Unit Three
Adolescent Psychiatric Disorders & Treatment

Unit Goal
To provide officers with a broad understanding of the most common adolescent psychiatric disorders among youth in contact with the juvenile justice system and general treatment options for most disorders.

Scope
In this unit, officers will be introduced to the most common adolescent psychiatric disorders, along with treatment strategies for addressing these disorders.

Performance Objectives
At the conclusion of the unit, officers will be able to:

3-1 Relay national estimates of mental health prevalence rates among youth involved with the juvenile justice system.

3-2 Define mental illness and describe common myths about mental health and juveniles.

3-3 Describe the signs, symptoms, and clinical characteristics of the most common psychiatric disorders among youth in the juvenile justice system.

3-4 List treatment options and settings for youth.

Materials
- Cards to be used in exercise on slide 3-5
- Handout: Myths & Facts
- Cards to be used in exercise on slide 3-9
- Handout: Medication Information Sheet
Unit Outline

I. Objectives
II. National Mental Health Prevalence Data
III. What are Mental Illnesses?
IV. Myths and Facts
V. Signs of Mental Disorder in Youth
VI. Mental Disorders and Symptoms
   a. Disruptive Disorders
      i. Attention-Deficit/Hyperactivity Disorder
      ii. Oppositional Defiant Disorder
      iii. Conduct Disorder
   b. Depressive (“Mood”) Disorders
      i. Depression
         1. Adolescent Suicide
         2. Other Self-Harming Behaviors
      ii. Bipolar Disorder
   c. Anxiety Disorders
      i. Generalized Anxiety Disorder
      ii. Panic Disorder
      iii. Separation Anxiety Disorder
   d. Trauma and Stressor-Related Disorders
      i. Posttraumatic Stress Disorder
   e. Psychotic/Thought Disorders
   f. Substance-Related Disorders
      i. Co-occurring Disorders
   g. Neurodevelopmental Disorders
      i. Intellectual Disorders
      ii. Communication Disorders
      iii. Autism Spectrum Disorders

VII. Treatment of Mental Disorders
### Training Aids

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<thead>
<tr>
<th>Slide 3-1</th>
<th>Adolescent Psychiatric Disorders &amp; Treatment</th>
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<td><strong>Adolescent Psychiatric Disorders &amp; Treatment</strong></td>
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### Content/Instructional Delivery Notes

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<tr>
<th>Description</th>
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<tr>
<td>Describe your expertise in adolescent psychiatric disorders and treatment.</td>
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<thead>
<tr>
<th>Slide 3-2</th>
<th>Objectives</th>
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<td><strong>Objectives</strong></td>
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<tr>
<td>- Relay national mental health prevalence rates</td>
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<td>- Define mental illness and discuss common myths</td>
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<td>- Describe the signs, symptoms, and characteristics of disorders common among youth in the juvenile justice system</td>
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<td>- Identify treatment options and settings for youth</td>
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<tr>
<th>Description</th>
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<tr>
<td>Briefly review the objectives for this unit of the training. Encourage officers to engage by asking questions and participating in discussion.</td>
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<tr>
<th>Slide 3-3</th>
<th>A National Perspective</th>
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<td><strong>A National Perspective</strong></td>
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<tr>
<td>- There are nearly 1.5 million arrests of youth under the age of 18 each year. (OJJDP, 2014)</td>
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<td>- The majority of these youth – 65 to 70 percent – have a diagnosable mental disorder.</td>
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<td>- Over 50 percent meet criteria for two mental health diagnoses.</td>
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<td>- Almost 30 percent experience disorders so severe that their ability to function is highly impaired. (Shufelt &amp; Cocozza, 2006)</td>
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<th>Description</th>
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<tr>
<td>This is what we know about the national juvenile population:</td>
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<td>There are nearly 1.5 million areas of youth under the age of 18 each year. Many of these youth formally end up in the system – either in juvenile detention or correctional facilities.</td>
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<td>Current data suggest that the prevalence of mental disorders among youth in the juvenile justice system is significantly higher than among youth in the general population:</td>
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<tr>
<td>- <strong>General youth population</strong></td>
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<tr>
<td>- 20 percent of youth have a diagnosable mental health disorder.</td>
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<td>- <strong>Juvenile justice population</strong></td>
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<td>- Up to 70 percent of youth have a diagnosable mental health disorder.</td>
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<td>- Over 50 percent have multiple disorders, including substance use disorders.</td>
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<td>- 27 percent are believed to be seriously disordered.</td>
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<tr>
<td>Ask how this information mirrors officers’ experience interacting with youth and families.</td>
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</table>
**Content/Instructional Delivery Notes**

*Note to Instructor:* If available, include state or local mental health prevalence data or information on youth involved with your state’s juvenile justice system. Discuss how your state or community’s numbers resemble or differ from the national estimates.

National data indicates that minority “youth of color” tend to experience disproportionate contact with and confinement in the juvenile justice system. Research also indicates that youth are at greater risk for developing a mental disorder if they must contend with multiple adversities and stressors, such as life in dangerous communities, families experiencing significant poverty, parental substance abuse or mental illness, domestic violence, child abuse, or parental incarceration. Because “youth of color” are disproportionately more likely to live in poverty and to experience one or more of these other risk factors, they are also more likely to develop mental disorders – especially mood and anxiety disorders – which they present when coming into contact with the juvenile justice system.

These youth are less likely to have access to effective community-based mental health treatment and may end up “referred” to the juvenile justice system in a misguided effort to secure mental health services.

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**Training Aids**

**Slide 3-4**

**What are mental illnesses?**

Mental illnesses are health conditions that change a person’s thinking, feelings, or behavior (or all three) and cause the person distress and difficulty in functioning.

**Broadly defined, mental illnesses result in problems with thinking, emotions, and/or behavior to the point that they impair functioning.**
**EXERCISE:** Do you know your myths and facts?

1. All youth in the juvenile justice system are mentally ill.
2. All mental health disorders cause criminal behavior.
3. Family members of youth with mental health disorders are resistant to treatment.
4. Mental health disorders and mental retardation are identical.
5. Mental health programming and treatment do not work with delinquent youth who have mental health disorders.
6. Mental health screening services should be provided to a limited number of youth who enter the juvenile justice system.
7. The Americans with Disabilities Act does not apply to mentally ill youth being disciplined in juvenile justice settings for violating the law.

Thank officers and ask them to grade themselves. The answer to all of the questions is FALSE. They are all myths about mental illness and developmental disability.

**HANDOUT:** *Myths & Facts*

Review the *Myths and Facts* handout, reiterating the importance of better understanding mental health problems among youth involved with the juvenile justice system.
### Slide 3-7

**How would you know that a youth might be experiencing a mental health problem?**

Ask question on slide. Officers will likely rely on professional and personal experience. It is likely that officers will begin with the obvious, such as suicidal behavior or psychotic symptoms (e.g., hearing voices). Encourage officers to think specifically about youth.

