

TEACHING STRATEGIES
for all Learners



**Unlocking the Mysteries
of Children's Mental Health:
An Introduction for Future Teachers**



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UNLOCKING THE MYSTERIES OF CHILDREN'S MENTAL HEALTH

This curriculum unit contains lecture notes, background information, and resources for presentations toward fulfillment of the Standards of Effective Practice for Teachers, specifically the following areas:

Subpart 3. Standard 2 B, C, D, and E
Subpart 4. Standard 3 B, D, I, K, M, N, and Q
Subpart 5. Standard 4 B, F, and I
Subpart 6. Standard 5 C, H, and O
Subpart 11. Standard 10 B, G, I, J, and K

Recommended text for use with these lectures:

Minnesota Association for Children's Mental Health (MACMH). (2002). A teacher's guide to children's mental health. St. Paul, MN: Author.

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This guide is dedicated to the legion of parents who persistently seek out information and share their insights into the challenging children they love — and to the teachers who listen.

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TO THE INSTRUCTOR

One of the most challenging educational concerns of our era is how to successfully educate children with special learning needs due to mental health disorders. Future teachers who are now participating in pre-service general education training programs will play a front-line role in attempts to improve the current situation.

A 2002 study estimates that 12 to 22% of all school students have emotional or behavioral disorders. (Adelman & Taylor, 2002). The Association of School Counselors notes that 18% of students require interventions that go beyond resources available in a typical classroom (Dunn and Baker, 2002).

The majority of children with diagnosed or undiagnosed mental health disorders are placed in general education classrooms. They need teachers who understand the multiple challenges they face and who can develop academic and behavioral interventions based on the latest findings in brain research.

Concern is especially high for children receiving special education services for emotional or behavioral disorders (EBD). Whether they are included in regular classrooms or not, their rate of literacy skills, high school graduation, and successful employment continue to be appallingly low. Students eligible for the EBD classification in special education represent 2% of Minnesota's school population. They constitute approximately 16% of all Minnesota students in special education. Astonishingly, these students represent fully 52% of the special education students expelled from school (MDHS, 1999; MDCFL, 2002; MDCFL, 1999).

Children with mental health disorders and their families face many barriers, including disparities in county services, an extreme shortage of service providers, and a lack of parity in health insurance, which makes mental health treatment even more difficult to access. Many parents are unemployed or underemployed because frequent family crises require them to be available at any time. In addition, the prevailing stigma toward mental illness means that these families are usually isolated and often openly rejected by neighbors, the community, and even their own extended families.

This curriculum on children’s mental health in the schools was developed by the Minnesota Association for Children’s Mental Health (MACMH), an advocacy organization for families that include children with mental health disorders. We have worked with countless parents and teachers over nearly 15 years to try to improve classroom success for children with mental health disorders in specialized and main-stream classrooms.

Please note that these materials use the term “mental health disorder” throughout to avoid confusion between the many possible terms used in the educational and service systems. Other terms are defined as they are introduced in the lesson. To further avoid confusion, all pronouns are masculine. There is, however, growing recognition of the extent of mental health disorders among school-aged girls.

PLEASE NOTE:

SED (Severely Emotionally Disturbed) is a state and county classification that allows access to a full range of mental health outpatient and inpatient services.

EBD (Emotional or Behavioral Disorder) is an education term signifying that the student meets criteria for this category of special education services.

EBD and SED are terms that cannot be used as a diagnosis. A mental health diagnosis is usually determined by a licensed mental health professional using the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, published by the American Psychiatric Association). We will look at both sets of criteria and DSM-IV listings during the third lecture of this series. A child may not have a diagnosis but is classified as EBD in the school system, or diagnosed but not eligible for or in need of EBD services. Classrooms also continue to contain many children whose mental health needs have been overlooked.

GOALS AND OBJECTIVES

These activities are designed to help teacher educators prepare pre-service teacher education students so they will understand and effectively teach children who have a diagnosed or undiagnosed mental health disorder. This lecture series will help teacher preparation students understand the barriers to learning and acquire tools for effectively teaching children who have mental health disorders. It will also encourage teachers to consider each child with a mental health disorder individually, gain an introductory understanding of positive behavior supports, and learn how to use simple modifications and adaptations that coincide with the trend toward brain-based teaching.

The specific learner objectives for this project are:

- Learners will understand the scope of mental health disorders in children, the impact of such disorders on learning, and the challenges general education teachers can expect in the classroom.
- Learners will understand how the normal brain functions in learning and what factors may interfere with the learning process.
- Learners will identify major mental health categories seen in school populations and specific characteristics of several key diagnoses.
- Learners will be able to develop positive behavioral supports and classroom accommodations when they are given a case history and description of a child.
- Learners will understand the impact of childhood mental health disorders on students, families, and communities; learners will also know the assistance available and how to support and advocate for families.

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CONTEXT FOR INSTRUCTION

The complete instructor's packet includes the following components:

- Lecture Guide
- PowerPoint Presentations 1 - 4
- Master Copy of note-taking handouts
- Master Copy of Children's Mental Health Disorder Fact Sheets for the Classroom

These components are available at www.macmh.org.

Recommended Textbook

Saxhaug, D. & Giguere, N. (2002). A teachers guide to children's mental health
Minnesota Association for Children's Mental Health, St. Paul, MN.

Equipment Needed

Portable computer, multimedia projector, and screen or
Overhead projector, screen, and transparencies of slides
A pointer or laser pointer
Classroom conducive to small group work

PREPARING FOR THE LESSONS ON CHILDREN'S MENTAL HEALTH

As the state's leading advocacy organization for families raising children with mental health disorders, the **Minnesota Association for Children's Mental Health** believes that every classroom teacher should be prepared for the challenges posed by integrated classrooms. We urge you to allow a minimum of 4 hour-long class meetings to give enough time for this "mini-course" to fulfill all of the objectives previously stated.

In fact, the authors strongly encourage you to expand this unit if feasible. Some possibilities for using extra class time include:

- Allow time for oral presentation of some homework assignments and full classroom discussion.
- Invite a parent advocate to speak on parent-professional relationships.
- Invite parents to appear as a panel to share their successes and challenges. This firsthand contact will help your class understand the strengths these children bring to the classroom, as well as the very real challenges they pose to their families, their teachers, and their communities.
- Supplement classroom activities with one or more of the recommended videos listed in the Resources section of this guide.

Critical Incidents

At various points during the four lectures, critical incidents are inserted to allow a chance for more experiential learning. These may, of course, be modified to fit your class size, available time, and teaching preferences. We have included suggested quiz questions as critical incidents, and you may also wish to convert some of the suggested homework assignments for use as open-note quizzes or class discussion questions.

PowerPoint®

The PowerPoint® presentations designed to accompany this guide (available at www.macmh.org) include three introductory slides for each lecture. All other slides are keyed to the text of the lectures. The download also includes original clip art for student handouts accompanying Lecture 2. If you prefer, you may use PowerPoint software to print overhead transparencies. We also recommend printing the 3-slide per page notetaking format for use as student handouts.

