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DEPRESSION AND DISORDERS OF MOOD

Magdalena Śniegulska

I. DEFINITION ASPECTS

Is the following statement true or false?
Depression and mood disorders are a group of mental disorders which have nothing to do with bodily illness.

This statement is **false**. Mood disorders such as depression are indeed diseases primarily related to the nervous system. However, apart from the mental sphere, they do also affect somatic functioning. They can often be accompanied by persistent ailments such as stomach, head, muscle, spine pain, a sense of constant fatigue and lack of sleep, chest pain, dizziness, weight fluctuations, dry mouth or palpitations. Mood disorders can be both the cause and the result of many somatic diseases.

In the 1970s, the first descriptions and attempts to classify mood (formerly: affective) disorders in children and adolescents appeared in psychiatry textbooks. Interestingly, depression, which is included among these disorders, was described earlier (in the 1940s) by René A. Spitz – an Austrian-American psychoanalyst, who observed the peculiar reactions of children separated from their mothers. Despite these reports, until the early 1980s it was widely believed that depression only affected adults. Currently, there is no doubt that children and adolescents also suffer from various types of mental ailments. Depression and mood disorders are diseases which are talked about not only in doctors' offices, but also in the media, schools or social meetings.

Mood disorders are described as a group of internalizing disorders, i.e. those in which the problems experienced by the affected person significantly affect her or his internal experiences ("inner world") and cause suffering and a feeling of psychological discomfort. Their characteristic features include strong periodic mood swings, as well as a variable intensity of emotions experienced and their valence (i.e. assessment of how pleasant and desirable or, alternatively, how difficult or unwanted they are). These fluctuations are a source of mental

suffering. Young people often describe their experiences as extremely severe and unpredictable. Their emotions "inundate" them, often obscuring the world outside. Many of them talk about it as follows: *"I wake up in the morning and I know that my life is hopeless"*, *"I look in the mirror and what I see only confirms it; whatever I look at and whatever I touch … I want to scream… It hurts so much that sometimes I think that only physical pain can bring me relief. And then it all goes away… And it's really OK. Although I know that this agony will come back… this is what I fear most; and that I'm going crazy"* (excerpts from an introductory interview with a 15-year-old student, published with the patient's consent). These disorders can result in a gradual withdrawal from life. They are often accompanied by somatic symptoms (e.g. headaches or abdominal pain), various fears may appear or intensify. Will I make it or will I embarrass myself? Can everybody see what a hopeless person I am? – these questions and the like begin to prevail in the thinking of young people suffering from mood disorders. Of course, these changes will affect not only the patient's mental or emotional condition, but also her or his everyday activities. In extreme cases, the suffering experienced can even lead to death.

Mood disorders include conditions such as depressive disorders, bipolar or related disorders with periods of mania and hypomania, seasonality of mood swings (rapid cycling, melancholy) or mixed depressive and anxiety disorder. Each of these has characteristics of its own.

Mania is an affective disorder in which a person experiences an elevated or irritable mood with no connection to the context in which they function. Regardless of what happens in her or his life, emotions begin to take over. The manic state is usually described by patients as very pleasant – they feel happy, experience a sense of power, omnipotence even. This condition persists for at least a week and makes it much more difficult to function in everyday life. In the case of irritable mania, experiences are not pleasant ones. Anger and frustration are often present. A lot of the time, people try to discharge excess energy in a destructive way, e.g. by throwing away valuable things or destroying important documents to "clean up". In hypomania, on the other hand, the mood is mildly elevated, often accompanied by greater irritability. This condition persists for several days. The functioning of the patient is clearly difficult, but not to the same extent as in mania.

The bipolar disorder, sometimes called bipolar affective disorder, is a group of recurrent psychiatric disorders with depressive and manic or hypomanic syndromes (periods of strong agitation) separated (or not) by periods without symptoms. These states can change even from one day to another.

Things are different with the seasonal affective disorder. Here, depression appears every year around October or November and persists throughout the winter, until a complete remission occurs around March or April, when the days become noticeably longer. Unfortunately, the seasonal depression sometimes turns into periods of mania.

Mixed depressive and anxiety disorders, on the other hand, are characterized by the joint occurrence of depression and anxiety (usually of a relatively mild nature). Their level of intensity

makes it impossible to consider any of these symptoms as dominant. It is often said that in order for the diagnosis to be given of mixed depressive-anxiety disorders, it is necessary to have at least periodic vegetative symptoms, such as accelerated heartbeat, gastrointestinal disorders (diarrhea, diarcia), tremor or dry mouth. Patients complain of irritability, tearfulness, excessive excitability and a pessimistic interpretation of reality: "something terrible is sure to happen."

Treatments available for mental disorders nowadays are quite effective. However, we still face serious difficulty with proper diagnosis, especially among children and adolescents (Avenevoli et al. 2015). Meanwhile, untreated depression and other mood disorders can have a number of detrimental effects. Sometimes they cause significant learning difficulties and school failures, they also cause a risk of experiencing or being the perpetrator of violence. They can lead to self-harm, substance and alcohol abuse, suicidal behaviors, or even death (*Adams 2002*). We need to bear in mind that the effects of a child's suffering also affect the closest people and the environment in which the child lives.

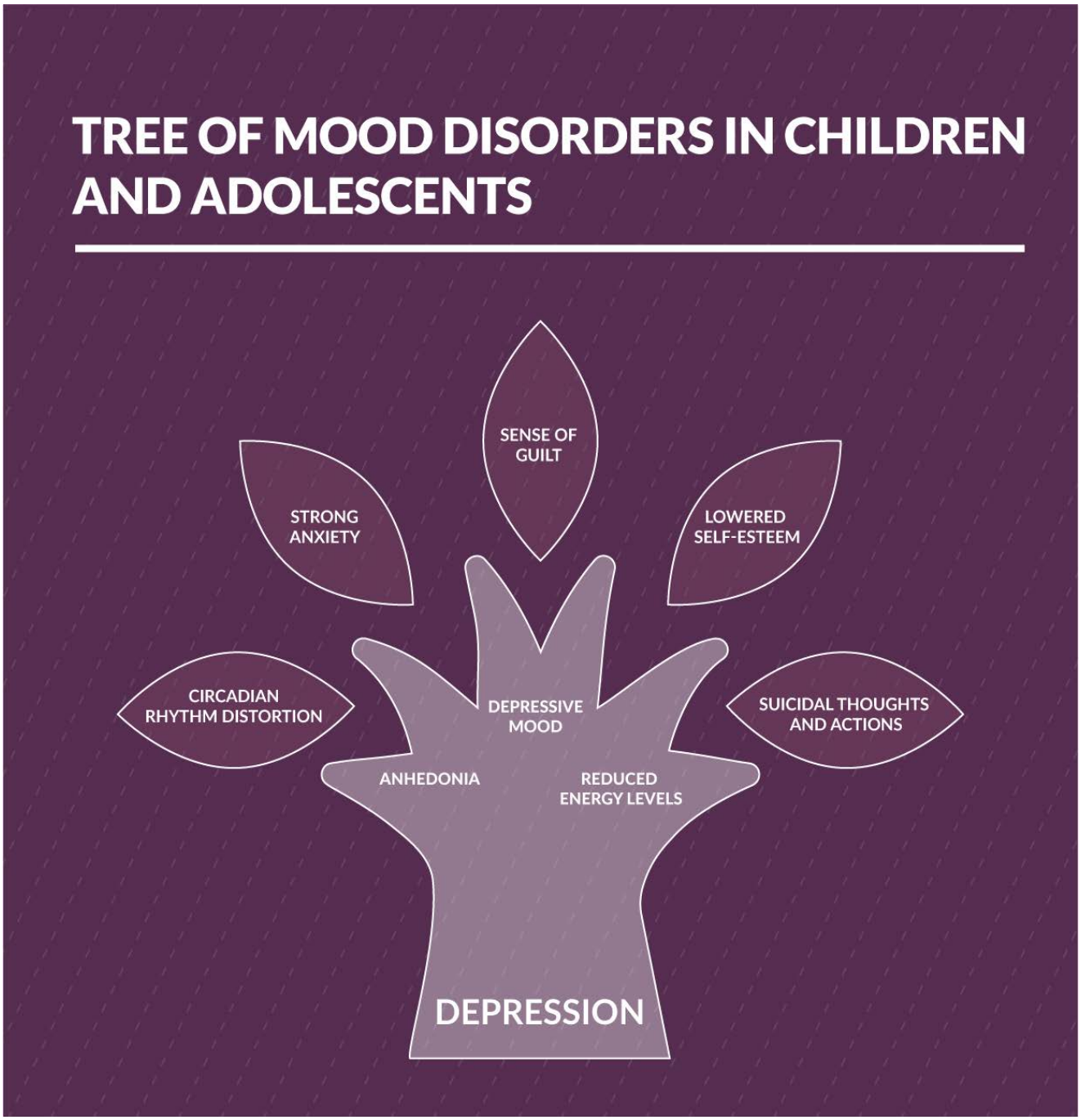
Depression is a systemic disease of a very complex etiology. We already know that it is not just sadness, a drop in motivation or a temporary reluctance to live. Depression incorporates a range of symptoms and is classified among mental disorders. Nowadays, it is described in terms of different types, due to its multifactorial background, both biological and psychosocial. Among the biological factors, genetic conditions and predispositions are most often indicated (a higher incidence of this disease is observed if one of the parents also suffers from mood disorders), perinatal damage, certain past somatic diseases, as well as brain damage or dysfunction resulting from experiencing difficult situations or related to individual characteristics of a person (e.g. some types of personality). Other factors include: excessive production of cortisol, increased activity of the hypothalamic-pituitary-adrenal axis associated with prolonged stress during the critical period of brain development and long-term administration of glucocorticoids (Budziszewska 2016). Psychosocial risk factors include problems in relationships with others, especially close persons, disorganization of family life, loss of loved ones, difficult or traumatic events, growing up in insufficient social conditions and unavailability of caregivers due to illness or abuse of psychoactive substances (Jerzak 2016).