Point out to officers that youth may be born into a family with a history of mental illness, but this doesn’t guarantee they will genetically inherit the problem. Additionally, adolescents tend to be resilient, thus a diagnosis of mental illness does not guarantee they will struggle with the problem for the rest of their life.

### Slide 3-8

**Signs that MAY indicate a youth is experiencing a mental disorder:**

- Harming or threatening themselves, others, or pets
- Unusually large amount of time spent alone
- Sudden change in school performance
- Using alcohol or other substances
- Drastic mood swings or changes in behavior
- Significant changes in peer group
- Lack of interest in previously pleasurable hobbies, social and/or recreational activities

Review signs, noting that these only indicate the possibility that a mental illness is emerging or already present. These are good points to include when interviewing parents, siblings, or other collaterals in assessing a situation involving a child/adolescent. How are these “signs” similar and different from what was just reviewed about adolescent development?

It is important to note that any one of these signs, in and of itself, does not warrant a diagnosis. The expectation of this training is not to turn officers into clinicians, but rather to sensitize them to the signs and symptoms that may indicate mental disorders in youth.

### Slide 3-9

**EXERCISE: How much do you know about mental health disorders and their symptoms in youth?**

Ask officers to form groups of three to five. Give officers a card with each of the disorders below (one disorder per card). Then, distribute cards with each symptom below (one per card). Ask officers to match symptoms to disorders.

Because this course is for CIT-trained officers, they should all be somewhat familiar with these disorders; this exercise serves as a quick review and can be used to gauge the level of knowledge in the group.
### Depressive Disorder
- Extreme sadness
- Feeling hopeless and helpless
- Trouble concentrating

### Bipolar Disorder
- Severe mood swings
- May not need sleep at times
- Alternating between depression and mania

### Attention-Deficit/Hyperactivity Disorder
- Frequent inattention
- Severe impulsivity
- Easily distracted and agitated

### Conduct Disorder
- Repeatedly violating rules or rights of others
- Blaming others for things they’ve done
- Lacking remorse

### Post-Traumatic Stress Disorder
- Frequent nightmares
- Flashbacks
- Startles easily

### Psychotic Disorder
- Impaired sense of reality
- Hallucinations
- Delusions

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**Slide 3-10**

**Common mental disorders: How do they impact your interaction with youth?**

Introduce the concept that understanding mental disorders can help officers tend to troubled youth.
### Training Aids

**Slide 3-11**

**DISRUPTIVE DISORDERS**
- Attention-Deficit/Hyperactivity Disorder
- Oppositional Defiant Disorder
- Conduct Disorder

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**Slide 3-12**

**Attention-Deficit/Hyperactivity Disorder (ADHD)**
- Inattention: difficulties in sustaining attention, listening, following instructions, attending to details
- Hyperactivity/impulsivity: constant squirming or fidgeting, difficulty in playing quietly, talking excessively

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**Slide 3-13**

**Oppositional Defiant Disorder (ODD)**

This disorder involves a persistent pattern of hostile and defiant behavior:
- arguing with adults
- defying rules/requests
- blaming others
- being easily annoyed
- being angry
- being spiteful and vindictive

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### Content/Instructional Delivery Notes

Disruptive disorders include conditions involving problems in the self-control of emotions and behaviors that violate the rights of others, bringing the individual into conflict with authority. These disorders are relatively common in the juvenile justice population. Diagnoses of disruptive disorders focus on the overt actions of the youth, rather than on an underlying clinical condition.

ADHD is estimated to affect about 20 percent of youth in the juvenile justice population. ADHD can impact all areas of functioning. It is most likely to become the focus of attention when children begin school – a time when difficulty with maintaining attention, completing tasks, and functioning within a highly structured environment is highlighted. Some of the hyperactive features of ADHD diminish in adolescence, but the cognitive features of ADHD (such as inattention and difficulty with concentration) can continue into adulthood.

ADHD is more common in males. Females are more likely to have inattention as the primary symptom. ADHD commonly co-occurs with other mental health disorders.

ODD is characterized by a pattern of angry/irritable mood, argumentative/defiant behavior, and vindictiveness. Youth with ODD often have temper tantrums and stubbornly refuse to comply with rules or requests.

A recent study of youth in detention found that 14.5 percent of males and 17.5 percent of females met the criteria for the diagnosis of ODD (Teplin et al., 2006).
This disorder is characterized by a persistent pattern of behavior which violates the basic rights of others:
- aggression toward people or animals
- destruction of property
- lying and theft
- bullying or intimidation
- initiation of physical fights

The core features of conduct disorder include aggression (directed toward people, animals, or property), fighting, lying, theft, rule violations, bullying, and intimidation. Given that most of these behaviors are illegal, youth with conduct disorder are highly likely to come in contact with the juvenile justice system.

Males with a diagnosis of conduct disorder tend to engage more in fighting, stealing, vandalism, school discipline problems, and physical aggression. Females are more likely to exhibit lying, truancy, running away, substance use, prostitution, and relational aggression.

From a cultural perspective, the diagnosis of conduct disorder may be misapplied to individuals in settings where some patterns of disruptive behavior are viewed as necessary for survival (e.g., in very threatening high-crime areas or war zones) (American Psychiatric Association, 2013).

The early onset of conduct disorder (prior to age 10) predicts a worse prognosis and an increased risk of criminal behavior and substance-related disorders in adulthood. Early onset has also been found to be more strongly associated with the development of other mental health disorders, including ADHD and major depression (McMahon, Wells & Kotler, 2006).

Introduce what some refer to as "mood disorders." Acknowledge officers' previous training and current knowledge of this area: "As you know, there are two major categories of depressive ("mood") disorders: depression and bipolar disorder. Our focus will be on how these disorders appear in youth."
Adolescent Mood Disorders

- Difficult to diagnose
- Underdiagnosed
- Interaction of brain chemistry, life events, and genetics

When it comes to mood disorders, adolescents do not necessarily experience or exhibit the same symptoms as adults. It is more difficult to diagnose mood disorders in children, especially because children are not always able to express how they feel.

Clinicians and researchers believe that mood disorders in children and adolescents remain one of the most underdiagnosed mental health problems. Mood disorders in adolescents also put them at risk for other conditions (most often anxiety disorder, disruptive behavior, and substance abuse disorders) that may persist long after the initial episodes of depression are resolved.

What causes mood disorders in adolescents is not well known. There are chemicals in the brain that are responsible for positive moods. Other chemicals in the brain, called neurotransmitters, regulate the brain chemicals that affect mood. Most likely, depression (and other mood disorders) is caused by a chemical imbalance in the brain. Life events (such as trauma and neglect) also contribute to chemical imbalance.

Mood disorders often run in families and so there appears to be a genetic component to them as well.

Depression in Youth

- More somatic complaints (headaches, stomach aches)
  - Can lead to frequent absences from school
- Irritability
- Temper tantrums
- Running away

Depression in youth can present like a typical adult depression, including depressed mood most of the day, decreased interest in pleasurable activities, loss of energy, feelings of worthlessness, recurrent thoughts of death, etc. However, youth often present with somatic complaints, as well as irritability and social withdrawal.

