

The committee of subject matter experts appointed by the Texas Commission on Law Enforcement in conjunction with the Texas School Safety Center at Texas State University has completed its development of the School-Based Law Enforcement Training per [HB 2684](#). This training is now available for a 30-day public comment period. Please refer to the Texas Commission on Law Enforcements website at www.tcole.texas.gov for access to this curriculum draft and the link to submit public comment. The link to public comment will be open from November 23, 2015-December 22, 2015.

The School-Based Law Enforcement Train-the-Trainer Course will begin in January 2016 and will be conducted at various locations throughout the State of Texas. Please refer to the following website: <https://txssc.txstate.edu/events/sble-summits-ttt/> for information on your eligibility to attend one of these trainings.

School-Based Law Enforcement Training



Texas Commission on Law Enforcement
December 2015

School-Based Law Enforcement Training

ABSTRACT

This guide is designed to assist the instructor in developing an appropriate lesson plan or plans to teach the course learning objectives. The learning objectives are the minimum required content of the School-Based Law Enforcement Training. This course is a required course for all school district peace officers and school resource officers who are commissioned by or who provides law enforcement at a school district with an enrollment of 30,000 or more students.

Note: A school district peace officer or school resource officer is not required to complete this training program if the officer has successfully completed one of the following options:

- *Advanced Training Course from the National Association of School Resource Officers (NASRO)*
- *Course # 3952 or 3953 Texas School-Based Law Enforcement Conference (SBLE) **PLUS** a TCOLE Crisis Intervention Training (CIT)*

Note to Trainers: it is the responsibility of the coordinator to ensure this curriculum and its materials are kept up to date. Refer to curriculum and legal resources for changes in subject matter or laws relating to this topic as well as the Texas Commission on Law Enforcement website at www.tcole.texas.gov for edits due to course review.

Target Population: Peace Officers and School Resource Officers who are commissioned by or who provide law enforcement at a school district with an enrollment of 30,000 or more students.

Student Prerequisites:

- Employed by a Law Enforcement agency or assigned as a School-Based Law Enforcement Officer or a School Resource Officer (before or within 120 days of the officer's commission by or placement in the district or a campus of the district)

Instructor Prerequisites:

- Successful completion of School Based Law Enforcement Train the Trainer Course and a School Based Law Enforcement Proficiency Certificate, or a
- Subject Matter Expert with School Based Law Enforcement experience

Length of Course: 20 hours

Method of Instruction:

- Lecture
- Group Discussion
- Scenarios and Role-Play

Assessment: Instructors are responsible for assessing and documenting student mastery of all objectives in this course.

In addition, the Commission highly recommends a variety of testing/assessment opportunities throughout the course which could include: oral and written testing, interaction with instructor and students, case study and scenario, and other means of testing students' application of skills, as the instructor or department deems appropriate.

Reference materials:

- **House Bill 2684**
- **Occupations Code 1701**
- **Education Code 37**

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Section One:

Child and Adolescent Development and Psychology

(4 Hours)

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Instructor Guide

1.0 Section One: Child and Adolescent Development and Psychology

1.1 Unit Goal: Discussion of Child and Adolescent Psychology and its significance to the School-Based Law Enforcement and School Resource Officer

1.1.1 Participants will be able to recognize the components that contribute to building emotional intelligence.

Elaboration: The desired outcome of this training block will cover emotional development and explain temperament and attachment in adolescence. Following completion of this training, it is our hope that participants will adopt a sense of empathy and recognition towards the many factors that contribute to the overall development of an adolescent. Once an understanding of how influential emotions, temperaments, and developed attachment styles can be, the participant will be able to appropriately respond to an individual's behavior.

Emotional Development

- The process of a child's ability to regulate and control emotions and to establish social competence.
- Contributing factors: emotional intelligence, rate of brain development, and group differences.

Elaboration: Emotional development is the process of a child's ability to regulate and control emotions and to establish social competence that will continue to develop through adolescence and carry on into adulthood. Contributing factors that help shape an individual's emotional development are emotional intelligence, the rate of brain development, and group differences.

Emotional Intelligence

- Emotional Intelligence (EQ) - a person's ability to manage his/her emotions through self-awareness and interpersonal skills.

Elaboration: A person's emotional intelligence, or EQ, describes his or her ability to manage emotions through self-awareness, such as identifying one's emotions and interpersonal skills, such as applying empathy to others, resolving conflict, and developing a cooperative spirit.

Because of the many factors that influence development, social problems among children are becoming increasingly common. About 12 percent of elementary students alone face social problems such as peer rejection. To put this number in perspective, 12 percent accounts for 4 million students who face social struggles daily. Such issues are considered threats to an adolescent's emotional intelligence and puts a student at potential risk for: failing, dropping out, and developing conduct and mental health problems.

Recognizing and Managing Emotions

- Ability to interpret non-verbal and social cues
- Influences social competence
- Challenging for adolescents with learning disabilities
- Self-regulating behavior

Elaboration: Emotional intelligence applies to recognizing both personal emotions and the emotions of others.

Children begin inferring others' emotions from infancy through facial expression, tone of voice, and posture. This ability to interpret non-verbal and social cues contributes to an overall social competence, which refers to an individual's skill set in managing interpersonal relationships. In addition, self-regulation is the ability to control behavior in response to a situation and enables an individual to "sustain attention, control impulses, and delay gratification." As a result of self-regulating, students may prove to become socially and academically successful. In contrast, individuals with learning disabilities are challenged by recognizing emotions and in turn may be impaired towards peer relationships and social success.

Developing Empathy

- Response to outside emotions
- Encourages teens to care for others
- How to build empathy in an adolescent:
- Tolerance and compassion
- Social participation
- Build emotional vocabulary
- Counsel

Elaboration: Empathy is the ability to interpret and appropriately respond to another's emotions and concerns and is acquired through building on traits such as tolerance, compassion, and discerning between right and wrong.

Ways to encourage students to build empathy are: demonstrating appropriate behaviors through thoughts, words, and actions; participating in service-oriented organizations that focus on issues "larger than yourself"; help build a student's emotional vocabulary so that they may feel comfort and confidence in conveying thoughts and feelings; teach social awareness so that young people may understand consequences of prejudice; talk with and counsel a student so that he/she may feel compassion for others experiencing suffering.

Ultimately, developing empathy will create a stronger social competence through interpreting social issues and establishing social goals and solutions.

Learning to Resolve Conflict Constructively

- Encouraging emotional communication
- Establish confidence in emotional understanding
- Outcomes of emotional communication consist of productive problem solving in the future

Elaboration: Children begin learning to talk about their emotions at 18 to 24 months old. Family conversation that encourages emotional communication contributes to an individual's confidence and understanding of his/her emotional responses and consideration towards the feelings of others. Upon studying 3-year-olds, it was discovered that the toddlers that announced their emotions and experiences with family were better at identifying with the emotions of their peers and resolving conflict once in grade school.

Other studies support the theory that children who learn early on to communicate emotionally demonstrate an understanding of conflicting emotions with the ability to analyze mixed feelings. Achieving such abilities contributes toward social competence and the sustaining of positive relationships

Developing a Cooperative Spirit

- Emotional display rules
- Especially influenced in grade school years
- Enables control of emotions and increases social competence
- Ultimate goal is maintaining social harmony

Elaboration: Learning emotional display rules complements the ability to regulate emotions and allows individuals to determine what emotions are socially acceptable to express. Being able to pick up on emotional display rules early on allows an adolescent to control his or her emotions, such as disappointment by receiving an unwanted gift.

Developing emotional regulation begins at home and accelerates once a child enters grade school where teachers and peers influence what emotions and behaviors an individual perceives as acceptable. Research suggests that adolescents' ability to control emotion contributes to a strong self-perception and enables an individual to manage emotions, especially expressions, in social settings. Furthermore, individuals who have demonstrated adequate control of emotions end up becoming "pro-social", is not easily pressured and develops empathy.

Ultimately, developing a cooperative spirit by managing emotions contributes to maintaining "social harmony".

Signs of a Child with Low EQ versus High EQ

- **Low EQ:**
 - Peer rejection
 - Lack of self-control
 - Aggression
 - Social withdrawal

- **High EQ:**
 - Sociable
 - Positive relationships
 - Little anger or sadness
 - Spoken of favorably by teachers

Elaboration: Such emotional competencies and strong emotional developments formulate an individual's emotional intelligence. Often times, a child's EQ level is identifiable through behavior and response to outside influences. For example, students who show positive attitudes are spoken of more favorably by teachers and form positive peer relationships easily, as compared to students who demonstrate frequent moody emotions such as anger and sadness. Students who find it challenging to regulate their emotions often face peer rejection and demonstrate lack of self-control, aggression, anxiety, depression, and social withdrawal.

Rate of Brain Development

- Process of emotions compared to adults
- Heightened sensitivity
- Full brain development is not achieved until mid-twenties

Elaboration: Until reaching full cognitive development, adolescents process emotions through a different part of the brain than adults, which can produce emotional misinterpretations. For example, teens are likely to misinterpret non-verbal cues such as body language and facial expression. To avoid further miscommunications, adults can help teens by explaining a breakdown of what they really mean rather than assuming a teen understands based on short communication and body language.

Instructor Note:

The following video will provide insight on how an adolescent's brain develops and the common emotions, behaviors, and responses children and teens share.

Short Video Illustrations – Discuss Videos

<https://www.youtube.com/watch?v=f9Ya0mHslgM>

<https://www.youtube.com/watch?v=LWUkW4s3XxY>

1.1.2 Participants will discuss the implementation of a supportive environment for individuals struggling with developing identity.

Group Differences

- Minorities that influence emotional development

- Sexual Orientation
- Gender
- Ethnicity

Elaboration: American culture is becoming more and more diverse, which creates changing social norms for youth. Adolescents that have acquired unique preferences that go against the “norm” of their peers and social influences face challenges in emotional development.

Sexual Orientation

- Lesbian, gay, and bisexual preferences
- Developing awareness and providing a supportive environment
- Risks
 - Health concerns
 - Discrimination
 - Social acceptance/rejection

Elaboration: Adolescence is a time for individuals to develop their sexual identity and can pose as a particularly challenging time for those that identify as lesbian, gay, and bisexual, especially in a youth culture that has not fully accepted sexual differences. Adolescents identifying as such may feel fear at the time of their initial awareness so providing a safe and accepting environment is crucial to assist these individuals in working through the process. Professionals should be aware that discovering sexual orientation can be confusing for teens and could simply be a result of experimentation. In addition, those identifying as lesbian, gay, or bisexual are at possible risk for verbal and physical violence. Outside support for these individuals is crucial in order to provide a safe haven for anyone feeling emotionally pressured and unstable due to “intolerable stress”.

Professionals can offer support to adolescents who may be in the process of establishing their sexual identity by:

- Providing accurate information about sexual orientation to dispel stereotypes about gay, lesbian, or bisexual sexuality.
- Avoid communicating disapproval
- Help the individual identify any discrimination and reject its messages
- Avoid pressuring the adolescent to make a decision about his or her sexual orientation
- Provide appropriate information about sexual behaviors (both same-sex and opposite sex) and health risks
- Be aware of the heightened risk of suicide for some individuals and offer referrals for counseling help for distressed youth
- Acknowledge and address any biases they may have about gay, lesbian, or bisexual youth

(American Psychological Association)

Gender

- Socialization differences in boys and girls
- Traits to be encouraged
 - Boys: a cooperative spirit, acknowledgment of emotions
 - Girls: assertiveness, confidence

Elaboration: Often times through adolescence, gender stereotypes are pressed upon boys and girls such as encouraging girls to wear pink, play with dolls, and avoid getting dirty or for boys to wear blue, play sports, and avoid showing weakness. As an adolescent begins to develop self-identity, gender cues can cause confusion and may need outside advisement in aiding identity formation. Typically it tends to be easier for boys to express confidence and a secure self-esteem than girls. Because of this, girls often need direction in developing assertiveness and boys commonly need to be taught a cooperative spirit rather than a constantly competitive one, as well as learning to accept and express emotions.

Ethnicity

How an adolescent identifies with his/her ethnicity

Ethnic identity consists of:

- Shared values
- Traditions, practices, rituals
- Clothing
- History

Elaboration: How an adolescent identifies and feels confident towards his or her ethnicity, especially if considered a minority, will affect emotional development. Traditions vary greatly amongst a diverse culture of adolescents, especially in American public schools. Developing a strong identity with one's family and ethnic traditions will encourage a stronger self as well as ethnic identity. An individual's ethnic identity can consist of shared values, traditions, practices and rituals, specific clothing, history, holidays, and music. It is important that professionals encourage youth to identify with their ethnicity and help build confidence and skills when dealing with possible discrimination. Professionals can encourage ethnic identity furthermore by bringing awareness to majority groups in regards to racism, discrimination and the negative consequences it inflicts.

1.1.3 Participants will be able to define temperament and recognize temperamental traits.

Temperament

Defined as "a person's characteristic modes of responding emotionally and behaviorally to

environmental events, including such attributes as activity level, irritability, fearfulness, and sociability.”

Elaboration: Temperament can often be described as a type of coping mechanism and focuses on the patterns of how a person self-regulates and responds to changes from internal and external environments.

Classifications of Various Temperaments

Common traits and types used to determine a child’s temperament.

- Common traits considered:
 - Activity
 - Rhythmicity
 - Approach/withdrawal
 - Adaptability
 - Intensity
 - Mood
 - Persistence and attention span
 - Distractibility
 - Sensory threshold

Elaboration: Research has formulated common traits and types of temperaments in determining a child’s temperament. These types and traits correlate with one another in response to the reactivity of basic emotions and regulation.

Activity refers to a child’s style of activity level; is the child constantly active and moving or is he/she more relaxed?

Rhythmicity evaluates a child’s regularities in daily tasks such as eating and sleeping.

Approach and withdrawal regards an individual’s behavior when meeting, or never meeting, a stranger – does the child avoid meeting new people or shy away from new people or things?

Adaptability questions the child’s adjustment ability when introduced to new plans or changes in routines.

Intensity refers to an adolescent’s reaction towards situations; does he or she react positively or negatively, excitedly or quietly?

The mood of an adolescent determines whether he or she express optimistic or pessimistic views and the consistency, or lack thereof, one’s mood.

Persistence and attention span refers to the length of time an individual’s attention can be held or does the mind tend to get distracted? Does the individual push through issues or quit?

Distractibility expands more on attention span in determining to what extent a child is becomes distracted, or shuts out distractions.

Sensory threshold refers to how bothersome outside stimuli tend to be for an individual such as, loud noises, bright lights, and food textures.

Classifications of Various Temperaments

- Temperament types:
 - Easy or flexible
 - Difficult, active, or feisty
 - Slow to warm up or cautious

Elaboration: Once an individual's traits are analyzed, a temperament type is determined.

- Easy or flexible children tend to be calm, happy, and regular in sleeping and eating patterns, adaptable, and overall, not easily upset. This temperament style requires that parents and adults initiate communication when noticing potential frustrations or hurts in the child, otherwise the child will not open up about his or her feelings.
- Difficult, active or feisty children demonstrate signs of irritability, irregularities in sleeping and eating habits, are skeptical of new people and situations, and are generally intense in their reactions to outside influences. Encouraging additional activity to exert stored up energy, offering the opportunity to choose, and preparing the child for times of transition allows the individual to be successful.
- Initially, slow-to-warm-up or cautious children appear to be inactive and meticulous and often withdraw or react negatively to new situations but over time, adopt a positive outlook to repeated exposure to what was once a new situation. Offering patience and consistency with routines will allow a child to develop independence.

The “Stability” of Temperamental Attributes

- Components of temperament that become stable throughout development (activity level, irritability, etc.)
- Behavioral Inhibition – “a temperamental attribute reflecting one's tendency to withdraw from unfamiliar people or situations.”

Elaboration: The stability of temperamental attributes refers to the temperamental traits that carry on into adulthood. Temperamental traits as mentioned before such as an individual's intensity level, mood, and attention span are examples of traits that can develop into becoming stable. A study done in New Zealand evaluating the stability of temperaments confirmed that certain attributes lasted into adulthood and predicted future behaviors regarding relationships and sociability.

A particular temperamental attribute named behavioral inhibition refers to an individual's “tendency to withdraw from unfamiliar people or situations.” Behavioral inhibition has proven to remain consistently stable because of its biological roots.

The acknowledgment of stable temperaments is important to understanding an individual's response to certain situations and environmental factors.

Direct Influences

- Studies involving fraternal and identical twins
- Genetics
- Home environment
- Culture

Elaboration: Many studies done in the comparing of fraternal and identical twins has provided a foundation to demonstrate what extent certain factors determine and influence one's temperament. Study results show that common factors that influence temperament are genetics, one's home environment, and cultural upbringing and setting.

Genetics

- Temperaments displayed within first year of life
- "Degree of resemblance" between siblings
- Comparison of identical twins, fraternal twins, and non-twin siblings

Elaboration: The idea that temperament is determined by genetics has been successfully demonstrated in the comparative research of identical twins, fraternal twins, and non-twin siblings. By six months of age identical twins begin to reveal similarities in behavior and temperaments, so much that when the "degree of resemblance" was measured, identical twins displayed almost double the resemblance what fraternal twins displayed and three times that of non-twin siblings.

Home Environment

- Similarities in sibling temperament
- Positive attributes from shared environments
- Negative attributes from non-shared environments

Elaboration: Siblings often reflect positive attributes from shared environments, typically at home. Such positive attributes consist of smiling and sociability. Non-shared environments such as extracurricular activities and school settings have more influence towards negative temperamental attributes such as how one's activity level or approach/withdrawal traits develop away from familiar, shared environments.

Culture

- Interpreting temperaments vary amongst cultures
- Temperaments that are considered weak and risky for development (i.e. shyness)
- Cultural desirability and acceptance of certain temperaments

Elaboration: Culture has a way of determining the effect of particular temperaments and the desirability of such temperaments fluctuates amongst cultures. For example, a shy

temperament in the United States is viewed as a social disadvantage and poses challenges for an adolescent's peer relationships and self-esteem. In contrast, Asian cultures regard shyness as a social advantage.

1.1.4 Participants will be able to recognize an adolescent that has developed a secure attachment or insecure attachment.

Attachment

- Defined as a close, reciprocal, emotional relationship between two people.
- Development of secure versus insecure attachment styles
- Carries on into and affects adulthood
- Influencing factors
- Parental presence
- Family environment

Elaboration: Attachment can be defined as, “a close, reciprocal, emotional relationship between two persons, characterized by mutual affection and a desire to maintain proximity.” Attachment differs from bonding in that attachment occurs between an older infant, who is capable of forming an emotional relationship, and another person; bonding is a one-way relationship that the parent feels toward the child.

From infancy, children learn self-regulating behaviors through attachment, which indicates the importance of building a secure attachment between a parent or caregiver and a child. While research has proven that humans are “biologically prepared” to form attachment, secure *emotional* attachments require a reciprocal relationship. For children growing up with unhealthy or absent parental relations, insecure attachments can be formed and a sense of security hindered thus challenging development.

Secure vs. Insecure Attachment

- Signs of a secure attachment
- Signs of an insecure attachment
- Different outcomes based on cultural values (i.e. Western versus Asian cultures)

Elaboration: A secure attachment represents a developed bond between a child and caregiver “in which the child establishes a trusting relationship to the caregiver and uses this person as a “secure base” or reference from which to learn from.

Insecure attachments can be described as resistant, avoidant, and disorganized or disoriented. An adolescent that has developed a secure attachment will later in life demonstrate behavior such as insecurities when introduced to new situations, social resistance, and lack of emotional control.

In Western societies, the formation of secure attachment enables a child to develop independence and become goal oriented. However, attachment styles vary amongst cultures;

once again we look at how Asian cultural values contrast with American culture. For example, the ultimate goal Asian families hope to instill in their children is to form group-oriented goals that collectively contribute to the betterment of society, whereas American cultures encourage independence and self-sustainability. Similar attachment styles may be utilized in both cultures but because of their values, will produce a different outcome.

1.1.5 Participants will be able to recognize external factors that influence an adolescent's attachment security.

Factors Influencing Attachment

- “Emotional climate” of home
- Quality of caregiving
- 6 Characteristics of caregiving that leads to secure attachment
 - Sensitivity, positive attitude, synchrony, mutuality, support, stimulation
- Health conditions and temperaments

Elaboration: The emotional climate of a home refers to the relationship between parents and a parent's individual emotionality; for example, a parent that is depressed tends to demonstrate a lack of responsiveness causing anger and discomfort in a child.

Also, a parent who has experienced abuse as a child may respond oversensitively and feel rejection by a child's emotional distress.

Unplanned pregnancies can affect the attachment bond formed between a parent and child. Studies have shown that if a parent lacks sensitivity and desirability to contribute to the development of a child, as a result, the child could experience a challenging development in personal health, academics and social success.

Insensitive parenting can also come as a result of parents facing financial and health-related issues.

Ultimately the quality of caregiving has a dominating influence towards the development of healthy attachment styles. Through the meta-analysis of sensitivity and attachment, common qualities of caregiving that can lead to a secure attachment consist of:

- Sensitivity by responding promptly and appropriately to the infant's signals;
- A positive attitude by expressing positive affect and affection for an infant;
- Synchrony of structuring smooth, reciprocal interactions with infant;
- Mutuality through structuring interactions in which the parent and infant attend to same thing;
- Support by attending closely to and providing emotional support for the infants activities;
- And finally, the stimulation of frequently directing actions toward the infant;

(Based on “Sensitivity and Attachment: a Meta-Analysis on Parental Antecedents of Infant

Attachment”)

Finally, parental presence has strong effects on attachment development. Different attachment styles develop correlating with each parent; typically, a father is seen as a playmate and a mother as caregiver. It is not unusual for one parent to develop a stronger attachment than the other with a child.

Studies have shown that present fathers who cultivate a healthy relationship with the child contribute greatly to his or her emotional security. Studies have proven that children share a secure attachment with the father develop better self-regulation, social competence and less behavioral issues later in life.

While it is beneficial for a child to form a secure attachment with at least one parent, it is always beneficial and contributes more to development when a secure attachment is formed with both parents.

Correlation between Temperament and Attachment Security

- Temperamental profiles that correspond to attachment profiles
- Temperament hypothesis
- Lack of temperamental effects on attachment styles

Elaboration: Certain temperamental profiles such as “easy, difficult, and slow-to-warm up” correlates to particular attachment classifications such as secure, resistant, and avoidant. From these correlations, the “temperament hypothesis” was proposed, supporting the notion that an infant’s temperament profile controls the outcome of his or her attachment security. While there are few temperament traits such as irritability and negative emotionality that do directly influence attachment outcomes, there has been no further proof that temperament predicts attachment. Additional studies have provided support against the temperament hypothesis stating that the temperament of children with developmental and psychological disorders proved to have no influence on attachment securities.

The Effect of Attachment Security

- Attachment securities developed through adolescence carries on into adulthood
- Attachment styles are expressed through adult relationships
- Intervention and assistance programs

Elaboration: Although a majority of attachment is studied during infancy, later evaluations have proven that the establishment of secure attachments early on enabled children to possess better problem solving, creativity, positivity, and social than those who experienced insecure attachments. In contrast, children that were insecurely attached have been shown to become hostile and aggressive towards their peers once in grade school.

Secure attachments are the cornerstone for healthy psychological development through adolescence and into adulthood. The attachment style and type of security an individual develops throughout life will have influence in future adult relationships at work, through dating,

and into marriage.

Implications: In severe cases, intervention programs such as social worker visits and support have proven to be beneficial. In one case, a mother, overwhelmed by poverty, was regularly visited by a professional who offered support to help the mother manage stress and provide appropriate responsiveness to the child.

When encountering a child that demonstrates signs of insecure attachments, remember that outside influences from peers, teachers, counselors, and other leaders can contribute to redeveloping attachment securities.

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1.2 Unit Goal: Development of Self-Concept in Children and Adolescents

Instructor Note: Ask students:

How does the self-concept develop?

How do children and adolescents figure out who they are?

What are the significant differences between age groups in the concepts of self-recognition, self-behavior and self-esteem?

1.2.1 Participants will be able to explain how self-concept develops in children and adolescents in addition to defining those terms associated with self-concept.

Define the terms

- What is the “self”
- Define “self-concept”
- Define “self-esteem”
- Explain the differences and nuances of the above and how they are different

Elaboration:

- Self: The combination of physical and psychological attributes that is unique to each individual. We are not sure if infants are born with a sense of “self”.
- Self-concept: One’s perception of one’s unique attributes or traits
- Self-esteem: One’s evaluation of one’s worth as a person based on an assessment of the qualities that make up the self-concept
- Differences: Self-concept requires reflection on one’s own self and behavior while self-esteem is the general attitude toward yourself.

1.2.2 Participants will be able to identify the differences between age groups of self-recognition, self-behavior and self-esteem.

Elaboration:

- It is not clear exactly how the self is discovered during infancy. Research can be interpreted in different ways to support different hypotheses, but we may never know the truth about whether or not infants are born with a sense of self.
- Infants learn the limits of their own bodies during the first month or two and differentiate the “physical self” from the external objects that they can control.

- Age group differences (self-recognition, self-behavior and self-esteem)
- Self-recognition → the ability to recognize oneself in a mirror or a photograph

The Differences between Self-Esteem and Self-Concepts

What is self-esteem and how is it different from self-concept?

- Definitions
- Origins and Development

Elaboration:

Origins and development of self-esteem → the origin of self-esteem is modified in terms of experiences that we go through. We draw conclusions about ourselves through our comparisons to other people.

1.2.3 Participants will be able to describe factors such as peer interactions, parenting styles, culture and ethnicity, and how they affect self-esteem.

Social Factors in Developing Self Esteem

- Peer Interactions – their influences on self esteem
- Parenting Styles – their influence on self esteem
- Culture & Ethnicity – how it can effect development of self-esteem in children and adolescents

Elaboration:

Achievement Motivation and Academic Pursuits

- How these concepts develop and their impact(s) on self-esteem and self-concept of children and adolescents
- Achievement Motivation Stages
 - Mastering Challenges
 - Seeking Approval
 - Comparison Seeking

Elaboration:

Many 3 year olds are highly motivated to master challenges and can take pride in their accomplishments

Mastering Challenges: Efforts to master tasks, achieve excellence, perform better than others. Motive to explore, understand, and control one's environment.

Seeking Approval: Seeking approval from others. Seek recognition when mastering challenges and expect disapproval when failing.

Comparison Seeking: Comparing performance with others

1.2.4 Participants will be able to identify the different home influences that affect achievement.

Home Influences on Achievement

- Quality of Attachment
- The Home Environment
- Child Rearing and Achievement
- Peer Group
- Cultural Influences on Achievement

Elaboration:

- Parents should encourage achievement
- American vs other cultures

Quality of Attachment: Children whose attachments are secure on entering school tend to remain more self-assured and do better than their insecurely attached peers

The Home Environment: Stimulating home environments foster good grades among children from all ethnic groups and social classes.

Child Rearing and Achievement: Parents who stress independence and who reinforce self-reliant behavior contribute in a positive way to achieving motivation.

Peer Group: Children whose parents value education highly and work hard to promote their achievements tend to associate with peers who share those values.

Cultural Influences on Achievement: Different cultures view achievements motivation and personal failures differently

1.2.5 Participants will be able to explain learned helplessness.

Learned Helplessness

Elaboration:

Learned helplessness: All children fail on occasion as they attempt to master challenges. They don't all respond to failure the same way

Creating a Sustainable Identity in Childhood and Adolescents – Factors and Influences on Stable Identity Formation

- Identity Diffusion
- Identity Foreclosure
- Identity Moratorium

- Identity Achievement

Elaboration:

Helping the helpless achieve

Identity Diffusion: Have not yet thought about or resolved identity issues

Identity Foreclosure: Committed to identity but have made this commitment before deciding what suits them better

Identity Moratorium: Actively asking questions about life commitments and seeking answers

Identity Achievement: Resolved identity issues by making personal commitments to particular goals, beliefs, and values.

Influences on Identity Formation and its Effects on Adolescent Self-Concept, Self-Esteem and Achievement

- Cognitive Influences
- Parenting Influences
- Scholastic Influences
- Social-Cultural Influences

Elaboration:

Cognitive Influences: Adolescents who have achieved solid mastery of formal-operational thought and can reason logically are better to imagine and contemplate future identities

Parenting Influences: It is difficult to establish one's own identity without being able to identify with respected parental figures

Scholastic Influences: Attending College does seem to push people toward career goals and making stable career commitments

Social-Cultural Influences: Identity formation is influenced by the broader social and historical context in which it occurs.

Minority Youth and Identity Formation Influences

- Ethnic Identity Formation
- Assimilation and Self-Concept
- Prejudice, Discrimination and Identity Formation

Elaboration:

Forging a positive ethnic identity is an adaptive development for minority youths

Ethnic Identity Formation: Important part of how we see ourselves

Assimilation and Self-Concept:

Prejudice, Discrimination and Identity Formation: establishing some kind of ethnic identity is an

adaptive developmental outcome for members of a minority group

Instructor Note:

Short Video Illustrations – Discuss Videos

<https://www.youtube.com/watch?v=ikGVWEvUzNM>

Identity Short Film “Part 13” by Rhian Sheehan

This film shows the adversities involving identity that children and adolescents go through in a school setting. How a child determines who they are internally is crucial to the development of their self-esteem, self-concept, etc.

Self Concept:

<https://www.youtube.com/watch?v=PaA0mLVQd3k>

Discussion about Videos

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<http://psychologytomorrowmagazine.com/dave-stant-self-concept-approach-happiness/>

1.3 Unit Goal: Sex differences and gender role development in Children and Adolescents

1.3.1 Participants will be able to define sex differences and gender typing.

Defining Sex and Gender

For most people, the terms “gender” and “sex” are used interchangeably. We assume “gender” and “sex” is relating to a person to identify whether male or female and do not realize that there is a difference. The confusion will be cleared up on the following slides with definitions of each term. One term refers to the physical attributes of a person and the other term will refer to one’s internal sense of how one identifies.

Elaboration: The terms do not mean the same thing. We are all born with a sex but may identify as a different gender.

Sex

A person’s biological identity; his or her chromosomes, physical manifestations of identity, and hormonal influences (Shaffer & Kipp, 2014).

Elaboration: Anatomical sex refers to the physical structure of one’s reproductive organs that is naturally assigned at birth. Biological sex is determined by chromosomes (XX for females; XY for males); hormones (estrogen/progesterone for females, testosterone for males); and internal and external genitalia (vulva, clitoris, vagina for assigned females, penis and testicles for assigned males). Given the potential variation in all of these, biological sex must be seen as a range of outcomes or possibilities instead of only two options. (www.genderspectrum.org)

Gender

A person’s social and cultural identity as male or female (Shaffer & Kipp, 2014).

Elaboration: Gender identity is one’s innermost concept of self as male or female or both or neither. This term refers to how individuals see themselves, what they call themselves and how they want others to perceive them. One’s gender identity can be the same or different than the sex assigned at birth. A person is aware of this between the ages 18 months and 3 years. Most people develop a gender identity that matches their biological sex but for others their gender identity is different from their sex assigned at birth. Some of these individuals choose to socially, hormonally and/or surgically change their sex to more fully match their gender identity. (www.genderspectrum.org)

When a new baby is on the way or a new baby arrives one of the most asked questions will be, “Is it a boy or a girl?” Sex and gender are a part of all cultures and society. Typically, we are born as a specific sex with either male or female parts. As we experience childhood and adolescence, we will identify as a particular gender.

A popular example would be Caitlyn Jenner, previously known as Bruce Jenner. From birth Jenner’s sex was male but from an early age (keep in mind gender typing occurs in childhood) identified more female than male. Her gender is now female and had always been so

according to her. Many people in this situation indicate that they have always felt like they are stuck in the wrong body. Imagine yourself the way you are exactly now, your thoughts, your actions, your passions but with one specific difference you have the body of your opposite sex. This would make a huge impact on your life because although we may *feel* a certain way we will be *perceived* another.

Gender Typing

The process by which a child becomes aware of his or her gender and acquires motives, values, and behaviors considered appropriate for member of that sex (Shaffer & Kipp, 2014).

Elaboration: Gender expression in gender typing process refers to the ways in which a child or adolescent externally communicates their gender identity to others through mannerisms, clothing preference, voice, hair style and other forms of presentation. Gender expression also works in reverse as people assign gender to others based on their looks and characteristics. Sometimes, transgender people seek to match their physical expression with their gender identity, rather than their birth-assigned sex. Gender expression should not be viewed as an indication of sexual orientation.

