

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 of more of our Center's *Quick Training Aids*.

Each of these offer a brief set of resources to guide those providing an inservice session. (They also are a form of quick self-tutorial and group discussion.)

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- 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

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Excerpts from *Addressing Barriers to Learning Newsletter*

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The real difficulty in changing the course of any enterprise lies not in developing new ideas but in escaping old ones.

John Maynard Keynes

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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 skill *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, and they want curricula to enhance values and character, including responsibility (social and moral), integrity, self-regulation (self-discipline), and a work ethic and that also 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.

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 and anti-social acts and various mental health problems. Disciplinary procedures also are associated with dropping out of school. It is not surprising, then, that some concerned professionals refer to extreme disciplinary practices as "pushout" strategies.

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

Logical Consequences

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

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

Basically, consequences involve depriving students of something they want and/or making them experience something they don't want. Consequences usually take the form of (a) removal/deprivation (e.g., loss of losses due to the misbehavior), and (b) recantations (e.g., apologies, plans for avoiding future problems). For instance, teachers commonly deal with acting out behavior by removing a student from an activity. To the teacher, this step (often described as "time out") may be a logical way to stop the student from disrupting others by isolating him or her, or the logic may be that the student needs a cooling off period. It may be reasoned that (a) by misbehaving the student has shown s/he does not deserve the privilege of participating (assuming the student likes the activity) and (b) the loss will lead to improved behavior in order to avoid future deprivation.

Most teachers have little difficulty explaining their reasons for using a consequence. However, if the intent really is to have students perceive consequences as logical and nondebilitating, it seems logical to determine whether the recipient sees the discipline as a legitimate response to misbehavior. Moreover, it is well to recognize the difficulty of

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).

administering consequences in a way that minimizes the negative impact on a student's perceptions of self. Although the intent is to stress that it is the misbehavior and its impact that are bad, the student can too easily experience the process as a characterization of her or him as a bad person.

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

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

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

Social Skills Training

Suppression of undesired acts does not necessarily lead to desired behavior. It is clear that more is needed than classroom management and disciplinary practices.

Is the answer social skill 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.)

See the *Lessons Learned* column on p. 8 for a synthesis of curriculum content areas for fostering social and emotional development. For a comprehensive bibliography of articles, chapters, books, and programs on social skills and social competence of children and youth, see Quinn, Mathur, and Rutherford, 1996. Also, see Daniel Goleman's (1995) book on *Emotional Intelligence* which is stimulating growing interest in ways to facilitate social and emotional competence.

Addressing Underlying Motivation

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

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

Of course, misbehavior in the classroom often also is reactive, stemming from avoidance motivation. This behavior can be viewed as *protective reactions*. Students with learning problems can be seen as motivated to avoid and to protest against being forced into situations in which they cannot cope effectively. For such students, many teaching and therapy situations are perceived in this way. Under such circumstances, individuals can be expected to react by trying to protect themselves from the unpleasant thoughts and feelings that the situations stimulate (e.g., feelings of incompetence, loss of

autonomy, negative relationships). In effect, the misbehavior reflects efforts to cope and defend against aversive experiences. The actions may be direct or indirect and include defiance, physical and psychological withdrawal, and diversionary tactics

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

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

In general, intrinsic motivational theory suggests that corrective interventions for those misbehaving reactively requires steps designed to reduce reactance and enhance positive motivation for participating in an intervention. For youngsters highly motivated to pursue deviance (e.g., those who proactively engage in criminal acts), even more is needed. Intervention might focus on helping these youngsters identify and follow through on a range of valued, socially appropriate alternatives to deviant activity. From the theoretical perspective presented above, such alternatives must be capable of producing greater feelings of self-determination, competence, and relatedness than usually result from the youngster's deviant actions. To these ends, motivational analyses of the problem can point to corrective steps for implementation by teachers, clinicians, parents, or students themselves. (For more on approaching misbehavior from a motivational perspective, see Adelman and Taylor, 1990; 1993; Deci & Ryan, 1985.)

Some Relevant References

- Adelman, H.S., & Taylor, L. (1990). Intrinsic motivation and school misbehavior: Some intervention implications. *Journal of Learning Disabilities*, 23, 541-550.
- Adelman, H.S. & Taylor, L. (1993). *Learning problems and learning disabilities: Moving forward*. Pacific Grove, CA: Brooks/Cole.
- Bear, G.G. (1995). Best practices in school discipline. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology -- III*. Washington, DC: National Association of School Psychologists.
- Bauer, A.M., & Sapona, R.H. (1991). *Managing classrooms to facilitate learning*. Englewood Cliffs, NJ: Prentice-Hall.
- Deci, E.L. & Ryan, R.M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York: Plenum Press.
- Duncan, B.J. (1997). Character education: Reclaiming the social. *Educational Theory*, 47, 119-126.
- Elias, M.J. Gara, M.A., Schuyler, T.F., Branden-Muller, L.R., & Sayette, M.A. (1991). The promotion of social competence: Longitudinal study of a preventive school-based program. *American Journal of Orthopsychiatry*, 61, 409-417.
- Forness, S.R. & Kavale, K.A. (1996). Treating social skill deficits in children with learning disabilities: A meta-analysis of the research. *Learning Disability Quarterly*, 19, 2-13.
- Goleman, D. (1995). *Emotional Intelligence*. New York: Bantam Books, Inc.
- Greenberg, M.T., Kusche, C.A., Cook, E.T., & Quamma, J.P. (1995). Promoting emotional competence in school-aged children: The effects of the PATHS curriculum. *Development and Psychopathology*, 7.
- Gresham, F.M. (1995) Best practices in social skills training. In A Thomas & J. Grimes (Eds.), *Best practices in school psychology -- III* (pp.1021-1030). Washington, DC: National Association of School Psychologists.
- Hyman, I., Flanagan, D., & Smith, K. (1982). Discipline in the schools. In C.R. Reynolds & T.B. Gutkin (Eds.), *The handbook of school psychology* (pp. 454-480). New York: Wiley.
- Knoff, H.M. (1987). School-based interventions for discipline problems. In C.A. Maher & J.E. Zins (Eds.), *Psychoeducational interventions in the schools* (pp. 118-140). New York: Pergamon.
- Mathur, S.R., & Rutherford, R.B. (1995). Is social skills training effective for students with emotional or behavioral disorders? Research issues and needs. *Behavioral Disorders* 22, 21-28.
- Quinn, M.M., Mathur, S.R., & Rutherford, R.B. (1996). *Social skills and social competence of children and youth: A comprehensive bibliography of articles, chapters, books, and programs*. Tempe, AZ: Arizona State University.
- Wolfgang, C.H. & Glickman, C.D. (1986). *Solving discipline problems: Strategies for classroom teachers* (2nd ed.). Boston: Allyn & Bacon.

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)

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Normality and exceptionally (or deviance) are not absolutes; both are culturally defined by particular societies at particular times for particular purposes.

Ruth Benedict

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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

It is not surprising that debates about labeling young people are so heated. Differential diagnosis is difficult and fraught with complex issues (e.g., Adelman, 1995; Adelman & Taylor, 1994;

Carnegie Council on Adolescent Development, 1989; Dryfoos, 1990).

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. This is well-illustrated by the widely-used *Diagnostic and Statistical Manual of Mental Disorders -- DSM IV* (American Psychiatric Association, 1994) and by MMPI categories, as well as the dimensions formulated by Achenbach and others based on behavior rating scales.

As a result, comprehensive *formal* systems used to classify problems in human functioning convey the impression that all behavioral, emotional, or learning problems are instigated by internal *pathology*. Some efforts to temper this notion see the pathology as a vulnerability that only becomes evident under stress. However, most differential diagnoses of children's problems are made by focusing on identifying one or more disorders (e.g., oppositional defiant disorder, attention-deficit/hyperactivity disorder, or adjustment disorders), rather than first asking: *Is there a disorder?*

Bias toward labeling problems in terms of *personal* rather than *social causation* is bolstered by factors such as (a) *attributional bias* -- a tendency for observers to perceive others' problems as rooted in stable personal dispositions (Miller & Porter, 1988) and (b) *economic and political influences* -- whereby society's current priorities and other

extrinsic forces shape professional practice (Becker, 1963; Chase, 1977; Hobbs, 1975; Schact, 1985).

Overemphasis on classifying problems in terms of personal pathology skews theory, research, practice, and public policy. One example is seen in the fact that comprehensive classification systems do not exist for environmentally caused problems or for psychosocial problems (caused by the transaction of internal and environmental factors).

There is considerable irony in all this because so 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's helps to approach all diagnosis guided by a broad perspective of what determines human behavior.

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

To illustrate the nature of transactional thinking, let's look at learning problems. In teaching a lesson, a classroom teacher will find some students learn easily, and some do not; some misbehave, some do not. Even a good student may appear distracted on a given day.

Why the differences?

A common sense answer suggests that each student brings something different to the situation and therefore experiences it differently. And that's a pretty good answer -- as far as it goes. What gets lost in this simple explanation is the essence of the reciprocal impact student and situation have on each other -- resulting in continuous change in both.

A Broad View of Human Functioning

Before the 1920s, 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.

To clarify the point: For purposes of the present discussion, any student can be viewed as bringing to each situation *capacities and attitudes* accumulated over time, as well as *current states of being and behaving*. These "person" variables transact with each other and also with the environment (Adelman & Taylor, 1993).

At the same time, the situation in which students are expected to function not only consists of *instructional processes and content*, but also the *physical and social context* in which instruction takes place. Each part of the environment also transacts with the others.

Obviously, the transactions can vary considerably and can lead to a variety of outcomes. Observers noting student capacities and attitudes may describe the outcomes in terms of *desired, deviant,*

disrupted, or delayed functioning. Any of these outcomes may *primarily* reflect the impact of person variables, environmental variables, or both.

Toward a Broader Framework

The need to address a wider range of variables in labeling problems is clearly seen in efforts to develop multifaceted systems. The multiaxial classification system developed by the American Psychiatric Association in its *Diagnostic and Statistical Manual of Mental Disorders -- DSM IV* represents the dominant approach (American Psychiatric Association, 1994). This system does include a dimension acknowledging "psychosocial stressors." However, this dimension is used mostly to deal with the environment as a contributing factor, rather than as a primary cause.

The following conceptual example illustrates a broad framework that offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid overdiagnosing internal pathology. As outlined in the accompanying figure, 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 and referred to as Type I problems. At the other end are problems caused primarily by pathology within the person; these are designated as Type III problems. In the middle are problems stemming from a relatively equal contribution of environmental and person sources, labelled Type II problems.

To be more specific: In this scheme, 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. Obviously, some problems caused by pathological conditions within a person are not manifested in severe, pervasive ways, and there are persons without such pathology whose problems do become severe and pervasive. The

intent is not to ignore these individuals. As a first categorization step, however, it is essential they not be confused with those seen as having Type III problems.