The following analogy may be helpful: Think of mood disorders like a physical illness. We all may catch a cold, but some of us will have
<table>
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<th>Training Aids</th>
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<tr>
<td>• Social withdrawal</td>
<td>nasal congestion, while others will have a sore throat. This can be confusing for those who respond to youth in crisis, because it can be difficult to determine what is going on.</td>
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<td>• Unexplained crying</td>
<td>Remind officers that any one individual sign is less predictive than multiple signs. That is, the more signs you see, the more likely that there is a problem.</td>
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<td>• Extreme sensitivity to rejection or failure</td>
<td>In one community sample, more girls (25 percent) than boys (10 percent) reported symptoms of depression (Saluja et al., 2004). Different groups of adolescents also report different prevalence rates for symptoms of depression. The same study found 29 percent of Native American youth acknowledged symptoms of depression, compared to 22 percent of Hispanic youth, 18 percent of White youth, 17 percent of Asian youth, and 15 percent of African-American youth. Rates of acknowledging symptoms of depression may be influenced by the stigma associated with admitting indications of a mental disorder among different ethnic groups.</td>
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<td>Assessment and intervention are discussed in the next unit, but an important point to make is that whenever officers see a youth (or anyone) who appears depressed, it’s critical to inquire about suicidal thoughts, plans, or actions.</td>
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<td>Slide 3-18</td>
<td>Youth suicide is a significant public health issue. In the general population, suicide is the second leading cause of death among youth ages 10-18. In 2013, about one in thirteen high-school students attempted suicide.</td>
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<tr>
<td><strong>Depression in Youth: What to Watch For</strong></td>
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<tr>
<td>• Separation anxiety</td>
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<tr>
<td>• Unrealistic fears/anxieties/phobias</td>
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<td>• Negativity/irritability</td>
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<td>• Aggressive/overactive behavior</td>
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<td>• Behavior problems (truancy, shoplifting, harming self)</td>
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<td>• Substance use</td>
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<tr>
<td>• Family history of mood disorder, substance abuse, and/or violence</td>
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<tr>
<td>• Suicidal thoughts/actions</td>
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<td>Slide 3-19</td>
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<td><strong>Suicide in the General Youth Population</strong></td>
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<tr>
<td>• Youth suicide is a significant public health issue.</td>
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<tr>
<td>• Suicide is the second leading cause of death among youth ages 10-18.</td>
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<tr>
<td>• One in thirteen high-school students attempt suicide.</td>
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<td>(National Action Alliance for Suicide Prevention, 2013)</td>
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### Adolescent Suicide
- Girls are two times more likely to attempt suicide.
- Boys are four times more likely to complete suicide.

### Indications for Immediate Help
Signs that immediate help for suicide risk is needed include the following:
- perceived crisis
- unusual or sudden changes in personality, behavior, or mood
- talking about wanting to die or kill oneself
- withdrawal from friends, family, or usual activities
- expressions of hopelessness or feeling trapped
- actively securing access to lethal means

### Detecting Suicidal Thoughts in Youth
- Suicide talk?
- Note?
- Injury to self?
- (Realistic) plan?
- Previous attempt?

Here are some other relevant facts:
- Males are more likely to die by suicide and females are more likely to attempt suicide.
- Nearly 88,000 youth ages 10-18 were treated in emergency rooms for self-harm injuries in 2011.
- Certain populations of youth (e.g. American Indian, Alaskan Native, and sexual minority youth) have increased rates of suicide.  
  (National Action Alliance for Suicide Prevention, 2013)

Ask officers why they think gender differences exist. Emphasize the likelihood that males are action oriented and much more likely to find the lethal means necessary to complete suicide.

Officers should always be alert to sudden changes in a youth’s behavior, appearance, thoughts, emotions, or mood. Threats of suicide should always be taken seriously and the youth should be seen immediately by a mental health professional.

**Note to Instructor:** Prior to showing the next slide, ask officers how to detect suicidal thoughts in youth.

The same way officers assess suicidal risk in adults applies to youth (as briefly reviewed on the slide). However, it is important to note that there is some evidence that suggests that whereas adults who attempt suicide often have chronic problems that influence their decision to try to kill themselves, adolescent suicide attempts will more likely be an acute reaction to a specific precipitating event.
### Training Aids

- Signs of depression? Expressing hopelessness?
- Giving away prized possessions?

### Content/Instructional Delivery Notes

It is important to ask whether youth are thinking of hurting themselves and whether they are thinking of killing themselves – as those questions will be answered differently by some individuals.

Many times suicides occur by accident (i.e., the adolescent hoped to get someone else’s attention and had not intended to die, but died anyway).

Cutting is used as a means of relief and doesn’t mean the person is suicidal. However, any self-harming behaviors must be taken seriously.

Remind officers that bipolar disorder used to be called “manic depression.” These two labels refer to the same disorder.

This slide should be presented as a quick review.

Some individuals experience mania as “feeling fabulous/over the moon” while others experience it as extreme restlessness and agitation, as if a freight train is moving inside of them, trying to get out. This varies across individuals and within the same individual during different episodes of mania.

Ask for someone to briefly describe an interaction he/she has had with a manic adult. Then, ask for someone to describe an interaction with a manic youth. You might hear a description similar to the adult description or perhaps something a bit different (as detailed below).

### Slide 3-23

#### Other Self-Harming Behaviors

- Used as release for emotional or physical pain
- Can occur as group activity
- Can have lethal results

### Slide 3-24

#### Bipolar Disorder

- This disorder is characterized by extreme changes in mood.
- The mood changes usually cycle from depression to mania or vice versa.

### Slide 3-25

#### Mania

- Inflated self-esteem
- Rapid/erratic speech
- Decreased need for sleep
- Euphoria
- Flight of ideas
- Grandiose ideas
- Excessive involvement in pleasurable activities
- Irritability
- Lack of focus and/or concentration
Highlight the critical safety issues when encountering youth. There can be increased danger due to the impulsivity and intensity of manic symptoms. Things can change very quickly and unexpectedly.

In the event that no one volunteers, provide a brief youth-oriented description as a transition to the next slide. Mania/bipolar disorder in youth can sometimes look a bit different. Once thought to be rare in youth, it has become a more common diagnosis.

Note that the description on the previous slide pertains to youth as well as adults. This slide is more specific to youth (although not necessarily exclusive to youth).

Read the first three bullet points and ask officers: What does this sound like? Explain that youth with ADHD present with these same symptoms. However, youth with bipolar disorder have additional symptoms that are not seen in those with ADHD (previously described above – flight of ideas, decreased sleep, grandiose ideas).

Also, it is common for youth with bipolar disorder to have “multiple cycles” during the day. That is, they can be “high” or euphoric and then quickly move to the depressed phase and feel suicidal.

