

LECTURE 4:

CREATING CONDITIONS FOR CLASSROOM SUCCESS

Focus: *Planning classroom accommodations that enable learning and support positive behaviors.* [SLIDE 4]

[SLIDES 5-6] When a teacher recognizes that difficult behaviors in the classroom can be symptoms of mental health disorders, it becomes easier to design changes that will reduce barriers to successful learning. A no-fault atmosphere is the most scientific as well as the most effective beginning. Think of how most teachers would react to a student with a chronic illness such as asthma or diabetes. They do what must be done with a minimum of disruption and without the “great debate” about whether the behaviors are “deliberate.” This is the model we recommend for any classroom that includes children with mental health disorders.

[SLIDES 7-8] The Minnesota Association for Children’s Mental Health (MACMH) has worked with countless parents and teachers for nearly 15 years, to improve classroom success rates for children in specialized and mainstream classrooms. These years of experiences have shown that *when the overall classroom climate is supportive, the student feels secure and able to tackle academic challenges, and the teachers are freed to do what they do best: teach.* The Individuals with Disabilities Education Act (IDEA) clearly requires the student’s team to “explore the need for strategies and support systems to address any behavior that may impede the learning of the child with the disability or the learning of his or her peers.” (20 U.S.C. §614(d)(3)(B)(i)). This is an effective policy for any students who experience difficulties in the classroom.

LOOKING BEYOND BEHAVIOR

In July of 2003, President Bush’s New Freedom Commission on Mental Health reported that care for those with mental health disorders must go beyond managing medications and symptoms to helping people live fuller lives and develop skills for job success and personal relationships. This is a mandate that clearly must start with the nation’s schools. Teaching students who have mental health disorders requires techniques that break down the barriers to learning which the disorders and their accompanying behaviors impose.

This lecture draws upon the specific scientific and psychiatric knowledge presented in the previous lectures. It will focus on how teachers, students, families, and supporting professionals can formulate methods for reducing or eliminating the impact of mental health disorders on individual students and on educational settings. It will also introduce the essentials of conducting Functional Behavior Analysis (FBA) and developing Positive Behavior Support (PBS).

PLEASE NOTE:

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

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[SLIDE 9] *Children do well if they can. If they can't, we need to figure out why, so we can help... . The vast majority of children do not get their jollies by making themselves and those around them miserable. (Greene, 2001)*

[SLIDE 10] *My motto: "I only expect my kids to do their best and, at any given time, I believe they ARE doing their best; even when they are throwing a fit, they are telling me something and I need to help them find what that is." (Parent of child with FAS, Thunder Spirit Lodge, 1999)*

Simply by starting from the concept reflected in these two quotes, a teacher can change the tone of a classroom almost overnight. Instead of identifying a student as a troublemaker, the teacher, family, and student can partner to identify a troubling symptom and work together to overcome it or render it manageable.

Before discussing specific accommodations, let's look again at the problem of academic failure among students with mental health disorders. A recent study has confirmed earlier research that shows that behavior problems, AD/HD, and reading disabilities often co-exist (Lonigan, 1999). But this study also indicates that "behavior problems and [inadequate early] literacy skills are associated *prior* to formal schooling and that this association is present regardless of the economic status of children's families." (Emphasis added). This is another indication of the brain-based origin of these closely related problems.

Yet in most schools, children who show inappropriate behavior are placed in classes that focus on modifying behavior through rewards, consequences, and "level" systems. Too often, specific problems with learning are not diagnosed or not treated. Students who might have needed only a little support to succeed in a regular classroom fall further and further behind their peers. Aside from the loss to these students, society as a whole also loses out when so much potential is wasted. In both general education and special education, the goal must be to reduce the behavioral barriers so that teachers can teach and children can learn.

In addition, research has established that teacher behavior tends to be profoundly different when faced with a student who has both academic and behavioral deficits. In other words, students' behaviors not only affect their own learning and the behavior of their classmates, but also the behavior of their teachers.

It has been demonstrated that teachers' instruction is more limited and characterized by easier tasks for children exhibiting problem behaviors than for children who do not exhibit such behaviors... . In fact, a cycle of negative reinforcement has been used to characterize teacher-student instructional interactions in classrooms for students with EBD... that is, the disruptive behaviors of students with EBD are negatively reinforced by the removal of academic task demands, and teachers are negatively reinforced by the removal of the disruptive behaviors....The academic deficits of these students thus may be exacerbated by the lack of effective academic instruction they receive, which in turn is due in part to their disruptive classroom

behavior. (Sutherland, 2002)

One method for improving academic accommodations has become known as “Instructionally Differentiated Programming.” This is a needs-based approach for meeting the academic deficits of the student with behavioral disorders. The theory behind this method is explained in a Colorado Department of Education monograph:

Children with disabling conditions constitute as heterogeneous a group as non-disabled children. Therefore, to equate a specific handicapping condition with a specific set of educational needs borders on stereotyping.... Rather, the focus should be on what the child needs [emphasis in original]. The needs of a child relate to the outcomes established for that child...the purpose of special education is to teach students, not to correct or eliminate their disabilities...the primary focus of special education is to help students with disabilities learn. (Swize, 1993)

FOUR STEPS TO UNCOVERING BARRIERS TO LEARNING

[SLIDE 11] *Step one*

The first step a regular education teacher faced with unacceptable behavior should take is to document the times, activities, and circumstances of any behavioral incidents so that patterns can be uncovered. In addition, notes should be made of what happens immediately before and after the incident and later in the day or week.

In one case, an observant teacher discovered that a student’s uncontrolled distractibility coincided with preparation of lunch in the cafeteria across the hall. During a discussion the student said she “couldn’t wait” to find out what food was being prepared. With the agreement of the kitchen staff, the student and a peer were allowed to go across the hall and check the lunch menu each day, reporting back to the class. After that, the menu was posted in the classroom and the student was satisfied to check it when the cooking aromas became strong. The student was then able to return to her studies until lunchtime, curiosity satisfied.

Another student had an explosive first day of summer school, including episodes of property destruction and unprovoked aggression. This behavior was first attributed to the change in classroom routines. The parents later reported, however, that the student had developed a severe rash during that day but had been unable to pinpoint or communicate the actual source of his distress.

With consistent record keeping, it often becomes clear—as it did with these students—that a child’s behavior becomes unmanageable in a specific situation, with a certain person, or at a specific time of day. And following up with parents allows a teacher to know when a behavior might be a short-term episode that has little or nothing to do with the actual classroom situation.

Step two

The next step involves determining if there is a direct academic “cause” or antecedent event to the behavioral flare-ups. This is the time to check academic functioning with

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care: many children find it hard to admit that they do not understand a task and find it easier to refuse to do it by goofing around, defying instructions, or creating chaos in other ways.

Children often misbehave when they have difficulty with an assignment. They are afraid to ask for assistance. Their experience has taught them that to request help is to risk rebuke. They would rather be punished for acting up than ridiculed for ignorance. A teacher's best antidote to misbehavior is a willingness to be helpful.
(Ginott, 1993)

The student's fear may be based on experiences in previous classrooms or at home, or on misperceptions, but their fear must be treated as valid because the student believes it and is basing his actions on this fear.

Step three

The third step is the modification of the curriculum, the presentation, or the specific task that is provoking the behavior. For example, substituting computer use for hand-writing may be all that is needed to calm unruly behavior before it becomes a habitual response. Check and recheck the conditions for good learning: people learn well when they feel safe and supported, when information is personally meaningful, when they have immediate, accurate feedback, and when input is varied. The learning challenge involved must be appropriate to the student's learning level so as not to generate fear. These are not preferences—this is how the brain is set up to function. Accommodating these needs is not spoiling a student. Rather, it is good science and good teaching.

