



An introductory packet on

***Conduct and Behavior Problems:  
Intervention and Resources for  
School Aged Youth***



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## OVERVIEW

In this introductory packet, the range of conduct and behavior problems are described using fact sheets and the classification scheme from the American Pediatric Association.

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

For those readers ready to go beyond this introductory presentation or who are interested in the topics of school violence, crisis response, or ADHD, we also provide a set of references for further study and, as additional resources, agencies and websites are listed that focus on these concerns.

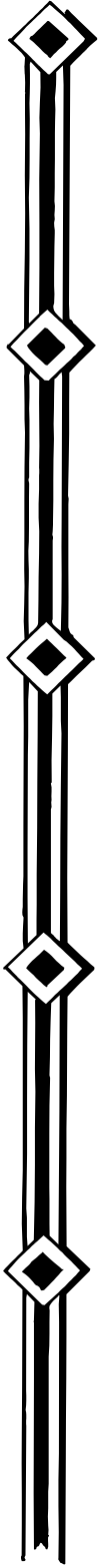


# Conduct and Behavior Problems: Interventions and Resources



This introductory packet contains:

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**I. CLASSIFYING CONDUCT AND BEHAVIORAL PROBLEMS: KEEPING THE ENVIRONMENT IN PERSPECTIVE AS A CAUSE OF COMMONLY IDENTIFIED PSYCHOSOCIAL PROBLEMS**

- A. Labeling Troubled and Troubling Youth
- B. Common Behavior Responses to Environmental Situations and Potentially Stressful Events



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

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

## A. Labeling Troubled and Troubling Youth: The Name Game

*She's depressed.*

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

*He's learning disabled.*

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

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

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

### *Diagnosing Behavioral, Emotional, and Learning Problems*

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

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

### ***A Broad View of Human Functioning***

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

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

### ***Toward a Broad Framework***

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

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

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

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

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

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

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

Problems 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)
----- ----- -----			P
Type I problems	Type II problems		Type III problems
<ul style="list-style-type: none"> <li>•caused primarily by environments and systems that are deficient and/or hostile</li> </ul>	<ul style="list-style-type: none"> <li>•caused primarily by a significant <i>mismatch</i> between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)</li> </ul>		<ul style="list-style-type: none"> <li>•caused primarily by person factors of a pathological nature</li> </ul>
<ul style="list-style-type: none"> <li>•problems are mild to moderately severe and narrow to moderately pervasive</li> </ul>	<ul style="list-style-type: none"> <li>•problems are mild to moderately severe and pervasive</li> </ul>		<ul style="list-style-type: none"> <li>•problems are moderate to profoundly severe and moderate to broadly pervasive</li> </ul>

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.

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.

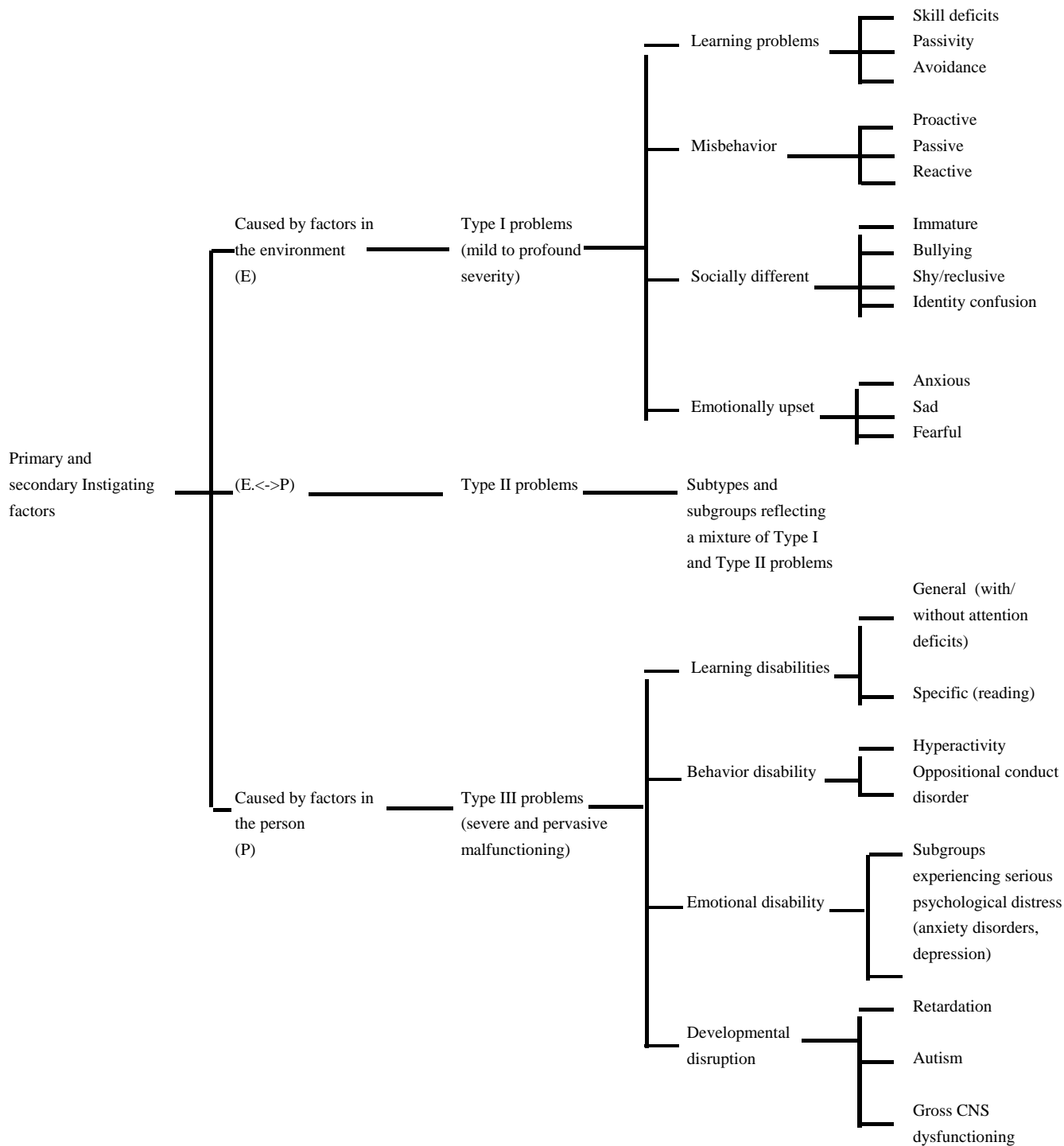
Ryan, W. (1971). *Blaming the victim*. New York: Random House.

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

*Nicholas Hobbs*



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



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

## **B. Environmental Situations and Potentially Stressful Events**

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

### **ENVIRONMENTAL SITUATIONS AND POTENTIALLY STRESSFUL EVENTS CHECKLIST**

#### **Challenges to Primary Support Group**

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

#### **Changes in Caregiving**

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

#### **Other Functional Change in Family**

- Addition of Sibling
- Change in Parental Caregiver

#### **Community of Social Challenges**

- Acculturation
- Social Discrimination and/or Family Isolation

#### **Educational Challenges**

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

#### **Parent or Adolescent Occupational Challenges**

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

#### **Housing Challenges**

- Homelessness
- Inadequate Housing
- Unsafe Neighborhood
- Dislocation

#### **Economic Challenges**

- Poverty
- Inadequate Financial Status

#### **Legal System or Crime Problems**

#### **Other Environmental Situations**

- Natural Disaster
- Witness of Violence

#### **Health-Related Situations**

- Chronic Health Conditions
- Acute Health Conditions

\*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/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 being alone
- Substance Use/Abuse...**

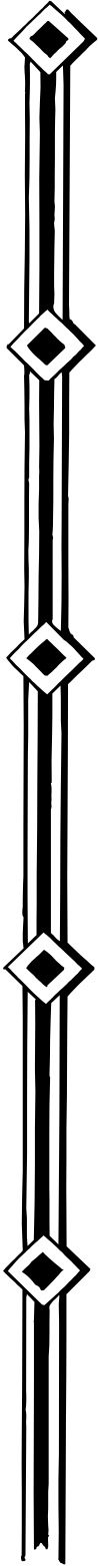
**EARLY CHILDHOOD (3-5Y)**  
***BEHAVIORAL MANIFESTATIONS***

- 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



## II. THE BROAD CONTINUUM OF CONDUCT AND BEHAVIORAL PROBLEMS

- A. *Developmental Variations*
- B. *Problems*
- C. *Disorders*

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

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



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

### DEVELOPMENTAL VARIATION

#### Negative Emotional Behavior Variation

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

### COMMON DEVELOPMENTAL PRESENTATIONS

#### Infancy

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

#### Early Childhood

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

#### Middle Childhood

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

#### Adolescence

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

### SPECIAL INFORMATION

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

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

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

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

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

## DEVELOPMENTAL VARIATIONS

### Aggressive/Opositional Variation

#### *Oppositionality*

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

## COMMON DEVELOPMENTAL PRESENTATIONS

### Infancy

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

### Early Childhood

The child's negative behavior includes saying "no" as well as all of the above behaviors but with increased sophistication and purposefulness. The child engages in brief arguments, uses bad language, purposely does the opposite of what is asked, and procrastinates.

### Middle Childhood

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

### Adolescence

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

## SPECIAL INFORMATION

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

## DEVELOPMENTAL VARIATIONS

### Aggressive/Opositional Variation

#### *Aggression*

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

## COMMON DEVELOPMENTAL PRESENTATIONS

### Infancy

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

### Early Childhood

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

### Middle Childhood

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

### Adolescence

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

## SPECIAL INFORMATION

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

\*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**

#### **Negative Emotional Behavior Problem**

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

### **COMMON DEVELOPMENT PRESENTATIONS**

#### **Infancy**

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

#### **Early Childhood**

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

#### **Middle Childhood**

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

#### **Adolescence**

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

### **SPECIAL INFORMATION**

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

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

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

## PROBLEM

### Aggressive/Oppositional Problem

#### Oppositionality

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

## COMMON DEVELOPMENT PRESENTATIONS

### Infancy

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

### Early Childhood

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

### Middle Childhood

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

### Adolescence

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

## SPECIAL INFORMATION

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

## PROBLEM

### Aggressive/Oppositional Problem

#### Aggression

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

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

## COMMON DEVELOPMENT PRESENTATIONS

### Infancy

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

### Early Childhood

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

### Middle Childhood

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

### Adolescence

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

## SPECIAL INFORMATION

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



## 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)

### DISORDERS

#### Conduct Disorder Childhood Onset

#### Conduct Disorder Adolescent Onset

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

(see DSM-IV criteria ...)

#### Adjustment Disorder With Disturbance of Conduct

(see DSM-IV criteria ...)

#### Disruptive Behavior Disorder, NOS

(see DSM-IV criteria ...)

#### Infancy

It is not possible to make the diagnosis.

#### Early Childhood

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

#### Middle Childhood

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

#### Adolescence

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

### SPECIAL INFORMATION

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

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

## DISORDERS

### Oppositional Defiant Disorder

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

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

(see DSM-IV Criteria...)

## COMMON DEVELOPMENT PRESENTATIONS

### Infancy

It is not possible to make the diagnosis.

### Early Childhood

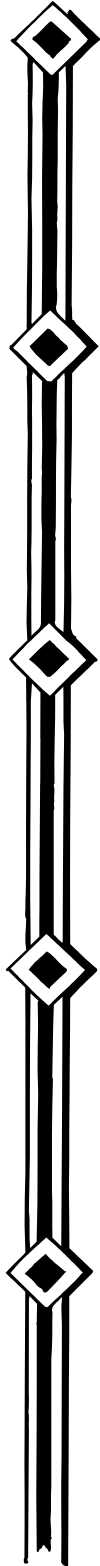
The child is extremely defiant, refuses to do as asked, mouths off, throws tantrums.

### Middle Childhood

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

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

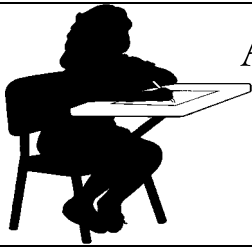
*\*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics*



### III. INTERVENTIONS FOR CONDUCT AND BEHAVIOR PROBLEMS

- A. *Accommodations to Reduce  
Conduct and Behavior Problems*
- B. *Behavior Management and Self  
Instruction*
- C. *Empirically Supported Treatment*
- D. *Medications*





## A. Accommodations to Reduce Conduct and Behavior Problems

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

### Behavior Problems: What's a School to Do?

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

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

#### Discipline

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

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

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

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

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

# Intervention Focus in Dealing with Misbehavior

## *I. Preventing Misbehavior*

- A. Expand Social Programs
  - 1. Increase economic opportunity for low income groups
  - 2. Augment health and safety prevention and maintenance (encompassing parent education and direct child services)
  - 3. Extend quality day care and early education
- B. Improve Schooling
  - 1. Personalize classroom instruction (e.g., accommodating a wide range of motivational and developmental differences)
  - 2. Provide status opportunities for nonpopular students (e.g., special roles as assistants and tutors)
  - 3. Identify and remedy skill deficiencies early
- C. Follow-up All Occurrences of Misbehavior to Remedy Causes
  - 1. Identify underlying motivation for misbehavior
  - 2. For unintentional misbehavior, strengthen coping skills (e.g., social skills, problem solving strategies)
  - 3. If misbehavior is intentional but reactive, work to eliminate conditions that produce reactions (e.g., conditions that make the student feel incompetent, controlled, or unrelated to significant others)
  - 4. For proactive misbehavior, offer appropriate and attractive alternative ways the student can pursue a sense of competence, control, and relatedness
  - 5. Equip the individual with acceptable steps to take instead of misbehaving (e.g., options to withdraw from a situation or to try relaxation techniques)
  - 6. Enhance the individual's motivation and skills for overcoming behavior problems (including altering negative attitudes toward school)

## *II. Anticipating Misbehavior*

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

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

## *III. During Misbehavior*

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

## *IV. After Misbehavior*

- A. Implement Discipline -- Logical Consequences/ Punishment
  - 1. Objectives in using consequences
    - a. Deprive student of something s/he wants
    - b. Make student experience something s/he doesn't want
  - 2. Forms of consequences
    - a. Removal/deprivation (e.g., loss of privileges, removal from activity)
    - b. Reprimands (e.g., public censure)
    - c. Reparations (e.g., of damaged or stolen property)
    - d. Recantations (e.g., apologies, plans for avoiding future problems)
- B. Discuss the Problem with Parents
  - 1. Explain how they can avoid exacerbating the problem
  - 2. Mobilize them to work preventively with school
- C. Work Toward Prevention of Further Occurrences (see I & II)

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

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

### Logical Consequences

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

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

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

## Defining and Categorizing Discipline Practices

Two mandates capture much of current practice:

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

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

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

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

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

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

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

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

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

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

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

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

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

## **Social Skill Training**

Suppression of undesired acts does not necessarily lead to desired behavior. It is clear that more is needed than classroom management and disciplinary practices. Is the answer social skills training? After all, poor social skills are identified as a symptom (a correlate) and contributing factor in a wide range of educational, psychosocial, and mental health problems.

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

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

## **Addressing Underlying Motivation**

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

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

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

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

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

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

misbehavior from a motivational perspective, see Adelman & Taylor, 1990; 1993; Deci & Ryan, 1985).

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## **B. Behavior Management and Self-Instruction**



1. Positive Behavioral Support
2. School-wide Behavioral Management Systems
3. In the Face of Predictable Crises
4. Managing Violent and Disruptive Students
5. Addressing Student Problem Behavior
6. Behavior Management in Inclusive Classrooms
7. How to Manage Disruptive Behavior in Inclusive Classrooms
8. Enhancing Students' Socialization: Key Elements
9. Screening for Special Diagnoses

Excerpts From:

# Positive Behavioral Support

## Helping students with Challenging Behaviors Succeed

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Fighting, biting, hitting, scratching, kicking, screaming—as well as extreme withdrawal—are behaviors that challenge even the best educators and families. For years, researchers and practitioners alike have asked the question: Why does a particular child act that way?

Positive behavioral support (PBS) offers one approach for understanding why the challenging behavior occurs—its function or its purpose for the individual. In addition to helping practitioners and families understand the individual with the challenging behavior, PBS also helps them understand the physical and social contexts of the behavior.

Unlike traditional behavioral management, which views the individual as the sole problem and seeks to "fix" him or her by quickly eliminating the challenging behavior, PBS views such things as settings and lack of skill as parts of the "problem" and works to change those. As such, PBS is characterized as a long-term approach to reducing the inappropriate behavior, teaching a more appropriate behavior, and providing the contextual supports necessary for successful outcomes.

... the following research-based actions to support positive behaviors in individuals with significant disabilities:

- **Respond to individual needs.** Services and programs should be responsive to the

preferences, strengths, and needs of individuals with challenging behavior. In addition, students may benefit from instruction in self-determination skills, social skills, goal-setting, and independent learning skills.



- **Alter environments.** If something in the individual's environment influences the challenging behavior, it is important to organize the environment for success. For example, clearly defined work spaces and quiet work areas may assist a child who is noise-sensitive.
- **Teach new skills to the individual with challenging behavior and members of his or her social network.** Individuals need to be taught alternative, appropriate responses that serve the same purpose as the challenging behavior.
- **Appreciate positive behaviors.** It is important to reinforce and acknowledge all positive behaviors consistently. . .

To address the behavioral needs of all students...

- ***Schoolwide support*** - procedures and processes that are intended for all students, all staff, and all settings. The most important element of support is a building-wide team that over-sees all development, implementation, modification, and evaluation activities.
- ***Specific setting support*** - a team-based mechanism for monitoring specific settings that exist within the school environment. In settings where problem behaviors occur, teams should develop strategies that prevent or minimize their occurrence.
- ***Classroom support*** - processes and procedures of the individual classrooms where teachers structure learning opportunities. They should parallel the features and procedures that are used schoolwide.
- ***Individual student support*** - immediate, relevant, effective, and efficient responses to students-who present the most significant behavioral challenges; processes and procedures for high-intensity, specially designed and individualized interventions for the estimated 3 to 7 percent of students who present the most challenging behavior.

Strategies for the schoolwide, specific setting, and classroom levels include having:

- A clear, positive purpose.
- A set of positively stated expectations for prosocial behavior.
- Procedures for teaching schoolwide expectations.
- A continuum of procedures for encouraging students to display expected behaviors.
- A continuum of procedures for discouraging violations of schoolwide expectations.
- A method for monitoring implementation and effectiveness.

At the student level, procedures include functional assessment strategies, social skills instruction, self-management training, and direct instruction. For implementation of the procedures at the individual student level to be effective, schoolwide PBS must be in place and functioning efficiently....

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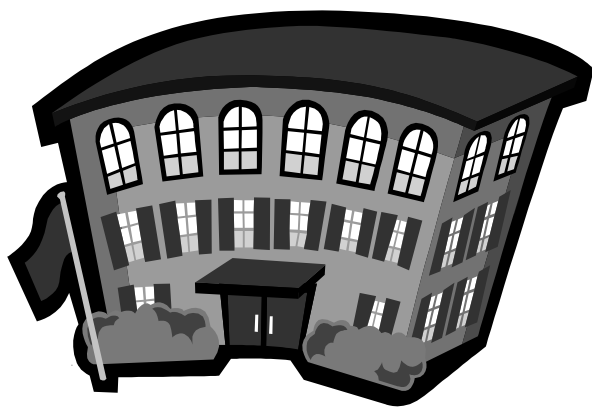
# School-Wide Behavioral Management Systems

By: Mary K. Fitzsimmons

ERIC Digest

For over a quarter of a century, the number one concern facing America's public schools has been discipline. What educators are finding, however, is that the root of the problem goes beyond rule-breaking. Many of today's students need more than just sound and consistent discipline policies they also need positive behavioral instruction.

Consequently, educators have been seeking new ways to move beyond traditional "punishment" and provide opportunities for all children to learn self-discipline. Simultaneously, researchers have begun to study and advocate for broader, proactive, positive school-wide discipline systems that include behavioral support. One promising avenue for achieving the dual goals of teaching self-discipline and managing behavior is school-wide behavior management.



While there are different variations of school-wide systems of behavioral support, most have certain features in common (see box below). The emphasis is on consistency both throughout the building and across classrooms. The entire school staff (including cafeteria workers and bus drivers) is expected to adopt strategies that will be uniformly implemented. As a result, these approaches necessitate professional development and long-term commitment by the school leadership for this innovation to take hold. A few examples of promising behavioral management systems follow.

## EFFECTIVE BEHAVIORAL SUPPORT

Effective Behavioral Support (EBS) refers to a system of school-wide processes and individualized instruction designed to prevent and decrease problem behavior and to maintain appropriate behavior. It is not a model with a prescribed set of practices. Rather, it is a team-based process designed to address the unique needs of individual schools. Teams are provided with empirically validated practices and, through the EBS process, arrive at a school-wide plan. Steps in the process include:

1. Clarify the need for effective behavioral support and establish commitment, including administrative support and participation. Priority for this should be reflected in the school improvement plan.
2. Develop a team focus with shared ownership.
3. Select practices that have a sound research base. Create a comprehensive system that prevents as well as responds to problem behavior. Tie effective behavioral support activities to the school mission.
4. Develop an action plan establishing staff responsibilities.
5. Monitor behavioral support activities. Continue successful procedures; change or abandon ineffective procedures.

According to researcher Tim Lewis of the University of Missouri, several factors foster EBS success:

1. Faculty and staff must agree that school-wide behavioral management is one of their top priorities and will probably require 3 to 5 years for completion.
2. Teams must start with a "doable" objective that meets their needs and provides some initial success.

3. Administrators must support the process by respecting team decisions, providing time for teams to meet, securing ongoing staff training, and encouraging all staff to participate.

### **COMMON FEATURES OF SCHOOL-WIDE BEHAVIORAL MANAGEMENT SYSTEMS**

1. Total staff commitment to managing behavior, whatever approach is taken.
2. Clearly defined and communicated expectations and rules. Consequences and clearly stated procedures for correcting rule-breaking behaviors.
3. An instructional component for teaching students self-control and/or social skill strategies.
4. A support plan to address the needs of students with chronic, challenging behaviors.

### **EXPANDING PLACEMENT OPTIONS**

As part of an OSEP research project designed to support systems change strategies for students with emotional and behavioral disabilities, researcher Doug Cheney of the University of Washington and his colleagues are studying school-wide management plans that (a) teach and support prosocial behavior and (b) identify consistent school-wide responses to challenging behaviors.

Initial findings are encouraging: The implementation of school-wide structures appears to add to the presently existing continuum of services, which increases the school's ability to expand placement options for students with severe emotional disturbance.

One school in the process of implementing this model began by developing a unified code of conduct. When a child does not follow the code, teachers use a standard set of school-wide disciplinary procedures. When the behavior escalates above typical, low-level classroom violations, the procedures include a social cognitive problem-solving component.

### **SCHOOL-WIDE CODE OF CONDUCT**

- **Safety:** Are my actions safe for myself and for others?
- **Respect:** Do my actions show respect for myself and for others?

- **Honesty:** Do my words and actions represent truth?
- **Responsibility:** Do my actions meet the expectation to take care of myself and be a dependable member of the community?
- **Courtesy:** Do my actions help make this a nice place, where people feel welcome and accepted, and where they can do their work without disruptions?

Developed by Fuller Elementary School, North Conway NH.

### **UNIFIED DISCIPLINE**

As part of an OSEP-funded primary prevention project, Bob Algozzine and Richard White, at the University of North Carolina-Charlotte, are studying a school-wide approach to behavioral management called Unified Discipline.

Four objectives drive the efforts to implement this system:

1. **Unified attitudes:** Teachers and school personnel believe that instruction can improve behavior, behavioral instruction is part of teaching, personalizing misbehavior makes matters worse, and emotional poise underlies discipline methods that work.
2. **Unified expectations:** Consistent and fair expectations for behavioral instruction are a key to successful discipline plans.
3. **Unified consequences:** Using a warm yet firm voice, teachers state the behavior, the violated rule, and the unified consequence and offer encouragement.
4. **Unified team roles:** Clear responsibilities are described for all school personnel.

Preliminary data on Unified Discipline show promising trends such as reductions in office referrals.

### **IS A SCHOOL-WIDE SYSTEM RIGHT FOR YOU?**

Clearly, from a preventive standpoint, researchers would agree that all schools can benefit from having in place a clearly defined, consistently enforced behavioral management system that is designed to support students in controlling their own behaviors.

In cases where school staff have significant concerns about discipline, a school-wide system may be a welcome solution. For a fuller look at the research discussed in this digest, the reader is referred to Research Connections, Fall 1997, published by the ERIC/OSEP Special Project.

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Excerpt:

"In the Face of Predictable Crises"  
Developing a Comprehensive Treatment Plan for Students  
with Emotional or Behavioral Disorders

Vernon F. Jones

THE COUNCIL FOR EXCEPTIONAL CHILDREN TEACHING  
EXCEPTIONAL CHILDREN NOV/DEC 1996 pp 54-59



**... Key Intervention Components**

Behavior change programs for students with serious emotional and behavioral disorders fall into four major categories of interventions:

1. Ecological/environmental.
2. Skill building.
3. Contingency management.
4. Self-esteem/insight-oriented issues.

Wood (1990) suggested a similar categorization when, after discussing behavioral interventions, he stated, "The term *interventions* covers a broad array of approaches which have emerged from developmental and social perspectives, including social skills training, ecological interventions, and affective education" (p. 106). Though these areas are not mutually exclusive, they stem from separate research paradigms and groups of researchers.

**Ecological/Environmental Factors**

Many researchers have focused on how school and classroom factors influence student learning and behavior. This work has perhaps best been summarized in *Looking in Classrooms* (Good & Brophy, 1994). These researchers have involved special educators and psychologists in assessing the factors most important for facilitating learning.

Ecological changes are almost always necessary. Indeed, if the school environment were effective in eliciting acceptable behavior and learning from a child, it is highly unlikely that a Multidisciplinary Team would determine a child eligible for special services. Walker (1986) has thoughtfully discussed the importance of

including the behavior requirements of the mainstream environment when developing a student's behavior change plan. We should also consider modifications that can be made in the environment to respond to the special education student's unique learning and personal needs (Fuchs, Fuchs, Fernstrom, & Hohn, 1991; Good & Brophy, 1994; Hawkins, Doueck, & Lishner, 1988; Jones & Jones, 1995; Maag & Reid, 1994).

**Skill Building**

Although modified environments can dramatically alter children's behavior, most students with serious emotional and behavioral disorders need to learn specific new skills if they are to function successfully in the mainstream. The second category of strategies, *skill building*, generally includes interventions often termed *cognitive-emotional interventions* (Anger & Cole, 1991). These include self-instruction, problem-solving, and social skill training.

As Knitzer et al. (1990) indicated, social skill training is included in some EBD programs; but teachers too often fail to design specific practice of these new skills, reinforce students' use of the skills, or help students correct and repractice skills that they fail to use consistently.

**Contingency Management**

The third category includes contingency management methods. These are described by Nelson and Rutherford (1988) as *behavior enhancement and reduction procedures* and **include various types of reinforcement, as well as such methods as extinction, response cost, and timeout.**

Many students with serious behavioral disorders will require contingency management intervention designed to maintain their behavior within acceptable limits. This will be necessary both to maintain the student within the school setting and to provide an opportunity for other interventions to be effective.

*Limit setting* enables students to be reinforced for appropriate behavior and also assists students in benefiting from the cognitive-behavioral interventions designed as part of the student's IEP. Masterson and Costello (1980) noted that behavioral limits prevent students with emotional and behavioral disorders from acting out feelings. This increases the likelihood that the feelings will be expressed, and the student can be assisted in appropriately expressing and understanding the feelings.

Contingency management interventions may take the form of *point and levels systems* used with all students in the program (Smith & Farrell, 1993) or may involve a variety of individualized behavior management approaches, including self-monitoring or individual contracts (Jones & Jones, 1995; Lloyd, Landrum, & Hallahan, 1991; Sprick & Howard, 1995).

### **Self-Esteem/Insight-Oriented Issues**

Finally, many students with serious emotional and behavioral disorders suffer from *serious self-esteem, depression, and anxiety impairment* (Capaldi, 1992; Greenberg, Speltz, & DeKlyen, 1993; Morse, 1985). Their developmental histories have often been characterized by turmoil, uncertainty, abuse, neglect, unclear family communication, abandonment, and ineffective modeling (Dishion, French, & Patterson, 1995; Izard & Harris, 1995). For example, a child who is terrified of an abusive parent and yet afraid of being abandoned by this parent may withdraw into fantasy or strike out against other children or adults who are safer than the parent. A purely behavioral program may focus exclusively on modifying the aggressive or fantasy behavior. A number of writers have discussed the importance of interventions in the affective domain which help

students understand themselves and their environment (Jones, 1992; Masterson & Costello, 1980; Nichols & Shaw, 1995; Nielsen, 1983; Wilkes, Beschler, Rush, & Frank, 1994).

Providing students with an *understanding of their own dysfunctional perceptions and clarifying their own reality* can provide a basis for healthy self-esteem and productive self-talk. My own work with students experiencing serious emotional disorders (Jones, 1992) supports the work cited above in suggesting that treatment programs are most effective when staff point out both the child's overgeneralized comments and clarify the underlying clinical issues associated with the child's emotional disturbance and unproductive behaviors....

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*Excerpts from:*

# MANAGING VIOLENT AND DISRUPTIVE STUDENTS

By: A. LEE PARKS

*in: Crisis Intervention Strategies for School-Based Helpers*

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## INTRODUCTION

...A certain amount of aggression is a sign of a well-balanced personality. Occasionally, normal children are violent and disruptive - hitting others, being verbally abusive, or creating commotions while the teacher is instructing. They are learning how to assert themselves, often reacting to short-term situational stress-failure, family difficulties, growing pains, etc. After a few days or weeks their behaviors return to normal. This chapter is not about those children; it is about children who are regularly and severely disruptive and violent, exhibiting behaviors month after month that impact the lives of their teachers, peers, and community members. Nearly every teacher has had one or two such children, and hopes never to have another. But as society changes, schools will see more, not less, of these students. This chapter is about the Bobbys in our schools; it is about how to help them and how to help ourselves.

### Who These Children Are

It is probably best not to classify violent and disruptive students as behaviorally or emotionally disturbed—though some may be. There is wide disagreement about the definition of these terms. In addition, there is general reluctance on the part of school personnel to use state department of education guidelines since programs for those labeled as behaviorally disordered are very expensive. To classify them obligates the school to provide services either within district or to contract for them from another source. There are also psychiatric categories but these have not typically been useful to school-based helpers.

Incidence figures for violent and disruptive students as a distinct category are not available. Estimates of the number of behavior disordered school-age persons range from about 2 to 10 percent. However, not all of these persons are violent and disruptive. In the author's experience, not more than 1 in 100 is

considered violent and disruptive if we concern ourselves with only those who are chronic problems for school personnel and the community. But as society changes such problems will inevitably increase.

Students develop aggression for a variety of reasons. Some come from homes that are in turmoil, with a higher than normal incidence of divorce, physical and sexual abuse, alcohol and chemical abuse, rejection, and inconsistent discipline. They have models for their aggressive ways and are communicating the frustration and distress that builds when one has to endure such conditions for a prolonged time. They are predominantly males in elementary and junior high school. By the time they are of high school age, many have dropped out or are expelled. Teachers are able to informally identify them in the primary grades—and sometimes as early as kindergarten. Most remain in regular classes. When they are in special education, it is usually a program for learning disabled rather than behaviorally disordered students. Genetic, hormonal, and biochemical factors are often used to explain aggressive behaviors. It is popularly believed that aggressive behaviors are inherited or are the result of improperly functioning glands. These may contribute to aggression, but most professionals agree that they are not the primary factors. The environment, including the family, school, and community are in all but a small percentage of cases the major cause of such problems.

## PREVENTION

Those who have had to contend with such students appreciate the wisdom of an "ounce of prevention." Confrontation with violent and disruptive students is much like doing battle. Though school-based service providers are professionals paid to work with all students, it is extremely taxing and often unnecessary to meet every situation head-on at the intervention level. Prevention should always be preferred to confrontation.

There is no clear delineation between prevention and intervention. A physician with whom the author worked pointed out that taking aspirin could be viewed as both treatment and prevention. It eliminates the present headache as well as prevents one that is worse. Likewise, many of the intervention procedures described in this chapter could be seen in the same way—especially in the case of minimal intrusion techniques discussed later in the intervention section. One general approach to prevention is restructuring the school environment.

## Restructuring the School Environment

Some problems can be dealt with by restructuring the school environment so that problem behaviors are less likely to occur. It is much easier to use this approach than to deal with the consequences of not preventing problems.

### Plan Ahead

Be prepared when you have "him" in your class. Arrive at school 5 to 10 minutes earlier than usual. This suggestion might sound insignificant but its importance should not be underestimated. The disruptive student takes advantage of those who are unprepared. Know what your daily routine will be, have well-defined lesson plans, and rehearse your strategies. Easier said than done, but to not be prepared is to invite disaster.

### General Modifications

Rearrange the environment to reduce problems. There are a number of easily identified antecedents to disruptive behavior. Teachers know that certain physical conditions in the room can lead to problems. Things to consider are:

- 1. SEATING ASSIGNMENT.** Locate the disruptive student near those who are least likely to set him off or away from distracting areas of the room. Place him a reasonable distance from peers without obviously attempting separation. The objective is to reduce crowding—not isolate.
- 2. HEATING AND LIGHTING.** Over-heated rooms can cause troubles. After P.E. or recess on cold days, a hot room might indirectly lead to difficulties. The student becomes tired, sets his assignments aside, and gets into trouble. Lighting should also be considered. Too little can interfere with academic performance. Type of lighting may also be important. Though some educators

maintain that fluorescent lights cause hyperactivity, research findings are unclear.

- 3. CONTROLLED, PREDICTABLE, AND SUPPORTIVE ENVIRONMENT.** "What can we do at school? The family has them most of the day." In fact, between the ages of 6 and 18 the school has students almost as many waking hours as do the parents—12,960 hours. In many cases, the educational system is one of the best sources of support for troubled children and adolescents. It provides a controlled predictable and supportive environment that is more or less consistent over time. A record of assessments and social and educational performance is passed on from year to year and is shared with various school- and community-based helpers. For disruptive and violent students it is especially important that consistent support be provided. He should be regularly reassured that the school really does care about him. He should know the rules and why they exist....
- 4. REDUCED EXPECTATIONS.** The facts are that most disruptive students will not complete assignments as quickly or correctly as their more normal classmates. Consequently, those who accommodate for this reality can avoid dooming the student to more failure and frustration. This can be accomplished by: (a) reducing the number of problems assigned, (b) allowing him to turn in assignments late, (c) excusing him altogether from some of the more stressful activities, (d) providing extra cues (e.g., showing a few examples of completed problems, printing instructions for assignments on 3 x 5 cards and taping them to the desk, asking if there are any questions), and (e) and encouraging peer assistance.
- 5. PRODUCTIVE ACTIVITIES.** Ancient admonitions about the tribulations of idle hands should definitely be heeded when working with disruptive students. They are able to turn even the best planned situations into chaos. When left with nothing to do, they will do something—and it often means trouble for the teacher. Problems can be prevented if idle time is held to a minimum. Plan a menu of activities that can be kept on hand. Have available extra seatwork assignments, educational games, or activities that relate to one of their personal interests (if they are legal).
- 6. ASSIGN A FRIEND.** These students usually do not have many friends. The ones they do have are

like those attracted to comedian Rodney Dangerfield—people who can do them no good. School-based helpers could consider assigning a peer to assist the disruptive student during specific times, e.g., academic projects or field trips. This peer should be someone who is accepting and supportive and who is not intimidated by the student. In some cases it may be necessary to assign two peers. In this way they can be reinforcing to each other for working with what their classmates may feel is an "untouchable." Two will also be less intimidated.

