassurance from trusted caregivers (Kenardy et al., 2011). Some children may engage in self soothing behaviour in a routine way and can include includes rocking, self-stimulation, sleeping, playing computer games, listening to music and eating. These behaviours can be helpful for the child to focus their attention and move into a relaxed state. However, if a child becomes pre-occupied with these behaviours their benefit is decreased (Kenardy et al., 2011). Once a child reaches 8 to 10 years old their reactions to trauma become more similar to those of an adult as cognitively the child can understand more about the situation and see more of the long-term consequences of the trauma as well as being more able to reflect on their own role in the traumatic events.

Impact on the individual and interactions

Exposure to different types of trauma and the resulting PTSD have been associated with complex and varying adverse outcomes, including adverse effects on cognitive functioning, attention, memory, academic

performance, and school-related behaviours (de Bellis et al., 2014). Exposure to traumatic events can disrupt brain development having immediate and lifelong negative effects on social, emotional, and physical wellbeing, including inadequacy in executive functioning, developmental delays, behavioural problems, impaired social-emotional regulation, academic performance and school behaviour problems (McClean, 2016).

Children with PTSD have suffered a traumatic event or events and these events often cause the body to react with its stress response system. When in stress the body's biological functioning activates the brains amygdala to respond with fight, flight, freeze or fawn reactions. A child with PTSD can often remain in this mode or state of heightened vigilance for long periods of time, and brain research has shown that the amygdala grows larger (Bryce et al., 2019). Children have no sense of what to expect next so remain in this heightened state finding it difficult to know how to feel calm, how to feel safe and how to feel in control (Dalgleish et al., 2001). As a consequence of trauma suffered, children lack adaptability and in varying situations and contexts have difficulty responding in different ways as the trauma has left them with limited coping strategies and limited strategies to guide their actions (Costello et al., 1998). With limited coping strategies children with PTSD are likely to just react to situations rather than respond. They are also reluctant to forming new relationships or connections with others, including their peers, due to the need to self-protect (Gearity, 2015). It is often difficult for children with PTSD to separate the past from the present and often their reactions in the present are reactions from the past when triggered by a reminder from the traumatic event such as a smell, sound or sight as well as feelings of past fear and insecurity. This difficulty impacts negatively on the child's ability to develop a strong sense of who they are and where they belong and they find it difficult to find where they fit into the environment around them. Given traumatised children often display challenging behaviour, they have difficulties functioning in classrooms and with peers (Peterson, 2018). They may be severely withdrawn and therefore have few opportunities to develop peer relationships or relationships with significant adults. These displays of adaptive survival were effective at the time of the trauma but are counterproductive if continued into the present where the trauma no longer exists.

Suggested Interventions

In a school setting the primary focus for students displaying PTSD would be trauma informed management of behaviours and making room in their working memory for learning. In order to accomplish this, I would begin with the Australian Childhood Foundation (2022) developed Trauma and Connection assessment (TECA). The TECA is an assessment process that enables understanding of trauma expressions a child may be displaying and assists to identify how their PTSD is impacting on their behavioural and relational presentations (Australian Childhood Foundation, 2022). Central to trauma responsive practice is safety and promotion of strong, safe and healthy relationships which can be used as a resource to support healing. As an implementation tool the TECA supports co-regulation, decreasing a child's trauma behaviours by recommending prescribed therapeutic responses that are matched to the

individual child's needs (Australian Childhood Foundation, 2022). The TECA assessment is based on behaviours that are likely to be observed in a child with PTSD, the behaviours are organised neurologically into the categories of flight, fight, freeze and fawn. The behaviours in each category are rated as often seen, sometimes seen, rarely seen, never seen and a simple check box for the appropriate observed behaviours is checked (Australian Childhood Foundation, 2022). Observations could be completed by families, teachers, support staff at school or guidance officers. Each category is then scored and given an intensity rating with the intensity ratings giving information about the trauma response area most experienced by the child (Australian Childhood Foundation, 2022). Activities for fight, flight, freeze and fawn are then detailed; these activities are specifically designed to move the child out of the trauma response and open them up for learning, development and self-regulation. Fight activities are designed to help the child make their own body a safe place to inhabit and flight activities are grounding activities to keep the child focused in the present. Freeze activities are designed to move a child out of shut down and Fawn activities are designed to build confidence and decrease the need for the child to appease (Australian Childhood Foundation, 2022). Once suitable activities are identified, the child could be included in choosing activities, an individual classroom plan could be developed and trialled. In any intervention there needs to be scheduled reviews and opportunities to modify or change activities for the child.

PART VI

SUICIDAL IDEATION

41.

ADOLESCENCE

Sue Thompson

Adolescence

As young people move from childhood to adulthood, they enter the period of human development defined as adolescence. This period, between the ages 10 to 19, sees a young person transition from being part of a family group, towards closer affiliation with a peer group, and then on to independence as an adult (Geldard et al., 2019). The World Health Organisation (WHO; 2022c) recognises this unique stage of development as an important time for laying the foundations of good health. Adolescents experience rapid physical, cognitive and psychosocial growth that affects how they feel, think, make decisions, and interact with the world around them (WHO, 2022c). Despite many commonalities amongst young people, individual experiences of adolescence can be vastly different. Adolescents face biological, cognitive, psychological, social and spiritual challenges that can lead to mental health problems if not managed adaptively (Geldard et al., 2019). These challenges include changing relationships with parents, peer pressure, increased academic expectations, emerging personal and sexual identity, and moral decision making (Geldard et al., 2019). These encounters are influenced by childhood experiences or environmental stresses or hazards that result in some young people not being emotionally equipped to navigate them without professional support (Ivey et al., 2017; Weare, 2015). Where social support is lacking and adolescents have an accumulation of adverse childhood experiences, they are more at risk of developing a variety of mental health concerns (Rigby & Slee, 1999).