Ask officers for ideas about ways to engage someone who is depressed.

Explain that a depressed youth may have an “I don’t care” attitude, so encouraging engagement is the biggest challenge.

De-escalation and communication techniques are covered in Unit 4. For now, introduce these ideas:
### Training Aids

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<thead>
<tr>
<th>Slide 3-28</th>
<th>ANXIETY DISORDERS</th>
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<tbody>
<tr>
<td>- Anxiety disorders are the most common mental illness.</td>
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<td>- More than 19 million Americans are affected each year.</td>
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<tr>
<td>- Anxiety is the most common mental illness affecting youth.</td>
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<td>- It affects 13 percent of youth of ages 9 - 17.</td>
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<tr>
<th>Slide 3-29</th>
<th>Anxiety Disorders</th>
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<tr>
<td>- Generalized Anxiety Disorder</td>
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<td>- Panic Disorder</td>
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<tr>
<td>- Separation Anxiety Disorder</td>
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### Content/Instructional Delivery Notes

In general, for mood-based disorders:
- Be aware of the alternations in mood and behavior, as well as management issues.
- Motivate the youth and encourage youth to participate in activities.
- Encourage youth to engage others and talk with people.

Specific to mania:
- Stay calm. Reasoning someone out of mania will not work. Keep the youth as safe as possible. Mania increases impulsive and unsafe behaviors.
- Maintain eye contact.
- Speak directly and help the youth understand what is being asked.

Introduce the topic of anxiety disorders.
Provide a brief review of “anxiety.” Anxiety is a normal reaction to stress. It helps one deal with a tense situation or study harder for an exam, etc. In general, it helps one cope. But when anxiety becomes excessive, or makes one feel an irrational dread of everyday situations, or if it leads to extreme reactions, it is a “disorder” that requires attention and treatment.

There are a few anxiety disorders, as noted on the slide.
Youth with generalized anxiety disorder are described as “worry warts” because they have excessive fears, worries, and tension.

**Panic disorder** is marked by intense anxiety, nausea, sweating, and chest pain that looks/feels like a heart attack. People fear they are dying. Because they fear an attack is going to happen in public, they stay home, so they
can become isolated. EMS personnel might be asked to bring these youth to an ER.

**Separation anxiety disorder** is characterized by excessive and age-inappropriate anxiety concerning separation from individuals to whom youth are attached. Youth worry about the well-being or death of the person from whom they are separated and constantly want to know the whereabouts of that person. They may become particularly upset when they do not hear from the person at a scheduled time.

Trauma and stressor-related disorders involve exposure to a highly arousing, frightening event and one’s emotional reactions to the event over an extended period of time.

The most well-known of these disorders, posttraumatic stress disorder (PTSD), was originally used in response to acute stress reactions to combat some soldiers experienced. However, the PTSD diagnosis is not limited to combat soldiers; anyone (even youth) can develop trauma symptoms.

A re-experiencing of the event (flashbacks) can be triggered by sights, sounds, smells, or touch that would seem ordinary to a non-traumatized individual, but which the traumatized person associates with the original event. This re-experience can include visualizing the experience and “dissociating” or disconnecting from the present reality.

Other symptoms of trauma include heightened arousal (difficulty sleeping, irritability, and difficulty with concentration) and hypervigilance (scanning the environment for real or anticipated threats).

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<tr>
<th>Slide 3-30</th>
<th>TRAUMA AND STRESSOR-RELATED DISORDERS</th>
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<td><strong>There are multiple trauma-related diagnoses. All of them include three essential components:</strong></td>
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<td>• a stressful event</td>
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<td>• an ongoing intense, negative emotional experience</td>
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<td>• lasting, negative effects</td>
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<tr>
<th>Slide 3-31</th>
<th>Posttraumatic Stress Disorder</th>
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<td>Exposure to actual or threatened death, serious injury, or sexual violence can result in PTSD. Symptoms include the following:</td>
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<td>• re-experience of the event (e.g., flashbacks, nightmares)</td>
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<td>• avoidance behaviors</td>
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<td>• heightened arousal and hypervigilance</td>
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<td>• exaggerated negative beliefs about the world</td>
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### Training Aids

**Slide 3-32**  
**Symptoms of Trauma and Stressor-Related Disorders**
- Numbing & detachment – being in “a daze”
- Difficulty remembering aspects of event
- Intrusive images, thoughts, or dreams
- Flashbacks
- Avoidance of reminders of event
- Increased arousal

**Slide 3-33**  
**Youth-Specific Symptoms**
- Repetitive play
- Frightening dreams

**Slide 3-34**  
**Stressful Events in Children’s Lives**
- Victim of or witness to:
  - Violence (especially interpersonal violence)
  - Physical/sexual, verbal, emotional abuse and/or neglect
- Illness/separation/death of a family member

### Content/Instructional Delivery Notes

This should be a review for the officers, so there is no need to spend much time detailing the symptoms.

- Clear up myths/TV portrayals of flashbacks. In reality, they can last for just seconds. It’s important to remember that the person is truly re-experiencing some part of the trauma. A flashback is actually re-living, feeling, and/or seeing part of a traumatic event at any given time. This is not a dream. The brain actually replays part of the trauma while the person is awake. They may appear to “zone out” and have a blank stare. They may say things or physically react to the trauma (i.e., become startled or frightened for no apparent reason).
- Mention increased arousal: Difficulty falling or staying asleep, irritability, difficulty concentrating, hyper-vigilance, exaggerated startle response

Youth may exhibit some of these symptoms in a different way. For example, instead of reporting intrusive images or distressing recurring thoughts about the event, young children might engage in repetitive play in which aspects of the trauma are expressed.

Rather than specific dreams about the trauma, they may experience frightening dreams without recognizable content.

Youth who experience high-stress events in the course of their development are more likely to develop short-term and long-term stress responses, including full-blown PTSD. These youth may be immigrants from war conflict zones; live in places where community violence is common; or whose experience of entering the country involved family separation, exposure to violence, or difficulties in adaptation once in the United States. These
<table>
<thead>
<tr>
<th>Training Aids</th>
<th>Content/Instructional Delivery Notes</th>
</tr>
</thead>
</table>
| • Parents’ separation/divorce  
• Relocation | youth may also be American-born youth – disproportionately members of ethnic, linguistic, and/or cultural minorities – who live in impoverished and high-crime communities and/or have experienced parental incarceration, transience and instability of living situations, violence within their families, parental substance abuse, significant parental psychiatric disability, involvement with child protection authorities, and/or their own victimization by physical or sexual violence in their communities. If the youth’s history of exposure to high-stress or even traumatic events is not taken into account, some symptoms of mental disorder may inaccurately be attributed to mental disorders focusing on attention/concentration/impulsivity (ADHD) or extreme mood instability (bipolar disorder). Understanding a youth’s history of exposure to stressful or traumatic events and especially the youth’s own perception of those events is critical to understanding the response to those events.  
Inform officers that the youth’s perception of the stressor is most important and will determine his/her response.  
What one person perceives as stressful may not be the same for someone else. Our histories can trigger different responses/outcomes.  
Remind officers that, depending on a particular youth’s history, just seeing a police officer can trigger increased anxiety and/or traumatic memories. |

Slide 3-35

What can YOU do when you encounter a youth who appears anxious and/or has symptoms of PTSD?