Step Four

If you are still unclear about how to proceed with particular student, go back to the student's records and consult with other members of the team (See Background Brief C, page 76). Review the information on specific mental health disorders. Next, consult with the parents, who are always the number one source for information about a student. No one else has as much experience in as many settings as a student's parents.

Whether you speak with them informally by telephone, at a formal conference, or in a team meeting, follow these rules to ensure a productive meeting:

- Begin with the student's strengths.
- Describe the behavior as clearly as possible.
- Listen carefully.

This will not be the first time the parents have heard about problems in the classroom, and they are as eager as the teacher is to find solutions. While a parent may initially react defensively, a teacher's positive input about their child will convey the strengths you see in their child and that you are an ally. Ask them what works at

home, and what doesn't work; ask for new ideas to try. Don't be afraid to experiment. A teacher's responsibility is to teach this child, not to "fix" his disability. By focusing on the goal of overcoming barriers to learning, teachers and parents together may discover that the right accommodations and a supportive attitude will do a remarkably good job of reducing inappropriate behaviors.

FUNCTIONAL BEHAVIORAL ASSESSMENTS

[SLIDES 12-13] Those four steps may seem to be based on nothing more than common sense. But they are, in fact, the basis of the Functional Behavioral Assessment (FBA), a procedure that many school districts are beginning to use. The FBA has been defined as "the process of identifying events that reliably predict and maintain problem behaviors" (Horner, 2000). The final products of an FBA include an operational definition of the behavior, a description of the events that predict the behavior, those that reinforce or maintain the behavior, and direct data from observation that supports this hypothesis. Tools used in such an assessment include interviews, descriptive observations, and functional analysis (observation plus systematic manipulation of the environment to define what exactly determines the behavior).

Positive Behavior Supports

The purpose of an FBA is to develop positive behavior supports so that a student can be helped to change behaviors that are interfering with learning, school success, and social interaction.

[SLIDES 14-15] *Positive behavior support involves the assessment and reengineering of environments so that people with problem behaviors experience reductions in problem behaviors and an increase in the social, personal, and professional quality of their lives. (Horner, 2000)*

The primary tool for behavior support is the formal system of accommodations or adjustments to conditions in classroom material, environment, or presentation.

GENERAL ACCOMMODATIONS

[SLIDE 16] There are as many accommodations for classrooms as there are students and teachers. Any advocacy group can provide a list of suggestions tailored to a given disability such as autism, Tourette syndrome, or bipolar disorder. In addition, you can find a multitude of specific ideas on Internet web sites and in books included in the Resources handout included with this curriculum. Such accommodations are authorized under IDEA, federal civil rights laws, and Minnesota state education regulations. As one researcher concluded, the goal is "the development of alternative behavioral repertoires and...the establishment of enriched and supportive environments that serve to effectively prevent the occurrences of undesirable target behaviors" (Kern, 2001). Kern reviews several studies which demonstrate that "curricular and instructional variables can be modified to successfully reduce problem behavior and increase desirable behavior in the classroom."

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[SLIDE 17] Before preparing accommodations specifically for behavior change, *review the student's academic functioning*. As stated earlier, matching the academic challenge to the student's ability is often the best behavior management tool available; certainly it is also the best teaching tool.

Academic accommodations usually involve changing the following:

- The way material is presented (providing written handouts rather than expecting a student to copy from the blackboard).
- The amount of work or the deadline to accommodate students who cannot work as fast as "typical" students.
- The method of response (an oral presentation may replace a writing assignment or an essay may be spell-checked on the computer).
- The use of learning aids (number lines, calculators, word banks).
- The learning level of the material (low-level, high-interest reading material; simplified vocabulary).

Other students may simply need a lesson modified or "differentiated" to fit a learning style that is more visual or motor-oriented. Many experienced teachers do these kinds of modifications almost as second nature. New teachers should be encouraged to seek the advice of master teachers or teacher mentors, as well as school psychologists familiar with learning styles theory.

DEVELOPMENTAL DIFFERENCES

[SLIDE 18] Another factor to consider when individualizing or differentiating a student's school day is that the brain differences that result from mental health disorders create great variance in developmental levels and can lead to unexpected patterns of skill acquisition. "Clinical experience suggests that a student with AD/HD may have cognitive, behavioral, social, and emotional age equivalents to approximately 2/3 the student's chronological age. For example, a neurologically impaired 12-year-old may have a functional age of 8." (Barkley, 1990).

Equivalent developmental delays in specific areas are identified for most other mental illnesses. Teachers can expect that control over emotional responses, social relationships, and decision-making skills will be slightly to greatly delayed in these students. Their disorders can also be expected to impair memory and problem-solving skills. In some cases, especially when there is prenatal damage from alcohol or other toxins, students will appear to know information one day and to have forgotten it completely the next. These factors should be taken into account in writing accommodations. Usually the team will write a crisis plan with different goals for days when interfering symptoms escalate. A crisis plan might call for quiet supervised reading or computer work with familiar skills rather than new learning challenges. A crisis plan should not be limited to disciplinary actions.

MAINTAINING A CALM CLASSROOM

[SLIDE 19] When teachers have children who are impulsive, inattentive, restless, or openly defiant in the classroom—and they will—the burden is on the adult to maintain a calm, respectful, and even-handed attitude. Make sure that the curriculum matches the student’s needs and learning style, use praise generously but honestly, and keep rules few, simple, and non-negotiable.

Provide a safe place for your students to go when they are losing control, and help them learn to recognize their own symptoms. Saying “I see your fists are clenched and that shows me you are upset. Would you like to take a walk to the nurse’s office?” (or other pre-agreed safe place) accomplishes the objective and helps a student learn his own cues. Be sure to acknowledge and honor students who can tell you that they are losing control without any adult cueing and allow them to “escape” in a prearranged way when needed. Help them identify the emotions and needs that led to the clenched fists.

If a student needs urging to leave the situation, keep instructions calm and impersonal, and allow the student to save face. (“I know it’s hard to walk away when you are certain you’re right, but I need you to leave my desk now.”) Ignore any mumbling and muttering that may accompany the exit. The crisis has been averted. Teaching can resume and developing a more graceful exit can be worked on later.

The responsibility is on the adults to provide appropriate accommodations and to intervene before a student’s self-control is lost. When frustration or anger is mounting, here are some things to remember:

- Avoid power struggles. A flat command or an angry voice will probably bring about the opposite result of what you wish to accomplish.
- Enlist help: “Can you help me keep the room quiet so we can get this work done before lunch?”
- Offer distraction or escape: “Would you move these books over to the shelves for me? You can finish that worksheet later.”
- Use a pre-arranged cue that the student helps choose. This may be a special hall pass, a special word, or a visual cue.

Here are some other ideas for preventing explosive behavioral responses:

- Avoid adding intense sensory input that will propel the student out of control. Examples of such input are eye contact, saying “no,” arguing, insisting on an action “right now,” and touching the student in any way unless he has requested this as his cue.
- Avoid offering a list of options or choices; the student is not in shape to do that cognitive work right now. Next time, intervene earlier with options.
- Have some or all of the following available (these are often calming and acceptable

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to students who are losing control and can be fitted into a general education classroom without comment): hand lotion, soft music, lower lighting, warmer temperature in the classroom, or a quiet corner in the classroom with a beanbag chair and a visual barrier (bookshelf, screen) to provide shelter from curious classmates. Ask an occupational therapist to help you find other ideas that work; chewing gum or chewy candies often work magic.

- Create an accepting climate in your classroom. Do not allow hurtful teasing of any kind. Model acceptance and you will be teaching a valuable life lesson, even if your original lesson plan for the day has been changed.