Suicidal Ideation

Suicidal ideation refers to having thoughts about suicidal acts and can involve a range of degrees of intent and detail regarding those thoughts (Be You, 2021). Suicidal ideation often emerges in adolescence and is prevalent among this age group, particularly among females (McKinnon et al., 2016). The Department of Health and Aged Care (2000) estimated that over 785,000 men and over 1,130, 000 women experience suicidal ideation at some point in their life. They also state that studies of suicidal ideation usually rely on self-report in interviews or questionnaires. Acts of suicide and suicide attempts are increasingly identified as options by young people with poor coping strategies (Geldard et al., 2019). Given that suicide ideation strongly relates to suicide attempts and suicide, identifying potentially modifiable risk factors and strengthening protective factors are essential for preventing deaths (McKinnon et al., 2016). Whether a young person thinks of suicide as an option, and/or chooses it, is dependent on their personal coping

resources (Be You, 2021). Geldard et al. (2019) suggest that individuals who consider or attempt suicide often exhibit some of the following characteristics both at home, school and within the wider community:

- They may over-invest themselves in few, very intense interpersonal relationships.
- They tend to express problematic feelings through behaviour rather than verbal communication.
- They may perceive an inability to control their environment.
- They express high levels of hopelessness and the belief that circumstances will not improve.
- They tend to overreact or may be hypersensitive to certain situations.

Evidence of Symptoms

The prevalence of adolescent suicidal ideation and behaviours varies across countries, yet a consistent set of risk factors of suicidal behaviours is evident across all regions and most countries (McKinnon et al., 2016). Adolescents with a history of childhood abuse or other adverse life experiences demonstrate significantly more risk factors for suicide or suicide ideation; for example, depression, substance abuse and disruptive behaviour (Geldard et al., 2019). Literature indicates further possible risk factors for suicidal thoughts or behaviours include severe anxiety and inability to experience pleasure, alcohol, relationship loss, serious interpersonal conflict or weak family and peer relationships and exposure to bullying or harassment (Ivey et al., 2017; McKinnon et al., 2016). Risk factors impact a young person's ability to cope with life's challenges and increase the probability that problems will occur, while a warning sign such as statements of hopelessness or social withdrawal, may indicate that a problem has already begun (Be You, 2021). These warnings signs may be apparent at school when a young person's behaviour or performance changes, for example, truancy, negative conduct, a decline in academic or other areas of achievement. At home they may become disconnected, seem hopeless and helpless, or excessively angry and irritable (Be You, 2021). It becomes imperative for those working with young people to maintain a watchful eye for suicide potential and provide immediate crisis support or client referral when required (Ivey et al., 2017).

Identifying suicidal ideation in young people can be complex and often relies on self-reporting or peer submissions (Rigby & Slee, 1999). A survey by McKinnon et al. (2016) used standardised school-based sampling and a set of core questionnaire modules that addressed leading causes of mental illness and mortality worldwide, including alcohol and drug use, mental health, violence and unintentional injury and sexual behaviours. Such questionnaires would be a useful method for helping to identify prevalence of risk factors within a school population. Rigby and Slee (1999) investigated relationships among suicidal ideation, involvement in bully–victim problems at school, and perceived social support with samples of adolescent students in South Australia. Results were obtained from self-reports and peer nomination procedures and identified bullies and victims' involvement in bully-victim problems at school. The results indicated that involvement in these problems at school, especially for students with relatively little social support, was significantly related to degree of suicidal ideation. It can be surmised that when a young person feels excluded, harassed, or disconnected and does not have the support of an understanding adult, feelings of hopelessness and impending thoughts of suicide are more likely.

Impact on the Individual and Interactions

Not only does suicidal ideation increase an adolescent's risk of suicide attempts and of death by suicide, but it is also an important indicator of an array of significant mental health needs, sexual risk behaviour, substance use, and delinquent behaviour (Thompson et al., 2012). As previously stated, adverse life experiences are important in understanding suicidal ideation in high-risk youth. Suicidal ideation is a maladaptive coping strategy that interferes with a young person's education, work, and relationships (Geldard et al., 2019). There is a heightened risk of abnormal psychosocial and psychopathological functioning for young people who experience suicidal ideation in adolescence (WHO, 2022).

Suggested Interventions

Setting up a quiet room with regular talk-therapy sessions for young people experiencing suicidal ideation is a recommended support strategy. Be You (2021) recommends this process for either individual or small groups within the school setting. This would include the availability of a quiet, reflection room set up by the school Counsellor for students who are at risk of suicide attempt or experiencing suicide ideation. Open during school hours, it would be a place for young people to go to receive support and have some quiet time to reflect. A safe, supervised location where young people's emotions and needs can be expressed, responded to, and monitored (Be You, 2021). While many adults may seek out talk-therapy when they are experiencing challenges or crises, young people often need encouragement to develop this as a coping strategy (Geldard et al., 2019). The establishment of productive counsellor and adolescent communication entails the counsellor being present by using attentive listening skills, open questioning, and empathetic understanding of the young persons' needs. The effectiveness of talk therapy as an intervention is such that many successful and happy people use talk-therapy as a regular part of their self-care routine well into their adult lives (Kendall, 2011). Whilst Kendall (2011) urges that additional professional support is recommended in cases of severe suicidal tendencies, talking through suicidal ideation and the accompanying feeling of hopelessness allows young people to look at situations objectively and create greater sense of awareness and understanding.

When advocating for the social-emotional wellbeing of adolescents, Weare (2015) recognises that the effects of regular talk therapy within a support room with a trusted counsellor can be long lasting, and the benefits include:

- Increased self-awareness, understanding and self-compassion
- Increased understanding and empathy towards others
- Learn how to process and manage emotions
- Develop coping strategies for challenging situations
- Identify the causes of symptoms and distress
- Increasing a support network in a non-judgemental environment

- Helps teens identify their goals and existing strengths as well as areas for growth

Young people will come to see talk-therapy as a positive approach to taking control back in their lives and to develop self-accountability (Kendall, 2011; Weare, 2015).

