Able Scouts

Articles on Scouting with special needs and disabilities

J: Understanding Anxiety, Depression, and Other Mental Health Concerns

IN THIS MODULE

IF YOU OR SOMEONE YOU CARE ABOUT IS PRESENTLY EXPERIENCING THOUGHTS OF SUICIDE, SELF-HARM, OR HARM TO OTHERS

STOP NOW AND CALL
LOCAL EMERGENCY SERVICES (911)

OR IF MORE APPROPRIATE,
SUICIDE & CRISIS LIFELINE (988), or
NATIONAL SUICIDE PREVENTION LIFELINE
800-273-8255

This Module in PDF **[1]**

OVERVIEW

Anxiety, depression, and other mental health[2] disorders affect both youth and adults. At the outset, we need to recognize that Scouting volunteers generally lack the expertise to diagnose or treat youth with these conditions. The primary purpose of this module is to help you recognize when a Scout may be struggling, how you can support the Scout, and when these struggles are a cause for concern. That way you know when to turn to family members and professionals to assist the Scout with his or her immediate needs.

It may not seem like mental health concerns share much with other kinds of special needs and disabilities, but many techniques for supporting a Scout with a mental health concern are also useful in other situations. The broadly applicable methods are in Module F – Methods That Apply to Many Types of Special Needs and Disabilities (https://ablescouts.org/toolbox/f/). That material will only be repeated here if needs to be emphasized for a particular reason.

A Scout leader needs to be careful not to make assumptions about a Scout. Mental health symptoms can look different from one individual to another. Some behaviors that look like a mental health symptom may also be age-appropriate or developmentally "typical" behaviors at different ages. Children and adolescents are maturing as they grow, and are learning and developing new skills for regulating their emotions and motivating themselves. For example, a behavior such as a tantrum or emotional meltdown may be age-appropriate behavior rather than a sign of a mental health concern.

We need to be understanding if a Scout needs to take a break from participation in Scouting. Scouts experiencing severe mental health symptoms may need to step away for a while due to high level needs such as in-patient treatment. Scout leaders should be prepared to support the Scout and family when they re-integrate into the Scout unit and understand that advancement may not be the top priority. Participation in Scouting in general may be an important way for them to get back to their day to day activities and social skill building.

If you want to obtain more training, the National Council for Behavioral Health (thenationalcouncil.org or mentalhealthfirstaid.org) sponsors 8-hour training courses in Mental Health First Aid, for non-professionals that could encounter a person experiencing distress. You may also want to familiarize yourself with typical developmental milestones[3], to better understand developmentally appropriate behavior.

COMMUNICATION WITH FAMILIES

In Module F (https://ablescouts.org/toolbox/f/), there are sections that discuss *Joining Conferences (https://ablescouts.org/toolbox/f/#joining)* and *Communication (https://ablescouts.org/toolbox/f/#communication)* with the Scout with a special need, the family, and other Scouts in the unit. Rather than repeat that information here, we encourage you to stop and read those sections before continuing.

The Joining Conference will set a foundation of trust for ongoing communication with the family of a Scout. If you see behaviors as you go along that make you concerned for a Scout, or see signs of excessive fears or worries, share your concerns privately with parents and guardians. It is possible that these concerns are related to mental health conditions.

If you believe you need to talk to a family about behaviors that concern you, it is vital that you do not come across as telling the family what to do. You must not give the impression that you want them to seek therapy or that their child can't continue to be a Scout unless they do something. When you describe a behavior, stick to the facts and do not provide your own interpretation of what you see. It is actually better to give the impression that you are seeking information more than giving it. By asking if there is anything you need to do differently to support their child, it will be clear that you are on their side.

These discussions can continue with parents and guardians throughout the years that the Scout is part of your unit. You don't need to know a diagnosis in order to gain an understanding of the situation. Like with any special need, it helps to ask parents and guardians what trigger situations to manage or avoid and which behaviors signal that their child is getting into distress. It is also helpful to ask parents and guardians about any skills or methods of coping that help a Scout manage a behavioral or emotional hurdle.

