DOCUMENT RESUME

ED 464 307 CG 031 740

TITLE	Social and Interpersonal Problems Related to School Aged Youth. An Introductory Packet.
INSTITUTION	California Univ., Los Angeles. Center for Mental Health in Schools.
SPONS AGENCY	Health Resources and Services Administration (DHHS/PHS), Washington, DC. Maternal and Child Health Bureau.; Substance Abuse and Mental Health Services Administration (DHHS/PHS), Rockville, MD. Center for Mental Health Services.
PUB DATE	1999-02-01
NOTE	91p.
CONTRACT	U93-MC-00175
AVAILABLE FROM	School Mental Health Project, Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563. Tel: 310-825-3634; Fax: 310-206-8716; e-mail: smhp@ucla.edu. For full text: http://smhp.psych.ucla.edu/intropak.htm.
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	Behavior Modification; Counseling Techniques; Elementary Secondary Education; *Interpersonal Relationship; *Intervention; Mental Health; *Resource Materials; Social Adjustment; *Social Problems; *Student Behavior; Youth

ABSTRACT

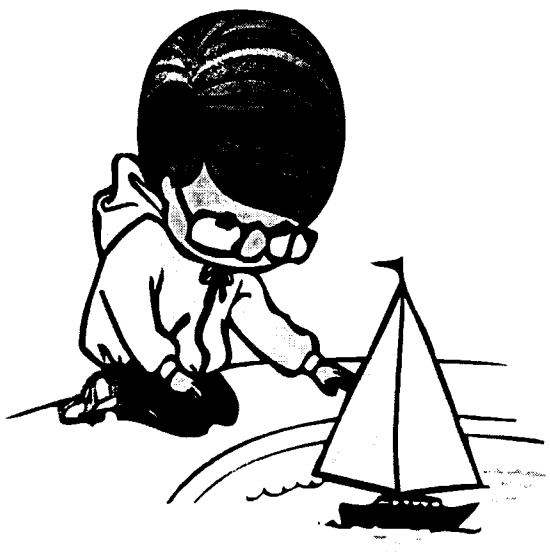
This introductory packet provides an introduction to recent efforts to synthesize fundamental social and interpersonal areas of competence and problem functioning, while framing the discussion within the classification scheme developed by the American Pediatric Association. The range of interventions discussed is consistent with that framework, emphasizing the importance of accommodations as well as strategies to change the individual. The packet is divided into six sections. Section 1 highlights the classification of social and interpersonal problems. Sections 2 and 3 provide a discussion of the broad continuum of social and interpersonal problems and a quick overview of some basic resources. Section 4 presents interventions for social and interpersonal problems, including accommodations to reduce problems, behavior management, and empirically supported treatments. Section 5 presents additional resource aids. Section 6 contains a discussion on keeping social and interpersonal problems in broad perspective. The packet concludes with a brief list of references and agency resources as a starting point for gathering additional information. (GCP)

Mental Health in Schools Center
Training and Technical Assistance

*From the Center's Clearinghouse ...**

An introductory packet on

Social and Interpersonal Problems Related to School Aged Youth



This document is a hardcopy version of a resource that can be downloaded from the Center's website (http://smhp.psych.ucla.edu). The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspice of the School Mental Health Project, Dept. of Psychology, UCLA. Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563 (310) 825-3634 Fax: (310) 206-8716; E-mail: smhp@ucla.edu

Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of the U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

CMHS
Center for Mental Health Services
SAMHSA

Please reference this document as follows: Center for Mental Health in Schools at UCLA. (1999). An introductory packet on social and interpersonal problems related to school aged youth. Los Angeles, CA: Author.

Created February 1999

Copies may be downloaded from: http://smhp.psych.ucla.edu

If needed, copies may be ordered from:
Center for Mental Health in Schools
UCLA Dept. of Psychology
P.O. Box 951563
Los Angeles, CA 90095-1563

The Center encourages widespread sharing of all resources.

UCLA CENTER FOR MENTAL HEALTH IN SCHOOLS*

Under the auspices of the School Mental Health Project in the Department of Psychology at UCLA, our center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

MISSION: ***To improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools.***

Through collaboration, the center will

- **enhance practitioner roles, functions and competence**
- **interface with systemic reform movements to strengthen mental health in schools**
- **assist localities in building and maintaining their own infrastructure for training, support, and continuing education that fosters integration of mental health in schools**

***Technical Assistance** **Hard Copy & Quick Online Resources**
Monthly Field Updates Via Internet **Policy Analyses**
Quarterly Topical Newsletter
Clearinghouse & Consultation Cadre
Guidebooks & Continuing Education Modules
National & Regional Networking*

Co-directors: Howard Adelman and Linda Taylor
Address: UCLA, Dept. of Psychology, 405 Hilgard Ave., Los Angeles, CA 90095-1563.
Phone: (310) 825-3634 FAX: (310) 206-8716 E-mail: smhp@ucla.edu
Website: http://smhp.psych.ucla.edu/

Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of the U.S. Department of Health and Human Services.

About the Center's Clearinghouse

The scope of the Center's Clearinghouse reflects the School Mental Health Project's mission -- to enhance the ability of schools and their surrounding communities to address mental health and psychosocial barriers to student learning and promote healthy development. Those of you working so hard to address these concerns need ready access to resource materials. The Center's Clearinghouse is your link to specialized resources, materials, and information. The staff supplements, compiles, and disseminates resources on topics fundamental to our mission. As we identify what is available across the country, we are building systems to connect you with a wide variety of resources. Whether your focus is on an individual, a family, a classroom, a school, or a school system, we intend to be of service to you. Our evolving catalogue is available on request; and available for searching from our website.

What kinds of resources, materials, and information are available?

We can provide or direct you to a variety of resources, materials, and information that we have categorized under three areas of concern:

- Specific psychosocial problems
- Programs and processes
- System and policy concerns

Among the various ways we package resources are our *Introductory Packets, Resource Aid Packets, special reports, guidebooks*, and *continuing education units.* These encompass overview discussions of major topics, descriptions of model programs, references to publications, access information to other relevant centers, organizations, advocacy groups, and Internet links, and specific tools that can guide and assist with training activity and student/family interventions (such as outlines, checklists, instruments, and other resources that can be copied and used as information handouts and aids for practice).

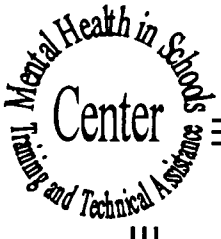
Accessing the Clearinghouse

- E-mail us at **smhp@ucla.edu**
- FAX us at (310) 206-8716
- Phone (310) 825-3634
- Write School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, Los Angeles, CA 90095-1563

Check out recent additions to the Clearinghouse on our Web site: **http://smhp.psych.ucla.edu**

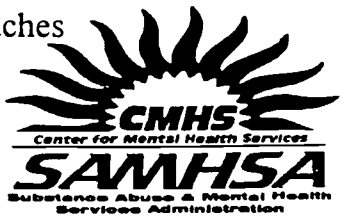
All materials from the Center's Clearinghouse are available for order for a minimal fee to cover the cost of copying, handling, and postage. Most materials are available for free downloading from our website.

If you know of something we should have in the clearinghouse, let us know.



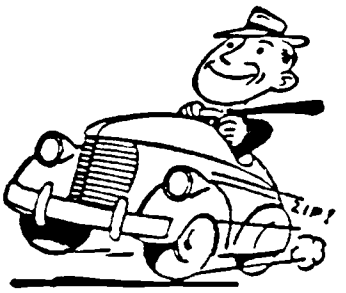
The *Center for Mental Health in Schools* operates under the auspices of the School Mental Health Project at UCLA.* It is one of two *national centers* concerned with mental health in schools that are funded in part by the U.S. Department of Health and Human Services, Office of Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration -- with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (Project #U93 MC 00175).

The UCLA Center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. In particular, it focuses on comprehensive, multifaceted models and practices to deal with the many external and internal barriers that interfere with development, learning, and teaching. Specific attention is given policies and strategies that can counter marginalization and fragmentation of essential interventions and enhance collaboration between school and community programs. In this respect, a major emphasis is on enhancing the interface between efforts to address barriers to learning and prevailing approaches to school and community reforms.



*Co-directors: Howard Adelman and Linda Taylor.
Address: Box 951563, UCLA, Dept. of Psychology, Los Angeles, CA 90095-1563.
Phone: (310) 825-3634 FAX: (310) 206-8716 E-mail: smhp@ucia.edu
Website: http://smhp.psych.ucla.edu

Need Resource Materials Fast?



Check out our *Quick Finds !!!!*

Use our Website for speedy access to Psychosocial resources!!!!!

Stop on by for a visit at

http://smhp.psych.ucla.edu

Just click *SEARCH* from our home page and you are on your way!!

You can:

- **QUICK FIND:** *To quickly find information on Center topics*
- **SEARCH OUR WEB SITE:** *For information available on our web pages.*
- **SEARCH OUR DATABASES:** *For resource materials developed by our Center, clearinghouse document summaries, listings of cadre members, organizations and internet sites.*

Quick Find Responses include:

- Center Developed Resources and Tools
- Relevant Publications on the Internet
- Selected Materials from Our Clearinghouse
- A whole lot more, and if we don't have it we can find it !!!! We keep adding to and improving the center — So keep in contact!

Social and Interpersonal Problems

This introductory packet contains:

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 of 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.

I. Classifying Social and Interpersonal 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.

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 anxiety disorder, phobia, 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.

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 environ-mental 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<--->p). Toward the other end, person variables account for more of the problem (thus e<--->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 *mismatch* 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.

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

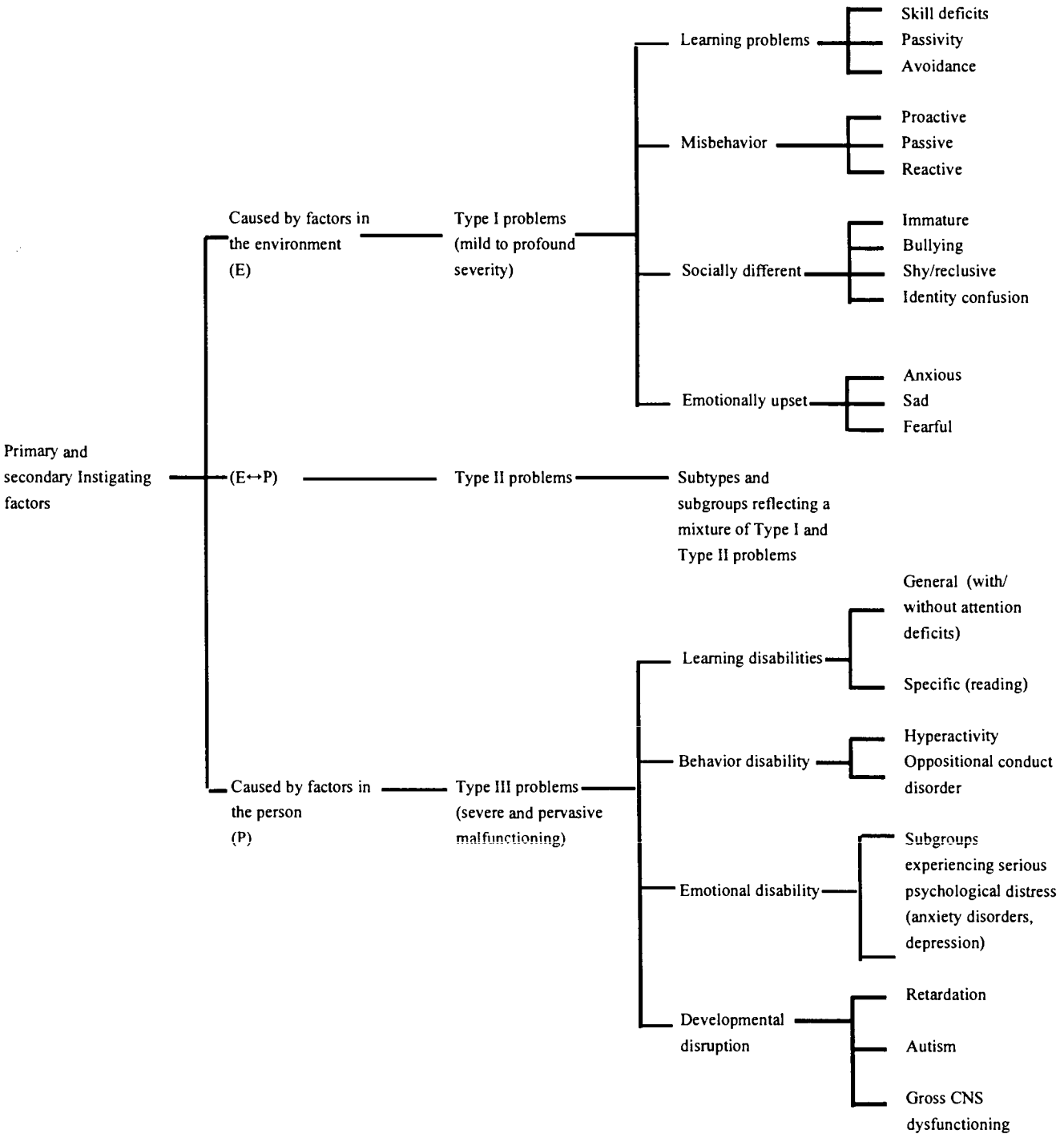
After the general groupings are identified, it becomes relevant to consider the value of differentiating subgroups or subtypes within each major type of problem. For example, subtypes for the Type III category might first differentiate behavioral, emotional, or learning problems arising from serious 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.

References

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

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

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



Source: H. S. Adelman and L. Taylor (1993). Learning problems and learning disabilities. Pacific Grove. Brooks/Cole. Reprinted with permission.

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

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

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

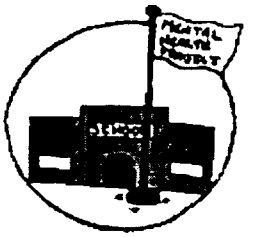
Sexual Behaviors
- Preoccupation with sexual issues

Relationship Behaviors
- Change in school activities
- School absences
- Change in social interaction such as withdrawal

Substance Use/Abuse...

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

Adapted from the School Mental Health Project/
Center for Mental Health in Schools – UCLA
Newsletter: Addressing Barriers to Learning,
Vol. 2 (2), Spring, 1997



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

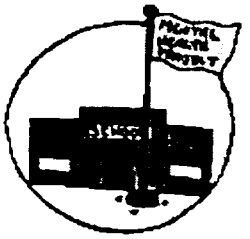
- identifying and labeling feelings
- expressing feelings
- assessing the intensity of feelings
- managing feelings
- delaying gratification

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



The W. T. Grant consortium list is designed with prevention in mind. It can be compared and contrasted with frameworks suggested for training children manifesting behavior problems. Below is the set of skills prescribed by M.L. Bloomquist (1996) in *Skills Training for Children with Behavioral Disorders.* After stressing the importance of (a) increased parental involvement, (b) greater use of positive reinforcement, and (c) enhanced positive family interaction skills, Bloomquist details the following as areas parents should focus on with their children.

- compliance (listening and obeying adults' directives)
- following rules (adhering to formal rules)
- social behavior skills (making and keeping friends)
- social and general problem-solving skills (stopping and thinking before working on a problem, thinking and doing in a step-by-step manner)
- coping with anger (stopping outbursts)
- self-directed academic behavior skills (organizing work, budgeting time, self-monitoring and staying on task, using study skills)
- understanding and expressing feelings (increasing one's "feelings vocabulary," observing and practicing awareness and expression of feelings)
- thinking helpful thoughts (identifying one's negative thoughts, understanding how they influence one's emotions, strategies to change negative thoughts in order to experience more positive emotions)
- self-esteem (coming to evaluate oneself positively as a result of developing skills, experiencing positive feedback, and positive family interactions)

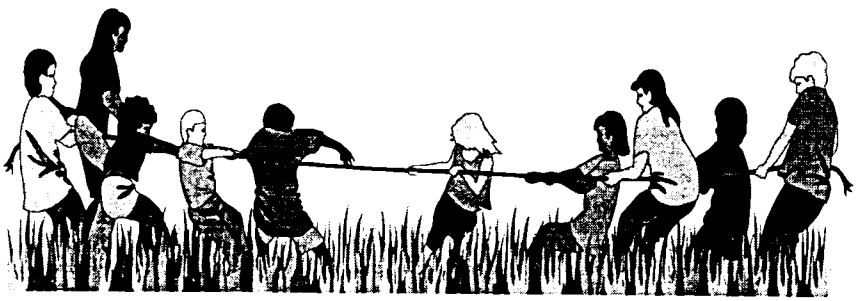
*W.T. Grant Consortium on the School-Based Promotion of Social Competence (1992). Drug and alcohol prevention curriculum. In J.D. Hawkins, et al. (Eds), *Communities that Care*. San Francisco: Jossey-Bass.

On the following pages are discussions of

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

B. Problems: Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but not Severe Enough to meet Criteria of a Mental Disorder

C. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association



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

DEVELOPMENTAL VARIATION	COMMON DEVELOPMENTAL PRESENTATIONS

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.

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 sightly 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

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

B. 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

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.

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

C. 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

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

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

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

DEVELOPMENTAL VARIATION	COMMON DEVELOPMENTAL PRESENTATIONS
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.	**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 sightly 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

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

B. 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

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.

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

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

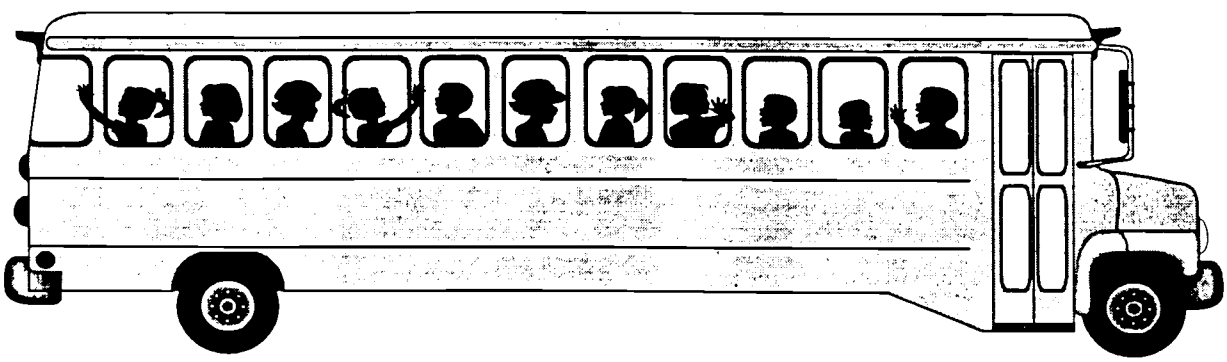
The avoidant behavior often starts in infancy or childhood with shyness, isolation, and fear of strangers and new situations. Although shyness in childhood is a common precursor of Avoidant Personality Disorder, in most individuals it tends to gradually dissipate as they get older. In contrast, individuals 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.

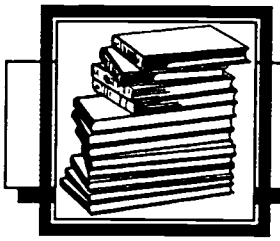
On the following pages are discussions of

A. A Few References and Other Sources of Information

B. Agencies and Online Resources

C. Consultation Cadre





A Few References and Other Sources for Information*

Asher, S. (1990). Recent advances in the study of peer rejection. In S. Asher & J. Coie (Eds.), *Peer Rejection in Childhood.* NY: Cambridge Univ. Press.

Bhavnagri, N., & Parke, R. (1991). Parents as direct facilitators of children's peer relationships: Effects of age of child and sex of parent. *Journal of Social and Personal Relationship,* (pp. 8, 423- 440).

Black, B., & Logan, A. (1995). Links between communication patterns in mother-child, father-child, and child-peer interactions and children's social status. *Child Development,* (pp. 66, 255-271).

CASEL (1996). *Collaborative for the Advancement of Social and Emotional Learning* (CASEL). CASEL, Department of Psychology (M/C 285), The University of Illinois at Chicago, 1007 W. Harrison St., Chicago, IL 60607-7137; Phone: (312)413-1008; Fax:(312)355-0559.

Dodge, F. A., Pettit, G. S., McClaskey, C. L., & Brown, M. M. (1986). Social competence in children. *Monographs of the Society for Research in Child Development* (2, Serial No. 213),(p 51).

Eisenberg, N., Cameron, E., Tryon, F., & Dodez, R (1981). Socialization of prosocial behavior in the preschool classroom. Development Psychology, (pp. 17, 773-782).

Elias, M.J., & Clabby, J. (1992). *Building Social Problem Solving Skills: Guidelines from a School-Based Program.* San Francisco: Jossey-Bass.

Elias, M.J., Bruene-Butler, L., Blum, L., & Schyler, T. (May 1997). How to launch a Social & Emotional Learning Program. *Educational Leadership*, (pp. 15-19).

Elliott, S.N., & Gresham, F.M. (1991). *Social Skills Intervention Guide.* Circle Pines, MN: American Guidance Service.

Goetz, T. E. & DwecK, C. S. (1980). Learned helplessness in social situations. *Journal of Personality and Social Psychology,* (pp 39, 246-255).

Gresham, F. M. (1995). Best Practices in Social Skills Training in A. Thomas and J. Grimes (Eds.) Best Practices in School Psychology-III (pp. 1021-1030). Washington, D.C.: The National Association of School Psychologists.

Howes, C. (1988). Peer interaction of young children. *Monographs of the Society for Research in Child Development* (1, Serial No. 217),(p. 53)

Ladd, G. W. (1990). Having friends, keeping friends, making friends, and being liked by peers in the classroom: Predictors of children's early school adjustment? *Child Development,* (pp. 6,1, 312-331).

Mize, J., Pettit, G.. S., & Brown, E. G. (1995). Mothers' supervision of their children's peer play: Relations with beliefs, perceptions, and knowledge. *Developmental Psychology,*(pp. 31, 311-321).

Parke, P.D., & Ladd, G.W. (1992). *Family-peer relationships: Modes of linkages.* Hillsdale, NJ: Erlbaum.

Pettit, G.S., Dodge, FA., & Brown, M.M. (1988). Early family experience, social problem, social patterns, and children's social competence. *Child Development*, (pp. 59, 107-120).

Schneider, B. (1993). *Children's Social Competence in Context.* NY: Pergamon.