Depressive disorders are characterized primarily by: persistent depressed mood, limited interests and impaired ability to experience pleasure, decreased energy and increased fatigue (Radziwiłłowicz 2020).

In order to be able to make a diagnosis, these symptoms must persist for at least 2 weeks, although this condition usually lasts much longer. Thus, the three basic diagnostic criteria are:

- depressive mood,
- anhedonia (inability to feel pleasure),
- reduction of energy.

These are also often accompanied by symptoms such as circadian rhythm disorders (sleep, appetite, libido, menstrual disorders), severe anxiety, sense of guilt, reduced self-esteem, suicidal thoughts or actions. A characteristic feature of depression during childhood and adolescence is the frequent co-occurrence of many other diseases or disorders. It is often accompanied by additional diagnoses of ADHD, autism spectrum, dyslexia or chronic somatic diseases.



Source: Own work.

The increasing number of hospitalizations of children and adolescents is particularly worrying. And yet, psychiatric hospitalization is usually treated as a last resort and is associated with a serious condition of the patient (Marcus et al. 2012). This observation proves that the problem is worth deeper analysis.

If the issues described in the text are of particular interest to you, or if you are facing a similar problem in your school, we encourage you to read the following materials.

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II. EPIDEMIOLOGY

Childhood and adolescence are a period typically associated with absence of problems, living carefree under someone's care. Is there room for mood disorders in this idyllic picture? Do children experience fluctuations in emotions and activity severe enough to qualify as disorders?

a. Children are free of mood disorders. They may just function poorly in a wrong environment.

b. Children and adolescents suffer from mood disorders, just like adults.

c. Adolescence is a time of special sensitivity and personality formation – it is only in this period that mood disorders appear.

> Much as we would like to protect young people from all the evils of the world, children, just like adults, unfortunately suffer from somatic diseases and experience mental illnesses, including mood disorders. The correct answer is **b**.

According to the latest UNICEF report (Keeley et al. 2021) on the wellbeing of children and adolescents (based on research in 21 countries around the world), over 13% of adolescents aged 10-19 struggle with diagnosed mental disorders. That is nearly 86 million young people aged 15-19 and 80 million 10-14 year olds worldwide. When we look at the gender breakdown, 89 million boys and 77 million girls aged 10-19 experience this type of conditions.

Anxiety and depression account for the largest percentage (nearly 40%) of all the disorders diagnosed. According to a UNICEF report (Keeley et al. 2021), children and adolescents have recently been frequently reporting experiencing severe stress. This is an outcome of the psychosocial context in which they live. Such ailments are not classified as a mental disorder, but they significantly interfere with life, health and future prospects. On average, 19% of 15- to 24-year-olds reported frequent feelings of depression or reluctance to engage in any activities during the first half of 2021. These can constitute important risk factors for mood disorders. Nearly 83% of the surveyed youth (15-24 years old) believe that what is most helpful in case

of mental health difficulties is sharing their own experiences with other people and seeking support. Such a strategy is assessed as much more effective than tackling problems by oneself. The only question is whether we, adults, are prepared to handle this. Are we able to provide support? And what do we know about children's mental health?

Let us also look at another extensive epidemiological study (Barbican et al. 2020) on the prevalence of mental disorders in children and adolescents, conducted in 11 countries on a representative sample of 61,545 children aged 4–18 between January 1990 and February 2021 (all data was obtained before the COVID-19 pandemic). The results indicated that the prevalence of mental disorders in childhood is 12.7%. Anxiety disorders were the most common (5.2%), followed by depressive disorders (1.3%). Among the children with mental disorders surveyed, only 44.2% received any medical help. Based on the results, it can be concluded that every one child in eight has mental disorders that require treatment. However, even in high-income countries, most of these children are not provided with adequate assistance.

Various data estimate the prevalence of depressive disorders in children within a range between 0.2–2.5%. In children, depression is less common than among adolescents (Namysłowska 2012; Wolańczyk, Komender 2015), and most studies indicate that boys and girls are affected equally often. The risk of depression in children whose parents suffer from it increases to 15-45%. In the case of adolescents, depressive disorders affect 2%-8.3% of the population (some statistics even give a rating of 15%). Most data indicates that 20%–25% of young people will experience at least one depressive episode before the age of 18 (Burmaher et al. 1996). Polish research conducted in the 1980s showed the presence of depressive symptoms in 27-54% of the youth surveyed (Modrzejewska, Bomba 2006). Differences in the data quoted may depend on different factors, including the method of conducting the study. As far back as the 1960s, it was observed that the frequency of a given phenomenon is influenced by the presence of a parent during the study.

During adolescence and adulthood, girls and women fall ill more frequently, or are diagnosed with depressive disorders more often. A higher number of occurrences among this sex begins to be clearly visible around the age of 13 (Namysłowska 2012). Sleep issues and appetite fluctuations are more typical among girls.

70% of teenagers experience a relapse of depression over the subsequent 5 years. Depressive disorders are frequently accompanied by suicide attempts, which are more common among girls, but more effective among boys.

Interesting results were obtained in the latest study conducted among children and adolescents (7–17 years) by the Institute of Psychiatry and Neurology in Warsaw as part of the EZOP II project on a representative sample of 400,000 people. The study took place before the pandemic (in 2018-2019), and 50.1% of the group were boys. 11% of the families of the surveyed children benefited from social welfare.

The results showed that the prevalence of affective disorders among children aged 7–11 years is 0.8% (nearly 16.6 thousand children surveyed). In adolescents aged 12-17, this proportion increases to 2.4% (which means nearly 54,000 respondents). One in eight children aged 7-17 has experienced a mental disorder. Also in this study, anxiety disorders were a majority.

Gender vs. mental disorders (general)	**7-11 years**		**12- 17 years**	
	Boys	Girls	Boys	Girls
Depressive disorders	11,5 %	10,6%	16%	14,6 %
	2,03 %	0,67%	4,59 %	3,22 %

Age vs. mental disorders	**7-9 years**		**10-11 years**		**12-13 years**		**14-15 years**		**16-17 years**	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
	9,1 %	11,2%	16,4 %	8,9%	12,7 %	15,4%	11,7 %	9,8%	25,1%,	20,7 %.
Age vs. depressive disorders	1,87 %	0,92%	2,36%	no data available	1,53 %	2,36%.	4,75 %	3,33%	8,67%	4,54 %.

Source: Own work.

Some of the results proved surprising. In the studies presented, depressive disorders were more common in boys than in girls, contrary to previous empirical and clinical observations. Parental education did not affect most outcomes, except for anxiety disorders (those were more common in children of parents with higher education). The highest prevalence of mental disorders was observed in large cities (over 200,000 inhabitants), and the lowest among people living in rural areas, but these differences were not significant.