Stress and Behavior

When teachers talk to parents, they often find that the student's behavior varies widely between school and home. This is especially true in students with the disorders highly affected by stress, including all the anxiety disorders, Tourette syndrome, and schizophrenia. Teachers will find a couple of common patterns:

- The student's behavior may be the result of feeling insecure or threatened at school, and the parents may report no similar behavior at home.

or

- A student who is behaving well in your classroom but not succeeding academically may show explosive behavior at home. This is because home is a "safe place" to release symptoms that have been held under tight control in the school setting. These students show their struggles first in academic failure, since their battle to stay in control is both exhausting and distracting.

The most common scenario is the first of the two: behavior that escalates during periods of intense stress or anxiety in the school setting, sometimes moving from calm directly to "rage attacks" that seem to appear out of the blue. The obvious need is to reduce classroom stress as much as possible.

[SLIDE 20] Reducing stress can take many forms. Calling a student's name before asking a question reduces the tension of waiting to find out if it's "your turn." Many students need to be warned in advance that a task is about to begin and or end; this reduces the stress of waiting or of interrupting an unfinished task. Students with disabilities stemming from early development such as the autism spectrum or Fetal Alcohol Syndrome (FAS/FAE) frequently explode under the stress of an unexpected change in routine, such as having a substitute teacher or missing an expected class due to a school assembly.

Some students need to move around since simply attempting to sit still can be stressful. Others are stressed by unrecognized sensations and may overreact to the humming of fluorescent lights. Some may under react to pain from a bitten hangnail. And others may be overly distracted by events outside a classroom window. Students like these can benefit from an evaluation by an occupational therapist experienced in techniques that center and reorient the nervous system. After the evaluation, the ther-

apist can advise the teacher about how best to work with these students. (For more information on sensory integration disorders in the classroom, see Background Brief G, page 115.)

SPECIFIC ACCOMMODATIONS

[SLIDE 21] Mood and Anxiety Disorders

These are disorders that some students can hide for a long time. Although great stress may cause a behavioral outburst, these are more often the children who just sit quietly and fail.

[SLIDE 22] When working with these students, teachers should try to reduce stress and environmental stimulation as much as possible for example, lower the lights or reduce background noise levels. Having headphones available for these students may help if they have difficulty concentrating. Many students like background music, but many others just use headphones to muffle classroom sounds.

Encourage students to “check in” daily and let the teacher know if they’re having a difficult time, or use a parent notebook with younger students. Teachers can then decrease work demands or provide extra encouragement and support. For some students, the combination of anxiety and medication side effects will result in the need for a shortened school day, usually a late start. Other students may need to spend part of the day in a quiet, one-on-one setting.

When correction is needed, offer nonjudgmental feedback. “I asked you to ...” is one example. “Let’s think this problem through together,” is a gentler way to say an answer is incorrect. Some of these students are trapped in their own perfectionism and take any criticism as proof of their unworthiness. Be sure that classroom rules are clearly defined, consistent, and stated in the positive.

[SLIDE 23] Watch these students carefully for classic warning signs of suicidal ideation or potential such as withdrawing from favored activities, isolating from friends, giving away possessions, or statements such as “The class (or my family) would be better off without me.” Do not hesitate to consult other staff if any of these signs appear. The school nurse can also be a valuable resource for teachers who have concerns about eating disorders, self-mutilation (“cutting”), and other anxiety-related disorders.

Social Skills Deficits (Autism, Asperger’s Syndrome, FAS/FAE, etc.)

[SLIDE 24] This category of challenge involves the inability to learn nonverbal social “rules” by observation. These students may come to a classroom with a history of schooling in more restrictive settings. Or, they may need to move into a more restrictive setting as school life becomes more complex in secondary school. But many of them can do well in a regular education classroom as long as rules and procedures are clear, consistent, and reviewed frequently.

Escalation into acting-out behaviors is usually caused by sensory overload or high

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levels of anxiety. When dealing with these students, review those accommodations suggested for anxious students. Then, enlist the help of the school speech-language and occupational therapists to help teach the social skills that are delayed or nonexistent. Remember that these students often verbalize beyond their actual understanding, have difficulty retrieving information from their memory, and have significant problems learning from experience. Use favored learning modalities to help the student—visual schedules of the day, picture charts of the rules, role-playing, and simple songs are prime examples. If something doesn't work, try something different rather than repeating the failed lesson—frustration will only escalate your reaction and the student's.

While a teacher may see acting out behaviors and occasional rages, it is necessary to be alert to signs of depression as well. Many of these students are isolated socially and understand that they are different from others. They may be the target of teasing, name-calling, and harassment. Help them to find their gifts and use them to gain acceptance and build their self-esteem. Create opportunities for showing off a student's special talents or splinter skills. For example, allow a student preoccupied with a specific topic to be the class "expert." Keep these projects low-key so that they do not cause increased anxiety.

"Acting Out" and Defensive Reactions

[SLIDE 25] These are the children who annoy everyone around them. They may be defiant, bullying, or destructive. They are often distractible and off-task. They have the classic "attitude problem" on the outside, but they are often hurting badly on the inside. A chair outside the principal's office will not help their behavior, nor will it help their academic progress. A sense of humor, flexibility, and clear, consistent expectations are needed.

Children with a history of acting out, especially those diagnosed with oppositional defiant disorder or conduct disorder, often develop a reflexive defensive attitude and pattern of behaviors. These are conditioned, rapid, semi-automatic responses that are triggered by almost any verbal input from a person perceived as judgmental. You might see resistance to even a gentle suggestion. You may also see extreme reactions to praise, such as tearing up a picture when you say it was well done. Defensiveness can be a reaction to a history of constant "evaluation" in a child's environment.

Defensive reactions include flat denial, blaming other people or circumstances, arguing a small detail, name-calling or counter-attacks, insincere agreement to stop the interaction, shutting down (blocking the incoming message), shrugging off valid criticism or valid praise, or making a joke of it.

Some [adults]...seem to think that the main duty of parenting [or teaching] is evaluation. Almost everything the child does goes through a perceptual filter and comes out with a grade attached. What's appropriate is the middle ground between managing every little thing and a total lack of supervision. (Waugh, 1997)

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To break the cycle with a young student, avoid abstract explanations. Teach alternatives such as self-talk when you find yourself reacting defensively (“Boy, I’d like to blame someone else for losing that paper, but I know I did it myself.”) Pick your battles; keep a calm, non-threatening voice; and reduce unnecessary criticism. A contrary, humorous (but not cynical) challenge sometimes turns the situation around in a heartbeat (“I’ll give you a nickel if you can keep arguing for five minutes” said with a smile usually results in a stunned silence followed by laughter.)

With an older student, have someone who does not trigger a defensive reaction explain to the student that their own reactions may be interfering with making new relationships and with learning new ideas. Present the idea that reacting this way is something children learn when they’re young to stop feeling bad about themselves. Then directly teach a new “reflex” reaction the student can use when there is a perceived or actual criticism, such as demonstrating genuine curiosity or interest rather than a “wise guy” reaction. (“Tell me more. or Why do you feel that way?”)

Teach that the defensive feeling is OK but the expression must change. Be prepared to accept statements such as “I hate this, but I guess I’ll try,” or “I wish you hadn’t caught me, but, yes, I did that.”

Disinhibition

[SLIDE 26] In the lecture on brain structure, it was noted that damage to the frontal lobe is responsible for the uninhibited behavior of many children with mental health disorders. Even those who promise most earnestly and try the hardest are unable to keep themselves under control. They blurt out answers, interrupt, shift moods without warning, move around constantly, and may act aggressively or explosively.

AD/HD expert Russell Barkley (1990) identifies disinhibition as “the hallmark of Attention Deficit Disorder.” Tourette syndrome researcher David E. Comings, M.D. (1990) says that TS and other disorders are problems “more of disinhibition of the nervous system than a specific chemical change or psychological background causing a specific disorder.” Behavior change due to this kind of neurological disinhibition can be sudden, excessive, intense, and out of proportion. Another author defines disinhibition as “an excessive oppositional state or a destabilization in an individual that results in involuntary behavior. The individual knows what he is doing is wrong but, for whatever reason, is unable to stop” (Wood, 1996).