Gender roles that children become aware of include activities, expectations and behaviors assigned to females and males by society. Our culture recognizes two basic gender roles: masculine (having the qualities attributed to males) and feminine (having the qualities attributed to females). People who step out of their socially assigned gender roles are sometimes referred to as transgender. Other cultures have three or more gender roles. (www.genderspectrum.org)

Some non-heterosexual children and adolescents will experience a hard time in school. According to the cdc.gov website:

“Most lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are happy and thrive during their adolescent years. Going to a school that creates a safe and supportive learning environment for all students and having caring and accepting parents are especially important. This helps all youth achieve good grades and maintain good mental and physical health. However, some LGBTQ youth are more likely than their heterosexual peers to experience difficulties in their lives and school environments, such as violence.”(www.cdc.gov)

1.3.2 Participants will be able to identify male and female categorization.

Male and Female Categorization: Standards of Gender Roles

Categorizing males and females into strict gender roles could lead to restricting a child or adolescent from their full potential or cause stress and affect their overall well-being. We might think that gender roles occur naturally, but in fact, we all play a huge part in society on how gender role standards develop and how female and male categorization can affect a child or adolescent's development.

Gender-Role Standard

A behavior, value, or motive that members of a society consider more typical or appropriate for members of one sex (Shaffer & Kipp, 2014).

Elaboration: A study was done observing both boys and girls changing their behavior in potentially harmful ways in order to adhere to gender norms. For example, girls who enjoyed sports often avoided physical activity at school because they thought it wouldn't be a feminine thing to do, they were concerned they might look unattractive while running, or get ridiculed by the male students. The girls also restricted their food intake because they believed desirable women must be thin.

"All of the girls were within very healthy weights, but they were all restricting their intake of food in some way. So what we're really talking about here is 14-year-old girls, whose bodies are changing and developing, depriving themselves at every meal," Pereira said. "In the extreme, that can lead to things like eating disorders. But even for the women who don't reach the extreme, it can be very unhealthy for them."(Pereira)

For men the study found the following: "... the male participants in the study all faced intense pressure to demonstrate the extent of their manliness, which led to what Pereira calls "everyday low-level violence": slapping and hitting each other, as well as inflicting pain on other boys' genitals. They were encouraged to physically fight each other if they were ever mocked or offended. They felt like they had to drink unhealthy amounts of alcohol because that's what a man would do. And they were under certain mental health strains, too; struggling with anxiety about proving themselves and suppressing their feelings, all while lacking a strong emotional support system."

The study concluded that, "this constant effort to manage one's everyday life in line with gender norms produces significant anxiety, insecurity, stress and low self-esteem for both boys and girls, and both for 'popular' young people and those who have lower status in school." (thinkprogress.org)

Expressive Role

A social prescription, usually directed towards females, that one should be cooperative and kind.

Elaboration: This role usually kept by women means that their role is to create a home atmosphere and take care of everyone in the household. From a young age you might find that women are introduced to expressive roles they are bought toy baby dolls to play with so they can learn to be a "good mommy". In schools you might find more females in the home economics class because they have been encouraged since a young age to behave in an expressive role.

Instrumental Role

A social prescription, usually directed towards males, that one should be dominant,

independent, assertive, competitive, and goal oriented. (Shaffer & Kipp, 2014).

Elaboration: This role is usually kept by a man, like the husband in a family. Their tasks may include leading the family and being a good provider. Males, beginning from a young age are enrolled to participate in competitive sports. Parents instill the idea of being a tough, strong leader in their behavior. They are expected and sometimes encouraged to be rougher and more aggressive than girls.

1.3.3 Participants will be able to describe facts vs. myths regarding gender role stereotypes.

Gender Role Stereotypes in Children and Adolescents

“Gender stereotypes are generalizations about the roles of each gender. Gender roles are generally neither positive nor negative; they are simply inaccurate generalizations of the male and female attributes. Since each person has individual desires, thoughts, and feelings, regardless of their gender, these stereotypes are incredibly simplistic and do not at all describe the attributes of every person of each gender.” (healthguidance.org)

Elaboration:

Feminine

Not aggressive

Dependent

Easily influenced

Submissive

Passive

Home-Oriented

Easily hurt emotionally

Indecisive

Talkative

Gentle

Sensitive to other’s feelings

Cries a lot

Masculine

Aggressive

Independent

Not easily influenced

Dominant

Active

Worldly

Not easily hurt emotionally

Decisive

Not at all talkative

Tough

Less sensitive to other’s feelings

Rarely cries

Emotional	Logical
Verbal	Analytical
Kind	Harsh
Tactful	Blunt
Nurturing	Not nurturing/Selfish

Facts vs. Myths

While most people realize that stereotypes are untrue; many still make assumptions based on gender. There are many stereotypes we may all be guilty of, such as assuming that all women want to marry and have children, or that all men love sports.

Elaboration:

The facts are simply what we can prove are the differences between men and women. Fact is that if you are born with male genitalia you are considered of the male sex and female if you are born with female parts. Myths are stereotypes and are not necessarily true such as the following statements about men and women:

- Women are supposed to make less money than men
- The best women are stay at home moms
- Women don't need to go to college
- Women don't play sports
- Women are not politicians
- Women are quieter than men and not meant to speak out
- Women are supposed to be submissive and do as they are told
- Women are supposed to cook and do housework
- Women are responsible for raising children
- Women do not have technical skills and are not good at "hands on" projects such as car repairs
- Women are meant to be the damsel in distress; never the hero
- Women are supposed to look pretty and be looked at
- Women love to sing and dance

OR

- All men enjoy working on cars
- Men are not nurses, they are doctors
- Men do "dirty jobs" such as construction and mechanics; they are not secretaries, teachers, or cosmetologists
- Men do not do housework and they are not responsible for taking care of children
- Men play video games
- Men play sports
- Men enjoy outdoor activities such as camping, fishing, and hiking

- Men are in charge; they are always at the top
- As husbands, men tell their wives what to do
- Men are lazy and/or messy
- Men are good at math
- It is always men who work in science, engineering, and other technical fields
- Men do not cook, sew, or do crafts

Psychological Differences between Males and Females

We know there are differences between boy and girl brains because brain-imaging technology shows the differences in living color. The differences between male and female brains are apparent in different studies but scientists have discovered exceptions to every “gender rule”. You may know boy who is very emotional and enjoys expressing their feelings. You may also know a female who is distant, aloof, and a sports fanatic. Male and female brains process the same neurochemicals but to different degrees and through gender-specific body-brain connections.

Elaboration: According to Psychology Today studies show:

“The female brain, in part thanks to far more natural blood flow throughout the brain at any given moment (more white matter processing), and because of a higher degree of blood flow in a concentration part of the brain called the cingulate gyrus, will often ruminate on and revisit emotional memories more than the male brain.”

Males, in general, are designed a bit differently. Males tend, after reflecting more briefly on an emotive memory, to analyze it somewhat, then move onto the next task. During this process, they may also choose to change course and do something active and unrelated to feelings rather than analyze their feelings at all. Thus, observers may mistakenly believe that boys avoid feelings in comparison to girls or move to problem-solving too quickly.”

<https://www.psychologytoday.com/blog/hope-relationships/201402/brain-differences-between-genders>

Some dominant neurochemicals are serotonin, testosterone, estrogen and oxytocin. The hormones affect our behavior, thus making men and women psychologically different.

Serotonin helps us sit still. Testosterone is our sex and aggression chemical. Estrogen is a female growth and reproductive chemical and oxytocin is a bonding-relationship chemical. Because of our differences in processing these chemicals males on average tend to be more impulsive and aggressive. Males process less oxytocin than females.

Verbal Abilities

Girls talk earlier than boys, have larger pre-school vocabularies, and use more complex sentence structures. Once in school, girls are generally one to one-and-a-half years ahead of boys in reading and writing. Boys are twice as likely to have a language or reading problem and three to four times more likely to stutter. Girls do better on tests of verbal memory, spelling and verbal fluency. On average, girls utter two to three times more words per day than boys and even speak faster---twice as many words per minute.

Elaboration: The list goes on and on with the differences persisting throughout life. Among elderly stroke victims, for example, women recover their speech much more quickly than men.

A growing body of research on these differences point us to a girl brain built with a language head start. During infancy the left hemisphere (the brain's language center for most people) develops before the right for little girls, whereas the order is reversed for boys. Even more convincing, females have at least 20 percent more neurons than males in the brain's Broca area (where we produce language), and they have as much as 18 percent more volume in the Wernicke's area (where we interpret language).

Visual Spatial Abilities

Boys' brains favor spatial skills that make it easier to mentally manipulate or otherwise draw inferences about pictorial information (Shaffer & Kipp 2014).

Elaboration: "Historically, boys and men have long excelled in spatial ability tests over girls and women. Some have proposed a hunter-gatherer theory, predicting that men excel in spatial abilities such as navigation, map reading and mental rotations because survival depended on the ability to hunt, hurl a spear through space at a moving target, and find one's way home. Women, on the other hand, required better spatial location memory in their work as gatherers (Silverman & Eals, 1992)."

Mathematical Abilities

At the start of adolescence, boys show a slight but consistent advantage over girls on tests of *arithmetic reasoning* (Halpern, 1997, 2004; Hyde, Fennema, & Lamon, 1990). Girls actually exceed boys in computational skills and even earn higher grades in math, partially because girls are more likely than boys to work harder at learning and improving mathematical skills than to prioritize performance goals, yet boys tend to have more confidence in their ability and have acquired more mathematical problem solving strategies that enable them to outperform girls on complex word problems, geometry, and the mathematical portion of the SAT (Byrnes & Takahira, 1993; Casey, 1996; Lips 2006).

Elaboration: An important factor is social forces. The messages that are received from society about their abilities can impact their mathematical, verbal, and visual/spatial skills. (Shaffer & Kipp 2014)

Aggression

Boys are more physically and verbally aggressive than girls, starting as early as age 2. Girls are more likely than boys of using snubbing or ignoring towards others when upset to undermine their relationships or social status (Crick, Casas & Mosher, 1997; Crick & Grotpeter, 1995). In the U.S., almost three quarter of a million girls under 18 are arrested, accounting for 26 percent of the total juvenile arrests. Very few adolescent girls (1-2 percent) commit very serious or multiple offenses. Boys are about 10 times more likely than girls to be involved in antisocial behavior and violent crime during adolescence (Barash, 2002; Snyder, 2003).

Elaboration: Adolescent boys commit the majority of violent crimes with a prevalence ratio in comparison to girls of from 3:1 to 12:1 depending upon the exact type of violent offense reported. The high male-to-female ratio diminishes from preadolescence to adolescence. Boys also have higher drug use than girls.

While boys commit more antisocial crimes than girls, the rate of girls charged with violent crimes has increased twice as fast as boys. In recent years, female offenders are entering the juvenile justice system at a younger age and at a higher rate.

Girls are more likely to be incarcerated for minor offenses. Status offenses (cases involving minors under the age of 17 who repeatedly refuse to obey parents, do not attend school or run away from home) account for about a quarter of all girl arrests, but for only 10 percent of boy arrests (run away, juvenile prostitution) (teachsafeschools.org)

Activity Level

Boys are generally more active than girls, and rough-and-tumble play is more common among boys (Shaffer & Kipp, 2014)

Elaboration: Generally, boys are more active and restless than girls, but it's a small difference. Girls tend to play more passive games while boys keep busy by running jumping, and throwing things. All children need some level of activity everyday but boys on average do have a higher level of activity that is consistent.

Fear and Risk Taking

As early as first year of life, girls appear to be more fearful or timid in uncertain situations than are boys. They are also more cautious and less assertive in these situations than are boys, taking fewer risks (Christopherson, 1989; Feingold, 1994; Shafer & Kipp, 2014)

Elaboration: The term "risk" should not always have a negative connotation, especially when it comes to girls. Girls' risky behavior elicits images of unsafe sex, drug use and criminality. But there are positive risks, like learning to ride a bike or taking on a difficult course to challenge your academic ability. Both examples have risks like getting hurt on the bike or failing the course because the material was difficult. Teaching risk in only a negative perspective is a huge disadvantage to the development of children and adolescents.

Emotional Expressivity/Sensitivity

As infants, boys and girls do not differ much in their displays of emotion (Brody, 1998). But from toddlerhood onward, boys are more likely than girls to display anger (Fabes et al., 1991; Kockanska, 2001). By 2 years old girls are already using more emotion related words than boys and are likely to have more social support for reflecting feelings which may explain why they feel freer to express them than do boys and men (Fischer et al., 2004; Fuchs & Thelen, 1998; Saarni, 1999; Chang et al., 2003; Shaffer & Kipp, 2014)

Elaboration: Studies have shown girls have higher rates of anxiety and sadness than the boys, but outwardly expressed more cheerfulness and joy. The differences were only apparent

when the children were in the presence of strangers. In front of parents, children expressed a wide range of emotions, making the gender differences virtually non-existent. It is inferred that children may feel more comfortable with parents and may feel free to express all of their emotions. In social settings, children may feel the need to conform and therefore may not freely express their true emotions which leads to internalizing behaviors.

Compliance

From early childhood, girls are more compliant than boys with the requests and demands of parents, teachers, and other authority figures (Calicchia & Santostefano, 2004; Smith et al., 2004; Schaffer & Kipp, 2014).

Elaboration: As previously mentioned, boys are more active, physical and play in larger spaces than girls. In contrast, girls are more compliant, prosocial and play closer to adults than boys. Children's gendered behavior becomes more similar to those they spend time with. Girls may play with other girls because they enjoy the same activities and vice versa with boys and their choice of friends.

Self-Esteem

Boys show a small edge over girls in global self-esteem (Kling et al., 1999). This sex difference becomes more noticeable in early adolescence and persists throughout adulthood (Robins et al., 2002).

Elaboration:

Current research shows that the differences in scores on tests of self-esteem between the genders is actually very small. In fact, in an analysis of several hundred studies of men and women, boys and girls, ages 7 – 60, the males came up with only slightly better scores.

Cultural Myths

Many gender role stereotypes are “cultural myths” that have no basis on fact (Maccoby & Jacklin, 1974)

Some unfounded beliefs about sexes are:

- Girls are more social than boys.
- Girls lack achievement motivation.

The facts are that both sexes are interested in socializing. Boys and girls may have different goals but their achievement motivation differences are non-existent.

Elaboration: Among the most widely accepted “myths” are the notions that females are more sociable, suggestible, and illogical, and less analytical and achievement-oriented than males. (Shaffer & Kipp, 2014)

When a certain group acts a certain way the observer confirms and strengthens their belief; yet when the group acts in a way not consistent with expectations, the action is likely to be

unnoticed (Maccoby and Jacklin).

1.3.4 Participants will be able to recognize possible biologic influences in gender role development.

Possible Biologic Influences in Gender Role Development

Biological factors such as genetics and hormones will affect and influence gender role developments. Some differences between boys and girls can be explained by the effect of genes on sex chromosomes, and by the levels of sex hormones and their effect on the brain during early development.

Elaboration: Socialization plays a role by altering biological influences. For example, girls exposed to higher levels of male hormones before birth have more interest in “boy” activities, but socialization may force them to behave in a way that is more typically feminine.

Genetic Influences

Genetic factors may contribute to some sex differences in personality, cognitive abilities, and social behavior (Shaffer & Kipp, 2014).

Elaboration: For example, several of the developmental disorders more commonly seen among boys may be X- linked recessive traits for which their mother is a carrier. Also timing of puberty, a biological variable- both boys and girls who mature late tend to outperform those who mature early on some visual/spatial tasks, allegedly because slow maturation promotes increasing specialization of the brain’s right hemisphere, which serves spatial functions (Shaffer, 259).

Hormonal Influences

Research suggests that early exposure to male hormones may have a “masculinizing effect” on a female fetus’s brain (Shaffer & Kipp, 2014).

Elaboration: Below are two genetic conditions that affect gender role development in children.

- Congenital adrenal hyperplasia (CAH) – a genetic anomaly that causes one’s adrenal glands to produce unusually high levels of androgen from the prenatal period onward; often has masculinizing effects on female fetuses (Shaffer & Kipp, 2014).
- Androgenized females – females who develop male external genitalia because of exposure to male sex hormones during the prenatal period (Shaffer & Kipp, 2014).

Cultural influences

Western societies have become more accepting of gender role stereotype violations. In other cultures that are focused on living up to social expectations, children are strongly encouraged to conform to traditional gender role prescriptions (Shaffer & Kipp, 2014)

Elaboration: The biological factors influencing gender-role development may influence the psychological factors, but so will the cultural influences. Your hormones, genes and how you are treated in society will sometimes shape the way of thinking. Outside influences have a strong effect on self-fulfilling prophecies. If you expect your daughter to be bad at math, it is likely she will be bad at math. If you have the attitude of “boys will be boys” and not address the situation it will continue or could worsen. Parents and teachers have a huge influence in children and adolescent development.

1.3.5 Participants will be able to describe the concepts of social labeling & cultural influences.

Possible Social Labeling & Cultural Influences

Social labeling influences and cultural influences impact child & adolescent development in a major way. By labeling a person or a group a certain way you are letting them know how you view them in society and perhaps influence how they see themselves.

Social labeling influences – can modify or even reverse biological predisposition. For example, in some androgenized girls were labeled boys at birth and raised as such until their abnormalities were detected. This study found that there were few adjustment problems for girls under age 3 but after age 3, gender reassignment was more difficult because these genetic females have been exposed to prolonged masculine gender typing and already labeled themselves as boys (Shaffer & Kipp, 2014)

Cultural influences –The fact that most societies encourage instrumental traits in males and expressive traits in females has led some theorists to conclude that traditional gender roles are part of the natural order of things- a product of bio evolutionary history (Archer, 1996; Buss, 1995) Yet, there are sizeable differences across cultures in what people expect of boys and girls (Whiting & Edwards, 1988) Gender-role behaviors are often specific to one’s culture (Shaffer & Kipp, 2014).

Elaboration: These facts lead into a nature vs. nurture debate. It seems not only does social labeling along with cultural influence affect gender role development, but so do the biological factors such as hormonal and genetic influences.

Instructor Note:

Short Video Illustration – Discuss Video

<https://youtu.be/AXj3DenRsOg>

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1.4 Unit Goal: Aggression, Altruism, and Moral Development in Children and Adolescents

Elaboration: By the end of this unit, you will be familiar the manner with which children express aggression and the harm it can do. You will better understand how the development of children influences their aggression as well as their sense of morality and altruism. This is a list of topics you will understand more deeply as a result of this lecture.

1.4.1 Participants will be able to identify the different types of aggression.

Definitions and Development of Aggression

Aggression

An action or behavior *intended* to harm another living being whose desire it is to avoid this treatment

Hostile Aggression

An act of aggression with the sole intent being to harm another person.

Instrumental Aggression

An act of aggression committed against another person with an additional goal in mind, such as stealing lunch money.

Elaboration: Notice in the definition of simple **aggression** that it is the *intent* to harm the other individual that categorizes the behavior as aggression. We've all seen instances where clowning around resulted in unintentional injury. However, this unintentional injury is not aggression. It is this *intent* to single someone out *to do them harm* that classifies the behavior as aggression.

There are two types of aggression. One is **hostile aggression**. This occurs when the only motivation is to cause harm to the other human being. The aggressor does not want anything from the individual. The sole motivation is to hurt or harm that person. This type of aggression is often spontaneous and without forethought.

The second type of aggression is **instrumental aggression**. The intent is still to do harm but to do so with a goal in mind. The victim generally has something the aggressor wants and the aggressor is going to get it through intimidation and causing harm. Instrumental aggression is often planned in advance and is more calculated than hostile aggression.

A single act can be **both** hostile and instrumental aggression. Think of siblings playing ball. One child gets angry with his brother and hits him. When the brother cries, the aggressor teases him and grabs his new basketball. Clearly this is hostile aggression. But, when the aggressor decided to capitalize on his brother being momentarily incapacitated by taking the ball, it became instrumental aggression as well.

1.4.2 Participants will be able to identify how children in different age groups express aggression.

The Development of Aggression

There are very normal developmental trends of aggression in children.

Elaboration: It's important to remember that there are developmental stages of aggression in children and these trends are very much a part of age-appropriate behavior. What may be surprising to you is the age at which aggression can first be detected. Let's begin with a look at these developmental milestones.

The Developmental Trends in Aggression - Age

One to Two Years of Age

Aggression can be seen as early as one year of age. However by age two, these babies often avoid aggression as they learn to negotiate with help from parents or caregivers.

Three to Five Years of Age

During the preschool years, conflicts may become less physical and more verbally aggressive.

Six to Nine Years of Age

Physically aggressive behavior tends to decrease during this time.

The Good News

Only 3 percent of children are very aggressive as young children and remain so throughout childhood.

Elaboration: Aggression between same-age children is very common between **ages one and two**. Childcare workers know that those sweet, loving one-year-olds can be very aggressive toward one another over desirable toys. This is the age when biting becomes a problem in nurseries and childcare centers. These babies learn quickly that biting is a very effective means to get control of that toy. Luckily, for all concerned, this stage passes as negotiating skills increase.

From **three to five years of age**, children enter pre-school and their increased verbal skills allow for more verbal aggression such as teasing and less physical aggression. Most disagreements are still about toys and the aggression becomes more instrumental in nature. These children are now able to plan how they will get that toy. They will also utilize tattling to enlist the help of a teacher to achieve their goal.

When we look at **six to nine year olds**, we can, for the most part, breathe a sigh of relief. There is a decrease in the overall levels of aggression during these years. During these years, children learn better ways to settle disagreements and disputes.

Some good news! A study that followed children from pre-school through fourth grade showed that a *very* small percentage – just 3 percent - were considered very aggressive

throughout those years. What this tells us is that 97 percent of the aggression we see in children is developmentally appropriate.

1.4.3 Participants will be able to distinguish between forms of aggression favored by boys and those favored by girls.

Developmental Trends in Aggression – Sex Differences

Data from across the globe indicate that males are more aggressive than females due in part to:

- Parental behavior and expectations
- Toys such as guns, tanks, and other weapons
- Testosterone
- Could we be missing some feminine aggression?

Elaboration: It's interesting that we find this clear-cut difference in aggression between the genders regardless of the country of residence, or whether they live in the country or the city. Boys and men are simply more aggressive. It's universal.

Parental Behavior and expectations certainly contribute. Parents, especially fathers, play rougher with their sons. Additionally, there is an expectation for girls to behave "like ladies." However, we do not see one-year-old boys behaving more aggressively than their girl counterparts. In fact, girls seem to be more aggressive until around age three. This is about the time that children begin playing with gender-specific toys and are rewarded by parents for being a "tough big boy" or a "pretty princess."

Toys such as guns, tanks, swords, etc. encourage rough play. This could promote aggressive behavior.

Testosterone, the male hormone, certainly may contribute to this difference. Around middle school, boys tend to expect some type of benefit from aggressive behavior such as admiration from peers or deflecting attention away from a poor grade.

Could we be missing some feminine aggression? It is possible that those measuring aggression only measure the more brazen aggression of boys and men and overlook the more surreptitious aggression that we see in middle school girls. Anyone who has seen the movie *Mean Girls* understands the aggression that takes place among adolescent girls. It's mean-spirited and can be extremely subtle.

From Aggression to Antisocial Conduct and Relational Aggression

- Openly aggressive behavior decreases in both genders from age 9 through the teen years
- Teenage boys begin antisocial behavior such as abusing drugs, stealing, and skipping school
- About 15 percent of all 17-year-old boys have been arrested

- Teenage girls take part in a much more subtle, but very harmful, form of aggression called **relational aggression**. As mentioned earlier, it's very effective in excluding other teens and can lead to some devastating outcomes.
- Girls account for 28 percent of all juvenile arrests.

Elaboration: Openly aggressive behavior such as fighting continues to decrease from about age nine through the teen years in both boys and girls. This does not indicate that the teens are better behaved. It simply means they find different outlets for their frustrations. Some of these outlets are more harmful than others.

Teenage boys tend to take part in activities such as skipping school, drug abuse, stealing, or risky sexual conduct.

Teenage girls engage in behavior known as **relational aggression**. This behavior includes ignoring, belittling, shaming, or isolating someone, or spreading rumors about someone. It's often difficult to observe relational aggression because it is very subtle and it's often the "popular crowd" that engages in it. Frequently, it is overlooked because adults simply don't think the compliant, popular, honor student engages in such an activity.

In place of the past aggressive behaviors such as hostile or instrumental aggression, we see **antisocial conduct** that can lead to real trouble for the teens. As we look at these statistics – 15 percent of 17-year-old boys have had been arrested and that girls represent 28 percent of all juvenile arrests – we can see that the feelings and emotions that were behind open aggression have found a new home in antisocial behavior.

Aggressiveness: Stable or Variable Characteristic?

- A non-aggressive child is likely to become a non-aggressive adolescent and adult.
- A child who is moderately aggressive is likely to engage in antisocial conduct later in life.
- A highly aggressive child tends to become a highly aggressive adult who engages in violent behavior that results in arrests.

Elaboration: Many studies done over the years reflect that aggressiveness is a stable characteristic. If a **child is non-aggressive** as an early elementary student, he/she will likely not behave aggressively throughout his life.

Likewise, a **moderately aggressive child** will likely engage in some antisocial behavior in adolescence or adulthood. The degree of aggressiveness tends to remain stable over a long period of years.

The highly aggressive child—and remember, this is only about 3 percent of children—is likely to become a violent individual, often times physically harming his or her spouse or children later in life. They frequently are convicted of crimes.

Individual Differences in Aggressive Behavior

Proactive Aggressors are children who are highly aggressive individuals who depend on aggression to solve their problems or obtain their goals.

Reactive Aggressors are children who are distrustful individuals who tend to expect others to “have it in for them.” They readily assess blame to those who bump into them and retaliate quickly and forcefully.

Retaliatory Aggression is the aggression that takes place in response to real or imagined harassment.

Hostile Attribution Bias describes an inclination to attribute malicious intent to actions that could have been an accident. Reactive aggressors tend to have this characteristic.

Elaboration: These **proactive aggressors** are those children who are very comfortable with their aggression. This aggressive behavior has helped them accomplish their goals for quite some time. These aggressors have honed their skills and use instrumental aggression to take what they want. Since they have a reputation for getting what they want, peers tend to give in to them before any serious bodily harm is done. This tends to boost the proactive aggressors self-esteem and reinforces the behavior.

Reactive aggressors, as the name suggests, become aggressive in *reaction* to someone else’s behavior. If someone bumps into his or her desk, the reactive aggressor automatically assumes the individual acted with purpose and intended to cause harm. The reactive aggressor might very likely trip that person who bumped into the desk. Retaliation is swift and, usually, harsh. These reactive aggressors are distrustful of others and tend to react quickly to a perceived threat.

Retaliatory aggression is that aggression demonstrated by the reactive aggressors. In the example we just used, it is the tripping that would be the retaliatory aggression.

Continuing with that example, the behavior of jumping to the conclusion that whomever bumped into the reactive aggressor’s desk had intended to do harm is an example of **hostile attribution bias**. The reactive aggressor is showing his or her hostile attribution bias when he or she assumes that harm was intended.

Individual Differences in Aggressive Behavior

Passive Victims of Aggression are children who seemingly do nothing to trigger abuse from bullies. These children tend to be timid and nervous with low self-esteem.

Provocative Victims of Aggression are children who are antagonistic, restless, and adversarial. They attract the attention of aggressors simply because they irritate them.

Elaboration: Victims, in general, may not be liked by their peers. However, all victims are not alike in their behaviors. First, there is the **passive victim**. These victims are unlikely to defend themselves or fight back. They tend not to be physically strong and really do nothing to encourage the aggressor. These passive victims often have an overprotective mother and

have been encouraged to verbalize their feelings. These traits are not typical “male behavior” and are not favored by their male peers.

The **provocative victims** bring attention to themselves simply because they irritate their peers. Perhaps they move around a lot, ask a lot of questions, or are anxious or moody. While fewer in number than the passive victims, the provocative victims tend to have the hostile attributional bias (*thinking* someone meant harm before *knowing* if that is the case) and they tend to have been abused at home. Because of this abuse they view people with suspicion and expect the worst from their peers. Provocative victims often engage in retaliatory aggression.

Information Processing of Aggressors

The following are six mental steps that the **victim** goes through before reacting to a possible act of aggression:

- **Encodes** (Did he mean to do it?)
- **Interprets** (Is this kid usually mean to me or others?)
- **Formulates a Goal** (What should I do to resolve this situation?)
- **Generates Problem-Solving Strategies** (Shall I let it go? Shall I teach him a lesson?)
- **Evaluates which one will work best** (What has worked in the past?)
- **Enacts a Response**

Elaboration: As victims are going through these mental steps, let's think about how the victim's mental state will affect the outcome. If the victim is a **reactive aggressor**, and someone bumps into him, the victim is likely to *assume* the person intended to bump into him at the encoding stage and go quickly to a very aggressive response. He is looking for ways to make this assumption the correct one because he has no experience with interpreting the situation, looking for different ways to resolve this situation, or deciding just to let it go. He quickly moves to the only solution he knows, which is retaliatory aggression. Incidentally, boys and girls are equally likely to be reactive aggressors.

Now let's suppose the victim is a **proactive aggressor**. We already know that he won't automatically think that bumping the desk was intentional. But, it does mean that he is comfortable with aggression. And, let's suppose that someone nearby laughed when the desk was bumped. So the proactive aggressor will go through the steps and will likely decide that even if no harm was intended, this person should pay a price for not being careful and causing laughter. Since this proactive aggressor is confident in a positive outcome, he will probably laugh as he trips the person who bumped his desk. So, now, no one is laughing at him they are laughing *with him*.

It becomes very clear that past social experiences, home life, and the mental states that these children bring into an aggressive situation, whether they are aggressors or victims, influences the outcome of the confrontation. Often times, these children do not know that there is a

different way to resolve a conflict or deflect aggression. Each one of these six mental steps is an opportunity to bring a conflict to a peaceful, satisfactory resolution. And, if shown how to do so, the victims may make a better choice next time.

1.4.4 Participants will be able to identify common traits of bullies and their victims.

Differences in Perpetrators and Victims

A study by Nansel et al., 2001 involving 15,000 sixth- through tenth-graders offers insight into the aggressors and their victims. Here are the findings:

- **17 percent of students have been bullied at times over the school year.**
- **19 percent of students bullied someone at times over the school year.**
- **6 percent have bullied someone and have been bullied at times over the school year.**
- **Boys, more than girls, were bullies or bullied.**
- **Boys are physically bullied and girls are more likely to be verbally bullied.**
- **Most bullying takes place in sixth to eighth grades and occurs equally in rural, suburban and urban schools.**
- **Bullies tend to drink alcohol, smoke and be poor students.**

Elaboration: These statistics show that almost one fifth of students in grades six through ten participate in aggressive behavior toward peers. And, 6 percent have been both a victim and an aggressor. Boys take part in aggression more than girls and are more physical with their aggression whereas, girls are more verbal with their aggression. Furthermore, bullies are drinking and smoking more than their non-aggressive peers and are less likely to excel in school.

Reflecting on your sixth through tenth grade school experience, do these numbers feel right? Do you remember being an aggressor, a victim, or both? Were you a part of a group or were you ostracized? Many emotions come to the surface when we reflect on social interactions during adolescence. It is helpful to remember those feelings when dealing with adolescents going through very similar social interactions.

Other Facts on Bullying

- **Bullies tend to have other bullies as friends who support and assist them.**

- Aggressive adolescents tend to agree on who should be bullied and then they torment the same victims.
- Some bullies are in the “popular” crowd but most are disliked by their fellow students.
- Interventions and programs are needed to help victims and discourage bullying

Elaboration: These bullies like to surround themselves with others who will support and assist them as needed. Then, within that social group they select victims they deem as “easy targets,” or those who have something they want.

Most highly aggressive bullies are disliked. Some who are particularly adept in manipulating their peers may be seen as “cool” but for the most part they are given their space, much like those passive victims. Getting too close to a bully could mean he could turn on you and getting too close to a chronic victim could mean you might become a victim as well.

Programs to address the issues surrounding chronic victims and bullying would prove to be very helpful to these students.

Popularity and Aggression

- Popular students maintain high status but are not necessarily well liked.
- Popular students often maintain their standing through relational aggression.
- Popular students are not viewed as aggressors by parents, teachers, or administrators.
- Aggressive behavior, whether overt or relational, permeates every adolescent social group.

Elaboration: While some popular students are certainly well liked, it would be a mistake to assume all are. Many of these students maintain their positions through relational aggression. Often just the threat of excluding someone or threatening to spread a rumor is enough to keep ensure their own popularity. This behavior is so subtle that adults do not view these popular, good students as aggressors. But, research shows that aggressive is found in every adolescent social construct. Programs to lessen aggressive behavior among adolescents would require addressing the entire social culture of a school, not just the overt bullies or the relational aggressiveness of the popular crowd.

