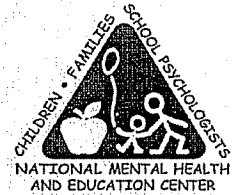


SPECIAL NEEDS

Helping the Student With ADHD in the Classroom



INFORMATION FOR FAMILIES AND EDUCATORS

STRATEGIES FOR TEACHERS

By Stephen E. Brock, NCSP, CSU, Sacramento

Introduction

Affecting three to seven percent of the population, Attention Deficit/Hyperactivity Disorder (ADHD) is one of the most common of the childhood behavior disorders. Associated with this disorder's core symptoms of inattention, hyperactivity and impulsivity are a variety of disruptive classroom behaviors (e.g., calling out, leaving seat, interrupting activities, etc.). Consequently, it is not surprising that these students often require behavioral interventions.

Expectations for the use of behavioral interventions for students with ADHD have been generated by Section 504 of the Vocational and Rehabilitation Act of 1973 and the Individuals with Disabilities Education Act (IDEA) of 1997. Section 504 has been used to require the development of general education accommodation plans. These plans are designed to ensure that the student with ADHD is provided a free and appropriate education. Among the recommended components of these plans are a variety of classroom interventions (including behavior intervention planning), with a special emphasis on environmental modifications. Similarly, the reauthorization of IDEA, with its requirements for functional behavior assessments, has increased the frequency with which classroom-based behavioral interventions are considered for these students.

General Behavior Intervention Suggestions

While students with ADHD do have a core of common problems, this group is very heterogeneous. Thus, instead of focusing on ADHD symptoms per se, behavior intervention should first directly target the specific problem behavior(s). Next, an appropriate alternative behavior, incompatible with the problem behavior, should be selected. It is important to keep both behaviors in mind. Not only is it important to identify for students what behavior is unacceptable (what we don't want a student to do), but it is also essential to make clear what behavior is acceptable (what we want a student to do). These behaviors should be carefully defined so that the teacher will be able to accurately monitor them.

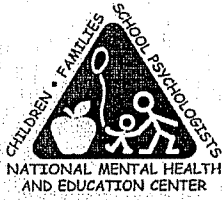
It is also important to ensure that the behavior intervention plan is based upon a careful functional assessment of the behaviors. Antecedents and consequences of both the problem and replacement behaviors need to be studied. Antecedents will suggest environmental changes that set up the student for success or failure. Analysis of consequences, on the other hand, will identify those environmental contingencies that reinforce both desired and undesired behavior. The function of the problem behavior should guide intervention plans. For example, if the behavior is maintained by negative reinforcement (e.g., the behavior allows the student to avoid an undesired academic task), then the intervention should ensure that this goal is not obtained by the problem behavior. At the same time the intervention should teach the student that performing the desirable behavior is a more effective way of obtaining a desirable outcome.

*Ensuring a
healthy start.*

*Promoting a
bright future.*



NATIONAL
ASSOCIATION OF
SCHOOL
PSYCHOLOGISTS



The National Mental Health & Education Center for Children & Families

As one of many NASP public service programs, the Center fosters best practices in education and mental health by providing information on topics affecting today's youth, families, and schools. The Center's goal is to improve outcomes for children and youth by helping parents, teachers, and other related professionals work more effectively together to promote healthy learning and development. The Center offers free or low cost resources, programs, and services that promote effective strategies, greater collaboration, and improved outcomes on a wide range of psychological, social/emotional, and academic issues. Resources can be downloaded or ordered from the Center website or ordered directly from the Center.

For materials or further information contact the Center by phone at (301) 657-0270; by e-mail at center@naspweb.org; or on the web at www.naspcenter.org.

Environmental and Instructional Considerations

While it is important to treat each student as an individual and to tailor interventions to meet specific behavioral challenges, research has identified several strategies as potentially effective. Specific strategies for promoting success for students with ADHD include the following:

TASK DURATION

To accommodate to the student's short attention span, academic assignments should be brief and feedback regarding accuracy immediate. Longer projects should be broken up into manageable parts. Short time limits for task completion should be specified and enforced with timers.

DIRECT INSTRUCTION

Attention to task is improved when the student with ADHD is engaged in teacher-directed as opposed to independent seat-work activities. In addition, the teaching of note-taking strategies increases the benefits of direct instruction. Both comprehension and on-task behavior improve with the development of these skills.

PEER TUTORING

Class-wide peer tutoring provides many of the instructional variables known to be important in setting up students with ADHD for success. For example, it provides frequent and immediate feedback. When combined with a token economy, peer tutoring has been associated with dramatic academic gains.

SCHEDULING

Based on evidence that the on-task behavior of students with ADHD progressively worsens over the course of the day, it is suggested that academic instruction be provided in the morning. During the afternoon, when problem solving skills are especially poor, more active, nonacademic activities should be scheduled.

NOVELTY

Presentation of novel, interesting, highly motivating material will improve attention. For example, increasing the novelty and interest level of tasks through use of increased stimulation (e.g., color, shape, texture) reduces activity level, enhances attention and improves overall performance.

STRUCTURE AND ORGANIZATION

Lessons should be carefully structured and important points clearly identified. For example, providing a lecture outline is a helpful note-taking aid that increases memory of main ideas. Students with ADHD show improved memory when material is meaningfully structured for them.

