Addressing Barriers to Learning

New ways to think . . .

Better ways to link

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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

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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

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 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.

To clarify the point: For purposes of the present discussion, any student can be viewed as

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Center News

Have you checked out our web site? Requested or shared Clearinghouse resources? Networked with someone on the Consultation Cadre list? Asked us for technical assistance? If not, maybe the following updates will lead you to us.

Clearinghouse Grows

We think of our Clearinghouse as an opportunity for you to find resources, share and network. With contributions from those willing to share, it contains an increasing array of information on resources and activity related to mental health in schools and addressing barriers to learning.

Of special interest is our growing selection of ***Introductory Packets.*** These highlight key topics related to specific psychosocial problems, programs and processes, and system concerns. These aids provide an quick overview of a topic and relevant resources -- references, introductory discussions, models, a guide to major agencies providing assistance, internet sites, and a list of some Consultation Cadre members with expertise in the area. Seven packets are now available:

(1) *Teen Pregnancy Prevention and Support*
(2) *Parent and Home Involvement in Schooling*
(3) *Evaluation and Accountability*
(4) *Collaborative Teams, Cross-Disciplinary Training, and Interprofessional Education*
(5) *Learning Problems & Learning Disabilities*
(6) *Least Intervention Needed: Toward Appropriate Inclusion of Students with Special Needs*
(7) *Dropout Prevention.*

In the works are packets on financing, preventing staff burnout, creating safe schools, and issues relating to confidentiality.

Electronic Networking: Good Today, Better Tomorrow

By now, we hope those of you with access have checked out our web site. (The Mental Health Net just gave it an award for content and presentation!) We recently included a job announcement page to list relevant positions we hear about. We've added linkages to popular web sites -- over 32 sites are listed under four categories: government, educational, organizational and policy related. Other recent additions include a profiling of Consultation Cadre members, and descriptions of Clearinghouse *Introductory Packets*. A guest sign-in page has been added to provide another way for you to communicate with us.

To begin the process of developing active networks among practitioners and policy makers, we also are reaching out to all who have given us an e-mail address. We want to outreach as far as possible, so feel free to forward the information we send to anyone you think might be interested.

Looking ahead, we anticipate establishing an electronic bulletin board and piloting the use of telecommunications for networking and training.

Access our web site:

http://www.lifesci.ucla.edu/psych/mh/

E-mail us: **smhp@ucla.edu**

Consultation Cadre: Colleagues Helping Colleagues

Already, over 200 professionals have volunteered to network with others to share what they know. Cadre members have indicated expertise related to major system concerns, a variety of program and processing issues, and almost every type of psychosocial problem. They work in urban and rural areas across the country.

Who's on board? Some run programs (for example, one directs the Safe and Drug-Free Schools program for a state education agency). Many work directly with kids in a variety of settings and on a wide range of problems. Others are ready to share their expertise on policy, funding, and system changes (for example, one professor is enmeshed in developing a model for a statewide, school-based mental health system; another is involved with school restructuring).

Someone asked how we screen cadre members. We don't! It's not our role to endorse anyone. We think it's wonderful that so many professionals want to help their colleagues, and our role is to provide a way for you all to connect with each other. And to make the process easier, in the near future, those with the capability to do so will be able to access the cadre list through our web site.

In response to a barrage of difficult questions from the teacher, the student groaned:

If I knew all the answers,
I wouldn't need to come to school!

Regional Conferences

We have now completed two regional conferences -- one in Los Angeles, another in Albuquerque. (A third will take place in Portland, Maine on September 30th.) Focusing on the topic of *Addressing Barriers to Student Learning,* leaders concerned with mental and physical health, education, and human services discussed *New Directions for Policy and Practice.* A good sample of states and regional groups were represented. Participants (a) shared information on current trends and initiatives related to urban, rural, and frontier communities/schools, (b) explored recommendations for moving toward more comprehensive, integrated approaches, and (c) targeted key people for inclusion in networking to accelerate progress.

In Albuquerque, the staff of the New Mexico School Mental Health Initiative co-hosted the regional meeting and planned and implemented a statewide conference the following day . The Center's co-directors presented to the state participants. The New Mexico initiative is one of five state projects funded by the Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health. The other four are in Maine, North Carolina, Minnesota, and Kentucky. While in New Mexico, the Center's co-directors also presented to participants attending the first meeting sponsored by the U.S. Department of Education's new Comprehensive Resource Center for the region, which is housed in Albuquerque.

For our Regional conference in Maine, their state's project staff will co-host, and both our Center and our sister center at the University of Maryland, Baltimore will present and assist with the statewide conference that has been planned to mesh with our meeting. A report including a summary, analysis, and recommendations based on information from the regionals and our various needs assessments will be prepared and circulated by the end of the year.