7. **HIGH ENERGY ACTIVITIES.** Many disruptive and violent students seem to have an excess of energy, especially for doing the wrong things. Some educators believe it is helpful to "burn off" this energy by engaging these students in physical activity prior to more sedentary tasks. An example would be scheduling P.E. before English. However, others reason just the reverse—activity begets activity. If the student is in relaxing situations, he is more likely to be calm; if he is in active situations, he will respond with more activity. The evidence is not clearly supportive of either position. The school-based helper should observe each student to determine which of the two approaches is most likely to apply—and then adjust activities accordingly.

## INTERVENTION

What can be done to help these students? The answer varies according to educators' beliefs about the causes of these behaviors. "He's just like his father." "What can you expect from an environment like that?" "All those sweets and food additives are causing it." This section discusses the premises of three models of human behavior and specific intervention techniques. Interventions are presented in order from informal to formal, and from simple to difficult to apply. The classroom is the setting for most of the interventions since there is where the majority of violent and disruptive behaviors occur.

### Models

It has been popular professional behavior among educators and psychologists to adhere to particular well-defined models of intervention; e.g., psychodynamic, psychoeducational, or behavioral. With each there are beliefs about the nature of humans and the purpose of their various behaviors. Likewise, there are strategies appropriate to each

model. Human behavior is sufficiently complex as to enable each professional group to believe their approach to treatment is most legitimate. The descriptions that follow are presented only to provide school-based helpers with a perspective about various models.

- ***Psychodynamic Approach***

The psychodynamic approach holds that behavior is fueled by unconscious drives or needs. Abnormal behavior is presumed to be the result of inadequate development in one or more stages. In Freudian psychology, these are psychosexual stages. The therapist's role is to provide ways for clients to bring into consciousness their repressed desires and needs.

A number of therapists have developed psychotherapeutic approaches for disturbed adolescents. Bettelheim, Redl, and Newman have all taken a psychoanalytic approach to the problems of disturbed children and youth. Each relies to some degree on expression of feelings to deal with disturbed behaviors. This is usually done through creating an atmosphere of permissiveness and trust. Behaviors themselves are viewed as symptoms of the underlying emotional problems.

- ***Humanistic Approach***

The humanistic approach to treatment of behavioral problems seeks to understand the whole person. It uses procedures for working with troubled children like acceptance and helping the student reflect on his own behavior. As a consequence, the student begins to develop insight and is able to modify his own behavior so that it is more acceptable and self-satisfying. Most humanistic therapists advocate developing an atmosphere within school environments that communicate acceptance, trust, and empathy towards students. Rogers, Gordon, and Axline have all developed humanistic treatment programs that have been used with children and adolescents.

- ***Behavioral Approach***

The behavioral approach is the most recent therapy to emerge in the schools, though it has been in existence for the past 40 years. Psychologists and educators pioneered its development with severely disturbed and retarded individuals. The basic premise is that behavior is learned. People are, in large measure, developed by the environments in which they are raised. Behavioral approaches require the systematic application of well-defined principles like

shaping, reinforcement, extinction, and punishment. The procedures now in general use in public schools include various types of systematic reinforcement systems (e.g., token economies and contracts).

Critics and even some behaviorists maintain that behaviorism does not concern itself with the causes of behavior. Actually, the disagreement is about which are the important causes. Behaviorists accept "here and now" observable causes, while psychodynamic and humanistic therapists accept inner states and distant past events as important. Probably each of the approaches discussed has value with certain students. Fine (1973) has depicted in schematic form a range of therapeutic interventions (see Figure 1). He states: Behavior change strategies can be distributed roughly on a continuum in terms of the amount of external structuring they possess. Such a distribution is tenuous since individual teachers and psychologists add their own twists to a given procedure. Yet there does seem to be at least a face validity to the chart. For example, the kinds of children involved in totally engineered environments (Hewett, 1968) are extremely disorganized children in terms of behavior control and learning capacity. Their behavior presumably becomes more ordered as a function of the structuring and shaping influences of that environment (p. 69).

Violent and disruptive students are clearly those who exhibit poor self-control, appear impulsive and need externally imposed structure.

Though the intervention techniques discussed are not identified with a single therapeutic approach, they are ones that have been found to be most effective with students who are impulsive and uncontrolled.

School-based helpers are busy and are expected at times to perform a variety of activities concurrently, such as class management and instruction. Consequently, all else being equal, those procedures that are the least time consuming and least difficult to apply are preferred.

### **Minimal Intrusion Techniques**

Techniques will be presented in order of least intrusive, simple to apply to most intrusive, most difficult to apply. The eight techniques discussed below are based on the work of Long and Newman (1965).

- ***Planned Ignoring***

Some of the things that violent and disruptive students do can be ignored. If their intent is to get attention or provoke a confrontation, the school service provider is, in effect, walking into a trap when he/she attends to attention-getting behaviors. Planned ignoring means that the student's behaviors are intentionally not noticed. For example, the teacher "does not hear" humming, pencil tapping, or the barely uttered threat. For students who are waiting for a chance to blow up or for those whose self-control is so poor that minor infractions of rules are unconscious and inadvertent, the teacher who reacts has unwittingly allowed herself to be slapped across the face with a glove—the duel is on and more problems, not fewer, will ensue.

There are instances that cannot be ignored. A student threatening physical harm to another or being extremely disruptive cannot be ignored by the teacher or his classmates. Planned ignoring is only appropriate for minor infractions. Save your efforts and energy for those things that really matter. Violent and disruptive students provide unlimited opportunities to do battle, so choose wisely what is worth the effort and what is not. This procedure is similar to extinction, which will be discussed later.

*Behavioral Characteristics of the Child*

Poor self-control

Good self-control

Impulsive-disorganized

Self-controlled, well-organized

*Child's Need for Structure*

Needs external imposed structure

Manages with self-imposed structure

*Illustrative Kinds of Intervention Strategies*

Adult is in control	Token economy	Life space interview	Limited communication techniques	Tolerating	Child is in control
	Engineered classroom	Contingency management	Reality counseling Techniques	Minimal influence	

Figure 8-1. Matching the Intervention Strategy to the Child.

• **Signal Interference**

Teachers use a wide variety of signals with their typical students. These are especially common in the lower grades. "Lights off" means "I want everyone quiet." Eye contact with most children is sufficient to convey dissatisfaction with their behavior. Signals like these can be used to unobtrusively cue a student to stop performing a disruptive behavior. Many of these techniques are nonverbal and do not need to put the student in an embarrassing position in front of the rest of the class. The teacher can meet privately with the student in order to mutually determine the signal that cues him *not* to engage in disruptive behaviors. Examples of signals that could be used to cue a student are: (a) clearing throat; (b) snapping fingers; (c) ringing a small bell; (d) placing a warning sign on

the board, teacher's desk, or student's desk; and (e) using hand gestures (e.g., one finger for strike one," etc.).

• **Proximity Control**

When a teacher casually walks down the aisles in her classroom, misbehaviors tend to decrease and attention increases. On occasion, this technique can also be used with disruptive students just as effectively. The use of touch can also help. This closeness helps the student know that the teacher is interested and concerned. Putting the student's desk near the teacher's can also be effective if it is not perceived as punishment. Some teachers have a desk near theirs that can be used by the disruptive student on an as needed basis. Proximity control can be used

in combination with signal interference—sitting closer to the teacher so that she can provide less obtrusive signals. Both procedures alert the student and help him refocus his attention on the appropriate activity.

- ***Interest Boosting***

It is a challenge to maintain the interest of a disruptive student. It is wise to have available a few topics of interest to be used at the appropriate time. These focus his interest on something appropriate rather than losing him completely because of boredom or disruptiveness. Focusing on something of interest may prevent a costly outburst. A simple and direct procedure is to show interest in the lesson on which the student is currently struggling. Other approaches are to: (a) obtain interesting and unusual facts that can be used during various academic lessons; (b) have available a book of facts to boost interest; e.g., *Guinness Book of Records*; (c) determine areas of interest the disruptive student has and be ready to use them in minor modification of lessons; and (d) use high interest activities that support lessons, such as educational games.

- ***Use of Humor***

When hostility and aggression are encountered, it is natural to counter with more hostility and aggression. Yet, as many wise leaders have found, tensions can be reduced through humor. Physically, laughter produces a relaxation response.

The school-based helper can use humor to defuse potentially volatile situations and help everyone involved feel less threatened and more comfortable. Miss Wilson was engaged in a heated debate with a student in her class about some problems he did not want to do. In an effort to bring calm to the situation, she used humor. She said, "I don't know the meaning of the word defeat . . . and several thousand other words." Those without a sense of humor are destined to face countless tribulations, especially if they work in a human services profession. Henry Ward Beecher comments, "A person without a sense of humor is like a wagon without springs—jolted by every pebble in the road. " It is especially critical for school-based helpers who serve violent and disruptive students to have a sense of humor. I would not hire one who does not.

- ***Support from Routine***

One of the most important things the school can do for a student with behavioral problems is to provide a well-defined routine. Predictability and structure, under the supervision of a caring teacher, are extremely important. During the transitions from one activity to another is when most problems occur. Going from reading to art or from math to recess breed problems. These are times when violent and disruptive students wreak havoc on their classmates.

Well-defined schedules prevent problems. Once developed, do not keep them secret—share them with the students. They are especially important for ancillary staff to have and maintain. School-based helpers who cannot be counted on to show up on time lose a significant amount of effectiveness with students who have behavioral problems. These students need a stable and predictable environment.

- ***Removing Seductive Objects***

The wide variety of high appeal items marketed for children and adolescents, is on occasion, in fierce competition with the teacher. Toy cars and stereos and many other items cause distractions and fights among students. Wise teachers know that such items frequently need to be taken from a student and returned after class. In a later section we will look at how they can be used to improve behavior when contingently returned based on certain predefined conditions having been met...

- ***Systematic Praise***

One of the least costly and simple to use techniques is systematic praise. Since these students make themselves unpraiseworthy, it is usually necessary to assist teachers and others in establishing a specific system of praise. Many ask, "Why should I reinforce him for what all the other students do normally?" Though there is some validity in this point of view, it is necessary to break the cycle of hostility. School-based helpers can play an important role in this regard...

- ***Self-management***

Productive self-management is one of the most obvious deficits of violent and disruptive students. They are often described as uncontrolled. The strategies presented above (praise, token systems, contracts, and modeling) are used to help students learn productive behaviors under carefully specified and monitored conditions. After the student begins to behave in a more prosocial fashion under the



guidance of a school-based helper, he should be gradually taught self-control techniques.

This training has four components: (a) self-selected behaviors to change, (b) self-determined reinforcements, (c) self-administered reinforcements, and (d) self-monitoring of progress. Students respond surprisingly well to being given control of their own development programs...

Teaching self-management skills is analogous to teaching study skills. Some students seem instinctively to know how to study effectively. Others need to be shown effective techniques. They are amazed to see that these simple procedures work—to them it is almost like cheating. Similarly with self-management, major changes can be made with the consistent application of a few easy-to-learn techniques...

### Home-School Cooperation

Disruptive students require close communication between school and home. Disruptiveness can be a reaction to home stress. Aggressiveness may be a way of coping within the family. Working only with the student is not likely to be effective. To modify behavior, the school and home need to be restructured to provide positive experiences for the student. Some are angry at the world and resist assistance—lacking trust in adults. Extraordinary measures may be necessary to build that trust. They may feel neglected and have learned to act out to gain attention. Schools frequently give attention to negative behaviors. Suspension and expulsion do little to teach students what is expected of them. Often they create feelings of anger and blame in students and parents. Below are suggestions for working with the parents:

1. Meet with the parents as soon as possible. Get to know them. Convey your interest in helping their student. Most of their contacts with the school have probably been negative, informing them of what Bill did again today. If they know you and appreciate your professional interest in helping their child, more home-school cooperation is likely.
2. Give the parents advice on things they can do to help their child. Some of the things these students often need from the home are positive attention

and praise, protection from parental stresses, rest, a balanced diet, and hygienic care.

3. Set up a home-school communication system to regularly share progress or difficulties the student is experiencing. Weekly phone calls, notes, behavior report cards, or visits to the school can all be helpful.
4. Help parents develop a contract with the student at home. It could address problems that are also being worked on at school. When the school and home are attending to similar behaviors more generalization is likely to occur.
5. Encourage parents to meet with others who are experiencing similar difficulties. Parent groups provide support and offer alternative strategies. The school could help form such a program if one does not exist.

Praise parents for progress their child makes. Being the parent of a troubled child is a difficult task. Recognize the student's progress - or attempts at progress. These positive contacts with the home can be opportunities to help them learn effective child-rearing skills.

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Excerpts from:

# ADDRESSING STUDENT PROBLEM BEHAVIOR

## AN IEP TEAM'S INTRODUCTION TO FUNCTIONAL BEHAVIORAL ASSESSMENT AND BEHAVIOR INTERVENTION PLANS

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Educators have long understood that behavior difficulties can keep students from functioning productively in class. Many school personnel have been considering the effects of behavior on learning for some time....

### **WHY A FUNCTIONAL ASSESSMENT OF BEHAVIOR IS IMPORTANT**

Although professionals in the field hold a variety of philosophical beliefs, they generally agree that there is no single cause for problem behaviors...

To illustrate this point, again consider the acting-out behaviors previously described. Reactive procedures, such as suspending each student as a punishment for acting-out, will only address the symptoms of the problem, and will not eliminate the embarrassment. . . Therefore, each of these behaviors are likely to occur again, regardless of punishment, unless the underlying causes are addressed.

*Functional behavioral assessment is generally considered to be an approach that incorporates a variety of techniques and Strategies to diagnose the causes and to identify likely interventions intended to address problem behaviors. In other words, functional behavioral assessment looks beyond the overt topography of the behavior, and focuses, instead, upon identifying biological, social, affective, and*

environmental factors that initiate, sustain, or end the behavior in question. This approaches important because it leads the observer beyond the "symptom" (the behavior) to the student's underlying motivation to escape, avoid," or "get" something (which is, to the tractional analyst, the root of all behavior).Research and experience have demonstrated that behavior intervention plans stemming from the knowledge of *why* a student misbehaves (i.e., based on a functional behavioral assessment) are extremely useful addressing a wide range of problems.

*The functions* of behavior are not usually considered inappropriate. Rather, it is the behavior itself that is judged appropriate or inappropriate. For example, getting high grades and acting-out may serve the same function (i.e., getting attention from adults), yet the behaviors that lead to good grades are judged to be more appropriate then those that make up acting-out behavior...

### **IDENTIFYING THE PROBLEM BEHAVIOR**

Before a functional behavioral assessment can be implemented, it is necessary to pinpoint the behavior causing learning or discipline problems, and to define that behavior in concrete terms that are easy to communicate and simple to measure and record. If descriptions of behaviors are vague (e.g. poor attitude), it is difficult to determine. . .

It may be necessary to carefully and objectively

observe the student's behavior in different settings and during different types of activities, and to conduct interviews with other school staff and care givers, in order to pinpoint the specific characteristics of the behavior.

Once the problem behavior has been defined concretely, the team can begin to devise a plan for conducting a functional behavioral assessment to determine functions of the behavior. The following discussion can be used to guide teams in choosing the most effective techniques to determine the likely causes of behavior.

## **POSSIBLE ALTERNATIVE ASSESSMENT STRATEGIES**

The use of a variety of assessment techniques should lead teams to better understand student behavior. Each technique can, in effect, bring the team closer to developing a workable intervention plan.

A well developed assessment plan and a properly executed functional behavioral assessment should identify the contextual factors that contribute to behavior. Determining the specific contextual factors for a behavior is accomplished by collecting information on the various conditions under which a student is most and least likely to be a successful learner. That information, collected both indirectly and directly, allows school personnel to predict the circumstances under which the problem behavior is likely and not likely to occur.

Multiple sources and methods are used for this kind of assessment, as a single source of information generally does not produce sufficiently accurate information, especially if the problem behavior serves several functions that vary according to circumstance (e.g., making inappropriate comments during lectures may serve to get peer attention in some instances, while in other situations it may serve to avoid the possibility of being called on by the teacher).

It is important to understand, though, that contextual factors are more than the sum of observable behaviors, and include certain affective and cognitive behaviors, as well. In other words, the trigger, or antecedent for the behavior, may not be something that anyone else can directly observe, and, therefore, must be identified using indirect measures. For instance, if the student acts out when given a

worksheet, it may not be the worksheet that caused the acting-out, but the fact that the student does not know what is required and thus anticipates failure or ridicule. Information of this type may be gleaned through a discussion with the student.

Since problem behavior stems from a variety of causes, it is best to examine the behavior from as many different angles as possible. Teams, for instance, should consider what the "pay-off" for engaging in either inappropriate or appropriate behavior is, or what the student "escapes," "avoids," or "gets" by engaging in the behavior. This process should identify workable techniques for developing and conducting functional behavioral assessments and developing behavior interventions. When considering problem behaviors, teams might ask the following questions.

### ***Is the problem behavior linked to a skill deficit?***

Is there evidence to suggest that the student does not know how to perform the skill and, therefore cannot? Students who lack the skills to perform expected tasks may exhibit behaviors that help them avoid or escape those tasks. If the team suspects that the student "can't" perform the skills, or has a skill deficit. They could devise a functional behavioral assessment plan to determine the answers to further questions, such as the following:

- Does the student understand the behavioral expectations for the situation?
- Does the student realize that he or she is engaging in unacceptable behavior, or has that behavior simply become a "habit"?
- Is it within the student's power to control the behavior, or does he or she need support?
- Does the student have the skills necessary to perform expected, new behaviors?

### ***Does the student have the skill,, but, for Some reason, not the desire to modify his or her behavior?***

Sometimes it may be that the student can perform a skill, but, for some reason, does not use it consistently

(e.g., in particular settings). This situation is often referred to as a "performance deficit." Students who can, but do not perform certain tasks may be experiencing consequences that affect their performance (e.g., their non-performance is rewarded by peer or teacher attention, or performance of the task is not sufficiently rewarding). If the team suspects that the problem is a result of a performance deficit, it may be helpful to devise an assessment plan that addresses questions such as the following:

- Is it possible that the student is uncertain about the appropriateness of the behavior (e.g., it is appropriate to clap loudly and yell during sporting events, yet these behaviors are often inappropriate when playing academic games in the classroom)?
- Does the student find any value in engaging in appropriate behavior?
- Is the behavior problem associated with certain social or environmental conditions?
- Is the student attempting to avoid a "low-interest" or demanding task?
- What current rules, routines, or expectations does the student consider irrelevant?

## TECHNIQUES FOR CONDUCTING THE FUNCTIONAL BEHAVIORAL ASSESSMENT

Indirect assessment. *Indirect or informant assessment* relies heavily upon the use of structured interviews with students, teachers, and other adults who have direct responsibility for the students concerned. Individuals should structure the interview so that it yields information regarding the questions discussed in the previous section, such as:

- In what settings do you observe the behavior?
- Are there any settings where the behavior does not occur?
- Who is present when the behavior occurs?
- What activities or interactions take place just prior to the behavior?
- What usually happens immediately after the behavior?
- Can you think of a more acceptable behavior that

might replace this behavior?

Interviews with the student may be useful in identifying how he or she perceived the situation and what caused her or him to react or act in the way they did. Examples of questions that one may ask include:

- What were you thinking just before you threw the textbook?
- How did the assignment make you feel?
- Can you tell me how Mr. Smith expects you to contribute to class lectures?
- When you have a "temper tantrum" in class, what usually happens afterward?

Commercially available student questionnaires, motivational scales, and checklists can also be used to structure indirect assessments of behavior. The district's school psychologist or other qualified personnel can be a valuable source of information regarding the feasibility of using these instruments.

Direct assessment. *Direct assessment* involves observing and recording situational factors surrounding a problem behavior (e.g., *antecedent* and *consequent* events). An evaluator may observe the behavior in the setting that it is likely to occur, and record data using an Antecedent-Behavior-Consequence (ABC) approach. (Appendix A shows two examples of an ABC recording sheet.)

The observer also may choose to use a *matrix* or *scatter plot* to chart the relationship between specific instructional variables and student responses. (See Appendix B for examples.) These techniques also will be useful in identifying possible environmental factors (e.g., seating arrangements), activities (e.g., independent work), or temporal factors (e.g., mornings) that may influence the behavior. These tools can be developed specifically to address the type of variable in question, and can be customized to analyze specific behaviors and situations (e.g., increments of 5 minutes, 30 minutes, 1 hour, or even a few days).

Regardless of the tool, observations that occur consistently across time and situations, and that reflect both quantitative and qualitative measures of the behavior in question, are recommended.

Data analysis. Once the team is satisfied that enough data have been collected, the next step is to compare and analyze the information. This analysis will help the team to determine whether or not there are any patterns associated with the behavior (e.g., whenever Trish does not get her way, she reacts by hitting someone). If patterns cannot be determined, the team should review and revise (as necessary) the functional behavioral assessment plan to identify other methods for assessing behavior.

Hypothesis statement. Drawing upon information that emerges from the analysis, school personnel can establish a hypothesis regarding the function of the behaviors in question. This hypothesis predicts the general conditions under which the behavior is most and least likely to occur (antecedents), as well as the probable consequences that serve to maintain it. For instance, should a teacher report that Lucia calls out during instruction, functional behavioral assessment might reveal the function of the behavior is to gain attention (e.g., verbal approval of classmates), void instruction (e.g., difficult assignment), seek excitement (i.e., external stimulation), or both to gain attention and avoid a low-interest subject.

Only when the relevance of the behavior is known is it possible to speculate about the true function of the behavior and establish an individual behavior intervention plan. In other words, before any plan is set in motion, the team needs to formulate a plausible explanation (*hypothesis*) for the student's behavior. It is then desirable to manipulate pious conditions to verify the assumptions made by the team regarding the function the behavior...

## BEHAVIOR INTERVENTION PLANS

After collecting data on a student's behavior, and after developing a hypothesis of the likely function of that behavior, a team develops (or revises) the student's behavior intervention plan or strategies in the IEP. These may include positive strategies, program or curricular modifications, and supplementary aids and supports required to address the disruptive behaviors in question. It is helpful to use the data collected during the functional behavioral assessment to develop the behavior intervention plan or strategies and to determine the discrepancy between the child's actual and expected behavior.

The input of the general education teacher, as appropriate (i.e., if the student is, or may be participating in the regular education environment),

is especially crucial at this point. He or she will be able to relay to the team not only his or her behavioral expectations, but also valuable information about how the existing classroom environment and/or general education curriculum can be modified to support the student.

Intervention plans and strategies emphasizing skills students need in order to behave in a more appropriate manner, or plans providing motivation to conform to required standards, will be more effective than plans that simply serve to *control* behavior. Interventions based upon *control* often fail to generalize (i.e., continue to be used for long periods of time, in many settings, and in a variety of situations)—and many times they serve only to *suppress* behavior—resulting in a child manifesting unaddressed needs in alternative, inappropriate ways. Positive plans for behavioral intervention, on the other hand, will address both the source of the problem and the problem itself....

## ADDRESSING SKILL DEFICITS

An assessment might indicate the student has a *skill deficit* and does not know how to perform desired skills. The functional behavioral assessment may show that, although ineffective, the child may engage in the inappropriate behavior to escape or avoid a situation: (1) for which he or she lacks the appropriate skills; or (2) because she or he lacks appropriate, alternative skills and truly believes this behavior is effective in getting what he or she wants or needs. For example, a child may engage in physically violent behavior because he or she believes violence is necessary to efficiently end the confrontational situation, and may believe that these behaviors will effectively accomplish his or her goals. However, when taught to use appropriate problem-solving techniques, the student will be more likely to approach potentially volatile situations in a nonviolent manner. If this is the case, the intervention may address that deficit by including, within the larger plan, a description of how to teach the problem-solving skills needed to support the child.

## ADDRESSING PERFORMANCE DEFICITS

If the functional behavioral assessment reveals that the student knows the skills necessary to perform the behavior, but does not consistently use them, the intervention plan may include techniques, strategies, and supports designed to increase motivation to perform the skills.

If the assessment reveals that the student is engaging in the problem behavior because it is more desirable (or reinforcing) than the alternative, appropriate behavior, the intervention plan could include techniques for making the appropriate behavior more desirable. For instance, if the student makes rude comments in class in order to make her peers laugh, the plan might include strategies for rewarding appropriate comments as well as teaching the student appropriate ways to gain peer attention. *Behavioral contracts or token economies* and other interventions that include peer and family support may be necessary in order to change the behavior.

## ADDRESSING BOTH SKILL AND PERFORMANCE DEFICITS

Some student problems are so significant they require a combination of techniques and supports. For example, if the student finds it difficult to control his or her anger, she or he may need to be taught certain skills, including the following:

- recognize the physical signs that he or she is becoming angry,
  - use relaxation skills,
  - apply problem-solving skills, and
  - practice communication skills;
- and have the added support of:
- the school counselor,
  - the school psychologist, and
  - curricular or environmental modifications.

In addition, the student may need to be provided with external rewards for appropriately dealing with anger.

Many professionals and professional organizations agree that it is usually ineffective and often unethical to use *aversive* techniques to control behaviors, except in very extreme cases, such as situations in which:

- the child's behavior severely endangers her or his safety or the safety of others,
- every possible positive intervention has been tried

for an appropriate length of time and found ineffective, and

- the behavior of the student severely limits his or her learning or socialization, or that of others.

## MODIFYING THE LEARNING ENVIRONMENT

In addition to factors of skill and motivation, the functional behavioral assessment may reveal conditions within the learning environment, itself, that may precipitate problem behavior. Factors that can serve as precursors to misbehavior range from the physical arrangement of the classroom or student seating assignment to academic tasks that are "too demanding" or "too boring." Again, simple curricular or environmental modifications may be enough to eliminate such problems.

### *Providing Supports*

Sometimes *supports* are necessary to help students use appropriate behavior. The student, for example, may benefit from work with school personnel, such as counselors or school psychologists. Other people who may provide sources of support include:

- Peers, who may provide academic or behavioral support through tutoring or conflict-resolution activities, thereby fulfilling the student's need for attention in appropriate ways;
- Families, who may provide support through setting up a homework center in the home and developing a homework schedule;
- Teachers and paraprofessionals, who may provide both academic supports and curricular modifications to address and decrease a student's need to avoid academically challenging situations; and
- Language pathologists, who are able to increase a child's expressive and receptive language skills, thereby providing the child with alternative ways to respond to any situation

Whatever the approach, the more proactive and inclusive the behavior intervention plan -and the more closely it reflects the results of the functional behavioral assessment - the more likely that it will succeed. In brief, one's options for positive behavioral

interventions may include:

- Replacing problem behaviors with appropriate behaviors that serve the same (or similar) function as inappropriate ones;
- Increasing rates of existing appropriate behaviors;
- Making changes to the environment that eliminate the possibility of engaging in inappropriate behavior; and
- Providing the supports necessary for the child to use the appropriate behaviors.

Care should be given to select a behavior that likely will be elicited by and reinforced in the natural environment, for example, using appropriate problem-solving skills on the playground will help the student stay out of the principal's office.

## EVALUATING THE BEHAVIOR INTERVENTION PLAN

It is good practice for IEP teams to include two evaluation procedures in an intervention plan: one procedure designed to monitor the faithfulness with which the management plan is implemented, the other designed to measure changes in behavior. . . .

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## Behavior Management in Inclusive Classrooms

A popular approach for working with youngsters with behavioral problems in classrooms was summarized in an article entitled **Behavior Management in Inclusive Classrooms**, which appeared in *Remedial and Special Education*, Vol 17 (4), July, 1996, by Stephanie L. Carpenter and Elizabeth McKee-Higgins. The following excerpt from her article captures the idea of this approach.



A primary measure of effectiveness for instructional programs is student academic achievement. However, teachers identify behavioral dimensions as a high priority for the success of students with disabilities and students at risk for school failure in general education classrooms—often as a higher priority than academic skills (Blanton, Blanton, & Cross, 1994; Ellett, 1993; Hanrahan, Goodman, & Rapagna, 1990; Mayer, Mitchell, Clementi, Clement-Robertson, Myatt, & Bullara, 1993). Indeed, students' behaviors during instruction may impact the classroom climate and the extent to which all students are actively engaged in instruction, an indicator of achievement outcomes (Christenson, Ysseldyke, & Thurlow, 1989). A classroom climate characterized by learning and cooperative interactions with groups of students who are motivated, responsive to traditional authority figures and systems (e.g., teachers and schools), and compliant with established rules and routines may be jeopardized by the presence of students who have not learned or adopted behaviors that are compatible with performing within a classroom community of learners. At times the misbehavior of one student or a small group of students seems to spread to other students even when classwide or schoolwide behavioral expectations are established and communicated to students (Smith & Rivera, 1995). When teachers take excessive time to respond to inappropriate student behaviors, valuable instructional momentum and time may be lost. As the diversity of students' characteristics within

classrooms increases, the need increases for classroom behavior management systems that are responsive to group and individual student characteristics (Lewis, Chard, & Scott, 1994).

The purpose of this article is twofold. First, proactive behavior management programs are described as an effective means to respond to diverse behavioral characteristics among all students, both those with and without disabilities. Second, one teacher's experiences are described; she incorporated components of a proactive behavior management plan to address both her students' and her own behaviors in order to minimize the negative impact of students' misbehavior on instruction and achievement. An underlying premise is that it is by changing their own behaviors that teachers may have the greatest impact on their students' classroom behaviors.

### PROACTIVE BEHAVIOR MANAGEMENT PROGRAMS

Traditional approaches to managing problem behavior have not been responsive to the behavioral and learning characteristics of students with chronic behavior problems (Colvin, F Kameenui, & Sugai, 1993). Despite evidence that effective discipline programs recognize and reward appropriate behavior to promote a positive school climate (Colvin et al., 1993; Mayer et al., 1993), many school or classroom management procedures are reactive, punitive, or control oriented (Colvin et al., 1993; Reitz, 1994).

The assumption is that punishment will change behavior in desirable directions. Colvin et al. stated:

To manage behavior school discipline plans typically rely on reprimands, penalties, loss of privileges, detention, suspension, corporal punishment, and expulsion. By experiencing these reactive consequences it is assumed that students will learn the "right way" of behaving and be motivated sufficiently to comply to the expectations of the school. (p. 364)

Conversely, *effective behavior management programs* that are responsive to individual and group behaviors for classroom or school interactions and participation *are proactive* in nature. Proactive behavior management programs

- Use instructional techniques to develop desired behaviors;
- Promote a positive climate to motivate students;
- Are dynamic and responsive to students' changing behavioral skills; and
- Use collegial interactions to support teachers' use of effective procedures.

### ***Instructional Approach***

In an instructional (Colvin et al., 1993) or educative (Reitz, 1994) approach to addressing behavior management, educators view students' participation and interaction behaviors in a way that is similar to their view of students' academic behaviors. The focus is on providing students with structured opportunities to learn and practice desirable behaviors rather than using negative consequences to eliminate undesirable behaviors. The main components of an instructional approach to behavior management include "teaching objectives, explanation of procedures, practice activities, prompts, reinforcement, feedback, and monitoring" (Colvin et al., 1993, p. 366). Colvin and his colleagues developed a model for addressing chronic behavior problems that parallels instruction to remediate chronic academic problems. In this model, teachers (a) identify the functional relationships between behavior and the environment, (b) identify expected or acceptable behaviors, (c) modify the environment so that students can practice expected behaviors in the absence of stimuli that are likely to

elicit the inappropriate behavior, (d) reinforce correct responding by using differential reinforcement, and (e) move toward less restrictive or more naturally occurring programming to foster generalization and maintenance of acceptable behaviors.

\* \* \*

### ***Positive Climate***

A positive learning climate is one in which the classroom environment is a desirable place to work and to interact with others. For some students, school is not a pleasant place to be because they engage in behaviors that are viewed as undesirable in the classroom environment. When these undesirable behavior patterns are coupled with academic difficulties, a cycle of school failure often emerges that leads many students to stay away from school or ultimately to drop out. Redesigning behavior management programs to create environments that are more desirable places in which to learn should promote greater student motivation to participate in school programs (Dunlap et al., 1993; Mayer et al., 1993). Teachers enhance the learning climate when they recognize the desirable aspects of students' behaviors and structure the classroom environment to facilitate productive work habits and positive interpersonal interactions.

\* \* \*

Reitz (1994) proposed a model for designing comprehensive classroom-based programs for students with emotional and behavioral problems that also included academic and behavioral techniques. Of 10 components presented as essential, five directly or indirectly addressed the creation of a positive class climate:

1. Consistent classroom schedule and structure in which rules, expectations, consequences, and routines are clearly communicated to students and consistently followed by the teacher. Students may be involved in developing classroom procedures. The teacher should maintain positive focus by emphasizing desired behaviors and their consequences.
2. High rates of student academic involvement and achievement in which the curriculum

(content) and instructional delivery (teacher behavior) focus on high rates of student engagement during instruction and practice.

3. High rates of social reinforcement from teachers to promote the learning of new behaviors. Teachers' use of approval statements is an effective teaching tool.
4. System to ensure high rates of tangible reinforcement in which points or "tokens" are given immediately following the occurrence of a desired student behavior and exchanged later by the student to obtain predetermined privileges, activities, or items.
5. A repertoire of teacher responses to mild disruptive behavior that keeps minor problems from escalating into major ones. Combinations of praise for appropriate behavior and ignoring of inappropriate behavior (e.g., differential reinforcement) are effective in maintaining a focus on the positive.

Teachers promote a positive class climate by structuring the learning environment, emphasizing the desirable aspects of students' behaviors, and engaging in positive interpersonal interactions with all students. Both an instructional orientation and a positive classroom climate are necessary in order for behavioral interventions to be dynamic and responsive to students' changing behavioral skills.

#### ***Dynamic and Responsive Interventions***

Effective behavior management programs are dynamic processes whereby teachers adjust interventions in response to students' changing behaviors. The premise is that behavior management systems, while maintaining a positive orientation, should impose only as much teacher or outside influence as is necessary to achieve desirable student behaviors and a positive learning climate. Knowing "how much is enough" is a function of experience and knowing students' behavioral characteristics. However, when teachers are faced with classrooms composed of diverse student populations, beginning with more structure paired with ample reinforcement and moving toward less permits teachers the opportunity to set the stage for desirable student behaviors early on.