However, studies have revealed a significant variation in the incidence of mental disorders in children and adolescents due to:

- age (highest prevalence in the oldest age group of 16–17 years),
- social status of the family (much higher prevalence in families benefiting from social welfare).

It should be noted that nearly 63% of the respondents were accompanied by parents, which can affect the results significantly. The results in different groups differed significantly. Depressive disorders were found in 6.9% of respondents without a parent present and in 2.2% of respondents in the presence of a parent.

If the issues described in the text are of particular interest to you, or if you are facing a similar problem in your school, we encourage you to read the following materials.

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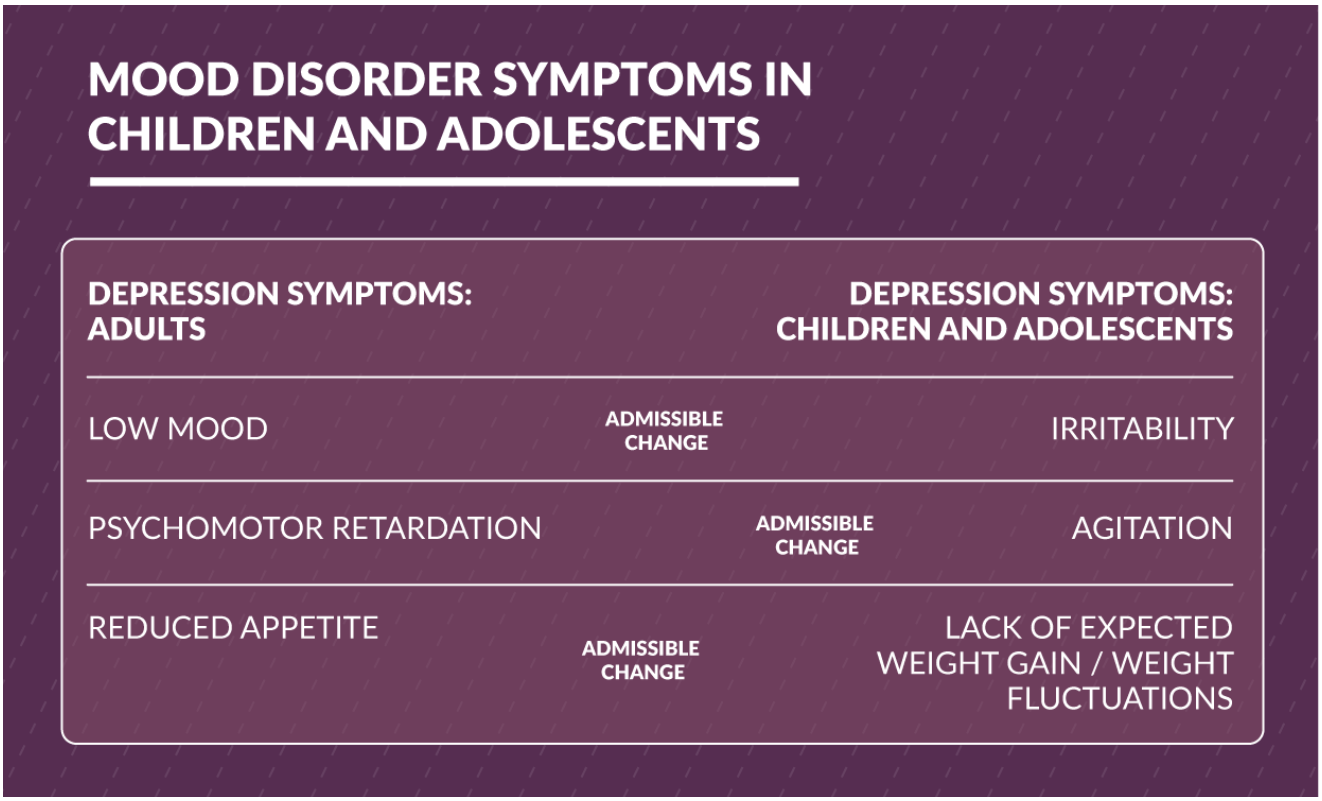
III. A COMMON MYTH

Is the following statement true or false?

A depressed student is a young person with different faces – sometimes sad and withdrawn, sometimes full of energy or irritable.

Interestingly, this is **true**. Depression in children and adolescents is diagnosed on the basis of the same symptoms as in adults, however, peculiar symptoms are admissible, such as irritability occurring instead of a significant decrease in mood, agitation instead of psychomotor retardation, lack of expected weight gain or weight fluctuations despite not following a diet instead of a significant reduction in appetite (Radziwiłłowicz 2020).



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Clinical observations and studies also show some patterns typical for different developmental periods.

In early childhood, around the age of 3, when children have difficulty properly describing their emotional states, the diagnosis of depression is made primarily on the basis of observation. Often there is an increase in separation anxiety. In terms of behavior, there may be regressions to earlier developmental periods, manifested in enuresis, for example. In young children, eating disorders are one of the clinical signs of depression. Psychomotor agitation and anxiety can also be often observed. In addition to the aforementioned symptoms, there may be moments of depressed mood: the child does not enjoy things that have so far been associated with joy or relief, sadness and depressive moods appear – evident in the child's facial expressions and behavior.

In the next developmental period (middle childhood – 3-6 years), somatic symptoms prevail in the picture of depression, irritability and boredom can be observed. A child with depression does not actually behave aggressively or self-aggressively, but there is a negative self-image, perfectionism, fear of tasks and failures. As in the previous period, there may be an increase in separation anxiety and regressions (e.g. enuresis).

In late childhood (7-11 years), patients with depression may exhibit a number of somatic symptoms and chronic fatigue. Emotional lability, aggressive and oppositional-defiant behavior may be observed. Characteristic features are: strong sense of guilt and tendencies towards social isolation. There symptoms are also subject to greater variability.

Depression in adolescence takes on interesting forms. We know that this period is not homogeneous, it is often divided into 3 stages:

- preadolescence/early adolescence (10–12 years),
- middle adolescence (13–16 years),
- late adolescence (17–19 years).

Characteristic features of the picture of teenage depression include somatic symptoms, such as headaches or abdominal pain and trouble sleeping – primarily difficulties in falling asleep and waking up. Young people mainly complain of chronic fatigue (observed as lying on the school desk, parents also often say that their children „loiter" and sleep a lot). Often there are mood disorders and anhedonia.

Symptoms of depression can be observed in cognitive functioning. They manifest themselves primarily in attention and memory disorders, which in turn result in various difficulties at school. Paradoxically, instead of slowing down, it is during this period that we can most often observe psychomotor agitation and anxiety. This is probably the most common problem for parents or teachers watching young people. In the common belief, depression is predominantly represent-

ed by the image of a withdrawn, sad person, with no energy to live. Meanwhile, in the case of adolescents, a completely different picture may come to the fore. This causes adults to either downplay the remaining symptoms or deny the diagnosis already made. Young people may also exhibit aggressive and oppositional-defiant behaviour. They often have a negative image of themselves and their body – which often results in social isolation. In early adolescence, there may also be a feeling of boredom with life and high emotional lability. It is during this period that the fear of failure is the greatest. Between 13 and 16 years of age, appetite problems may also occur. Significant irritability may also be present, whereas lability is no longer observed. Fear of failure is no longer important in the picture of depression.

In the period of late adolescence, we observe above all a significant increase in the number of symptoms. In addition to those characteristic of early and middle adolescence, there may be a sensitivity to rejection, tendencies to substance abuse or criminal behavior may also emerge.

Childhood and adolescent depression is still less well understood than adult depression. Longitudinal studies conducted over a period of 10 years have shown that rates of this disease increase sixfold during adolescence (Hankin, Abramson, Siler 1998). About 2% of 13-year-olds struggle with depression, but this percentage rapidly increases and by the age of 18 it reaches 17% (Angold et al. 2002).

If the issues described in the text are of particular interest to you, or if you are facing a similar problem in your school, we encourage you to read the following materials.

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IV. TYPICALLY AT SCHOOL...

When a depressed person is found among the class, the teacher's role is to:

a. strengthen the person and tell them that everything will be fine;

b. not encroach on the competences of a psychologist (a person with depression in the class simply has to be in it – it is up to them what they will avail themselves of; teachers do not have the competence to deal with such a person);

c. plan activities suited to the person's situation, preferably based on consultations with a psychologist or doctor, parents of the young person and the person themselves.

Answer **c** is correct.