If you
need help,
want to network with colleagues,
are willing to share your expertise,
have comments about our efforts,

you can access us through the internet (see the above addresses) or by **FAX** at **(310) 206-8716**.

Or, if you don't have access to these electronic toys, we are still old fashioned enough to appreciate letters (see our return address) and phone calls -- **(310) 825-3634**.

Continuing Education Modules

We are developing inservice modules on mental health concerns for various groups of school professionals. For example, we have agreed to provide a series of continuing education units to the National Association of School Nurses. These will be readily adaptable for other school professionals.

As part of our ongoing work with one of the New American Schools Development Corporation (NASDC) "break the mold" school models, we are producing a 6-7 hour module focused on enhancing regular teachers' willingness and ability to work with students with mild-moderate emotional, behavioral, and learning problems. For school administrators and lead personnel involved in systemic reform, we are piloting a 12 hour module (six-2 hour sessions) around the concept of restructuring schools to address barriers to student learning.

With respect to mental health facets of school-based health centers, we continue to provide copies of our previously developed guidebook units. These will be updated one by one over the next year and a half.

Do You Know About . . . *?*

To reduce fragmentation, the U.S. Dept. of Education has asked (but not mandated) that each state prepare a consolidated plan for implementing federally funded school programs (e.g., the various "Titles" of the *Improving America's School Act* that support compensatory education, bilingual, migrant, safe and drug free schools, professional development). The intent is "to improve the academic achievement of all children" and "to make your state's consolidated plan an integral part of your state's reform strategies."

As part of this effort, the various technical assistance centers supported by U.S.D.O.E. have been consolidated into 15 regional comprehensive centers, and one of their responsibilities is to provide technical assistance to state's in developing plans for consolidation. Given the importance of these programs in addressing barriers to learning, you may want to contact your state's education agency and the comprehensive center serving your region to see how you can interface with the effort.

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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, l994). 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

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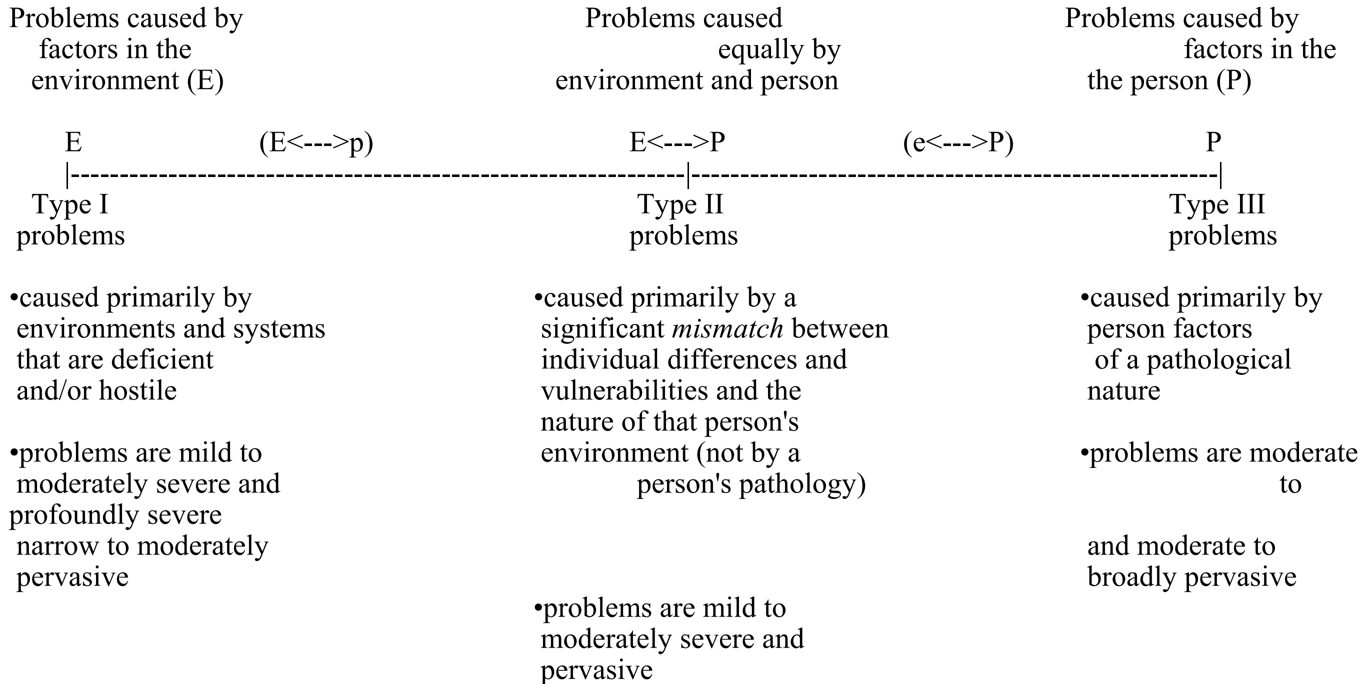
. . . and a host of graduate and undergraduate students

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.

