

# Because kids grow up ...



For families touched by childhood-onset brain disorders (mental illnesses) and professionals who care

Spring 2001

## NAMI News

### What's Inside

Bullying: Two Families' Stories . . . . page 1

Nearly One in Three U.S. Teens Are Targets or Perpetrators of Bullying . . . . . page 3

One Student's Quest: A Mental Health Resource Room for His High School . . . . . page 3

Ask The Doctor . . . . . page 4

Surgeon General Calls For More Screening, Improved Access To Treatment, Services For People With Serious Brain Disorders . . . . . page 7

Help End School Violence: A Call for Mandatory Screening of Children for Mental Illness . . . . . page 8

Study Indicates That Family Connectedness Protects Against Adolescent Suicide . . . . . page 9

Virus May Contribute to Some Schizophrenia Cases . . . . . page 9

Red Flags Idaho . . . . . page 10

Volunteers Educate Teens About Mental Illness . . . . . page 11

Hearts and Minds Video Receives Peabody Broadcast Journalism Award . . . . . page 12

Minds Under Siege . . . . . page 13

Iris the Dragon Campaign for Children With Mental Illness . . . . . page 14

### Bullying: Two Families' Stories

#### What is it about our junior high culture?

By *Mary Ann Widenhouse*

Two months ago we removed our son, age 12, from a public junior high school because he was extremely upset about the teasing and harassment he experienced there. My two daughters also had experienced teasing in junior high; unfortunately, they did not inform us of the situation until only recently, when our son began showing signs of serious mental health problems. Although one of my daughters has recovered fairly well from her experiences in junior high, my eldest daughter developed eating disorders at age 13 and had an episode of major depression in college. She is still in counseling for these life-threatening illnesses.

After discovering that our son's school experience had become tortuous, which may have soon caused him to refuse to attend school, and because he was showing evidence of post-traumatic stress disorder and depression, we sought a psychiatric evaluation for him.

After talking to other parents whose children had been harassed at school, I went before the school board and addressed the issue of school bullying from my personal perspective and asked that a task force be formed to investigate school bully-

ing. I received only one response: The school board president said he would have the superintendent look into the matter. The rest of the board members sat there and said nothing. I plan to go to the next meeting and ask what progress has been made.

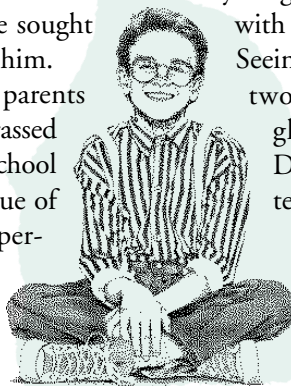
I am very concerned that school bullying is having serious effects on our children's health, especially as a precipitating factor in the development of serious psychiatric illnesses in children and adolescents.

#### "A" is for ...

By *I. M. Dehaven*

The image of the 15-year-old gunman was haunting. Charles Andrew "Andy" Williams was a boy so slight that he seemed lost in his orange, jail-issue jumpsuit. His expression was difficult to read - frightened, stunned, traumatized? What had happened that impelled this youngster to enter his school armed with a gun and an intention to kill? Seeing him reminded me of a day two years ago when I found a gloomy poem called "I Am a Dog" that my son Paul had written.

I knew that my son had been upset about being bullied at school. It wasn't



*Continued on page 2*

Continued from page 1

anything new, though. The bullying had begun several years before. I was not, however, aware that he was feeling so defeated that he no longer believed he deserved to live.

Much like Andy Williams, Paul was called “gay,” “faggot,” and “queer.” Although he was barely overweight, he was nicknamed “wide load” and “training bra.” And because he has lush eyelashes, some classmates said he wore makeup. One boy ripped the hood off Paul’s jacket and punched him in the back of the head. My son often was pushed and kicked and tripped in the school halls.

At an age when acceptance and approval are so important, Paul was afraid to eat lunch in the school cafeteria. He quit attending his after-school club activity after being bullied there. Paul’s most desperate attempt to decrease the teasing was when he cut his eyelashes to the eyelid, hoping to dispel the rumors that he wore makeup.

Some mornings, Paul begged to be allowed to miss school. Afternoons, he arrived home angry and explosive or weepy and defeated. “What should I wear so they won’t call me fat?” he asked me. “What should I say if they call me gay? What should I do if they kick me when no adults are around?” I didn’t have any magic solution.

On numerous occasions, I spoke and wrote to teachers and administrators about Paul’s situation. Their response was that Paul’s answer to the bullying, which was typically loud attempts at retort, was causing the bullying to occur. Bullying, in this particular school, is apparently the victim’s fault. This reminded me of rape victims being accused of having brought it on themselves because of their choice in clothing.

After finding Paul’s poem, I wrote a detailed letter to our superintendent of schools, requesting that the school system implement a policy that addressed bullying specifically. I mailed copies to local public officials. Two months later, I received the superintendent’s response. He wrote, “[O]ur county’s public schools have both policies/regulations and programs to address bullying and violence in schools and take the issue of bullying and aggressive behavior very seriously.” He noted that “some” county schools already had implemented the bully-proofing programs I had suggested in my letter.

I wrote again, giving examples of when the school system’s policy for “physical attack on a student and verbal abuse” was not implemented when my son was bullied. However, I received no further response from the superintendent or any other school representative. Was I perceived as just an overprotective mother? No, I thought. Paul’s teachers had indicated he wasn’t the only child who was being bullied at his school. Retrospectively, I can say, “At least my son had me to stand up for him.”

Andy Williams, the Santee, CA, high school gunman, reportedly had little contact with his mother and little support from his father. Andy was also bullied and, likely more than anything else, was angry. He didn’t know what to do to solve his problems, so, in seconds, he made the horrible choice to ruin his own life and selfishly deprived two other teenagers of their lives. What remains frightening is that surely more Andys are out there.

My son is now enrolled in a private school where bullying isn’t tolerated, and he is doing much better. But I can’t help but feel that it is truly a shame when our public schools pretend that bullying isn’t a problem.



**Editor’s note:** These are just two examples of the battle zone many kids face daily. However, would it really make any difference if our school boards paid more than lip service to stop bullying? Do written policies really

deal with bullying and harassment of students? Or is bullying a result of the climate created in today’s “factory schools,” which are so large and crowded that teachers rarely know what is going on with many children because students are just names in a grading book?

Is this a problem over which school officials have ultimate control? Or is this a pervasive problem of our culture? Or is the human need to compete and seek popularity so innate that bullying is just bound to happen?

Or could it be that we have become, as a society, so intolerant of variations that we are unwilling or unable to teach our children to celebrate individual differences?

Perhaps we should consider that students, parents, teachers, and school boards have a collective accountability to reverse the unacceptable situation that pervades public schools in most communities and that we all must start working together to avoid further tragedies in our schools.