Depression and mood disorders are diseases in which the life of a student is under a real threat. It is worth realizing that often what we observe in the classroom is not bad behavior or a consequence of bad upbringing. This can be particularly difficult if irritability and unwillingness to contact, aggression or hostility are most strongly expressed in the clinical picture of a person's depression.

Mood disorders can be accompanied by extremely dangerous complications from the developmental point of view, such as experimenting with psychoactive substances, falling into various types of addictions, problems finding motivation to perform school duties, not getting up for school, increasingly frequent skipping of classes and extracurricular activities (even those that have so far been done for pleasure, e.g. theater club), entering completely new relationships with unknown people, often random and unsettling for the adults, or not coming home at night. All this can arouse fear, helplessness or anger in the educator, and finally – the desire to resort to various disciplinary solutions. Often, in the face of the young people's difficulties, teachers begin to look for somewhere to place the blame (parents, bad company, modern times, fash-

ion). It is worth remembering that depression, like other mood disorders, is an extremely complex disease and it can be triggered by many factors. Seeking culprits of a student's depression or depressed mood seems rather ineffective. It's like seeing a house on fire and starting to go and look for the arsonist instead of dealing with the real problem – putting out the fire.

It is advisable to put particular emphasis on the relationship of the teacher with the young person going through a difficult time – it is the quality of this relationship that can facilitate or hinder the treatment process.

What might a person working with a depressed student encounter? What will they see in the classroom?

First, it is important to realize that depression affects the **cognitive functioning** of a young person. We often observe a pessimistic way of explaining things, associated with severe cognitive distortions. There may be:

- the so-called "black-and-white" thinking: "F in a test – well, it is a known for a fact that I am hopeless";
- peculiar generalizations: "I entered the locker room today, and Johnny did not say 'hello' to me – **nobody** likes me!";
- selective attention: "Today the teachers paid no attention to me again" – even though the math teacher asked how the weekend was;
- ignoring or downplaying the positives: "I only got this B because the task was trivial and the teacher likes me";
- mind reading: "She gave me a D – she hates me!";
- foretelling the future: "I failed chemistry... There is no future for me other than a beekeeping technical school";
- personalization: "Everyone can see that I've gained weight. They laugh at me."

In class, young people may have major problems focusing and a drop in work efficiency, which results in numerous errors and mistakes – we see such people "freezing up", not following the course of the lesson, looking through the window. Sometimes they even give the impression of being attentive (they look at us and nod), but when asked, they are unable to give an answer. There is often a reduced ability to find constructive solutions. The person is overburdened by tasks (however easy or difficult) and feels helpless. There are definite problems with memory. Students with depression are often "immersed" in the past – they dwell on it constantly. Compulsive suicidal thoughts may also appear.

Cognitive problems in depression make a young person more vulnerable to various accidents and injuries. Agitation or sedation is observed, sometimes interchangeably. The person often lies down on the bench, falls asleep during lessons, comes late, misses the first lessons. Alternatively, she or he may be constantly on the move, unable to sit still, comes up to the desk – it is change in

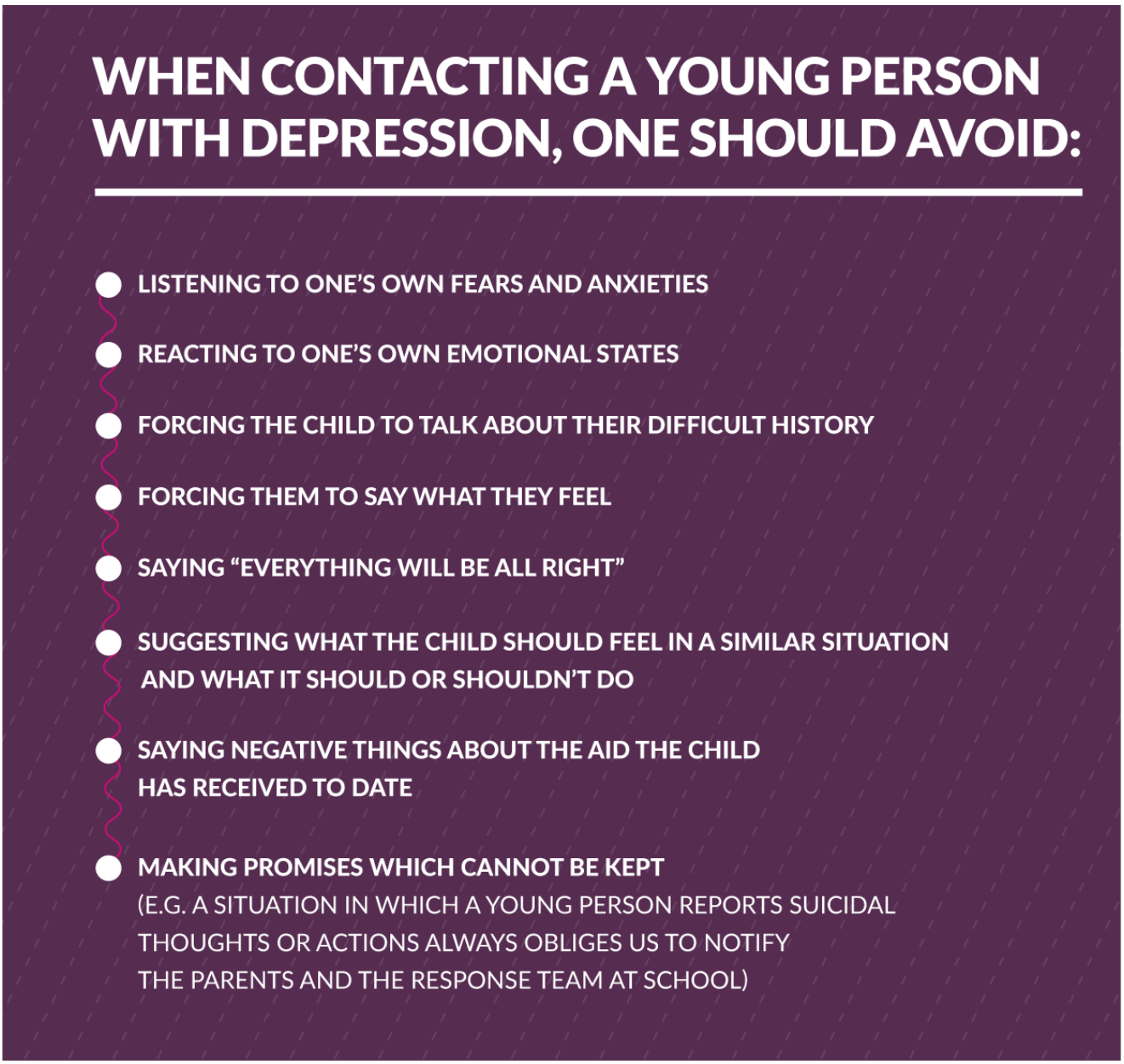
the current behavior that matters! We can also observe more frequent use of energy drinks and even psychoactive substances. Sometimes it is the educator that is the first to observe a change in eating habits: overeating or avoiding food. A change that should also be worrying is the lack of care about one's looks – for example, a student comes in the same tracksuit all week, does not wash, does not use deodorant, starts to smell bad. Social withdrawal may prevail in behavior (a person disappears during breaks, leaves school, locks himself in the toilet, is reluctant to answer questions). Self-mutilation (marks on arms, legs) and eventually suicide attempts may also occur.

The prevailing **emotions** are sadness, depression, fear. A young person often reports a general malaise, s/he is irritable. Anhedonia appears – nothing pleases her or him. Even if s/he is aware that there are positive moments in their life, s/he is actually expecting bad and sad moments all the time. Some talk about the unpleasant feeling of "having no feelings" – which is related to this state of suspension. Pupils complain of losing control of their lives. They feel guilty that they can't (as their caregivers would like them to) just pull themselves together, not worry, enjoy what's good. They often feel hostile about it – no one understands them! They are irritated, sometimes helpless in the face of the symptoms of the disease.

In a school situation, the teacher's willingness to ask and listen to the young person may be helpful. Many adults believe that their main task in caring for children and young people is to give advice and find ready-made solutions. Meanwhile, in the situation of a child with depression, it is important to restore a sense of control, control over one's own life, even to a small extent. So it's worth asking, "How can I help you? What do you need the most right now?". And at the same time accepting the answer "I don't know", possibly reacting to it by saying something like: "How would you like us to think about this together?".