RULE REMINDERS AND VISUAL CUES

The rules given to students with ADHD must be well defined, specific, and frequently reinforced through visible modes of presentation. Well-defined rules with clear consequences are essential. Relying on the student's memory of rules is not sufficient. Visual rule reminders or cues should be placed throughout the classroom. It is also helpful if rules are reviewed before activity transitions and following school breaks. For example, token economy systems are especially effective when the rules for these programs are reviewed daily.

AUDITORY CUES

Providing auditory cues that prompt appropriate classroom behavior is a helpful strategy for students with ADD. For example, use of a tape with tones placed



at irregular intervals to remind students to monitor their on-task behavior has been found to improve arithmetic productivity.

PACING OF WORK

When possible, it is helpful to allow students with ADHD to set their own pace for task completion. The intensity of problematic ADHD behaviors is less when work is self paced, as compared to situations where work is paced by others.

INSTRUCTIONS

Because students with ADHD have difficulty following multi-step directions, it is important for instruction to be short, specific, and direct. Further, to ensure understanding, it is helpful if these students are asked to rephrase directions in their own words. Additionally, teachers must be prepared to repeat directions frequently, and recognize that students often may not have paid attention to what was said.

PRODUCTIVE PHYSICAL MOVEMENT

The student with ADHD may have difficulty sitting still. Thus, productive physical movement should be planned. It is appropriate to allow the student with ADHD opportunities for controlled movement. Examples might include a trip to the office, a chance to sharpen a pencil, taking a note to another teacher, watering the plants, feeding classroom pets, or simply standing at a desk while completing classwork. Alternating seatwork activities with other activities that allow for movement is essential. It is also important to keep in mind that on some days it will be more difficult for the student to sit still than on others. Thus, teachers need to be flexible and modify instructional demands accordingly.

ACTIVE VS. PASSIVE INVOLVEMENT

In line with the idea of providing for productive physical movement, tasks that require active (as opposed to passive) responses may help students with ADHD channel their disruptive behaviors into constructive responses. While it may be difficult for these children to attend to a long lecture, teachers might find that students with ADHD can be successful when asked to assist with a lecture in some way (e.g., help with audio-visual aids, write important points on the chalkboard, etc.).

DISTRACTIONS

Generally, research has not supported the effectiveness of complete elimination of all irrelevant stimuli from the student's environment. However, as

these students have difficulty paying attention to begin with, it is important that attractive alternatives to the task at hand be minimized. For example, activity centers, mobiles, aquariums and terrariums should not be placed within the student's visual field.

ANTICIPATION

Knowledge of ADHD and its primary symptoms is helpful in anticipating difficult situations. It is important to keep in mind that some situations will be more difficult than others. For example, effortful problem solving tasks are especially problematic. These situations should be anticipated and appropriate accommodations made. When presenting a task that the teacher suspects might exceed the student's attentional capacity, it is appropriate to reduce assignment length and emphasize quality as opposed to quantity.

CONTINGENCY MANAGEMENT: ENCOURAGING APPROPRIATE BEHAVIOR

Although classroom environment changes can be helpful in reducing problematic behaviors and learning difficulties, by themselves they frequently are insufficient. Thus, contingencies need to be available that reinforce appropriate or desired behaviors, and discourage inappropriate or undesired behaviors.

POWERFUL EXTERNAL REINFORCEMENT

First, it is important to keep in mind that the contingencies or consequences used with these students must be delivered more immediately and frequently than is typical for most students. Additionally, the consequences used need to be more powerful and of a higher magnitude than is required for students without ADHD. Students with this disorder need external criteria for success and need a pay-off for increased performance. Relying on intangible rewards may not be enough.

While current practice emphasizes the use of positive behavioral interventions, the use of both negative and positive consequences has been suggested to be effective when working with ADHD students. However, before negative consequences are implemented, appropriate and rich incentives should first be developed to reinforce desired behavior. It is essential to give much encouragement, praise and nurturance as these students are easily discouraged. When negative consequences are administered, they should be given in a fashion that does not embarrass or put down students. In addition, it is important to keep in mind that the rewards used with these students lose their reinforcing power quickly and must be changed or rotated frequently.



TOKEN ECONOMY SYSTEMS

These systems proven behavioral strategies for improving both the academic and behavioral functioning of students with ADHD. Typically, these programs involve giving students tokens (e.g., poker chips) when they display appropriate behavior. These tokens are in turn exchanged for tangible rewards or privileges at specified times.

RESPONSE-COST PROGRAMS

These programs provide mild negative consequences when problem behavior is displayed. For example, a student may lose earned points or privileges when previously specified rules are broken. There is evidence that such programming decreases ADHD symptoms such as impulsivity. A specific response-cost program found to be effective with ADHD students involves giving a specific number of points at the start of each day. When a rule is broken (a problem behavior is displayed), points are taken away. Thus, to maintain their points, students must avoid breaking the rule. At the end of the period or day, students are typically allowed to exchange the points they have earned for a tangible reward or privilege. While these procedures are effective with students with ADHD, it is recommended that they be used only with the most disruptive classroom behaviors and only when the staff has been carefully trained.