Sheridan, S. (1995). Building Social Skills in the Classroom In S. Goldstein (Ed.), *Understanding and Managing Children: Classroom Behavior.*(pp. 375-396). New York: John Wiley & Sons,.

Vaughn, S. & La Greca, A. (1993). Social Skills training: Why, Who, What, and How. In Bender, W.N., PhD., *Learning Disabilities: Best Practices for Professionals*, (pp. 251-271) Boston, MA: Andover Medical Publishers, Inc.

Weissberg, R.P., Caplan, M., & Harwood, R. (1991). Promoting competency-enhancing environments: A systems-based perspective on primary prevention. *Journal of Consulting and Clinical Psychology, 59*, 830-841.

Weissberg, R.P., Shriver, T.P., Bose, S.,& DeFalco, K. (May 1997). Creating a District wide Social Development Project. Educational Leadership (pp. 37-39).

* See references in previous excerpted articles.

Agencies and Online Resources Related to Social and Interpersonal Problems

Center for Effective Collaboration and Practice (CECP)
http://www.air.org/cecp

The mission of the Center for Effective Collaboration and Practice is to support and to promote a reoriented national preparedness to foster the development and adjustment of children with or at risk of developing serious emotional disturbances (SED). To achieve that goal, the Center is dedicated to a policy of collaboration at federal, state, and local levels that contributes to and facilitates the production, exchange, and use of knowledge about effective practices. The Center is strategically organized to identify promising programs and practices, promote the exchange of useful information, and facilitate collaboration among stakeholders and across service system disciplines.

Center on Families, Communities, Schools and Children's Learning
http://ericeece.org

The mission of this center is to conduct research, evaluations, policy analyses, and dissemination to produce new and useful knowledge about how families, schools, and communities influence student motivation, learning, and development. Another goal is to improve the connections between and among these major social institutions.

Children First: The Website of the National PTA
http://www.pta.org

The National PTA is the oldest and largest volunteer association in the United States working exclusively on behalf of children and youth. The PTA is created to support and speak on behalf of children and youth in schools, in the community, and before governmental bodies and other organizations that make decisions affecting children; to assist parents in developing the skills they need to raise and protect their children; and to encourage parent and public involvement in the public schools of this nation. The website allows you to get information on annual conventions, periodical subscritptions, updates on legislative activity, PTA membership, links to other PTAs and children advocacy groups, as well as chats, bulletin boards, and more.

Collaborative for the Advancement of Social and Emotional Learning (CASEL) (see below)
CASEL is an international collaborative of educators, scientists, policy makers, foundations, and concerned citizens promoting social and emotional educational and development in schools. Its mission is to promote social and emotioal learning (SEL) as an integral part of educaiton in schools throughout the world. CASEL's purpose is to encourage and support the creatino of safe, caring learninhg environments that build social, cognitive, and emotional skills.

Contact: University of Illinois at Chicago 1007 W. Harrison St., Chicago, IL 60607-7137
Ph. (312)413-1008 / Fax: (312)355-0559

Cyber-Psych
http://www.webweaver.net/psych

Cyber-Psych is committed to bringing high quality, professional psychological care and information to the on-line community. We believe that the internet provides a non-threatening, interactive medium through which mental health care can be provided to the rapidly increasing population of people on-line.

Dealing with the Angry Child
http://labyrinth.net.au/~cccav/dec96/angry.html

An on-line issue of the Newsletter from the Child Care Centres Association Of Victoria.

Developmental Coordination Disorder
http://www.dcd.org/

The Developmental Coordination Disorder Association works to: Provide support for children with DCD and their families; Educate physicians, social workers, educators, parents, and the public to encourage the early identification, treatment, and accomodation of children with DCD; Help integrate children with DCD into the mainstream of educational, recreational, and social activities; Promote research into the causes and treatment of DCD

Education World
http://www.educationworld.com

An education-based resource and internet search site designed especially for teachers, students, administrators and parents.

Family Resource Coalition of America (FRCA)
http://www.familysupportamerica.org/content/home.htm

Brings together community-based program providers, school personnel, those who work in the human services, trainers, scholars, and policymakers. Provides Resources and Publications, offers technical assistance and consulting services, and undertakes public education and advocacy efforts.

Health Answers
http://www.healthanswers.com

General health information availa ble on-line.

Internet Mental Health
http://mentalhealth.com

Goal is to improve understanding, diagnosis, and treatment of mental illness throughout the world.

Mental Health Net
http://mentalhelp.net

Run by psychologist, Dr. John Grohol and is an information service sponsored by CMHC Systems.

The Shyness Home Page
http://www.shyness.com

This is an index to resources for shyness and social phobia.

Society for the Study of Social Problems
http://itc.utk.edu/sssp/

Promotes research on and serious examination of problems of social life. The SSSP works to solve these problems and to develop informed social policy.

→ Brief List of Some Major Social Emotional Learning Programs

The **Collaborative for the Advancement of Social and Emotional Learning (CASEL)** has produced a list of programs operating in schools and communities around the country. Some of these are presented below. They have taken some of the program descriptions from Chapter 5 of *Getting Started: The National Mental Health Association (NMHA) Directory of Model Programs to Prevent Mental Disorders and Promote Mental Health* (NMHA can be contacted at 703/838-7534).

CASEL notes that it "is currently engaging in a process of working with experts in the field of social and emotional learning to determine standards and to identify social and emotional learning programs that meet these standards. The list will be broadened as additional programs are identified. CASEL does not endorse the effectiveness of these programs and there is no implication that programs not included here are less well developed or less effective."

➙ ***The Child Development Project***

Enc Schaps, Catherine C. Lewis, Marilyn Watson
Developmental Studies Center, 2000 Embarcadero, Suite 305, Oakland, CA 94606-5300
Phone: (510) 533-0213

The Child Development Project (CDP) is an effort to take research knowledge and theory about how elementary-school-age children learn and develop—ethically, intellectually, emotionally, and socially--and translate it into a comprehensive, practical program for classroom, school and home use. The CDP program seeks to strengthen children's tendencies to be caring and responsible, their motivation to learn, and their higher-order cognitive development. The overall program is both intensive and comprehensive. It includes a Classroom Program which focuses broadly on curriculum content, pedagogy, and classroom climate; a Schoolwide Program which focuses on school politics, practices, and events; and a Family Involvement Program which concentrates on creating, expanding, and maintaining links between school and home. In the Child Development Project, children become integrated into a school community in which the members are mutually supportive, concerned about one another's welfare, and interested in contributing to the life of the community. Evaluation findings have shown that CDP children do see their classrooms as caring communities, and that the more they do, the more their social, ethical and intellectual development are enhanced.

➙ *Going For The Goal Program (GOAL) at The Life Skills Center*

Steven J. Danish, Director; Alice Westerberg, Administrative Assistant
Virginia Commonwealth University, 800 W. Franklin Street
Richmond, VA 23284-2018 Phone: (804) 8284384 (VCU-GFTG) Fax: (804) 828-0239

The Life Skills Center is an independent entity connected to Virginia Commonwealth University. The Center has as its mission to develop, implement and evaluate life skill programs for children, adolescents, and adults. Life skills are those skills that enable us to succeed in the environments in which we live. Some of these environments are in the family, schools, the workplace, neighborhood, and community. The Going for the Goal Program (GOAL) is our largest program. It is designed to teach adolescents a sense of personal control and confidence about their future so that they can make better decisions and ultimately become better citizens. To be successful in life it is not enough to know what to avoid; one must also know how to succeed. Thus, the focus is on teaching "what to say yes to" as opposed to "just say no." GOAL is a ten session, ten hour program taught by high school students to middle school students, both during school and after school. The life skills taught in GOAL are how to: (1) identify positive life goals; (2) focus on the process (not the outcome) of attaining these goals; (3) use a general problem-solving model; (4) identify health-compromising behaviors that can impede goal attainment; (5) identify health-promoting behaviors that can facilitate goal attainment; (6) seek and create social support; and (7) transfer these skills from one life situation to another.

➙ ***I Can Problem Solve (ICPS): An Interpersonal Cognitive Problem Solving Program***

M yrna B. Shure, Ph.D., Professor, Hahnemann University, Broad and Vine MS 626, Philadelphia, PA 19102 Phone: (215)762-7205 Fax: (215)762-4419

This program promotes problem solving, interpersonal interaction, and decision making. It is designed for preschool and school age children between the ages of 2 and 12. The program provides training in interpersonal cognitive problem solving skills, and also provides some parent training. Interpersonal Cognitive Problem Solving (ICPS) is designed to teach children not *what* to think, but *how* to think in ways that will help them to successfully resolve interpersonal problems. ICPS received the 1982 National Mental Health Association Lela Rowland Prevention Award in recognition of outstanding programming for the prevention of mental-emotional disabilities. The program is designed for children in preschool as well as elementary school students, with different curricula for each age group. Three teacher manuals for different age groups (preschool, kindergarten & primary grades, and intermediate elementary grades) are available from Research Press, 2612 N. Mattis Avenue, Champaign, IL 61821, 1-800-519-2707. A program for parents can be found in *Raising a Thinking Child,* Holt, 1994; paperback, Pocket Books, 1996. In addition, *Raising a Thinking Child: A Workbook will* also be available from Henry Holt soon. On-site training is available if desired. A video demonstration video tape can be obtained from the Mental Health Association of Illinois.

➙ ***The New Haven Schools Social Development Program***

Ramona Gattison, New Haven Public Schools, 54 Meadow Street, New Haven, CT 06519
Phone: (203) 946-5837

The Social Development Project of the New Haven Public Schools was launched in the fall of 1989 to respond to pervasive behavioral problems in students. Six years later, the project has become an official department of the school system. Its programming spans all 13 grade levels in all 43 schools. Evaluation data show these Social Development programs are responsive to the needs of students, teachers, parents, and administrators. "The Social Development Department" was titled in a conscious effort to use words and symbols that denote growth and development. The department continues in its original form today emphasizing three major goals: 1. To develop, implement, and evaluate a K-12 social competence promotion curriculum designed to promote positive and healthy development, while reducing the incidence of problem behaviors; 2. To design diverse school and community activities that reinforce the curriculum, chanel energy of both children and adults into pro-social, structured activities in tandem with other prevention efforts; and 3. To strengthen school-based planning teams that include parents, teachers, and administrators to promote collaborative ownership of prevention programs and to strengthen the trust, climate, and relationships in both the school and the community.

➙ ***The PATHS Curriculum***

Mark T. Greenberg, Ph.D, FAST Track, 146 N. Canal Street, Seattle, WA 98103
Phone: (206) 685-3927 Fax: (206) 685-3944 E-mail: mgp@u.washington.edu

The PATHS (Providing Alternative Thinking Strategies) Curriculum is a program for educators and counselors designed to aid development of self-control emotional awareness, and interpersonal problem-solving skills. The PATHS Curriculum provides teachers and counselors with a systematic developmental procedure for enhancing social competence and understanding in children. Children learn first to "stop and think," to develop and use verbal thought. Second, they learn the words to help mediate understanding of self and others. Third, students integrate this understanding with cognitive and linguistic skills to solve problems. Fourth and very critically, the program encourages language skills for self-control. PATHS is designed to help children: 1. develop specific strategies that promote reflective responses and mature thinking skills; 2. become more self-motivated and enthusiastic about learning, 3. obtain information necessary for social linking and pro social behavior, 4. increase their ability to generate creative alternative solutions to problems; and 5. learn to anticipate and evaluate situations, behaviors, and consequences. There have been three controlled studies with randomized control groups: one with regular children, one with special education-classified children and one with deaf/hearing impaired children. In *all three* studies, the use of the PATHS Curriculum has significantly increased the children's ability to do the following as assessed by individual child interviews:
(a) Understand social problems, (b) Increase the children's understanding and recognition of emotions, (c) Develop effective alternative solutions, (d) Decrease the percentage of aggressive/violent solutions.

➙ ***Positive Adolescents Choices Training (PACT)***

W. Rodney Hammond, Ph.D., Associate Professor, School of Professional Psychology, Wright State University, Ellis Human Development Institute, 9 N. Edwin C. Moses Blvd., Dayton, OH 45407 Ph: (513) 873-4300 or (513) 873-4361 Fax: (513) 873-4323

The PACT program prevents aggression in children through the promotion of social adjustment, social skills/competence, and anger management. The program is designed for African American middle school students between the ages of 12 and 15. PACT provides training in social and communication skills. The PACT program is a culturally sensitive training program developed specifically for African American youth to reduce their disproportionate risk for becoming victims or perpetrators of violence. The cognitive/behavioral group training approach equips youngsters with specific social skills to use in situations of interpersonal conflict. The rationale for a social skills training approach rests on the assumption that poor interpersonal Skills, such as the inability to negotiate differences in opinion, increases the likelihood that a youngster may be drawn into physical aggression.

➙ ***Reach Out to Schools: Social Competency Program***
Pamela Seigle, Program Director, The Stone Center, Wellesley College, 106 Central Street, Wellesley, MA 02181-8268 Phone: (617) 283-2847

The Reach Out to Schools: Social Competency Program is a comprehensive, multi-year social competency training program for elementary school (grades K-5) children, their teachers, principals, and parents. The year-long curriculum contains 40 lessons in three competency areas: 1) creating a cooperative classroom environment, 2) solving interpersonal problems, and 3) building self-esteem and positive relationships. Lessons are conducted twice each week for 15 minutes in an "Open Circle" format. The Open Circle provides a structured format to facilitate teaching social competency skills and also provides a consistent context for discussion of other issues important to members of the class. The Reach Out to Schools Program is an innovative prevention model that recognizes the central role that relationships play in the academic and social success of children. The Program works to develop growth-enhancing relationships in classrooms and throughout the entire school communities. The Program has identified goals for all levels of participants, from teachers and students to school administrators and parents. The Program will: (a) strengthen the social competency and facilitation skills of teachers and enable them to effectively implement the Social Competency Program curriculum in their classroom, (b) provide students with a structured and consistent environment in which they can establish, explore, and enhance relationships with their peers and adults and thereby develop their communication, self-control, and interpersonal problem-solving skills, (c) familiarize parents of participating children with the language, approaches, and objectives of the SCP curriculum and enable parents to effectively apply its principles to improve their parenting skill, (d) strengthen the social competency skills of school administrators and enable them to support the implementation of the core components of the SCP Program and to model its basic principles in their relationships with students, faculty, staff, and parents.

➙ ***Resolving Conflict Creatively Program***
Linda Lantieri, Director, RCCP National Center, 163 Third Avenue, #103, New York, NY 10003
Phone: (212) 387-0225 Fax: (212) 387-0510

The Resolving Conflict Creatively Program (RCCP) is a pioneering school-based program in conflict resolution and intergroup relations that provides a model for preventing violence and creating caring, learning communities. RCCP shows young people that they have many choices besides passivity or aggression for dealing with conflict; gives them the skills to make those choices real in their own lives; increases their understanding and appreciation of their own and other cultures; and shows them that they can play a powerful role in creating a more peaceful world. The overall goals of the RCCP National Center are: (a) to prepare educators to provide high quality instruction and effective school programs in conflict resolution and intergroup relations in a variety of settings across the country and (b) to transform the culture of participating schools so that they model values and principles of creative, non-violent conflict resolution. The program's primary strategy for reaching young people is professional development of the adults in their lives--principals, teachers, and parents. Through RCCP, we work intensively with teachers, introducing them to concepts and skills of conflict resolution, and continue supporting them as they teach those concepts and skills in an ongoing way to their students. RCCP provides teachers with in-depth training, curricula, and staff development support; establishes student peer mediation programs; offers parent workshops; and conducts leadership training for school administrators.

➙ ***The Responsive Classroom***
Northeast Foundation for Children, 71 Montague City Road, Greenfield, MA 01301
Ph: (800) 360-NEFC Fax: (413) 772-2097 E-mail: nefc@crocker.com
They offer a free semi-annual newsletter

The Responsive Classroom is an approach to learning that integrates the teaching of academic skills and the teaching of social skills as part of everyday school life. Implemented by many public schools over the last fifteen years, The Responsive Classroom has six components:

- **Classroom Organization** that provides active interest areas for students and space for an appropriate mix of whole class, group and individual instruction.
- **Morning Meeting** which gives children daily opportunity to practice greetings, conversation, sharing and problem solving, motivating them to meet the day's academic challenges.
- **Rules and Logical Consequences** that are generated, modeled and role-played with the children and that

become the cornerstone of classroom life.
- **Choice Time** for all children each day in which they must take control of their learning in some meaningful way, both individually and cooperatively.
- **Guided Discovery** of learning materials, room areas, curriculum content, and ways of behaving which deliberately and carefully introduces children to each new experience. There is no assumption that children already know how to do something before they begin.
- **Assessment and Reporting** to parents that is an evolving process of mutual communication and understanding.

→ *The Social Competence Promotion Program for Young Adolescents (SCPP-YA)*
Roger P. Weissberg, PhD., Professor of Psychology, University of Illinois at Chicago
Department of Psychology (WC 285), 1007 West Harrison Street, Chicago, IL 60607-7137
Phone: (312) 413-1012 Fax: (312) 413-4122

The Social Competence Promotion Program for Young Adolescents (SCPP-YA) develops skills for self-control to help adolescents control their emotions and engage in pro social coping behavior. The program also builds self-esteem, improves interpersonal interaction among peers, and teaches self and stress management. Within the academic and classroom environment, SCPP-YA promotes comprehensive school health education for improving student attitudes and students' school adjustment. The goals are to prevent adolescent pregnancy, aggressive behavior, conduct disorders, and juvenile delinquency. The program targets middle school students between the ages of 10 and 12. SCPP-YA provides training in assertiveness, social skills, and communication. These acquired skills are then applied to drug, health, and sex education. Teacher education is also used to facilitate the intervention. This is a school-based program involving young adolescents, who are given intensive instruction in social problem-solving skills while addressing other important issues like human growth and development, AIDS, adolescent pregnancy, sexual activity, and substance abuse. The core of this program includes a 27-lesson module wherein classroom teachers provide intensive instruction in social problem-solving skills.

→ **The Social Decision Making and Life Skills Development Program: A Framework for Promoting Students' Social Competence and Life Skills and Preventing Violence, Substance Abuse and Related Problem Behaviors**
Maurice J. Elias, PhD., John Clabby, Ph.D., Thomas Schuyler, University of Medicine and Dentistry of New Jersey Community Mental Health Center at Piscataway, 240 Stelton Road Piscataway, NJ 088563248 Phone: (908) 235-4939 Fax: (908)235-5115

The Social Decision Making and Problem Solving (SDM-PS) program promotes decision making and conflict resolution skills in an academic environment to improve social competence. The goal is to prevent academic future, school dropout, violent social behavior, adolescent pregnancy, alcohol and other drug usage, and juvenile delinquency. This intervention targets elementary and middle school children between the ages of 6 and 14. SDM-PS provides training in problem solving, decision making, conflict resolution, group building, character development, communication, social skills and parenting through school-based academic, social, and health education. Social Decision Making and Problem Solving (SDM-PS) teaches children to think clearly under stress -- a skill considered to be common denominator in the effective promotion of academic and personal success and in the prevention of such serious problems as substance abuse, delinquency, and violence. Social Decision Making represents a family of curricular approaches with a common set of objectives:
- to calm down and re-organize themselves when they are under stress such as negative peer pressure
- to develop their understanding of social situations and their feelings and perspective of people to elaborate and clarify personally meaningful and prosocial goals
- to consider possible alternative actions and their consequences
- to plan detailed strategies for reaching their goals
- to understand and accept some decisions for which there are no alternative, such as those related to drug use, illegal alcohol use, smoking, and the use of violence to resolve interpersonal disputes and conflicts.

Social and Interpersonal Problems Related to School Aged Youth Consultation Cadre List

Professionals across the country volunteer to network with others to share what they know. Some cadre members run programs, many work directly with youngsters in a variety of settings and focus on a wide range of psychosocial problems. Others are ready to share their expertise on policy, funding, and major system concerns. The group encompasses professionals working in schools, agencies, community organizations, resource centers, clinics and health centers, teaching hospitals, universities, and so forth.

People ask how we screen cadre members. We don't! It's not our role to endorse anyone. We think it's wonderful that so many professionals want to help their colleagues, and our role is to facilitate the networking. If you are willing to offer informal consultation at no charge to colleagues trying to improve systems, programs, and services for addressing barriers to learning, let us know. Our list is growing each day; the following are those currently on file related to this topic. Note: the list is alphabetized by Region and State as an aid in finding a nearby resource.