42.

ADOLESCENCE

Le Thi Phuong Nhung

Adolescence

Adolescents as defined by the United Nations are people between the ages of 10 and 19. There are 1.3 billion adolescents in the world, making up to 16% of the world's population in the world today (UNICEF, 2022b). Adolescence is the transition period from childhood to adulthood; young people experience significant growth and development in physical, cognitive and psychological ways and it is a time for exploration of identity and learning independence to become an adult (Gerldard et al., 2019). In adolescence, young people may experience high levels of emotional intensity which lead to mood disruption in adolescence (Silvers et al., 2012). In the process of gaining their autonomy, adolescents may engage in risky behaviours or conflict with adults (Arnett, 1999). Most young people can go through adolescence smoothly; however some are struggling and facing certain psychological problems. According to the World Health Organisation (WHO; 2021a) one in seven adolescents experience mental health disorders, of which depression, anxiety and behavioural disorder are leading causes of the illness. It is important to appropriately address mental health concerns in adolescence to give people opportunities to have a fulfilling life as an adult.

Suicidal ideation

Suicidal ideation is defined as thinking about, considering or planning to take our own life or suicide (WHO, 2021e). Suicidal ideation can appear in various forms, from brief thoughts to detailed planning to die (WHO, 2021e). Adolescents are more disposed to experience suicidal thoughts than other groups (Rozanov & Rakhimkulova, 2017). Although not all people who have suicidal ideation conduct suicide attempts, suicidal ideations are considered a risk factor for proceeding to actual suicide (Franklin et al., 2017), given that suicide is the fourth leading cause of death in adolescents in the age group of 15 to19 years (WHO, 2021e). In a recent study of 397,299 adolescents from 90 countries, the prevalence of suicidal ideations was significantly higher in girls than boys, while there was no different by age or sex in suicidal attempts (Campisi et al., 2020).

Depression and other mood disorders are the strongest risk factors for suicidal ideations (Mandelli et al., 2015; Sekhon & Gupta, 2020). Gijzen et al. (2021) suggest that suicidal ideation seems suggestive or symptomatic of depressive disorder symptoms during adolescence. The major symptoms of depression

are loneliness, sadness, low self-esteem, self-criticism and self-hatred, of which loneliness is the strongest contributing factor to suicidal ideations (Gijzen et al., 2021). From the perspective of another mood disorder, people with bipolar disorder experience both high and low emotions (depression and mania) and during their lows, people with bipolar are at greatest risk for suicide (Dome et al., 2019). More than half of children and adolescents experience suicidal ideation, and about 25% are at risk of suicidal attempts (Hauser et al., 2013). In addition, medical side effects from antidepressant medications which are commonly used for depression treatment might increase the risk of suicidal thoughts in some patients (Reeves & Ladner, 2010).

Suicidal ideation is also associated with many different life events, such as sexual trauma or other trauma and injury, being exposed or witnessed to violence (Liu & Miller, 2014; Gårdvik et al., 2021). In a short term follow up review Howarth et al. (2020) found that the association between stressful life events and suicidal ideation is stronger in young adults, especially for boys. Research also suggests there is strong link between family risk factors such as negative parent-child relationships, child maltreatment and family with antisocial disorders history and youth suicidal ideations and behaviours (Dardas, 2019). Of these, parental divorce and substance abuse and a family history of suicidal behaviours are more strongly associated with active suicidal ideation and fatal suicide, while low cohesion and adaptability in family, or insecure parent-child attachment are more associated with passive suicidal ideations and nonfatal suicidal symptoms (Wagner et al., 2003).

In addition, with the development of internet, media contamination is an important factor that triggers suicidal ideation in adolescents (Hawton et al., 2012). Peer relations are important in adolescents' lives, in which peer rejection and having no close friends also creates suicidal ideation among adolescents, both boys and girls (Campisi et al., 2020). While bullying is a significant reason for suicidal ideation among young girls, fighting is for young boys ages 13 to 15 years old (Campisi et al., 2020).

Evidence of Symptoms

Most people who are experiencing suicidal ideation give warning signs that they are intending to end their life by suicide. Different people experience suicidal ideation in various ways. However, suicide is preventable. Understanding the symptoms and signs of suicidal ideation is the best way to prevent the tragedy from happening (Campisi et al., 2020). The most common warning symptoms and signs of suicidal ideations could include the following areas.

People who experience suicidal thoughts believe there is no way to solve their problems and the best and the only solution is ending their life. Their minds are preoccupied with death and dying. They may experience memory impairment, unable to concentrate and fulfil tasks or responsibilities. Physically, they may experience insomnia or hypersomnia, as well as significant changes in their weight (Healthdirect, 2021; Beyond Blue, n.d.).

Psychological symptoms of suicidal ideations could be feelings of hopelessness, sadness, worthless and being trapped in their intense emotional pain. People may experience high levels of mood swings such as being emotionally high one day, and deeply depressed the next day. They may feel paranoid; have increased anxiety and poor hygiene (Healthdirect, 2021; Beyond Blue, n.d.).

Behaviourally speaking, those suffering from suicidal ideation may start talking about death, dying, using sign phases such as "when I am gone" or "I am going to kill myself". Some may say goodbye to their loved ones or give away their prized or valued processions. People who experience suicidal thoughts may withdraw from social activities or activities that once pleasurable to them. They may increase use or abuse of drugs and/or alcohol and self-harm (Healthdirect, 2021; Beyond Blue, n.d.).