Background Briefs

A series of “Background Briefs” are included with this unit; they cover basic information concerning special education, mental health services, and other concepts. They are designed to give you, the instructor, some necessary information if you do not normally teach in these areas. They may also be used as handouts or discussion topics for your students. There is additional background information in the Teacher’s Guide to Children’s Mental Health, which is the recommended textbook for this unit.

Assignments

A wide variety of research assignments are included with each lecture’s notes. Many of them require 1- to 3-page essays; others require compilation of lists of resources. Each assignment is designed to broaden the pre-service teacher’s background and understanding of issues in children’s mental health. For maximum impact, you may wish to assign different topics to your students and distribute the results to all class members. This would greatly expand the set of resources available for use in their professional career. Instructors may choose from these assignments to create a take-home exam for the entire unit.

Readings

Readings may be duplicated for student handouts, or placed on reserve. All other rights are reserved by the original sources

GRADING RUBRIC FOR HOMEWORK AND TEST ESSAYS

Homework for this series of classes is designed to help pre-service teacher training students to discover and synthesize concepts and resources they may find useful in the classroom. It will also help pre-service teachers gain experience in evaluating emotional or behavioral problems that form barriers to learning, and to plan modifications of their curriculum, presentation, and/or classroom environment that will support their students in overcoming those barriers. Grading should be based on quality of reading/research, understanding and communication of basic concepts, and demonstration of your student's awareness of the relevance of the information gained. We suggest the following guidelines:

| | |
|----------------------------|---|
| Exemplary | Provides a clear and complete response with a coherent line of reasoning or evidence of a broad research effort. Communicates with identified audience, shows understanding of the intent of the assignment. Includes all aspects of the problem posed. May present a strongly supported position or examples of differing positions. |
| Competent | Provides a clear and complete response that reveals careful reading and/or a strong attempt at research. Communicates awareness of the intent of the assignment. Presents support for opinions or conclusions. |
| Satisfactory | Completes the assignment with some indication of understanding the intent, but stopped short of a broad investigatory effort or communicates results unclearly. May include unsupported positions or no conclusions. |
| Nearly Satisfactory | Begins the task appropriately but may fail to complete all elements, answer all questions, etc. Demonstrates inability or lack of effort in fulfilling the purpose of assignment. Minor flaws in presentation may put essay in this category. |
| Inadequate | Begins but fails to complete assignment; i.e., uses no more than one research resource, reports no data available, etc. Major flaws in presentation may put essay in this category. |
| Unacceptable | Answer reflects lack of understanding of task. Misrepresents the data or research. Writing is plagiarized or incomprehensible. |

LECTURE 1: INTRODUCTION TO THE RELATIONSHIP BETWEEN CHILDREN'S MENTAL HEALTH & LEARNING

Focus: *Understanding the scope and social cost of mental illness in the school-aged population, the relationship between mental health and learning, and the impact teachers can have on lifetime outcomes.* [SLIDE 4]

[SLIDE 5] Childhood mental health disorders are too often overlooked or greatly misunderstood. After all, common thinking goes, all children go through rough times at school, with their friends, or in their families. Especially during the stormy preteen and teenage years, emotions may shift and change with bewildering rapidity. Most “normal” emotional problems—like feeling sad after a friend moves away—have a definite reason and clear up with time and increasing maturity.

[SLIDE 6] But when children exhibit behaviors or moods that seem more dramatic than those of their same-age peers, continue for a longer time, or are no longer age-appropriate — like extreme separation anxiety in a child of 8 or 9 years old — adults should consider the possibility of a mental health (emotional or behavioral) disorder and take steps to intervene.

[SLIDE 7] *Mental Health—A Definition*

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society. (USDHHS, 1999)

[SLIDE 8] *National Statistics*

The above definition should be our social goal for every child. However, on any given day, almost 21% of children in the United States have a diagnosable mental, emotional, or behavioral disorder (USDHHS, 1999). About 6% of children under age 17 have attention-deficit/hyperactivity disorder (AD/HD) (USDHHS, 2002) and 3 in every 1,000 babies are born with brain damage from prenatal alcohol exposure (IM, 1996). As many as 1 in 8 adolescents and 1 in every 33 younger children may have depression (USDHHS-SAMSHA, 1996).

A landmark report from the U.S. Surgeon General's office estimates that fewer than 1 in 5 children with some level of impairment due to mental illness receive needed treatment (USDHHS, 2001).

PLEASE NOTE:

Slides for this lecture can be downloaded at no charge from www.macmh.org.

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Minnesota Statistics

In Minnesota, some idea of the magnitude of the problem can be gained by reviewing county and school statistics. One out of every 20 children has been declared eligible for county services for a severe emotional disturbance (SED) (MDHS, 1999). (See Background Brief A for more information on county services.) During the 2000–2001 school year, 16% of special education students met the criteria for emotional or behavioral disorders (EBD), which is 1 of 13 special education categories (MDCFL, 2002).

Suicide is the 2nd leading cause of death for Minnesotans ages 15 to 34. (MDHS, 1999). The overall suicide rate in the state is 3 times higher than the number of deaths by homicide (MDH, 1999). Sixteen percent of American Indian 9th graders and 14% of Hispanic 9th graders self-declare that they have considered or attempted suicide (Mgeni, 1998).

In one Minnesota county where mental health screenings were done on 1,354 youth adjudicated to juvenile detention, test results indicate that 23% of the youth had possible suicidal ideation, 33% had possible drug/alcohol issues, and 25% had possible depression and/or anxiety disorders (DCCSD, 2003).

IMPLICATIONS FOR TEACHERS

[SLIDE 9] What does this mean for our classrooms? The Surgeon General's report points out that mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem. These are the ingredients of each individual's successful contribution to community and society. Americans are inundated with messages about success—in school, in a profession, in parenting, in relationships — without appreciating that successful performance rests on a foundation of mental health. (USDHHS, 1999)

[SLIDES 10-11] Childhood mental health disorders can be difficult to recognize and are too often undiagnosed or misinterpreted. Early behavioral symptoms may be overlooked or treated as simple misbehavior. Trained teachers who can pick up early symptoms can often help a child and family move forward toward a formal diagnosis. Teachers can institute classroom accommodations to help a student overcome barriers to learning, and they can also be a valuable support and resource for parents moving through this difficult process.

PLEASE NOTE:

SED (Severely Emotionally Disturbed) is a state and county classification that allows access to a full range of mental health outpatient and inpatient services.

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Best practice for treating childhood mental disorders requires expert differential diagnosis, therapy, often medication, and consistent behavioral support across settings (home, school, and community). Teachers should contribute their observations in writing during the diagnostic process and ensure that the necessary behavioral support is maintained during the school day. With early and consistent treatment, every child with emotional or behavioral challenges has the possibility to succeed in life.

