



Mindful
Continuing Education

Psychosocial Problems Facing School-Aged Youth



Time for Straight Talk about Mental Health Services and MH in Schools

When you hear the term *Mental Health in Schools* or *School Mental Health*, what comes to mind?

Probably you think about students who have psychological problems, about what services they need, and how schools don't provide enough of such services. This is not surprising given the widespread tendency for the term *mental health* to be thought of as referring to mental disorders/illness and for relevant interventions to be seen as services (e.g., counseling/therapy).

As a result, many well-intentioned initiatives and policy reports have focused on expanding mental health *services* in schools. Bluntly stated, however, advocacy for more mental health *services* in schools often detracts from efforts to encourage policy makers to address the full range of mental health concerns confronting school staff, students, and their families.

Our analyses of policy and practice stress understanding the following matters as key to advancing a broad approach to mental health in schools.*

- The concept of mental health encompasses a continuum of concerns ranging from *promoting positive social and emotional development to treating mental disorders*.
- Mental health *problems* are fully enmeshed with psychosocial and educational problems.
- Given the above, schools have a role to play in (a) promoting positive mental health (e.g., social-emotional development), (b) preventing learning, behavior, and emotional problems, (c) intervening as early as feasible when such problems arise, and (d) treating severe and chronic problems.
- However, since the mission of schools is education, a mental health agenda (and especially a clinical services agenda) *by itself* is too narrow to be a high priority for our society's schools.

Those concerned with enhancing the role of mental health in schools must guide policy makers to a clear understanding of

- the many factors that are interfering with learning and teaching
- the large number of students who are experiencing learning, behavior, and emotional problems
- the fragmented and marginalized state of affairs related to the limited set of services, programs, and initiatives currently provided as student/learning supports
- the small proportion of students reached
- the counterproductive competition for sparse resources.

All the above realities work against enhancing every student's civil right to *equity of opportunity* for success at school and beyond.

Given all this, it is time to focus on transforming student/learning supports. Doing so is fundamental to improving intervention effectiveness in ways that enhance equity of opportunity, promote whole child development, and engender a positive school climate. Doing so requires ending the marginalization of student/learning supports in school improvement policy and then framing and operationalizing them as a unified, comprehensive, and equitable system that weaves together school and community resources.

In the process, a broad definition of mental health in schools can be embedded into a transformed system of student/learning supports. Doing so will help

- reduce the unrealistic and often inappropriate call for more and more one-on-one direct services
- counter the mistaken view that collocating community services on school campuses can ever be a sufficient approach to filling critical intervention gaps at schools and for enhancing community and home engagement
- increase classroom, school-wide, and community interventions that can reduce the need for one-on-one services
- facilitate the weaving together of school, home, and community resources to gain economic benefits and enhance outcomes
- enhance coordination and cohesion of all resources (school, community, family) intended to support young people.

The bottom line in terms of equitable policy is that we cannot continue to provide a small number of sites with a few more health and social services to establish a few islands of excellence (demonstrations, pilots) and “Cadillac models.” The scale of need demands moving quickly in fundamentally new directions. With over 90,000 public schools in the U.S.A. and so many students who are not doing well, it is time to embed mental health in schools into a unified, comprehensive, and equitable system of learning supports. This will enhance the fit with the mission of schools and contribute in a powerful way to schools playing a role in fully promoting social-emotional development and comprehensively addressing barriers to learning and teaching.

*For further elaboration of these points, see

- >Adelman, H.S. & Taylor, L. (2010). *Mental Health in Schools: Engaging Learners, Preventing Problems, and Improving Schools*. Thousand Oaks, CA: Corwin Press.
- >Adelman, H.S. & Taylor, L. (2012). *Mental Health in Schools: Moving in New Directions. Contemporary School Psychology*. <http://smhp.psych.ucla.edu/pdfdocs/contschpsych.pdf>
- >*Embedding Mental Health into a Learning Supports Component: An Essential Step for the Field to Take Now*. <http://smhp.psych.ucla.edu/pdfdocs/embeddingmh.pdf>
- >Adelman, H.S. & Taylor, L. (2017). *Addressing Barriers to Learning: In the Classroom and Schoolwide*. access from the Center's homepage at <http://smhp.psych.ucla.edu/>
- >Adelman, H.S. & Taylor, L. (2018). *Transforming Student and Learning Supports: Developing a Unified, Comprehensive, and Equitable System*. San Diego: Cognella Academic. <https://titles.cognella.com/transforming-student-and-learning-supports-9781516512782.html>
- >Adelman, H.S. & Taylor, L. (2018). *Improving School Improvement*. Free access from the Center's website at http://smhp.psych.ucla.edu/improving_school_improvement.html
- >Adelman, H.S., Taylor, L., Mayer, M.J., & Dwyer, K.P. (in press). Intersection of School Safety, Mental Health and Wellness, and Family/Community Issues. In D. Osher, M. Mayer, R. Jagers, K. Kendziora, & L. Wood (Eds). *Keeping Students Safe and Helping Them Thrive*. Santa Barbara: ABC-CLIO.

and the resources cited as part of the *National Initiative for Transforming Student and Learning Supports* – <http://smhp.psych.ucla.edu/newinitiative.html> .

Moving Forward: MH in Schools & Student/Learning Supports

Over the last decades, research findings have made it evident that any initiative to expand the school's role in addressing mental health concerns will be marginalized if it is not fully integrated into school improvement policy and planning.

Current school policy proclaims the aim for every student to succeed, and those proposing school-based interventions must recognize the full implications of the word every. An intervention focus on all students requires addressing the problems of the many youngsters who aren't benefitting from instructional reforms because of a host of external and internal barriers interfering with their development and learning and that are reflected in the wide range of psychosocial and mental health concerns school must cope with each day.

Enhanced school-community collaboration is essential, but the narrow focus on expanding school-based mental health services (including colocating agency resources at schools) is not a viable approach. The limited impact of various initiatives to link health and social services have demonstrated this reality. Simply stated, a mental health services orientation doesn't account for the full continuum of interventions needed to promote mental health and prevent and treat psychosocial and mental health problems.

For many years, our Center's policy analyses have stressed ways to enhance the school's role related to mental health concerns by embedding mental health into school improvement policy and practice. In 2015, the Center established the National Initiative for Transforming Student and Learning Supports -- see <http://smhp.psych.ucla.edu/newinitiative.html> . In 2017, to more fully underscore the breadth of the work, the Center name was expanded; the name is now the Center for MH in Schools & Student/Learning Supports.

Given our expanded focus, we want to encourage Center users concerned about mental health in schools to avail themselves of a wide range of resources for addressing barriers to learning and teaching and re-engaging disconnected students. With this in mind, we are no longer updating the following ***Sampling of References Related to Mental Health in Schools***. While the list will no longer be updated, it remains a useful resource so we are simply archiving it.

In place of such a list, we are continuously updating our online clearinghouse Quick Finds. SO ... for links to a wide range of relevant resources, we direct you to our Quick Finds. See the drop down menu at <http://smhp.psych.ucla.edu/quicksearch.htm> .

And when you need more, you can always do

>a regular Google search -- https://www.google.com/?gws_rd=ssl#spf=1498966622326

>a Google Scholar search -- <http://scholar.google.com/>

I. Keeping The Environment in Perspective as a Cause of Commonly Identified Psychosocial Problems.

A large number of students are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters have trouble behaving in classrooms; only a small percent have attention deficit or a conduct disorder. In some schools, large numbers of students have problems learning; only a few have learning disabilities. Individuals suffering from true internal pathology represent a relatively small segment of the population. A caring society tries to provide the best services for such individuals; doing so includes taking great care not to misdiagnose others whose "symptoms" may be similar, but are caused by factors other than internal pathology. Such misdiagnoses lead to policies and practices that exhaust available resources in ineffective ways. A better understanding of how the environment might cause problems and how focusing on changing the environment might prevent problems is essential.

A. Labeling Troubled and Troubling Youth: The Name Game

She's depressed.

*That kid's got an attention deficit
hyperactivity disorder.*

He's learning disabled.

What's in a name? Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" -- making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as ADHD, depression, and LD. This happens despite the fact that the problems of most

youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

Diagnosing Behavioral, Emotional, and Learning Problems

The thinking of those who study behavioral, emotional, and learning problems has long been dominated by models stressing *person* pathology. This is evident in discussions of cause, diagnosis, and intervention strategies. Because so much discussion focuses on person pathology, diagnostic systems have not been developed in ways that adequately account for psychosocial problems.

Many practitioners who use prevailing diagnostic labels understand that most problems in human functioning result from the interplay of person and environment. To counter nature *versus* nurture biases in thinking about problems, it helps to approach all diagnosis guided by a broad perspective of what determines human behavior.

A Broad View of Human Functioning

Before the 1920's, dominant thinking saw human behavior as determined primarily by person variables, especially inborn characteristics. As behaviorism gained in influence, a strong competing view arose. Behavior was seen as shaped by environmental influences, particularly the stimuli and reinforcers one encounters.

Today, human functioning is viewed in *transactional* terms -- as the product of a reciprocal interplay between person and environment (Bandura, 1978).^{*} However, prevailing approaches to labeling and addressing human problems still create the impression that problems are determined by *either* person or environment variables. This is both unfortunate and unnecessary -- unfortunate because such a view limits progress with respect to research and practice, unnecessary because a transactional view encompasses the position that problems may be caused by person, environment, or both. This broad paradigm encourages a comprehensive perspective of cause and correction.

^{*}Bandura, A. (1978). The self system in reciprocal determination.
American Psychologist, 33, 344-358.

Toward a Broad Framework

A broad framework offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid over-diagnosing internal pathology. Such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems caused by the environment are placed at one end of the continuum (referred to as Type I problems). At the other end are problems caused primarily by pathology

within the person (Type III problems). In the middle are problems stemming from a relatively equal contribution of environmental and person sources (Type II problems).

Diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as $E \leftarrow \rightarrow P$). Toward the other end, person variables account for more of the problem (thus $e \leftarrow \rightarrow P$).

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the the person (P)		
E	(E<--->p)	E<--->P	(e<--->P)	P
----- ----- ----- -----				
Type I problems		Type II problems		Type III problems
•caused primarily by environments and systems that are deficient and/or hostile		•caused primarily by a significant <i>mismatch</i> between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)		•caused primarily by person factors of a pathological nature
•problems are mild to moderately severe and narrow to moderately pervasive		•problems are mild to moderately severe andpervasive		•problems are moderate to profoundly severe and moderate to broadly pervasive

Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. However, the above conceptual scheme shows the value of starting with a broad model of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward blaming the victim (Ryan, 1971).^{*} It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

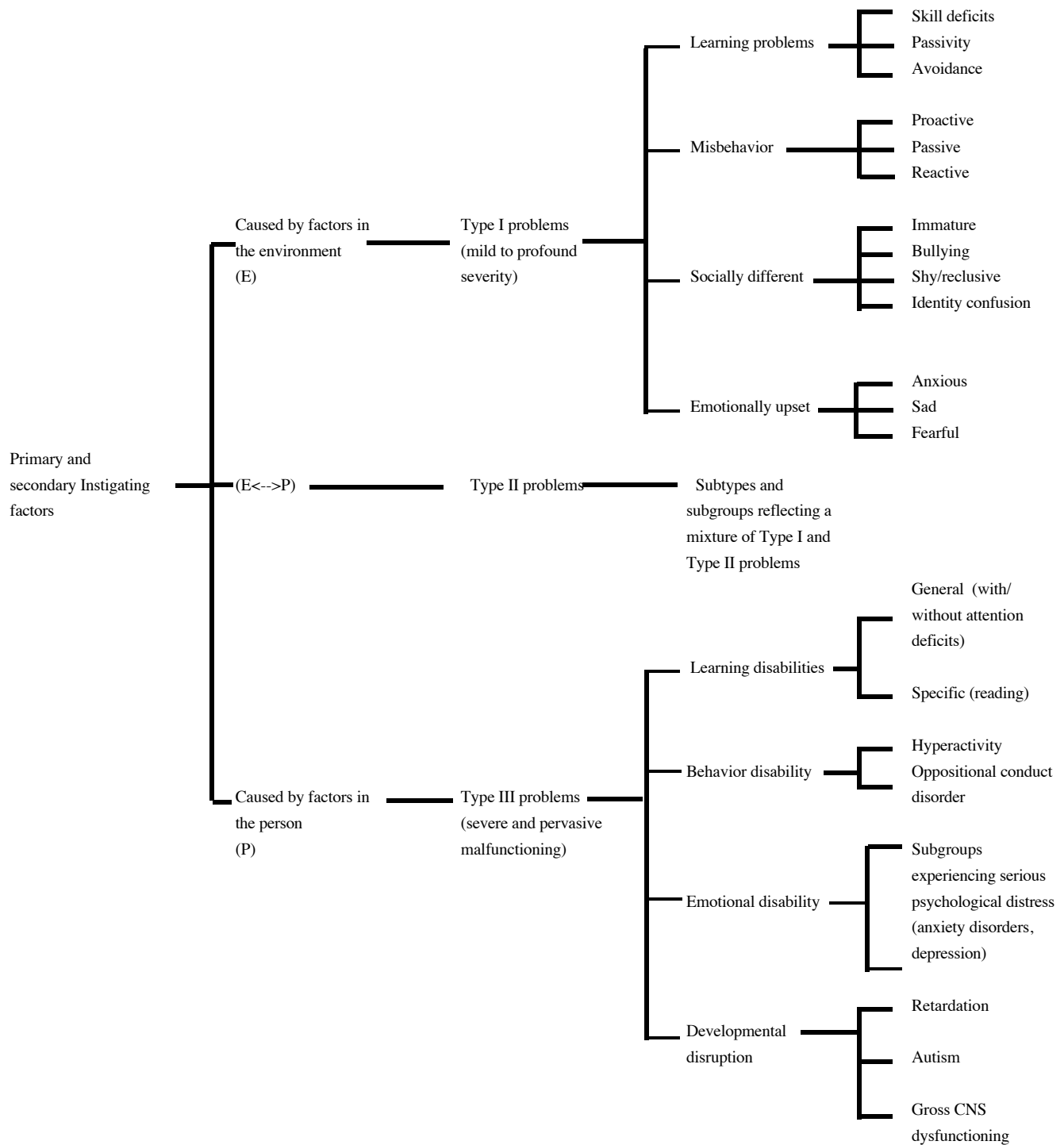
^{*}Ryan, W. (1971). *Blaming the victim*. New York: Random House.

After the general groupings are identified, it becomes relevant to consider the value of differentiating subgroups or subtypes within each major type of problem. For example, subtypes for the Type III category might first differentiate behavioral, emotional, or learning problems arising from serious internal pathology (e.g., structural and functional malfunctioning within the person that causes disorders and disabilities and disrupts development). Then subtypes might be differentiated within each of these categories. For illustrative purposes: Figure 2 presents some ideas for subgrouping Type I and III problems.

There is a substantial community-serving component in policies and procedures for classifying and labeling exceptional children and in the various kinds of institutional arrangements made to take care of them. "To take care of them" can and should be read with two meanings: to give children help and to exclude them from the community.

Nicholas Hobbs

Figure 2: Categorization of Type I, II, and III Problems



B. Environmental Situations and Potentially Stressful Events

The American Academy of Pediatrics has prepared a guide on mental health for primary care providers. The guide suggests that commonly occurring stressful events in a youngsters life can lead to common behavioral responses. Below are portions of Tables that give an overview of such events and responses.

ENVIRONMENTAL SITUATIONS AND POTENTIALLY STRESSFUL EVENTS CHECKLIST

Challenges to Primary Support Group

- Challenges to Attachment Relationship
- Death of a Parent or Other Family Member
- Marital Discord
- Divorce
- Domestic Violence
- Other Family Relationship Problems
- Parent-Child Separation

Changes in Caregiving

- Foster Care/Adoption/Institutional Care
- Substance-Abusing Parents
- Physical Abuse
- Sexual Abuse
- Quality of Nurture Problem
- Neglect
- Mental Disorder of Parent
- Physical Illness of Parent
- Physical Illness of Sibling
- Mental or Behavioral disorder of Sibling

Other Functional Change in Family

- Addition of Sibling
- Change in Parental Caregiver

Community of Social Challenges

- Acculturation
- Social Discrimination and/or Family Isolation

Educational Challenges

- Illiteracy of Parent
- Inadequate School Facilities
- Discord with Peers/Teachers

Parent or Adolescent Occupational Challenges

- Unemployment
- Loss of Job
- Adverse Effect of Work Environment

Housing Challenges

- Homelessness
- Inadequate Housing
- Unsafe Neighborhood
- Dislocation

Economic Challenges

- Poverty
- Inadequate Financial Status

Legal System or Crime Problems

Other Environmental Situations

- Natural Disaster
- Witness of Violence

Health-Related Situations

- Chronic Health Conditions
- Acute Health Conditions

Common Behavioral Responses to Environmental Situations and Potentially Stressful Events

INFANCY-TODDLERHOOD (0-2Y) BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors

N/A

Emotions and Moods

Change in crying
Change in mood
Sullen, withdrawn

Impulsive/Hyperactive or Inattentive Behaviors

Increased activity

Negative/Antisocial Behaviors

Aversive behaviors, i.e., temper tantrum, angry outburst

Feeding, Eating, Elimination Behaviors

Change in eating
Self-induced vomiting
Nonspecific diarrhea, vomiting

Somatic and Sleep Behaviors

Change in sleep

Developmental Competency

Regression or delay in developmental attainments
Inability to engage in or sustain play

Sexual Behaviors

Arousal behaviors

Relationship Behaviors

Extreme distress with separation
Absence of distress with separation
Indiscriminate social interactions
Excessive clinging
Gaze avoidance, hypervigilant gaze...

MIDDLE CHILDHOOD (6-12Y) BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors

Transient physical complaints

Emotions and Moods

Sadness
Anxiety
Changes in mood
Preoccupation with stressful situations
Self -destructive
Fear of specific situations
Decreased self-esteem

Impulsive/Hyperactive or Inattentive Behaviors

Inattention
High activity level
Impulsivity

Negative/Antisocial Behaviors

Aggression
Noncompliant
Negativistic

Feeding, Eating, Elimination Behaviors

Change in eating
Transient enuresis, encopresis

Somatic and Sleep Behaviors

Change in sleep

Developmental Competency

Decrease in academic performance

Sexual Behaviors

Preoccupation with sexual issues

Relationship Behaviors

Change in school activities
Change in social interaction such as withdrawal
Separation fear
Fear of being alone

Substance Use/Abuse...

EARLY CHILDHOOD (3-5Y) BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors

N/A

Emotions and Moods

Generally sad
Self-destructive behaviors

Impulsive/Hyperactive or Inattentive Behaviors

Inattention
High activity level

Negative/Antisocial Behaviors

Tantrums
Negativism
Aggression
Uncontrolled, noncompliant

Feeding, Eating, Elimination Behaviors

Change in eating
Fecal soiling
Bedwetting

Somatic and Sleep Behaviors

Change in sleep

Developmental Competency

Regression or delay in developmental attainments

Sexual Behaviors

Preoccupation with sexual issues

Relationship Behaviors

Ambivalence toward independence
Socially withdrawn, isolated
Excessive clinging
Separation fears
Fear of being alone

ADOLESCENCE (13-21Y) BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors

Transient physical complaints

Emotions and Moods

Sadness
Self-destructive
Anxiety
Preoccupation with stress
Decreased self-esteem
Change in mood

Impulsive/Hyperactive or Inattentive Behaviors

Inattention
Impulsivity
High activity level

Negative/Antisocial Behaviors

Aggression
Antisocial behavior

Feeding, Eating, Elimination Behaviors

Change in appetite
Inadequate eating habits

Somatic and Sleep Behaviors

Inadequate sleeping habits
Oversleeping

Developmental Competency

Decrease in academic achievement

Sexual Behaviors

Preoccupation with sexual issues

Relationship Behaviors

Change in school activities
School absences
Change in social interaction such as withdrawal

Substance Use/Abuse...

II. A FULL RANGE OF PROGRAMS TO ADDRESS BEHAVIORAL, EMOTIONAL, AND LEARNING PROBLEMS

Amelioration of the full continuum of problems, requires a comprehensive and integrated programmatic approach. Such an approach may require one or more mental health, physical health, and social services. That is, any one of the problems may require the efforts of several programs, concurrently and over time. This is even more likely to be the case when an individual has more than one problem. And, in any instance where more than one program is indicated, it is evident that inter-ventions should be coordinated and, if feasible, integrated.

A. A Continuum of Community-School Programs: Primary Prevention through Treatment

To illustrate the comprehensive range of programs needed, a continuum is outlined on the following page. The continuum ranges from programs for primary prevention (including the promotion of mental health) and early-age intervention -- through those for addressing problems soon after onset -- on to treatments for severe and chronic problems. With respect to *comprehensiveness*, the range of programs highlights that many problems must be addressed developmentally and with a range of programs --some focused on individuals and some on environmental systems, some focused on mental health and some on physical health, education, and social services. With respect to concerns about *integrating* programs, the continuum underscores the need for concurrent inter-program linkages and for linkages over extended periods of time.

When behavior, emotional, and learning problems are labeled in ways that overemphasize internal pathology, the helping strategies used primarily are some

form of clinical/remedial intervention. For the most part, such interventions are developed and function in relative isolation of each other. Thus, they represent another instance of using piecemeal and fragmented strategies to address complex problems. One result is that an individual identified as having several problems may be involved in programs with several professionals working independently of each other.

Caution:

As community agencies and schools struggle to find ways to finance programs for troubled and troubling youth, they continue to tap into resources that require assigning youngsters labels that convey severe pathology. Reimbursement for mental health and special education interventions is tied to such diagnoses. This fact dramatically illustrates how social policy shapes decisions about who receives assistance and the ways in which problems are addressed. It also represents a major ethical dilemma for practitioners. That dilemma is not whether to use labels, but rather how to resist the pressure to inappropriately use those labels that yield reimbursement from third party payers.