• Be calm.

Respond to a youth who appears anxious by:

• Being calm, reassuring, and supportive.
• Using verbal de-escalation techniques. Patience and active listening provides needed support during times of crisis.
### Training Aids

- Use verbal de-escalation techniques.
- Speak directly.
- Be aware that your presence may be a trigger.
- Explain interventions before you act.

### Content/Instructional Delivery Notes

- Being aware that your presence may trigger memories of past traumatic events. Prior to putting “hands on” explain what exactly you are going to do and why.

### Slide 3-36

**What can YOU do to help youth cope with trauma?**

- As officers, it is not helpful or important to ask the person to recount traumatic experiences over and over. This can cause re-traumatization.

  Traumatized youth may have strong startle reactions and even experience flashbacks when being restrained. **Reassuring these youth that they are safe and will not be harmed is critical.** Here are specific suggestions to consider:

  - Ask female officers to search/pat-down a teenage girl who reports (or who you suspect has suffered) past sexual abuse.
  - Do not use handcuffs unless absolutely necessary.

In response to the widespread prevalence of violence and its effects in children’s lives, many communities have formed partnerships among police departments, mental health, and other child-serving agencies.

Mention that it is helpful for officers to become familiar with local services that specialize in reducing the impact of trauma. More on this topic is included in Unit 7.

For more information about creating a trauma-informed law enforcement system, see: [http://www.nctsnet.org/sites/default/files/assets/pdfs/SS_brief_law_enforcement.pdf](http://www.nctsnet.org/sites/default/files/assets/pdfs/SS_brief_law_enforcement.pdf)

### Slide 3-37

**PSYCHOTIC/THOUGHT DISORDERS**

- Impaired sense of reality

There are many different ways to describe psychotic/thought disorders. Depending on their previous training, CIT course participants may have had this material presented.
### Training Aids

- Hallucinations
- Delusions
- Bizarre ways of behaving
- Difficulty relating to others
- Drug-induced hallucinations, delusions, paranoia
- Social isolation

### Content/Instructional Delivery Notes

differently, perhaps in learning about schizophrenia since that is where thought disorder is most commonly observed.

Thought disorders are inferred from speech and often referred to as “disorganized speech.” Thought disorders are most often observed in those with schizophrenia, as noted above, or mania.

Ask officers for examples of disorganized speech that they have observed. Once described, try to label the behavior per the list on the slide.

Emphasize that it is not necessary to remember the types of thought disorders, but it helps to be aware of them in order to describe them to others.

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**Slide 3-38**

**What can YOU do when you encounter a youth experiencing a psychotic/thought disorder?**

It is not possible to talk someone out of a delusion, but it is important to keep him/her safe. Respond to youth who you suspect may have a psychotic/thought disorder by

- Maintaining appropriate eye contact.
- Talking directly to the youth.
- Helping the youth understand what is being asked.
- Being honest (“No, I don’t hear that voice, but tell me what it is saying.”)
- Being empathic (“It must be confusing – or scary – for you to hear that when no one else does.”)

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**Slide 3-39**

**SUBSTANCED-RELATED DISORDERS**

Substance-related disorders involve a pattern of substance use leading to significant impairment and distress:

- taking the substance in larger amounts or over a longer period than intended

A diagnosis of substance-related disorder is appropriate when substance use adversely impacts an individual’s functioning at home, in school, or in relationships, or brings the individual in contact with the legal system (e.g., Driving Under the Influence).

As noted earlier, adolescence can be a time of sensation seeking and experimentation. For
Training Aids

- craving the substance
- making unsuccessful attempts to reduce substance use
- experiencing recurring interpersonal problems

Slide 3-40

**Substance-Related Disorders**

Problematic effects of the substance can include

- craving,
- tolerance,
- withdrawal, and
- inducing other disorders (e.g., delirium, depression, sleep disorder, or sexual dysfunction).

Content/Instructional Delivery Notes

many youth, this often results in experimentation with and using alcohol, marijuana, and stimulants.

Symptoms can include “craving” (intense desire or urge for the drug), “tolerance” (needing increasing amounts of the substance in order to achieve the same effect), and “withdrawal” (varies by drug but may include anxiety, tremors, vomiting, and hallucinations when the use of the substance is abruptly interrupted or discontinued).

Research shows that the earlier youth become involved in substance use, the more debilitating it can be. For example, according to the National Longitudinal Survey of Youth, the odds of developing alcohol dependence decreased with each year that the onset of drinking was delayed (Grant, Stinson & Harford, 2001). Sadly, some youth in substance abuse treatment have reported initiating their alcohol use at age 11, progressing to weekly use by age 13 (Brown et al., 1996). For youth with co-occurring disorders, these numbers trend toward even earlier onset and progression to regular use (Abrantes et al., 2004).
Co-occurring Disorders

- Substance use can precipitate or worsen existing mental health disorders.
- Mental illness in combination with substance use increases the risk of violent behavior.
- Heavy use of some substances can disrupt brain development and lead to lasting impairment.

Prior studies indicate that among youth with other major mental disorders, over 60 percent had co-occurring substance use problems. The presence of substance use can precipitate (bring on) or worsen existing mental health disorders, even though a person’s perception may be that substance use reduces stress, suffering, and symptoms. Youth with a mental health disorder sometimes use substances as a coping mechanism, so some symptoms may not manifest themselves until after the youth has stopped the substance use.

The use of substances in childhood and adolescence can adversely impact brain development in ways that may not be reversible even after the person discontinues use.

In cases of co-occurring disorders, it can be difficult to tell what the primary problem is at any point in time. Remind officers to always ask whether the youth has ingested any substances.

NEURODEVELOPMENTAL DISORDERS

- Intellectual Disabilities
- Communication Disorders
- Autism Spectrum Disorder

Neurodevelopmental disabilities are briefly mentioned in this section as a brief review of officers’ previous training.

Neurodevelopmental disabilities are a diverse group of severe chronic conditions prompted by mental and/or physical impairments. People with neurodevelopmental disabilities have problems with major life activities, such as language, mobility, learning, self-help, and independent living. Neurodevelopmental...
### Intellectual Disabilities
- Impaired intellectual functioning (reasoning, problem solving, judgment, and learning from experience)
- Adaptive impairment (independent living, social and communication skills)

### Communication Disorders
- Deficits in speech, language, and nonverbal communications
- Must take into account cultural background, including growing up in a household where English is not the primary language
- May result in youth having difficulty understanding basic instructions

### Note to Instructor:
Be sure to include in the “Connecting to Resources” unit any local treatment providers and facilities that specialize in developmental disabilities.