Academic outcomes continue to be dismal for this population. In Minnesota, as in other states, students classified as EBD are more likely to be served in segregated classrooms, have higher school absence rates, be retained in one or more grades, and drop out of school (Digest, 1997). Minnesota students classified as EBD constitute about 71% of students in special education and 1.9% of the overall student enrollment, a rate higher than the national average. When compared to students with Specific Learning Disabilities, EBD students show lower graduation rates and higher dropout rates. Students classified as EBD are more likely than other special education students to be expelled. In addition, when considering the EBD category of special education, boys outnumber girls by a ratio of 4 to 1, and there is a disproportionately large number of African American and American Indian students.

Nationally, 20% of identified SED students are arrested at least once before they leave school; and 58% are arrested within 5 years of leaving school. That figure rises to 73% for those who drop out of school before graduation (Chesapeake Institute, 1994). A 1994 survey of former special education students in Minnesota revealed that only 36% of the EBD students surveyed had been continuously employed since high school. Sixty percent of the employed EBD students earned an average weekly wage under \$250 (MDE, 1994).

[SLIDE 12] *Early Intervention*

Early intervention is vital for successful behavioral and educational outcomes. Children who are treated and supported from the time they first show early warning signs of a mental health disorder have the best chance for success as adults. Most mental health conditions worsen if not treated because the brain's development continues to be assaulted by negative influences. Early treatment can reduce both the duration and severity of symptoms.

In addition to the original mental health disorder, a range of life problems affecting the child, his family, and the community around them can develop as a result of the disorder. The social and emotional implications of these effects, sometimes called "secondary symptoms," may turn out to be more severe than the original mental health symptoms (Streissgeith, 1997). Secondary symptoms may include:

- Disruption of normal family life affecting parents, the marriage itself, siblings, the family's employment goals and financial well-being, relationships with friends and extended family, and the physical health of family members due to unremitting stress.
- Increased risk of emotional and/or physical abuse.

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- Disruption of normal development, including the delayed acquisition of social skills that prevents integration into formal and informal community life including neighborhood play, youth activities, and spiritual life.
- Interference with academic development due to undiagnosed learning disabilities that are “hidden” by problematic behavioral or emotional struggles, time lost from school due to treatment or disciplinary action, and curriculum that does not meet the individual child’s strengths and challenges.
- Increased risk of dropping out without completing school.
- Social isolation caused by rejection due to societal stigma.
- Increased risk of chemical abuse.
- Increased risk of involvement with justice systems, both adult and juvenile. (MDE, 1994)
- Increased risk of suicide attempts and suicide.

A recent report assesses the economic burden on families raising a child with attention-deficit/hyperactivity disorder (AD/HD). Children with AD/HD had 2.6 times more medical claims and also were treated for other mental disorders 5 times more frequently than a matched control group without AD/HD. In addition, family members without AD/HD had 60% more claims than control families and twice the rate of treatment for psychiatric disorders. In all, direct medical costs per family member were twice as high (Swensen, 2003).

Because children spend so many hours of the day in the school setting, a teacher can play a vital role in ensuring early intervention. Teachers are not expected to be diagnosticians or therapists, but a trained and alert teacher can make a major difference by helping children with emotional or behavioral challenges get assistance and by reducing the barriers to their learning.

Critical Incident

Classroom discussion on the impact on families: In what other ways might a childhood mental illness affect the economic well-being of a family? The social activities? The relationships between family members? Recommended Reading: Ken Moses, “The Impact of Childhood Disabilities,” (see page 29).

PROFESSIONAL THEORIES

Over the decades, professionals have disagreed — sometimes sharply — as to the cause and best treatment for childhood mental health disorders and unacceptable behaviors. Prior to the passage of federal special education laws in 1975, most children with disabilities were excluded from schools, kept at home, or institutionalized. Once Congress passed PL 94-142 (the precursor to today’s Individuals with Disabilities Education Act [IDEA]), public schools established specialized classrooms, or separate “centers,” as sites for educating students whose behaviors varied from defiance and aggression to a medicated state of reduced awareness.

Most disruptive behaviors were attributed to poor parenting or outright neglect and abuse. Other theories advanced a “born to be bad” concept, which was popularized by Hollywood in the movie *The Bad Seed*. Cultural misunderstandings and distorted views of generational poverty are two possible reasons for the disproportionate number of over-referrals of children of color to special education classrooms.

General educators historically developed a wide range of disciplinary methods, many of which were negative, reactive, and exclusionary. Early special education professionals created schedules of demands with parallel rewards and punishments based on the behavior modification studies of B.F. Skinner and others. Students who “refused” to comply were suspended or expelled, in effect sending them back into exile at home. At that time, there was little or no understanding of how behavior fit into the whole learning picture. Furthermore, the whole field of child psychology was very young. It is only now that the prevalence of children’s mental health disorders is becoming apparent.

[SLIDE 13] In too many school districts, exclusion is still the discipline of choice for students with mental health disorders. A recent study by the Bazelon Center documents the increase in so-called “zero-tolerance policies,” in spite of 1997 revisions in IDEA that mandate the use of positive behavior supports (Setzer, 2003). It has actually been more than 25 years since the concept of positive behavior supports was first reported as a successful classroom management tool.

IDEA '97 strengthened students’ rights to education in the “least restrictive environment (LRE),” more districts now place students with mental health disorders in mainstream classrooms. Mainstreaming has left many regular education teachers concerned about whether they have adequate training to work in a classroom where students have diverse behaviors. In addition, some people, both teachers and the general population, still believe the behaviors are purposeful and the child and/or the family are to blame.

HIDDEN DISABILITIES

Society’s lack of understanding about children’s mental health disorders stems, in part, from the fact that these disorders are often “hidden” or unseen disabilities. In a recent study, researchers classified teachers’ attitudes toward disabled students in regular education classes as “attached,” “concerned,” “indifferent,” or “rejecting.” Author Bryan G. Cook reports that “students with mild or hidden disabilities are significantly over-represented among teachers’ nominations in the ‘rejected’ category”. Inclusive education outcomes, he concludes, seem to be “most problematic” for students with mild disabilities rather than severe (Cook, 2001).

Previous studies of inclusive education demonstrate that these four teacher attitudes (attached, concerned, indifferent, and rejecting) are directly related to students’ education and opportunities. “Teachers have seemingly ‘given up’ on students whom they nominate in the ‘rejected’ category because of students’ behavioral, social, and

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attitudinal problems... . Teachers often come to think of these students solely in behavioral terms and teachers' interactions with them are therefore almost entirely void of instructional content (emphasis added)" (Cook, 2001). This group of students is seldom given feedback when their answers are incorrect, are criticized more frequently, and are given fewer turns at reading.

Too often, a school's approach to a child's problems is to insist the child change. It's actually more effective to change the environment to meet the child's needs — so why isn't this the first reaction to a student in trouble? Pamela Wright, a nationally-known special education advocate, points out that school climate is determined by professionals who seldom consider other factors in academic failure because they have been trained to focus on child "exceptionalities." She cites research that shows a consistent focus on student problems rather than other crucial factors such as administrative attitude, fitness of the academic curriculum, and skill of the teacher. These factors are overlooked while goals, rewards, and consequences are set only for the child (Wright, 2003).