From Primary Prevention to Treatment of Serious Problems: A Continuum of Community-School Programs to Address Barriers to Learning and Enhance Healthy Development

Intervention Continuum

Examples of Focus and Types of Intervention (Programs and services aimed at system changes and individual needs)

Primary prevention

1. Public health protection, promotion, and maintenance to foster opportunities, positive development, and wellness
 - economic enhancement of those living in poverty (e.g., work/welfare programs)
 - safety (e.g., instruction, regulations, lead abatement programs)
 - physical and mental health (incl. healthy start initiatives, immunizations, dental care, substance abuse prevention, violence prevention, health/mental health education, sex education and family planning, recreation, social services to access basic living resources, and so forth)

Early-after-onset intervention

2. Preschool-age support and assistance to enhance health and psychosocial development
 - systems' enhancement through multidisciplinary team work, consultation, and staff development
 - education and social support for parents of preschoolers
 - quality day care
 - quality early education
 - appropriate screening and amelioration of physical and mental health and psychosocial problems
3. Early-schooling targeted interventions
 - orientations, welcoming and transition support into school and community life for students and their families (especially immigrants)
 - support and guidance to ameliorate school adjustment problems
 - personalized instruction in the primary grades
 - additional support to address specific learning problems
 - parent involvement in problem solving
 - comprehensive and accessible psychosocial and physical and mental health programs (incl. a focus on community and home violence and other problems identified through community needs assessment)
4. Improvement and augmentation of ongoing regular support
 - enhance systems through multidisciplinary team work, consultation, and staff development
 - preparation and support for school and life transitions
 - teaching "basics" of support and remediation to regular teachers (incl. use of available resource personnel, peer and volunteer support)
 - parent involvement in problem solving
 - resource support for parents-in-need (incl. assistance in finding work, legal aid, ESL and citizenship classes, and so forth)
 - comprehensive and accessible psychosocial and physical and mental health interventions (incl. health and physical education, recreation, violence reduction programs, and so forth)
 - Academic guidance and assistance
 - Emergency and crisis prevention and response mechanisms
5. Other interventions prior to referral for intensive and ongoing targeted treatments
 - enhance systems through multidisciplinary team work, consultation, and staff development
 - short-term specialized interventions (including resource teacher instruction and family mobilization; programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts)

Treatment for severe/chronic problems

6. Intensive treatments
 - referral, triage, placement guidance and assistance, case management, and resource coordination
 - family preservation programs and services
 - special education and rehabilitation
 - dropout recovery and follow-up support
 - services for severe-chronic psychosocial/mental/physical health problems

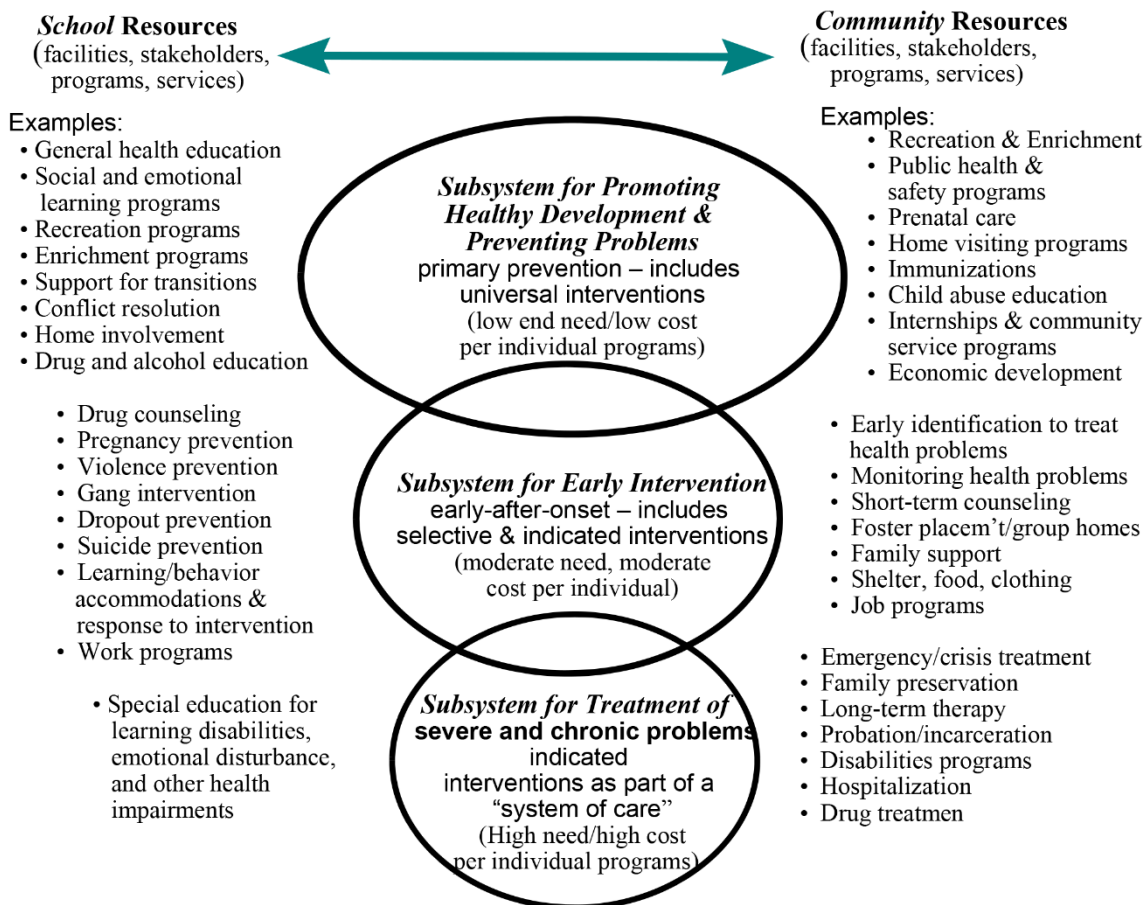
Figure 2. Interconnected subsystems for meeting the needs of all students.

Graphically portrayed below are three subsystems:

- promote healthy development and prevent problems,
- intervene early to address problems as soon after onset as is feasible, and
- assist with chronic and severe problems.

(a) each level represents a subsystem, (b) the three subsystems overlap, and (c) all three require integration into an overall system that weaves together school and community resources. Note that this framework expands thinking beyond the multitiered framework that schools tend to use.

Exhibit 3.3 Intervention Continuum: Interconnected Subsystems



B. Accommodations to Reduce Problems

It is easy to fall into the trap of thinking that corrective interventions for problems always should be directed at a specific individual. Adopting an interactional view, however, points to an expanded set of options regarding who or what should be the object of change (see Figure).

Currently, when a person is identified as having problems, efforts are made, directly or indirectly, to produce changes in the individual. Direct efforts include remediation, psychotherapy, and medically-related approaches. Indirect efforts include changing the way parents and teachers interact with youngsters.

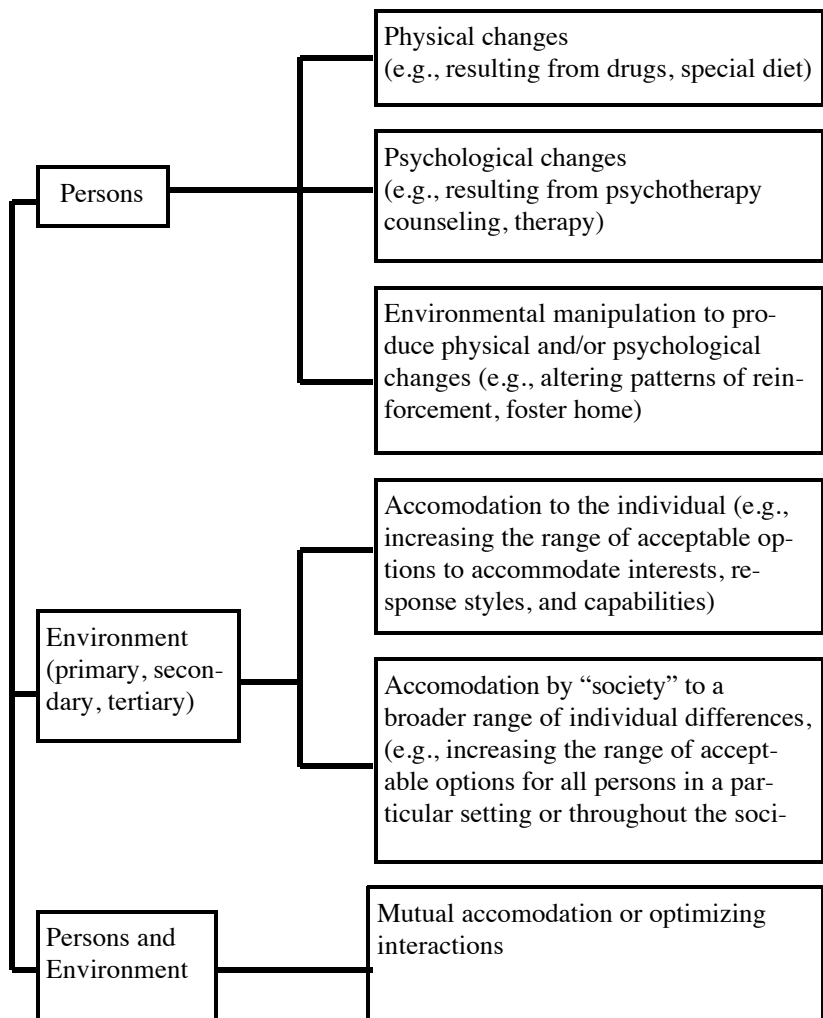
Interventions designed to change the individual may be the most appropriate choice in any given case. Sometimes, however, the environment needs to change in ways that attempt to accommodate rather than modify individual differences. Such environmental changes are not the same as modifying the environment as an indirect way of changing the individual.

Instructing parents and teachers to be more discriminating in their use of reinforcement contingencies is meant to be an indirect way of changing the child. It is not a strategy for teaching parents and teachers the value of offering additional options whenever appropriate and feasible -- such as increasing the range of choices about what a child is allowed to do and how the child is allowed to pursue a chosen option. It also is not the same as helping them and others in the society to understand the impact of appropriately changing their expectations about what is acceptable behavior, performance, and progress.

The implications of an expanded focal point for intervention are immense. For one, environments and the interactions between persons and environments become primary concerns for assessment activity and corrective interventions. Problem prevention efforts expand to include pro-grams that encourage accommodation of a wider range of individual differences in schools and society. And the broadened perspective works against presumptions about dysfunctions within people as the source of most problems.

Options Related to Focal Point of Intervention

(Who or what is to be the object of change)



Accommodations for Individuals with Disabilities is More than a Good Idea--it's the Law

From an article by Michael Perla, Ed. S., NCSP, Cobb County (GA) Public Schools

Section 504 An Introduction for Parents

Background

Section 504 is part of the Rehabilitation Act of 1973, and applies to all institutions receiving federal financial assistance, such as public schools. The law essentially places an obligation on public schools to provide a "free appropriate public education" to children with disabilities, along with related services such as transportation and counseling. The main purpose of 504 is to prohibit discrimination while assuring that disabled students have educational opportunities and benefits equal to those provided to non-disabled students. The Office of Civil Rights (OCR) monitors compliance under 504. Unlike special education laws, Section 504 does not provide financial support to schools.

A student is considered to be handicapped under 504 if he or she (1) has a physical or mental impairment that substantially limits one or more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment. Limiting a major life activity is an important part of this definition and includes handicaps that limit taking care of oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing or learning. The last example, learning, is the one frequently considered in 504 cases in the schools. Section 504 requires school districts to offer services to some children who might not qualify for special education benefits under the Individuals with Disabilities Education Act of 1990 (IDEA; this federal act funds special education services). For example, children who have AIDS, asthma and diabetes may all be covered under Section 504.

Eligibility/ Assessment/ Accommodations Under 504

Schools must notify parents of their rights regarding identification, evaluation and placement of children with suspected handicaps prior to starting a Section 504 evaluation. In addition, students who are not found eligible under IDEA should be considered for possible eligibility under Section 504. In a 504 referral, the school often tries to determine: (1) Does the student have a physical or mental

impairment? (2) Does the impairment affect one of the major life activities? If the answers to these questions are yes, the student may be entitled to a Section 504 accommodation plan. Accommodations must be based on a child's educational needs and may include curricular, classroom, school and grading modifications.

Section 504 requires school districts to develop detailed procedures for identifying and serving children with disabilities. Like other special education laws, 504 requires schools to conduct activities that will help locate and identify children who have disabilities and are not currently receiving needed special services.

Parental Rights and Procedures Under 504

Referral: Parents, guardians or school personnel may refer students suspected of having a handicap to the Section 504 coordinator or similar personnel. Potential candidates for 504 services include children with cancer, communicable diseases, medical conditions and Attention Deficit Hyperactivity Disorder...

Services under 504: If a child is found eligible under 504, services are primarily provided in the regular education classroom. The types of services offered might include the use of behavioral management techniques (e.g., a token economy), adjusting class schedules, mollifying tests and tailoring homework assignments.

Home-school collaboration: Parents can help increase the likelihood that 504 plans are effective by working closely with general educators and other school personnel to implement intervention programs both at school and at home. Regular parent-teacher conferences are likely to help foster this relationship.

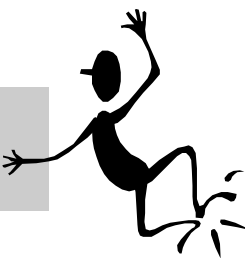
Resources for Parents

Laura Rothstein and Scott F. Johnson (2013). *Special Education Law*, Fifth Edition
Thousand Oaks: Sage.

A parent's guide to Section 504 in public schools
<https://www.greatschools.org/gk/articles/section-504-2/>

Ideas into Practice

Asking for Accommodations



PPrimary health care providers, parents, and others who identify youngsters experiencing behavior, emotional, and learning problems need to know about Section 504 of the 1973 Rehabilitation Act.

Section 504 is anti-discrimination, civil rights legislation (not a grant program). It provides a basis to seek accommodations at school not only for students

who are eligible under the Individuals with Disabilities Education Act (IDEA) but for any who are identified as having some physical or mental impairment that affects a major life activity, such as learning at school. Accommodations to meet educational needs may focus on the curriculum, classroom and homework assignments, testing, grading, and so forth. Such accommodations are primarily offered in regular classrooms.

Below is a fact sheet developed by folks in New Mexico to provide a quick overview. (Thanks to Steve Adelsheim for sharing it!)

General Purpose

Section 504 is a broad civil rights law which protects the rights of individuals with "disabilities" in programs and activities that receive federal financial assistance from the U.S. Department of Education.

Who is protected?

Section 504 protects all school-age children who qualify as disabled, i.e., (1) has or (2) has had a physical or mental impairment which substantially limits a major life activity or (3) is regarded as disabled by others. Major life activities include walking, seeing, breathing, teaming, working, caring for oneself and performing manual tasks. The disabling condition need only limit one major life activity in order for the student to be eligible. Children receiving special education services under the Individual's with Disabilities Act (IDEA) are also protected by Section 504.

Examples of potential 504 disabling conditions not typically covered under IDEA are:

- *communicable diseases
- *Tuberculosis
- *HIV/AIDS
- *medical condition (asthma, allergies, diabetes, heart disease)
- *temporary conditions due to illness or accident
- *Attention Deficit Hyperactivity Disorder
- *behavioral difficulties
- *drug/alcohol addiction (if the student is no longer using drugs/alcohol)

A 504 plan provides:

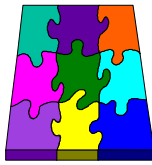
- *an evaluation based on current levels of performance, teacher reports, and documentation of areas of concern
- *the development/implementation of an accommodation plan which specifies "reasonable" modifications in order for the student to benefit from his/her educational program;
- *procedural safeguards for students and parents including written notification of all District decisions concerning the student's evaluation or educational placement and due process;
- *review and re-evaluation of modifications and placement on a regular basis and prior to any change in placement.

A 504 plan should be considered when:

- *a student shows a pattern of not benefiting from the instruction being provided
- *retention is being considered
- *a student returns to school after a serious illness or injury
- *long-term suspension or expulsion is being considered
- *a student is evaluated and found not eligible for Special Education services or is transitioning out of Special Education
- *a student exhibits a chronic health or mental health condition
- *substance abuse is an issue
- *when a student is "at risk" for dropping out
- *when a student is taking medication at school

For more information, contact your local school administration.

Broadening the Concept of Cultural Competence



Because many young people experience biases and prejudices associated with one or more "cultural differences," the *Family and Youth Services Bureau** has taken pains to define cultural diversity. An African American lesbian, for example, is tied to, and sometimes torn between, communities of color, gender, and sexual orientation, and may have experienced different forms of racist, sexist, and homophobic attitudes in each. The following expanded definitions, therefore, are meant to foster appreciation of the need to develop cultural competence. Each factor, of course, must be considered in the context of individual experience.

•**Ethnic/Racial Background:** Any of the different varieties or populations of human beings distinguished by physical traits, blood types, genetic code patterns, or inherited characteristics unique to an isolated breeding population. People from different racial backgrounds have diverse perspectives, customs and social up-bringing. Because of the historically dominant nature of a majority culture, most people have little exposure to different racial cultures.

•**Gender Culturalization:** Societal influences, messages, or "training" to behave in a certain ways based on one's gender. The majority culture in most parts of the world is the patriarchy, where male 'qualities' are more valued and men are provided access to greater opportunity. Thus, in very insidious ways, young girls and boys are acculturated differently, which affects their sense of self-worth and ability to fulfill their potential.

•**Socioeconomic/Educational Status:** Involving both social and economic factors and/or access to educational opportunities. A person's socioeconomic status can be a major factor in development as it relates to access to opportunity, social status, the ability to meet primary survival needs (food, clothing, shelter), and the messages received about what can be hoped for and attained. Closely related to socioeconomic status is access to educational opportunities that result in exposure to new ideas, the ability to think critically, and a willingness to consider different points of view.

•**Sexual Orientation:** A person's interest in, or innate desire to, develop emotional and physical relationships that are heterosexual, homosexual, or bisexual. The majority culture sanctions heterosexual behavior as the norm. Homosexuals and bisexuals, therefore, have been forced to keep their sexual orientation private, often out of fear, and those struggling with gender identity issues face similar isolation. Homo-phobia remains a public acceptable discrimination.

•**Physical Capacity:** The ability to function or perform tasks based on one's physical capabilities or limitations. The majority culture has until recently created systems and structures primarily suited for those with full physical capacity, and has devalued people without such capacity. Passage of the Americans with Disabilities Act now requires local organizations to modify systems and structures to provide broader access to persons with disabilities.

•**Age/Generational:** The distinct phases of human development, both innate and socialized; the beliefs/attitudes/values of persons born during the same period of time. Each generation has its own distinct culture, and values, based on the time they were born, lived as children, and transitioned to adulthood. The division between youth, adults, and the elderly has become more pronounced due to family relocations and breakdowns in intergenerational activities.

•**Personality Type:** The patterns and qualities of personal behavior as expressed by physical, emotional, or intellectual activities or responses to situations and people. People have innate personality types that affect their interaction with others. Extroverts, for example, may be more comfortable in large group settings, while introverts, who can adapt to such settings, may draw strength from their private time. While personality type is affected by age, experience, and circumstance, key personality-related preferences and styles remain with most people throughout their lifetime.

•**Spirituality/Religious Beliefs:** Of the spirit or soul as distinguished from material matters; characterized by the adherence to a religion and its tenets or doctrines. There are numerous religions, both formal and informal, that guide people's lives. Each has its own distinct traditions and belief systems. Further, while some people do not belong to an organized religion, they believe in spiritual feelings and the connectedness between people with certain values.

•**Regional Perspectives:** The words, customs, etc., particular to a specific region of a country or the world. Each corner of the world, and even the regions within a country, has traditions, rites of passage, learning experiences, and customs that are unique. Working with people requires an understanding of the special perspectives/life experiences they acquired growing up in different parts of the world.

•**New Immigrant Socialization:** The adaptation process of those recently relocated to a new environment. Relocating to a new country or region of the world requires adapting to new sights, sounds, and customs. This process is typically different for each generation of a family, with young people often adapting more quickly to the new culture. These differential adaptation patterns can affect the family unit as much as the change in culture itself.

Getting Started...and Moving On...

Planning, Implementing and Evaluating Cultural and Linguistic Competency for Comprehensive Community Mental Health Services for Children and Families

Implications for Systems of Care

This checklist was developed by the National Center for Cultural Competence (NCCC). It is one in a series designed to assist organizations and systems of care to develop policies, structures and practices that support cultural and linguistic competence. This checklist focuses on systems of care and organizations concerned with the delivery of services and supports to children and youth with emotional, behavioral and mental disorders and their families. Cultural competence is a key principle that must be integrated within all aspects of systems of care. This checklist is also designed to support efforts by the Child, Adolescent and Family Branch, Substance Abuse and Mental Health Services Administration, U.S. Department of Health & Human Services to eliminate racial and ethnic disparities in mental health.

Nationally, systems of care and organizations are attempting to respond effectively to the needs of children, youth and families from culturally and linguistically diverse groups. There is no one method for getting started on the journey towards cultural and linguistic competency—at either the individual or system level. Organizations may embark on this journey at different points of departure with different estimated times of arrival for achieving specific goals and outcomes. Health care, mental health and human service organizations are at various stages along the cultural competence continuum. Similarly, their personnel have different levels of awareness, knowledge and skills related to cultural and linguistic competence. Few organizations or systems of care have evolved to a degree of proficiency in which cultural and linguistic competency is infused at the levels of policy, administration, practice and service delivery, and consumer/family engagement (Modified from Cross, et al., 1989). This checklist provides guidance for *getting started ... and moving on!*

- **Create a structure.** Convene work groups with the sole purpose of addressing cultural and linguistic competency. A work group can be created by the governance body for the system of care and in each of the partner agencies and organizations. Work groups should have representation from all levels of a given organization. Such groups should also reflect the diversity within the organization and community at large—including youth and families. A work group can serve as the primary body to plan, implement and provide oversight to the organization's and system's cultural competence efforts.
- **Clarify values and philosophy.** Ensure that the organizations and agencies within the system of care have values, principles and/or mission that incorporate culture as an integral aspect of all of their endeavors. Use an inclusive process to re-visit and if necessary amend the organization's values and mission. The inclusion of families, youth and community constituency groups can enrich this process.
- **Develop a logic model for cultural and linguistic competence.** There are numerous concepts and definitions for cultural and linguistic competence. Reach consensus on a definition or framework for cultural competence *and* linguistic competence within the context of your organization and the communities it serves. Engage key stakeholders in this process. This process is also beneficial to partner organizations and agencies to reach consensus on a logic model for cultural and linguistic competence for the entire system of care. A work group may assume leadership or facilitate these efforts at the organization and system level.
- **Keep abreast of community demographics.** Identify the racially, ethnically, culturally and linguistically diverse populations served by the system of care as a whole and each partner agency and organization. Compare this information with the demographics of the geographic area. Determine and address any disparity in access and utilization of services. Be cognizant of the sub-cultures and within-group differences among these populations.
- **Assess family and youth satisfaction.** Use multifaceted approaches to assess the degree to which youth and families are satisfied with services they receive. Include probes that elicit the extent to which families and youth feel their belief systems and cultural practices are respected and integrated in the care they receive. Telephone interviews, written surveys and focus groups are commonly used processes. Key informants or cultural brokers can provide guidance on approaches to best assess consumer satisfaction that are consistent with the cultural norms of youth, families and communities.
- **Create structures for family and youth involvement.** Families and youth should be integrally involved in the design and implementation of services they receive. Establish governance boards, advisory committees, task forces and work groups to facilitate the meaningful involvement of families and youth in all aspects of your organization. Ensure an environment where trust, respect and shared power are highly valued and required.

DEFINITIONS

Cultural Competence

The NCCC embraces a conceptual framework and definition of cultural competence that requires organizations to:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- have the capacity to (1) value diversity; (2) conduct self-assessment, (3) manage the dynamics of difference, (4) adapt to diversity and the cultural contexts of the communities they serve.
- incorporate the above in all aspects of policy development, administration, and practice/service delivery and involve consumers/families systematically (Modified from Cross, et al., 1989).

Linguistic Competence

Linguistic competence is the capacity of an organization and its personnel to communicate effectively with persons of limited English proficiency, those with low literacy skills or who are not literate, and individuals with disabilities. The organization must have policy, structures, practices and procedures and dedicated resources to support this capacity (Goode & Jones, 2002).

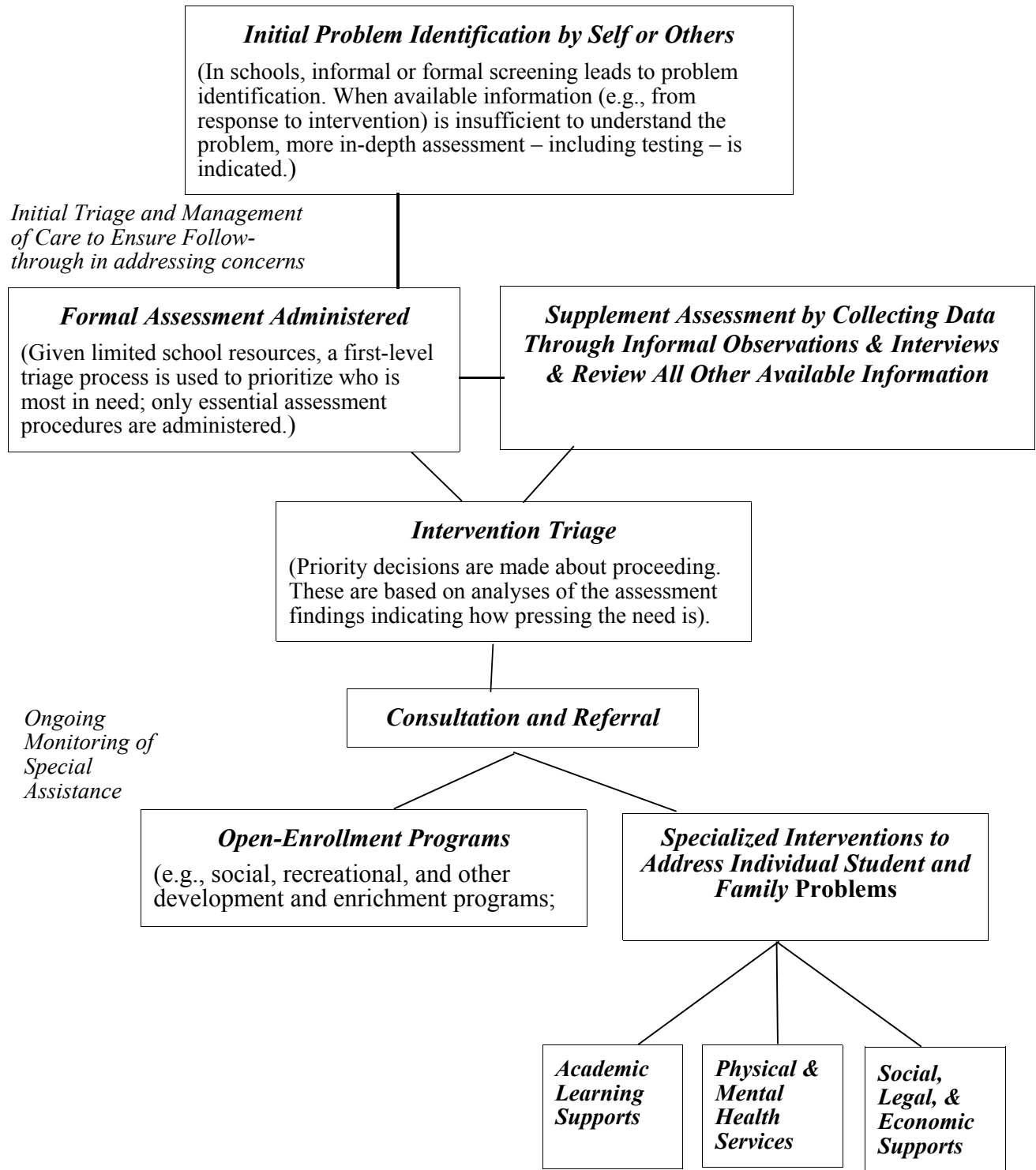
Logic Model

For the purposes of this document the term logic model refers to a visual schematic that summarizes the relationship between the resources, activities and outcomes of a culturally and linguistically competent system of care (Santiago, 2003).