\* \* \*

#### ***Collegial Interactions***

Collegial interactions serve two primary purposes during the development and implementation of proactive behavior management systems: (a) support for changes in teacher behaviors and (b) programming consistency. Strong collaborative relationships among school staff facilitates commitment to developing, implementing, and maintaining schoolwide plans for proactive behavior management programs (Colvin et al., 1993; Mayer et al., 1993; Reitz, 1994). Cheney and Harvey (1994) found that teachers desired consultations and feedback so that they could ensure that they were making correct decisions. Indeed, understanding behavioral interventions is a prerequisite for effective implementation (Reimers, Wacker, & Koepl, 1987). Other teachers, administrators, support personnel, or university faculty may provide ongoing feedback, dialogue, and assistance for teachers as they attempt to adapt their behavior management practices (Dettmer, Thurston, & Dyck, 1993; Idol, Nevin, & Paolucci-Whitcomb, 1994). Reimers et al. reported that teachers who implement behavioral programs proficiently and experience benefits in terms of improved student behaviors rate behavioral interventions as more acceptable and are more likely to use them consistently. Taken together, the research suggests that collegial relationships can influence the success teachers experience with behavior management systems, the consistency of implementation, and ultimately the effectiveness of the program.

\* \* \*

#### ***The Problem: Looking Deeper***

We used a four-step approach to gather information and arrow the scope of the problem:

1. Determine when behaviors seem to present the greatest barrier to instruction and learning.
2. Determine which behaviors are most problematic and identify alternative behaviors that are desired.
3. Identify teacher, classmate, or environmental variables that precede and/or follow the undesired and desired

behaviors.

4. Collect data on student and teacher behaviors.

Synthesizing information about the problem proved helpful in identifying patterns associated with the inappropriate behaviors. Patterns of student behaviors and teacher responses emerged that were useful in designing a comprehensive intervention.

\* \* \*

### CONCLUSIONS

For many educators the prospect of educating children with disabilities (and possibly a greater variability of behavioral challenges) in general education classrooms is daunting when (a) the numbers of students in classes are increasing, (b) behavior management procedures are taxed by the range of unacceptable behaviors exhibited by students without disabilities, and (c) supports for using new teaching practices are minimal. From such a perspective, undesirable student behavior is viewed as the *problem* within classrooms and schools. An alternative perspective is to view student behavior as integrally related to the context of the classrooms and schools. In other words, a more fundamental consideration may be the way educators respond to students' behaviors, both desirable and undesirable. The "instructional" methods used, class climate created, individuality supported, and collegiality practiced by educators can significantly influence the behavioral and achievement outcomes for the individual child.

Several lessons emerged as young students with disabilities were included in a first-grade classroom. First, when behavior management procedures only marginally (and perhaps negatively) address the behaviors of students without disabilities, including students with disabilities may amplify existing problems. Proactive behavior management programs that

are systematically and thoughtfully implemented provide structure and reinforcement that is beneficial for the class as well as the individual child. Second, even though educators may already know about behavior management methods that work, sometimes individual teachers are too close to challenging classroom situations to see clearly what is happening. The collaboration and encouragement of a trusted colleague, or just seeing things through a different lens, can lead to improved outcomes for students and teachers. A final related issue may be the importance of intensive and appropriate intervention at a young age for students, with and without disabilities, who may be at the beginning of a cycle of school failure. Traditionally, the response has been to place such students in separate classes or programs without consideration for how the current environment might be modified and whether modifications are implemented effectively. However, as teachers are encouraged and supported to use known, effective practices in order to be more responsive to all students' learning characteristics, the focus for managing students' behaviors may shift (a) from *where* interventions occur to *what* interventions are effective and (b) from viewing *students as the problem* to viewing *educators as the solution*.

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# How to Manage Disruptive Behavior in Inclusive Classrooms

by Vera I. Daniels

Available at: <http://www.teachervision.fen.com/lesson-plans/lesson-2943.html>

## **Special Focus on Discipline**

### **Due Process in Discipline**

In the movement toward inclusive classrooms (and inclusion schools), general education classrooms have included an increasing number of students with mild disabilities (e.g., emotional/behavioral disorders, learning disabilities, mild mental disabilities) (U.S. Department of Education, 1996). The guiding principle of this movement is the provision of equitable educational opportunities for all students, including those with severe disabilities, with needed supplementary aids and support services, in age-appropriate general education classes in their neighborhood schools (National Center on Educational Restructuring and Inclusion, 1994). Educators, researchers, and policymakers are beginning to examine educational practices and outcomes for students both with and without disabilities in inclusion classrooms. Researchers and others are looking at four factors:

- The ability of classroom teachers to provide instruction to students with disabilities in general classroom settings.
- The academic, behavioral, and social outcomes for students with and without disabilities.
- Legal ramifications that may result from inappropriate instructional and management practices.
- Litigation and case law resulting from the use of disciplinary practices such as suspension, expulsion, and time-out.

Maintaining appropriate classroom behavior can be a complex and difficult task. This task becomes more stressful when it involves students with disabilities. When students with disabilities display disruptive behavior, classroom teachers must carefully and methodically think about the discipline strategies they might employ. Although the disruptive behavior some of these students exhibit is similar to that of students without disabilities, the discipline strategies used to correct or redirect disruptive behavior can vary considerably (see box, "Due Process"). This article provides classroom teachers in inclusion settings with suggestions for addressing behavioral infractions of students with disabilities. In using these strategies, teachers and other practitioners should develop skills in diagnostic, reflective thinking and in making choices among strategies.

### **The Same or Different Disciplinary Strategies?**

Generally, classroom teachers can use the same disciplinary practices to manage the disruptive behavior of students with disabilities that they use to manage the behavior of students without disabilities. Much of the undesirable behavior exhibited by both groups is similar in nature. The differences, however, may originate in the teacher's selection of the particular behavioral intervention....

The Individuals with Disabilities Education Act Amendments (IDEA, 1997, formerly known as the Education for All Handicapped Children Act, Public Law 94-142) encourages the inclusion of children with disabilities in the least restrictive environment (LRE) to the maximum extent appropriate with children who are not disabled. Specifically, this act states: Special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. Although the procedural safeguards in IDEA historically provided the foundation for ensuring access to a free and appropriate public education for all children with disabilities in the LRE, these safeguards have not always been clear when it comes to the discipline of students with disabilities. Much of the past controversy concerning the discipline of students with disabilities has focused on the use of corporal punishment, suspension, expulsion, time out, and case law resulting from the use of these procedures (Katsiyannis, 1995; Sorenson, 1990; Yell, 1990). The passage of the IDEA Amendments of 1997, however, should significantly lessen much of the future controversy and court litigation on disciplinary practices of students with disabilities. The due process procedures in the IDEA

- Retain the "stay-put" provision.
- Add clarification to the procedural safeguard provisions to facilitate conflict resolution.
- Describe how schools may discipline children with disabilities, including those who affect the school safety of peers, teachers, and themselves.
- Provide comprehensive guidelines on the matter of disciplining children with disabilities so that both educators and administrators will have a better understanding of their areas of discretion in disciplining student with disabilities.
- Finally, in cases where the child's behavior is not a manifestation of the disability, IDEA permits a public agency to apply the same disciplinary procedures that would ordinarily apply to children without disabilities.

Here are 10 questions that may help you diagnostically analyze situations that foster disruptive behavior in students with disabilities. These discussions may provide guidance as you select behavior-reduction strategies.

**Question 1. Could this misbehavior be a result of inappropriate curriculum or teaching strategies?**

Inappropriate curriculum and teaching strategies can contribute to student misbehavior--but not all misbehavior is attributable to these factors. Some misbehavior may arise as a function of the teacher's inability to meet the diverse needs of all students. Consider these factors:

- Group size.
- Group composition.
- Limited planning time.
- Cultural and linguistic barriers.
- Lack of access to equipment, materials, and resources.

If the misbehavior evolves as a result of inappropriate curriculum or teaching strategies, redress the content and skill level components of your curriculum, its futuristic benefit for the student, and the formats you use in instructional delivery. When you identify the instructional needs of students within the context of the classroom, using a diagnostic prescriptive approach, and make curricular adaptations both in content and instructional delivery, you can greatly reduce the occurrence of student misbehavior.

Madsen and Madsen (1983) emphasized the following ways that teachers can give positive feedback to students to encourage desirable behavior in the classroom:

- Words (spoken-written: wonderful, absolutely right, fantastic, terrific, marvelous, splendid, all right, clever, thank you, that's good work, well thought out, that shows a great deal of work, I agree, keep working hard, you're improved).
- Physical expressions (facial-bodily: smiling, nodding, signaling OK, thumbs up, shaking head).
- Closeness (nearness-touching: interacting with class at recess, sitting on desk near students, walking among students, patting shoulder, touching hand).
- Activities (individual-social: leading student groups, running errands, putting away materials, choosing activities, leading discussions, movies, playing records, visiting another class, making a game of subject matter, presenting skits).
- Things (materials, food, playthings, awards, e.g., games book markers, stapler, bulleting board, puzzles, popcorn, ice cream, cookies, candy bars, medals, plaques, citations).

**Question 2. Could this misbehavior be a result of the student's inability to understand the concepts being taught?**

When there is a mismatch between teaching style and the learning styles of students, misbehavior inevitably results. Incidents of misbehavior may also result when students refuse to learn concepts because they are unable to see the relationship between the skills being taught and how these skills transcend to the context of the larger environment. In these situations, you should employ strategies and tactics that show students how component skills have meaning in the classroom and in the community...

**Question 3. Could this misbehavior be an underlying result of the student's disability?**

Some disruptive behavior may be a result of the student's disability (e.g., emotional/behavioral disorders). Meanwhile, other behavior may result from deliberate actions taken by the student to cause classroom disruption. Determining the underlying cause of a student's disruptive behavior involves a careful analysis of the behavior, as follows:

- Try to clarify what kinds of behavior are causing concern.
- Specify what is wrong with that behavior. Decide what action should be taken to address the behavior. -Specify what behavior you desire from the student.
- Implement a plan to correct conditions, variables, or circumstances that contribute to the problem behavior (Charles, 1996)...



**Question 4. Could this misbehavior be a result of other factors?**

Many aspects of classroom life may contribute to students' misbehavior: the physical arrangement of the classroom, boredom or frustration, transitional periods, lack of awareness of what is going on in every area of the classroom. Remember, however, that classroom climate and physical arrangements can also encourage desirable behavior. You should regularly assess your teaching and learning environment for conditions or procedures that perpetuate or encourage misbehavior. Because inappropriate behavioral manifestations of students can also stem from certain types of teaching behavior, teachers need to become more cognizant of the kinds of behavior they emit and the relationship between their teaching behavior and the resultant behavior of students. Examine your instruction and interactions with students in ongoing classroom life, as follows:

- The development of relevant, interesting, and appropriate curriculums.
- The manner in which you give recognition and understanding of each student as an individual with his or her unique set of characteristics and needs.
- Your own behavior as a teacher, and characteristics such as those identified by Kounin (1970)--withitness, overlapping-- that reduce misbehavior, increase instructional time, and maintain group focus and movement management of students.

**Question 5. Are there causes of misbehavior that I can control?**

As a teacher, you can control many variables to thwart undesirable behavior. You may modify or change your curriculum; make adaptations in instruction to address multiple intelligences; and make changes in your communication style, attitude toward students with disabilities, and expectations of these students. Analyze how much positive feedback you give students.

**Question 6. How do I determine if the misbehavior is classroom based?**

This is a difficult question. Conducting a self-evaluation of teaching style and instructional practices--as in the previous questions--may provide some insight into whether the behavior is related to the disability or is classroom based. You may find a classroom ecological inventory (Fuchs, Fernstrom, Scott, Fuchs, & Vandermeer, 1994) helpful in determining cause-effect relationships of student misbehavior. The classroom ecological inventory could help you assess salient features of the learning environment of your school or classroom...

**Question 7. How do I teach students to self-regulate or self-manage behavior?**

You can teach students to self-regulate or self-manage their behavior by teaching them to use the skills of self-management:

- Self-instruction, self-recording, or self-monitoring.
- Self-reinforcement, self-evaluation, and self-punishment.
- Multiple-component treatment packages (Carter, 1993; Hughes, Ruhl, & Peterson, 1988; Rosenbaum & Drabman, 1979)...

**Question 8. How do I determine what methods of control are appropriate without violating the rights of students with disabilities mandated under P.L. 105-17?**

Determining which behavior-reduction methods to use with students with disabilities is not as difficult as you may think. As mentioned previously, the behavioral interventions typically used with students without disabilities can also be used with students with disabilities with a few exceptions.

### **Question 9. How do I use reinforcement strategies to reduce disruptive behavior?**

Teachers can use many types of reinforcers to teach desirable behavior. Madsen and Madsen (1983) identified five categories of responses available for teaching desired behavior: the use of words, physical expressions, physical closeness, activities, and things used as rewards or positive feedback...

### **Question 10. Is it appropriate for me to use punishment?**

Punishment, the most controversial aversive behavior management procedure, has been used and abused with students with disabilities (Braaten, Simpson, Rosell, & Reilly, 1988). Because of its abuse, the use of punishment as a behavioral change procedure continues to raise a number of concerns regarding legal and ethical ramifications. Although punishment is effective in suppressing unacceptable behavior, it does have some limitations:

- The reduction in disruptive behavior may not be pervasive across all settings.
- The effect may not be persistent over an extended period of time.
- The learner may not acquire skills that replace the disruptive behavior (Schloss, 1987)...

### **Final Thoughts**

There is no "one plan fits all" for determining how teachers should respond to the disruptive behavior of students with disabilities in inclusion settings. An initial starting point would include establishing classroom rules, defining classroom limits, setting expectations, clarifying responsibilities, and developing a meaningful and functional curriculum in which all students can receive learning experiences that can be differentiated, individualized, and integrated.

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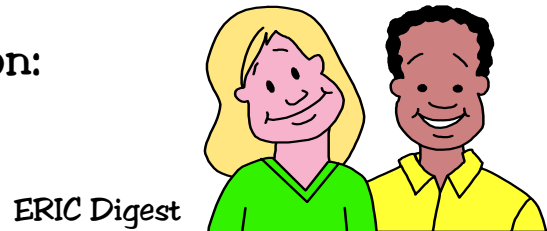
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# Enhancing Students' Socialization: Key Elements

By Jere Brophy



Coping with students who display problems in personal and social adjustment can be frustrating. Success in teaching problem students often requires extra time, energy, and patience. Recent research reviewed by Jones (1996) indicates that teachers rank individual students who have serious or persistent behavior problems as their chief cause of stress. However, teachers can take direct actions toward minimizing classroom conflicts by socializing students into a classroom environment conducive to learning.

Key elements of successful student socialization include modeling and instruction of prosocial behavior; communicating positive expectations, attributes, and social labels; and reinforcing desired behavior (Dix, 1993; Good & Brophy, 1994, 1995). Successful socialization further depends on a teacher's ability to adopt an authoritative teaching style for classroom management, and to employ effective counseling skills when seeking to develop positive relationships with individual students.

## **MODELING**

Modeling prosocial behavior is the most basic element for enhancing student socialization, because teachers are unlikely to be successful socializers unless they practice what they preach. Modeling, accompanied by verbalization of the self-talk that guides prosocial behavior, can become a very influential method of student socialization because it conveys the thinking and decision making involved in acting for the common good. In situations in which prosocial behavior is difficult for students to learn, modeling may have to be supplemented with instruction (including practice exercises) in desirable social skills and coping strategies. Such instruction should convey not only PROPOSITIONAL KNOWLEDGE (description of the skill and an explanation of why it is desirable), but also PROCEDURAL KNOWLEDGE (how to implement the skill) and CONDITIONAL KNOWLEDGE (when and why to implement it).

## **PROJECTING POSITIVE EXPECTATIONS**

Consistent projection of positive expectations, attributes, and social labels to students may have a significant impact on fostering self-esteem and increasing motivation toward exhibiting prosocial behaviors. Students who are consistently treated as if they are well-intentioned individuals who respect themselves and others and who desire to act responsibly, morally, and prosocially are more likely to develop these qualities than students who are treated as if they had the opposite inclinations especially if their positive qualities and behaviors are reinforced through expressions of appreciation. When delivered effectively, such reinforcement is likely to increase students' tendencies to attribute their desirable behavior to their own personal traits and to reinforce themselves for possessing and acting on the basis of those traits.

## **AUTHORITATIVE TEACHING**

Teachers, as the authority figure in the classroom, need to be authoritative rather than either authoritarian or laissez-faire. Teachers have the right and the responsibility to exert leadership and to exercise control, but they increase their chances of success if they are understanding and supportive of students and if they make sure that students understand the reasons behind their demands. Focusing on desired behavior (stressing what to do rather than what not to do) and following up with cues and reminders is also effective. Teachers should be prepared to supply objectively good reasons for their behavior demands.

When situations calling for disciplinary interventions arise, it is important for teachers to handle them effectively. General principles for doing so can be identified: minimize power struggles and face-saving gestures by discussing the incident with the student in private rather than in front of the class; question the student to determine his or her awareness of the behavior and explanation for it; make sure that the student understands why the behavior is inappropriate

and cannot be tolerated; seek to get the student to accept responsibility for the behavior and to make a commitment to change; provide any needed modeling or instruction in better ways of coping; work with the student to develop a mutually agreeable plan for solving the problem; concentrate on developing self-regulation capacities through positive socialization and instruction rather than on controlling behavior through the assertion of power. Teachers who employ effective student socialization strategies can develop genuine solutions to students' chronic personal and behavioral problems rather than merely inhibiting the frequency of misconduct by applying sanctions.

### **COUNSELING SKILLS**

Basic socialization and counseling skills may be needed for working with individual students, especially those who display chronic problems in personal development or adjustment. These basic skills include developing personal relationships with problem students and reassuring them of your continued concern about their welfare despite their provocative behavior; monitoring them closely and, if necessary, intervening frequently but briefly and nondisruptively to keep them engaged in academic activities during class; dealing with their problems in more sustained ways outside of class time; handling conflicts calmly without becoming engaged in power struggles; questioning them in ways that are likely to motivate them to talk freely and supply the needed information; using active listening, reflection, interpretation, and related techniques for drawing them out and helping them to develop better insights into themselves and their behavior; insisting that the students accept responsibility for controlling their own behavior while at the same time supportively helping them to do so; and developing productive relationships with their parents.

### **ATTRIBUTES OF SUCCESSFUL TEACHERS**

Good and Brophy (1995) have identified some general attributes of teachers that contribute to their success in socializing students. These attributes include:

- **SOCIAL ATTRACTIVENESS**, based on a cheerful disposition, friendliness, emotional maturity, sincerity, and other qualities that indicate good mental health and personal adjustment;

- **EGO STRENGTH**, exhibited in self-confidence that allows teachers to be calm in a crisis, listen actively without being defensive, avoid win-lose conflicts, and maintain a problem-solving orientation;
- **REALISTIC PERCEPTIONS OF SELF AND STUDENTS**, without letting perceptions become clouded by romanticism, guilt, hostility, or anxiety;
- **ENJOYMENT OF STUDENTS**, while maintaining their identity as an adult, a teacher, and an authority figure; being friendly but not overly familiar; and being comfortable with the group without becoming a group member;
- **CLARITY ABOUT TEACHER ROLES** and comfort in playing them, which enables teachers to explain coherently to students what they expect;
- **PATIENCE AND DETERMINATION** in working with students who persist in testing limits;
- **ACCEPTANCE OF THE INDIVIDUAL**, though not necessarily of all of his or her behavior, and making this attitude clear to students; and
- **THE ABILITY TO STATE AND ACT ON FIRM BUT FLEXIBLE LIMITS** based on clear expectations, keeping rules to a minimum and liberalizing them as students become more independent and responsible over time.

Developing these personal qualities and using research-based principles for managing the classroom will set the stage for student socialization and will go a long way toward minimizing the need for disciplinary interventions.

### **CONCLUSION**

Teachers are asked to take responsibility for an increasingly diverse population of students in situations where individual differences are to be expected and accepted. An attitude of caring and an orientation to students is crucial to success in socializing students into a classroom culture that fosters learning. Interacting with students for several

hours each day in various situations puts teachers in a position to take direct action in helping students cope with their problems.

Research shows that teachers' feelings of self-efficacy or confidence are correlated with their effectiveness ratings. Developing the skills for enhancing student socialization represents an expansion of the teacher's role beyond that of instructor or classroom manager. Teachers who believe that they possess, or at least are developing, good management and student socialization skills will be able to remain patient and focused on seeking solutions when confronted with difficult problems. In contrast, teachers who view management and socialization skills as talents in which they are lacking may tend to become frustrated and give up easily. Through developing their role as facilitators of students' socialization into the learning environment, teachers can create the potential for having a significant impact on the lives of problem students.

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See also: Brophy, Jere. (1995). *ELEMENTARY TEACHERS' PERCEPTIONS OF AND REPORTED STRATEGIES FOR COPING WITH TWELVE TYPES OF PROBLEM STUDENTS*. ED 389 390.

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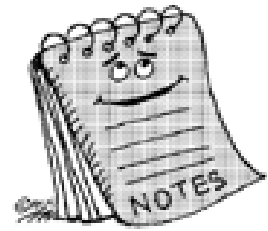
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# Screening for Special Diagnoses

By: Susan de La Paz & Steve Graham

ERIC Digest



## OVERVIEW

Congress enacted Public Law 94-142, the Education for All Handicapped Children Act, in November, 1975. It requires that all children with disabilities receive a free and appropriate public education. Determining who has a disability and who is eligible for special services, however, is not an exact science. It is complicated by vague definitions and varying interpretations of how to identify specific handicapping conditions (Hallahan & Kauffman, 1991). Nevertheless, recent government figures indicate that 7 percent of children and youth from birth to 21 are identified as having a disability that requires special intervention (Hunt & Marshall, 1994).

While practices differ greatly both across and within states (Adelman & Taylor, 1993), screening is an important part of the assessment process mandated by Public Law 94-142. Screening for the purpose of special diagnoses begins at birth and continues throughout the school years. In the first few years of life, most forms of screening center around developmental norms for physical, cognitive, and language abilities. Many children with severe disabilities (cerebral palsy, spina bifida, Down's syndrome, autism, severe sensory impairments, or children with multiple disabilities, for example) are identified early in life by physicians and other health professionals. However, other children, such as those with learning disabilities, attention deficit disorders, behavioral problems, and so forth, are usually not identified until they start school.

## SCHOOL-BASED SCREENING

Most public schools periodically "screen" large groups of students, typically between kindergarten through third grade, to identify children who may have a disability (as yet unidentified) or may be at risk for school failure. For example, a student with an extremely low test score on a standardized achievement test administered to all first graders in a school may become the focus of further inquiry to determine the validity of the screening observation and, if warranted, to determine the causes of the child's difficulties. This may lead to a recommendation to conduct a formal evaluation to decide if the child has a specific, identifiable disability. In addition to systematically "screening" students, children with a "suspected" disability may also be identified through referrals by

parents, teachers, or other school personnel. Typically, a child who is having academic or behavioral problems in the classroom may be referred for further testing to determine if a disability is present. Before testing for diagnosis begins, however, the school must obtain consent from the child's parents to do the evaluation.

While most children with a disability are identified by third grade, some are not identified until the upper elementary grades or even junior or senior high school. In some instances, a problem does not become evident until the demands of school exceed the child's skills in coping with his or her disability. In other cases, the disability may not occur until the child is older. For instance, a disability may be acquired as a result of a traumatic brain injury or as a result of other environmental factors. A disability may also not be identified until a child is older because the procedures used for screening, referral, testing, and/or identification are ineffective.

## PROBLEMS AND SOLUTIONS FOR SCHOOL SCREENING

It is important to understand that there is no standard or uniform battery of tests, checklists, or procedures to follow for the identification of most students with disabilities. While there is a basic structure to the identification process, there is considerable variability in how students may come to be identified, including the types of tests used in screening and the processes by which they are referred.

Critics have argued that the procedures used to identify children and youth with special needs have resulted in over- as well as under-identification of students with disabilities. As several studies have shown, a referred child almost always qualifies for special education (Christenson, Ysseldyke, & Algozzine, 1983). Over-identification has been particularly problematic in the area of learning disabilities (Hunt & Marshall, 1994), as approximately half of all students receiving special education services are identified as learning disabled! In contrast, students with behavioral disorders appear to be under-identified, particularly children who are compliant and nonaggressive but suffer from problems such as depression, school phobia, or social



isolation (Walker et al., 1990).

To remedy problems of over- and under-identification, educators have begun to institute several changes in the screening and referral process. One approach has involved the development of better screening procedures. For example, Walker and his colleagues (1990) devised a screening process, the Systematic Screening for Behavioral Disorders, that relies on a three-step process. Teachers (1) rank-order students along specified criteria and then (2) use checklists to quantify observations about the three highest-ranked students. Then, (3) other school personnel (for example, school psychologists or counselors) observe children whose behaviors exceed the norm for the teacher's classroom. Referrals are made for further evaluation only after the three-step process is completed.

A second common practice aimed at improving the identification process involves the use of prereferral interventions (Chalfant, 1985). These interventions have been developed to reduce the number of referrals to special education and provide additional help and advice to regular education teachers. Before initiating a referral for testing for special diagnosis, teachers first attempt to deal with a child's learning or behavioral problems by making modifications in the regular classroom. If these modifications fail to address the difficulties the child is experiencing adequately and the teacher believes that special services may be warranted, then the referral process is set into motion. Currently, 34 of 50 states require or recommend some form of prereferral intervention (Sindelar, Griffin, Smith, & Watanabe, 1992).

Two of the more common prereferral intervention approaches include Teacher Assistance Teams, (TATs), and collaborative consultation. Both approaches involve professionals helping regular educators deal with students who have problems in their classroom; however, they differ in an essential way. TATs typically consist of a team of three teachers with the referring teacher as the fourth member. The TAT model provides a forum where teachers meet and brainstorm ideas for teaching or managing a student. In contrast, most collaborative consultation models employ school specialists (resource room teachers, speech-language clinicians) who work directly with the referring teacher to plan, implement, and evaluate instruction for target students in the regular classroom.

### **SUMMARY**

Screening procedures are an important part of the assessment process to identify children and youth who

have disabilities. Such procedures must be used with care, however, as they provide only a preliminary sign that a child has a disability. Additional testing is required to affirm or disprove the presence of a handicapping condition. If a disability is identified during follow-up assessment, the focus shifts to providing the student with an appropriate education.

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## C. 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 2008 report, which appears in the *Journal of Clinical Child Psychology*, 37(1), 215-237.

### **Evidence-based psychosocial treatments for children and Adolescents with disruptive behavior**

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This article reviews the literature from 1996 to 2007 to update the 1998 Brestan and Eyberg report on evidence-based psychosocial treatments (EBTs) for child and adolescent disruptive behavior, including oppositional defiant disorder and conduct disorder. Studies were evaluated using criteria for EBTs developed by the task force on promotion and dissemination of psychological procedures (Chambless et al., 1998; Chambless et al., 1996). Sixteen EBTs were identified in this review, up from 12 in the earlier report, and 9 "possibly efficacious" treatments (Chambless & Hollon, 1998) were identified as well. This article describes the EBTs and their evidence base and covers research on moderators and mediators of treatment outcome, as well as the clinical representativeness and generalizability of the studies. Best practice recommendations from the current evidence base also are offered, as well as calls for future research that increases understanding of the moderators and mechanisms of change for children and adolescents with disruptive behavior disorders.

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In this update, we identified 16 EBTs, of which 15 met criteria for probably efficacious treatments and one of which met criteria for a well-established treatment (shown in Table 2). As in the original review, no treatment was identified as evidence based by evidence from single-subject design studies. Because of a recording error in the earlier review, one treatment previously classified as well established was reclassified in this review as probably efficacious,<sup>1</sup> and three treatments previously classified as probably efficacious did not meet PE criteria in this review.<sup>2</sup> Seven treatments previously classified as probably efficacious maintained this classification. In addition, 6 new treatments met PE criteria in

this review, and 1 previously identified treatment with two versions shown to be superior to attention placebo conditions has now been reclassified as 2 separate probably efficacious treatments. We briefly describe these 16 evidence-based treatments.

#### **EBT TREATMENT PROTOCOLS**

##### **Anger Control Training (Lochman, Barry, & Pardini, 2003)**

Anger Control Training is a cognitive-behavioral intervention for elementary school age children with disruptive behavior. Typically, children meet once per

week for 40 to 50 min during the school day in separate groups of approximately 6 children. In group sessions, children create specific goals and take part in exercises based on the social information-processing model of anger control (Crick & Dodge, 1994; Dodge, 1986). Within the group, children discuss vignettes of social encounters with peers and the social cues and possible motives of individuals in the vignettes. Children learn to use problem solving for dealing with anger-provoking social situations, and they practice appropriate social responses and self-statements in response to different problem situations, first by behavioral rehearsal of the situations with feedback for correct responses. Later in treatment, the group provides children practice in situations designed to arouse their anger and provides support for their use of their new anger control strategies. Children also learn strategies to increase their awareness of feelings. In the two well-conducted studies identified for this review, treatment length was between 26 and 30 sessions in one investigation (Lochman, Coie, Underwood, & Terry, 1993) and 15 sessions in the other study (Robinson, Smith, & Miller, 2002). Both studies found the Anger Control Training superior to no-treatment control conditions in reducing disruptive behavior. Because these studies, by different research teams, were compared to no-treatment control conditions rather than alternative treatment or placebo control conditions, this evidence-based treatment meets criteria for a probably efficacious treatment (see Tables 1 and 2).

### **Group Assertive Training (Huey & Rank, 1984)**

Based on the verbal response model of assertiveness (Winship & Kelley, 1976), with adaptations for cultural differences incorporated from the recommendations of Cheek (1976), two versions of this brief school-based treatment for aggressive classroom behavior among black adolescents (eighth and ninth graders) have been found superior to both professional- and peer-led discussion groups and no-treatment controls. The group treatments both involve 8 hr of assertive training, with treatment groups of 6 adolescents meeting twice a week for 4 weeks.

The two treatments, Counselor-Led Assertive Training and Peer-Led Assertive Training, are identical except for the qualifications of the group leaders. In both treatments, group leaders receive the same training program that they later provide to the adolescents in treatment, and in both treatments, group leaders are instructed to adhere strictly to structured training outlines in leading the groups. One well-conducted study found both treatments superior to counselor-led discussion groups as well as no-treatment controls (Huey & Rank, 1984). Both evidence-based treatments meet criteria as probably efficacious treatments for disruptive classroom behaviors of black adolescents because, although they have only one supportive study, both of the target treatments were compared to an alternative treatment in that study (see Tables 1 and 2).

### **Helping the Noncompliant Child (HNC; Forehand & McMahon, 1981)**

This treatment for preschool and early school-age children (ages 3-8 years) with noncompliant behavior is administered to families individually as a secondary prevention program. The parent and child are generally seen together for 10 weekly sessions (60-90 min each) with a therapist. Parents are instructed in skills aimed at disrupting the coercive cycle of parent-child interaction, which include increasing positive feedback to the child for appropriate behaviors, ignoring minor negative behaviors, giving children clear directions, and providing praise or time-out following child compliance and noncompliance, respectively. Parents learn skills through modeling, role-plays, and in vivo training in the clinic or home and progress as each skill is mastered. One well-conducted study found HNC superior to systemic family therapy in reducing child noncompliance in the clinic and at home (Wells & Egan, 1988; see Table 1), providing evidence that HNC meets criteria for a probably efficacious treatment for 3- to 8-year-olds with disruptive behavior.

## **Incredible Years** (IY; Webster-Stratton & Reid, 2003)

IY is a series of treatment programs designed to reduce children's aggression and behavior problems and increase social competence at home and at school. There are three distinct treatment programs—one for parents, one for children, and one for teachers. The three programs have been tested for efficacy individually and in all possible combinations. Both the IY Parent Training Program and the IY Child Training Program have been found probably efficacious, and several combination packages have met criteria for possibly efficacious treatments (see Table 3).

### **Incredible Years Parent Training (IY-PT)**

This is the original program in the series, a 13-session (2 hr per session) group parent training program in which parents of 2- to 10-year-old children diagnosed with disruptive behavior meet with a therapist in groups of 8 to 12 parents. During treatment, parents view 250 videotape vignettes, each about 1 to 2 min in length, that demonstrate social learning and child development principles and serve as the stimulus for focused discussions and problem solving. The program begins with a focus on positive parent-child interaction in which parents learn child-directed interactive play skills, followed by a focus on effective discipline techniques including monitoring, ignoring, commands, logical consequences, and time-out. Parents are also taught how to teach problem-solving skills to their children. Two well-conducted studies have found IY-PT superior to waitlist control groups in reducing preschoolers' (M age = 5) disruptive behavior, thus meeting criteria for a probably efficacious treatment (see Table 1).

### **Incredible Years Child Training (IY-CT)**

IY-CT is a 22-week videotape-based program for 3- to 8-year-olds who meet with a therapist in small groups of 6 children for 2 hr each week. The program includes more than 100 video vignettes of real-life conflict situations at home and school that model child problem-solving

and social skills. After viewing the vignettes, children discuss feelings, generate ideas for more effective responses, and role-play alternative scenarios. IY-CT is typically administered in conjunction with the IY-PT program, although three studies have found it superior to waitlist or no-treatment control groups on its own in reducing child disruptive behavior (see Table 1). This treatment meets criteria as a probably efficacious treatment for children (M age = 6 years) with disruptive behavior.

### **Multidimensional Treatment Foster Care (MTFC; Chamberlain & Smith, 2003)**

MTFC is a community-based program, originally developed as an alternative to institutional-, residential-, and group-care placements for youth with severe and chronic delinquent behavior. Youth are placed one per foster home for 6 to 9 months and given intensive support and treatment in the foster home setting. The foster parents receive a 20-hr preservice training conducted by experienced foster parents and learn to implement a daily token reinforcement system that involves frequent positive reinforcement and clear and consistent limits. Foster parents give the youth points daily for expected behaviors (e.g., getting up on time, attending school) and remove points for negative behaviors. Youth may exchange the points for privileges. For minor problem behaviors, foster parents also use brief privilege removal or small work chores, and for extreme problems they may use a short stay in detention. During treatment, the foster parents report point levels daily by telephone to program supervisors and meet weekly with supervisors for support and supervision.

Youth in MTFC meet at least weekly with individual therapists who provide support and advocacy and work with the youth on problem-solving skills, anger expression, social skills development, and educational or vocational planning. They also meet once or twice a week (2 to 6 hr per week) with behavioral support specialists trained in applied behavior analysis who focus on teaching and reinforcing prosocial behaviors

during intensive one-on-one interactions in the community (e.g., restaurants, sports teams). Finally, youth have regular appointments with a consulting psychiatrist for medication management.