Impact on the Individual and Interactions

The impact of suicidal ideation can be catastrophic for everyone involved. Suicidal ideation sees not only an increased risk in suicidal attempts and deaths by suicide, but may also lead to serious traumatic experiences and other psychological problems, risky sexual behaviours, substance use and delinquency (Uddin et al., 2019). The effect of suicidal ideation can persist long into adulthood and cause serious damage, both physically and mentally. Physically, it could cause severe injury and damage to all organ systems, brain damage or death (Thompson et al., 2012). Mentally, suicidal ideation could cause serious mental health impairment in adolescents and adult life (APA, 2020c).

Suicidal ideation in adolescence is tremendously challenging, and often devastating to people around when the individual completes suicide (Young et al., 2022). Suicide survivors can suffer complicated grieving, extremely guilt, anger, shame and serious depression, and their experience can be worsened by societal stigma around suicide (Young et al., 2022). The negative emotions associated with grief in adolescence might cause an increasing risk for a copycat suicide among children and adolescence suicide survivors (Kim et al., 2020).

Suggested Interventions

Suicide ideation is a major concern for public health (Pistone et al., 2019). Educational intervention programs for preventing suicidal behaviours significantly contribute to reduction of suicidal ideation and suicide attempts in adolescents (Pistone et al., 2019). Youth Aware of Mental health (YAM) is a school-based mental health and suicide prevention program for young people ages 13 to 17 that build students' knowledge about mental health through student-led interactive discussion and role-play (Mental Health in Mind International (MHiM), 2022). In the program, young people are encouraged to practice their sympathy, build up resilience, develop problem-solving skills and learn from each other. YAM invites young people to reflect on their emotions and discuss their approaches to the difficult challenges in their life, or their mental health concerns. Through the activities, YAM helps grow harmony among young people

and promote positive mental health practices. YAM has trained more than 800 instructors and conducts intervention with more than 85,000 adolescents in 16 countries (MHiM, 2022). A recent study of the YAM program of 556 students in Australian secondary schools suggests YAM is a promising program for intervention for schools, especially for increasing help-seeing activities and reducing suicidal ideation and depression in adolescence (McGillivray et al., 2021).

43.

ADOLESCENCE

Katherine Stringer

Adolescence

There are close to 3.1 million adolescents in Australia who contribute to 18.2 percent of the entire population (Australia Bureau of Statistics, 2022c). Adolescence is one of the most influential developmental periods of a person's life and incorporates some specific challenges. During this time of life there are numerous neurological changes influencing memory, perceptions, emotion regulation, abstract thinking, and the acquisition and processing of information (Shettleworth, 2009; Steinberg, 2007; Yurgelun-Todd, 2007). Some behavioural challenges are also faced, most commonly regarding the participation in risky behaviours. A consequence of risky behaviours has resulted in an increase in the incidence of preventable deaths, including accidents and homicides (Casey, 2015). Road injuries and self-harm are also in the top three causes of injury for adolescents aged 15 to 19 (World Health Organisation [WHO], 2022e). Society presents challenges such as the pressure to develop independence, gain and maintain the correct friendships, educational goals, occupation and physique (Crosnoe & Johnson, 2011; Geldard et al., 2019). Some environmental challenges, which can be a significant influence on later life developments of mental ill-health for adolescents, are factors such as poverty, exposure to conflict or violence, forced migration, gender inequalities and humanitarian emergencies (WHO, 2021c).

Suicidal Ideation

In Australia results have shown that 7.5 per cent of people aged 12 to 17 years had seriously considered attempting suicide (Lawrence et al., 2015), which is a suicidal behaviour associated with suicidal ideation. Suicidal ideation is defined as thoughts that life is not worth living (Scanlan & Purcell, 2009). These thoughts range from brief thoughts every now and then to more determined and detailed plans for committing suicide. The number of adolescents who have considered suicide throughout their life is between 22 and 38 per cent (Scanlan & Purcell, 2009). Individuals are more inclined to experience suicidal ideation if they also demonstrate impulsivity, hopelessness, previous diagnosis of a mental disorder (Klonsky et al., 2016), alcohol use disorder (WHO, 2021d), or who have clinically significant symptoms of depression (Klonsky et al., 2016; Scanlan & Purcell, 2009; WHO, 2021d). Suicidal ideation can occur following an extreme event in a person's life and an inability to deal with life's stresses (WHO, 2021d). An extreme event for an adolescent could be a relationship breakdown or rejection, chronic pain, bereavement, history of abuse, family disturbances and social isolation (Geldard et al., 2019; Scanlan & Purcell, 2009).

This list is not exhaustive and there could be many more factors which could influence someone to experience suicidal ideation, including a combination of multiple extreme events simultaneously. The incidence of suicidal ideation is also increased in many minority groups who are vulnerable and could have experienced discrimination (WHO, 2021d). Adolescents who have previously attempted suicide also have increased prevalence of suicidal ideation (Neupane & Mehlum, 2022; WHO, 2021d). Suicidal ideation does not discriminate and can affect adolescents at all stages of their development. If an extreme event has occurred in the life of an adolescent, they should be closely monitored in case they develop some warning signs of suicidal ideation.

Evidence of Symptoms

Suicidal ideation is a mental health condition which may only be revealed during conversations or interactions with an at-risk individual. It is suggested to be mindful of particular warning signs for suicidal ideation, such as; an adolescent threatening to harm themselves, looking for ways to suicide, such as seeking pills or weapons, talking about death or suicide, feeling trapped, anxiousness, agitation or withdrawing from friends, family or society (Scanlan & Purcell, 2009). Alongside these internal aspects of suicidal ideation, there may be a number of external behaviours which can be prevalent when suicidal ideation is occurring. Someone experiencing suicidal ideation may participate in deliberate attempts to self-harm, such as scratching, cutting or burning themselves (Neupane & Mehlum, 2022; Scanlan & Purcell, 2009). Problematic externalising behaviours such as rage, anger, revenge seeking, increasing use of alcohol or substances and dramatic changes in mood could also indicate increased risk of suicidal ideation (Scanlan & Purcell, 2009). Inadequate sleep is indicative of increased suicidal ideation in adolescence (Scanlan & Purcell, 2009; Wong et al., 2011). Therefore, if there are dramatic changes of mood or sleep behaviours it would be prudent to explore why these changes are occurring. As stated, the most common precipitating factor for suicidal ideation is an extreme event, which is generally traumatic and quite negative for this individual. An extreme event which leaves an adolescent feeling pain, either physically or emotionally, coupled with feelings of hopelessness has been widely found to indicate potential for suicidal ideation (Geldard et al., 2019; Klonsky et al., 2016; McCallum et al., 2022; Scanlan & Purcell, 2009).