Intellectual disabilities (which previously included the diagnosis of “mental retardation”) are characterized by significant intellectual and adaptive functioning deficits. Without ongoing support, the person has limited functioning in daily living skills. Officers may be familiar with intellectual disability being defined as having very low scores on standardized intelligence tests and low “adaptive functioning.”

Communication disorders can result in a significant discrepancy between measured achievement and age, school level, or ability.

Given these youth may have difficulty understanding staff, it is important to give instructions clearly and slowly, with repetition.
## Autism Spectrum Disorder

- Deficits in social communication and social interactions
- Restricted, repetitive patterns of behavior and interests

Autism spectrum disorder now encompasses the previous diagnoses of autistic disorder, Asperger’s disorder, childhood disintegrative disorder, and pervasive developmental disorder.

Diagnostic features of autism spectrum disorder include:
- Deficits in social communication and social interactions
- Restricted, repetitive patterns of behavior and interests

## Engaging Youth with Neurodevelopmental Disorders

- Be patient.
- Speak clearly, concisely, and slowly.
- Be prepared to de-escalate.
- Expect to repeat directions.
- Ask youth to summarize what you explained to ensure his/her understanding.

Follow these guidelines when engaging youth who have neurodevelopmental disorders:
- Exercise patience. Do not rush the youth.
- Encourage youth to complete tasks that are within his/her capabilities.
- Provide verbal cues on a frequent basis and in concise language, speaking slowly.
- Be aware that transitioning from one activity to another may be difficult for youth who have neurodevelopmental disorders.
- Be alert for incidents that agitate youth.
- Be prepared to de-escalate youth before agitation has reached the point of uncontrollable rage.
- Expect to repeat directions.
- Rely on prompts and behavioral cues.
- Ask youth to summarize what you explained so to confirm his/her understanding.

## Categories of Treatment

- Therapy/counseling
  - Individual
  - Group

There are two main categories of treatment offered to youth: therapy and medication.

Therapy (counseling) is a general phrase that encompasses different treatment approaches – individual counseling, group therapy, or different
<table>
<thead>
<tr>
<th>Training Aids</th>
<th>Content/Instructional Delivery Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Family</td>
<td>types of family therapy.</td>
</tr>
<tr>
<td>- Parent</td>
<td>The involvement of parents in the treatment is essential. For younger children, parent counseling is often an integral part of treatment.</td>
</tr>
<tr>
<td>• Medication</td>
<td>There are many medications used to treat childhood psychiatric disorders. (Refer to the Medication Information Sheet handout.)</td>
</tr>
<tr>
<td>Slide 3-49</td>
<td>Note to Instructor: Officers may comment about reports over the past few years of youth being over-prescribed psychiatric medications. Consider addressing this controversy by stating that individual decisions about medication prescriptions should be left to mental health professionals and parents. It may be useful to note that certain youth, especially those who aren’t seen by child psychiatrists, may actually be under-prescribed certain medications. That is, youth may receive an “appropriate” medication, but not at an optimal dose.</td>
</tr>
<tr>
<td>HANDOUT: Medication Information Sheet</td>
<td>Note to Instructor: Providers of mental health treatment are briefly introduced here and revisited with more specificity in Unit 7.</td>
</tr>
<tr>
<td>Slide 3-50</td>
<td>Hospital Emergency Departments (EDs) offer initial evaluations, treatment recommendations, and around-the-clock availability. Many communities use EDs as a main point of diversion for law enforcement. That is, if police judge a youth to be in significant distress, they often will arrange for the youth to be seen in the ED.</td>
</tr>
<tr>
<td>Providers of Treatment</td>
<td>The highest level, or most intensive level of care, is a hospital inpatient unit. There are both acute (short-term) and longer-term hospitals for youth. However, the vast majority of youth are treated outside of hospitals.</td>
</tr>
<tr>
<td>• Emergency departments</td>
<td></td>
</tr>
<tr>
<td>• Hospital inpatient units</td>
<td></td>
</tr>
<tr>
<td>• Residential treatment facilities/group homes</td>
<td></td>
</tr>
<tr>
<td>• Home and community-based models</td>
<td></td>
</tr>
<tr>
<td>• Clinics/private practice offices</td>
<td></td>
</tr>
<tr>
<td>• Schools</td>
<td></td>
</tr>
</tbody>
</table>
Training Aids

Residential treatment facilities are places where youth live for an extended period of time. Another version of residential treatment facilities is a group home.

Home and community-based models of care involve professionals seeing youth and families in their homes or at other locations in the community. There are a variety of specialized approaches that have been developed to address youth and their families.

In most communities, public mental health clinics are where the majority of youth/families are seen for assessment and treatment. Private practice offices are an alternative to this.

Some schools have mental health professionals based in the school and/or specialized programs for youth with disorders.

Content/Instructional Delivery Notes

Slide 3-51

Responding to Youth in Distress

Ask the following questions to more completely understand the situation:

- Are you in treatment?
- Do you see a mental health professional?
  - Where? How often? What sort of program do you participate in?
- Do you have a prescription for medicine?
  - Do you take the medicine?

When responding to a youth in distress, officers should be reminded to ask whether the youth is currently engaged in treatment. If yes, officers should ask additional questions to more completely understand the situation.

If the participating officers work in diverse neighborhoods, they might also ask:

- Are you being seen by a mental health professional who can speak to you and your parents or family members in your/their preferred language?
- Are you being seen by a mental health professional who understands the values, beliefs and practices of your culture/community?
### Diversity and Mental Health Treatment

- Differences in **conceptualization** of mental health disorders across cultures
- Differences in **expression** of mental disorders across cultures
- Differences in **stigma** of mental health disorders across cultures
- Differences in the **capacities** of mental health care available to provide culturally competent mental health care for specific communities and individuals

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### Content/Instructional Delivery Notes

Acknowledge that different cultures have different ways of understanding and even expressing mental disorders.

- Some cultures manifest depression or anxiety in more physical “somatic” symptoms than in symptoms of sadness.
- Some cultures do not consider genetic vulnerabilities to mental disorder, instead referring to curses or spirits as the cause.
- Still other cultures view mental disorders as reflecting a special sacred status.
- Individuals in cultures that view mental disorders negatively are unlikely to admit or acknowledge symptoms.

The most important thing for officers to appreciate is that there may be differences in how readily a youth or a parent reports or acknowledges a symptom of a mental disorder, or how they understand its causes and treatments. Officers also need to appreciate that some mental health providers may be able to offer culturally competent treatment that takes into account cultural differences, while others may not be as effective in doing so. Because of this variation, officers are encouraged to learn about how diverse communities view mental disorders and which local providers are best suited to provide culturally appropriate care.
Myth 1: All youth in the juvenile justice system are mentally ill.

Facts:
- Up to 70 percent of youth in juvenile correctional facilities have a mental health disorder.
- About 50 percent of youth in juvenile correctional facilities are in need of special education classes.
- Mental health disorders may be significantly different than behavioral disorders.