At the same time youth are in MTFC treatment, the biological parents (or other after-care resource) receive intensive parent management training. This training is designed to assist in the reintegration of youth back into their homes and communities after treatment. Two well-conducted studies have found MTFC superior to usual group home care for adolescents with histories of chronic delinquency (see Table 1), meeting criteria for probably efficacious treatment.

### **Multisystemic Therapy (MST; Henggeler & Lee, 2003)**

MST is an intervention approach for treating adolescents with serious antisocial and delinquent behavior that combines treatments and procedures as needed to provide an intensive family and community-based intervention designed for the individual family, with the goal of promoting responsible behavior and preventing the need for out-of-home placement. The treatments include cognitive-behavioral approaches, behavior therapies, parent training, pragmatic family therapies, and pharmacological interventions that have a reasonable evidence base (Henggeler & Lee, 2003). MST is provided in the family's natural environment (e.g., home, school) with a typical length of 3 to 5 months. Families are usually in contact with the MST therapist more than once per week (in person or by phone), and therapists are always available to assist families.

Because there is considerable flexibility in the design and delivery of treatments within MST, MST is operationalized through adherence to nine core principles that guide treatment planning. These principles involve the following: (a) assessing how identified problems are maintained by the family's current social environment; (b) emphasizing the

positive aspects of family systems during treatment contacts; (c) focusing interventions on increasing responsible behavior and decreasing irresponsible behavior; (d) orienting interventions toward current, specific problems that can be easily tracked by family members; (e) designing interventions to target interaction sequences both within and across the systems that maintain target problems; (f) fostering developmentally appropriate competencies of youth within such systems as school, work environments, and peer groups; (g) designing intensive interventions that require continuing effort by the youth and family on a daily or weekly basis; (h) evaluating intervention plans and requiring treatment team accountability for positive outcomes; and (i) promoting generalization across time by teaching caregivers the skills to address problems across multiple contexts.

Two well-conducted studies with adolescents who committed criminal offenses found MST superior to control conditions, one showing superiority to usual community services and one showing superiority to alternative community treatments (see Table 1). Both studies were conducted by the same investigatory team. Therefore, this evidence-based approach to treatment meets criteria for a probably efficacious treatment for adolescents with disruptive behavior.

### **Parent-Child Interaction Therapy (PCIT; Brinkmeyer & Eyberg, 2003)**

PCIT is a parenting skills training program for young children (ages 2-7 years) with disruptive behavior disorders that targets change in parent-child interaction patterns. Families meet for weekly 1-hr sessions for an average of 12 to 16 sessions, during which parents learn two basic interaction patterns. In the child-directed interaction phase of treatment they learn specific positive attention skills (emphasizing behavioral descriptions, reflections, and labeled praises) and active ignoring skills, which they use in applying

differential social attention to positive and negative child behaviors during a play situation. The emphasis in this phase of treatment is on increasing positive parenting and warmth in the parent-child interaction as the foundation for discipline skills that are introduced in the second phase, the parent-directed interaction phase of treatment. In this second phase, and within the child-directed context, parents learn and practice giving clear instructions to their child when needed and following through with praise or time-out during in vivo discipline situations. Therapists coach the parents as they interact with their child during the treatment sessions, teaching them to apply the skills calmly and consistently in the clinic until they achieve competency and are ready to use the procedures on their own. Parent-directed interaction homework assignments proceed gradually from brief practice sessions during play to application at just those times when it is necessary for the child to obey.

In two well-conducted studies, PCIT has been found superior to waitlist control conditions in reducing disruptive behavior in young children (see Table 1). Although the studies were conducted by independent research teams, neither study compared the target treatment to an alternative treatment or placebo treatment condition. This evidence-based treatment therefore meets criteria as a probably efficacious treatment for 3- to 6-year-olds with disruptive behavior.

### **Parent Management Training Oregon Model (PMTO; Patterson, Reid, Jones, & Conger, 1975)**

PMTO is a behavioral parent training program that focuses on teaching parents basic behavioral principles for modifying child behavior, encouraging parents to monitor child behaviors, and assisting parents in developing and implementing behavior modification programs to improve targeted child behavior problems. In the well-conducted studies supportive of PMTO, therapists met individually with the parents of children between ages 3 and

12 years. Length of time in treatment typically varies according to the needs of the families and involves weekly treatment sessions and telephone contacts with parents. Patterson, Chamberlain, and Reid (1982) reported an average of 17 hr of therapist time to treat families participating in their treatment program. Bernal, Klinnert, and Schultz (1980) reported 10 one-hour sessions for each family plus twice-weekly telephone contacts. Two well-conducted studies have found PMTO superior to alternative treatment in reducing disruptive behavior (see Table 1). These two studies (Bernal et al., 1980; Patterson et al., 1982), conducted by independent research teams, provide evidence for designating PMTO a well-established treatment for children with disruptive behavior.

### **Positive Parenting Program (Triple P; Sanders, 1999)**

Triple P is a multilevel system of treatment, with five levels of intensity designed to match child and family needs based on problem severity. Level 1 (Universal Triple P) is a universal prevention program that distributes parenting information to the public via sources such as television and newspaper. Level 2 (Selected Triple P) is a brief, 1- or 2-session intervention delivered by primary health care providers for parents with concerns about one or two mild behavior problems. Level 3 (Primary Care Triple P) is a slightly more involved 4-session intervention, also delivered by primary health care providers, in which parents learn parenting skills to manage moderately difficult child behavior problems. Level 4 (Standard Triple P) is a parent training program for disruptive behavior that is delivered in up to 12 sessions by mental health providers in both group and individual formats as well as a self-directed format. Level 5 (Enhanced Triple P) is a behavioral family intervention delivered by mental health providers that targets family stressors such as parent depression or marital problems as well as disruptive child behavior. Both Standard Triple P Individual Treatment and Enhanced

Triple P meet criteria for probably efficacious treatments and are described next.

### **Triple P Standard Individual Treatment**

In individual Standard Triple P, parents are taught 17 core parenting skills (e.g., talking with children, physical affection, attention, setting limits, planned ignoring) designed to increase positive child behaviors and decrease negative child behaviors. Standard Triple P also includes planned activities training to increase generalization of treatment effects. Two well-conducted studies have found Triple P Standard Individual Treatment superior to wait-list control conditions in reducing disruptive behavior in preschool-age children (see Table 1).

### **Triple P Enhanced Treatment**

Enhanced Triple P is an intensive, individually tailored program (up to eleven 60- to 90-min sessions) for families with child behavior problems and family dysfunction. Program modules include home visits to enhance parenting skills, partner support skills, and mood management/stress coping skills. In two well-conducted studies by the same investigative team, Enhanced Triple P has been found superior to waitlist control conditions in reducing the disruptive behavior of 3- and 4-year-olds in dysfunctional families. Because these two studies were not conducted by independent investigatory teams and did not compare the target treatment to an alternative or placebo treatment, this evidence-based treatment meets criteria as a probably efficacious treatment for young children.

### **Problem-Solving Skills Training (PSST; Kazdin, 2003)**

PSST is a behavioral treatment designed for children ages 7 to 13 years with disruptive behavior. Treatment usually consists of 20 to 25 sessions (40-50 min each) conducted with the

child, with occasional parent contact. In PSST, children are taught problem-solving strategies and encouraged to generalize these strategies to real-life problems. Skills include identifying the problem, generating solutions, weighing pros and cons of each possible solution, making a decision, and evaluating the outcome. Therapists use in-session practice, modeling, role-playing, corrective feedback, social reinforcement, and token response cost to develop the problem-solving skills gradually, beginning with academic tasks and games and moving to more complex interpersonal situations through role-play. One research team found PSST superior to relationship therapy in two studies (Kazdin, Bass, Siegel, & Thomas, 1989; Kazdin, Esveldt-Dawson, French, & Unis, 1987b) and superior to contact controls (Kazdin et al., 1987b). This evidence-based treatment for school-age children with disruptive behavior meets criteria for a probably efficacious treatment (see Table 1).

### **PSST + Practice (Kazdin et al., 1989)**

This treatment adds to PSST an in vivo practice component in which children participate in therapeutically planned activities outside the session. These activities, called “supersolvers,” are homework assignments in which the child is assigned to practice the problem-solving steps learned in treatment during interactions with parents, siblings, teachers, or peers. The therapist and parent gradually decrease the amount of assistance they give the child in accomplishing these homework tasks, and they reward the child for successful task completion, with greater rewards for more complex supersolvers. One study has demonstrated the superiority of PSST + Practice to relationship therapy in decreasing child disruptive behavior, providing evidence for this combined intervention as a probably efficacious treatment.

### **PSST + Parent Management Training**

(PSST + PMT; Kazdin, Esveldt-Dawson, French, & Unis, 1987a; Kazdin, Seigel, & Bass, 1992)

This treatment adds to PSST the PMTO treatment described earlier (Patterson et al., 1975).

In PSST + PMT, Both the PSST component and the PMT component of this combined treatment are provided individually to children and parents rather than in group format, and the child and parent components occur concurrently. In the PMT component, parents meet for 13 to 16 individual parent-training sessions of approximately 1 1/2 to 2 hr each. The content of PSST and PMT is not overlapping, but parents and children are informed of what the other is learning. Thus, parents learn about the problem-solving steps and are encouraged to praise their child's use of the skills. Similarly, children are informed about what their parents are learning and attend selected PMT sessions that involve negotiating and contracting reinforcement contingencies. One well-conducted study found PSST + PMT superior to a contact placebo control condition for 7- to 12-year-old children hospitalized for antisocial behavior. This evidence-based combination treatment meets criteria for a probably efficacious treatment (see Table 1).

### **Rational-Emotive Mental Health Program** (REMH; Block, 1978)

This is a cognitive-behavioral school-based program for high-risk 11th and 12th graders with disruptive school behavior. The students meet for daily 45-min small-group sessions for 12 consecutive weeks. Adapted from rational-emotive education methods (Knaus, 1974), the group focus is on cognitive restructuring through the practice of adjustive rational appraisal, activity exercises, group-directed discussion, and psychological homework. Group leaders are highly active and directive in presenting themes for each session and use role-play exercises extensively to help students internalize and apply the concepts

presented. Emphasis is placed on teaching self-examination through self-questioning techniques. In one well-conducted study, REMH was found superior to human relations training in decreasing classroom disruptive behavior and class cutting. This evidence-based treatment meets criteria for a probably efficacious treatment (see Table 1).



# Evidence-Based Treatment for Children and Adolescents

<http://www.wjh.harvard.edu/>

## Conduct and Oppositional Problems

### Introduction

Conduct and oppositional problems are those that interfere with a child or adolescent's ability to learn, or to engage effectively in their environment. Such youth may engage in various behaviors deemed inappropriate, or which negatively impact their environment, such as stealing, arguing, lying, etc. These behaviors may also impede an adolescent's or child's ability to interact successfully in society and/or with peers. These problems may also seriously disrupt family life, and be a source of concern for parents. The two main types of disorders which cover several different problem behaviors, (i.e. aggression, lying, impulsivity, etc.), are listed below. Specific problem behaviors, such as aggression only, or disregard for rules, only, can also be addressed by many of the treatments discussed for oppositional and conduct problems.

### **Conduct/Oppositional Disorders**

**(with treatment options for each)**

Oppositional Defiant Disorder

Conduct Disorder

## D. PSYCHOTROPIC MEDICATIONS

This chart provides some brief information on psychotropic medications frequently prescribed for students. The medications are listed with respect to the diagnosis that leads to their prescription. For more information, see the *Physicians Desk Reference*.



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Diagnosis: Conduct Disorder – Medication Types and Treatment Effects  
(There continues to be controversy over whether medication is indicated for this diagnosis. However, because it is prescribed widely for such cases, it is included here.)

### A. *Anti-psychotics*

Used to treat severe behavioral problems in children marked by combativeness and/or explosive hyperexcitable behavior (out of proportion to immediate provocations). Also used in short-term treatment of children diagnosed with conduct disorders who show excessive motor activity impulsivity, difficulty sustaining attention, aggressiveness, mood lability and poor frustration tolerance.

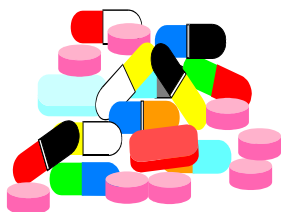
### B. *Anti-manic*

Used to reduce the frequency and intensity of manic episodes. Typical symptoms of mania include pressure of speech, motor hyperactivity, reduced need for sleep, flight of ideas, grandiosity, or poor judgement, aggressiveness, and possible hostility.

### C. *Beta-adenergic antagonists*

Although primarily used in controlling hypertension and cardiac problems, beta-adenergic antagonists such as propranolol hydrochloride are used to reduce somatic symptoms of anxiety such as palpitations, tremulousness, perspiration, and blushing. In some studies, propranolol is reported as reducing uncontrolled rage outbursts and/or aggressiveness among children and adolescents (Green, 1995).

\*Because many side effects are not predictable, all psychotropic medication requires careful, ongoing monitoring of psychological and physical conditions. Pulse, blood pressure, and signs of allergic reactions need to be monitored frequently, and when medication is taken for prolonged periods, periodic testing of hematological, renal, hepatic, and cardiac functions are essential. Prior to any other physical treatment (surgery, dentistry, etc.), it is important to inform physicians/dentists that psychotropic medication is being taken. Finally, common side effects of many medications are drowsiness/insomnia and related factors that can interfere with effective school performance.



Names: Generic (Commercial)	Some Side Effects and Related Considerations
<i>A. Anti-psychotics</i>	
thioridazine hydrochloride [Mellaril, Mellaril-S]	May manifest sedation, drowsiness, dizziness, fatigue, weight gain, blurred vision, rash, dermatitis, extrapyramidal syndrome (e.g. pseudo-Parkinson, Tardive dyskinesia, hyperactivity), respiratory distress, constipation, photosensitivity. Medication is to be taken with food or a full glass of water or milk. Care to avoid contact with skin because of the danger of contact dermatitis. Gradual discontinuation is recommended. Drowsiness can be reduced with decreased dosages. Youngster is to move slowly from sitting or lying down positions. Care must be taken to minimize exposure to strong sun.
chlorpromazine hydrochloride [Thorazine; Thor-Pram]	
haloperidol [Haldol]	May manifest insomnia, restlessness, fatigue, weight gain, dry mouth, constipation, extrapyramidal reactions (e.g., pseudo-Parkinson, Tardive dyskinesia, dystonia, muscle spasms in neck and back, trembling hands), blurred vision, photosensitivity, decreased sweating leading to overheating. menstrual irreg.  Avoid sun and overheating. Discontinue gradually.
<i>B. Anti-manic</i>	
lithium carbonate/citrate [Lithium, Lithane, Lithobid, Lithotabs, Lithonate, EskalithCibalith]	Safety and effectiveness have not been established for those under 15 years of age. May manifest tremor, drowsiness, dizziness, nausea, vomiting, fatigue, irritability, clumsiness, slurred speech, diarrhea, increased thirst, excessive weight gain, acne, rash. Serum levels must be monitored carefully because of therapeutic dose is close to toxic level. Care must be taken to maintain normal fluid and salt levels
propranolol hydrochloride [Inderal]	May manifest sleep disturbance, drowsiness, confusion, depression, light-headedness, nausea, vomiting, fatigue, dry mouth, heartburn, weight gain, leg fatigue. Administer before meals and bed. Avoid having extremities exposed to cold for long periods. Discontinue gradually over a two week period.



## Revisiting Medication for Kids

Psychiatrist Glen Pearson is president of the American society for Adolescent Psychiatry (ASAP). The following is republished with his permission from the society's newsletter.

It happens several times a week in my practice of community child and adolescent psychiatry: Our society's overwhelming belief in medically controlling our kids' behavior finds expression in ever more Huxleyesque demands on the psychiatrist to prescribe. This week's winners are the school district, the juvenile court, and a religious shelter for homeless families with children. Their respective would-be victims are LaShondra, Trevor, and Jimmy.

Jimmy is a 9 year old boy with a long history of treatment for severe emotional disturbance. He's in a school-based day treatment program and seems to be making terrific progress on self-managing his behavior. This turnaround has occurred just in the past few weeks, following an acute psychiatric hospital stay during which the many psychotropic medications he'd been taking without apparent benefit were tapered and discontinued. He was discharged to the day treatment facility and is receiving case management and therapeutic services at home in the community. Unfortunately, the grandmother with whom he lives has been evicted from her residence, and has applied for assistance to a homeless family program. She and Jimmy are scheduled to be admitted to a shelter program next week, but the shelter has made it a condition of receiving services that Jimmy be on medication.

LaShondra is 14. She is in special education classes at her junior high school because of mild mental retardation and emotional disturbance. She bears both physical and psychic scars of early prolonged abuse, and has symptoms of borderline personality pathology and PTSD. She likes school and wants to learn, but keeps getting expelled for behavioral outbursts. The school, too, has made it a condition of her readmittance to classes that she be on medication. LaShondra experiences psychotropic medication as inimical to her emerging adolescent autonomy, and has had negative therapeutic effects during past trials of treatment.

Trevor, at 15, is incarcerated in the Juvenile Detention Center, awaiting a hearing on certification to stand trial as an adult on two charges of capital murder. We have evaluated him for fitness to proceed and determined that he's not mentally ill, but are involved in providing services to Trevor in consultation with the juvenile authorities because he is persistently threatening suicide. We think the best plan is to keep him closely supervised in detention, but the juvenile department is concerned about their liability and petition the court to transfer him to a psychiatric hospital. Two hearings are held on the same day. At the first hearing Trevor is committed to a private facility, on condition that the facility accepts the admission. The facility refuses. At the second hearing, Trevor is committed to the state hospital on

condition that the hospital certifies that they can guarantee security. The hospital can't. The Court then orders that Trevor be involuntarily administered unspecified psychotropic agents by injection.

I am not making these things up. These three cases have so far occupied the last three days of my week, and I'm telling you about them not to garner sympathy for the kids (only two of whom have any sympathy coming in any case), or for me (despite my clearly deserving some), but to focus attention on the astonishing degree to which everyone in our society has come to believe in the prescribing of psychotropic medication as a cure, or at least a control, for disturbing behavior in kids. How did we arrive at this state of affairs? Though a very complex interaction among a myriad of scientific, social, and historical factors, of which I want to mention just two of the scientific ones: progress in psychiatric nosology, and progress in biological psychiatry.

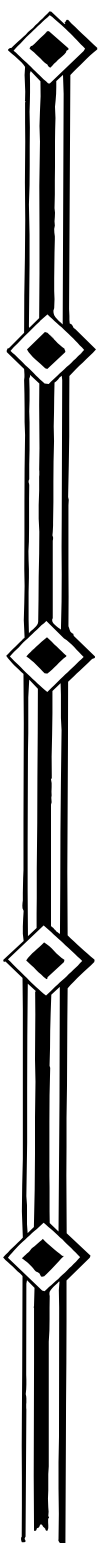
Since 1980, we've trained a generation or two of psychiatrists in the phenomenological approach to diagnosis. The last three editions of the DSM (III-R, and IV) are determinedly atheoretical and empirical in their approach (the majority of members of the Work Groups on Child and Adolescent Disorders for the last three DSM's have been pediatric psychopharmacology researchers), and I think we have long since abandoned trying to teach residents to think about the meanings of symptoms to patients (and ourselves), about the dynamics of intrapsychic structure and interpersonal process. During the same time, the explosive growth of neuroscience and pharmacology has given us many new tools with which to work (if only we knew

how: my friend and teacher Bob Beavers used to say, "if the only tool you have is a hammer, everything looks like a nail to you!").

In short, I think we've unwittingly relinquished our most powerful and proven tool: appropriately affectionate, professionally respectful, intimate personal engagement of the patient in mutual exploration of inner meanings. We're frittering our therapeutic potency away on serial trials of psychotropic drugs, and we're prescribing for patients when we don't know the person. There are too many kids on too many drugs, and many of the kids have been given medication as a substitute for engagement and exploration of personal issues.

The point I'm trying to make is that every sector of today's society contributes to this pressure to prescribe. Parents believe medication will cure, schools believe it, courts believe it, even nonpsychiatric mental health professionals believe it. Well, I don't believe it, and it's been my experience with ASAP that most of our members don't believe it either. And, if not only do we not believe that medicine cures, but also we do believe that we have a more powerful and effective treatment which provides an essential context for medication to be helpful, let's stand up and say so. I look forward to hearing from y'all: agree or disagree.





#### IV. A FEW RESOURCE AIDS

- A. An Example of One State's Disciplinary Programs
- B. Fact Sheets
- C. More Resources from our Center

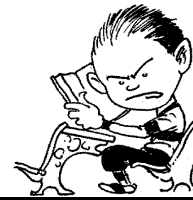


## A. An Example of One State's Disciplinary Programs

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Florida Department of Education  
Bureau of Family & Community Involvement

<http://www.fldoe.org/family/dropoutp/strategies.asp>



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**PROGRAM TITLE: BAKER COUNTY ALTERNATIVE SCHOOL**

523 West Minnesota Ave., Macclenny, FL 32063

Phone: (904) 259-1724 Fax: (904) 259-1728

**DISTRICT: BAKER**

The Baker County Alternative School provides an opportunity for 4th through 12th grade students to continue their education in an environment which best meets their needs while insuring the safety and welfare of the general student body. A "second chance" assignment in a highly structured counseling setting provides the incentive and guidance necessary to enable these students to avoid expulsion from school.

This center is designed to limit instances which seriously endanger the safety and security of school personnel and other students. It creates a more positive attitude toward education and the community in the student, increases the graduation rate, and decreases the dropout and non-promotion rate. The program also provides a "second chance" in lieu of expulsions for students who misbehave in other programs or have committed serious infractions of the Student Code of Conduct. The program aims to help students understand the serious consequences of their actions and the need to modify behavior to ensure success at school and in life.

The staff includes two fully certified teachers, one instructional assistant and an on-site administrator. The GED/HSCT Exit Option is available and the program offers performance-based and computer-assisted instruction.

**PROGRAM TITLE: HARRY SCHWETTMAN EDUCATION CENTER**

5520 Grand Boulevard, New Port Richey, Fl 34652

Phone: (727) 774-0000

**DISTRICT: PASCO** <http://sec.pasco.k12.fl.us>

Schwettman Education Center is a shining example of what's right with education. Looking for a positive way to impact an alternative education curriculum, a class was designed and implemented to teach the art of stained glass to disruptive students in grades 6 to 12. Schwettman Education Center created this innovative program with the purpose of teaching academic success and life skills through hands-on vocational training.

Since this program was unique to our county, it had to be built from the ground up. Schwettman staff developed a curriculum, designed and outfitted a glass studio, and sought school funds, as well as community endowments, to get the program established. After countless hours of planning and preparation, and the student-assisted renovation of a dilapidated building, Schwettman staff began teaching stained glass art to students.

In the beginning, classes were limited to one period each school day and held in an old, remodeled wood shop. Today, stained glass classes are scheduled for every class period and a new glass studio has replaced the old accommodations. After-school classes have been added for the convenience of community members and staff who have been inspired to learn the art of stained glass after observing their students' success.

Vocational classes in stained glass have been a powerful motivating force for students. These classes have helped many students change their view of education. They can see the value of learning a skill that merges academic substance with life skills training. The success of these stained glass classes have translated into personal success for students at Schwettman Education Center.

**PROGRAM TITLE: EXCEL MIDDLE AND HIGH SCHOOL ALTERNATIVE SCHOOL**

114 West 1st Street Sanford, FL 32771

Phone (407) 330-0880 Fax (407) 330-0886

**DISTRICT: SEMINOLE** <http://www.excelalternatives.com>

EXCEL is a one-of-a-kind, nontraditional educational program designed to meet the needs of the at-risk population in middle and secondary schools. EXCEL services are contracted through the School Board of Seminole County and have been providing services to expelled students since 1994.

EXCEL operates as a business. From the time a student arrives at EXCEL, the business simulation model begins. Students punch a timeclock and use a professional planner to maintain a schedule, uphold their professional skills, and balance a behavioral budget system. All new students are required to successfully complete EXCEL Business Training (which consists of specific behavioral skills training) to advance to placement in the traditional EXCEL programs.

All students are assigned to a team and Team Leader. The students begin and end each day with their Team Leader and participate in a Team Building Class with their assigned team to develop the "soft skills" needed for social and professional development. Each student is issued a portfolio to guide them through their daily performance while participating in the program. Students are required to participate in SCANS 2000 competencies to acquire the skills necessary to be successful in school and in the work force.

Upon successful completion of EXCEL, students return to the zoned school and are assigned a Professional Development Trainer from the EXCEL staff. Trainers make visits to zoned schools on a biweekly basis to continue to provide encouragement and support for students. In addition, trainers provide SCANS and School-To-Work workshops in all Seminole County Public Schools. Students in grades K-12 experience professional development training on an as-needed basis.

**PROGRAM TITLE: CYPRESS RUN EDUCATION CENTER**

2251 Northwest 18<sup>th</sup> Street, Pompano Beach, FL 33069

Phone: (754) 321-6500 Fax: (754) 321-6540

**DISTRICT: BROWARD** <http://web.mac.com/cypressdoc/iWeb/Site/Welcome.html>

Cypress Run Education Center is a disciplinary school that strives to provide quality education to students in grades 6 through 12 in a positive learning environment. Individualization, modifications, and support systems maximize opportunities for students' functional and successful transition into society.

Cypress Run utilizes a level system as a mechanism for student management and training. The behavior management level system is the means by which students learn responsibility and earn the privilege of returning to their home schools. The level system allows students to advance at their own rate while enrolled at the alternative site. The four-tiered system allows students to advance through a point earning process.

Full time mainstreaming back to a regular school program, vocational center, adult education program, and/or employment are goals that students may attain based on attitude, behavior, attendance, and academic achievement.



**PROGRAM TITLE: JACKSON ALTERNATIVE SCHOOL**

2701 Technology Circle, Marianna, FL 32448

Phone: (850) 482-9666 | Fax: (850) 482-9800

**DISTRICT: JACKSON**    <http://150.176.80.203/schools/JAS>

The Jackson Alternative School (JAS) is a cooperative venture of the Jackson County School Board, the district's schools that have grades six through twelve, and other appropriate agencies. The school serves a maximum of thirty students, ages 12 through 18, who are unable to function successfully in a regular school setting due to problems that include disruptive behavior, acting-out, assaultive behavior, substance abuse, possession of weapons on campus, truancy, or activities in or out of school that result in involvement with the criminal justice system. Students who have dropped out of school due to disciplinary problems or were unsuccessful in traditional schools are also retrieved. Based on the superintendent's recommendation and the school board's action, students who have committed expellable offenses may be given the option of attending ACE School in lieu of expulsion from other Jackson County Schools.

JAS provides an educational and behavioral program that uses individualized performance-based instruction geared to the specific abilities and needs of each student. Individual and/or group counseling is provided, as well as testing and assessment of each student where deemed appropriate.

The behavioral component of the JAS is designed to provide students with incentives that will facilitate their successful re-entry into a regular public school. The performance component includes computer instruction tailored to each student's academic level. Students in grades 9 through 12 are enrolled in performance-based instruction and are awarded credits toward a standard high school diploma. Students below grade 9, complete units that allow promotion to the next grade level. ACE also offers GED prep courses for interested students.

JAS was awarded a Title IV Community Service Grant Award. The grant project was entitled "A Joint Endeavor for Extreme Results" partnered JAS with the Florida Caverns State Park providing a unique opportunity for students, the park, and community. Working on various projects with park rangers, students are educated about the environment, ecosystems, and erosion. Students also have the opportunity to write about their experiences at the park, write research papers on the various topics of each project (based on the Florida Writes scoring rubric), and learn employability skills. Through out the projects the students will be given the opportunity to demonstrate skills they are learning and will be empowered to help direct the day-to-day operations of the project.

## B. FACT SHEETS



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## plain talk about...

# dealing with the **ANGRY CHILD**

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NATIONAL INSTITUTE OF MENTAL HEALTH • Division of Communications and Education • Plain Talk Series • Ruth Key, editor

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Handling children's anger can be puzzling, draining, and distressing for adults. In fact, one of the major problems in dealing with anger in children is the angry feelings that are often stirred up in us. It has been said that we as parents, teachers, counselors, and administrators need to remind ourselves that we were not always taught how to deal with anger as a fact of life during our own childhood. We were led to believe that to be angry was to be bad, and we were often made to feel guilty for expressing anger.

It will be easier to deal with children's anger if we get rid of this notion. Our goal is not to repress or destroy angry feelings in children—or in ourselves—but rather to accept the feelings and to help channel and direct them to constructive ends.

Parents and teachers must allow children to feel all their feelings. Adult skills can then be directed toward showing children acceptable ways of expressing their feelings. Strong feelings cannot be denied, and angry outbursts should not always be viewed as a sign of serious problems; they should be recognized and treated with respect.

To respond effectively to overly aggressive behavior in children we need to have some ideas about what may have triggered an outburst. Anger may be a defense to avoid painful feelings; it may be associated with failure, low self-esteem, and feelings of isolation; or it may be related to anxiety about situations over which the child has no control.

Angry defiance may also be associated with feelings of dependency, and anger may be associated with sadness and depression. In childhood, anger and sadness are very close to one another and it is important to remember that much of what an adult experiences as sadness is expressed by a child as anger.

Before we look at specific ways to manage aggressive and angry outbursts, several points should be highlighted:

- We should distinguish between anger and aggression. Anger is a temporary emotional state caused by frustration; aggression is often an attempt to hurt a person or to destroy property.

- Anger and aggression do not have to be dirty words. In other words, in looking at aggressive behavior in children, we must be careful to distinguish between behavior that indicates emotional problems and behavior that is normal.

In dealing with angry children, our actions should be motivated by the need to protect and to teach, not by a desire to punish. Parents and teachers should show a child that they accept his or her feelings, while suggesting other

ways to express the feelings. An adult might say, for example, "Let me tell you what some children would do in a situation like this . . ." It is not enough to tell children what behaviors we find unacceptable. We must teach them acceptable ways of coping. Also, ways must be found to communicate what we expect of them. Contrary to popular opinion, punishment is not the most effective way to communicate to children what we expect of them.

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### **Responding to the Angry Child**

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Some of the following suggestions for dealing with the angry child were taken from *The Aggressive Child* by Fritz Redl and David Wineman. They should be considered helpful ideas and not be seen as a "bag of tricks."

- **Catch the child being good. Tell the child what behaviors please you.** Respond to positive efforts and reinforce good behavior. An observing and sensitive parent will find countless opportunities during the day to make such comments as, "I like the way you come in for dinner without being reminded"; "I appreciate your hanging up your clothes even though you were in a hurry to get out to play"; "You were really patient while I was on the phone"; "I'm glad you shared your snack with your sister"; "I like the way you're able to think of others"; and "Thank you for telling the truth about what really happened."

Similarly, teachers can positively reinforce good behavior with statements like, "I know it was difficult for you to wait your turn, and I'm pleased that you could do it"; "Thanks for sitting in your seat quietly"; "You were thoughtful in offering to help Johnny with his spelling"; "You worked hard on that project, and I admire your effort."

- **Deliberately ignore inappropriate behavior that can be tolerated.** This doesn't mean that you should ignore the child, just the behavior. The "ignoring" has to be planned and consistent. Even though this behavior may be tolerated, the child must recognize that it is inappropriate.

- **Provide physical outlets and other alternatives.** It is important for children to have opportunities for physical exercise and movement, both at home and at school.

- **Manipulate the surroundings.** Aggressive behavior can be encouraged by placing children in tough, tempting situations. We should try to plan the surroundings so that certain things are less apt to happen. Stop a "problem" activity and substitute, temporarily, a more desirable one.

Sometimes rules and regulations, as well as physical space, may be too confining.

**Use closeness and touching.** Move physically closer to the child to curb his or her angry impulse. Young children are often calmed by having an adult nearby.

**Express interest in the child's activities.** Children naturally try to involve adults in what they are doing, and the adult is often annoyed at being bothered. Very young children (and children who are emotionally deprived) seem to need much more adult involvement in their interests. A child about to use a toy or tool in a destructive way is sometimes easily stopped by an adult who expresses interest in having it shown to him. An outburst from an older child struggling with a difficult reading selection can be prevented by a caring adult who moves near the child to say, "Show me which words are giving you trouble."

**Be ready to show affection.** Sometimes all that is needed can be tolerated for any angry child to regain control is a sudden hug or other impulsive show of affection. Children with serious emotional problems, however, may have trouble accepting affection.

**Ease tension through humor.** Kidding the child out of a temper tantrum or outburst offers the child an opportunity to "save face." However, it is important to distinguish between face-saving humor and sarcasm or teasing ridicule.

**Appeal directly to the child.** Tell him or her how you feel and ask for consideration. For example, a parent or a teacher may gain a child's cooperation by saying, "I know that noise you're making doesn't usually bother me, but today I've got a headache, so could you find something else you'd enjoy doing?"

**Explain situations.** Help the child understand the cause of a stressful situation. We often fail to realize how easily young children can begin to react properly once they understand the cause of their frustration.

**Use physical restraint.** Occasionally a child may lose control so completely that he has to be physically restrained or removed from the scene to prevent him from hurting himself or others. This may also "save face" for the child. Physical restraint or removal from the scene should not be viewed by the child as punishment but as a means of saying, "You can't do that." In such situations, an adult cannot afford to lose his or her temper, and unfriendly remarks by other children should not be tolerated.

**Encourage children to see their strengths as well as their weaknesses.** Help them to see that they can reach their goals.

**Use promises and rewards.** Promises of future pleasure can be used both to start and to stop behavior. This approach should not be compared with bribery. We must know what the child likes—what brings him pleasure—and we must deliver on our promises.

**Say "NO!"** Limits should be clearly explained and

enforced. Children should be free to function within those limits.

**Tell the child that you accept his or her angry feelings,** but offer other suggestions for expressing them. Teach children to put their angry feelings into words, rather than fists.

**Build a positive self-image.** Encourage children to see themselves as valued and valuable people.

**Use punishment cautiously.** There is a fine line between punishment that is hostile toward a child and punishment that is educational.

**Model appropriate behavior.** Parents and teachers should be aware of the powerful influence of their actions on a child's or group's behavior.

**Teach children to express themselves verbally.** Talking helps a child have control and thus reduces acting out behavior. Encourage the child to say, for example, "I don't like your taking my pencil. I don't feel like sharing just now."

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## The Role of Discipline

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Good discipline includes creating an atmosphere of quiet firmness, clarity, and conscientiousness, while using reasoning. Bad discipline involves punishment which is unduly harsh and inappropriate, and it is often associated with verbal ridicule and attacks on the child's integrity.

As one fourth grade teacher put it: "One of the most important goals we strive for as parents, educators, and mental health professionals is to help children develop respect for themselves and others." While arriving at this goal takes years of patient practice, it is a vital process in which parents, teachers, and all caring adults can play a crucial and exciting role. In order to accomplish this, we must see children as worthy human beings and be sincere in dealing with them.