Aggression and Cultural Components

Some cultures are more aggressive and violent than others

- The U.S. is an aggressive society ranking the highest of any industrialized nation in assault and murder.

- Children from lower socioeconomic homes are more aggressive than children from middle class homes.
- Physical punishment is more prevalent in lower socioeconomic homes and aggressive solutions are encouraged when conflicts arise.
- Parents from lower socioeconomic homes are often unable to monitor children's whereabouts due to their stressful lives and work schedules.

Elaboration: We are an aggressive society in the United States. Studies indicate that socioeconomic status is the greatest predictor of aggressive behavior, especially in urban males.

Physical punishment in the home is more prevalent among lower income families. Children who are hit by their parents learn to hit other children. Also, these parents tend to encourage the children to use aggression to solve conflicts with their peers.

Additionally, the stressful lives of parents in the lower socioeconomic strata make it difficult to monitor children's whereabouts, leading to delinquent and aggressive behavior in the children.

The Home: Where is Aggression?

- Parents' behavior toward each other affects children's behavior.
- Children's aggressive behavior can help create a chaotic home.
- A coercive home environment influences aggression in children
- Negative reinforcement contributes to aggression in children.

Elaboration: **Parental fighting** is very upsetting to children and the aggressive behavior the parents demonstrate toward each other becomes a model for how the children learn to resolve conflicts. As children see more of this aggressive behavior, their behavior becomes more aggressive.

To continue this vicious, aggressive cycle, **children's aggressive behavior** elevates chaos in the home causing more stress on the parents who then argue even more.

This creates a **coercive home environment**, which is a home in which constant bickering and aggression take place. It is a home where peaceful conflict resolution is not practiced.

And, finally, this results in **negative reinforcement** such as nagging, yelling, and hitting to get the aggressor to stop. The hitting and yelling usually escalate so as to stop the irritating aggressive behavior and thus reinforces even more aggressive behavior within the home.

Controlling Aggression in Children

- Non-Aggressive play environments with plenty of room and resources reduce aggression.
- Eliminating payoffs for aggressive behavior promotes pro-social conduct.
- Social-Cognitive interventions can help.

Elaboration: By creating **non-aggressive play environments**, aggression can be reduced. This requires plenty of resources such as toys, books, and play space. If financial resources are limited this can be difficult, but with creativity such as assigning young children to certain play areas on a rotational basis, a decrease in aggression can still be accomplished.

Also, **eliminating payoffs** for aggressive behavior by ignoring all but the worst offenses and praising pro-social, cooperative behavior will lower the aggressive behavior in a classroom. By doing this, it becomes easier to gain praise by behaving than by escalating bad behavior.

Very aggressive children benefit from **social-cognitive interventions**. By teaching them strategies to resolve conflicts by peaceful means, to control their anger, to look for the best in others, and to put one's self in another's place, they learn that there are alternatives to aggressive behavior.

ALTRUISM

- Altruism is an unselfish concern or devotion for the welfare of others.
- Most parents want their children to become altruistic.
- Pro-social behavior is any act that helps others and includes making someone feel welcome, offering comfort or relief, saying nice things, or sharing.

Elaboration: **Altruism** is just being nice to other people. It's about being pro-active to make someone else feel comfortable or at ease. It's about sharing your lunch or lending someone a pen. It's about letting someone else give the right answer. And, most **new parents** want their children to have this trait.

If someone has the trait of altruism, he or she practices **pro-social behavior**. There are varying degrees of altruism. This comes more naturally to some than others. To get a better idea of how it develops, let's take a look at when it begins.

1.4.5 Participants will be able to describe pro-social behavior.

Pro-social Behavioral Origins

- Children begin "helping" their parents with tasks around 12 to 18 months of age.
- Two-year olds will often share a treat or a toy with another toddler.

- Two-year-olds often provide comfort or sympathy to another toddler.
- Toddlers are more compassionate when parents direct their attention to the harm done rather than scolding when they misbehave.

Elaboration: Children seem to be born with a desire to be helpful. **While still in diapers, children** already have a desire to help parents with simple chores like dusting or sweeping.

Two-year-olds are very capable of sharing treats or toys with another toddler without being prompted to do so. They also will comfort or commiserate with a friend who is in distress.

When a toddler has hurt another child, if **the parent directs attention** to the way that the toddler made the other child feel rather than scolding him or her, the toddler learns to be compassionate. This method of having the toddler reflect on his or her actions in respect to another's feelings, teaches the toddler empathy and the causal affect his or her actions have on another.

Gender Differences in Altruism

- Most people believe that girls are more altruistic than boys.
- In fact, boys and girls are almost equal in altruistic behavior.
- So, why the misconception?

Elaboration: **Girls** are slightly more altruistic than boys but not enough to account for the misconception that they are much more so. Boys and girls are actually very close in this behavior. The reason most of us think of girls being more helpful than boy is that **boys tend to be more competitive than girls and are less cooperative than girls.** These behaviors give the appearance of being less helpful but do not affect the actual helpfulness. What does slightly affect altruism in boys is their desire to look good in front of peers and their competitive nature might keep them from providing assistance when they are surrounded by a group of their peers.

What makes for an Altruistic Child?

- Pro-social Moral Reasoning
- Empathy – What triggers this emotion?
- Age Trends
- Felt Responsibility

Elaboration: **Pro-social moral reasoning** is the thought process one goes through when deciding whether or not to offer assistance or comfort. Those past social experiences, home life, and the mental states that affected retaliatory aggression can affect pro-social moral

reasoning in much the same way. If a high-school student has had the exposure to and benefited from others' compassion he or she will be more likely to respond in a compassionate manner to someone in distress even if he or she

Empathy is the ability to understand and share the feelings of another person. The development of **empathy can be bolstered in children by their parents**. If parents behave empathetically, their children are more likely to do so. Also, as we have seen before, when a child misbehaves and the parent points out the harm caused to another, that child tends to develop empathy for others.

In looking at **age trends**, we find that pre-school children may experience negative reactions to their peers being in distress and be unable to react favorably to them. However, by about 2nd to 4th grades, most children are able to relate others' distress to the distress they have felt and react in a compassionate way.

But, how does this empathy motivate altruistic behavior as children age? It seems that the more children learn about caring behavior, the more likely they are to engage in it. **Felt responsibility** is a term used to describe how empathy motivates altruistic behavior by causing one to think about what is normal compassionate behavior—or *what is one expected to do?*—and then making them feel obligated to help.

A Look at Altruism through Culture

- Influences – Individualist versus Collectivist cultures
- Reinforcing
- Practicing and Preaching

Elaboration: Basically, cultures that are more **individualist and industrialized**, such as the United States, have children who score lower in altruism. In Kenya, for example, 100 percent of the children score high in altruism whereas, 8 percent of the children in the United States scored high. This can be attributed that children in **collectivist, non-industrialized** countries participate in harvesting and preparing food for the family, taking care of siblings, gathering wood, and fetching water for the family. Their survival depends on contributing to the welfare of others.

The adults in children's lives play a huge role in **reinforcing altruism**. If adults model altruistic behavior, the children become more altruistic. However, bribing or offering tangible rewards in exchange for a child being nice to someone is not an effective training tool. These children simply learn to want bigger and better rewards.

Practicing and preaching altruism in the home is the most effective way to promote altruistic behavior in children. Children really do learn by watching their role models and then emulating them. If you want an altruistic child, practice altruism in your daily life.

Creating Altruistic Children

- Unusually altruistic parents tend to have altruistic children.

- When correcting children, direct their attention to the harm they have done rather than being punitive and harsh.

Instructor Note:

View Video: Raising Moral, Compassionate Children – Discuss Video

<https://www.youtube.com/watch?v=uzTdAMYxKs&list=PLs3plh1YBV2rGIYP69CP3JKF3gGiQz6em>

Elaboration: As we have seen repeatedly in this lesson, **children learn by example.** Another important lesson is that children’s attention (and this applies to older children and adolescents) should be directed to the harm caused someone else instead of disciplined harshly. Implicit in this is that children need not be disciplined harshly for accidents such as spilling or dropping something. By helping them clean up the mess and speaking of the importance of being careful will model the behavior of helping someone else clean up after a spill.

MORAL DEVELOPMENT IN CHILDREN AND ADOLESCENTS

Let’s begin with some definitions:

- **Morality** – a system of principles that enables one to distinguish right from wrong.
- **Internalization** – adopting others beliefs and standards as your own.
- **Moral Affect** – the emotional part of morality, how it makes you feel.
- **Moral Reasoning** – the thought process that takes place when deciding what is right or wrong.

Elaboration: Morality means that we know the difference between right and wrong and can act on it. Generally, knowing how to make the distinction results in feeling good about doing the right thing, and guilt over those actions that do not measure up to one’s standards.

Internalization takes place when one decides what is good and right and what is wrong according to their own moral compass. This takes place independently without anyone dictating what they should believe or think. Through this process, people reach moral maturity.

Moral affect is that emotional part of morality. How does it make you feel? Moral decisions have the capacity to make you feel proud, guilty, shameful, or angry. It is this aspect of morality that referred to as the moral affect.

The cognitive component is called **moral reasoning.** This refers to those thoughts we have when making moral decisions. Intellectually, we are weighing the advantages and disadvantages of choosing either right or wrong.

MORAL DEVELOPMENT IN CHILDREN AND ADOLESCENTS

Definitions:

- **Moral Behavior** – consists of our actions that are congruent or, perhaps, incongruent with our individual moral code.
- **Mutually Responsive Relationship** – a healthy parent-child relationship in which parent and child are responsive to the other's needs.

Committed Compliance – describes the attitude of a child who is willing and even eager to comply and cooperate with a responsive parent.

Situational Compliance – this applies to the power of the parent to control the child's behavior.

Elaboration: Experts agree that to achieve our goals and lead a fulfilling life we must live in an authentic manner. This includes having **moral behavior** that is consistent with our morality. When actions are congruent with beliefs, we are happier, more productive humans.

Within a healthy parent-child relationship there will be **mutual responsiveness**. Both the parent and the child strive to respond to the needs of the other. Once this is achieved, a child will generally demonstrate **committed compliance**, which means that he is willing and eager to cooperate with the responsive parent.

Conversely, if the parents have not shared enjoyable activities with the child or have been distant or nonresponsive to the child, the child then minds the parent because the child knows the parent has control. This is called **situational compliance**.

Components of Morality

- Cognitive Component
- How children and adolescents know what is right and what is wrong
 - Piaget's Theory
 - Kohlberg's Theory

Elaboration: We saw a glimpse of the **cognitive** component of morality when we reviewed the definitions. We decide on the **morality** of a situation or principle and then we adopt it as our own when we **internalize** it. This process of thinking about morality is the cognitive aspect of moral development.

How children and adolescents know what is right and what is wrong.

Several experts have studied how children and adolescents know what is right and what is wrong. **Piaget's theory** focuses on the respect for the rules and how and what children think about justice. He found that preschoolers have little respect for the rules. They want to have fun and make their own rules. Then between ages five and ten, children gain respect for the rules. They follow the rules and insist that everyone else follows them as well. And finally, around age ten or eleven children realize that they can make up their own rules, adapt the rules to accommodate the group. Things become much more flexible for these pre-teens. Piaget suggested that moral development is closely related to cognitive growth.

Another theorist, **Kohlberg**, developed his theory by asking boys aged 10, 13 and 16 moral questions that involved requiring the boy to choose between obeying authority and doing something that went against the rules but served a dire human need. Kohlberg was not so much interested in the decisions the boys made but in how they arrived at their decisions. Out of these studies, he theorized that cognitive development is not enough for moral development. In addition to cognitive development, Kohlberg believes that children must be exposed to moral dilemmas that push against the limits of their moral perspectives. So, according to Kohlberg, it is both cognitive development and social experiences that lead to moral development.

How Children and Adolescents Behave when Tempted to Lie, Cheat, or Break the Rules

- Bandura and Mischel Social Learning
- A look at 10,000 children who were tempted to lie, cheat, or steal
- Children and Adolescents: Learning to Resist Temptation

Elaboration: Social-Learning theorists **Bandura and Mischel** believe that morality is learned through reinforcement, punishment and observing. Additionally, they think moral behavior is molded by specific moral situations to which we are exposed. Bandura and Mischel state that it is not unusual for a person to adhere to a strict moral code in one area while being completely deceitful in another.

In a study conducted over a 5-year period observed **10,000 eight- to sixteen-year-olds** while tempting them to lie, cheat, or steal in varied situations. Researchers found that children were not consistent in their dishonesty. A child might be dishonest in one particular setting and scrupulously honest in another. Also, children who cheated were just as likely as those who did not cheat to label dishonest behavior as wrong. The researchers concluded that dishonesty is situational rather than a consistent trait.

Children and Adolescents: Learning to Resist Temptation

- It is important for children to know **WHY** they should resist temptations.
- If children think that being honest, “good”, or responsible is expected and valued they tend to act that way
- Role models have an important impact on child and adolescent moral development

Elaboration: As we saw in our discussion of moral development, the cognitive process is extremely important in making moral decisions. And, just as we saw in retaliatory aggression, it is necessary to go through cognitive steps when making decisions about right and wrong. Also, we have seen that disciplinary measures that include directing the child’s attention to the harm they have caused are the most effective in reducing aggression. So, it should be no surprise that children and adolescents need to be made aware of **WHY** they should resist temptations. They need to be made aware of the fairness of a situation, the harm that can

come from giving in to temptations. By explaining these outcomes, children and adolescents can internalize them and be better equipped to resist temptation.

When adults are very clear with children and adolescents about their expectations in the areas of lying, cheating and stealing and communicate an expectation of adherence children have a tendency to be **honest and responsible**.

When children are put in positions of authority they are very likely to follow the rules. And in doing so, they become passive role models for other children who follow their lead. The key component in this situation is that the children who were put in authority internalize that they are people who follow rules.

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Section Two:

Mental Health Crisis Intervention

(4 Hours)

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Instructor Guide

Section Two: Mental Health Crisis Intervention

2.1 Unit Goal: Discussion of mental illness and crisis intervention in children and adolescents; its significance to the School-Based Law Enforcement and School Resource Officer.

2.1.1 Participants will be able to define mental illness in children and adolescents

Mental Illness Defined

- Children and teens can suffer from the same mental illnesses as adults, but they may present very differently than adults
- A mental illness is any disorder or illness that impacts a child's behavior, mental awareness or emotional response
- Mental illnesses are diagnosed and treated by a Mental Health Professional
- To diagnose any type of disorder, the DMS-5 is used - Diagnostic and Statistical Manual of Mental Disorders, most updated version is the 5th edition
- Mental illness in children can be very difficult to identify

Causes of Mental Illness in Children and Teens

Heredity- Mental illness runs in families

- Biology- Caused by abnormal brain function, regions of the brain that control emotion, reasoning, thinking and perception function differently than that of a normal brain
- Psychological Trauma- Could be caused by trauma in early life, such as emotional or physical abuse, sexual abuse and/or the loss of a parent or caregiver
- Environment- A traumatic or stressful home life

Personality Disorders

Defined: The way an individual thinks or feels about oneself and others that affects the way an individual functions in day-to-day interactions

Characteristics:

- Inflexible
- Inappropriate reactions to situations
- Lack of empathy

Elaboration: Children with personality disorders can be very manipulative and have a tunnel vision of their actions. They will feel that there is nothing wrong with their behavior. The child will have a hard time connecting with others in a socially acceptable way. It is difficult to diagnose children with these disorders. Many will not recognize the symptoms as a disorder but as a normal highs and lows of life. When dealing with children with these disorders be firm but understanding.

Paranoid Personality Disorder

Define: Individual's with a pervasive and persistent mistrust of others. People with highly cynical view of themselves, others, and the world at large.

Characteristics:

- Believe others are using, lying to, or harming them
- Will have doubts about the loyalty and trustworthiness of others
- Will hold grudges, jealous, and suspicious

Elaboration: These children will not be trusting of many, it will take a long time to build trust. You must be honest with them at all times. Once trust is broken it cannot be repaired. These children will have a hard time seeing their involvement in conflict, they feel that they are always right. Criticism is not taken well, and could be understood as a personal attack of their character.

Antisocial Personality Disorder

Define: A consistent disregard of the rights of others. Persons must be 18 years of age to be diagnosed, most will present as conduct disorder by age 15.

Characteristics:

- Disregard for right or wrong
- Uses lying and cheating to get ahead of others
- Failure to conform to social norms
- Impulsivity
- Lack of planning ahead
- Reckless behavior that may cause harm to self of others
- Lack of remorse
- Multiple physical altercations

Elaboration: These children will be testing limits, they will be pushing other to breaking points. They will be angry and acting out, placing blame on others for their behavior. It will be difficult to get close to these children, and they will not comply easily or at all with normal social behavior. These children deal with the fear of abandonment so they avoid getting close to anyone, that way no one can leave them.

Borderline Personality Disorder

Define: A pattern of unhealthy interpersonal relationships, mood swings, impulsive behavior and unrealistic self- image.

Characteristics:

- Unstable interpersonal relationships
- Identity disturbance
- Unstable sense of self or self- image
- Impulsive behavior (sex, drug abuse, spending)
- Suicidal behavior or self-mutilation (cutting)

Elaboration: These children have trouble with relationships, especially with those closest to them. They will have wild mood swings that could leave people feeling used or abused. To help ease some of these reactions, establish firm limits and set consequences. Open communication is key to dealing with the symptoms. Borderline personality is rarely diagnosed on its own; it normally coincides with other mental disorders such as depression, anxiety, or bipolar disorder.

Mood Disorders

Define: A category of mental illness where there is a serious change in mood in a short amount of time or unprovoked change in mood.

Characteristics:

- Can cause mood swings
- Extreme feelings of sadness
- Depression - often there is a withdrawal from normal activities
- Manic behavior- overly active, extreme excitement, frantically busy with goal-related activities

Anxiety Disorders

Define: A severe overwhelming feel of fear or worry that keeps one from doing day to day tasks.

Characteristics:

- Extreme worry
- Cannot relax
- Difficulty concentrating
- Nausea
- Headaches

Obsessive Compulsive Disorder

Define: Unwanted thoughts that cannot be avoided or changed (obsessions) while also having a compulsion to complete ritualistic behaviors and routines (compulsions) to help relieve the stress of the obsessions.

Characteristics:

- Counting
- Hand washing
- Repeating behaviors over and over again
- Unable to move on to next task without finishing ritualistic behavior

Elaboration: A disorder of the brain and behavior. The person with OCD will feel that their brain will change its reaction with the completion of ritualized behaviors. Washing hands so many times will ease the anxiety of leaving the house, or counting the number of times the turn signal clicks before being able to turn right.

Post-Traumatic Stress Disorder (PTSD)

Define: Is triggered by a traumatic event, either by direct experience or witness to event.

Characteristics:

- Nightmares
- Flashbacks
- Severe anxiety

Elaboration: Anyone that has witness or lived through a traumatic event. Sexual abuse, rape, car accident, death of family member, natural disaster or terrorist attack, could all be cause of PTSD. Post-Traumatic Stress Disorder in children is a new area of study. Until recently, PTSD was only considered a problem for war veterans.

Generalized Anxiety Disorder

Define: Chronic anxiety, extreme worry that keeps one from doing everyday tasks.

Characteristics:

- Extreme worry
- Cannot relax
- Difficulty concentrating
- Nausea
- Headaches
- Muscle aches
- Trembling
- Hot flashes
- Avoid social situations

Elaboration: Anxiety that consumes day-to-day life. Worry and fear that keeps one from doing day-to-day activities. The worry gets so bad that physical symptoms such as headaches, nausea and muscle pains. Children may start skipping classes, avoiding social situations. Can start in early childhood, and last a lifetime.

Psychosis

Define: A break with reality, involving seeing or hearing things that are not there.

Characteristics:

- Break with reality
- Manic behavior
- Anxiety
- Hallucinations

Elaboration: Normally psychosis is part of other mental disorders, but it can present on its own. Sometimes as part of a drug use or alcohol use. In rare cases, epilepsy can cause a psychosis. When someone is in the midst of a psychotic episode, they have disorganized thoughts and speech. They will hear, feel or see things, people or animals that are not there.

Schizophrenia

Define: Chronic brain disorder, it is severe and disabling. May hear voices telling them to harm themselves or others. Feel that others are reading their minds and plotting against them.

Characteristics:

- Changes in sleep patterns
- Changes in eating habits
- Hearing voices, Seeing things that are not there (hallucinations)
- Nightmares
- Excessive worrying
- Drug or Alcohol abuse
- Self-harming behaviors
- Thoughts of suicide

Elaboration: A brain disorder that makes it hard to think clearly. Behave in socially abnormal ways. It is one of the most complex mental disorders. Many with schizophrenia suffer from depression, anxiety, and suicidal thoughts and actions. They have a hard time determining what is real and what is not.

2.1.2 Participants will recognize the characteristics of childhood depression

Depression

Define: Persistent feeling of overwhelming sadness. Affects how one thinks, feels, reacts, and behaves. There are mental and physical problems.

Characteristics:

- Overly Sad
- Loss of interest in activities
- Change in appetite
- Low energy
- Trouble sleeping or sleeping more than normal
- Feelings of worthlessness or guilt
- Thoughts of Suicide

Elaboration: Everyone goes through the normal ups and downs of life. Someone with depression is stuck in that down part of life. They cannot just get over it or span out of it. The feelings they are dealing with consume their life, they are stuck feeling worthless, sad and lonely. These feeling will keep the child from doing day-to-day activities. Depression can last weeks, months or even years. Self-harming behavior is common among people dealing with depression, cutting on arms legs, and attempts on one's own life. It is a very serious problem for the person affected and the family of the person

2.1.3 Participants will be able to describe bipolar disorder

Bipolar Disorder

Define: Extreme mood swings with abnormal highs and very dramatic lows. When on a high or manic one feels euphoric and overly energetic. When on a low or depressed he feels lonely overly sad or suicidal. Bipolar sufferers will swing back and forth between these two extremes with no warning and will feel the feeling of highs and lows in extreme ways

Characteristics:

- Mood shifts
- Manic- high euphoric feelings, overly happy
- Depression- Mania
- Very difficult to diagnose in children
- The symptoms can resemble those of other childhood mental disorders
- Thoughts of suicide

Elaboration: Bipolar is a disorder which last a lifetime but isn't normally diagnosed until mid-teens to early twenties. Behavior will swing back and forth between overly manic and overly depressed. With bipolar the manic and depressed behavior will be in extremes.

2.1.4 Participants will be able to identify conduct disorder

Conduct Disorder

Define: A pattern of behavior in which the child or adolescent disregards the rights of others. The behavior happens at school, home and in public spaces. The child will have difficulty with academic, social and family functioning.

Characteristics:

- Overly aggressive toward people and animals
- Destruction of property
- Stealing/Shoplifting
- Setting fires
- Lying
- Skipping school

Elaboration: More common among boys than girls. These children will have more physical injuries from risky behavior. Can affect children under ten years of age. They will have more marked problems with academics and peer relationships. Conduct disorder is the most commonly diagnosed disorder.

Instructor Notes:

How to approach, what to do and what not to do when dealing with a person with ...

Paranoid Personality Disorder:

Do - Set boundaries. Help them make the right choices. Be honest. Be patient.

Don't – Don't avoid the talking about the behavior or situation. Don't enable the behavior. Don't try to fix it.

Antisocial Personality Disorder:

Do- Set limits. Use clear language. Be patient.

Don't- Don't take the behavior personally.

Borderline Personality Disorder:

Do - Set limits and keep them. Use clear language, explain fully and clearly.

Do - Help set realistic goals. Stay calm when talking with them. Be patient.

Don't - Don't use threats or ultimatums.

Depression:

Do – Be patient.

Don't – Do not use the tough love approach. This will come across as hurtful.

Don't try to minimize the pain or feelings of the person. This causes shame and makes the person feel like their issue does not matter.

Bipolar Disorder:

Do- Set limits. Communicate openly. Answer questions honestly. Be positive. Be patient.

Don't- Don't place blame. Don't take the behavior personally.

Obsessive Compulsive Disorder:

Do- Find humor in the small things. Speak open and honestly. Be positive and be patient.

Don't - Don't enable the behavior. Don't use negative language.

Post-Traumatic Stress Disorder (PTSD):

Do - Give them a safe place to talk. Listen to them. Keep your promises. Be patient.

Don't - Don't stop the person from talking about their feelings or fears. Don't give unsolicited advice. Don't minimize the person and their feelings. Don't give ultimatums.

Generalized Anxiety Disorder:

Do - Let them know they can speak open and honestly. Understanding is important. Spend time with them in a normal everyday setting. Encourage them to try new activities. Be patient.

Don't - Don't use guilt as a way to get results. Don't expect major changes overnight. Don't get frustrated when speaking with them.

Psychosis:

Do - Set realistic goals. Be a safe place to talk. Know when to get help (call 911). Speak plainly and clear. Be patient.

Don't – Don't use sarcasm, it will not be understood. Don't express anger or frustration. Avoid yelling. Don't place blame.

Schizophrenia:

Do - Set realistic goals. Be a safe place to talk. Know when to get help (call 911). Be patient

Don't - Don't use sarcasm. Don't express anger or frustration. Avoid yelling. Don't place blame.

Conduct Disorder:

Do - Reinforce good behavior. Set limits. Set clear goals. Speak calmly and clearly. Answer questions honestly. Follow up often. Be patient.

Don't - Don't use sarcasm. Never use threats. Don't express anger. Don't get frustrated when speaking with them.

Video:

- Bipolar video - <http://www.cnn.com/videos/health/2014/11/05/bipolar-disorder-explained-sanjay-orig-mg.cnn/video/playlists/sanjay-gupta-health/>
- OCD video- <https://www.youtube.com/watch?v=aX7jnVXXG5o>

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<https://www.psychologytoday.com/conditions/paranoid-personality-disorder>

<http://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml>

<http://www.mentalhealthamerica.net/conditions/conduct-disorder>

<http://www.psychone.net/list-of-personality-disorders.php>

http://my.clevelandclinic.org/services/neurological_institute/center-for-behavioral-health/disease-conditions/hic-paranoid-personality-disorder

<http://www.medicalnewstoday.com/info/anxiety/>

<https://www.youtube.com/watch?v=aX7jnVXXG5o>

<http://outofthefog.net/Disorders/PPD.html>

<https://iocdf.org/about-ocd/>

<http://patient.info/doctor/personality-disorders-and-psychopathy>

2.2 Unit Goal: This unit aims to foster in participants a deeper understanding of all aspects of bullying in schools. Discussion will include what bullying is, what causes it, what its consequences are, and what we can do to address it. By the end of this unit, you will be better prepared to identify bullying, intervene in bullying situations, and prevent future incidents.

2.2.1 Participants will be able to define and describe bullying.

Defining Bullying

Bullying Definition #1

“Bullying occurs when a child is the target of any *behavior* that is:

- Harmful or done with intent to harm
- Repeated or occurs over time
- Characterized by an imbalance of power, such that the victim does not feel he or she can stop the interaction.”

Bullying Definition #2

“Bullying is an unprovoked attack intended to cause distress and discomfort to others.”

Elaboration: Implicit in **definition #1** is that bullying cannot be accidental. It is an intentional, harmful behavior. It’s important to note that the power imbalance does not necessarily have to be a physical power imbalance. The power imbalance may be in areas such as perceived social prestige, number of bullies present or even personality.

Definition #2 is an all-inclusive definition that has the one condition of the attack being “unprovoked.” We can agree that most all “attacks” are intended to cause distress and discomfort. Let’s look into how we know it’s bullying.

How do we know it’s bullying?

We will look at the research that has been done over the last 20 to 30 years.

The easiest way is to ask a child or adolescent who has recently been bullied.

Elaboration: It’s interesting that there are many definitions of bullying in print. Experts debate whether or not certain aspects of bullying such as “repeated” incidents or “intent” are necessary components of bullying. If you ask a child or adolescent who has been victimized by a bully, there is no hesitation, they KNOW when they have been bullied. In addition to definitions, it’s helpful to see what type of behaviors can be included as bullying behavior.

Examples of Bullying

Aggressive behaviors that can be included as bullying behavior include:

Glaring, teasing, assault, harassment, damaging or destroying property, excluding someone, physical assault, ethnic or gender-specific slurs or threatening the use of weapons. Bullying can be done in person, over the phone, on social media, indirectly through a third party or by a group of bullies.

2.2.2 Participants will be able to identify common bullying tactics.

Elaboration: There is a wide variety of behaviors that can be included as bullying behavior. This is by no means an exhaustive list but rather examples that illustrate bullying can include anything from a stare to assault. Before discounting a stare as bullying behavior, imagine a student who is a grade or two ahead of a particularly small child. When that child goes to lunch the older student stares at the small child throughout lunch.

Bullying can take place anywhere, anytime and technology enables bullies to work round the clock to terrorize, humiliate and harm others.

Who bullies whom and why?

- Bullies tend to bully same-gender peers
- Bullying usually happens with people you know
- More than one bully is present when an act of aggression takes place

Elaboration: For the most part girls bully girls and their bullying is more verbal bullying, whereas boys tend to bully other boys and their bullying takes the form of physical bullying. Victims usually know their aggressors fairly well. Perhaps the most intimidating aspect of bullying is that bullies tend to gang up on their victims so the power imbalance becomes very real and very scary for these children. Even when the bullies are separated, they can still intimidate their victim between classes or in the halls at school. This robs the victim of a feeling of safety almost at every turn.

What is cyber bullying?

According to researcher Tokunaga cyber bullying can be defined as follows:

“Cyber bullying is any behavior performed through electronic or digital media by individuals or groups that repeatedly communicates hostile or aggressive messages intended to inflict harm or discomfort on others.”

Cyber bullying modes include:

- Spreading rumors
- Threats
- Sharing inappropriate photos
- Sharing intimate secrets

Instructor notes:

Video-Discuss

https://www.ted.com/talks/shane_koyczan_to_this_day_for_the_bullied_and_beautiful?language=en

<https://www.youtube.com/watch?v=YkzwHuf6C2U>

Elaboration: With the advent of technology came a new way to bully peers. Cyber bullying can be a particularly harsh form of indirect or verbal bullying. It can be anonymous, or the bully can pretend to be someone else, or even the victim. Cyber bullying can become direct bullying if there is a loss of property due to theft of phones or sending computer viruses through email.

Cyber bullying has had devastating effects on victims. Recently, in response to the suicide of a victim of cyber bullying, Monica Lewinsky has begun to speak out on the topic in an intelligent and compassionate manner. She asserts that she was probably the first victim of cyber bullying.

How common is bullying in our schools?

- Between 15 percent and 20 percent of the students are bullied
- Middle school children seem to experience more bullying than others
- In grades six through ten, 30 percent of the students were involved in bullying
- Various studies show a wildly varied percentage of students affected by cyber bullying. The percentages ranged from 6 percent to 38 percent, depending on the study.

Elaboration: These numbers can appear too variable to trust, but it is the many definitions of bullying that are used that make it difficult to get consistent numbers. In the U.S. we've only been studying bullying in earnest since the late 1990s after it was reported that the shooters in the Columbine High School massacre had been victims of bullying.

It's safe to say that almost one-fifth of our students are involved with bullying in some way in schools. And, cyber bullying is probably even more prevalent. Unfortunately, cyber bullying sprang up right along with new technology so it's difficult for students to separate the use of social media from bullying behavior. They have no idea what social media would look like without cyber bullying.

The personal and social costs of bullying.

Who is affected by bullying and how?

Bullies. What does bullying cost them?

Victims. What price do they pay?

Bystanders. Are they innocent?

Elaboration: Who is affected by bullying in our schools? **Everyone!** When approximately one-fifth of the students are involved in an activity that requires monitoring by teachers and

administrators, forces students to change their behavior, such as missing school to avoid being bullied, and distracts students who are not directly involved in bullying, it becomes a HUGE, time- and resource-consuming problem. It is arguable that learning cannot take place when anxiety and fear are constantly present in the classroom.

Perhaps the ones who pay the biggest price for bullying are the **bullies** themselves. Bullies are often suspended because of aggression toward other students, resulting in poor performance in school. This often causes relationships with teachers and other students to become strained. Research shows that those who are successful at bullying and adopt it as a way to get what they want frequently become delinquent adolescents. This behavior then leads to criminal activity as adults, especially in the area of domestic violence.

Victims suffer from more emotional conditions such as anxiety, depression and low self-esteem than students who are not victimized. Additionally, they tend to miss more school than their peers, resulting in lower academic performance. Unfortunately, these victims may require professional counseling even after the bullying stops for treatment of these psychological issues.