## Because Kids Grow Up

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**Brenda Souto**  
Editor

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NAMI is a grassroots, family and consumer, self-help, support, education, and advocacy organization dedicated to improving the lives of youths with severe mental illnesses.

Severe mental illnesses are biologically based brain disorders that can profoundly disrupt a person’s ability to think, feel, and relate to others and their environment.



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# Nearly One in Three U.S. Teens Are Targets or Perpetrators of Bullying

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Almost 30 percent of middle-school and high-school students in the U.S. are affected by bullying according to a national survey involving public and private schools. This report is from the *Journal of the American Medical Association* of April 25 and includes data on 15,686 students.

Dr. Tonja R. Nansel, of the National Institute of Child Health and Human Development in Bethesda, Maryland, and associates, evaluated results of the World Health Organization's Health Behavior in School-aged Children survey administered in 1998 to children in grades 6 through 10.

Thirteen percent of respondents to the survey reported moderate or frequent bully of others during the current school term, 10.6 percent reported having been a target of bullying and 6.3 percent reported both.

Among boys, 12.9 percent reported bullying others at least weekly, compared

with 5.2 percent of girls. Significantly more bullying took place among children in 6th through 8th grade versus those in 9th or 10th grade.

Youth who were bullied were more likely to demonstrate poor social and emotional adjustment, difficulty making friends, and high levels of loneliness. The bullies exhibited poorer academic achievement and more problem behaviors such as drinking alcohol and smoking. Those who were both targets and perpetrators were at greater risk of social isolation, failure in school, and involvement in problem behaviors.

Dr. Nansel revealed that "Prior to this study, there were no nationwide data on the prevalence of bullying in this country. "Attitudes that reflect "kids will be kids," and "bullying is part of growing up" has traditionally been accepted in the U.S." However, the frequency of bullying threatens children's development according to Dr. Nansel.

Dr. Howard Spivak of the New England Medical Center and Dr. Deborah Porthrow-Stith of the Harvard School of Public Health both in Boston, suggest, in an editorial, that the study is central to understanding the epidemic of youth violence.

"The level of attention that bullying has received in this country is ironically sad," Dr Spivak states, "because we have a much bigger problem with youth violence in this country than in most other countries in the world."

He added "This study raises concern that bullying is a red flag that kids are having problems and need to be supportively attended to, not punitively attended to. Kids need evaluation, they need services, and bullying should be seen as a cry for help, not as an opportunity to punish and to isolate kids."

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## One Student's Quest: A Mental Health Resource Room for His High School

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By Benjamin Cohen

Shortly after turning 15, I began to realize how my family had been affected by mental illness. I was an average high school kid from Madison, WI, with normal issues. When I learned that several family members had turned to treatment to address their problems, I felt a need to become involved in the solution. That is when I discovered NAMI. I began by participating in a NAMI Family-to-Family education course to get a better understanding of what mental illness is all about and, most important, to use the knowledge to cope with my family's mental health issues. As my interest in mental health and NAMI grew, I was offered the

opportunity to run for a position on the board of directors and was elected. I am currently using that position to create a greater awareness of mental health issues in my community, especially at my high school, Madison West.

With the help of my local NAMI affiliate and our high school social workers, I organized a mental health resource room in the student services area last year. During the summer I gathered information booklets, posters, and balloons to decorate the room. By the time the current school year began, posters were up around the school to inform students about the new resource room.

During the school year, students vis-

ited the room and helped themselves to the resources available concerning mental health issues. Topics covered a broad range, from anxiety to anger management to brain disorders such as major depression and schizophrenia. On-site social workers and guidance counselors directed students who needed this type of information to the room. The room provided students with educational materials that they were unable to find elsewhere and an atmosphere conducive to the comfortable exchange of ideas.

Over the past summer, our subcommittee of my NAMI Dane County (WI) affiliate began coordinating and planning

*Continued on page 12*



# Ask The Doctor

## ***Could the school shooting that left two students in Santee, CA, dead and 13 people injured have been prevented?***

*The search for the roots of unexpected violence such as this incident has included a closer look at interactions once thought innocent. For example, the seemingly playful teasing between children may not be harmless give-and-take but may escalate into more serious harassment that results in aggression. Read about bullies and their victims — who they are and what can be done to help them.*

### **Bullies: More Than Sticks, Stones, and Name Calling**

By Robin F. Goodman, Ph.D.

**Editor's Note:** To learn more about research in teasing and bullying behavior, Dr. Goodman interviewed Alice Pope, Ph.D., associate professor of psychology at St. John's University and the author of numerous publications on peer relations. Their interview follows.

#### **Isn't teasing just part of growing up?**

**Dr. Pope:** Teasing among people may be an inevitable fact of life, and unfortunately, young children are initiated into this behavior at a young age. Children cope with teasing in a variety of ways. For example, they may walk away, stand up to the individual who is doing the teasing, or confront a teaser with friends who will stand up for them. However, when the teasing turns to taunting and the child is afraid that any attempt to stop the aggressor will cause harm, the situation is more serious and possibly crosses the line into bullying.

#### **Can occasional episodes of teasing really be harmful?**

**Dr. Pope:** Teasing may not be harmful for most kids and is part of learning about group culture and peer relationships. However, it can be damaging to those who are more vulnerable and at risk for other problems. Obviously, teasing can have an extremely negative impact on children who are less well equipped physically, socially, or emotionally to ride it out. More specifically, children who have an emotional or physical handicap, who are depressed, or who have low self-esteem may

be less able to effectively cope with teasing behavior.

#### **So what exactly do we mean by bullying? How is it different from teasing?**

**Dr. Pope:** Bullying is more than just one single act of aggressive teasing or fighting. Current definitions of bullying behavior stem from the original research conducted with Norwegian and Swedish students by Dan Olweus. As Olweus (1995) has described it, "A student is being bullied or victimized when he or she is exposed, repeatedly and over time, to negative actions on the part of one or more other students. Negative actions can include physical contact, words, making faces or dirty gestures, and intentional exclusion from a group. An additional criterion of bullying is an imbalance in strength (an asymmetric power relationship). The student who is exposed to the negative actions has difficulty defending himself or herself."

Bullying behaviors themselves have been further classified as either direct or indirect, with direct bullying characterized by open attacks and indirect bullying characterized by social isolation, exclusion, or nonselection (Bosworth et al., 1999). Thus, the hallmark of bullying behavior is an ongoing pattern of physical or psychological aggression that is threatening, coercive, and relentless and leaves the victim feeling powerless. The bully is not necessarily bigger or stronger but is usually intimidating. Often, bullying does not occur solely in the context of a one-to-one relationship. In fact, there is usually more than one bully and more than

one victim. Typically the bully has an assistant and an organization of helpers, which Olweus calls the bully's "henchmen," who may carry out the acts. The bully may be in charge but may not be the one caught.