Updated 8/15/01

Central States

Kansas

Joyce Markendorf
School Health Consultant
Kansas State Dept of Health & Environment
3422 SW Arrowhead Rd.
Topeka, KS 66614
Phone: 913/296-1308
Fax: 913/296-4166
Email: JoyMarx@aol.com

Minnesota

Jose Gonzalez
Interpreter / Supervisor
Minneapolis Dept. of Health & Family Support
250 4th St. So., Rm 401
Minneapolis, MN 55415
Phone: 612/673-3815
Fax: 612/673-2891

Missouri

Beverly McNabb
Director of Child & Adolescent Education
St. John's Behavioral Health Care
St. John's Marian Center
1235 E. Cherokee
Springfield, MO 65804
Phone: 417/885-2954
Fax: 417/888-8615
Email: BAM6749

Andrea Woodward
Clinical Director
Counseling Association Network
1734 East 63rd Street, Suite 446
Kansas City, MO 64110
Phone: 816/523-6990
Fax: 816/523-7071
Email: clgascatwk@hotmail.com

Joseph E. Zins
Professor
University of Cincinnati
339 Teachers College
Cincinnati, OH 45221-0002
Phone: 513/556-3341
Fax: 513/556-1581
Email: joseph.zins@uc.edu

East

District of Columbia

Meredith Branson
Psychologist
Department of Pediatrics, Georgetown University Hospital
2 PHC Georgetown U. Hospital 3800 Reservoir Rd. NW.
Washington, DC 20007
Phone: 202/687-5437
Fax: 202/687-7161
Email: walkerl@medlib.georgetown.edu

Leslie Walker
Georgetown Univesity Medical Center
3800 Reservoir Rd. NW 2PHC
Washington, DC 20007
Phone: 202/687-8839

Delaware

Gregory Durrette
Project Cood.
Christiana Care Health Services, The Wellness Center
DelCastle Technical High School
1417 Newport Road, Rm. B101-C
Wilmington, DE 19804
Phone: 302/892-4460
Fax: 302/892-4463
Email: gdurrette@state.de.us

Deanna Mears Pandya
Mental Health Counselor
VNA Wellness Center
1901 S. College Avenue
Newark, DE 19702
Phone: 302/369-1501
Fax: 302/369-1503

Kathy Spencer
Social Worker
Dover High School Wellness Center -VNA
1 Patrick Lynn Drive
Dover, DE 19901
Phone: 302/672-1586
Fax: 302/674-2065

Maryland

Lawrence Dolan
Principal Research Scientist
Center for Res. on the Education of Students Placed at Risk
Johns Hopkins University
3505 N. Charles Street
Baltimore, MD 21218
Phone: 410/516-8809
Fax: 410/516-8890
Email: larryd@jhunix.hcf.jhu.edu

New Hampshire

Charles Kalinski
Learning Resource Specialist
Merrimack High School
38 McElwain St.
Merrimack, NH 03054
Phone: 603/424-6204
Fax:
Email: currenttides@mediaonc.net

Pennsylvania

Ann O'Sullivan
Associate Professor of Primary Care Nursing
University of Pennsylvania School of Nursing
420 Guardian Drive
Philadelphia, PA 19104-6096
Phone: 215/898-4272
Fax: 215/573-7381
Email: osull@pobox.upenn.edu

Rhode Island

Robert Wooler
Executive Director
RI Youth Guidance Center, Inc.
82 Pond Street
Pawtucket, RI 02860
Phone: 401/725-0450
Fax: 401/725-0452

Northwest

Alaska

Michele Schindler
School Counselor
Harborview Elementary School
10014 Crazy Horse Dr.
Juneau, AK 99801
Phone: 907/463-1875
Fax: 907/463-1861
Email: schindlm@jsd.k12.ak.us

Oregon

Philip Bowser
School Psychologist
Roseburg Public Schools
1419 Valley View Drive, NW
Roseburg, OR 97470
Phone: 503/440-4038
Fax: 503/440-4003
Email: pbowser@roseburg.k12.or.us

Southeast

Arkansas

Maureen Bradshaw
State Coordinator, for Behavioral Interventions
Arch Ford Education Service Cooperative
101 Bulldog Drive
Plummerville, AR 72117
Phone: 501/354-2269
Fax: 501/354-0167
Email: mbradshaw@conwaycorp.net

Florida

Howard M. Knoff
Professor
School Psychology Program/Institute for School Reform
University of South Florida
4202 East Fowler Avenue, EDU 162
Tampa, FL 33620-7750
Phone: 813/974-9498
Fax: 813/974-5814
Email: knoff@tempest.coedu.usf.edu

Christy Monaghan
Psychologist
Florida School for the Deaf and Blind
207 N San Marco Ave.
St. Augustine, FL 32084
Fax: 904/823-4039
Email: monaghane@mail.fsdb.k12.fa.us

Georgia

Ronda Talley
Executive Director and Professor
Rosalynn Carter Institute for Human Development
Georgia Southwestern State University
800 Wheatley St.
Americus, GA 31709
Phone: 912/928-1234
Fax: 912/931-2663
Email: rtalley@canes.gsw.edu

Kentucky

Daniel Clemons
Coordinator
Fairdale Youth Service Center
1001 Fairdale Road
Fairdale, KY 40118
Phone: 502/485-8866
Fax: 502/485-8761

William Pfohl
Professor of Psychology
Western Kentucky University
Psychology Department
1 Big Red Way
Bowling Green, KY 42101
Phone: 270/745-4419
Fax: 270/745-6474
Email: william.pfohl@wku.edu

Louisiana

Dean Frost
Director, Bureau of Student Services
Louisiana State Department of Education
P.O. Box 94064
Baton Rouge, LA 70804
Phone: 504/342-3480
Fax: 504/342-6887

Southeast (contd.)

North Carolina

Bill Hussey
Section Chief
Dept. of Public Instruction
301 N. Wilmington St.
Raleigh, NC 27601-2825
Phone: 919/715-1576
Fax: 919/715-1569
Email: bhussy@dpi.state.nc.us

Regina C. Parker
Community Relations Coordinator
Roanoke-Chowan Human Service Center
Rt. 2 Box 22A
Ahoskie, NC 27910
Phone: 252/332-4137
Fax: 252/332-8457

William Trant
Director Exceptional Programs
New Hanover County Schools
1802 South 15th Street
Wilmington, NC 28401
Phone: 910/254-4445
Fax: 910/254/4446
Email: wtrant@wilmington.net

Tennessee

Mary Simmons
Director
School Counseling Services
Tennessee Department of Education
710 James Robertson Pkwy., 5th Floor
Nashville, TN 37243-0379
Phone: 615/532-6270
Fax: 615/532-8536
Email: msimmons@mail.state.tn.us

Virginia

Richard Abidin
Director of Clinical Training
Curry Programs in Clinical and School Psychology
University of Virginia
405 Emmet Street, 147 Ruffner Hall
Charlottesville, VA 22903-2495
Phone: 804/982-2358
Fax: 804/924-1433
Email: rra@virginia.edu

West Virginia

Lenore Zedosky
Executive Director
Office of Healthy Schools
West Virginia Department of Education
1900 Kanawha Blvd., Building 6, Room 309
Charleston, WV 25305
Phone: 304/558-8830
Fax: 304/558-3787
Email: lzedosky@access.k12.wv.us

Southwest

California

Marcia London Albert
7900 Loyola Blvd.
Los Angeles, CA 90045-8208
Phone: 310/338-2847
Fax: 310/338-7657
Email: malbert@lmumail.lmu.edu

Jackie Allen
Professor
Allen Consulting Associates
705 Montana Vista Ct.
Fremont, CA 94539
Phone: 510/656-6857
Fax: 510/656-6880
Email: jallen20

Bonny Beach
Lead Counselor
Fallbrook Union Elementary School District
Student Assistant Program
P.O. Box 698; 321 Iowa Street
Fallbrook, CA 92028
Phone: 619/723-7062
Fax: 619/723-3083

Howard Blonsky
School Social Worker
Program Integration & Compliance, Special Education Services
1500 Howard Ave #206
Burlingame, CA 94010
Phone: 415/355-6904
Fax: 415/355-6910
Email: hblonsk@muse.sfusd.edu

California (cont.)

Claire Brindis
Director
Ctr for Reproductive Health Research and Policy, Univ. of Calif.
Institute for Health Policy Studies/ Professor, Department of Pediatrics, Division of Adolescent Med
Box 0936, Laurel Heights Campus
San Francisco, CA 94143-0936
Phone: 415/476-5255
Fax: 415/476-0705
Email: brindis@itsa.ucsf.edu

Kelly Corey
Regional Director of Business Dev.
Provo Canyon School
P.O. Box 892292
Temecula, CA 92589-2292
Phone: 909/694-9462
Fax: 909/694-9472

Christine Davis
Counselor
LAUSD
Manual Arts Cluster
5972 W. 76th Street
Los Angeles, CA 90045
Phone: 213/731-0811
Email: davis5972

Sylvia Dean
Coordinator of Psychological Service
Los Angeles School District
11380 W. Graham Place - Bldg. Y
Los Angeles, CA 90064
Phone: 310/444-9913
Fax: 310/497-5722

Todd Franke
Assistant Professor
School of Public Policy and Social Research
University of California, Los Angeles
3250 Public Policy Building, Box 951656
Los Angeles, CA 90095-1452
Phone: 310/206-6102
Email: tfranke@ucla.edu

Randall Hansen
Licensed Educational Psychologist
Family Medical Care
110 North Spring Street
Blythe, CA 92225
Phone: 760/921-3167
Fax: 760/921-3167
Email: rhansen@telis.org

John Hatakeyama
Deputy Director
Children and Youth Services Bureau
L.A. County Dept. of Mental Health, C&FSB
550 S. Vermont Ave.
Los Angeles, CA 90020
Phone: 213/738-2147
Fax: 213/386-5282
Email: jhatakeyama@dmh.co.la.ca.us

Janice Jetton
Pediatric/Adolescent Nurse Practitioner
Kaiser Permanente, Orange County
Coordinator/Huntington Beach Union High SD
1982 Port Locksleigh Place
Newport Beach, CA 92660
Phone: 949/640-1977
Fax: 949/640-0848
Email: JanJetton@aol.com

Christy Reinold
School Counselor
Lodi Unified School District/Oakwood Elementary
1315 Woodcreek Way
Stockton, CA 95209
Phone: 209/953-8018
Fax: 209/953-8004

Marian Schiff
School Psychologist
LAUSD Montague St. School
13000 Montague St.
Pacoima, CA 91331
Phone: 818/899-0215

Susan Sheldon
School Psychologist
Los Angeles Unified School District
5423 Monte Vista St.
Los Angeles, CA 90042
Phone: 213/254-7262
Fax: 213/259-9757

Robert Spiro
School Psychologist
6336 Beeman Ave.
North Hollywood, CA 91606
Phone: 818/760-2577

Howard Taras
District Physician
San Diego City Schools
2351 Cardinal Lane, Annex B
San Diego, CA 92123
Phone: 858/627-7595
Fax: 858/627-7444
Email: htaras@ucsd.edu

California (contd.)

Lois Weinberg
Education Specialist
Mental Health Advocacy Service
1336 Wilshire Blvd., Suite 102
Los Angeles, CA 90017
Phone: 213/484-1628
Fax: 213/484-2907
Email: weinberg@gse.ucla.edu

Andrea Zetlin
Professor of Education
California State University, Los Angeles
School of Education
5151 State University Drive
Los Angeles, CA 90032
Phone: 310/459-2894
Fax: 310/459-2894
Email: azetlin@calstatela.edu

Colorado

Anastasia Kalamaros-Skalski
Assistant Research Professor
School of Education
University of Colorado at Denver
P.O. Box 173364, Campus Box 106
Denver, CO 80217-3364
Phone: 303/620-4091
Fax: 303/556-4479
Email: stacy_kalamaros-skalski@together.cudenver.edu

Hawaii

Harvey Lee
Program Specialist
Pacific Resources for Education and Learning
1099 Alkea Street
Honolulu, HI 96813-4500
Phone: 808/441-1300
Fax: 808/441-1385
Email: leeh@prel.hawaii.edu

Don Leton
Psychologist
Honolulu Schools
Special Services
4967 Kilauea Av.
Honolulu, HI 96816
Phone: 808/733-4940
Fax: 808/733-4944
Email: leton@hula.net

Nevada

Rita McGary
Social Worker
Miguel Rivera Family Resource Center
1539 Foster Rd.
Reno, NV 89509
Phone: 702/689-2573
Fax: 702/689-2574
Email: sunwindy@aol.com

On the following pages are discussions of

Accommodations to Reduce Social and Interpersonal Problems

- Shyness
- Creating a Districtwide Social Development Project
- Enhancing Motivation and Skills in Social Functioning

Behavior Management and Self Instruction

- Getting to the Bottom of Social Skills Deficits
- FIG TESPN: A Skill Based Classroom and Group Intervention

Empirically Supported Treatments for Social and Interpersonal Problems

Accommodations to Reduce Social and Interpersonal Problems

Shyness

Martha E. Scherer
University of South Florida

National Association Of School Psychologists

➤ Background

Most people have felt shy at some time or in some situation. As many as 25% of high school and college students report having been shy most of their lives (Schwartz & Johnson, 1985). Excessive shyness, however, reduces both the amount and quality of social interactions a child has with others and results in lowered peer acceptance and fewer opportunities to acquire social skills. It is not clear why some children are bashful and withdrawing whereas others tend to be more outgoing. Several factors may be involved, including genetics, temperament, anxiety, and lack of social skills.

➤ Development

Some degree of shyness in children is to be expected and is part of the child's normal development (Berk, 1989). A fairly high percentage of preschoolers are described as bashful and avoiding contact with others (Schwartz & Johnson, 1985). Between 30% and 50% of school-age children report feeling shy (Peterson, 1987). When shyness is experienced by the child in many or most situations over an extended period of time, interventions to help the child interact more appropriately are called for. Chronic and severe shyness can have a negative impact on social, emotional, and academic development. Shy children often have poor self-concept, feelings of failure, and make negative self-statements. The anxiety that accompanies shyness impairs memory and concentration and may keep children from asking for needed help in school.

➤ What Can I Do as a Parent?

It will be important for your child to learn ways to reduce his or her anxiety in social situations. If the child does not possess the social skills needed to interact with others, it may be necessary to teach social skills directly. The child also needs to learn to feel better about himself or herself as a person. There are many ways to accomplish these goals. Make sure your child knows that they are loved and valued regardless of their behavior or performance. Talk with your child. about their experiences and help them to evaluate those experiences in nonjudgmental ways that allow them to feel good about themselves. Many times children judge themselves much more harshly than we realize and blame themselves for situations and events they cannot control.

As a parent, you can give your child more independence and opportunities to demonstrate responsibility. Successful handling of independence and responsibility will help to foster an improved self-image. A child's image of himself or herself is built on a foundation of many small experiences. The more of those that demonstrate to the child that they possess the capability to succeed, the better the resulting self-image will be.

Parents can seek out and provide activities that will allow the child to experience success in social environments. Structured group activities or small groups of one or two other children may facilitate success for the shy child. Parents can discuss, rehearse, and role-play activities with children such as introducing oneself, asking a peer to play, or joining a group of children who are playing a game. If the child is involved in a social-skills training program, parents can reinforce targeted

social skills and provide opportunities for rehearsal of skills.

If your child is severely shy and inhibited in most situations, the best course of action may include seeking professional help, either through the school, local mental health agency, or your family physician. Severe shyness affects many aspects of the child's life and should not be left unaddressed.

➤ What Can I Do as a Teacher?

Shy children may be easily overlooked in a busy classroom because they do not present classroom management problems and usually comply with instructions. Teachers need to be sensitive to the needs of shy children and facilitate their interaction with others and their participation in the class. Because shy children are often characterized by anxiety, it is best to avoid drawing attention to them or putting them in situations that will require that they be the center of attention. Structured interactions and small group activities may best facilitate participation by shy students. When children are to work on projects in small groups, the teacher should form the groups rather than allowing students to group themselves. Teachers can take this opportunity to pair shy youngsters with socially competent students who will serve as models for them.

Teachers need to avoid reinforcing shy behavior, to be sensitive to the needs of shy children but to refrain from giving the shy child special attention or privileges. When shy children interact appropriately that is the behavior that should be reinforced. There is a natural tendency to either ignore or be overly protective of shy children, but neither of these responses benefits the child. Shy children should be encouraged to interact, provided with opportunities to interact in small, structured settings, and reinforced for interacting. Direct social-skills training and contingency management procedures have been found to produce positive results and may be beneficial for the entire class.

References

Berk, L. (1989). *Child development.* Boston: Allyn & Bacon.

Peterson, D. W. (1987). Children and shyness. In A. Thomas & J. Grimes *(Eds.), Children's needs: Psychological perspectives* (pp. 542-547). Washington, DC: The National Association of School Psychologists.

Schwartz, S., & Johnson, J. H. (1985). *Psychopathology of childhood* (2nd ed.). New York: Pergamon Press.

Accommodations to Reduce Social and Interpersonal Problems

Excerpts from:

Creating a Districtwide Social Development Project

Roger P. Weissberg, Timothy P. Shriver, Sharmistha Bose, and Karol DeFalco

published in *Educational Leadership May 1997*

. . . In the New Haven, Connecticut, public schools, we have found that *sustained* efforts to enhance children's social and emotional development can help students become knowledgeable, responsible, and caring citizens (Elias et al. in press). This positive approach promotes competence—and it prevents many high-risk behaviors. For the past 10 years, we have continued to develop this program and have enhanced students' academic performance, social competence, and health.

Task Force Findings

. . . The New Haven task force noted that the same students experienced several problems simultaneously—problems that seemed to have common roots, such as poor problem-solving and communication skills; antisocial attitudes about fighting and education; limited constructive after-school opportunities; and a lack of guidance and monitoring by adults who are positive role models. The task force recommended that New Haven create a comprehensive K-12 social development curriculum to address these needs.

The Social Development Project

The superintendent and board of education established a district-level Department of Social Development— with a supervisor and staff of facilitators—that coordinated all prevention and health-promotion initiatives. The department ensured broad, representative, ongoing involvement by school staff, parents, and community members in establishing coordinated social and emotional education opportunities for all students—in regular, special, and bilingual education.

The goals are to educate knowledge-able, responsible, and caring students who acquire a set of basic skills, values, and work habits for a lifetime of meaningful work and constructive citizenship. Other goals include helping students develop positive self-concepts and helping them learn to live safe, legal, and healthy lives.

Curriculum objectives and content. Curriculum committees at all grade levels developed a K-12 scope and sequence for the Social Development curriculum. . . . Throughout the process, the committees considered federal standards, state mandates, and the priorities of local educators, parents, community members, and students; and they obtained the support of university psychologists.

Over a period of five years, New Haven phased in the new curriculum, with 25-50 hours of instruction at each grade. The curriculum emphasizes the following:

- Self-monitoring, problem solving, conflict resolution, and communication skills.
- Values such as personal responsibility and respect for self and others.
- Content about health, culture, interpersonal relationships, and careers.

. . .

Professional development. The Department of Social Development established professional development programs to support and train teachers, administrators, and pupil personnel staff who implement these programs. Master teachers and coaches are the core of this effort, as they help coordinate classroom instruction with school and community programming. In this ongoing program, teachers bring their successes and challenges back to the group. . . .

Program evaluation. Finally, the department designed monitoring and evaluation strategies to assess the effectiveness of the program and to identify ways to improve it. . . . research has demonstrated positive effects on students' problem-solving skills, attitudes about conflict, impulse control, social behavior, delinquency, and substance use (Weissberg et al. 1997, Caplan et al. 1992, Kasprow et al. 1991).

Recommendations

. . .

• School-based prevention programs should embrace a broad conceptualization of health and positive youth development, addressing children's social, emotional, and physical health through coordinated programming.

• Programs should offer develop-mentally appropriate, planned, sequential K-12 classroom instruction, using culturally relevant information and materials.

• Effective prevention involves teaching methods that ensure active student engagement, emphasize positive behavior change, and improve student-adult communication. Students are more likely to benefit when they are encouraged to apply skills to real-life situations and to learn effective communication skills.

• Peers, parents, the school, and community members should work together to reinforce classroom instruction.

• Team members must design programs that are acceptable to and reach students at risk, including students already engaging in risky behaviors. Classroom instruction must be better coordinated with social, mental health, and health services that are provided to high-risk youth.

• Districts must develop system wide practices and infrastructures to support social and emotional devol-opment programs.

. . . Healthy social and emotional learning goes beyond the prevention of specific negative outcomes. We need to abandon piecemeal approaches to prevention; we must provide supportive, creative, and caring learning environments to nurture the healthy development of children.

References

Caplan, M., R.P.M. Weissberg, J.S.D. Goober, PJ. Silo, D. Grady, and C. Jacob. (1992). Social Competence Promotion with Inner-City and Suburban Young Adolescents: Effects on Social Adjustment and Alcohol Use." *Journal of Clinical and Consulting Psychology 60,* 1:56 63.

Centers for Disease Control and Prevention. (March *24,* 1995). "CDC Surveillance Summaries." *Morbidity and Mortality Weekly Review44 (SS-1):* 1-56.

Draftees, JG (1997). The Prevalence of Problem Behaviors: Implications for Programs." In *Healthy Children 2010: Enhancing Children's Well,* edited by R.P.M. Weissberg, T.P. Gallate, R.L. Hampton, B.A. Ryan, and G.R. Adams. Thousand Oaks, Calif.: Sage.

Dusenbury, L.A., and M. Falco. (1997). "School-Based Drug Abuse Prevention Strategies: From Research to Policy and Practice." In *Healthy Children 2010: Enhancing Children's Well,* edited by R.P.M. Weissberg, T.P. Gallate, R.L. Hampton, B.A. Ryan, and G.R. Adams. Thousand Oaks, Calif.: Sage.

Elias, MJ., J.E. Zins, R.P.M. Weissberg, K.S. Frey, M.T. Greenberg, N.M. Haynes, R. Kessler, M.E. Schwab-Stone, and T.P. Shriver. (in press). *Fostering Knowledgeable, Responsible, and Caring Students: Social and Emotional Education Strategies.* Alexandria, Va.: ASCD.

Kasprow, WJ., R.P.M. Weissberg, C.K. Voyce, A.S. Jackson, T. Fontana, M.W. Arthur, E. Borrnan, N. Mormorstein, J. Zeisz, T.P. Shriver, K. DeFalco, W. Elder, and M. Kavanaugh. (1991). *New Haven Public Schools Social Development Project: 1990 91 Evaluation Report.* New Haven: New Haven Public Schools.

Shriver, T.P., and R.P.M. Weissberg. (May 15, 1996). "No New Wars!" *Education Week 15,* 34: 33, 37.

Weissberg, R.P.M., H.A. Barton, and T.P. Shriver. (1997). "The Social Competence Promotion Program for Young Adolescents." In *Primary Prevention Exemplars: The Lela Rowland Awards,* edited by G.W. Albee and T.P. Gallate. Newbury Park, Calif.: Sage.

Roger P. Weissberg is Professor of Psychology at the University of Illinois at Chicago, Senior Researcher for the Mid-Atlantic Regional Laboratory for Student Success, and Executive Director of the Collaborative for the Advancement of Social and Emotional Learning (CASEL).

Timothy P. Shriver is President of Special Olympics International, Washington, D.C., and the former Supervisor of the Department of Social Development for the New Haven, Connecticut, Public Schools.

Sharmistha Bose is a senior research associate for CASEL.

Karol DeFalco is a facilitator for Social Development, New Haven Public Schools.

Address correspondence to Roger P. Weissberg at CASEL, Department of Psychology (MtC 285), University of Illinois, 1007 West Harrison St., Chicago, IL 60607-7137 (e-mail: rpw@uic.edu).

Accommodations to Reduce Social and Interpersonal Problems

Enhancing Motivation and Skills in Social Functioning

Adelman, H. S., and Taylor, L. (1993).
Learning Problems & Learning Disabilities: Moving Forward (pp. 362-364).
Pacific Grove, CA: Brooks/Cole Publishing Co.