The author notes that this does not mean that teachers or parents should overlook the behavior. The neurological damage explains the situation but does not excuse it, and accountability must be maintained. Suggestions for reacting to an explosion are:

- Allow a cool-down time, then implement consequences quietly and calmly.

PLEASE NOTE:

For more information on a program to train students in self-awareness and self-management, see the information on “How Does Your Engine Run?” in Background Brief G, page 115.

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- Allow flexibility and an opportunity to make amends and reinstate privileges; reassure the student of your continued regard.
- Understand that full control may not be possible without addressing the issue of medication.

Here are some techniques Wood (1996) suggests for pre-teaching disinhibited students more about self-control:

- Secure the attention of the individual and draw attention to the specific behavior that needs to be changed.
- Contract with him to use an alternative behavior and choose a natural, fair consequence for repeated melt-downs.
- Use daily visual or verbal reminders of the chosen alternative behavior.
- Encourage a sense of control and reinforce the student's choices; express confidence in the possibility of continued improvement.
- Review the rules and consequences before stressful activities, outings, and changes in routine.
- Creativity is paramount as rewards and consequences will need to change frequently —be sure to review changes with the student beforehand.
- Use high-interest activities as incentives: spending time on the computer, visiting a favorite person in school, quiet reading time, etc.
- Reward the student for any attempt to alert you to impending loss of control, any attempt at self-control, and any independent attempts to make restitution for damage done.

Meltdowns and Rage Attacks

[SLIDE 27] These are both informal terms parents often use for a neurological loss of control. As well as defiance and aggression toward people or property, there may be physiological changes such as a reddened face, shouting, and glazed eyes. Inside the chaos of a rage attack is a child who is frightened by his loss of control and wants the security of knowing that someone can restore calm.

A total meltdown is disruptive and frightening for teachers, classmates, and most of all for the student involved. A screaming, hitting, or throwing child is a child that is no longer capable of reasoning. Orders, choices, and arguments are useless. Take a deep breath and assess the situation. If necessary for safety's sake, separate the student from his classmates, but do not leave him alone. Using a calm, reassuring voice, repeat that you will not let him hurt himself or others. "I will help you get calm again" is a message that provides needed reassurance to a child who is out of control, afraid, and embarrassed. An adult who is also out of control only adds to the crisis.

A behavior support plan for a child who may be prone to a meltdown should include a crisis plan that is well thought-out and designed to restore the student to "ready to

learn” status as quickly as possible. Discuss the plan beforehand with school administrators so that there is agreement about issues such as restraint, seclusion, and police intervention.

Follow a behavior support plan for that child and/or the suggestions that have been made here or those offered by the occupational therapist, parents, and team members. Seek help as needed. Remember that this meltdown is not deliberate, but is a crisis similar to a seizure or an episode of low blood sugar. A teacher's goal is not to punish, but to protect and support the student and return to teaching as quickly as possible.

When the crisis is past, review the student's IEP and FBA, or begin the process to establish an FBA. Try to determine what triggered this outburst and how the process can be interrupted earlier next time. What coping skills can you directly teach the child? To help in this process, be sure to document the incident as thoroughly as possible, including what happened just before, what was done to calm the student, what adults were present, and what happened afterward. Most often teachers may find out that the storm signaled the onset of an illness, a reaction to a crisis at home, or a reaction to some disruption in the normal school day that caught the student unaware.

It is also important for a teacher to communicate to the student that you know he has a hard time controlling his behavior, but he is responsible to fix the damage he has done. Hold the student responsible for finding a way to repair damage to property or relationships, and then help with this problem solving. Some schools have trained peer groups or circles of justice to participate in this process. This is a prime opportunity for direct teaching.

Traditional behavior management techniques, except for positive reinforcement and time-out, are usually ineffective in modifying the behavior of a student with neurological impairments. These methods rely on the student's ability to attend, concentrate, and neurologically remain in control...The neurologically impaired student often cannot generate strategies or solve problems by accessing prior acquired knowledge. (Pruitt, 1998)

Shifting Symptoms

[SLIDE 28] During the presentations of diagnoses, it was pointed out that some students have shifting symptoms. Tourette syndrome (TS) or bipolar disorder, for example, seem to have a rhythm all their own. TS tics tend to wax, wane, and shift over time in spite of treatments. A child who has been kicking out or dealing with a shoulder twitch may suddenly come to school with a verbal tic. Students with bipolar

PLEASE NOTE:

Many children with mental health disorders do not learn social interaction skills by watching adults and friends as other children do. If they are to develop the ability to read nonverbal cues, learn social rules for behavior, and interact normally, they must be taught in a direct, systematic way, just as they are taught math and reading. See Background Brief H, page 119 on Direct Social Skills Instruction for more information.

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disorder do not generally follow the adult pattern of long slow descents into depression or escalation into mania—instead a teacher might see incredible irritability in the morning and uncontrollable giggling in the afternoon.

Some children with obsessive-compulsive disorder (OCD) also may change their fixations and fears over time. Others may spend years trapped in a ritual created by their fear of fire, germs, etc. For still others, OCD symptoms may come and go, each episode appearing to be nothing more than a spell of excessive “stubbornness.” A student may refuse to interrupt a project that is unfinished, for instance, or explode when a peer or teacher attempts to “help” by changing a dull pencil for a sharp one or moving a puzzle piece.

What almost all have in common, however, is the fact that anxiety will escalate symptoms. A substitute teacher, a change in daily schedules, a fire drill, even a new student in the class may be enough to worsen symptoms or set up a full-fledged crisis. Again, *a teacher’s advance warning, calm attitude, and reassurance is what is needed.* “This might be hard, class” or “Tomorrow will be different” are key phrases teachers can use to introduce news of a change.

Critical Incident

[SLIDE 29] Case Studies: For the remaining class time, use pairing or small groups to review the following case studies and develop appropriate accommodations. The goal is not to prepare a “set” of accommodations, but to explore the wide range of possibilities and consider the possible outcomes in specific circumstances. There are no “right” or “wrong” answers, but the class should be encouraged to discuss which suggestions might have the best possibilities of working and which would be realistic to implement. Consider the academic challenges that might be reflected in the case study as well as the behavior that is disrupting educational work. Keep the simulations you did earlier (Lecture 3) in mind as you work.

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REFERENCES

- Barkley, Russell. (1990). *Attention deficit disorder*. Gilford Press.
- Chesapeake Institute. (1994). *National agenda for achieving better results for children and youth with serious emotional disturbance*. Available from Center for Effective Collaboration and Practice at <http://cedcp.ari.org/resources.html>.
- Comings, David E. (1990). *Tourette syndrome and human behavior*. Hope Press.
- Cook, Bryan G. (Winter 2001). "A comparison of teachers' attitudes toward their included students with mild and severe disabilities." *Journal of Special Education*.
- Ginott, Haim. (1993). *Teacher and child*. Macmillan Publishing Co.
- Greene, Ross W. (2001) *Explosive child: A new approach for understanding and parenting easily frustrated chronically inflexible children*. HarperCollins Publishers.
- Horner, Robert H. (2000). "Positive behavior supports." *Focus on Autism and other Developmental Disabilities*. 15(2), 97-105.
- Kern, Lee. (Winter 2001). "Improving the classroom behavior of students with emotional and behavioral disorders using individualized curricular modifications." *Journal of Emotional and Behavioral Disorders*.
- Lonigan, Christopher J. (Spring 1999). "Relations among emergent literacy skills, behavior problems, and social competence in preschool children from low-and middle-income backgrounds." *Topics in Early Childhood Special Education*.
- Minnesota Department of Education (MDE). (1994). "A report on graduates."
- Pruitt, Sheryl. (1998). Unpublished lecture notes.
- Setzer, Tammy. (2003). "Suspending Disbelief." Bazelon Center for Mental Health Law: Washington, DC.
- Sutherland, Kevin S. (Spring 2002). "Examination of the relationship between teacher praise and opportunities for students with EBD to respond to academic requests." *Journal of Emotional and Behavioral Disorders*.
- Swize, Myron. (1993). "Colorado's needs-based model." In Kay Cessna (Ed.), *Instructionally differentiated programming: A needs-based approach for students with behavior disorders*, (pp. 3-6). Colorado Department of Education.
- Thunder Spirit Lodge. (1999). *A parent's perspective*. [Brochure]. Columbia Heights, MN.
- Wood, Rose. (1996). "Disinhibition in Tourette syndrome." Unpublished lecture handout.
- Wright, Pamela Darr. (2003). "The blame game! Are school problems the kids' fault?" Retrieved from web site: www.wrightslaw.com.