TIME-OUT

Removing the student from positive reinforcement, or time-out, typically involves removing the student from classroom activities. Time-out can be effective in reducing aggressive and disruptive actions in the classroom, especially when these behaviors are strengthened by peer attention. Time-out is not helpful, however, when problem behavior is a result of the student's desire to avoid school-work. The time-out area should be a neutral environment and a student should be placed in it for only a short time. Time-out is

ended based upon a pre-set (brief) time limit and the student's display of appropriate behavior. At the end of the time-out, a very brief discussion of what went wrong and how to prevent the problem in the future takes place between teacher and student. As was the case for response-cost programs, while these procedures are effective with students with ADHD, it is recommended that they be used only with the most disruptive classroom behaviors and only when there is well-trained staff in the classroom. ☺

Summary

Students with ADHD are a heterogeneous group. There is no one intervention (or set of interventions) that will improve the classroom functioning of all students with this disorder. Thus, it is suggested that classroom modifications be tailored to the unique behavioral needs of each student. In developing these interventions it is perhaps best to begin by examining how the classroom environment might be changed to increase the probability of success for the student with ADHD. The next step is to consider the implementation of a contingency management system designed to provide external incentives for appropriate classroom behaviors. In doing so it is important to remember that behavior support programs must be consistently applied. Further, it is essential to avoid excessive use of negative consequences (such as reprimands, time-out) and to avoid the use of unrealistic standards that severely limit opportunities for success. In other words, it is essential that students be frequently reinforced for what we want them to do, rather than simply punished for what we do not want them to do. ☺

© 2002, National Association of School Psychologists. This handout was published on the NITV website, Teachers First, June 2002.

Barkley, R. A. (1997). *ADHD and the nature of self-control*. New York: Guilford Press.

Barkley, R. A. (1998). *Attention Deficit Hyperactivity Disorder: A handbook for diagnosis and treatment* (2nd ed.). New York: Guilford Press.

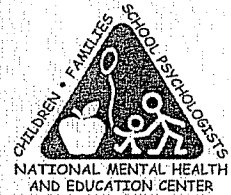
Merculigiano, M., Power, T. & Blum, N. (1999). *Clinician's Practical Guide to Attention Deficit Hyperactivity Disorder*. NY: Brookes. (Available from NASP at www.nasponline.org/store.)

Power, T., Karustis, J. & Habboushe, D. (2001). *Homework Success for Children with ADHD: A Family-School Intervention Program*. NY: Guilford Press. (Available from NASP at www.nasponline.org/store.)

Stephen E. Brock, Ph.D., NCSP, is an Assistant Professor at California State University, Sacramento. This handout is updated from the Communiqué, February 1998.

SOCIAL/EMOTIONAL DEVELOPMENT

Depression in Children and Adolescents



INFORMATION FOR FAMILIES AND EDUCATORS

Information for School Personnel

By *Ralph E. Cash, Ph.D., NCSP*

“What we do to children, they will do to society” (*Menninger*)

Definition

Depression is a serious health problem that can affect people of all ages, including children and adolescents. It is generally defined as a persistent experience of a sad or irritable mood as well as “anhedonia,” a loss of the ability to experience pleasure in nearly all activities. It also includes a range of other symptoms such as change in appetite, disrupted sleep patterns, increased or diminished activity level, impaired attention and concentration, and markedly decreased feelings of selfworth. Major depressive disorder, often called clinical depression, is more than just feeling down or having a bad day, and it is different from the normal feelings of grief that usually follow an important loss, such as a death in the family. It is a form of mental illness that affects the entire person. It changes the way one feels, thinks and acts and is not a personal weakness or a character flaw. Children and youth with depression cannot just “snap out of it” on their own. If left untreated, depression can lead to school failure, substance abuse, or even suicide. ☺

Scope of the Problem

As many as one in every 33 children and up to one in eight adolescents are victims of depression (Mayo Clinic, 1998). Research indicates that the onset of depression is occurring earlier in life today than in past decades and often coexists with other mental health problems such as chronic anxiety and disruptive behavior disorders. In 1997 in the United States, suicide was the third leading cause of death among those 10 to 24 years old. Among adolescents who develop major depressive disorder, up to 7% may eventually commit suicide. ☺

Risk Factors

Children and teens who are under stress, who have experienced a significant loss, or who have attention, learning, or conduct disorders are at greater risk for developing clinical depression. In childhood, there is no difference between the sexes in their vulnerability to depression, but during adolescence, girls develop depressive disorders twice as often as boys. Children who suffer from major

*Ensuring a
healthy start.*

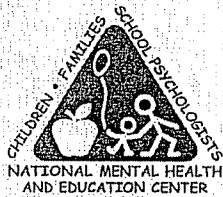


*Promoting a
bright future.*



NATIONAL
ASSOCIATION OF
SCHOOL
PSYCHOLOGISTS

| Continued on page 2



The National Mental Health & Education Center for Children & Families

As one of many NASP public service programs, the Center fosters best practices in education and mental health by providing information on topics affecting today's youth, families, and schools. The Center's goal is to improve outcomes for children and youth by helping parents, teachers, and other related professionals work more effectively together to promote healthy learning and development. The Center offers free or low cost resources, programs, and services that promote effective strategies, greater collaboration, and improved outcomes on a wide range of psychological, social/emotional, and academic issues. Resources can be downloaded or ordered from the Center website or ordered directly from the Center.

For materials or further information contact the Center by phone at (301) 657-0270; by e-mail at center@naspweb.org; or on the web at www.naspcenter.org.