Persons with learning disabilities and other learning problems often do not behave in ways others think they should. The behavior of such persons has been labeled behavior problems, misbehavior, adaptive behavior deficits, lack of social skills, and so forth. (Public Law 94-142 specifically requires assessment of "adaptive" behavior.) Recently, there has been a trend to view these behavior "problems" as an indication of immature social development, especially a lack of skills for interpersonal functioning and problem solving. This has led to a variety of "social skills training" programs.

How promising are programs for training social skills? Recent reviewers have been cautiously optimistic about the potential value of several proposed approaches. At the same time, there is concern that such skill training seems limited to what is specifically learned and to the situations in which the skills are learned. Moreover, the behaviors learned seem to be maintained for only a short period after the training. These concerns have been raised in connection with (1) training specific behaviors, such as teaching a person what to think and say in a given situation, and (2) strategies that emphasize development of specific cognitive or affective skills, such as teaching a person how to generate a wider range of options for solving interpersonal problems.

As with other skill training strategies, the limitations of current approaches seem to result from a failure to understand the implications of recent theory and research on human motivation. It is evident that many social skill training programs lack a systematic emphasis on enhancing participants' motivation to avoid and overcome interpersonal problems and to learn and continue to apply interpersonal skills to solve such problems.

In keeping with the ideas presented in Part 3, we have been exploring ways to engage a student initially in a variety of activities intended to overcome or minimize avoidance and enhance positive motivation for improving social functioning, especially the solving of interpersonal problems. The general assumptions underlying this work are discussed in Chapters 8 through 11. In addition, with regard to social functioning, we assume that

1. not all problems with social functioning are indications that a person lacks social skills
2. assessment of social skill deficiencies is best accomplished after efforts are made (a) to minimize environmental factors causing interpersonal problems and (b) to maximize a student's motivation for coping effectively with such problems
3. regular teaching and remedial strategies to improve skills for social functioning are best accomplished in interaction with systematic strategies to enhance motivation (a) for avoiding and overcoming interpersonal problems and (b) for continuing to apply social skills

The specific steps we have developed so far to address major motivational considerations in overcoming interpersonal problems are outlined in Feature 1. Steps in enhancing skills are outlined in Feature 2.

Because we have not addressed the topic of social skills in any depth in the text, a few words about the steps outlined in Feature 1 seem in order. The interest in training social skills has resulted in a rapidly growing body of literature specifying skills and procedures (see references at the end of Chapter 11). Although most social skills curricula await further evaluation, we have drawn upon available work to arrive at what appears to be a promising synthesis of "skills" and practices. Furthermore, our approach to teaching the skills uses a general problem-solving sequence. In essence, individuals are taught to (1) analyze interpersonal problem situations, (2) generate and evaluate a range of options and specific steps for resolving problems, and (3) implement and evaluate the chosen option, and then (4) if necessary, select another alternative.

These abilities can be practiced as lessons or when natural interpersonal problems arise in the classroom. For those who are interested and capable, the problem-solving framework itself can be taught. When formal lessons are used, small-group instruction is favored because it provides a social context for learning about social matters; however, individuals should be given private lessons when necessary. We propose that groups meet each day for 30-45 minutes over a period of about eight weeks.

For each step, three guidelines shape the choice of

On the following pages are discussions of

Accommodations to Reduce Social and Interpersonal Problems

- Shyness
- Creating a Districtwide Social Development Project
- Enhancing Motivation and Skills in Social Functioning

Behavior Management and Self Instruction

- Getting to the Bottom of Social Skills Deficits
- FIG TESPN: A Skill Based Classroom and Group Intervention

Empirically Supported Treatments for Social and Interpersonal Problems

Accommodations to Reduce Social and Interpersonal Problems

Shyness

Martha E. Scherer
University of South Florida

National Association Of School Psychologists

➤ Background

Most people have felt shy at some time or in some situation. As many as 25% of high school and college students report having been shy most of their lives (Schwartz & Johnson, 1985). Excessive shyness, however, reduces both the amount and quality of social interactions a child has with others and results in lowered peer acceptance and fewer opportunities to acquire social skills. It is not clear why some children are bashful and withdrawing whereas others tend to be more outgoing. Several factors may be involved, including genetics, temperament, anxiety, and lack of social skills.

➤ Development

Some degree of shyness in children is to be expected and is part of the child's normal development (Berk, 1989). A fairly high percentage of preschoolers are described as bashful and avoiding contact with others (Schwartz & Johnson, 1985). Between 30% and 50% of school-age children report feeling shy (Peterson, 1987). When shyness is experienced by the child in many or most situations over an extended period of time, interventions to help the child interact more appropriately are called for. Chronic and severe shyness can have a negative impact on social, emotional, and academic development. Shy children often have poor self-concept, feelings of failure, and make negative self-statements. The anxiety that accompanies shyness impairs memory and concentration and may keep children from asking for needed help in school.

➤ What Can I Do as a Parent?

It will be important for your child to learn ways to reduce his or her anxiety in social situations. If the child does not possess the social skills needed to interact with others, it may be necessary to teach social skills directly. The child also needs to learn to feel better about himself or herself as a person. There are many ways to accomplish these goals. Make sure your child knows that they are loved and valued regardless of their behavior or performance. Talk with your child. about their experiences and help them to evaluate those experiences in nonjudgmental ways that allow them to feel good about themselves. Many times children judge themselves much more harshly than we realize and blame themselves for situations and events they cannot control.

As a parent, you can give your child more independence and opportunities to demonstrate responsibility. Successful handling of independence and responsibility will help to foster an improved self-image. A child's image of himself or herself is built on a foundation of many small experiences. The more of those that demonstrate to the child that they possess the capability to succeed, the better the resulting self-image will be.

Parents can seek out and provide activities that will allow the child to experience success in social environments. Structured group activities or small groups of one or two other children may facilitate success for the shy child. Parents can discuss, rehearse, and role-play activities with children such as introducing oneself, asking a peer to play, or joining a group of children who are playing a game. If the child is involved in a social-skills training program, parents can reinforce targeted

social skills and provide opportunities for rehearsal of skills.

If your child is severely shy and inhibited in most situations, the best course of action may include seeking professional help, either through the school, local mental health agency, or your family physician. Severe shyness affects many aspects of the child's life and should not be left unaddressed.

➤ What Can I Do as a Teacher?

Shy children may be easily overlooked in a busy classroom because they do not present classroom management problems and usually comply with instructions. Teachers need to be sensitive to the needs of shy children and facilitate their interaction with others and their participation in the class. Because shy children are often characterized by anxiety, it is best to avoid drawing attention to them or putting them in situations that will require that they be the center of attention. Structured interactions and small group activities may best facilitate participation by shy students. When children are to work on projects in small groups, the teacher should form the groups rather than allowing students to group themselves. Teachers can take this opportunity to pair shy youngsters with socially competent students who will serve as models for them.

Teachers need to avoid reinforcing shy behavior, to be sensitive to the needs of shy children but to refrain from giving the shy child special attention or privileges. When shy children interact appropriately that is the behavior that should be reinforced. There is a natural tendency to either ignore or be overly protective of shy children, but neither of these responses benefits the child. Shy children should be encouraged to interact, provided with opportunities to interact in small, structured settings, and reinforced for interacting. Direct social-skills training and contingency management procedures have been found to produce positive results and may be beneficial for the entire class.

References

Berk, L. (1989). *Child development.* Boston: Allyn & Bacon.

Peterson, D. W. (1987). Children and shyness. In A. Thomas & J. Grimes *(Eds.), Children's needs: Psychological perspectives* (pp. 542-547). Washington, DC: The National Association of School Psychologists.

Schwartz, S., & Johnson, J. H. (1985). *Psychopathology of childhood* (2nd ed.). New York: Pergamon Press.

Accommodations to Reduce Social and Interpersonal Problems

Excerpts from:

Creating a Districtwide Social Development Project

Roger P. Weissberg, Timothy P. Shriver, Sharmistha Bose, and Karol DeFalco

published in *Educational Leadership May 1997*

. . . In the New Haven, Connecticut, public schools, we have found that *sustained* efforts to enhance children's social and emotional development can help students become knowledgeable, responsible, and caring citizens (Elias et al. in press). This positive approach promotes competence—and it prevents many high-risk behaviors. For the past 10 years, we have continued to develop this program and have enhanced students' academic performance, social competence, and health.

Task Force Findings

. . . The New Haven task force noted that the same students experienced several problems simultaneously—problems that seemed to have common roots, such as poor problem-solving and communication skills; antisocial attitudes about fighting and education; limited constructive after-school opportunities; and a lack of guidance and monitoring by adults who are positive role models. The task force recommended that New Haven create a comprehensive K-12 social development curriculum to address these needs.

The Social Development Project

The superintendent and board of education established a district-level Department of Social Development— with a supervisor and staff of facilitators—that coordinated all prevention and health-promotion initiatives. The department ensured broad, representative, ongoing involvement by school staff, parents, and community members in establishing coordinated social and emotional education opportunities for all students—in regular, special, and bilingual education.

The goals are to educate knowledge-able, responsible, and caring students who acquire a set of basic skills, values, and work habits for a lifetime of meaningful work and constructive citizenship. Other goals include helping students develop positive self-concepts and helping them learn to live safe, legal, and healthy lives.

Curriculum objectives and content. Curriculum committees at all grade levels developed a K-12 scope and sequence for the Social Development curriculum. . . . Throughout the process, the committees considered federal standards, state mandates, and the priorities of local educators, parents, community members, and students; and they obtained the support of university psychologists.

Over a period of five years, New Haven phased in the new curriculum, with 25-50 hours of instruction at each grade. The curriculum emphasizes the following:

- Self-monitoring, problem solving, conflict resolution, and communication skills.
- Values such as personal responsibility and respect for self and others.
- Content about health, culture, interpersonal relationships, and careers.

. . .

Professional development. The Department of Social Development established professional development programs to support and train teachers, administrators, and pupil personnel staff who implement these programs. Master teachers and coaches are the core of this effort, as they help coordinate classroom instruction with school and community programming. In this ongoing program, teachers bring their successes and challenges back to the group. . . .

Program evaluation. Finally, the department designed monitoring and evaluation strategies to assess the effectiveness of the program and to identify ways to improve it. . . . research has demonstrated positive effects on students' problem-solving skills, attitudes about conflict, impulse control, social behavior, delinquency, and substance use (Weissberg et al. 1997, Caplan et al. 1992, Kasprow et al. 1991).

Recommendations

• School-based prevention programs should embrace a broad conceptualization of health and positive youth development, addressing children's social, emotional, and physical health through coordinated programming.

• Programs should offer develop-mentally appropriate, planned, sequential K-12 classroom instruction, using culturally relevant information and materials.

• Effective prevention involves teaching methods that ensure active student engagement, emphasize positive behavior change, and improve student-adult communication. Students are more likely to benefit when they are encouraged to apply skills to real-life situations and to learn effective communication skills.

• Peers, parents, the school, and community members should work together to reinforce classroom instruction.

• Team members must design programs that are acceptable to and reach students at risk, including students already engaging in risky behaviors. Classroom instruction must be better coordinated with social, mental health, and health services that are provided to high-risk youth.

• Districts must develop system wide practices and infrastructures to support social and emotional devol-opment programs.

. . . Healthy social and emotional learning goes beyond the prevention of specific negative outcomes. We need to abandon piecemeal approaches to prevention; we must provide supportive, creative, and caring learning environments to nurture the healthy development of children.

References

Caplan, M., R.P.M. Weissberg, J.S.D. Goober, PJ. Silo, D. Grady, and C. Jacob. (1992). Social Competence Promotion with Inner-City and Suburban Young Adolescents: Effects on Social Adjustment and Alcohol Use." *Journal of Clinical and Consulting Psychology 60,* 1:56 63.

Centers for Disease Control and Prevention. (March *24,* 1995). "CDC Surveillance Summaries." *Morbidity and Mortality Weekly Review44 (SS-1):* 1-56.

Draftees, JG (1997). The Prevalence of Problem Behaviors: Implications for Programs." In *Healthy Children 2010: Enhancing Children's Well,* edited by R.P.M. Weissberg, T.P. Gallate, R.L. Hampton, B.A. Ryan, and G.R. Adams. Thousand Oaks, Calif.: Sage.

Dusenbury, L.A., and M. Falco. (1997). "School-Based Drug Abuse Prevention Strategies: From Research to Policy and Practice." In *Healthy Children 2010: Enhancing Children's Well,* edited by R.P.M. Weissberg, T.P. Gallate, R.L. Hampton, B.A. Ryan, and G.R. Adams. Thousand Oaks, Calif.: Sage.

Elias, MJ., J.E. Zins, R.P.M. Weissberg, K.S. Frey, M.T. Greenberg, N.M. Haynes, R. Kessler, M.E. Schwab-Stone, and T.P. Shriver. (in press). *Fostering Knowledgeable, Responsible, and Caring Students: Social and Emotional Education Strategies.* Alexandria, Va.: ASCD.

Kasprow, WJ., R.P.M. Weissberg, C.K. Voyce, A.S. Jackson, T. Fontana, M.W. Arthur, E. Borman, N. Mormorstein, J. Zeisz, T.P. Shriver, K. DeFalco, W. Elder, and M. Kavanaugh. (1991). *New Haven Public Schools Social Development Project: 1990 91 Evaluation Report.* New Haven: New Haven Public Schools.

Shriver, T.P., and R.P.M. Weissberg. (May 15, 1996). "No New Wars!" *Education Week 15,* 34: 33, 37.

Weissberg, R.P.M., H.A. Barton, and T.P. Shriver. (1997). "The Social Competence Promotion Program for Young Adolescents." In *Primary Prevention Exemplars: The Lela Rowland Awards,* edited by G.W. Albee and T.P. Gallate. Newbury Park, Calif.: Sage.

Roger P. Weissberg is Professor of Psychology at the University of Illinois at Chicago, Senior Researcher for the Mid-Atlantic Regional Laboratory for Student Success, and Executive Director of the Collaborative for the Advancement of Social and Emotional Learning (CASEL).

Timothy P. Shriver is President of Special Olympics International, Washington, D.C., and the former Supervisor of the Department of Social Development for the New Haven, Connecticut, Public Schools.

Sharmistha Bose is a senior research associate for CASEL.

Karol DeFalco is a facilitator for Social Development, New Haven Public Schools.

Address correspondence to Roger P. Weissberg at CASEL, Department of Psychology (MtC 285), University of Illinois, 1007 West Harrison St., Chicago, IL 60607-7137 (e-mail: rpw@uic.edu).

Accommodations to Reduce Social and Interpersonal Problems

Enhancing Motivation and Skills in Social Functioning

Adelman, H. S., and Taylor, L. (1993).
Learning Problems & Learning Disabilities: Moving Forward (pp. 362-364).
Pacific Grove, CA: Brooks/Cole Publishing Co.

Persons with learning disabilities and other learning problems often do not behave in ways others think they should. The behavior of such persons has been labeled behavior problems, misbehavior, adaptive behavior deficits, lack of social skills, and so forth. (Public Law 94-142 specifically requires assessment of "adaptive" behavior.) Recently, there has been a trend to view these behavior "problems" as an indication of immature social development, especially a lack of skills for interpersonal functioning and problem solving. This has led to a variety of "social skills training" programs.

How promising are programs for training social skills? Recent reviewers have been cautiously optimistic about the potential value of several proposed approaches. At the same time, there is concern that such skill training seems limited to what is specifically learned and to the situations in which the skills are learned. Moreover, the behaviors learned seem to be maintained for only a short period after the training. These concerns have been raised in connection with (1) training specific behaviors, such as teaching a person what to think and say in a given situation, and (2) strategies that emphasize development of specific cognitive or affective skills, such as teaching a person how to generate a wider range of options for solving interpersonal problems.

As with other skill training strategies, the limitations of current approaches seem to result from a failure to understand the implications of recent theory and research on human motivation. It is evident that many social skill training programs lack a systematic emphasis on enhancing participants' motivation to avoid and overcome interpersonal problems and to learn and continue to apply interpersonal skills to solve such problems.

In keeping with the ideas presented in Part 3, we have been exploring ways to engage a student initially in a variety of activities intended to overcome or minimize avoidance and enhance positive motivation for improving social functioning, especially the solving of interpersonal problems. The general assumptions underlying this work are discussed in Chapters 8 through 11. In addition, with regard to social functioning, we assume that

1. not all problems with social functioning are indications that a person lacks social skills
2. assessment of social skill deficiencies is best accomplished after efforts are made (a) to minimize environmental factors causing interpersonal problems and (b) to maximize a student's motivation for coping effectively with such problems
3. regular teaching and remedial strategies to improve skills for social functioning are best accomplished in interaction with systematic strategies to enhance motivation (a) for avoiding and overcoming interpersonal problems and (b) for continuing to apply social skills

The specific steps we have developed so far to address major motivational considerations in overcoming interpersonal problems are outlined in Feature 1. Steps in enhancing skills are outlined in Feature 2.

Because we have not addressed the topic of social skills in any depth in the text, a few words about the steps outlined in Feature 1 seem in order. The interest in training social skills has resulted in a rapidly growing body of literature specifying skills and procedures (see references at the end of Chapter 11). Although most social skills curricula await further evaluation, we have drawn upon available work to arrive at what appears to be a promising synthesis of "skills" and practices. Furthermore, our approach to teaching the skills uses a general problem-solving sequence. In essence, individuals are taught to (1) analyze interpersonal problem situations, (2) generate and evaluate a range of options and specific steps for resolving problems, and (3) implement and evaluate the chosen option, and then (4) if necessary, select another alternative.

These abilities can be practiced as lessons or when natural interpersonal problems arise in the classroom. For those who are interested and capable, the problem-solving framework itself can be taught. When formal lessons are used, small-group instruction is favored because it provides a social context for learning about social matters; however, individuals should be given private lessons when necessary. We propose that groups meet each day for 30-45 minutes over a period of about eight weeks.

For each step, three guidelines shape the choice of specific instructional objectives. Recognizing that both motivational and developmental readiness must be accom-

specific instructional objectives. Recognizing that both motivational and developmental readiness must be accommodated, the guidelines stress the following:

• Not teaching previously learned skills or those that the individual does not want to pursue currently. (In such instances, scheduled lessons are replaced by enrichment activities; needed skills instruction is postponed until sufficient interest can be established.)

• Teaching the skills most needed in pursuing current relationships. (Lessons are not necessarily presented in the order listed in Feature 2.) Optimally, objectives are keyed to match the individual's current needs. Such needs are identified by the individual involved or by school personnel who have assessed the deficiencies by closely observing well-motivated attempts at solving interpersonal problems.

• Developing missing prerequisites for learning and performing needed skills. When necessary, individuals are involved in additional exercises to improve (1) communication, (2) divergent thinking, (3) recognition and understanding of individual differences, and/or (4) understanding the value of respect and concern for others.

Feature 1 Initial Steps for Enhancing and Maintaining Motivation to Solve Interpersonal Problems

Activities such as direct discussions, responding to direct questions, sentence completion, or Q-sort items, role playing, audiovisual presentations,* and so on are used as vehicles to present, elicit, and clarify

1. specific times when the individual experiences interpersonal problems (without assigning blame)

2. the form of the problems (again, no judgments are made)

3. the individual's perceptions of the causes of the problems**

4. a broader analysis of possible causes (the individual's thoughts about other possible reasons and about how other people might interpret the situation; intervener examples of other perceptions and beliefs)

5. any reasons the individual might have for wanting the interpersonal problems not to occur and for why they might continue

6. a list of other possible reasons for people not wanting to be involved in such problems

7. the reasons that appear personally important to the individual and why they are significant, underscoring the individual's most important reasons for wanting not to be involved in such problems

8. general ways in which the individual can deal appropriately and effectively with such problems (avoid them; use available skills; develop new skills)

9. the individual's (a) general desire not to continue to experience interpersonal problems, (b) specific reasons for wanting this, and (c) desire to take some action

10. the available alternatives for avoiding problems, using acquired skills, and developing new skills

11. the available options related to activities and objectives associated with learning new skills (the specific activities and materials, mutual expectations, and so on)

12. specific choices stated as a mutually agreeable plan of action for pursuing alternatives clarified in steps 10 and 11.

Any step can be repeated as necessary (perhaps because of new information). Also, once the skill development activities are initiated, some of the steps must be repeated in order to maintain an individual's motivation over time.

*Videotapes are particularly useful to make points vividly (to portray others in comparable situations, to present others as models). **Each step does not require a separate session (for example, steps 1 through 3 can be accomplished in one session).

Feature 2 Steps to Enhance Skills for Solving Interpersonal Problems

1. Presentation of examples of interpersonal problem solving (read by the instructor using visual aids or a videotape presentation).*

2. Group discussions of examples stressing (a) why the person in the example wanted to solve the problem, (b) the way the problem was analyzed, (c) possible solutions that were generated, and (d) the way in which pros and cons of solutions were considered, and choices made, implemented, and evaluated.

3. Presentation of an interpersonal problem and group discussion of why the person involved wants to resolve the problem and of how to analyze it.

4. Presentation of an appropriate analysis of a problem and group discussion and categorization of options.

5. Presentation of a range of options and specific steps for solving a problem; group discussion of pros and cons for evaluating which one should be pursued.

6. Presentation of a chosen alternative for solving a problem; group discussion of how to evaluate its effectiveness and to choose another option if necessary.

7. Presentation of a new problem with the preceding steps repeated as needed.

It is proposed that at least four problems be pursued in this fashion. By the fourth, the individual is to be able to do each facet of the problem-solving sequence during a given session. If not, up to three additional problems will need to be presented.

Evaluative feedback will underscore progress and satisfaction associated with accomplishment of program objectives and solving interpersonal problems at school. Consequences that the individual experiences when such problems are not solved appropriately also need to be highlighted.

*During any step, as appropriate, the discussion may include role-playing, use of puppets with younger children, and so on. Initially, the intervener provides categories of ideas that may have been missed. All ideas generated during discussion are to be charted for subsequent reference.

Summing up

Obviously, the ideas discussed here represent only a beginning. Given the growing interest in the areas of systematic enhancement of motivation and the training of social skills, we anticipate that programs for individuals with learning and behavior problems will increasingly incorporate procedures that reflect strategies for simultaneously enhancing motivation and skills.

Behavior Management & Self-Instruction

A popular approach for working with youngsters with social and interpersonal problems in classrooms was published in LD Forum, Vol 21 (1), Fall, 1995, by Judith Osgood Smith from Purdue University Calumet.