LECTURE 4: CREATING CONDITIONS FOR CLASSROOM SUCCESS

LECTURE 4: CASE STUDYS

Case Study 1 — Andrea

Andrea is 13. She is diagnosed with AD/HD and moderate depression that may be bipolar disorder. She reads at a 4th-grade level and has considerable difficulty with writing and spelling. Seated assignments over 10 minutes in duration increase Andrea's agitation and decrease her attention to the task. She often leaves her desk and walks around the room or distracts the class in other ways.

What We Know:

What We Need to Know:

Possible Academic Accommodations:

Possible Behavioral Accommodations:

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Case Study 2 — Johnny

Johnny is 9 years old. He has a sister, age 3, and two brothers, ages 7 and 12. Johnny's father is an airline pilot and is frequently gone as many as 5 days a week. His mother works a 30-hour week for a county public health department that allows her to work a 4-day week for 6 months on a special family leave plan.

Johnny was diagnosed with AD/HD at 4 years old and attended Early Childhood Special Education programming until age 5.9, when he transitioned to kindergarten. Last year, a new diagnostic evaluation changed his diagnosis to bipolar disorder. He remains very active and curious; he is often out of his seat, blurting out answers in the classroom. He is frequently irritable, shouting or cursing at peers when he feels they "got in my face" or have been "unfair." He loves science class, but hates it if he cannot be the helper when experiments are done. He sometimes reverts to babyish behavior when he feels "picked on," which, of course, increases the teasing from his classmates. He is frequently put in time-out or even sent to in-school suspension after shoving matches in the lunchroom, gym, or playground.

Johnny is on an IEP and does his math and English with a special education teacher. He also sees the school counselor once a week to participate in an anger management class. Johnny is on medication and supervised by a pediatric psychiatrist. He also has individual at-home therapy weekly, which focuses on his relationship with his parents and siblings.

Lately, Johnny has been arriving at school late, or not at all. He says that he "can't wake up" in the morning and his mother says that new medication is causing the problem. She has been reluctant to set up a meeting, hoping he would "adjust" to the new medication.

What We Know:

What We Need to Know:

Possible Academic Accommodations :

Possible Behavioral Accommodations :

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Case Study 3 — Danny

Danny is 6 years old, small for his age, and language delayed. He is prone to sudden rages and unexpectedly aggressive behavior, although he is a very cheerful and friendly boy most of the time. During play with blocks, puzzles, and toy vehicles, etc. he usually prefers to be alone. He can express his need to play alone verbally, but generally his classmates ignore his request and tend to “baby” him by trying to help. Danny has responded to these advances by flying into a rage or hitting. This is a problem particularly at his half-day childcare setting, which is less structured and offers more “free play” time than his kindergarten class.

What We Know:

What We Need to Know:

Possible Academic Accommodations:

Possible Behavioral Accommodations:

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Case Study 4 — Pedrito

Pedrito is an anxious little boy whose home life has been chaotic since his house in Florida was destroyed in a hurricane and his family moved in with grandparents in Minnesota. He is 7 years old and attends a 1st-grade class that includes both normally developing children and several children with special needs. Pedrito dislikes being touched and is prone to temper tantrums if asked to partner with another child for an activity. He is not aggressive but his teacher is anxious to structure the classroom and its activities to encourage Pedrito to spend time in a close physical setting with one or more peers and to have opportunities to act in a friendly manner toward others.

What We Know:

What We Need to Know:

Possible Academic Accommodations:

Possible Behavioral Accommodations:

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Case Study 5 – Carol and Juan

Carol and Juan, both 16 years old, have been overheard making rude remarks to classmates about their social studies teacher, Mr. Wong. They were sent to the principal when they were overheard. This seemed to decrease Juan's name-calling, but Carol's rude remarks increased. Mr. Wong met separately with both sets of parents—differing reasons for Carol and Juan's behaviors emerged.

Carol's grades had been low since middle school but she is now nearly failing several subjects, including social studies. Her mother reported that she was worried about Carol's grades, but even more concerned about her daughter "looking stupid" in front of her friends. Carol's acting out apparently allowed her to escape the uncomfortable situation in the classroom.

Juan, on the other hand, was merely trying to show off to his friends. This goal was effectively thwarted, however, when he was sent to the office. Nevertheless, Mr. Wong was still concerned about the frequent interruptions of Juan's academic work.

What We Know:

What We Need to Know:

Possible Academic Accommodations:

Possible Behavioral Accommodations:

Case Study 6 – Kenny

In 3rd grade, Kenny was a whirlwind of activity. In spite of medication for Tourette syndrome, Kenny was unable to stay put for more than 5 minutes at a time, especially when seated at his desk. When a reading task was required, he would refuse, throw the reading material across the room, and run between the classroom's desks — at times he even ran out of the classroom. Kenny would only complete a worksheet if given one-to-one assistance and several breaks to walk around. He was unable to successfully master the 100 Dolsch words or read more than four words in a book. Kenny had high sensory integration problems, and the school occupational therapist had worked with the classroom teacher to provide many ways for him to calm himself, allowing him to stay in the classroom.

What We Know:

What We Need to Know:

Possible Academic Accommodations:

Possible Behavioral Accommodations:

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Case Study 7 — Michael

Michael is 7 years old and extremely hyperactive—it is almost impossible for him to sit at a desk and do paperwork. He has learned to do simple addition and subtraction using manipulatives (like building blocks) but is still unable to recite his numbers from 1 to 20 or give accurate answers to simple addition problems. In other words, he can take 2 blocks from 5 when asked to subtract 2, but gives a random answer when asked how many blocks are left.

Knowing that fetal alcohol exposure has likely damaged Michael's memory processing, and that he is best able to pay attention during structured activities that allow physical activities, his teacher searched for ways to help Michael memorize and retrieve his numbers. She also wanted to integrate him more into the class's social life.

What We Know:

What We Need to Know:

Possible Academic Accommodations:

Possible Behavioral Accommodations:

LECTURE 4: CASE STUDY ANSWER GUIDELINES

Case Study 1 — Andrea

What We Know

- Attention deficit, depression or bipolar, agitated by seat work.
- Deficits in writing and spelling.
- Behaviors are disturbing to others.

What We Need to Know

- Exact evaluation data on writing, spelling (reading?).
- Information on favored learning style, teaching methods.
- Occupational therapist consultation.

Possible Academic Accommodations

- Intensive academic assistance, perhaps with computer-assisted practice or pre-school tutoring rather than pull-out.
- Modify assignments to current reading level, or tape them.
- Allow computer word processing and spell-check for writing assignments.

Possible Behavioral Accommodations

- Allow access to items designed for sensory distraction (“fidget” items, gum or chewy candy).
- Allow extra time for assignments or shorten tasks. Allow her to complete work at home and return it the next morning.
- Grade for content rather than spelling or grammar unless that is the lesson.
- Have a standing desk available in the classroom.
- Encourage a movement break every half hour or so.
- Assign a work buddy to help student stay on task.