As is discussed in *Joining Conferences (https://ablescouts.org/toolbox/f/#joining)*, the parents or guardians control how much information that they will share with you about a Scout's condition, or allow you to share with others. With mental health concerns, expect the family of the Scout to be careful about sharing, as they want to protect their child's self-image and prevent mistreatment by other children. If an unexpected but serious incident is witnessed by others, parents and guardians may feel pressured to either share unpleasant information or to remove their child from the Scout unit. Quick and compassionate response from the unit leaders may allow a youth to remain in Scouting who would otherwise miss out.

As with other types of special needs, parents of Scouts with mental health concerns may need to attend a Scout activity with their children at times, if the activity is more stressful to them than most or has a specific risk of triggering difficulty. Communicating the nature of the activity to families in advance will help everyone make good decisions about how to accommodate the Scout. It is fine for a Scout to receive extra guidance or monitoring during an event, opt out of part of an event, or leave an event early.

ANXIETY

Anxiety is a combination of nervousness, fear, apprehension, and worry. Fear itself is not a medical condition. It is a natural emotion that is vital for responding to danger. Many fears are normal and appear at different ages. Young children can be fearful of separation and monsters. As children get older, they may worry about how their peers see them.

Everyone experiences different levels of anxiety from time to time. When a person's worries or fears are irrational or excessive for the situation, then it is cause for concern. When a child has an anxiety disorder, the fear and worry are persistent enough to cause problems in everyday life.

Some people experience excessive anxiety on a thinking, intellectual level, with self-talk, worrying, and brooding on a topic that triggers the anxiety. Sometimes, a child is very aware of the situations that cause anxiety. At other times, the anxiety acts at a more subconscious level, where the child may not feel OK, but not be able to identify what is triggering the feeling. Reactions could include avoidance of triggers or excessive seeking of reassurance from adults. Sleep disturbances are also common with anxiety. Anxiety can result in difficulty focusing and being distracted, which can be confused with attention deficit hyperactivity disorder (ADHD), which is discussed in Module K (https://ablescouts.org/toolbox/k/).

Anxiety can cause a wide variety of physical symptoms that resemble the adrenaline rush of a fight-or-flight moment. Racing heartbeat, shortness of breath, tense muscles, nausea, lightheadedness, and headaches have all been reported. Unfortunately, these same sudden symptoms can be caused by a serious medical emergency. The anxiety is amplified by the fear brought on by the physical symptoms. As a Scout leader, you need to err on the side of caution and **treat these symptoms as a medical emergency** regardless of whether or not you suspect anxiety. At the same time, there is no harm in doing what you can to try to help the Scout be calm. You want to do your best to keep your cool and speak calmly and confidently to the Scout. Use your other leaders to manage onlookers and help them not be swept up in the moment.

In a Scouting environment, excess anxiety could manifest itself with the Scout "getting stuck" and appearing fearful of trying an activity. It could also manifest itself as a panic attack with some of the physical symptoms listed above. One important clue is when the uncomfortable feelings do not ease when you try to coax or reason with the youth. It is OK to try to explain how perceived danger and risk have been managed and why the activity is safe, but if that reasoning makes no difference, it may be time to involve the family and or a health professional. Another "first-aid" method is to find or create a quiet space where the Scout can get away from the trigger and the larger group and try to self-regulate his or her emotions. (See Self Removal in Module F (https://ablescouts.org/toolbox/f/#self)). Realistically, if quiet time is not helping fairly quickly, it is time to reach out to the family and allow the Scout to leave the event to take a longer break or receive care.

DEPRESSION

Depression can affect life in multiple ways including your mood, physical symptoms, and how you feel about yourself (self-image) or your world. While most would think people with depression feel sad or down in the dumps, this is only one associated feature. Another distinctive feature of depression is the inability or reduced ability to experience pleasurable emotions such as joy. This may be seen as inability to have fun or no longer having fun during activities that used to be enjoyable.