Adapted from "The Aggressive Child" by Luleen S. Anderson, Ph.D., which appeared in *Children today* (Jan-Feb 1978) published by the Children's Bureau, ACYF, DHEW. (Reprinting permission unnecessary.)

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# Anger Control Problems

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**Background**—How do we define anger? **Anger is a social emotion**, involving some type of conflict between people (Bowers, 1987), and because it allows people to identify and resolve sources of conflict, it is considered to be a normal part of our social interactions. More specifically, Novaco (1985) defines anger as a stress response that has three response components: cognitive, physiological, and behavioral. The cognitive component is characterized by a person's perceptions and interpretations of a social situation. The physical component of anger may involve an increase in both adrenaline flow and muscle tension. Behaviorally, anger is frequently seen in tantrum behaviors, yelling, hitting, and kicking. Children with anger control problems fall into two different categories: (a) those with a behavioral excess (anger is too intense, too frequent, or both), or (b) those with a behavioral deficit (an inability to express anger). Because anger can serve as a constructive force in relationships, children who are unable to express their anger in ways that facilitate conflict resolution are considered to have anger problems (Bowers, 1987).

## **Development**—

Behavioral manifestations of anger change from flailing arms and kicking legs in infancy to temper tantrums at 18 months, and finally, to verbal expressions of anger as a child's language skills develop (Gesell, Ilg, Ames, & Bullis, 1977). Tantrums usually appear during the second year, reach a peak by age 3, and are decreasing by age 4 (Bowers, 1991). How anger is expressed is learned by watching, listening to, or interacting with others and varies across and within cultures (Bowers, 1987).

Because aggressive children are most often referred because of their behavior problems, the focus of the interventions offered below will deal with children who have excessive anger. Aggressive behavior, defined as the set of interpersonal actions that consist of verbal and physical behaviors that are destructive or injurious to others or to objects, is displayed by most children (Bandura, 1973; Lochman, 1984). Aggression poses a problem when it is exceptionally severe, frequent, and/or chronic (Lochman, White, & Wayland, 1991). Children who display a wide range of different kinds of aggressive, antisocial behavior, and who are highly antisocial in multiple settings are at greatest risk for aggression problems in

adulthood (Loeber & Schmalting, 1985), and for negative outcomes such as criminality, personality disorder, and substance abuse (Robins, 1978; Kandel, 1982; Lochman, 1990).

**Causes**—Feindler (1991) indicates that faulty perceptions, biases, beliefs, self-control deficits, and high states of emotional and physiological arousal contribute to the aggressive child's response to provocation. Aggressive youths generate fewer effective solutions and fewer potential consequences in hypothetical problem-solving situations (Asarnow & Callan, 1985), and display irrational, illogical, and distorted social information processing (Kendall, 1989).

## **What Should I Do as a Parent/Teacher?**—

The first step is to define and assess the situation. The following areas of investigation are suggested:

- 1) What is the severity of the problem (frequency, intensity, duration, pervasiveness)?
- (2) What factors may be causing the anger (e.g., academic frustration, grieving, illness,

abuse problems with peers, parental divorce)?

(3) What happens after the child/adolescent has an outburst?

(4) What skills and attitudes do the child, family, and school bring to the intervention process?

An observation of specific behaviors used by the child and his/her peer group in the setting in which the problem behavior occurs is an important component of the assessment process. This allows a direct comparison of the child's behavior with his/her peer group. Recording the frequency, duration, and intensity of anger outbursts can provide further information- in addition, it may be beneficial to record descriptions of: (a) how the anger is manifested (e.g., hitting, yelling, threatening), (b) the setting in which the behavior occurs (e.g., time of day, location, type of activity), and (c) the events that occur before (stressors that provoke anger) and after the anger outburst (the consequences). Finally, normative measures (Feindler & Fremouw, 1983), interviews (students, parents, and teachers), and an examination of self-monitoring and self-evaluation data (Feindler & Fremouw, 1983) often provide valuable information to the person(s) investigating the situation.

Once the problem has been defined, the following approaches are recommended:

(1) Try to keep your composure; it is important to appear approachable, empathetic, calm, and understanding (Bowers, 1987);

(2) Try to model the appropriate use of anger in situations where anger can be used to facilitate conflict resolution;

(3) Praise children when they are not angry (Bowers, 1987);

(4) Suggest that the explosive child temporarily leave the room to regain composure (Bowers, 1987);

(5) if further treatment is necessary, the following interventions have been suggested by Bower (1987):

(a) Stress-inoculation training, a procedure that allows the child/adolescent to acquire coping skills, including adaptive self-statements and relaxation. This three step process involves cognitive preparation, skills acquisition, and applied practice.

(b) Behavior modification strategies such as response cost, mediated essay, behavioral contracting, and direct reinforcement of alternative behavior (DRA) are often useful with nonverbal or noncompliant children; and

(c) Social skills training, which systematically teaches and reinforces behaviors that enhance social competence, can reduce the child's/adolescent's need to rely on anger for problem resolution.

Feindler (1991) suggests that there are five basic components of anger control training: "(1) arousal reduction, (2) cognitive change, (3) behavioral skills development, (4) moral reasoning development, and (5) appropriate anger expression." Feindler also suggests that there are a number of strategies that can be used to enhance the maintenance and generalization of anger control training techniques. For example, Feindler and her colleagues (i.e., Feindler, Marriott, & Iwata, 1984) have recommended the use of **group anger control training programs** over **individual anger control training programs**. They suggest that the role-played scenarios of conflict and the provocation that occur in the group training experience are more like the "real world" experiences that occur when the therapy session is over. **Incorporating strategies to enhance self-management (self-observation, self-recording, self-reinforcement, and self-punishment) and self-efficacy** (belief that the treatment will be effective and that the child can actually implement the skills) also seem to be imperative. In addition, the **use of contingency management** (e.g., cues in the **environment, goal-setting intervention, and homework**

assignments), and the inclusion of additional change agents (e.g., staff members, parents, church youth groups, peer trainers, self-help groups) are believed to increase the effectiveness of the training.

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# Behavioral Disorders: Focus on Change

ERIC Digest

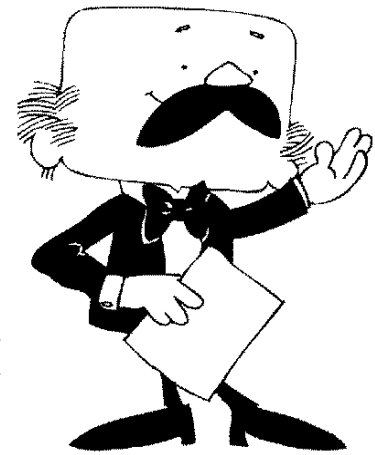
## **FOCUS ON BEHAVIORS THAT NEED TO BE CHANGED**

Students who are referred to as having "conduct disorders" and students who are referred to as having "emotional disabilities," "behavioral disorders," "serious emotional disturbances," or "emotional and behavioral disorders" have two common elements that are instructionally relevant: (1) they demonstrate behavior that is noticeably different from that expected in school or the community and (2) they are in need of remediation.

In each instance, the student is exhibiting some form of behavior that is judged to be different from that which is expected in the classroom. The best way to approach a student with a "conduct disorder" and a student with a "behavioral disorder" is to operationally define exactly what it is that each student does that is discrepant with the expected standard. Once it has been expressed in terms of behaviors that can be directly observed, the task of remediation becomes clearer. A student's verbally abusive behavior can be addressed, whereas it is difficult to directly identify or remediate a student's "conduct disorder," since that term may refer to a variety of behaviors of widely different magnitudes. The most effective and efficient approach is to pinpoint the specific behavioral problem and apply data-based instruction to remediate it. (Lewis, Heflin, & DiGangi, 1991, p.9)

## **IDENTIFY NEW BEHAVIORS TO BE DEVELOPED**

Two questions need to be addressed in developing any behavior change procedure regardless of the student's current behavioral difficulty: "What do I want the student to do instead?" and "What is the most effective and efficient means to help the student reach his or her goals?" Regardless of whether the student is withdrawn or aggressive, the objective is to exhibit a response instead of the current behavior. We may want the student to play with peers on the playground instead of playing alone. We may want the student to play appropriately with peers on the



playground instead of hitting peers during games. For both behavior patterns, we have identified what we want them to do

instead of the current problem behavior. (Lewis, Heflin, & DiGangi, 1991, p.14)

Using effective teaching strategies will promote student academic and social behavioral success. Teachers should avoid focusing on students' inappropriate behavior and, instead, focus on desirable replacement behaviors. Focusing behavior management systems on positive, prosocial replacement responses will provide students with the opportunity to practice and be reinforced for appropriate behaviors. Above all else, have fun with students! Humor in the classroom lets students view school and learning as fun. Humor can also be used to avoid escalating behaviors by removing the negative focus from the problem. (Lewis, Heflin, & DiGangi, 1991, p.26).

## **PROVIDE OPPORTUNITIES TO PRACTICE NEW BEHAVIORS**

If we expect students to learn appropriate social skills we must structure the learning environment so that these skills can be addressed and practiced. We need to increase the opportunity for students to interact within the school environment so that prosocial skills can be learned. If all a student does is perform as a passive participant in the classroom, then little growth in social skill acquisition can be expected. Just as students improve in reading when they are given the opportunity to read, they get better at interacting when given the opportunity to initiate or respond to others' interactions.

It is necessary to target specific prosocial behaviors for appropriate instruction and assessment to occur. Prosocial behavior includes such things as:



- Taking turns, working with partner, following directions.
- Working in group or with others.
- Displaying appropriate behavior toward peers and adults.
- Increasing positive relationships.
- Demonstrating positive verbal and nonverbal relationships.
- Showing interest and caring.
- Settling conflicts without fighting.
- Displaying appropriate affect. (Algozzine, Ruhl, & Ramsey, 1991, pp. 22-23)

### **TREAT SOCIAL SKILLS DEFICITS AS ERRORS IN LEARNING**

Social skills deficits or problems can be viewed as errors in learning; therefore, the appropriate skills need to be taught directly and actively. It is important to base all social skill instructional decisions on individual student needs. In developing a social skill curriculum it is important to follow a systematic behavior change plan.

During assessment of a student's present level of functioning, two factors should be addressed. First, the teacher must determine whether the social skill problem is due to a skill deficit or a performance deficit. The teacher can test the student by directly asking what he or she would do or can have the student role play responses in several social situations (e.g., "A peer on the bus calls you a name. What should you do?").

- If the student can give the correct response but does not display the behavior outside the testing situation, the social skill problem is probably due to a performance deficit.
- If the student cannot produce the socially correct response, the social skill problem may be due to a skill deficit.

More direct instruction may be required to overcome the skill deficits, while a performance deficit may simply require increasing positive contingencies to

increase the rate of displaying the appropriate social response. During assessment, it is important to identify critical skill areas in which the student is having problems.

Once assessment is complete, the student should be provided with direct social skill instruction. At this point, the teacher has the option of using a prepared social skill curriculum or developing one independently. It is important to remember that since no single published curriculum will meet the needs of all students, it should be supplemented with teacher-developed or teacher-modified lessons.

Social skill lessons are best implemented in groups of 3 to 5 students and optimally should include socially competent peers to serve as models. The first social skill group lesson should focus on three things:

- (1) an explanation of why the group is meeting,
- (2) a definition of what social skills are, and
- (3) an explanation of what is expected of each student during the group. It may also be helpful to implement behavior management procedures for the group (i.e., contingencies for compliance and non-compliance).

It is important to prompt the students to use newly learned skills throughout the day and across settings to promote maintenance and generalization. It is also important to reinforce the students when they use new skills. (Lewis, Heflin, & DiGangi, 1991, pp.17-18)

### **TEACH STUDENTS TO TAKE RESPONSIBILITY FOR THEIR OWN LEARNING**

Often overlooked is the need to increase student independence in learning. Students with BD may be particularly uninvolved in their learning due to problems with self-concept, lack of a feeling of belonging to the school, and repeated failures in school. Instructional strategies involving self-control, self-reinforcement, self-monitoring, self-management, problem solving, cognitive behavior modification, and metacognitive skills focus primarily on teaching students the skills necessary for taking responsibility and showing initiative in making decisions regarding their own instruction. These strategies, typically used in combination or in a "package format" that incorporates extrinsic

reinforcement, have shown promise for enhancing student learning and independence. (Gable, Laycock, Maroney, & Smith, 1991, p.24)

### **FOCUS ON FUNCTIONAL SKILLS THAT WILL HAVE BROAD APPLICATIONS**

Essential in a curriculum for students with behavioral problems are skills that can directly improve the ultimate functioning of the student and the quality of his or her life. The concept of functional skills is not limited to the areas of self-help or community mobility, but also include skills such as those required to seek and access assistance, be life-long independent learners, respond to changes in the environment, succeed in employment, be adequately functioning adults and parents, and achieve satisfying and productive lives. The concepts of the functional curriculum approach, the criterion of ultimate functioning, and participation to the highest degree possible in life must be extended to students with BD, many of whom will otherwise fail to fulfill their potential. (Gable, Laycock, Maroney, & Smith, 1991, p.28)

This digest was developed from selected portions of three 1991 ERIC publications listed below. These books are part of a nine-book series, "Working with Behavioral Disorders." Stock No. P346.

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## Bullying: Facts for Schools and Parents

[http://www.naspcenter.org/factsheets/bullying\\_fs.html](http://www.naspcenter.org/factsheets/bullying_fs.html)

**By Andrea Cohn & Andrea Canter, Ph.D., NCSP  
National Association of School Psychologists**

Bullying is a widespread problem in our schools and communities. The behavior encompasses physical aggression, threats, teasing, and harassment. Although it can lead to violence, bullying typically is not categorized with more serious forms of school violence involving weapons, vandalism, or physical harm. It is, however, an unacceptable anti-social behavior that is *learned* through influences in the environment,

A **bully** is someone who directs physical, verbal, or psychological aggression or harassment toward others, with the goal of gaining power over or dominating another individual. Research indicates that bullying is more prevalent in boys than girls, though this difference decreases when considering indirect aggression (such as verbal threats).

A **victim** is someone who repeatedly is exposed to aggression from peers in the form of physical attacks, verbal assaults, or psychological abuse. Victims are more likely to be boys and to be physically weaker than peers. They generally do not have many, if any, good friends and may display poor social skills and academic difficulties in school

### Facts About Bullying

- Bullying is the most common form of violence in our society; between 15% and 30% of students are bullies or victims.
- A recent report from the American Medical Association on a study of over 15,000 6th-10th graders estimates that approximately 3.7 million youths engage in, and more than 3.2 million are victims of, moderate or serious bullying each year.

- Between 1994 and 1999, there were 253 violent deaths in school, 51 casualties were the result of multiple death events. Bullying is often a factor in school related deaths.
- Membership in either bully or victim groups is associated with school drop out, poor psychosocial adjustment, criminal activity and other negative long-term consequences.
- Direct, physical bullying increases in elementary school, peaks in middle school and declines in high school. Verbal abuse, on the other hand, remains constant. The U.S. Department of Justice reports that younger students are more likely to be bullied than older students.
- Over two-thirds of students believe that schools respond poorly to bullying, with a high percentage of students believing that adult help is infrequent and ineffective.
- 25% of teachers see nothing wrong with bullying or putdowns and consequently intervene in only 4% of bullying incidents.

### Why Do Some Children and Adolescents Become Bullies?

Most bullying behavior develops in response to multiple factors in the environment—at home, school and within the peer group. There is no one cause of bullying. Common contributing factors include:

- *Family factors:* The frequency and severity of bullying is related to the amount of adult supervision that children receive—bullying behavior is reinforced when it has no or inconsistent consequences. Additionally, children who observe parents and siblings exhibiting bullying behavior, or who are themselves victims, are likely to develop bullying behaviors. When

children receive negative messages or physical punishment at home, they tend to develop negative self concepts and expectations, and may therefore attack before they are attacked—bullying others gives them a sense of power and importance.

- *School factors:* Because school personnel often ignore bullying, children can be reinforced for intimidating others. Bullying also thrives in an environment where students are more likely to receive negative feedback and negative attention than in a positive school climate that fosters respect and sets high standards for interpersonal behavior.
- *Peer group factors:* Children may interact in a school or neighborhood peer group that advocates, supports, or promotes bullying behavior. Some children may bully peers in an effort to “fit in,” even though they may be uncomfortable with the behavior.

### **Why Do Some Children and Adolescents Become Victims?**

- Victims signal to others that they are insecure, primarily passive and will not retaliate if they are attacked. Consequently, bullies often target children who complain, appear physically or emotionally weak and seek attention from peers.
- Studies show that victims have a higher prevalence of overprotective parents or school personnel; as a result, they often fail to develop their own coping skills.
- Many victims long for approval; even after being rejected, some continue to make ineffective attempts to interact with the victimizer.

### **How Can Bullying Lead to Violence?**

- Bullies have a lack of respect for others’ basic human rights; they are more likely to resort to violence to solve problems without worry of the potential implications.
- Both bullies and victims show higher rates of fighting than their peers.
- Recent school shootings show how victims’ frustration with bullying can turn into vengeful violence.

### **What Can Schools Do?**

Today, schools typically respond to bullying, or other school violence, with reactive measures. However, installing metal detectors or surveillance cameras or

hiring police to patrol the halls have no tangible positive results. Policies of “Zero Tolerance” (severe consequence for any behavior defined as dangerous such as bullying or carrying a weapon) rely on exclusionary measures (suspension, expulsion) that have long-term negative effects.

Instead, researchers advocate school-wide prevention programs that promote a positive school and community climate. Existing programs can effectively reduce the occurrence of bullying; in fact, one program decreased peer victimization by 50%. Such programs require the participation and commitment of students, parents, educators and members of the community. Effective school programs include:

- *Early intervention.* Researchers advocate intervening in elementary or middle school, or as early as preschool. Group and building-wide social skills training is highly recommended, as well as counseling and systematic aggression interventions for students exhibiting bullying and victim behaviors. School psychologists and other mental health personnel are particularly well-trained to provide such training as well as assistance in selecting and evaluating prevention programs.
- *Parent training.* Parents must learn to reinforce their children’s positive behavior patterns and model appropriate interpersonal interactions. School psychologists, social workers and counselors can help parents support children who tend to become victims as well as recognize bullying behaviors that require intervention.
- *Teacher training.* Training can help teachers identify and respond to potentially damaging victimization as well as to implement positive feedback and modeling to address appropriate social interactions. Support services personnel working with administrators can help design effective teacher training modules.
- *Attitude change.* Researchers maintain that society must cease defending bullying behavior as part of growing up or with the attitude of “kids will be kids.” Bullying can be stopped! School personnel should never ignore bullying behaviors.
- *Positive school environment.* Schools with easily understood rules of conduct, smaller class sizes and fair discipline practices report less violence. A positive school climate will reduce bullying and victimization.

## What Can Parents Do?

- **Contact** the school's psychologist, counselor or social worker and ask for help around bullying or victimization concerns. Become involved in school programs to counteract bullying.
- **Provide positive feedback** to children for appropriate social behaviors and model interactions that do not include bullying or aggression.
- **Use alternatives to physical punishment**, such as the removal of privileges, as a consequence for bullying behavior.
- **Stop bullying behavior** as it is happening and begin working on appropriate social skills early.

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Safe and Responsive Schools Project  
[www.indiana.edu/~safeschl/](http://www.indiana.edu/~safeschl/)

Safe Schools/Healthy Students Action Center  
<http://www.cdc.gov/HealthyYouth/>

National Resource Center for Safe Schools  
<http://www.safetyzone.org/>

*This article was developed from a number of resources including the chapter by George Batsche.*

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## BULLYING

Bullying is a common experience for many children and adolescents. Surveys indicate that as many as half of all children are bullied at some time during their school years, and at least 10% are bullied on a regular basis.

Bullying behavior can be physical or verbal. Boys tend to use physical intimidation or threats, regardless of the gender of their victims. Bullying by girls is more often verbal, usually with another girl as the target. Recently, bullying has even been reported in online chat rooms and through e-mail.

Children who are bullied experience real suffering that can interfere with their social and emotional development, as well as their school performance. Some victims of bullying have even attempted suicide rather than continue to endure such harassment and punishment.

Children and adolescents who bully thrive on controlling or dominating others. They have often been the victims of physical abuse or bullying themselves. Bullies may also be depressed, angry or upset about events at school or at home. Children targeted by bullies also tend to fit a particular profile. Bullies often choose children who are passive, easily intimidated, or have few friends. Victims may also be smaller or younger, and have a harder time defending themselves.

If you suspect your child is bullying others, it's important to seek help for him or her as soon as possible. Without intervention, bullying can lead to serious academic, social, emotional and legal difficulties. Talk to your child's pediatrician, teacher, principal, school counselor, or family physician. If the bullying continues, a comprehensive evaluation by a child and adolescent psychiatrist or other mental health professional should be arranged. The evaluation can help you and your child understand what is causing the bullying, and help you develop a plan to stop the destructive behavior.

If you suspect your child may be the victim of bullying ask him or her to tell you what's going on. You can help by providing lots of opportunities to talk with you in an open and honest way.

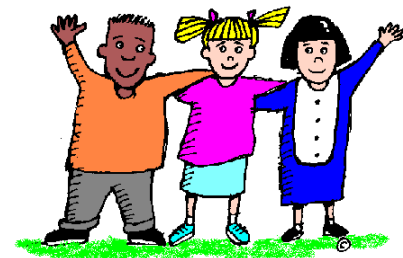
It's also important to respond in a positive and accepting manner. Let your child know it's not his or her fault, and that he or she did the right thing by telling you. Other specific suggestions include the following:

- Ask your child what he or she thinks should be done. What's already been tried? What worked and what didn't?
- Seek help from your child's teacher or the school guidance counselor. Most bullying occurs on playgrounds, in lunchrooms, and bathrooms, on school buses or in unsupervised halls. Ask the school administrators to find out about programs other schools and communities have used to help combat

bullying, such as peer mediation, conflict resolution, and anger management training, and increased adult supervision.

- Don't encourage your child to fight back. Instead, suggest that he or she try walking away to avoid the bully, or that they seek help from a teacher, coach, or other adult.
- Help your child practice what to say to the bully so he or she will be prepared the next time.
- Help your child practice being assertive. The simple act of insisting that the bully leave him alone may have a surprising effect. Explain to your child that the bully's true goal is to get a response.
- Encourage your child to be with friends when traveling back and forth from school, during shopping trips, or on other outings. Bullies are less likely to pick on a child in a group.

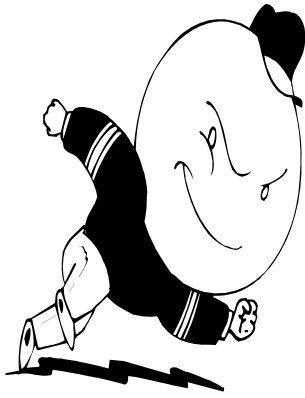
If your child becomes withdrawn, depressed or reluctant to go to school, or if you see a decline in school performance, additional consultation or intervention may be required. A child and adolescent psychiatrist or other mental health professional can help your child and family and the school develop a strategy to deal with the bullying. Seeking professional assistance earlier can lessen the risk of lasting emotional consequences for your child.



Facts for Families Fact sheets are available online at [http://www.aacap.org/cs/roots/facts\\_for\\_families/fact\\_for\\_families](http://www.aacap.org/cs/roots/facts_for_families/fact_for_families) (AACAP, Special Friends of Children Fund, P.O. Box 96106, Washington, D.C. 20090)

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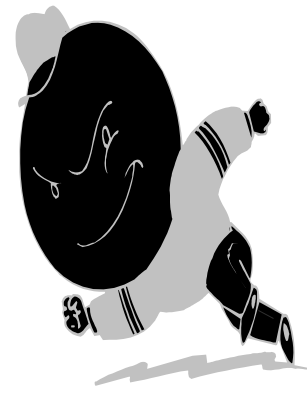
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# Bullying in Schools

by Ron Banks

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**B**ullying in schools is a worldwide problem that can have negative consequences for the general school climate and for the right of students to learn in a safe environment without fear. Bullying can also have negative lifelong consequences--both for students who bully and for their victims. Although much of the formal research on bullying has taken place in the Scandinavian countries, Great Britain, and Japan, the problems associated with bullying have been noted and discussed wherever formal schooling environments exist.

Bullying is comprised of direct behaviors such as teasing, taunting, threatening, hitting, and stealing that are initiated by one or more students against a victim. In addition to direct attacks, bullying may also be more indirect by causing a student to be socially isolated through intentional exclusion. While boys typically engage in direct bullying methods, girls who bully are more apt to utilize these more subtle indirect strategies, such as spreading rumors and enforcing social isolation (Ahmad & Smith, 1994; Smith & Sharp, 1994). Whether the bullying is direct or indirect, the key component of bullying is that the physical or psychological intimidation occurs repeatedly over time to create an ongoing pattern of harassment and abuse (Batsche & Knoff, 1994; Olweus, 1993).

## EXTENT OF THE PROBLEM

**V**arious reports and studies have established that approximately 15% of students are either bullied regularly or are initiators of bullying behavior (Olweus, 1993). Direct bullying seems to increase through the elementary years, peak in the middle school/junior high school years, and decline during

the high school years. However, while direct physical assault seems to decrease with age, verbal abuse appears to remain constant. School size, racial composition, and school setting (rural, suburban, or urban) do not seem to be distinguishing factors in predicting the occurrence of bullying. Finally, boys engage in bullying behavior and are victims of bullies more frequently than girls (Batsche & Knoff, 1994; Nolin, Davies, & Chandler, 1995; Olweus, 1993; Whitney & Smith, 1993).

## CHARACTERISTICS OF BULLIES AND VICTIMS

**S**tudents who engage in bullying behaviors seem to have a need to feel powerful and in control. They appear to derive satisfaction from inflicting injury and suffering on others, seem to have little empathy for their victims, and often defend their actions by saying that their victims provoked them in some way. Studies indicate that bullies often come from homes where physical punishment is used, where the children are taught to strike back physically as a way to handle problems, and where parental involvement and warmth are frequently lacking. Students who regularly display bullying behaviors are generally defiant or oppositional toward adults, antisocial, and apt to break school rules. In contrast to prevailing myths, bullies appear to have little anxiety and to possess strong self-esteem. There is little evidence to support the contention that they victimize others because they feel bad about themselves (Batsche & Knoff, 1994; Olweus, 1993).

Students who are victims of bullying are typically anxious, insecure, cautious, and suffer from low self-esteem, rarely defending themselves or retaliating when confronted by students who bully

them. They may lack social skills and friends, and they are often socially isolated. Victims tend to be close to their parents and may have parents who can be described as overprotective. The major defining physical characteristic of victims is that they tend to be physically weaker than their peers--other physical characteristics such as weight, dress, or wearing eyeglasses do not appear to be significant factors that can be correlated with victimization (Batsche & Knoff, 1994; Olweus, 1993).

## CONSEQUENCES OF BULLYING

As established by studies in Scandinavian countries, a strong correlation appears to exist between bullying other students during the school years and experiencing legal or criminal troubles as adults. In one study, 60% of those characterized as bullies in grades 6-9 had at least one criminal conviction by age 24 (Olweus, 1993). Chronic bullies seem to maintain their behaviors into adulthood, negatively influencing their ability to develop and maintain positive relationships (Oliver, Hoover, & Hazler, 1994).

Victims often fear school and consider school to be an unsafe and unhappy place. As many as 7% of America's eighth-graders stay home at least once a month because of bullies. The act of being bullied tends to increase some students' isolation because their peers do not want to lose status by associating with them or because they do not want to increase the risks of being bullied themselves. Being bullied leads to depression and low self-esteem, problems that can carry into adulthood (Olweus, 1993; Batsche & Knoff, 1994).

## PERCEPTIONS OF BULLYING

Oliver, Hoover, and Hazler (1994) surveyed students in the Midwest and found that a clear majority felt that victims were at least partially responsible for bringing the bullying on themselves. Students surveyed tended to agree that bullying toughened a weak person, and some felt that bullying "taught" victims appropriate behavior. Charach, Pepler, and Ziegler (1995) found that students considered victims to be "weak," "nerds," and "afraid to fight back." However, 43% of the students in this study said that they try to help the victim, 33% said that they should help but do not, and only 24% said that bullying was none of their business.

Parents are often unaware of the bullying problem and talk about it with their children only to a limited extent (Olweus, 1993). Student surveys reveal that a low percentage of students seem to believe that adults will help. Students feel that adult intervention is infrequent and ineffective, and that telling adults will only bring more harassment from bullies. Students report that teachers seldom or never talk to their classes about bullying (Charach, Pepler, & Ziegler, 1995). School personnel may view bullying as a harmless rite of passage that is best ignored unless verbal and psychological intimidation crosses the line into physical assault or theft.

## INTERVENTION PROGRAMS

Bullying is a problem that occurs in the social environment as a whole. The bullies' aggression occurs in social contexts in which teachers and parents are generally unaware of the extent of the problem and other children are either reluctant to get involved or simply do not know how to help (Charach, Pepler, & Ziegler, 1995). Given this situation, effective interventions must involve the entire school community rather than focus on the perpetrators and victims alone. Smith and Sharp (1994) emphasize the need to develop whole-school bullying policies, implement curricular measures, improve the schoolground environment, and empower students through conflict resolution, peer counseling, and assertiveness training. Olweus (1993) details an approach that involves interventions at the school, class, and individual levels. It includes the following components:

- An initial questionnaire can be distributed to students and adults. The questionnaire helps both adults and students become aware of the extent of the problem, helps to justify intervention efforts, and serves as a benchmark to measure the impact of improvements in school climate once other intervention components are in place.
- A parental awareness campaign can be conducted during parent-teacher conference days, through parent newsletters, and at PTA meetings. The goal is to increase parental awareness of the problem, point out the importance of parental involvement for program success, and encourage parental support of program goals. Questionnaire results are publicized.



- Teachers can work with students at the class level to develop class rules against bullying. Many programs engage students in a series of formal role-playing exercises and related assignments that can teach those students directly involved in bullying alternative methods of interaction. These programs can also show other students how they can assist victims and how everyone can work together to create a school climate where bullying is not tolerated (Sjostrom & Stein, 1996).
- Other components of anti-bullying programs include individualized interventions with the bullies and victims, the implementation of cooperative learning activities to reduce social isolation, and increasing adult supervision at key times (e.g., recess or lunch). Schools that have implemented Olweus's program have reported a 50% reduction in bullying.

## CONCLUSION

**B**ullying is a serious problem that can dramatically affect the ability of students to progress academically and socially. A comprehensive intervention plan that involves all students, parents, and school staff is required to ensure that all students can learn in a safe and fear-free environment.

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Excerpts from

# BULLYING: PEER ABUSE IN SCHOOLS

U.S. Department of Education

Every day in our Nation's schools, children are threatened, teased, taunted and tormented by schoolyard bullies. For some children, bullying is a fact of life that they are told to accept as a part of growing up. Those who fail to recognize and stop bullying practices as they occur actually promote violence, sending the message to children that might indeed makes right.

Bullying often leads to greater and prolonged violence. Not only does it harm its intended victims, but it also negatively affects the climate of schools and the opportunities for all students to learn and achieve in school.

## What Is Bullying?

Bullying among children is commonly defined as intentional, repeated hurtful acts, words or other behavior, such as name-calling, threatening and/or shunning committed by one or more children against another. These negative acts are not intentionally provoked by the victims, and for such acts to be defined as bullying, an imbalance in real or perceived power must exist between the bully and the victim.

Bullying may be physical, verbal, emotional or sexual in nature. For example:

- **Physical bullying** includes punching, poking, strangling, hair pulling, beating, biting and excessive tickling.
- **Verbal bullying** includes such acts as hurtful name calling, teasing and gossip.
- **Emotional bullying** includes rejecting, terrorizing, extorting, defaming, humiliating, blackmailing, rating/ranking of personal characteristics such as race, disability, ethnicity, or perceived sexual orientation, manipulating friendships, isolating, ostracizing and peer pressure.
- **Sexual bullying** includes many of the actions listed above as well as exhibitionism, voyeurism, sexual propositioning, sexual harassment and abuse involving actual physical contact and sexual assault.

Bullying among schoolchildren is quite common in the United States. In a study of junior high and high school students from small Midwestern towns, 88 percent of

students reported having observed bullying, and 76.8 percent indicated that they had been a victim of bullying at school. Of the nearly 77 percent who had been victimized, 14 percent indicated that they experienced severe reactions to the abuse.

A study of 6,500 fourth- to sixth-graders in the rural South indicated that during the three months preceding the survey, one in four students had been bullied with some regularity and that one in 10 had been bullied at least once a week. In the same survey, approximately one in five children admitted that they had bullied another child with some regularity during the three months preceding the survey.

Bullying also occurs under names. Various forms of hazing—including "initiation rites" perpetrated against new students or new members on a sports team—are nothing more than bullying. Same-gender and cross-gender sexual harassment in many cases also qualifies as bullying.

## Who Is Hurt?

Bullying and harassment often interfere with learning. Acts of bullying usually occur away from the eyes of teachers or other responsible adults. Consequently, if perpetrators go unpunished, a climate of fear envelops the victims.

Victims can suffer far more than actual physical harm:

- Grades may suffer because attention is drawn away from learning.
- Fear may lead to absenteeism, truancy or dropping out.
- Victims may lose or fail to develop self-esteem, experience feelings of isolation and may become withdrawn and depressed.
- As students and later as adults, victims may be hesitant to take social, intellectual, emotional or vocational risks.
- If the problem persists, victims occasionally feel compelled to take drastic measures, such as vengeance in the form of fighting back, weapon-carrying or even suicide.

- Victims are more likely than non-victims to grow up being socially anxious and insecure, displaying more symptoms of depression than those who were not victimized as children.

Bystanders and peers of victims can be distracted from earning as well. They may:

- Be afraid to associate with the victim for fear of lowering their own status or of retribution from the bully and becoming victims themselves;
- fear reporting bullying incidents because they do not want to be called a "snitch," a "tattler" or an "informer";
- experience feelings of guilt or helplessness for not standing up to the bully on behalf of their classmate;
- be drawn into bullying behavior by group pressure;
- feel unsafe, unable to take action or a loss of control.

Bullies themselves are also at risk for long-term negative outcomes. In one study, elementary students who perpetrated acts of bullying attended school less frequently and were more likely to drop out of school than other students. Several studies suggest that bullying in early childhood may be an early sign of the development of violent tendencies, delinquency and criminality.

### **A Comprehensive Approach:**

Bullying and the harm that it causes are seriously underestimated by many children and adults. Educators, parents and children concerned with violence prevention must also be concerned with the phenomenon of bullying and its link to other violent behaviors.

Research and experience suggest that comprehensive efforts that involve teachers and other school staff, students, parents and community members are likely to be more effective than purely classroom-based approaches. Identified by the Center for the Study and Prevention of Violence as one of 10 model violence prevention programs is that of Norwegian researcher Dan Olweus. The U.S. application of his comprehensive model program included the following core elements.