Sometimes, when you hear statements like "I'm hopeless", "Nobody likes me" – the natural reaction is denial: "You're exaggerating!", "This is not true". In the case of a young person with depression, it is important to refrain from such comments, because they can be perceived as disregard for their feelings. It is worth seeing through them the emotions of the student. "I understand that you feel that way now" – sometimes that is all that is needed.

It is also important to be willing to help in dealing with the realities of the experience. This is especially true for young people in recovery, who are in the process of convalescence. Returning to school after a long absence (and thus the need not only to catch up, but also to be up to date with the material) may become a risk factor for relapse. The teacher can plan the communication to the environment (about absences, health and current functioning) in dialogue with the child and his/her parents. It is important to remember to respect the young person's decision – whether and what kind of information s/he wants to convey to the class or teaching staff. It is also important not to suggest to the child that s/he should use psychological help because s/he has a problem. It is better to first report worrying symptoms to a psychologist or school psychologist and parents. Give the child support and check what they need and whether they know whom to address if they themselves want to.



Source: Own work.

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References

Jerzak M. [Ed.] (2017). *Zaburzenia psychiczne i rozwojowe dzieci a szkolna rzeczywistość*, Warszawa: Wydawnictwo PWN.

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Rozmawiajz klasą – Szkoła dobrostanu

Iceland Liechtenstein Norway grants

DEPRESSION AND DISORDERS OF MOOD

Magdalena Śniegulska

V. HOW CAN ONE INFLUENCE IT?

When we have a student with depression or mood disorders in the form, appropriate actions must be taken first of all by:

a. the child's family;

b. the homeroom teacher;

c. the school in consultation with the family and the child himself, as well as with the therapeutic team.

Answer **c** is correct, of course. In practice, very often the responsibility falls primarily on the homeroom teacher, but such help provided by only one person alone may not bring the intended results.

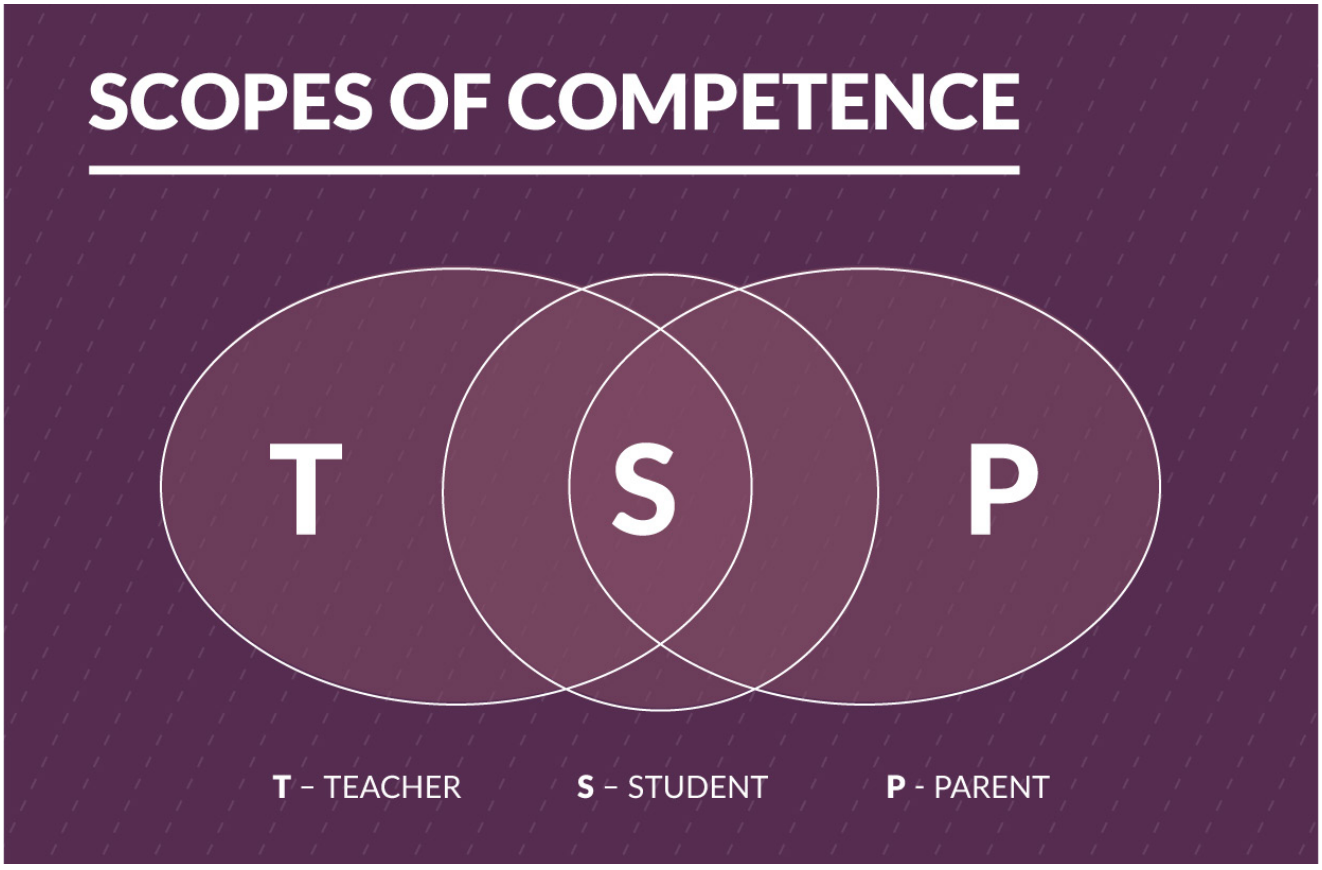
There are certain conditions that must be met in order for the activities undertaken within the school to be effective. One of the most important of those is the transparency of such activities towards those involved in them, trust and a sense of working together as a team in this difficult situation. Ensuring this is often the most difficult task. Sometimes parents and people with a diagnosis themselves are afraid of the reaction of the environment, stigmatization, labeling. It even happens that parents know the diagnosis, but neither the child nor the school knows it. Lack of communication and honesty significantly hinders the implementation of effective treatment methods. A young person who does not know what is happening to them, does not understand it or is afraid to reveal their condition, stands little chance of improvement. It is, therefore, crucial to ensure trust and, at the same time, to respect a person's right to secrecy about their own health.

A big challenge is the class, who see the change and feel that something is awry. Their support can be an important therapeutic factor, but for this to happen, one needs to inform them what is happening with their colleague. It is very important to determine with the young person what specific message his or her peers should hear – what s/he is ready to divulge. It is also worth presenting to them and their parents the consequences of keeping their

health-related secret. Such mental education is an important part of the treatment process. The interview can be conducted by the school psychologist. Teachers (especially those who act as educators) cannot be left alone in the face of new challenges.

Sometimes, the helping activities require revisiting (or perhaps establishing) the areas of influence. Students function in a multitude of different environments. Just as adults take on different roles and behaviors at work, at home and at a party, so do young people test out different ways of functioning – they look for a role for themselves, which is often different from the one they present at home, for example. The two main living environments of a young person are, of course, home and school. We sometimes forget that these two areas partly overlap (the teaching staff interfere in the family environment, for example by giving homework; parents also have different expectations towards the school, e.g. they want to release their child from lessons due to important celebrations). To realize these spheres of influence can be relieving, because just as the teacher does not decide what washing powder is to be used in the student's home, the parent cannot expect the teaching staff to use his or her favorite didactic methods.

When working with a person with issues, it is extremely important to define the scope of activities together. In theory, I could agree to the child's request not to tell his parents about the suicidal thoughts. There is also a temptation to conduct the child's treatment – after all, I have knowledge and various experiences of my own. However, it is good to know what I can and know how to do as a teacher, and where my competence ends.



Source: Own work.

In a perfect situation, all environments in which a person with mood disorders functions work hand-in-hand. Parents inform the school about the diagnosis, the current condition of the child, therapeutic and medical recommendations. They are constantly in touch with the school, encourage talking to experts. Where necessary, consultations are held. Parents, the child and the homeroom teacher agree together on how (and to what extent) they will inform the class and the teaching staff about the health status and how the recommendations are to be implemented. The school establishes a support team, which, in addition to the headmaster, homeroom teacher, psychologist or guidance counselor, includes at least one other person conducting classes in a form in which there is a child with difficulties. The teaching staff observe the young person and inform the team working with him or her about any changes and progress. The homeroom teacher often signs contracts and statements with parents or with the child regarding various types of therapy elements to be carried out at the school. Based on observations and conversations, s/he writes regular notes about the child's functioning. If any specialist recommendations are unclear or their implementation on the school premises is impossible, s/he immediately submits her or his comments and proposes solutions together with the team. It is important for all the interested parties to understand and approve of the final shape of the influences.