Risk Factors

(Continued from page 1)

depression are likely to have a family history of the disorder, often a parent who also experienced depression at an early age. Depressed adolescents are also likely to have depressed relatives, although the correlation is not as high as it is for younger children. Other risk factors for child and adolescent depression include cigarette smoking, loss of a parent or loved one, break-up of a romantic relationship, chronic illnesses such as diabetes, abuse or neglect, and other traumas, including natural disasters. ☺

Signs and Symptoms

Characteristics of depression which usually occur in children, adolescents and adults include the following:

- persistent sad and irritable mood
- loss of interest in activities once enjoyed
- significant change in appetite and/or body weight
- difficulty sleeping or oversleeping
- physical signs of agitation or excessive lethargy and loss of energy
- feelings of worthlessness or inappropriate guilt
- difficulty concentrating
- recurrent thoughts of death or suicide

The way symptoms are expressed varies with the developmental level of the youngster. Symptoms associated with depression more commonly in children and adolescents than in adults include:

- frequent vague, non-specific physical complaints (e.g., headaches, muscle aches, etc.)
- frequent absences from school or unusually poor school performance
- outbursts of shouting, complaining, unexplained irritability, or crying
- chronic boredom
- lack of interest in playing with friends
- alcohol or drug abuse
- social isolation and poor communication
- fear of death
- extreme sensitivity to rejection or failure
- increased irritability, anger, or hostility
- reckless behavior
- difficulty maintaining relationships

The presence of one, or even all, of these signs and symptoms does not necessarily mean that a particular individual is clinically depressed. If several of the above characteristics are present, however, it could be a cause for concern and may suggest the need for professional evaluation. ☺

Evaluation and Treatment

The good news is that depression is treatable. Virtually everyone who receives proper, timely intervention can be helped. Early diagnosis and appropriate treatment are essential for depressed children and adolescents. Youngsters who exhibit signs of clinical depression should be referred to and



evaluated by a mental health professional who specializes in treating children and teens. A thorough diagnostic evaluation may include a physical examination, laboratory tests, interviews with the youngster and his or her parents, behavioral observations, psychological testing and consultation with other professionals. A comprehensive treatment plan often involves psychotherapy, ongoing evaluation and monitoring, and, in some cases, psychiatric medication. Optimally this plan is developed with the family and, whenever possible, the child or adolescent participates in treatment decisions. ♪

What Adults Can Do to Help

It is important that all adults who have frequent contact with children and/or adolescents know the warning signs of depression. If you suspect a young person may be depressed, make sure parents and/or guardians are informed. Don't hesitate to ask a young person if they have thought about, intend, or have plans to commit suicide. You won't give them any new ideas, and you may save a life by asking. If a youngster admits to feeling suicidal, stay with them and get professional help immediately. School personnel can also provide important support by linking families with information and referral to community agencies. ♪

What Schools Can Do

Schools can facilitate prevention, identification and treatment for depression in children and adolescents. Students spend much of their time in schools where they are constantly observed and evaluated, and come into contact with many skilled and well-educated professionals. Effective interventions must involve collaboration between schools and communities to counter conditions that produce the frustration, apathy, alienation and hopelessness experienced by many of our youth. Involvement in research-based programs such as the Surgeon General's "Call to Action to Prevent Suicide" can greatly enhance schools' efforts to organize prevention and intervention programs to combat depression. Some of the most important steps for schools to take include:

- develop a caring, supportive school environment for children, parents and faculty;

- ensure that every child and parent feels welcome in the school;
- prevent all forms of bullying as a vigorously enforced school policy;
- establish clear rules, publicize them, and enforce them fairly and consistently;
- have suicide and violence prevention plans in place and implement them;
- have specific plans for dealing with the media, parents, faculty and students in the aftermath of suicide, school violence, or natural disaster;
- break the "conspiracy of silence", i.e., make it clear that it is the duty of every student to report any threat of violence or suicide to a responsible adult;
- ensure that each student has at least one responsible adult in the school who takes a special interest in him or her;
- emphasize and facilitate home-school collaboration;
- train faculty and parents to recognize the risk factors and warning signs of depression;
- train faculty and parents in appropriate interventions for students suspected of being depressed;
- utilize the expertise of mental health professionals in the school (school psychologists, school social workers and school counselors) in planning prevention and intervention, as well as in training others. ♪

Resources

American Psychological Association, 750 First Street, N.E., Washington, DC 20002; (202) 336-5500; www.apa.org

American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005; (202) 682-6000; www.psych.org

National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314; (800) 969-NMHA; www.nmha.org

National Association of School Psychologists, 4340 East West Highway, Suite 402, Bethesda, MD 20814; (301) 657-0270; www.nasponline.org

National Institute of Mental Health, Office of Communications and Public Liaison, Information

**Resources**

(Continued from page 3)

Resources and Inquiries Branch, 6001 Executive Boulevard, Room 8184, MSC 9663, Bethesda, MD 20892; (301) 443-4513; www.nimh.nih.gov

U.S. Public Health Service (1999). The Surgeon General's Call to Action to Prevent Suicide. Washington, DC: Author. (www.surgeongeneral.gov)

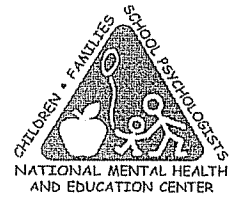
World Health Organization (2000). Preventing suicide: A resource for teachers and other school staff. Geneva: Mental and Behavioral Disorders, Department of Mental Health (WHO).