#### *School-level interventions*

- Administration of a student questionnaire to determine the nature and extent of bullying problems at school.
- Formation of a bullying prevention coordination committee (a small group of energetic teachers, administrators, counselors and other school staff, who plan and monitor the school's activities).
- Teacher in-service days to review findings from the questionnaire, discuss problems of bullying, and plan the school's violence prevention efforts.
- School wide events to launch the program (e.g., via school television or assemblies).

- Increased supervision in areas that are hot spots for bullying and violence at the school.
- Development of school wide rules and sanctions against bullying.
- Development of a system to reinforce prosocial behavior (e.g., "Caught you Caring" initiatives).
- Parent involvement in school activities (e.g., highlighting the program at PTA meetings, school open houses, and special violence prevention programs; encouraging parents' participation in planning activities and school events).

#### *Classroom Activities*

- Regularly scheduled classroom meetings during which students and teachers engage in discussion, role-playing and artistic activities related to preventing bullying and other forms of violence among students.

#### *Individual Interventions*

- Immediate intervention by school staff in all bullying incidents.
- Involvement of parents of bullies and victims of bullying, where appropriate.
- Formation of "friendship groups" or other supports for students who are victims of bullying.
- Involvement of school counselors or mental health professionals, where appropriate.

#### *Community Activities*

- Efforts to make the program known among a wide range of residents in the local community (e.g., convening meetings with leaders of the community to discuss the school's program and problems associated with bullying, encouraging local media coverage of the school's efforts, engaging student in efforts to discuss their school's program with informal leaders of the community).
- Involvement of community members in the school's anti-bullying activities (e.g., soliciting assistance from local business to support aspects of the program, involving community members in school district wide "Bully-Free Day" events).
- Engaging community members, students, and school personnel in anti-bullying efforts within the community (e.g., introducing core program elements into summer church school classes).

Clearly, there is no "silver bullet" for preventing bullying other forms of violence at school. A comprehensive approach, such as this one, shows the most promise in helping to create a safe school environment that will help children to grow academically and socially. Before implementing any efforts to address bullying or other violence at school, school administrators should keep in

5mind that:

- Ideally, efforts should begin early—as children transition into kindergarten—and continue throughout a child's formal education;
- Effective programs require strong leadership and ongoing commitment on the part of school personnel;
- Ongoing staff development and training are important to sustain programs;
- Programs should be culturally sensitive to student diversity issues and developmentally appropriate; and
- Parental and community involvement in the planning and execution of such programs is critical.

Following are suggested action steps, strategies and resources that school administrators, educators, students and parents can employ in an effort to stop bullying in schools.

### **Action Steps for School Administrators**

- Assess the awareness and the scope of the bullying problem at your school through student and staff surveys
- Closely supervise children on the playgrounds and in classrooms, hallways, rest rooms, cafeterias and other areas where bullying occurs in your school.
- Conduct school wide assemblies and teacher/staff in service training to raise awareness regarding the problem of bullying and to communicate a zero tolerance for such behavior.
- Post and publicize clear behavior standards, including rules against bullying, for all students. Consistently and fairly enforce such standards.
- Encourage parent participation by establishing on campus parents' centers that recruit, coordinate and encourage parents to take part in the educational process and in volunteering to assist in school activities and projects.
- Establish a confidential reporting system that allows children to report victimization and that records the details of bullying incidents.
- Ensure that your school has all legally required policies and grievance procedures for sexual discrimination. Make these procedures known to parents and students.
- Receive and listen receptively to parents who report bullying. Establish procedures whereby such reports are investigated and resolved expeditiously at the school level in order to avoid perpetuating bullying.
- Develop strategies to reward students for positive, inclusive behavior.
- Provide school wide and classroom activities that are designed to build self-esteem by spotlighting special talents, hobbies, interests and abilities of all students and that foster mutual understanding of and appreciation for differences in others.

### **Strategies for Classroom Teachers**

- Provide students with opportunities to talk about bullying and enlist their support in defining bullying as unacceptable behavior.
- Involve students in establishing classroom rules against bullying. Such rules may include a commitment from the teacher to not "look the other way" when incidents involving bullying occur.
- Provide classroom activities and discussions related to bullying and violence, including the harm that they cause and strategies to reduce them.
- Develop a classroom action plan to ensure that students know what to do when they observe a bully/victim confrontation.
- Teach cooperation by assigning projects that require collaboration. Such cooperation teaches students how to compromise and how to assert without demanding. Take care to vary grouping of participants and to monitor the treatment of participants in each group.
- Take immediate action when bullying is observed. All teachers and school staff must let children know that they care and will not allow anyone to be mistreated. By taking immediate action and dealing directly with the bully, adults support both the victim and the witnesses.
- Confront bullies in private. Challenging a bully in front of his/her peers may actually enhance his/her status and lead to further aggression.
- Notify the parents of both victims and bullies when a confrontation occurs, and seek to resolve the problem expeditiously at school.
- Refer both victims and aggressors to counseling whenever appropriate.
- Provide protection for bullying victims, whenever necessary. Such protection may include creating a buddy system whereby students have a particular friend or older buddy on whom they can depend and with whom they share class schedule information and plans for the school day.
- Listen receptively to parents who report bullying and investigate reported circumstances so that immediate and appropriate school action may be taken.
- Avoid attempts to mediate a bullying situation. The difference in power between victims and bullies may cause victims to feel further victimized by the process or believe that they are somehow at fault.

### **Strategies for Students**

Students may not know what to do when they observe a classmate being bullied or experience such victimization themselves. Classroom discussions and activities may help students develop a variety of appropriate actions that they can take when they witness or experience such victimization. For instance, depending on the situation and their own level of comfort, students can:

- seek immediate help from an adult;
- report bullying/victimization incidents to school personnel;
- speak up and/or offer support to the victim when they see him/her being bullied—for example, picking up the victim's books and handing them to him or her;
- privately support those being hurt with words of kindness or condolence;
- express disapproval of bullying behavior by not joining in the laughter, teasing or spreading of rumors or gossip; and
- attempt to defuse problem situations either singlehandedly or in a group—for example, by taking the bully aside and asking him/her to "cool it."

### Strategies for Parents

The best protection parents can offer their children who are involved in a bully/victim conflict is to foster their child's confidence and independence and to be willing to take action when needed. The following suggestions are offered to help parents identify appropriate responses to conflict experienced by their children at school:

- Be careful not to convey to a child who is being victimized that something is wrong with him/her or that he/she deserves such treatment. When a child is subjected to abuse from his or her peers, it is not fair to fault the child's social skills. Respect is a basic right: All children are entitled to courteous and respectful treatment. Convince your child that he or she is not at fault and that the bully's behavior is the source of the problem.
- It is appropriate to call the school if your child is involved in a conflict as either a victim or a bully. Work collaboratively with school personnel to address the problem. Keep records of incidents so that you can be specific in your discussion with school personnel about your child's experiences at school.
- You may wish to arrange a conference with a teacher, principal or counselor. School personnel may be able to offer some practical advice to help you and your child. They may also be able to intervene directly with each of the participants. School personnel may have observed the conflict firsthand and may be able to corroborate your child's version of the incident, making it harder for the bully or the bully's parents to deny its authenticity.
- While it is often important to talk with the bully or his/her parents, be careful in your approach. Speaking directly to the bully may signal to the bully that your child is a weakling. Speaking with the parents of a bully may not accomplish anything since lack of parental involvement in the child's life is a typical characteristic of parents of bullies. Parents of bullies may also fail to see anything wrong with bullying, equating it to "standing up for oneself."

- Offer support to your child but do not encourage dependence on you. Rescuing your child from challenges or assuming responsibility yourself when things are not going well does not teach your child independence. The more choices a child has to make, the more he or she develops independence, and independence can contribute to self-confidence.
- Do not encourage your child to be aggressive or to strike back. Chances are that it is not his or her nature to do so. Rather, teach your child to be assertive. A bully often is looking for an indication that his/her threats and intimidation are working. Tears or passive acceptance only reinforces the bully's behavior. A child who does not respond as the bully desires is not likely to be chosen as a victim. For example, children can be taught to respond to aggression with humor and assertions rather than acquiescence.
- Be patient. Conflict between children more than likely will not be resolved overnight. Be prepared to spend time with your child, encouraging your child to develop new interests or strengthen existing talents and skills that will help develop and improve his/her self esteem. Also help your child to develop new or bolster existing friendships. Friends often serve as buffers to bullying.
- If the problem persists or escalates, you may need to seek an attorney's help or contact local law enforcement officials. Bullying or acts of bullying should not be tolerated in the school or the community. Students should not have to tolerate bullying at school any more than adults would tolerate such situations at work.

### Classroom Resources

Both bullies and their victims need help in learning new ways to get along in school. Children need to learn about training, using and abusing power and about the differences between negotiating and demanding. They must also learn to consider the needs, behaviors and feelings of others. Curriculum developers and publishers now offer a variety of prevention/intervention materials to eliminate bullying and other forms of personal conflict from school life. Curricula such as those listed below are examples of tools that may be used as *part* of a comprehensive approach to bullying:

- *No Bullying*. This Johnson Institute curriculum, first implemented during the 1996-97 school year in schools across the country, describes the tell-or-tattle dilemma facing many victims of bullying. Teachers are given step-by-step guidelines on how to teach students the difference between telling and tattling. Teachers are also shown how to establish and use immediate consequences when dealing with bullies.
- *Bullyproof: A Teacher's Guide on Teasing and Bullying for Use with Fourth and Fifth Grade Students*. This guide

by Lisa Sjoström and Nan Stein contains 11 sequential lessons designed to help children understand the difference between teasing and bullying and to gain awareness about bullying and harassment through class discussions, role-play and writing, reading and art exercises.

- *Bully-Proofing Your School*. This program, available from Sopris West, uses a comprehensive approach. Key elements include conflict resolution training for all staff members, social skills building for victims, positive leadership skills training for bullies, intervention techniques for those who neither bully nor are bullied and the development of parental supporter
- *Quit it! A Teacher's Guide on Teasing and Bullying*. This guide by Merle Frosche, Barbara Sprung, and Nancy Mullin-Rindler with Nan Stein contains 10 lesson plans. Each lesson is divided into activities geared to the developmental needs of students in kindergarten through third grade. Class discussions, role plays, creative drawing and writing activities, physical games and exercises and connections to children's literature give children a vocabulary and a conceptual framework that allows them to understand the distinction between teasing and bullying.
- *Second Step*. The Committee for Children's Second Step curriculum teaches positive social skills to children and families, including skill building in empathy, impulse control, problem solving and anger management. Initial evaluations of *Second Step* indicate that second and third grade students engaged in more prosocial behavior and decreased physically aggressive behavior after participating in the program.<sup>6</sup>
- "Bullying." This video and accompanying teacher's guide (produced by South Carolina's Educational Television in collaboration with the Institute for Families in Society at the University of South Carolina) contains five lesson plans that incorporate classroom discussions, role playing and artistic exercises. It is appropriate for older elementary and middle-school students.

In the effort to make schools and communities safer, educators, parents and concerned citizens are encouraged to support school wide programs that address bullying. As part of this school wide effort, adults—including bus drivers, playground supervisors, hall monitors, security officers, cafeteria workers, maintenance personnel, clerical staff, teachers, parent volunteers, counselors and administrators—must present a united front that communicates to all students that bullying will not be tolerated at school.

### **Innovative Approaches to Bully Prevention**

School-based bullying prevention programs across the United States vary a great deal in their target populations, their comprehensiveness and the specific approaches they take. When considering use of a given curriculum or

program to eliminate bullying, request from the publisher evaluation data and names of persons to contact for information about the effectiveness of the program, its procedures and materials.

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Facts for Families Fact sheets are available online at  
<http://www.aacap.org/page/ww?section=Facts+for+Families&name=Facts+for+Families>  
or contact (AACAP, Special Friends of Children Fund, P.O. Box 96106, Washington, D.C. 20090).

## CONDUCT DISORDERS

"Conduct disorders" are a complicated group of behavioral and emotional problems in youngsters. Children and adolescents with these disorders have great difficulty following rules and behaving in a socially acceptable way. They are often viewed by other children, adults and social agencies as "bad" or delinquent, rather than mentally ill.

Children or adolescents with conduct problems may exhibit some of the following behaviors:

### **Aggression to people and animals**

- bullies, threatens or intimidates others
- often initiates physical fights
- has used a weapon that could cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife or gun)
- is physically cruel to people or animals
- steals from a victim while confronting them (e.g. assault)
- forces someone into sexual activity

### **Destruction of Property**

- deliberately engages in fire setting with the intention to cause damage deliberately
- deliberately destroys other's property

### **Deceitfulness, lying, or stealing**

- has broken into someone else's building, house, or car
- lies to obtain goods, or favors or to avoid obligations
- steals items without confronting a victim (e.g. shoplifting, but without breaking and entering)

### **Serious violations of rules**

- often stays out at night despite parental objections
- runs away from home
- often truant from school

Children who exhibit these behaviors should receive a comprehensive evaluation. Many children with a conduct disorder may have coexisting conditions such as mood disorders, anxiety, PTSD, substance abuse, ADHD, learning problems, or thought disorders which can also be treated. Research shows that youngsters with conduct disorder are likely to have ongoing problems if they and their families do not receive early and comprehensive treatment. Without treatment, many youngsters with conduct disorders are unable to adapt to the demands of adulthood and continue

to have problems with relationships and holding a job. They often break laws or behave in an antisocial manner.

Many factors may contribute to a child developing conduct disorders, including brain damage, child abuse, genetic vulnerability, school failure and traumatic life experiences.

Treatment of children with conduct disorder can be complex and challenging. Treatment can be provided in a variety of different settings depending on the severity of the behaviors. Adding to the challenge of treatment are the child's uncooperative attitude, fear and distrust of adults. In developing a comprehensive treatment plan, a child and adolescent psychiatrist may use information from the child, family, teachers, and other medical specialties to understand the causes of the disorder.

Behavior therapy and psychotherapy are usually necessary to help the child appropriately express and control anger. Special education may be needed for youngsters with learning disabilities. Parents often need expert assistance in devising and carrying out special management and educational programs in the home and at school. Treatment may also include medication in some youngsters, such as those with difficulty paying attention and controlling movement or those with depression.

Treatment is rarely brief since establishing new attitudes and behavior patterns takes time. However, early treatment offers a child a better chance for considerable improvement and hope for a more successful future.

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# *FACT SHEET:* *CONDUCT DISORDER*



## ***Definition***

Conduct Disorder is a persistent pattern of behavior in which a child or adolescent ignores the basic rights of others and breaks major norms or rules of society.

## ***Symptoms***

Symptoms may include stealing; running away; lying; fire-setting; truancy; breaking and entering; destruction of property; physical cruelty to animals or people; forcing sexual activity on others; using weapons in fights; frequent physical fights; drug or alcohol abuse; cheating in games and/or at school; manipulating or taking advantage of others; verbally or physically bullying; intimidating or threatening others; frequent outbursts; impairment in social, school or occupational functioning; staying out late at night despite parental prohibition (under age 13); or disobeying rules.

## ***Cause***

The cause of conduct disorder is unknown at this time. The following are some of the theories:

- It may be related to the child's temperament and the family's response to that temperament.
- It may be inherited in some families.
- There may be physical causes.
- It may be caused by a chemical imbalance in the brain.

## ***Course***

The course of Conduct Disorder is variable. Mild forms tend to improve over time. More severe forms (those that require hospitalization or day hospital treatment) are more likely to be prolonged. Without treatment, the severe forms can lead to illegal or criminal activity and can be

complicated by drug abuse or dependence; school suspension; sexually transmitted diseases; unwanted pregnancy; or high rates of physical injury from accidents, imprisonment, fights and suicidal behaviors. With treatment, reasonable social and work adjustment can be made in adulthood.

## ***Treatment***

Treatment of Conduct Disorder often consists of group, individual and/or family therapy and education about the disorder; structure; support; limit-setting; discipline; consistent rules; identification with healthy role models; social skills training; behavior modification; remedial education (when needed); and sometimes residential or day treatment or medicine.

## ***Self-Management***

- Attend therapy sessions.
- Use time-outs.
- Identify what increases anxiety.
- Talk about feelings instead of acting on them.
- Find and use ways to calm yourself.
- Frequently remind yourself of your goals.
- Get involved in tasks and activities that direct your energy.
- Learn communication skills.
- Develop a predictable daily schedule of activity.
- Develop ways to get pleasure that do not interfere with the rights of others.
- Learn social skills.
- Establish mutually acceptable limits of behavior and consistently reinforce those limits.

### ***Dealing with Relapse***

When symptoms return, you are said to be having a relapse. During a period of good adjustment, the patient, his family and the therapist should make a plan for what steps to take if signs of relapse appear. The plan should include what specific symptoms are important warning signs that immediate steps must be taken to prevent relapse. An agreement should be made to call the therapist at once when those specific symptoms occur, and at the same time to notify friends and other people who can help. Concrete ways to limit stress and stimulation and to provide structure should be planned in advance.

### **Resources**

There are several good books about Conduct Disorder and its treatment:

Russell Barkley. Defiant Children, second edition. Guilford Press, 1997.

Rex Forehand and Nicholas Long. Parenting the Strong-Willed Child. NTC Publishing Group, 1996.

Ross W. Greene. The Explosive Child. Harper Collins, 1998.

Robert L. Hendren (editor). "Disruptive Behavior Disorders in Children and Adolescents." In Review of Psychiatry, vol. 18, American Psychiatric Press, 1999.

Harold Koplewicz. It's Nobody's Fault: New Hope and Help for Difficult Children and Their Parents. Random House, 1997.

Carol W Peschel et. al., (editors). Neurobiological Disorders in Children and Adolescents. Jossey-Bass, 1992.

The following organizations can provide help, information and support:

### **American Academy of Child and Adolescent Psychiatry**

A professional organization that provides many publications for the layperson. Call 202-966-7300 or reach them online at [www.aacap.org](http://www.aacap.org)

### **Family Self-Help Group for Parents of Children and Adolescents.**

Sponsored by the National Alliance for the Mentally Ill (NAMI). Offers support, information and advice for parents of children with psychiatric disorders. To see if there is a group in your area, call NAMI at 1-800-950-NAMI or reach them online at [www.nami.org](http://www.nami.org).

### **Family Ties.**

A self-help group for parents of children with psychiatric or behavior problems. Call your local self-help clearinghouse for information about meetings near you, or call the National Self-Help Clearinghouse at 1-212-817-1822. Not available in all areas.

### **Toughlove**

Provides mutual support for parents whose children are having trouble. A self-help group. You can find their number in your local telephone book, or reach them online at [www.toughlove.com](http://www.toughlove.com)

For information or referral, call 1-888-694-5700

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## Children's Mental Health Facts

### Children and Adolescents with Conduct Disorder

#### What is conduct disorder?

Children with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely when symptoms continue for 6 months or longer. Conduct disorder is known as a "disruptive behavior disorder" because of its impact on children and their families, neighbors, and schools.

Another disruptive behavior disorder, called oppositional defiant disorder, may be a precursor of conduct disorder. A child is diagnosed with oppositional defiant disorder when he or she shows signs of being hostile and defiant for at least 6 months. Oppositional defiant disorder may start as early as the preschool years, while conduct disorder generally appears when children are older. Oppositional defiant disorder and conduct disorder are not co-occurring conditions.

#### What are the signs of conduct disorder?

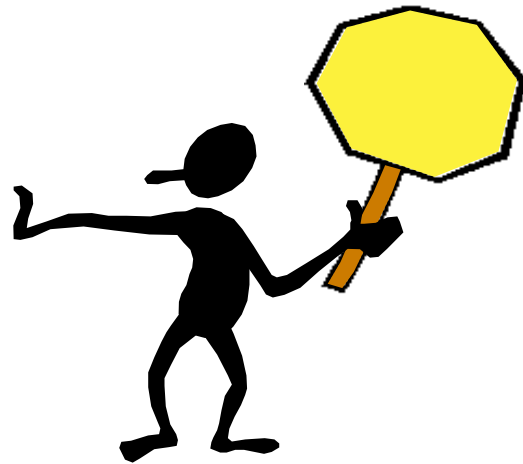
Symptoms of conduct disorder include:

- Aggressive behavior that harms or threatens other people or animals;
- Destructive behavior that damages or destroys property;
- Lying or theft;
- Truancy or other serious violations of rules;
- Early tobacco, alcohol, and substance use and abuse; and
- Precocious sexual activity.

Children with conduct disorder or oppositional defiant disorder also may experience:

- Higher rates of depression, suicidal thoughts, suicide attempts, and suicide;
- Academic difficulties;
- Poor relationships with peers or adults;
- Sexually transmitted diseases;

- Difficulty staying in adoptive, foster, or group homes; and
- Higher rates of injuries, school expulsions, and problems with the law.



#### Who is at risk for conduct disorder?

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

- Early maternal rejection;
- Separation from parents, without an adequate alternative caregiver;
- Early institutionalization;
- Family neglect;
- Abuse or violence;
- Parental mental illness;
- Parental marital discord;
- Large family size;
- Crowding; and
- Poverty.

### **How common is conduct disorder?**

Conduct disorder affects 1 to 4 percent of 9- to 17-year-olds, depending on exactly how the disorder is defined (U.S. Department of Health and Human Services, 1999). The disorder appears to be more common in boys than in girls and more common in cities than in rural areas.

### **What help is available for families?**

Although conduct disorder is one of the most difficult behavior disorders to treat, young people often benefit from a range of services that include:

- Training for parents on how to handle child or adolescent behavior.
- Family therapy.
- Training in problem solving skills for children or adolescents.
- Community-based services that focus on the young person within the context of family and community influences.

### **What can parents do?**

Some child and adolescent behaviors are hard to change after they have become ingrained. Therefore, the earlier the conduct disorder is identified and treated, the better the chance for success. Most children or adolescents with conduct disorder are probably reacting to events and situations in their lives. Some recent studies have focused on promising ways to prevent conduct disorder among at-risk children and adolescents.

In addition, more research is needed to determine if biology is a factor in conduct disorder. Parents or other caregivers who notice signs of conduct disorder or oppositional defiant disorder in a child or adolescent should:

- Pay careful attention to the signs, try to understand the underlying reasons, and then try to improve the situation.
- If necessary, talk with a mental health or social services professional, such as a teacher, counselor, psychiatrist, or psychologist specializing in childhood and adolescent disorders.
- Get accurate information from libraries, hotlines, or other sources.
- Talk to other families in their communities.
- Find family network organizations.

People who are not satisfied with the mental health services they receive should discuss their concerns with their provider, ask for more information, and/or seek help from other sources.

### **Important Messages about Children's and Adolescents' Mental Health:**

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.

For free publications, references, and referrals to local and national resources and organizations, call 1 -800-789-2647 or visit [www.mentalhealth.samhsa.gov/child](http://www.mentalhealth.samhsa.gov/child).

### **Endnotes**

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# Research and Training Center ON FAMILY SUPPORT & CHILDREN'S MENTAL HEALTH

<http://www.rtc.pdx.edu/>

## CONDUCT DISORDER

### DESCRIPTION / SYMPTOMS/ DIAGNOSIS

Conduct disorder is a persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms or rules are violated. The behaviors must occur over time, not just be isolated antisocial acts. Symptoms begin during childhood or adolescence.

Conduct disorders may be mild, moderate or severe in nature. Mild forms tend to dissipate as a child matures, but more severe forms are often chronic. Conduct disorders appear in many settings, including the home, the school, with peers, and in the community. Children with conduct disorders are often physically aggressive and cruel to other people and animals. They may set fires, steal, mug, or snatch purses. In later adolescence, they may commit more serious crimes such as rape, assault, or armed robbery. These children typically lie and cheat in games and in schoolwork are often truant and may run away from home. Children with conduct disorders often show no concern for the feelings of others and fail to show remorse or guilt for harm they have inflicted.

A child is labeled conduct disordered if he or she meets specific behavioral criteria. These children project an image of toughness, but usually have low self-esteem. They often have other difficulties as well, such as depression, low problem-solving skills, learning disorders, and problems with substance abuse. A large number of these children are also diagnosed as having attention-deficit/hyperactivity disorder.

### CAUSATION/INCIDENCE

There are various factors that may predispose children and youth to the development of conduct disorders. Most believe that it is a complex interaction of numerous biological, interpersonal, and environmental factors. Developmental disorders and mental retardation we commonly found in conjunction with conduct disorders. Social stressors often include difficulties in the home, a parental history of alcohol dependence, and economic factors. The disorder can begin before puberty. Childhood onset is more commonly seen in boys and adolescent onset is seen more commonly in girls. Approximately 9 percent of boys and 2 percent of girls under age 18 are thought to have the disorder in the United States, conduct disorders are becoming more common for both sexes and are being seen in younger children. Conduct disorders that are severe enough to result in arrests have been increasing in recent years.

### TREATMENT

Just as there are many potential factors which predispose a youngster to the development of conduct disorder, there are also many forms of treatment. Some are directed toward the child (individual therapy, behavioral therapy, training in problem solving), the family (parent management training, family therapy), the peer group (group therapy), and community-based interventions (recreation and youth centers). At present, none of these forms of treatment have had more than limited success. Behavior modification and group counseling

have had limited success during treatment, but there is no evidence that they provide long term benefits. Among the family therapies, only functional family therapy (FFT), an integrative approach based on behavioral techniques presented in a family systems context, has had positive outcomes. A goal of FFT is to improve the communication and support of the family. It also appears that a combination of parent management training (PMT) and problem-solving skills training for children has medium range positive effects on behavior.

### ROLE OF FAMILY/IMPACT ON FAMILY

Life with a child who has a serious emotional disorder may be associated with a number of troubling and conflicting feelings: love, anger, anxiety, grief, guilt, fear, and depression. These feelings are not unusual; most parents find it is helpful to share these feelings with someone else--family, friends, a support group, or some other informal group. Parents need to realize the scope and limitations of their responsibility and learn to take care of themselves as well as their child. Professional help in the form of individual, couples, or family counseling may be helpful in providing emotional support, guidance, and help in the child's recovery.

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## CHILDREN WITH OPPOSITIONAL DEFIANT DISORDER

All children are oppositional from time to time, particularly when tired, hungry, stressed or upset. They may argue, talk back, disobey, and defy parents, teachers, and other adults. Oppositional behavior is often a normal part of development for two to three year olds and early adolescents. However, openly uncooperative and hostile behavior becomes a serious concern when it is so frequent and consistent that it stands out when compared with other children of the same age and developmental level and when it affects the child's social, family, and academic life.

In children with Oppositional Defiant Disorder (ODD), there is an ongoing pattern of uncooperative, defiant, and hostile behavior toward authority figures that seriously interferes with the youngster's day to day functioning. Symptoms of ODD may include:

- frequent temper tantrums
- excessive arguing with adults
- active defiance and refusal to comply with adult requests and rules
- deliberate attempts to annoy or upset people
- blaming others for his or her mistakes or misbehavior
- often being touchy or easily annoyed by others
- frequent anger and resentment
- mean and hateful talking when upset
- seeking revenge

The symptoms are usually seen in multiple settings, but may be more noticeable at home or at school. Five to fifteen percent of all school-age

children have ODD. The causes of ODD are unknown, but many parents report that their child with ODD was more rigid and demanding than the child's siblings from an early age. Biological and environmental factors may have a role.

A child presenting with ODD symptoms should have a comprehensive evaluation. It is important to look for other disorders which may be present; such as, attention-deficit hyperactive disorder (ADHD), learning disabilities, mood disorders (depression, bipolar disorder) and anxiety disorders. It may be difficult to improve the symptoms of ODD without treating the coexisting disorder. Some children with ODD may go on to develop called conduct disorder.

Treatment of ODD may include: Parent Training Programs to help manage the child's behavior, Individual Psychotherapy to develop more effective anger management, Family Psychotherapy to improve communication, Cognitive-Behavioral Therapy to assist problem solving and decrease negativity, and Social Skills Training to increase flexibility and improve frustration tolerance with peers.

A child with ODD can be very difficult for parents. These parents need support and understanding. Parents can help their child with ODD in the following ways:

- Always build on the positives, give the child praise and positive reinforcement when he shows flexibility or cooperation.
- Take a time-out or break if you are about to



make the conflict with your child worse, not better. This is good modeling for your child. Support your child if he decides to take a time-out to prevent overreacting.

- Pick your battles. Since the child with ODD has trouble avoiding power struggles, prioritize the things you want your child to do. If you give your child a time-out in his room for misbehavior, don't add time for arguing. Say "your time will start when you go to your room."
- Set up reasonable, age appropriate limits with consequences that can be enforced consistently.
- Maintain interests other than your child with

ODD, so that managing your child doesn't take all your time and energy. Try to work with and obtain support from the other adults (teachers, coaches, and spouse) dealing with your child.

- Manage your own stress with exercise and relaxation. Use respite care as needed.

Many children with ODD will respond to the positive parenting techniques. Parents may ask their pediatrician or family physician to refer them to a child and adolescent psychiatrist, who can diagnose and treat ODD and any coexisting psychiatric condition.

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## **FACT SHEET:** **OPPOSITIONAL DEFIANT DISORDER**

### **Definition**

Oppositional Defiant Disorder is a persistent pattern (lasting for at least six months) of negativistic, hostile, disobedient, and defiant behavior in a child or adolescent without serious violation of the basic rights of others.

### **Symptoms**

Symptoms of this disorder may include the following behaviors when they occur more often than normal for the age group: losing one's temper; arguing with adults; defying adults or refusing adult requests or rules; deliberately annoying others; blaming others for their own mistakes or misbehavior; being touchy or easily annoyed; being angry and resentful; being spiteful or vindictive; swearing or using obscene language; or having a low opinion of oneself. The person with Oppositional Defiant Disorder is moody and easily frustrated, has a low opinion of him or herself, and may abuse drugs.

### **Cause**

The cause of Oppositional Defiant Disorder is unknown at this time. The following are some of the theories being investigated:

1. It may be related to the child's temperament and the family's response to that temperament.
2. A predisposition to Oppositional Defiant Disorder is inherited in some families.
3. There may be neurological causes.
4. It may be caused by a chemical imbalance in the brain.

### **Course**

The course of Oppositional Defiant Disorder is different in different people. It is a disorder of childhood and adolescence that usually begins by age 8, if not earlier. In some children it evolves into a conduct disorder or a mood disorder. Later in life, it can develop into Passive Aggressive Personality Disorder or Antisocial Personality Disorder. With treatment, reasonable social and occupational adjustment can be made in adulthood.

### **Treatment**

Treatment of Oppositional Defiant Disorder usually consists of group, individual and/or family therapy and education, providing a consistent daily schedule, support, limit-setting, discipline, consistent rules, having a healthy

role model to look up to, training in how to get along with others, behavior modification, and sometimes residential or day treatment and/or medication.

### **Self-Management**

To make the fullest possible recovery, the person must:

1. Attend therapy sessions.
2. Use self time-outs.
3. Identify what increases anxiety.
4. Talk about feelings instead of acting on them.
5. Find and use ways to calm oneself.
6. Frequently remind oneself of one's goals.
7. Get involved in tasks and physical activities that provide a healthy outlet for one's energy.
8. Learn how to talk with others.
9. Develop a predictable, consistent, daily schedule of activity.
10. Develop ways to obtain pleasure and feel good.
11. Learn how to get along with other people.
12. Find ways to limit stimulation.
13. Learn to admit mistakes in a matter-of-fact way.

### **Dealing with Relapse**

During a period of good adjustment, the patient and his family and the therapist should plan what steps to take if signs of relapse appear. The plan should include what specific symptoms are an important warning of relapse. An agreement should be made to call the therapist immediately when those specific symptoms occur, and at the same time to notify friends and other people who can help. Specific ways to limit stress and stimulation and to make the daily schedule more predictable and consistent should be planned during a stable period.

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# Children and Temper Tantrums

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## Background

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One of the most unsettling periods in a child's life, and certainly one of the most unnerving periods for parents, is the stage of development often referred to as "the terrible twos." The behavior that makes "the terrible twos" so terrible for many toddlers and their parents is the arrival of temper tantrums. Many children develop some form of temper tantrum behavior during their toddler years. Though two-year-olds seem to be especially prone to temper tantrums, tantrum behavior characteristic of "the terrible twos" may occur in children of any age.

Temper tantrums can include relatively mild behaviors such as pouting, whining, crying, and name calling. They can also include more disruptive behaviors such as screaming, kicking, punching, scratching and biting, and even self-injurious behaviors like head banging and holding one's breath to the point of fainting.

For most young children, the development of tantrums is only a temporary stopping point along the path of learning how to cope with frustration. For others, temper tantrums become a block to further emotional growth and development. The difference between tantrum behavior that is a step toward maturity and tantrum behavior that becomes a block to further growth lies in the way parents and caretakers deal with their youngster's tantrums.

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## Development

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*Why do many children display temper tantrums in the course of normal development?*

The world is an exciting place for toddlers. Their ability to crawl, and later to walk, allows them to reach and explore any area they can see. Toddlers are constantly getting into things that their parents would prefer they left alone. In addition to their improved ability to move around and explore things, toddlers also grow rapidly in their ability to understand and use words. The growth of their vocabulary allows them to express

their needs and to understand simple commands. The combination of these two factors, increased ability to move around and increased understanding of words, leads to an event that toddlers find very frustrating: the introduction of verbal rule training by their parents.

Verbal rule training is the flood of necessary do's and don'ts that parents shower upon their toddlers in order to protect them from harm and to keep them out of mischief. "Don't touch!" "Don't go in there!" "Don't hit!" "Don't cry!" "Do eat your carrots." "Do be quiet." "Do put that away." "Do be



good." These are just a few examples of the many commands that toddlers face each day.

Though infants learn to talk instead of gurgling and babbling, they never give up smiling, laughing, frowning or crying as ways of communicating how they feel. Crying or screaming by a two or three-year-old communicates frustration in a way with which the youngster is familiar. The experience of verbal rule training can be very frustrating to toddlers. In response to this frustration toddlers will often revert to screaming and crying to proclaim to the

world that they are "fed-up." An occasional outburst of screaming or crying by a two or three-year-old child is not an uncommon or worrisome occurrence. A child of this age finds it hard to accept brief frustrations and putting these frustrations into words is an equally difficult task.

*If a period of tantrum behavior is normal for many children, how do I tell the difference between "normal" tantrums and tantrum behavior that I should be worried about?*

The best way to answer this question is to take a close look at your child's tantrum behavior and the behavior of you and your family when tantrums occur. Do any of these things happen in your family?

- Your child has tantrums in many settings, not just at home.
- Your child has tantrums regardless of who in the family is caring for the youngster.
- Your child is having more and more tantrums each day as time goes on.
- Your child's tantrums are becoming more severe as time goes on.
- Your child hurts him or herself or tries to hurt others during tantrums.
- Your child receives extra attention from family members when a tantrum occurs. For example, when your child has a tantrum someone hugs or holds the child, or perhaps someone scolds or lectures the child.
- Members of your family try to stop your child's tantrums by giving the youngster what he or she wants.
- Members of your family avoid taking a tantrum-prone child grocery shopping, to church, to visit friends or relatives, out to eat, etc., because they are afraid the child will tantrum in those settings.
- You find it hard to get someone to babysit your tantrum-prone child.