A number of experts have explored aspects of a person's personality to investigate whether certain characteristics are more obvious for those who experience suicidal ideation (Endo et al., 2017; McCallum et al., 2022; Planellas & Calderón, 2022). Hopelessness, impulsivity, sensation seeking and high levels of anxiety sensitivity were all found to be implicated with increased suicidal ideation (McCallum et al., 2022). Planellas and Calderón (2022) also identified particular combinations of traits, from the Big Five Inventory, which are generally found with increased suicidal ideation. Specifically, some combinations discovered relevant to increased suicidal ideation were; high levels of neuroticism and low levels of extraversion, high neuroticism and low conscientiousness, high neuroticism and openness, and high neuroticism and agreeableness particularly with emotionally unstable adolescents (Planellas & Calderón, 2022). A personal preference for solitude and a socially isolated adolescent has been highlighted as the highest risk for suicidal

ideation and self-harm (Endo et al., 2017). Given that adolescence is a time when individuals are developing more independence, they often pull away from their parents and find more connections with their peers. However, it is detrimental to adolescent well-being for parents to completely cease all monitoring and attempts at communication with their adolescent to allow for independence (Geldard et al., 2019). It is suggested that, despite the resistance they may experience, parents continue to maintain communication and attempts at monitoring as it will provide a support for their adolescent if or when they need it.

In order to identify potential risk of suicidal ideation which could progress to suicide attempts or completion there are a number of scales and measures to consider. Initially to assess personality trait risk factors a Big Five Inventory (Costa & McCrae, 1988) could be implemented. If there has been an extreme event occur for an adolescent then a Kessler Psychological Distress Scale (K10; Kessler et al., 2002) could be used to measure levels of psychological distress and identify needs for further treatment. There are also a number of scales specifically geared towards suicidal ideation which could be beneficial when referring an adolescent for further treatments. The Suicidal Ideation Attributes Scale (SIDAS; Van Spijker et al., 2014) or the Scale for Suicide Ideation (SSI; Beck et al., 1979) are suitable examples however it is not appropriate to administer all of these measures simultaneously. It would be dependent on aspects specific to each individual adolescent which would determine the appropriate course of action.

Impact on the Individual and Interactions

As stated, an adolescent who experiences an extreme event could be at risk for experiencing suicidal ideation. Following an extreme event an adolescent may feel supported or unsupported within their relationships. The most commonly supportive relationships are those between an adolescent and their parents or caregiver. Parental monitoring, supportive relationships with parents or caregivers, trust and communication will all benefit an adolescent following an extreme event (Stroem et al., 2021). When an adolescent feels supported and is encouraged to maintain adequate sleep, a healthy diet and develop protective coping strategies, such as active coping and support seeking, they are less likely to be at risk for mental ill-health (Cairns et al., 2014). Therefore, adolescents who could be prone to experiencing suicidal ideation can be supported in their relationships with family and friends and their mental health risks could diminish. When an individual is feeling unsupported, they could develop negative coping strategies which could increase their chances of developing depression, mental health disorders or suicidal ideation (Cairns et al., 2014). Similarly, peer relationships can contribute to the preoccupation with unhealthy habits which can prolong the time an adolescent employs negative coping strategies (Stroem et al., 2021).

Schools and communities can help in supporting adolescents at risk of experiencing suicidal ideation by creating environments which foster socio-emotional life skills in adolescents and learn about early identification, assessment, management and follow-up care for those affected by suicidal ideation (WHO, 2021d). Similarly, governments and communities may develop suitable protocols for media responses to reporting incidences of suicide (WHO, 2021d) as some adolescents can be triggered by media articles relating to suicide. If someone becomes triggered by reading or hearing about a suicide in the community

either by the media or by personal interactions it could create a contagion effect (Liu et al., 2022). A contagion effect occurs when suicide is experienced and then subsequently publicised or talked about and others who previously were not considering suicide develop suicidal ideation or self-harm as a result (Liu et al., 2022).

Suggested Interventions

School counsellors and staff should be trained to be vigilant for warning signs of suicidal ideation for the adolescents they work with. It is suggested that extra supervision is provided to those who are more prone to suicidal ideation, such as females, minority groups, bully-victims or physically aggressive bullies (Espelage & Holt, 2013). If suicidal ideation can be discovered and support can be provided then there may be less likelihood of developing clinical depression and attempting suicide (Scanlan & Purcell, 2009). A school counsellor will obviously need to refer an adolescent for more specialised treatment in the case of suicidal ideation (Geldard et al., 2019). They can also work under close supervision to implement Rational Emotive Behaviour Therapy (REBT), after receiving appropriate training to do so, as this can relieve symptoms of suicidal ideation by challenging self-destructive beliefs, such as hopelessness (Geldard et al., 2019).

Suicide prevention, including addressing suicidal ideation, needs to include a coordinated and collaborative effort between all factors of society (WHO, 2021d). Therefore, education sectors, health, businesses, law, political and media institutions need to be working together. They could implement the recommendations by the World Health Organisation's LIVE LIFE guide for suicide prevention (WHO, 2021d). When there are multiple factors in an adolescent's environment working towards supporting them and their mental well-being the incidences of suicidal ideation may decrease.

44.