This unit will present some methods of using knowledge of the brain and its functioning to make practical modifications in classroom environment, curriculum, and even how teachers communicate effectively. This will improve teaching and learning, and it will make a world of difference for those students with the most intense needs.

Critical Incident

Classroom discussion of hidden disabilities: What other disabilities fall into this category? Allow time, if possible, for students to share stories of their own experiences and reactions to people with various disabilities.

BRAINS AT WORK: BRAIN-BASED TEACHING

[SLIDE 14] The recent advances in knowledge of the brain have already had a great impact on teaching theory. Education specialists rapidly saw the usefulness of visually tracing the process of receiving new material, storing into memory, retrieving it, and comparing it with already stored facts. Private organizations and associations offer trainings on brain-based teaching techniques (Jenson, 2002). These trainings define prime conditions for learning that work for any classroom, and many of these brain-based techniques lead directly to the accommodations that are suggested here for children whose brains do not operate at peak capability.

Factors that Inhibit and Enhance Learning

Most children with mental health disorders also have difficulty academically, even though learning disabilities may not be diagnosed. (Chesapeake Institute, 1994). These students require the very best a teacher can offer. Implementing brain-based classroom practices is crucial to the elimination of barriers to learning in your classroom. According to experts in brain-based teaching, *learning is enhanced by challenge and inhibited by threat*. The foremost condition for the brain to accept and integrate new information is a safe environment. Under conditions of intimidation, threat, or fear, the more primitive parts of the brain take over in the classic “fight or flight” response. This response floods the brain with hormones that literally block other brain functions — including learning and problem solving. This piece of information alone carries enormous weight when making classroom management decisions. Remember, a behavior may be a symptom of mental illness, or it may be caused by a lack of understanding or a fear of not being able to do the requested action. As educator Haim Ginott pointed out 20 years ago, children would rather appear “bad” than “stupid” (Ginott, 1993). Yet too many teachers assume that a child “won’t” rather than “can’t.”

Critical Incident

Have the classroom discuss the issue of “safety in the classroom.” What does the research tell us about a child who is continually threatened with disciplinary action? Can we expect him to be able to keep up with his classmates academically? Can he pay attention or restrain his impulsivity like his peers? What steps can be taken to reduce the fear in his environment? Remember, a behavior may be a symptom of mental illness, or it may be the student’s way of handling his fears.

The Role of Emotions

We do not mean to say that emotions do not belong in the classroom. A certain level of emotion provides a powerful stimulus to the brain, alerting the system that drives attention, and thereby making learning possible if the environment feels safe. Tasks that students perceive as emotionally meaningful hold their attention, so learning is quicker and easier. Reviewing percentages by calculating a car loan beats a worksheet any day. A pretend restaurant or pet store allows early readers to experiment with the world of print and mathematics in an emotionally rich context. Experiential learning through community service projects can be another example of learning with high

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emotional impact. An ideal task, then, would be challenging and appealing enough to alert the brain's processing system, but not so difficult that it creates fear.

This also means that the overall school environment should be safe, without threats, bullying, sarcasm, rigidity, and excessive pressure.

Two of four essential elements for a brain-compatible classroom have just been described: 1) an environment that is safe and non-threatening and 2) learning that is active and emotionally meaningful.

A third key factor in brain-based teaching is providing students with timely, accurate feedback. This is one of the reasons why skills practice using a well-designed computer program works so well, since the best programs patiently repeat feedback and encouragement indefinitely. Manipulative learning materials also provide their own immediate feedback without imposing criticism or pressure. A timely response by a teacher makes classroom information more meaningful for a child, prevents misunderstanding, and helps imprint information on the brain. Feedback should be timely and specific to be meaningful; these qualities are not present in a simple letter grade, a quarterly report card, or an annual standardized test result.

Most classroom feedback comes in the form of "teacher talk." A recent study rated three forms of teacher talk as most helpful to students classified as EBD:

- Giving the student a direct opportunity to respond.
- Providing an academic explanation.
- Praise for a correct response.

Other forms of teacher talk, like general encouragement and reminders that time is running out actually increase off-task behavior, according to researchers. This means that using the above forms of teacher talk improves both behavior and academic progress (Sutherland, 2002).

The fourth guideline offered for brain-based teaching is active and varied input (D'Arcangelo, 2000; Jensen, 1998). Completing successive pages of a workbook is not stimulating to the brain, and therefore not effective for learning. Some examples of varying input are:

- Hands-on learning that creates a product or provides a service.
- Practice in real-world situations.
- Working with varied groups of classmates.
- Student-driven assignments.
- Self-evaluations.

Wayne Jennings and Joan Caulfield (quoted in D'Arcangelo, 2000) summarize the key elements of brain-compatible teaching this way:

- Providing a safe, secure setting free from threat and open for risk-taking.
- Providing powerful (meaningful) and varied input.
- Providing immediate and helpful feedback and continuous coaching.
- Offering many opportunities to apply lessons in experiential projects.

In addition, recent research provides a scientific basis for teachers wishing to experiment with sensory input to soothe or arouse the nervous system and heighten the transfer of information. Many of these techniques have already been tested in classrooms, such as classical music for calming at the start of the day or allowing periodic breaks for simple stretches or exercises to increase oxygen intake. Since the sense of smell is the strongest link to memory, D'Arcangelo recommends introducing strongly scented treats such as chocolate or peppermint when vital facts are being presented, and then again at test time to aid recall of the same information.

Most children with mental health disorders need reduced stimulation of their sensory systems. A few may need more sensory input or an outlet for sensory over-stimulation (e.g., a stress ball, being allowed to doodle, etc.). A classroom and curriculum based on sensory integration principles will be more flexible, more welcoming, and easier to navigate. (See Background Brief G, page 113. You may want to provide this to your students in hand-out form.)

These ideas for brain-based teaching were developed for regular education. They also provide a basis for many of the accommodations and techniques that will be presented in the 3rd lecture of this series. The next lecture discusses some specific brain structures and functions that underlie what might be seen in the classroom.

LECTURE 1: INTRODUCTION

Critical Incident Quiz

LECTURE 1: QUIZ OF DISCUSSION

TRUE OR FALSE

1. Children from non-European cultures rarely threaten or commit suicide.
2. The former Surgeon General of the United States issued a report saying fewer than 1 in 5 children with some level of impairment due to mental illness are receiving needed treatment.
3. A teacher should not be considered a primary diagnostician of children's mental health problems.
4. A child's emotional and behavioral problems have little impact outside of his own happiness.
5. Mental illness does not affect children before their teen years.
6. Learning is enhanced by an intact sensory integration system.
7. A student may show delays in learning if teasing is allowed in the classroom.

ANSWER WITH A SHORT PARAGRAPH

1. List 5 secondary symptoms that may develop in a child with mental illness and his family.
2. What is wrong with this statement: "This child has been diagnosed as EBD."
3. What kinds of "teacher talk" are the most helpful to students?
4. Describe what happens when a student feels afraid in the classroom.