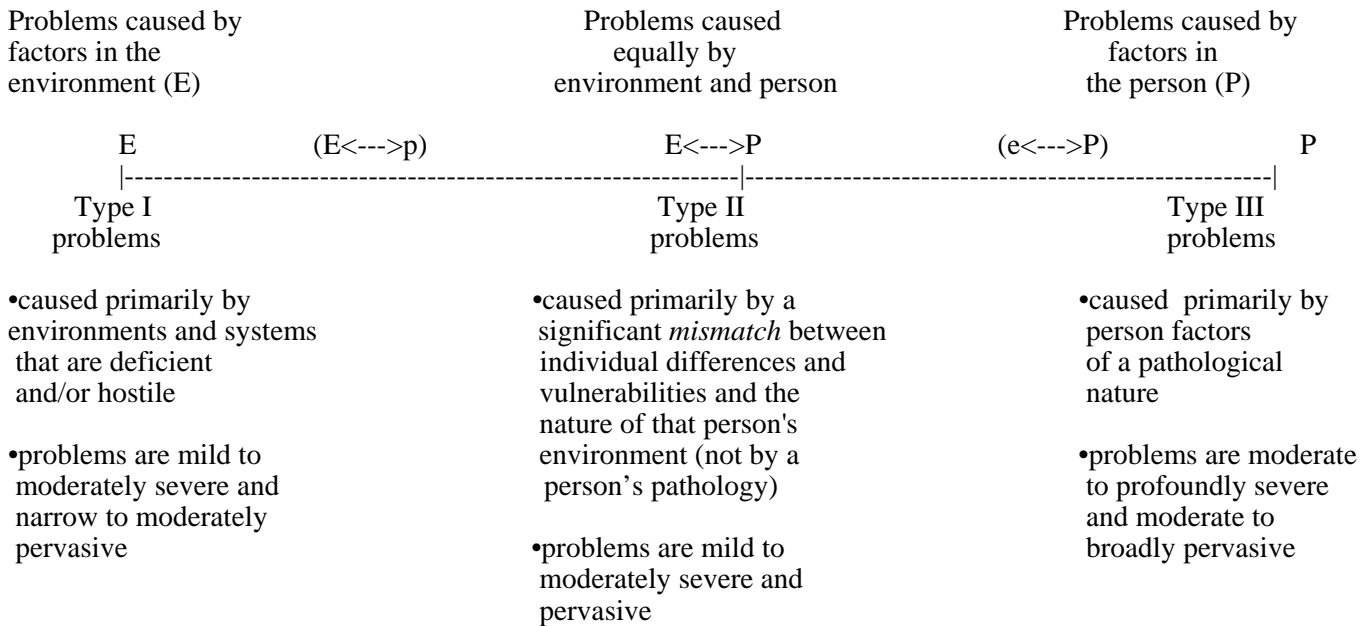
At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's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

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

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

Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. Furthermore, some problems are not easily assessed or do not fall readily into a group due to data limitations and comorbidity. 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

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



In this conceptual scheme, the emphasis in each case is on problems that are beyond the early stage of onset.

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.

Addressing the Full Range of Problems

When behavior, emotional, and learning problems are labelled in ways that overemphasize internal pathology, the helping strategies used primarily are some form of clinical/remedial intervention. For the most part, such interventions are developed and function in relative isolation of each other. Thus, they represent another instance of using piecemeal and fragmented strategies to address complex problems. One result is that an individual identified as having several problems may be involved in programs with several professionals working independently of each other. Similarly, a youngster identified and treated in special infant and pre-school programs who still requires special support may cease to receive appropriate help upon entering school. And so forth.

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

To illustrate the comprehensive range of programs needed to address Type I, II, and III problems, a continuum is outlined on the following page. The continuum ranges from programs for primary prevention (including the promotion of mental health) and early-age intervention -- through those for addressing problems soon after onset -- on to treatments for severe and chronic problems. With respect to *comprehensiveness*, the range of programs highlights that many problems must be addressed developmentally and with a range of

programs -- some focused on individuals and some on environmental systems, some focused on mental health and some on physical health, education, and social services. With respect to concerns about *integrating* programs, the continuum underscores the need for concurrent interprogram linkages and for linkages over extended periods of time.

Concluding Comments

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

A large number of young people are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters behave in ways that distress others; only a small percent have ADHD or a conduct disorder. In some schools, the majority of students have garden variety learning problems; only a few have learning disabilities. Thankfully, those suffering from true internal pathology (those referred to above as Type III problems) represent a relatively small segment of the population. Society must never stop providing the best services it can for such individuals and doing so means taking great care not to misdiagnose others whose "symptoms" may be similar but are caused to a significant degree by factors other than internal pathology (those referred to above as Type I and II problems). Such misdiagnoses lead youngsters behave in ways that distress others; only a small percent have ADHD or a conduct disorder. In some schools, the majority of students have garden variety learning problems; only a few have learning disabilities. Thankfully,

Establishing a comprehensive, integrated approach is excruciatingly hard. Efforts to do so are handicapped by the way interventions are conceived and organized and the way professionals understand their functions. Conceptually, intervention rarely is envisioned comprehensively. Organizationally, the tendency is for policy makers to mandate and planners and developers to focus on specific programs. Functionally, most practitioners and researchers spend most of their time working directly with specific interventions and samples and give little thought or time to comprehensive models or mechanisms for program development and collaboration. Consequently, programs to address physical, mental health, and psychosocial problems rarely are coordinated with each other or with educational programs.

Limited efficacy seems inevitable as long as the full continuum of necessary programs is unavailable; limited cost effectiveness seems inevitable as long as related interventions are carried out in isolation of each other. Given all this, it is not surprising that many in the field doubt that major breakthroughs can occur without a comprehensive and integrated programmatic thrust. Such views have added impetus to major initiatives are underway designed to restructure community health and human services and the way schools operate (Adelman, in press; Adler & Gardner, 1994; Center for the Future of Children Staff, 1992; Hodgkinson, 1989; Taylor & Adelman, 1996).

those suffering from true internal pathology (those referred to above as Type III problems) represent a relatively small segment of the population. Society must never stop providing the best services it can for such individuals and doing so means taking great care not to misdiagnose others whose "symptoms" may be similar but are caused to a significant degree by factors other than internal pathology (those referred to above as Type I and II problems). Such misdiagnoses lead to policies and practices that exhaust available resources in serving a relatively small percent of those in need. That is a major reason why there are so few resources to address the barriers interfering with the education and healthy development of so many youngsters who are seen as troubled and troubling.

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

Intervention Continuum

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

Primary prevention

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

Early-after-onset intervention

Treatment for severe/chronic problems

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

References

- Adelman, H.S. (1995). Clinical psychology: Beyond psychopathology and clinical interventions. *Clinical Psychology: Science and Practice*, 2, 28-44.
- Adelman, H.S. (in press). Restructuring education support services: Toward the concept of an enabling component. Manuscript submitted for publication.
- Adelman, H.S. & Taylor, L. (1993). *Learning problems and learning disabilities: Moving forward*. Pacific Grove, CA: Brooks/Cole.
- Adelman, H.S. & Taylor, L. (1994). *On understanding intervention in psychology and education*. Westport, CT: Praeger.
- Adler, L., & Gardner, S. (Eds.), (1994). *The politics of linking schools and social services*. Washington, DC: Falmer Press.
- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.
- Bandura, A. (1978). The self system in reciprocal determination. *American Psychologist*, 33, 344-358.
- Becker, H.S. (1963). *Outsiders: Studies in the sociology of deviance*. Glencoe, ILL: Free Press.
- Carnegie Council on Adolescent Development. (1989). *Turning points: Preparing American Youth for the 21st century*. New York: Carnegie Corporation.
- Center for the Future of Children Staff (1992). Analysis. *The Future of Children*, 2, 6-188.
- Chase, A. (1977). *The legacy of Malthus: The social costs of the new scientific racism*. New York: Knopf.
- Dryfoos, J.G. (1990). *Adolescents at risk: Prevalence and prevention*. London: Oxford University Press.
- Hobbs, N. (1975). *The future of children: Categories, labels, and their consequences*. San Francisco: Jossey-Bass.
- Hodgkinson, H.L. (1989). *The same client: The demographics of education and service delivery systems*. Washington, DC: Institute for educational Leadership. Inc./Center for Demographic Policy.
- Miller, D.T., & Porter, C.A. (1988). Errors and biases in the attribution process. In L.Y. Abramson (Ed.), *Social cognition and clinical psychology: A synthesis*. New York: Guilford.
- Ryan, W. (1971). *Blaming the victim*. New York: Random House.
- Schact, T.E. (1985). DSM-III and the politics of truth. *American Psychologist*, 40, 513-521.
- Taylor, L., & Adelman, H.S. (1996). Mental health in the schools: Promising directions for practice. *Adolescent Medicine: State of the Art Reviews*, 7.