Everyone feels sad or down at times, which is completely normal when there is an unfortunate life experience. For many youth with depression, they seem more irritable or cranky than sad or tearful. If you are concerned about a Scout's mood, compare the behavior you see to what you know about the Scout's recent life experience. Is there a rational connection between the mood and actual experience?

One way a Scout leader may notice depression is by socially isolating behaviors. For youth with depression, it may become difficult to maintain friendships, make friends, and have positive interactions with others. When a teen disengages from social groups it may be a sign of depression or other mental health disorders.

Likewise, the physical symptoms of depression can be compared to past behavior. Appetite can change in either direction, with weight loss or weight gain outside of normal growth patterns. This may be difficult to notice, especially for Scouts in early adolescence where growth spurts and puberty make weight gain or loss developmentally appropriate. Sleep patterns can shift in either direction as well, either sleeping more than usual or insomnia. A general lack of energy, despite getting plenty of sleep, is another sign. A Scout leader will rarely spend enough time with a Scout to detect these kinds of changes. What you may notice is the Scout is failing to complete tasks or acting sluggish on outings.

Depression can also cause difficulty with distraction, concentration, motivation, and focus. This aspect can be confused with attention deficit hyperactivity disorder (ADHD), which is discussed in Module K (https://ablescouts.org/toolbox/k/).

Negative thinking patterns associated with depression can also significantly impact a Scout, particularly in how they view themselves or their environment. Youth can lose confidence in themselves and see themselves as having low value to others. A person who is depressed may also show signs of anxiety. More serious feelings would be continuing guilt or seeing himself or herself as a burden to the family. The most serious version is suicidal thinking, where the youth begins to believe the family or world would be better off without him or her.

The main thing to remember is that if a youth is depressed enough for you to notice it as a Scout leader, the youth needs help and likely needs treatment. A starting point is a frank and private conversation with the parents or guardians to share your concern. It is up to them to obtain treatment for their child but as a Scout leader, providing support can be seen as very helpful.

OBSESSIVE COMPULSIVE DISORDER

Obsessive compulsive disorder (OCD) is another mental health disorder that has anxiety as a feature. The distinction is that the trigger of the anxiety is a recurring thought or image (the obsession) and the youth performs some kind of repetitive ritual activity (the compulsion) to manage the negative anxious feelings. Rituals and routines are not harmful in and of themselves. For example, having routines for sleep times, meal times and bath times are important for young children to have a sense of security and belonging in the family. Older children have routines for school, and rules and routines for playing games. Adolescents develop persistent interests in hobbies or activities that give them a sense of belonging in the social world.

What makes OCD different is a matter of degree, where the rituals become so frequent or involved that they take away too much time from the regular activities of daily life. They are time consuming and must be performed in order to decrease the obsessions. Rituals may be easily observed physical actions, like handwashing, or more mental activities, like silently counting things. The rituals involved in OCD run a wide gamut[4], but there does appear to be a theme to the more common rituals in that they tend to be tasks that make things organized, clean, or “right”. Individuals with OCD are searching for

certainty, knowing something is clean, perfect or right.

In a Scouting context, we want to be sensitive to the social implications for a Scout with OCD. The ritual behaviors may make him or her stand out from the group and there is a risk of being socially isolated or bullied as a result. As a leader, you may need to emphasize and model empathy with your Scouts more than usual. If the family and professionals have a plan to help the Scout manage the disorder, you can help by being part of the redirection process. In many situations, the symptoms are not overtly problematic. For example, a youth may use the bathroom more frequently, but the ritual itself (e.g. handwashing or checking) may be less obvious.

OTHER MENTAL HEALTH DISORDERS

Bipolar disorder, historically called manic depression, is characterized by mood swings that are extreme compared to the ordinary ups and downs of daily life. It is much less common than either anxiety or depression, and does not usually emerge until late adolescence or early adulthood. It is unlikely that a Scout leader will spend enough time with a youth to notice the patterns of symptoms that go with bipolar disorder. Like the other disorders discussed in this module, the basic behavior is not a disorder, it is a matter of degree. Adolescents typically have mood swings, but if you become concerned about the degree, it is good to discuss the matter privately with the family.