LECTURE 4: CREATING CONDITIONS FOR CLASSROOM SUCCESS

Case Study 2 — Johnny

What We Know

- Parents are overworked and stressed.
- His diagnoses are AD/HD and bipolar disorder.
- He is active, curious, and wants to be center of attention.
- He is sometimes irritable and quickly escalates to aggression.
- He has a hard time waking up in the morning. This might be a side effect of new medication.

What We Need to Know

- Is sleep problem really a side effect? Will it go away?
- How can we keep him connected to school and on target academically?
- Are there alternatives to the anger management sessions that have not been effective?
- Can we establish more continuity between home and school?

Possible Academic Accommodations

- Continue with special education for math and English, but reschedule English for a later period.
- Schedule Johnny for a late start (2 hours) for a two month period; meet again to review his status and return to full schedule as quickly as possible.

Possible Behavioral Accommodations

- Switch focus of classes with counselor to helping Johnny find other ways of expressing his feelings with peers. Try drawing pictures or “comic strips” when processing an incident. Use the comic strips and role-playing to re-create the interaction in a new way.
- Consult with in-home therapist and parents on managing sleep hygiene and sibling relationships in a way consistent with school plans.
- Recruit several older students to “buddy” with Johnny during lunchtime, recess, and playground periods. Train them to give friendly reminders to help Johnny remember the strategies he had practiced and helped him integrate into peer activities.

Case Study 3 — Danny

What We Know

- Danny can express his needs verbally, but they carry little weight with his peers, who see him as babyish and needing help.
- Danny has greater trouble in less structured environments and needs to have consistency between his kindergarten and day care settings.

What We Need to Know

- How can we help Danny communicate with his peers efficiently enough so that he does not get frustrated and aggressive?
- How can we create a consistent structure between school and day care?

Possible Academic Accommodations

- None at this time.

Possible Behavioral Accommodations

- Set up consultation between school teacher and day care teacher to discuss and share behavior supports for Danny.
- Prepare a laminated card with pictures of two children playing on one side and a boy playing alone on the other side. Put Danny in charge of placing the card near his play mat and choosing which side is up. Teach class to look for the card and respect its message.

Notes:

- When this plan was implemented, one little girl explained that “I wish Danny wanted to play with me more, but I know I have to wait when his ‘alone picture’ is showing.”

LECTURE 4: CREATING CONDITIONS FOR CLASSROOM SUCCESS

Case Study 4 — Pedrito

What We Know

- Pedrito does not like to be touched, especially without warning.
- His parents need support to help him through his reactions to the stress he has experienced.
- He needs direct teaching and practice interacting with peers.

What We Need to Know

- Would sensory integration techniques be helpful in reducing sensitivity to touch?
- What environmental changes will increase peer-to-peer interaction?
- Will a classroom program on friendly behavior assist with Pedrito's integration into the classroom?

Possible Academic Accommodations:

- Pair a typical learner and one with disabilities for most activities.
- Limit the number and variety of materials available and choose those that invite interaction (one scissors for two children).
- Structure activities so there is a goal that requires cooperation, and help each child understand their role.
- Several days a week, implement lessons that focus on friendship and expressions of friendship.

Possible Behavioral Accommodations:

- Reduce rate of adult intervention in peer play.
- Directly teach interaction skills for all class members, with multiple opportunities to practice and reinforcement for appropriate interactions.
- Encourage peers to reinforce each other's expressions of friendship and acknowledge expressions of displeasure without anger.
- Do not allow Pedrito to withdraw from an activity because of a temper tantrum.
- Help Pedrito develop a self-monitoring strategy and self-calming techniques; help the cultural liaison teach the same techniques to Pedrito's family and encourage them to implement the program at home as well.

[Adapted from Turnbull, Rud, et al. (2002). *Exceptional lives: Special education in today's schools*, 3/E. Prentice Hall.]

Case Study 5 — Carol and Juan

What We Know

- The same intervention had very different results. Carol's grades are low to failing; she is embarrassed by "looking stupid."
- Juan is doing well academically, but is focused on being ringleader of a group of students; he frequently misses class for disciplinary purposes.

What We Need to Know

- Details of Carol's academic problems.
- Ways to reduce Carol's anxiety in class.
- Positive redirection for Juan's leadership ambitions.

Possible Academic Accommodations

- Refer Carol for a special education evaluation.
- Meanwhile, reduce Carol's homework and provide assistance such as word banks with her assignments.
- Mr. Wong met privately with Carol and offered to call on her only when she raised her hand.
- With Juan in mind, Mr. Wong developed short lessons on "How to be a leader" for the class and taught them before small group activities occurred.

Possible Behavioral Accommodations

- Mr. Wong met privately with Juan and explained the impact of his behaviors. Juan was promised a chance to lead small group work when he resisted the urge to "show off."

Notes:

- Carol's parents decided to seek a psychological evaluation as well.
- Carol was enthusiastic about Mr. Wong's offer, thanked him profusely, and her rude remarks stopped at once.
- Small group activities became more valuable learning tools as the class members learned to assume leadership and take responsibility for the results of the lesson.

[Adapted from Center for Effective Collaboration and Practice (CECP), American Institutes for Research. What should IEP teams consider when choosing positive intervention plans and supports. Available from web site, www.air.org/cecp.]

LECTURE 4: CREATING CONDITIONS FOR CLASSROOM SUCCESS

Case Study 6 — Kenny

What We Know

- He has Tourette Syndrome and is very hyperactive.
- He is unable to read or remember sight words, and he resists trying.
- He is unable to work independently.
- He has high sensory integration needs, and the classroom teacher, working with school occupational therapist, makes many accommodations.

What We Need to Know

- How can we extend Kenny's on-task performances beyond 5 minutes?
- What are the reasons for his problems with reading?
- Which modifications will reduce anxiety and keep Kenny in the classroom?

Possible Academic Accommodations

- Set up specialized work areas in the classroom (available to any students) and allow Kenny to choose where to work. Work areas include standard desk, beanbag, and standing desk. Each area provides unique nervous system and muscle input.
- In spite of mother's request, the team felt Kenny would not benefit from one-on-one work with a reading specialist until his behavior was under better control.

Possible Behavioral Accommodations

- Kenny and his teacher made a picture list of approved activities he could use to "escape" a stressful situation. These included several sensorimotor "changers" (See Background Brief G) and "work visits" to several favored school staff outside his classroom.

Notes:

- Kenny was often able to finish his work when "visiting" in a classroom where students modeled desired behaviors.
- Over time, Kenny became able to monitor his level of agitation and request an escape activity from his list before losing control.
- [Author's Note: While Kenny's classroom behavior did improve, his progress in reading continued to be minimal until age 16, when a private vision therapist began working with Kenny on tracking and other eye movement training. At age 18, Kenny is able to read for pleasure on a 3rd-grade level; however his skill level is still below the level he will need to live completely independently. Kenny is the author's son.]

Case Study 7 — Michael

What We Know

- He has fetal alcohol syndrome, hyperactivity, his short-term memory is untrustworthy, and he perseverates on certain topics.
- He understands basic numbers and counting.
- His learning is heightened by accompanying physical activity.
- He has mastered many routine living skills and activities.

What We Need to Know

- How can we help Michael express his number knowledge?
- How can we integrate Michael into activities with his peers?
- How does Michael learn home activities?