#### **How serious is the bullying problem?**

**Dr. Pope:** Bullying is a pervasive problem for school children in the United States as well as internationally. Studies of incidence range from a high of 80%, where "only 20% reported no bullying behavior" in a 30-day period (Bosworth et al., 1999), to studies showing a conservative 10% of kindergarten through high school students being bullied (Hodges & Perry, 1996). Some groups of children are also at greater risk; for example, Garrity and Barris (1996) reported on a study finding "that 33% of mainstreamed, special-needs children had been targets of bullying, compared to 8% of their normal classmates" (p. 97).

#### **Are there differences between boy and girl bullies and victims?**

**Dr. Pope:** Although bullying is more common among boys, both girls and boys can be bullies (Kumpulainen et al., 1998) or victims. However, boys are more likely to be attacked by boys whereas girls may be attacked by girls, boys, or mixed groups (Schuster, 1996). Boys and girls tend to use different types of bullying behavior. Boys engage in and perpetrate more physical forms of attack whereas girls give and get more indirect forms such as being ridiculed or victimized by rumors (Schuster, 1996; Smith & Myron-Wilson, 1998).

*Continued on page 5*

### What kind of kid is likely to become a bully?

**Dr. Pope:** Research aimed at identifying psychological factors predictive of bullying (Bosworth et al., 1999; Kumpulainen et al., 1998) found that bullies

- have higher levels of anger
- lack confidence in the use of nonviolent strategies
- accept aggression as justifiable and satisfactory
- are unhappy at school
- are impulsive
- have feelings of depression
- lack a sense of belonging in school
- dislike or are dissatisfied with school
- have problems at home

### What kind of kid is likely to become a victim?

**Dr. Pope:** Victims have also been found to have certain features in common. They

- tend to score higher on internalizing and psychosomatic behaviors (Kumpulainen et al., (1998), which means that instead of aggressively acting out, they are prone to anxious and depressed feelings, perhaps to the point of displaying physical symptoms
- may contribute to bullying by virtue of their being irritating (e.g., hyperactive; Kumpulainen et al., (1998), different, or socially awkward or insecure
- may be “physically weak...quick to submit to their peer’s demands...reward their attackers by displaying signs of distress...and by giving up desired resources...low in social skills...use inappropriate group entry tactics, and they lack humor and pro-social skills” (Hodges & Perry, 1996)
- may have few friends and thus less peer protection, and are rejected more often

In light of this, we now realize that bullies should not be the sole focus of interventions intended to reduce the incidence

of bullying and victimization.

### Do you agree with the idea that bullies and victims have similar psychological profiles?

**Dr. Pope:** It’s more complicated than that. Bullies and victims are not just two sides of the same coin. It’s certainly possible that bullies were victimized at one time and are identifying with the powerful figures in their lives. But as bullies, they are not necessarily acting out feelings of victimization. Research suggests three motivations for bullies: They may have a need for power and dominance, be hostile toward the environment and feel satisfied when inflicting injury and suffering, or be compelled to acquire things of value that confer prestige (Olweus, 1995).

### Are kids likely to pick up bullying behavior at home?

**Dr. Pope:** Although we don’t know how bullying arises in all cases, some contributing childrearing factors include

- Authoritarian or punitive parenting. Children brought up in a harsh home environment often become angry and aggressive.
- Coercive parenting. Parents who use power-assertive techniques, especially physical punishment, yelling, and name calling, often generate fear about punishment in their children. These children also tend to identify with and model such aggressive authority figures.
- Caretakers’ attitudes such as indifference and lack of warmth or involvement
- Permissiveness for aggression seen as inadequate limit setting
- Temperament of the child, such as active or hotheaded (Olweus, 1995)

But keep in mind that just as we do not know the direct cause of bullying, we also do not know why some children who grow up in a home that could be expected to foster bullying behavior do not succumb to following this path. It may also

be that factors in children’s social environment, particularly the classroom, permit bullying to arise and continue.

### Are parents doing things to encourage their children to become victims?

**Dr. Pope:** Just as particular parenting practices have been associated with the development of bullies, so too certain parenting techniques have been correlated with the development of victim behavior in children.

Various researchers have identified such factors as insecure attachment to the primary caregiver as being associated with victimization (Hodges & Perry, 1996). Others have focused on gender differences, looking at how different behaviors by mothers and fathers relate to different victim behavior in girls and boys (Smith & Myron-Wilson, 1998).

Victims have also been categorized in various ways, depending on their being passive or aggressive/provocative (Hodges & Perry, 1996; Kumpulainen et al., 1998), with aggressive or bullying victims having a history of exposure to violence at home (Smith & Myron-Wilson, 1998). But these results are always complicated by the interaction, in specific individual cases, between parental style and child temperament.

### Evidence is mounting that aggressive and violent behavior may have its roots in the early years. Do you think there’s a relationship between teasing and bullying at an early age and adolescent aggression?

**Dr. Pope:** Bullying is not just a schoolyard problem. Childhood bullies tend to have problems later in life. These can include poor school attendance, performance problems, and engagement in criminal behavior (Limber, 1996). Systematic peer abuse can also have a lasting impact on victims. For instance, peer abuse experiences can affect victims’ self-esteem, sexual relationships, and vulner-

ability to depression and even suicide (Kumpulainen et al., 1998).

### Don't children have to learn how to deal with bullies? Should adults intervene?

**Dr. Pope:** Children should not be expected to handle bullies on their own. Kids need to be taught that bullying is unacceptable. And because bullying often happens in peer environments, this message has to be reinforced and supported on all levels - at home and in school. Hodges found that children who have friends who stand up for them against bullies are less likely to become victims. But one individual's attempts don't necessarily stop the bully completely because the bullying often occurs in a group situation. Furthermore, the bullying can affect everyone in a group, not just the obvious bully or victim. For example, children who have not been targeted are secretly relieved when someone else is bullied, which in turn creates widespread avoidance of the bully and lack of involvement with the victim. This unfortunate silent majority is ill prepared, ineffective, and equally fearful. The bully system can create a groupwide undercurrent of intimidation that is difficult to overcome singlehandedly. Therefore, it is imperative to enlist aid from adults.

Parents, teachers, and even pediatricians must become more adept and sensitive at identifying possible victims and bullies. The adults who are in a position to intervene on behalf of the victims must band together to take power away from the bully. Because bullies themselves are skillful at avoiding apprehension or punishment, an important step is identifying and stripping the bully of his or her power. Thus once a bullying situation is revealed and identified, adults must act immediately.

### What should parents do?

**Dr. Pope:** Parents must provide a secure

attachment for their child, monitor their own behavior and aggression, provide appropriate models of conflict resolution, encourage autonomy and independence in their child, be concerned and responsive regardless of whether their child is the reported bully or victim, offer suggestions and advice for dealing with problematic peers (such as staying in public places as much as possible), and involve the school if abuse continues (Hodges & Perry, 1996; Shea, 1996).