ASSIGNMENTS

Assign your choice(s) of the following projects.

1. Scan a major city newspaper for the last year and report on what mental health topics were covered as news stories, as science news, as features. Write a 3-page summary of the press coverage.
2. Use the Internet to locate recent local reports on children's mental health needs or services, suicide/suicide prevention, or similar topics. Write a 1-page summary of your findings. Suggested sites include:
 - MN Department of Human Services: www.dhs.state.mn.us
 - MN Department of Health: www.health.state.mn.us
 - MN Department of Education: <http://education.state.mn.us>
3. Call a local school district office and obtain statistics on their students identified as EBD. Write a 1-page summary including
 - How many students are classified EBD at the elementary, middle school, and secondary school levels?
 - What percentage are in mainstream or integrated classrooms and what percentage are in separate educational settings?
 - How many district students (of what ages) are currently in residential treatment centers or other out-of-home placements, including foster care, group homes, and juvenile justice facilities?
4. Prepare a 3-page paper on the impact of child and adolescent mental health disorders on the individual, the family, and the community. For resources, use one of the following:
 - *The Challenge of Fetal Alcohol Syndrome: Overcoming Secondary Disabilities* by Ann P. Streissguth
 - Federation of Families for Children's Mental Health web site: www.ffcmh.org
 - The Federal Center for Mental Health Services web site: www.mentalhealth.org/child
 - Portland Research & Training Center web site: www.rtc.pdx.edu
 - *The Impact of Childhood Disability: The Parent's Struggle*, by Ken Moses, Ph.D., included in the handouts (see pages 29-36).
5. Contact a social service agency that assists foreign-born families settling in your area. Ask them for statistics on the number of school-aged children who have moved into your area in the last 5 years. Ask about the major concerns these families face and what kind of emotional/mental health problems the agency notes among the population. Find out what culturally specialized services are available, if any. Write a 2-page report detailing your findings.

LECTURE 1: INTRODUCTION

6. Contact a social service agency that assists homeless families or families at risk of homelessness and request the same information from them that is listed in question 3; write a 2-page report.
7. Write a 1-page description of a classroom or other learning environment that felt safe to you, and a 1-page description of an environment that felt threatening. In each case, focus on what may have interfered or helped with learning, what specific actions of the teacher or your classmates stand out, and what knowledge from the two experiences you can take into your future work.

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LECTURE 1: INTRODUCTION

LECTURE 1: ANSWER GUIDELINES

True or False

1-F 2-T 3-T 4-F 5-F 6-T 7-T

Short Answer

1. Possible answers include: disruption of family life, increased risk of emotional or physical abuse, disruption of normal development including social skills, interference with academic progress, increased risk of dropping out, social isolation, increased risk of chemical abuse, increased involvement with police and courts, increased risk of suicide attempts and suicide.
2. EBD is a special education category, not a medical diagnosis. A student “has” AD/HD or other disorders, but “is placed” in an EBD classroom or “receives services as EBD.”
4. Opportunities to respond, providing information, praise or encouragement
5. Fear triggers a chemical response in the brain that shuts off access to many brain functions needed for learning.

ADDITIONAL RESOURCES

Books

- Byrnes, J.P. (2001). *Minds, brains, and learning*. The Guilford Press.
- Fadiman, A. (1997). *The spirit catches you and you fall down: a Hmong child, her American doctors, and the collision of two cultures*. Farrar, Straus and Giroux.
- Greene, R. (2002). *The explosive child*. HarperCollins.
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- Papolos, D. & Papolos, J. (2002). *The bipolar child*. Broadway Books.
- Pruitt, S.K. & Dornbush, M.P. (1995). *Teaching the tiger: a handbook for individual involved in the education of students with attention deficit disorders, Tourette syndrome or obsessive compulsive disorders*. Hope Press.
- Turnvull, R. et.al.(2002). *Exceptional lives: special education in today's schools*. Prentice Hall.
- Williams, M.S. & Shellenberger, S. (1996). *How does your engine run?* TherapyWorks Inc.
- Wright, P. D. & Wright, P. (1999). *Wrightslaw: Special Education Law*. Harbor House Law Press.
- Wright, P. D. & Wright, P. (2002). *From emotions to advocacy*. Harbor House Law Press.

Web sites

- American Academy of Child and Adolescent Psychiatry: www.aacap.org
- Center for Mental Health in the Schools, UCLA: <http://smhp.psych.ucla.edu>
- Federation of Families for Children's Mental Health: www.ffcmh.org
- Minnesota Department of Education: www.education.state.mn.us
- Minnesota Department of Human Services: www.dhs.state.mn.us
- Minnesota Education law (posted within 48 hours of passage): Chapters 120-129B:
www.leg.state.mn.us/leg/statutes.htm
- NICHCY (National Information Center for Children and Youths with Disabilities): www.nichcy.org
- Office of Civil Rights: www.ed.gov/officer/OCR
- Pacer Center, Minnesota Parent Training Center: www.pacer.org
- Pete Wright (Special Education Advocacy): www.wrightslaw.com
- Research and Training Center on Family Support and Children's Mental Health: www.rtc.pdx.edu
- Society for Neuroscience: www.sfn.org
- The Bazelon Center (mental health law): www.bazelon.org
- The Brain Place: www.brainplace.org
- The Council of Educators for Students with Disabilities (Information on 504 Plans):
www.504idea.org/index.html
- U.S. Office of Special Education and Rehabilitation Services:www.ed.gov/offices/OSERS

LECTURE 1: INTRODUCTION

Videos

"My Sister's Keeper," Hallmark Hall of Fame Video; Topics: schizophrenia, family impact

"As Good As It Gets," Columbia/Tristar; Topic: Obsessive-Compulsive Disorder

"The Tic Code," Universal Studios; Topic: Tourette Syndrome in childhood, adulthood; family impact

"The Touching Tree," Obsessive Compulsive Foundation, 676 State Street, New Haven, CT 06511;
Topics: OCD in childhood, effects on school and peers

"Be My Friend," Minnesota Tourette Syndrome Association, 7317 Cahill Road, Suite 231, Edina, MN 55439; Topics: TS in childhood; developed to explain TS to elementary-age peers

"Worth the Trip," Vida Health Communications, 6 Bigelow Street, Cambridge, MA 02139; Topics: Fetal Alcohol Syndrome/Effects, family impact, school impact

"Almost Home" and "Teacher's Little Helper," ABC News/Prentice Hall Video Library Cassette 1;
Topics: EBD classroom, AD/HD

"Stephen's World," ABC News/Prentice Hall Video Library Cassette 3; Topics: Autism

BACKGROUND BRIEF A

PARENTS AND THE MAZE OF MENTAL HEALTH SERVICES

Parents who have children with behavior problems and seek out services beyond the school enter a complex and confusing world. Along with a mental health disorder comes a whole range of systems and professionals, each with their own eligibility requirements, paperwork, appointments, and new vocabulary. A teacher who understands the basics of the mental health system is an invaluable support for families who must cope with this complexity.