II. Fact Sheets/Practice notes

A. The Broad Continuum of Conduct and Behavioral Problems

1. Developmental Variations

2. Problems

3. Disorders

B. Fact Sheet: Conduct Disorder in Children and Adolescents

<http://www.mentalhealth.org/publications/allpubs/CA-0010/CA-0010.pdf>

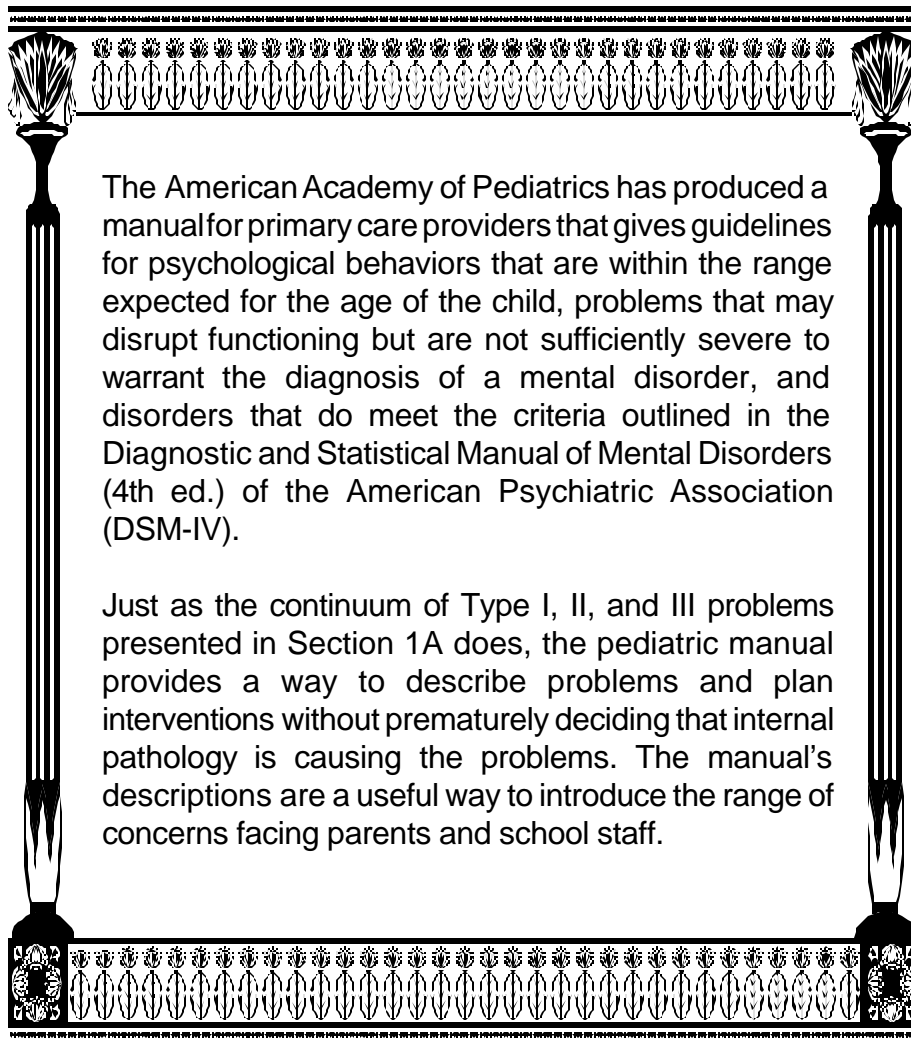
C. Fact Sheet: Oppositional Defiant Disorder

<http://www.noah-health.org/english/illness/mentalhealth/cornell/conditions/odd.html>

D. Reducing Behavior Problems

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.

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

DEVELOPMENTAL VARIATION

Negative Emotional Behavior Variation

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

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

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

Early Childhood

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

Middle Childhood

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

Adolescence

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

SPECIAL INFORMATION

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

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

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

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

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

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

DEVELOPMENTAL VARIATIONS

Aggressive/Oppositional Variation

Oppositionality

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

DEVELOPMENTAL VARIATIONS

Aggressive/Oppositional Variation

Aggression

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

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

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.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

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

Early Childhood

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

Middle Childhood

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

Adolescence

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

SPECIAL INFORMATION

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

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

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

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.

PROBLEM

Aggressive/Oppositional Problem

Aggression

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

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

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

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.

COMMON DEVELOPMENT PRESENTATIONS

Infancy

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

Early Childhood

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

Middle Childhood

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

Adolescence

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

SPECIAL INFORMATION

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

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

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

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

COMMON DEVELOPMENT PRESENTATIONS

Infancy

It is not possible to make the diagnosis.

Early Childhood

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

Middle Childhood

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

Adolescence

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

SPECIAL INFORMATION

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

DISORDERS

Oppositional Defiant Disorder

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

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

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



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 if symptoms continue for 6 months or longer. Because of the impact conduct disorder has on children, their families, neighbors, and schools, it is known as a "disruptive behavior disorder."

Another disruptive behavior disorder, called **oppositional defiant disorder**, may be a precursor of conduct disorder. Oppositional defiant disorder is diagnosed when a child is 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?

Some symptoms of conduct disorder include the following:

- Aggressive behavior that harms or threatens other people or animals
- Destructive behavior that damages or destroys property
- Lying or theft

Some diagnosed cases of conduct disorder may be considered serious emotional disturbances. Systems of care for children's mental health offer children with serious emotional disturbances and their families a wide range of comprehensive and community-based services to help them reach their full potential. To learn more about systems of care, call 301.443.1333, or request the free fact sheet on systems of care (see p. 4 for ordering information).

- Truancy or other serious violations of rules
- Early tobacco, alcohol, and substance use and abuse
- Precocious sexual activity

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

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

www.mentalhealth.org/child

For information about children's mental health contact the Knowledge Exchange Network

Toll-free: 1.800.789.2647
Fax: 301.984.8796
TTY: 301.443.9006



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

How Common Is Conduct Disorder?

Conduct disorder affects 1 to 4 percent of 9–17 year-olds, depending on exactly how the disorder is defined.¹ The disorder appears to be more common in boys than girls and in cities than rural areas. Those with an early onset of conduct disorder may also be at risk for antisocial personality disorder.

Who Is at Risk?

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 the following:

- Early maternal rejection
- Separation from parents with no adequate alternative caregiver available
- Early institutionalization
- Family neglect
- Abuse or violence
- Parental psychiatric illness
- Parental marital discord
- Large family size
- Crowding
- Poverty

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 the following:

- Training for parents on how to handle their children’s or adolescents’ behavior
- Family therapy
- Training in problemsolving 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 conduct disorder is identified and treated, the better. Some recent studies have focused on promising ways to prevent conduct disorder among at-risk children and adolescents. Most children or adolescents with conduct disorder are probably reacting to events and situations in their lives. More research is needed to determine if biology is a factor in conduct disorder.

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.

A parent or caregiver who notices signs of conduct disorder or oppositional defiant disorder in a child or adolescent should:

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

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

Mental Health Resources on the Internet:

Centers for Disease Control and Prevention:
www.cdc.gov

ClinicalTrials.gov, National Institutes of Health:
www.clinicaltrials.gov

Food and Drug Administration:
www.fda.gov

Substance Abuse and Mental Health Services Administration:
www.samhsa.gov

National Institute of Mental Health:
www.nimh.nih.gov

Endnote

¹U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services.

This is one of many fact sheets in this series on children's mental health disorders. All of the fact sheets listed below are written in an easy-to-read style. Families, caretakers, and media professionals find them helpful when researching particular mental health disorders. To obtain free copies, call 1.800.789.2647 or visit www.mentalhealth.org/child.

Other Fact Sheets in This Series:

Order

Number

Title

CA-0000	Caring for Every Child's Mental Health Campaign Products Catalog
CA-0004	Child and Adolescent Mental Health
CA-0005	Child and Adolescent Mental Health: Glossary of Terms
CA-0006	Children and Adolescents With Mental, Emotional, and Behavioral Disorders
CA-0007	Children and Adolescents With Anxiety Disorders
CA-0008	Children and Adolescents With Attention-Deficit/Hyperactivity Disorder
CA-0009	Children and Adolescents With Autism
CA-0011	Children and Adolescents With Severe Depression
CA-0014	Facts About Systems of Care for Children's Mental Health

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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What Works Clearinghouse: Practice Guides

http://ies.ed.gov/ncee/wwc/pdf/practiceguides/behavior_pg_092308.pdf

Reducing Behavior Problems in the Elementary School Classroom

Released: September 2008

Overview

Much of the attention currently given to improving students' academic achievement addresses issues of curriculum, instructional strategies, and interventions or services for struggling learners, and rightfully so. However, even after addressing these issues, barriers still remain for some students. An estimated one-third of students fail to learn because of psychosocial problems that interfere with their ability to fully attend to and engage in instructional activities, prompting a call for "new directions for addressing barriers to learning." These new approaches go beyond explicitly academic interventions to take on the learning challenges posed by problematic student behavior and the ways schools deal with it. Approaches aimed at improving school and classroom environments, including reducing the negative effects of disruptive or distracting behaviors, can enhance the chances that effective teaching and learning will occur, both for the students exhibiting problem behaviors and for their classmates.

In many schools general education elementary classrooms are generally orderly, teacher-student and student-student relationships are positive, and teaching and learning go on without major disruption. Teachers in such classrooms recognize the importance of preventing significant behavior problems and are effectively using fundamental prevention tools—engaging instruction, well-managed classrooms, and positive relationships with students.

Looking to these prevention fundamentals should always be the first step in promoting good behavior at school. However, some teachers have a class in which one or a few students exhibit persistent or significant problem behaviors—those that are disruptive, oppositional, distracting, or defiant. Sometimes when a number of students in a classroom demonstrate such behaviors, it can create a chaotic environment that is a serious impediment to learning for all students. In these cases teachers have exhausted their classroom management strategies without successfully eliminating the obstacles to learning that problem behaviors pose. The purpose of this practice guide is to give teachers additional tools to help them deal proactively and effectively with behaviors that seriously or consistently fail to meet classroom expectations.

This practice guide offers five concrete recommendations (see table 2) to help elementary school general education teachers reduce the frequency of the most common types of behavior problems they encounter among their students. The recommendations begin with strategies teachers can use immediately on their own initiative in their classrooms

(recommendations 1–3), then broaden to include approaches that involve resources from outside the classroom. We recognize that teachers encounter situations where they need the guidance, expertise, and support of parents and other teachers or behavior professionals (for example, a school psychologist or behavior specialist) in the school or community, and that school administrators play a critical role in enabling mentoring and collaborative opportunities for staff (recommendation 4). We also acknowledge that the social and behavioral climate of a classroom can reflect the climate of the school more broadly, and we address the contributions of schoolwide strategies or programs to improving student behavior (recommendation 5).

Fundamental to these recommendations is the notion that behavior is learned— children’s behaviors are shaped by the expectations and examples provided by important adults in their lives and by their peers. In the elementary grades, general education classroom teachers are arguably the most important adults at school for the large majority of students. As such, they can play a critical role both in proactively teaching and reinforcing appropriate student behaviors and in reducing the frequency of behaviors that impede learning. Accepting responsibility for the behavioral learning of all students is a natural extension of the responsibility for the academic learning of all students that general education teachers exercise with such purpose every day. The goal of this practice guide is to help teachers carry out their dual responsibility by recommending ways to shape and manage classroom behavior so that teaching and learning can be effective.

Understanding what prompts and reinforces problem behaviors can be a powerful tool for preventing them or reducing their negative impacts when they occur. The first recommendation emphasizes teachers’ gathering information about important aspects of problem behaviors in their classrooms—for example, the specific behavior a student exhibits, its effects on learning, and when, where, and how often it occurs. This information can provide important clues to the underlying purpose of the problem behavior and a foundation for developing effective approaches to mitigate it.

The second recommendation points to classroom conditions or activities that teachers can alter or adapt to influence the frequency or intensity of problem behaviors. When teachers understand the behavioral hot spots in their classroom in terms of timing, setting, and instructional activities, for example, they can proactively develop classwide and individual student strategies (such as a change in instructional groupings, the seating plan, or the order or pace of reading and math instruction) to reduce the contribution of these classroom factors to students’ problem behaviors.

The third recommendation recognizes that, just as poor academic performance can reflect deficits in specific academic skills, some students’ failure to meet behavioral expectations reflects deficits in specific social or behavioral skills. And just as explicit instruction can help students overcome some academic deficits, explicit instruction can help students learn the positive behaviors and skills they are expected to exhibit at school. Showing students how

they can use appropriate behaviors to replace problem behaviors and consistently providing positive reinforcement when they do so can increase students' chances of experiencing social and behavioral success.