### What can schools do?

**Dr. Pope:** The most effective intervention program requires focusing on the bully, the victim, the peer culture, and the school and home environments (Garrity et al., 1996). Since bullying often goes undetected and is out of the range of vision of most adults, adult investigation and recognition of the problem are essential for initiating an effective program to stem the tide of bullying. A variety of school intervention plans focus on (National School Safety Center, 1996)

- helping both the bully and the victim develop improved self-esteem

- establishing a no-tolerance policy for bullying
- creating and enforcing rules of respectful and responsible behavior
- educating students about the issue
- encouraging reporting of bullying behavior
- training of educational staff
- involving parents and the community

A successful bullying prevention program is built around a multisystem approach - one that sends a clear and consistent message to bullies and victims alike that bullies are not in charge and that all children are safe.

**About the Author:** Robin F. Goodman, Ph.D., is a clinical associate professor at NYU School of Medicine and is the project director of [www.AboutOurKids.org](http://www.AboutOurKids.org). She is also co-editor of *Childhood Revealed: Art Expressing Pain, Discovery and Hope* and a frequent contributor to national television and print media.

*This copyrighted article is available at [www.aboutourkids.org](http://www.aboutourkids.org), the website of the New York University Child Study Center.*

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## Resources for Kids and Parents

Bullying, both physical and verbal, is a huge problem among children everywhere. The effects of being bullied can be far-reaching, ranging from physical ailments to destructive behavior that can isolate the child from his or her parents and peers.

Here are three books that may help you or your child deal with harassment or bullying

### **How to Handle Bullies, Teasers and Other Meanies : A Book That Takes the Nuisance Out of Name Calling and Other Nonsense**

Kate Cohen-Posey; Betsy A. Lampe  
(Illustrator)

For students in grades 4 to 7  
List Price: \$8.95  
Paperback, 91 pages  
Rainbow Books, Inc.  
(November 1995)

### **Bullying : Practical and Easy-to-Follow Advice (Your Child Series)**

by Jenny Alexander

For parents  
List Price: \$9.95  
Paperback  
128 pages  
Harper Collins - UK  
(June 1998)

### **Bullies and Victims: Helping Your Children Through the Schoolyard Battlefield** by Suellen Fried, Paula Fried, Ph.D.

List Price: \$19.95  
Hardcover (October 1996)  
Paperback (September 1997)  
112 pages

## Surgeon General Calls For More Screening, Improved Access To Treatment, Services For People With Serious Brain Disorders

Every year, more than 30,000 Americans take their own lives. Suicide is the eighth-leading cause of death in the United States, and the third among our youth, ages 15 to 24. Most suffer from treatable mental illnesses, biologically based brain disorders that can lead to tragic consequences. The majority suffers from some form of depression.

In 1999, the Surgeon General, David Satcher, M.D., issued his Call to Action to Prevent Suicide. Today, this call to action has been followed up with the release of his National Strategy for Suicide Prevention (NSSP), the result of a two-year collaboration between advocates, clinicians, researchers, and survivors of suicide. The national strategy addresses the very serious public health problem of suicide with a community-based public health approach that calls on a variety of organizations and individuals to become involved in suicide prevention. The NSSP is the first national attempt to prevent suicide by designing a framework for coordinating resources and services at all levels of government and with the private sector. It offers a plan to develop effective services and programs through recommended changes in the judicial, educational, social services, and healthcare systems.

At a news conference on May 2, the Surgeon General led a coalition of public and private groups to introduce an outline of goals and objectives as the first part of his national strategy. These goals and objectives highlight NAMI's position that the best way to prevent suicide is through early recognition, diagnosis, and treatment. There are 11 broad goals and 68 more specific objectives in the first part of the strategy, which can be found, along with a summary of the entire NSSP, on the Internet at <http://www.mentalhealth.org/suicideprevention>

NAMI members and advocates should be aware that future activities surrounding the proposed implementation

of the NSSP could help improve treatment and services for children and adults with serious brain disorders. Some goals and objectives of particular importance include:

- Promoting awareness that suicide is a preventable public health problem,
- Defining and implementing screening guidelines for schools, colleges, and correctional institutions, along with guidelines on links with service providers,
- Developing and implementing strategies to reduce the stigma of being a consumer of mental health, substance abuse, and suicide prevention services,
- Increasing access to and community links with mental health and substance abuse services,
- Providing treatment for more suicidal persons with mental illness,
- Increasing the number of states that require health insurance plans to cover mental health and substance abuse care equally with coverage for physical health care,
- Incorporating suicide-risk screening at the primary-healthcare level,
- Improving reporting and accurate portrayals of suicidal behavior, mental illness, and substance abuse in entertainment and the news media.

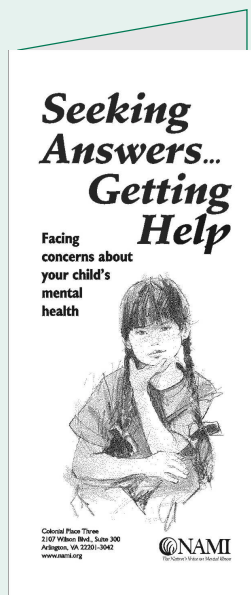
The second part of the National Strategy for Suicide Prevention, to be released later this year is a publication recommending safe approaches for media coverage of suicide-related events based on the current Center for Disease Control (CDC) guidelines. Future components of the national strategy will be released as the work is completed. To view the complete set of goals and objectives for the NSSP go to <http://www.mentalhealth.org/suicideprevention>.

Dr. David Satcher is credited with being the first Surgeon General to focus on suicide and mental health in general.

## *Seeking Answers...Getting Help: Facing Concerns About Your Child's Mental Health*

A new brochure focusing on caregiver concerns and where to turn for advice has been added to the NAMI store. The brochure is substantially like the acclaimed "Help and Hope" brochure introduced a year ago and developed in conjunction with the Center for the Advancement of Children's Mental Health.

This 22-page brochure introduces information about brain disorders to families and offers resources for getting help.



The price of the new brochure is 60¢ each. To purchase these from the NAMI store, request stock number B001. (Minimum quantities apply.) Purchases can be made on the NAMI Web site or by faxing your order form from the NAMI Resource Catalog. If you do not have access to the Internet, please contact the NAMI HelpLine. They will provide the necessary information on ordering from the NAMI store.

# Help End School Violence: A Call for Mandatory Screening of Children for Mental Illness

*By Jacqueline Shannon, President, NAMI Board of Directors*

From Columbine to Santee, violence in America's schools is no longer rare; it's epidemic. The public is outraged, parents are grieving, and fingers are pointed at the availability of guns, broken families, peer pressure, and a pervasively violent culture. But no matter what the experts say, we all should know instinctively at least one thing: 14- and 15-year-olds who resort to violence may be suffering from more than just alienation.