Symptoms reported by a young person should be taken seriously, without judgment, lecturing or criticizing, even if they seem irrational. If the child talks about suicidal thoughts, you need to be vigilant, but also calm. Don't panic! Our composure will have a calming effect on the child. Whenever possible, give them time and space for crying, anger, and other difficult emotions. Show self-confidence, faith in the future, determination in finding solutions. It's also worth simply asking, "How can I help you?"

Treating depression and other mood disorders is no time to deal with upbringing. Sometimes one even has to stray from the rules in place. For example, it may be the case that the use of mobile phones is prohibited at school, but for an ill person it is an important safety valve. However, in order to agree to change the rules, we must have the permission of the parents and the child to inform the class about the reasons. It is not necessary to go into details, but other people should understand what is happening around them. From the point of view of the therapeutic process, a plan for a gradual return to pre-disease duties is also very important. Remember, however, that even when the child is already in the convalescence period, our attention and care should not decrease!

Sometimes, in certain specific circumstances (e.g. when a child self-harms or reports suicidal thoughts, and a school trip is approaching that they really want to go on), the school decides to make a contract. In literature, you can find examples of the so-called life contract, in which a person undertakes not to hurt themselves during the contract period. Such an agreement, however, is not overly effective. Studies confirm that methods based on containment/inhibition have little psychological effectiveness. This type of contract mistakenly assumes that suicide is an intentional, rational, and fully controllable decision. Often, a long (e.g. until the end of the semester) or indefinite duration of the contract proposed also reduces its effectiveness.

Methods are more effective that propose action instead of holding back. Therefore, it is worth jointly developing a contract in which the child declares that during our cooperation he or she will use preventive measures to reduce the risk of suicide or self-harm. It is also a good idea to preempt potential difficulties and agree that the young person will communicate problems and crises, i.e. reveal the need for help. The contract can make it easier for him or her to notice the moment when action is needed. She or he will also know how to ask for support, and we will feel that we have some control over the situation.

In a security contract, it is extremely important to determine its duration. The contract period should be realistic, and in the beginning it should be no longer than 2 weeks – that way we will be able to test the contract and check its strengths and weaknesses in practice. It is even a good idea to write one-day contracts with some people – it depends on the diagnosis and the level of risk of undesirable behaviors (e.g. previous episodes, high impulsivity and aggressiveness).

After determining the contract period, we identify risk situations – we draw up a list of circumstances that may worsen the way a young person functions. This is often a very important moment – the student realizes that the difficulty is not the going to school as a whole, but some aspects of it. It is necessary to make the young person aware that before these moments appear, she or he has control over their behavior and emotions – s/he can implement remedial actions even before the onset of difficult emotions.

When we know the opponent and understand the situation, we can start planning ways to deal with it. It is worth encouraging the young person to think about countermeasures for themselves. Let us also agree that she or he will use them even when she feels better. This is important because, on the one hand, it allows for continuous training and testing of solutions, and on the other hand, preventive activities are put in motion. The key is to develop a whole list of effective methods. If we decide that a visit to a psychologist or a phone call to a friend is to be helpful, and in a critical situation the psychologist is on sick leave and the friend does not answer, this solution will not work. So you need a plan A, B, C, and sometimes even D :) It is a good idea to discuss exactly what the young person in a difficult situation should do and how they should act when the methods on the list cannot be implemented.

The most pleasant, but also very important element is kept for the end: together we determine the consequences of the contract. This is a big change in the way of thinking. We must make the young person aware that the occurrence of difficult situations needs not be a bad thing, it does not mean failure, and taking up action should be associated with readiness to reward themselves. It is worth coming up with various natural rewards for sticking to the contract.

Let us also remember to emphasize from the beginning that such a contract is a living creation. Both sides should be prepared to review the contract and possibly renegotiate its terms.

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References

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DEPRESSION AND DISORDERS OF MOOD

Magdalena Śniegulska

VI. THE IMPACT OF THE TEACHER'S COMPETENCE

A teacher who works with a student with a mood disorder or depression must be equipped with, in particular:

a. reliable, up-to-date knowledge about the symptoms, conditions and methods of treating depression;

b. access to professional psychological support – both for oneself (as a person exposed to a difficult situation) and for the purpose of consulting the student's situation;

c. soft skills (such as the ability to empathize), specific tools for working with such a person, reliable knowledge, but also support of the support team.

Answer **c** is correct. Although much can be done with reliable knowledge, and one can dream of all teachers having access to psychological help, in the case of a young person with mood disorders and depression, specific competences and skills are also important.

When we think of a student with depression or mood disorders, we need to be aware of a few important issues. Working with such a person imposes a heavy burden. Teachers often feel that they are constantly on high alert, expecting something terrible to happen. At the same time, the contact in itself can be difficult. "It's like being in the company of a Dementor," a young man once told me, and I think it's the perfect description of the situation of helping a person with depression, whatever their age.

Understanding behavior – often it is the teachers who are the first to notice changes in the behavior or mood swings of their student. It is thanks to them that the young person gets a chance to get support. Therefore, basic **KNOWLEDGE** about the symptoms that should worry us is important, but the power of observation seems to be key.

What's so hard about it? After all, every one of us applies observation every day. However, where it comes to gathering information, hypothesizing about the functioning of a young person and planning action, a very specific skill is needed – that of observation without judgment. Sometimes we look at the form and immediately know: Steven is bored in class, Alice is unpleasant to Sandra, and Jimmy, of course, is always rude. This is how the brain works – I look and make judgments, I assess the situation according to my knowledge and experience. In this case, however, it is about the skill which enables me to tell how I knew that Steven is bored in class. What did my eyes see, what did my ears hear, and what did my nose feel? I can describe it by referring to facts. **OBSERVATION** is a powerful tool! Of the 26 different diagnostic techniques, school psychologists indicate it as the one they use the most – 15 times a month on average (Wilson and Reschly 1996). Observation is also used by teachers, for example in the specific "observation of a selected student" technique. Observation as a research tool employs dry, factual language. It can be compared to the operation of a camera that does not register that someone is sad, but can record that their tears are flowing, their lips are bent into a horseshoe, their shoulders are slouched, they cover their eyes with their hands.

Why is this so important? Because it helps to assess a person's behavior and analyze changes in it – is something happening more or less often now? Has anything changed? In what situations does the behavior occur? In addition, the transition from language of judgment to factual expressions facilitates communication with teachers and experts (e.g. psychologist or guidance counselor), as well as with parents. When we say "Your son is lazy and doesn't work in class," we can trigger a number of defense mechanisms. A parent will want to protect their child from an assessment that seems unfair. Instead, we can say, "I have an observation from the last 3 weeks – something has changed. During each class we do 3-4 tasks from the section together, and Steven only has 2 tasks and only one solution written down. I often see him looking at the window. When I approach him, he gets back to work for a moment, but he doesn't write anything in his notebook." Not only is this type of message a better starting point for conversation, but also an incentive to generate solutions.

It is also important **to be able to OBSERVE ONESELF** (not only one's fears, but also one's resources or condition) and to be ready to ask for help when you accompany a depressed student in everyday life.

Listening to our own fears can make our work and planning much more difficult. It is natural that we worry about the condition of our pupils. We are afraid that we will do something wrong, and are paralyzed by a sense of responsibility. The diagnosis of mood disorders or depression often triggers the fear of the worst – will the person not commit suicide? Fear can be so paralyzing that we will be focused on and ready to notice even the most subtle hints of depressed mood. It can also make us tiptoe around the student and avoid making any demands on them. What a young person with depression badly needs, however, is the teacher's **ATTENTION** also (or perhaps above all) when things are fine. So, it is worth talking not only

about sadness and powerlessness, but also about ordinary, everyday matters: what was for dessert on Sunday and what book have you read recently. It is also crucial to determine with a psychologist (preferably one who is working with a young patient or the school psychologist) the optimal requirements tailored to the current state and functioning of the student.