Possible Academic Accommodations

- Mother reports that Michael's memory is assisted by rhythm and melody and that she often chants a sequence of tasks with him or sets them to a simple childhood song. The teacher developed a simple number song to the tune of "Row, Row, Row Your Boat" to use during arithmetic activities.
- In addition, a hopscotch-like pattern of numbers was placed on the classroom floor and Michael was encouraged to hop, jump, or toss beanbags as he said or sang the numbers.
- This activity proved so intriguing to the other students, that the teacher was able to create new social experiences for Michael and his peers. To her surprise, a number of other students increased their arithmetic skills as well after using "Michael's game."

LECTURE 4: CREATING CONDITIONS FOR CLASSROOM SUCCESS

Critical Incident

Quiz

LECTURE 4: QUIZ OR DISCUSSION

QUESTIONS FOR QUIZ OR DISCUSSION

1. A mother recently called a mental health advocate to say that her child's teacher wrote a note asking her to explain to the child that he "must pay attention" in school. The child's diagnosis is AD/HD. What is problematic with the teacher's approach and what alternatives do you recommend?
2. One traditional teacher stance is "Do what I say because I'm in charge and I say so." Which students are most likely to have difficulty in a classroom that uses this authoritarian stance? Other than power struggles, what other factors is this teacher overlooking, and what effect would those factors have on the child's classroom behavior and performance? List three phrases more likely to create compliance, even in a child with mental health disorders.
3. You have a student with AD/HD. One of your colleagues gives you this recommendation: "Tell the parents to put him on Ritalin and he'll be fine." How would you respond? Do you think that this is a good idea? Why or why not?

LECTURE 4: CREATING CONDITIONS FOR CLASSROOM SUCCESS

ASSIGNMENT

Browse the following web site and write a 2-page report on the principles and initiatives advocated by this group of policy specialists. Include your own comments and opinions based on information from this lecture series and/or other class work in the field. <http://wmhp.psych.ucla.edu>.

LECTURE 4: QUIZ OR DISCUSSION ANSWERS

1. School environments are structured for normal neurology, and children with AD/HD often cannot cope with the over-stimulation of the regular classroom and its distractions. With some basic understanding of brain functioning it becomes clear that this is not a matter of willfulness, but inability. To expect a child with AD/HD to regulate his attention by sheer willpower is no different from expecting a child with diabetes to regulate his blood sugar by thinking about it.

Alternatives to speeches from teacher or mother could include:

- Reducing distracting elements in the classroom such as wall displays.
 - Changing the student's seating to an area out of traffic.
 - Using cues such as the student's name or a light touch when his attention is needed by the teacher.
 - Allowing for periods of movement to break up time periods when sitting and listening is required.
2. Children with ODD or Conduct Disorder; many others. The teacher is overlooking possible academic deficits, and the fact that a shutdown may be caused by anxiety or fear. Phrases enlisting cooperation such as "Can you tell me what I asked you to do?" or "Would you help the class by..." or offering a distraction are generally more successful than a command or a request with a "yes" or "no" answer.
 3. Teachers should avoid putting themselves in a position of diagnosing or prescribing, roles that belong to medical professionals. In addition, medication is just one part of the recommended therapy for AD/HD and other mental health diagnoses. Children with these disorders also require modifications in their environments and special behavior supports to succeed. It is all right to suggest that a parent seek a full mental health and learning evaluation and to discuss the possibilities in a supportive way. It is not, however, legal for schools to refuse to teach a student whose parents refuse to do this, or to charge the parents with educational neglect.

BACKGROUND BRIEF G **SENSORY INTEGRATION**

*For a person to interpret a situation accurately **and** make an appropriate response, all senses must work together in a complex yet coordinated coordination... This process and organization of the senses is Sensory Integration.*
(Based on the work of Jean Ayers, Ph.D., OTR)

Sensory integration (SI) is an unconscious and automatic process that allows us to respond and act on a completely new task in an adaptive (productive) manner. SI considers the operation of 7 sensory systems, rather than the commonly understood 5 senses. They encompass all of the neurological connections between the brain and the outside world:

- **Olfactory** – the sense of smell, most closely linked to memory.
- **Visual** – the sense of sight.
- **Auditory** – the sense of hearing.
- **Gustatory** – the sense of taste.
- **Tactile** – the sense of touch.
- **Vestibular** – the sense of gravity and movement; the foundation for the orientation of the body to surrounding space; responds to body movement through space and changes in head position; coordinates the movements of eyes, head, and body; balances the alertness level of the brain.
- **Proprioceptive** – sensory responses of the muscles, joints, and tendons; creates awareness of body position; guides arm and leg movements without having to watch the process; orients body parts in relation to one another.

In a normally developing brain, integration of sensory input develops automatically during the course of typical infant and childhood activities, from sticking a foot in the mouth to crawling and chewing. In Lecture 2 you will learn that specific areas of the brain receive incoming data from the senses, which are then integrated with memory and other functions in the sub-cortical areas of the brain. Damage in any of these areas can result in SI disorders — in other words, the brain can process sounds, sight, and touch, but does not make sense of the information or use it appropriately.

When sensory integration does not occur, the results may be seen in learning, developmental, and/or behavioral problems. Among the reactions that might have been seen or reported by parents are:

- Incessant spinning, somersaulting, touching, or swinging of objects.
- Oversensitivity to touch, movement, light or visual clutter, or sounds.
- Failure to respond to sensory stimulation such as pain.
- Activity level that is unusually high or low.

LECTURE 4: CREATING CONDITIONS FOR CLASSROOM SUCCESS

BACKGROUND BRIEF G, CONTINUED

- Difficulty with coordination of large muscles or small (running, writing, eating).
- Refusal to eat foods of certain temperatures or textures.
- Delays in speech, language, motor skills, or academic achievement.
- Impulsivity, distractibility, fearfulness.

Most school occupational therapists can identify signs of sensory integration disorder and assist the teacher and student through consultation or direct therapy. A complete evaluation of sensory integration function should be performed by a therapist who is specially certified in this area.

Many therapists are using a program called “How Does Your Engine Run?”, which trains students to identify their own levels of alertness and shows them how to change their level to one suitable for the task at hand. This program can be conducted with an entire class (Williams and Shellenberger, 1998).

Each student’s sensory system is unique, and adults working with an individual must be willing to modify the environment to meet his or her needs. This may mean dimming lights in the classroom, or giving a student permission to move in the hallways before or after the normal rush of students. Recognize that a child can be distracted by something as “minor” as the alignment of a sock or a “scratchy” tag on a shirt.

When a student’s reaction is distracting or annoying to others, patient detective work can usually uncover what kind of sensory input or escape the child is seeking. For instance, if pencil tapping is the habit, is the “reward” in the hand movement or the sound of pencil on tabletop? Sometimes a substitute means of achieving the needed input can be developed.

If the child is able to sustain attention and stay on task, a teacher may choose to just ignore the activity. (During a class meeting, notice how your fellow pre-service teacher education students maintain their alertness — drinking water, picking at their nails, twirling a lock of hair, chewing on a pencil, doodling!) There are young children whose sensory systems are so disturbed that they cannot listen at all unless they are allowed to sit in a rocker or on a stationary bike during presentation times.

You will need to modify the behavior if the child is still unable to attend to your teaching, if there is a definite disruption for others, or if the behavior is unsafe. Try to suggest alternative behaviors that are within the same category as the undesired behavior: oral-motor, muscle work and movement, touch, vision and sound. Some ideas are reproduced on the next page for your convenience.

RESOURCES

Ayres, A. Jean. (1979). *Sensory integration and the child*. Western Psychological Services.

Williams, Mary Sue & Shellenberger, Sherry. (1996). “How does your engine run?”™: A leader’s guide to The Alert Program™ for self regulation. TherapyWorks.