- **Conduct a self-assessment.** Assessing attitudes, policies, structures and practices is a necessary, effective and systematic way to plan for and incorporate cultural and linguistic competence in organizations. Determine which instruments and consultants best match your needs and interests. The self-assessment process should include families, youth and other key stakeholders.
- **Create a plan for achieving cultural and linguistic competence.** Use the self-assessment results to develop an organizational plan for achieving and/or enhancing cultural and linguistic competence. Such results may lead to changes in: organizational values, mission, policies and structures; budgets/allocation of fiscal resources; composition of advisory boards and committees; strategic planning processes; staffing patterns, position descriptions and personnel performance measures; approaches to practice, treatment and interventions; delivery of supportive services; quality assurance and evaluation methods; approaches to community engagement and information dissemination; professional development and inservice training activities; management information systems; telecommunication systems; and facility design and décor. Develop an action plan and allocate resources to support this process.
- **Determine staff and volunteer development needs/interests.** Conduct periodic assessments of organizational personnel and volunteers, including family organizations and youth groups, to determine their needs and interests related to cultural and linguistic competence. The assessment should query persons on the preferred methods, approaches and formats for increasing awareness and acquiring new skills and areas of knowledge. Ensure that resources are budgeted to support these efforts.
- **Engage communities.** Develop partnerships that acknowledge strengths and build upon the resiliency and the many networks of support within diverse communities. Communities have the inherent ability to recognize their own problems, including the health of their members, and intervene appropriately on their own behalf (Goode, 2002). Expand collaborative relationships to include natural helpers, community informants, cultural brokers, faith-based organizations, ethnic-specific and advocacy organizations and local merchants. Give careful consideration to delineating the values and principles that underpin community engagement.
- **Adopt or adapt “lessons learned”.** Network within and dialog with other organizations or systems of care that focus on children and youth with emotional, behavioral and mental disorders and their families that have begun the journey of achieving cultural and linguistic competency. Consider the following: (1) reviewing their policies and practices, (2) adapting those that are consistent with your philosophy of care, and (3) negotiating opportunities for mentoring, training, consultation and technical assistance. Access resources from public and private sector centers and programs that have expertise in cultural and linguistic competence (e.g. integrated therapies, indigenous practices, in-home services, health literacy, advocacy and community outreach/engagement and youth and family partnerships). Gather and categorize resource materials to expand your organization’s library/resource center.
- **Create a refuge for sharing and learning.** Provide safe, non-judgmental forums for personnel and volunteers, including family organizations, to honestly explore cultural considerations—their own and those of the children, youth, families and communities they serve. Including youth, families and community partners can inform and enhance these experiences.

Developing Systems at a School for Problem Identification, Triage, Referral and Management of Care*

Processes for Problem Identification, Triage, Referral, & Management of Interventions



Note: Proper application of special assistance involves ongoing assessment, information sharing, and care monitoring and management. These processes can be facilitated by a computerized information management system (with effective privacy safeguards).

The following outline highlights matters to be considered as a school develops its systems for problem identification, triage, referral, and management of care.

Problem identification

- (a) Problems may be identified by anyone (staff, parent, student).
- (b) There should be an Identification Form that anyone can access and fill out.
- (c) There must be an easily accessible place for people to turn in forms.
- (d) All stakeholders must be informed regarding the availability of forms, where to turn them in, and what will happen after they do so.

Triage processing

- (a) Each day the submitted forms must be reviewed, sorted, and directed to appropriate resources by a designated and trained triage processor. Several individuals can share this task; for example, different persons can do it on a specific day or for specified weeks.
- (b) After the sorting is done, the triage processor should send a Status Information Form to the person who identified the problem (assuming it was not a self-referral).

Clients directed to resources or for further problem analysis and recommendations

- (a) For basic necessities of daily living (e.g., food, clothing, etc.), the triage processor should provide information about resources either through the person who identified the problem or directly to the student/family in need.
- (b) If the problem requires a few sessions of immediate counseling to help a student/ family through a crisis, the triage processor should send the form to the person who makes assignments to on-site counselors.
- (c) The forms for all others are directed to a small triage "team" (1-3 trained professionals) for further analysis and recommendations. (If there is a large case load, several teams might be put into operation.) Members of such a team may not have to meet on all cases; some could be reviewed independently with recommendations made and passed on the next reviewer for validation. In complex situations, however, not only might a team meeting be indicated, it may be necessary to gather more information from involved parties (e.g., teacher, parent, student).

Interventions to ensure recommendations and referrals are pursued appropriately

- (a) In many instances, peripheral interventions should be recommended. This means a site must be equipped to implement and monitor the impact of such recommendations.
- (b) When students/families are referred for health and social services, procedures should be established to facilitate motivation and ability for follow-through. Care management should be designed to determine follow-through, coordination, impact, and possible need for additional referrals.
- (c) Referrals to assess the need for special or compensatory education often are delayed because of a waiting list. Back logs should be monitored and arrangements made to catch-up (e.g., by organizing enough released time to do the assessments and reviews).

Management of care (case monitoring and management)

- (a) Some situations require only a limited form of monitoring (e.g., to ensure follow-through). A system must be developed for assigning care monitors as needed. Aides and paraprofessionals often can be trained to for this function.
- (b) Other situations require intensive management by specially trained professionals to (1) ensure interventions are coordinated/integrated and appropriate, (2) continue problem analysis and determine whether appropriate progress is made, (3) determine whether additional assistance is needed, and so forth. There are many models for intensive management of care. For example, one common approach is to assign the responsibility to the professional who has the greatest involvement (or best relationship) with the student/family.
- (c) One key and often neglected function of the care manager is to provide appropriate status updates to all parties who should be kept informed.

D. Treatments for Psychosocial Problems and Disorders

A continuum of interventions for addressing psychosocial problems was presented at the beginning of section II. It is easy to conceptualize a comprehensive set of interventions. It is excruciatingly hard to (1) establish such a range of programs, (2) integrate those that are in operation, and (3) conduct the type of research that advances understanding.

Given the difficulty in establishing comprehensive, integrated programmatic efforts, it is not surprising that research on this topic is almost nonexistent. Physical and mental health programs, for example, rarely are coordinated with each other or with social service, educational, and vocational programs, and thus illustrate the problem of piecemeal and fragmented intervention.

For the most part, programs for each type of problem are developed and function separately. An individual identified as having several problems may be involved in counseling with several professionals working independently of each other.

Deficiencies related to comprehensiveness and interface are attributable in significant measure to the way interventions are conceived and organized and the way professionals understand their roles and functions. Most practitioners and intervention researchers spend the majority of their time working directly with specific interventions and samples and give little thought or time to comprehensive models of mechanisms for program development and collaboration.

There is agreement in making general decisions about intervening for problems that activity should be kept to the necessary minimum. For example, if an individual with emotional problems can be helped effectively at a community agency, this seems better than placing the person in a mental hospital. For special education populations, when a student with learning or behavior problems can be worked with effectively in a regular classroom, placement in a special education program is inappropriate. There is strong disagreement, however, in treatment orientations. Should one focus on underlying factors, on observable behaviors, or both?

The *underlying factors* orientation is based on the assumption that many problems in functioning are symptoms of an underlying problem. As outlined in the Table, practitioners adopting this orientation hypothesize and attempt to address motivational and developmental differences.

The roots of the orientation are found in medical,

psycho-therapeutic, and educational concepts. For instance, emotional distress is identified as underlying a behavior problem. In turn, the emotional distress is seen as psychologically based.

Corrective interventions emerging from the underlying factors orientation usually are built on assessments designed to analyze areas such as perceptual, motor, cognitive, language, social, and emotional functioning. In addition, psychoneurological or neurological testing may be done to aid diagnosis. Intervention strategies draw on psycho-therapeutic principles. Examples are application of broad-based psychodynamic principles, use of social interaction and modeling, rapport building to reduce anxiety and increase positive involvement, and so forth. When underlying factors appear resistant to treatment, interveners teach individuals ways to compensate for their problems. And although the primary overall concern is with underlying factors, intervention rationales may also designate provision of support for ongoing growth and learning.

In contrast, interveners adopting an *observable factors orientation* see no value in assumptions about underlying factors. Instead, individuals with problems are seen as not yet having learned necessary skills or as having acquired interfering behaviors.

The conceptual roots of the observable factors orientation are in behaviorism (operant and cognitive behavior modification). Proponents of this approach assess knowledge and skills directly associated with daily life tasks. Performance below prevailing standards for an individual's level of development is seen as indicating missing capabilities. Behavioral objectives are formulated to teach these missing capabilities and to address any interfering behaviors. Direct intervention approaches are stressed, such as eliciting and reinforcing specific responses and instruction in cognitive self-direction and monitoring. That is, corrective strategies emphasize direct and systematic teaching and behavior management drawing on behavior change principles.

Because neither orientation is sufficiently effective over the long run, proponents in each camp have looked to contemporary cognitive concepts and methods in evolving their approaches. Essentially, they have incorporated instruction of efficient strategies for planning, self-direction, remembering, self-monitoring, problem solving, and so forth. Currently, *metacognitive strategies* are widely used in both camps. Proponents of the two prevailing orientations adapt such strategies to fit in with their own views. That is, those with an underlying factors orientation view metacognitive strategies as an underlying ability or as a way for an individual to compensate for an area of dysfunction.

Advocates of observable factors see metacognitive strategies as another set of skills clients should acquire through direct instruction.

Treatment and remedial approaches in psychology and education have been described extensively in books and journals. One reads about counseling, behavior modification, psychodynamic therapy, remedial techniques, rehabilitation, metacognitive strategies, and so forth.

Table: Contrasting Orientations to Treatment and Remediation

	UNDERLYING FACTORS ORIENTATION	OBSERVABLE FACTORS ORIENTATION
PRIMARY OVERALL CONCERN	Motivational and developmental differences and disabilities that disrupt desired functioning	Unlearned skills and interfering behavior
	Specific Areas of Concern <i>Motivation</i> • reactive motivation problems • proactive motivation problems <i>Development</i> • perceptual problems • motor problems • cognitive problems • language problems • social problems • emotional problems <i>Knowledge, skills, and attitudes to compensate for disabilities</i>	Specific Areas of Concern Knowledge and skills relevant for performing life tasks • readiness needs • contemporary task needs • general life adjustment needs Interfering behaviors (e.g., poor impulse control, lack of sustained attention)
SECONDARY CONCERNS	Enhancing intrinsic motivation knowledge and skills relevant for performing life tasks	
TERTIARY CONCERNS	Interfering behaviors	
PROCESS COMPONENTS	Assessment Construct-oriented assessment of developmental and motivational functioning as a basis for program planning and evaluation Form of Objectives Nonbehavioral, as well as behavioral and criterion-referenced objectives Treatment/Remedial Rationale and Methods Therapeutic-oriented interventions (primary emphasis on establishing rapport through interpersonal dynamics and use of a variety of intervention models) • counseling and psychotherapy • expanded life task options and choices • minimized coercion • enhanced interpersonal option • accommodation of a wide range of motivational and developmental differences • exercises intended to correct developmental anomalies and accelerate lagging development • eclectic instruction related to compensatory strategies • eclectic strategies for reducing interfering behaviors	Assessment Task-based assessment of knowledge and sequential skills as a basis for program planning and evaluation Form of Objectives Behavioral and criterion-referenced objectives Treatment/Remedial Rationale and Methods Behavior change interventions (primary emphasis on establishing control over behavior through manipulation of reinforcers and use of cognitive self-direction and monitoring) • direct instruction to teach missing skills and information • behavior management to reduce interfering behaviors

III. FREQUENTLY IDENTIFIED PSYCHOSOCIAL PROBLEMS; DEVELOPMENTAL VARIATIONS, PROBLEMS, DISORDERS AND INTERVENTIONS

The American Academy of Pediatrics has produced a manual for primary care providers that gives guidelines for psychological behaviors that are within the range expected for the age of the child, problems that may disrupt functioning but are not sufficiently severe to warrant the diagnosis of a mental disorder, and disorders that do meet the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) of the American Psychiatric Association.

Just as the continuum of Type I, II, and III problems presented in Section 1A does, the pediatric manual provides a way to describe problems and plan interventions without prematurely deciding that internal pathology is causing the problems. The manual's descriptions are a useful way to introduce the range of concerns facing parents and school staff. Therefore, these descriptions provide the bases for the following presentation of five psychosocial problems commonly seen in school settings.

Overview

Included in this section are excerpts from a variety of sources, including government fact sheets and the classification scheme developed by the American Pediatric Association.

“Symptoms” are discussed in terms of degrees of severity and appropriate forms of intervention -- ranging from enviromental accommodations to behavior management to medication. Because the intent is only to provide a brief overview, also included is a set of references for further reading and a list of agencies that provide information on attention problems and interventions.

Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

This is one of a series of fact sheets on the mental, emotional, and behavior disorders that can appear in childhood or adolescence. The Center for Mental Health Services extends appreciation to the National Institute of Mental Health for contributing to the preparation of this fact sheet. Any questions or comments about its contents may be directed to the CMHS National Mental Health Services Knowledge Exchange Network (KEN)--see contact information below.

What Is Attention-Deficit/Hyperactivity Disorder?

Young people with attention-deficit/hyperactivity disorder typically are overactive, unable to pay attention, and impulsive. They also tend to be accident prone. Children or adolescents with attention-deficit/hyperactivity disorder may not do well in school or even fail, despite normal or above-normal intelligence. Attention-deficit/hyperactivity disorder is sometimes referred to as ADHD.

What Are the Signs of Attention-Deficit/Hyperactivity Disorder? There are actually three different types of attention-deficit/hyperactivity disorder, each with different symptoms. The types are referred to as inattentive, hyperactive-impulsive, and combined attention-deficit/hyperactivity disorder.

Children with the inattentive type:

- have short attention spans;
 - are easily distracted;
 - do not pay attention to details;
 - make lots of mistakes;
 - fail to finish things;
 - are forgetful;
 - don't seem to listen; and
 - cannot stay organized.
- Children with the hyperactive-impulsive type:
- fidget and squirm;
 - are unable to stay seated or play quietly;
 - run or climb too much or when they should not;
 - talk too much or when they should not;
 - blurt out answers before questions are completed;
 - have trouble taking turns; and
 - interrupt others.

In this fact sheet, "Mental Health Problems" for children and adolescents refers to the range of all diagnosable emotional, behavioral, and mental disorders. They include depression, attention-deficit/hyperactivity disorder, and anxiety, conduct, and eating disorders. Mental health problems affect one in every five young people at any given time.

"Serious Emotional Disturbances" for children and adolescents refers to the above disorders when they severely disrupt daily functioning in home, school, or community. Serious emotional disturbances affect 1 in every 10 young people at any given time.

Combined attention-deficit/hyperactivity disorder, the most common type, is a combination of the inattentive and the hyperactive-impulsive types.

A diagnosis of one of the attention-deficit/hyperactivity disorders is made when a child has a number of the above symptoms, and the symptoms began before the age of 7 and lasted at least 6 months. Generally, symptoms have to be seen in at least two different settings (for example, at home and at school) before a diagnosis is made.

How Common Is Attention-Deficit/Hyperactivity Disorder?

Attention-deficit/hyperactivity disorder is found in as many as 1 in every 20 children. Studies have shown that boys with attention-deficit/hyperactivity disorder outnumber girls with the disorder about three to one.²

Children and adolescents with attention-deficit/hyperactivity disorder are at risk for many other disorders. About half of all young people with attention-deficit/hyperactivity disorder also have oppositional or conduct disorder, and about a fourth have an anxiety disorder. As many as one-third have depression, and about one-fifth have a learning disability. Sometimes a child or adolescent will have two or more of these disorders in addition to attention-deficit/hyperactivity disorder. Also, children with attention-deficit/hyperactivity disorder are at risk for developing personality disorders and substance abuse disorders when they are adolescents or adults.

Attention-deficit/hyperactivity disorder is a major reason why children are referred for mental health care. Boys are more likely to be referred for treatment than girls, in part because many boys with attention-deficit/hyperactivity disorder also have conduct disorder. The mental health services and special education required by children and

adolescents with attention-deficit/hyperactivity disorder cost millions of dollars each year. Underachievement and lost productivity can cost these young people and their families even more.

What Causes Attention-Deficit/Hyperactivity Disorder?

Many causes of attention-deficit/hyperactivity disorder have been studied, but no one cause seems to apply to all young people with the disorder. There is strong evidence that genetic factors are important. But other factors such as viruses, harmful chemicals in the environment, problems during pregnancy or delivery, or other things that impair brain development may play a role as well.

What Help Is Available for Families?

Many treatments-some with good scientific basis, some without-have been recommended for children and adolescents with attention-deficit/hyperactivity disorder. The best proven treatments are medication and behavior treatments.

Medication

The most widely used drugs for treating attention-deficit/hyperactivity disorder are stimulants, such as amphetamine (Dexedrine, Dextrostat, Desoxyn), methylphenidate (Ritalin), and pemoline (Cylert). Stimulants increase the activity in parts of the brain that are underactive in children and adolescents with attention-deficit/hyperactivity disorder. Experts believe that this is why stimulants improve attention and reduce impulsive, hyperactive, or aggressive behavior. Individuals may respond better to one medication than to another. For example, clonidine (Catapres) is often used, although its effectiveness has not been clearly shown. A few antidepressants may also work for some patients. Tranquilizers like thioridazine (Mellaril) have also been shown to work for some young people. Care must be used in prescribing and monitoring all medication.

Like most medications, those used to treat attention-deficit/hyperactivity disorder have side effects. When taking these medications, some children may lose weight, have a smaller appetite, and temporarily grow more slowly. Others may have trouble falling asleep. However, many doctors believe the benefits of medication outweigh the possible side effects. Side effects that do occur can often be handled by reducing the dosage.

Behavior Treatment

Behavior treatments include:

- teaching parents and teachers how to manage and modify the child's or adolescent's behavior, such as rewarding good behavior;
- a daily report card to link the home and school efforts (where the parent rewards the child or adolescent for good school performance and behavior);
- summer and Saturday programs;
- special classrooms that use intensive behavior modification; and
- specially trained classroom aides.

It is clear that both stimulants and behavior treatment can be helpful in the short run (a few weeks or months). However, it is not clear how long the benefit lasts. The Federal Government's National Institute of Mental Health is supporting research on the long-term benefits of various treatments as well as research to find out whether medication and behavior treatment are more effective when combined. There is also research on new medicines and other new treatments. Other Federal agencies carrying out research on attention-deficit/hyperactivity disorder include the Center for Mental Health Services and the Department of Education.

A child or adolescent in need of treatment or services and his or her family may need a plan of care based on the severity and duration of symptoms. Optimally, this plan is developed with the family, service providers, and a service coordinator, who is referred to as a case manager. Whenever possible, the child or adolescent is involved in decisions. Tying together all the various supports and services in a plan of care for a particular child and family is commonly referred to as a "system of care." A system of care is designed to improve the child's ability to function in all areas of life-at home, at school, and in the community. For a fact sheet on systems of care, call 1.800.789.2647.

Can Attention-Deficit/Hyperactivity Disorder Be Prevented?

Because there are so many suspected causes of attention- deficit/hyperactivity disorder, prevention may be difficult. However, it always is wise to obtain good prenatal care and stay away from alcohol, tobacco, and other harmful chemicals during pregnancy and to get good general health care for the child. These recommendations may be particularly important if attention-deficit/hyperactivity disorder is suspected in other family members. Knowing that attention-deficit/hyperactivity disorder is in the family can alert parents to take early action to prevent bigger problems.

What Else Can Parents Do?

When it comes to attention-deficit/hyperactivity disorder, parents and other caregivers should be careful not to jump to conclusions. A high energy level alone in a child or adolescent does not mean that he or she has attention-deficit/hyperactivity disorder. The diagnosis depends on whether the child or adolescent can focus well enough to complete tasks that suit his or her age and intelligence. This ability is most likely to be noticed by a teacher. Therefore, input from teachers should be taken seriously.

If parents or other caregivers suspect attention-deficit/hyperactivity disorder, they should:

- Make an appointment with a psychiatrist, psychologist, child neurologist, or behavioral pediatrician for an evaluation. (Check with the child's doctor for a referral.)
- If the young person is diagnosed with attention- deficit/hyperactivity disorder, be patient. The disorder may take a long time to improve.
- Instill a sense of competence in the child or adolescent. Promote his or her strengths, talents, and feelings of self-worth.
- Remember that failure, frustration, discouragement, low self- esteem, and depression, in many cases, cause more problems than the disorder itself.
- Get accurate information from libraries, hotlines, or other sources.
- Ask questions about treatments and services.
- Talk with other families in the community.
- Find family network organizations.

It is important that people who are not satisfied with the mental health care they are receiving to discuss their concerns with the provider, to ask for information, and/or to seek help from other sources.

In a "System of Care," local organizations work in teams-with families as critical partners-to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more information on systems of care, call 1.800.789.2647.)

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available-publications, references, and referrals to local and national resources and organizations-call 1.800.789.2647; TTY 301.443.9006 .

1. Developmental Variations: Behaviors within the Range of Expected Behaviors for That Age Group *

DEVELOPMENTAL VARIATION

Hyperactive/Impulsive

Variation

Young children in infancy and in the pre-school years are normally very active and impulsive and may need constant supervision to avoid injury. Their constant activity may be stressful to adults who do not have the energy or patience to tolerate the behavior.

During school years and adolescence, activity may be high in play situations and impulsive behaviors may normally occur, especially in peer pressure situations.

High levels of hyperactive/impulsive behavior do not indicate a problem or disorder if the behavior does not impair functioning.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Infants will vary in their responses to stimulation. Some infants may be overactive to sensations such as touch and sound and may squirm away from the caregiver, while others find it pleasurable to respond with increased activity.

Early Childhood

The child runs in circles, doesn't stop to rest, may bang into objects or people, and asks questions constantly.

Middle Childhood

The child plays active games for long periods. The child may occasionally do things impulsively, particularly when excited.

Adolescence

The adolescent engages in active social activities (e.g., dancing) for long periods, may engage in risky behaviors with peers.

SPECIAL INFORMATION

Activity should be thought of not only in terms of actual movement, but also in terms of variations in responding to touch, pressure, sound, light, and other sensations. Also, for the infant and young child, activity and attention are related to the interaction between the child and the caregiver, e.g., when sharing attention and playing together.

Activity and impulsivity often normally increase when the child is tired or hungry and decrease when sources of fatigue or hunger are addressed.

Activity normally may increase in new situations or when the child may be anxious. Familiarity then reduces activity.

Both activity and impulsivity must be judged in the context of the caregiver's expectations and the level of stress experienced by the caregiver. When expectations are unreasonable, the stress level is high, and/or the parent has an emotional disorder (especially depression ...), the adult may exaggerate the child's level of activity/impulsivity.

Activity level is a variable of temperament (...). The activity level of some children is on the high end of normal from birth and continues to be high throughout their development.

2. Problems—Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

PROBLEM

Hyperactive/Impulsive

Behavior Problem

These behaviors become a problem when they are intense enough to begin to disrupt relationships with others or begin to affect the acquisition of age-appropriate skills. The child displays some of the symptoms listed in the section on ADHD predominantly hyperactive/impulsive subtype. However, the behaviors are not sufficiently intense to qualify for a behavioral disorder such as ADHD, or of a mood disorder (see section on Sadness and Related Symptoms), or anxiety disorder (see section on Anxious Symptoms).

A problem degree of this behavior is also likely to be accompanied by other behaviors such as negative emotional behaviors or aggressive/oppositional behaviors.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

The infant squirms and has early motor development with increased climbing. Sensory underreactivity and overreactivity as described in developmental variations can be associated with high activity levels.

Early Childhood

The child frequently runs into people or knocks things down during play, gets injured frequently, and does not want to sit for stories or games.