Recognizing the collective wisdom and problem-solving abilities of school staff, the fourth recommendation encourages teachers to reach out to colleagues in the school—other classroom teachers, special educators, the school psychologist, or administrators—to help meet the behavioral needs of their students. Similarly, by engaging family members, teachers can better understand their students' behavior issues and develop allies in intervening both at school and at home to help students succeed. When behavior problems warrant the services of behavioral or mental health professionals, teachers are encouraged to play an active role in ensuring that services address classroom behavior issues directly.

Several principles run throughout these recommendations. One relates to the importance of relationships in any focus on student behavior. Schooling is “an intrinsically social enterprise.” Student behavior is shaped by and exhibited and interpreted in a social context that involves multiple actors (teachers, students, support personnel, specialists), multiple settings (classrooms, hallways, lunch room, playground), and multiple goals (enhancing academic performance, encouraging development of the whole child). Positive behavior is more likely to thrive when relationships at all levels are trusting and supportive and reflect a shared commitment to establish a healthy school and community.

In the classroom, for example, positive teacher-student interactions are at the heart of the recommendation regarding modifying classroom environment and instructional factors to improve student behavior. Associations have been found between positive interactions with teachers and increases in students' social skills, emotional regulation, motivation, engagement, cooperation with classroom rules and expectations, and academic performance. Associations also have been noted between negative interactions with teachers and increases in students' risk for school failure. Teachers show the warmth, respect, and sensitivity they feel for their students through small gestures, such as welcoming students by name as they enter the class each day, calling or sending positive notes home to acknowledge good behavior, and learning about their students' interests, families, and accomplishments outside of school. Teachers also can help students develop peer friendships by having them work together, thereby learning to share materials, follow directions, be polite, listen, show empathy, and work out disagreements. Fostering students' social and emotional development can improve their interactions and attitudes toward school, thereby reducing problem behaviors...

III. Tools/Handouts

A. What is a Behavioral Initiative?

B. School-Wide Behavioral Management Systems

http://www.ed.gov/databases/ERIC_Digests/ed417515.html

C. Student's Perspectives / Addressing Underlying
Motivation to Change

What is a Behavioral Initiative?

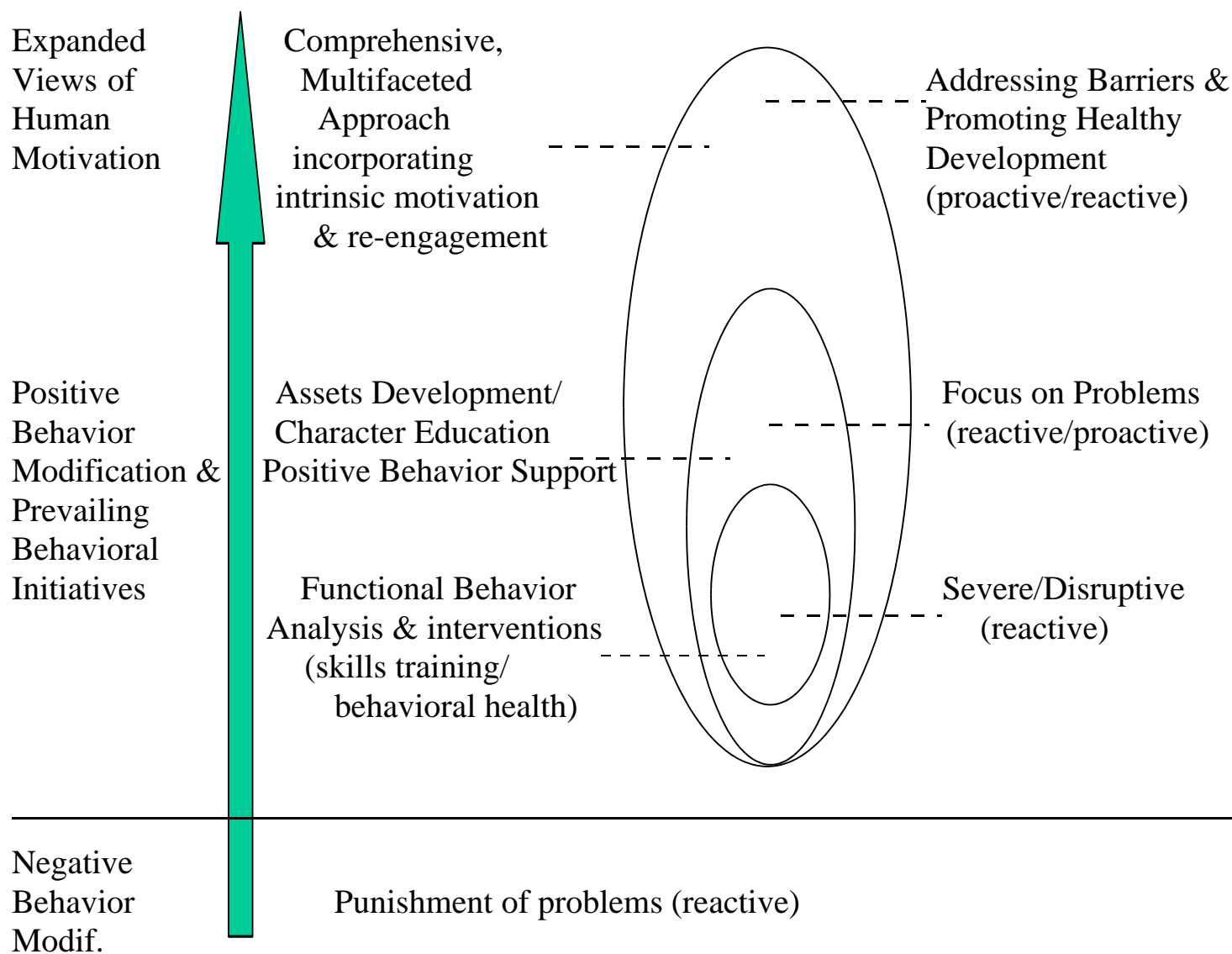
Flaunting the rules, vandalizing property, bullying others, acting out in disrespectful, defiant, and violent ways -- schools across the country are being called on to do more about such student misbehavior. From the general public's perspective, the incidence of "discipline" problems is far too great; from the perspective of teachers and other school staff and many students, the problems represent additional barriers to teaching and learning. Concern about all this is heightened by the movement to keep special education students in regular classrooms, including those who need special interventions to address behavioral needs.

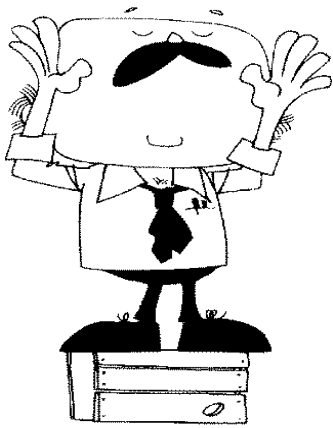
How should schools respond to problem behavior? In too many cases, the tendency is to overrely on strategies such as denying privileges, detention, and suspension. Too often, such measures are ineffective and even counterproductive. The necessity for schools to improve how they respond to behavioral needs is delineated in the 1997 reauthorization of IDEA (Individuals with Disabilities Education Act) which calls for IEPs (Individual Education Programs) to address such needs among children with disabilities early and comprehensively.* This requirement is a catalyst for schools to enhance the way they address behavioral concerns of all students.

And so the move to behavioral initiatives. In response to increasing need and the deficiencies of current practices, those responsible for public education are now developing behavioral initiatives. Such initiatives emphasize proactive programs to address student misbehavior. They provide families, schools, and communities with reforms and tools to reduce behavioral barriers to learning. In the process, they have the potential to foster school wide approaches to addressing barriers to learning and enhance positive relationships among school, family, and community.

What does a behavioral initiative look like? Because there is no consensus about the characteristics of such interventions, marked variations can be expected as initiatives develop. Some will focus on underlying causes of misbehavior; a few will emphasize holistic approaches; many will focus directly on behavioral interventions and functional assessments; some will emphasize direct and indirect ways to promote student social and emotional development; some will focus on enhancing school and community attitudes, skills, and systems. All will recognize the need for schools and communities to work together. The state of Montana, for example, sees its initiative as assisting "educators and other community members in developing the attitudes, skills, and systems necessary to ensure that each student leaves public education and enters the community with social competence appropriate to the individual regardless of ability or disability." The aim is to develop students who are "personally and socially ready to participate as productive citizens." This is to be accomplished through "a comprehensive staff development venture created to improve the capacities of schools and communities to meet the diverse and increasingly complex social, emotional and behavioral needs of students."

Developmental Trend in Intervention Thinking: Behavioral Initiatives and Beyond





School-Wide Behavioral Management Systems

By: Mary K. Fitzsimmons

ERIC Digest

http://www.ed.gov/databases/ERIC_Digests/ed417515.html

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:

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.

Unified expectations: Consistent and fair expectations for behavioral instruction are a key to successful discipline plans.

Unified consequences: Using a warm yet firm voice, teachers state the behavior, the violated rule, and the unified consequence and offer encouragement.

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.

ED417515 98 School-Wide Behavioral Management Systems. ERIC/OSEP Digest #E563. Author: Fitzsimmons, Mary K.

ERIC Clearinghouse on Disabilities and Gifted Education, Reston, VA.

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> REFERENCES

- Cheney, D., Barringer, C., Upham, D., & Manning, B. (1995). Project DESTINY: A model for developing educational support teams through interagency networks for youth with emotional or behavioral disorders. *Special Services in the Schools*, 10(2), 57-76.
- Colvin, G., Kameenui, E. J., & Sugai, G. (1993). Reconceptualizing behavior management and school-wide discipline in general education. *Education and Treatment of Children*, 16(4), 361-381.
- Jones, V. (1993). Assessing your classroom and school-wide student management plan. *Beyond Behavior*, 4(3), 9-12.
- Lewis, T. (1997). Responsible decision making about effective behavioral support. Available through the ERIC Clearinghouse.
- Pennsylvania Department of Education, Bureau of Special Education. (1995). *Guidelines: Effective behavioral support*. Harrisburg, PA: Author.
- Reavis, H. K., Kukic, S. J., Jenson, W. R., Morgan, D. P., Andrews, D. J., & Fister, S. (1996). *BEST Practices*. Longmont, CO: Sopris West Publishers.
- Sugai, G. & Pruitt, R. (1993). *Phases, steps and guidelines for building school-wide behavior management programs: A practitioners handbook*. Eugene, OR: Behavior Disorders Program.
- Taylor-Green, S., Brown, D., Nelson, L., Longton, J., Cohen, J., Swartz, J., Horner, R., Sugai, G., & Hall, S. (in press). School-wide behavioral support: Starting the year off right. *Journal of Behavioral Education*.
- Thomas, A., & Grimes, J. (1995). *Best practices in school psychology - III*. Silver Spring, MD: National Association of School Psychologists.
- Walker, H., Horner, R., Sugai, G., Bullis, M., Sprague, J., Bricker, D., & Kaufman, M. (1996). Integrated approaches to preventing antisocial behavior patterns among school age children and youth. *Journal of Emotional and Behavioral Disorders*, 4, 193-256.