As the mother of a son with schizophrenia and a former classroom teacher, I earnestly hope the epidemic of school violence forces us to confront the fact that, contrary to some popular misconceptions, children and adolescents do develop diagnosable and treatable mental illnesses. Early diagnosis, appropriate intervention, and treatment can save lives.

With preventable tragedies seeming to occur almost weekly, early screenings for mental illness should be mandatory. Learning the signs and symptoms of mental illness should be part of all teacher and counselor training curricula. In addition, parents, coaches, and friends should learn to recognize where normal adolescent development ends and mental health problems begin.

Too often, children with mental disorders go undiagnosed. Family doctors rarely ask about mental health problems. Routine mental health screenings, which should begin at an early age, rarely are performed. Unfortunately, the stigma of mental illness may be keeping doctors and parents from even talking about it.

But the U.S. Surgeon General has called for both a war against stigma and routine assessment of children and adolescents. Even when young people choose not to kill their peers, suicide today remains the third leading cause of death for youth aged 15 to 24.

Detection of mental illness is not a new science. Tools exist, and as responsible adults and caring friends, we must learn to use them. NAMI and the Columbia University Department of Child and Adolescent Psychiatry are working hard to introduce a program called the TeenScreen™. It employs a screening tool known as the Voice DISC, a computerized diagnostic interview tool for children that employs voice-over technology.

A regular program of screening can help to prevent tragedies like those at Columbine and Santee. As parents or teachers, we must ask whether our schools, physicians, and communities are screening children. The price of silence is too great.

David Shaffer, M.D., chief of the Division of Child Psychiatry at Columbia Presbyterian Medical Center, is a firm believer in the DISC. Dr. Shaffer has spoken out on the connection between mental health problems in young people and school failure, substance abuse, and even suicide. He insists that doctors and parents need more information to recognize and treat serious depression and the early onset of manic depression and schizophrenia.

If your community is ready to do something about preventing tragedies using science-based methods, contact NAMI at 703-516-7987 and ask for more information on the Columbia TeenScreen™ program. The tools are available today.

# Study Indicates That Family Connectedness Protects Against Adolescent Suicide



Perceived parent and family connectedness reduces adolescents' risk for attempting suicide, reports a study published in the March issue of *Pediatrics*. The study also suggests that a variety of factors increase adolescents' risk for attempting suicide.

For the study, the authors interviewed 13,110 non-Hispanic black, Hispanic, and non-Hispanic white adolescents in grades 7 through 12 who took part in the National Longitudinal Study of Adolescent Health. The adolescents were interviewed twice, once in 1995 and again in 1996. The purpose of the study was to identify risk factors and protective factors for suicide attempts among white, black, and Hispanic male and female adolescents.

Study findings included the following:

- During the 12 months preceding the 1996 survey, 5.1% of the girls and 2% of the boys attempted suicide;
- White and Hispanic girls were most likely to have attempted suicide during the 12 months preceding the 1996 survey;
- Risk factors for suicide attempts included a previous suicide attempt, violence victimization, violence perpetration, alcohol use, marijuana use, and school problems;
- Among girls, emotional well-being and perceived parent and family connectedness were protective against suicide attempts; and
- Among boys, a higher grade point average and perceived parent and family connectedness were protective against suicide attempts.

The authors propose that health care providers and clinicians identify risk factors and protective factors for suicidal behavior among adolescents and that they educate parents about restricting access to guns and illicit substances in the home.

Further, they conclude that “applying family-level interventions to adolescents at high risk for suicidal behavior, including those with previous suicidal behavior or depression, is also supported by the significant protective effect of parent-family connectedness on attempting suicide in this study, an effect that cross-cut all of the gender and racial/ethnic groups studied.”

**Research article cited:** Borowsky, I.W., Ireland, M., & Resnick, M.D. 2001. Adolescent Suicide Attempts: Risks and Protectors. *Pediatrics* 107(3), 485-493.

## Virus May Contribute to Some Schizophrenia Cases

Compelling evidence that a virus may contribute to some cases of schizophrenia was reported in mid-April 2001 by a research team led by a scientist at Johns Hopkins School of Medicine.

Bits of genetic code resembling viral genes were found in the cerebrospinal fluid and brain tissue of some of the 35 schizophrenia patients who took part in the study.

Researchers found the molecular “footprint” of a retrovirus in the cerebrospinal fluid of 29% of subjects with newly diagnosed acute schizophrenia. It also was found in 7% of those with a chronic form of the disease. In contrast, the retroviral genes were not present in the brains or cerebrospinal fluid of healthy people or people with other types of neurological illnesses.



Lead researcher Dr. Robert Yolken of Johns Hopkins said in an interview, “It certainly suggests that viruses are involved in the process.... At this point, whether the virus is causing some of the cases of schizophrenia or whether it’s activated during the process, we don’t actually know.”

Essentially, scientists found the virus at the scene of the crime, but are struggling to figure out whether it is the perpetrator or an innocent bystander. If viruses are found to be a cause of schizophrenia, Yolken said antiviral therapies could prove effective in treating a disorder that condemns about 1% of people to a world of hallucinations, distorted thoughts, and frequently paranoia.

The researchers said the greater frequency of retroviral genes found in patients with newly diagnosed instead of chronic schizophrenia hinted that the activation of these genes may contribute to the onset and initial progression of the

disease in some individuals.

Previous research suggested that activation of the viruses and the onset of certain forms of schizophrenia are caused by both genetic and environmental factors. The new study points to a retrovirus as a prime candidate for the environmental component of some schizophrenia cases.

The human genome naturally harbors many retroviral genes whose activation has been linked to a number of chronic diseases, including multiple sclerosis, autoimmune arthritis, and diabetes.

Yolken reported that scientists have a number of clinical trials in the planning stages to look at whether antiviral medications would alter the course of schizophrenia. “I think it’s certainly a very fertile area for study,” he said.

The study appears in the *Proceedings of the National Academy of Sciences*. Scientists at the University of Heidelberg (Germany) contributed to the research.

# Red Flags Idaho

By Ann Kirkwood, NAMI Idaho

Red Flags Idaho is a project of NAMI Idaho and Idaho State University's Institute of Rural Health. It is a program designed to help parents identify possible emotional and behavioral problems in their junior high and middle school students and get the help the family needs to remain self-reliant. It is modeled after the Red Flags program first introduced and piloted in Ohio in 1998-1999.

In Idaho, the Department of Health and Welfare (DHW) set aside some of the savings from welfare reform to help families at risk of needing Temporary Assistance for Needy Families (TANF). The funding for Red Flags Idaho is provided by the Idaho DHW from those savings.

Too often, the emotional and behavioral problems of a teen can destabilize his or her family and put all members at risk financially and emotionally, in addition to threatening the family's cohesiveness. The Red Flags Idaho program is designed to help parents - as well as teachers, school counselors, and nurses - learn more about the warning signs of mental illness in children and to assist them in finding help.