Myth 2: All mental health disorders cause criminal behavior.

Facts:
- Mental health disorders may or may not be associated with criminal/delinquent offenses. For example, research shows that substance use introduces people to different types of crime, but doesn’t necessarily cause the crime.
- Mental health disorders and delinquent behaviors may be related, but are not necessarily causative. The disorder, if undetected or untreated, can manifest in behaviors that could bring a youth to the attention of law enforcement.
- Mental health disorders may be genetic or environmental in nature.

Myth 3: Family members of youth with mental health disorders are resistant to treatment.

Facts:
- Family members often feel disconnected from treatment (or even blamed), especially in juvenile detention and secure care settings.
- Many evidence-based practices focus on taking the blame off of any one person in a family and refocus attention so that problems (mental illness included) are an issue for everyone in the family to address and everyone can be part of the solution.
- Family members may assist in transitioning youth back into the community after an offense has been committed (youth need support and resources to sustain change). For example, when there is a smooth transition from detention or institutional care to the community, treatment is more effective and can continue to help the child beyond confinement.
Myth 4: Mental health disorders and mental retardation are identical.

Facts:
- Mental retardation is a separate and distinct set of disorders affecting intelligence and educational abilities.
- Mental health disorders are complex, affecting thinking, perception, mood, and behaviors.

Myth 5: Mental health programming and treatment do not work with delinquent youth who have mental health disorders.

Facts:
- Certain treatments have been shown to be effective.
- Interventions that are designed to work with youth in the context of their environment (family, home, peer, school, work, neighborhood) have been found to be more effective than traditional office-based or institutional interventions.
- Treatments that focus on teaching skills and reinforcing youth and family as they utilize those skills in the “real world” are more effective than educational programs or interventions that only allow youth to demonstrate skills in a controlled environment (e.g., office or institution).

Myth 6: Mental health screening should be provided to a limited number of youth who enter the juvenile justice system.

Facts:
- All youth entering the juvenile justice system should be screened for mental disorders and other related issues.
- Screening and assessing youth assist in developing effective treatment planning.

Myth 7: The Americans with Disabilities Act does not apply to mentally ill youth being disciplined in juvenile justice settings for violating the law.

Facts:
- Accommodations must be made for youth with mental disorders.
- Youth need to be held accountable for their actions, but should not be punished for a symptom of their mental disorder (they should be treated).
Materials

Medication Exercise

Instructions

Instructor may wish to illuminate the variety and number of medications taken by children and adolescents for conditions that may be present as one condition, as co-occurring conditions, and as side effects.

A simple method to display the complexity of medications is to use buttons or candies that are color-coded and identified as a specific medication. Pass out to the class the “dosage” for a day for one, two, co-occurring, and side effect medications that are commonly seen in this population.

Discuss with the group what it might be like to remember to take these pills and experience the side effects. Include in the discussion the stigma of mental illness, what kids think of other kids who are always at the nurse’s station, etc.

(See next page for Medication Information Sheet.)
### Medication Information Sheet