There is little research on the **bystanders** in bullying. These bystanders can step in to assist the victim or, more commonly, stand by and watch the bullying take place. To step in while bullying takes place is a very difficult action to take. Not only could you place yourself in harm's way but also you could become a target for bullying at a later date. Many individuals simply don't know what action to take to de-escalate a bullying situation. There are intervention programs at some schools to inform the students of strategies they can use. Unfortunately, these programs are not widespread. Time given to bullying intervention is time taken away from learning in the classroom.

Causes of the Bullying Problem

Social Learning Theory

- Direct transmission
- Observing others
- Victims

Social Cognitive Theory

- Addressing the environment
- Addressing bullying behavior
- Addressing victims' needs

Elaboration: **Social learning theory** provides one possible insight to bullying behavior. This theory states that there are two ways children can learn. The first is **by direct transmission** through reinforcement and punishment and the other is by **indirect observation of others** and the consequences they receive as a result of their behavior. Under this theory, bullying behavior can be explained by the bullies being exposed to adults or peers who are aggressive and react with bullying behavior to those around them. An excellent example of this is when parents use harsh, physical punishment or are abusive to the child, the child then models this behavior with his peers and bullying becomes his method of social interaction.

Social cognitive theory basically takes social learning theory a little further by adding in the thought processes that take place during direct transmission and the observation of others. For example, while children are being rewarded for good behavior and punished for bad behavior or observing others being rewarded or punished, this theory addresses the thoughts that the children might be thinking during this process. And, if you can possibly change those thoughts, you can empower children to expect a different outcome, think of coping strategies to get them through their situation, etc.

So, schools have taken this theory and have addressed the **school environment** by increasing awareness of bullying and teaching children how to report bullying incidents. This theory is also used to decrease bullying behavior by teaching bullies different ways to interact with peers and removing the rewards the bullies get for aggressive behavior. By teaching bullies how to have satisfactory peer relationships with socially appropriate behavior, they no longer need to bully to get what they want.

And, the issues facing **victims** are addressed by helping them select new and various coping strategies as well as teaching them to see that, while they have come to expect bullying, the actions they attribute to bullying may, in fact, be something else. For example, a victim who is accustomed to being bullied might misinterpret good-natured kidding as bullying. These victims often lack the social skills needed to make that distinction.

Who is at risk and what do they look like?

Bullies

Are they socially inept or skillfully dominant?

Victims

Being shy or awkward and entering a new school puts students at risk.

Bystanders

They recognize bullying behavior but are trying to navigate around it themselves.

Elaboration: **Bullies** are viewed in two ways: first, as lacking appropriate social skills so they resort to bullying or, the second view that they are very socially adept in manipulation and use it to get what they want.

In the first view, research does show that bullies don't have a strong moral code, possibly because they are not aware of right and wrong or they may not care. They lack the ability to put themselves in another's place – they lack empathy. Also, possibly because of their home environment, they seem to think others are out to get them. They are wary of others and do not trust them. So, in this instance, the bully would engage in "I'll get you before you can get me."

The second view that the bully is actually very socially skilled is due in part because he is often viewed by his peers as "popular" (not necessarily well-liked) and dominant within his social group. Even if bullies are largely disliked, they do have friends who usually exhibit the same or similar aggressive behaviors.

So, which view is correct? It's possible that they can both be correct. Imagine a bully who has poor social skills as they relate to kindness, caring, empathy, etc. Now imagine that same bully has excellent social skills as they relate to power, coercion, and even leadership. It's possible that appropriate social skills have never been modeled for him and these others have. It might be that those skills that he seems to possess could be used for positive social interactions.

Victims tend to be withdrawn, quiet, awkward children. They often display helplessness making them vulnerable to bullying. With older children and adolescents, moving to a new school can put them at risk for bullying. Generally, the more self-confidence that a student exhibits, the less chance he or she will become a victim.

Bystanders, as we've already pointed out, often lack the skills necessary to know what to do when witnessing a bullying incident. Education and information in the schools regarding this topic could be extremely beneficial in curbing bullying incidents.

2.2.3 Participants will be able to identify who is at risk of being bullied.

Identifying Bullies and Victims

- Anonymous self-reporting
- Anonymous peer reporting

Elaboration: Children and adolescents do not like to openly admit they are bullies. And, teachers and peers can overlook the popular student who practices aggressive behavior. Furthermore, victims are often embarrassed that they have fallen prey to the class bully and seldom admit it to a person in authority. So how can these bullies and victims be identified? Two methods have proven fairly reliable.

Anonymous self-reporting is performed by giving a questionnaire to all students. They do not put their names on it and they answer the questions about bullying. Using this method, students do report fairly accurately and this provides insight into the problem. However, going back to the definitions of bullying, many students do not understand the questionnaires' definitions or they have experienced bullying that differs from the definitions used.

Anonymous peer reporting can be helpful in that the students truly know about most of the bullying that occurs and who is doing it. The way this works is that the students are given a list of names and asked to indicate a certain number of students who are victims or bullies. The downside to this method is that it does not match well with anonymous self-reporting and asking for a fixed number could falsely identify someone or omit someone if they happen to be at the bottom of the list and the quota has been filled.

2.2.4 Participants will be able to implement anonymous reporting programs to address bullying in schools.

Prevention Programs

The Whole-School Approach

This has proven to be the most effective approach and includes:

- Assessing level of bullying
- Establishing a code of conduct
- Stopping bullying and ensuring safety of victims
- Changing social behavior of bullies and victims

Elaboration: These steps are fairly straightforward and that could be an indication of why this program is successful. Simpler is usually better. Let's take a look at the steps involved:

Assessing the level of bullying: It's important to have a baseline so that success or failure can be determined at a later date.

Establishing a code of conduct: This should be a very clear, enforceable document that outlines all expectations and penalties for violating the rules.

Stopping the bullying and ensuring safety of victims: Once the code of conduct is in place, students should have a clear path for reporting bullying and the code of conduct will also increase awareness of and clarify exactly what constitutes bullying.

Changing the social behavior of bullies and victims: Bullying can and should be addressed in the classroom. This is a very valuable step but some problems such as helping victims to change their behavior may require assistance outside the classroom.

This whole-school approach includes researchers' findings that prevention strategies must include system interventions, staff, student and parent involvement, interventions with bullies, and educational approaches with students.

Shedding Light and Transparency on Bullying

- Bullying thrives on a bed of secrecy
- Guaranteed anonymous reporting
- Provide hotline or reporting boxes
- Provide concrete strategies for coping with bullies

Elaboration: Bullying thrives on shame, secrecy and intimidation, but it does not fare so well when light has been shed on it. In conjunction with the whole-school approach, another approach that is effective in decreasing bullying is that of becoming a "telling school." This is a "media blitz" on the entire school that encourages reporting every incident of bullying. For this to be successful, students must be **guaranteed anonymous reporting**. Everyone is encouraged and even *expected* to report every incident of bullying. This action changes the dynamic of those who "tattle" into those who "report crimes." **Designated telephone hotlines or reporting boxes** that are simple boxes placed around school much like "suggestion boxes" are used to ensure anonymity of the person reporting.

Concrete strategies for coping must be provided for students. Some of these strategies include:

When you are being bullied: look them in the eye and tell them to stop, get away, and tell an adult what happened

After you have been bullied: Don't blame yourself, tell your family or teacher and bring a friend for support; if needed, be persistent until someone listens to you.

What to say: Tell them what happened, how often, who was involved, who saw it, where it happened and what have you done about it already.

2.2.5 Participants will demonstrate how to intervene in ongoing bullying incidents.

Intervention Strategies

- Victim-Inclusive Strategies
- Restorative Justice
- Method of Shared Concern
- Class Meetings and Bully Courts

Elaboration: Since bullying is a relational activity, interventions that include both the victim and the bully can be helpful in stopping the behavior. Let's look at three victim inclusive strategies:

Restorative Justice focuses on the unjust behavior of the bully and demonstrating the harm caused by his or her actions. After the bully admits the harm, action is taken to remedy the situation or to "restore justice." Think of this as a group intervention to allow the bully an opportunity to feel appropriate responses such as guilt or empathy for the victim. This approach is usually successful but depends on the willingness of all parties to take part.

Method of Shared Concern takes the restorative justice approach a step further. This approach includes a problem-solving strategy with the intent of creating positive relationships between the victim and the bully and helping the victim feel safe.

Class Meetings and Bully Courts take it yet another step and place the responsibility into the hands of the students. The class meetings take place at least once a week and have guidelines in place as to which bullying issues will be discussed during that particular meeting. Bullying activity is decreased by rules established by the students, encouraging empathy, helping victims and being inclusive. **Bully Courts** are convened when a student has a complaint about someone who has bullied him or her. The complaint must be in writing and both must attend the "court" and promise to tell the truth. It very much imitates a court of law with a verdict being voted on by the class representatives. A teacher acts as moderator.

Victim- or Bully-Focused Interventions

- Social-Cognitive Interventions
- Counseling Interventions

- Promoting Issues In Common
- Brief Therapy: Solution-Focused Counseling
- Support Groups

Elaboration: Victim or Bully-Focused Interventions are based on the idea that either the bully or the victim needs assistance in improving social, behavioral or cognitive skills. This type of intervention deals separately with the victim and /or the bully.

Social-Cognitive Interventions offer strategies and provide information so the victims and/or bullies can develop better coping strategies, self-control, change outcome expectations, etc. Additionally, real and clear consequences for aggressive behavior are provided, as are, anger management skills and empathy training. There are programs that have been developed for different age groups and are quite effective in reducing aggressive behavior and increasing emotional competency and problem solving in children.

Counseling Interventions address those thinking and emotional issues that are a byproduct of bullying. All students, even bystanders, can benefit from this type of counseling. Greater understanding and empathy for all concerned is a goal of this intervention.

Promoting Issues in Common is a 3-step intervention that is used for bullies and victims who had a neutral relationship prior to the aggressive incident. The first step is to gain control and stop the bullying. The next step is interviewing each one individually. The final step focuses on direct interventions based on the needs that were identified in step two. This intervention is limited in that a neutral relationship is not all that common in bullying. Typically, there is “a history” between the victim and bully.

Brief Therapy: Solution-Focused Counseling, as the name implies, is therapy that addresses a very specific issue. The student states their goal and the therapist helps the student arrive at that goal. Most of us have probably experienced this situation. As an adolescent we went to a school counselor seeking help with a specific problem. Possibly, we met one to three times and the issue was resolved or we felt better about the situation or better about ourselves.

Support Groups can be extremely helpful as they group people together who have experienced similar events. It’s an excellent way to gain emotional support for a particular problem such as bullying. However, it is important not to label a group, “Support Group for Victims,” as it will subject the students to possible ridicule from the bullies and others.

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2.3 Unit Goal: Puberty can be such a difficult time for children to face, as they change physically and psychologically. This unit will help you gain awareness of and sensitivity toward some of the particular challenges children face during puberty.

2.3.1 Participants will be able to define puberty.

Definitions of Puberty:

“Puberty is a normal phase of development that occurs when a child’s body transitions into an adult body and readies for the possibility of reproduction.” (tweenparenting.com)

“The period during which adolescents reach sexual maturity and become capable of reproduction.” (google.com)

Elaboration: These two definitions of “puberty” come from fairly common, decidedly *unscientific* sources. They are easily understood, and we can all agree that they are both accurate statements.

If we look further for deeper, more scientific definitions, the subject becomes very complicated, very fast. Scientists, physicians, psychologists, and sociologists seem to have different markers indicating when puberty begins and what impact puberty has on adolescents, depending on their particular field of study. To complicate matters further, because there are no standardized markers indicating the very beginning of puberty, it is difficult to compare one study to the next because different criteria were measured in each study.

So, for our purposes, we will mainly focus on the psychosocial aspect of puberty with a brief look at the physiology of puberty. We will look at the psychological, behavioral, social, and health impacts puberty has on adolescents. We will also take a look at the expectations and constraints our society places on these adolescents as they transition into adults.

Puberty: When does the onset occur? And, when does it end?

Girls

- The average girl experienced the first occurrence of menstruation (menarche) about one year earlier in the mid-1900s than did their counterparts in the late 1800s.
- Over the last 40 years, the age of menarche in girls has remained steady at about 12.5 years of age.
- Puberty generally ends between 15 and 17 years of age.

Boys

- While there is not a singular event used to measure the age of onset in boys, the average age in the U.S. is around 12 years of age.
- Puberty in boys generally ends between 15 and 17 years of age.

Elaboration: The age of menarche is used in girls to determine the onset of puberty simply because it is a specific, definable moment. Hormonal changes actually begin about two years prior to menarche. The change in the average age of menarche from late 1800s to the mid-1900s is attributed to better nutrition and improved health care in the United States.

Using very loose definitions of what constitutes the age of puberty onset, it is generally accepted that the average age is around 12 to 12.5 years of age for both boys and girls. In the U.S., this usually means puberty occurs as children transition between elementary and middle schools.

In both boys and girls, puberty ends between 15 and 17 years of age.

2.3.2 Participants will be able to describe the behavioral consequences of early onset puberty.

Next we need to look at the implications of puberty beginning at a significantly earlier age.

Why does it matter if puberty shifts to an earlier age?

Behavioral Consequences of Early Puberty

Those who experience early onset puberty are at risk for the following behaviors.

- Having sexual experiences earlier than their peers
- Exhibiting increased delinquent behavior
- Smoking more than their peers
- Having a higher rate of substance use
- And, to compound the problems for some, adolescents from disadvantaged neighborhoods are much more likely than their early onset peers from higher income neighborhoods to take part in undesirable behavior.

Elaboration: Sexual experiences at an earlier age could put adolescents at risk for unplanned pregnancy, sexually transmitted diseases, and emotional turmoil, and as they are ill-equipped to handle these serious consequences.

Delinquent behavior such as skipping school, minor criminal offenses, smoking, and using drugs and alcohol could be a consequence of these physically mature adolescents becoming friends with the older teens who look more like them.

Those teens that are especially at risk are those who reach puberty early and live in economically disadvantaged neighborhoods. They are far more likely to take part in delinquent behavior and commit minor criminal offenses.

These can have very dire effects on these young people. Adolescence is already a time of upheaval and strife. The added burdens of smoking, earlier sexual experiences, and substance use along with delinquency can have devastating effects on these teens' lives. Studies show that the teens who use drugs and alcohol at an earlier age, experience a more rapid progression through substance abuse. There is definitely a correlation between these behaviors in adolescence and troubling behavior in young adulthood.

Causes of Early Onset Puberty

Overweight or obese girls begin menstruating at an earlier age than their peers who are normal weight. Incidentally, overweight or obese boys begin puberty later than their peers who are normal weight.

Chaotic home life, physical and sexual abuse, absentee fathers and poor or negligent parenting are linked to early onset of menarche. Conversely, loving, supportive homes with fathers present are linked to a later onset of puberty.

Elaboration: Research shows that being overweight, especially being obese, puts a girl at risk for earlier menarche. Interestingly, while there is much less research on the subject, obesity tends to delay puberty in boys.

The home life that girls experience can have an impact on their menarche. Chaos, abuse, absentee fathers and poor parenting can all have negative effects on these girls' emotional stability and lead to early menarche.

In contrast, girls who live in homes that are loving and supportive with a father present tend to begin menstruation about ½ year later than average.

Impact of Puberty on Girls' Psychosomatic Symptoms

Girls sometimes exhibit hypochondria and obsession with perceived symptoms of serious illness.

Girls with early onset puberty tend to experience this more frequently.

Elaboration: These psychosomatic symptoms generally appear at the onset of puberty. One explanation might be the preoccupation with the changing body. It follows that the younger the girl, the less equipped she is emotionally to handle these changes.

2.3.3 Participants will be able to describe the physical effects of puberty.

The Physical Changes in Normal Puberty

Girls

- Between the ages of 9 to 11, breasts buds appear.
- Pubic hair follows shortly thereafter.
- Breasts develop over approximately 4 ½ years.
- During early breast development, the growth spurt begins. Full height is reached before menarche.
- Menarche occurs around age 12 ½ years.

Boys

- Growth of testes is typically the initial sign of puberty.
- Phallus and pubic hair begin to develop.
- After genital and pubic hair growth is nearly complete, full height is reached.

Elaboration: Girls: As hormone levels increase, breasts begin to develop between ages nine and eleven with the appearance of breast buds, followed by the appearance of pubic hair. Breasts continue to develop over 4 ½ years during which the growth spurt begins. When full height is reached, typically menarche follows shortly thereafter.

Boys: Growth of testes is typically the initial sign of puberty in boys and occurs about 6 months after breast buds appear in the average girl. The phallus and pubic hair begin to develop at the same time with the phallus developing more rapidly. After genital and pubic hair growth is nearly complete, boys generally reach their full height.

The Psychological Implication of Normal Puberty

- Attractiveness is important in our culture
- Biological processes determine the physical changes during puberty
- Physical changes include: weight, height, body hair, and facial features
- How a child feels about these changes will impact his or her adolescent experience
- Post-puberty adolescents have adult bodies yet social restrictions are imposed on them by parents and society

Elaboration: Puberty is a time when the body is changing faster than the child can become accustomed to these changes. Acne often develops at this time. The body is growing so fast that the child can become clumsy and appear uncoordinated as he or she adapts to this new shape and size. Just as these adolescents are closely monitoring themselves and others for attractiveness and worth, they can appear awkward and gawky.

This lowers self-esteem. Also, there will be some adolescents who will make seemingly flawless transitions while others' transitions seem to last an eternity. Socially, this is an extremely difficult time for those creeping through puberty. Additionally, at the end of puberty adolescents have body features of an adult but not they have not yet reached the age of adulthood with all the freedoms that implies.

What Puberty Means to Young Women

- Girls are particularly sensitive to body changes and self-image
- A girl may find that her body is no longer ideal for her favorite sport
- Standards for being attractive are narrower for females than males
- Weight may become an issue for the first time in a girl's life
- Adolescents will reject peers for being overweight

Elaboration: Our culture places incredible pressure on these early adolescents. Their magazines may show photos of very thin models that have been altered to make them appear even thinner. One photo advertising a very popular brand of clothing had actually been altered so that the model's waist was narrower than the width of the model's face! When these images are held up as the ideal adolescent girl, self-esteem plummets and even normal weight girls begin to think they are fat.

Another change that can take place in these girls' lives is that their bodies may be less than ideal for a sport that they have enjoyed for years. It is important for these girls to have options.

They should be encouraged to continue activities that they love or, if *they* desire, encouraged to begin a new activity better suited for their new body type.

What Puberty Means to Young Men

- Boys gain more muscle than fat in puberty
- Increased height is always valued in boys in our society
- If boys are normal weight, they are less likely than girls to experience poor body image after puberty
- Unlike girls, boys receive very little information from parents about puberty
- Boys tend to joke with each other about going through puberty but seldom talk with anyone about it

Elaboration: Boys' bodies become more consistently in line with the norms for attractiveness post-puberty. The weight they gain tends to be from muscle gain and the height gained during the growth spurt is positive as well. However, boys do not receive much information about their body changes as opposed to the information girls receive. Most boys actually receive more information on menarche than they do on ejaculation. Research shows that the vast majority of boys do not discuss their body changes with friends but *all* do joke about it.

What Puberty Means to Parent-Child Relationship

- Little research has been done in this area
- Young adolescent's state that they are uncomfortable speaking to parents and their peers who are the opposite sex. The exception is girls talking to mothers about menarche.
- Girls become angry when overhearing parents discussing breast development or menarche.
- Girls have a more positive attitude about puberty when the fathers were told about the beginning of menstruation.

Elaboration: While research is lacking in this area, these children experience embarrassment when puberty is discussed. The possible exception is when they come from a home in which the fathers were advised of their daughter's menarche. Possibly this indicates that there is more openness and better communication in these homes about sexual and physical issues.

The Impact of Puberty on Gender Roles

- With puberty comes pressure to act in ways that are sex-stereotypical
- These pressures seem to be stronger on girls than on boys
- Girls have more problems with independence and boys more with intimacy
- Boys not discussing puberty with peers may have long-term effects

Elaboration: It has been suggested that since these adolescents look more gender specific, society expects them to behave in that way.

Girls tend to retain a strong connection with their mothers through puberty. The mothers tend to exert more control, perhaps surreptitiously, over their daughters after menarche.

In contrast, boys achieve more independence than their girl peers. However, it has been suggested that because boys are not encouraged to discuss personal issues such as puberty, this may actually affect the structures of their friendships in adolescence and beyond.

Puberty and the Impact on Sexual Behavior

- Approximately 60 percent of black males have intercourse by age 16
- Approximately 60 percent of white males have intercourse by age 18

- Approximately 60 percent of black females have intercourse by age 18
- Approximately 60 percent of white females have intercourse by age 19

Most teens do not consciously plan to become sexually active

Teens who feel they can't communicate with their parents tend to initiate sex earlier

What teens *think* their friends are doing influences their own sexual behavior

Poor school performance and lower socioeconomic levels lead to early sexual activity

Elaboration: The percentages of sexual activity in teenagers have remained steady since the early 1980s. Approximately 60 percent of teens have sexual intercourse.

Teens describe becoming sexually active as something that “just happened” as opposed to planning to become sexually active.

Teens who *think* their friends are engaging in sexual activity tend to become sexually active. Also, teens who have a strong, open relationship with parents tend to delay sexual intercourse. In contrast, those with poor relationships with parents tend to engage in sexual activity earlier.

Finally, poor school performance and being from a lower socioeconomic home lead to early sexual activity.

2.3.4 Participants will be able to describe the relationship between puberty and depression.

The Health Impact of Normal Puberty

- Depression
- Behavior Disorders
- Eating Disorders
- Teen Brain Development:

Instructor Notes:

https://www.ted.com/talks/sarah_jayne_blakemore_the_mysterious_workings_of_the_adolescent_brain?language=en

Video: [Depression Awareness Program](#)

Discuss Video: <https://www.youtube.com/watch?v=Rsj6dW6qKRc>

Elaboration: Depression is more common in girls than in boys after puberty. Females are more prone to depression than males. This tendency could also be attributed to the gender-role expectations and body image.

Boys tend more toward delinquent behavior than girls. As we've already seen with the teens with early onset puberty, these behaviors include skipping school, smoking and using alcohol and drugs.

Girls, especially upper-middle class girls, are likely to fall victim to eating disorders during this time. In our culture, these girls prefer a thin, athletic, even lanky body. It has become the norm in the U.S. With puberty, curves develop and girls tend to store more body fat. Anorexia nervosa and bulimia are the two most common eating disorders.

Impact of Puberty on Boys' Peer Relationships and Depression

Boys who experience problems with peers are at risk for depression

Elaboration: Much attention has been given to depression and girls going through puberty. There has been some research studying the likelihood of boys experiencing depressive symptoms. Results show that boys who go through puberty at an earlier age are more likely to experience problems over time with peers. These peer problems are linked to a greater increase in incidence of depression.

2.3.5. Participants will be able to discuss puberty and the socialization process

Puberty and Socialization Norms and Rules

Socialization: a process by which individuals are supposed to recognize and accept the rules and norms of society.

Elaboration: Socialization generally occurs in our society without one even being aware it is taking place. We learn or become aware of the expected behavior and more or less adhere to that behavior. We individually act out our expected role as a student, teacher, police officer, etc. However, puberty can be a bumpy ride in this socialization process. Teens' bodies have changed, and expectations on how they should behave have changed as well.

Puberty and Socialization Process

Norms and rules should be clearly defined

Society, parents, teachers, peers, all have expectations of how these teenagers should behave

Media, religion, culture all place direct or indirect expectations on the teens

Elaboration: In our culture we often lack a defining moment—a rite of passage—to guide the behaviors of these adolescents and their families. Messages and expectations can get muddled leaving the teen confused and angry. For example, parents and teachers may expect more mature behavior from the teen that has gone through puberty as opposed to the

expectations they have for another who is just beginning the process *even though the two teens are the same age*.

Parents often place more responsibility on the teen but withhold freedom without explanation to the child. The media send mixed messages to teens. All of this can cause confusion, rebellion and anger resulting in poor socialization.

So, to better help the teen, clear, consistent messages of changed expectations along with comparable and appropriate freedom will go a long way to proper socialization for the teen that is neither a child nor an adult.

Puberty and Developmental Tasks

R. J. Havighurst introduced the concept of developmental task in 1948. This concept states that individuals have to perform or solve certain tasks at various stages of their lives in order to live productive, happy lives and to go on to perform appropriate tasks at the next stage of development.

Elaboration: As an example, a task to be completed during puberty is accepting a changing body and learning to use it efficiently. This task is more difficult for girls, those living in a lower socioeconomic neighborhood and those who begin puberty earlier.

So, adults in those teens' lives would do well to offer special support and encouragement to them as they transition into adulthood.

2.4 Unit Goal: Suicide in children and adolescents is a major public health problem and accounts for at least 100,000 annual deaths in young people worldwide (World Health Organization, 2002). This unit will discuss warning signs, risk factors and response factors.

Tween and Teen Suicide Statistics

- 100,000 annual deaths in young people worldwide
- In the U.S., suicide accounts for more adolescent deaths than all natural causes combined
- Approximately 4,000 young people ages 15 – 24 die by suicide a year
- Estimated every 2 hours a teenager kills him- or herself (Miller and Emanuele, 2013)

Elaboration: In the United States suicide accounts for more adolescent deaths than all natural causes combined, with approximately 4,000 young people ages 15 to 24 dying by suicide in 2002 (Kochanek, Murphy, Anderson, & Scott, 2004). The American Association of Suicidology (2003) estimated that in the United States a teenager kills him- or herself every 2 hours.

- Third leading cause of death in U.S. of ages 10 – 14 yr. olds and 15 – 19 yr. olds
- Of 1 million teenagers surveyed, nearly 20 percent seriously considered suicide in the past year
- 15 percent made a specific plan
- 9 percent reported an attempt
- Approximately 700,000 received medical attention for an attempt (Miller & Emanuele, 2013)

Expansion: Miller and Emanuele (2013) indicate that suicide ranks as the third leading cause of death in the United States among the 10- to 14-year-old and 15- to 19-year-old age groups, exceeded by only accidents and homicide (Anderson, 2002). The Centers for Disease Control and Prevention's Youth Risk Behavior Survey found that of 1 million teenagers surveyed, nearly 20 percent seriously considered suicide in the past year, 15 percent made a specific plan to attempt suicide, and 9 percent reported an attempt; approximately 700,000 received medical attention for their attempt (Grunbaum et al., 2002).

Suicide Stats

- Suicide attempts are less common before adolescence, then they increase significantly during adolescence with a peak between 16 and 18.
- The rate of suicide attempts is highest during adolescence.
- For each youth suicide, there are approximately 100 to 200 youth attempts (Miller & Emanuele, 2013)

Expansion: Miller & Emanuele (2013) and other researchers suggest that although suicide attempts are less common before adolescence, they increase significantly during adolescence, with a peak between ages 16 and 18 (Lewinsohn, Rohde, & Seeley, 1996). After age 18 the frequency of suicide attempts declines markedly, especially for young women (Kessler, Borges, & Walters, 1999; Lewinsohn, Rohde, Seeley, & Baldwin, 2001). As a result, the rate of suicide attempts across the life span is highest during adolescence, whereas the rate of

completion is highest among persons older than age 65. For each youth suicide, there are approximately 100 to 200 youth suicide attempts (American Association of Suicidology, 2003). Researchers found that 31 percent to 50 percent of adolescents who attempt suicide reattempt suicide (Shaffer & Piacentini, 1994), with 27 percent of boys and 21 percent of girls reattempting within 3 months of the first attempt (Lewinsohn et al., 1996). Strikingly, 50 percent of adolescents who attempt suicide fail to receive any follow-up mental health treatment (Spirito, Brown, Overholser, & Fritz, 1989); of those who do receive treatment, up to 77 percent do not attend therapy appointments or fail to complete treatment (Trautman, Stewart, & Morishima, 1993). Suicidal behavior is the leading reason for admission to adolescent inpatient psychiatric units in the United States and abroad. With shorter lengths of stay mandated by managed care companies, psychiatric hospitals have become revolving doors for highly troubled youth. These data have major treatment implications, including the need for evidence-based treatments that effectively engage and retain high-risk suicidal youth in outpatient settings. The evidence-based assessment and management of suicidality in children and adolescents is critical and complex for even the most seasoned clinician (Miller & Emanuele, 2013).

2.4.1 Participants will recognize the risk factors that can contribute to children/teens being at risk for suicide.

Risk Factors in Child and Adolescent Suicide

- Having a psychiatric disorder, such as depression, anxiety, etc.
- A history of suicide attempts or a family history of suicidal behavior
- A family history of mood disorder
- A history of physical or sexual abuse
- Exposure to violence, such as being injured or threatened with a weapon

Expansion: According to Miller & Emanuele (2013) and other researchers:

Risk Factors:

Mental Disorders

Clinical researchers agree that suicidal behaviors among adolescents are clearly associated with diagnosable mental disorders (e.g., see Kovacs, Goldston, & Gatsonis, 1993; Lewinsohn et al., 1996). Psychological autopsy studies have reported greater than 90 percent of adolescent suicide victims with a mental illness at the time of their death, although younger adolescent suicide victims tend to have lower rates of mental illness, averaging around 60 percent (e.g., see Beautrais, 2001; Brent, Baugher, Bridge, Chen, & Chiappetta, 1999). Although a variety of mental disorders exist among adolescents who committed suicide, adolescents internationally are diagnosed with one of three classes of Axis I disorders: (a) affective and anxiety disorders, (b) disruptive and antisocial behavior disorders, or (c) alcohol and substance use disorders (e.g., see Fergusson & Lynskey, 1995; Gould et al., 2003).

Prior Suicide

It has become well established that a prior suicide attempt is one of the single most important predictors of completed suicide (Gould, Greenberg, Velting, & Shaffer, 2003), with a thirtyfold increased risk for boys and a threefold increased risk for girls (Shaffer et al., 1996). Numerous autopsy studies of adolescents who committed suicide have found high rates of previous suicide attempts, ranging between 10 percent and 44 percent (Marttunen, Aro, & Lönnqvist, 1992). Furthermore, in a study of adolescents who attempted suicide evaluated in an emergency department, researchers discovered 8.7 percent of the boys and 1.2 percent of the girls committed suicide within 5 years (Kotila, 1992).

Affective and Anxiety Disorders. Depressive disorders have been reported among adolescents who attempted suicide and those who committed suicide, ranging from 49 percent to 64 percent (Brent, Perper, et al., 1993; Shaffer et al., 1996), with rates highest among psychiatric inpatients (Spirito et al., 1989). Suicidal behaviors are common among adolescents with early-onset depressive disorders (Brent, Perper, et al., 1993). Kovacs et al. (1993) found a four- to fivefold increase in suicidal ideation and behavior among adolescents with affective disorders compared with adolescents with other mental disorders. These statistics are noteworthy because the risk of developing a depressive disorder increases as one gets older but rises dramatically between ages 9 and 19 (King, 1997). In addition, although bipolar disorder is less prevalent among adolescents, it has been considered a significant risk factor in many studies (e.g., see Brent et al., 1988; Geller et al., 2002). Lewinsohn et al. (1996) identified anxiety disorders as a risk factor for suicidal behavior among adolescents. Goldston et al. (1999) reported trait anxiety to be predictive of post hospitalization suicide attempts, independent of mental disorder. In another study, investigators found that adolescents with a history of panic attacks were 3 times more likely to express suicidal ideation and 2 times more likely to report suicide attempts than those without a history (Pilowsky, Wu, & Anthony, 1999). Moreover, post-traumatic stress disorder has also been associated with adolescent suicidal behavior (Giaconia et al, 1995; Mazza, 2000).

Disruptive and Antisocial Disorders. Several researchers have suggested that most completed suicides by adolescents are impulsive, with only about 25 percent providing evidence of planning (Hoberman & Garfinkel, 1988). Aggression with impulsivity has also been linked with suicidal behavior in children and adolescents (e.g., see Apter et al., 1995; Brent et al., 1994). A study of suicidal adults suggested that a personality style marked by pronounced impulsivity and aggression characterized individuals at risk of suicide attempts regardless of mental disorder (Mann, Waternaux, Haas, & Malone, 1999). It should not be a surprise that disruptive behavior disorders are a common diagnosis among suicidal adolescents (e.g., Kovacs et al., 1993), especially boys (Brent, Johnson, et al., 1993; Shaffer et al., 1996). Furthermore, Apter et al. (1995) suggested that aggression, a large component of conduct disorder, may be as important a risk factor as depression in some kinds of suicidal behavior.