The skill of **ACCEPTANCE** is also necessary. In this context, it means agreeing and understanding that difficulties are bound to arise in the relationship with a young person. We are dealing with a disease, so we must be able to prioritize goals: first treatment, then education. Understanding the mechanisms behind it will certainly help to accept the disease. Acceptance strengthens patience – we know that the healing process takes time, that despite our own and the patient's efforts, falls, relapses and very difficult moments will occur. Sometimes a depressed student exhibits extremely difficult behaviors that seem unacceptable. We need to remember here that acceptance does not mean consent to certain behaviors. It is rather an understanding that at a given moment, in certain circumstances (here: illness, developmental period and environmental context) a person COULD have acted just like that. Of course, even if we know and understand all this, sometimes there are difficult moments between us. It even happens that we explode or start pressing on the person to take some actions or commitments. Unfortunately, this is not an effective strategy, although for a moment it can calm us down and give us hope that we will be less worried. Let us remember, however, that it is us – teachers – who must modify the school environment of a young person in such a way as to facilitate the healing process as much as possible. Unfair as it may seem, it is up to us to find the optimal solution. Therefore, it is also a good idea to be ready to take a step back, admit your mistake and try again.

EMPATHY is a competence that facilitates acceptance. To develop empathy, we should train ourselves to recognize and name the emotions of students. It is also important to be able to separate one's own emotional states from those of others. It is worth remembering that young people may feel something completely different than we do in the same situation and that this is only natural. Empathy is also different from syntony, in which other people's emotions overwhelm us and hinder effective action.

Depression changes the image of the world and of oneself, and one's way of thinking. Everything around looms in dark colors. Criticism, jokes and the teacher's attention can make this outlook worse yet. A depressed person needs a teacher who can apply wise **PRAISE AND APPRECIATION**. Everyday contacts must involve statements and actions through which the educator expresses appreciation to the young person, names their strengths and shows that he or she is noticing real, positive changes. Good praise is one that is authentic and, above all, that we believe in. Sentences like "You're great", "Alright, way to go" will not work! Giving praise well is great art. Fortunately, there are more and more sources on the market that will help in acquiring this competence.

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References

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Rozmawiajmy z klasą – Szkoła dobrostanu

SCHEME - PHILOSOPHY

Activities promoting student wellbeing (regardless of the area addressed in our project) should be implemented in a logical and coherent way involving the whole school community. What follows is a clear description of a strategic way of thinking about a specific area, important for young people's wellbeing and mental health. We show how it can be holistically addressed in the school. In order to make the strategy as practical as possible, its different stages are presented in blocks, together with questions that the school management and teaching staff need to answer at each respective stage.

Such an analysis should help the management to see whether the activities in a particular area carried out in the school follow a model that has a good chance of being effective. The analysis can provide basis for a decision about what to improve and how. Teachers can assess how appropriate in terms of the subject matter are the activities conducted in school and consider how to coordinate their individual work with them. Even the best teacher initiatives, in which a lot of time and energy is invested, are often not very effective if they are not coherent with the activities of others in the school and with a shared philosophy. Of course, it is clear that the quality of activities aimed at young people's wellbeing and the awareness of important issues in this area differ from one school to another. However, it is always worth starting where we are, with the potential we have at our disposal. It is useful to know the goal we are aiming for, namely system-wide action at a level of the school as a whole.

For each of the six thematic areas, we have prepared an extensive list of activities that can be carried out within it, with a brief description of each.

STRATEGIES

1. Is this area related to the wellbeing of pupils important in our school?

Baseline – the problem	Baseline – actions	Baseline – support and training
Have there been any major events that have made the given issue important in our school?	What activities in a particular area (effective and well-received by the community) are already being carried out by our school?	What is our knowledge of the issue in question? What training have we attended? What is our competence in the area concerned?
What data do we have from diagnostic studies (e.g. surveys of the problem at school)?	How are the activities in this area carried out by our school so far evaluated by: pupils, parents, teachers?	What knowledge and support do we lack?
Have learners, parents, teachers or anyone else reported that there are any problems/gaps in the area?	Which activities carried out by our school in this area are ineffective or have very little effect?	What support do we as a school use in a particular area? Which experts leaves, professionals and institutions are helping us?
	Which activities carried out by our school have proven to be effective, producing good or very good results?	How do we evaluate the support we already use?
	Are the activities related to this area coordinated in our school?	Are there any establishments, professionals carrying out activities in this area that are worth following or implementing?
	What actions are missing in this area?	What are the costs of the measures we want to implement, and do we have or can we get the funds for them?
		Are there entities or institutions that can provide support to our school at no cost?

2. Are we acting in this area according to a common philosophy and together?

Philosophy of action	Joint actions
Do we all define an area in the school in a similar way? (This includes learners, teachers, parents as well as other school staff).	When planning activities, do we include everyone (learners and teachers, parents, other school employees) in the discussions and decision-making processes, and how?
Do we have a school-wide document that defines the area and describes what the school does within the area?	When implementing solutions in an area, do we listen to and take into account everyone's voices about the actions being implemented (both positive and critical)?
Do we define the area not only negatively (e.g. anti-violence), but also positively (e.g. fostering positive peer relationships)?	Do we constructively resolve conflicts at school when differences of opinion arise about what to do and how to run a particular programme?
What professional literature do we use to define an area?	How do we take into account the special needs of certain students (or groups of students), e.g. those with specific disabilities, in programmes in the area?

3. Are our activities in a specific area logically planned for the long term?

Activity structure – planning phase	Structure of measures – implementation phase	Structure of activities – evaluation phase
When planning activities, do we discuss the results of the diagnosis or carry out additional diagnostic activities?	Are the tasks in the area being implemented according to the agreed plan?	Do we continuously review the effects of the area's activities and the implementation process itself?
Are we using good quality methodological and scientific studies when planning solutions?	Do we document the introduction of activities in the area?	Are we using ongoing lessons learned to modify and improve operations?

3. Are our activities in a specific area logically planned for the long term?

Activity structure – planning phase	Structure of measures – implementation phase	Structure of activities – evaluation phase
Do we review and consult solutions with external experts before implementing them?	Does the team responsible for implementing the activities discuss implementation difficulties on an ongoing basis and seek ways to deal with those?	Is an evaluation conducted after each major (predefined) period of programme implementation?
Is there a clearly defined, leader-led team working on action planning in the area, in which – at least to some extent – all important groups in the school are represented?	Do we have good quality internal and external communication about what the school is doing in the area?	Are the results of the evaluation discussed and the conclusions used in further implementation of the solutions?
Does the team set for themselves tasks to be completed within a certain timeframe and check that they have been completed? na środku nic, a po prawej: Are the results of the evaluation communicated (at least to some extent) internally and externally? How? To whom are they communicated?		

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ROZMAWIAJ Z KLASĄ SZKOŁA DOBROSTANU

DEPRESSION AND MOOD DISORDERS

Magdalena Śniegulska

Activities to promote students' wellbeing (regardless of the area addressed in our project) should be implemented in a logical and coherent way, so as to involve the whole community.

As we have highlighted in the presented model, activities related to preventive mental health care, school participation in the processes of prevention, diagnosis and treatment of depression and mood disorders in children and adolescents should be implemented according to a shared philosophy and understanding of the problem. These assume that:

- When faced with the threat or diagnosis of a mood disorder in a young person, members of the school community (pupils, teachers, parents, administrative staff) act together.
- Particular attention should be paid to pupils who may be at risk of depression and mood disorders, and to those who already have this diagnosis.
- It is crucial to give agency to a student with a diagnosis of a mood disorder.
- The school is not a psychotherapy centre, but the teaching and psychological-educational staff are responsible for the process of diagnosis and therapy support for pupils with mood disorders.
- It is important to create multi-person support teams to plan, implement and evaluate interventions to support young people with a diagnosis of behavioural disorders.
- The school management is responsible for organising the work of the support teams.
- It is necessary to create clear, understandable and realistic (taking into account the reality of the specific organisation) procedures for the cooperation of all parties involved.

STRATEGIES

- The ongoing exchange of information between school staff and parents of persons with a diagnosis of (or at risk of) a mood disorder is fundamental to the good functioning of support teams.
- It is important to remember that illness is only one of many characteristics of a person - yet it does actually affect how they function.
- It is essential to prioritise: the therapeutic process first, then parenting and education.
- The support activities should involve all actors in the school, i.e. pupils, their parents, teachers and external experts.
- One should keep in mind collaboration with public and non-public child and adolescent mental health providers.
- Peer crisis intervention should be taught to young people and there should be access to adults who can provide support in such a situation.
- Helplines need to be popularised.
- Taking care of the mental health of teachers and pupils is key.
- Thorough knowledge of mental health and developmental processes needs to be continuously improved.
- There should be mutual respect in the relationship between teaching staff and students.