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic Name</th>
<th>Indication</th>
<th>Common Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify</td>
<td>Aripiprazole</td>
<td>Antipsychotic</td>
<td>Nausea, headache, dizziness, insomnia, anxiety</td>
</tr>
<tr>
<td>Adderall</td>
<td>Dextroamphetamine/amphetamine</td>
<td>Stimulant (for ADHD)</td>
<td>Difficulty sleeping, feeling irritable or restless, dry mouth, dizziness, loss of appetite, headache, feeling shaky, nausea</td>
</tr>
<tr>
<td>Ambien</td>
<td>Zolpidem</td>
<td>Sedative</td>
<td>Drowsiness, dizziness, difficulty with coordination, headache, nausea</td>
</tr>
<tr>
<td>Anafranil</td>
<td>Clomipramine</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness</td>
</tr>
<tr>
<td>Antabuse</td>
<td>Disulfiram</td>
<td>Alcoholism</td>
<td>Drowsiness, headache, “metallic” taste</td>
</tr>
<tr>
<td>Asendin</td>
<td>Amoxapine</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness, stiffness</td>
</tr>
<tr>
<td>Ativan</td>
<td>Lorazepam</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>BuSpar</td>
<td>Buspirone</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, dry mouth, headache, nausea, fatigue</td>
</tr>
<tr>
<td>Catapres</td>
<td>Clonidine</td>
<td>Impulsive/aggressive behaviors</td>
<td>Drowsiness, dizziness, dry mouth, headache, weakness, constipation</td>
</tr>
<tr>
<td>Campral</td>
<td>Acamprosate</td>
<td>Alcoholsim</td>
<td>Dizziness, headache, nausea, tremor, diarrhea, insomnia, sweating</td>
</tr>
<tr>
<td>Celexa</td>
<td>Citalopram</td>
<td>Antidepressant</td>
<td>Nausea, nervousness, drowsiness, headache, change in appetite</td>
</tr>
<tr>
<td>Cymbalta</td>
<td>Duloxetine</td>
<td>Antidepressant</td>
<td>Nausea, dry mouth, constipation, dizziness, drowsiness</td>
</tr>
<tr>
<td>Clozapine</td>
<td>Clozapine</td>
<td>Antipsychotic</td>
<td>Sedation, increased salivaion, constipation, increased appetite, low blood pressure (Seizures may occur at high doses)</td>
</tr>
<tr>
<td>Dalmane</td>
<td>Flurazepam</td>
<td>Sedative</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Depakote</td>
<td>Valproate, valproic acid, divalproex</td>
<td>Mood Stabilizer (Antimanic)</td>
<td>Nausea, vomiting, sedation, increased appetite</td>
</tr>
<tr>
<td>Desyrel</td>
<td>Trazodone</td>
<td>Antidepressant</td>
<td>Sedation, dizziness, dry mouth, blurred vision, headache</td>
</tr>
<tr>
<td>Dexamethine</td>
<td>Dextroamphetamine</td>
<td>Stimulant (for ADHD)</td>
<td>Difficulty sleeping, feeling irritable or restless, dry mouth, dizziness, loss of appetite, headache, feeling shaky, nausea</td>
</tr>
<tr>
<td>Effexor</td>
<td>Venlafaxine</td>
<td>Antidepressant</td>
<td>Headache, dry mouth, nausea, constipation, drowsiness, nervousness, trouble sleeping</td>
</tr>
<tr>
<td>Elavil</td>
<td>Amitriptyline</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness</td>
</tr>
<tr>
<td>Eskalith CR Lithobid Lithotab Lithonate</td>
<td>Lithium Carbonate</td>
<td>Mood Stabilizer (Antimanic)</td>
<td>Nausea, shakiness, and tremor, dry mouth, diarrhea, drowsiness, increased thirst, increased urination With overdose: confusion, slurred speech, seizures, muscle twitching, severe vomiting, coma, and death</td>
</tr>
<tr>
<td>Geodon</td>
<td>Ziprasidone</td>
<td>Antipsychotic</td>
<td>Sedation, restlessness, dizziness, constipation, nausea, tremor</td>
</tr>
<tr>
<td>Halcon</td>
<td>Triazolam</td>
<td>Sedative</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Haldol</td>
<td>Haloperidol</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Invega</td>
<td>Paliperidone</td>
<td>Antipsychotic</td>
<td>Sedation, restlessness, dizziness, nausea, headache</td>
</tr>
<tr>
<td>Klonopin</td>
<td>Clonazepam</td>
<td>Antianxiety, anti-seizure</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Lamictal</td>
<td>Lamotrigine</td>
<td>Mood Stabilizer, anti-seizure</td>
<td>Dizziness, nausea, diarrhea, headache, blurred vision, drowsiness, incoordination</td>
</tr>
<tr>
<td>Lexapro</td>
<td>Escitalopram</td>
<td>Antidepressant</td>
<td>Sedation, nausea, diarrhea, sweating, dizziness</td>
</tr>
<tr>
<td>Librium</td>
<td>Chlordiazepoxide</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Loxitane</td>
<td>Loxapine</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Luvox</td>
<td>Fluvoxamine</td>
<td>Antidepressant</td>
<td>Nausea, nervousness, drowsiness, headache, change in appetite</td>
</tr>
<tr>
<td>Melliaril</td>
<td>Thoridazine</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Drug</td>
<td>Brand Name</td>
<td>Category</td>
<td>Side Effects</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
<td>----------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Moban</td>
<td>Molindone</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Nardil</td>
<td>Phenelzine</td>
<td>Antidepressant</td>
<td>Dizziness, dry mouth, nausea, shakiness, blurred vision, increased appetite, difficulty sleeping</td>
</tr>
<tr>
<td>Navane</td>
<td>Thiothixene</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Neurontin</td>
<td>Gabapentin</td>
<td>Antianxiety, nerve pain</td>
<td>Dizziness, fatigue, incoordination, drowsiness, tremor</td>
</tr>
<tr>
<td>Norpramin</td>
<td>Desipramine</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness</td>
</tr>
<tr>
<td>Pamelor</td>
<td>Nortriptyline</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness</td>
</tr>
<tr>
<td>Paxi</td>
<td>Paroxetine</td>
<td>Antidepressant</td>
<td>Nausea, nervousness, drowsiness, headache, change in appetite</td>
</tr>
<tr>
<td>Prolixin</td>
<td>Fluphenazine</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Prozac</td>
<td>Fluoxetine</td>
<td>Antidepressant</td>
<td>Nausea, nervousness, drowsiness, headache, change in appetite</td>
</tr>
<tr>
<td>Remeron</td>
<td>Mirtazapine</td>
<td>Antidepressant</td>
<td>Sedation, increased appetite, dizziness, nausea, dry mouth, constipation, impaired motor skills</td>
</tr>
<tr>
<td>Restoril</td>
<td>Temazepam</td>
<td>Sedative</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>ReVia</td>
<td>Naltrexone</td>
<td>Alcoholism</td>
<td>Nausea, vomiting, nervousness, dizziness, anxiety, insomnia</td>
</tr>
<tr>
<td>Risperdal</td>
<td>Risperidone</td>
<td>Antipsychotic</td>
<td>Insomnia, anxiety, constipation, some stiffness at higher doses</td>
</tr>
<tr>
<td>Ritalin Concerta</td>
<td>Methylphenidate (for ADHD)</td>
<td>Stimulant</td>
<td>Difficulty sleeping, feeling irritable or restless, dry mouth, dizziness, loss of appetite, headache, feeling shaky, nausea</td>
</tr>
<tr>
<td>Serax</td>
<td>Oxazepam</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Seroquel</td>
<td>Quetiapine</td>
<td>Antipsychotic</td>
<td>Sedation, dizziness, constipation, dry mouth, low blood pressure</td>
</tr>
<tr>
<td>Serzone</td>
<td>Nefazodone</td>
<td>Antidepressant</td>
<td>Dizziness, drowsiness, dry mouth, nausea, constipation, weakness</td>
</tr>
<tr>
<td>Sinequan</td>
<td>Doxepin</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness</td>
</tr>
<tr>
<td>Strattera</td>
<td>Atomoxetine</td>
<td>For ADHD</td>
<td>Constipation or diarrhea, dizziness, dry mouth, headache, nausea</td>
</tr>
<tr>
<td>Stelazine</td>
<td>Trifluoperazine</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Symbyax</td>
<td>Fluoxetine/Olanzapine</td>
<td>Bipolar depression</td>
<td>Drowsiness, dizziness, headache, dry mouth, increased appetite</td>
</tr>
<tr>
<td>Tegretol</td>
<td>Carbamazepine</td>
<td>Mood Stabilizer (Antimanic)</td>
<td>Dizziness or lightheadedness, clumsiness or unsteadiness, nausea, weakness, blurred or double vision, drowsiness</td>
</tr>
<tr>
<td>Tenex</td>
<td>Guanfacine</td>
<td>Impulsive/aggressive behaviors</td>
<td>Drowsiness, dizziness, dry mouth, headache, weakness, constipation</td>
</tr>
<tr>
<td>Thorazine</td>
<td>Chlormazine</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Tofranil</td>
<td>Imipramine</td>
<td>Antidepressant</td>
<td>Dry mouth, blurred vision, constipation, sedation, dizziness</td>
</tr>
<tr>
<td>Tranxene</td>
<td>Clorazepate</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Trilafon</td>
<td>Perphenazine</td>
<td>Antipsychotic</td>
<td>Stiffness, shakiness, unusual muscle movements, sedation, dry mouth, blurred vision</td>
</tr>
<tr>
<td>Trileptal</td>
<td>Oxcarbazepine</td>
<td>Mood stabilizer</td>
<td>Dizziness, nausea, tremor, headache, blurred vision, unsteady gait</td>
</tr>
<tr>
<td>Valium</td>
<td>Diazepam</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Wellbutrin SR/XL</td>
<td>Bupropion</td>
<td>Antidepressant</td>
<td>Anxiety, trouble sleeping, dry mouth, loss of appetite, headache, constipation, shakiness</td>
</tr>
<tr>
<td>Xanax</td>
<td>Alprazolam</td>
<td>Antianxiety</td>
<td>Drowsiness, dizziness, slurred speech, difficulty with coordination, memory loss</td>
</tr>
<tr>
<td>Zoloft</td>
<td>Sertraline</td>
<td>Antidepressant</td>
<td>Nausea, nervousness, drowsiness, headache, change in appetite</td>
</tr>
<tr>
<td>Zyprexa</td>
<td>Olanzapine</td>
<td>Antipsychotic</td>
<td>Sedation, constipation, increased appetite, dizziness, tremor</td>
</tr>
</tbody>
</table>

04/08 – Commonly Used Psychotropics, prepared by Sue Hahn, Pharm.D., Mental Health Center of Denver.
References