ADOLESCENCE

Julie Pearce

Adolescence

Today there are 1.3 billion adolescents in the world, more than ever before, making up 16 per cent of the world's population (UNICEF, 2018). Adolescence is defined by the United Nations as the period between the ages of 10 and 19. Adolescents experience a transition period between 'dependency' in childhood, though to 'independence' to adulthood (Geldard et al., 2019) with significant growth and development. Adolescence face life-stressors including physiological, biological, cognitive, behavioural, social and environmental challenges. Additionally, some young people may face and be exposed to physical, mental, verbal, and sexual abuse that may lead to mental health challenges and risks, including anxiety, depression and suicide ideation that need to be recognized.

It's normal to feel down or sad from time to time. For some people, feelings of sadness and unhappiness can outweigh happy and excited emotions. Rates of suicide in Australia have caused a great deal of concern, as youth suicide is now the leading cause of death in young Australians aged from 15 to 24 years of age (Australian Institute of Health and Welfare, 2021c). Many more young people attempt suicide or consider taking their lives (Department of Education, 2022). On occasions, adults often rub off adolescent depression symptoms simply as a phase, or a reaction to a situation or life-stressor that the young person has been exposed to, or simply could not handle. Unfortunately, all of these stressors can result in many young individuals experiencing some level of suicide ideation, attempt or suicide.

Suicidal Ideation

There are many factors that can contribute to someone experiencing suicidal thoughts (Headspace, 2022c). These thoughts can be related to a person's 'mood, past or current life circumstances' (Headspace, 2022c), or as a part of a mental health condition, including anxiety and depression.

Many adolescents have thoughts of suicidal ideation when life seems unbearable and they want to end their pain. Most adolescents who have suicidal thoughts may not actually want to die, they just can't imagine another way out of what they are going through. Families, schools and environments have a critical role and influence on the young person who is at risk of suicidal ideation as a "young person clearly has no control" over their family (Geldard et al., 2019). Suicide, suicide attempt and ideation are strongly linked to

childhood and childhood abuse (Calder et al., 2010). Exposure to family problems including breakdowns and stability as well as serious impairment of communication between parents and the young person heighten the risks (Geldard et al., 2019). A youngster who has been predisposed to abuse during childhood is at a greater risk of suicide ideation, and if the abuse continues, including physical abuse this escalates greater risk factors for suicide and attempts (Kaplan et al., 1997).

School is a multi-dimensional context for a young person and plays a critical role in their individual lives that can have a lasting impact (Geldard et al., 2019). School is not just a place for learning. Schools offer a place where relationships and friendships are formed as well as direct pressures from parents, teachers and peers to perform academically, and additionally to conform to social and behavioural expectations. These expectations may be positive or negative to educational outcomes and wellbeing. Suicidal ideation can occur at school when the young person is unable to adaptively deal with life-stressors when confronted. Life-stressors include relationship or friendship breakdowns, exclusion from peers, bullying and experience of academic pressure and failure. These are factors that can contribute to someone experiencing suicidal thoughts and heighten to suicide when the young person is feeling isolated and alone to the point of it being unbearable.

The world is moving at such a rapid pace, and this predisposes today's modern adolescent to the risk of media. Media is risk factor that adolescents are continually exposed to, as they are bombarded with pervasive, consumerism influences (Larson, 2002) through Tik-Tok, Facebook, Messenger Apps, Instagram and Snapchat, damaging an individual's self-esteem, confidence and reputation and exposing them to cyberbullying on a scale that has never been seen before. The Australian Institute of Health and Wellbeing (2020a) identify one in four children have had unwanted contact online and almost half of adolescents have been bullied online, on at least one occasion. The statistics are alarming, identifying risk factors that may impact on the individual young person's mental health and heightens risks of suicidal ideation, attempts and suicide.

Evidence of Symptoms

Suicidal thoughts can happen as part of a metal health condition, like depression, personality disorder or other mood difficulties (Headspace, 2022c). The precursors and symptoms are increasing in Western society, resulting in suicidal ideation, attempted suicide and completed suicide (Dacey et al., 2006). For many young people who attempt or complete suicide they often have more stressful lives, fewer coping strategies and are often under-achieving, with poor school performance. Particularly "vulnerable to suicide are those young people who suffer from a depressive illness" (Geldard et al., 2019). They are more likely to commit to "suicide than young people with other psychiatric or medical illnesses" (World Health Organisation, 2016).

Suicide is complex. It's unlikely to be the result of a single problem or event, but more likely a combination of stressors that result in a young person feeling overwhelmed and unable to cope (Headspace, 2015).

Because teachers have day-to-day contact with many young people, a teacher is in a critical position to notice suicide warning signs. Behavioural warning signs include self-harming, giving away their possessions, writing goodbye letters to people in their life, seeming to have less physical energy, feeling trapped and helpless, abusing drugs or alcohol and isolating themselves to the point that they feel alone or unsupported. When young people are demonstrating suicidal behaviours or advise that they will commit suicide, "it must always be taken seriously" and reported (Headspace, 2022c).

Suicidal ideation and suicide is a difficult topic for many people and young people who belong to an identified high-risk group, including Australia's Aboriginal and Torres Strait Islander peoples, so additional considerations are required. Young people are commonly bombarded by social life-stressors and expectations, as well as direct and indirect pressures from family, peers, school and community. Adolescents who are overwhelmed, or fail to perform to society social expectations, are identified high-risk of considering suicidal ideation, attempt or suicide.

Impact on the Individual and Interactions

Many young people consider or attempt suicide. A higher percent of males in this age group die by suicide, as compared to females (Headspace, 2015). According to Headspace (2015) many adolescents who die by suicide are experiencing mental health conditions such as depression at the time of their death. While it's a rare phenomenon, 'suicide contagion', is when 'one suicidal act' within a school or community increases the likelihood that others 'will attempt or die by suicide' (Headspace, 2015).