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 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.

> 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).

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 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.

(references on p. 9)

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
Early-after-onset intervention	3. Early-schooling targeted interventions • orientations, welcoming and transition support into school and community life for students and their families (especially immigrants) • support and guidance to ameliorate school adjustment problems • personalized instruction in the primary grades • additional support to address specific learning problems • parent involvement in problem solving • comprehensive and accessible psychosocial and physical and mental health programs (incl. a focus on community and home violence and other problems identified through community needs assessment) 4. Improvement and augmentation of ongoing regular support • enhance systems through multidisciplinary team work, consultation, and staff development • preparation and support for school and life transitions • teaching "basics" of support and remediation to regular teachers (incl. use of available resource personnel, peer and volunteer support) • parent involvement in problem solving • resource support for parents-in-need (incl. assistance in finding work, legal aid, ESL and citizenship classes, and so forth) • comprehensive and accessible psychosocial and physical and mental health interventions (incl. health and physical education, recreation, violence reduction programs, and so forth) • Academic guidance and assistance • Emergency and crisis prevention and response mechanisms 5. Other interventions prior to referral for intensive and ongoing targeted treatments • enhance systems through multidisciplinary team work, consultation, and staff development • short-term specialized interventions (including resource teacher instruction and family mobilization; programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts)
Treatment for severe/chronic problems	6. Intensive treatments • referral, triage, placement guidance and assistance, case management, and resource coordination • family preservation programs and services • special education and rehabilitation • dropout recovery and follow-up support • services for severe-chronic psychosocial/mental/physical health problems

Do You Know About . . . ?

Financing for Schools to Enhance Coordination of Programs & Services to Address Barriers to Learning

Title XI of the Improving Americas Schools Act of 1994 is designed to foster coordinated services to address problems that children face outside the classroom that affect their performance in schools. Under this provision, school districts, schools, and consortia of schools may use up to 5 percent of the funds they receive under the Elementary and Secondary Education Act (ESEA) to develop, implement, or expand efforts to coordinate services.

The intent is to improve access to social, health, and education programs and services to enable children to achieve in school and to involve parents more fully in their children's education. Among the barriers cited in the legislation as impeding learning are poor nutrition, unsafe living conditions, physical and sexual abuse, family and gang violence, inadequate health care, lack of child care, unemployment, and substance abuse.

Interested applicants should contact:

Assistant Secretary for Elementary and Secondary Education
400 Maryland Ave., S.W.
Washington, D.C. 20202-0131
(201) 401-1576

Several school districts have already initiated efforts under Title XI. You may want to contact either of the following to get a sense of their approach.

Sally Coughlin, Assistant Superintendent
Student Health & Human Services
Los Angeles Unified School District
450 N. Grand Ave.
Los Angeles, CA 90012
(213) 625-5635

Jenni Jennings, Coordinator
Youth & Family Centers
Dallas Public Schools
425 Office Parkway
Dallas, TX 75204
(214) 827-4333

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Lessons Learned

Revisiting Medication for Kids

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

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

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

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

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

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

I am not making these things up. These three cases have so far occupied the last three days of my week, and I'm telling you about them not to garner sympathy for the kids (only two of whom have any sympathy coming in any case), or for me (despite my clearly deserving some), but to focus attention on the astonishing degree to which everyone in our society has come to believe in the prescribing of psychotropic medication as a cure, or at least a control, for disturbing behavior in kids.

How did we arrive at this state of affairs? Though a very complex interaction among a myriad of scientific, social, and historical factors, of which I want to mention just two of the scientific ones: progress in psychiatric nosology, and progress in biological psychiatry.

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

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

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

Ideas into Practice

Safe Schools: Enhancing Motivation for Interpersonal Problem Solving

Safe schools, violence prevention, conflict reduction -- all are of major concerns in addressing barriers to learning. One response to these concerns are the many programs to improve interpersonal functioning and problem solving -- including a variety of "social skills training" approaches.

How promising are programs for training social skills? Reviewers are cautiously optimistic, but outcomes tend to be limited to what is specifically learned and to situations in which skills are learned. Moreover, the behaviors learned usually are maintained only for a short period. This is the case for (a) training specific behaviors, such as teaching what to think and say in a given situation, and (b) strategies to develop specific cognitive or affective skills, such as how to generate a wider range of options to solve interpersonal problems.