Other Factors In Combination Can Increase Risk of Teen Suicide

- Access to means, such a firearms, pills, etc.
- Loss or conflict with close friends or family members
- Use of alcohol or drugs
- Becoming pregnant
- Social Isolation

- Exposure to suicide

Expansion: Clearly risk factors of having access to weapons, significant fatal medications or other means are risk factors for teens/children considering suicide. But often people lessen their concern if they don't THINK a child has access to the means to commit suicide. For example, if the weapons have been removed from the home, if the medicines have been locked up, etc. people will let their guard down and we all know children can GET the means to commit suicide if they are that determined. But removing the possible sources of suicide can remove the threat of a spontaneous "bad day" impulse to kill themselves.

Conflict with peers, friends, teammates, siblings and/or parents can be another contributing risk factor for children to consider there is "no hope" or to view something as "unfixable". Often children/teens just do not have enough life experience of working through problems to see and understand that most problems/situations are not relationship ending and are not life ending. They just do not have enough life experience to understand this.

Unwanted pregnancy, for both boys and girls, can feel overwhelming enough to contemplate suicide. The notion of "my parents will kill me" or "I am going to go to hell" or whatever childlike ideations they have in their brain can lead them to feel that they might as well end their life because it is "over anyway". Again, not enough life experience to understand these things can/do work out and people get through them.

Social isolation, bullying and exclusion from groups are another factor that can lead children to think there is no point in continuing living and to consider suicide as an option. Those students that you see on the outskirts or that people perceive as outsiders can be more at risk for suicide.

Exposure to suicide of a peer, some big media event/person that involves suicide, a local person that commits suicide or someone/something that gets a lot of exposure/attention for an act of suicide can tip the scales for someone already thinking about suicide. At that point, upon the exposure to suicide, it no longer seems quite as scary or as unfamiliar. Thinking might be, "If he can do it, I can do it" etc.

Link to Antidepressants

- Some studies have shown a possible link between starting treatment with an antidepressant and an increased risk of suicide
- FDA requires manufacturers of all antidepressants to include a warning stating that antidepressants might increase suicide risk in children, adolescents and young adults
- Link is not clear and withholding treatment can also increase risk of suicide
- Anyone beginning treatment with antidepressants, should be watched closely for signs of suicidal thoughts or actions

Expansion:

According to the Mayo Clinic:

What role do antidepressants play?

Some studies have shown a possible link between starting treatment with an antidepressant and an increased risk of suicide. The Food and Drug Administration (FDA) requires manufacturers of all antidepressants to include a warning stating that antidepressants might increase suicide risk in children, adolescents and young adults.

However, the link between antidepressants and suicidal thinking isn't clear — and withholding appropriate treatment also increases the risk of suicide. To be safe, anyone who starts taking an antidepressant should be watched closely for signs of suicidal thinking.

2.4.2 Participants will be able to recognize warning signs of possible feelings of suicide in students/others.

Warning Signs

- Talking about or hinting at suicide; saying things such as “I am just going to kill myself” or “I might as well just end it all” or “I won't be causing you problems much longer” or “I won't be here to worry about it” etc.

Expansion: According to the Youth Suicide Prevention Program - most suicidal young people don't really want to die; they just want their pain to end. About 80 percent of the time, people who kill themselves have given definite signals or talked about suicide. The key to prevention is to know these signs and what to do to help. Watch for these signs. They may indicate someone is thinking about suicide. The more signs you see, the greater the risk.

- A previous suicide attempt
- Current talk of suicide or making a plan
- Strong wish to die or a preoccupation with death
- Giving away prized possessions
- Signs of depression, such as moodiness, hopelessness, withdrawal
- Increased alcohol and/or other drug use
- Hinting at not being around in the future or saying good-bye
- These warning signs are especially noteworthy in light of:
 - A recent death or suicide of a friend or family member
 - A recent break-up with a boyfriend or girlfriend, or conflict with parents
 - News reports of other suicides by young people in the same school or community
 - Other key risk factors include:
 - Readily accessible firearms
 - Impulsiveness and taking unnecessary risks
 - Lack of connection to family and friends (no one to talk to)

2.4.3 Participants will recall what to do when encountering a child/teen who might be suicidal.

What to do if you see the warning signs? If a teen mentions suicide, take it seriously. If he or she has expressed an immediate plan, or has access to a gun or other potentially deadly means, **do not leave him or her alone. Get help immediately.**

- **Talking about, writing about or being obsessed with “death” themed content**

Expansion: If you notice a child/teen is more pre-occupied with death events, death “talk”, the “afterlife”, media events regarding death, certain types of death occurrences, this could be a sign they are contemplating or even very curious about events that occur around death experiences. Sometimes teachers might notice students writing about death or death as a reoccurring theme in their written stories, etc.

- **Increased use of alcohol and/or drugs**

Expansion: Alcohol and/or many drugs are depressants. If a child is already having a hard time, upset about something or just overall very down, they think if they drink or do drugs they will “forget about it” or will be able to go out and have fun, but often it can be a downward spiral and can feed into depression and feelings of hopelessness and shame.

- **Feeling helpless/hopeless and/or having no purpose**

Expansion: Children/teens who think they are going nowhere, feel they are boxed into a corner, have been shamed in some way on social media, are being bullied with no relief in sight, feel misunderstood or generally like they are unable to escape whatever bad circumstances they might be facing can see suicide as their only way out or their only option for escape. It is essential to direct them to a place/person that they can actually get into the “solution” and try to make some active steps to solving problems and seeing some kind of light at the end of the tunnel.

- **Withdrawing from social interactions, situations and contact**

Expansion: Teens/children that begin withdrawing from their usual social circles could be indicating there are problems that they do not feel like they can handle. Often these problems could be in school, in their peer group or could even be based in some form(s) of social media

- **Extreme mood swings**

Expansion: Be on the lookout for children/teens that one day seem happy, might wear “lighter” clothing, might smile more or just be in general happier and more active and then on any other given day might be dressed in some kind of disheveled way or somehow indicating in their dress that they do not care or it just isn’t worth it to put any effort in towards their appearance. Paired with days of depressive looking behaviors, withdrawn, frowning/scowling, not talking or interacting etc. These swings back and forth can be indicative of a problem.

- **Changing the regular routine – could be eating and/or sleeping patterns, no longer exercising or doing things they enjoy**

Expansion: When children seem to no longer care, no longer are in the homework routine, the routine of athletics, alter their home life/routine, are up all night, try to sleep all day, are no longer interested in food OR are OVERLY interested in food, this could be a sign of a problem.

- **Acting aggressively, recklessly and not being concerned with “normal” consequences of those behaviors**

Expansion: Reckless behavior, lack of fear of consequences for poor (or even illegal) behavior can be a sign of suicidal feelings. Obviously someone that is not suicidal would have some concern over very risky behavior or some feelings of fear but suicidal ideations remove the fear of consequences since “I may not be around anyway”.

- **Giving away belongings or getting affairs in order when there is no other logical explanation for why this is being done. Might be like they are going away or on a long trip BUT that is not the case.**

Expansion: Children and teens contemplating suicide, once they really have some form of a plan or sincere idea of what they might do will write notes of appreciation, give things away that are significant to them, thank teachers/counselors, etc. This does not always occur, but if this behavior is noticed it should be taken seriously. This is usually a step reserved for once a plan or timeline for a suicidal attempt is in place.

- **Major personality changes, severe anxiety or extreme agitation**

Expansion: As with other behaviors that have been mentioned, extreme agitation, anxiety, anger, etc. can be signs of suicidal feelings in children/teens. CHANGES are also key. It could be that a child is exhibiting what one might term “positive” behaviors – seems happier, resolute with some issues, and could even seem more at peace. That is because there is turmoil in the decision “Should I or should I not?” – “Will I or will I not?” and once the decision has been made, they are ironically more at peace.

- **Scars or wounds from what look like self-inflicted injuries or unexplainable cuts, burns, etc.**

Expansion: Children/Teens that have suicidal ideations and/or feelings will often cut themselves, drag a knife across their skin, rub erasers until the skin is removed in places, burn themselves with lighters, matches, cigarettes and things such as that. These things can be viewed as little tests and inquiries about pain, hurting, being “brave enough” to complete the act of suicide.

Different Conceptualization of Suicide

Suicide is an attempt to solve a problem of intense emotional pain with impaired problem-solving skills (Kalafat & Underwood, 1989)

Instructor Notes:

Video: Discuss Video

https://www.ted.com/talks/kevin_briggs_the_bridge_between_suicide_and_life?language=en

Expansion: Kalafat & Underwood’s definition is a more progressive definition of suicide. Often suicide, the thoughts of suicide, suicidal ideations are treated as messed up, stupid or even weak. Truly when working with suicidal people, you see that they are in such crisis, their decision making is impaired because of all of the pain that they are in. It is not really a rational

decision but the emotional pain they are in is overshadowing and circumventing what might normally be rational problem solving skills.

Suicide as a Response

There are many ways to think about suicide, but the above definition, which frames suicide in a behavioral context, presents it in a way that minimizes both judgment and personal interpretation. It reminds us that suicide is a response to something emotionally painful that's going on in a student's life, and the student's response—suicide—results from an impaired ability to cope.

Expansion: Shneidmann's (1985) definition focuses on the impaired ability to cope and tries to remove judgment and subjective personal interpretation from how we normally conceptualize suicide. Often there is judgment there of weakness but truthfully people that commit suicide cannot seem to find any other coping mechanisms.

Suicide as a Response

One of the first mental health practitioners to study suicide, Edwin Shneidmann (1985, *Definition of Suicide*, New York: Wiley), outlined some basic characteristics of suicide that may help in understanding it.

Shneidmann's 5 Basic Characteristics of Suicide

1. Suicide is an alternative

Expansion: Viewing suicide from this perspective has several important implications. For one, just as a teen may get a temporary high from a drug, he or she may obtain temporary attention, support, or even popularity after a suicide attempt. These positive effects are short-lived, however, if the basic problems that underlie the attempt aren't addressed. These initial problems are usually exacerbated by the stigma that eventually surrounds any suicide attempt.

A second implication of viewing suicide as an alternative is that suicide can then be understood less as a wish to die than as a wish to escape the intense emotional pain generated by what appears to be an inescapable situation. The most salient question is, "What's going on in your life right now that has you feeling that death is the only answer?" Be careful when talking about this, however, not to offer the familiar cliché, "Suicide is a permanent solution to a temporary problem." Clichés, as a rule, are dismissive and impersonal. Few people really stop to internalize the meaning of cliché. And because so many people have heard the suicide cliché before, few people really listen to it!

2. Crisis thinking impairs problem solving

Expansion: When we think of a crisis as any situation in which we feel that our skills do not meet the demands of the environment, we realize that crises can be frequent visitors in most of our lives. No matter how diverse one's repertoire of coping skills might be, there are certain situations we will all encounter for which no backlog of experience seems totally sufficient. Although crises, using this definition, are normal occurrences in the course of everyone's life, most youth lack sufficient life experience to realize the normality of crises or the fact that they are usually resolved. Crisis thinking, which is usually emotional, extreme, and constricted,

characterizes problem solving. Sometimes the level of crisis thinking can be lessened just by pointing out that whenever anyone is in a crisis, figuring out what to do is harder than it is when we are not in crisis and can think more clearly. Some types of problems that seem hopeless are in fact solvable. In addition, being able to talk through the feelings with someone who listens is another way to reduce their intensity.

3. A suicidal person is often ambivalent

Expansion: What this means is that the person is feeling two things at the same time; there is a part of that person that wants to die and a part that wants to live. When talking with a suicidal student, we must acknowledge both of these components. While we align with and unequivocally support the side that wants to live, this can't be done by ignoring or dismissing the side that wants to die. If you think about times in your life when you've had a strong feeling and someone close to you ignored it or told you that you don't really feel that way, you know that this type of response only makes you feel misunderstood and unsupported, and shuts down communication for good. Acknowledging that there is a part of the person that really wants to die and letting them talk about it may be scary, but it will lower that person's anxiety. Ignoring those feelings or discounting them can raise anxiety and increase the feelings of isolation that are so prevalent in people who are feeling suicidal.

4. The choice of suicide has an irrational component

Expansion: People who are suicidal are often unaware of the consequences of suicide that are obvious to the rest of the world. For example, they are usually not thinking about the impact of their death on others, or they hold a perception that they will be reincarnated or somehow still present to see how others react to their deaths. This irrationality reflects how trapped and helpless the person feels. In these situations, it is usually more helpful to talk rationally about the reasons the person may have for living rather than try to address their irrational thoughts about dying.

5. Suicide is a form of communication

Expansion: For people who are suicidal, normal communication has usually broken down. The suicide attempt may be the person's way of sending a message or reacting to the isolation they feel because their communication skills are ineffective. The question that addresses this breakdown can be phrased in the following way: "Who did you want your suicide attempt to send a message to and what did you want that message to be?"

2.4.4 Participants will recall other factors that can increase risk of teen suicide

Other Possible Contributing Factors

- Sexual Orientation
- Socioeconomic Class
- Family Dysfunction & Parental Psychopathology
- Stressful Adverse Life Events
- Suicide in Social Circles
- Academic Difficulties

- Sexual and Physical Abuse

Expansion from Miller & Emanuele (2013) and other researchers/authors:

Sexual Orientation. Cross-sectional and longitudinal epidemiological studies found homosexual adolescents of both sexes to be 2 to 6 times more likely to attempt suicide than their heterosexual peers (Blake et al., 2001; Russell & Joyner, 2001). Garofalo, Wolf, Wissow, Woods, and Goodman (1999) found that self-identified gay, lesbian, and “not sure” youth were 3.41 times more likely to report a suicide attempt than their peers. In addition, they found sexual orientation to have an independent association with suicide attempts for male adolescents. For female adolescents, the association of sexual orientation with suicidality may be mediated by drug use and violence-victimization behaviors.

Socioeconomic Status The data are mixed regarding the effect of socioeconomic status and suicide (Miller et al., 2007). Several studies have found that youth who have attempted suicide have higher rates of socioeconomic disadvantage than community control participants, even after controlling for other social and mental health risk factors (e.g., see Fergusson, Woodward, & Horwood, 2000). Other studies have found little effect of socioeconomic disadvantage on suicide victims generally after adjusting for family history of mental illness or suicide (Agerbo, Nordentoft, & Mortensen, 2002).

Family Dysfunction and Parental Psychopathology Various theories, coupled with research data, suggest that family functioning plays an important role in the etiology and maintenance of adolescent suicidal ideation and behavior (e.g., see Adams, Overholser, & Lehnert, 1994). A family history of suicidal behavior significantly increases the risk of completed suicide (Gould, Fisher, Parides, Flory, & Shaffer, 1996) and attempted suicide (Bridge, Brent, Johnson, & Connolly, 1997). Agerbo et al. (2002) found youth suicide to be nearly 5 times more likely in the offspring of mothers who have completed suicide and twice as common in the offspring of fathers, even after adjusting for parental mental disorder. Furthermore, parental depression and substance abuse have been associated with suicidal ideation, attempts, and completed suicide in adolescents (e.g., see Gould et al., 1996). Impaired parent-child communication and low levels of emotional support and expressiveness are also associated with adolescent suicidal behavior (e.g., see Wagner, 1997).

Stressful Adverse Life Events Historically, interpersonal conflicts and separations are considered the most common precipitants to adolescent suicide (Miller & Glinski, 2000). Breakup of a romantic relationship, disciplinary or legal problems, and arguments are some of the stressful life events identified in attempted and completed suicide of youth worldwide, even after adjusting for family, personality factors, and psychopathology (e.g., see Beautrais, 2001). Specific stressors may vary depending on age. For example, romantic difficulties are common precipitants among older adolescents, and parent-child conflicts are common among younger adolescents (Miller & Glinski, 2000).

Suicide in the Social Milieu Exposure to the suicidal behavior of others, including through the media, can precipitate imitative suicidal behavior, at least in some individuals (Velting & Gould, 1997). Adolescents are highly susceptible to suggestion and imitative behavior, as these are primary modes of social learning and identity formation. Velting and Gould (1997) proposed that modeling cues through personal acquaintance, community exposures, and exposure to

media coverage may all play a role in imitative suicidal behavior. Numerous studies have found significantly more peers, friends or family members had attempted or completed suicide in the social networks or families of those who ideated about, attempted, and committed suicide than in control groups. In addition to increased rates of suicidal behavior in the relatives and friends of suicide victims, suicidologists have examined cluster suicides. A suicide cluster may be defined as a group of suicide attempts that occur closer together in time and space than would normally be expected in a given community (Centers for Disease Control and Prevention, 1988). In a review of the suicide cluster literature, Velting and Gould (1997) argued that suicide contagion is a real effect, even though it appears to be a less potent risk factor than other psychiatric and psychosocial risk factors for suicide. In addition, adolescents are at highest risk for a cluster suicide.

Academic Difficulties School difficulties, not working or attending school, and dropping out of high school have been identified as risk factors for attempted and completed suicide in several countries, even after controlling for psychopathology and social risk factors (e.g., see Wunderlich, Bronish, & Wiichen, 1998).

Sexual and Physical Abuse Researchers have found that childhood sexual and physical abuse are also associated with suicidal behavior in adolescents, even after controlling for a variety of potentially confounding variables, including the adolescent's psychopathology, parental psychopathology, and demographics (Gould et al., 2003; Johnson et al, 2002). Functional Impairment From Physical Disease and Injury Physical diseases and injury and related functional impairment have been found to increase the risk of future suicide attempts in adolescents (Lewinsohn et al., 1996). Nevertheless, certain diseases require more attention in this population. For example, a diagnosis of HIV/ AIDS, although considered a more definitive risk factor among adults, has not received adequate empirical study among adolescents.

What to Do When You Are Worried About Child/Adolescent Suicide

- Tell SOMEONE within the school that has the ABILITY to do something/help
- Address depression/anxiety when you see it as a factor (contributing factors)
- PAY ATTENTION
- Share YOUR feelings
- Discourage Isolation
- Encourage Physical Activity
- Support the child/family/counselors/administrators/treatment plan
- Make sure those around the child are aware of the "means" of suicide that a child might have access to

Expansion: Although SRO's are not therapists, they are often put in a position, whether they want to be or not, to "counsel" with children. The below are illustrations and suggestions from Miller & Emanuele (2013) as to potential ways to respond to children that might be suicidal.

According to Miller & Emanuele (2013) and other researchers:

Delay Impulses and Restore Hope

One of the greatest problems for suicidal youth is that they cannot see a way out of the pain they are experiencing. In these circumstances, therapists need to simultaneously use assessment and intervention strategies. Many suicidal patients describe their current experience as though there is a mountain of accumulated problems in front of them that appears insurmountable. Thus, the challenge for the therapist is to model how to break down this mountain into manageable problems that can be solved in the present. A protective factor for suicide is when the patient can identify reasons for living. The therapist can ask the suicidal patient, "What reasons do you have for living right now?" The therapist hopes that the patient does not require significant prompting. However, because suicidal patients are often in acute emotional distress, the therapist might prompt with statements such as, "What about your family and friends?"; "How would they feel if you killed yourself?"; "What about your future?"; "What do you want to be when you grow up?"; and "What about your religion?" If these reasons for living are significant, they can serve as a protective factor against imminent suicidal behavior. With minor prompting, Donna was able to acknowledge the painful feelings she had when she considered how hurt her mother and family would be if she killed herself. The therapist was able to provide validation for the anguish Donna was feeling and help her recognize that she now had another advocate to help her to decrease her pain. In addition, the therapist told Donna that despite feelings to the contrary, she could make it through this difficult period if she gave the therapist a chance to help. The therapist reminded her of prior occasions that Donna had stuck it out and came out on the other side feeling better. If recalling past coping successes is ineffective, the therapist can use statements such as, "How do you know you will feel less upset after you kill yourself?"; "Why don't you give us a chance to work on solving your problems and lessen your pain?"; and "What do you have to lose?" If the patient cannot identify any reasons for living and is unable to demonstrate any future perspective in terms of goals, the therapist must recognize this as an absence of protective factors that needs to be factored into the decision about psychiatric hospitalization.

Problem-Solve the Current Problem

Frequently, the adolescent's assumptions about the outcomes of his or her behavioral choices are unrealistic and need to be gently but directly confronted. Ideally, therapists help patients generate their own solutions to their problems. However, in an emergency there are times when the patient does not know what to do. In these circumstances it is advisable for the therapist to give direct, concrete suggestions about how to manage specific situations (Miller, Nathan, & Wagner, in press). Therapists should be careful not to assume that a patient who generates a solution also knows exactly how to carry it out. Thus, therapists should pay attention to these details and generate solutions for the patient to try. The therapist was able to recognize that Donna was overwhelmed by her emotions and suicidal thoughts. The therapist helped Donna identify that she had survived these thoughts and feelings before by using specific strategies, including talking with her mother, listening to music, and writing poetry. For Donna, the long-term goal of therapy was to learn to affiliate with people, particularly boyfriends, who would treat her respectfully. The therapist, however, helped Donna focus on the short-term goal, which was to get through this suicidal emergency situation. As a result, in addition to helping Donna identify strategies for managing her emotions, the therapist also made herself available by pager 24 hours a day and added an additional session later in the week to increase social support.

Reduce High Risk Behavioral Factors

Regardless of whether the lethal means is a gun, liquid poison, or pills of some sort, it is imperative that the therapist spend a portion of the emergency session ensuring that the removal of lethal means has occurred or will occur. Depending on the acute nature of the emergency, the therapist may instruct the patient to bring the lethal items to the next session or insist that the patient go home and bring in the items immediately. In other cases, when the patient calls the therapist in a suicidal emergency, the therapist may instruct the patient to flush the pills down the toilet and should wait on the phone while the patient complies. In other cases, family members, significant others, or roommates may be enlisted to facilitate the removal of lethal means from the patient's home. Locking up a firearm in the home or separating the ammunition from the gun is not sufficient. The weapon needs to be secured outside of the home. Because Donna is a minor, the therapist brought Donna's mother into the session to inform her of Donna's suicidal thoughts, plan, and possible intent. The therapist specifically asked Donna's mother whether all the medications in the house were locked away and told her that if they were not, she should insure they were as soon as they returned home. Donna agreed to this plan, stating that she did not trust herself with access to the pills. If the adolescent refuses to consent and is noncompliant with the therapist's recommendations to remove lethal items herself, it is typically a bad prognosis regarding the adolescent's willingness and capacity to maintain safety and thus may require an inpatient admission. Either way, because suicidal behavior is at issue, the therapist is justified in breaking confidentiality by contacting a family member to remove the lethal means. In addition, some patients self-medicate with drugs or alcohol. During a suicidal emergency, the patient needs to be instructed to discontinue any alcohol or drug use because of their disinhibiting properties. If the adolescent is unwilling to discontinue drug or alcohol use, the therapist must factor this high-risk behavior into the decision about psychiatric hospitalization.

Commit to a Plan of Action

After a sufficient number of solutions are generated, the therapist asks the patient to commit to a plan of action. Considerable evidence suggests that the commitment to behave in a particular way, especially when the commitment is made publicly instead of privately, is strongly related to future performance (Linehan, 1999). First and foremost is obtaining the patient's commitment to not engage in any suicidal or self-harm behaviors until the next session. Donna, with the therapist's assistance, identified the specific strategies she would use to survive this emergency situation. She committed to staying alive until the next scheduled session and agreed to tell her mother if her suicidal thoughts became unbearable. She also agreed to tolerate distress by listening to music, writing poetry, and calling her friends on the phone. Donna informed her mother about the plan.

Troubleshoot the Plan— Tolerate Distress

Therapists working with suicidal patients need to suggest that one additional solution to their problems is to simply tolerate the painful consequences, including the negative effect that the situation has generated. At first blush, many suicidal patients have trouble grasping the value and function of this solution. However, with practice, patients begin to recognize and appreciate the idea of tolerance as a solution. In Donna's case, the therapist validated her pain and normalized that anyone would feel this way after an abrupt breakup of a romantic

relationship. The therapist noted that although it sounded strange, “Learning how to tolerate pain and disappointment is a difficult and important life lesson. I don’t wish pain and disappointment on anyone, especially you, Donna, but I actually think this is an opportunity for me to help you learn how to soothe yourself during difficult times in your life.”

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DRAFT

Section Three:

De-escalation Techniques and Techniques for Limiting the
Use of Force
(4 Hours)

DRAFT

Instructor Guide

Section Three: De-escalation Techniques and Techniques for Limiting the Use of Force

This discussion is divided into three component parts; officer responsibilities for behavior in our schools, behavior development model, and the seven phases of escalating behavior. Each of the three components will give attention to de-escalation techniques for limiting the use of force, including the use of physical restraints. The components will then relate back to the role of a school law enforcement officer and school safety.

3.1 Unit Goal: Progress toward "expanding" your capacity and knowledge on de-escalation is critical to the school's sustained effectiveness in meeting the needs of its students and maintaining the safety and security of all.

Instructor Note:

Discussion questions:

Name the two ways that an individual can act out (verbal, physical)?

There are innumerable ways that a person can act out, but many people will come up with a logical way of categorizing acting-out behavior: verbal acting out and physical acting out. This response allows you to talk about the fact that each of these ways of acting out requires a different response from staff.

List the levels of behavior an individual may experience in a crisis situation and staff responses. Listen to the participants' responses and validate their experiences.

The purpose of this question is twofold. First, it gets people thinking about the fact that there are levels of behavior an individual experiences when in crisis. Second, it introduces the idea that there is a relationship between the behavior of acting-out individuals and the behavior of staff members—that different behaviors call for different responses.

Have you ever needed to handle an agitated individual? Many people will choose the answer "frequently." Responding to this question gives you an opportunity to affirm that on a day-to-day basis, the participants do a good job of working with the individuals in their charge. It is when people become agitated and begin to act out that staff may have less confidence in their abilities to handle the situations they encounter. The purpose of this training is to help staff manage these crisis moments effectively.

You may wish to point out that we are all "agitated individuals" at times. Most of us, however, have some skills to cope with that agitation. Many of the acting-out individuals with whom we work do not have such skills, and as a result, they may be verbally or physically aggressive. Our role as staff is not only to keep them (and ourselves) safe during such episodes, but also to look at ways to help them gain control over their own behavior so that the crises are not endlessly repeated.

One way that we can do this is to recognize the early signs that an individual may be headed for a crisis and to intervene early enough to head off difficult behavior before it escalates.

3.1.1 Review state requirements for handling behavioral issues, including legislation on the use of restraints. Referencing the Texas Penal Code and the Texas Administrators Code, students will assess an officer's responsibility referencing behavior, through the use of a group activity.

Instructor Notes:

Review:

19 TAC Chapter 89, Subchapter AA. Commissioner's Rules Concerning Special Education Services

Education Code, CHAPTER 37, Subchapter E-1. Penal Provisions

H.B. No. 2684

Understanding the Risks of Restraints

The Use of Restraints

This course focuses on crisis prevention and the creation of restraint-free environments through a commitment from all school staff. While a restraint may be called for, it should only be considered as a last resort. Any physical intervention should be used only when all other options have been exhausted and when an individual is a danger to self or others. Even in those moments, an assessment is still necessary to determine the best course of action to protect the student's safety and mental health and well-being. Physical intervention should be considered only when the danger presented by the acting-out individual outweighs the risks of physical intervention.

Dangers of Restraints

The events leading up to a crisis situation and the struggling that occurs during a restraint can result in a lot of stress for the individual being restrained. This negative stress is sometimes called distress. Consequently, it is not unusual for a restrained individual to show signs of distress, both physically and emotionally.

Always keep in mind that the acting-out student might have health problems. Therefore, everyone being restrained should be considered at risk. It is also important to understand that in some cases, restrained individuals have gone from a state of no distress to death in a matter of moments.

Reducing the Risks of Restraints

There are ways to minimize risks involved in any physical intervention. The very best way to avoid injury is to avoid the need to restrain in the first place. Get to know the people in your care. Be aware of changes in their behavior that can be warning signs of anxiety. Intervene early. Learn to set limits effectively. Avoid being drawn into power struggles. Work as hard at

learning verbal intervention skills as you do at learning physical intervention skills. Treat everyone with dignity and respect.

3.1.2 Identify proactive, preventative strategies of Behavior Development that will decrease the occurrence of escalating behavior.

Behavior Development Model

Basic Behavior Assumptions

We all have a set of beliefs that influence our interpretation of the environment and the way we interact with others. These are called assumptions. Assumption analysis describes the activity adults engage in to bring to awareness beliefs, values, cultural practices, and social structures regulating behavior and to assess their impact on daily activities. Assumptions may be typical, narrow, or causal. Assumptions structure our way of seeing reality, govern our behavior, and describe how relationships should be ordered.

Instructor Note:

What are your individual assumptions about behavior?

Do you believe: Behavior serves a purpose; behavior falls into predictable patterns; if we can predict behavior, we can promote appropriate alternatives?

We model respect because it has been modeled to us. However, what happens to our values when we are stressed and life becomes complicated? How do we behave when the children in our school are falling instead of rising? Where does our level of standard respect start? If we aren't level headed how do we expect everyone to stay level headed?

Discipline vs. Punishment

Instructor Notes:

- *Have students discuss words or phrases that come to mind when they hear the word discipline.*
- *Have students discuss words or phrases that come to mind when they hear the word punishment.*
- *Next have each group actually write a definition for the word discipline and the word punishment.*
- *Have them compare their definition with Cambridge definition of discipline: training that produces obedience or self-control, often in the form of rules and punishments if these are broken, or the obedience or self-control produced by this training: Control that is gained by requiring that rules or orders be obeyed and punishing of bad behavior.*

Discipline is used to teach and guide.

Punishment is used for the purposes of controlling and retribution.

Discipline teaches children a particular misbehavior is bad because it violates the social order, thus promoting the development of internal controls.

Punishment causes children to focus their attention and anger toward an “unfair” adult rather than on learning to be responsible for their own actions.

Effective Behavior Support

School-wide positive behavior support (PBS) is a broad set of research-validated strategies designed to create school environments that promote and support appropriate behavior of all students. These environments are brought about through the identification of common behavioral expectations that are valued by the school community and can apply to all students’ in all school settings and situations. These common expectations are directly and explicitly taught to all students to create an atmosphere in which students know what is expected of them at all times. Furthermore, in a PBS framework, students are systematically and frequently acknowledged for their appropriate behavior. Undesired behavior, when it occurs, is responded to swiftly and consistently. A school environment is therefore created that (a) teaches students skills to behave appropriately, (b) positively acknowledges students engaging in those behaviors, and (c) provides consistency and stability in interactions among students and staff members.

Speak Up

How can you prevent acting-out behavior?

How can you tell when a student’s behavior is escalating?

What do you do when a student is acting out?

How do you deal with a student who is fully escalated?

Guiding Principles for Every Situation

Will my response meet the person’s needs? Is my response respectful and dignified? Will my response maintain safety?

Key Assumptions

Key assumptions when dealing with behavior.

1. Severe behavior can be expressed in many ways but there are common threads or reasons for these behaviors that can be identified.
2. Students of all ages and levels of disabilities can manifest severe behavior yet there are identifiable common features across student populations in terms of analysis and interventions.
3. Severe behavior usually does not occur as a separate event. Rather it occurs as part of a behavior chain or pattern. Analysis and interventions need to address the entire chain and all phases of the problem behavior.
4. Successful interventions need to target all settings where the problem behavior occurs and involve key persons in each of these settings.
5. Some students will need support and services by community agencies.
6. Students who exhibit severe behavior are often served by multiple agencies. These services need to be coordinated.
7. Severe problem behavior is most effectively addressed by applying: effective strategies before the severe behavior arises and effective follow-up strategies after the behavior occurs.
8. Severe and chronic behavior is most effectively addressed as part of the PBS system in which school-wide and classroom management systems are already in place.

3.1.3 Identify the seven phases of escalating behavior and practice de-escalation techniques for limiting the use of force, including the use of physical restraints.

Instructor Note:

HANDOUT #1

Activity

There will be times when a child will engage in challenging behavior even after proactive strategies have been planned and implemented. Adults in this situation may struggle with trying to de-escalate the situation without inadvertently reinforcing the challenging behavior.

Examine the 2 scenarios: Michael and Jason

Example 1: Michael

During passing period you see Michael in the hall walking slowly to class. Students are expected to clear the halls in a timely manner. Michael decides to sit slouched against the wall outside of his classroom, feet stretched out, head down staring at the floor and looking very serious. The successive interactions are presented along with a brief description of the adult and student's behavior.

Adult: "Michael, it is time to get in to your math class."

Michael: "I don't want to go to Math!"

Adult: "That is your first class this morning. You need to get to class."

Michael: "I got my schedule changed!"

Adult: "Well let me see your new schedule please."