BACKGROUND BRIEF G, CONTINUED**Sensorimotor Methods to Change Engine Levels**

- **Put something in your mouth.** Oral motor input has a range of characteristics, including the following (Wilbarger, J., 1993 and Oetter, P. 1991).
 - a) Action Variables (what you do): Blowing, sucking, swallowing, biting, crunching, chewing, or licking.
 - b) Quality Variables (how it feels or tastes): Physical feeling of resistance when biting, crunching, chewing, sucking, and blowing; the taste of sour, sweet, salty, spicy, or bitter; the temperature of food such as hot chocolate, cold popsicle, or warm soup.
 - c) Medium Variables (with what?): Whistle, straw, bubbles, musical instrument, exercise water bottle, candy, beef jerky, rubber tubing, fruit, crackers, pretzels, gum, bagels, popcorn, etc.

- **Move.** Vestibular and proprioceptive inputs include:
 - a) Oscillation (up and down): Sitting on a teeter-totter, trotting on a horse, jumping, sitting and bouncing on a therapy ball, or jumping on a trampoline.
 - b) Linear (front and back): Swinging on a playground swing, rocking in a rocking chair or on a rocking horse, or swinging on a glider.
 - c) Rotary (circles): Riding on a merry-go-round, using a “Sit’n Spin,” standing and twirling, or spinning on a tire swing.
 - d) Inverted (upside down): Hanging by the knees on a playground bar with hands near the ground, bending over with head between knees, “wheelbarrow” walking, or on tummy laying over therapy ball.
 - e) One type of proprioception (heavy work), meaning input to muscles, tendons, and joints: Crossing the monkey bars on a playground, climbing a tree, pushing furniture, lifting firewood, or pulling a sled uphill.
 - f) Another type of proprioception (crash and bump): Jumping into a large pile of pillows, doing a “cannon ball” off the diving board, tackling a player in football, or driving bumper cars.

- **Touch.** Tactile input variables include:
 - a) Fidgeting and holding objects, such as Koosh balls, Squish balls, paper clips, flexible straws, or stuffed animals.
 - b) Temperature variables, such as warm baths, cool showers, or the neutral warmth of being held by another or snuggled under blankets.
 - c) Light touch, such as tickling, light back scratch, petting a dog or cat, or sleeping under flannel sheets.
 - d) Deep touch, such as playing with resistive clay or therapy putty, deep “bear hug,” or deep massage.

LECTURE 4: CREATING CONDITIONS FOR CLASSROOM SUCCESS

BACKGROUND BRIEF G, CONTINUED

- **Look.** Visual input can include:
 - a) Variations in light (natural lighting versus artificial lighting, or dim lighting versus bright lighting).
 - b) Variations in color (walls painted a bright color instead a pastel color, or classroom bulletin boards decorated with brilliant red, orange, and yellow instead muted brown, beige, and rose).
 - c) Variations in the amount of visual distractions (visually cluttered room versus sparsely decorated room).

- **Listen.** Auditory input can include:
 - a) Variations in noise level (loud music versus quiet music, or screaming versus whispering).
 - b) Variations in rhythm (fast versus slow music, or arrhythmic versus rhythmic music).
 - c) Variations in amount of auditory distractions (quiet working environment versus noisy working environment, or sudden unexpected sounds versus constant background noise such as a clock ticking).

BACKGROUND BRIEF H

TEACHING SOCIAL SKILLS

Students with mental health disorders typically show delays in social skills that interfere with both peer and adult relationships. They are frequently unable to “read” non-verbal social clues such as facial expressions and body language. Their sense of comfortable social distance may be distorted. In addition, there may be deficits in understanding, specialized language skills such as classroom directions, figures of speech, and slang common to their peer age group. Memory and language problems may interfere with reconstructing and explaining an event (“What did you do to make Billy mad?”) or dealing with abstractions (“Why did you do that?”).

These are skills that must be directly taught, preferably in the natural setting of your classroom. Here are several suggestions and resources for use in this process:

- Social stories are simple, concrete stories that teach expected behavior. These were developed for students with autism spectrum disorders but are useful with a wide range of students. If possible, write them with the student’s participation; he is always the “hero.” Use a brief, problem and resolution format and reread it frequently. Illustrations are optional. You may find it useful to write the story inside a manila folder and laminate it. (Gray, 2000)
- Comic Strip Stories are stories of interactions, using stick figure illustrations and cartoon “word balloons.” These are most useful for explaining the thoughts behind someone’s actions or spoken words, or the meaning of proverbs and figures of speech. Use a continuous-line word balloon for the spoken words, a dotted-line balloon for the thoughts. (Gray, 1994)
- Coached Observations are especially useful during group activities including field trips or in a school cafeteria. Call attention to a small group nearby. Describe or question the student about the group: Are they happy? Is anyone bored? Tired? Angry? Do you think they are friends? and so on. Draw attention to how each of you decided how to answer: “I think the girl is having fun because she is smiling and holding her mother’s hand.” Videos, TV shows, and magazines can also be used.
- Role-playing and story-telling are time-honored teaching methods that can be applied to social skills development. When coaching, suggest that students “show an angry face,” “walk as if they’re tired,” etc. Use the exaggeration of expression in the activity to help stress the importance of watching for these signs in everyday life.
- Discipline as teaching. Use a story format to help student(s) recall and sequence the event in question. Involve all the participants. Focus on restitution, not punishment. Create a ceremonial closure so students do not “get stuck” on the incident.

RESOURCES

Gray, Carol. (1994). *Comic strip conversations*. Future Horizons, Inc.

Gray, Carol and Jonker, Sue. (Eds.). (2000). *The new social story book*, Future Horizons.

Gray, Carol et al. (Eds.), (2002). *My social stories book*. Jessica Kingsley Pub.

Nowicki, Stephen and Duke, Marshall P. (1992). *Helping the child who doesn't fit in*. Peachtree Publishers.

LECTURE 4: CREATING CONDITIONS FOR CLASSROOM SUCCESS

BACKGROUND BRIEF I **DATA PRIVACY**

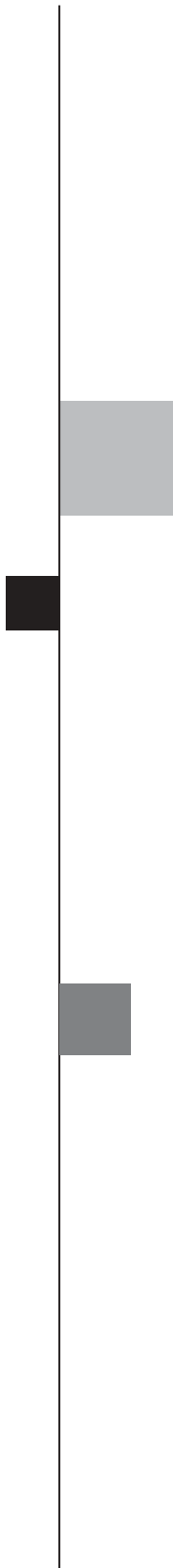
Data privacy concerns often prevent teachers from asking the questions needed to fully understand their student. Professionals who provide mental health or support services can supply important information about the dynamics of the child's non-school hours. This information is essential to the development and implementation of a consistent support program.

To access this information, provide a "consent for release of information" form to the parent or legal guardian and have them sign it. Explain what information you need and how you will use it. Be sure to advise parents and indicate on the form if you will also be sharing school information with the provider.

Most parents are happy to allow this partnering when they are fully informed. In addition, you will want to point out that permission can be withdrawn anytime, upon receipt of a written request.

When you are requesting information from a health provider, you should know that their privacy regulations fall under federal controls that are quite strict, so you must indicate clearly why you need the data you are requesting. A simple phrase such as "for consistency in program planning" should fill this requirement.

You should also be aware that all student records are open for a parent or legal guardian to review. If a parent makes such a request, follow school or district procedure, which usually means directing them to an administrator. When reviewing a student's file, do not overlook any parent notes or inclusions. Federal special education law includes the provision that a parent can contest or provide a differing explanation for any entry in the file with which they disagree.



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