As with other skill training strategies, these limitations seem to result from a failure to understand the implications of recent theory and research on human motivation. Improving relationships among students and between students and school staff requires a major emphasis on translating ideas about enhancing intrinsic motivation into practice. All interpersonal problem solving training programs need to include a systematic emphasis on enhancing motivation to avoid and overcome interpersonal problems, as well as facilitating the learning of skills for doing so. In this respect, it also is important to remember that

(1) not all problems with social functioning are indications that a person lacks social skills;

(2) assessment of social skill deficiencies is best accomplished after efforts are made (a) to minimize environmental factors causing interpersonal problems and (b) to maximize a student's motivation for coping effectively with such problems;

(3) regular teaching and remedial strategies to improve skills for social functioning are best accomplished in interaction with systematic strategies to enhance motivation (a) for avoiding and overcoming interpersonal problems and (b) for continuing to apply social skills.

Some steps in addressing motivation to overcome interpersonal problems are outlined in the shaded box. As indicated, a general problem solving sequence is used. Small group instruction is favored because it provides a social context for learning about social matters; however, as an initial step, some youngsters may have to be worked with individually.

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Initial Steps for Enhancing and Maintaining Motivation to Solve Interpersonal Problems

Over a series of sessions, the emphasis is on helping each individual understand her/his expectations and values related to interpersonal problem solving. To these ends, a range of activities are used as stimuli to engage discussion (e.g., pictures, sentence completion items, Q-sort items, role playing, audiovisual presentations -- videotapes are particularly useful to make points vividly by portraying others in comparable situations and as models).

The first focus is on *describing the problem* by exploring (without assigning blame)

Gspecific times when each individual experiences interpersonal problems
Gthe form such problems take
Geach individual's perceptions of the causes of the problems

At this point, a *broader analysis of possible causes* is explored (e.g., each individual's thoughts about other possible reasons and about how other people might interpret the situation; the intervener provides examples of other feasible perceptions and beliefs).

Then, the focus shifts to eliciting each individual's *expectations and values* related to interpersonal functioning:

Gwhy the individual and other people might want interpersonal problems not to occur (underscoring each individual's most important reasons for wanting not to be involved in such problems)
Gwhy the problems might continue

This is followed by efforts to *develop/enhance positive expectations and values* through

Gidentifying some interpersonal problems that the individual wants to eliminate
Gunderscoring the specific reasons for wanting to do so
Geliciting a public commitment to take some positive action

Finally, the emphasis is on *problem solving strategies*:

Gavailable alternatives for avoiding problems, using acquired skills, and developing new skills

In enhancing motivation to problem solve, *options and choice* are key concepts. That is, it is important to present an array of activity options and engage individual's in

Recognizing that both motivational readiness and developmental capabilities must be accommodated, the following guidelines are stressed:

- Avoid teaching previously learned skills or those the student does not want to pursue currently (i.e., no skill instruction until sufficient interest is established)
- Teach the skills the student most needs for pursuing current relationships (match current needs).
- Develop any missing prerequisites for learning and performing needed skills (communication, divergent thinking, recognizing and understanding individual differences and the value of respect and concern for others).

It is unlikely that any program to make schools safer will achieve its objectives without incorporating a sophisticated, systematic approach to enhancing students' intrinsic motivation to solve interpersonal conflicts. Skills are necessary, but insufficient, and often are not the problem in the first place.

The work of Ed Deci provides a fine review of the literature on intrinsic motivation with a discussion of applications for educational and psychological practice. For example, see E.L. Deci and R.M. Ryan (1985), *Intrinsic Motivation and Self-Determination in Human Behavior.* New York: Plenum Press.

A Few References on Making Schools Safe

Hathaway, J. (Ed) (1996). Safe schools: Policies and practice. *Education and Urban Society,* (entire August issue).

Johnson, D. & Johnson, R. (1995). Why violence prevention programs don't work and what does. *Educational Leadership, 52,* 63-67.

La Cerva, V. (1996). *Pathways to peace: Forty steps to a less violent America.* Tesque, NM: Heartsongs Publications.

Bey, T.M. & Turner, G.Y. (1995). *Making school a place of peace.* Newbury Park, CA: Corwin Press.

In its *Practicing Administration Leadership Series*, Corwin Press offers several, concise works relevant to safe schools.

The surprised principal, waving the achievement test scores, confronts Ms. Smith, the second-grade teacher.
"How did you get these low IQ students to do so well?"
"Low IQ?" she repeats with equal surprise. "What do you mean, low IQ?"
"Well, didn't you see their IQ scores on the list I sent you last fall?"
"Oh no!" Ms. Smith exclaims, "I thought those were their locker numbers!"

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