Michael puts his head back against the wall.

Adult: "Do you have a copy?"

Michael: "Since when do I have to provide a copy for you?"

Adult: "Michael, you need to stop playing games and get to class."

Michael: "I don't play games!"

Adult: "Michael, look, I know you know what you are doing. You know the rules so get up and get to class now!"

Michael: "No way. I'm done!"

Adult: "OK. Here is your choice. Get to math now or you will have detention."

Michael: "F... you."

Adult: "You aren't going to talk to me like that. Let's go to the office."

Michael throws his book across the hall.

Adult: "Alright. It's to the Office." Nudges student on the elbow.

Michael swings arm in direction of adult and makes solid contact with their arm.

Example 2: Jason

Jason is a person with autism and limited verbal skills. He also has cognitive disabilities and a cleft palate. In addition, he hits his face often and pulls out his hair.

Presently Jason is sitting at a table in the cafeteria rolling his head and making noises. He normally can sit calmly. He is being asked to get up and walk to class. Adult prompts Jason to pick up his tray to dispose of it. Jason shakes his head and begins to rock back and forth making even louder noises. Teacher hands him his tray and nudges his elbow. Jason slowly takes the item and pushes it down the table. Teacher taps the table near his tray and asked Jason to pick up the tray and take it to the trash. Jason took the tray and dropped the tray on the table. Jason turns his hands palm up and slaps his face. Teacher holds his hands, taps table, and slowly lets the hand go. Jason turns his hands, slaps his face, and begins to pull his hair out. Jason rolls his head and yells continuously, louder than earlier.

What similarities do you see between the two examples?

Have the participants chart commonalities between the 2 students. Write the responses on the flip chart.

Direct the discussion to the following four critical features common to each of these examples, which are critical to UNDERSTANDING and ADDRESSING severe behavior.

- 1. Each student was expected to engage in a task.*
- 2. Each student displayed signs of agitation*
- 3. Presence of successive interactions between teacher and student*
- 4. Presence of an escalating behavior chain*

Successive Interactions

Features of Severe Behavior Cycle

In each case EVERY student behavior was preceded by adult behavior (like a game of "emotional tennis"). Each student, although very different in terms of disability and level of functioning, exhibited very similar behavior patterns implying very similar analyses and interventions. The differences in strategies will lie largely in the area of communication and structure. These patterns provide the cornerstone for a model to describe serious problem behavior commonly seen in classrooms and school settings. It is most important to examine the context in which the behavior occurs. When this is carefully done, similarities will be seen and basic principles will be evident.

Instructor Note:

Discuss the signs each student displayed...

Questions to discuss, “What if the adult didn’t take a turn?” Or, “What if the adult took a different turn?” The need to have the last word becomes a power struggle; therefore, successive interactions will occur.

Each student was expected to engage in a task. Task avoidance could be possible for any number of reasons such as:

Does the student understand the directions?

Does the student have the pre-requisite skills to begin the task? Is there immediate negative history from the previous task or activity?

Model for Escalating Behavior Chain

The specific phases that describe the successive student behaviors rise as the interaction escalates to what is usually referred to as severe or serious behavior and falls away as the student behavior de-escalates. The escalating behaviors are depicted in phases one through five, followed by the de-escalating behaviors in phases six and seven.

Let’s look now at detailed descriptions for the behavioral characteristics of each of the seven phases. As we proceed through the model, you will probably think of many strategies that can be used. The issue is not the effectiveness of the strategy itself; rather it is when the strategy is used. That is: TIMING - using the strategy in the right place in the model.

As we go through each phase, try to think of a specific student you’re familiar with who you’ve seen in that phase. We will discuss real examples after we have reviewed all of the phases.

Each cycle can be described in terms of seven phases: 1. Calm 2. Trigger 3. Agitation 4. Acceleration 5. Peak 6. De-escalation 7. Recovery

Two Components for Managing Escalating Behavior

Understanding the Model and Developing Strategies for Each Phase

Calm phase

One strategy to use early in the calm phase is to provide plenty of praise for appropriate behavior. Children who exhibit a lot of anti-social behavior often get ignored when they are compliant or quiet. Care providers can become tired out by these children and ignore them when they are not demanding attention. It is important to note how often you are providing positive feedback to these children and to increase the attention you provide when they are behaving appropriately. When children are calm throughout the day, it is also important to acknowledge their emotions to help them name and identify their own feelings. Children cannot recognize feelings in others that have not been acknowledged in them. So throughout the day use naturally occurring events to help children identify their feelings.

Trigger Phase

Try to recognize early signs of agitation or withdrawal to intervene early in the cycle. If you notice the child’s behavior changing, offer strategies for problem solving. Ask the child what is wrong to help him identify the source of the problem. Allow the child to express his feelings in a socially acceptable way and validate his feelings.

Instructor Note:

Use the following triggers to initiate class discussions

SCHOOL-BASED TRIGGERS

Conflicts. The sources of student conflicts occurring at school fall into two broad categories: 1. Denial of something the student wants or needs; and 2. Something negative is inflicted on the student.

Changes in routine. Students with acting-out behavior often react negatively to sudden changes in routines, especially if the activity is something that has fully engaged them or something they haven't quite finished.

Peer provocations. Unfortunately, other students sometimes see these easily triggered students as 'fair game'. Consequently, these peers can very predictably because their readily triggered peers to escalate and get into trouble.

Pressure. School can be viewed as a very high-demand situation in which students are expected to comply with a wide variety of directions and complete a number of often-complex tasks during the course of a school day. In many cases, the students with serious problem behavior do not have the skills necessary to meet these expectations; consequently they feel they are under constant pressure.

Ineffective problem solving. Students with severe problem behavior generally have limited strategies for identifying sources of problems, generating adaptive options, evaluating them, negotiating with others, and implementing plans accordingly.

Facing errors during instruction. When these students face new or challenging work, or make errors, the situation can escalate to serious acting-out behavior or lead to avoidance of the work.

Facing correction procedures. Easily triggered students often have problems in accepting assistance after errors have been made or with being required to do the task over again.

NON-SCHOOL BASED TRIGGERS

High-needs homes. Students who have behavior disorders often come from homes where many critical needs are not met.

Health problems. There is no question that student behaviors are different when the students are healthy compared to when they are sick. To compound this, unfortunately, in our society, there are many parents who do not have health insurance or have very limited insurance coupled with low income.

Nutrition needs. One of the most serious outcomes for families afflicted with poverty is that the children (and adults for that matter) do not have regular, well-balanced meals and are often hungry. Deficits in nutrition not only impact health and general well-being, but may also seriously and adversely affect student behavior.

Inadequate sleep. Sleeping patterns of many students are often irregular and inadequate. Children need adequate rest to function appropriately in school and inadequate sleep makes it

very difficult for children to behave appropriately and to participate effectively during instruction and other school activities.

Dual diagnoses. In some cases children are given dual diagnoses and the respective treatments may interact negatively with each other.

Substance abuse. Students who use drugs and alcohol often exhibit serious and unpredictable acting-out behavior at school.

Gangs and deviant peer groups. Membership in gangs and deviant peer groups sets the stage for serious problems at school, especially with school authority and peer relationships.

Compound triggers. While the triggers have been presented in two groups, school-based and non-school-based, some students with serious problem behavior experience these triggers in both settings. In addition, there can be carryover of triggering events from previous situations, settings, and interactions.

Summary of Phase Two: TRIGGER Overall behavior involves a series of unresolved problems.

Agitation Phase

In this phase, supportive techniques can be used to help the child effectively manage his agitation and de-escalate. In this phase, the child may have a grimacing facial expression or be fidgety or exhibit other signs of agitation. Some supportive techniques to use during this phase include therapeutic language, such as asking, "Are you ok?" or directly saying, "You are looking upset. Can I help you?" Care providers can also provide the child with physical space, preferred activities or items, adults being close and available to provide attention, physical movement, or sensory activities such as water play, a sand table, shaving cream, etc. If possible, involve the child in the plan by offering a choice of acceptable options to help them learn self-regulation. Empathy toward the child's feelings at this stage is critical to helping the child regulate his feelings.

Instructor Note:

Have the group discuss:

- *Physical bodily reactions to anger and personal reaction to anger*
- *Discuss the 5 senses when responding to anger*
- *Discuss "fight or flight."*

Instructor Note:

Discussion Points:

Increases in Behavior

Darting eyes. Students look here and look there with a certain level of intensity but with little focus or purpose to their eye movements.

Non-conversational language. For example, when students are asked a question, they answer very cryptically or bluntly, communicating that they don't really want to talk to you.

“Busy” hands. Students often display a noticeable increase in hand movements. These behaviors resemble those of a student with hyperactivity except that the student does not exhibit these behaviors during the Calm phase. This behavior is very prevalent among students with severe disabilities especially in areas of language and communication.

Decreases in Behavior

Staring into space. The student appears to be daydreaming and staring into space and seems to be looking at something with a certain amount of concentration but his or her mind is somewhere else.

Veiled eyes. The student avoids eye contact by looking away, looking down, pulling his hat down over his eyes, or pulling up the lapels of his jacket and sinking his head as low into the jacket as he can.

Language subdued. Student responses are such that it is difficult to build a conversation. Essentially the students communicate that they do not wish to talk.

Contained hands. By contrast to the other group where busy hands were a signal of agitation, this group may hide their hands by sitting on them, folding their arms or putting their hands behind their backs.

Withdrawal from groups. These students show a tendency to withdraw from the group, shut down, engage in independent activities or move to isolated areas. There is the clear communication -- “Leave me alone.”

Summary of Phase Three: AGITATION Overall behavior is unfocused and distracted.

Acceleration Phase

In this phase, the situation may begin to feel out of control. If the child is on the Hyperarousal Continuum, he will become defiant and will generally refuse to comply with any request. He may begin to tantrum or yell. In this phase, it is critical for care providers to remain calm to avoid escalating the behavior further by engaging in power struggles or shouting matches. The adult’s behavior should be controlled and nonjudgmental. The following are some suggestions for approaching children in this phase. Establish an eye-level position with the child and speak privately, respectfully, and calmly with the child. Move slowly and deliberately toward the child and try to minimize body language that could be interpreted as threatening such as pointing a finger or crowding the child. Stay focused on the problem at hand. Acknowledge the cooperation of the child if the behavior begins to de-escalate and the child complies. If the behavior escalates, move away from the child and follow emergency procedures if the child begins to injure him/herself, property or others nearby.

In the Acceleration phase, the student is saying, “I want to engage you.” In other words, the student exhibits engaging behavior that is highly likely to obtain a response from another person, typically the adult.

Instructor Note:

To help accentuate the difference between the acceleration phase and the agitation phase, use this example:

A student comes to school head down, muttering and looking upset. He drops a book and utters the 'F' word.

You tell another student that he has to stay after school if he doesn't hurry up and get to class. The student looks at you and shouts, "F__ you".

In both these cases, the students have uttered an expletive. What is the difference? (Allow time for class to respond)

In the first case, the student's utterance is not directed to anybody. It is a reaction. In the second case, the utterance is expressly directed towards the adult. In general, agitation is non-directed behavior.

Acceleration is directed behavior designed to engage the other person. Another way of looking at this is that in the agitation phase, the student internalizes the behavior. In the acceleration phase, the student externalizes the behavior.

Typical engaging behaviors in the Acceleration phase include:

- **Questioning and arguing.** Students set themselves up to need help or ask questions and then proceed to argue about the responses or details of the task given to them. Educators are suckers for questions. We feel as if we have to answer all questions. In an escalation cycle we need to learn not to respond to some questions.
- **Noncompliance and defiance.** Here the students refuse to cooperate, usually in response to adult directions, demands or classroom rules and expectations. The stage is now set for confrontation or further negative interactions.
- **Off-task behavior.** Some students will stop working or engage in off-task behavior because they know the adult will respond.
- **Provocation of others.** Students sometimes exhibit behaviors that irritate others and cause them to react strongly. Once the reaction occurs, especially if it is a strong one, the stage is set for further negative interactions.
- **Compliance with accompanying inappropriate behavior.** This behavioral event, which is a form of limit testing, has two components: (1) Students actually complete the task or follow the direction; and also (2) Students exhibit additional social behavior that is unacceptable.
- **Rule violation.** Students will deliberately break a rule knowing that staff will respond and follow through. Once staff respond to the rule violation, there are likely to be further negative interactions.
- **Threats and intimidation.** When a student with problem behavior threatens staff, there is the expectation that this staff person will be intimidated. However, if staff responds to this threat in any form that suggests a challenge, then it is highly likely that serious confrontation and perhaps unsafe behavior on the part of the student may occur. For example, the student who is upset with the adult says in a threatening tone, "I know where you live." The adult leans toward the student and says in a similar tone, "And, I'll be waiting for you." The suggestion is that this exchange is not productive.
- **Verbal abuse.** Similarly, when students use offensive or abusive language toward staff, there is a strong likelihood that staff will address the behavior immediately. Staff response to verbal abuse can set the stage for more serious behavior from the student.

- **Property damage.** When students deliberately damage or disfigure property, staff will take immediate action that may lead to further negative interactions. Students deliberately damage property but not too seriously, such as writing their name on the desk in pencil or creasing the pages of a book. With extensive property damage we are talking about the next phase, which is severe behavior.

Summary of Phase Four: ACCELERATION Overall behavior is spiraling out of control.

Peak Phase

In this phase, the child is in the height of his response cycle. He is often out of control and your main focus should be on the safety of the child and those around him. It is critical to stay calm and not become agitated yourself. Have a crisis intervention plan prepared ahead of time with the team in your classroom that has been pre-approved by both the administration and the child's parents. The short-term plan is to wait until the child begins to de-escalate. In this phase, there is no negotiating or interacting with the child and it is best to let him work through the episode by making sure he is in a safe place where he cannot harm others or himself. The long-term plan is to analyze why the child escalated and to plan interventions that will address the problem behaviors earlier in the stress response cycle.

These severe or Peak behaviors include:

- **Serious destruction of property.** These behaviors involve substantial and costly damage to property.
- **Physical attacks.** The student targets someone with the intent to cause physical harm such as punching, kicking, throwing objects, hair pulling, and even more serious behaviors including attacks with objects or weapons.
- **Self-abuse.** In this case the harmful behaviors are self-directed as in face slapping, hitting, pinching, hair pulling, head banging, and scratching.
- **Severe tantrums.** These behaviors include screaming, yelling, throwing objects, pushing desks over, and flailing on the floor.
- **Running away.** In many cases, when students are out of control there is the choice of "fight or flight." Some students will elect to escape the situation and run away. Their departure is generally accompanied with explosive behavior such as yelling, cursing, banging doors and kicking walls and furniture.

Summary of Phase Five: PEAK Overall behavior is out of control.

De-escalation and Recovery Phase

Once the child has peaked, he is usually exhausted from the emotional and physical strain. Allow him time to cool off in a safe and quiet environment. Let him engage in independent work until he is ready to rejoin the group. Once he is calm, let him resume the regular schedule and do not dwell on the episode. Positive reassurance that he can try again will help him reintegrate into activities. With this approach, you are not "giving in" to his challenging behavior but instead you are recognizing that the child is caught in a chain of behaviors that he may have very little control over. The greatest task is to intervene before the peak episode. Once the episode has occurred, the best course of action is to start over and analyze your own

response to the child's chain of behaviors to see if you can intervene earlier to avoid the escalation of behavior in the future.

The common behaviors manifested in the De-escalation phase are:

- **Confusion.** Here students will sometimes display confused, seemingly random behavior. In effect, there appears to be a clear lack of focus to the student's behavior.
- **Reconciliation.** Some students will want to make up or test the waters to see if the adult still likes them.
- **Withdrawal.** Students may put their heads down and try to sleep, either to withdraw from the situation or they may be genuinely fatigued following a prolonged episode of severe behavior.
- **Denial.** Many students will engage in denial about their behavior especially regarding the most serious behavioral episodes.
- **Blaming others.** A common form of denial is to blame others. Students will frequently become quite animated and convey compelling conviction that the incident was caused by someone else.
- **Avoidance of debriefing.** Consistent with the students' reluctance to participate in class discussions and activities involving interactions, students will display avoidance behavior during any talk about the episode and their behavior or events leading up to the incident. For this reason debriefing should be conducted in Phase Seven, Recovery.

The specific behavioral characteristics for the Recovery Phase are:

- **Eagerness for independent work or activity.** Typically, the students will become engaged in, or may actively seek, some kind of relatively independent "busy work."
- **Subdued behavior in group work.** While there is some interest in getting back on track, these students find activities that involve interactions with other students or staff very difficult.
- **Subdued behavior in class discussions.** Similarly, these students find it very difficult to contribute to class discussions at this stage.
- **Defensive behavior.** In this phase as they are recovering from a serious episode, some students will display behavior that is cautious and almost measured.

It is important to understand how the choices adults make when responding to children affect the escalation of their challenging behavior. It is important to use this information to identify what phase of escalation the child may be in when they are exhibiting challenging behavior and into what continuum their behavior may fall. The choices the adult makes in responding to the child's challenging behavior can lead either to the escalation of behavior along a particular continuum or the adult's response can help facilitate a de-escalation and recovery from the episode. It is critical, then, for care providers to stay calm and recognize the child's needs in these highly stressful situations. The seven-phase conceptual model for depicting severe problem behavior allows us to develop a procedure for assessing student behavior and developing corresponding interventions.

Strategies for Addressing and Managing Severe Behavior

Instructor Note:

What is the most important variable in a school for preventing severe and chronic behavior in the classroom?

A difficult and potentially dangerous situation for officers involves being called to a scene and engaging with a person who is disabled or may have special needs. Most individuals with special needs or even mental illness are not dangerous, but a special set of skills is required to bring a mutually successful end to the encounter.

Although an officer's inclination may be to intervene immediately, that may not always be the best response. As long as the individual isn't an immediate danger to self or others, there's time to make a quick assessment.

How does an officer make the decision about how to treat that individual? Of course the answer is communication: talking to the person and evaluating the responses. But what if the person is unable or unwilling to speak? Again, as long as the person is not a danger to self or others, there is time. Use it to listen to what the person is saying—not only with words, but also with body language and tone of voice.

De-escalation strategies for each of the seven phases.

Prevention strategies are introduced for implementation during the Calm and Trigger phases. These strategies are designed to keep the student in the Calm phase, actively engaged with the class instruction and activities.

Instructor Note:

The prevention strategies for phases 1 and 2 are adult-related so they will not be discussed in detail.

Strategies for Agitation

Defusing interventions are described for the Agitation and Acceleration Phases. These strategies are designed to catch the problems early, thereby preventing escalation to more serious behavior and giving the student a chance to engage productively in the activities.

Defusing Approaches

Even though the prevention strategies may have been implemented, there is always the chance that problem behavior may arise. This topic is designed to defuse problem behavior at its earliest onset, thereby preventing the occurrence of serious problem behavior. These defusing strategies are implemented in the early phases of the severe behavior cycle, specifically during the Agitation and Acceleration phases.

Review slides on – Strategies – Agitation and Strategies - Acceleration

The overall emphasis of all of the strategies is to intervene before the severe behavior emerges and carefully follow-through in the event severe behavior occurs.

Let's take a look at several strategies for addressing agitation that can be applied in a school setting:

Agitation Phase:

- **Maintain a non-threatening stance.** Appear calm and self-assured even if you don't feel it. Maintain limited eye contact. Maintain a neutral facial expression. Place your hands in front of your body in an open and relaxed position. Be at the same eye level. Encourage the client to be seated, but if he/she needs to stand, stand up also.
- **Diffusion Statements.** Using calm language, along with other communication techniques, to diffuse, re-direct, or de-escalate a conflict situation by using statements that end verbal engagement.
- **Adult empathy.** Perhaps the most powerful supportive strategy an adult may use is to demonstrate empathy. To be effective, empathy involves two critical parts : (1) Understanding or recognizing that the student has a problem; and (2) Communicating concern to the student. It is very important to realize that the strategy of using empathy is much more effective if the adult has already connected with the student.
- **Providing space.** A very effective strategy for reducing agitation is for the adult to provide some level of space or isolation from the rest of the students. Quite often the student wants to be left alone so giving them space meets this need.
- **Providing assurances and additional time.** In general, students who display agitation on a frequent basis do not have effective problem solving skills. Consequently, they may panic and exhibit worse behavior. In these situations it is often helpful to give the student some assurances and allow more time to deal with a task.
- **Adult proximity.** Often times when students become agitated, they become insecure. Consequently, when the adult stands near the student during this period of agitation, the student may be reassured. Again, this strategy is more effective if the adult is already connected with the student.
- **Movement activities.** Movement is a tool that adults can use to help a student who is agitated. Many students automatically show an increase in their behavioral levels when they are agitated. Consequently, when the adult provides students with an opportunity to move, there is more chance that the students' needs will be met, helping them to become calm and focused.
- **Student self-management.** Self-management is the ultimate, long- term goal of any intervention program for problem behavior. Consequently, it is very important to actively involve students, where appropriate, in a plan to control agitation. Students often have their own strategies to reduce agitation and can contribute to the plan or program.
- **Control tone and delivery of verbal communication.** Do not get loud or yell over a screaming person. Wait until he/she takes a breath, speaking calmly at normal volume. Respond simply. Repeat if necessary. Answer informational questions, no matter how rudely asked.

Giving Choices

Effective choices help individuals feel in control. For years educational psychologists have known that an essential element of motivation is an individual's need to feel autonomous. In other words, people who believe that they have control tend to be more motivated than individuals who feel as if outside forces are compelling them. Effective choices also encourage students to feel competent, particularly in challenging situations. In general, people who believe they will succeed during challenging activities tend to be more motivated to do the right thing.

Instructor Note:

“You have a choice, you can ____ and ____ will happen, or you can ____ and ____ will happen. It’s up to you.”

“First Then"

Non-Strategies for Agitation Stage

Consequently, staff may react, become agitated, and resort to “in-your-face” kinds of behavior, such as finger pointing, that are highly likely to escalate the student. It is crucial for staff to display calmness, respect and detachment while addressing students in this acceleration phase in order to lessen the chance of escalation.

Acceleration Phase:

It is in the acceleration phase when some teachers first notice a problem, because the child increases his efforts to engage the adult – often through arguing, refusing to do what was asked, and perhaps beginning to push or kick other children or things. Once again, our goals needs to be to cool things off and calm the child down, even if it means ignoring some of these behaviors for the time being. The worst thing an adult can do at this point is engage in a power struggle. This adds tension and intensity to the child’s emotional state and will push the child right into the peak phase. Imagine the child’s behavior as a run-away train. We can either help put on the brakes, or add fuel to the engine that pushes it into worse behavior. Intervention is focused on safety: Implement before onset of escalation.

Escalating Prompts in Acceleration

We will now look at general responses to engaging behavior from students. Effective defusing approaches are critically important during this phase in the cycle of acting-out behavior because, if the behaviors are not managed successfully here, the student is highly likely to exhibit the severe problem behavior. In effect, this is the last opportunity to defuse the situation prior to the onset of severe behavior. Key approaches include:

Thoughtfully avoiding escalating prompts. Student behaviors during this phase are characterized as engaging. There is always the likelihood that some staff may directly respond to these behaviors and inadvertently escalate the situation. Responses from staff that result in more serious behavior from the student are called escalating prompts. The root problem is that staff may take the behaviors exhibited by the students personally.

Instructor Note:

ACTIVITY: Diffusion Statement Handout #2

Staff realizing that the student is “playing a game here” achieves calmness; that is, trying to engage staff. The most powerful response for staff is no immediate response; that is, to pause. The pause tells the student that his or her behavior is not getting to staff personally. There is less chance of escalating the student if the adult can pause slightly and then in a calm, measured and serious tone inform the student that the behavior is very unacceptable and that some action would be taken. Moreover, the adult is serving as a good role model in the face of problem behavior.

Respect for the student's dignity and rights must be a critical consideration when adults respond to problem behavior. Any indication of disrespect will likely escalate the student to serious acting-out behavior. A useful guideline for the adult is to focus on the student BEHAVIOR versus focusing on the STUDENT. Similarly, in addressing a problem the adult can communicate respect by beginning with the student's name. Another respectful strategy is to speak to the student privately, such as taking the student aside. By emphasizing the privacy of the conversation, the adult is also lessening the chance of the student having to "save face" in the presence of peers.

Detachment is a disposition that the adult communicates to the student to indicate that the student is ultimately responsible for his or her behavior. In effect, the choice belongs to the student. While staff care about the student, it is very important not to communicate any degree of anxiety or any sense of coaxing and pleading for the student to behave appropriately. In this context, it is best to communicate in as matter-of-fact a manner as possible and to make it very clear to the student that the inappropriate engaging behavior needs to cease or there will be consequences. The choice lies with the student.

Review the scenario sheets you have been given. Come up with effective diffusers for the situations described. Feel free to use some of the examples discussed, or use your own examples.

You have 3 minutes to complete this activity then select someone from your group to share one of your responses with.

Peak Phase

So far, we have looked at triggers, agitation, and acceleration in children's acting out cycle. With careful observation and skills, we will never have to experience the Peak Phase of the cycle. Our goal should always be prevention. However, many children move rapidly through the cycle and we might be unable to intervene quickly enough.

In the Peak Phase, the child is clearly out of control, perhaps kicking, throwing his body on the floor, screaming, and so on. There is nothing that can be done to prevent the behavior at this point, so the focus needs to be on keeping the child, other children, and property safe. Think ahead of time of a plan for out-of-control behavior so that all the adults in the room know how to respond. When adults refer to severe behavior, they typically mean behaviors that occur in the peak phase such as behaviors that cause serious disruption and/or possible danger to themselves and others. The main goal for strategies in this phase is to ensure safety of all and to enable school and classroom activities to continue. Focus is on crisis management and implementing your plan (contact admin, clear room, etc.).

Instructor Note:

Discuss the need for law enforcement in a school setting to be aware of crisis procedures.

The following are considered essential components of safe and research-based practices for developing school emergency plans:

Clear school or district policy. All schools or districts should have a clearly written policy regarding school safety that is consistent with the stated educational vision of the state, district,

and school. The school safety policy needs to be clearly written in positive terms with an emphasis on creating an environment conducive to the support of learning, individual rights, and safety. This policy should be reviewed periodically and disseminated systematically. Remember, “Practice makes permanent.”

De-escalation

As the child enters the De-escalation Phase, he/she will be calmer, and may withdraw or try to make amends. This is the time to get the class refocused on what they need to be doing and will lead us to the next phase: Recovery.

After prevention and diffusion strategies designed to pre-empt severe problem behavior, the next most important intervention is designed for implementation AFTER the severe behavior has occurred. These strategies target the De-escalation and Recovery phases of the severe behavior cycle and are intended to help prevent future occurrences of the severe behavior.

The following steps, presented in sequence, are designed to assist the student to de-escalate and resume the regular program:

Step 1: Isolate the student. The following guidelines are recommended:

- Choose a location (ahead of time if possible)
- Provide adequate supervision
- Allow sufficient cool-down time

Step 2: Decide whether to send the student home or retain the student.

Depending on arrangements, school resources, district resources, and severity of the behavior problems exhibited in the Peak phase, the student may be sent home. In these cases, it is recommended that the student complete Step 1 above and then leave the school or setting. Clearly a student should not be sent home in a highly agitated state or when still engaged in the serious acting-out behavior. If the decision has been made to send the student home, once the student has settled down and the parent or designee has arrived, then the student may be released. The debriefing session described earlier should be conducted as soon as possible after the student returns to school. If the decision has been made to retain the student in the school setting and to return the student to class or current school activity, then continue with the following steps.

Step 3: Allow cool-down time. Be sure to allow sufficient time for the student to gain some level of composure. Do not be in a hurry to move to the following steps. The student’s level of cooperation will provide information on the student’s degree of recovery.

Step 4: Determine and deliver consequences. Given the student has exhibited serious behavior, consequences need to be delivered. Consequences are designed to provide feedback to the student that his or her behavior is unacceptable and should not occur again. Consequences should be tied to the context if possible.

Step 5: Engage in independent work with clear criteria. The primary reason for introducing independent work at this stage is to help the student regain focus. As the student recovers, thinking processes begin to function slowly. Use the following guidelines:

- Check the student's level of cooperation
- Ensure the student has a reasonable level of mastery of the given task
- Choose tasks that require active responses from the student
- Set a reasonable standard for completion
- Permit the student to complete the task in his or her time

Step 6: Complete exit paperwork as appropriate.

Paperwork is necessary to document the student's behavior and to provide information for the debriefing session in the next topic (Re- Integration). This information is usually collected in the form of an incident report or office referral describing the behavior and its relevant circumstances. It's also very helpful to have the student complete some type of standardized behavior form to be used in the debriefing process.

Step 7: Restore the environment if appropriate. It is very helpful in terms of student accountability for the student to restore the environment where appropriate. In some cases, there is value in having the student do some community service activity either at this time or later.

Step 8: Resume regular schedule. At this point, the student has been given an opportunity to settle down and has cooperated with a series of tasks (independent work completing a product to a reasonable standard, filling out the behavior form with reliable information, and restoring the environment as appropriate). As a result, the student is likely to cooperate when returned to class. In effect the student is ready to enter the final phase: Recovery.

Recovery Phase Strategies

Think of the Recovery Phase as a teachable moment. It's important to review what happened with the child and possibly with the class if there was a major interruption of their activities. Point out what might have triggered the meltdown, and make a plan with the child for how you will help her avoid triggers, or learn new behaviors for calming down, using words to express emotions or other needed social and emotional skills. And of course, follow up on your plan.

In this final phase, Recovery, the students are back in the normal schedule. It is very important to understand that just because the student had regained composure and was cooperating in the previous phase, there is no guarantee that the student will maintain cooperation in the normal schedule. Students need strategies that are designed to help them become reintegrated both personally (getting themselves together) and being able to function within the class.

Intervention focuses on returning to normal activities:

- Follow through with consequences
- Positively reinforce any displays of appropriate behavior
- Debrief/rehearse problem solving routine

Instructor Note:

Activity: Escalation or De-Escalation

- *Assess the situation.*
- *Note some of the comments the officer said.*
- *Discuss what diffusion statements he should have used.*
- *Describe what the officers' actions would have looked like had he used the discussed strategies:*

Responding Appropriately to Student Behavior

No matter how carefully we teach positive behavior, students will still sometimes misbehave. They'll forget the rules, their impulses will win out over their self-control, or they'll just need to test where the limits are. As they learn to negotiate social expectations, children test limits, get carried away, forget, and make mistakes. In fact, having these experiences—and seeing how adults respond to them—is one way children learn about how to behave. Just as when we teach academics, we can use students' behavioral mistakes as opportunities for learning. To do this well, however, we adults must respond to misbehavior in ways that show all of our students that we will keep them safe and see to it that school rules are observed. In doing so we have to ask the right questions.

Ask the right questions

- Is the behavior a result of the student's disability? If so, what does the student's Individualized Education Program say about how to respond?
- Does the student know and/or understand that they are violating classroom/school rules?

Respond Appropriately

- Verbal responses
- Body language
- Positive re-enforcers

The SRO and School Relationship

Communication:

Instructor Note:

What does the campus principal expect from you?

- *What does your Chief of Police expect?*
- *Do you know your role on your campus?*

Building positive relationships and maintaining open lines of communication create a successful School Resource Officer Program. Prior to the start of the school year the SRO should meet with the school principal and the administrative team. Before school begins, the SRO will need to become familiar with school policies as well as the administrative staff that they will be working with, with all parties discussing their roles and expectations.

The SRO and the Principal need to answer key questions, such as: how will all the members of the SRO team communicate? When will the SRO be called to assist in searches? What are the current issues which affect the safety of the school?

Instructor Notes:

What else can the Principal do to promote the SRO program at their school? How would you introduce the SRO program to parents, to the students? Should the school district/police department promote the SRO through the media?

The SRO and the Principal will also need to review the school crisis plan. The Principal should supply the officer with a faculty handbook and school emergency phone numbers in addition to pertinent information regarding special education students and needs.

The SRO should be invited to be a part of faculty orientation meetings just prior to the start of the school year. The SRO needs to meet the office and custodial staff. The SRO should be allowed to make several brief presentations on his or her role in maintaining school safety. It is important that people who work in the building get to know who and what the SRO stands for in order to start developing positive relationships with the whole school community.

The SRO should also utilize this time before school starts to discuss with teachers what type of law-related education presentations could be conducted by the SRO throughout the year. The SRO should be introduced to the incoming student body just as any other member of the student support team (guidance counselors, school nurse, etc.). Additionally the SRO should attend "Back to School Night" and the PTSA meetings to introduce themselves to parents and the greater school community.

The first few weeks establish the SRO as part of the school community. This effort builds the foundation of successful school-based community policing.