GETTING TO THE BOTTOM OF SOCIAL SKILLS DEFICITS

When someone mentions **behavior management,** our first thought may be about controlling students or stopping them from performing inappropriate behaviors. We expend a great deal of energy managing students so that inappropriate behaviors will not occur. However, successful termination of inappropriate behavior is no guarantee that appropriate behavior will take its place. One of the most puzzling and frustrating problems encountered by parents and teachers of students with learning disabilities (LD) is not the student who obviously acts out or engages in overtly antisocial behaviors, but rather the one who simply fails to perform the appropriate behavior for a given circumstance or setting. This problem is frequently labeled a social skill deficit (Gresham & Elliott, 1989).

Students with LD may exhibit social skill deficits that are either skill-based or performance-based. In other words, either the skill may not be in the student's repertoire or the student may have acquired the skill but it is not performed at an acceptable level. Effective intervention requires identification and remediation of the specific type of deficit exhibited by the student. This article will delineate the differences between skill-based and performance-based social skills deficits and present intervention approaches in each area.

SKILL-BASED DEFICITS

A skill-based deficit exists when a student has not learned how to perform a given behavior. For example, a student who has not learned to do long division could be said to have a long division skill deficit. Similarly, a student who hasn't mastered the skill of greeting others appropriately may have a skill deficit in that area. Few parents or teachers would punish a student for not knowing how to do long division. Unfortunately, however, we sometimes become angry with students when they don't demonstrate the social skill we desire them to display. Reprimands and loss of privileges are common reactions. A critical issue is whether the student actually possesses the desired skill. If not, it is unreasonable to demand that it occur or scold the student if it doesn't. Our anger and punishment can only add to the frustration of the student who knows he or she did something wrong, but has no clue as to how to fix it.

We may determine if a student has a skill deficit by observing whether the desired skill has ever been performed. If not, one may hypothesize that the skill is not in the student's repertoire. This may be tested further by providing strong incentives to perform the desired behavior. If the student fails to perform under these conditions, it is likely that the problem stems from a skill deficiency. The bottom line: don't scold or reprimand the student for having a skill-based deficit; instead, teach the skill.

Teaching Social Skills

Generally, a skill-based deficit is due to lack of opportunity to learn or limited models of appropriate behavior (Gresham & Elliott, 1989). Even given the opportunity to learn and the appropriate model,

students with LD may not learn these skills incidentally or intuitively. In these instances, direct instruction, or skill training, is necessary. The same principles apply to teaching social skills as to academic skills: provide ample demonstration/ modeling, guided practice with feedback, and independent practice.

Hazel, Schumaker, Sherman, and Sheldon-Wildgen (1981) listed eight fundamental social skills which can be taught through direct instruction:

1. Giving positive feedback (e.g., thanking and giving compliments),
2. Giving negative feedback (e.g., giving criticism or correction),
3. Accepting negative feedback without hostility or inappropriate reactions,
4. Resisting peer pressure to participate in delinquent behavior,
5. Solving personal problems,
6. Negotiating mutually acceptable solutions to problems,
7. Following instructions, and
8. Initiating and maintaining a conversation.

They recommended teaching these skills by providing definitions, illustrations with examples, modeling, verbal rehearsal, behavioral rehearsal, and additional practice.

Similarly, Walker, Colvin, and Ramsey (1995) recommended a nine-step direct instructional procedure, the ACCEPTS instructional sequence. The steps include:

1. Definition of the skill with guided discussion of examples,
2. Modeling or video presentation of the skill being correctly applied,
3. Modeling or video presentation of incorrect application (non example),
4. Review,
5. Modeling or video presentation of a second example with debriefing,
6. Modeling a range of examples, coupled with hypothetical practice situations,
7. Modeling or video presentation of another positive example if needed,
8. Role playing, and
9. Informal commitment from student to try the skill in a natural setting.

In summary, students with LD who have not acquired social skills are not likely to learn casually or incidentally. Intervention for skill-based deficits should focus on direct instruction of the skill. Effective instructional methods include demonstration/modeling with guided practice and feedback.

PERFORMANCE-BASED DEFICITS

A performance-based deficit exists when the student possesses a skill but doesn't perform it under the desired circumstances. This may occur if there is a problem with either motivation or with ability to discriminate as to when to exhibit the appropriate behavior.

Motivational Deficit

When a motivational deficit exists, the student possesses the appropriate skill, but doesn't desire to perform it. A motivational deficit may be hypothesized if observations reveal that the student has acquired the desired skill, but motivational conditions are not sufficiently strong to elicit it. The hypothesis may be confirmed if the student performs the behavior following introduction of a motivational strategy. For example, in the area of conversation skills, we may suspect that a student is capable of interpreting cues from peers that indicate that it is someone else's turn to talk, but instead chooses to interrupt. This theory may be verified if the student waits to speak when rewarded for taking turns. The student could then be considered to have a motivational deficit. In situations such as this, behavioral interventions are effective.

Motivational Strategies. Parents and teachers of students with motivational deficits can manipulate contingencies that will encourage performance of prosocial behaviors by using the principles of Applied Behavior Analysis (ABA). The steps include defining the target behavior operationally, identifying antecedents and consequences related to the behavior, and finally developing and carrying out a plan to alter the antecedents and consequences so that the desired behavior will occur. For example, the behavior of "interrupting" may be defined as "speaking before your partner has completed his or her sentence." The antecedents to this behavior may be poor models and the consequence to interrupting may be attention from

the listener. The next step is to develop a plan which encourages turn taking during conversations. An antecedent technique may be to remind the student about taking turns prior to a conversation and a consequence may be to pay attention only when the student waits his or her turn prior to speaking. Good school/home communication and collaboration can ensure consistency of carrying out the plan in both settings.

Most students of ABA who have succeeded at a self-improvement program such as a diet or exercise regime will confirm that the principles of ABA can be effectively used on oneself. Bos and Vaughn (1995) postulated that these same principles can be taught to adolescents so that they can implement a self-management program. The adolescent with LD would first learn to identify the behavior he or she wants to change, then identify the antecedents and consequences connected to the behavior, and, finally, develop an intervention which alters the antecedents and provides consequences that will maintain the desired behavior. A further suggestion would be to have the adolescent chart his or her progress toward a self-selected reward. To summarize, once identified, motivational deficits can be remediated using behavior management techniques, either by the adult in the situation, or by the student in question.

Discrimination Deficit

A student with a discrimination deficit has the desired skill in his or her repertoire, is motivated to behave properly, but can't discriminate, (i.e., doesn't know when to exhibit the desired behavior). A discrimination deficit may be confirmed if the student frequently performs the desired behavior, but fails to perform it under specific conditions. This may be due to an inability to glean relevant information from social situations. When a discrimination deficit exists, the student possesses the desired behavior but may not be sure as to when, where, and how much to engage in that behavior.

Bryan (1991) reviewed research on social competence of students with LD. Most studies found that students with LD had poorer social cognition than nondisabled or low-achieving students. A deficit in social cognition may be apparent in a student who is oblivious to social cues or who lacks understanding of the social demands of a situation (Bryan, 1994).

The Hidden Curriculum. Given the same information as everyone else, students with LD may not demonstrate appropriate social skills because they do not understand the hidden curriculum ascertained by more socially adept students. Lavoie (1994) suggested assessment of the student's knowledge of the hidden curriculum as a step in teaching the student to discriminate the appropriate behavior for a given situation. The first step is to determine the hidden curriculum, or culture, pertaining to the school the student attends. For example, what extracurricular activities are viewed by others as important? What are the hidden rules governing social functions? What is the administrative framework? Which teachers emphasize completion of daily assignments, punctuality, and/or class participation? This information can be obtained from teachers, support staff, and school publications such as the yearbook or school newsletter.

Once the hidden curriculum is identified, the next step is to assess the student's knowledge in key areas. There are many things which we may take for granted about which the student may be embarrassed or incapable of obtaining an explanation. Specifically, the following questions should be answered:

1. Does the student understand how the schedule works?
2. Does the student know how to get from one place to another in the school building?
3. Is the student aware of the requirements for participation in extracurricular activities, including deadlines and eligibility procedures?
4. Can the student identify the social cliques?
5. Can the student identify support staff (e.g., the school nurse, the guidance counselor)? Does he or she know how to gain access to their services?

In short, the hidden curriculum must first be identified and then the student's level of understanding of it must be assessed. Only then can information be provided to the student to fill in the gaps.

Teaching Discrimination. A common characteristic of students with LD is impulsivity, the tendency to act without considering the consequences or appropriateness of one's behavior. This may be seen as an interfering behavior, which will be discussed in the following section. However, what on first glance appears to be impulsivity may in reality be an inability

to understand the limits of acceptable behavior. Acceptability of behavior frequently varies according to the setting or circumstance. For example, a student may not know which teachers tolerate conversation and when it is appropriate to talk with peers. What is acceptable behavior on the playground may not be acceptable in the classroom.

According to Smith and Rivera (1993), "educators must help students learn to discriminate among the behavioral options in each school situation and match that situation with the proper behavior pattern" (p. 24). Some social skill problems occur simply because students do not understand how to read environmental cues that indicate whether or not a behavior is acceptable. In short, when there is a discrimination deficit, we must help the student size up the social situation and determine what to do. If the student cannot discriminate, we must teach what is acceptable in a given circumstance.

Lavoie (1994) introduced a problem-solving approach to teaching discrimination called the social autopsy. A social autopsy is the examination or inspection of a social error in order to determine why it occurred and how to prevent it from occurring in the future. When a student makes an academic error, we provide the right answer and use the mistake as an opportunity to learn. In other words, we teach the student how to "fix" the mistake. Similarly, Lavoie (1994) suggested that instead of punishing the student for making a social mistake, we should analyze it and use it as an opportunity to learn. The process involves asking the student, "What do you think you did wrong? What was your mistake?" By actively involving the student in discussion and analysis of the error, a lesson can be extracted from the situation which enables the student to see the cause-effect relationship between his or her behavior and the consequences or reactions of others.

Underlying the social autopsy are the following principles:

1. Teach all adults who have regular contact with the student to perform social autopsies. This includes family members, custodial staff, cafeteria workers, bus drivers, teachers, secretaries, and administrators. This will foster generalization by ensuring that the student participates in dozens of autopsies daily.
2. Conduct social autopsies immediately after the error occurs. This will provide a direct and instantaneous opportunity to demonstrate the cause and effect of social behaviors.
3. Use social autopsies to analyze socially correct behaviors as well as errors. This will provide reinforcement which may assist the student in repeating the appropriate behavior in another setting.
4. Help students identify and classify their own feelings or emotions.

There are several advantages of this method: (a) It uses the sound learning principles of immediate feedback, drill and practice, and positive reinforcement; (b) It is constructive and supportive rather than negative or punishing; (c) It provides an opportunity for the active involvement of the student, rather than an adult-controlled intervention; and (d) It generally involves one-on-one assistance to the student.

To summarize, limited awareness of the conventions of behavior and inability to decode the hidden curriculum and social cues contribute to deficits in discrimination of social skills. Interventions for students with these problems should be geared toward helping the student analyze the components of social situations so that discrimination can occur.

SELF-CONTROL

This article has discussed the classification and remediation of social skills deficits. However, there is one problem that may inhibit success, even if we are able to classify successfully the student's problem and design an appropriate intervention. Interfering or competing behaviors may interrupt the student's ability to learn or demonstrate appropriate social skills. Such problems can contribute to both skill and performance deficits so that a student may have difficulty either learning a new skill or performing it when appropriate.

Common interferences experienced by students with LD are impulsivity (the tendency to act without considering consequences or to choose the first solution that comes to mind), distractibility (tendency to focus on minor details, to pay attention to everything), and perseveration (repetition of behavior due to inability to change motoric or verbal responses; inability to shift gears). Hyperactivity (excessive

motor activity) can also interfere. Either a systematic behavioral approach or self-management techniques may be helpful, depending on the student, the situation, and the interfering behavior. For the distractible student, self-monitoring and charting of attention or work completed may be helpful. Students who are impulsive can learn problem-solving strategies which force them to dissect problems and evaluate possible consequences. Bos and Vaughn (1994) recommended a strategy called FAST for this purpose.

The steps in FAST are:

1. **F**reeze and think! What is the problem?
2. **A**lternatives? What are my possible solutions?
3. **S**olution evaluation. Choose the best solution: safe? fair?
4. **T**ry it! Slowly and carefully. Does it work (p.371)?

CONCLUSION

In conclusion, remediation must be directly related to the type of social skill deficit. If the student has a skill-based deficit, the appropriate intervention strategy is to teach the deficient skill. If motivation is a problem, behavioral interventions are appropriate. If the student has difficulty discriminating what is the acceptable behavior for a given circumstance, we must provide the information needed so that discrimination is possible and assist the student in analyzing positive social behaviors as well as social errors. Interfering behaviors must also be considered. Educators and parents can do much to alleviate social skills problems by discerning whether social skills deficits are skill-based or performance-based and designing interventions accordingly.

REFERENCES

Bos, C. S., & Vaughn, S. (1994). *Strategies for teaching students with learning and behavior problem* (3rd ed.). Needham Heights, MA: Allyn & Bacon.

Bryan,T. (1991). Assessment of social cognition: Review of research in learning disabilities. In H. L. Swanson (Ed.), *Handbook on the Assessment of Learning Disabilities: Theory, Research, and Practice* (pp. 285-311). Austin, TX: Proed.

Bryan, T. (1994). The social competence of students with learning disabilities over time: A response to Vaughn and Hogan. *Journal of Learning Disabilities, 27,* 304-308.

Gresham, F., & Elliott, S. (1989). Social skills deficits as a primary learning disability. *Journal of Learning Disabilities, 22,* 120-124.

Hazel, J. S., Schumaker, J. B., Sherman, J. A., & Sheldon-Wildgen, J. (1981). *ASSET: A social skills program for adolescents.* Champaign, Il: Research Press.

Lavoie, R. D. (1994). *Learning disabilities and social skills with Richard Lavoie: Last one picked...First one picked on* [Video and Teacher's Guide]. (Available from PBS Video, 1320 Braddock Place, Alexandria, VA 22314-1698).

Smith, D. D., & Rivera, D. M. (1993). *Effective discipline* (2nd ed.). Austin, TX: Proed.

Walker, H., Colvin, G., & Ramsey, E. (1995). *Antisocial behavior in school: Strategies and best practices.* Pacific Grove, CA: Brooks/Cole.

Behavior Management & Self-Instruction

FIG TESPN: A SKILL-BASED CLASSROOM AND GROUP INTERVENTION

Excerpts from:

Social Problem Solving: Interventions in the Schools

Marice J. Elias and Steven E. Tobias

Guilford School Practitioner Series 1996

. . . FIG TESPN is an acronym for the sequence of steps that guides students through the process of social decision making and problem solving (see Table). It provides a centralizing concept for students to understand the steps as a whole process to engage in when confronted with a problem or decision. The unique "name," FIG TESPN, is also a mnemonic that re-inforces memory. In addition, it is a convenient prompt for teachers to use; for example, they can ask a student, "How can FIG TESPN help you with this problem?"

This model was developed to be implemented in a flexible manner across a broad variety of settings. Rather than a set of eight discrete steps to problem solving, FIG TESPN is taught as a whole process. It is through the repetition of the whole that the skills embedded within it are learned without losing the overall purpose of solving the student's problem. Each time the process is repeated, a subskill (such as identification of feelings, goal setting, role playing assertive behaviors, etc.) can be highlighted and reviewed.

FIG TESPN can be thought of as "Jiminy Cricket," the character from *Pinocchio* who sits on Pinocchio's shoulder, or like a coach who helps you develop skills but ultimately has to stay on the sidelines. Although FIG TESPN, initially with the leader's assistance, guides the student through the problem-solving process, the student is responsible for generating the ideas that will be used in the process. It is important for the facilitators to keep in mind that the overall goal is to develop students' independent and responsible problem solving The following are some of the important features of each problem-solving step.

TABLE: FIG TESPN: Social Problem Solver

1. **FEELINGS** cue me to problem solve.
2. **I** have a problem.
3. **GOALS** give me a guide.
4. **THINK** of things to do.
5. **ENVISION** outcomes.
6. **SELECT** my best solution.
7. **PLAN** the procedure, anticipate pitfalls, practice, and pursue it.
8. **NOTICE** what happened and now what?

Feelings cue me to problem solve. Feelings are the first step in problem solving because they provide a cue that something needs to be done. Often when students have negative feelings, they get stuck in those feelings and become immobilized or act out inappropriately. FIG TESPN teaches them to use these feelings, not as an end result of some unpleasant event, but as a beginning to help them get what they want. A useful analogy is physical pain. If someone got a cut and it did not hurt, they might not notice and could bleed to death or get an infection. The pain from the cut lets them know that there is a problem and that they need to do something to take care of it. If they do not

cut lets them know that there is a problem and that they need to do something to take care of it. If they do not take care of this problem, then things will probably get worse. Bad feelings work the same way. Being upset lets you know that there is a problem that needs to be solved; if you do not solve it, it will most likely get worse. By using feelings as the cue to problem solving, the bad feelings get reframed and students become empowered into action.

I have a problem. This does not mean that the problem was the student's fault, but it does mean that it is the student's responsibility to solve it. Students often externalize blame and thereby externalize responsibility for solving the problem. This then leaves the student powerless to impact on the problem. The purpose of this step is not to ascribe blame but to have the student put the problem into words, which is the first step in solving it. Problems cannot be solved at the feeling level; this step begins to introduce a cognitive process that can lead to solutions.

It is important to identify the problem and sort it out from the various other problems or feelings that may be occurring. Having students verbalize a problem is another technique for fostering impulse control through self-verbalization. At this point, if students come up with problems that seem to be irrelevant to a situation, do not censor them or direct them to the "correct" problem. Allow them to continue through the subsequent steps. At some point, they may see that their solution does not address the problem as stated. At that point, go back and reformulate the problem.

For example, two students had a fight. The teacher asks what the problem is. One student says that the problem is that John is a jerck. The student then attempts to develop goals and options to deal with this. He may see that regardless of what his goal or solution is, he is not addressing the fact that John is a jerk. At that time, you may help the student refor-mulate the problem, such as "John keeps teasing me."

Goals give me a guide. This step involves turning the problem upside down into a positive statement of desired outcome. The purpose of FIG TESPN is for students to get what they want. However, it will be necessary for students to set appropriate and obtainable goals.

At this step, students should define what a goal is (e.g., a specific thing you want to accomplish or have happen). The facilitator can explain that goals give us direction so that we can work for something. Clarifying goals enables us to develop plans to reach them. It is important for students to develop reasonable and reachable goals. It may also be necessary to identify subgoals; a student who wants to get an "A" in science must first get an "A" on the next test. Having students define general goals for themselves and discussing them can be a worthwhile activity in itself.

Think of things to do. Students generally do not recognize that there is more than one way to meet a goal. Often, even if they think before they act, they do not necessarily think of multiple things they can do. But the more potential solutions they can generate, the better their chance of getting what they want.

It is necessary to teach students how to brainstorm options. This involves writing down everything they can think of relevant to the problem. When brainstorming, it is important not to be critical in the initial stages because outrageous options may stimulate thought about more realistic ones. After brainstorming, then go through the options and refine or combine them. Refrain from rejecting options based on their potential outcomes at this point. Wait for the next step to help students understand that the option may have unpleasant outcomes for them.

Envision outcomes. After generating a list of things to do, it is necessary to go back over them and envision what would happen if they tried one of them. The word "envision" was chosen carefully to evoke imaging, or seeing in a concrete way what would happen. It is helpful if students picture the outcomes, not just think about them.

The facilitator should discuss with students the importance of anticipating the consequences of actions. Students need to understand that for every action there is a consequence. Have students generate examples of actions and consequences. Encourage students envision of several consequences for each action or option; the use of flow charts or webs can make this more graphic. You may also wish to develop a rating system to evaluate potential outcomes for each option, from positive to negative. Some students have difficulty with this and it may be necessary for the facilitator to suggest potential outcomes that were unforeseen by the students.

Select my best solution. When selecting the best solution, refer back to the original problem and goal.

Often, students have become distracted by this point and have lost sight of their original goal. Remind them of whatl they said they wanted. Make sure that the solution addresses this. It may be necessary to rethink one or several of the previous steps. When formulating a solution, several options can be combined. For example, where the goal is to pass a test, the solution may be to develop a study schedule, ask a friend to study with you, and outline all of the chapters.

Plan the procedure, anticipate pifalls, practice, and pursue it. There are obviously a lot of important skills packed into this step. If students could just do this step, they would be good problem solvers. That actions can be thought out and planned beforehand is often a new but not necessarily welcomed concept to students. However, it should be emphasized to students that planning gives them a better chance of getting what they want.

Planning is often a difficult step for students and they are not accustomed to thinking in a deliberate manner before acting. The use of relevant analogies to reinforce the importance of this can be helpful: the planning that goes into a space shuttle launch, the planning necessary for a family vacation, planning how and when to ask someone for a date. Plans can be broken down into four components: who, what, when, and where. Make sure plans involve each of these components.

Anticipating pitfalls, roadblocks, or obstacles to the plan is extremely important. The leader should ask, "What could happen that ssould prevent you from implementing your plan?" By preparing students ahead of time for these pitfalls you will be inoculating them to some degree against frustration and feelings of futility.

Notice what happended and now what? It is important for the leader to follow up with the student as to what happened and to have the student engage in self-evaluation. Did the plan work? How does he feel now? Were there unanticipated obstacles? Was the goal realistic and obtainable?

At this step it is important for students to understand that despite their best efforts, their plans might not meet with success. It is necessary to self-evaluate and, if necessary to rethink the problem or decision. It may be necessary to engage in another FIG TESPN using the result of the initial FIG TESPN as the problem to be solved.Make sure to start with the feelings about not having solved the problem or the decision not working out.

As noted previously, FIG TESPI can be implemented flexibly in a variety of settings. Despite the complexity of the skills involved, it is important to run through all the steps even if some are not given a full treatment. It is through the repetition that the process is mastered. Each time the process is repeated, a certain step or skill can be highlighted.

EMPIRICALLY SUPPORTED TREATMENTS

In an effort to improve the quality of treatment, the mental health field is promoting the use of empirically supported interventions. The following pages contain excerpts from a 1995 report entitled "Prevention of Behavioral and Social Problems: The Need for Preventive Services by J. A. Durlak, from *School-based prevention programs for children and adolescents*. Thousand Oaks, CA: Sage.