Middle Childhood

The child may butt into other children's games, interrupts frequently, and has problems completing chores.

Adolescence

The adolescent engages in "fooling around" that begins to annoy others and fidgets in class or while watching television.

SPECIAL INFORMATION

In infancy and early childhood, a problem level of these behaviors may be easily confused with cognitive problems such as limited intelligence or specific developmental problems (...). However, cognitive problems and hyperactive/impulsive symptoms can occur simultaneously.

A problem level of these behaviors may also be seen from early childhood on, as a response to neglect (...), physical/sexual abuse (...), or other chronic stress, and this possibility should be considered.

3. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)

DISORDER

Attention-Deficit/Hyperactivity Disorder

Predominantly Hyperactive-Impulsive Type

This subtype should be used if six (or more) of the following symptoms of hyperactivity-impulsivity (but fewer than six symptoms of inattention [...]) have persisted for at least 6 months. They present before the age of 7 years. The symptoms need to be present to a significantly greater degree than is appropriate for the age, cognitive ability, and gender of the child, and the symptoms should be present in more than one setting (e.g., school and home).

Hyperactive-impulsive symptoms:

These symptoms must be present to a degree that is maladaptive and inconsistent with developmental level, resulting in significant impairment.

Hyperactivity

- often fidgets with hands/feet or squirms in seat
- often leaves seat in classroom or in other situations in which remaining seated is expected
- often runs about or climbs excessively in situation in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- often has difficulty playing or engaging in leisure activities quietly
- is often "on the go" or often acts as if "driven by a motor"
- often talks excessively

Impulsivity

- often blurts out answers before questions are completed
- often has difficulty awaiting turn
- often interrupts or intrudes on others

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

The infant squirms frequently and has early motor development with excessive climbing. The infant has a hard time focusing on people or objects and squirms constantly. The infant does not organize purposeful gestures or behavior. The infant may show interest in gross motor activities such as excessive climbing but may also have difficulties in motor planning and sequencing (imitating complex movements). However, these behaviors are nonspecific and a disorder diagnosis is extremely difficult to make in this age group.

Early Childhood

The child runs through the house, jumps and climbs excessively on furniture, will not sit still to eat or be read to, and is often into things.

Middle Childhood

The child is often talking and interrupting, cannot sit still at meal times, is often fidgeting when watching television, makes noise that is disruptive, and grabs from others.

Adolescence

The adolescent is restless and fidgety while doing any and all quiet activities, interrupts and "bugs" other people, and gets into trouble frequently. Hyperactive symptoms decrease or are replaced with a sense of restlessness.

SPECIAL INFORMATION

Specific environmental situations and stressors often make a significant contribution to the severity of these behaviors, though they are seldom entirely responsible for a disorder-level diagnosis of these behaviors. Situations and stressors that should be systematically assessed include:

Marital discord/divorce (...)
Physical abuse/sexual abuse (...)
Mental disorder of parent (...)
Other family relationship problems (...)

Difficulties with cognitive/adaptive skills, academic skills, and speech and language skills often lead to frustration and low self-esteem that contribute to the severity of these behaviors. These conditions may also co-exist with ADHD and therefore should be systematically assessed.

DISORDER, CONTINUED

Predominantly Hyperactive-Impulsive Type, Continued

Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years. Some impairment from the symptoms is present in two or more settings (e.g., at school and at home). There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning. The symptoms do not occur exclusively during the course of an autistic disorder (see following differential diagnostic information), and are not better accounted for by another mental disorder (see following differential diagnosis information).

Combined Type

This subtype should be used if criteria, six (or more) symptoms of hyperactivity-impulsivity and six (or more) of the symptoms of the inattention (...), have persisted for at least 6 months.

Attention-Deficit/Hyperactivity Disorder, NOS

(see DSM-IV Criteria ...)

COMMON DEVELOPMENTAL PRESENTATIONS

SPECIAL INFORMATION

Specific environmental situations and stressors often make a significant contributions to the severity of these behaviors, though they are seldom entirely responsible for a disorder-level diagnosis of these behaviors. Situations and stressors that should be systematically assessed include:

Marital discord/divorce, (...)
Physical abuse/sexual abuse, (...)
Mental disorder of parent, (...)
Other family relationship problems, (...)
Loss/bereavement, (...)

Difficulties with cognitive/adaptive skills, academic skills, and speech and language skills often lead to frustration and low self-esteem that both contribute to the severity of these behaviors. These conditions may also co-exist with ADHD and therefore should be systematically assessed.

Overview

In this section, the range of conduct and behavior problems are described using a government fact sheet and the classification scheme from the American Pediatric Association.

Differences in intervention needed are discussed with respect to variations in the degree of problem manifested and include exploration of environmental accommodations, behavioral strategies, and medication.

For those readers ready to go beyond this introductory presentation, we also provide a set of references for further study and, as additional resources, agencies and websites are listed that focus on these concerns.

Conduct Disorder in Children and Adolescents

This is one of a series of fact sheets on the mental, emotional, and behavior disorders that can appear in childhood or adolescence. The Center for Mental Health Services extends appreciation to the National Institute of Mental Health for contributing to the preparation of this fact sheet. Any questions or comments about its contents may be directed to the CMHS National Mental Health Services Knowledge Exchange Network (KEN)-see contact information below.

What Is Conduct Disorder?

Children with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely if the behavior continues for a period of 6 months or longer. Because of the impact conduct disorder has on the child and his or her family, neighbors, and adjustment at school, conduct disorder is known as a "disruptive behavior disorder."

Another disruptive disorder, called oppositional defiant disorder, often occurs before conduct disorder and may be an early sign of conduct disorder. Oppositional defiant disorder is diagnosed when a child's behavior is hostile and defiant for 6 months or longer. Oppositional defiant disorder can start in the preschool years, whereas conduct disorder generally appears when children are somewhat older. Oppositional defiant disorder is not diagnosed if conduct disorder is present.

What Are the Signs of Conduct Disorder?

Some symptoms of conduct disorder include:

- aggressive behavior that harms or threatens to harm other people or animals;
- destructive behavior that damages or destroys property;
- lying or theft; and
- skipping school or other serious violations of rules.
- Children with oppositional defiant disorder or conduct disorder may have other problems as well, including:
 - hyperactivity;
 - anxiety;
 - depression;
 - academic difficulties; and
 - problems with peer relationships.

In a "System of Care," local organizations work in teams-with families as critical partners-to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more information on systems of care, call 1.800.789.2647.)

How Common is Conduct Disorder?

As many as 1 in 10 children and adolescents may have conduct disorder.² Most children and adolescents with conduct disorder do not have lifelong patterns of conduct problems and antisocial behavior.

Who Is at Risk?

Years of research show that the most troubling cases of conduct disorder begin in early childhood, often by the preschool years. In fact, some infants who are especially "fussy" are at risk for developing conduct disorder. Other factors that may make a child more likely to develop conduct disorder include:

- inconsistent rules and harsh discipline;
- lack of enough supervision or guidance;
- frequent change in caregivers;
- poverty;
- neglect or abuse; and
- a delinquent peer group.

What Help Is Available for Families?

Conduct disorder is one of the most difficult behavior disorders of childhood and adolescence to treat successfully. However, young people with conduct disorder often benefit from a range of services, which might include:

- parent training on how to handle their child's or adolescent's behavior;
- family therapy;
- training in problem-solving skills for children or adolescents; and
- community-based services that focus on the young person within the context of family and community influences.

A child or adolescent in need of treatment or services and his or her family may need a plan of care based on the severity and duration of symptoms. Optimally, this plan is developed with the family, service providers, and a service coordinator, who is referred to as a case manager. Whenever possible, the child or adolescent is involved in decisions. Tying together all the various supports and services in a plan of care for a particular child and family is commonly referred to as a "system of care." A system of care is designed to improve the child's ability to function in all areas of life-at home, at school, and in the community.

What Can Parents Do?

Antisocial behavior in children and adolescents is very hard to change after it has become ingrained. Therefore, the earlier the problem is identified and treated, the better. Some recent studies have focused on promising ways to prevent conduct disorder among children and adolescents who are at risk for developing the disorder. Most children or adolescents with conduct disorder are probably reacting to events and situations in their lives. More research is needed to determine if biology is a factor in conduct disorder.

Parents should:

- Pay careful attention when a child or adolescent shows signs of oppositional defiant disorder or conduct disorder and try to understand the reasons behind it. Then parents can try to improve the situation or their own reactions.
- Talk with a mental health or social service professional, such as a teacher, counselor, psychiatrist, or psychologist specializing in childhood and adolescent disorders (if parents cannot reduce their child's or adolescent's antisocial behavior on their own).
- Get accurate information from libraries, hotlines, or other sources.
- Talk to other families in their community.
- Find family network organizations.

It is important for people who are not satisfied with the mental health care they are receiving to discuss their concerns with the provider, to ask for information, and/or to seek help from other sources.

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available-publications, references, and referrals to local and national resources and organizations-call 1.800.789.2647; TTY 301.443.9006 or go to www.mentalhealth.org.

1. Developmental Variations: Behaviors that are Within the Range of Expected Behaviors for That Age Group*

DEVELOPMENTAL VARIATION

Negative Emotional Behavior Variation

Infants and preschool children typically display negative emotional behaviors when frustrated or irritable. The severity of the behaviors varies depending on temperament. The degree of difficulty produced by these behaviors depends, in part, on the skill and understanding of the caregivers.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

The infant typically cries in response to any frustration, such as hunger or fatigue, or cries for no obvious reason, especially in late afternoon, evening, and nighttime hours.

Early Childhood

The child frequently cries and whines, especially when hungry or tired, is easily frustrated, frequently displays anger by hitting and biting, and has temper tantrums when not given his or her way.

Middle Childhood

The child has temper tantrums, although usually reduced in degree and frequency, and pounds his or her fists or screams when frustrated.

Adolescence

The adolescent may hit objects or slam doors when frustrated and will occasionally curse or scream when angered.

SPECIAL INFORMATION

These negative emotional behaviors are associated with temperamental traits, particularly low adaptability, high intensity, and negative mood (...). These behaviors decrease drastically with development, especially as language develops. These behaviors are also especially responsive to discipline.

Environmental factors, especially depression in the parent (...), are associated with negative emotional behaviors in the child. However, these behaviors are more transient than those seen in adjustment disorder (...).

These behaviors increase in situations of environmental stress such as child neglect or physical/sexual abuse (...), but again the behaviors are more transient than those seen in adjustment disorder (...).

As children grow older, their negative emotions and behaviors come under their control. However, outbursts of negative emotional behaviors including temper tantrums are common in early adolescence when adolescents experience frustration in the normal developmental process of separating from their nuclear family and also experience a normal increase in emotional reactivity. However, a decrease in negative emotional behaviors is associated with normal development in middle to late adolescence.

DEVELOPMENTAL VARIATIONS

Aggressive/Oppositional Variation

Oppositionality

Mild opposition with mild negative impact is a normal developmental variation. Mild opposition may occur several times a day for a short period. Mild negative impact occurs when no one is hurt, no property is damaged, and parents do not significantly alter their plans.

DEVELOPMENTAL VARIATIONS

Aggressive/Oppositional Variation

Aggression

In order to assert a growing sense of self nearly all children display some amount of aggression, particularly during periods of rapid developmental transition. Aggression tends to decline normatively with development. Aggression is more common in younger children, who lack self-regulatory skills, than in older children, who internalize familial and societal standards and learn to use verbal mediation to delay gratification. Children may shift normatively to verbal opposition with development. Mild aggression may occur several times per week, with minimal negative impact.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

The infant sometimes flails, pushes away, shakes head, gestures refusal, and dawdles. These behaviors may not be considered aggressive intentions, but the only way the infant can show frustration or a need for control in response to stress, e.g., separation from parents, intrusive interactions (physical or sexual), overstimulation, loss of family member, change in caregivers.

Early Childhood

The child's negative behavior includes saying "now" as well as all of the above behaviors but with increased sophistication and purposefulness. The child engages in brief arguments, uses bad language, purposely does the opposite of what is asked, and procrastinates.

Middle Childhood

The child's oppositional behaviors include all of the above behaviors, elaborately defying doing chores, making up excuses, using bad language, displaying negative attitudes, and using gestures that indicate refusal.

Adolescence

The adolescent's oppositional behaviors include engaging in more abstract verbal arguments, demanding reasons for requests, and often giving excuses.

SPECIAL INFORMATION

Oppositional behavior occurs in common situations such as getting dressed, picking up toys, during meals, or at bedtime. In early childhood, these situations broaden to include preschool and home life. In middle childhood, an increase in school-related situations occurs. In adolescence, independence-related issues become important.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

The infant's aggressive behaviors include crying, refusing to be nurtured, kicking, and biting, but are usually not persistent.

Early Childhood

The child's aggressive behaviors include some grabbing toys, hating siblings and others, kicking, and being verbally abusive to others, but usually responds to parental reprimand.

Middle Childhood

The child's aggressive behaviors include some engaging in all of the above behaviors, with more purposefulness, getting even for perceived injustice, inflicting pain on others, using profane language, and bullying and hitting peers. The behaviors are intermittent and there is usually provocation.

Adolescence

The adolescent exhibits overt physical aggression less frequently, curses, mouths off, and argues, usually with provocation.

SPECIAL INFORMATION

In middle childhood, more aggression and self-defense occur at school and with peers. During adolescence, aggressive and oppositional behaviors blend together in many cases.

2 Problems—Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria

PROBLEM

Negative Emotional Behavior Problem

Negative emotional behaviors that increase (rather than decrease) in intensity, despite appropriate caregiver management, and that begin to interfere with child-adult or peer interactions may be a problem. These behaviors also constitute a problem when combined with other behaviors such as hyperactivity/impulsivity (see Hyperactive/ Impulsive Behaviors cluster ...), aggression (see Aggressive/ Oppositional Behavior cluster, ...), and/or depression (see Sadness and Related Symptoms cluster, ...). However, the severity and frequency of these behaviors do not meet the criteria for disorder.

COMMON DEVELOPMENT PRESENTATIONS

Infancy

The infant flails, pushes away, shakes head, gestures refusal, and dawdles. These actions should not be considered aggressive intentions, but the only way the infant can show frustration or a need for control in response to stress—e.g., separation from parents, intrusive interactions (physical or sexual), overstimulation, loss of a family member, or change in caregivers.

Early Childhood

The child repeatedly, despite appropriate limit setting and proper discipline, has intermittent temper tantrums. These behaviors result in caregiver frustration and can affect interactions with peers.

Middle Childhood

The child has frequent and/or intense responses to frustrations, such as losing in games or not getting his or her way. Negative behaviors begin to affect interaction with peers.

Adolescence

The adolescent has frequent and/or intense reactions to being denied requests and may respond inappropriately to the normal teasing behavior of others. The adolescent is easily frustrated, and the behaviors associated with the frustration interfere with friendships or the completion of age-appropriate tasks.

SPECIAL INFORMATION

Intense crying frustrates caregivers. The typical response of caregivers must be assessed in order to evaluate the degree of the problem.

The presence of skill deficits as a source of frustration must be considered (e.g., the clumsy child who does not succeed in games in early childhood or in sports in later childhood and adolescence, or the child with a learning disability [...]).

PROBLEM

Aggressive/Oppositional Problem

Oppositionality

The child will display some of the symptoms listed for oppositional defiant disorder (...). The frequency of the opposition occurs enough to be bothersome to parents or supervising adults, but not often enough to be considered a disorder.

COMMON DEVELOPMENT PRESENTATIONS

Infancy

The infant screams a lot, runs away from parents a lot, and ignores requests.

Early Childhood

The child ignores requests frequently enough to be a problem, dawdles frequently enough to be a problem, argues back while doing chores, throws tantrums when asked to do some things, messes up the house on purpose, has a negative attitude many days, and runs away from parents on several occasions.

Middle Childhood

The child intermittently tries to annoy others such as turning up the radio on purpose, making up excuses, begins to ask for reasons why when given commands, and argues for longer times. These behaviors occur frequently enough to be bothersome to the family.

Adolescence

The adolescent argues back often, frequently has a negative attitude, sometimes makes obscene gestures, and argues and procrastinates in more intense and sophisticated ways.

SPECIAL INFORMATION

All children occasionally defy adult requests for compliance, particularly the requests of their parents. More opposition is directed toward mothers than fathers. Boys display opposition more often than girls and their opposition tends to be expressed by behaviors that are more motor oriented. The most intense opposition occurs at the apex of puberty for boys and the onset of menarche for girls.

PROBLEM

Aggressive/Oppositional Problem

Aggression

When levels of aggression and hostility interfere with family routines, begin to engender negative responses from peers or teachers, and/or cause disruption at school, problematic status is evident. The negative impact is moderate. People change routines; property begins to be more seriously damaged. The child will display some of the symptoms listed for conduct disorder (...) but not enough to warrant the diagnosis of the disorder. However, the behaviors are not sufficiently intense to qualify for a behavioral disorder.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care*. (1996) American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

COMMON DEVELOPMENT PRESENTATIONS

Infancy

The infant bites, kicks, cries, and pulls hair fairly frequently.

Early Childhood

The child frequently grabs others' toys, shouts, hits or punches siblings and others, and is verbally abusive.

Middle Childhood

The child gets into fights intermittently in school or in the neighborhood, swears or uses bad language sometimes in inappropriate settings, hits or otherwise hurts self when angry or frustrated.

Adolescence

The adolescent intermittently hits others, uses bad language, is verbally abusive, may display some inappropriate suggestive sexual behaviors.

SPECIAL INFORMATION

Problem levels of aggressive behavior may run in families. When marked aggression is present, the assessor must examine the family system, the types of behaviors modeled, and the possibility of abusive interactions.

3. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the

DISORDERS

Conduct Disorder Childhood Onset

Conduct Disorder Adolescent Onset

A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. Onset may occur as early as age 5 to 6 years, but is usually in late childhood or early adolescence. The behaviors harm others and break societal rules including stealing, fighting, destroying property, lying, truancy, and running away from home.

(see DSM-IV criteria ...)

Adjustment Disorder With Disturbance of Conduct

(see DSM-IV criteria ...)

Disruptive Behavior Disorder, NOS

(see DSM-IV criteria ...)

COMMON DEVELOPMENT PRESENTATIONS

Infancy

It is not possible to make the diagnosis.

Early Childhood

Symptoms are rarely of such a quality or intensity to be able to diagnose the disorder.

Middle Childhood

The child often may exhibit some of the following behaviors: lies, steals, fights with peers with and without weapons, is cruel to people or animals, may display some inappropriate sexual activity, bullies, engages in destructive acts, violates rules, acts deceitful, is truant from school, and has academic difficulties.

Adolescence

The adolescent displays delinquent, aggressive behavior, harms people and property more often than in middle childhood, exhibits deviant sexual behavior, uses illegal drugs, is suspended/expelled from school, has difficulties with the law, acts reckless, runs away from home, is destructive, violates rules, has problems adjusting at work, and has academic difficulties.

SPECIAL INFORMATION

The best predictor of aggression that will reach the level of a disorder is a diversity of antisocial behaviors exhibited at an early age; clinicians should be alert to this factor. Oppositional defiant disorder usually becomes evident before age 8 years and usually not later than early adolescence. Oppositional defiant disorder is more prevalent in males than in females before puberty, but rates are probably equal after puberty. The occurrence of the following negative environmental factors may increase the likelihood, severity, and negative prognosis of conduct disorder: parental rejection and neglect (...), inconsistent management with harsh discipline, physical or sexual child abuse (...), lack of supervision, early institutional living (...), frequent changes of caregivers (...), and association with delinquent peer group. Suicidal ideation, suicide attempts, and completed suicide occur at a higher than expected rate (see Suicidal Thoughts or Behaviors cluster). If the criteria are met for both oppositional defiant disorder and conduct disorder, only code conduct disorder.

DISORDERS

Oppositional Defiant Disorder

Hostile, defiant behavior towards others of at least 6 months duration that is developmentally inappropriate.

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults' requests or rules
- often deliberately annoys people
- often blames others for his or her mistakes or misbehavior
- is often touchy or easily annoyed by others
- is often angry and resentful
- is often spiteful or vindictive

(see DSM-IV Criteria...)

COMMON DEVELOPMENT PRESENTATIONS

Infancy

It is not possible to make the diagnosis.

Early Childhood

The child is extremely defiant, refuses to do as asked, mouths off, throws tantrums.

Middle Childhood

The child is very rebellious, refusing to comply with reasonable requests, argues often, and annoys other people on purpose.

Adolescence

The adolescent is frequently rebellious, has severe arguments, follows parents around while arguing, is defiant, has negative attitudes, is unwilling to compromise, and may precociously use alcohol, tobacco, or illicit drugs.



Accommodations to Reduce Conduct and Behavior Problems

From the newsletter of the *Center for Mental Health in Schools* of UCLA

Behavior Problems: What's a School to Do?

In their effort to deal with deviant and devious behavior and create safe environments, schools increasingly have adopted social control practices. These include some *discipline* and *classroom management* practices that analysts see as "blaming the victim" and modeling behavior that fosters rather than counters development of negative values.

To move schools beyond overreliance on punishment and social control strategies, there is ongoing advocacy for social skills *training* and new agendas for *emotional "intelligence" training* and *character education*. Relatedly, there are calls for greater home involvement, with emphasis on enhanced parent responsibility for their children's behavior and learning. More comprehensively, some reformers want to transform schools through creation of an atmosphere of "caring," "cooperative learning," and a "sense of community." Such advocates usually argue for schools that are holistically-oriented and family-centered. They want curricula to enhance values and character, including responsibility (social and moral), integrity, self-regulation (self-discipline), and a work ethic and also want schools to foster self-esteem, diverse talents, and emotional well-being.

Discipline

Misbehavior disrupts; it may be hurtful; it may disinhibit others. When a student misbehaves, a natural reaction is to want that youngster to experience and other students to see the consequences of misbehaving. One hope is that public awareness of consequences will deter subsequent problems. As a result, the primary intervention focus in schools usually is on *discipline* -- sometimes embedded in the broader concept of *classroom management*. More broadly, however, as outlined on p. 2, interventions for misbehavior can be conceived in terms of:

- efforts to prevent and anticipate misbehavior
- actions to be taken during misbehavior
- steps to be taken afterwards.

From a prevention viewpoint, there is widespread awareness that program improvements can reduce learning and behavior problems significantly. It also is recognized that the application of consequences is an insufficient step in preventing future misbehavior.

For youngsters seen as having emotional and behavioral disorders, disciplinary practices tend to be described as strategies to modify deviant behavior. And, they usually are seen as only one facet of a broad intervention agenda designed to treat the youngster's disorder. It should be noted, however, that for many students diagnosed as having disabilities the school's (and society's) socialization agenda often is in conflict with providing the type of helping interventions such youngsters require. This is seen especially in the controversies over use of corporal punishment, suspension, and exclusion from school. Clearly, such practices, as well as other value-laden interventions, raise a host of political, legal, and ethical concerns.

Unfortunately, too many school personnel see punishment as the only recourse in dealing with a student's misbehavior. They use the most potent negative consequences available to them in a desperate effort to control an individual and make it clear to others that acting in such a fashion is not tolerated. Essentially, short of suspending the individual from school, such punishment takes the form of a decision to do something to the student that he or she does not want done. In addition, a demand for future compliance usually is made, along with threats of harsher punishment if compliance is not forthcoming. And the discipline may be administered in ways that suggest the student is seen as an undesirable person. As students get older, suspension increasingly comes into play. Indeed, suspension remains one of the most common disciplinary responses for the transgressions of secondary students.