STUDENTS' PERSPECTIVES / ADDRESSING UNDERLYING MOTIVATION



This **Quick Training Aid** was 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).

Beyond discipline, 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 behavior stemming from such approach motivation can be viewed as pursuit of deviance.

Of course, misbehavior in the classroom often also is reactive, stemming from avoidance motivation. This behavior can be viewed as *protective reactions*. Students with learning problems can be seen as motivated to avoid and to protest against being forced into situations in which they cannot cope effectively. For such students, many teaching and therapy situations are perceived in this way. Under such circumstances, individuals can be expected to react by trying to protect themselves from the unpleasant thoughts and feeling that the situations stimulate (e.g., feelings of incompetence, loss of autonomy, negative relationships). In effect, the misbehavior reflects efforts to cope and defend against aversive experiences. The actions may 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 to 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 these motivational concerns in a comprehensive, normative way results in approaching passive and often hostile students with practices that can 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 problem 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 and Taylor, 1990;1993; Deci & Ryan, 1985.)

On the following pages are two versions of an interview instrument that can be used to elicit a student's perception of the problem and underlying motivation to address the problem. One form of the tool is for older students, the other for young students.

(Version 1: For use with all but very young students)

Student's View of the Problem -- Initial Interview Form
--

Interviewer _____ Date _____

Note the identified problem:

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

Questions for student to answer:

Student's Name _____ Age _____ Birthdate _____

Sex: M F Grade _____ Current Placement _____

Ethnicity _____ Primary Language _____

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

(1) How would you describe your current situation? What problems are you experiencing?

What are your main concerns?

(2) How serious are these matters for you at this time?

1	2	3	4
very serious	serious	Not too serious	Not at all serious

(3) How long have these been problems?

___ 0-3 months ___ 4 months to a year ___ more than a year

(4) What do you think originally caused these problems?

(5) Do others (parents, teachers, friends) think there were other causes?
If so, what they say they were?

(6) What other things are currently making it hard to deal with the problems?

(7) What have you already tried in order to deal with the problems?

(8) Why do you think these things didn't work?

(9) What have others advised you to do?

(10) What do you think would help solve the problems?

(11) How much time and effort do you want to put into solving the problems?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	quite a bit	very much

If you answered 1, 2, or 3, why don't you want to put much time and effort into solving problems?

(12) What type of help do you want?

(13) What changes are you hoping for?

(14) How hopeful are you about solving the problems?

1	2	3	4
very hopeful	somewhat	not too	not at all hopeful

If you're not hopeful, why not?

(15) What else should we know so that we can help?

Are there any other matters you want to discuss?

(Version 2: For use with very young students)

Student's View of the Problem -- Initial Interview Form
--

Interviewer _____ Date _____

Note the identified problem:

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

Questions for student to answer:

Student's Name _____ Age _____ Birthdate _____

Sex: M F Grade _____ Current Placement _____

Ethnicity _____ Primary Language _____

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

(1) Are you having problems at school? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(2) How much do you like school?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about school don't you like?

What can we do to make it better for you?

(3) Are you having problems at home? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(4) How much do you like things at home?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about things at home don't you like?

What can we do to make it better for you?

(5) Are you having problems with other kids? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(6) How much do you like being with other kids?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about other kids don't you like?

What can we do to make it better for you?

(7) What type of help do you want?

(8) How hopeful are you about solving the problems?

1	2	3	4
very hopeful	somewhat	not too	not at all hopeful

If you're not hopeful, why not?

(9) What else should we know so that we can help?

Are there any other things you want to tell me or talk about?

IV. Model Programs

A. Social Skills Training (Examples)

B. Violence Prevention and School Safety Programs

C. Excerpts from: *Building on the Best, Learning from What Works: Five Promising Discipline and Violence Prevention Programs*

Student and Family Assistance Programs and Services: *Social Skills Training For Externalizing and Internalizing Behaviors*



This **Quick Training Aid** was excerpted from a Technical Assistance Sampler entitled: *A Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning*, Appendix C, pp. 5-6. Center for Mental Health in Schools (1999).

Programs Focused on Externalizing Behaviors

- Researchers evaluated the effects of a social skills cognitive training program on locus of control for middle school students with behavior problems. Sixth and seventh grade students were randomly selected from three middle schools based on the following criteria: receipt of one or more disciplinary referrals which reflected problems with school authority figures or peers and two or more conduct reports from teachers. They were then randomly assigned to a social skills training program or to a control group within each school. Significant differences were found between the pre- and post-test scores on the measure of locus of control (functioning) and on teacher's ratings of self-control (symptoms). The subjects that participated in the treatment experienced a significant shift in locus of control and were better able to restrict their behaviors than the control group.

For more information, see:

Dupper & Krishef (1993). School-based social-cognitive skills training for middle school students with school behavior problems. *Children and Youth Services Review*, 15, 131-142.

- A school-based social skills training model that incorporated cognitive-behavioral strategies was evaluated with African American aggressive, rejected, and nonaggressive rejected children. Children were randomly assigned to the social skills intervention or to a control group. Posttreatment and 1-year follow-up assessments indicated that the social relations intervention was effective with the aggressive and rejected children but not with the nonaggressive children in promoting nonimpulsive problem solving (functioning).

For more information, see:

Lochman, J.E., Coie, J., Underwood, M., & Terry, R. (1993). Effectiveness of a social relations intervention program for aggressive and nonaggressive, rejected children. *Journal of Consulting and Clinical Psychology*, 61, 1053-1058.

- *Anger Coping Program*: Described as involving 18 sessions that teach affect identification, self-control, and problem-solving skills. Children role-play and practice skills in a small group setting and under conditions of affective arousal. Goal setting and reinforcement are incorporated to support skill acquisition. Data indicate the program lowers boys observed disruptive and aggressive behavior in the classroom, and in some cases, improves parent ratings of aggressive behavior.

For more information, see:

Lochman, J.E., Burch, P.R., Curry, J.F. & Lampron, L.B. (1984). Treatment and generalization effects of cognitive behavioral and goal-setting interventions with aggressive boys. *Journal of Consulting and Clinical Psychology*, 52, 915-916.

- *Brainpower Program*: In one study, aggressive 10 to 12 year old boys were paired with non-aggressive peers and exposed to a 12-lesson school-based intervention focusing on improving the accuracy of children's perceptions and interpretations of others' actions. Compared to a randomized control group, teacher ratings indicated that the Brainpower program was successful at reducing their aggressive behavior immediately following the intervention.

For more information, see:

Hudley, C. & Graham, S. (1993). An attributional intervention to reduce peer-directed aggression among African-American boys. *Child Development*, 64, 124-138.

Hudley, C., & Graham, S. (1995). School-based interventions for aggressive African-American boys. *Applied & Preventive Psychology*, 4, 185-195.

- *Peer Coping Skills Training Program*: Targeted 94 first to third grade students with high teacher-rated aggression ratings. Students were randomly assigned to either a treatment group or control. In the treatment condition, integrated teams of children were taught prosocial-coping skills in 22 weekly 50-minute sessions. The teams progressed through different skills and levels of difficulty; new skills were not introduced until the team had demonstrated mastery of the previous skills. This format encouraged and reinforced peer support. Outcomes measured at post-test and 6 months following the intervention supported its positive effects. Children in the PCS program were rated by teachers as significantly less aggressive than controls at post-test ($p < .02$) and follow-up ($p < .01$). Significant improvements were also noted in the intervention children's prosocial coping and teacher-rated social skills.

For more information, see:

Prinz, R.J., Blechman, E.A., & Dumas, J.E. (1994). An evaluation of peer coping-skills training for childhood aggression. *Journal of Clinical Child Psychology*, 23, 193-203.

- *Social Relations Program* -- described as consisting of 26 social skills training sessions on improving the skills needed for entrance into peer groups and positive peer play. In one study, children were also trained in social problem solving and anger management. The majority of the sessions were held individually but eight were conducted in small groups and provided the children with some time to practice the skills they were learning. The program was evaluated on a sample ($n=52$) of 9 to 11-year-old, African-American children. Results indicated that compared to matched controls, the aggressive-rejected children were rated as significantly less aggressive by teachers and more socially accepted by peers at post-test. The effects of the intervention were maintained at one-year follow-up. The students in the aggressive-rejected intervention group were rated by teachers as significantly less aggressive ($p < .03$) and more prosocial ($p < .03$) compared to aggressive-rejected students in the control group.

For more information see:

Coie, J.D., Lochman, J.E., Terry, R., & Hyman, C. (1992). Predicting early adolescent disorder from childhood aggression and peer rejection. *Journal of Consulting and Clinical Psychology*, 60, 783-792.

Programs Focused on Internalizing Behaviors

- Disliked first-, second-, and third-grade boys who showed high levels of negative social behavior during pretreatment observations were randomly assigned to one of four conditions: instructions and coaching in positive behaviors; prohibitions and response cost for negative behaviors; a combination of instructions and prohibitions; and no treatment. Interventions were implemented during 10 half-hour, supervised, small group play sessions, and treatment effects were assessed using behavioral observations, and peer and teacher ratings. A comparison was made between the effects of positive instructions and negative inhibitions in a social skills training program for boys with negative social behavior and were rejected by their peers. Results showed that the boys who received the combined program showed immediate post treatment decreases in negative initiations, later decreases in negative peer responses, and stable positive peer interactions (symptom reductions and functional improvements).

For more information, see:

Bierman, Miller & Stabb (1987). Improving the social behavior and peer acceptance of rejected boys: Effects of social skill training with instructions and prohibitions. *Journal of Consulting and Clinical Psychology*, 55, 194-200.

- Investigation of an interactive videodisc social skills training program on peer acceptance was performed. Children in six elementary school resource rooms were randomly assigned to participate in the treatment or to continue their resource room program. Experimental group students scored significantly higher on a post-training measure of peer acceptance than did control group students (functioning).

For more information, see:

Thorkildssen (1985). Using an interactive videodisc program to teach social skills to handicapped children. *American Annals of the Deaf*, 130, 383-385.

- In a study evaluating the effectiveness of a stress management program on children's locus of control orientation, self-concept and acquisition of appropriate coping strategies (functional outcomes). Sixty-five students from an inner-city school were randomly assigned to the stress management program or control group. The children in the stress management program demonstrated a more internal locus of control and a higher self concept on school-related tasks and behavior problems.