Excerpted here are the abstract, an adapted table categorizing relevant research, and the authors' conclusions.

Abstract from J. A. Durlak, from *School-based prevention programs for children and adolescents*. Thousand Oaks, CA: Sage.

Although there is no standardized reporting system, information summarized by Knitzer, Steinberg, and Fleisch (1990) suggests that relatively few maladapting schoolchildren receive school-based mental health care and that those who do receive services that are neither lengthy nor timely. For instance, although up to 15% of schoolchildren experience clinical-level dysfunction, schools formally designate only 1% of the school population as having serious problems, labeling them behaviorally or emotionally disturbed. Only two-thirds to three-fourths of these children receive any school mental health services, and less than half receive more than five sessions a year. Finally, although most children with serious problems are identified in the early primary grades, the majority who receive any mental health treatment are between 12 and 16 years old. Programs to prevent behavioral and social maladjustment could fill an important need by helping many school-age children who will likely never receive any mental health care....

The following pages highlight the gist of the author's conclusions.

PRIMARY PREVENTION

Durlak, Lampman, Wells, and Cotten (1993) conducted a meta-analysis evaluating controlled outcome studies of primary prevention that had appeared through the end of 1991. The major findings for the 131 school-based programs in this review are presented in Table 2.1. Results for different types of programs are expressed in terms of mean effect sizes (ESs), which are standardized mean differences comparing the postintervention statuses of experimental and control groups. In brief, an ES reflects how much change has occurred from an intervention; higher numbers indicate stronger program impact. The appendix to this volume presents a brief explanation of ESs and their interpretation.

In general, all types of programs had significant positive impacts on participants; the mean ESs ranged from 0.25 to 0.50. It is helpful to compare these outcomes with those obtained from other types of treatments. Lipsey and Wilson (1993) report that the mean ES obtained from 156 different meta-analyses evaluating various social, behavioral, and educational treatments was 0.47 (SD = 0.28). The results obtained for primary prevention programs are within this range. Compared with treatments for dysfunctional children, slightly lower mean effects can be expected for primary prevention programs, because children in such programs are initially functioning within the normal range.

Table 2.1 also presents mean ESs expressed in terms of either assessed competencies or problems. Outcomes assessing problems would include symptom checklists, self-reports of anxiety, and observations of inappropriate behavior; those evaluating competence would focus on assertiveness, interpersonal problem-solving skills, increases in self-esteem or self-efficacy, and so on. With the exception of problem-solving interventions, programs produced similar and significant effects on both competencies and problems. In other words, primary prevention programs had the dual effect of improving participants' status on indicators of both adjustment and maladjustment.

Competency enhancement coupled with a reduction in problems has important preventive implications. For example, a program that ends with participants having greater self-confidence and better coping abilities would seem to place participants at lower risk for future problems than a program that only reduces pathology.

Although outcome data for primary prevention programs are generally positive, conclusions about program impact are offered cautiously for two main reasons. First, only a minority of programs collected follow-up data (26%), and follow-up periods were relatively short in many cases. The median follow-up period was only 8 weeks, and only eight studies collected follow-up data at 1 year or later. Therefore, the durability of program impact for many interventions is largely unknown. Second, in several cases there was a failure to formulate and test specific hypotheses. For example, researchers have not always articulated specific program objectives or presented theory-based rationales for why interventions should achieve certain outcomes. The presence of vague goals (e.g., "to prevent school maladjustment") coupled with the use of measures that assess general aspects of functioning (e.g., self-esteem or anxiety) makes it difficult to interpret an intervention's preventive impact. There are significant exceptions to the above, however, and some exemplary programs that offer the strongest evidence for preventive effects are described in the following sections. Different types of interventions are presented below using the

TABLE 2.1 Mean Effect Sizes for Primary Prevention Programs to Prevent Behavioral and Social Problems

Type of Program (no. of studies)	*All Outcomes*	*Mean Effect Size Competencies*	*Problems*
Environmental programs (17)	0.35	0.56	0.26
Transition programs			
divorce (7)	0.36	0.33	0.38
school entry/change (9)	0.39	0.41	0.36
Person-centered programs			
affective education (46)	0.29	0.31	0.26
interpersonal problem solving (23)	0.39	0.44	0.06[a]
Other programs			
behavioral (26)	0.50	0.44	0.55
nonbehavioral (16)	0.25	0.24	0.25

SOURCE: Data are drawn from Durlak et al. (1993).

NOTE: [a]. Only mean effect *not* significantly different from zero.

conceptual distinctions discussed in Chapter 1.

Person-Centered Approaches

Mental health promotion. One strategy in primary prevention involves health promotion, and two groups of studies fit this mold: those involving affective education and those involving interpersonal problem-solving training.

Programs involving affective education represent a diverse set of interventions that share the common goal of emotional and social growth. The general intent of these programs is to improve children's adjustment by increasing their self-understanding and self-acceptance, and by helping them understand factors that influence their own and others' feelings and behaviors. The availability of commercial programs and the intuitive appeal of this approach for teachers have made affective education very popular in the schools. Lesson plans and units are available for early and middle elementary students that combine puppet play, music, stories, group discussions, and various exercises....

* * *

Transition or Milestone Programs

There are two types of school-based transition programs: those designed for children of divorcing parents and those designed for children who are changing schools. The potential negative effects of divorce on children are well known (Emery, 1988). Programs for children of divorce adapt a variety of clinical techniques to help children deal with the stress of divorce. Opportunities for discussion, ventilation of feelings, and social support are provided, usually in a group context (e.g., Alpert-Gillis, Pedro-Carroll, & Cowen, 1989).

Because at least one third of all children will eventually experience the divorce of their parents, and in growing recognition that divorce can have negative effects on children's peer relations, school achievement, and personality functioning, interventions for children of divorce are becoming increasingly popular in the schools. Emery (1988) and Grych and Fincham (1992) offer excellent overviews of the issues involved in implementing and evaluating such interventions.

Children who must change schools represent another opportunity for primary prevention interventions. Approximately 6 million students (ages 5-13) change schools each year, and it is believed that many of them experience some difficulty in adjusting (Jason et al., 1992). Jason et al. (1992) have summarized findings from their School Transition Project, an attempt to help high-risk multiethnic middle school children (Grades 4-6) who were entering new inner-city schools. In successive studies, children considered to be at academic risk on the basis of low standardized achievement scores received an orientation program conducted by a sixth-grade peer and in-school academic tutoring during the new school year from college undergraduates or home tutoring from trained parents. In Study 1, experimental children improved significantly in achievement scores compared with controls, and 50% more experimental than control children moved out of the academic at-risk category. In Study 2, tutored children in both conditions again demonstrated academic gains and parent tutoring produced more favorable results on measures of classroom social behavior than in-school tutoring. Finally, 1-year follow-up of the first cohort indicated that experimental children had maintained their academic gains.

Environmental Programs

Although programs attempting environmental changes are in the minority (n = 17), the results of several interventions have been particularly impressive. For example, attempts at changing a school's psychosocial environment to increase peer and teacher support for low-income, multi-ethnic students have been successful (Felner & Adan, 1988). Instead of frequently changing classes and teachers, program students were kept together for core academic subjects. These students were in homerooms in which assigned teachers were trained to function as counselors and to offer social support for school-related difficulties. Significant program effects were obtained for grades, school attendance, self-concept, and positive perceptions of the school environment. A 3-year follow-up indicated significantly higher grades and lower absenteeism for program students and a 48% lower school dropout rate.

Weinstein et al. (1991) also successfully changed the school environment through a multicomponent intervention that focused on eight school features, including curricular student ability groupings,

evaluation procedures, teacher-student relationships, and parent involvement. At-risk, multiethnic high school students changed significantly in grades, disciplinary referrals, and school absences compared with controls, and at 1-year follow-up had a 50% lower school dropout rate.

Hawkins et al. (1991) sought to prevent aggression and other acting-out behaviors by changing both the classroom and home environments of subjects in a program that combined teacher and parent interventions. Parents of low-income multiethnic children entering first grade received training in behavioral management practices for use in the home. Teachers were trained in proactive classroom management (see Chapter 4) and in specific interactive teaching methods. The latter included changing several instructional procedures in the class so that teachers monitored and reinforced student progress on individually paced academic tasks. Children were also trained in interpersonal problem-solving skills by their teachers. Compared with controls, experimental boys were significantly less aggressive and experimental girls were significantly less self-destructive, according to teacher ratings. Only 6% of experimental boys, compared with 20% of control boys, were in the clinical range of dysfunction on aggressive behavior.

Finally, the Houston Program (Johnson, 1988), which targeted low-income Mexican American families, is an example of environmental change occurring during early childhood. In this case, the multicomponent intervention involved the creation of a new setting, a child development center offering services to the entire family. The program, which began when the child was 1 year old, involved biweekly home visits and weekend sessions conducted by a paraprofessional child educator. These visits focused on issues related to parent-child interactions and early child development. ...

* * *

SECONDARY PREVENTION

Secondary prevention programs (or indicated preventive interventions) provide prompt intervention for problems that are detected early; they typically operate as follows. A particular population in one or more schools (e.g., all first graders, all those in junior high) is screened or evaluated in some way and criteria are used to target some for intervention, which follows quickly after the collection of more information confirming the nature of the children's difficulties. The intent of secondary prevention is to help children with subclinical problems so that they avoid developing full-blown disorders. It is believed that the earlier the intervention occurs, the greater the likelihood of success. In other words, it makes sense to intervene when problems are just beginning rather than to wait for them to intensify over time.

There are two main aspects to secondary prevention programs. The first involves the early identification of school problems; the second involves the treatment provided to target children....

...A few examples illustrate the diversity of procedures used in secondary prevention programs. The best-known secondary prevention program is the Primary Mental Health Project (PMHP) begun by Cowen and his colleagues in Rochester, New York, in 1957 (see Cowen, 1980). so called because of its focus on the primary (early elementary) school grades and not because it is a primary prevention program, the PMHP basically offers individual relationship-oriented (nonbehavioral) treatment to children who have externalizing or internalizing problems as well as learning difficulties. Trained homemakers have been the major therapeutic agents.

Other programs have used social and token reinforcement to modify children's acting-out and shy/withdrawn behaviors (Durlak, 1977; Kirschenbaum, DeVoge, Marsh, & Steffen, 1980). Cognitive-behavioral therapy techniques emphasizing self-monitoring and self-control have been used effectively to reduce aggressive behavior (Camp, Blom, Herbert, & Van Doorninck, 1977; Lochman, Burch, Curry, & Lampron, 1984) and depressive symptomatology (Kahn et al., 1990). La Greca and Santogrossi (1980) used social learning procedures to train social isolates in skills designed to increase their rates of peer acceptance. In a frequently cited study, Oden and Asher (1977) found it was possible to coach socially isolated children on how to improve their peer interactions. Most of the above interventions have been offered in group formats, have been relatively brief (12 or fewer sessions), and have successfully used a variety of change agents, such as teachers (Camp et al., 1977), school counselors (Durlak, 1977; Kahn et al., 1990), and graduate and undergraduate students (Kirschenbaum et al., 1980; La Greca &

Santogrossi, 1980; Lochman et al., 1984; Oden & Asher, 1977).

Program Outcomes

Durlak and Wells (1994) conducted a meta-analytic review of the impact of secondary prevention by evaluating the results of 130 published and unpublished controlled outcome studies appearing by the end of 1991. All of these studies used person-centered approaches, and most (94%) were conducted in schools. As the findings did not vary when the few nonschool programs were removed, results for the complete review are discussed here. Programs focused strictly on academic remediation and those to prevent drug taking were not included, but such programs are discussed in Chapters 3 and 4.

The design of secondary prevention programs varied widely. For example, a relatively high percentage of studies randomly assigned participants to treatment and control conditions (71%), used multiple outcome measures (91%), and had low attrition (76%). In contrast, relatively few designs included attention placebo controls (28%), collected follow-up data (29%), or used normed outcome measures (2096). None of the above procedures was significantly related to program outcomes, but the data reported above indicate how methodological improvements can be made in future studies.

Table 2.3 summarizes the main findings from this meta-analysis. Results are presented first for the general type of treatment used, which was the most important factor affecting outcomes. Behavioral and cognitive-behavioral treatments were equally effective in producing moderately strong effects (mean ES of 0.51 and 0.53, respectively), which were almost twice as high as those emanating from nonbehavioral interventions (mean ES = 0.27).

The effectiveness in treating different types of presenting problems is also indicated in Table 2.3. Surprisingly, programs targeting externalizing problems achieved the highest effects (mean ES = 0.72). This category included aggression and other forms of acting-out problems. Loeber (1990) has indicated that the possibility of modifying acting-out behaviors decreases with age. Therefore, prompt intervention for dysfunction detected early might be responsible for the ability of secondary prevention to reduce acting-out behaviors.

The most common internalizing problems treated in secondary prevention programs have been anxiety and depression, which appear amenable to early intervention (mean ES = 0.49). Although the effects for children with academic problems and poor peer relations are more modest (ESs of 0.26 and 0.30, respectively), each of these dimensions is predictive of later adjustment, so that even modest changes on these indices can have some preventive impact.

The bottom of Table 2.3 summarizes follow-up data for secondary prevention programs. The results are encouraging, given that there is no lessening of program impact over time; however, only 29% of all programs collected follow-up information and the follow-up period was relatively short in most cases.

Finally, in a fashion similar to the findings for primary prevention, ESs were analyzed separately for outcome measures assessing competencies and problems. Although behavioral treatment produced higher effects than nonbehavioral interventions, both treatments were similar in ability to modify problems or competencies (mean ESs = 0.46 and 0.44 for behavioral treatment and 0.20 and 0.24 for nonbehavioral treatment, respectively). Cognitive-behavioral treatment did enhance competencies (mean ES = 0.39), but obtained much higher effects in terms of reducing problems (mean ES = 0.84).

In summary, results from 130 controlled outcome studies provide strong support for a secondary prevention model emphasizing timely intervention for subclinical problems detected early. Secondary prevention is applicable across a wide range of school settings, is appropriate for several different forms of dysfunction, and can be delivered in individual or group formats by diverse change agents. Various clinical procedures can be easily adapted once children in need of treatment are identified. Outcomes vary according to the type of treatment and presenting problem. In general, the best results are obtained for cognitive-behavioral and behavioral treatments and interventions targeting externalizing problems.

On the following pages are discussions of

A. ERIC Digest: Understanding and Facilitating Preschool Children's Peer Acceptance

B. ERIC Digest: Having Friends, Making Friends, and Keeping Friends: Relationships as Educational Contexts

C. ERIC Digest: Young Children's Social Development: A Checklist

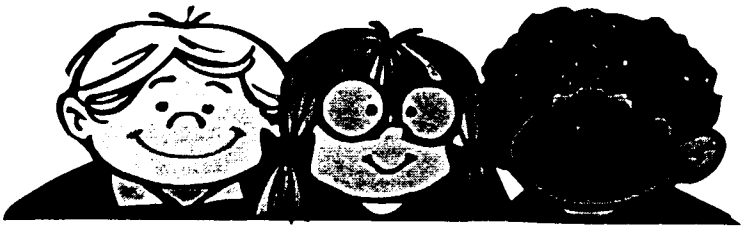
D. Parent Talk: Building Emotionally Health Families

E. Parent Talk: Before friendships can form, kids must first like themselves

F. Forming Partnerships with Parents: Toward Improving Home Involvement in Schooling

G. Fostering Students Social and Emotional Development: Toward a Caring School Culture

H. Relevant Center Materials: Some Special Resources from the Clearinghouse



Understanding and Facilitating Preschool Children's Peer Acceptance

➤PEER ACCEPTANCE AND CHILDREN'S BEHAVIOR

Children's understanding of emotional expressions and situations has been found to relate to how well peers like or dislike them. A study at George Mason University suggests that well-liked children are better able than other children to read and respond to peers' emotions. Disliked children may misinterpret peers' emotions, leading to difficult interactions and eventual rejection by peers.

In general, positive behaviors, such as cooperation, are associated with being accepted by peers, and antisocial behaviors, such as aggression, are associated with being rejected. This is confirmed by recent studies identifying characteristics and behaviors related to being liked or disliked by peers.

Good communication is a skill important to the continuation of social play. Well-liked children appear to communicate better than disliked children. In a study at the University of Texas, well-liked children were more likely than others to be clear in direct communications by saying the other child's name, establishing eye contact, or touching the child they intended to address. Well-liked children more often replied appropriately to children who spoke to them, rather than ignoring the speaker, changing the subject, or saying something irrelevant. While well-liked children were not any less prone to reject peers' communications toward them, they were more likely to offer a reason for the rejection or suggest alternatives. For example, in rejecting a peer's suggestion--"let's pretend we are hiding from the witch"--a well-liked child was more likely to say, "no, we played that yesterday," or, "no, let's be robbers instead," rather than just saying, "no."

➤PEER ACCEPTANCE AND SOCIAL REPUTATION

It is important to recognize the role of the peer group in maintaining a child's level of social acceptance. Once a child has established a reputation among peers either as someone with whom it is fun to play or as someone with whom joint play is unpleasant or dissatisfying, this reputation may influence the way other children perceive the child's later behavior. If a negative reputation is developed, helping the child become accepted may require more than a change in the child's behavior; it may also be necessary to point out to the other children when the child's behavior changes and to guide them to respond to the child in positive ways.

➤HOW CAN TEACHERS AND OTHER ADULTS HELP?

Studies such as those mentioned above suggest important elements to be considered by those who wish to understand why a particular child is unpopular and need to decide what to do to help that child gain social acceptance. To assist a disliked child in gaining acceptance, careful, informed observation is needed.

Observe behavior and note: Does the child have greater success interacting with one or two peers than with larger groups? Does the child often seem to misinterpret the apparent intentions and emotional cues of other children? When rejecting a playmate's suggestion, does the child provide a reason or an alternative idea? Do classmates consistently rebuff or ignore the child's attempts to engage in play, even when the child is using strategies that should work?

There is no recipe for facilitating acceptance. To help a child, it is essential to identify the child's areas of difficulty.

➤STRATEGIES TO CONSIDER

Adults who work with groups of children may feel frustrated in their attempts to help a child achieve social acceptance. Many approaches can be adapted to particular situations and needs of individual children. Special play activities can be arranged, such as grouping children who lack social skills with those who are socially competent and will thus provide examples for learning effective skills. Planning special play sessions with a younger child may help the socially isolated child. Research reports that socially isolated preschoolers exposed to play sessions with pairs of younger children eventually become more socially involved in the class than do isolated children who play with children of their own age. The decision to pair a child with a younger or more socially skilled child should depend on whether the child's social isolation is due to ineffective social skills or lack of confidence. Some children have adequate social skills, but are anxious and inhibited about using them. Opportunities to be the big guy in play with a younger child may give the inhibited child a needed boost of social confidence.

Sometimes disliked children behave aggressively because they don't know how to resolve conflicts. Planned activities can help children generate alternative solutions to difficult social situations. Skits, puppet shows, or group discussions that present hypothetical situations can encourage a wide range of ideas for potential solutions. Such methods can increase the number of appropriate strategies, such as taking turns or sharing, that are available to the children. However, to effectively implement such newly learned strategies in the classroom, children must be given on-the-spot guidance when real conflict situations occur. To help with conflict resolution, the adult can encourage the children involved to voice their perspectives, generate potential solutions, and jointly decide on and implement a mutually acceptable solution.

When a child has difficulty entering ongoing play, an adult can steer the child toward smaller or more accepting groups, or can structure the environment to include inviting spaces for private small group or one-on-one play. A loft, a tent, or a large empty box might make an inviting space. When a child asks, "Can I play?" the teacher can guide the child in observing the ongoing play, figuring out the group's theme and purpose, and thinking of a role to play or of ways to contribute to the group.

On-the-spot guidance by adults can facilitate communication, which contributes to successful play. A child who rejects playmates' ideas without offering explanations or alternatives could be told, "Ben I don't think Tom understands why you don't want to play store. Can you tell him why?" or "Can you tell him what else you could do together?" A disliked child having difficulty reading others' emotional cues might be given a suggestion--"Look at Mary's face. Do you think she likes it when you poke her?"

In addition to using techniques that focus on the disliked child, adults may need to translate for the peer group the unpopular child's behavior and apparent intentions. For example, an adult might say, "Thomas wants to play with you. If you don't need another father, who could he be instead?" However, when intervention focuses on the peer group, adults should not force peers to play with a disliked child. This may cause resentment and increase rejection of the child.

The teacher's attempts to help a disliked child find a comfortable niche in the peer group may prove more successful if the child's family is involved, either directly or indirectly. After describing to the parent what techniques are being tried in the classroom, the teacher may suggest how the parent can use some of the strategies to help the child play with peers at home or interact with siblings. Children who feel good about themselves and experience loving family relationships may bring their expectations of acceptance and success to the peer group. Such expectations can become self-fulfilling prophecies.

For the child whose poor self-concept reflects difficulties in the child's family, parent conferences in which the teacher can offer support may be helpful. Literature on such topics as positive discipline and effective parent-child interaction can be offered on a parent reading shelf or bulletin board. Parent discussion groups, facilitated by a knowledgeable professional, can provide information about the importance of social competence and guidance strategies that can help parents facilitate their child's development.

➤EDITOR'S NOTE: This is the second in a series of three ERIC/EECE digests that focus on children's peer relationships as educational contexts. These digests are adapted from articles that originally appeared in the Fall 1991 (Vol. 19, No. 1) issue of the EARLY REPORT of the University of Minnesota's Center for Early Education and Development.

➤FOR MORE INFORMATION

Denham, S.A., McKinley, M., Couchoud, E.A., and Holt, R. "Emotional and Behavioral Predictors of Preschool Peer Ratings." CHILD DEVELOPMENT 61 (1990): 1145-1152.

Furman, W., Rahe, D., and Hartup, W.W. "Rehabilitation of Socially Withdrawn Preschool Children Through Mixed-Age and Same-Age Socialization." CHILD DEVELOPMENT 50 (1979): 915-922.

Hazen, N.L., and Black, B. "Preschool Peer Communication Skills: The Role of Social Status and Interaction Context." CHILD DEVELOPMENT 60 (1989): 867-876.

Hazen, N.L., Black, B., and Fleming-Johnson, F. "Social Acceptance: Strategies Children Use and How Teachers Can Help Children Learn Them." YOUNG CHILDREN 39 (September 1984): 23-26.