Intervention Focus in Dealing with Misbehavior

I. Preventing Misbehavior

A. Expand Social Programs

1. Increase economic opportunity for low income groups
2. Augment health and safety prevention and maintenance (encompassing parent education and direct child services)
3. Extend quality day care and early education

B. Improve Schooling

1. Personalize classroom instruction (e.g., accommodating a wide range of motivational and developmental differences)
2. Provide status opportunities for nonpopular students (e.g., special roles as assistants and tutors)
3. Identify and remedy skill deficiencies early

C. Follow-up All Occurrences of Misbehavior to Remedy Causes

1. Identify underlying motivation for misbehavior
2. For unintentional misbehavior, strengthen coping skills (e.g., social skills, problem solving strategies)
3. If misbehavior is intentional but reactive, work to eliminate conditions that produce reactions (e.g., conditions that make the student feel incompetent, controlled, or unrelated to significant others)
4. For proactive misbehavior, offer appropriate and attractive alternative ways the student can pursue a sense of competence, control, and relatedness
5. Equip the individual with acceptable steps to take instead of misbehaving (e.g., options to withdraw from a situation or to try relaxation techniques)
6. Enhance the individual's motivation and skills for overcoming behavior problems (including altering negative attitudes toward school)

II. Anticipating Misbehavior

A. Personalize Classroom Structure for High Risk Students

1. Identify underlying motivation for misbehavior
2. Design curricula to consist primarily of activities that are a good match with the identified individual's intrinsic motivation and developmental capability
3. Provide extra support and direction so the identified individual can cope with difficult situations (including steps that can be taken instead of misbehaving)

B. Develop Consequences for Misbehavior that are Perceived by Students as Logical (i.e., that are perceived by the student as reasonable fair, and nondenigrating reactions which do not reduce one's sense of autonomy)

III. During Misbehavior

A. Try to base response on understanding of underlying motivation (if uncertain, start with assumption the misbehavior is unintentional)

B. Reestablish a calm and safe atmosphere

1. Use understanding of student's underlying motivation for misbehaving to clarify what occurred (if feasible, involve participants in discussion of events)
2. Validate each participant's perspective and feelings
3. Indicate how the matter will be resolved emphasizing use of previously agreed upon logical consequences that have been personalized in keeping with understanding of underlying motivation
4. If the misbehavior continues, revert to a firm but nonauthoritarian statement indicating it must stop or else the student will have to be suspended
5. As a last resort use crises back-up resources
 - a. If appropriate, ask student's classroom friends to help
 - b. Call for help from identified back-up personnel
6. Throughout the process, keep others calm by dealing with the situation with a calm and protective demeanor

IV. After Misbehavior

A. Implement Discipline -- Logical Consequences/ Punishment

1. Objectives in using consequences
 - a. Deprive student of something s/he wants
 - b. Make student experience something s/he doesn't want
2. Forms of consequences
 - a. Removal/deprivation (e.g., loss of privileges, removal from activity)
 - b. Reprimands (e.g., public censure)
 - c. Reparations (e.g., of damaged or stolen property)
 - d. Recantations (e.g., apologies, plans for avoiding future problems)

B. Discuss the Problem with Parents

1. Explain how they can avoid exacerbating the problem
2. Mobilize them to work preventively with school

C. Work Toward Prevention of Further Occurrences (see I & II)

As with many emergency procedures, the benefits of using punishment may be offset by many negative consequences. These include increased negative attitudes toward school and school personnel which often lead to behavior problems, anti-social acts, and various mental health problems. Disciplinary procedures also are associated with dropping out of school. It is not surprising, then, that some concerned professionals refer to extreme disciplinary practices as "pushout" strategies.

(Relatedly, a large literature points to the negative impact of various forms of parental discipline on internalization of values and of early harsh discipline on child aggression and formation of a maladaptive social information processing style. And a significant correlation has been found between corporal punishment of adolescents and depression, suicide, alcohol abuse, and wife-beating.)

Logical Consequences

Guidelines for managing misbehavior usually stress that discipline should be reasonable, fair, and nondegrading. Motivation theory stresses that "positive, best-practice approaches" are disciplinary acts recipients experience as legitimate reactions that neither denigrate one's sense of worth nor reduce one's sense of autonomy. To these ends, discussions of classroom management practices usually emphasize establishing and administering logical consequences. This idea plays out best in situations where there are naturally-occurring consequences (e.g., if you touch a hot stove, you get burned).

In classrooms, there may be little ambiguity about the rules; unfortunately, the same often cannot be said about "logical" penalties. Even when the consequence for a particular rule infraction has been specified ahead of time, its logic may be more in the mind of the teacher than in the eye of the students. In the recipient's view, any act of discipline may be experienced as punitive -- unreasonable, unfair, degrading, disempowering.

Basically, consequences involve depriving students of things they want and/or making them experience something they don't want. Consequences take the form of (a) removal/deprivation (e.g., loss of privileges, removal from an activity), (b) reprimands (e.g., public censure), (c) reparations (e.g., to compensate for losses caused by misbehavior), and (d) recantations (e.g., apologies, plans for avoiding future problems).

Defining and Categorizing Discipline Practices

Two mandates capture much of current practice:

- (a) *schools must teach self-discipline to students;*
- (b) *teachers must learn to use disciplinary practices effectively to deal with misbehavior.*

Knoff (1987) offers three definitions of discipline as applied in schools: "(a) ... punitive intervention; (b) a means of suppressing or eliminating inappropriate behavior, of teaching or reinforcing appropriate behavior, and of redirecting potentially inappropriate behavior toward acceptable ends; and (c) ..a process of self-control whereby the (potentially) misbehaving student applies techniques that interrupt inappropriate behavior, and that replace it with acceptable behavior". In contrast to the first definition which specifies discipline as punishment, Knoff sees the other two as nonpunitive or as he calls them "positive, best-practices approaches."

Hyman, Flannagan, & Smith (1982) categorize models shaping disciplinary practices into 5 groups:

- psychodynamic-interpersonal models
- behavioral models
- sociological models
- eclectic-ecological models
- human-potential models

Wolfgang & Glickman (1986) group disciplinary practices in terms of a process-oriented framework:

- relationship-listening models (e.g., Gordon's Teacher Effectiveness Training, values clarification approaches, transactional analysis)
- confronting-contracting models (e.g., Dreikurs' approach, Glasser's Reality Therapy)
- rules/rewards-punishment (e.g., Canter's Assertive Discipline)

Bear (1995) offers 3 categories in terms of the goals of the practice -- with a secondary nod to processes, strategies and techniques used to reach the goals:

- preventive discipline models (e.g., models that stress classroom management, prosocial behavior, moral/character education, social problem solving, peer mediation, affective education and communication models)
- corrective models (e.g., behavior management, Reality Therapy)
- treatment models (e.g., social skills training, aggression replacement training, parent management training, family therapy, behavior therapy).

For instance, teachers commonly deal with acting out behavior by removing a student from an activity. To the teacher, this step (often described as "time out") may be a logical way to stop the student from disrupting others by isolating him or her, or the logic may be that the student needs a cooling off period. It may be reasoned that (a) by misbehaving the student has shown s/he does not deserve the privilege of participating (assuming the student likes the activity) and (b) the loss will lead to improved behavior in order to avoid future deprivation.

Most teachers have little difficulty explaining their reasons for using a consequence. However, if the intent really is to have students perceive consequences as logical and nondebilitating, it seems logical to determine whether the recipient sees the discipline as a legitimate response to misbehavior. Moreover, it is well to recognize the difficulty of administering consequences in a way that minimizes the negative impact on a student's perceptions of self. Although the intent is to stress that it is the misbehavior and its impact that are bad, the student can too easily experience the process as a characterization of her or him as a bad person.

Organized sports such as youth basketball and soccer offer a prototype of an established and accepted set of consequences administered with recipient's perceptions given major consideration. In these arenas, the referee is able to use the rules and related criteria to identify inappropriate acts and apply penalties; moreover, s/he is expected to do so with positive concern for maintaining the youngster's dignity and engendering respect for all.

For discipline to be perceived as a logical consequence, steps must be taken to convey that a response is not a personally motivated act of power (e.g., an authoritarian action) and, indeed, is a rational and socially agreed upon reaction. Also, if the intent is a long-term reduction in future misbehavior, it may be necessary to take time to help students learn right from wrong, to respect others rights, and to accept responsibility.

From a motivational perspective, it is essential that logical consequences are based on understanding of a student's perceptions and are used in ways that minimize negative repercussions. To these ends, motivation theorists suggest (a) establishing a publicly accepted set of consequences to increase the likelihood they are experienced as socially just (e.g., reasonable, firm but fair) and (b) administering such consequences in ways that allow students to maintain a sense of integrity, dignity, and autonomy. These ends are best achieved under conditions where students are "empowered" (e.g., are involved in deciding how to make improvements and avoid future misbehavior and have opportunities for positive involvement and reputation building at school).

Social Skills Training

Suppression of undesired acts does not necessarily lead to desired behavior. It is clear that more is needed than

classroom management and disciplinary practices. Is the answer social skills training? After all, poor social skills are identified as a symptom (a correlate) and contributing factor in a wide range of educational, psychosocial, and mental health problems.

Programs to improve social skills and interpersonal problem solving are described as having promise both for prevention and correction. However, reviewers tend to be cautiously optimistic because studies to date have found the range of skills acquired are quite limited and generalizability and maintenance of outcomes are poor. This is the case for training of specific skills (e.g., what to say and do in a specific situation), general strategies (e.g., how to generate a wider range of interpersonal problem-solving options), as well as efforts to develop cognitive-affective orientations (e.g., empathy training). Based on a review of social skills training over the past two decades, Mathur and Rutherford (1996) conclude that individual studies show effectiveness, but outcomes continue to lack generalizability and social validity. (While their focus is on social skills training for students with emotional and behavior disorders, their conclusions hold for most populations.)

For a comprehensive bibliography of articles, chapters, books, and programs on social skills and social competence of children and youth, see Quinn, Mathur, and Rutherford, 1996. Also, see Daniel Goleman's (1995) book on *Emotional Intelligence* which is stimulating growing interest in ways to facilitate social and emotional competence.

Addressing Underlying Motivation

Beyond discipline and skills training is a need to address the roots of misbehavior, especially the underlying motivational bases for such behavior. Consider students who spend most of the day trying to avoid all or part of the instructional program. An intrinsic motivational interpretation of the avoidance behavior of many of these youngsters is that it reflects their perception that school is not a place where they experience a sense of competence, autonomy, and or relatedness to others. Over time, these perceptions develop into strong motivational dispositions and related patterns of misbehavior.

Misbehavior can reflect proactive (approach) or reactive (avoidance) motivation. Noncooperative, disruptive, and aggressive behavior patterns that are proactive tend to be rewarding and satisfying to an individual because the behavior itself is exciting or because the behavior leads to desired outcomes (e.g., peer recognition, feelings of competence or autonomy). Intentional negative behavior stemming from such approach motivation can be viewed as *pursuit of deviance*.

Of course, misbehavior in the classroom often also is reactive, stemming from avoidance motivation. This behavior can be viewed as *protective reactions*. Students with learning problems can be seen as motivated to avoid and to protest against being forced into situations in which they cannot cope effectively. For such students, many teaching and therapy situations are perceived in this way. Under such circumstances, individuals can be expected to react by trying to protect themselves from the unpleasant thoughts and feelings that the situations stimulate (e.g., feelings of incompetence, loss of autonomy, negative relationships). In effect, the misbehavior reflects efforts to cope and defend against aversive experiences. The actions may be direct or indirect and include defiance, physical and psychological withdrawal, and diversionary tactics.

Interventions for such problems begin with major program changes. From a motivational perspective, the aims are to (a) prevent and overcome negative attitudes toward school and learning, (b) enhance motivational readiness for learning and overcoming problems, (c) maintain intrinsic motivation throughout learning and problem solving, and (d) nurture the type of continuing motivation that results in students engaging in activities away from school that foster maintenance, generalization, and expansion of learning and problem solving. Failure to attend to motivational concerns in a comprehensive, normative way results in approaching passive and often hostile students with practices that instigate and exacerbate problems. After making broad programmatic changes to the degree feasible, intervention with a misbehaving student involves remedial steps directed at underlying factors. For instance, with intrinsic motivation in mind, the following assessment questions arise:

with intrinsic motivation in mind, the following assessment questions arise:

- Is the misbehavior unintentional or intentional?
- If it is intentional, is it reactive or proactive?
- If the misbehavior is reactive, is it a reaction to threats to self-determination, competence, or relatedness?
- If it is proactive, are there other interests that might successfully compete with satisfaction derived from deviant behavior?

In general, intrinsic motivational theory suggests that corrective interventions for those misbehaving reactively requires steps designed to reduce reactance and enhance positive motivation for participating in an intervention. For youngsters highly motivated to pursue deviance (e.g., those who proactively engage in criminal acts), even more is needed. Intervention might focus on helping these youngsters identify and follow through on a range of valued, socially appropriate alternatives to deviant activity. From the theoretical perspective presented above, such alternatives must be capable of producing greater feelings of self-determination, competence, and relatedness than usually result from the youngster's deviant actions. To these ends, motivational analyses of the problem can point to corrective steps for implementation by teachers, clinicians, parents, or students themselves. (For more on approaching misbehavior from a motivational perspective,

Overview

In providing an introduction to anxiety problems, a government fact sheet is offered and the problems are framed with the classification scheme developed by the American Pediatric Association. The variations in degree of problem are discussed with respect to interventions that range from environmental accommodations to behavioral strategies to medication.

For pursuing further information, a set of references and a list of agencies and websites are included.

Anxiety Disorders in Children and Adolescents

This is one of a series of fact sheets on the mental, emotional, and behavior disorders that can appear in childhood or adolescence. The Center for Mental Health Services extends appreciation to the National Institute of Mental Health for contributing to the preparation of this fact sheet. Any questions or comments about its contents may be directed to the CMHS National Mental Health Services Knowledge Exchange Network (KEN)--see contact information below.

What Are Anxiety Disorders?

Young people with an anxiety disorder typically are so afraid, worried, or uneasy that they cannot function normally. Anxiety disorders can be long-lasting and interfere greatly with a child's life. If not treated early, anxiety disorders can lead to:

- missed school days or an inability to finish school;
- impaired relations with peers;
- low self-esteem;
- alcohol or other drug use;
- problems adjusting to work situations; and
- anxiety disorder in adulthood.

What Are the Signs of Anxiety Disorder?

There are a number of different anxiety disorders that affect children and adolescents. Several are described below.

Generalized Anxiety Disorder. Children and adolescents with this disorder experience extreme, unrealistic worry that does not seem to be related to any recent event. Typically, these young people are very self-conscious, feel tense, have a strong need for reassurance, and complain about stomachaches or other discomforts that don't appear to have any physical basis.

Phobias. A phobia is an unrealistic and excessive fear of some situation or object. Some phobias, called specific phobias, center on animals, storms, water, heights, or situations, such as being in an enclosed space. Children and adolescents with social phobias are terrified of being criticized or judged harshly by others. Because young people with phobias will try to avoid the objects and situations that they fear, the disorder can greatly restrict their lives.

Panic Disorder. Panic disorder is marked by repeated panic attacks without apparent cause. Panic attacks are periods of intense fear accompanied by pounding heartbeat, sweating, dizziness, nausea, or a feeling of imminent death. The experience is so scary that the young person lives in dread of another attack. He or she may go to great lengths to avoid any situation that seems likely to bring on a panic attack. A child with panic disorder may not want to go to school or be separated from his or her parents.

Obsessive-Compulsive Disorder. A child with obsessive-compulsive disorder becomes trapped in a pattern of repetitive thoughts and behaviors. Even though the child may agree that the thoughts or behaviors appear senseless and distressing, the repetitions are very hard to stop. The compulsive behaviors may include repeated hand washing, counting, or arranging and rearranging objects.

Post-Traumatic Stress Disorder. Post-traumatic stress disorder can develop in children or adolescents after they experience a very stressful event. Such events may include physical or sexual abuse; being a victim of or witnessing violence; or being caught in a disaster, such as a bombing or hurricane. Young people with post-traumatic stress disorder experience the event again and again in strong memories, flashbacks, or troublesome thoughts. As a result, the young person may try to avoid anything associated

In this fact sheet, "Mental Health Problems" for children and adolescents refers to the range of all diagnosable emotional, behavioral, and mental disorders. They include depression, attention deficit/hyperactivity disorder, and anxiety, conduct, and eating disorders. Mental health problems affect one in every five young people at any given time.

"Serious Emotional Disturbances" for children and adolescents refers to the above disorders when they severely disrupt daily functioning in home, school, or community. Serious emotional disturbances affect 1 in every 10 young people at any given time.¹

with the trauma. They may also overreact when startled or have difficulty sleeping.

How Common Are Anxiety Disorders?

Anxiety disorders are among the most common mental, emotional, and behavior problems that occur during childhood and adolescence. As many as 1 in 10 young people may have an anxiety disorder.² Among adolescents, more girls than boys are affected. About half of the children and adolescents with anxiety disorders also have a second anxiety disorder or other mental or behavioral disorder, such as depression.

Who Is at Risk?

Researchers have found that a person's basic temperament may play a role in some childhood and adolescent anxiety disorders. For example, some young people tend to be very shy and restrained in unfamiliar situations. This may be a sign that the child or adolescent is at risk for developing an anxiety disorder.

Researchers also suggest watching for signs of anxiety disorders when children are between the ages of 6 and 8. At this age, children grow less afraid of the dark and imaginary creatures and more anxious about school performance and social relationships. High levels of anxiety in a child aged 6 to 8, therefore, may be a warning sign that the child may develop anxiety disorder later. A child's fears may change as a child ages, which complicates research.

Studies suggest that children or adolescents are more likely to have an anxiety disorder if their parents have anxiety disorders. However, the studies do not prove whether the disorders are caused by biology, environment, or both. More studies are needed to clarify whether or not anxiety disorders can be inherited. The Federal Government's National Institute of Mental Health, a part of the National Institutes of Health, is pursuing a wide range of studies on anxiety disorders in children, adolescents, and adults.²

What Help Is Available for a Young Person With an Anxiety Disorder?

Children and adolescents with anxiety disorders can benefit from a variety of treatments and services. After an accurate diagnosis, possible treatments include:

- cognitive-behavioral treatment (where young people learn to deal with fears by modifying the way they think and behave);
- other individual therapy;
- family therapy;
- parent training; and
- medication.

While cognitive-behavioral approaches are effective in treating some anxiety disorders, medications work well with others. Some anxiety disorders benefit from a combination of these treatments. In general, more studies are needed to find which treatments work best for the various types of anxiety disorders.

A child or adolescent in need of treatment or services and his or her family may need a plan of care based on the severity and duration of symptoms. Optimally, this plan is developed with the family, service providers, and a service coordinator, who is referred to as a case manager. Whenever possible, the child or adolescent is involved in decisions.

Tying together all the various supports and services in a plan of care for a particular child and family is commonly referred to as a "system of care." A system of care is designed to improve the child's ability to function in all areas of life—at home, at school, and in the community.

What Can Parents Do?

If parents or other caregivers notice repeated symptoms of an anxiety disorder in a child or adolescent, they should:

- Talk with the child's doctor. The doctor can help determine whether the symptoms are caused by an anxiety disorder or by some other condition. Then, if needed, the doctor can refer the family to a mental health professional.
- Look for a mental health professional who has training and experience:
 - working with children and adolescents;
 - using cognitive-behavioral or behavior therapy; and
 - prescribing medications for this disorder or, if appropriate, cooperating with a physician who prescribes medications.

In a "System of Care," local organizations work in teams--with families as critical partners--to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more information on systems of care, call 1.800.789.2647.)

The mental health professional should be willing to work closely with the parents as well as with the child or adolescent and his or her school.

- Get accurate information from libraries, hotlines, or other sources.
- Ask questions about treatments and services.
- Talk to other families in the community.
- Find family network organizations.

It is important for people who are not satisfied with the mental health care they are receiving to discuss their concerns with the provider, to ask for information, and/or to seek help from other sources.

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available - publications, references, and referrals to local and national resources and organizations--call 1.800.789.2647; TTY 301.443.9006

1 Prevalence of serious emotional disturbance in children and adolescents. Mental Health, United States, 1996. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 1996.

2 This estimate provides only a rough gauge of the prevalence rates (number of existing cases in a defined time period) for these disorders. The National Institute of Mental Health is currently engaged in a nationwide study to determine with greater accuracy the prevalence of mental disorders among children and adolescents. This information is needed to increase understanding of mental health problems and to improve the treatments and services that help young people who are affected by these conditions.

1. Developmental Variation Within the Range of Expected Behaviors for That Age Group

DEVELOPMENTAL VARIATION

Anxious Variation

Fears and worries are experienced that are appropriate for developmental age and do not affect normal development.

Transient anxious responses to stressful events occur in an otherwise healthy child and they do not affect normal development.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Normal fears of noises, heights, and loss of physical support are present at birth. Fear of separation from parent figures and fear of strangers are normal symptoms during the first years of life. The latter peaks at 8 to 9 months. Feeding or sleeping changes are possible in the first year. Transient developmental regressions occur after the first year. Scary dreams may occur.

Early childhood

By age 3 years, children can separate temporarily from a parent with minimal crying or clinging behaviors. Children described as shy or slow to warm up to others may be anxious in new situations. Specific fears of thunder, medical settings, and animals are present.

Middle Childhood

In middle childhood, a child with anxious symptoms may present with motor responses (trembling voice, nail biting, thumb sucking) or physiologic responses (headache, recurrent abdominal pain, unexplained limb pain, vomiting, breathlessness). Normally these should be transient and associated with appropriate stressors. Transient fears may occur after frightening events, such as a scary movie. These should be relieved easily with reassurance.

Adolescence

Adolescents may be shy, avoid usual pursuits, fear separation from friends, and be reluctant to engage in new experiences. Risk-taking behaviors, such as experimentation with drugs or impulsive sexual behavior, may be seen.

SPECIAL INFORMATION

Clinicians should attempt to identify any potential stressful events that may have precipitated the anxiety symptoms (...).

Difficulty falling asleep, frequent night awakenings, tantrums and aggressiveness, and excessive napping may reflect anxiety.

2 Problems—Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet

PROBLEM

Anxiety Problem

An anxiety problem involves excessive worry or fearfulness that causes significant distress in the child. However, the behaviors are not sufficiently intense to qualify for an anxiety disorder or adjustment disorder with anxious mood.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy and Early Childhood

In infancy and early childhood, anxiety problems usually present with a more prolonged distress at separation or as sleep and feeding difficulties including anxious clinging when not separating.

Middle Childhood

In middle childhood, anxiety may be manifest as sleep problems, fears of animals, natural disasters, and medical care, worries about being the center of attention, sleep-overs, class trips, and the future (see Sadness and Related Symptoms cluster). Anxiety may involve some somatic symptoms such as tachycardia, shortness of breath, sweating, choking, nausea, dryness, and chest pain (...). Environmental stress may be associated with regression (loss of developmental skills), social withdrawal, agitation/hyperactivity, or repetitive reenactment of a traumatic event through play. These symptoms should not be severe enough to warrant the diagnoses of a disorder and should resolve with the alleviation of the stressors.

Adolescence

In adolescence, anxiety may be manifest as sleep problems and fears of medical care and animals. Worries about class performance, participation in sports, and acceptance by peers may be present. Environmental stress may be associated with social withdrawal, boredom (see Sadness and Related Symptoms cluster), aggressiveness, or some risk-taking behavior (e.g., indiscriminate sexual behavior, drug use, or recklessness).

SPECIAL INFORMATION

Anxiety problems have a number of different clinical presentations including persistent worries about multiple areas in the child's life, excessive or unreasonable fear of a specific object or situation, fear of situations in which the child has to perform or be scrutinized by others, excessive worry about separation from parents, or anxiety following a significant, identifiable stressor.

Separation difficulties may be prolonged if inadvertently rewarded by parents and can result in a separation anxiety disorder.

Parental response to the child's distress or anxiety is a key factor in the assessment of anxiety problems. The extent of the child's anxiety may be difficult to assess and the primary care clinicians should err on the side of referral to a mental health clinician if there is uncertainty about the severity of the condition.

3. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)

DISORDER

Generalized Anxiety Disorder

This disorder is characterized by at least 6 months of persistent and excessive anxiety and worry. Excessive and persistent worry occurs across a multitude of domains or situations, such as school work, sports, or social performance, and is associated with impaired functioning. The disorder is often associated with somatic and subjective/behavioral symptoms of anxiety (see Special Information).

(see DSM-IV Criteria...)

Social Phobia

This phobia involves a marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The person recognizes the fear is excessive or un-reasonable. Avoidance of the situation leads to impaired functioning.

(see DSM-IV Criteria ...)

Specific Phobia

Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation. Exposure to the phobic stimulus provokes an immediate anxiety response. In individuals under 18 years, the duration is at least 6 months. The anxiety associated with the object/situation is not better accounted for by another mental disorder.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Rarely diagnosed in infancy. During the second year of life, fears and distress occurring in situations not ordinarily associated with expected anxiety that is not amenable to traditional soothing and has an irrational quality about it may suggest a disorder.

The fears are, for example, intense or phobic reactions to cartoons or clowns, or excessive fear concerning parts of the house (e.g., attic or basement).

Early Childhood

Rarely diagnosed in this age group. In children, these disorders may be expressed by crying, tantrums, freezing, or clinging, or staying close to a familiar person. Young children may appear excessively timid in unfamiliar social settings, shrink from contact with others, refuse to participate in group play, typically stay on the periphery of social activities, and attempt to remain close to familiar adults to the extent that family life is disrupted.

Middle Childhood and Adolescence

Symptoms in middle childhood and adolescence generally include the physiologic symptoms associated with anxiety (restlessness, sweating, tension) (...) and avoidance behaviors such as refusal to attend school and lack of participation in school, decline in classroom performance or social functions. In addition, an increase in worries and sleep disturbances are present.