For more information, see:

Henderson, Kelbey, & Engebretson (1992). Effects of a stress-control program on children's locus of control, self-concept, and coping behavior. *School Counselor*, 40, 125-131.

- Researchers used a social learning approach to teach the acquisition of behavioral skills to resist the pressures to misuse alcohol (symptom and functioning). A total of 5,635 students from 213 classrooms were assigned randomly by school building to one of three experimental conditions: social skills training, social skills training plus follow-up training, and no training control. Students in the treatment groups showed significantly greater awareness of the curriculum content than did the control group at the 8-week follow-up. Alcohol use and misuse were not significantly different between treatment and control groups due to the low prevalence in both groups.

For more information, see:

Dielman, Shope, Butchart, and Campanelli (1986). Preventions of adolescent alcohol misuse: An elementary school program. *Journal of Pediatric Psychology*, 11, 259-282.

- *Penn Prevention Program* -- is described as altering the cognitive distortions and improving coping skills in at-risk youth. Results from a quasi-experimental evaluation study suggested that the program resulted in clinically significant reductions in depressive symptoms immediately post-treatment and at a 6-month follow-up.

For more information, see:

Gillham, J.E., Reivich, K.J., Jaycox, L.H., & Seligman, M.E.P. (1995). Prevention of depressive symptoms in schoolchildren: Two-year follow-up. *Psychological Science*, 6, 343-351.

Violence Prevention and School Safety Programs



This **Quick Training Aid** was excerpted from a Technical Assistance Sampler entitled: *A Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning*, Appendix D, pp. 6-10. Center for Mental Health in Schools (1999).

Second Step: A Violence Prevention Curriculum: Second Step is a school-based social skills curriculum for preschool through junior high that teaches children to change the attitudes and behaviors that contribute to violence. Second Step teaches the same three skill units at each grade level: Empathy, Impulse Control, and Anger Management. Lesson content varies according to the grade level, and the skills practiced are designed to be developmentally appropriate. There were no significant teacher- or parent-reported differences between those students participating in Second Step and a control group. However, two-weeks after the intervention was completed behavioral observations revealed that students in Second Step showed an overall decrease in physical aggression, and an increase in neutral/prosocial behavior, compared to the control group. Most of these effects persisted six months later.

For more information, see:

Grossman, D.C., Neckerman, H.J., Koepsell, T.D., Liu, P. Asher, K.N., Beland, K., Frey, K., & Rivara, F.P. (1997). Effectiveness of a violence prevention curriculum among children in elementary school: A randomized controlled trial. *Journal of the American Medical Association*, 277(20), 1605-1611.

Quinn, M. M., Osher, D., Hoffman, C. C., & Hanley, T. V. (1998). *Safe, drug-free, and effective schools for ALL students: What works!* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

For project information, contact:

Second Step: A Violence Prevention Curriculum: Committee for Children, 2203 Airport Way South, Suite 500, Seattle, WA 98134. (800) 634-4449, (206) 343-1223.

Responding in Peaceful and Positive Ways (RIPP) Program: The 25 session RIPP program focuses on social/cognitive skill-building to promote nonviolent conflict resolution and positive communication. The 25-session sixth grade curriculum is taught during a 45-minute class period once a week. Participants showed significantly lower rates of fighting, bringing weapons to school, and in-school suspensions than control subjects.

For project information, contact:

Farrell, A.D. & Meyer, A.L., & Dahlberg, L.L. (1996). The effectiveness of a school-based curriculum for reducing violence among urban sixth-grad students. *American Journal of Public Health*, 87, 979-984

Farrell, A.D., Meyer, A.L. & Dahlberg, L.L. (1996). Richmond youth against violence; A school based program for urban adolescents. *American Journal of Preventive Medicine*, 12, 13-21.

Farrell, A.D. & Meyer, A.L. (in press). Social Skills Training to Promote Resilience in Urban Sixth Grade Students: One product of an action research strategy to prevent youth violence in high-risk environments. *Education and Treatment of Children*.

First Step to Success: An early intervention program for grades K-3 that takes a collaborative home and school approach to diverting at-risk children from a path leading to adjustment problems, school failure and drop-out, social juvenile delinquency in adolescence, and gang membership and interpersonal violence. By recruiting parents as partners with the school, this program teaches children a behavior pattern that contributes to school success and the development of friendship. Children are screened for antisocial behavior, they participate in a social skills curriculum, and parents are taught key skills for supporting and improving their child's school adjustment and performance. Students who successfully complete the program show sustained behavior changes in the following areas, as indicated by teacher ratings and direct observations: adaptive behavior, aggressive behavior, maladaptive behavior, and the amount of time spent appropriately engaged in teacher-assigned tasks. Follow-up studies show that intervention effects persist up to two-years beyond the end of the initial intervention phase.

For more information, see:

Walker, H.M. (1998). First step to success: Preventing antisocial behavior among at-risk kindergartners. *Teaching Exceptional Children*, 30(4), 16-19.

Walker, H.M., Severson, H.H., Feil, E.G., Stiller, B., & Golly, A. (1997). *First step to success: Intervening at the point of school entry to prevent antisocial behavior patterns*. Longmont, CO: Sopris West.

Walker, H.M., Stiller, B., Severson, H.H., Kavanagh, K., Golly, A., & Feil, E.G. (in press). First step to success: An early intervention approach for preventing school antisocial behavior. *Journal of Emotional and Behavioral Disorders*, 5(4).

For program information, contact:

Jeff Sprague & Hill Walker, Co-Directors. Institute on Violence and Destructive Behavior, 1265 University of Oregon, Eugene, OR 97403. (541) 346-3591

Project ACHIEVE: A school wide prevention and early intervention program, that targets students who are academically and socially at risk. Students learn social skills, problem-solving methods, and anger-reduction techniques. Since 1990, the program has reduced aggression and violence in Project ACHIEVE schools. Disciplinary referrals decreased by 67%. Specifically, referrals for disobedient behavior dropped by 86%, fighting by 72% and disruptive behavior by 88%. Referrals for at-risk students for special education testing decreased 75% while the number of effective academic and behavioral interventions in the regular classroom significantly increased. Suspensions dropped to one-third of what they had been three years before. Grade retention, achievement test scores, and academic performance have improved similarly, and, during the past four years, no student has been placed in the county's alternative education program. The project's success has led to the adoption of the Project ACHIEVE model in over 20 additional sites across the United States.

For more information, see:

Knoff, H.M. & Batsche, G. M. (1995). Project ACHIEVE: Analyzing a school reform process for at-risk and underachieving students. *School Psychology Review*, 24(4), 579-603.

Knoff, H.M. & Batsche, G. M. *Safe Schools, Safe Students*. Edited by Ronda C. Talley & Garry R. Walz. National Education Goals Panel and National Alliance of Pupil Services Organizations. Produced in collaboration with ERIC Counseling and Student Services Clearinghouse.

Quinn, M. M., Osher, D., Hoffman, C. C., & Hanley, T. V. (1998). *Safe, drug-free, and effective schools for ALL students: What works!* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

For project information, contact:

Drs. Howie Knoff and George Batsche, Co-Directors, Institute for School Reform, Integrated Services, and Child Mental Health and Education Policy, School Psychology Program, FAO 100U, Room 268, The University of South Florida, Tampa, FL 33620-7750, (813) 974-3246.

Bullying Prevention Program: A universal intervention for the reduction and prevention of bully/victim problems. The main arena for the program is the school, and school staff has the primary responsibility for the introduction and implementation of the program. Program targets are students in elementary, middle, and junior high schools. All students within a school participate in most aspects of the program. Additional individual interventions are targeted at students who are identified as bullies or victims of bullying. The Bullying Prevention Program has been shown to result in: a substantial reduction in boys' and girls' reports of bullying and victimization; a significant reduction in students' reports of general antisocial behavior such as vandalism, fighting, theft and truancy; and significant improvements in the "social climate" of the class, as reflected in students' reports of improved order and discipline, more positive social relationships, and a more positive attitude toward schoolwork and school.

For more information, contact:

Dan Olweus, Ph.D., University of Bergen, Research Center for Health Promotion (HEMIL), Christiesgt. 13, N-5015, Bergen, Norway, 47-55-58-23-27, E-mail: olweus@psych.uib.no

Conflict Resolution and Peer Mediation Projects (CR/PM): Nine CR/PM programs throughout the country were evaluated. Data from this evaluation suggests that CR/PM projects may reduce the frequency of fighting and other undesirable behaviors at school, increase knowledge and modify student's attitudes about conflict, improve school discipline, and increase attendance. However, these findings are based on preliminary data, and success varies depends on how the curriculum is implemented.

For more information, see:

Altman E. (1994). *Violence Prevention Curricula: Summary of Evaluations*. Springfield, Ill: Illinois Council for the Prevention of Violence.

Powell, K. E., Muir-McClain, L., & Halasyamani, L. (1995). A review of selected school-based conflict resolution and peer mediation projects. *Journal of School Health*, 65 (10), 426-431.

Tolan, P. H. & Guerra, N. G. (1994). *What Works in Reducing Adolescent Violence: An Empirical Review of the Field*. Boulder, CO: Center for the Study and Prevention of Violence.

PeaceBuilders: A school-wide violence prevention program for elementary schools (K-5). This program is designed to prevent violence by reducing students' hostility and aggression by changing the school climate and promoting prosocial behavior. The project involves norm-setting, peace-building, and communication skills development. It reinforces prosocial behavior and enhances parent education and involvement, and includes mass media tie-ins. A year before PeaceBuilders began, 120 children were suspended and about 30 were arrested for crimes in the community. Two years into PeaceBuilders, the number of suspensions had dropped to five, and there were no arrests for community crimes. One school using the PeaceBuilders program reported that major student fights dropped from 125 to 23; another school reported a decrease from 180 to 24. Outcome assessments are still underway.

For more information, see:

Embry, D.D., Flannery, D.J., Vazsonyi, A.T., Powell, K.E., & Atha, H. (1996). PeaceBuilders: A theoretically driven, school-based model for early violence prevention. *American Journal of Preventive Medicine*. Youth Violence Prevention: Description and Baseline Data from 13 Evaluation Projects (Supp.), 12 (5), 91-100.

Walker, H.M., Colvin, G., Ramsey, E. (1995). *Anti-Social Behavior in Schools: Strategies and Best Practices*. Pacific Grove, California: Brooks/Cole.

For program information, contact:

Jane Gulibon, Heartsprings, Inc., P.O. Box 15258, Tuscon, AZ 85732, (520) 322-9977.