Conclusion

Instructor Note:

Review any topics or sections that class seemed to have problems or issues.

Summary: Severe problem behavior can be described by a seven-phase conceptual model. Specific behaviors can be identified for each phase of this model. The primary purpose of classifying behavior in this way is to enable practitioners to understand the behavioral processes involved in escalating interactions between teachers and students. The descriptions tell the teachers which problematic student behavior to expect at each stage of potentially explosive situations.

Strategies and procedures were described for managing student behavior at each phase in the cycle. The basic intent of the strategies is to arrest the behavior at that point in the chain, thereby preventing further escalation and, at the same time, to set the stage for students to engage in appropriate alternative behavior.

The overall emphasis is on identifying the early behaviors in the chain, redirecting the students toward appropriate behavior, and subsequently pre-empting the acting-out cycle of serious behavior. In Phases One through Four (Calm, Trigger, Agitation and Acceleration), the

emphasis is on effective teaching and proactive management practices. In the remaining phases, the emphasis is on safety, crisis management, and follow-up.

We hope the information you received in this workshop will serve as a practical tool in assisting you in the valuable work you do with these high needs students

Handout #1

Example 1: Michael

During passing period you see Michael in the hall walking slowly to class. Students are expected to clear the halls in a timely manner. Michael decides to sit slouched against the wall outside of his classroom, feet stretched out, head down staring at the floor and looking very serious. The successive interactions are presented along with a brief description of the adult and student's behavior.

Adult: "Michael, it is time to get in to your math class."

Michael: "I don't want to go to Math?"

Adult: "That is your first class this morning. You need to get to class."

Michael: "I got my scheduled changed!"

Adult: "Well let me see your new schedule please."

Michael puts his head back against the wall.

Adult: "Do you have a copy?"

Michael: "Since when do I have to provide a copy for you?"

Adult: "Michael, you need to stop playing games and get to class."

Michael: "I don't play games!"

Adult: "Michael, look, I know you know what you are doing. You know the rules so get up and get to class now!" Michael: "No way. I'm done!"

Adult: "OK. Here is your choice. Get to math now or you will have detention."

Michael: "F... you."

Adult: "You aren't going to talk to me like that. Let's go to the office."

Michael throws his book across the hall.

Adult: "Alright. It's to the Office." Nudges student on the elbow.

Michael swings arm in direction of adult and makes solid contact with their arm.

Example 2: Jason

Jason is a person with autism and limited verbal skills. He also has cognitive disabilities and a cleft palate. In addition, he hits his face often and pulls out his hair.

Presently Jason is sitting at a table in the cafeteria rolling his head and making noises. He normally can sit calmly. He is being asked to get up and walk to class. Adult prompts Jason to pick up his tray to dispose of it. Jason shakes his head and begins to rock back and forth making even louder noises. Teacher hands him his tray and nudges his elbow. Jason slowly takes the item and pushes it down the table. Teacher taps the table near his tray and asked Jason to pick up the tray and take it to the trash. Jason took the tray and dropped the tray on the table. Jason turns his hands palm up and slaps his face. Teacher holds his hands, taps table, and slowly lets the hand go. Jason turns his hands, slaps his face, and begins to pull his hair out. Jason rolls his head and yells continuously, louder than earlier.

What similarities do you see between the two examples?

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Handout #2

WHAT DIFFUSER COULD YOU USE?

Upon being questioned by the SRO for a bullying situation, Billy, a second grade student, tells you, "I'm not telling you shit! I have decided I don't like you! You are not like Officer Smith from last year and he was the best. He actually cared about us unlike you."

When you ask Brooke, a 10th grade student, to please be quiet and stop yelling in the cafeteria, she responds, "You know what, you just need to be quiet, what is up with you, go get laid or something because you are PMS-ing, hot-flashing or something big time. Don't take it out on us."

It is time to line up & go to the cafeteria for lunch. Mary, a 3rd grade student, gets on the computer, and tells the adult, "You guys go ahead, I am not going to the cafeteria anymore, it is too loud, all those kids drive me crazy. I am not going to the cafeteria and you can't make me." The SRO walks by and over hears the situation. Mary then yells to the SRO, "I'm just going to have lunch in the classroom from now on. What are you going to do about it? Arrest me?"

When you ask Robbie, an 8th grade student, to get to class, he starts to move and yells at you, "Maybe you need to move, too. I'm not the only one standing in the hall. Besides, we all know you and Mrs. Young are sneaking around in corners talking to each other, laughing, flirting and who knows what else. Does her husband know?"

CJ, a 4th grade student, won't stay with the class when transitioning from 4th period to recess, and he keeps running ahead. When you remind him of the expectation to stay with the group, he responds, "You're just jealous you stupid cop because you're so fat and you can't run."

The SRO reminded Nick, an 8th grade student, upon arriving to school, he must put his ID on before entering the building. Nick says, "This is just stupid and I am not doing it. ID's are gay and we all know how you swing. I got on your Facebook page, and your partner is way too young for you."

Identify Behavior at Each Phase

Phase	Of	Will	Teacher	Principal
Calm				
Trigger				
Agitation				
Acceleration				
Peak				
De-escalation				
Recovery				

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Section Four:

Mental and Behavioral Health Needs of Children with
Disabilities or Special Needs
(4 Hours)

DRAFT

Instructor Guide

Section Four: 4.0 Mental and Behavioral Health Needs of Children with Disabilities or Special Needs

Mental health is a key component in a child's healthy development; children need to be healthy in order to learn, grow, and lead productive lives. The mental health service delivery system in its current state does not sufficiently meet the needs of children and youth, and most who are in need of mental health services are not able to access them.

Rationale – evidence of increase in mental health disorders, suicide, violence against others, and lack of crisis protocol. Mental health and substance abuse problems occur commonly among today's youth and begin at a young age.

Instructor Note:

Test Your Knowledge

What do you know about mental health (MH) and MH in our schools? Let's take a short test...

- 1) The only difference between school mental health and outpatient mental health is the location. (T/F)*
- 2) School mental health services are only available to children with special education needs or mental health diagnoses. (T/F)*
- 3) Most children experience some degree of mental health issues. (T/F)*
- 4) School mental health services are primarily concerned with diagnosing and treating mental health issues of students. (T/F)*
- 5) School mental health services can improve access to mental health services for children. (T/F)*

4.1 Unit Goal: Responding to Student Mental Health Needs

Discussion

Research has shown that prolonged stress can create changes in the brain and its function. Furthermore, there are genetic or other neurological connections for many mental health disorders. They are now being diagnosed more accurately (and frequently) in children as scientific understanding of the brain progresses. In addition to traditional diagnostic tools, researchers using modern imaging technologies have associated specific brain differences with certain mental health disorders.

What does this statement mean to you?

Mental health is determined by many complex and related reasons, all of which can interact to determine the state of our mental health. Children come to school each day with more than their lunch and backpack. They bring a myriad of life factors that shape their learning and development. These influences range from family issues, health, and culture to behavior, learning style, and abilities. Virtually all are related to mental health.

Although historically mental health has been viewed through the lens of mental illness, (e.g., depression, schizophrenia, bipolar disease), we have come to recognize that good mental health is not simply the absence of illness but also the possession of skills necessary to cope with life's challenges. As educators we need to understand the role mental health plays in the school context because it is so central to our students' social, emotional, and academic success.

Current Mental Health Status in the US

Mental health is important to overall health. Mental disorders are chronic health conditions that can continue through life. Without early diagnosis and treatment, children with mental disorders can have problems at home, in school, and in forming friendships. This can also interfere with their healthy development, and these problems can continue into adulthood.

Children's mental disorders affect many children and families. Boys and girls of all ages, ethnic/racial backgrounds, and regions of the United States experience mental disorders. Based on the National Research Council and Institute of Medicine report (*Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*) that gathered findings from previous studies, it is estimated that 13 –20 percent of children living in the United States (up to 1 out of 5 children) experience a mental disorder in a given year and an estimated \$247 billion is spent each year on childhood mental disorders. Because of the impact on children, families, and communities, children's mental disorders are an important public health issue in the United States.

When treated, children and youth with mental health problems fare better at home, in schools, and in their communities. Even among those children and youth who are able to access mental health services, quality of care is often deficient. There is an insufficient number of providers, and many of them do not use effective, evidence-based, or empirically supported practices. The service delivery system lacks key elements of supportive infrastructure which results in poor provider capacity and competency. Components of a strong infrastructure include provider training and retention, adequate reimbursement, strong information technology systems, and robust family involvement in policy.

4.1.1 Participant will define Mental Health to assist in gaining information on the current mental health status in our schools.

What Does “Mental Health” Mean

Mental health encompasses overall social, emotional, and behavioral health. It is the ability to cope with life's challenges and difficult circumstances.

Mental Health is defined as, “A state of psychological well-being where the individual has the ABILITY to USE cognition and emotions to meet ordinary, everyday demands.”

The term mental health is commonly used in reference to mental illness. However, knowledge in the field has progressed to a level that appropriately differentiates the two. Although mental health and mental illness are related, they represent different psychological states.

Mental health is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” It is estimated that only about 17 percent of U.S adults are considered to be in a state of optimal mental health. There is emerging evidence that positive mental health is associated with improved health outcomes.

Mental illness is defined as “collectively all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.”

2. Depression is the most common type of mental illness, affecting more than 26 percent of the U.S. adult population.
3. It has been estimated that by the year 2020, depression will be the second leading cause of disability throughout the world, trailing only ischemic heart disease.
4. Evidence has shown that mental disorders, especially depressive disorders, are strongly related to the occurrence, successful treatment, and course of many chronic diseases including diabetes, cancer, cardiovascular disease, asthma, and obesity and many risk behaviors for chronic disease; such as, physical inactivity, smoking, excessive drinking, and insufficient sleep.

The causes of negative feelings, thoughts, and behaviors range from environmental/system deficits to relatively minor group/individual vulnerabilities on to major biological disabilities (that affect only a small proportion of individuals). It is the full range of causes that account for the large number of children and adolescents who are reported as having psychosocial, mental health, or developmental problems. In the USA, estimates are approaching 20 percent (11 million).

The Truth about Mental Illness

Anyone can have a mental illness regardless of age, gender, or socio-economic status and it is more common than cancer, diabetes, heart disease, or AIDS.

- What if we could determine which behaviors were caused by mental illness?
- What if we could understand the difference between lack of motivation, defiance, non-compliance and impulsivity and a true disability that the student could not control?
- What if we could intervene before the student met the end of the regular educational opportunity and before they went to “the alternative?”

What Causes Mental Health Issues

- Mental illnesses, in general, are thought to be caused by a variety of genetic and environmental factors:
- Inherited traits. Mental illness is more common in people whose blood relatives also have a mental illness. Certain genes may increase your risk of developing a mental illness, and your life situation may trigger it.
- Environmental exposures before birth. Exposure to environmental stressors, inflammatory conditions, toxins, alcohol or drugs while in the womb can sometimes be linked to mental illness.
- Brain chemistry. Neurotransmitters are naturally occurring brain chemicals that carry signals to other parts of your brain and body. When the neural networks involving these chemicals are impaired, the function of nerve receptors and nerve systems change, leading to depression.

Genetics plus environment compound mental issues.

- Exposure to stressful life events/abuse/trauma/difficult or abusive childhood
- Ongoing stress and anxiety
- Medical conditions and hormonal changes/chemical imbalance
- Side effects of medication/substance misuse and sensitivity
- Illness that is life threatening, chronic, or associated with pain

Mental illnesses sometimes run in families, suggesting that people who have a family member with a mental illness may be somewhat more likely to develop one themselves. Susceptibility is passed on in families through genes. Experts believe many mental illnesses are linked to abnormalities in many genes rather than just one or a few and that how these genes interact with the environment is unique for every person (even identical twins). That is why a person inherits a susceptibility to a mental illness and doesn't necessarily develop the illness.

Mental illness itself occurs from the interaction of multiple genes and other factors -- such as stress, abuse, or a traumatic event -- which can influence, or trigger, an illness in a person who has an inherited susceptibility to it.

Important Facts about Mental Illness

A substantial number of children suffer from serious emotional or behavioral problems. But, as research has also documented, most children do not receive care for these problems. And those at the greatest risk of problems, children and youth living in poverty or isolated rural areas, children belonging to racial minorities, or living in foster care, are even less likely to get help.

We know that there are a variety of treatments for most mental health problems and that they work. However, limited prevention and early intervention services in most communities; as well as inadequate financing, challenges those committed to improving children's lives.

- 20-25 percent of individuals may be affected by mental illness
- 7.5 million children are affected by mental, developmental or behavioral disorders
- Nearly two-thirds of all people with a diagnosable mental disorder do not seek treatment.
- On average, only 1 out of 4 children in need of mental health care actually get the help they need.
- 12-22 percent of all youth under age 18 are in need of services for mental, emotional or behavioral problems.

Mental Health Needs

Visualize a classroom with 20 students, 5 will possibly be affected by a mental health disorder.

One of these students may actually receive the help they need. Children and youth with mental health problems have lower educational achievement, greater involvement with the criminal justice system, and fewer stable and longer-term placements in the child welfare system than their peers.

The goal of all concerned is to overcome barriers and connect children with needed services. Early evidence shows that one of the best ways to accomplish that goal is through schools.

Ages 9 to 17:

- 21 percent (or one in five children) seen as experiencing the signs and symptoms of a disorder found in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) during the course of a year.
- 11 percent seen as experiencing significant impairment with about 5 percent experiencing extreme functional impairment (about 4 million young people).
- About 15-20 percent of these are reported as receiving MH services.
- Less than a third get MH help for these problems.

Why Mental Health in Schools

It is, of course, not a new insight that physical and mental health concerns must be addressed if schools are to function satisfactorily and students are to succeed at school. It has long been acknowledged that a variety of psychosocial and health problems affect learning and performance in profound ways. Such problems are exacerbated as youngsters internalize the debilitating effects of performing poorly at school and are punished for the misbehavior that is a common correlate of school failure. Because of all this, school policy makers have a lengthy (albeit somewhat reluctant) history of trying to assist teachers in dealing with problems that interfere with schooling. Prominent examples are seen in the range of counseling, psychological, and social service programs schools provide. School staff can play an important role in helping to identify and support children with mental health problems.

- Mental health is directly linked to educational outcomes.

- Schools are the optimal place to develop psychological competence and to teach children about making informed and appropriate choices concerning many aspects of their lives.
- Schools are the best places to integrate and to coordinate the efforts of school staff, families, mental health service providers, and administrators to foster the mental health of students.
- Problems of transportation, accessibility, and stigma are minimized when such services are provided in schools.

4.1.2 Participants will review federal/state mandates related to the identification and support of students with mental health disorders and apply these requirements in the school environment.

The Law

Instructor Note:

Reference Health and Safety Code Chapter 161: Public Health Provisions, and HB 2684.

You may want to have each group take a section and write down most important part to share out with group.

Why Mental Health Training for Those Who Work With Youth?

Thousands of students with emotional disorders, including clinical depression, chronic anxiety and post-traumatic stress, sit in classrooms each year, posing a widespread challenge to school staff and administrators' efforts to improve academic outcomes. The untreated disorders can lead to poor academic performance, behavioral issues in the classroom, social isolation at school, and in the most extreme cases, suicide and violence. By being trained, school staff can better identify a student with mental health issues and avoid possible tragic endings.

OFFICER AS AGENT FOR CHANGE

There are three ways officers can help youths with mental health needs.

1. Officers can interrupt a Cycle of Deteriorating or Self-Destructive Behavior. The presence of such behavior is frequently the cause of the officer's presence on the scene.
2. Officers can demonstrate a Constructive Attitude. Officers can teach families and youths by modeling an attitude of acceptance of behaviors as symptoms, of the youth as a valid human being, and through explaining the hopeful outcomes treatment can bring.
3. Officers can refer to Evaluation, Treatment, or Other Relevant Resources.

4.1.3 Participants will recognize warning signs and symptoms of Mental Health in students.

Factors That Can Increase Risk for Youth

Children and youth at increased risk for mental health problems include those in low-income households, those in the child welfare and juvenile justice systems, and those in military families. A greater proportion of children and youth in the child welfare and juvenile justice systems have mental health problems than those in the general population. Children and youth in military families tend to have higher rates of mental health problems than those in the general population, and those mental health problems are especially pronounced during a parent's deployment.

Instructor Note:

Activity

Brainstorm the different types of trauma, life events and stresses that may be experienced by youth and affect their mental health well-being.

What impact do you think these situations have on our students?

Who is affected?

The following are key findings from this report about mental disorders among children aged 3–17 years:

- Millions of American children live with depression, anxiety, ADHD, autism spectrum disorders, Tourette syndrome or a host of other mental health issues.
- ADHD was the most prevalent current diagnosis among children aged 3–17 years.
- The number of children with a mental disorder increased with age, with the exception of autism spectrum disorders, which was highest among 6 to 11 year old children.
- Boys were more likely than girls to have ADHD, behavioral or conduct problems, autism spectrum disorders, anxiety, Tourette syndrome, and cigarette dependence.
- Adolescent boys aged 12–17 years were more likely than girls to die by suicide.
- Adolescent girls were more likely than boys to have depression or an alcohol use disorder.

Data collected from a variety of data sources between the years 2005-2011 show:

Children aged 3-17 years currently had:

- ADHD (6.8 percent)
- Behavioral or conduct problems (3.5 percent)
- Anxiety (3.0 percent)
- Depression (2.1 percent)
- Autism spectrum disorders (1.1 percent)
- Tourette syndrome (0.2 percent) (among children aged 6–17 years)

Adolescents aged 12–17 years had:

- Illicit drug use disorder in the past year (4.7 percent)
- Alcohol use disorder in the past year (4.2 percent)
- Cigarette dependence in the past month (2.8 percent)

The estimates for current diagnosis were lower than estimates for "ever" diagnosis, meaning whether a child had ever received a diagnosis in his or her lifetime. Suicide, which can result from the interaction of mental disorders and other factors, was the second leading cause of death among adolescents aged 12–17 years in 2010.

Instructor Note:

Handout #1

Activity: Case Study

Case Study: Work with your table group and discuss the following case study.

Sara's Story / Case Study

Sara is a 7th grade student at a local middle school and has been recently placed in the foster care system. She was placed in foster care because she was physically abused by her step-father and neglected by her mother. Sara can be even-tempered at times, but most of the time she is quick to anger and often has outbursts where she will yell at others and then burst into tears.

Sara often gets into trouble at school for talking back to teachers and getting into arguments with other students in her class. Her teachers have noticed a decline in her school work. Sara reports being unable to sit still and concentrate on her work. Sara has been placed into ISS several times and is now labeled a "trouble-maker." She responds angrily to any kind of correction or criticism from adults or peers and begins to cry when she gets angry. She had made the comment that life isn't worth it. During elementary school, Sara was reportedly a good student who rarely got in trouble.

Read each scene in Sara's story and answer the corresponding questions.

Does the child demonstrate symptoms of a mental health issues?

If so what are the symptoms?

How does her behavior affect school safety?

What are some prevention and treatment options for Sara?

Continuums in Mental Health

All human behavior lies somewhere along a continuum of mental health. Personality traits, emotions and mental health problems exist along a continuum.

Continuums exist in many areas of life.

E.g. A scale from hot to cold, from wet to dry, from happiness to sadness, from anxious to calm, from sadness to the mental health problem depression. Even within mental

health problems there are continuums, e.g. mild to moderate to severe depression/anxiety/psychosis/eating disorders.

Continuums imply two important points about mental health problems –

1. Anyone can experience them because they are the extreme of a continuum that all individuals lie on. They are not something separate or special.
2. There are differences between individuals in their personality, emotions and mental health problems (this is highlighted when students marked different points on the continuum on the board).

Warning Signs and Symptoms of Mental Health

Trying to tell the difference between what expected behaviors are and what might be the signs of a mental illness isn't always easy. There's no easy test that can let someone know if there is mental illness or if actions and thoughts might be typical behaviors of a person or the result of a physical illness. Signs and symptoms of mental illness can vary, depending on the person's circumstances and other factors. Mental illness symptoms can affect emotions, thoughts and behaviors. There are a variety of signs and symptoms that may indicate a child or adolescent is struggling with one of the mental health concerns that we need to be familiar with to aid in support.

Warning signs can include:

- troubling thoughts and feelings
- changes in behavior
- loss of interest in activities he/she enjoyed
- change in school functioning
- engaging in problem behaviors

These symptoms can point to the existence of a mental health disorder.

Mental Health Concern – Suicide

Suicide is a significant problem in the United States:

Suicide is the third leading cause of death among persons aged 15-24 years. A renewed concern about youth suicide and depression are a welcome call to action. However, the actions must not simply reflect biological and psychopathological perspectives of cause and correction. The interventions must also involve schools and communities in approaches that counter the conditions that produce so much frustration, apathy, alienation, and hopelessness. This includes increasing the opportunities that can enhance the quality of youngsters' lives and their expectations for a positive future.

We must remember that not all who commit suicide are clinically depressed and that most persons who are unhappy or even depressed do not commit suicide.

Fact - even though we would like for the issue to go away, it is becoming more prevalent.

- From 2009 – 2011 we have seen:
 - Increase in students who seriously considered attempting suicide.
 - Increase in students who had made a plan.
 - Increase in attempted suicide.
 - Increase in suicide attempts that resulted in injury.

Fact - Suicidal ideation may be a common occurrence with several mental health disorders.

Suicide has become the “elephant in the room.” Used to be taboo, but it is becoming increasingly more frequent. It is an avoidable death! The suicide rate of people with major depression is eight times that of the general population; there also is a strong association between trauma and suicide (attempts and completions).

Risk Factors for Suicide

Suicide is a significant public health problem, and there is a lot to learn about how to prevent it. One strategy is to learn about the warning signs of suicide, which can include individuals talking about wanting to hurt themselves, increasing substance use, and having changes in their mood, diet, or sleeping patterns. When these warning signs appear, quickly connecting the person to supportive services is critical. Promoting opportunities and settings that strengthen connections among people, families, and communities is another suicide prevention goal.

Instructor Note:

Amanda Todd Video and questions

When Amanda Todd posted a video on YouTube with the use of flash cards, it seemed like a cry for help. She told the story of being abused, bullied, harassed, and stalked online and in person. She narrated her silent story of how she used self-harm, drugs, and alcohol in an attempt to silence the pain she suffered as a result of cyberbullying involving a photo. She was desperate for someone to understand her, listen to her and simply, she wanted a friend who got her.

A year later, the same person or another anonymous person sent her the picture and it went viral, creating a mass of bullying and teasing to the point that she had to change schools several times. Her reputation was ruined, she had no friends, she was beaten up by some classmates, and she tried drinking bleach but was saved at the last minute. Months later, Amanda Todd took her own life.

“She was afraid to go to school, people were looking at her, and she developed more depression, social anxiety. She was afraid people were watching her all the time.”

What warning signs did Amanda Todd show?

Approaches to Addressing Suicide

While it's a challenge to gather evidence for strategies that address suicide prevention, research indicates that certain approaches lead to increased awareness of risk factors, more referrals to treatment for those at risk, and reduced suicidal thoughts.

Step 1: Define the problem

Before we can prevent suicide, we need to know how big the problem is, where it occurs, and who it affects. CDC learns about a problem by gathering and studying data. These data are critical because they help us know where prevention is most needed.

Step 2: Identify risk and protective factors

It is not enough to know that suicide affects certain people in certain areas. We also need to know why. CDC conducts and supports research to answer this question. We can then develop programs to reduce or get rid of risk factors and to increase protective factors.

Step 3: Develop and test prevention strategies

Using information gathered in research, CDC develops and evaluates strategies to prevent suicide.

Step 4: Ensure widespread adoption

In this final step, CDC shares the best prevention strategies. CDC may also provide funding or technical help so communities can adopt these strategies.

What to Avoid When Addressing Suicide

Most important in managing a suicidal youth is an officer's willingness to listen. According to the AACP, "asking the child or adolescent whether he or she is depressed or thinking about suicide can be helpful. Rather than putting thoughts in the child's head, such a question will provide assurance that somebody cares and will give the young person the chance to talk about problems." Youths with mental health needs report that an officer who treats that youth with respect, empathy, and realistic encouragement can give them new hope and perspective. In all cases, show concern and ask questions in a straightforward and calm manner. Show you are willing to discuss suicide and that you aren't appalled or disgusted by it. Keep open lines of communication. Get care for the student.

4.1.4 Participants will locate information on Special Education Programming in schools.

The participant will gain a better understanding Special Education in public schools.

Special Education Acronyms

These are the most common Special Education Terms you might hear.

- IDEA
- 504

- FAPE
- LRE
- ARD
- IEP
- FBA
- BIP
- MDR
- FERPA
- HIPAA

Instructor Note:

Ask participants to show by raising their hand how many of the acronyms they know. Start with 11 and count down.

Individuals with Disabilities Education Act

The first acronym is: IDEA. The Individuals with Disabilities Education Act is our nation’s special education law and the basis of what we can do and why we do it.

IDEA has had several names in the past: EHA (Education of the Handicapped Act and the Education for All Handicapped Children Act). At one time, it was part of ESEA (the Elementary and Secondary Education Act). IDEA became IDEA in the amendments of 1990, when the name was changed to reflect people-first language. In its current reauthorization, IDEA is also referred to as IDEA 2004 (the year it was reauthorized). The actual title is: The Individuals with Disabilities Education Improvement Act of 2004. IDEA authorizes special education and related services in the United States. More than 6.8 million children with disabilities are served under its provisions.

IDEA also authorizes a wide range of supports to improve the results and outcomes that children with disabilities achieve in our schools and communities.

During this training, references will be made to federal and state rules. Federal regulations will be represented by CFR (Code of Federal Regulations) and will begin with the number 300. State laws or guidelines will have TAC (Texas Administrative Code) or TEC (Texas Education Code) and a number. Local education agencies must comply with both federal and state guidelines.

504

States can establish criteria in the disability areas and frequently do, establishing policies of their own that explain each of these disabilities in their own terms (provided that all children with disabilities who are in need of special education and related services who have impairments listed in the definition of “child with a disability” in IDEA and the final regulations are identified and receive appropriate special education and related services).

Any programs that receive federal funding (i.e., all U.S. public schools) are required to recognize Section 504.

Free Appropriate Public Education

IDEA entitles children with disabilities to a “free appropriate public education”; this is often referred to as FAPE. This means schools must provide to eligible children with a disability specially designed instruction to meet their unique needs; it must be provided at no cost to the child’s parents. This specially designed instruction is known as special education.

FAPE begins with F for free. Free is a vital part of the law’s requirement. The education of each child with a disability must be “provided at public expense...and without charge” to the child or the child’s parents.

A...for appropriate. Appropriate is an important term in IDEA. You’ll see it a lot, used in different contexts but generally meaning the same thing. It means whatever’s suitable, fitting, or right for a specific child, given that child’s specific needs, specific strengths, established goals, and the supports and services that will be provided to help the child in reaching those goals.

What is an “appropriate” education differs for each child with a disability. Yet each child with a disability is entitled to an education that is “appropriate” for his or her needs. The law specifies in some detail how the public agency and parents are to plan the education each child receives so that it is appropriate, meaning responsive to the child’s needs.

Least Restrictive Environment

LRE stands for Least Restrictive Environment.

A child's LRE is the environment where the child can receive an appropriate education designed to meet his or her special educational needs, while still being educated with nondisabled peers to the maximum extent appropriate.

LRE also depends on the individual child and that child’s specific needs, specific strengths, established goals, and the supports and services that will be provided to support the child in reaching those goals.

Admission, Review, and Dismissal

This annual review of a student’s special education program includes an update of the student’s progress, a review of the current Individualized Education Program (IEP), and development of an IEP for the upcoming year. This process is completed by the ARD Committee

In Texas this is what we call the IEP Team, which made up of a student’s parents and school staff who meet at least annually to:

- decide whether or not the student has an eligible disability,
- determine what special education and related services will be provided, and
- develop an individualized education program

Individualized Education Program

Ask for a show of hands. How many came to the session not knowing what IEP meant? Did they recognize the acronym and its meaning when the slide first came up?

The definition for FAPE includes a direct reference to the IEP, which is a cornerstone in the education of each child with disabilities. Cornerstones are very important in holding buildings up. The IEP is just as important to children with disabilities.

IDEA 2004 requires that each public school child with a disability who receives special education and related services must have an IEP.

Functional Behavior Assessment

FBA is a functional behavior assessment. Staff must have consent. It is the data required to make data-driven decisions so the child can receive an appropriate education designed to meet his or her special educational needs, while still being educated with nondisabled peers to the maximum extent appropriate.

Behavior Intervention Plan

BIP details depends on the individual child and that child's specific needs, specific strengths, established goals, and the supports and services that will be provided to support the child in reaching those goals.

Manifestation, Determination, and Review

The ARD committee determines if there is a causal relationship between the behavior for which the student was suspended and the student's disability (or a suspected disability of which school had knowledge before incident).

NOTE: It is NOT the purpose of an MDR to decide if the student did what he/she is accused of doing or to decide what the student's punishment should be.

When a child is being considered for a more restrictive placement based on discipline:

- Suspension of 10+ days for the year
- Removal to a disciplinary alternative education program (DAEP)
- Expulsion

Family Educational Rights and Privacy Act

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy interests of students. It affords parents the right to access and amend their children's education records, and gives them some control over the disclosure of the information in these records.

FERPA generally prevents an education agency or institution from sharing student records, or personally identifiable information in these records, without the written consent of a parent.

FERPA-related violations may have serious repercussions. A school district found to have violated FERPA will be required to implement a plan of action to ensure compliance, and schools that refuse to comply risk losing federal education dollars. Therefore, it is essential to train school staff in FERPA requirements, especially since the Family Policy Compliance Office (FPCO) investigates entire school districts even when complaints are filed against individual school officials.

The Health Insurance Portability and Accountability Act of 1996

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) to ensure continued health insurance coverage to individuals who change jobs, and to establish standards regarding the electronic sharing of health information. For purposes of HIPAA, “covered entities” include health plans, health care clearinghouses, and health care providers that transmit health information in electronic form in connection with covered transactions (45 CFR 160.103).

Technically, schools and school systems that provide health care services to students may qualify as “covered entities” under HIPAA. However, the final regulations for the HIPAA Privacy Rule exclude information considered “education records” under FERPA from HIPAA privacy requirements. This includes student health records and immunization records maintained by an education agency or institution, or its representative; as “education records” subject to FERPA. These files are not subject to HIPAA privacy requirements.

Education Disability List and Determining the Child’s Eligibility

States can establish criteria in the disability areas and frequently do, establishing policies of their own that explain each of these disabilities in their own terms (provided that all children with disabilities who are in need of special education and related services who have impairments listed in the definition of “child with a disability” in IDEA and the final regulations are identified and receive appropriate special education and related services)

There is a multidisciplinary approach to determining whether a child is a child with a disability that includes information from the parent. In making this determination school personnel do not rely on one informant or one source of data in making this determination. Together, as a team they assess the student to determine the child’s strengths and weaknesses and areas of educational need. In determining each disability, there are different qualified professionals that participate in the multidisciplinary team depending on the area being considered.

To receive a school diagnosis, a group of qualified professionals and the parent determines whether the child is a “child with a disability.” Must be an “educational need” for services.

4.1.5 Participants will recognize specific educational disabilities, including developmental disorders, specific mental health disabilities, behavioral characteristics and how to respond appropriately.

Developmental Disorders Commonly Seen in Our Schools

Two most common developmental disorders you will see:

- Autism (Autism Spectrum Disorder – ASD)
- Intellectual Disability (ID) (formerly known as Mental Retardation)

As long as so many students have social, emotional, and physical health deficits and other persistent barriers to learning, schools must find increasingly more potent ways to address such factors so that these youngsters can benefit appropriately from their schooling. This includes enhancing healthy development.

All the efforts are meant to contribute to reduction of problem referrals, an increase in the efficacy of mainstream and special education programs, and enhanced instruction and guidance that fosters healthy development. When given the opportunity, personnel dealing with mental health and psychosocial concerns also can contribute to program development and system reform, as well as helping enhance school-community collaborations.

Autism Spectrum Disorder

Students can display varying degrees on the spectrum, from mild to severe. Educators may be more familiar with the communication challenges and behavioral patterns, but it may be easy to overlook external stimuli that may cause the student's behavior to escalate.

Affects 1 in 68 persons

Male to Female Ratio: 1 female to 54 boys

Generally appears before age 3

Characteristics

- Important to provide support for the student.
- Understand they may need to be directly taught social skills and cues.
- Difficulties in social interaction
- Difficulties in verbal and nonverbal communication (incl. lack of eye contact)
- Repetitive behaviors (incl. attachment to objects, resistance to change and adherence to routines).