SPECIAL INFORMATION

Generalized anxiety disorder has subsumed the *DSM-III-R* diagnosis of overanxious disorder.

Severe apprehension about performance may lead to refusal to attend school. This must be distinguished from other causes of refusal, including realistically aversive conditions at school (e.g., the child is threatened or harassed), learning disabilities (...), separation anxiety disorder (see below), truancy (the child is not anxious about performance or separation), and depression (see Sadness and Related Symptoms cluster). To make these diagnoses in children, there must be evidence of capacity for social relationships with adults. Because of the early onset and chronic course of the disorder, impairment in children tends to take the form of failure to achieve an expected level of functioning rather than a decline from optimal functioning. Children with generalized anxiety disorder may be overly conforming, perfectionists and unsure of themselves and tend to redo tasks because of being zealous in seeking approval and requiring excessive reassurance about their performance and other worries.

DISORDER

Separation Anxiety Disorder

Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached.

(see DSM-IV Criteria ...)

Panic Disorder

This disorder involves recurrent unexpected (uncued) panic attacks. Apprehension and anxiety about the attacks or a significant change in behavior related to the attack persists for at least 1 month. A panic attack is a discrete episode of intense fear or discomfort with sudden onset combining the following psychological symptoms—a sense of impending doom, fear of going crazy, and feelings of unreality—with somatic symptoms such as shortness of breath/dyspnea, palpitations/tachycardia, sweating, choking, chest pain, nausea, dizziness, paresthesia.

(see *DSM IV Criteria* ...)

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Not relevant at disorder level.

Early and Middle Childhood

When separated from attachment figures, children may exhibit social withdrawal, apathy, sadness, difficulty concentrating on work or play. They may have fears of animals, monsters, the dark, muggers, kid-nappers, burglars, car accidents; concerns about death and dying are common. When alone, young children may report unusual perceptual experiences (e.g., seeing people peering into their room).

Adolescence

Adolescents with this disorder may deny feeling anxiety about separation; however, it may be reflected in their limited independent activity and reluctance to leave home.

Infancy

Not relevant at disorder level.

Early Childhood

In children, these disorders may be expressed by crying, tantrums, freezing, clinging, or staying close to a familiar person during a panic attack.

Middle Childhood

Panic attacks may be manifested by symptoms such as tachycardia, shortness of breath, spreading chest pain, and extreme tension.

Adolescence

The symptoms are similar to those seen in an adult, such as the sense of impending doom, fear of going crazy, feelings of unreality and somatic symptoms such as shortness of breath, palpitations, sweating, choking, and chest pain.

SPECIAL INFORMATION

Separation anxiety disorder must be beyond what is expected for the child's developmental level to be coded as a disorder. In infancy, consider a developmental variation or anxiety problem rather than separation anxiety disorder. Worry about separation may take the form of worry about the health and safety of self or parents.

Separation anxiety disorder may begin as early as preschool age and may occur at any time before age 18 years, but onset as late as adolescence is uncommon. Use early onset specifier if the onset of disorder is before 6 years. Children with separation anxiety disorder are often described as demanding, intrusive, and in need of constant attention which may lead to parental frustration.

Separation anxiety disorder is a common cause of refusal to attend school. Parental difficulty in separating from the child may contribute to the clinical problem (...). A break down in the marital relationship (marital discord) and one parent's over-involvement with the child is often seen (...). Children with serious current or past medical problems (...) may be overprotected by parents and at greater risk for separation anxiety disorder. Parental illness and death may also increase risk.

SPECIAL INFORMATION, CONTINUED

Although panic attacks can be overwhelming, the social impairment in panic disorders is the result of secondary avoidance, rather than the attacks themselves. Panic attacks or panic symptoms can occur in a variety of anxiety problems or disorders, including specific phobia, social phobia, separation anxiety disorder, and posttraumatic stress disorder. Panic attacks in these disorders, however, are situationally bound, or cued; that is, they are triggered by specific contexts or environmental stimuli. Unexpected or uncued panic attacks must occur for a diagnosis of panic disorder. Major depressive disorder frequently (50% to 65%) occurs in individuals with panic disorder.

DISORDER

Posttraumatic Stress Disorder (PTSD)

PTSD occurs following exposure to an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. The child or adolescent has symptoms in each of the following three areas for more than 1 month, causing significant distress or impairment of functioning: (1) persistent reexperiencing of the trauma, (2) avoidance of stimuli associated with the trauma and diminished general responsiveness, and (3) increased arousal or hyper vigilance. In infancy, a numbing of responsiveness may also occur.

(see DSM-IV Criteria ...)

Acute Stress Disorder

(see *DSM-IV* Criteria ...)

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Rarely diagnosed but may take the form of extra fears or aggressive behaviors in response to stress.

Early Childhood, Middle Childhood, Adolescence

In children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others. Reliving of the trauma may occur through repetitive play. Children may also exhibit various physical symptoms, such as stomachaches and headaches.

SPECIAL INFORMATION

PTSD follows exposure to acute or chronic stressors that involve actual or threatened death or serious injury to the child or others. The child must have reacted with intense fear, disorganized or agitated behavior, or helplessness. Stressors may be acute or chronic, single or multiple.

PTSD may be chronic and associated with significant morbidity. Symptoms of repetitive trauma re-enacting play and a sense of a foreshortened future may persist after distress is no longer present.

PTSD must be distinguished from normal bereavement. Bereavement is characterized by sadness and recurrent thoughts, but not by persistent impairment of functioning (see Sadness and Related Symptoms cluster).

Consider sexual abuse/rape (...). Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents and teachers. In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult.

DISORDER

Obsessive-Compulsive Disorder

The obsessions and/or compulsions interfere with functioning, cause marked distress, or occupy more than 1 hour a day.

(see DSM-IV Criteria...)

Anxiety Disorder, Not otherwise Specified

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Rarely presents at this age.

Early Childhood

The child evidences a higher degree of compulsive and ritualistic behavior, from holding onto certain objects, watching certain video-tapes, or lining up toys in certain sequences. These rigidities are less responsive to soothing and interaction than at the problem level. When these ritualistic behaviors are associated with problems in relating and communicating (see Social Interaction Behaviors cluster).

Middle Childhood and Adolescence

The child presents with obsessions and compulsions such as repetitive hand washing, ordering, checking, counting, repeating words silently, repetitive praying. The obsessions or compulsions interfere with listening or attending in class and frequently grades worsen because the child cannot sit still during tests or lectures.

The child may fear harming himself or herself or others if compulsion is not performed and has problems with task completion.

SPECIAL INFORMATION

The child may be reluctant to talk about the condition; parental report may be the only reliable history. Sexuality may be the underlying concern in certain cases (...).

Children are more prone to engage in rituals at home than in front of peers, teachers, or strangers.

Although obsessive-compulsive disorder usually presents in adolescence or early adulthood, it may begin in childhood. For the most part onset is gradual, but acute onset has been noted in some cases.

Overview

As is the case with the previous parts of this guidebook, this section is not intended to be exhaustive. Rather, it provides a brief introduction of relevant issues and a starting point for gathering information about affect and mood problems.

The section begins with a short piece on mood *disorders* and then reframes the topic into the broader framework provided by the American Pediatric Association's classification scheme. Included is information on the symptoms and severity of a variety of affect and mood problems, as well as information on interventions -- ranging from environmental accommodations to behavior management to medication. The section concludes with a brief list for further reading, as well as a list of agencies that can provide additional information.

TEEN..... DEPRESSION

Being a teenager can be tough. There are changes taking place in your body and brain that can affect how you learn, think, and behave. And if you are facing tough or stressful situations, it is normal to have emotional ups and downs.

But if you have been overwhelmingly sad for a long time (a few weeks to months) and you're not able to concentrate or do the things you usually enjoy, you may want to talk to a trusted adult about depression.



National Institute
of Mental Health

What Is Depression?

Depression (major depressive disorder) is a medical illness that can interfere with your ability to handle your daily activities, such as sleeping, eating, or managing your school work. Depression is common but that doesn't mean it isn't serious. Treatment may be needed for someone to feel better. Depression can happen at any age, but often symptoms begin in the teens or early 20s or 30s. It can occur along with other mental disorders, substance abuse, and other health conditions.

Why can't you just 'snap out' of depression?

Well-meaning friends or family members may try to tell someone with depression to "snap out of it," "just be positive," or "you can be happier if you just try harder." But depression is not a sign of weakness or a character flaw. **Most people with depression need treatment to get better.**

What Are the Signs and Symptoms of Depression?

Sadness is something we all experience. It is a normal reaction to a loss or a setback, but it usually passes with a little time. Depression is different.

If you are wondering if you may have depression, ask yourself these questions:

- ▶ Do you constantly feel sad, anxious, or even "empty," like you feel nothing?
- ▶ Do you feel hopeless or like everything is going wrong?

- ▶ Do you feel like you're worthless or helpless? Do you feel guilty about things?
- ▶ Do you feel irritable much of the time?
- ▶ Do you find yourself spending more time alone and withdrawing from friends and family?
- ▶ Are your grades dropping?
- ▶ Have you lost interest or pleasure in activities and hobbies that you used to enjoy?
- ▶ Have your eating or sleeping habits changed (eating or sleeping more than usual or less than usual)?
- ▶ Do you always feel tired? Like you have less energy than normal or no energy at all?
- ▶ Do you feel restless or have trouble sitting still?
- ▶ Do you feel like you have trouble concentrating, remembering information, or making decisions?
- ▶ Do you have aches or pains, headaches, cramps, or stomach problems without a clear cause?
- ▶ Do you ever think about dying or suicide? Have you ever tried to harm yourself?

What Should I Do If I am Considering Suicide or Harming Myself?

If you are in crisis and need help, call this toll-free number for the **National Suicide Prevention Lifeline (NSPL)**, available 24 hours a day, every day: 1-800-273-TALK (8255). The service is available to everyone. The deaf and hard of hearing can contact the Lifeline via TTY at 1-800-799-4889. All calls are confidential. You can also visit the Lifeline's website at www.suicidepreventionlifeline.org.

The **Crisis Text Line** is another free, confidential resource available 24 hours a day, seven days a week. Text "HOME" to 741741 and a trained crisis counselor will respond to you with support and information over text message. Visit www.crisistextline.org.

Not everyone with depression experiences every symptom. Some people experience only a few symptoms. Others may have many. The symptoms and how long they last will vary from person to person.

How Do I Get Help?

If you think you might have depression, you are not alone. Depression is common, but it is also treatable. Ask for help! Here are a few steps you can take:

- ▶ **Step 1:** Try talking to a trusted adult, such as your parent or guardian, your teacher, or a school counselor. If you don't feel comfortable speaking to an adult, try talking to a friend. If you are not sure where to turn, you can use TXT 4 HELP Interactive (www.nationalsafeplace.org/txt-4-help), which allows you to text live with a mental health professional.

For more ideas and a list of health hotlines, visit www.nimh.nih.gov (search words: children and adolescents).

- **Step 2:** If you're under the age of 18, ask your parent or guardian to make an appointment with your doctor for an evaluation. Your doctor can make sure you don't have a physical illness that may be affecting your mental health. Your doctor may also talk to you about the possibility of seeing a mental health professional, such as a psychiatrist, counselor, psychologist, or therapist. These practitioners can diagnose and treat depression and other mental disorders.

How is Depression Treated?

Depression is usually treated with psychotherapy, medication, or a combination of the two.

What is psychotherapy?

Psychotherapy (sometimes called “talk therapy”) is a term for treatment techniques that can help you identify and manage troubling emotions, thoughts, and behavior. Psychotherapy can take place in a one-on-one meeting with you and a licensed mental health professional. Sometimes you might be part of a group guided by a mental health professional.

Read more about psychotherapy at www.nimh.nih.gov/health/topics/psychotherapies.

What medications treat depression?

If your doctor thinks you need medicine to treat your depression, he or she might prescribe an antidepressant.

When you are taking an antidepressant, it is important to carefully follow your doctor's directions for taking your medicine. The medication could take up to six weeks to work and you should not stop taking it without the help of a doctor. You should also avoid using alcohol or drugs that have not been prescribed to you so that your medications can work.

When it is time to stop the medication, the doctor will help you slowly and safely decrease the dose so that your body can adjust. If you stop taking the medication too soon, your depression symptoms may return. Another reason to stop medication gradually is that stopping suddenly can cause withdrawal symptoms like anxiety and irritability.

Antidepressants can have side effects. These side effects are usually mild (possible stomach upsets or headaches) and may go away on their own. But talk to your doctor about any side effects that you experience because your doctor might adjust the dose or change the medicine. For more information about side effects, visit www.fda.gov.

Although antidepressants can be effective, they may present serious risks to some, especially children and teens. Anyone taking antidepressants should be monitored closely, especially when they first start taking them. Severe anxiety or agitation early in treatment can be especially distressing and should be reported to the doctor immediately.

For many people, the risks of untreated depression outweigh the side effects of antidepressant medications when they are used under a doctor's careful supervision. Information about medications changes frequently. Talk to your doctor and visit the U.S. Food and Drug Administration (FDA) website (www.fda.gov) for the latest safety information.

What else can I do to help manage my depression?

Be patient and know that treatment takes time to work. In the meantime, you can:

- ▶ Stay active and exercise, even if it's just going for a walk.
- ▶ Try to keep a regular sleep schedule.
- ▶ Spend time with friends and family.
- ▶ Break down school or work tasks into smaller ones and organize them in order of what needs to get done first. Then, do what you can.

What Can I Do If Someone I Know Might Have Depression?

If you think your friend might have depression, first help him or her talk to a trusted adult who can connect your friend to a health professional. You can also:

- ▶ Be supportive, patient, and encouraging, even if you don't fully understand what's going on.
- ▶ Invite your friend to activities, social events, or just to hang out.

- ▶ Remind your friend that getting help is important and that with time and treatment, he or she will feel better.
- ▶ **Never ignore comments about death and suicide**, even if it seems like a joke or overdramatic. Talking about suicide is not just a bid for attention but should be taken seriously. Talk to a trusted adult such as a parent, teacher or older sibling as soon as you can.

What Should I Do If Someone I Know Is Considering Suicide?

Often, family and friends are the first to recognize the warning signs of suicide and can take the first step toward helping the person find help.

Remember:

- ▶ If someone is telling you that he or she is going to kill himself or herself, do not leave him or her alone.
- ▶ Do not promise anyone that you will keep his or her suicidal thoughts a secret. Make sure to tell a trusted friend or family member, or an adult with whom you feel comfortable.
- ▶ Get help as soon as possible. Call 911 for emergency services and/or take the person to the nearest hospital emergency room.

You can also call 1-800-273-TALK (8255), the toll-free number for the **National Suicide Prevention Lifeline (NSPL)**, which is available 24 hours a day, every day. The service is available to everyone. All calls are free and confidential. You can also chat with the NSPL online (<http://www.suicidepreventionlifeline.org>).

The Crisis Text Line is another free, confidential resource available 24 hours a day, seven days a week. Text “HOME” to 741741 and a trained crisis counselor will respond to you with support and information via text message. Visit <https://www.crisistextline.org>.

What if someone is posting suicidal messages or something disturbing on social media?

If you see messages or live streaming suicidal behavior on social media, call 911 immediately, contact the toll-free National Suicide Prevention Lifeline at 1-800-273-TALK (8255), or text the Crisis Text Line (text HOME to 741741).

Some social media sites also have a process to report suicidal content and get help for the person posting the message. Each offers different options on how to respond if you see concerning posts about suicide. For example:

- ▶ Facebook Suicide Prevention webpage can be found at www.facebook.com/help/ [use the search term “suicide” or “suicide prevention”].
- ▶ Instagram uses automated tools in the app to provide resources, which can also be found online at <https://help.instagram.com> [use the search term, “suicide,” “self-injury,” or “suicide prevention”].
- ▶ Snapchat’s Support provides guidance at <https://support.snapchat.com> [use the search term, “suicide” or “suicide prevention”].

- ▶ Tumblr Counseling and Prevention Resources webpage can be found at <https://tumblr.zendesk.com> [use the search term “counseling” or “prevention,” then click on “Counseling and prevention resources”].
- ▶ Twitter’s Best Practices in Dealing With Self-Harm and Suicide at <https://support.twitter.com> [use the search term “suicide,” “self-harm,” or “suicide prevention”].
- ▶ YouTube’s Safety Center webpage can be found at <https://support.google.com/youtube> [use the search term “suicide and self-injury”].

Because help via these processes may be delayed, it is still important to call 911 if someone is posting suicidal messages or something disturbing on social media. People—even strangers—have saved lives by being vigilant.

For More Information

For more information on depression and suicide prevention, visit the National Institute of Mental Health (NIMH) website (www.nimh.nih.gov).

Related Resources:

- ▶ Medline Plus (National Library of Medicine): <https://medlineplus.gov/teenhealth.html> (En español: <https://medlineplus.gov/spanish/teenhealth.html>)
- ▶ NIDA for Teens, Drugs & Health: <http://teens.drugabuse.gov/blog>
- ▶ National Suicide Prevention Lifeline: <http://www.suicidepreventionlifeline.org>, 1-800-273-TALK (8255), free 24-hour help
- ▶ Anti-Bullying: <https://www.stopbullying.gov>

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1. Developmental Variations: Behaviors within the Range of Expected Behaviors for That Age Group*

DEVELOPMENTAL VARIATION

Sadness Variation

Transient depressive responses or mood changes to stress are normal in otherwise healthy populations.

Bereavement

Sadness related to a major loss that typically persists for less than 2 months after the loss. However, the presence of certain symptoms that are not characteristic of a "normal" grief reaction may be helpful in differentiating bereavement from a major depressive disorder. These include guilt about things other than actions taken or not taken by the survivor at the time of death, thoughts of death, and morbid preoccupation with worthlessness.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

The infant shows brief expressions of sadness, which normally first appear in the last quarter of the first year of life, manifest by crying, brief withdrawal, and transient anger.

Early Childhood

The child may have transient withdrawal and sad affect that may occur over losses and usually experiences bereavement due to the death of a parent or the loss of a pet or treasured object.

Middle Childhood

The child feels transient loss of self-esteem after experiencing failure and feels sadness with losses as in early childhood.

Adolescence

The adolescent's developmental presentations are similar to those of middle childhood but may also include fleeting thoughts of death. Bereavement includes loss of a boyfriend or girlfriend, friend, or best friend.

SPECIAL INFORMATION

A normal process of bereavement occurs when a child experiences the death of or separation from someone (person or pet) loved by the child. There are normal age-specific responses as well as responses related to culture, temperament, the nature of the relationship between the child and the one the child is grieving, and the child's history of loss. While a child may manifest his or her grief response for a period of weeks to a couple of months, it is important to understand that the loss does not necessarily go away within that time frame. Most children will need to revisit the sadness at intervals (months or years) to continue to interpret the meaning of the loss to their life and to examine the usefulness of the coping mechanisms used to work through the sadness. A healthy mourning process requires that the child has a sense of reality about the death and access to incorporating this reality in an ongoing process of life. Unacknowledged, invalidated grief usually results in an unresolving process and leads to harmful behaviors toward self or others. Symptoms reflecting grief reaction may appear to be mild or transient, but care must be taken to observe subtle ways that unexpressed sadness may be exhibited.

Children in hospitals or institutions often experience some of the fears that accompany a death or separation. These fears may be demonstrated in actions that mimic normal grief responses.

DEVELOPMENTAL VARIATION

Thoughts of Death Variation

Anxiety about death in early childhood.

Focus on death in middle childhood or adolescence.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Not relevant at this age.

Early Childhood

In early childhood anxiety about dying may be present

Middle Childhood

Anxiety about dying may occur in middle childhood, especially after a death in the family.

Adolescence

Some interest with death and morbid ideation may be manifest by a preference for black clothing and an interest in the occult. If this becomes increased to a point of preoccupation, a problem or a serious ideation should be considered.

DEVELOPMENTAL VARIATION

Thoughts of Death Problem

The child has thoughts of or a preoccupation with his or her own death.

If the child has thoughts of suicide, consider suicidal ideation and attempts (next page).

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Unable to assess

Early and Middle Childhood

The child may express a wish to die through discussion or play. This often follows significant punishment or disappointment.

Adolescence

The adolescent may express nonspecific ideation related to suicide.

SPECIAL INFORMATION

Between 12% and 25% of primary school and high school children have some form of suicidal ideation. Those with a specific plan or specific risk factors should be considered at most risk.

2 Problems—Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

PROBLEM

Sadness Problem

Sadness or irritability that begins to include some symptoms of major depressive disorders in mild form.

- depressed/irritable mood
- diminished interest or pleasure
- weight loss/gain, or failure to make expected weight gains
- insomnia/hypersomnia
- psychomotor agitation/retardation
- fatigue or energy loss
- feelings of worthlessness or excessive or inappropriate guilt
- diminished ability to think/concentrate

However, the behaviors are not sufficiently intense to qualify for a depressive disorder.

These symptoms should be more than transient and have a mild impact on the child's functioning. Bereavement that continues beyond 2 months may also be a problem.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

The infant may experience some developmental regressions, fearfulness, anorexia, failure to thrive, sleep disturbances, social withdrawal, irritability, and increased dependency, which are responsive to extra efforts at soothing and engagement by primary caretakers.

Early Childhood

The child may experience similar symptoms as in infancy, but sad affect may be more apparent. In addition, temper tantrums may increase in number and severity, and physical symptoms such as constipation, secondary enuresis (...), encopresis (...), and nightmares may be present.

Middle Childhood

The child may experience some sadness that results in brief suicidal ideation with no clear plan of suicide, some apathy, boredom, low self-esteem, and unexplained physical symptoms such as headaches and abdominal pain (...).

Adolescence

Some disinterest in school work, decrease in motivation, and day-dreaming in class may begin to lead to deterioration of school work. Hesitancy in attending school, apathy, and boredom may occur.

SPECIAL INFORMATION

Sadness is experienced by some children beyond the level of a normal developmental variation when the emotional or physiologic symptoms begin to interfere with effective social interactions, family functioning, or school performance. These periods of sadness may be brief or prolonged depending on the precipitating event and temperament of the child. Reassurance and monitoring is often needed at this level. If the sad behaviors are more severe, consider major depressive disorders.

The potential for suicide in grieving children is higher. Evaluation of suicidal risk should be part of a grief workup for all patients expressing profound sadness or confusion or demonstrating destructive behaviors toward themselves or others.

Behavioral symptoms resulting from bereavement that persist beyond 2 months after the loss require evaluation and intervention. Depressed parents or a strong family history of depression or alcoholism (...) puts youth at very high risk for depressive problems and disorders. Family and marital discord, ... exacerbates risk. Suicidal ideation should be assessed (see Suicidal Thoughts or Behaviors cluster).

Lying, stealing, suicidal thoughts (see Suicidal Thoughts or Behaviors cluster), and promiscuity may be present. Physical symptoms may include recurrent headaches, chronic fatigue, and abdominal pain (...).

3. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)*

DISORDERS

Major Depressive Disorder

Significant distress or impairment is manifested by five of the nine criteria listed below, occurring nearly every day for 2 weeks.

These symptoms must represent a change from previous functioning and that either depressed or irritable mood or diminished interest or pleasure must be present to make the diagnosis.

- depressed/irritable
- diminished interest or pleasure
- weight loss/gain
- insomnia/hypersomnia
- psychomotor agitation/retardation
- fatigue or energy loss
- feelings of worthlessness
- diminished ability to think/concentrate
- recurrent thoughts of death and suicidal ideation

(see *DSM-IV* Criteria ...)

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

True major depressive disorders are difficult to diagnose in infancy. However, the reaction of some infants in response to the environmental cause is characterized by persistent apathy, despondency (often associated with the loss of a caregiver or an unavailable [e.g., severely depressed] caregiver), nonorganic failure-to-thrive (often associated with apathy, excessive withdrawal), and sleep difficulties. These reactions, in contrast to the "problem" level, require significant interventions.

Early Childhood

This situation in early childhood is similar to infancy.

Middle Childhood

The child frequently experiences chronic fatigue, irritability, depressed mood, guilt, somatic complaints, and is socially withdrawn (...). Psychotic symptoms (hallucinations or delusions) may be present.

Adolescence

The adolescent may display psychomotor retardation or have hypersomnia. Delusions or hallucinations are not uncommon (but not part of the specific symptoms of the disorder).

SPECIAL INFORMATION

Depressed parents or a strong family history of depression or alcoholism puts youth at very high risk for depressive disorder (...). Risk is increased by family and marital discord (...), substance abuse by the patient (...), and a history of depressive episodes. Suicidal ideation should be routinely assessed.

Sex distribution of the disorder is equivalent until adolescence, when females are twice as likely as males to have a depressive disorder.