A list of system professionals and their responsibilities is included in Background Brief C, "Working as a Team," on page 74. In Minnesota, these services are usually provided by county employees or workers at agencies contracted through county social systems. Some families receive only services provided through private insurance plans. Regulations regarding both private and tax-funded services are subject to frequent change, especially in this period of budget deficits, so we will not go into great detail here. The latest information is available through most advocacy organizations in the state or through the Department of Human Services online at www.dhs.mn.us.

Here is a description of county social services that should be available to children determined to have Emotional Disturbance (ED) and Severe Emotional Disturbance (SED):

- Education and prevention services: parent training programs, support for advocacy services, publications, warmlines.
- Early identification and intervention services: home visiting programs, mental health/behavioral screenings, parenting classes.
- Emergency services: crisis hotlines, crisis teams, emergency rooms.
- Outpatient services: in-home and center-based therapy sessions.
- Case management services: record-keeping, service planning and resource allocation, usually by a social worker.
- Family community support services: respite care, personal care attendants, mental health behavioral aides, wraparound facilitators.
- Day treatment services: center or school-based programs providing a minimum of 3 hours of therapeutic activities plus a school program; usually 5 days a week.
- Therapeutic foster care: placement in a family setting with specially trained foster parents and a specific treatment plan.
- Benefits assistance: Medical Assistance (MA) and coordination with private insurers.
- Residential treatment services: placement at a specialized treatment facility, usually for 30 days to 1 year. May attend on-site school program or community schools.
- Acute care hospitalization: planned or emergency admission for a limited time to defuse crisis; may include evaluation services.

LECTURE 1: INTRODUCTION

BACKGROUND BRIEF A, CONTINUED

The 2003 legislature broadened the service menu by making case management, family community support services, and day treatment services available to children with ED. The legislature also provided funds for screening and providing treatment as needed for all children entering the welfare system and the juvenile justice system.

At the same time, drastic cuts in funding and cuts in payments to counties has meant that many families will face service cuts rather than expansion. In addition, increased fees for Medical Assistance (MA) mean that some families will be forced to turn down needed services because of the financial burden.

This is especially true for families using an expanded MA program called “waivered services,” which provides in-home support and other benefits for those in need of a level of care usually provided in residential facilities. Parental fees for these services were raised by as much as 1200% during the summer of 2003.

Because Minnesota is a county-driven state, even services that are mandated by law may not be available to families in every county. Parents can find out what services are available in their county by calling the county social service offices and asking for intake information.

Some areas can provide a method of support planning called “wraparound.” Wraparound is an individualized, strengths-based planning system that combines formal services and informal family and community supports to help a child and family meet its goals. In some areas, this process is facilitated through the schools; in others, teams are created and facilitated by the county or a children’s mental health collaborative. Wraparound is generally more family-friendly than traditional case management, and it works more deliberately toward establishing permanent supports.

RESOURCES

Minnesota Association for Children’s Mental Health. (2003). A survival manual for parents of children with emotional and behavioral disorders and mental health needs.

Summary of health and human services policy changes, in “NAMI-MN 2003 Legislative Session Summary.” (2003). Retrieved

The Impact of Childhood Disability: The Parent's Struggle

by Ken Moses, Ph.D.

I was taught that the way to deal with adversity or pain was to “tough it out.” If you could avoid showing the pain, then you had “beaten the rap,” and dealt with the problem competently. I am a psychologist who works with people who are grieving over profound losses. Few would argue that facing the devastating *and continuing* loss of having an impaired child is among the most painful experiences that a person can confront. After working with parents of the impaired for many years, I have come to believe that I was given bad advice. I have come to believe that pain is the solution, not the problem.

Parents, all *parents*, attach to their children through dreams, fantasies, illusions, and projections into the future. Children are our second chance, our ultimate “life products,” the reflection and extension of our very being. To know that a human life exists that grows from our genes, our bodies, that is a result of our existence, brings a measure of spirituality into the most hardened individual. Something basic to our sense of being is stirred when we witness the miracle of the continuity of life. What happens when this core experience is marred irreversibly by disability? How does a parent survive the devastation of a handicap in their child that shatters their heartfelt dream? How do they go on? How can they help their child, their other children, themselves?

Before I started working in this field, I noted that people who faced adversity basically became better or worse; none stayed the same. What made the difference? Some parents seem to pull their lives together around their child's impairment, others go to pieces. Over fifteen years ago, I ran my first parent group comprised of mothers of children with special needs. These people helped me enormously as I started to answer some of the important questions that relate to coping with childhood impairment.

I began the group using traditional group psychotherapy methods, an approach designed to intervene on psychopathology. That approach did not work for a simple reason: those mothers were not suffering from pathologies, they were reeling from the impact of having disabled children. Gradually, I let go of the old ways of doing things and permitted myself to listen and learn from this courageous group of parents. Slowly, a pattern emerged that surprised me. It became evident that these people were manifesting a grieving process. This left me confused. It was clear that they were alternately anxious, angry, denying, guilty, depressed or fearful, but they were not internally “disturbed” people. Conversations focused on experiencing regrets, being overwhelmed, and other feelings common to people who are bereaved. My puzzlement: “Who died?” At that time, my understanding of grief was simple, concrete, and exclusively tied to death.

LECTURE 1: INTRODUCTION

What followed was a remarkable process. The group members struggled with a number of concepts that led us all to some powerful contemplations about parental grief. Is it the loss of a “normal” child? Is it the disruption of one’s “normal” lifestyle? Is it the sense of shame or humiliation that is experienced with family, friends, or other peers? Is it the profound disappointment that some experienced with the ineffective responses of their ostensible support group? We might have shared such thoughts endlessly until I formulated a key question that helped to bring these diffused feelings and thoughts into focus. It came out innocently enough: “Think back to when you were anticipating the birth of your child. Who (or what) was this child to have been *for you*? What followed was a remarkable outpouring of poignant, anguished human sharing that, to this day, serves as the foundation for understanding and working with parents of impaired children.

Parents attach to children through core-level dreams, fantasies, illusions, and projections into the future. Disability, dashes these cherished dreams. The impairment, *not the child*, irreversibly, spoils a parent’s fundamental, heart-felt yearning. Disability shatters the dreams, fantasies, illusions, and projections into the future that parents generate as pan of their struggle to accomplish basic life missions. Parents of impaired children grieve for the loss of dreams that are key to the meaning of their existence, to their sense of being. Recovering from such a loss depends on one’s ability to separate from the lost dream, and to generate new, more attainable dreams.

As disability bluntly shatters the dreams, parents face a complicated, draining, challenging, frightening, and consuming task. They must raise the child they have, while letting go of the child they dreamed of. They must go on with their lives, cope with their child as he or she is now, let go of the lost dreams and generate new dreams. To do all this, the parent must experience the process of grieving,

Grieving is an unlearned, spontaneous, and self-sufficient process. It consists of states of feeling that provide the opportunity for self-examination, leading to both internal and external change. The grieving states that facilitate separation from a lost dream are as follows: denial, anxiety, fear, guilt, depression, and anger. The word states” is used instead of “stages,” to emphasize grieving is *not* a step-by-step process that evolves through discrete stages. This depiction of what a parent goes through is a presentation of theory, not irrefutable fact. It is meant to help people find their own ways of dealing with the unspeakable. I look at it as a map, not a recipe. A recipe tells people what to do if they desire a particular result. A map on the other hand, is one person’s partial impression of reality that can be used by another to help them get to where they wish to go.