Idaho's program began when a special legislative committee held hearings across the state. One of the major recommendations from the committee was that Idaho needed to do something about the stigma of mental illness because the stigma is the single most important barrier to getting help.

The following year, DHW held meetings across the state and sent surveys to 12,000 people. Again, a strong recommendation was that the department needed to take a leadership role in reducing stigma.

DHW then contacted the Idaho State Planning Council on Mental Health and Substance Abuse. This group, created by the governor and appointed by the



Staff of Red Flags Idaho (Left to Right) Ann Kirkwood, Project Director, Rez Price and Mandy Mathewson, Americorps members assisting with the project

department's director, agreed to work on an anti-stigma campaign. They conducted a social marketing analysis and identified the many groups they wanted to reach with the anti-stigma message.

Public service announcements for television were created, a 20-minute video was produced for high school students, and the department funded a documentary to be shown on public television. When it came to reaching the families of junior high and middle school students, the group studied the Ohio Red Flags program and decided to adopt it for use throughout Idaho.

A contract with Idaho State University and NAMI Idaho was approved to fund the program for one year.

First-year funding allows Red Flags Idaho to provide

- Free informational presentations to parents
- Free information and training to teachers, school counselors, and nurses
- Free informational materials from credible sources to parents, teachers, and youth
- A free in-service training for teachers on the Red Flags curriculum
- A toll-free number for information and referrals
- A website with links to other sources of reliable information on mental illness

- A free subscription to Because Kids Grow Up: NAMI News
- A free in-classroom curriculum, called "Claire's Story," for junior high/middle school students

As of February 2001, the program had reached more than 16,000 school staff through trainings, personal meetings, newsletter articles, and a special video feed to school districts provided by the Idaho Department of Education. Presentations and newsletter articles have reached 500 parents, and a special presentation was provided to the Idaho State Parent Teacher Association. School staff anticipate reaching thousands of youth through the Red Flags curriculum in the next 18 months.

## NAMI Fact Sheets

There are 10 NAMI fact sheets that can provide disorder-specific help for families with children. The collection includes: Attention Deficit/Hyperactivity Disorder (ADHD), Anxiety Disorders in Children and Adolescents, Asperger's Disorder, Childhood Obsessive Compulsive Disorder (OCD), Dual Diagnosis in Adolescents (Substance Abuse and Mental Illness), Early Onset Bipolar, Early Onset Depression, Teenage Suicide, Early Onset Schizophrenia and Tourette's Disorder that is often co-occurring with many brain disorders in children.

NAMI fact sheets are available free of charge from the NAMI Helpline (1-800/950-6264), or by visiting the NAMI Web site ([www.NAMI.org/youth/brochures.html](http://www.NAMI.org/youth/brochures.html)).

# Volunteers Educate Teens About Mental Illness

Like many NAMI affiliates across the country educating about mental illness in the schools has become a focal point of education and ‘stigma busting.’ The members of NAMI Orange County, CA, through an Orange County Community Foundation grant, teamed with the Mental Health Association to start the “Circle of Hope,” a program to raise awareness of mental illness and offer a referral center for teens and their families. One aspect of the program is school outreach.

The school outreach volunteers hope to help reduce discrimination and dispel the myths and stigma of mental illness through presentations to faculty and students. The volunteers sometimes hear startling comments from students. Donna Pollard, creator and organizer of the program, recalls a day she was constantly interrupted by one young man. Finally she told the youth, “Please be quiet. Your voice is bothering me!” The student replied softly, “So are the voices in my head.”

In a typical day, the class bell rings, chatting subsides, and students take their seats in Jan Baker’s English class at Laurel High School in Los Alamitos. At the front of the room, a guest speaker greets the 25 teens, who are 16 through 19 years old. “Good morning. I’m Kati Mester, and I’ve come to talk to you about mental illness,” she says. There are no giggles, whispers, or jeers. Students know this is serious stuff. Several have family members with mental illness or have it themselves.

“About one in five families have a loved one with mental illness,” Mester says. A few students respond with a knowing nod. NAMI staff members train speakers like Kati to help junior and senior high school students identify serious brain

disorders and learn how and where to seek treatment.

“Sadly, many people still think that only ‘bad’ people get mental disorders,” Mester tells students.

“Think of it like this: Diabetes and heart disease affect your body; mental illnesses occur in your brain,” she says. “These are severe and persistent biological disorders that disrupt your ability to think right and relate to others. I know, because I have a mental illness.”

The teens listen and ask questions as the speaker describes types of mental disorders. Mester is one of 35 men and women who are volunteer speakers from



NAMI Orange County. Nearly all volunteers have had a family member with a mental disorder or speak from personal experience with mental illness.

How effective is this outreach effort? “I have ‘bipolar’ so I already knew some things, but I learned more,” one student says after Mester leaves. Another says, “My mom has manic depression; I know I have to be aware of my feelings.” Another speaker, Jan Baker, related, “One student came to me and said she was glad we had the program; she recognizes symptoms in herself.” Similar comments come from students and teachers in letters to NAMI,

says school outreach coordinator Leah Ezzell. Many praise the speakers and request a return visit.

“We’ve made a commitment to reach more than 6,000 students this year and to increase our volunteer force,” Ezzell says. Speakers urge students to be alert to signs of mental illness in their friends before it’s too late. When people fail to get treatment, they sometimes seek relief by attempting suicide.

“Young adults might be hesitant to tell a friend to seek professional help, but it could save their friend’s life,” Mester tells students. Here are some signs of various mental illnesses:

- Major depression/clinical depression: persistent sadness, low energy, low self-esteem, change in the ability to work, sleep, eat
- Bipolar disorder/manic depression: recurrent mood swings with cycles of deep depressions and inappropriate highs
- Schizophrenia: depression, extreme anxiety, panic, extensive withdrawal from people, delusions, hallucinations
- Panic/anxiety disorder: unexpected, repeated episodes of intense fear, with unexplained physical symptoms
- Obsessive compulsive disorder: anxiety and a pattern of repetitive thoughts and behaviors, such as washing hands for hours

The school outreach program is free. Ezzell says it is appropriate for teacher in-service programs, parent groups, and health, science, psychology, and other classes at middle and high schools.

Considering that the onset of many mental illnesses is at ages 16 through 25, the program helps students, parents, and teachers to recognize symptoms and encourages them to see a psychologist, psychiatrist, or family physician.