Culture can influence the experience and communication of symptoms of depression, (e.g., in some cultures, depression tends to be expressed largely in somatic terms rather than with sadness or guilt). Complaints of "nerves" and headaches (in Latino and Mediterranean cultures), of weakness, tiredness, or "imbalance" (in Chinese and Asian cultures), of problems of the "heart" (in Middle Eastern cultures), or of being heartbroken (among Hopis) may express the depressive experience.

Subsequent depressive episodes are common. Bereavement typically improves steadily without specific treatment. If significant impairment or distress is still present over 2 months following the acute loss or death of a loved one, or if certain symptoms that are not characteristic of a "normal" grief reaction are present (e.g., marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation), consider diagnosis and treatment of major depressive disorder.

DISORDER

Dysthymic Disorder

The symptoms of dysthymic disorder are less severe or disabling than those of major depressive disorder but more persistent.

Depressed/irritable mood for most of the day, for more days than not (either by subjective account or observations of others) for at least 1 year.

Also the presence, while depressed/ irritable, of two (or more) of the following:

- poor appetite/overeating
- insomnia/hypersomnia
- low energy or fatigue
- poor concentration/difficulty making decisions
- feelings of hopelessness

(see *DSM-IV* Criteria ...)

Adjustment Disorder With Depressed Mood

(see *DSM-IV* Criteria ...)

Depressive Disorder, Not Otherwise Specified

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Not diagnosed.

Early Childhood

Rarely diagnosed.

Middle Childhood and Adolescence

Commonly experience feelings of inadequacy, loss of interest/pleasure, social withdrawal, guilt, brooding, irritability or excessive anger, decreased activity/productivity. May experience sleep/ appetite/weight changes and psychomotor symptoms. Low self-esteem is common.

SPECIAL INFORMATION

Because of the chronic nature of the disorder, the child may not develop adequate social skills.

The child is at risk for episodes of major depression.

DISORDER

Bipolar I Disorder, With Single Manic Episode

(see DSM-IV CRITERIA...)

Bipolar II Disorder, Recurrent Major Depressive Episodes With Hypomanic Episodes

Includes presence (or history) of one or more major depressive episodes, presence of at least one hypomanic episode, there has never been a manic episode (similar to manic episodes but only need to be present for 4 or more days and are not severe enough to cause marked impairment in function) or a mixed episode. The symptoms are not better accounted for by schizoaffective disorder, schizophrenia, delusional disorder, or psychotic disorder. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Not diagnosed.

Early Childhood

Rarely diagnosed.

Middle Childhood

The beginning symptoms as described for adolescents start to appear.

Adolescence

During manic episodes, adolescents may wear flamboyant clothing, distribute gifts or money, and drive recklessly. They display inflated self-esteem, a decreased need for sleep, pressure to keep talking, flights of ideas, distractibility, unrestrained buying sprees, sexual indiscretion, school truancy and failure, antisocial behavior, and illicit drug experimentation.

SPECIAL INFORMATION

Substance abuse is commonly associated with bipolar disorder (...).

Stimulant abuse and certain symptoms of attention-deficit/ hyperactivity disorder may mimic a manic episode (see Hyperactive/ Impulsive Behaviors cluster).

Manic episodes in children and adolescents can include psychotic features and may be associated with school truancy, antisocial behavior (...), school failure, or illicit drug experimentation. Long-standing behavior problems often precede the first manic episode.

One or more manic episodes (a distinct period of an abnormally and persistently elevated and expansive or irritable mood lasting at least 1 week if not treated) frequently occur with one or more major depressive episodes. The symptoms are not better accounted for by other severe mental disorders (e.g., schizoaffective, schizophrenogenic, delusional, or psychotic disorders). The symptoms cause mild impairment in functioning in usual social activities and relationships with others.

DISORDER

Suicidal Ideation and Attempts

The child has thoughts about causing intentional self-harm acts that cause intentional self-harm or death.

This code represents an unspecified mental disorder. It is to be used when no other condition is identified.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Unable to assess.

Early Childhood

The child expresses a wish and intent to die either verbally or by actions.

Middle Childhood

The child plans and enacts self-injurious acts with a variety of potentially lethal methods.

Adolescence

The adolescent frequently shows a strong wish to die and may carefully plan and carry out a suicide.

SPECIAL INFORMATION

A youngster's understanding that death is final is not an essential ingredient in considering a child or adolescent to be suicidal. However, very young children, such as preschoolers who do not appreciate the finality of death, can be considered to be suicidal if they wish to carry out a self-destructive act with the goal of causing death. Such behavior in preschoolers is often associated with physical or sexual abuse (...).

Prepubertal children may be protected against suicide by their cognitive immaturity and limited access to more lethal methods that may prevent them from planning and executing a lethal suicide attempt despite suicidal impulses.

The suicide rate and rate of attempted suicide increase with age and with the presence of alcohol and other drug use. Psychotic symptoms, including hallucinations, increase risk as well.

Because of societal pressures, some homosexual youth are at increased risk for suicide attempts (...).

In cases of attempted suicide that are carefully planned, adolescents may leave a note, choose a clearly lethal method, and state their intent prior to the actual suicide. In contrast, most suicide attempts in adolescence are impulsive, sometimes with little threat to the patient's life. The motivation for most attempts appears to be a wish to gain attention and/or help, escape a difficult situation, or express anger or love. However, irrespective of motivation, all suicide attempts require careful evaluation and all patients with active intent to harm themselves should have a thorough psychiatric evaluation.

Although suicidal ideation and attempts is not a disorder diagnosis, more extensive evaluation may identify other mental conditions (e.g., major depressive disorder).

Overview

After a short introduction to recent efforts to synthesize fundamental social and interpersonal areas of competence and problem functioning, the topic is outlined within the American Pediatric Association's framework. The range interventions discussed is consistent with that framework — emphasizing the importance of accommodations as well as strategies designed to change the individual.

As a starting point for gathering additional information about social and interpersonal problems, references and agency resources also are included.



Social and Emotional Functioning

There are no sound data on the scope of children's social and interpersonal problems. It is clear, however, that youngsters who have difficulty establishing or maintaining or ending interpersonal relationships are of major concern to teachers and parents. Problems in this area are associated with poor performance at school -- including a range of behavioral, learning, and emotional problems.

With the burgeoning of programs focused on preventing and correcting social and emotional problems, it helps to have a synthesis of fundamental areas of concern. W.T. Grant Foundation (in the 1980s) funded a five year project that brought together a consortium of professionals to review the best programs and create such a synthesis.* The following is their list of core social and emotional competence:

Emotional

- identifying and labeling feelings
- expressing feelings
- assessing the intensity of feelings
- managing feelings
- delaying gratification

Cognitive

- self-talk -- conducting an "inner dialogue" as a way to cope with a topic or challenge or reinforce one's own behavior
- reading and interpreting social cues -- for example, recognizing social influences on behavior and seeing oneself in the perspective of the larger community
- using steps for problem-solving and decision-making -- for instance, controlling impulses, setting goals, identifying alternative actions, anticipating consequences
- understanding the perspectives of others
- understanding behavioral norms (what is and is not acceptable behavior)
- a positive attitude toward life
- self-awareness -- for example, developing realistic expectations about oneself

Behavioral

- nonverbal -- communicating through eye contact, facial expressiveness, tone of voice, gestures, etc.
- verbal -- making clear requests, responding effectively to criticism, resisting negative influences, listening to others, helping others, participating in positive peer groups

1. Developmental Variations: Behaviors within the Range of Expected Behaviors for That Age Group*

DEVELOPMENTAL VARIATION

Social Interaction Variation

Because of constitutional and/or psychological factors, children and adolescents will vary in their ability and desire to interact with other people. Less socially adept or desirous children do not have a problem as long as it does not interfere with their normal development and activities.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Infants exhibit a variety of individual differences in terms of reactivity to sensation (underreactive or overreactive), capacity to process information in auditory, visual modes, as well as motor tone, motor planning, and movement patterns. For example, some babies are underreactive to touch and sound, with low motor tone, and may appear self-absorbed and require a great deal of parental wooing and engagement to be responsive. The ease with which the caregivers can mobilize a baby by dealing with the infant's individually different pattern suggests a variation rather than a problem or disorder.

Early Childhood

The child is self-absorbed, enjoys solitary play, with and without fantasy, but can be wooed into relating and interacting by a caregiver who tailors his or her response to individual differences. The child may be slightly slower in his or her language development and not make friends easily.

Middle Childhood

The child may not make friends easily and be less socially adept. The child may prefer solitary play at times.

Adolescence

The adolescent has limited concern regarding popular dress, interests, and activities. The adolescent finds it difficult to make friends at times.

SPECIAL INFORMATION

Consider expressive language disorder or mixed receptive-expressive language disorder

2. Problems—Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

PROBLEM	COMMON DEVELOPMENTAL PRESENTATIONS
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Social Withdrawal Problem

The child's inability and/or desire to interact with people is limited enough to begin to interfere with the child's development and activities.

Infancy

The infant has an unusually high threshold and/or low intensity of response, is irritable, difficult to console, overly complacent may exhibit head banging or other repetitive behavior. The infant requires persistent wooing and engagement, including, at times, highly pleasurable and challenging sensory and affective experiences, to keep from remaining self-absorbed and withdrawing.

Early Childhood

The child shows self-absorption, and prefers solitary play. The child has some verbal and/or nonverbal communication, is mildly compulsive, and shows rigid behaviors.

Middle Childhood

The child is very shy, reticent, shows an increased concern about order and rules, is socially isolated, rarely initiates peer interactions, and prefers solitary activities to peer group activities.

Adolescence

The adolescent shows difficulty in social situations, has limited friendships, is socially isolated, may be a "loner," prefers solitary activities to peer group activities, is reticent, has eccentric hobbies and interests, and has limited concern regarding popular styles of dress, behavior, or role models.

SPECIAL INFORMATION

Consider sensory impairments (vision, hearing).

Excessive sensory stimulation may increase anxiety and agitation.

There are children with initial symptoms severe enough to be considered as having an autistic disorder, who with appropriate and full intervention, will markedly improve.

3. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)*

Diagnostic criteria for Avoidant Personality Disorder

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood, and present in a variety of contexts, as indicated by four (or more) of the following:

- (1) avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection
- (2) is unwilling to get involved with people unless certain of being liked
- (3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed
- (4) is preoccupied with being criticized or rejected in social situations
- (5) is inhibited in new interpersonal situations because of feelings of inadequacy
- (6) views self as socially inept, personally unappealing, or inferior to others
- (7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

Avoidant Personality Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)

DIAGNOSTIC FEATURES

The essential feature of Avoidant Personality Disorder is a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation that begins by early adulthood and is present in a variety of contexts.

Individuals with Avoidant Personality Disorder avoid work or school activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection (Criterion 1). Offers of job promotions may be declined because the new responsibilities might result in criticism from co-workers. These individuals avoid making new friends unless they are certain they will be liked and accepted without criticism (Criterion 2). Until they pass stringent tests proving the contrary, other people are assumed to be critical and disapproving. Individuals with this disorder will not join in group activities unless there are repeated and generous offers of support and nurturance. Interpersonal intimacy is often difficult for these individuals, although they are able to establish intimate relationships when there is assurance of uncritical acceptance. They may act with restraint, have difficulty talking about themselves, and withhold intimate feelings for fear of being exposed, ridiculed, or shamed (Criterion 3).

Because individuals with this disorder are preoccupied with being criticized or rejected in social situations, they may have a markedly low threshold for detecting such reactions (Criterion 4). If someone is even slightly disapproving or critical, they may feel extremely hurt. They tend to be shy, quiet, inhibited and "invisible" because of the fear that any attention would be degrading or rejecting. They expect that no matter what they say, others will see it as "wrong," and so they may say nothing at all. They react strongly to subtle cues that are suggestive of mockery or derision. Despite their longing to be active participants in social life, they fear placing their welfare in the hands of others. Individuals with Avoidant Personality Disorder are inhibited in new interpersonal situations because they feel inadequate and have low self-esteem (Criterion 5). Doubts concerning social competence and personal appeal become especially manifest in settings involving interactions

with strangers. These individuals believe themselves to be socially inept, personally unappealing, or inferior to others (Criterion 6). They are unusually reluctant to take personal risks or to engage in any new activities because these may prove embarrassing (Criterion 7). They are prone to exaggerate the potential dangers of ordinary situations, and a restricted lifestyle may result from their need for certainty and security. Someone with this disorder may cancel a job interview for fear of being embarrassed by not dressing appropriately. Marginal somatic symptoms or other problems may become the reason for avoiding new activities.

ASSOCIATED FEATURES AND DISORDERS

Individuals with Avoidant Personality Disorder often vigilantly appraise the movements and expressions of those with whom they come into contact. Their fearful and tense demeanor may elicit ridicule and derision from others, which in turn confirms their self-doubts. They are very anxious about the possibility that they will react to criticism with blushing or crying. They are described by others as being "shy," "timid," "lonely," and "isolated." The major problems associated with this disorder occur in social and occupational functioning. The low self-esteem and hypersensitivity to rejection are associated with restricted interpersonal contacts. These individuals may become relatively isolated and usually do not have a large social support network that can help them weather crises. They desire affection and acceptance and may fantasize about idealized relationships with others. The avoidant behaviors can also adversely affect occupational functioning because these individuals try to avoid the types of social situations that may be important for meeting the basic demands of the job or for advancement.

Other disorders that are commonly diagnosed with Avoidant Personality Disorder include Mood and Anxiety Disorders (especially Social Phobia of the Generalized Type). Avoidant Personality Disorder is often diagnosed with Dependent Personality Disorder, because individuals with Avoidant Personality Disorder become very attached to and dependent on those few other people with whom they are friends. Avoidant Personality Disorder also tends to be diagnosed with Borderline Personality

Disorder and with the Cluster A Personality Disorders (i.e., Paranoid, Schizoid, or Schizotypal Personality Disorders) .

SPECIFIC CULTURE, AGE, AND GENDER FEATURES

There may be variation in the degree to which different cultural and ethnic groups regard diffidence and avoidance as appropriate. Moreover, avoidant behavior may be the result of problems in acculturation following immigration. This diagnosis should be used with great caution in children and adolescents for whom shy and avoidant behavior may be developmentally appropriate. Avoidant Personality Disorder appears to be equally frequent in males and females.

PREVALENCE

The prevalence of Avoidant Personality Disorder in the general population is between 0.5% and 1.0%. Avoidant Personality Disorder has been reported to be present in about 10% of outpatients seen in mental health clinics.

COURSE

The avoidant behavior often starts in infancy or childhood with shyness, isolation, and fear of strangers and new situations. Although shyness in childhood is a common precursor of Avoidant Personality Disorder, in most individuals it tends to gradually dissipate as they get older. In contrast, individuals who go on to develop Avoidant Personality Disorder may become increasingly shy and avoidant during adolescence and early adulthood, when social relationships with new people become especially important. There is some evidence that in adults Avoidant Personality Disorder tends to become less evident or to remit with age.

Increasing School Capacity to Prevent and Ameliorate Problems

For schools to be successful in addressing barriers to learning and teaching, they must build the capacity of the staff, expand the roles and functions of education support staff, enhance the involvement of those in the home, and a caring school culture. This section highlights these four key topics.

- A. Capacity Building for Teachers and School Staff
- B. Expanding the Role of Support Staff
- C. Enhancing Home Involvement and
Forming Partnerships with Parents
- D. Fostering a Caring School Culture
- E. Student and Learning Supports: Increasing Availability
and Enhancing Access and Use

MentalHealth.gov

Let's talk about it.

<https://www.mentalhealth.gov/talk/educators>

For Educators

Educators are often the first to notice mental health problems. Here are some ways you can help students and their families.

What Educators Should Know

You should know:

- The [warning signs](#) for mental health problems.
- Whom to turn to, such as the principal, school nurse, school psychiatrist or psychologist, or school social worker, if you have questions or concerns about a student's behavior.
- How to access [crisis support and other mental health services](#).

What Educators Should Look For in Student Behavior

Consult with a school counselor, nurse, or administrator and the student's parents if you observe one or more of the following behaviors:

- Feeling very sad or withdrawn for more than two weeks
- Seriously trying to harm oneself, or making plans to do so
- Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing
- Involvement in many fights or desire to badly hurt others
- Severe out-of-control behavior that can hurt oneself or others
- Not eating, throwing up, or using laxatives to make oneself lose weight
- Intense worries or fears that get in the way of daily activities
- Extreme difficulty concentrating or staying still that puts the student in physical danger or causes problems in the classroom
- Repeated use of drugs or alcohol
- Severe mood swings that cause problems in relationships
- Drastic changes in the student's behavior or personality

What Educators Can Do in Classrooms and Schools

You can support the mental health of all students in your classroom and school, not just individual students who may exhibit behavioral issues. Consider the following actions:

- Educate staff, parents, and students on [symptoms](#) of and [help](#) for mental health problems
- Promote social and emotional competency and build resilience
- Help ensure a positive, safe school environment
- Teach and reinforce positive behaviors and decision-making
- Encourage helping others
- Encourage good physical health
- Help ensure access to school-based mental health supports

Developing Effective School Mental Health Programs

Efforts to care for the emotional well-being of children and youth can extend beyond the classroom and into the entire school. School-based mental health programs can focus on promoting mental wellness, preventing mental health problems, and providing treatment.

Effective programs:

- Promote the healthy social and emotional development of all children and youth
- Recognize when young people are at risk for or are experiencing mental health problems
- Identify how to intervene early and appropriately when there are problems

Learn More about Ways to Support Your Students and Their Families

- Find how to assess mental health needs in your school and [develop and implement a school-based mental health program](#) .
- [Find tips for talking to children and youth after a disaster or traumatic event.](#)

B. Expanding the Role of Support Staff

The Role of Support Services

Pupil service professionals are confronted with a rapidly changing work situation. It seems clear that jobs will be reshaped as initiatives to restructure education and community services play out during the next decade. A widespread concern is that positions will be cut.

Rather than respond reactively, school support staff must proactively continue to assume major, varied, and expanding roles related to mental health in schools. As public schools struggle to address poor achievement and escalating psychosocial problems, many specific needs and opportunities related to addressing barriers to learning and enhancing healthy development warrant greater attention. There are fundamental concerns that must be handled regarding the understanding and classification of problems, what approaches are appropriate for different groups and individuals, how to plan and implement the most cost-effective intervention, and how to improve interventions and evaluate cost-effectiveness. These are areas to which school support staff have contributed already and can continue to do so. To clarify the point, a few examples should suffice.

Improving Efficacy and Cost Effectiveness

Emerging trends are reshaping the work of support services. With respect to intervention, support services must become a major force in expanding prevailing models and shaping current policy reforms. Efforts are particularly needed that focus on improving intervention efficacy and cost effectiveness through integrating physical and mental health and social services and restructuring that component of school programs designed to address psychosocial problems. For this to occur, however, attention must be devoted to conceptualizing, developing, implementing, and evaluating comprehensive, integrated models of intervention.

One place to begin is with analyses of the curricula used to train support service personnel. Ultimately, the field must develop a cadre of leaders who have a broader perspective than currently prevails if the next generation is to make significant breakthroughs in understanding and ameliorating students' problems and in facilitating psychosocial

development.

New directions call for going beyond direct service and beyond traditional consultation. Support services must be prepared not only to provide direct help but to assume key roles as advocates, catalysts, brokers, and facilitators of systemic reform and in resolving planning, implementation, and evaluation problems that arise related to school psychosocial and mental health programs. A pressing need is for research that clarifies what is involved in increasing the fidelity with which empirically supported interventions are translated into large-scale programs. In the process, such work will provide data upon which programs and systemic change strategies work and which do not in school settings. In this respect, a special focus is needed on expanding the concept of systems of care to all students who are involved in multiple programs of assistance and adding concepts such as systems of prevention and systems of early intervention and evolving ways such systems can operate in a seamless manner. By developing and demonstrating the efficacy of processes resulting in well-planned and implemented programs that weave together a continuum of interventions for youngsters, it should finally be possible to conduct evaluative research that fairly tests the cost-effectiveness of comprehensive, integrated approaches. Such research also should yield fundamental knowledge about human behavior and the nature of interventions that influence such behavior.

Needed: A Radical Change in the Systems that Educate School Support Staff

Clearly, this discussion stresses the need for major modification of preservice and continuing education for school professionals. Efforts to change the prevailing curriculum, of course, are continuing, and this is not the place for another discussion of the deficiencies in preservice and inservice education.

Instead, we offer an initial draft of a working curriculum content outline developed by the Center for Mental Health in Schools at UCLA. The outline is intended as an aid in rethinking the content of what school support staff need to know to play a potent role in creating a comprehensive, integrated approach to meeting the needs of the young by interweaving what

schools can do with what the community offers. As a next step in operationalizing a curriculum, the Center staff has generated continuing education modules based on this outline and has begun widespread dissemination through the Internet, as well as in hard copy format. The Center invites feedback to guide continuing efforts to evolve this work.

As the outline below suggests, changing roles for school support staff means a much expanded curriculum. It has always been clear that preservice education can provide only a modicum of what a professional must know and

be able to do. Despite this awareness, the curriculum for professionals rarely is conceived as a coordinated whole: preservice presents the minimal standards required for practice; the first years of inservice focus in a cohesive way on the uncovered content; and continuing education addresses the problems of specialization and continuing changes in the field. Although the modules developed by our Center are aimed at offering the content as continuing education to help meet the needs of practicing school support staff the intent also is to influence the redesign of preservice curricula and encourage a rethinking of inservice programs.

I. Mental Health in School: An Introductory Overview

II. The Need

- A. Barriers to Learning (including physical and mental health problems)
- B. Promoting Healthy Development (physical and mental including fostering resiliency)
- C. Personal and Systemic Barriers to Learning
 - Psychosocial problems
 - Psychopathology
 - Environmental stressors
 - Student and environment mismatch
- D. Family Needs for Social/Emotional Support
- E. Staff Needs for Social/Emotional Support
- F. Limitations as Challenges

III. Addressing the Needs

- A. Understanding What Causes Different Types of Problems
- B. Legislative Mandates
- C. Clinical Approaches in School Sites
- D. Programmatic Approaches: Going Beyond Clinical Interventions
 - Working with classroom teachers
 - Systems for student and family assistance
 - Crises/emergencies: response prevention
 - Supporting student and family transitions
 - Mobilizing parent/home involvement in schooling and health promotion
- E. Toward a Comprehensive, Integrated Continuum of Interventions
 - Primary prevention of problems (including a major emphasis on promoting opportunities, wellness, and positive physical and mental development)
 - Early-age interventions for problems (including prereferral interventions)
 - Early-after-problem onset interventions (including prereferral interventions)
 - After the problem has become chronic

IV. Roles for School Support Staff: A Multifaceted Focus

- A. Problem Identification, Referral, Triage, and Assistance (including helping to develop referral and triage systems)
 - Assessment
 - Psychological first aid
 - Open-enrollment programs
 - Information-giving and didactic approaches
 - Counseling
 - Support and maintenance of students receiving psychotropic medication
- B. Developing Systems for Case, Resource, and Program Coordination, Monitoring, and Management
- C. Collaborative Teams
- D. Community Outreach
- E. Training Aides, Volunteers, and Peers to Help with Targeted Individuals and Groups
- F. Providing Inservice Staff Training
- G. Working for Systemic Changes and Getting the Right Support from the School District

V. Working Relationships and Cultural, Professional, and Individual Differences

- A. Matching Motivation and Capabilities
 - Building on strengths and resiliency
 - Minimizing weaknesses, resistance, and reactance
 - Least intervention needed
- B. Support, Guidance, Accommodations, and Appropriate Limit Setting

A Team to Manage Care

When a client is involved with more than one intervener, management of care becomes a concern. This clearly is always the situation when a student is referred for help over and above that which her/his teacher(s) can provide. Subsequent monitoring as part of the ongoing management of client care focuses on coordinating interventions, improving quality of care (including revising intervention plans as appropriate), and enhancing cost-efficacy.

Management of care involves a variety of activity all of which is designed to ensure that client interests are well-served. At the core of the process is enhanced monitoring of care with a specific focus on the appropriateness of the chosen interventions, adequacy of client involvement, appropriateness of intervention planning and implementation, and progress. Such ongoing monitoring requires systems for

- tracking client involvement in interventions
- amassing and analyzing data on intervention planning and implementation
- amassing and analyzing progress data
- recommending changes

Effective monitoring depends on information systems that enable those involved with clients to regularly gather, store, and retrieve data. Schools rely heavily on forms for gathering necessary information (see Module II). In coming years, more and more of this information will be entered into computers to facilitate retrieval and assist in other ways with client care.