In bipolar disorder, there is a swing between symptoms of depression, which were described in the previous section, and "manic" episodes. The manic phase can include feelings of elation, happiness, extreme confidence, and/or euphoria. The manic phase can also include sleep disturbance (usually needing less sleep than normal), irritable mood, anger, aggressive behavior, or racing thoughts. All of the dangers of depression are still present with bipolar disorder. In the manic phase, there are some additional concerns such as impulsivity and thrill-seeking or sensation-seeking, like reckless driving or increased substance use or sexual activity.

Eating disorders are another group of disorders that you might encounter as a Scout leader. They don't always have symptoms that a leader would notice and even then it is unwise to make any assumptions because the normal growth "spurts" of children and adolescents can vary widely in their rate and timing. Even atypical eating behavior could be the result of a food allergy or food aversion, topics which are addressed in Module H (https://ablescouts.org/toolbox/h/). Eating disorders are discussed here to prepare you if a Scout or family discloses this as a special need.

Anorexia is the restriction of calories to the point of starvation. Those with anorexia often have a distorted body image where they see themselves as fat when they are actually perilously thin. Any concerns you have about a Scout's low weight or eating behaviors should be discussed privately with the family because there are many other mental and medical conditions that can impact weight and eating, such as hypothyroidism or social anxiety. Anorexia has serious implications for overall health because the lack of nutrients can cause organ damage.

Bulimia is characterized by cycles of binge eating of large amounts of food followed by compulsive efforts to purge the food by vomiting, laxatives, or extreme exercise. Bulimia is typically less visible than anorexia and harder to identify. The individual may be of normal weight for their height. They are usually aware that their binge and purge behaviors are outside of social norms, so they will hide these

activities from others. There is a risk of long-term damage to the gastro-intestinal tract from frequent vomiting and/or laxative use.

Binge-eating disorder, also called compulsive overeating, differs from bulimia in that the bingeing is not followed by an immediate forced purge. The binge may be followed by a cycle of extreme dieting. Those with binge-eating disorder may be normal weight for their age, overweight, or obese.

Substance abuse can take place without any underlying mental health issue. However, it bears mention in this module for several reasons. Often, substance abuse co-occurs with a mental health disorder, especially when the substance use is an attempt to manage emotions or feelings. In many instances, the use of alcohol or non-prescribed medication actually does the opposite and makes the mental health issue less manageable.

We hope that Scouts have a desire to be "mentally awake and morally straight" and "Clean" in accordance with the Scout Oath and Law. While a Scout may need to take a break from the Scouting program if he or she experiences substance abuse, this need not be a permanent disqualification.

Breaks from reality or psychosis are rare, but can occur in the context of substance abuse or a mental health disorder. A break from reality is when a Scout is no longer able to recognize the environment or the people around them. It can also be characterized by a Scout seeing or hearing things that others cannot see or hear. If a Scout leader suspects that this is happening, it should be treated as an urgent situation that requires professional help. Scout leaders are not equipped to handle this on their own.

A person who is experiencing a break from reality is not necessarily a danger to anyone. However, simply to make the situation easier to manage, you want to move other youth and uninvolved adults away from the immediate area while you are waiting for a professional to respond. If you feel in danger yourself, back away. If the person who needs help is moving around, do your best to keep track of where he or she is at so the professionals can be guided to the right location.

[1] The Boy Scouts of America would like to thank the Child Mind Institute (childmind.org) for collaborating with us and reviewing the contents of this module for accuracy and usefulness.

[2] The editors understand that the language used for these issues is constantly evolving and the term behavioral health is commonly used in professional circles. In order to accommodate non-professional readers, an editorial decision was made to use somewhat older terminology to make the information more accessible.

[3] https://www.stanfordchildrens.org/en/topic/default?id=the-growing-child-school-age-6-to-12-years-90-P02278 (https://www.stanfordchildrens.org/en/topic/default?id=the-growing-child-school-age-6-to-12-years-90-P02278)

[4] Examples include repeated: handwashing, counting, checking conditions, cleaning, stacking, organizing, repeating prayers, and recopying work.