# Hearts and Minds Video Receives Peabody Broadcast Journalism Award

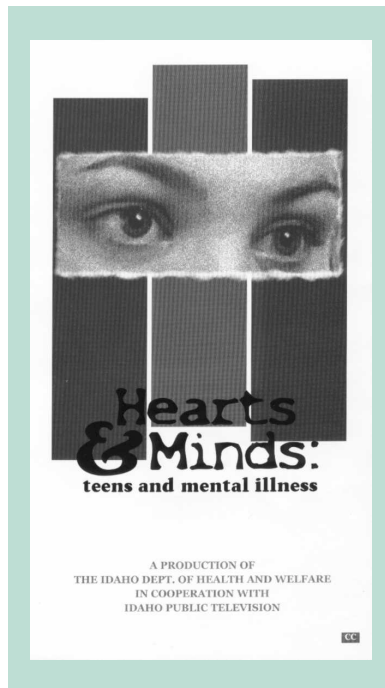
A children's mental health video project managed by NAMI Idaho member Ann Kirkwood has received a coveted International Peabody Award for broadcast journalism.

The Peabody Award went to Idaho Public Television and the Idaho Department of Health and Welfare. While working for Health and Welfare last year, Kirkwood managed the creation of a 30-minute video for senior high school students.

"Hearts and Minds: Teens and Mental Illness" aired statewide in November 2000 and was broadcast again in May 2001. The video also has been given to every high school in the state for use in 10th-grade health classes. It focuses on four youth, one with schizophrenia, one with bipolar disorder, one with obsessive compulsive disorder, and one with major depression.

To create the documentary, Kirkwood secured funding for the project, supervised scripting and production, and chaired a committee of mental health consumers, providers, advocates, and teens. She was responsible for conceptualizing the project and managing it through completion last fall.

The 34 winners of the 60th Annual George Foster Peabody Awards for radio and television were announced at the University of Georgia, which administers the awards. The award announcement described Idaho's documentary as a "comprehensive educational effort that presents a sympathetic and straightforward examination of mental illness that dispels myths and offers hope to teenage victims." Other



winners of the award included 60 Minutes II, Dateline NBC, 48 Hours, and Frontline: Drug Wars.

Kirkwood now works for NAMI-Idaho and Idaho State University, managing another mental health project for teens. Red Flags Idaho educates adolescents, their parents, and school staff about the signs and symptoms of mental illness in young people. (See story on page 10.)

The "Hearts and Minds" video may be available after mid-summer if there is enough interest. Please e-mail [Monique@NAMI.org](mailto:Monique@NAMI.org) to indicate if you would be interested in acquiring this video either for your personal use or to donate to a resource library. The estimated cost is under \$10 plus shipping and handling. (You may leave a message at (703) 516-7961 if e-mail is not available to you.)

*Continued from page 3*

another project called "Awareness Walk." This fund-raising walk allowed NAMI Dane and our school to raise more than \$9,700 for mental health research. Donations were given to NARSAD (National Alliance for Research on Schizophrenia and Depression). The walk was a great success, and we are currently planning another "Awareness Walk" for summer 2001.

At this time, I am working with the West High student government to organize a schoolwide "Awareness Week." It is designed to raise students' consciousness about many issues, including mental health, street drugs, sexual orientation, and life-altering diseases. Guest speakers will talk to the students during the week of focused educational programming, with a view toward overcoming the common stigmas attached to these issues.

I aspire to stay active in and around mental health and other issues. I am attempting to create a support group at West that will be made up of students for students. Optimally, this will develop into a peer-to-peer group where students may comfortably talk to each other about their mental health issues (and those of their family members).

As a graduating senior, my priority now is to identify another West High student who will carry on the goals of this educational effort. As the goals for mental health awareness that we have established are attained, our school will continue to encourage mental health education in a relaxed, supportive atmosphere. I hope that the type of resources made available through this resource room may provide an example for other high schools to follow.

**Editor's Note:** Ben is heading into the last few weeks of his senior year and is planning to attend college in the fall, probably in his hometown at the University of Wisconsin-Madison. He is considering a major in a business-related field. He also plans to remain involved with NAMI and to continue increasing mental health awareness through his college years.

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# Minds Under Siege

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by Vicki Sayles ©2000

Vicki is an advocate with NAMI-CAN, Bucks County, PA

Infant at rest, upon a loving breast  
Hope, potential, future~

Time goes by, inconsolable cries  
Tantrum, terror, psychosis

Hyperactive conduct, disordered thoughts  
Punish, prod, cajole~

Child of six, behavior not fixed  
Anxiety, rage, rejection

Labels of scorn, a child forlorn  
Lazy, crazy, stupid

Frequent tears, a mother's fears  
Blame, guilt, frustration

No one believes, the mother grieves  
Lonely, stalwart, searcher~

Failure chain, scholastic disdain  
Defeated, hopeless, spiral

Neurotransmitter dysfunction, at every junction  
Causing thought distortion

Pain and grief, without relief  
No one understands

Character flaw, mistaken belief  
It's under one's control

Ain't no use, substance abuse~  
Pain numbing solution

Drugs of the street, used to defeat  
Anxiety, depression, delusion

Dare slogans useless, "just say no to madness"  
Perpetuates the myth

Stigma and fear, society won't hear  
Illness of epic proportions

Victim agrees, fears this horrific disease~  
Absolute denial

Cannot accept, a mind less adept~  
Leprosy preferable~

Drunken rage, black and blue~  
Child, spouse, self

Homeless muttering, blank-eyed stare~  
Freezing, starving, souls

All connected, cause neglected  
Misguided goals

Alive but not living, society unforgiving  
Discarded, abused, despised

Crisis unfolds, the jail now holds  
Lost, creative, genius

Hatred runs deep, punish the creep  
Politicians eagerly oblige~

Refuse to believe, it is a disease~  
Affecting one in five~

It's not realistic, to deny the statistic  
40 million minds diagnosed

Lots more affected, yet go undetected  
Symptoms are denied

Someone you know, maybe yourself  
Affects one in five~

No need to debate, economic cost is great  
148 billion per year

Hospitals closing, no aftercare~  
Relapse, psychotic, suicide~

Shelters not the answer, we don't put people there~  
Who have cancer!

Six billion people, inhabit our planet  
Genetic role confirmed

Mental health low priority, not supported by majority  
Election to be won

Take away funding, pass the buck  
Bureaucrats turn deaf ear

Our money has gone, to the Pentagon  
Colombia, NASA, DEA

Crimes against humanity, condoned by our society  
U.N. must intervene~

How many must die, to make nations cry  
Before we respond

Favorite diseases, get media blitz  
Pamphlets, races, ribbons

Mental health ignored, affects many more~  
Silent, suffering, people~

Sound the alarm, too many are harmed  
Shout, march, riot~

Research holds the key, join our advocacy  
Voice, talent, time~

Recovery's in reach, if we enlighten and teach  
Please! Change society's mind

# Iris the Dragon Campaign for Children With Mental Illness

*An ancient dragon legend says that the stars in the heavens are guiding lights for all living creatures. Dragons know the secret of the stars and have been given the responsibility of keeping them from falling - Iris*

*Catch a Falling Star*, the first book in a new series of children's books featuring Iris the Dragon, is a fairy tale that portrays the early warning signs of potential mental illness in children between the ages of 6 and 12. The illness is revealed in a gentle manner through a friendly, imaginary dragon and a boy nicknamed "Fish."