If one or more of the items above describe the experience your family is having, your child may be developing a severe tantrum problem.

A severe tantrum problem is characterized by tantrum behavior that has become goal directed. When children first develop tantrums, they use crying and screaming as a way of expressing

frustration. Tantrums start out as a way for children to communicate that they are "fed up" with the limits placed upon them. If children learn, however that having tantrums can gain them extra attention from their family or can allow them to do things they would not otherwise be allowed to do, their tantrums will come to serve a different purpose. No longer will they use tantrums simply as a means of expressing frustration. Instead, such children will use tantrums as a tool for obtaining more attention and getting to do more things. Their tantrums will become goal directed.

Family members and other caretakers cause tantrums to become goal directed, usually without realizing they are doing so. If a child, for example, cries and screams because he desires a toy that is currently out of reach, hugging and rocking the child until he is calm will soothe the youngster for the moment, but will encourage him to cry and scream in the future when something else he wants is out of reach. Even though he/she was not given the toy as a result of his tantrums, he/she received a great deal of special attention. By repeating this pattern over and over again, family members may actually teach a child to have tantrums as a way of obtaining something he or she wants. This is not to say that children should never be soothed when they are upset. The key point to remember is that children should not be allowed to use tantrums as a way of getting special treatment from those around them.

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### **What Can I Do As A Parent?**

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Whether tantrum behaviors are just beginning to develop in your child, or tantrums have become a long standing problem, there are actions you and members of your family can take to help your child gain control over tantrum behavior.

*Some guidelines for dealing with tantrum behaviors when they first begin to develop.*

- Rule out the possibility that tantrums are being caused by a factor other than general frustration with verbal rule training. Some factors which may cause or contribute to tantrums include teething, the presence of seizure activity, the side effects of some medications, or a sudden emotional loss such as the death or long absence of a parent. In the vast majority of cases, tantrums are the result of frustration encountered in daily living. If a specific cause, such as one of those mentioned above is suspected, you should have your child evaluated by an appropriate health care professional.

- Do not allow your child to receive extra attention from family members as a result of having a tantrum.
- Do not allow your child to obtain things he or she would not otherwise be allowed to obtain as a result of having a tantrum.
- Do not scold or spank your child for having a tantrum. Scolding or spanking is likely to reinforce tantrum behavior and cause it to get worse.
- Tantrums are not an appropriate way of asking for a desired object. Even if the object is something your child would normally be allowed to have, do not allow the child to obtain it by having a tantrum. Provide the object only when the child is calm and has asked for it in an appropriate fashion, considering the child's age.
- Do not ignore your child when the youngster is being good because you are afraid of "setting the child off" and causing a tantrum to occur. Pay extra attention to your child when he or she is behaving appropriately and is not having a tantrum.

*Some guidelines for dealing with tantrum behavior that has become a serious, long standing problem.*

- If tantrum behaviors have become a severe problem for your child, arrange to visit with a child care professional such as a school psychologist or clinical child psychologist. A trained child care professional can help you develop a program that will deal with the specific circumstances of your child's situation. Tantrum behaviors that are deeply entrenched do not yield to "quick fix" solutions. A professional child care worker can help you to develop a comprehensive plan for dealing with severe tantrum behavior and can demonstrate the special skills you will need in order to help your child get tantrums under control. There are effective techniques available for dealing with tantrums that occur at home, in school, in public places such as grocery stores and restaurants, and for dealing with bedtime tantrums as well.
- As mentioned earlier, you should not scold or spank your child for having a tantrum. Scolding or spanking is likely to reinforce tantrum behavior and cause it to get worse.

- Try to pay extra attention to your child when he or she is not having tantrums. By making yourself available when your child is behaving well, you teach your child that special attention can be gained by a means other than having tantrums.

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## Resources

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*Living With Children* -- by G. R. Patterson. Research Press, Publisher, 1976. Chapter 14 of Patterson's book provides a model of a simple program for dealing with tantrums occurring in the home.

*Living With a Brother or Sister With Special Needs: A Book for Sibs* -- by D. J. Meyer, P. F. Vadasy and R. R. Fewell. University of Washington Press, Publisher 1985. This resource book, written for children of late elementary school age and older has a section devoted specifically to the questions children have regarding the role they must play in dealing with the behavior problems of a brother or sister.

*Tantrum, Jealousy and the Fears of Children* -- by L. Barrow, A. H. & A. W. Reed, Publisher 1968. This booklet in Barrow's series on child psychology provides a brief discussion of temper tantrum development in young children and includes descriptions by parents of tantrum problems they have dealt with in their own families.

# A Parents' Guide to Temper Tantrums

From the National Mental Health and Education Center

From time to time all young children will whine, complain, resist, cling, argue, hit, shout, run, and defy their parents and caregivers. Temper tantrums are normal; every parent can expect to witness some temper tantrums in their children from the first year through about age four. However, tantrums can become upsetting because they are embarrassing, challenging, and difficult to manage. At home, there are predictable situations that can be expected to trigger temper tantrums in individual children. These may include bedtime, supertime, getting up, getting dressed, bath time, watching TV, parent on the phone, visitors at the house, family visiting another house, car rides, public places, family activities involving siblings, interactions with peers, and playtime. On average, temper tantrums are equally common in boys and girls, and over half of young children will have one or more per week.

Temper tantrums can become special problems if they occur with greater frequency, intensity, and duration than are typical for children of that child's age. This article will help parents and caregivers understand "normal" tantrum behavior, how to best intervene, and how to determine when a child's tantrums may signal more serious problems.

## Typical Development of Tantrum Behavior

At about age 18 months, some children will start throwing temper tantrums. These outbursts can last until approximately four years of age. Some call this stage the "terrible two's" and others call it "first adolescence," because the struggle for independence is reminiscent of adolescence. There is a normal developmental course for temper tantrums:

- **18 months through 2 years of age.** Children during this stage will "test the limits." They want to see how far they can go before a parent or caretaker stops their behavior. At age 2, children are very egocentric; they cannot see another person's point of view. They want independence and self-control to explore their environment. When the child cannot reach a goal, he shows his frustration by crying, arguing, yelling, or hitting. When the child's need for independence collides with the adult's need for safety, conformity, or getting on with the task at hand, the conditions are perfect for a power struggle and a temper tantrum. The child's goal, of course, is to get the parent to give in or get out of the way.

What is most upsetting to caregivers is that it is virtually impossible to reason with a child who is having a temper tantrum. Thus, arguing and cajoling in response to a temper tantrum only escalates the problem.

- **3- and 4-year-olds.** By the time they reach age three to four, many children are less impulsive and they can use language to express their needs. Tantrums at this age are often less frequent and less severe. Nevertheless, some preschoolers have learned that a temper tantrum is a good way to get what they want.
- **4-year-olds.** By age four, most children will have completed, and most caregivers will have survived, the tantrum phase. By this age, children have attained the necessary motor and physical skills to meet many of their own needs without relying so much on adults. Their growing language skills allow them to express their anger and to problem-solve and compromise. Despite these improved skills, kindergarten and primary school-age children can still have temper tantrums when faced with demanding academic tasks or new interpersonal situations in school or at home.

## An Ounce of Prevention

It is much easier to prevent temper tantrums than it is to manage them once they have erupted. Here are some tips for preventing temper tantrums:

- **Notice and reward your child's positive behavior** rather than negative behavior. During situations when they are prone to temper tantrums, "catch 'em being good." For example, say, "Nice job sharing with your friend."
- **Don't ask your child to do something when they must do what you ask.** Don't say, "Would you like to eat now?" at dinner time; just announce, "It's supertime now."
- **Give the child control over little things whenever possible by giving them choices.** A little bit of power now can stave off the big power struggles later. "Which do you want to do first--brush your teeth or put on your pajamas?"
- **Keep off-limit objects out of sight** and therefore out of mind. During an art activity, keep the scissors out of reach if children are not ready to use them safely.
- **Distract the child by redirecting** her to another activity when she starts to tantrum over something

she should not do or cannot have. “Let’s read a book together.”

- **Change environments**, thus removing the child from the source of the temper tantrum. “Let’s go for a walk.”
- **Choose your battles**. Teach your child how to make a request without a temper tantrum and then honor his request. “Try asking for that toy nicely and I’ll get it for you.”
- **Make sure that your child is well rested and fed** when approaching situations where she is likely to have a temper tantrum. “Supper is almost ready; here’s a cracker for now.”
- **Avoid boredom**. “You have been working on that puzzle for a long time. Let’s take a break and do something else.”
- **Create a safe environment** that children can explore without getting into trouble. Child-proof your home so toddlers can explore safely.
- **Increase your tolerance level**. Remember that parenting is a full-time job. Are you available to meet this child’s reasonable needs? Evaluate how many times you say, “No” to this child. Avoid conflicts over minor things.
- **Establish routines and traditions**. These add structure and predictability to your child’s life. Start dinner with opportunity for sharing the day’s experiences; start bedtime with a story
- **Signal the child before you reach the end of an activity** so that he can get prepared for the transition. “When the timer goes off in five minutes, it will be time to turn off the TV and get ready for bed.”
- **Explain to your child beforehand what to expect when visiting new places or unfamiliar people**, “There will be lots of people at the zoo. Be sure to hold onto my hand.”
- **Provide learning, behavioral, and social activities that are the child’s developmental level** so that they do not become either frustrated or easily bored. Children should be ready for new experiences so that they find challenge without undue difficulty.
- **Keep a sense of humor** to divert the child’s attention and surprise them out of the tantrum. Humor and perspective can do much for your own sanity as well.
- **Help children to develop an awareness of early signs** of a temper tantrum. For example, say, “I see you are rocking in your chair now; what are you thinking?” With practice the child could learn to signal you when he notices that he is beginning to have a temper tantrum. Then help him with some of the above prevention strategies.
- **Teach your child some personal relaxation strategies** such as deep breathing, stretching, or

visual imagery—imagining pleasant places, activities, etc that help her feel calm and safe. Help her learn to use relaxation when she feels frustrated and on the brink of a meltdown.

- **Teach children to express anger constructively**. Model how *you* calm yourself down. For example, take your child for a walk with you when you get upset about something, and explain how the walk makes you feel better. Teach your child to avoid power struggles by reminding him that you will listen to his problem *only* when he has calmed down. Help your child develop a feeling vocabulary by labeling the feelings she is demonstrating. For example, say, “You look confused, let me see if I can help.” You and the child could come up with a variety of creative ways to deal with anger and draw pictures to illustrate these ideas. Some ways of avoiding anger might include playing with a favorite toy, drawing in a coloring book, listening to music, etc.

### Defusing a Tantrum in Progress

If prevention fails, there are a number of ways to handle a temper tantrum in progress:

- **Remain calm and don’t argue** with your child. Before you manage the child you must manage your own behavior. Spanking or yelling at the child will make the tantrum worse.
- **Think before you act**. Count to ten and then think about what is the source of the child’s frustration, what is this child’s characteristic response to stress (i.e., hyperactivity, distractibility, moodiness etc.) and what are the predictable steps that will likely escalate the tantrum.
- Next, **try to intervene before the child is out of control**. Get down at the child’s eye level and say, “You are starting to get revved up, slow down.” Now you have several choices of intervention.
- **“Positively distract” the child** by getting him/her focused on something else that is an acceptable activity. For example, you might remove the unsafe item and replace it with an age-appropriate toy.
- **Place the child in “time away.”** Time away is a quiet place where the child goes to “calm down,” “think” about what she needs to do, and with your help “make a plan” to change her behavior.
- **Ignore the tantrum** if they are throwing the tantrum to get your attention. Once they calm down, give them the attention they desire.
- **Hold the child who is out of control** and is going to hurt himself or someone else. Let him know that you will let him go as soon as he calms down. Reassure the child that everything will be all right and help them calm down. Parents may need to hug their child who is crying, and tell him they will

always love them no matter what, but that the behavior has to change. This reassurance can be comforting for a child who may be afraid because he lost control.

- **Use “time out.”**

If the child has escalated the tantrum to the point where you are not able to intervene effectively, then you may need to direct the child to “time-out.” If you are in a public place, carry your child outside or to the car. Tell the child that you will go home unless they calm down. If he refuses to comply, then place him in time-out for no more than one minute for each year of age. At home, the time out area can be any room or area free from toys and other desirable objects or activities; at the shopping mall, the back seat of the car can serve as a “quiet down” area. (If your child is already familiar with the concept of “time out” at home, it is easier to improvise a time out area elsewhere.)

- **Never give in to a tantrum,** under any circumstances. That response will only escalate the intensity and frequency of temper tantrums.



#### After the Tantrum Stops.....

- **Do not reward the child once she has calmed down** after a tantrum. Some children will learn that a temper tantrum is a good way to get a treat later.
- **Talk with your child after she calms down.** Once the child stops crying or screaming, talk with her about her frustration. Try to solve the problem if possible. Explain to the child that there are better ways to get what he or she wants. For the future, teach your child new skills to help avoid temper tantrums, such as how to ask appropriately for help; how to signal a parent or teacher that he needs to go to “time away” so he can “Stop, Think, and Make a Plan”; how to try a more successful way of interacting with a friend or sibling; how to express his feelings with words and recognize the feelings of others without hitting and screaming.
- **Never let the temper tantrum interfere with your otherwise positive relationship with the child**

#### When Tantrums Signal More Serious Problems

Despite parents’ diligent efforts to prevent and defuse tantrums, for some children these outbursts may increase in frequency, intensity, or duration. Particularly if the child is self-injurious, hurtful to others, depressed,

exhibits low self-esteem, or is overly dependent on a parent or teacher for support, it’s time to consult your health care provider. Your pediatrician or family physician can check for hearing or vision problems or illness, or refer you to a specialist to rule out a behavioral or developmental disorder. Most communities have professionals who specialize in severe behavior problems in young children. For help connecting with an appropriate provider, consult your child’s pediatrician, local school psychologist or preschool teacher.

Tantrums may indeed be a normal part of childhood, but their impact on family life can be minimized by some planning, modeling problem solving skills, consistent discipline strategies, and patience. Usually this stormy period will blow over as your child becomes more secure, confident and capable—in other words, as your child grows up!

#### Resources

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*Provided by the National Association of School Psychologists, this article is adapted from a handout written by Robert G. Harrington, PhD. Dr. Harrington has been a Professor in the Department of Psychology and Research in Education at the University of Kansas for 23 years. He has trained teachers and parents across the U.S. in the social skills development of their young children. This handout will appear in the second edition of Helping Children at Home and School: Handouts for Parents and Educators, to be published in 2004 by the National Association of School Psychologists. © NITV, 2003.*



## C. MORE RESOURCES FROM OUR CENTER



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## Quick Find On-line Clearinghouse

<http://smhp.psych.ucla.edu/qf/bully.htm>

### TOPIC: Bullying

The following reflects our most recent response for technical assistance related to this topic. This list represents a sample of information to get you started and is not meant to be exhaustive.

(Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one).

### Center Developed Resources and Tools

#### Newsletter Articles

- [Behavior Problems: What's a School to Do? - Spring '97](#)
- [Bullying and Addressing Barriers to Learning - Winter '05](#)

#### Introductory Packets

- [Conduct and Behavior Problems in School Aged Youth](#)

#### Quick Training Aids

- [Bullying Prevention](#)
- [Behavior Problems at School](#)

#### Technical Assistance Samplers

- [Behavioral Initiatives in Broad Perspective](#)

#### Practice Notes

- [Bullying: A Major Barrier to Student Learning](#)

### Relevant Publications on the Internet

**HRSA Has a Special Site on Stop Bullying Now!**

**With Special Features and Resources.  
Take a Stand. Lend a Hand.**

<http://stopbullyingnow.hrsa.gov/index.asp>

**SAMHSA has a wealth of resources on bullying and violence prevention.**

>>Go to the **Center for Mental Health Service's National Mental Health Information Center** – <http://www.mentalhealth.org/> (use search to find bullying)

Go to SAMHSA's library – <http://www.samhsa.gov/library/searchreal.aspx> (use search to find bullying)

A few examples of resources include:

- About Bullying – <http://www.mentalhealth.samhsa.gov/15plus/aboutbullying.asp>
- Prevention Pathways – The ABCs of Bullying: Addressing, Blocking, and Curbing School Aggression – [http://pathwayscourses.samhsa.gov/bully/bully\\_intro\\_pg1.htm](http://pathwayscourses.samhsa.gov/bully/bully_intro_pg1.htm)
- Take Action Against Bullying – <http://www.mentalhealth.samhsa.gov/publications/allpubs/SVP-0056/>
- Bullying is Not a Fact of Life – <http://www.mentalhealth.samhsa.gov/publications/allpubs/SVP-0052/>
- The School Bully Can Take a Toll on Your Child's Mental Health <http://www.mentalhealth.samhsa.gov/publications/allpubs/CA-0043/default.asp>
- School violence, bullying prevention, A Family Guide – use search at <http://www.samhsa.gov/library/searchreal.aspx>
- Bullying, teenage peer relationships, parenting tips Family Guide – use search at <http://www.samhsa.gov/library/searchreal.aspx>

- [15+ Make Time to Listen, Take Time to Talk](#)
- [The ABCs of Bullying: Addressing, Blocking, and Curbing School Aggression](#) (an online course)
- [About Bullying](#)
- [Addressing the Problem of Juvenile Bullying](#)
- [Anti-harassment and bullying policy](#)
- [At What Age Are Children Most Likely to be Bullied at School? \(PDF Document, 141K\)](#)
- [Bully Proof: A Teachers' Guide on Teasing and Bullying for use with Fourth and Fifth Grade Students](#)
- [Bullying](#)
- [Bullying is Not a Fact of Life](#)
- [Bullying in Schools](#)
- [Bullies in School: Who They Are and How to Make Them Stop \(2002\)](#)
- [Bullying and teasing of youth with disabilities](#)
- [Bullying at school](#)
- [Bullying Behaviors Among US Youth: Prevalence and Association with Psychosocial Adjustment](#)
- [Bullying Canada \(A youth-anti bullying website\)](#)
- [Bullying, harassment, school-based violence](#)
- [Bullying in the public schools](#)

- [Bullying in Schools and what to do about it](#)
- [Bullying, psychosocial adjustment, and academic performance in elementary school](#)
- [Bullying Resource Packet](#)
- [Bullying Widespread in Middle School, Say Three Studies](#)
- [The EDA Bullying Workbook](#)
- [Educational Forum on Adolescent Health: Youth bullying--Proceedings](#)
- ["Healing Cirlces", an effective tool in Anti-Bullying Programs, is now available as a separate video or DVD with Discussion Guide](#)
- [Helping your children navigate their teenage years: a guide for parents](#)
- [Juvenile Delinquency and Serious Injury Victimization](#)
- [Model policy prohibiting harassment, intimidation and bullying on school property, at school-sponsored functions and on school busses](#)
- [Organizing a No Name-calling Week in your school](#)
- [Operation Respect: Don't Laugh at Me, Dedicated to creating safe, caring and respect environments](#)
- [Peer exclusion and victimization: processes that mediate the relation between peer group rejection and children's classroom engagement and achievement. \(2006\) E. Buhs, et al. \*Journal of Eduational Psychology\*, 98\(1\) 1-13.](#)
- [The prevalence of teachers who bully students in schools with differing levels of behavioral problems](#)
- [Project ACHIEVE](#)
- [Relational aggression and bullying: It's more than just a girl thing](#)
- [Relationships between peer harrassment and adolescent problem behaviors \(2005\) J. Rusby, et al, \*Journal of Early Adolescence\*, 25\(4\) 453-477](#)
- [Resolving Conflict Creatively between Victims & Youth Offenders](#)
- [Resolving Conflict Creatively in the Multicultural Community](#)
- [Resolving Conflict Creatively in the School Community "Negotiation" & "Mediataion"](#)
- [Safe place to learn: Consequences of harassment based on actual or perceived sexual orientation and gender non-conformity and steps for making school safer](#)
- [Safeguarding Your Children from Bullying, Gangs, and Sexual Harrassment](#)
- [The School Bully Can Take a Toll on Youth Child's Mental Health](#)
- [School Bullying and the Law](#)
- [Steps to Respect program to reduce playground bullying](#)
- [Student reports of bullying: Results from the 2001 school crime supplement of the National Crime Victimization Survey](#)
- [Take Action Against Bullying](#)
- [Teaching students to be peacemakers](#)
- [Teasing and Bullying](#)
- [Think you know what a bully looks like?](#)
- [What's Bullying](#)

### **Nationwide/Statewide Campaigns**

- [The 2003 national school climate survey: The school-related experiences of our nation's gay, bisexual and transgender youth](#)
- [National Bullying Awareness Campaign](#)
- [National PTA resources on bullying](#)
- [HHS launches anti-bullying campaign; "Take a Stand: Lend A Hand. Stop Bullying Now!"](#)
- [State Anti-bullying Statutes \(2005\) J. Dournay, Education Commission of the States \(doc\)](#)

### **Bullying Prevention**

- [Take a stand. Lend a hand. Stop bullying now! Resource kit](#)
- [Prevention Pathways](#)
- [Developing an Anti-bullying program: Increasing safety, reducing violence](#)
- [Strategy: Make schools safe from bullying](#)
- [Bullyproof: Online Bullyproofing.](#)
- [Bully-Proof Your School](#)
- [Steps to Respect: A bullying prevention program](#)
- [The Olweus Bullying Prevention Program: Background and program overview](#)
- [Olweus Bullying Prevention](#)
- [Bullying Prevention is Crime Prevention](#)
- [Bullies Can Be Transformed Into Good Citizens: A Bullying Prevention Program](#)
- [Early violence prevention: Tools for teachers of young children](#)
- [Exploring the nature of prevention of bullying](#)
- [Schoolwide Prevention of Bullying](#)
- [Stop bullying now](#)

#### Selected Materials from our Clearinghouse

- [Bully Proof: A Teachers' Guide on Teasing and Bullying for use with Fourth and Fifth Grade Students](#)
- [Childhood Depression: Is it on the rise?](#)
- [Preventing Bullying: A Manual For Schools And Communities](#)
- [Preventing Youth Hate Crime](#)
- [Quit It!: A Teacher's Guide on Teasing and Bullying for Use with Students in Grades K-3](#)
- [School Bullying and Victimization](#)

#### Related Agencies and Websites

- [Anti-Bullying Network](#)
- [Bullying Canada](#) (Youth anti-bullying website)
- [Bullying Online](#)
- [Bullying in the Public School](#)
- [Bullying in Schools and What to do About it](#)
- [Center for Mental Health Service's National Mental Health Information Center](#)
- [From Bullies to Buddies](#)
- [National School Safety Center](#)
- [Stop Bullying Now](#) Take a Stand. Lend a Hand. HRSA sponsored site.
- [Stop Bullying Now.com](#)
- [The Peace Center](#)
- [What's bullying](#)

#### Relevant Publications That Can Be Obtained Through Libraries

- *The anti-bullying handbook.* Sullivan, K. (2000). Oxford University Press.
- [School Bullying and Suicidal Risk in Korean Middle School Students.](#) Young Shin Kim, Yun-Joo Koh and Bennett Leventhal. (2005). *Pediatrics*, 115, 357-363
- *The Bully Free Classroom : Over 100 Tips and Strategies for Teachers K-8 .* Beane, A.L. (1999). Free Spirit Pub.
- *The bully, the bullied, and the bystander: From preschool to high schools - How parents and teachers can help break the cycle of violence.* Coloroso, B. (2004). Harper Resource (2004)
- *Bullying: A Guide for Counselors, Managers, Teachers and Parents.* O'Donnell, V (1995).

- *Bullying at School : What We Know and What We Can Do (Understanding Children's Worlds)*. Olweus, D. (1994). Blackwell Pub.
  - *Bullying in American Schools: A Social-Ecological Perspective on Prevention and Intervention*. Espelage, D.L. & Swearer, S.M. (2004). Lawrence Erlbaum Associates: Mahwah, NJ.
  - *Childhood bullying and teasing: What school personnel, other professionals, and parents can do*. Ross, D. M. (1996). Alexandria, VA: American Counseling Association.
  - Children involved in bullying: Psychological disturbance and the persistence of the involvement. Kumpulainen, K., Raesaenen, E., & Henttonen, I. (1999). *Child Abuse and Neglect*, 23(12), 1253-1262.
  - *Peer harassment in school: The plight of the vulnerable and victimized*. Juvonen, J. & Graham, S. (2001). New York, NY: Guilford Press.
  - Perceptions of peer abuse and suicidal behavior during adolescence. Hanish, L.D., & Guerra, N. G. (2000). *School Psychology International*, 21(2), 213-223.
  - *Quit it! A teacher's guide on teasing and bullying for use in grades k-3*. Froschl, M., et al. (1998). Educational Equity Concepts
  - *Schools where everyone belongs: Practical strategies for reducing bullying* . Davis, S. (2004). Stop Bullying Now
  - *Stop the bullying: A handbook for schools*. Rigby, K. (2003). Australian Council for Education Research in 2003., Australia.
  - *Towards Bully-Free Schools*. Glover, D., Cartwright, N. & Gleeson, D. (1997). Open Univ Pr.
  - What Works- and Doesn't Work- in Bullying Prevention and Intervention. Limber, S., Snyder M. (2006). *The State Education Standard*, 7(1), 24-28.
  - *And words can hurt forever: How to protect adolescents from bullying, harassment, and emotional violence*. Garbarino, J. & deLara, E. (2002). Free Press
- 

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**TOPIC: Classroom Management**

The following reflects our most recent response for technical assistance related to this topic. This list represents a sample of information to get you started and is not meant to be exhaustive. (Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one).

**Center Developed Documents, Resources and Tools**

**Articles**

- [Involving Teachers in Collaborative Efforts to Better Address Barriers to Student Learning](#)
- L. Taylor & H.S. Adelman (1999). [Personalizing Classroom Instruction to Account for Motivational and Developmental](#). *Reading & Writing Quarterly*, 15 (4), 255-276.

**Continuing Education Module**

- [Continuing Education Module: Enhancing Classroom Approaches for Addressing Barriers to Learning: Classroom-Focused Enabling](#)

**Guidance Notes**

- [The Relationship of Response to Intervention and Systems of Learning Supports](#)

**Information Sheet**

- [About School Engagement and Re-engagement](#)

**Introductory Packets**

- [Conduct and Behavior Problems in School Aged Youth](#)

**Newsletter Articles**

- [Newsletter: Behavior Problems: What's a School to Do? \(Spring, '97\)](#)

**Quick Training Aids**

- [Quick Training Aid: Behavior Problems at School](#)
- [Quick Training Aid: Re-engaging Students in Learning](#)

**Practice Notes**

- [About Motivation](#)
- [Working with Disengaged Students](#)

**Technical Assistance Samplers**

- [Behavioral Initiatives in Broad Perspective](#)

**Training Tutorials**

- [Classroom Changes to Enhance and Re-engage Students in Learning](#)

### **Tools for Practice**

- [Classroom-based Approaches to Enable and Re-engage Students in Classroom Learning: A Self-Study Survey](#)

### **Other Relevant Documents, Resources, and Tools on the Internet**

- [Articles on Brain based Education: Classroom Management](#)
- [Creating a Climate for Learning: Effective Classroom Management Techniques](#)
- [Creating a Positive Climate for Learning: Lesson Ideas](#)
- [Classroom Management](#)
- [Classroom Management: Teaching Today](#)
- [Classroom Management: KY Department of Education](#)
- [Discipline Profiles](#)
- [Effective Classroom Management](#)
- [Guidelines - Classroom Management Tips](#)
- [Learning Disabilities Online: Adjustments in Classroom Management](#)
- [Learning to Discipline - Phi Delta Kappan](#)
- [Managing Today's Classroom: Finding Alternatives to Control and Compliance](#)
- [prep2: Classroom Management Techniques](#)
- [Schoolwide and Classroom Discipline](#)
- [State Class-size Reduction Measures](#)
- [The Definition of Classroom Management](#)
- [Welcome to Classroom Management Online Training](#)
- [What is your classroom management profile?](#)

### **Clearinghouse Archived Material**

- [Avoiding the Special Education Trap for Conduct Disordered Students](#)
- [Behavior Management in Inclusive Classroom](#)
- [Behavioral Interventions: Creating a Safe Environment in Our Schools](#)
- [Building Social Skills in the Classroom](#)
- [Screening for Understanding of Student Problem Behavior: An Initial Line of Inquiry](#)
- [The Education Together Class](#)
- [Understanding and Managing Children's Classroom Behavior Ch 9: Medication and Behavior in the Classroom](#)

### **Related Agencies and Websites**

- [Can Teach: Classroom Management: discipline & organization](#)
- [Classroom Management](#)
- [Classroom Management Links](#)
- [Classroom Management Resource Site](#)
- [NEA: Works4Me Tips Library - Managing Your Classroom](#)
- [ProTeacher: Classroom Management](#)
- [The Really Best List of Classroom Management Resources](#)
- [The Teacher's Guide: Classroom Management](#)
- [The Web-Based Interactive Teacher Development and the Classroom Management Database](#)
- [Teachervision.com: Classroom Management](#)



## Relevant Publications That Can Be Obtained through Libraries

- *Building Classroom Discipline*. By C.M. Charles (1996). New York: Longman Press.
  - *Classroom Management for Elementary Teachers*. By C. Evertson, E. Emmer, & M. Worsham (2000). Boston: Allyn & Bacon.
  - *Managing Secondary Classrooms*. By P.A. Williams, R.D. Alley, & K.T. Henson (1999). Boston: Allyn & Bacon.
- 

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## Quick Find On-line Clearinghouse

[http://smhp.psych.ucla.edu/qf/p3022\\_01.htm](http://smhp.psych.ucla.edu/qf/p3022_01.htm)

### TOPIC: Behavior Problems and Conduct Disorders

The following reflects our most recent response for technical assistance related to this topic. This list represents a sample of information to get you started and is not meant to be exhaustive.

(Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one).

### Center Developed Documents, Resources and Tools

#### Articles

- [Involving Teachers in Collaborative Efforts to Better Address Barriers to Student Learning](#)

#### Continuing Education Module

- [Enhancing Classroom Approaches for Addressing Barriers to Learning: Classroom-Focused Enabling \(Continuing Education Module\)](#)

#### Introductory Packets

- [Conduct and Behavior Problems in School Aged Youth \(Introductory Packet\)](#)
- [Violence Prevention and Safe Schools \(Introductory Packet\)](#)
- [Least Intervention Needed: Toward Appropriate Inclusion of Students with Special Needs \(Introductory Packet\)](#)

#### Newsletters

- [Behavior Problems: What's a School to Do? \(Newsletter, Spring, '97\)](#)
- [Labeling Troubled and Troubling Youth: The Name Game \(Newsletter, Summer, '96\)](#)
- [Bullying as a Major Barrier to Learning \(Newsletter, Fall, '01\)](#)
- [Enabling Learning in the Classroom: A Primary Mental Health Concern \(Newsletter, Spring, '98\)](#)

#### Practice Notes

- [Common Behavior Problems \(Practice Notes\)](#)
- [Bullying: A Major Barrier to Student Learning \(Practice Notes\)](#)

#### Quick Training Aids

- [Behavior Problems at School \(Quick Training Aid\)](#)
- [Bullying Prevention \(Quick Training Aid\)](#)
- [Violence Prevention \(Quick Training Aid\)](#)
- [Attention Problems in School \(Quick Training Aid\)](#)
- [Re-engaging Students in Learning \(Quick Training Aid\)](#)

#### Resource Aid Packets

- [Screening/Assessing Students: Indicators and Tools \(Resource Aid Packet\)](#)

#### Technical Assistance Samplers

- [Behavioral Initiatives in Broad Perspective \(Technical Assistance Sampler\)](#)
- [A Sampling of Outcomes Findings from Interventions Relevant to Addressing Barriers to Learning \(Technical Assistance Sampler\)](#)

#### **Training Tutorials**

- [Crisis Assistance and Prevention: Reducing Barriers to Learning \(Training Tutorial\)](#)
- [Classroom Changes to Enhance and Re-engage Students in Learning \(Training Tutorial\)](#)

#### **Other Relevant Documents, Resources, and Tools on the Internet**

- [Addressing Student Problem Behavior: An IEP Team's Introduction to Functional Behavioral Assessment and Behavior Intervention Plans-The Center for Effective Collaboration and Practice](#)
- [Bad conduct, defiance, and mental health](#)
- [Behavioral Disorders: Focus on Change](#)
- [Behavior problems of preschool children from low-income families: review of the literature](#)
- [Children and Adolescents with Conduct Disorder](#)
- [The effect of varying rates of opportunities to respond to academic requests on the classroom behavior of students with EBD](#)
- [Emotional competence and aggressive behavior in school-age children \(1\)](#)
- [Evidence Based Assessment of Conduct Problems in Children and Adolescents](#)
- [Helping children develop "impulse control"](#)
- [How to teach good behavior: tips for parents. \(Information from Your Family Doctor\)](#)
- [IDEA–Reauthorized Statute DISCIPLINE](#)
- [Improving the classroom behavior of students with emotional and behavioral disorders using individualized curricular modifications](#)
- [Introduction to the special series on positive behavior support in schools](#)
- [Managing Today's Classroom: Finding Alternatives to Control and Compliance-Scott Willis](#)
- [Mental, Emotional, and Behavior Disorders in Children and Adolescents](#)
- [NICHCY Connections...to Behavior at School](#)
- [Progress Review of the Psychosocial Treatment of Child Conduct Problems](#)
- [Relation of Age of Onset to the Type and Severity of Child and Adolescent Conduct Problems](#)

#### **Clearinghouse Archived Resources**

- [Building Social Skills in the Classroom-S.M. Sheridan](#)
- [Managing Violent and Disruptive Students-Lee Parks](#)
- [Screening for Understanding of Student Problem Behavior \(4 part packet of materials\)](#)

#### **Related Agencies and Websites**

- [Center for the Prevention of School Violence](#)
- [Center for the Study and Prevention of Violence \(CSPV\)](#)
- [Council for Children with Behavioral Disorders](#)
- [Institute on Violence and Destructive Behavior](#)
- [National School Safety Center](#)
- [National Youth Gang Center](#)
- [Oppositional Defiant Disorder Support Group](#)

- [Partnership Against Violence Network](#)
- [Safe and Drug-Free Schools Programs Office \(US Dept. of Ed.\)](#)
- [Social Development Research Group](#)
- [The Council for Exceptional Children \(CEC\)](#)
- [The Joey Support Group Home Page](#)

### Relevant Publications That Can Be Obtained through Libraries

- **Behavioral Approach to Assessment of Youth with Emotional/Behavioral Disorders : a Handbook for School-based Practitioners.** edited by Breen & Fiedler. (2003). Austin, TX : Pro-Ed.
- **Childhood Behavior Disorders : Applied Research and Educational Practice.** by Algozzine, Serna, & Patton. (2001). Austin, Texas, : Pro-Ed.
- **Child Delinquency : Early Intervention and Prevention.** Loeber, Farrington, and Petechuk. (2003). [Washington, DC] : U.S. Dept. of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- **Families and Positive Behavior Support : Addressing Problem Behavior in Family Contexts.** edited by Lucyshyn, Dunlap, and Albin. (2002). Baltimore, MD : P.H. Brookes Pub.
- **Helping Adolescents At Risk : Prevention of Multiple Problem Behaviors.** by Anthony Biglan, et al. (2004). New York, NY : Guilford Press.
- **How to Promote Children's Social and Emotional Competence.** by Carolyn Webster-Stratton. (1999). London : P. Chapman ; Thousand Oaks, Calif. : Sage Publications.
- **The incredible years parents, teachers, and children training series A multifaceted treatment approach for young children with conduct problems.** Webster-Stratton, C., & Reid, M.J. (2003). In Kazdin & Weisz, Ch 13,, pp.224-240.
- **Practitioner's Guide to Behavioral Problems in Children.** by Glen P. Aylward. (2003). New York : Kluwer Academic/Plenum Publishers.
- **Risks and Problem Behaviors in Adolescence.** edited by Lerner & Ohannessian. (1999). New York : Garland Pub.
- **Understanding and Supporting Children with Emotional and Behavioural Difficulties.** edited by Paul Cooper. (1999). London ; Philadelphia : Jessica Kingsley Publishers.
- **When interventions harm: Peer groups and problem behavior.** Dision, T.J., McCord, J., & Poulin, F. (1999). *American Psychologist*, 54, 755-764.