When theories of grieving are used as a recipe to produce acceptance, two false premises are inflicted on parents. The premise that grieving should move through a specific order is flatly inaccurate. A consistent pattern is *not* evident in people dealing with loss! Worse, when people believe that they are supposed to grieve in a certain way, they often end up thinking they are doing it wrong. Secondly, the concept of acceptance is totally unfounded. In almost twenty years of working with bereaved people, as well as dealing with my, own losses. I have never seen anyone achieve acceptance of

loss, only acknowledgement. Belief in the concept of acceptance leads parents into feeling like failures for not being able to attain it. Any use of grieving theory as a *recipe* is strongly discouraged. Though the feeling states of grieving do not adhere to any strict order, there is a loose pattern that can be detected. Denial is always first, but may reemerge again and again, as often as the parent needs to experience it. Anxiety generally follows denial, but it can follow other feeling states as well. It is not uncommon for two or more feeling states to be experienced at the same time. Different families are more or less comfortable with showing certain feelings while discouraging others. In short, each person who goes through the grieving process experiences each of the feeling states, but does so in their own unique manner and order.

It is clear that this spontaneous, unlearned grieving process is central to the well being of the child and parent alike. It is the only way that one can separate from a lost, cherished dream. Many people do not make it. They have their dreams shattered by disability and collapse emotionally under the assault. Resisting the grieving process, they hold feelings in, blame self or others, become embittered, dependent, or even bizarre in their interactions. They can range from the selfless crusader to the deserter, from the alcoholic to the workaholic, from the outrageously high-strung to the person who barely moves or talks. However they manifest their stuckness, these are the people who have become worse, not better, in response to loss. These are the people who could not or would not experience the feelings of grieving. Many of them resisted the process because their subculture (their family, neighbors, church, schools, and friends) sent out a consistent message: the feelings of grieving are *not* acceptable! Others foundered because they were stuck emotionally before they had their impaired child. Regardless of background, people become worse if they resist experiencing and sharing the spontaneous feelings of grieving. Each feeling state, no matter how negative, serves a specific and helpful function. To separate from a lost dream, one must experience and share denial, anxiety, fear, guilt, depression and anger in whatever order or manner the feelings surface.

The Feeling States of Grieving

Denial

People who deny are considered stupid, obstructionists, dull or deliberately irritating by many who have to deal with them. None of that is true. Parents of impaired children manifest denial as a normal course of trying to deal competently with loss. It is impossible to live life fully while maintaining an awareness of the awful things that can happen to people. Most people routinely shield themselves with such thoughts as "The terrible things that happen to other people can't happen to me, because..." This system works fine as long as nothing terrible happens, but when it does, no one is prepared to deal with it. This is where denial in the service of grieving comes in. Denial buys the time needed to blunt the initial impact of the shattered dream, to discover the inner strengths needed to confront what has really happened, and to find the people and resources needed to deal with a crisis for which one could not be prepared.

LECTURE 1: INTRODUCTION

Anxiety

When a person loses a dream that is central to their being they are forced to make major changes within themselves and within their environment. To deal with having an impaired child, parents go through dramatic changes that affect their attitudes, priorities, values, and beliefs, as well as altering day-to-day routines. Such changes require a great deal of energy. Anxiety mobilizes the energy needed to make these changes. Further, it gives focus to that energy so that the changes can be actualized. Anxiety, is the inner source of the need to act.

Anxiety, is generally seen as hysterical, inappropriate, and unacceptable. The culture's message is clear. As a rule we advise anxious people to "calm down," to take medication, or to use alcohol as a "solution" for the "problem" of anxiety. These unsolutions keep the parent from changing and often make things worse for all concerned. Realities must be faced, stressful as they might be. It does not take long for most parents to become aware that they, not some professional, are their child's medical, educational, and therapy managers, even though they may have minimal knowledge of these areas. That alone should drive home the urgent need for energies to be mobilized and focused by the crucial feeling of anxiety.

Fear

As anxiety mobilizes people to deal with change, fear is a warning that alerts the person to the seriousness of the internal changes that are demanded. One's sense of balance and order are dramatically challenged when one confronts a meaningful loss. The parents experience the terror of knowing that they will be required to change on a fundamental level, against their will, with full understanding that the process of internal change is very difficult.

Significant losses produce a profound sense of abandonment and vulnerability. We have a number of sayings to cope with this level of fear, e.g., "It is far better to have loved and lost, than to have never loved at all." Each person must find their own words to confront the sense of abandonment and vulnerability generated by a significant loss. Most parents experience the *fear* of vulnerability about having more children after they have had an impaired child, or about "over-protectionism," the gut wrenching fear of permitting their impaired child to do anything that feels risky. Given the ways that this part of grieving is manifest, it should not be difficult to see that fear is the medium that encourages the struggle to reattach, to love again in the face of a loss.

Guilt

Parents of impaired children manifest guilt through the normal course of grieving and are often criticized for doing so. Guilt is a feeling state that has become so identified with being neurotic that people feel guilty about feeling guilty. Since sharing such feelings often evokes negative judgments, it can be difficult for a sophisticated parent to talk about guilt freely. On the surface, guilt-ridden people may appear not only neurotic, but superstitious, ignorant and primitive. They are often viewed as unpleasant, uncomfortable people to be with and therefore are dismissed or treated harshly by friends, family, and professionals.

Generally, parents of impaired children express guilt in one of three ways. One way is by telling a story that explains how they are responsible for their child's handicap. Their story is often accurate and, on the whole, persuasive. The current emphasis on the prevention of birth defects has brought many parents to feel that they caused their child's impairment. The issue is not the logic, but the feeling of guilt. Another way that guilt is manifested is in the conviction that the child's impairment is punished for a past inappropriate thought, feeling, or action. One of the more common "guilt thoughts" is regretting the pregnancy sometime during gestation. When something goes wrong after that thought occurs, "it's all my fault" becomes a natural outcome. Lastly, guilt can be expressed through the parent's belief that good things happen to good people, and bad things happen to bad people. Because parents have an impaired child, they must be bad people. Because they have an impaired child, they must be bad people and consequently feel shame and guilt. How can such painful explanations of tragedy be useful to bereaved individuals? Simply by *being* explanations. Guilt "explains" the unexplainable. Human beings begin to question the "why" of things from very early on in their lives. What are the rules that govern the way of things: cause and effect as well as right and wrong? A most important "why" concerns how one's "right" or "wrong" actions effect one's life. What difference does it make that a person is moral, ethical, legal, caring, ambitious? How is it that one does or does not influence the events of one's life? Some of us found early and easy answers to these questions and have not considered them since. After a loss, such questions cannot be answered in an ordinary fashion. Rather, they must be addressed through the kind of grief-related struggles addressed here. When people confront a loss, the beliefs they held regarding cause and effect, right and wrong, and their impact upon life are deeply shaken. The order of things is totally upset when an innocent child suffers. The parent experiences deep pain, pain that can be used to reorder the rightness of the world. Guilt is the feeling state that facilitates this struggle to reorder. Basically the guilt-ridden person is saying that they are accepting responsibility for everything. It feels better to do that than to believe that they have no influence on anything! Guilt, in this sense helps one to re-define the issue of cause and responsibility in the light of loss.