Schools are in a critical position, if anyone is immediately affected by suicide ideation, attempt or suicide death. The individuals should be supported in a safe and secure place, where extra support including counselling can be provided and monitored. Family members also may need assistance to know how to support the affected person (Headspace, 2015). The role of the Guidance Officer is to provide immediate crisis support and ensuring a careful referral with client follow-up (Ivey et al., 2016). The Guidance Officer will provide them with resources and contact details for support services in the local community.

Suggested Interventions

Suicide and attempts have serious implications for school communities. Any suggestion of suicide should always be taken seriously and is to be brought to the immediate attention of the Guidance Officer (GO) and Principal. The suicide response plan will outline the critical response steps to be undertaken by the GO in this circumstance. This process is known as 'suicide postvention' (Headspace, 2019).

Responding to a student at risk of suicide can be very difficult and confronting, but there are strategies that can be implemented to support a student. The GO can utilise the GRIP Framework used in a high school setting (Responseability, 2007). The GRIP framework has four elements, Gather, Respond, Involve and Promote that will be applied under the 'close supervision' of the Senior Guidance Officer (Geldard et al.,

2019). A care team is developed to analyse the case, develop an Individual Support Plan and involve the appropriate internal (school context) and external agency through a referral process. This process guides the best approach to circumstances and offers necessary support to the individual and their family, as well as identified school staff, including the student's teachers on a strict confidential basis.

GO's in schools are in are in a advantageous position to help drive positive change (Be You, 2022c) and stigmas surrounding mental health. Responding to "students' wellbeing in a safe, supportive and inclusive environment assists children and young people to be resilient, confident and lifelong learners" (Commonwealth of Australia, 2008). The GO will take practical action and identify appropriate and necessary educational programs and training to support a school context at each level, student, educator, administration, family and community. Research has indicated the most effective approaches to mental health are those that involve and are accessible to everyone.

45.

ADOLESCENCE

Gabrielle Alder-Hughes

Adolescence

Adolescence is a tumultuous period characterised by a development of new cognitive skills, changes in personal and sexual identity, negotiating through puberty and emerging independence from parents on a personal, financial and emotional level (Christie & Viner, 2005). Nowadays adolescence is characterised by school, training and university which covers a period of ten years of more and can well be seen as a separate life stage due to its longevity and range of transitions. This is the stage that tests adolescents' ability to cope with new life requirements and opportunities. It is therefore considered an important part of the life course as it shapes a person and subsequently influences all succeeding life phases (Hurrelmann & Quenzel, 2018).

Suicidal Ideation

Suicidal Ideation (SI) or otherwise known as suicidal thoughts or ideas, is a broad term used to describe a range of contemplations, desires and plans for death or suicide. Harmer et al. (2022) highlight that SI presents in a waxing and waning manner. Therefore, it is vital to treat SI as heterogeneous in nature as it varies in intensity, duration and character depending on each individual (Harmer et al., 2022). According to Headspace (2019) "30% of young people between the ages of 12 and 20 have experienced suicidal thoughts." What is more concerning are the statistics published by the Substance Abuse and Mental Health Services Administration (SAMHSA; 2020) stating that suicide is the second leading cause of death for adolescents and young adults between the ages of 15 to 24 years. It is therefore paramount that SI is identified early, as it has been shown to be the most significant predictor of suicide attempt and completion (Hu et al., 2022).

Evidence of Symptoms

Social connectedness with family, peers and school plays an important role in preventing the risk of SI (Gunn, 2020). If an adolescent lacks social interaction particularly with peers, this may result in them feeling more socially isolated and suffer subsequent low self-esteem which are contributing triggers for SI. Moreover, the literature by Dickerson et al. (2021) highlight social status within school as a contributing factor to SI. For instance, adolescents that perceive themselves as a lower social status than their peers are

often more at risk of SI. Girls in particular are at higher risk as there is more pressure to appear and act a certain way amongst peers, resulting in more distorted self-perceptions. Recent literature has shown that social exclusion and emotion dysregulation relating to anxiety and depression amongst adolescents are important predictive precursors of SI (Morese & Longobardi, 2020).

Literature by Burke et al. (2015) highlight the increase in cognitive vulnerabilities associated with the transition from early to mid-adolescence, as many adolescents experience a higher risk of the onset and growth of SI and suicidal behaviours. Wenzel and Beck (2008) theorised that individuals who tend to display negative cognitive thought processes and maladaptive information processing biases will more likely be triggered by stressful life events, thus eventuating in SI (Burke et al., 2015). As a result of these cognitive vulnerabilities, adolescents may display low mood or have low self-esteem and view their world from a negative perspective which may result in SI.

Adolescents experiencing SI may either display internalising or externalising behaviours. Some may become disengaged in school and show a decrease in academic performance or spend less time with their peers. School work such as poetry, essay writing or artwork may also indicate thoughts of SI made by an adolescent. In contrast, other adolescents may use drugs or alcohol, get in trouble with the police or attempt to run away (Raising Children Network, 2021c). What is important for schools, peers and families is to be made aware of these behaviours in order to help identify SI early and prevent subsequent suicidal attempts.

Self-report scales such as the suicide probability scale (SPS) developed by Cull and Gill (1982), the reasons for living inventory for young adults (RFL-YA-II) developed by Gutierrez et al., (2002) and the suicidal ideation questionnaire (SIQ) by Reynolds et al., (1999) can be utilised to predict suicidal ideation and behaviour in adolescents aged from 13 to 18. These instruments assess the risk of suicide as well as evaluate beliefs and expectations of living as well as suicide attempts. They can be administered in a cost-effective way and give clinicians a quick and accurate measure of suicide risk in adolescents (Baek et al., 2021). As part of the formal assessment, assessing the presence of some or all suicidal thoughts in a patient's history will help to give a clearer indication as to their risk of acting on suicidal thoughts (First, 2008). It is also important to consider that the use of a structured interview in addition to a self-report scale will help to yield a more accurate and valid diagnosis of SI. This is particularly relevant for adolescents who display internalising problems or observable behaviours.