This article first published on the Guidance Channel website, Therapy and Counseling page (www.guidancechannel.com); reprinted with permission. Gene Cash, Ph.D., NCSP, is a school psychologist in private practice in Ft. Lauderdale, FL.

© 2001, The Guidance Channel (www.guidancechannel.com) and the National Association of School Psychologists, 4340 East West Highway, Suite 402, Bethesda, MD 20814, www.nasponline.org, (301) 657-0270.

BEHAVIOR PROBLEMS

Defusing Violent Behavior in Young Children: An Ounce of Prevention



INFORMATION FOR SCHOOL PRINCIPALS

By Diane Smallwood, Psy.D., NCSP
2002–2003 President, National Association of School Psychologists

It is Thursday morning and time for Ms. Smith's first graders to move from reading to art class. Most students put away their workbooks and line up as requested. Six-year old Andy ignores her instructions, even when she repeats them. Another student tells Andy to hurry up. Suddenly Andy swears loudly and hurls his book across the room, banging his fists on the desk. Ms. Smith tells Andy to stop and to pick up the book. Andy screams he wants to kill her, knocks over his chair, and proceeds to kick and hit nearby desks. Ms. Smith asks the class to wait while she brings Andy, struggling, to your office where he breaks down into angry tears. This is the third such episode in two weeks. Three days earlier, Andy had thrown his lunch tray on the ground when the cafeteria monitor told the table to quiet down. The week before, he threatened to "smash in" the face of a classmate who complained that Andy's rhythmic kicking of the chair leg was bothering him. Visits to your office, talks with the counselor, and restriction of privileges do not seem to be changing Andy's behavior.

If this scenario sounds familiar, you are not alone. The "explosive" behavior typified by Andy is at the extreme end of a growing trend in violent behavior among young children. Many elementary school principals and teachers spend an inordinate amount of time managing outbursts and stopping bullying or other forms of physical and verbal aggression. The exact cause of the trend is not clear but experts cite a number of societal and family factors as well as an increase in psychiatric disorders in children and the loss of social development time in the early elementary classroom. The costs, however, are clear. Violent or aggressive behavior undermines the integrity of the learning environment, interferes with children's academic and social outcomes, contributes to staff and student stress, and threatens school safety.

Addressing the problem in the preschool and early elementary grades is paramount. Redirecting inappropriate behavior in its beginning stages will more likely prevent later development of intractable patterns of violence and disruption. Violent behavior among young children does not necessarily reflect willfulness; often the child lacks the requisite social skills—skills that schools can help them learn. The key is to preserve the safety and learning experience of all students and to promote improved behavior on the part of the child in question. ☺

Changing Violent Behavior

Children who exhibit explosive or noncompliant behavior like Andy present the most difficult challenge to school personnel and parents. These children are chronically violent or aggressive and may be defiant, start fights, push, kick, hit or grab, throw things, verbally threaten classmates or staff, or destroy property. Some children respond to verbal prompts to interrupt and stop this type of behavior. Others melt down with little obvious provocation and, once they "lose it," cannot be

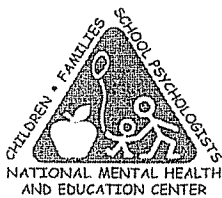
| Continued on page 2

*Ensuring a
healthy start.*

*Promoting a
bright future.*



NATIONAL
ASSOCIATION OF
SCHOOL
PSYCHOLOGISTS



The National Mental Health & Education Center for Children & Families

As one of many NASP public service programs, the Center fosters best practices in education and mental health by providing information on topics affecting today's youth, families, and schools. The Center's goal is to improve outcomes for children and youth by helping parents, teachers, and other related professionals work more effectively together to promote healthy learning and development. The Center offers free or low cost resources, programs, and services that promote effective strategies, greater collaboration, and improved outcomes on a wide range of psychological, social/emotional, and academic issues. Resources can be downloaded or ordered from the Center website or ordered directly from the Center.

For materials or further information contact the Center by phone at (301) 657-0270; by e-mail at center@naspweb.org; or on the web at www.naspcenter.org.

Changing Violent Behavior (Continued from page 1)

reached until they have exhausted their rage. Typically, these children do not handle transitions or unexpected change well and have low tolerance for frustration. This is different from violent behavior that is "episodic" (i.e., out of the norm for the child and perhaps the result of an isolated event at school or home) or "goal oriented" (i.e., employed to achieve a specific desire or targeted at a specific person).

The underlying cause(s) of explosive/noncompliant behavior are complex and may be accompanied by other negative behaviors or problems. Leading experts like Dr. Ross Greene, author of *The Explosive Child*, suggest that the most effective way to help such children is to give them the mechanisms to recognize and prevent outbursts before they happen. While the intensity and specificity of interventions may differ, the basic strategies outlined below can help build and reinforce positive behavior in all students.

Facilitate prevention and problem solving. Principals are instrumental to creating a school environment in which children learn positive behavior skills. Much of the time administrators spend with children like Andy is focused on disciplining or "cleaning up" after a meltdown, often with little long-term benefit. Certainly discipline plays a role in violence prevention, but it should be employed as a teaching mechanism, not just a means of containing the behavior. You will significantly increase your effectiveness if you put in place comprehensive prevention strategies and develop an intervention process that emphasizes problem solving, not punishment, and facilitates collaboration between staff, parents and students. (See inset box.) Effective strategies focus on:

- Prevention at both the system and individual levels.
- Understanding the underlying impetus for the behavior.
- Identifying and building the necessary skills to make more appropriate choices.

