



Monthly reports on the problems of children and adolescents growing up.

Special Focus Issue — School-Based Interventions

How to safeguard aggressive impulsive students in a school setting: Tips from the trenches

By Nancy Rappaport, M.D.

- A previously traumatized female student was hanging in front of the school with a group of boys. When they said provocative comments and leered at her, she poked angrily at them with an umbrella and she now faces expulsion.
- An adolescent retrieved his key for the high school elevator and a security guard spotted a pocket-knife on the student's key chain which as a result jeopardized his school placement.
- A student who is impulsive and prone to feel easily humiliated about his learning disorder exploded at a teacher and pushed her out of the

classroom. He was sent to an alternative remedial high school for a year as a result.

Capitalizing on aggressive students desire to be seen and their sometimes self-righteous indignation can be challenging for schools. Mental health professionals may provide a balanced voice of reason as they are not worn down by the daily stresses of managing the behavior.

Is there a way to encourage mental health professionals to take some precautionary steps so that their patients are not extruded from their schools and to increase the chances

that they will stay in school? As a child psychiatrist who has performed safety assessments for an urban school district for four years (Rappaport, 2004) and as Director of School programs at Cambridge Health Alliance, I have identified several practical suggestions.

It is critical to review with patients the importance of not bringing a weapon or anything that could be construed as a weapon to school.

Besides the obvious weapons of knives and guns, instruments such as pocketknives or a box cutter that a

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Skills for Academic and Social Success (SASS)

Treating social phobia: making a case for school-based intervention

Social phobia is among the nation's most untreated mental health care problems. Clinic-based treatments and a handful of pharmacological interventions have demonstrated efficacy in reducing the symptoms of the disorder in adolescents. However, a failure in identifying and diagnosing social phobia has contributed to a considerable gap in service utilization.

"Despite the availability of effective interventions, socially anxious adolescents are rarely referred and typically do not receive treatment," wrote Carrie Masia-Warner, Ph.D. in a December 2004 review paper. (*Clinical Child and Family*

Psychology Review)

Masia-Warner, Assistant Professor of Psychiatry at the NYU School of Medicine and a member of the Institute of Anxiety and Mood Disorders at the NYU Child Studies Center, has focused her recent work on the treatment of child anxiety in non-psychiatric settings. She believes that school-based interventions could be key in building awareness and increasing diagnosis.

"The current issue for school-based mental health," Masia-Warner

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FREE Parent Handout — Keys to Helping Socially Anxious Teenagers

was strongly associated with selling drugs: 71.6% of those who sold drugs scored in the highest 20% on the delinquency behavior index, vs. 16.7% of those who did not sell drugs. Violent behavior (“beat someone up”) was also associated with drug sales: 58.7% of drug sellers scored in highest 20%. Violent behavior in females was more strongly associated with selling drugs. Use of cigarettes, alcohol, marijuana and cocaine were all associated with selling drugs, with a particularly strong link for marijuana (58.2% of drug sellers reported using marijuana weekly), and a stronger

effect for males.

On psychosocial measures, students who had the support of friends and/or received mixed messages from parents and family were significantly more likely to engage in drug sales. Those with paid daily employment were also more likely to sell drugs, a variable that Steinman suggests may represent increased exposure to adults who support drug use. Those who engaged in weekly religious and/or family activities were less likely to sell drugs.

Steinman points out that students

academic achievement and extracurricular activity had little bearing on their likelihood to sell drugs. He wrote, “This finding is encouraging in that it suggests that many teens who sell drugs are still relatively engaged in academic and school-related activities. As such, they may be easier to identify and help, compared with young people who attend school only intermittently.”

*Funding sources not disclosed.

Steinman K: Drug selling among high school students: related risk behaviors and psychosocial characteristics. *J Adolesc Health* 2005; 36(1):71. E-mail: steinman.13@osu.edu.

Impulsive Students

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student uses for an after school job can trigger an administrative response that puts their education at risk. I also caution students not to draw pictures of weapons in school. (When exploring patients’ fantasies in my office, it is important to discuss both safe and inappropriate places to share their aggressive feelings and fantasies). I explain that inflammatory threats at school can seem comical to students but it can set off a level of scrutiny that they may wish that they never invited.

I encourage clinicians and families to work with the school in a preventive way to safeguard a student feeling backed into a corner and losing control. It is useful if the school can identify a safe adult who may help an impulsive student negotiate some of the seemingly trivial incidents that can quickly escalate to violence. Frequently with behaviorally disordered students who are prone to hostile attribution, their aggression occurs during recess, gym, transition to classes and after school.

Role of MH professionals

Mental health practitioners may be in a position to encourage schools to increase their monitoring and to structure activities proactively, rather

than waiting for students who are vulnerable to act out (Twemlow, 2001). Even if the clinician is not optimistic that the school will make the necessary accommodations, it is important to document that one has had this type of discussion. This will allow the clinician to advocate that their patient not be too severely penalized if there were inadequate provisions by the school to ensure student safety.