Depression

A common response to loss often is characterized by profound and painful sobbing. Parents report that at times it feels as though the tears will never stop. There is a rest, but then for no apparent reason, waves of despair and anguish wash over the parent once more. Between the tears, one can sit alone, staring silently. Those periods of silence can last well beyond the periods of tears. The thoughts of depression take over, thoughts like: "What's the use of trying, it's all over." or "Nothing I do matters, because nothing will change what has happened to my child!" Depression is subtly rejected and judged as pathological by much of our culture. When people display such feelings, they are often told to "cheer up", given medication, or offered distractions. Such responses are inappropriate, for depression is part of normal, necessary, and growthful grieving. It attends to another aspect of a basic human struggle that loss stirs.

As we mature, we develop and modify our definitions of the following words: competence, capability, value and potency. They are words of profound personal significance. They are the criteria that people use to decide if they are OK or not. What

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criteria does a person have to meet to feel like a competent parent, a capable worker, a valued friend, or a strong person? Each person determines these standards privately, even secretly, when parents are confronted with an impaired child, whatever definitions they held for competency, capability, value, and potency usually no longer apply. How does a mother feel competent when she has a retarded daughter? She can't use the measures of her peers, like having a daughter graduate from college, or become homecoming queen. What is the worth of a father who cannot "fix" what is broken in his impaired son? Out of this struggle of defining one's worth come the frightening feelings of helplessness, hopelessness, and haplessness. Faced with loss, a parent feels unable to act effectively (helpless), unable to imagine that things will ever get better (hopelessness), and unable to believe that their lives are touched by good luck (hapless).

Such feelings are terrifying for both the parents and those around them. For that reason, it is hard to see that depression is a normal and necessary part of the grieving process. Depression is the medium that helps parents come to new definitions of what it takes to be a competent, capable, valuable and strong people, even though their child has impairments that they cannot cure.

Anger

Anger, for many people, is the most disconcerting of the feeling states. It too is a natural and necessary part of the grieving process. Parents feel anger at the harm done to their child and the shattering of their dreams. When one encounters a significant loss, it is likely that one's internal sense of justice is severely challenged. To continue to trust in the world, one must have a sense of justice that confirms an orderliness and fairness to the way the world works.

A parent can righteously demand to know why he or she has an impaired child: "Why me, why not you!" Implicit in the question is the notion that there must be good reason that such a thing happens to one parent and not to another. A parent's concepts of justice, like value and worth, is another unique product of that individual's thinking and development. When confronted with the traumatic loss of a dream, that internal sense of justice is violated. Crying out in the face of injustice, the parent develops new ways to look at justice in the world. "What, after all, is fair, if this can happen?" Anger is the medium through which a parent redefines fairness and justice. It integrates new beliefs within the deepest emotional levels of the grieving parent.

Unfortunately, anger is an emotion that is actively When considering the feeling states of grieving, especially the feeling state of anger, logic and reason are irrelevant. Where is the logic behind cursing a rug that one has just tripped on? What is the purpose of kicking a flat tire? What good does it drejected by the culture at large and by people closest to the parent. The angry parent experiences rejection by others, confusion about *feeling* anger and *acting out* the feeling, the feeling of being out of control. All of this makes it very difficult for this important feeling to run its course.

Anger also poses other dilemmas. Unlike the other feeling states of grieving, anger is directed toward someone or something. Who (or what) is the object of parental anger?

This question deeply distresses most parents, because the honest answer is often so troubling that many people avoid asking themselves the question. The unacceptable answer, of course, is that the impaired child is the object of anger. After all, who has entered this parent's life, disrupted it, caused immeasurable pain, and drained the parent's time, energy, and money.

Most parents were raised to believe that feeling and expressing negative feelings about one's child is taboo. "The child never asked to be handicapped, let alone to be born. How can one be reasonably angry at this child?" If the child is blameless, then it must be unreasonable to feel anger toward the child — even though one does! The conflict between what parents feel and what they can permit themselves to express can cause a return to denial. Another outcome of this conflict is that the parent can displace the anger onto others. Spouses, non-impaired siblings of the impaired child, and professionals are all possible targets of this displaced anger.

When considering the feeling states of grieving, especially the feeling state of anger, logic and reason are irrelevant. Where is the logic behind cursing a rug that one has just tripped on? What is the purpose of kicking a flat tire? What good does it do to admonish anyone after they have already done the wrong thing? Expressing simple anger clears the way to getting on with the task at hand. Expressing anger opens the way to address the meaning of justice (though *enacting* angry *behavior* sidetracks the parent from the task at hand). While there is no logic, there is purpose and function to the expression of angry feelings. As events occur that violate one's sense of justice, the outrage must be expressed. Those expressions help to redefine one's concepts of fairness and justice.

The parent of an impaired child separates from dreams that were shattered by impairment through grieving. Denial, anxiety, fear, depression, guilt, and anger all emerge. If they are shared with other people, these feelings help parents grow and benefit from what might be the worst tragedy of their lives. Grief must be shared deeply and fully until the underlying issues are revealed. The reopening of these issues changes the parent's worldview. New perceptions of themselves and their world serve as a solid foundation for coping with the disability and for personal growth. Yielding to the grieving process helps parents find the inner strength and external support needed to face profound loss: to mobilize and focus the energies needed to change their lives; to reattach to new dreams and loves in spite of feeling abandoned and vulnerable; to redefine their criteria for competence, capability, value, and potency; to reassess their sense of significance, responsibility, and impact upon the world around them; and to develop new beliefs about the universal justice system that makes the world a tolerable place to live, even though terrible losses can occur. The culturally rejected feeling states of denial, anxiety, fear, depression, guilt, and anger may be used in surprisingly positive ways when the feelings are fully shared.

Perhaps you can now see why I think that experiencing and sharing the pain is the solution, not the problem. Through my life I have experienced many losses. For many years I dealt with these losses by stifling feelings, workaholism, toughing-it-out, and innumerable other ways that kept me from experiencing what had happened to me.

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I became one of the “walking wounded” that I was committed to helping. Ironically, it was not until I myself had a child with impairments that I began to take the advice that I had so freely given to other parents. I started to yield to the natural and necessary process of grieving. Like everyone else, I discovered that only now am I growing with the impact of, the loss. I **will** continue to grieve and to grow as my child and I develop and experience new losses and new strengths.

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