Management of care, of course, involves more than monitoring processes and outcomes. Management also calls for the ability to produce changes as necessary. Sometimes steps must be taken to improve the quality of processes, including at times enhancing coordination among several interveners. Sometimes intervention plans need to be revised to increase their efficacy and minimize their "costs" including addressing negative "side effects." Thus, management of care involves using the findings from ongoing monitoring to clarify if interventions need to be altered and then

implements strategies to identify appropriate changes and ensure they are implemented with continued monitoring. Along the way, those involved in managing the client's care may have to advocate for and broker essential help and provide the linkage among services that ensures they are coordinated. They also must enhance coordinated intervener communication with the student's care givers at home.

Who does all this monitoring and management of care? Ideally, all involved parties, interveners and clients assume these functions and become the management team. One member of such a team needs to take primary responsibility for management of care (primary manager). Sites with sufficient resources often opt to employ one staff member to fill this role for all clients. However, given the limited resources available to schools, a more practical model is to train many staff to share such a role. Ultimately, with proper instruction, one or more family members might be able to assume this role.

All who become primary managers of care must approach the role in a way that respects the client and conveys a sense of caring. The process should be oriented to problem-solving but should not be limited to problem treatments (e.g., in working on their problems, young people should not be cut off from developmental and enrichment opportunities). In most instances, a youngster's family will be integrally involved and empowered as partners, as well as recipients of care. Well-implemented management of care can help ensure that clients are helped in a comprehensive, integrated manner designed to address the whole person. A positive side effect of all this can be enhancement of systems of care.

Management teams should meet whenever analysis of monitoring information suggests a need for program changes and at designated review periods. Between meetings, it is the responsibility of the primary manager to ensure that care is appropriately monitored, team meetings are called as changes are needed, and that changes are implemented. It is the team as a whole, however, that has responsibility for designating necessary changes and working to ensure the changes are made.

The following list itemizes a few basic tasks for primary managers of care:

- Before a team meeting, write up analyses of monitoring data and any recommendations to share with management team.
- Immediately after a team meeting, write up and circulate changes proposed by management team and emphasize who has agreed to do which tasks and when.
- Set-up a "tickler" system to remind you when to check on whether tasks have been accomplished.
- Follow-up with team members who have not accomplished agreed upon tasks to see what assistance they need.

A Team to Manage Resources

School practitioners are realizing that since they can't work any harder, they must work smarter. For some, this translates into new strategies for coordinating, integrating, and redeploying resources. Such efforts start with new (a) processes for mapping and matching resources and needs and (b) mechanisms for resource coordination and enhancement.

An example of a mechanism designed to reduce fragmentation and enhance resource availability and use (with a view to enhancing cost-efficacy) is seen in the concept of a resource coordinating team. Creation of such a school-based team provides a vehicle for building working relationships and a good mechanism for starting to weave together existing school and community resources and encourage services and programs to function in an increasingly cohesive way.

Where such a team is created, it can be instrumental in integrating the center into the school's ongoing life. The team solves turf and operational problems, develops plans to ensure availability of a coordinated set of services, and generally improves the school's focus on mental health.

A resource coordinating team differs from teams created to review individual students (such as a student study team, a teacher assistance team, a case management team). That is, its focus is not on specific cases, but on clarifying resources and their best use. In doing so, it provides what often is a missing mechanism for managing and enhancing systems to coordinate, integrate, and strengthen

interventions. For example, this type of mechanism can be used to weave together the eight components of school health programs to better address such problems as on-campus violence, substance abuse, depression, and eating disorders. Such a team can be assigned responsibility for (a) mapping and analyzing activity and resources with a view to improving coordination, (b) ensuring there are effective systems for referral, case management, and quality assurance, (c) guaranteeing appropriate procedures for effective management of programs and information and for communication among school staff and with the home, and (d) exploring ways to redeploy and enhance resources such as clarifying which activities are nonproductive and suggesting better uses for the resources, as well as reaching out to connect with additional resources in the school district and community.

Although a resource-oriented team might focus solely on psychosocial programs, such a mechanism is meant to bring together representatives of all major programs and services supporting a school's instructional component (e.g., guidance counselors, school psychologists, nurses, social workers, attendance and dropout counselors, health educators, special education staff, bilingual and Title I program coordinators). This includes representatives of any community agency that is significantly involved at the school. It also includes the energies and expertise of one of the site's administrators, regular classroom teachers, non-certificated staff, parents, and older students. Where creation of "another team" is seen as a burden, existing teams can be asked to broaden their scope. Teams that already have a core of relevant expertise, such as student study teams,

teacher assistance teams, and school crisis teams, can extend their functions to encompass a focus on resources. To do so, however, they must take great care to structure their agenda so sufficient time is devoted to the added tasks.

Properly constituted, trained, and supported, a resource coordinating team can complement the work of the site's governance body through

providing on-site overview, leadership, and advocacy for all activity aimed at addressing barriers to learning and enhancing healthy development. Having at least one representative from the resource coordinating team on the school's governing and planning bodies helps ensure that essential programs and services are maintained, improved, and increasingly integrated with classroom instruction.

Mapping Resources

The literature on resource coordination makes it clear that a first step in countering fragmentation involves "mapping" resources by identifying what exists at a site (e.g., enumerating programs and services that are in place to support students, families, and staff; outlining referral and case management procedures. A comprehensive form of "needs assessment" is generated as resource mapping is paired with surveys of the unmet needs of students, their families, and school staff.

Based on analyses of what is available, effective, and needed, strategies can be formulated for resource enhancement. These focus on (a) outreach to link with additional resources at other schools, district sites, and in the community and (b) better ways to use existing resources. (The process of outreach to community agencies is made easier where there is policy and organization supporting school-community collaboration. However, actual establishment of formal connections remains complex and is becoming more difficult as publicly-funded community resources dwindle.)

Perhaps the most valuable aspect of mapping and analyzing resources is that the products provide a sound basis for improving cost-effectiveness. In schools and community agencies, there is acknowledged redundancy stemming from ill-conceived policies and lack of coordination. These facts do not translate into evidence that there are pools of unneeded personnel; they simply suggest there are resources that can be used in different ways to address unmet needs. Given that additional funding for reform is hard to come by, such redeployment of resources is the primary answer to the ubiquitous question: Where will we find the funds?

Available from the Center for Mental Health in Schools for a set of surveys designed to guide mapping of existing school-based and linked psychosocial and mental health programs and services.

Local Schools Working Together

To facilitate resource coordination and enhancement among a complex of schools (e.g., a high school and its feeder middle and elementary schools), a resource coordinating council can be established by bringing together representatives of each school's resource coordinating teams. Such a complex of schools

needs to work together because in many cases they are concerned with the same families (e.g., a family often has children at each level of schooling). Moreover, schools in a given locale try to establish linkages with the same community resources. A coordinating council for a complex of schools provides a mechanism to help ensure cohesive and equitable deployment of such resources.

Fully Integrated with School and Community Resources

Most schools and many community services use weak models in addressing barriers to learning. The primary emphasis in too many instances is to refer individuals to specific professionals, and this usually results in narrow and piecemeal approaches to complex problems, many of which find their roots in a student's environment. Over-reliance on referrals to professionals also inevitably overwhelms limited public-funded resources.

More ideal models emphasize the need for a comprehensive continuum of community and school interventions to ameliorate complex problems. Such a continuum ranges from programs for primary prevention and early-age intervention -- through those to treat problems soon after onset -- to treatments for severe and chronic problems. Thus, they emphasize that promoting healthy development and positive functioning are one of the best ways to prevent many problems, and they also address specific problems experienced by youth and their families.

Limited efficacy seems inevitable as long as the full continuum of necessary programs is unavailable; limited cost effectiveness seems inevitable as long as related interventions are carried out in isolation of each other. Given all this, it is not surprising that many in the field doubt that major breakthroughs can occur without a comprehensive and integrated programmatic thrust. Such views have added impetus to major initiatives designed to restructure community health and human services and the way schools operate.

To be most effective, such interventions are developmentally-oriented (i.e. beginning before birth and progressing through each level of schooling and beyond) and offer a range of activity -- some focused on individuals and some on environmental systems. Included are programs designed to promote and maintain safety at home and at school, programs to promote and maintain physical/mental health, preschool and early school adjustment programs, programs to improve and augment social and academic supports, programs to intervene prior to referral for intensive treatments, and intensive treatment programs. It should be evident that such a continuum requires meshing together school and community resources and, given the scope of activity effectiveness and efficiency require formal and long-lasting interprogram collaboration.

One implication of all this is formulated as the proposition that a comprehensive, integrated component to address barriers to learning and enhance healthy development is essential in helping the many who are not benefitting satisfactorily from formal education. Schools and communities are beginning to sense the need to adopt such a perspective. As they do, we will become more effective in our efforts to enable schools to teach, students to learn, families to function constructively, and communities to serve and protect. Such efforts will no longer be treated as supplementary ("add-ons") that are carried out as fragmented and categorical of services; indeed, they will be seen as a primary, essential and integrated component of school reform and restructuring.

Some General Guidelines Related to Establishing School-Site Collaborative Teams Focused on Addressing Barriers to Learning

A basic problem in forming teams is that of identifying and deploying committed and able personnel and establishing an organizational structure that nurtures the competence and commitment of team members. Based on experiences, the following general considerations related to school-based teams also are worth highlighting here.

1. Teams for programmatic areas may consist of current resource staff, special project staff, teachers, site administrators, parents, older students, and others from the community. In this last regard, representatives of school-linked community services must be included.
2. For staff, job descriptions must be written in ways that call on personnel to work in a coordinated and increasingly integrated way with the intent of maximizing resource use and enhancing efficacy.
3. To maximize the range of programs and services at a school, every staff member must be encouraged to participate on some team designed to enhance students' classroom functioning. The importance of such teams should be recognized through provision of time and resources that allow team members to work effectively together.
4. Each group can vary in size--from two to as many as are needed and interested. Major criteria used in determining size should be factors associated with efficient and effective functioning. The larger the group, the harder it is to find a meeting time and the longer each meeting tends to run. Frequency of meetings depends on the group's functions, time availability, and ambitions. Properly designed and trained teams can accomplish a great deal through informal communication and short meetings.
5. The core of a team is staff who have or will acquire the ability to carry out identified functions and make the mechanism work; others can be auxiliary members. All should be committed to the team's program-focused agenda. Building team commitment and competence should be one major focus of school management policies and programs.
6. Because several areas of program focus require the expertise of the same staff (nurse, psychologist, counselor, resource teacher, social worker), these individuals will necessarily be on several teams.
7. Each team needs a dedicated leader/facilitator who has the ability to keep the group task-focused and productive and someone who records decisions and plans and reminds members of planned activity and products.
8. Team functioning is enhanced through use of computer technology (management systems, electronic bulletin boards and mail, resource clearinghouses). Such technology facilitates communication, networking, program planning and implementation, linking activity, and a variety of budgeting, scheduling, and other management concerns.
9. Effective teams should be able to produce savings in terms of time and resources through appropriately addressing the programmatic areas in which they are involved. In addition, by tapping into public health-care funds, a district may be able to underwrite some of the costs of those team members who also provide specific services.

C. Enhancing Home Involvement and Forming Partnerships with Parents

Currently, all school districts are committed to some form of parent involvement. However, we have learned the hard way that the term means different things in different schools and among the various stakeholders at any school. There are two lessons that seem fundamental.

First, we find that most efforts to involve parents seem aimed at those who want and are able to show up at school. It's important to have activities for such parents. It's also important to remember that they represent the smallest percentage of parents at most schools. What about the rest? Especially those whose children are doing poorly at school. Ironically, efforts to involve families whose youngsters are doing poorly often result in parents who are even less motivated to become involved. Typically, a parent of such a youngster is called to school because of the child's problems and leaves with a sense of frustration, anger, and guilt. Not surprisingly, such a parent subsequently tries to avoid the school as much as feasible. If schools really want to involve such families, they must minimize "finger wagging" and move to offer something more than parent education classes.

A second basic lesson learned is that in many homes mothers or fathers are not the key to whether a youngster does well at school. Many youngsters do not even live with their parents. Besides those placed in foster care, it is common for children to live with grandparents, aunts, or older siblings. Moreover, even when a youngster is living with one or more parents, an older sibling may have the greatest influence over how seriously the individual takes school. Given these realities, we use the term home involvement and try to design involvement programs for whoever is the key influence in the home.

Home involvement is a basic area for enabling learning. Schools must develop programs to address the many barriers associated with the home and the many barriers in the way of home involvement. Unfortunately, as with other facets of enabling learning, limited finances often mean verbal commitments are not backed up with adequate resources. Meaningful home involvement requires on-site decision makers to commit fully. This means creating and maintaining effective mechanisms for program development and overcoming barriers related to home involvement.

There are many ways to think about an appropriate range of activities. We find it useful to differentiate whether the focus is on improving the functioning of individuals (students, parent care taker), systems (classroom, school, district), or both. And with respect to those individuals with the greatest impact on the youngster, we distinguish between efforts designed mainly to support the school's instructional mission and those intended primarily to provide family assistance (see below).

Improve Individual

- *meeting-basic obligations to the functioning student/helping caretakers meet their own basic needs
- *communicating about matters essential to the student
- *making essential decisions about the student
- *supporting the student's basic learning and development at home
- *solving problems and providing support at home and at school re: the students special needs
- *working for a classroom's/school's improvement
- *working for improvement of all schools

Improve system functioning

A Few Resources

From Parent Involvement to Parent Empowerment and Family Support -- A resource guide for school community leaders: Using the nationally-acclaimed RAINMAKER program, this resource calls for restructuring how educators and families work together, defines roles for each, highlights parent-run Family Resource Centers, provides a step-by-step model of training for parents, covers matters related to funding, and much more. By Briar-Lawson, Lawson, Rooney, Hansen, White, Radina, & Herzog. Available from the Institute for Educational Renewal. Ph: 513/529-6926.

Available from our Center:

Introductory packet: *Parent & Home Involvement in Schools*. Provides an overview of how home involvement is conceptualized and highlights models and resources. Issues of special interest to underserved families are addressed

Technical aid packet on: *Guiding Parents in Helping Children Learn*. Contains (1) a "booklet" to help nonprofessionals understand what is involved in helping children learn, (2) info about basic resources for learning more about helping parents and other nonprofessionals enhance children's learning, and (3) info on other resources parents can use.

D. Fostering a Caring School Culture

Schools often fail to create a caring culture. A caring school culture refers not only to caring for but also caring about others. It refers not only to students and parents but to staff. Those who want to create a caring culture can draw on a variety of ideas and practices developed over the years.

Who is Caring for the Teaching Staff?

Teachers must feel good about themselves if classrooms are to be caring environments. Teaching is one of society's most psychologically demanding jobs, yet few schools have programs designed specifically to counter job stress and enhance staff feelings of well-being.

In discussing "burn-out," many writers have emphasized that, too often, teaching is carried out under highly stressful working conditions and without much of a collegial and social support structure. Recommendations usually factor down to strategies that reduce environmental stressors, increase personal capabilities, and enhance job and social supports. (See our introductory packet: *Understanding and Minimizing Staff Burnout*)

What tends to be ignored is that schools have no formal mechanisms to care for staff. As schools move toward local control, they have a real opportunity to establish formal mechanisms and programs that foster mutual caring. In doing so, special attention must be paid to transitioning in new staff and transforming working conditions to create appropriate staff teams whose members can support and nurture each other in the classroom every day. Relatedly classrooms should play a greater role in fostering student social-emotional development by ensuring such a focus is built into the curricula.

Helping Youngsters Overcome Difficulty Making Friends

A caring school culture pays special attention to those who have difficulty making friends. Some students need just a bit of support to overcome the problem (e.g., a few suggestions, a couple of special opportunities). Some, however, need more help. They may be very shy, lacking in social skills or may even act in negative ways that lead to their rejection. Whatever the reason, it is clear they need help if they and the school are to reap the benefits produced when individuals feel positively connected to each other.

School staff (e.g., teacher, classroom or yard aide, counselor, support/resource staff) and parents can help such students. The following is one set of strategies that can be helpful:

- Identify a potential "peer buddy" (e.g., a student with similar interests and temperament or one who will understand and be willing to reach out to the one who needs a friend)
- Either directly enlist and train the "peer buddy" or design a strategy to ensure the two are introduced to each other in a positive way
- Create regular opportunities for shared activities/projects at and away from school (e.g., they might work together on cooperative tasks, be teammates for games, share special roles such as being classroom monitors, have a sleep-over weekend)
- Facilitate their time together to assure they experience good feelings about being together.

It may be necessary to try a few different activities before finding some they enjoy doing together. For some, the first attempts to match them with a friend will not work out. (It will be evident after about a week or so.) If the youngster really doesn't know how to act like a friend, it is necessary to teach some guidelines and social skills. In the long-run, for almost everyone, making friends is possible and is essential to feeling cared about.

A useful resource in thinking about strategies for helping youngsters find, make, and keep friends is: *Good Friends are Hard to Find* a 1996 book written for parents by Fred Frankl (published by Perspective Publishing); the work also has sections on dealing with teasing, bullying, and meanness and helping with stormy relationships.

Applying Rules in a Fair and Caring Way

Should different consequences be applied for the same offense when the children involved differ in terms of their problems, age, competence, and so forth?

Teachers and parents (and almost everyone else) are confronted with the problem of whether to apply rules and treat transgressions differentially. Some try to simplify matters by not making distinctions and treating everyone alike. For

example, it was said of Coach Vince Lombardi that he treated all his players the same -- like dogs! A caring school cannot treat everyone the same.

Teachers and other school staff often argue that it is unfair to other students if the same rule is not applied in the same way to everyone. Thus, they insist on enforcing rules without regard to a particular student's social and emotional problems. Although such a "no exceptions" strategy represents a simple solution, it ignores the fact that such a nonpersonalized approach may make a child's problem worse and thus be unjust.

A caring school culture must develop and apply rules and offer specialized assistance in ways that recognize that the matter of fairness involves such complicated questions as, Fair for whom? Fair according to whom? Fair using what criteria and what procedures for applying the criteria? Obviously what is fair for the society may not be fair for an individual; what is fair for one person may cause an inequity for another. To differentially punish two students for the same transgression will certainly be seen as unfair by at least one of the parties. To provide special services for one group's problems raises the taxes of all citizens. To deny such services is unfair and harmful to those who need the help.

Making fair decisions about how rules are applied and who should get what services and resources involves principles of *distributive justice*. For example, should each person be (1) responded to in the same way? given an equal share of available resources? (2) responded to and provided for according to individual need? (3) responded to and served according to his or her societal contributions? or (4) responded to and given services on the basis of having earned or merited them? As Beauchamp and Childress (1989) point out, the first principle emphasizes equal access to the goods in life that every rational person desires; the second emphasizes need; the third emphasizes contribution and merit; and the fourth emphasizes a mixed use of such criteria so that public and private utility are maximized (in *Principles of Biomedical Ethics*). Obviously, each of these principles can conflict with each other. Moreover, any may be weighted more heavily than another, depending on the social philosophy of the decision maker.

Many parents and some teachers lean toward an emphasis on individual need: That is, they tend to believe fairness means that those with problems should be responded to on a case-by-case basis and given special assistance. Decisions based on individual need often call for exceptions to how rules are applied and unequal allocation and

affirmative action with regard to who gets certain resources. When this occurs, stated intentions to be just and fair often lead to decisions that are quite controversial. Because building a caring school culture requires an emphasis on individual need, the process is not without its controversies.

It is easy to lose sight of caring, and it is not easy to develop and maintain a caring school culture. In an era when so many people are concerned about discipline, personal responsibility, school-wide values, and character education, caring counts. Indeed, it may be the key to student well-being and successful schools.

Research on Youth and Caring

Protective factors. In the May 1995 issue of *Phi Delta Kappan*, a series of articles discuss "Youth and Caring." Included is an overview of findings from the research Project on Youth and caring (carried out through the Chapin Hall center for Children at the University of Chicago). Among a host of findings, researchers in that program report that caring and connectedness can protect against specific risk factors or stressful life events. The protective facets of caring are seen as transcending differences in class, ethnicity, geography, and other life history variables.

What makes for a caring environment? Karen Pittman and Michelle Cahill studied youth programs and concluded that youngsters experience an environment as caring when it:

- creates an atmosphere where they feel welcome, respected, and comfortable,
- structures opportunities for developing caring relationships with peers and adults
- provides information, counseling, and expectations that enable them to determine what it means to care for themselves and to care for a definable group,
- provides opportunities, training, and expectations that encourage them to contribute to the greater good through service, advocacy, and active problem solving with respect to important matters.

Enhancing Student Access and Use

The intent of student and learning supports is to increase equity of opportunity to succeed at school by addressing barriers to learning and teaching and re-engaging disconnected students. This can only be accomplished if the students make use of the opportunities. To increase student use, steps must be taken to enhance awareness and interest, facilitate access, and gather student input about use. This is especially so for some subgroups. As Stanton-Salazar (2011), emphasizes "... access to resources and institutional support, among low-status students and youth, is significantly dependent upon the network characteristics, network-related capacities and skills, and networking orientations of those institutional agents devoted to supporting and empowering low-status youth...."

Four steps can help: (1) enhancing student participation in mapping, analysis, and decision making with respect to improving student and learning supports, (2) capitalizing on the ability of significant others to influence use of such supports, (3) facilitating student choice, access, and use of needed supports, and (4) eliciting feedback from students.

(1) *Student Participation in Mapping and Analyzing Resources* – Rarely are students, especially those not doing well as school, included in these processes; yet their input is vital to enhancing motivated student use. Student involvement can be expedited in various ways (e.g., surveys, interviews, focus groups, inclusion in work groups that map and analyze resources).

(2) *Mobilizing Others to Influence Student Use* – There is a growing research base related to the positive impact of a range of individuals who are able to make a personal connection with a student (e.g., some family members and school staff, peers, older youth, adults who work with youth in the community through agencies, organizations, churches). Such individuals provide role models, support, guidance, and inspiration. Obviously, mentor programs aim at providing such a connection.

From the Literature

As Stanton-Salazar and Spina (2003) note: "For many youth, older siblings, extended family members, peer, neighbors, and key adults in the community all play a very important role in helping to determine their overall well-being and future life changes. For youth from working-class ethnic minority communities, these agents often play a decisive role in guiding them away from risk factors and into productive adulthood. ... The research literature presents a strong body of evidence that in any population of urban, low-income youth, the most resilient tend to be those who are socially connected to supportive adults in the extended kinship group, school, or community."

With specific respect to mentors, Beam, Chen, and Greenberger (2002) stress "Practitioners and program planners should consider facilitating and strengthening the naturally occurring important relationships between adolescents and nonparental adults. ... many youths in need of additional adult investment languish on the waiting lists of assigned mentorship programs or may be ineligible for such programs. ... some youths *do* have existing relationships with adults in their environment who might play a more consequential role in their development."

(3) *Facilitating Student Choice, Access, and Use of Needed Supports* – The aim is to have students access and effectively use needed supports. They are more likely to do so if they *perceive* such supports as personally worthwhile and likely to lead to good outcomes. As suggested, such perceptions are enhanced when others the student values endorses the intervention. Positive perceptions also are enhanced when the students are empowered to make their own decisions. Moreover, school staff must do more than make referrals. They must actively work with students (and their families) to help overcome barriers that interfere with immediate and longer-term follow-through. This involves developing a personalized plan for immediate action and longer-term follow-through.

Note: One way to begin in developing a personalized plan is to engage the student in a structured discussion exploring such matters as:

- Who do you talk with when you have personal problems?
- Who helps you when you have problems at school?
- Who at the school seems to care about you? In the community?
- Is there anyone special and important in your life at this time? (e.g., someone you look up to, admire).
- What makes this person (or persons) so special?
- What programs or opportunities at school do you find helpful? In the community?
- What else at school do you think could be helpful to you? In the community?
- What and who could be most helpful to you at this time?

(4) *Using Student Input to Improve Intervention Attractiveness & Effectiveness* – Student input also is vital to improving interventions in ways that can enhance motivated participation. Again, such feedback can be expedited through personal interviews, surveys, focus groups, etc. The point is not to just ask about whether the support is O.K., but to elicit specifics about what's good and not so good and what the student thinks would make it better. This is especially important with respect to students who are not doing well as school and other subgroups (e.g., those with emotional problems, nondocumented students).

Concluding Comments

At the heart of a good student and learning support system is a welcoming and caring school that provides many ways for connecting students with good role models, valued activities, and supportive learning and social networks. Including students in design and development processes is seen as vital to maximizing the likelihood that they and their peers will perceive supports positively, seek them out, and participate in a motivated manner.



"This course was developed from the open access article: Common Psychosocial Problems of School Aged Youth:Developmental Variations, Problems, Disorders and Perspectives for Prevention and Treatment (Updated 2018) Center for MH in Schools & Student/Learning Supports, The Center is co-directed byHoward Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept.of Psychology"