Sometimes a school has exhausted their repertoire and even if the suspensions do nothing to modify the behavior, they still may mete out the punishment in the name of fairness and consistency with all students.

For explosive students who deteriorate with a power struggle, it can be critical to have discussions with school personnel to prioritize when they want to head into a collision course (usually when it is a matter of keeping everybody safe) and when they may want to be more flexible. This type of negotiation can be time consuming, and school personnel may pressure psychiatrists and families to alter the medication as an alternative, easier way of controlling the behavior. Medicating the student instead of improving the system can be counterproductive, as the school’s response to a volatile student may be adding gas to the fire. It is useful if the clinician advises the school how to optimize communication so that the student can acquire new skills of negotiation.

School personnel may hope that medications are a magic bullet, leading families and students to feel pressured that access to the least restrictive school setting is dependent on their acceptance of a stimulant, antipsychotic or mood stabilizer.

The treating psychiatrist is in the delicate position of trying to identify if there is an underlying medication-responsive psychiatric disorder that may account for the aggression while also recognizing that the family should not feel forced into prescriptive cures. I will often present the option of a circumscribed trial, with the hope that we can improve the student’s function, while supporting the family and student’s autonomy to choose.

Legislative help

It is key for a clinician to be familiar with the various provisions in school that provide protection to their patients. There are two federal mandates: Section 504 of the Rehabilitation Act of 1973 and the Individuals with Disabilities Educational Act (IDEA). In order to access the provisions of Section 504, attention and behavioral problems generally qualify as eligible impairments. The school psychologist and a teacher can make accommodations and design a behavioral management plan that may help students avoid severe disciplinary actions or placement in a more restrictive setting. Students who have a disability under

the provisions of IDEA need to have an evaluation to determine eligibility for special education services.

Such an evaluation is more time consuming and usually requires psychological testing by the school, a multidisciplinary team meeting and an individual education plan. This extensive evaluation is required if the school is going to fund a therapeutic placement, and it also allows students to have special disciplinary consideration. Under IDEA if the student missed ten consecutive school days of suspension, or ten non-consecutive days of suspension that constitute a pattern, then the school is required to conduct a meeting to determine if the behavior resulting in the student's suspension was related to the disability. If this is the situation, then the individual education plan and the behavioral management plan need to be altered.

The mental health clinician's testament (either presence at the meeting and/or written evaluation) can provide critical information to determine if the student's behavior is linked to his disability and to suggest modifications. For example, in the situation of this reactive traumatized student, if the clinician had talked with a school psychologist about providing accommodations, there may have been strategies developed to provide her with increased support in school and an understanding that she may be hypervigilant.

Making a "safe to return to school" decision

Schools will sometimes ask that mental health professionals provide assurance that an aggressive or disruptive student is "safe to return to school." This can occur as a request to the treating therapist or emergency personnel. Such a request is inordinately difficult as most assessments of safety are time limited and if conditions change a student can undermine the most diligent predictions. Students often need resources mobi-

lized to stabilize. The assessments are more useful if the school provides extensive background information about the violent incident or their concern about the aggressive student, and pertinent school records such as attendance, GPA and disciplinary record. (This allows the clinician to understand the context of the behavior and to help understand how the student is functioning.)

A clinician can help ascertain if the aggression was reactive aggression, meaning that the student acted defensively to protect against a perceived threat or provocation. In contrast, proactive aggression occurs when a student acts as a predator and is motivated with the goal to obtain specific rewards or to establish social dominance (an example is a bigger student who physically intimidates a

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weaker student to steal money).

It is helpful to understand if the student feels his aggression is justified and part of a normative response or if the student feels remorse. A clinician can also explore if the patient is using drugs or alcohol that may serve to disinhibit the student and lower the threshold for an aggressive response.

A careful exploration of the student's access to weapons is critical. Discussion with the school about how the student returns to school after a suspension is useful as this is frequently when another recurrence is likely. If the student is prone to misread situations and react aggressively, the clinician may advocate for a smaller school setting that is less overwhelming.

The clinician can also assess whether there is a psychiatric disorder such as increased irritability secondary to major depression, reactive aggression secondary to past trauma or an impulsive response secondary to ADD. Assessing the vulnerabilities of the patient can provide critical direction to the school. For example, if a student with a learning disorder has trouble communicating his needs and there is an increase in aggression, the student may need help with nonverbal signaling of distress and flexible modifications in the curriculum. Providing information about the patient's limited capacity to use words to mediate conflict can be useful.

Of course, there are situations where a student is intent on undermining the school authority, delights in asserting dominance in an intimidating way and has no investment in school. Such a student needs firm limits and a clear message that this behavior is not tolerated even if it is understood that their aggression is a way of distracting anyone from noticing their despair.

Capitalizing on aggressive students desire to be seen and their sometimes self-righteous

indignation can be challenging for schools. Mental health professionals may provide a balanced voice of reason as they are not worn down by the daily stresses of managing the behavior. They can encourage schools to mobilize resources, provide opportunities to succeed and encourage a cohesive strategy.

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