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## Quick Find On-line Clearinghouse

<http://smhp.psych.ucla.edu/qf/discip.htm>

### TOPIC: Discipline Codes and Policies

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### Relevant Documents, Resources, and Tools on the Internet

- [Clear, Consistent Discipline: Centennial High](#)
- [Code of Conduct for Elementary Schools \(PDF\)](#)
- [Code of Conduct for Secondary Schools \(PDF\)](#)
- [Code of Conduct for Students](#)
- [Cumberland County Schools Student Code of Conduct](#)
- ["Discipline of special Education Students" \(2002\)](#)
- [ERIC: School-Wide Behavioral Management Systems](#)
- ["Implementing IDEA '97 Disciplinary Provisions" \(2002\)](#)
- [Palm Middle School Conduct Expectations](#)
- [Policy Handbook for Parents & Students](#)
- [QuickGuide to Preventing Suspensions and Expulsions](#)
- [QuickGuide to Suspensions and Expulsions](#)
- [School Discipline: Individuals with Disabilities Education Act](#)
- [School Violence: Disciplinary Exclusion, Prevention and Alternatives](#)
- [Teaching Interrupted: Do discipline policies in today's public schools foster the common good?](#)

### Clearinghouse Archived Materials

- [Behavioral Interventions: Creating a Safe Environment in Our Schools](#)
- [Best Practices in School Psychology - III \(in particular Best Practices in School Discipline\)](#)

### Related Agencies

- [Center for the Prevention of School Violence](#)
- [Center for the Study and Prevention of Violence](#)
- [The National Alliance for Safe Schools](#)
- [National School Safety Center](#)
- [National Resource Center for Safe Schools](#)
- [Office of Elementary and Secondary School](#)
- [Safe and Responsive Schools Project](#)
- [National Association of School Psychologists \(NASP\)](#)
- [Recording for the Blind and Dylexic](#)

## Relevant Publications That Can Be Obtained through Libraries

- **Administrator's Complete School Discipline Guide : Techniques & Materials for Creating an Environment Where Kids Can Learn.** By R.D. Ramsey (1994). Prentice Hall Direct.
- **Behavior and Discipline in Schools : Practical, Positive and Creative Strategies for the Classroom.** By P.B. Galvin (1999). David Fulton Pub.
- **Building classroom discipline.** by C.M. Charles & G. W. Senter. (2005). Boston, MA : Pearson/Allyn & Bacon.
- **Developing and Implementing a Whole-School Behavior Policy : A Practical Approach (Resource Materials for Teachers).** By D. Clarke and A. Murray (Eds.) (1996). David Fulton Pub.
- **Discipline with Dignity for Challenging Youth.** by Allen N. Mendler & Richard L. Curwin. (1999). Bloomington, Ind. : National Educational Service.
- **Learning to Trust : Transforming Difficult Elementary Classrooms through Developmental Discipline.** by M. Watson & L. Ecken. (2003). San Francisco : Jossey-Bass.
- **The Caring Teacher's Guide to Discipline : Helping Young Students Learn Self-control, Responsibility, and Respect.** by Marilyn E. Gootman. (2001). Thousand Oaks, Calif.: Corwin Press.

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## Bullying: a major barrier to student learning

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*Estimates indicate that as many as 8 percent of urban junior and senior high school students miss one day of school each month because they are afraid to attend.*

**S**chool staff are painfully aware that bullying is by far the biggest violence problem on many school campuses in many countries. Bullying is repeated harassment, abuse, oppression, or intimidation of another individual physically or psychologically. It can take the form of teasing, threatening, taunting, rejecting (socially isolating someone), hitting, stealing, and so forth. A bully is someone who engages in such acts fairly often. Bullies often claim they were provoked and appear to lack empathy for their victims.

Best estimates are that approximately 15% of students either bully or are bullied regularly. Direct physical bullying is reported as decreasing with age (peaking in the middle school). Verbal abuse seems not to abate. While more boys than girls are bullies, the problem is far from limited to males. Girls tend to use less direct strategies (e.g., spreading malicious rumors and shunning). Bullies may act alone or in groups.

As with other forms of violence, the conditions at school can minimize or worsen bullying. To reduce violence and promote well-being, schools must create caring, supportive, and safe environments and generate a sense of community.

### Why Kids Bully and How Bullies Differ

Many underlying factors can lead to acting out or externalizing behavior. Those who bully tend to come from homes where problems are handled by physical punishment and physically striking out. This is frequently paired with caretaking that lacks warmth and empathy.

From a motivational perspective, the roots are in experiences that threaten one's feelings of competence, self-determination, or relatedness to others or that directly produce negative feelings about such matters.

What causes acting out behavior to take the form of bullying is unclear. Initially, bullying behavior may be "modeled" and/or encouraged by significant others (e.g., imitating family members or peers).

Over time, it is likely that bullying develops because a youngster (1) finds the aggression enhances feelings of competence, self-determination, or connection with valued others and (2) perceives the costs of bullying as less than the "benefits." Some bullies seem to use the behavior mostly as a reactive defense; others seem to find so much satisfaction in the behavior that it becomes a proactive way of life.

Unfortunately, much of the current literature on interventions to address bullying focuses on the behavior, per se. Too little attention is paid to underlying causes. Relatedly, there is little discussion of different types of bullying. And, solutions are often narrow programs (usually emphasizing only skill development), rather than comprehensive approaches to prevention and intervention.

When different types of bullying are considered, it helps interveners to differentiate how best to approach the problem. In particular, understanding the causes of the behavior helps place discussion of social/prosocial skills in proper context. Such understanding underscores that in many cases the problem is not one of undeveloped skills, and thus, the solution in such instances is not simply skill training. Indeed, the central task confronting the intervener often is to address motivational considerations. This encompasses the underlying motivation for not using already developed skills and/or finding ways to enhance motivation for acquiring and practicing under-developed skills.

For example, a great deal of bullying at school is done by groups "ganging up" on students who are "different." Many of those doing the bullying wouldn't engage in this activity on their own, and most probably know and can demonstrate appropriate social skills in other situations.

In this example, the cause of the problem indicates the focus of intervention should be on the subgroup and school culture, rather than specific individuals. Currently, this includes human relations programs (including strategies to enhance motivation to resist inappropriate peer pressure) and environment-oriented approaches (e.g., intended to create a sense of community and caring culture in schools). Such interventions require broad-based leadership on the part of staff and students. The essence of the work is to maximize inclusion of all students in the social support fabric of the school and, in the process, to minimize scapegoating and alienation.

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The center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 Phone: (310) 825-3634.

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Other students may bully in an attempt to feel a degree of mastery and control over situations in which their sense of competence is threatened by daily academic failure. These students often are expressing frustration and anger at the broader system by targeting someone more vulnerable than themselves. It is not uncommon for such students to have requisite social skills, but to manifest them only in the absence of threats to their sense of well-being. Here, too, an understanding of cause can help interveners address the source of frustration.

In the American Educational Research Journal (2004), Watts and Erevelles stress that "most pragmatic responses to school violence seek to assign individual blame and to instill individual responsibility in students." From the perspective of the intersection of critical race theory and materialistic disability studies, they argue that "school violence is the result of the structural violence of oppressive social conditions that force students (especially low-income, male African American and Latino students) to feel vulnerable, angry, and resistant to the normative expectations of prison-like school environments."

Some students do lack social awareness and skills and end up bullying others because they lack the ability to establish positive peer relationships. Their problem often is compounded by the frustration and anger of not knowing alternatives. In such cases, probably any contemporary synthesis of social skills and any rigorous theory of moral development provide important insights and relevant frameworks to guide intervention.

A few other youngsters fall into a more proactive category of bullying. These are students whose behavior is not motivated by peer pressure, and they are not reacting to threats to their feelings of competence, self-determination, or connection to others. They are unmoved by efforts to create a caring community. Instead, they proactively, persistently, and chronically seek ways to intimidate others, apparently motivated by the "pleasure" they derive from their actions.

In the Forward to the fourth (2001) edition of Indicators of School Crime and Safety <http://www.ojp.usdoj.gov/bjs/pub/pdf/iscs01.pdf> Gary Phillips (Acting Commissioner of Education Statistics) & Lawrence Greenfeld (Acting Director of the Bureau of Justice Statistics) state:

*The safety of our students, teachers, and staff at school continues to be the focus of considerable national attention. National indicators affirm that the levels of crime in school have continued to decline, that acts that promote fear and detract from learning are decreasing,*

*and that students feel more safe in school than they did a few years ago. Despite declining rates, students ages 12 through 18 were victims of about 2.5 million crimes of violence or theft at school in 1999. Violence, theft, bullying, drugs, and firearms still remain problems in many schools throughout the country and periodically the news headlines relate the details of a tragic event in a school somewhere in America.*

As the report stresses, the goal remains one of ensuring that schools are safe and secure places for all students, teachers, and staff members. "Without a safe learning environment, teachers cannot teach and students cannot learn."

By now it should be evident that bullying is a complex and multi-determined phenomenon. As such, comprehensive, multifaceted, and integrated approaches are needed to address the problem. These can be built on the resources of the family, teachers and other school staff, and community support networks. The process involves enhancing a caring and socially supportive climate throughout the school and in every classroom, as well as providing assistance to individual students and families.

As bullying becomes a hot political topic, there is a risk that bullying intervention will be another project-of-the-year for schools. If project thinking prevails, another golden opportunity to improve student support systems will be lost.

For those concerned with moving in new directions for student support, it is essential to resist "project mentality." Projects exacerbate the marginalization, fragmentation, counterproductive competition, and overspecialization that characterizes the student support enterprise.

Rather than pursuing one more discrete intervention, it is essential to use each initiative to catalyze and leverage systemic change. The aim should be to take another step toward transforming how schools go about ensuring that all students have an equal opportunity to succeed at school. This means proceeding in ways that establish a comprehensive, multifaceted, and cohesive approach so each school can address barriers to student learning effectively.

At this point, however, the first concern is staff development to enhance understanding of bullying.

**See the specially developed Center Quick Training Aid entitled:**

***Bullying Prevention***  
<http://www.smhp.psych.ucla.edu/pdfdocs/quicktraining/bullyingprevention.pdf>



# Quick Training Aids



## *Behavior Problems at School*

Periodically, windows of opportunities arise for providing inservice at schools about mental health and psychosocial concerns. When such opportunities appear, it may be helpful to access one or more of our Center's *Quick Training Aids*.

Each of these offers a brief set of resources to guide those providing an inservice session. (They also are a form of quick self-tutorial.)

Most encompass


- key talking points for a short training session
- a brief overview of the topic
- facts sheets
- tools
- a sampling of other related information and resources

*In compiling resource material, the Center tries to identify those that represent "best practice" standards. If you know of better material, please [let us know](#) so that we can make improvements.*

## Guide for Suggested Talking Points

### I. Brief Overview

A. Present main points from:





[Behavior Problems: What's a School to Do?](#)  - Excerpted from *Addressing Barriers to Learning* Newsletter.

1. Refer to the outline entitled *Intervention Focus in Dealing with Misbehavior* for a concise description of strategies for managing misbehavior before, during and after its occurrence.
2. Utilize the *Logical Consequences* section to discuss the nature and rationale for implementing consequences, as well as a review of appropriate guidelines for using discipline in the classroom.

B. [Labeling Troubled and Troubling Youth: The Name Game](#) - Excerpted from *Addressing Barriers to Learning* Newsletter, Vol. 1(3), Summer 1996.




- Refer to this document to provide a theoretical framework for understanding, identifying and diagnosing various behavioral, emotional and learning problems. This framework accounts for both individual and environmental contributions to problem behavior.

## II. Fact Sheets

- A. [The Broad Continuum of Conduct and Behavioral Problems](#)  - Excerpted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care*, American Academy of Pediatrics (1996). Excerpted from a Center Guidebook entitled: Common Psychosocial Problems of School Aged Youth, pp. III B-5 (1999) and a Center Introductory Packet entitled: conduct and Behavior Problems: Intervention and Resources for School Aged Youth (1999).
1. This document serves as an additional resource for understanding and identifying variations in the nature and severity of behavior problems.
  2. This document should be referenced for additional information on variations in the manifestation of specific problem behaviors at different stages of development (infancy through adolescence).
- B. [Conduct Disorder in Children and Adolescents](#)  - Center for Mental Health Services Fact Sheet (<http://mentalhealth.samhsa.gov/publications/allpubs/CA-0010/default.asp>).
1. Note the section titled *What Are the Signs of Conduct Disorder*, which lists the symptoms of Conduct Disorder. These signal more severe problems that must be addressed.
  2. Because families may look to teachers or school counselors for help and/or referrals for their child, it is important to know what resources exist. The section *What Help Is Available for Families?* may be helpful in generating ideas about referral interventions.
- C. [Fact Sheet: Oppositional Defiant Disorder](#)  - Excerpted from a Center Introductory Packet entitled: *Conduct and Behavior Problems in School Aged Youth*, pp. 113 (1999). As adapted from an *Ask NOAH About: Mental Health Fact Sheet: Oppositional Defiant Disorder*, The New York Hospital / Cornell Medical Center. (<http://www.noah-health.org/english/illness/mentalhealth/cornell/conditions/odd.html>).
1. Note the section titled *Symptoms*, which covers symptoms of Oppositional Defiant Disorder.
  2. Ideas for interventions might be found in the section titled *Treatment*, and families can be encouraged to use the principles listed under *Self-Management*.
- D. [Children and Adolescents with Attention-Deficit / Hyperactivity Disorder](#)  Center for Mental Health Services Fact Sheet (<http://mentalhealth.samhsa.gov/publications/allpubs/CA-0008/default.asp>).

1. Note the section titled *What Are the Signs of Attention-Deficit/Hyperactivity Disorder*, which lists the symptoms of ADHD.
2. Again, the section *What Help Is Available for Families?* may be helpful in generating ideas about referral interventions.



### III. Tools/Handouts

- A. [What is a Behavioral Initiative?](#)  - Excerpted from a Technical Assistance Sampler entitled: *Behavioral Initiatives in Broad Perspective*, Center for Mental Health in Schools (1998).
  - A brief overview of what a "behavioral initiative" is and why taking a proactive approach to behavior management is necessary under the reauthorization of the Individuals with Disabilities Education Act (IDEA).
- B. [School-Wide Behavioral Management Systems](#)  - Excerpted from an ERIC Digest by Mary K. Fitzsimmons.
  1. Note that one of the main points of the article is that effective behavioral management requires a system that will "provide opportunities for all children to learn self-discipline." Thus, the focus is not on discipline strategies.
  2. Reinforce the points made by Tim Lewis of the University of Missouri (at the bottom of page 1). Objectives need to be realistic, need-based, and accompanied by multiple levels of support.
  3. The section titled *Common Features of School-Wide Behavioral Management Systems* can be used to generate discussion about encouraging commitment to a school-wide program incorporating a code of conduct and social/emotional skills instruction.
- C. [Student's Perspectives / Addressing Underlying Motivation to Change](#)  - Excerpted from a Guidebook entitled: *What Schools Can Do to Welcome and Meet the Needs of All Students*, Unit VI, pp 16-17 and Unit VII, pp. 23-28. Center for Mental Health in Schools (1997).
  1. This resource addresses the question "why?" in the discussion of students' problem behaviors. It also provides a list of assessment questions to guide understanding of the problem when it occurs.
  2. An assessment tool is provided as a guide in the assessment of problems from the student's point of view. This tool comes in one form for young children, and another form for all other children and youth.

### IV. Model Programs

- A. [Social Skills Training \(Examples\)](#):  - Excerpted from a Technical Assistance Sampler

entitled: *A Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning*, Center for Mental Health in Schools.

- B. [Violence Prevention and School Safety](#)  - Excerpted from a Technical Assistance Sampler entitled: *A Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning*, Center for Mental Health in Schools.
- C. Excerpts from: [Building on the Best, Learning What Works: A Few Promising Discipline and Violence Prevention Programs](#)  - Excerpted from American Federation of Teachers (2000). ( <http://www.aft.org/pubs-reports/downloads/teachers/wwdiscipline.pdf> )

## V. Additional Resources

- QuickFinds related to Behavior Problems at School:
  - [Anger Management](#)
  - [Bullying](#)
  - [Classroom Management](#)
  - [Conduct Disorders & Behavior Problems](#)
  - [Oppositional Defiant Disorder](#)
  - [Safe Schools and Violence Prevention](#)


## VI. Originals for Overheads

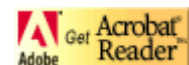
The following can be copied to overhead transparencies to assist in presenting this material.

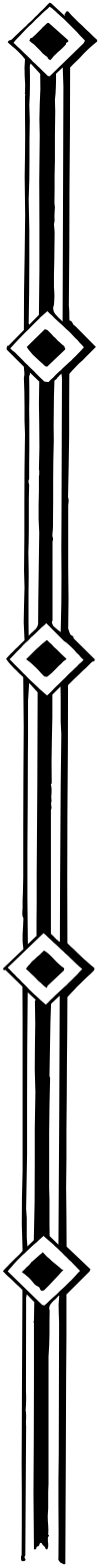
- A. [Behavior Problems: What's a School to Do?](#)
- B. [Labeling Troubled and Troubling Youth: The Name Game](#)
- C. [Addressing the Full Range of Problems](#)
- D. [Interconnected Systems for Meeting the Needs of All Students](#)

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by:

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**Note:** Documents in PDF format ( identified with a  )  
You will need *Adobe Acrobat Reader 5.0* or higher. Click [here](#) to  
download.

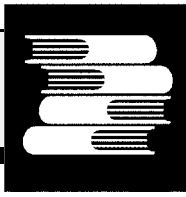




## V. A QUICK OVERVIEW OF SOME BASIC RESOURCES

- A. A Few References and Other Sources of Information
- B. Agencies and Online Resources Relevant to Conduct and Behavior Problems
- C. Conduct and Behavior Problems: Consultation Cadre Contacts





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*\* Also see references in previous excerpted articles*





## **B. Agencies and Online Resources Related to Conduct and Behavior Problems**

### **American Academy of Child & Adolescent Psychiatry (AACAP)**

The AACAP is the leading national professional medical association dedicated to treating and improving the quality of life for children, adolescents, and families affected by these disorders. This site is designed to serve both AACAP members, and Parents and Families. Information is provided as public service to aid in the understanding and treatment of the developmental, behavioral, and mental disorders which affect an estimated 7 to 12 million children and adolescents at any given time in the United States. You will find information on child and adolescent psychiatry, fact sheets for parents and caregivers, AACAP membership, current research, practical guidelines, managed care information, awards and fellowship descriptions, meeting information, and much more.

Contact: 3615 Wisconsin Ave., NW, Washington, D.C. 20016-3007

Voice: 202-966-7300

Fax: 202-966-2891

Website: [www.aacap.org](http://www.aacap.org)

### **Center for the Prevention of School Violence (CPSV)**

Established in 1993, CPSV serves as a resource center and "think tank" for efforts that promote safer schools and foster positive youth development. The Center's efforts in support of safer schools are directed at understanding the problems of school violence and developing solutions to them. The Center focuses on ensuring that schools function so that every student who attends does so in environments that are safe and secure, free of fear and conducive to learning. The Center's Safe Schools Pyramid focuses on the problem of school violence. This draws attention to the seriousness of school violence and act as a resource to turn to for information, program assistance, and research about school violence prevention.

Contact: 1801 Mail Service Center, Raleigh, North Carolina 27699-1801

Phone: 1-800-299-6054 or 919-733-3388 ext 332

Website: [www.cpsv.org](http://www.cpsv.org)

### **Center for the Study and Prevention of Violence (CSPV)**

CSPV works from a multi-disciplinary platform on the subject of violence and facilitates the building of bridges between the research community and the practitioners and policy makers. The CSPV Information House has research literature and resources on the causes and prevention of violence and provides direct information services to the public by offering topical searches on customized databases. CSPV also offers technical assistance for evaluation and development of violence prevention programs, and maintains a basic research component on the causes of violence and the effectiveness of prevention and intervention programs.

Contact: Institute of Behavioral Science, University of Colorado at Boulder

Campus Box 439 UCB. Boulder, CO 80309-0439

Phone: 303-492-8465

Fax: 303-443-3297

E-mail: [cspv@colorado.edu](mailto:cspv@colorado.edu)

Website: [www.colorado.edu/cspv/](http://www.colorado.edu/cspv/)

### **The Council for Children with Behavioral Disorders (CCBD)**

CCBD is the official division of the Council for Exceptional Children (CEC) committed to promoting and facilitating the education and general welfare of children and youth with emotional or behavioral disorders. CCBD is an international professional organization whose members include educators, parents, mental health personnel, and a variety of other professionals, actively pursues quality educational services and program alternatives for persons with behavioral disorders, advocates for the needs of such children and youth, emphasizes research and professional growth as vehicles for better understanding behavioral disorders, and provides professional support for persons who are involved with and serve children and youth with behavioral disorders

Website: [www.ccbd.net](http://www.ccbd.net)

### **The Council for Exceptional Children (CEC)**

CEC is the largest international professional organization dedicated to improving educational outcomes for individuals with exceptionalities, students with disabilities, and/or the gifted. They advocate for appropriate governmental policies, set professional standards, provides continual professional development, advocate for newly and historically underserved individuals with exceptionalities, & helps professionals obtain conditions and resources necessary for effective professional practice.

Contact: 1110 North Glebe Road, Suite 300, Arlington, VA 22201

Voice phone: 703-620-3660

TTY: 703-264-9446

Fax: 703-264-9494

Email: [service@cec.sped.org](mailto:service@cec.sped.org)

Website: [www.cec.sped.org/](http://www.cec.sped.org/)

### **Educational Resources Information Center** (note: some of these documents are included in this packet)

The ERIC database is the world's largest source of education information. The database contains more than 1 million abstracts of education-related documents and journal articles. You can access the ERIC database on the Internet or through commercial vendors and public networks. ERIC updates the database monthly (quarterly on CD-ROM), ensuring that the information you receive is timely and accurate.

Contact: 2277 Research Boulevard, 6M, Rockville, MD 20850

Toll Free: (800) LET-ERIC (538-3742)

Phone: (301) 519-5157

Fax: (301) 519-6760

E-mail: [accesseric@accesseric.org](mailto:accesseric@accesseric.org)

Website: [www.eric.ed.gov](http://www.eric.ed.gov)

### **Institute on Violence and Destructive Behavior**

The intention of the Institute on Violence and Destructive Behavior is to empower schools and social service agencies to address violence and destructive behavior, at the point of school entry and beyond, in order to ensure safety and to facilitate the academic achievement and healthy social development of children and youth. Combines community, campus and state efforts to research violence and destructive behavior among children and youth.

Contact: 1265 University of Oregon, Eugene, OR 97403-1265

Phone: (541) 346-3591

Fax: (541) 346-2594

Email: [ivdb@uoregon.edu](mailto:ivdb@uoregon.edu)

Website: [www.uoregon.edu/~ivdb](http://www.uoregon.edu/~ivdb)

### **The Joey Support Group Home Page.**

This site was created by a parent of a child diagnosed with both ADHD and ODD and includes links to related sites and where to find treatments and support. The Joey Support Group Home Page provides support and information on ADHD and ODD, including signs for parents and teachers to look for, and the interaction between ODD and ADHD.

Website: [members.aol.com/GramaRO/index.html](http://members.aol.com/GramaRO/index.html)

### **Mental Health Matters**

This site was created to supply information and resources to mental health consumers, professionals, students and supporter.

Contact: Get Mental Help, Inc., PO. Box 82149, Kenmore, WA 98028

Phone: (425) 402-6934

Email: [info@mental-health-matters.com](mailto:info@mental-health-matters.com)

Website: [www.mental-health-matters.com](http://www.mental-health-matters.com)

### **National Educational Service**

The Bullying Prevention Handbook: A Guide for Teachers, Principals and Counselors

By John Hoover and Ronald Oliver

This handbook provides a comprehensive tool for understanding, preventing, and reducing the day-to-day teasing and harassment referred to as bullying. This collection of effective teaching and counseling models is designed for use by all building-level educators and other professionals involved with disciplinary issues.

Contact: 304 West Kirkwood Ave. Suite 2, Bloomington, IN 47404-5132

Phone: 1-800-733-6786 or 812-336-7700 Fax: 812-336-7790

Email: nes@nesonline.com

Website: <http://www.solution-tree.com/Public/Media.aspx?ShowDetail=true&ProductID=BKF233>

### **National Mental Health Association (NMHA)**

The National Mental Health Association is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. With more than 340 affiliates nationwide, NMHA works to improve the mental health of all Americans, especially the 54 million people with mental disorders, through advocacy, education, research and service.

Contact: 2001 N. Beauregard Street, 12th Floor, Alexandria, VA 22311

Phone: (703) 684-7722 Fax: (703) 684-5968

Toll free: 800 969-NMHA TTY Line 800 433-5959

Website: [www.nmha.org](http://www.nmha.org)

### **National School Safety Center (NSSC)**

Created by presidential directive in 1984 to meet the growing need for additional training and preparation in the area of school crime and violence prevention. Affiliated with Pepperdine University, NSSC is a nonprofit organization whose charge is to promote safe schools -- free of crime and violence -- and to help ensure quality education for all America's children.

Contact: 141 Duesenberg Drive Suite 11, Westlake Village, CA 91362

Phone: (805) 373-9977 Fax: (805) 373-9277

Email: [info@nssc1.org](mailto:info@nssc1.org) Website: [www.nssc1.org](http://www.nssc1.org)

### **National Youth Gang Center**

Purpose is to expand and maintain the body of critical knowledge about youth gangs and effective responses to them. Assists state and local jurisdictions in the collection, analysis, and exchange of information on gang-related demographics, legislation, literature, research, and promising program strategies. Also coordinates activities of the Office of Juvenile Justice & Delinquency Prevention (OJJDP) Youth Gang Consortium -- a group of federal agencies, gang program representatives, and service providers.

Contact: Post Office Box 12729, Tallahassee, FL 32317

Phone: (850) 385-0600 Fax: (850) 386-5356

E-mail: [nygc@iir.com](mailto:nygc@iir.com) Web site: <http://www.iir.com/nygc/>

### **Oppositional Defiant Disorder Patient/Family Resources**

From the University of Alabama College of Community Health Sciences (CCHS), this page contains information and resources on or about Oppositional Defiant Disorder. Its main goal is to give parents and professionals some ideas that may help bring some piece of mind to the child and the family. It includes parenting information and organizational books that help parents learn skills on behavior and anger management

Website: [cchs-dl.slis.ua.edu/patientinfo/psychiatry/childhood/disruptive/oppositional-defiant-disorder.htm](http://cchs-dl.slis.ua.edu/patientinfo/psychiatry/childhood/disruptive/oppositional-defiant-disorder.htm)

### **Oppositional Defiant Disorder Support Group**

This site is a companion site to a wonderful message board filled with personal stories. The message board started in mid-90's when a parent, in desperation, reached out to other parents by starting a message board.

Website: [www.conductdisorders.com/](http://www.conductdisorders.com/)

### Oppositional Defiant Disorder (ODD)

<http://www.klis.com/chandler/pamphlet/oddcdd/oddcddpamphlet.htm>

ODD is a psychiatric disorder that is characterized by two different sets of problems. These are aggressiveness and a tendency to purposefully bother and irritate others. It is often the reason that people seek treatment. When ODD is present with ADHD, depression, tourette's, anxiety disorders, or other neuropsychiatric disorders, it makes life with that child far more difficult. For Example, ADHD plus ODD is much worse than ADHD alone, often enough to make people seek treatment. The criteria for ODD are:

A pattern of negativistic, hostile, and defiant behavior lasting at least six months during which four or more of the following are present:

1. Often loses temper
2. often argues with adults
3. often actively defies or refuses to comply with adults' requests or rules
4. often deliberately annoys people
5. often blames others for his or her mistakes or misbehavior
6. is often touchy or easily annoyed by others
7. is often angry and resentful
8. is often spiteful and vindictive



### Partnerships Against Violence Network

PAVNET Online is a "virtual library" of information about violence and youth-at-risk, representing data from seven different Federal agencies. It is a "one-stop," searchable, information resource to help reduce redundancy in information management and provide clear and comprehensive access to information for States and local communities.

Website: [www.pavnet.org/](http://www.pavnet.org/)

### Safe and Drug-Free Schools Programs Office (ED)

The Safe and Drug-Free Schools Program is the Federal government's primary vehicle for reducing drug, alcohol and tobacco use, and violence, through education and prevention activities in our nation's schools. The program supports initiatives to meet the seventh National Education Goal, which states that by the year 2000 all schools will be free of drugs and violence and the unauthorized presence of firearms and alcohol, and offer a disciplined environment conducive to learning. These initiatives are designed to prevent violence in and around schools, strengthen programs that prevent illegal use of substances, involve parents, and are coordinated with related Federal, State and community efforts and resources.

Phone: 1-800-USA-LEARN (1-800-872-5327) TTY: 1-800-437-0833

Fax: 202-401-0689

Email: [osdfs.safeschl@ed.gov](mailto:osdfs.safeschl@ed.gov) Website: [www.ed.gov/offices/OESE/SDFS/](http://www.ed.gov/offices/OESE/SDFS/)

### Social Development Research Group

Research focus on the prevention and treatment of health and behavior problems among young people. Drug abuse, delinquency, risky sexual behavior, violence, and school dropout are among the problems addressed. J. David Hawkins, director, and Richard F. Catalano, associate director, began in 1979 to develop the Social Development Strategy, which provides the theoretical basis for risk- and protective-focused prevention that underlies much of the groups' research.

Contact: 9725 3<sup>rd</sup> Ave. NE, Suite 401, Seattle, WA 98115

Phone: (206) 685-1997

Fax: (206) 543-4507

Email: [sdrg@u.washington.edu](mailto:sdrg@u.washington.edu)

Website: [depts.washington.edu/sdrg](http://depts.washington.edu/sdrg)



**Teaching Children Not To Be -- Or Be Victims Of -- Bullies**  
**<http://www.kidsource.com/kidsource/content3/bullies.parenting.p.k12.4.html>**

From the National Association for the Education of Young Children  
([www.naeyc.org](http://www.naeyc.org))  
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National Association for the Education of Young Children.

Parents and teachers are sometimes reluctant to intervene in conflicts between young children. They don't want to see children harm or ridicule one another, but they want to encourage children to learn how to work out problems for themselves. In such cases, adults have a responsibility to stop violence or aggression in the classroom or at home -- both for children who demonstrate harmful behavior and for all other children. We can teach children not to take part in -- or become victims of -- bullying.

Children who demonstrate aggression, or "bully" other children may be unable to initiate friendly interactions, express their feelings, or ask for what they need. If these children do not improve their social skills, they will continue to have problems relating to peers throughout their lives. In addition, if other children see that aggressors get what they want through bullying, they are more likely to accept or imitate this undesirable behavior.

Young children who are unable to stand up for themselves are easy targets for aggressive playmates. These children inadvertently reward bullies by giving in to them, and risk further victimization. Adults do not help by speaking for victims and solving their problems for them. Children must learn that they have the right to say "No," not only when they are threatened, but in a wide range of everyday situations.

## **Consultation Cadre Contacts with advice related to Conduct and Behavior Problems in School Aged Youth**

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 3/5/08*

### **Central States**

#### **Ohio**

Betty Yung  
Co-Director, Violence Training Inst.  
School of Professional Psychology, Wright State  
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Ellis Inst., SOPP, Wright State University  
9 N. Edwin Moses Blvd.  
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#### **Kentucky**

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Western Kentucky University  
Psychology Department  
1 Big Red Way  
Bowling Green, KY 42101  
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#### **Minnesota**

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961 West Nebraska Ave.  
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#### **Pennsylvania**

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Children's Policy Specialist  
Pennsylvania Community Providers Associaton  
2400 Park Drive  
Harrisburg, PA 17110  
Phone: 717:657-7078 Fax: 717/657-3552  
Email: connell@paparviders.org

#### **Texas**

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## East

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National Association of School Psychologist  
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### Maryland

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## Northwest

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Seattle, WA 98105  
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### Wisconsin

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## Southeast

### Arkansas

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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

Howard Knoff  
Director  
Project ACHIEVE  
49 Wooberry Road  
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## Southwest

### California

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### Hawaii

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Email: hlee@tiffe.org

### Nevada

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Miguel Rivera Family Resource Center  
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Reno, NV 89509  
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Email: sunwindy@aol.com

### New Mexico

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Mark Oldknow  
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Department of Children, Youth & Families  
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## VI. KEEPING CONDUCT AND BEHAVIOR PROBLEMS IN BROAD PERSPECTIVE

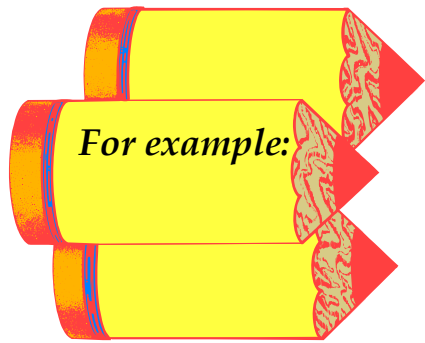


Affect and related problems are often key factors interfering with school learning and performance. As a result, considerable attention has been given to interventions to address such problems. Our reading of the research literature indicates that most methods have had only a limited impact on the learning, 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.