Q&A With the Expert

Combining Medications and Behavioral Techniques in Schools

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Dr. Rappaport is the co-author of "*The Behavior Code*," published by Harvard Education Press. Dr. Carlat has reviewed this interview and found no evidence of bias in this educational activity.

CCPR: Dr. Rappaport, in our companion interview in this issue we discussed with behavior analyst Jessica Minahan, MEd, various behavioral techniques for dealing with challenging behavior in classrooms. As a child psychiatrist, can you help us understand how we can apply some of this knowledge in the context of a busy practice? After all, a psychiatrist may not have the time to engage in the kind of time-consuming behavioral analysis that some of these techniques call for.

Dr. Rappaport: Sure, there are several things that a child psychiatrist can do. The first thing is to shift your orientation from viewing the behavior as an individual problem to seeing that there's a context in the school environment that might be causing or aggravating problems. A very common example is when the school nurse calls and says that a child who is taking ADHD medication is having meltdowns in the afternoon. A reasonable intervention would be to switch to a longer-acting medication or to have the child take a second dose later in the day. This might work, but often it doesn't, and then you need to be curious about the context. It's known that some children do poorly during unstructured time that occurs later in the day, especially lunchtime in the cafeteria. It can be anxiety provoking and can be the root cause of the afternoon meltdown. If that's the case, you can discuss with the school staff or the parents the possibility of trying an alternative lunch arrangement, such as having a small comic book group in a separate, smaller room. That can turn a situation that terrifies a student into one they look forward to.

CCPR: That's interesting. Any other common examples?

Dr. Rappaport: Take the case of a child who has anxiety issues, maybe a history of trauma. You've started her on Tenex (guanfacine), but she's been getting aggressive and has been restrained twice. Upping the Tenex dose hasn't helped, and you're considering other medication options. The school is saying that these episodes are entirely unpredictable. But I know from experience that if the episode is caused by the child's underlying anxiety that will not be obvious to the school because it's hidden. In that case, the key might be to help the teachers see that relating to the student differently might help her to self-regulate. I've found that schools underestimate the power of relationship in self-regulation. For example, Robert Pianta has written a book called *Enhancing Relationships Between Teachers and Students* (Washington, DC: American Psychological Association; 1999), and the bottom line is if you have a child with attachment issues, which 80% of abused children have, it is a good idea for teachers to do what he coined "banking," which is providing one-on-one time for 10 minutes a day, and that may turn around a child's behavior. Here's another situation—this one's not very common, but it's serious when it happens: the student who has sexualized behavior in the school. He's masturbating and he's about to get expelled. In addition, the school has filed a report with the state's child protection agency for suspected sexual abuse in the home.

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CCPR: That is a serious situation. How do you diagnose that? Are there even any potential medication options?

Dr. Rappaport: Usually not. Very occasionally this could be a symptom of bipolar disorder in a child. For example, I once evaluated a kindergartener who was stripping down in the classroom and getting on the table and yelling obscenities. She had a family history of bipolar disorder and this was her first clear manic episode and we started a mood stabilizer. But generally there's not going to be an easy fix. First, you have to explain to educators that not all children with sexualized behavior have been sexually abused, meaning that a report to the state child protection agency for suspected sexual abuse is not always appropriate. Then, you work with the teachers and parents to get a sense of what's behind the behavior. It might be a social skill deficit, and the student might not understand that this is not okay, or thinks this is a good way to get attention. He might have impulsiveness and problems with self-regulation. If this is an impulsive child, you might recommend a replacement behavior, such as a rabbit foot on a key chain to stroke as a replacement for masturbation.

CCPR: What else can child psychiatrists do to improve how the schools are handling our patients?

Dr. Rappaport: I encourage all child psychiatrists to ask parents to bring in the child's individualized education plan (IEP), as well as the teacher's classroom behavioral plan. They can look at it and give the parents some advice about it. Often schools have overlooked the skills that need to be taught. And a lot of these behavioral plans are triggering and end up escalating students.

CCPR: Can you give me an example?

Dr. Rappaport: An example would be that you have a child who has a behavioral plan that says, "If Bobby will stay calm, he gets three stars." So Bobby gets three stars 80% of the time, but when Tommy pushes Bobby he goes ballistic and he starts to rip up

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Below are the questions for this month's CME post test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning objectives are listed on page 1.

1. According to a study that found bullying is common, what percentage of children experience it at some point during their school years (Learning Objective #1)?
   [ ] a) 25 % [ ] b) 35% [ ] c) 50% [ ] d) 65%

2. You may be able to help children facing a bullying situation, by providing what kind of training (LO #1)?
   [ ] a) Training in karate [ ] b) Training in social skills
   [ ] c) Training in flexible thinking skills [ ] d) Training in organizational skills

3. What are 'response strategies' (LO #2)?
   [ ] a) A way to deal with reactive aggression [ ] b) Medications kept on hand to calm children in emergencies
   [ ] c) Plans put in place by social workers [ ] d) Back-up plans for teachers in case strategies to prevent problem behaviors fail

4. Which of the following is considered a major "hotspot" in the school day that tends to be anxiety provoking for many children (LO #2)?
   [ ] a) Being dropped off by parents in the morning
   [ ] b) Reading group
   [ ] c) Unstructured time, such as being in the cafeteria or going outside for recess
   [ ] d) Anticipating the end of the school day

5. All children with sexualized behaviors have likely been sexually abused and educators should file a report with the state child protection agency for suspected abuse (LO #3)?
   [ ] a) True [ ] b) False

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Expert Interview: Dr. Rappaport

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papers. Then the teacher says, "Well you are not going to get your stars," and he escalates more, and that is your behavior plan. So it works 80% of the time and it fails 20% of the time. So now, you as a clinician see the child because he has been suspended for three days for destroying the classroom and there is a question about whether he needs more medication. That is unfortunate if you haven't had an opportunity to weigh in on the behavior plan. It might have been more effective to have some role playing about what Bobby is going to do when he gets in a fight with Tommy. This kind of social skills training can occur when the child has not escalated, and might have prevented the flare up in the first place. Go through those plans with the parents and look for two things. First, ensure that the plans are providing explicit instructions to teach the kids some of the skills that they are missing so they are not warehoused in self-contained classrooms without an exit plan. Are they being taught the skills and self-regulation? Are they being taught how to recognize thinking traps, to improve social skills, to improve executive functioning? Second, is there anything in the plan that talks about helping the child to self-monitor? If those components are missing, talk to the teacher or go to an IEP meeting and register your concerns.

CCPR: My sense is that given the demands on the time of child psychiatrists it can be difficult for them to attend those meetings and to have much communication with the schools.

Dr. Rappaport: It's unfortunate. We have too few child psychiatrists who are able or willing to commit their time to helping school staff. We have 8,000 child psychiatrists, 80,000 public schools, and probably at maximum only 100 working full-time in schools, and another small percentage who are consulting to schools. The result is that schools are sometimes resorting to the emergency room simply to get access to a psychiatrist. The danger is if you have a student who has learned that if they say provocative comments or make threats, they then end up going in an ambulance and get to escape activities for the rest of the day, then you have actually reinforced the behavior that you don't want to reinforce.

CCPR: Thank you, Dr. Rappaport.