Positive Adolescent Choices Training (PACT): Designed to reduce the chances that African-American and other at-risk adolescents will become victims or perpetrators of violence. Primarily targets youth between 12 and 16 identified as socially deficient or with a history of violence. Participants receive hands-on training and practice in 3 areas: prosocial skills, anger control, and violence risk education. Data suggest that those who completed the program showed reduced violence-related behavior as well as gains in skills predictive of future abilities to avoid violence. The data also suggest that others perceived the trained participants to have improved social skills and that trainees themselves had more confidence in their abilities to perform the new behaviors.

For more information, see:

Hammond, W.R., & Yung, B.R. (Winter, 1991). Preventing violence in at-risk African-American Youth. *Journal of Health Care for the Poor and Underserved*, 359-373.

For program information, contact:

B. Yung, Center for Child and Adolescent Violence Prevention, Wright State University, Ellis Human Development Institute, 9 N. Edwin C. Moses Blvd, Dayton, OH 45407, (937) 775-4300.

Resolving Conflict Creatively Program (RCCP): Curriculum stresses modeling of nonviolent alternatives for dealing with conflict and teaches negotiation and other conflict resolution skills. Conflict resolution and communication skills are taught in the classroom and practiced at least once a week. Several students are trained as “mediators” to assist others in resolving conflicts. Teachers who participate report decreases in name-calling and physical violence among students. When students are tested, most learn the key concepts of conflict resolution and are able to apply them when responding to hypothetical conflicts. In addition, students themselves have reported getting in fewer fights and engaging less frequently in name-calling compared with matched control groups. For the peer mediation component, 80% of students and teachers report that students are helped by contact with mediators. Nine out of ten teachers who participated in the program said that they had improved understanding of children’s needs and were more willing to let students take responsibility for resolving their own conflicts.

For more information, see:

DeJong, W. *Building the Peace: The Resolving Conflict Creatively Program (RCCP)*. National Institute of Justice: Program Focus. US Dept. Of Justice, Office of Justice Programs.

For project information, contact:

Linda Lantieri, RCCP National Center, 163 3rd Ave, Room 103, New York, NY 10003, (212) 387-0225.

The Mediation in the Schools Program: Promotes positive resolution of conflict in schools. The program consists of three components: conflict management curriculum for the classroom; adult modeling of mediation in conflict resolution; and training of student mediators to provide mediation services to other students. Evaluation showed that the program seemed to be “owned” by the students. Students were described as being more in control and empowered, as well as exhibiting higher self-esteem. Coordinators and administrators reported decreased levels of violence since the introduction of the program. Program teachers perceived less violence and hurtful behaviors among students believed that the program was effective in teaching students alternative, positive dispute resolution strategies and in decreasing levels of violence at school.

For more information, see:

Carter, S.L. Evaluation report for the New Mexico center for dispute resolution. *Mediation in the Schools Program, 1993-1994 school year*. Albuquerque: New Mexico Center for Dispute Resolution, 1994.

Lam, J.A. *The impact of conflict resolution programs on schools: A review and synthesis of the evidence*. Amherst, Mass.: National Association for the Mediation in Education, 1988.

For program information, contact:

National Resource Center for Youth Mediation, New Mexico Center for Dispute Resolution 620 Roma NW, Suite B, Albuquerque, NM 87102, (505)247-0571 / fax: (505)242-5966

For evaluation information, contact:

Susan Lee Carter, Ph.D, P.O. Box 67 Cerrillos, NM 87010, (505)424-0244

Lions-Quest Working Toward Peace: This program is designed to help young people develop lifelong habits of peaceful conflict resolution. The four-part course of study for grades 6-8 includes sessions on managing anger, resolving conflicts peacefully, and promoting peace. An optional one-day workshop provides an introduction to hands-on experience with the curriculum. Program goals are: To help students understand the value of peaceful conflict resolution and study peaceful role models; To enable students to learn ways to manage their own anger; To teach students a wide repertoire of techniques for reducing the level of tension in conflicts and resolving the conflicts peacefully; To encourage young people to apply their skills by planning and carrying out a service-learning project relating to peaceful conflict resolution. It is viewed as equipping educators and parents to help young adolescents take responsibility for finding peaceful solutions to conflict. Program implementation results in improved school climate, fewer discipline referrals, a safer school environment, and increased family and community involvement.

For more information, see:

<http://www.quest.edu/content/OurPrograms/6-8Programs/WorkingTowardsPeace/wtp.htm>

For program information, contact:

Program Representative at 800/446-2700

Michigan Model for Comprehensive School Health Education: This is implemented in over 90% of Michigan's public schools and more than 200 private charter school servicing grades K-12. The model is also in place in over 42 states, foreign countries, universities and medical schools. The program was established as a cooperative effort of seven state agencies to provide an efficient delivery mechanism for key disease prevention and health promotion messages. The current curriculum facilitates interdisciplinary learning through lessons that integrate health education into other curricula (e.g., language arts, science, math). Stated advantages of the program include: Cost savings on the purchase of support materials; training for teachers; responsiveness to the need for new curricula; efficient delivery of a wide range of curricula and support materials; mechanisms for parent support; and a nationally recognized, research based curriculum. Research reports indicate that the Michigan Model substance abuse lessons had a statistically significant positive impact in curtailing rates of alcohol, tobacco and marijuana use in middle school students. A 1996 national program analyses done by Drug Strategies, Inc. of Washington, DC published under the title "Making the Grade," designated the Michigan Model as one of the top substance abuse prevention programs in the United States. The Michigan model was the only comprehensive health program to receive this "A" designation. They also rated the Michigan Model as one of the best violence prevention programs in the United States.

For more information, see:

bridging Student health Risk and Academic Achievement through Comprehensive School Health programs, Journal of School health, August 1997. 67 (6).

For program information, contact:

The Educational Materials Center (EMC) at Central Michigan University, 139 Combined Services Building, Central Michigan University, Mt. Pleasant, MI 48859 Ph: 800/214-8961 e-mail: emc@cmich.edu
web: <http://www.emc.cmich.edu/>

***Building on the Best, Learning from What Works:
A Few Promising Discipline and Violence Prevention
Programs***

American Federation of Teachers (2000).

Full document is available in pdf format at the following website address:

<http://www.aft.org/edissues/downloads/wwdiscipline.pdf>

Before deciding whether to adopt one of these programs, we recommend that schools conduct a careful audit (self-study) to gain a better understanding of what is working and what needs to be improved. For the vast majority of students and schools, attention to the basic steps described above effective interventions for troubled students, and the ability to remove the few violent and chronically disruptive students from the classroom will be enough to restore order.

Schools and classrooms with persistent problems and/or in which a high proportion of students need behavioral support should consider their options carefully particularly the trade-offs involved in adopting an extensive intervention program. Is the percentage of students with behavior problems high enough to warrant using the class time of all students to teach social and behavioral skills? Would the school's time and resources be better spent in improving the quality of the targeted interventions provided to individual students? Could this be a sign of widespread academic difficulties, signaling the need for more remedial services and a revamped academic program?

In deciding which additional steps must be taken, school staffs are encouraged to ask themselves these and several similar questions:

- Will this help address the school's most urgent needs, as identified by the audit?
- Will this help us spot and respond to problems earlier and more effectively?
- Will this help prevent problems from occurring (or recurring)?
- Do we have adequate resources and staff/administrative support to implement this well?
- Is this likely to help us use existing personnel and resources more effectively?
- Is this a good fit with the school's goals and academic program?
- Is this likely to result in more class time to spend on teaching and learning, or less?@

On the following pages are brief descriptions of:

- *Promoting Alternative Thinking Strategies (PATHS)*
- *Consistency Management & Cooperative Discipline (CMCD)*
- *The Good Behavior Game (GBG)*
- *I Can Problem Solve (ICPS)*

***Promoting Alternative
Thinking Strategies
(PATHS)***

Targeted Grades: Kindergarten through grade 5

Materials: Materials include six volumes of PATHS lessons and an instruction manual to assist with implementation.

Instructional Support/ Professional Development: Teachers, support personnel, and administrative staff receive training, which initially includes a two- to three-day workshop, preferably given just before the beginning of the school year. Additional professional development, in the form of observation and feedback from program consultants, is ongoing, either weekly or bi-weekly.

Results: There have been four clinical trials of PATHS, two involving children with disabilities and two involving regular education students. In each case, the program was shown to improve positive indicators (Social cognition, social and emotional competencies) and reduce behavioral risk factors (aggression and depression) across a wide variety of elementary school-aged children.

For More Information

Mark Greenberg, Ph.D.

Director, Prevention Research Center, Pennsylvania State University

110 HDFB - Henderson Bldg. South University Park, PA 16802-6504

Phone: 814/863-0112 E-mail: prevention@psu.edu

***Consistency Management
&
Cooperative Discipline
(CMCD)***

Targeted Grades: Available to schools in geographic feeder patterns preK-12, moving with students at each level over a three-year period, starting with the elementary schools, then middle, and finally the high school.

Materials: Materials focus on building self-discipline in students, but also cover several other topics, such as writing, conflict resolution, time management, and job training skills (including resume writing, interviews, and team building).

Instructional Support/ Professional Development: CMCD includes four phases of professional development: awareness, implementation, follow-up, and sustaining support. The implementation phase typically consists of two on-site training sessions led by CMCD staff during the spring prior to implementation. These are followed by a two-day academy that is held before the next academic year. During the follow-up phase-which lasts for the initial year of implementation - CMCD holds a series of workshops (Usually six), held on site or at a neighboring school. Sustaining support is provided in years two and three, during which an orientation training session and occasional workshops are provided for new teachers. During this phase, veteran teachers from the school are also selected to become program facilitators, providing additional training and support to new staff. CMCD staff members are also available to conduct additional schoolwide training, if needed. This program depends upon the commitment, collaboration, and support of school staff. Thus, CMCD hosts awareness workshops for schools and districts, then requires that 70 percent of the school staff vote to approve the program's adoption. In addition, the program requires one full-time facilitator for every three CMCD elementary schools and one facilitator for every CMCD secondary school in the district.

Results: Evaluations indicate that CMCD schools have from 72 percent to 78 percent fewer discipline referrals to the principal's office. Research also indicates increases in student attendance, teacher attendance, and student achievement, as well as improvements in classroom climate reported by students, teachers, and principals. In addition, research suggests that the program can help to increase instructional time-that is, time not lost to handling discipline problems.

For More Information

**H. Jerome Freiberg, Ed.D. College of Education, University of Houston
Houston, TX 77204-5874 Phone: 713/743-8663 Fax: 713/743-8664
Web: <http://www.coe.uh.edu/CMCD> E-mail: CMCD@uh.edu**

The Good Behavior Game ***(GBG)***

Targeted Grades: Grades 1 and 2

Materials: A detailed manual (available on the Internet at <http://www.bppjhu.edu>) provides an overview of the program, an explanation of the theoretical basis for the design, instructions for putting the game into effect, and evaluation forms to use during and after implementation.