The implementation of such a philosophy of crisis intervention actions involves the following list of solutions that should be implemented as components of the coherent school strategy discussed above:

- Building the competence to conduct sound observations by teachers, school psychologists and pedagogues. Strengthening the ability to use factual descriptive language.
- Introducing peer observations in lessons.

STRATEGIES

- Introducing of peer supervision.
- Defining the responsibilities and competences of teachers, parents (guardians or carers) and pupils.
- Regular evaluation of the impacts caused.
- Making plans for an ongoing exchange of information between members of the support team.
- Providing good quality training to teachers on mental health, developmental tasks and risk factors.
- Organising meetings for parents (carers or guardians) on mental health.
- Educational materials for parents (carers or guardians) on mental health.
- Providing good quality training to teachers on taking care of their own mental health and wellbeing.
- Providing supervision for teachers (and especially for those in the role of homeroom tutors and school psychologists).
- Building an atmosphere of forbearance and acceptance of crises. An integral understanding of the pupils' psyche, without limiting it to the intellectual sphere only.
- Providing inclusive education for people in crisis, with mental illness and disorders.

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ROZMAWIAJ Z KLASĄ SZKOŁA DOBROSTANU

Iceland Liechtenstein Norway grants

DEPRESSION AND MOOD DISORDERS
SCENARIOS AND SHORT ACTIVITIES

Stanisław Bobula

METAPHORS

Objectives

- Orientation in the emotional state of the pupils.
- Identifying students with serious problems that they cannot cope with by themselves.

Duration

3-5 minutes (depending on the group)

Introduction

This activity can help you find out how students are feeling – if someone is sleepy, sad, if someone has a headache. The exercise also has a deeper sense. Metaphors stimulate the right hemisphere of the brain, which is responsible for emotions, among other things. If a person in the class has a problem that he or she has been dealing with for some time and has not told anyone about it, sometimes the stimulation of the right hemisphere causes the problem to literally "surface", e.g. through tears, which are very difficult to hold back. In this way, you can see who needs help, even though for various reasons they do not tell us.

Steps

Ask pupils to say how they feel and which colour best suits their mood. Also ask them to justify why they chose that particular colour.

Modifications

Instead of a colour, you can use the weather forecast for the rest of the day, a piece of music, a character from a cartoon or film, etc. Each time, individuals choose what best fits their mood.

DEPOSITORY OF CONCERNS

Objective

- Helping students to define the problems they are experiencing.
- Putting off thinking about the problem for the duration of the lesson (or longer).

Introduction

This simple exercise assumes that it is easier for us when we voice our problem or write it down.

Steps

Place slips of paper and a box labelled 'Deposit of Concerns' next to the entrance to the classroom. Then ask pupils entering the classroom to write down their worries (if applicable) on the slips of paper and put them in the box. This allows individuals to come to class with clear, problem-free heads and makes it easier for them to focus on the lessons. On leaving the class, the students can take the slips of paper (to do this, they must sign them before dropping them in).

Modifications

In another version of this exercise, the cards stay in the box. At the end of the school year, in consultation with the class, put the cards in a bottle. Label it (e.g. 'Troubles of form 7A in school year X') and bury it somewhere around the school.

dr Wiesław Poleszak

DEPRESSION – DEFINING THE PROBLEM

Objective

The pupil knows what depression is and can list the symptoms of depression.

Materials

- A piece of paper or notebook and something to write with
- Flipchart and markers

Duration

15-20 minutes

Introduction

Review the materials on depression in children and adolescents (resources can be found at *https://www.szkolazklasa.org.pl/obszary/szkola-dobrostanu/depresja-i-zaburzenia-nastroju/*). Conduct a brainstorming activity or a discussion (if the class is usually active in conversation). Its aim will be to equip young people with knowledge about depression and its symptoms. It is worth knowing that recent research (Poleszak, Kata, Bieniek, 2023) shows that more than 30% of students in Poland have high or very high levels of depression as measured with a standardised psychological tool (CDI-2).

Steps

1. Warm-up – ask each person to write down their associations with the word 'depression'.
2. Ask them to share their associations and summarise them – were they positive or negative?
3. Then divide the pupils into groups of 4-5.
4. Each team sits down together and is given a sheet of flipchart paper and a marker.
5. The group's task is to create a common definition of depression based on their associations and knowledge of the subject.
6. Ask each team to present their definition.
7. Then provide a definition from the materials, while showing how many pertinent insights the pupils and students had in their definitions and how much of what they said was based on stereotypes.
8. It is important to sound out at the end that depression is not a life sentence or a weakness, but a health problem like any other. It needs to be addressed and should not be taken lightly.

THE BODY, EMOTIONS AND THE COGNITIVE SPHERE

Objective

The pupil understands the complex relationships of the body, emotional and cognitive spheres.

Materials

Texts for "the body, emotions and the cognitive sphere" scenario

Duration

10-15 minutes

Introduction

Depression is an affective disorder – that is, it involves the sphere of emotions. In the simplest terms, this sphere takes control of a person's entire life. Emotions are no longer "for us", but we are "for them".

The proposed activity is about the relationship of different spheres of life to our own SELF. Therefore, the texts in the appendix refer to: 1 – the body, 2 – emotions, 3 – the cognitive sphere, 4 – relationships with others. 5 is our SELF. The exercise is meant to show a kind of developmental chaos, where information from different spheres overloads our management system, that is the inner SELF. At the same time, it is to present the correct relationship between the self and the other spheres.

Steps

1. To begin with, ask the class to count down to 5. Then make sure each person knows their number.
2. Present on an overhead projector or multimedia board the texts from the attachment that the pupils will be asked to present (each person is supposed to memorise the text with the number they were given at the countdown). If you find it easier, you can print out the appendix and then cut the sheet into strips and distribute them to the class.
3. Instruct the students to divide into groups – so that in each group there are numbers 1, 2, 3, 4 and 5. Numbers 1 to 4 close the 5 in the middle, holding each other's arms.
4. On your command, each person is to shout their line (assigned text), repeating it several times until they get tired.
5. Stop the exercise when the dynamics naturally wanes and things become quiet.
6. Ask the class about their feelings – especially the people who had number 5 and were in the middle.
7. Introduce the objectives of the exercise to the pupils as described in the introduction. If time allows, lead a discussion – ask the participants if they can distance themselves from different areas of their lives.

Texts for exercise

1.
I AM POISONED, I HAVE PIECES OF ME MISSING

2.
I AM AFRAID, BECAUSE I DON'T KNOW WHAT WILL HAPPEN

3.
I WANT TO SEE SOMETHING INTERESTING

4.
I WANT TO BE ACCEPTED

5.
LET ME SPEAK

MANAGING EMOTIONS

Objective

The pupil identifies risky emotion management mechanisms.

Materials

Worksheet for the “Managing emotions” scenario

Duration

20-30 minutes

Introduction

The exercise aims to capture the mechanism of emotion management. Some of us focus mainly on negative emotions (due to their alarming nature) and overlook those with a positive sign, which leads to a depressive mood.

Steps

1. Print out the attachment in as many copies as there are people in the class.
2. Distribute the printed worksheets to the students.
3. Ask each person to write down the emotions they have experienced most often in the last month, divided into positive and negative ones.
4. Wait until most of the class has finished the task (about 10 min).
5. Ask the participants to note how many positive emotions they have written down and how many negative ones.
6. Then have each person look for positive things that have happened over the last month. If they cannot find them, ask them to talk to their important others and have them look for these positive experiences together.
7. Encourage pupils to reflect upon and discuss the exercise.
8. Summarise the exercise by pointing out that many people focus on negative emotions and overlook the positive ones. This leads to a loss of emotional balance.

Worksheet

MY EMOTIONS OVER THE LAST MONTH	
POSITIVE EMOTIONS	**NEGATIVE EMOTIONS**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.

The School of Wellbeing project benefits from EUR 127,000 in funding from Iceland, Liechtenstein and Norway under the EEA Grants. The aim of the project is to create a pedagogical innovation that will raise awareness of the role of the school in strengthening the mental health of students.

The project is co-financed by the Polish-American Freedom Foundation.

Program Leader: School with Class Foundation

Partner: Szkoła Polska w Reykjaviku

Funding: Iceland Liechtenstein Norway grants; Polish-American Freedom Foundation

Rozmawiaj z klasą – Szkoła dobrostanu