Prevention and Problem Solving Strategies

- Implement a school-wide approach to build positive behavior skills for all students.
- Communicate to students, staff, and parents expectations for behavior and how specific social skills will help students achieve that behavior.
- Reinforce behavior values and desired skills throughout the building by using bulletin boards, wall charts, morning announcements, etc.
- Have teachers introduce expectations at the beginning of the year and regularly incorporate opportunities for learning coping skills into the school day.
- Congratulate children when you see them make a good choice.
- Model the skills you want the children to learn.
- Provide teachers and support staff, including playground aides, lunchroom monitors, and bus drivers, with training.
- Develop a problem solving, team approach with your staff.
- Designate an office or special place as a "time out room" for children who need to regain safe control. Make sure children know where it is and what adult(s) will be there to help them. This is often the counselor's office or your office.
- Reach out to parents. Invite them to let you know if they are concerned about behavior problems at home. Offer to be a resource.
- Build trust with students by being accessible and encouraging.

Create a positive framework for changing behavior. Although explosive/non-compliant children need individual assessment and interventions, they benefit like all children from school-wide programs that promote positive behavior skills. Many schools have adopted social skills programs as part of the curriculum with great success. These programs emphasize teaching positive skills, not punishing negative



behavior; provide a universal language or set of steps to facilitate learning desired behaviors; and foster values of empathy, caring, respect, self-awareness, and self-restraint. Your school psychologist or counselor can help select and implement a well-established program that is best suited to your school. A school-wide approach helps children with violent behavior in four important ways:

- Provides them the natural opportunity to learn and practice alternative skills under a variety of daily circumstances.
- Lays out an action plan for children to help themselves and each other behave appropriately.
- Gives children a common language with which to express their feelings and communicate with peers and adults.
- Puts the aggressive child's need for more intensive interventions within the positive context of learning something everyone else is learning, too.

"Normalizing" social learning enables children to understand that classmates like Andy need extra help from the teacher to learn to cope with frustration, just as Susie may need special help learning to read. You also want to help children distinguish between *unacceptable behavior* and *acceptable differences* in learning and socialization. Clearly Andy's reaction was inappropriate, but his need to complete his work or transition differently than his classmates is not. This perspective helps preserve the troubled child's self-esteem and is a valuable message in teaching children tolerance.

Identify the underlying impetus of the behavior. The first and crucial step to changing behavior is to determine why the child resorts to violence or aggression in the first place. Ultimately the behavior is accomplishing what the child wants—or feels he wants—and it is important to know why. Is he frustrated or angry, avoiding an undesirable task or anticipated stressor, seeking attention, exacting revenge, or modeling behavior of others? He also may be exhibiting symptoms of a psychiatric disorder. Explosive/noncompliant behavior is often linked to a psychiatric diagnosis, such as bipolar disorder, oppositional defiant disorder, ADHD, Tourette Syndrome, Asperger's disorder, and depression. You can work with the parents, teacher, and school psychologist to identify the cause as well as triggers for the behavior, and to determine if a more thorough psychiatric evaluation is warranted. The goal is to address the underlying issue(s) and help the child reframe his objective (e.g., learning to master the task instead of

avoiding it) at the same time he is building communication and self-control skills.

Determine the circumstances that trigger outbursts. Identifying a pattern of when and how the child acts out helps define the factors that trigger the behavior and, subsequently, suggests strategies that will most effectively correct it. For instance, is the child aggravated by a particular kind of activity like writing or because he is slower than his classmates; uncomfortable in a specific setting; responding to interaction with a certain child; resistant to an adult command; or unnerved by the transition process? In some cases, the best approach may be to keep the child away from those situations that prove especially difficult, modify situational demands to reduce stress, or directly teach the child necessary coping or performance skills. You and the teacher may also need to "ignore" certain non-risky behaviors (e.g., walking around in the middle of class) that, when interrupted, set the child off. At a minimum you want to establish alternatives that he and the teacher know are acceptable. It is also a good idea to ask your school psychologist to develop uniform criteria for assessing behavior. This helps minimize inconsistencies in referrals due to different behavior tolerances among teachers.

Stay in front of the meltdown. Everyone is better off—the child, his classmates, and the staff—if adults can help the child stop the meltdown before it starts. Not only does this minimize the negative impact on others, it changes the child's expectation that "losing it" is his only option. In the beginning, school staff may need to intervene quite a bit, but the eventual objective is to enable the child to manage his reactions himself.

Identifying the precursor behaviors that indicate the child is getting upset is important. Children usually have a pattern of behaviors that express their growing frustration, e.g., clenching their fists, jiggling their leg, or making sounds of exasperation. These clue the teacher as to when to intervene. It also is important to teach the child to recognize these signs and the corresponding feelings and thoughts in order to *implement coping strategies* before losing control. Again, you want to work with all of the adults involved and the student to determine what approaches are most effective. If applicable, these strategies would be incorporated into the child's IEP. Examples include establishing a "safe" place in the classroom where the child can collect himself, developing a signal between the teacher and student that says, "I am having trouble," allowing the child extra time to complete work or transition to another activity, or providing alternative means to do an assignment. Even eliciting the help of a classmate can be effective. Asking Tyler to help Andy organize his things not only minimizes Andy's frus-

Continued on page 4 226



Changing Violent Behavior
(Continued from page 3)

tration but also fosters positive social interactions between the two boys.