Impact on the Individual and Interactions

Particular groups such as the LGBTQ+ community, ethnic minority or those that come from a low socioeconomic background are more prone to suffer from SI. According to SAMHSA (2020), lesbian, transgender, gay and bisexual adolescents are four times more likely to report SI. These statistics demonstrate how this group of adolescents are affected by experiencing stressors in school by peers or in the community such as violence, bullying and discrimination relating to their identity. In addition, risk factors such as academic difficulties, low self-esteem, bullying and mental health issues can also trigger SI.

Peers begin to have more of an influence during adolescence and therefore may become the primary source for sharing SI or attempts as opposed to family. However, this becomes problematic when adolescents seek support from their peers who are not appropriately equipped thus creating a bidirectional effect, or may have attempted suicide themselves (Boyd et al., 2021).

The familial microsystem also plays a vital role in influencing SI and suicidal behaviour. Boyd et al. (2021) state that lower levels of parental support and communication are linked to a higher risk of SI. Parents' beliefs surrounding sex, relationships and life choices can also heavily influence an adolescent's attitude towards life. This becomes an issue when an adolescent may not conform to their parent's beliefs, which may affect the relationship and the ability for an adolescent to confide in their parents about life choices. Without parental support adolescents may begin to despair and experience SI.

Suggested Interventions

Schools are the most effective settings and provide the best opportunities to identify children and adolescents at risk of SI. In order to successfully prevent future suicidal behaviour, it is essential that guidance counsellors identify at risk children early by utilising formal suicide risk assessments (SRAs) such as questionnaires and interviews. Literature has demonstrated that SI is an initial stage on a continuum of suicidality and thus a predictor or future suicidal behaviour (Reynolds & Mazza, 1999). In fact, according to SAMHSA (2020) over one third of adolescents who experience SI will go on to attempt suicide. If guidance counsellors are able to identify at-risk students early, this will allow for referrals to external agencies and more effective intervention.

In order for intervention to be effective, a holistic approach needs to be adopted. Instead of solely focusing on students that are displaying signs of SI, at risk students also need to be targeted. Guidance counsellors can use the school curriculum and classroom time to aid in the prevention of SI by providing education to students on recognising the signs and risk factors of suicidal thoughts and behaviours. It is also important that guidance counsellors teach the difference between normal versus abnormal behaviour as well as information on where to seek help (Schiro, 2020). In addition, Guidance Counsellors could run workshops for school staff in recognising at risk students to increase knowledge and confidence in early identification and referral. This approach will enable a more collaborative and effective approach to the early identification and prevention of suicidal behaviour. These tools can be particularly helpful for adolescents as this is the period in which they spend more time with peers, and will therefore be able to identify warning signs not just for themselves but for others.

CONCLUSION

Eseta Tualaulelei

A healthy mental state is essential for all learners to thrive in school and in their daily lives. Positive mental well-being lies on a continuum along which individuals shift in relation to life stressors and biological and psychological factors. While these shifts occur at every stage of human development, children and adolescents are especially vulnerable to the detrimental effects of poor mental health as it can affect their social relationships at school, their identities, their academic progress and later life chances. Social and emotional learning programmes offered at the school level are effective at promoting positive mental health, but more important, are school staff who are knowledgeable about and responsive to students' mental health states. At the individual level, teachers and guidance counsellors are best-placed to assist learners with recognising mental health as a priority.

This book, authored by post-graduates with a deep understanding and intimate experience of schools, gives school staff a handy reference for mental health challenges experienced by learners. Each chapter offered a range of ideas that can help school staff recognise each mental health challenge and intervene to support their learners. Each chapter can also be shared more broadly with families as a resource. The title of this book, *Hearts and Minds*, serves as a reminder that healthy minds require a commitment of helping hands and kind hearts that value and protect positive mental health. It is an essential human right, and is integral to strengthening our learners, schools and wider communities.

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PEER REVIEWS

The brilliance of this book is in the uniqueness of the how the content has been gathered through the research of UniSQ's Master of Guidance and Counselling students. Each student embarked on a journey of discovery in their research projects to capture the essence of what is considered to be best practice in schools when it comes to supporting the mental health of students.

Hearts and Minds is a significant contribution to understanding the challenges that schools experience in supporting the mental health of students. The book then celebrates the journey of these Master's students with the publishing of their work in their research projects. Aspiring guidance officers/school counsellors and other educators will be able to access succinct literature reviews of a variety of mental health conditions. This then provides the reader with a source of pertinent information that is based upon the literature to guide their practice in supporting students. Hearts and Minds then most importantly provides suggested interventions that are being successfully implemented in our schools. Educators based in the classroom, support staff and administration teams will do well by familiarising themselves with the book to use a resource in understanding the underpinnings of mental health disorders. The beauty of Hearts and Minds is the provision of suggested interventions that educators can draw upon to support the mental health of students.

Dr Greg Souvan

Guidance Officer, Department of Education

What a fabulous resource and contribution from UniSQ Master of Guidance and Counselling students. *Hearts and Hands: Mental Health Support for Schools* certainly is an informative overview of a range of mental health disorders affecting children and young people. This resource is not only factual but provides educators with practical, evidence-based interventions and suggestions to apprise their practice and investigate the need for further student supports. Additionally, graduates equipped with this resource have a starting point to enhance their awareness of the role requirements of a Guidance Officer or school counsellor, where positive mental health and mental health difficulties are areas of significance in their daily practice. *Hearts and Hands: Mental Health Support for Schools* is a necessary contribution and valuable resource for Guidance Officers and other wellbeing professionals as a guide and reference point to their work in schools.

Sally Bryant

Senior Guidance Officer/ Psychologist, Department of Education