Kemple, K.M., Speranza, H., and Hazen, N.L. "Cohesive Discourse and Peer Acceptance: Longitudinal Relationships in the Preschool Years." MERRILL-PALMER QUARTERLY: in press.

Rogers, D.L., and Ross, D.D. "Encouraging Positive Social Interaction Among Children." YOUNG CHILDREN 41 (March 1986): 12-17.

Spivack, G., and Shure, M. SOCIAL ADJUSTMENT OF YOUNG CHILDREN: A Cognitive Approach to Solving Real-life Problems. San Francisco: Jossey-Bass, 1974.

Stein, L.C., and Kostelnik, M.J. "A Practical Problem-solving Model for Conflict Resolution in the Classroom." CHILD CARE QUARTERLY 13 (1984): 5-20.

➤➤➤➤➤➤➤➤➤➤➤➤➤➤➤➤➤➤➤➤➤

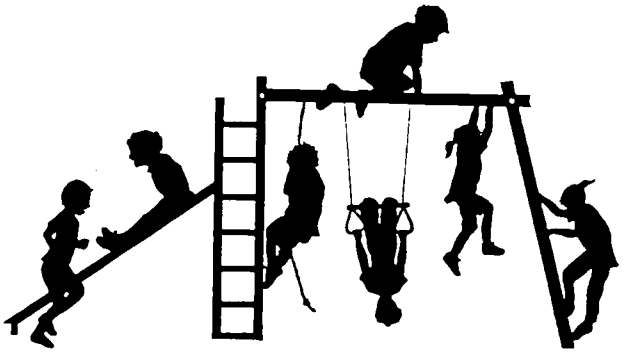
ED345866 92 Understanding and Facilitating Preschool Children's Peer Acceptance. ERIC Digest.
Author: Kemple, Kristen M.

ERIC Clearinghouse on Elementary and Early Childhood Education, Urbana, Ill.

THIS DIGEST WAS CREATED BY ERIC, THE EDUCATIONAL RESOURCES INFORMATION CENTER. FOR MORE INFORMATION ABOUT ERIC, CONTACT ACCESS ERIC 1-800-LET-ERIC

This publication was prepared with funding from the Office of Educational Research and Improvement, U.S. Department of Education, under OERI contract no. RI88062012. The opinions expressed in this report do not necessarily reflect the positions or policies of OERI or the Department of Education.

Having Friends, Making Friends, and Keeping Friends: Relationships as Educational Contexts



Peer relations contribute substantially to both social and cognitive development and to the effectiveness with which we function as adults. Indeed, the single best childhood predictor of adult adaptation is not school grades, and not classroom behavior, but rather, the adequacy with which the child gets along with other children. Children who are generally disliked, who are aggressive and disruptive, who are unable to sustain close relationships with other children, and who cannot establish a place for themselves in the peer culture, are seriously at risk.

THE CONDITIONS OF FRIENDSHIP

The essentials of friendship are reciprocity and commitment between individuals who see themselves more or less as equals. Interaction between friends rests on a more equal power base than the interaction between children and adults. Some writers regard friendships as "affiliative relations " rather than attachments; nonetheless, young children make a large emotional investment in their friends, and their relationships are relatively enduring.

The main themes in friendship relations--affiliation and common interests--are first understood by children in early childhood. Among preschool and younger school-aged children, expectations for friendship center on common pursuits and concrete reciprocities. Later, children's views about their friends center on mutual understanding, loyalty, and trust. Children also expect to spend time with their friends, share their interests, and engage in self-disclosure with them. Friends have fun with one another; they enjoy doing things together; and they care about one another.

Although school-aged children and adolescents never use words like EMPATHY or INTIMACY to describe their friends, in their thinking, these constructs distinguish friends from other children.

FRIENDSHIP FUNCTIONS

Friendships are:

- emotional resources, both for having fun and adapting to stress;
- cognitive resources for problem-solving and knowledge acquisition;
- contexts in which basic social skills (for example, social communication, cooperation, and group entry skills) are acquired or elaborated; and
- forerunners of subsequent relationships.

Above all, friendships are egalitarian. They are symmetrically or horizontally structured, in contrast to adult-child relationships, which are asymmetrically or vertically structured. Friends are similar to each other in developmental status, engaging each other mostly in play and socializing.

FRIENDS AS EMOTIONAL RESOURCES.

As emotional resources, friendships furnish children with the security to strike out into new territory, meet new people, and tackle new problems. Friends set the emotional stage for exploring one's surroundings, not unlike the manner in which caretakers serve as secure bases for the young child. These relationships also support the processes involved with having fun. Researchers have found

that the duration and frequency of laughing, smiling, looking, and talking are greater between friends than between strangers, and that friends mimic one another more extensively.

Friendships may buffer children and adolescents from the adverse effects of negative events, such as family conflict, terminal illness, parents' unemployment, and school failure. Some studies suggest that friendships ease the stress associated with divorce, though in different manners for boys and girls. School-aged boys turn readily to friends, seemingly to distance themselves from the troubled household. Girls, however, enter into friendships but need their mothers' support.

✣FRIENDS AS COGNITIVE RESOURCES.

Children teach one another in many situations and are generally effective in this activity. Peer teaching occurs in four main varieties:

- PEER TUTORING is the didactic transmission of information from one child to another, ordinarily from an expert to a novice.
- COOPERATIVE LEARNING requires children to combine problem-solving contributions and share rewards.
- PEER COLLABORATION, in contrast, occurs when novices work together on tasks that neither can do separately.
- PEER MODELING refers to information transferred by imitation.

It has yet to be determined whether friends are better tutors than nonfriends or the manner in which friendship affects cooperative learning and modeling. Peer collaboration among both friends and nonfriends has been studied more extensively. One would expect friends to share motives and develop verbal and motor scripts that enable them to combine their talents in achieving their goals. And indeed, recent studies show that collaboration with friends results in more mastery of certain tasks than collaboration between nonfriends. Friends talk more, take more time to work out differences in their understanding of game rules, and compromise more readily than nonfriends do. This evidence suggests that friendships are unique contexts for transmitting information from one child to another.

✣FRIENDS AND SOCIAL SKILLS.

Considerable evidence shows that both cooperation and conflict occur more readily in friendships than in other contexts. Preschool children engage in more frequent cooperative exchanges with their friends than with neutral associates or with children whom they don't like. Conflicts occur more often between friends than nonfriends, but friends emphasize disengagement and equity in conflict management to a greater extent than nonfriends do. Research corroborates the notion that children's relationships with their friends support cooperation and reciprocity and effective conflict management.

✣FRIENDSHIP AND SUBSEQUENT RELATIONSHIPS.

Children's friendships are thought to be templates for subsequent relationships. While new relationships are never exact copies of old ones, the organization of behavior in relationships generalizes from old ones to new ones. Smoothly functioning friendships have been shown to rub-off on relationships between preschool children and their younger siblings.

FRIENDSHIP EXPERIENCE AND DEVELOPMENTAL OUTCOMES

Relatively few investigators have actually sought to verify the developmental significance of friendship. The issue is certainly complicated. Close relationships may support good adjustment and its development, but, alternatively, well-adjusted children may simply be better at establishing friendships than poorly adjusted ones. Nevertheless, studies show that friendships forecast good adjustment during the early weeks of kindergarten, and that making new friends changes children's adjustment in positive directions during the school year.

Outcomes, however, may depend on the nature of the relationship. Friendships are not all alike. Some are secure and smooth-sailing; others are rocky with disagreement and contention. New evidence shows that these differences spill over into school adjustment. Students whose friendships are marked by conflict and rivalry become progressively disruptive and disengaged. However, close

relationships are unlikely to contribute to EVERYTHING. While emerging evidence strongly suggests that having friends, making friends, and keeping them forecasts good developmental outcomes, it is unlikely that these results can be attributed EXCLUSIVELY to such relationships. On the contrary, friendship may contribute more to certain adaptations, such as positive self-attitudes or self-regard, than to social skills broadly conceived. Friendship may also contribute more to relationship functioning (for example, with siblings, other friends, or romantic partners) than to being generally well-liked.

Whether friends are NECESSITIES in child and adolescent development remains uncertain. Should friends not be available, other relationships may be elastic enough to serve the friendship functions enumerated earlier. Children with friends are better off than children without friends, but if necessary, other relationships may be substituted for friendships. Consequently, friendships are best viewed as developmental advantages rather than developmental necessities, and the current evidence concerning friendships as educational contexts should be read in this light.

EDITOR'S NOTE: This is the first in a series of three ERIC/EECE digests that focus on children's peer relationships as educational contexts. These digests are adapted from articles that originally appeared in the Fall 1991 (Vol. 19, No. 1) issue of the EARLY REPORT of the University of Minnesota's Center for Early Education and Development.

FOR MORE INFORMATION

Hartup, Willard W., and Moore, Shirley G. "Early Peer Relations: Developmental Significance and Prognostic Implications." EARLY CHILDHOOD RESEARCH QUARTERLY 5 (March, 1990): 1-17.

Hartup, Willard W., and Laursen, Brett. CONTEXTUAL CONSTRAINTS AND CHILDREN'SFRIENDSHIP RELATIONS. ERIC Document number ED 310 848.

Katz, Lilian G., and McClellan, Diane E. THE TEACHER'S ROLE IN THE SOCIAL DEVELOPMENT OF YOUNG CHILDREN. Urbana, IL: ERIC/EECE, 1991. ED 331 642.

Ladd, Gary W. "Having Friends, Keeping Friends, Making Friends and Being Liked by Peers in the Classroom: Predictors of Children's Early School Adjustment?" CHILD DEVELOPMENT 61 (August, 1990): 1,081-1,100.

ED345854 92 Having Friends, Making Friends, and Keeping Friends: Relationships as Educational Contexts. ERIC Digest.
Author: Hartup, Willard W.

ERIC Clearinghouse on Elementary and Early Childhood Education, Urbana, Ill.

THIS DIGEST WAS CREATED BY ERIC, THE EDUCATIONAL RESOURCES INFORMATION CENTER. FOR MORE INFORMATION ABOUT ERIC, CONTACT ACCESS ERIC 1-800-LET-ERIC

This publication was prepared with funding from the Office of Educational Research and Improvement, U.S. Department of Education, under OERI contract no. RI88062012. The opinions expressed in this report do not necessarily reflect the positions or policies of OERI or the Department of Education.

73

Young Children's Social Development: A Checklist

Authors: McClellan, Diane E.; Katz, Lilian G.

Early childhood educators have traditionally given high priority to enhancing young children's social development. During the last two decades a convincing body of evidence has accumulated to indicate that unless children achieve minimal social competence by about the age of six years, they have a high probability of being at risk throughout life. Hartup suggests that peer relationships contribute a great deal to both social and cognitive development and to the effectiveness with which we function as adults (1992). He states that:

Indeed, the single best childhood predictor of adult adaptation is NOT IQ, NOT school grades, and NOT classroom behavior but, rather the adequacy with which the child gets along with other children. Children who are generally disliked, who are aggressive and disruptive, who are unable to sustain close relationships with other children, and who cannot establish a place for themselves in the peer culture are seriously "at risk" (Hartup, 1991).

The risks are many: poor mental health, dropping out of school, low achievement and other school difficulties, poor employment history, and so forth (see Katz and McClellan, 1991). Given the life-long consequences, relationships should be counted as the first of the four R's of education.

Because social development begins in the early years, it is appropriate that all early childhood programs include regular periodic formal and informal assessment. of children's progress in the acquisition of social competence. The set of items presented below is based largely on research identifying elements of social competence in young children, and on studies in which the behavior of well-liked children has been compared to that of less well-liked children (Katz and McClellan, 1991).

THE SOCIAL ATTRIBUTES CHECKLIST

The checklist provided in this digest includes attributes of a child's social behavior and preschool experience which teachers should examine every three or four months. Consultations with parents and other caregivers help make the attributes and assessments realistic and reliable.

In using the checklist, teachers should pay attention to whether the attributes are typical. This requires sampling the child's functioning over a period of about three or four weeks. Any child can have one or two really bad days, for a variety of reasons; if assessments are to be reasonably reliable, judgments of the overall pattern of functioning over a period of about a month is required.

Healthy social development does not require that a child be a "social butterfly." The quality rather than quantity of a child's friendships is the important index to note. Keep in mind also that there is evidence that some children are simply shyer than others, and it may be counter-productive to push such children into social relations which make them uncomfortable (Katz and McClellan, 1991). Furthermore, unless that shyness is severe enough to prevent a child from enjoying most of the "good things of life," like birthday parties, picnics, and family outings, it is reasonable to assume that, when handled sensitively, the shyness will be spontaneously outgrown.

Many of the attributes listed in the checklist in this digest indicate adequate social growth if they USUALLY characterize the child. This qualifier is included to ensure that occasional fluctuations do not lead to over-interpretation of children's temporary difficulties. On the basis of frequent direct contact with the child, observation in a variety of situations, and information obtained from parents and other caregivers, a teacher or caregiver can assess each child according to the checklist.

Teachers can observe and monitor interactions among the children and let children who rarely have difficulties attempt to solve conflicts by themselves before intervening. If a child appears to be doing well on most of the attributes and characteristics in the checklist, then it is reasonable to assume that occasional social difficulties will be outgrown

without intervention.

However, if a child seems to be doing poorly on many of the items on the list, the adults responsible for his or her care can implement strategies that will help the child to overcome and outgrow social difficulties. We suggest that this checklist be used as a guide among teachers and parents. The intent is not to supply a prescription for "correct social behavior," but rather to help teachers observe, understand, and support children as they grow in social skillfulness. If a child seems to be doing poorly on many of the items on the list, the adults responsible for his or her care can implement strategies that will help the child to establish more satisfying relationships with other children (Katz and McClellan, 1991).

Finally, it is also important to keep in mind that children vary in social behavior for a variety of reasons. Research indicates that children have distinct personalities and temperaments from birth. In addition, nuclear and extended family relationships obviously affect social behavior. What is appropriate or effective social behavior in one culture may be less effective in another culture. Children from diverse cultural and family backgrounds thus may need help in bridging their differences and in finding ways to learn from and enjoy the company of one another. Teachers have a responsibility to be proactive rather than laissez faire in creating a classroom community that is open, honest, and accepting.

THE SOCIAL ATTRIBUTES CHECKLIST

I. Individual Attributes

The child:

1. Is USUALLY in a positive mood

2. Is not EXCESSIVELY dependent on the teacher, assistant or other adults

3. USUALLY comes to the program or setting willingly

4. USUALLY copes with rebuffs and reverses adequately

5. Shows the capacity to empathize

6. Has positive relationship with one or two peers; shows capacity to really care about them, miss them if absent, etc.

7. Displays the capacity for humor

8. Does not seem to be acutely or chronically lonely

II. SOCIAL SKILL ATTRIBUTES

The child USUALLY:

1. Approaches others positively

2. Expresses wishes and preferences clearly; gives reasons for actions and positions

3. Asserts own rights and needs appropriately

4. Is not easily intimidated by bullies

5. Expresses frustrations and anger effectively and without harming others or property

6. Gains access to ongoing groups at play and work

7. Enters ongoing discussion on the subject; makes relevant contributions to ongoing activities

8. Takes turns fairly easily

9. Shows interest in others; exchanges information with and requests information from others appropriately

10. Negotiates and compromises with others appropriately

11. Does not draw inappropriate attention to self

12. Accepts and enjoys peers and adults of ethnic groups other than his or her own.

13. Gains access to ongoing groups at play and work

14. Interacts non-verbally with other children with smiles, waves, nods, etc.

III. PEER RELATIONSHIP ATTRIBUTES

The child is:

1. USUALLY accepted versus neglected or rejected by other children

2. SOMETIMES invited by other children to join them in play, friendship, and work.

This digest is adapted from the article, "Assessing the Social Development of Young Children. A Checklist of Social Attributes," which appeared in the Fall 1992 issue of DIMENSIONS OF EARLY CHILDHOOD (pp. 9-10).

FOR MORE INFORMATION

Asher, S., and J. Coie. PEER REJECTION AND CHILDHOOD EDUCATION. New York: Cambridge University Press, 1990.

Cassidy, J. and S.R. Asher. "Loneliness and Peer Relations in Young Children." CHILD DEVELOPMENT 63 (1992): 350-365.

Hartup, W.W. HAVING FRIENDS, MAKING FRIENDS, AND KEEPING FRIENDS: RELATIONSHIPS AS EDUCATIONAL CONTEXTS. Urbana, IL: ERIC Clearinghouse on Elementary and Early Childhood Education, 1992. ED 345 854.

Katz, L.G. and D. McClellan. THE TEACHER'S ROLE IN THE SOCIAL DEVELOPMENT OF YOUNG CHILDREN. Urbana, IL: ERIC Clearinghouse on Elementary and Early Childhood Education, 1991. ED 346 988.

Newcomb, A.F., W.M. Bukowski, and L. Tattee. "Children's Peer Relations: A Meta-analytic Review of Popular, Rejected, Neglected, Controversial, and Average Sociometric Status." PSYCHOLOGICAL BULLETIN 113(1) (1993): 99-128.

Paley, G. YOU CAN'T SAY YOU CAN'T PLAY. Cambridge, MA: Harvard University Press, 1992.

Rizzo, Thomas. FRIENDSHIP DEVELOPMENT AMONG CHILDREN IN SCHOOL. Norwood, NJ: Ablex, 1989.

References identified with an ED (ERIC document) number are cited in the ERIC database. Documents are available in ERIC microfiche collections at more than 825 locations worldwide. Documents can also be ordered through EDRS: (800) 443-ERIC. References with an EJ (ERIC journal) number are available through the originating journal, interlibrary loan services, or article reproduction clearinghouses: UMI (800) 732-0616; or ISI (800) 523-1850.

This publication was funded by the Office of Educational Research and Improvement, U.S. Department of Education, under contract no. RI88062012. Opinions expressed in this report do not necessarily reflect the positions or policies of OERI. ERIC Digests are in the public domain and may be freely reproduced and disseminated.

ED356100 93 Young Children's Social Development: A Checklist. ERIC Digest.
Authors: McClellan, Diane E.; Katz, Lilian G.

ERIC Clearinghouse on Elementary and Early Childhood Education, Urbana, Ill.

PARENT
TALK

Building emotionally healthy families

Emotional health begins at home. It's important because it affects how children see the world, and it shapes the relationships within the whole family — now and later in life. Infancy and early childhood are especially important, but even parents who successfully guide their children through that phase may need advice in guiding their children through adolescence. Following is helpful parenting information for families at all stages.

Emotionally healthy infants & toddlers

Recent research shows that a person's experience in infancy and early childhood plays an important role in that person's development of competence.

For example, an infant whose cries are answered learns that he or she can control the environment. An infant who cries without receiving a response learns that he or she has no control and eventually stops trying. The first child's experiences teaches him or her to explore new areas, to change things, if desired. The second child's experiences teaches him or her that it's useless to try. This child learns merely to endure.

The latest research shows that the following steps contribute to the greatest emotional health in infants, which leads to strong emotional health in adulthood. Parents should:

■ **Develop a strong parent-child bond** — it's one of the most important factors for strong emotional health. The bond can be with the mother, father or other primary caregiver. With this bond, your children will feel more secure, be more likely to explore — within the boundaries you set — and will be more likely to ask for help when needed. This child also develops independence by trying to do things alone until he or she needs help.

■ **Make sure your child has a secure relationship with you.** Children with a secure relationship with an adult can function well in a nursery school or other environment outside the home. They have learned that they can master their environment and have full confidence that their mother or father will return as expected after each session.

■ **Provide a stimulating environment for your child** — with limits. An interesting environment helps children develop emotionally. For instance, talk directly to your youngster sometimes — without doing anything else. Most parents talk to their child while changing their diapers, feeding them or tickling them. But parents who also talk to them without any other activity end up with children who have strong language skills and who can express themselves clearly and easily with words. Also, some babies can be overstimulated if parents try to talk and tickle at the same time, for instance.

■ **Provide a rich social life for your child.** The most competent children have twice as much social experience as their peers. A 12- to 15-month-old, for instance, can greatly benefit from playing a few hours a day with siblings, other children or even various adults. This helps a child learn subtle social skills that can build confidence and form leadership skills. Even 9-month-old babies can benefit. Babies who have played with other babies are more confident around newcomers and are more likely to make the first approach than babies without such experiences.

■ **Provide toys that will encourage competence.** For infants, a mobile can become a confidence-builder by taping a piece of soft cotton yarn loosely around a baby's wrist and tying the other end to the mobile. When the baby moves his hand, the mobile moves, and the baby loves it. The baby learns that he or she can control the mobile — the first step in controlling the environment. Other such toys include a rattle — it makes a noise only when the baby shakes it — and a mirror. The baby sees something in the mirror only if he or she makes a move first. For older children, a rubber ball or building blocks are much better than a do-it-all toy that requires a push of a button and probably costs hundreds of dollars.

The whole family

As children grow and families become busier, sometimes family members grow apart. And that can be emotionally harmful. In fact, the most emotionally healthy families are those who listen, talk honestly, play together and foster a strong sense of right and wrong and respect for privacy. All that takes time.

But even if your family seems to have time only to argue now and then, don't be discouraged. Arguing can be a sign that your family members feel that they can express their anger or other emotions honestly. The following tips can help your family rediscover the more pleasurable aspects of an emotionally healthy family.

■ **Ask each member of the family about his or her day.** Listen to the answer. That means to put down the grocery list or the newspaper, or turn off the television.

■ **Turn off the television every now and then.** If you do watch television as a family, be sure to turn down the volume at commercials and talk about the show.

■ **Pay attention to what your family members don't say.** Most emotions aren't expressed with words but rather in facial expressions or body language. If you pay attention, you'll know how others are feeling, and your example will teach your children empathy. Give family members room to feel mad or sad or glad.

■ **Note what kind of humor your family uses.** Close families know a comment made in jest can be hurtful. Recognize what's OK to joke about and what's not OK.

■ **Eat dinner — and other meals — together.** Establish a ritual or tradition. Often meals are the only time the entire family can be together. It's a good time to talk in a relaxed manner. Don't use dinner time to lecture or punish. Allow family members to interrupt each other — as long as everyone gets an equal chance. Overly polite dinner conversation is an indication that the family members don't feel they can express themselves honestly.