Show the child that you are an advocate for his success. As a principal, you advocate for every student's success, but children with serious behavior problems may need extra encouragement to feel supported. Begin interactions with the child by acknowledging some strength or example of his competency. Go out of your way to catch him succeeding. Try to spend some time with him other than in the midst of a crisis. For instance, eat lunch together or play a favorite game at recess. Convey that your involvement in a problem does not signal a failure on his part but rather your commitment to help him, his teacher and parents find a solution. This problem-solving approach is not only more effective, it also helps establish a sense of trust with the student and reduces parent defensiveness.

Engage parents as partners. The cooperation of the child's parents is essential to changing difficult behavior. The child is almost certainly exhibiting similar behavior at home. The parents themselves may be worried or frustrated. They may also need to adjust some of their own behavior or approach to the problem and may feel they are being judged. Do not try to establish your relationship with them over the phone. Schedule a meeting. Good face-to-face communications from the start will minimize confrontation and help parents view you and your staff as a resource. Avoid beginning the conversation with a litany of negatives. Instead emphasize the child's strengths and how they can be built into the problem solving process.

Ask the parents to identify triggers and precursor behaviors that they have observed and to recommend coping strategies that work at home. Maintain open communication and determine how they prefer to be contacted if their child is having difficulty, e.g., a phone call, note home, or e-mail. ☺

An Ounce of Prevention Is Worth a Pound of Cure.

The upfront work involved in helping the explosive/noncompliant child may seem daunting but the investment is worth it. These children have the potential to become positive contributors to or serious problems for society in the future. The skills they learn in elementary school will carry them through later school experiences and into adulthood. As in all areas of life, the cost of prevention strategies is far lower than the cost of remediating or containing far more serious problems down the road. ☺

Diane Smallwood served as 2002–2003 President of NASP and is a school psychologist in the South Brunswick (NJ) School District.

© 2003, National Association of School Psychologists, 4340 East West Highway, Suite 402, Bethesda, MD 20814, www.nasponline.org, (301) 657-0270. An adapted version of this article first appeared in the National Association of Elementary School Principals' newsletter, "Here's How," spring 2003.

The ACCEPTS Program, www.proedinc.com/store/index.php?mode=product_detail&id=0365

The Explosive Child, Dr. Ross Greene, www.explosivechild.com/

The FAST Track Program (Families and Schools Together, www.fasttrackproject.org/

The Incredible Years Parents Teachers and Children Training Series, www.incredibleyears.com/

National Association of School Psychologists publications, [Helping Children at Home and School: Handouts From Your School Psychologist](#) and [Preventing School Problems—Promoting School Success, Strategies and Programs That Work](#), www.nasponline.org/bestsellers

The PREPARE Curriculum, www.researchpress.com/scripts/product.asp?item=5063

Primary Mental Health Project, www.sharingsuccess.org/code/eptw/profiles/48.html

Inhalants

www.drugabuse.gov

National Institute on Drug Abuse • National Institutes of Health • U.S. Department of Health & Human Services

Inhalants are breathable chemical vapors that produce psychoactive (mind-altering) effects. A variety of products commonplace in the home and in the workplace contain substances that can be inhaled. Many people do not think of these products, such as spray paints, glues, and cleaning fluids, as drugs because they were never meant to be used to achieve an intoxicating effect. Yet, young children and adolescents can easily obtain them and are among those most likely to abuse these extremely toxic substances. Parents should monitor household products closely to prevent accidental inhalation by very young children. Inhalants fall into the following categories:

Solvents

- Industrial or household solvents or solvent-containing products, including paint thinners or removers, degreasers, dry-cleaning fluids, gasoline, and glue
- Art or office supply solvents, including correction fluids, felt-tip-marker fluid, and electronic contact cleaners

Gases

- Gases used in household or commercial products, including butane lighters

and propane tanks, whipping cream aerosols or dispensers (whippets), and refrigerant gases

- Household aerosol propellants and associated solvents in items such as spray paints, hair or deodorant sprays, and fabric protector sprays
- Medical anesthetic gases, such as ether, chloroform, halothane, and nitrous oxide (“laughing gas”)

Nitrites

- Aliphatic nitrites, including cyclohexyl nitrite, an ingredient found in room odorizers; amyl nitrite, which is used for medical purposes; and butyl nitrite (previously used to manufacture perfumes and antifreeze), which is now an illegal substance

Health Hazards ———

Although they differ in makeup, nearly all abused inhalants produce short-term effects similar to anesthetics, which act to slow down the body’s functions. When inhaled via the nose or mouth into the lungs in sufficient concentrations, inhalants can cause intoxicating effects. Intoxication usually lasts only a few minutes.

However, sometimes users extend this effect for several hours by breathing in inhalants repeatedly. Initially, users may feel slightly stimulated. Successive inhalations make them feel less inhibited and less in control. If use continues, users can lose consciousness.