Instructional Support/ Professional Development: GBG is a simple behavior management tool, requiring little or no technical assistance for implementation. At present, the primary means disseminating the game is through the manual (See above). Interested schools are advised to look at the manual, then consider what (if any) additional implementation support may be necessary. Contact the Prevention Research Center at Johns Hopkins University to explore the possibilities for consultations, implementation support, and advice.

Results: After one year of implementation, teachers reported a reduction in first-grade students' shy and aggressive behaviors, with the most significant effects observed in students initially considered most aggressive. These effects also appeared to be sustained, with boys considered to be the most aggressive in first grade showing reduced aggression at the end of sixth grade.

For More Information

Sheppard G. Kellam Prevention Research Center

Mason F. Lord Building, Suite 500

5200 Eastern Avenue Baltimore, MD 21224

Phone: 410/550-3445 Fax: 410/550-3461

E-mail: skellam@welchlink.welch.jhu.edu or skellam@air.org

I Can Problem Solve (ICPS)

Targeted Grades: Pre-K through grade 6.

Materials: The program is based around a number of scripted lessons - 59 for use during preschool, 83 for kindergarten and the primary grades, 77 for the intermediate elementary grades-that teachers can use to help children learn to resolve problems peacefully. The lessons consist of games, stories, and/or dialogues that last up to 20 minutes each and are implemented in small groups over a period of about three months. The lessons are contained in three separate training manuals, one for each of the age groups. (See the "Resources" section for ordering information.)

Instructional Support/ Professional Development: In addition to the formal lessons, the program helps teachers acquire an informal style of communication, called "problem solving dialoguing," which helps children learn to apply their problem-solving skills to non-classroom situations. The training manuals also provide examples of the use of ICPS dialogue techniques in real-life situations.

Results: Evaluations indicate that ICPS children demonstrate less impulsive and less inhibited classroom behavior and better problem-solving skills than do students in comparison groups. One longitudinal study followed a group of poor, inner-city students who had received ICPS in kindergarten and first grade, and found that benefits, as measured by improved classroom behavior and problem-solving skills, were sustained for as long as four years after the intervention. A study that looked at the use of the program with fifth- and sixth-graders also found that ICPS students showed more positive, pro-social behaviors, fewer negative behaviors, healthier peer relationships, and better problem-solving skills.

For More Information

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V. Additional Resources

QuickFinds related to Behavior Problems at School

- Anger management
- Bullying
- Classroom management
- Conduct disorder & behavior problems
- Oppositional defiant disorder
- Safe schools & violence prevention

Quick Find On-line Clearinghouse

(http://smhp.psych.ucla.edu/qf/p2108_06.htm)

TOPIC: Anger Management

The following 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

Guides to Practice

- [Common Psychosocial Problems of School-Age Youth \(Guides to Practice\)](#)

Introductory Packets

- [Violence Prevention and Safe Schools \(Introductory Packet\)](#)
- [Conduct and Behavior Problems in School Aged Youth \(Introductory Packet\)](#)

Quick Training Aids

- [Behavior Problems at School \(Quick Training Aid\)](#)

Resource Aid Packets

- [Responding to Crisis at a School \(Resource Aid Packet\)](#)

Other Relevant Documents, Resources, and Tools on the Internet

- [Anger and Aggression Management Techniques](#)
- [Anger in Our Teens and in Ourselves](#)
- [Anger Management](#)
- [Anger Management Resources](#)
- [Anger Management and Schools](#)
- [Anger Might Be a Symptom of Depression in Children and Adolescents](#)
- [Controlling Anger: Before It Controls You](#)
- [Early Identification and Intervention: Anger Management](#)
- [Helping Young Children Deal with Anger](#)
- [Intermittent Explosive Disorder Affects up to 16 Million Americans](#)
- [Lesson Plan: "Managing Anger"](#)
- [Managing and Coping with the Angry Child](#)
- [Methods for Handling Our Own Aggression/Anger](#)
- [A school-based anger management program for developmentally and emotionally disabled high school students](#)
- [School Connectedness, Anger Behaviors, and Relationships of Violent and Nonviolent American Youth](#)
- [Aggression/Fighting](#)

Related Agencies and Websites

- [Anger Main Page--Controlling the Volcano Within](#)

- [Anger Management for Youth Program--School Mediation Center](#)
- [Anger Management suggested reading list \(angrykids.com\)](#)
- [Anger Management Services](#)
- [Center for the Study and Prevention of Violence](#)
- [Ohio Commission on Dispute Resolution & Conflict Management](#)

Relevant Publications That Can Be Obtained through Libraries

- A Preliminary Evaluation of the Colorado "Rethink Parenting" and Anger Management Program. By, R. J. Fetsch, C. J. Schultz, & J. J. Wahler. In: *Child Abuse & Neglect*. 1999 Apr. 23 (4): p. 353-360.
- A teacher's guide to anger management. (2001). by Paul Blum. London ; New York : Routledge/Falmer.
- Adolescent Anger-Management Groups for Violence Reduction. By, E. L. Feindler, & M. Scalley. In: Karen Callan Stoiber, Ed; Thomas R. Kratochwill, Ed; et al. *Handbook of group intervention for children and families*. Allyn & Bacon, Inc: Boston, MA, USA, 1998. p. 100-119.
- Anger Management: A Holistic Approach. By, B. Dunbar. In: Journal of the American Psychiatric Nurses Association, 10(1), 16-23.
- Anger Management: Diagnostic Differences And Treatment Implications. (2004). By, H.C. Lench. In: Journal of Social & Clinical Psychology, Aug; 23(4):512-531.
- Anger Management: The complete treatment guidebook for practitioners. (2002). By, H. Kassinove, R.C. Tafrate. In: *The practical therapist series*. Atascadero, CA, US: Impact Publishers Inc.
- Anger management for youths: What works and for whom? By, D.C. Smith, J.D. Larson, B. DeBaryshe, & M. Salzman. In: D.S. Sandhu, C.B. Aspy. (2000). *Violence in American schools: A practical guide for counselors*. Alexandria, VA, US: American Counseling Association. p.217-230. 81-90.
- Anger management in schools: alternatives to student violence. (2002). By Jerry Wilde. Lanham, Md.: Scarecrow Press.
- Anger management training for children: A group approach. (2004). By, D.G. Nemeth, K.P. Ray, & M.M. Schexnayder. In: L. Vander Creek. School of Professional Psychology; et al. *Innovations in clinical practice: A source book*. Sarasota, FL, US: Professional Resource Press/Professional Resource Exchange, Inc. 99-122.
- Cross-Cultural Perspectives on Anger. By, J. Tanaka-Matsumi. In: Howard Kassinove, Ed; et al. *Anger disorders: Definition, diagnosis, and treatment*. Taylor & Francis: Washington, DC, USA, 1995. p. 81-90.
- Increasing anger log use during school among middle school students with emotional/behavioral disorders. By M. H. Kellner, L. Colletti, B. H. Bry. (2003). In: Child & Family Behavior Therapy, 25(3), 7-21.
- Is anger a thing-to-be-managed? By, A. E. Roffman. In: Psychotherapy: Theory, Research, Practice, Training, 41(2), 161-171.
- Principles of empirically supported interventions applied to anger management. (2002). By, J.L. Deffenbacher, E.R. Oetting, R.A. DiGiuseppe. In: *Counseling Psychologist*. 30(2). 262-280.
- Promoting emotional literacy: Anger management groups. By, P. Sharp, E. Herrick. In: N. Barwick. (2000). *Clinical counseling in schools. Clinical counseling in context*. New York, NY, US: Routledge. 81-90.
- Teaching anger management skills to students with severe emotional or behavioral disorders. (2002). By, M. H. Kellner, L. Colletti, B. H. Bry. In: *Behavioral Disorders*. 27(4). 400-407.

- **Use of play therapy for anger management in the school setting. By, B.A. Fischetti. In: A.A. Drews, L.J. Casey, et al. (2001) *School-based play therapy*. New York, NY, US: John Wiley & Sons, Inc. Press/Professional Resource Exchange, Inc. 238-255.**
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We hope these resources met your needs. If not, feel free to contact us for further assistance. For additional resources related to this topic, use our [search](#) page to find people, organizations, websites and documents. You may also go to our [technical assistance page](#) for more specific technical assistance requests.

If you haven't done so, you may want to contact our sister center, the [Center for School Mental Health](#) at the University of Maryland at Baltimore.

If our website has been helpful, we are pleased and encourage you to use our site or contact our Center in the future. At the same time, you can do your own technical assistance with "[The fine Art of Fishing](#)" which we have developed as an aid for do-it-yourself technical assistance.

Quick Find On-line Clearinghouse

(<http://smhp.psych.ucla.edu/qf/bully.htm>)

TOPIC: Bullying

The following 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 w Text

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
- 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](#)
- [Direct from the Field: A guide to bullying prevention, Commonwealth of MA](#)
- [The EDA Bullying Workbook](#)
- [Educational Forum on Adolescent Health: Youth bullying--Proceedings](#)
- [Eyes on bullying...What can you do?](#)
- ["Healing Circles", 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 Educational 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 harassment 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" & "Mediation"](#)
- [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 Harassment](#)
- [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](#)
- [Youth Violence and Electronic Media: Similar Behaviors, Different Venues? \(Sponsored by the Centers for Disease Control and Prevention\)](#)

Nationwide/Statewide Campaigns

- [The 2003 national school climate survey: The school-related experiences of our nation's gay, bisexual and transgender youth](#)
- [HHS launches anti-bullying campaign; "Take a Stand: Lend A Hand. Stop Bullying Now!"](#)
- [Kentucky Center for School Safety](#)

- [National Bullying Awareness Campaign](#)
- [National PTA resources on bullying](#)
- [State Anti-bullying Statutes \(2005\) J. Dournay, Education Commission of the States \(doc\)](#)

Bullying Prevention

- [Bullies Can Be Transformed Into Good Citizens: A Bullying Prevention Program](#)
- [Bullying Prevention](#) (a fact sheet from the CPSV)
- [Bullying Prevention is Crime Prevention](#)
- [Bullyproof: Online Bullyproofing.](#)
- [Bully-Proof Your School](#)
- [Developing an Anti-bullying program: Increasing safety, reducing violence](#)
- [Direct From the Field: A Guide to Bullying Prevention](#)
- [Early violence prevention: Tools for teachers of young children](#)
- [Exploring the nature of prevention of bullying](#)
- [The Olweus Bullying Prevention Program: Background and program overview](#)
- [Olweus Bullying Prevention](#)
- [Prevention Pathways](#)
- [Schoolwide Prevention of Bullying](#)
- [Steps to Respect: A bullying prevention program](#)
- [Stop bullying now](#)
- [Take a stand. Lend a hand. Stop bullying now! Resource kit](#)

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](#)
- [The Olweus Bullying Prevention Program](#)
- [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.