Iris the Dragon is the creation of author Gayle Grass and illustrator Coral Nault - two women with a common bond. Gayle and Coral each have a child with mental illness. Two years ago, while working together in Coral's studio, the idea of Iris the Dragon and a series of Iris books was born. In *Catch a Falling Star*, Coral brings the fauna and flora of Canada's eastern Ontario lake country to life.

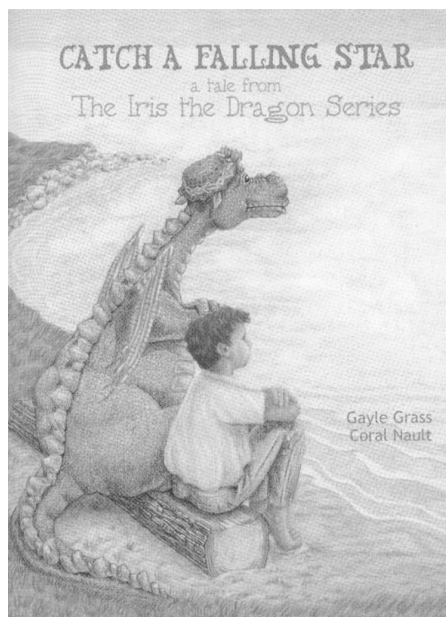
## Birth of the Series

According to Gayle, who visited NAMI headquarters in Northern Virginia recently, the Iris the Dragon series was created to reaffirm the message that mental illness exists, is increasingly diagnosed, and needs to be understood better. "I believe that a well-designed illustrated book can be an effective tool to help decrease the stigma attached to mental illnesses and open the door to acceptance through understanding," she says. "It is our hope that the words and illustrations will be clues to parents and teachers and the generations of children they read this book to that illnesses can also strike the brain, our most precious organ."

Gayle and Coral want to provide a tool to help children, parents, and educators understand that early detection, intervention, and education can help to alleviate, if not prevent, mental illness in children. The fairy-tale format was specifically chosen because this medium dissociates the topic from the real world

and allows the reader to see mental illness and its effects in a nonthreatening light.

To help children, along with their mentors, understand that mental illness can be caused by a chemical or a neurological disorder and is not the fault of the child or parents, Iris provides support to Fish when he is experiencing especially difficult moments. Iris helps Fish appre-



ciate that his illness is like any other disease and needs to be recognized and treated like any other.

As the great child psychologist Bruno Bettelheim wrote in his book *The Uses of Enchantment*, "For a story to truly hold the child's attention, it must...be attuned to his anxieties and aspirations: give full recognition to his difficulties...suggesting solutions to the problems which perturb him...and promoting confidence in himself and his future." And as Charles Dickens put it: "The imagery of fairy tales helps children...(achieve) a more mature consciousness to civilize the chaotic pressures of the unconscious."

The book is not only for children, but is also for caregivers and others who deal directly with children, to enhance their awareness of the issues surrounding mental illness. This awareness is essential in ensuring a better future for all children suffering from mental illness. It is one more step in the further development and implementation of a national agenda to advocate for new models of treatment and mental health services, funding of additional research, and new sources of education, information, and advocacy.

Peter Jensen, M.D., director of the Center for the Advancement of Children's Mental Health, is one of many mental health professionals who have endorsed *Catch a Falling Star*. "Children with mental illness suffer greatly, not just because of the impact of these devastating conditions themselves, but also because they lack the grown-up capacity to understand what has happened to their feelings, their thoughts, their behavior - in short - to themselves.... To be effective, hope and help must be offered in children's own language and metaphors. The mythical but magical Iris the Dragon assists not just the young boy who meets Iris the Dragon in this story, but also all children who read about the boy and Iris.... My highest recommendation for parents and their children afflicted with mental illness."

**Editor's Note:** Advocates for children with mental health disorders are eager to support this project because of its ongoing efforts to help the public understand that disorders of the brain should not be stigmatized any more than any childhood illness, be it asthma, diabetes, or juvenile arthritis. Think of an elementary school teacher who might benefit from having a copy for his or her classroom. (*To order, see next page.*)

To order a copy/copies of *Catch a Falling Star*, please provide the following information on a sheet of paper and mail it to:

Iris the Dragon, Inc., Otter Creek, 667 Highway 15, RR#1, Lombardy, ON, Canada, KOG 1 L0.

If you have any questions or want information about discounts on orders of 20 or more books, you can write to the above address, e-mail: [iristhedragon@hotmail.com](mailto:iristhedragon@hotmail.com), call 613-284-2049, or fax: 613-283-9507.

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**PLEASE SEND ME:** *Catch a Falling Star*<sup>®</sup>

Quantity desired: \_\_\_\_\_  U.S. \$10.95    Total Cost: U.S. \$ \_\_\_\_\_

Cdn. \$15.95    Cdn. \$ \_\_\_\_\_

For each address:

Shipping & Handling (*for up to 5 books*): \$ 5.00

\$1.00 for each additional book to same address: \$ \_\_\_\_\_

Subtotal: \$ \_\_\_\_\_

Canadian orders add 7% GST \$ \_\_\_\_\_

Total Amount: \$ \_\_\_\_\_

**METHOD OF PAYMENT:**

Enclosed is a:     Check     Money Order    Make checks payable to *Iris the Dragon, Inc.*

*Charge my:*     Visa     MasterCard    Expiration date: \_\_\_\_\_

Name on card: \_\_\_\_\_

Signature (as on the card): \_\_\_\_\_

**SHIP TO:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State/Province: \_\_\_\_\_

ZIP/Postal Code: \_\_\_\_\_

If a gift card is desired, please indicate how it should read:

\_\_\_\_\_  
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If sending books to more than one address, please list each additional address separately.

## Have you visited the NAMI Web site lately?



Since New Year 2001, there is a totally new look. Please visit us to find the latest information on early onset disorders, screening, identification, research, and treatments.

By sliding your mouse across the four areas below NAMI Is... (Support, Education, Advocacy, and Research), new drop down menus will lead you into various areas of interest. Information on children and adolescents is available by clicking on the front page (lower center), or through the education area.

Visit [www.NAMI.org](http://www.NAMI.org) soon ... and come back often!

## Join NAMI Now!



Sustain the education, support and advocacy efforts of NAMI's 1200 affiliates. Join with the other 210,000 NAMI members working to increase early detection, appropriate diagnosis, advanced treatment options and access to the best mental health care.

Benefits of NAMI National membership include a subscription to NAMI's quarterly news magazine, the *Advocate*, which features cutting-edge articles about the latest research, treatments, and medications for mental illnesses; the status of major policy and legislation at the federal, state, and local levels; and provocative editorials and columns.

Visit the NAMI web site at [www.NAMI.org](http://www.NAMI.org) for membership information and easy and secure application.