Sniffing highly concentrated amounts of the chemicals in solvents or aerosol sprays can directly induce heart failure and death within minutes of a session of prolonged use. This syndrome, known as "sudden sniffing death," can result from a single session of inhalant use by an otherwise healthy young person. Sudden sniffing death is particularly associated with the abuse of butane, propane, and chemicals in aerosols.

High concentrations of inhalants also can cause death from suffocation by displacing oxygen in the lungs and then in the central nervous system so that breathing ceases. Deliberately inhaling from an attached paper or plastic bag or in a closed area greatly increases the chances of suffocation. Even when using aerosols or volatile products for their legitimate purposes (i.e., painting, cleaning), it is wise to do so in a well-ventilated room or outdoors.

Chronic abuse of solvents can cause severe, long-term damage to the brain, the liver, and the kidneys.

Harmful irreversible effects that may be caused by abuse of specific solvents include:

- Hearing loss—toluene (spray paints, glues, dewaxers) and trichloroethylene (cleaning fluids, correction fluids)
- Peripheral neuropathies, or limb spasms—hexane (glues, gasoline) and nitrous oxide (whipping cream, gas cylinders)
- Central nervous system or brain damage—toluene (spray paints, glues, dewaxers)
- Bone marrow damage—benzene (gasoline)

Serious but potentially reversible effects include:

- Liver and kidney damage—toluene-containing substances and chlorinated hydrocarbons (correction fluids, dry-cleaning fluids)
- Blood oxygen depletion—aliphatic nitrites (known on the street as poppers, bold, and rush) and methylene chloride (varnish removers, paint thinners)

Abuse of amyl and butyl nitrites has been associated with Kaposi's sarcoma (KS), the most common cancer reported among AIDS patients. Early studies of KS showed that many people with KS had used volatile nitrites. Researchers are continuing

to explore the hypothesis of nitrites as a factor contributing to the development of KS in HIV-infected people.

Extent of Use —————

Initial use of inhalants often starts early. Some young people may use inhalants as a cheap, accessible substitute for alcohol. Research suggests that chronic or long-term inhalant abusers are among the most difficult drug abuse patients to treat. Many suffer from cognitive impairment and other neurological dysfunction and may experience multiple psychological and social problems.

2002 Monitoring the Future Study (MTF)*

NIDA's nationwide annual survey of drug use among the Nation's 8th-, 10th-, and 12th-graders indicates that inhalant use for 8th- and 10th-graders appears to have peaked in 1995, and in 1990 for 12th-graders, and has declined since then. In 2002, lifetime, past-year, and past-month inhalant use among 8th- and 10th-graders was the lowest seen in the history of the survey and the lowest in about 20 years for high school seniors.

In 2002, a pattern of higher rates of use by younger children continued as more 8th-graders than 10th- or 12th-graders said they used inhalants. However, the

percentage of 8th-graders who said they had ever used inhalants decreased from 17.1 percent in 2001 to 15.2 percent in 2002. This represents a substantial decline from the peak year of 1995 when 21.6 percent of 8th-graders said they had used inhalants during their lifetimes.

2002 Drug Abuse Warning Network (DAWN)**

Emergency department mentions of inhalants increased 187 percent, from 522 in 2001 to 1,496 in 2002, returning to the approximate level observed in 2000.

2002 National Survey on Drug Use and Health (NSDUH)***

Among youths age 12 to 17, 11.6 percent were current illicit drug users in 2002, and 1.2 percent were current inhalant users. Among 12- or 13-year-olds, 1.4 percent used inhalants. In 2002, 71 percent of inhalant users were age 12 to 25.

The number of new inhalant users increased from 627,000 new users in 1994 to 1.2 million in 2000. During this period, more males initiated inhalant use than females. The number of new inhalant users in 2001 was similar to the number in 2000 (1.1 million). Inhalant initiates in 2001, as well as in prior years, were predominantly under age 18 (71 percent in 2001).

Other Information Sources —————

For additional information on inhalants, please refer to the following sources on

NIDA's Web site, www.drugabuse.gov:

Inhalant Abuse—*Research Report Series*
Various issues of *NIDA NOTES* (search by "inhalants" or "solvents")

*Conducted annually since 1975, MTF assesses drug use and attitudes among 8th-, 10th-, and 12th-graders, college students, and young adults nationwide. The survey is conducted by the University of Michigan's Institute for Social Research and is funded by NIDA. Copies of the latest published survey are available from the National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686 or may be downloaded from www.monitoringthefuture.org.

** The latest data on drug abuse-related hospital emergency department (ED) visits are from the 2002 DAWN report, from HHS's Substance Abuse and Mental Health Services Administration. These data are from a national probability survey of 437 hospital EDs in 21 metropolitan areas in the U.S. during the year. For detailed information from DAWN, visit www.samhsa.gov/statistics/statistics.html, or call the National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686.

***The 2002 NSDUH, produced by HHS's Substance Abuse and Mental Health Services Administration, creates a new baseline for future national drug use trends. The survey is based on interviews with 68,126 respondents who were interviewed in their homes. The interviews represent 98 percent of the U.S. population age 12 and older. Not included in the survey are persons in the active military, in prisons, or other institutionalized populations, or who are homeless. Findings from the 2002 National Survey on Drug Use and Health are available online at www.DrugAbuseStatistics.samhsa.gov.

Revised 10-1-03



National Institutes of Health – U.S. Department of Health and Human Services

This material may be used or reproduced without permission from NIDA. Citation of the source is appreciated.