■ **Problems happen — tackle them together.** Give everyone a chance to express an opinion, but remember that you get the final say. Emotionally healthy families listen to each other but don't let kids make the family decisions.

For more help

If you need more advice, call FRES, crisis counseling, at (810) 257-3740, where a counselor is always available. ©

Genesee County Community Mental Health
Prevention & Information Services

Prevention & Information Services • 420 W. Fifth Avenue • Flint, Michigan • (810) 257-3707

PARENT TALK

Before friendships can form, kids must first like themselves

Children are never lonely when they have best friends with whom to share giggles, secrets, a game of tag, toys, sad times or an ice cream cone.

Children who feel good about themselves, share with others, console their friends and relate well with adults are attractive to other children. Parents want their children to be sociable, happy and popular with others.

When a child cries, "Nobody likes me," parents recall the pain and loneliness of being excluded, the last child chosen for the team and childhood difficulties in learning social skills.

Although social skills and the first signs of friendship begin during the toddler years, it is at ages 6 to 8 that a child's image of themself in relation to their peers becomes very important.

Children with a realistic understanding of themselves are likely to make friends more easily than those children whose self-image is inflated or weak.

Adequate self-esteem in children is essential to developing friendships. Parents can be most helpful by clearly looking at their child and setting realistic expectations.

If a child has been strongly criticized, their self-image may be too low to make friends. On the other hand, a child's peers may avoid them if they are thought to be a superkid.

It is important for parents to remember that children have different social habits. Young children tend to like other children who are similar; older children find friends who have different interests.

If a child has not gained the necessary social skills for making friends, parents can offer support.

Whatever the problem may be, listen carefully to what a child is saying and feeling. Let the youngster know you understand their feelings and then offer suggestions for improvement through humor or a game.

Daily positive reinforcement is one way to help a child modify his or her behavior. When a youngster is making a sincere effort or showing signs of progress, compliment them.

As children identify areas where they lack skills or confidence, parents can be supportive. Poor reading skills or being overweight, for example, may make a child feel inadequate socially.

Helping children learn to like themselves and cope with disappointments is the basis for developing confidence.

Of course, not all children are sociable to the same degree. Some children are loners and less outgoing than others. The overriding question is whether or not a child seems happy and content. If so, then a child's socialization is probably OK.

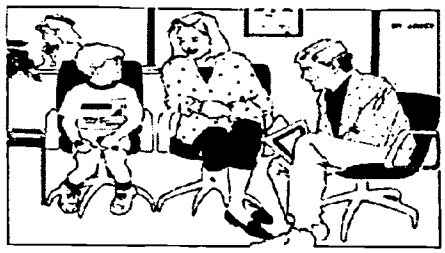
In addition, parents need to help their youngster realize what qualities - beyond appearances - they like in friends. Friends may be special because they are kind, obedient to their parents, a good student, a hard worker, honest and fun to be with.

Childhood friendships may last for the week spent at camp, all summer until school begins, or for a lifetime.

Once a child feels confident about themself and their social skills, they may have best friends at school, church and in their neighborhood.

For Your Well-Being!
GENESEE COUNTY COMMUNITY MENTAL HEALTH
PREVENTION & INFORMATION SERVICES
420 W. Fifth Avenue • Flint, Michigan • (313) 257-3707

Forming Partnerships with Parents



Toward Improving Home Involvement in Schooling

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.

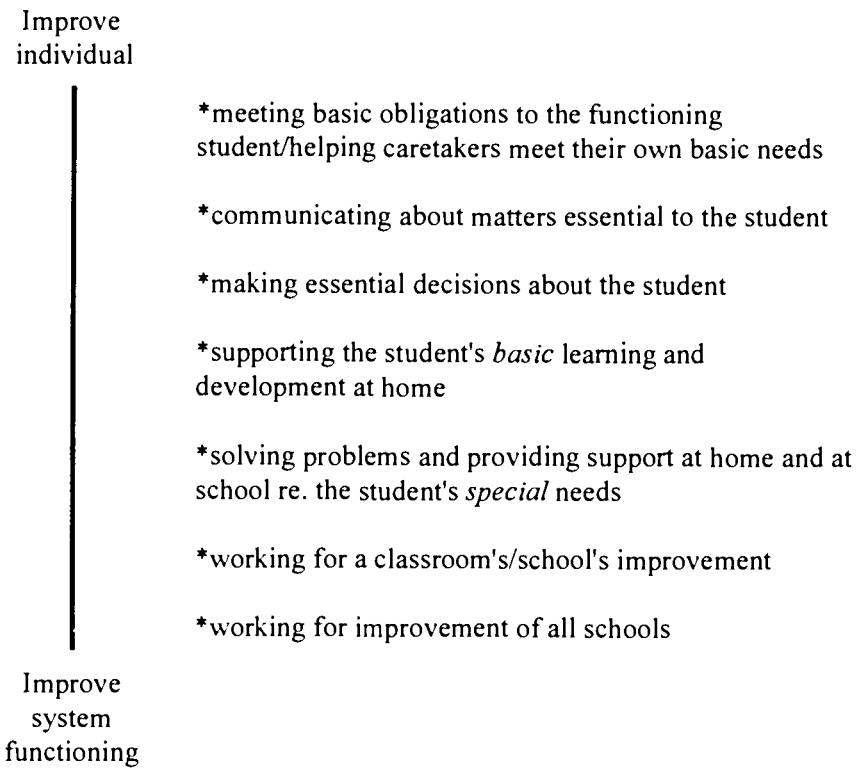
First, we find that most efforts to involve parents seem aimed at those who want and are able to show up at school. It's important to have activities for such parents. It's also important to remember that they represent the smallest percentage of parents at most schools. What about the rest? Especially 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/caretaker), 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 figure).



A Few Resources

Just out: From Parent Involvement to Parent Empowerment and Family Support -- A resource guide for school community leaders -- Using the nationally-acclaimed RAINMAKER program as a centerpiece, this resource outlines a philosophy that calls for restructuring the way educators and families work together, defines roles for each, highlights parent-run Family Resource Centers, provides an overview of 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:

An introductory packet on: *Parent and Home Involvement in Schools* -- Provides an overview of how home involvement is conceptualized and outlines current models and basic resources. Issues of special interest to underserved families are addressed

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

Fostering Students Social and Emotional Development

Toward 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.

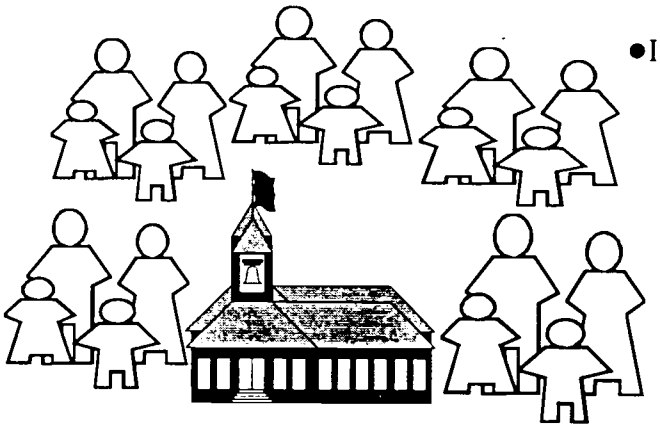
In discussing "burn-out," many writers have emphasized that, too often, teaching is carried out under highly stressful working conditions and without much of a collegial and social support structure. Recommendations usually factor down to strategies that reduce environmental stressors, increase personal capabilities, and enhance job and social supports. (Our center provides an overview of this topic in an introductory packet entitled 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 (discussed in Lessons Learned in the Spring 1997 newsletter; ask for a copy).

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 the source staff) and parents can work together to 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 ensure 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 book written for parents by Fred Frankl (1996, 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 culture 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

Research on Youth and Caring

Protective factors. In the May 1995 issue of Phi Delta Kappan, a series of articles discuss "Youth and Caring." Includes 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.

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 should be 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.

UCLA Center for Mental Health in Schools

SOME SPECIAL RESOURCES FROM THE CLEARINGHOUSE

The mission of the Center is to improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools in schools.

Under the auspices of the School Mental Health Project in the Department of Psychology, our Center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given to policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

A partial list...

I. Introductory Packets

Working Together: From School-Based Collaborative Teams to School-Community-Higher Education Connections

This packet discusses the processes and problems related to working together at school sites and in school-based centers. It also outlines models of collaborative school-based teams and interprofessional education programs.

Violence Prevention and Safe Schools

This packet outlines selected violence prevention curricula and school programs and school-community partnerships for safe schools. It emphasizes both policy and practice.

Least Intervention Needed: Toward Appropriate *Inclusion* of Students with Special Needs

This packet highlights the principle of *least intervention needed* and its relationship to the concept of *least restrictive environment.* From this perspective, approaches for including students with I disabilities m regular programs are described.

Parent and Home Involvement in Schools

This packet provides an overview of how home involvement is conceptualized and outlines current models and basic resources. Issues of special interest to under-served families are addressed.

Assessing to Address Barriers to Learning

This packet discusses basic principles, concepts, issues, and concerns related to assessment of various barriers to student learning. It also includes resource aids on procedures and instruments to measure psychosocial, as well as environmental barriers to learning.

Dropout Prevention

This packet highlights intervention recommendations and model programs, as well as discusses the motivational underpinnings of the problem.

Learning Problems and Learning Disabilities

This packet identifies learning disabilities as one highly circumscribed group of learning problems, and outlines approaches to address the full range of problems.

Teen Pregnancy Prevention and Support

This packet covers model programs and resources and offers an overview framework for devising policy and practice.

II. Resource Aid Packets

Screening/Assessing Students: Indicators and Tools

This packet is designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems.

Responding to Crisis at a School

This packet provides a set of guides and handouts for use in crisis planning and as aids for training staff to respond effectively. It contains materials to guide the organization and initial training of a school-based crisis team, as well as materials for use in ongoing training, and as information handouts for staff, students, and parents.

Addressing Barriers to Learning: A Set of Surveys to Map What a School Has and What It Needs

This packet provides surveys covering six program areas and related system needs that constitute a comprehensive, integrated approach to addressing barriers and thus enabling learning. The six program areas are (1) classroom-focused enabling, (2) crisis assistance and prevention, (3) support for transitions, (4) home involvement in schooling, (S) student and family assistance programs and services, and (6) community outreach for involvement and support (including volunteers).

Students and Psychotropic Medication: The School's Role

This packet underscores the need to work with prescribers in ways that safeguard the student and the school. It contains aids related to safeguards and for providing the student, family, and staff with appropriate information on the effects and monitoring of various psychopharmacological drugs used to treat child and adolescent psycho-behavioral problems.

Substance Abuse

This packet offers some guides to provide schools with basic information on widely abused drugs and indicators of substance abuse. It also includes some assessment tools and reference to prevention resources.

Clearinghouse *Catalogue*

Our Clearinghouse contains a variety of resources relevant to the topic of mental health in schools. This annotated catalogue classifies these materials, protocols, aids, program descriptions, reports, abstracts of articles, information on other centers, etc. under three main categories: policy and system concerns, program and process concerns, and specific psychosocial problems. (Updated regularly)

Catalogue of Internet Sites Relevant to Mental Health in Schools

This catalogue contains a compilation of Internet resources and links related to addressing barriers to student learning and mental health in schools. (Updated regularly)

Organizations with Resources Relevant to Addressing Barriers to Learning: A Catalogue of Clearinghouses, Technical Assistance Centers, and Other Agencies

This catalogue categorizes and provides contact information on organizations focusing on children's mental health, education and schools, school-based and school-linked centers, and general concerns related to youth and other health related matters. (Updated regularly)

Where to Get Resource Materials to Address Barriers to Learning

This resource offers school staff and parents a listing of centers, organizations, groups, and publishers that provide resource materials such as publications, brochures, fact sheets, audiovisual & multimedia tools on different mental health problems and issues in school settings.

III. Technical Aid Packets

School-Based Client Consultation, Referral, and Management of Care

This aid discusses why it is important to approach student clients as consumers and to think in terms of managing *care,* not *cases.* It outlines processes related to problem identification, triage, assessment and client consultation, referral, and management of care. It also provides discussion of prereferral intervention and referral as a multifaceted intervention. It clarifies the nature of ongoing management of care and the necessity of establishing mechanisms to enhance systems of care. It also provides examples of tools to aid in all these processes ware included.

Technical Aid Packet: School-Based Mutual Support Groups (For Parents, Staff; and Older Students)

This aid focuses on steps and-tasks related to establishing mutual support groups in a school setting. A sequential approach is described that involves (1) working within the school to get started, (2) recruiting members, (3) training them on how to run their own meetings, and (4) offering off-site consultation as requested. The specific focus here is on parents; however, the procedures are readily adaptable for use with others, such as older students and staff.

Volunteers to Help Teachers and School Address Barriers to Learning

This aid outlines (a) the diverse ways schools can think about using volunteers and discusses how volunteers can be trained to assist designated youngsters who need support, (b) steps for implementing volunteer programs in schools, (c) recruitment and training procedures and (d) key points to consider in evaluating volunteer programs. The packet t also includes resource aids and model programs.

Welcoming and Involving New Students and Families

This aid offers guidelines, strategies, and resource aids for planning, implementing, and evolving programs to enhance activities for welcoming and involving new students and families in schools. Programs include home involvement, social supports, and maintaining involvement.

Guiding Parents in Helping Children Learn

This aid is specially designed for use by professionals who work with parents and other nonprofessionals, and consists of a "booklet" to help nonprofessionals understand what is involved in helping children learn. It also contains information about basic resources professionals can draw on to learn more about helping parents and other nonprofessionals enhance children's learning and performance. Finally, it includes additional resources such as guides and basic information parents can use to enhance children's learning outcomes.

IV. Technical Assistance Samplers

Behavioral Initiatives in Broad Perspective

This sampler covers information on a variety of resources focusing on behavioral initiatives to address barriers to learning (e.g., state documents, behavior and school discipline, behavioral assessments, model programs on behavioral initiatives across the country, school wide programs, behavioral initiative assessment instruments, assessing resources for school-wide approaches).

V. Guides to Practice and Continuing Education Units--Ideas into Practice

What Schools Can Do to Welcome and Meet the Needs of All Students and Families

This guidebook offers program ideas and resource aids that can help address some major barriers that interfere with student learning and performance. Much of the focus is on early-age interventions; some is on primary prevention; some is on addressing problems as soon after onset. The guidebook includes the following: Schools as Caring, Learning Environments, Welcoming and Social Support: Toward a Sense of Community Throughout the School; Using Volunteers to Assist in Addressing School Adjustment Needs and Other Barriers to Learning; Home Involvement in Schooling; Connecting a Student with the Right Help; Understanding and Responding to Learning Problems and Learning Disabilities; Response to Students' Ongoing Psychosocial and Mental Health Needs; Program Reporting: Getting Credit for All You Do and, Toward a Comprehensive, Integrated Enabling Component.

NEW CONTINUING EDUCATION MODULES

Addressing Barriers to Learning: New Directions for Mental Health in Schools

This module consists of three units to assist mental health practitioners in addressing psychosocial and mental health problems seen as barriers to students' learning and performance. It includes procedures and guidelines on issues such as initial problem identification, screening/assessment, client consultation & referral, triage, initial and ongoing case monitoring, mental health education, psychosocial guidance, support, counseling, consent, and confidentiality.

Mental Health in Schools: New Roles for School Nurses

The above three units have been adapted specifically for school nurses. A subset of the nursing material will appear in video/manual self-study format produced by National Association of School Nurses with support of the Robert Wood Johnson Foundation and National Education Association.

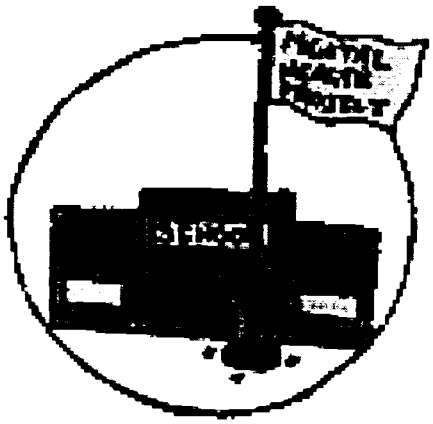
Continuing Education Related to the Enabling Component

Classroom Focused Enabling (available)

This module consists of guidelines, procedures, strategies, and tools designed to enhance classroom based efforts by increasing teacher effectiveness for preventing and managing problems m the classroom and helping address barriers to learning.

- Other units for this module are in preparation.

VI. Keeping Social and Related Problems in Broad Perspective

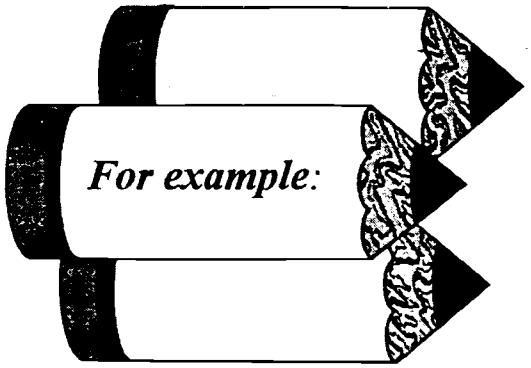


Social and related problems are often key factors interfering with school learning and performance. As a result, considerable attention has been given to interventions to address such problems. Our reading of the research literature indicates that most methods have had only a limited impact on the learning, behavior, and emotional problems seen among school-aged youth. The reason is that for *a few*, their reading problems stem from unaccommodated disabilities, vulnerabilities, and individual developmental differences. For many, the problems stem from socioeconomic inequities that affect readiness to learn at school and the quality of schools and schooling.

If our society truly means to provide the opportunity for all students to succeed at school, fundamental changes are needed so that teachers can personalize instruction and schools can address barriers to learning. Policy makers can call for higher standards and greater accountability, improved curricula and instruction, increased discipline, reduced school violence, and on and on. None of it means much if the reforms enacted do not ultimately result in substantive changes in the classroom and throughout a school site.

Current moves to devolve and decentralize control may or may not result in the necessary transformation of schools and schooling. Such changes do provide opportunities to reorient from "district-centric" planning and resource allocation. For too long there has been a terrible disconnection between central office policy and operations and how programs and services evolve in classrooms and schools. The time is opportune for schools and classrooms to truly become the center and guiding force for all planning. That is, planning should begin with a clear image of what the classroom and school must do to teach all students effectively. Then, the focus can move to planning how a family of schools (e.g., a high school and its feeders) and the surrounding community can complement each other's efforts and achieve economies of scale. With all this clearly in perspective, central staff and state and national policy can be reoriented to the role of developing the best ways to support local efforts as defined locally.

At the same time, it is essential not to create a new mythology suggesting that every classroom and school site is unique. There are fundamentals that permeate all efforts to improve schools and schooling and that should continue to guide policy, practice, and research.



• The curriculum in every classroom must include a major emphasis on acquisition of basic knowledge and skills. However, such basics must be understood to involve more than the three Rs and cognitive development. There are many important areas of human development and functioning, and each contains "basics" that individuals may need help in acquiring. Moreover, any individual may require special accommodation in any of these areas.

• Every classroom must address student motivation as an antecedent, process, and outcome concern.

• Remedial procedures must be *added* to instructional programs for certain individuals, but only after appropriate nonremedial procedures for facilitating learning have been tried. Moreover, such procedures must be designed to build on strengths and must not supplant a continuing emphasis on promoting healthy development.

• Beyond the classroom, schools must have policy, leadership, and mechanisms for developing school-wide programs to address barriers to learning. Some of the work will need to be in partnership with other schools, some will require weaving school and community resources together. The aim is to evolve a comprehensive, multifaceted, and integrated continuum of programs and services ranging from primary prevention through early intervention to treatment of serious problems. Our work suggests that at a school this will require evolving programs to (1) enhance the ability of the classroom to enable learning, (2) provide support for the many transitions experienced by students and their families, (3) increase home involvement, (4) respond to and prevent crises, (5) offer special assistance to students and their families, and (6) expand community involvement (including volunteers).

• Leaders for education reform at all levels are confronted with the need to foster effective scale-up of promising reforms. This encompasses a major research thrust to develop efficacious demonstrations and effective models for replicating new approaches to schooling.

• Relatedly, policy makers at all levels must revisit existing policy using the lens of addressing barriers to learning with the intent of both realigning existing policy to foster cohesive practices and enacting new policies to fill critical gaps.

Clearly, there is ample direction for improving how schools address barriers to learning. The time to do so is now. Unfortunately, too many school professionals and researchers are caught up in the day-by-day pressures of their current roles and functions. Everyone is so busy "doing" that there is no time to introduce better ways. One is reminded of Winnie-The-Pooh who was always going down the stairs, bump, bump, bump, on his head behind Christopher Robin. He thinks it is the only way to go down stairs. Still, he reasons, there might be a better way if only he could stop bumping long enough to figure it out.

To maintain a broad perspective of the reforms needed to address barriers to learning, we organize our thinking and materials around the following three categories:

Systemic Concerns

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
  - Collaborative Teams
  - School-community service linkages
  - Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
  - Systemic change strategies
  - Involving stakeholders in decisions
  - Staffing patterns
  - Financing
  - Evaluation, Quality Assurance
  - Legal Issues
- Professional standards

Programs and Process Concerns

- Clustering activities into a cohesive, programmatic approach
  - Support for transitions
  - Mental health education to enhance healthy development & prevent problems
  - Parent/home involvement
  - Enhancing classrooms to reduce referrals (including prereferral interventions)
  - Use of volunteers/trainees
  - Outreach to community
  - Crisis response
  - Crisis and violence prevention (including safe schools)
- Staff capacity building & support
  - Cultural competence
  - Minimizing burnout
- Interventions for student and family assistance
  - Screening/Assessment
  - Enhancing triage & ref. processes
  - Least Intervention Needed
  - Short-term student counseling
  - Family counseling and support
  - Case monitoring/management
  - Confidentiality
  - Record keeping and reporting
  - School-based Clinics

Psychosocial Problems

- Drug/alcoh. abuse
- Depression/suicide
- Grief
- Dropout prevention
- Learning problems
- Pregnancy prevention/support
- Eating problems (anorexia, bulim.)
- Physical/Sexual Abuse
- Neglect
- Gangs
- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Gender and sexuality
- School adjustment (including newcomer acculturation)
- Reactions to chronic illness

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

Reproduction Basis

This document is covered by a signed "Reproduction Release (Blanket)" form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").