Instructor Note:

Scenario

Upon entering an incident, you notice one of the students is jumping up-and-down, hitting himself in the head. The student doesn't make eye contact and is incoherent in speech. The staff member informs you that the student is autistic and worried that he may hurt other students.

What do you do?

What steps do you take?

Intellectual Disability

In Texas, intellectual disability is defined as a usually permanent condition originating sometime between birth and age 18. The person's general intellectual functioning is significantly below average (roughly an IQ of 70 or below) and his or her behavior does not meet the level of personal independence and social responsibility expected of the person's age and culture.

Intellectual disability is found among all races and cultures. An estimated three percent of the population has intellectual disability.

Frequently recognized causes include:

- Substance abuse (the most common cause today).
- Certain illnesses experienced by the mother during pregnancy.
- Chromosome abnormality.
- Metabolic disorders.
- Destruction of brain tissue or interference with brain development.
- Environmental factors.

Mental Illness vs. Intellectual Disability

American population: 1-3 percent Intellectual Disability while 26.2 percent Mental Illness

- MI is unrelated to intellectual functioning
- ID has deficits
- MI develops at any time in life
- ID prior to age 18
- Both are lifelong conditions, though MI can be managed with therapy and medications

Mental Health Disorders Commonly Seen in Our Schools

If all students are to have an equal opportunity to succeed at school and if schools are to leave no child behind, then all school staff must enhance their understanding of how to address barriers to student success – including a variety of mental health (MH) and psychosocial concerns. Too many young people are not very happy. This is quite understandable among those living in economically impoverished neighborhoods where daily living and school conditions frequently are horrendous. But even youngsters with economic advantages too often report feeling alienated and lacking a sense of purpose.

Youngsters who are unhappy usually act on such feelings. Some do so in “internalizing” ways; some “act out;” and some respond in both ways at different times. The variations can make matters a bit confusing. Is the youngster just sad? Is s/he depressed? Is this a case of ADHD? Individuals may display the same behavior and yet the causes may be different and vice versa. And, matters are further muddled by the reality that the causes vary.

Instructor Note:

See Handout #2

Activity - Matching

Match the symptoms with the disorder.

- *Anxiety Disorders*
- *ADD/ADHD/ODD*
- *Bipolar Disorder*
- *Depression*
- *Eating Disorders*
- *Emotional Disturbance*
- *PTSD Disorder*
- *Substance Use Disorders*

Definitions Exercise: Find the Match

Have the class participate in an exercise to connect commonly heard terms with appropriate disorders and definitions. Using the template included in the handouts, give each participant a bag with all the names of the disorders, characteristics and their definitions. Depending on the size of your class, allow the group about 5-10 minutes to find their mate, thus pairing the disorder with its definition and the characteristics associated with that disorder.

Once every table has completed the task, show slide and walk through the disorders listed. Read the disorder from the slide, and then invite the groups to share the definition. Stress that these are not the only disorders that can affect youth, but are disorders that many of us may have heard about. The goal of the exercise is simply to add appropriate definition to commonly heard terms, so that the class has shared meaning during the rest of the course.

Have groups answer the following questions: answer the following questions:

- *What is the definition of this disorder?*
- *What are the key symptoms of this disorder?*
- *What are three risk factors for this disorder?*

Depression

According to the Centers for Disease Control and Prevention, by 2020 depression is expected to be the second most common cause of disability and death in the United States. Although depressive symptoms tend to increase with age, depression does not need to be a normal part of growing older, as depression is treated successfully 80 percent of the time. Depression is currently an under-treated condition.

Symptoms of Major Depressive Disorder

Significant distress or impairment is manifested by five of the nine criteria listed below, occurring nearly every day for 2 weeks. These symptoms must represent a change from previous functioning and that either depressed or irritable mood or diminished interest or pleasure must be present to make the diagnosis.

- Depressed/irritable
- Diminished interest or pleasure

- Weight loss/gain
- Insomnia/hypersomnia
- Psychomotor agitation/retardation
- Fatigue or energy loss
- Feelings of worthlessness
- Diminished ability to think/concentrate
- Recurrent thoughts of death or suicidal ideation

(See DSM-IV criteria)

Depression Interventions

Depression in children and adolescents is treatable and responds well to medical intervention. Students with depression need encouragement and positive reinforcement.

Flexibility of academic and personal deadlines can be an important additional resource in the treatment of depression.

Other Health Impairment

There has been an increase in students identified as Other Health Impaired, or also referred to as OHI. There is a specific definition that is provided for us when identifying students with OHI. The federal guidelines give us a definition to follow that considers the student's limited strength, vitality, alertness (including their response to environmental stimuli) that impact them in the educational setting. The following difficulties are the result of medical conditions.

Attention Deficit Hyperactivity Disorder

Attention deficit hyperactivity disorder (ADHD) is a condition in which characterized by inattention, hyperactivity and impulsivity.

- ADHD is most commonly diagnosed in young people, according to the Center for Disease Control and Prevention (CDC).
- An estimated 9 percent of children between ages 3–17 have ADHD.

ADD/ADHD – Neurological Disorder

Each side of the brain is designed to perform specific tasks that frequently must work in unison. For example, the left brain processes information, and the right brain interprets it. It means the left brain reads the words, but the right brain understands the story. We have dozens of specialized centers on either side of the brain that process particular types of information and control specific functions. The fact that we can then mix and match or combine these different areas of the brain within each side and between each side gives us an almost limitless repertoire of skills that we can tap into and develop. However, both sides of the brain must act simultaneously. The timing and speed of coordination gives the human brain its unique ability, but it also makes the brain vulnerable.

Changing from an intuitive to a cognitive mindset requires an effort and some moments to adjust. When a child is hyper-focusing and in an intuitive mind state and a parent

enters the room and gives a list of instructions, which is cognitive, the child needs time to adjust from intuitive to cognitive thinking. Not getting that time to adjust to a new mindset causes frustration and irritation, and consequently bad behavior.

The average person's brain is wired for cognitive thinking, while the ADHD brain is wired for intuitive thinking.

Symptoms of ADHD

Commonly seen in academic settings, due to required attention. Problems with attention are consistent and most commonly seen by age 12.

Options for treatment – Increased structure, maintain a healthy diet, medication

If left untreated, can evolve into Oppositional Defiant Disorder and/or Conduct Disorder.

- Give instructions 1 or 2 at a time.
- Allow student to help you with something that allows him to get up and about.
- Provide student with “code word” or gesture for refocus (reduces embarrassment).
- Provide positive reinforcement for desired behavior.
- Allow time in a re-focus zone.

Implications of ADHD on School Safety

The school experience can be challenging for students with ADHD. Students usually are identified only after consistently demonstrating a failure to understand or follow rules or to complete required tasks. Other common reasons for referral include frequent classroom disruptions and poor academic performance.

Post-Traumatic Stress Disorder

More and more schools are experiencing tragedy, and PTSD is a common response. Younger students may act out experience in play. Older students may begin abusing substances to self-medicate. The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers. People who have PTSD may feel stressed or frightened even when they're no longer in danger.

Symptoms of PTSD

Students with PTSD are often overwhelmed by everyday interactions. Allowing students to leave the room to regain control and reduce stimuli can be a very successful option (Re-focus Zone). Students may need a non-judgmental person to allow them to express themselves and their situation. People working with students with PTSD will want to be cautious about physical touch as a reassurance or bonding technique.

- Stop activities that are upsetting for the student.
- Reduce auditory and visual stimuli, when possible.
- Allow student to move to “re-focus” zone.
- If the student wants to talk about the event, do not discourage.

- Allow the student to express his/her feelings without judgment.
- Be cautious with physical touch.
- Care should be taken in facial expressions and body language.

Instructor Note:

See Handout #3

Randal's Story

Read each scene in Randal's story and answer the corresponding questions.

Randal's Story Scene 1

Randal is a 15-year-old boy that you've known for years. He seems typical in every way: he has a normal amount of friends, has decent grades and is involved in a few activities after school. He seems to get along well with his friends, teachers and parents. You heard that over the summer, he was involved in a pretty serious car accident with his older brother and another friend. The friend was driving and everyone healed well from their injuries. Randal doesn't seem like himself this year. He seems less interested in things, although he still manages to keep solid grades. You notice, however, that he seems a bit more emotional than he used to and that he doesn't hang out much with friends. Instead, he seems to only want to be with his brother.

Group Discussion: You are a SRO at Randal's school. How do you approach him?

Randal's Story Scene 2

Randal blows off your initial outreach, telling you that everything is fine and nothing has changed. As you gently probe a bit deeper, you can see that he's stressed and upset, but he makes it clear that he doesn't want to talk.

Randal's Story Scene 3

Nothing seems to change much for Randal as the semester continues. He still doesn't really seem like himself. He's stopped all of his afterschool activities, and spends most afternoons watching his older brother's basketball practice. He seems really jumpy and over-reacts to almost any loud noise. He looks tired, as if he's not getting much sleep.

Randal's Story Final

The Crisis Scenario

A student stops you in the hall to tell you that Randal is "freaking out" in the bathroom. You rush in to see a group of students just staring at Randal, who is in the corner of the bathroom, rocking back and forth, sweating profusely, with his hands over his ears. You ask another student what happened and he said that Randal just started screaming right after the bell rang. He said someone had dropped a tray of beakers from the

Science lab in the hall and then two other guys were goofing around and slamming doors, but that nothing unusual was happening.

What do you think is happening with Randal? How do you respond to the situation?

Anxiety Disorder

Anxiety disorder is persistent, excessive fear or worry in situations that are not threatening. It is the most common mental health concern in the United States. Approximately 8 percent of youth experience the negative impact of an anxiety disorder.

Preparing students with anxiety for upcoming events, assignments, etc. can be helpful. In severe cases, providing an isolated location for a student to complete assignments may also be helpful. Anxiety disorder can easily lead to substance abuse.

Symptoms of Anxiety Disorder

Increase in number of students with anxiety due to testing pressures and staff members' reactions to pressures, peer pressure and demands at home.

May ask questions about future events prior to expected time (Ex. At the beginning of class, "Are we going to have a test today?")

Implications of Anxiety on School Safety

Because students with anxiety disorders are easily frustrated, they may have difficulty completing their work. They may worry so much about getting everything right that they take much longer to finish than other students. Or they may simply refuse to begin out of fear that they won't be able to do anything right. Their fears of being embarrassed, humiliated, or failing may result in school avoidance. Getting behind in their work due to numerous absences often creates a cycle of fear of failure, increased anxiety, and avoidance, which leads to more absences. Furthermore, children are not likely to identify anxious feelings, which may make it difficult for educators to fully understand the reason behind poor school performance.

Instructor Note:

*Activity: Mental Health Simulation
Handout #4*

Verbal Hallucination Activity – *Have participants get in groups of 3-4. One or two participant/s should take a piece of paper and roll it to use like a megaphone. One participant will be the student, one will be a SRO and one to two will read the script through the megaphone. The student and the SRO will attempt to have a conversation while the other participant/s will read the script into the student's ear.*

SCRIPT:

Why are you talking to him (her)?

Don't trust him.

They are all laughing at you.

You look ugly.

You are so stupid. Why do you even try?

Is he looking at you?

Why would he (she) want to talk with you?

Do you think you can trust him (her)?

You can't trust him (her). You can't trust anyone.

When the activity is over process with participants.

Describe your experience.

Thoughts/Feelings?

Auditory hallucinations feature prominently in many psychiatric disorders. It has been estimated that approximately 75 percent of people with schizophrenia experience auditory hallucinations. These hallucinations are also relatively common in bipolar disorder (20 percent to 50 percent), in major depression with psychotic features (10 percent), and in post-traumatic stress disorder (40 percent).

Not all auditory hallucinations are associated with mental illness, and studies show that 10 percent to 40 percent of people without a psychiatric illness report hallucinatory experiences in the auditory modality. A range of organic brain disorders is also associated with hallucinations, including temporal lobe epilepsy; delirium; dementia; focal brain lesions; neuro-infections, such as viral encephalitis; and cerebral tumors. Intoxication or withdrawal from substances such as alcohol, cocaine, and amphetamines is also associated with auditory hallucinations.

Emotional Disturbance

A condition exhibiting one or more specific characteristics over a long period of time, and to a marked degree that adversely affects a child in more than one environment (child's educational performance and home).

- Learning difficulties
- Interpersonal relationships
- Inappropriate behaviors
- Pervasive mood of unhappiness, depression, fear, etc.
- An inability to learn that cannot be explained by intellectual, sensory or health factors
- An inability to build or maintain satisfactory interpersonal relationships
- Inappropriate types of behavior or feelings under normal circumstances

- A general pervasive mood of unhappiness or depression
- A tendency to develop physical symptoms or fears associated with personal or school problems

The co-occurrence of emotional disturbance and other disabilities may intensify students' behavioral problems and further compromise academic performance. Many students with emotional disturbance are at great risk for substance abuse disorders and negative encounters with the juvenile justice system. These problems may exacerbate the impact of emotional disturbance and of any co-occurring disabilities. Students with emotional disturbance are particularly vulnerable to environmental changes such as transitions and to a lack of positive behavioral support during transitions. These students' presenting behavior, as well as its intensity, is sporadic, subject to change over time and may serve to direct attention away from underlying issues such as depression. These variations in behavior often result in students with emotional disturbance being blamed for disability-related behavior or subject to negative reactions from their peers and teachers.

Characteristics of Emotional Disturbance (ED)

ED students present with a complex range of disabilities, from conduct disorder to schizophrenia. Within this statistically and diagnostically diverse population, females appear to be underrepresented, and African Americans appear to be overrepresented. The majority of students with emotional disturbance continue to receive most of their services in environments that separate them from students who do not have emotional disturbance.

Collaboration among all professionals involved with the student is imperative so strategies are consistent for the student.

What to Do

Positive behavioral supports are the strategies to be used in classrooms and in the behavior intervention plan.

FACTS AND IMPLICATIONS

A police officer's ability to recognize symptoms of mental illness can be invaluable when assessing a scene.

- A sensitive intervention by a police officer can be a reassuring and steadying influence on an internally struggling youth.
- Desperate parents can be guided to appropriate community resources by a knowledgeable officer.
- Symptoms of mental illness often first appear during adolescence.
- Mental illness and bizarre behavior are not criminal.
- Failure to follow police instructions during a psychotic episode is most likely NOT a deliberate act of defiance.
- These youths heal with treatment, not jail. When incarcerated their illnesses often worsen, especially since psychiatric medications are often withheld.

Instructor Note:

Handout #5

Jessica's Story

Read each scene in Jessica's story and answer the corresponding questions.

Jessica's Story Scene 1

Jessica is a 14-year-old girl who is labeled with an Emotional Disturbance. You have noticed Jessica just never seemed to fit in. She doesn't have a lot of friends, often seems to struggle to find people to sit with at lunch, is usually selected last in PE and is picked on by Jeff, a boy who likes to make a public display of his comments. She has a few close friends, and other kids don't seem to pick on her, but avoid Jessica so that Jeff doesn't turn his attention on them. You've noticed that Jessica seems less outgoing lately and does not engage as much with others as she used to at school. She has also been seen ignoring her teachers and other adults in the building.

Group Discussion: You are an SRO at Jessica's school. How would you approach her?

Jessica's Story Scene 2

Jessica seems embarrassed that you've noticed that she gets picked on. She tells you everything is okay, pointing out that her grades are good, she just got a role in the school play and that she just placed in the state art contest. As you talk, however, she begins to open up about just wanting to disappear when Jeff starts picking on her.

How do you respond to her comments?

Jessica's Story Scene 3

As the conversation continues, Jessica seems relieved to have someone to talk to. She eventually admits to "playing sick" a lot recently to avoid going to school—and thus avoiding Jeff. She says she's having trouble concentrating and shares that she got a lower than usual grade on her algebra test last week. She's even thinking of dropping out of the school play, because she's afraid that it will only give Jeff more reason to pick on her.

What steps do you take to ensure school safety?

Jessica's Story Final

The Crisis Scenario

A few weeks later you saw Jessica at the local swimming pool and you see several cuts on Jessica's thighs. You pull her aside to ask what happened and she starts to tell you a long, complicated story about falling. You note that the cuts don't look like injuries from

a fall, and that some look infected. She eventually admits that she's been cutting herself with a nail file.

Not surprisingly, many students with emotional disturbance experience poor academic results. They fail more courses, earn lower grade point averages, miss more days of school, and are retained at grade more than students with other disabilities. Fifty-five percent leave school before graduating; only 42 percent graduate. School factors such as a lack of academic and social supports, reactive teaching styles, and frequent placement changes contribute to poor results. Failure to address the needs of students with emotional disturbance is a portent for poor community results as well as poor academic results.

Mental Health Needs for Special Education Students

Many students identified with special education needs pursuant to the Individuals with Disabilities Education Act ("IDEA") have been diagnosed with mental health disorders.

School districts may permit mental health service providers into schools to render various services to special education students. These mental health workers often provide services that seek to address the student's social, emotional, and behavioral needs. Nonetheless, it is the child's school district that is required under the IDEA to provide a Free Appropriate Public Education ("FAPE"). More specifically, the child's school district must develop and implement an appropriate educational program in the Least Restrictive Environment.

When a special education student is also receiving mental health services, there are several significant implications that school districts must consider. First, school districts are required to address all of the student's special education needs through an appropriate Individualized Education Plan ("IEP"). The student's academic, social, emotional, behavioral, developmental, and physical needs must be addressed in the child's IEP. Indeed, the IDEA specifically requires school districts to provide "...supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes...school health services and school nurse services, social work services in schools, and parent counseling and training."

Implications of Student Mental Health

Many youth with mental health issues are incarcerated for minor, non-violent offenses, while others have not been charged with a crime at all. These youth are entering the juvenile justice system solely to access mental health services and supports or because of disruptive or inappropriate behaviors that are often symptoms of an unidentified, untreated or ineffectively treated mental illness.

There is no more important endeavor than safeguarding the welfare of our children and youth. Creating safe and supportive schools is central to this purpose and must be a national priority. School safety is not achieved with a single program or piece of security equipment. Rather, effective school safety starts with prevention; provides for students' mental health; integrates physical and psychological safety; and engages schools, families, and communities as partners.

Implications of Training Staff on Mental Health in Schools

Providing a proactive approach to reducing and preventing crises.

Teaches staff skills to effectively prevent or de-escalate a crisis situation, and effectively communicate with youth experiencing mental health issues in the school environment.

Reduces the need for the use of force in a crisis.

Gets youth the help they need so they do not experience the negative outcomes associated with untreated mental illness.

Ensures consistency in a school's approach to responding to mental health crises.

Untreated mental illness in children is likely to persist and lead to school failure, limited or non-existent employment opportunities and poverty. No other illnesses harm children as seriously.

Early Identification:

- Children can be effectively identified and treated.
- Can help prevent the loss of critical developmental, academic and emotional maturity.
- Early intervention can significantly minimize delinquent and violent youth from a future of crime.

Increase staff's ability to identify symptoms of different mental health disorders.

Communication Skills Overview

Basic Strategies While Communicating

Advice vs. Reassuring Information

A: I remember my first breakup, here's what you need to do...

RI: Breakups can be tough. It's natural for you to be hurt and upset.

A: You really need to talk to a counselor about that.

RI: I'm here for you if you want to talk. There are also people who are trained to help you work through these feelings.

A: You'll get over it. Just don't worry about it so much.

RI: You are not alone.

Considerations When Providing MH Help

Families whose children are struggling with mental health issues are profoundly affected by their children's troubles and may want schools to do whatever might possibly help their children. Parents are commonly coping not only with the child's problems at school, but with the impact of the child's behavior on siblings and family relationships.

Further, families are rarely equipped to navigate the process of obtaining modified classroom instruction for their children. In addition to coping with the daily stresses of raising a child experiencing problems in school, they are usually not familiar with the process of evaluation or the learning strategies teachers typically use. However, they may be extremely helpful partners with school staff by supplying insights about the child, key information about the child's condition and interventions that are effective at home, and by reinforcing strategies at home that are effective at school.

Tips When Responding to a Student Experiencing Mental Health Issues

- Try to understand the symptoms for what they are.
- Empathize with how the person is feeling about his or her beliefs and experiences.
- Try not to confront the person, criticize or blame.
- Don't take delusional comments personally.
- Be aware that the young person's feelings are very real.
- Be accepting even though you may not agree.
- Be aware of your body language and facial expressions.
- Be positive with your feedback.
- Refrain from the use of sarcasm or patronizing statements.
- Listen non-judgmentally.
- Using "I" statements, state nonjudgmentally what you have noticed.

Things to Remember When Providing Help

Realize it may be a relief for the young person to talk about how they feel. Remember it's about them, not you:

- Their experiences are not the same as ours
- Their perspective is not the same as ours or necessarily of other youth in the family or peer group
- Their culture may not be the same as ours
- They need our empathy
- They may use language that makes us uncomfortable

Important Points for School Staff

Keep in mind that children may behave very differently (worse or better) at home than at school.

Don't assume that a student's difficulties in school are caused by a mental health condition or by the medications used to treat it.

Parents may have a very different perception and understanding of the child's situation than the school staff. Remarks such as, "but he has no problem with that here," may be perceived by parents as judgmental, since it is not uncommon for children to conduct themselves differently in different settings.

A mental health condition, particularly if it is severe, may mask other problems, such as learning disorders. A student who becomes upset in class may be overwhelmed because of an undiagnosed learning problem that makes it hard to do the required work. In students with mental health conditions, the stress caused by an untreated learning disorder may exacerbate the mental health condition.

Implications of Student Mental Health on School Safety

Increasingly, youth with MH issues enter the juvenile justice system.

For some youth, contact with law enforcement is their first call for help and may be the first time they have the opportunity to get the help they need.

An alarming number of youth with mental health needs struggle in school and at home with undiagnosed and untreated conditions. MH training provides an opportunity to prevent the tragic consequences of undiagnosed and untreated mental health issues. By including school personnel, school-based law enforcement officers, child and adolescent mental health providers, parents and youth in the partnership, we can identify youth with mental health needs before they become entangled with the juvenile justice system, before they fail or drop out of school or before they develop a more difficult-to-treat, chronic condition.

Many schools have proven to be a pipeline into the juvenile justice system with school personnel contacting law enforcement officers when students engage in disruptive behaviors, including cases involving a mental health crisis. All too often, the opportunity for communities to intervene with these youth is lost—resulting in poor outcomes for everyone involved, including schools, law enforcement, youth, and their families.

It only takes one person to make a positive difference in a child's life and to redirect them down a brighter path. In short, by helping youth with mental health needs we can assist them in creating a better future.

Genuine security encompasses both physical and psychological safety. Our schools must not resemble fortresses or jails. We cannot barricade against all possible harm; trying to do so is counterproductive to maintaining a healthy learning environment and is an ineffective use of resources. Excessive building security (e.g., metal detectors, armed guards) can actually decrease students' sense of safety and does not necessarily guarantee protection. To truly improve school safety, reasonable physical security such as locked doors, lighted hallways, and visitor check-in systems must be combined with reasonable psychological safety efforts that promote a positive school climate. These efforts include establishing trust among staff, students, and families; and creating an environment where students feel empowered to report any safety concerns.

Importantly, supporting students' psychological safety helps build their resilience and ability to cope when a crisis does occur in any setting.

Student access to mental health supports is essential to ensuring school safety. Supporting students' mental health can lead to improvements in behavior, school climate, adult–student relationships, and academic success, all of which contribute to overall school safety. Children and youth spend six or more hours per day in school, making schools an ideal setting to provide access to mental health services. It is critical that students have access to well-trained professionals, caring adults, and support services that can help to facilitate and build upon existing school–family relationships. Schools can play a critical role in supporting students' mental wellness, positive behavior, and resilience by ensuring access to mental health supports.

There is no more important endeavor than safeguarding the welfare of our children and youth. Creating safe and supportive schools is central to this purpose and must be a national priority. School safety is not achieved with a single program or piece of security equipment. Rather, effective school safety starts with prevention; provides for students' mental health; integrates physical and psychological safety; and engages schools, families, and communities as partners.

Implications of Student Mental Health on School Performance

Safety and learning go hand-in-hand. Safety is essential to student well-being and learning. Students who do not feel supported and safe at school, both physically and psychologically, cannot learn to their fullest potential. We enable students' ability to learn when we ensure that they: (a) come to school feeling safe, welcomed, and respected; (b) have a trusting relationship with at least one adult in the building; (c) understand clear academic and behavioral expectations; and (d) have access to needed mental health supports. Effective school safety programming, such as bullying prevention and positive discipline, is equally as important to school success as high quality instruction, and should be fully integrated into school planning, attitudes, expectations, policies, and practices through the use of a multi-tiered system of supports.

Stand Up for Mental Health

Caring begins when students first arrive at a school. Schools do their job better when students feel truly welcome and have a range of social supports. A key facet of welcoming is to connect new students with peers and adults who will provide social support and advocacy. Over time, caring is best maintained through personalized instruction, regular student conferences, activity fostering social and emotional development, and opportunities for students to attain positive status.

HANDOUTS

Handout #1

Activity – Case Study

Sara is a 7th grade student at a local middle school and has been recently placed in the foster care system. She was placed in foster care because she was physically abused by her step-father and neglected by her mother. Sara can be even-tempered at times, but most of the time she is quick to anger and often has outbursts where she will yell at others and then burst into tears.

Sara often gets into trouble at school for talking back to teachers and getting into arguments with other students in her class. Her teachers have noticed a decline in her school work. Sara reports being unable to sit still and concentrate on her work. Sara has been placed into ISS several times and is now labeled a “trouble-maker.” She responds angrily to any kind of correction or criticism from adults or peers and begins to cry when she gets angry. During elementary school, Sara was reportedly a good student who rarely got in trouble.

Case Study: Work with your table group and discuss the warning signs in the following case study.

Does the child demonstrate symptoms of a mental health disorder? If so what are the symptoms?

What are some prevention and treatment options for Sara?

Sara’s Story Scene 1

Everyone knows 14-year-old Sara’s story. The school has called children’s services several times because of reports of physical abuse and illegal drug use at home by her stepfather. Sara seems pretty resilient but has struggled to fit in and establish close friends.

In spite of the problems, she is generally upbeat and manages to make passing grades. Lately, Sara’s appearance seems to have changed. She looks sloppy, even dirty, at times. She no longer sits with her best friend at lunchtime and has been late to school more and more often.

Group Discussion: You are a SRO at Sara’s school. How do you approach her?

Sara's Story Scene 2

Sara tells you that it's the "same old, same old" at home. When you talk with Sara, you learn that she's really lost her confidence and is feeling desperate to fit in. She feels hopeless, ugly and rejected. She says that she'll be better liked if she could just lose weight. (Sara is already quite thin). She also said that maybe if she were prettier her stepdad would be nicer to her. She then begs you not to call children's services again. She doesn't believe it will do any good, and says things at home always get worse after he comes back.

CUT-----

Sara's Story Scene 3

During the next few weeks, Sara's grades begin to drop and her behavior becomes somewhat erratic. Sara is very focused on losing weight and avoiding food. Some days she seems increasingly rebellious and even aggressive. Other days, she's withdrawn and moody. She eventually shares that she's overwhelmed and feels like she has no control over her life.

CUT-----

Sara's Story Final

The Crisis Scenario

Sara gets into trouble at school for fighting because kids were making fun of her. To make matters worse, she, when you try to talk with her after the fight, she seems disoriented and wobbly. As you're trying to talk with her, she passes out.

What steps do you take at this point?

After a three-day suspension, she does not return to school, and no one seems to know why.

What action do you take?

Handout #2

DEFINITIONS EXERCISE: FIND THE MATCH

Have the class participate in an exercise to connect commonly heard terms with appropriate disorders and definitions. Using the template included in the handouts, give each participant a bag with all the names of the disorders, characteristics and their definitions. Depending on the size of your class, allow the group about 5-10 minutes to find their mate, thus pairing the disorder with its definition and the characteristics associated with that disorder.

Once every table has completed the task, show slide and walk through the disorders listed. Read the disorder from the slide, and then invite the groups to share the definition. Stress that these are not the only disorders that can affect youth, but are disorders that many of us may have heard about. The goal of the exercise is simply to add appropriate definition to commonly heard terms, so that the class has shared meaning during the rest of the course.

Have groups answer the following questions: answer the following questions:

What is the definition of this disorder?

What are the key symptoms of this disorder?

What are three risk factors for this disorder?

Handout #3

Randal's Story Scene 1

Randal is a 15-year-old boy that you've known for years. He seems typical in every way: He has a normal amount of friends, has decent grades and is involved in a few activities after school. He seems to get along well with his friends, teachers and parents. You heard that over the summer, he was involved in a pretty serious car accident with his older brother and another friend. The friend was driving and everyone healed well from their injuries. Randal doesn't seem like himself this year. He seems less interested in things, although he still manages to keep solid grades. You notice, however, that he seems a bit more emotional than he used to and that he doesn't hang out much with friends. Instead, he seems to only want to be with his brother.

Group Discussion: You are a SRO at Randal's school. How do you approach him?

CUT-----

Randal's Story Scene 2

Randal blows off your initial outreach, telling you that everything is fine and nothing has changed. As you gently probe a bit deeper, you can see that he's stressed and upset, but he makes it clear that he doesn't want to talk.

CUT-----

Randal's Story Scene 3

Nothing seems to change much for Randal as the semester continues. He still doesn't really seem like himself. He's stopped all of his afterschool activities, and spends most afternoons watching his older brother's basketball practice. He seems really jumpy and over-reacts to almost any loud noise. He looks tired, as if he's not getting much sleep.

CUT-----

Randal's Story Final

The Crisis Scenario

A student stops you in the hall to tell you that Randal is "freaking out" in the bathroom. You rush in to see a group of students just staring at Randal, who is in the corner of the bathroom, rocking back and forth, sweating profusely, with his hands over his ears. You ask another student what happened and he said that Randal just started screaming right after the bell rang. He said someone had dropped a tray of beakers from the Science lab in the hall and then two other guys were goofing around and slamming doors, but that nothing unusual was happening.

What do you think is happening with Randal? How do you respond to the situation?

Handout #4

Verbal Hallucination Activity – Have participants get in groups of 3-4. One or two participant/s should take a piece of paper and roll it to use like a megaphone. One participant will be the student, one will be a SRO and one to two will read the script through the megaphone. The student and the SRO will attempt to have a conversation while the other participant/s will read the script into the student's ear.

SCRIPT:

Why are you talking to him (her)?

Don't trust him.

They are all laughing at you.

You look ugly.

You are so stupid. Why do you even try?

Is he looking at you?

Why would he (she) want to talk with you?

Do you think you can trust him (her)?

You can't trust him (her). You can't trust anyone.

Handout #5

Jessica's Story

Jessica's Story Scene 1

Jessica is a 14- year-old girl who is labeled with an Emotional Disturbance. You have noticed Jessica just never seemed to fit in. She doesn't have a lot of friends, often seems to struggle to find people to sit with at lunch, is usually selected last in PE and is picked on by Jeff, a boy who likes to make a public display of his comments. She has a few close friends, and other kids don't seem to pick on her, but avoid Jessica so that Jeff doesn't turn his attention on them. You've noticed that Jessica seems less outgoing lately and does not engage as much with others as she used to at school. She has also been seen ignoring her teachers and other adults in the building.

Group Discussion: You are an SRO at Jessica's school. How would you approach her?

CUT-----

Jessica's Story Scene 2

Jessica seems embarrassed that you've noticed that she gets picked on. She tells you everything is okay, pointing out that her grades are good, she just got a role in the school play and that she just placed in the state art contest. As you talk, however, she begins to open up about just wanting to disappear when Jeff starts picking on her.

How do you respond to her comments?

CUT-----

Jessica's Story Scene 3

As the conversation continues, Jessica seems relieved to have someone to talk to. She eventually admits to "playing sick" a lot recently to avoid going to school—and thus avoiding Jeff. She says she's having trouble concentrating and shares that she got a lower than usual grade on her algebra test last week. She's even thinking of dropping out of the school play, because she's afraid that it will only give Jeff more reason to pick on her.

What steps do you take to ensure school safety?

CUT-----

Jessica's Story Final

The Crisis Scenario

A few weeks later you saw Jessica at the local swimming pool and you see several cuts on Jessica's thighs. You pull her aside to ask what happened and she starts to tell you a long, complicated story about falling. You note that the cuts don't look like injuries from a fall, and that some look infected. She eventually admits that she's been cutting herself with a nail file.

How do you respond? What do you do Monday morning when you return to work?

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Responding to Youth with Mental Health Needs: A CIT for Youth Implementation Manual

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**Section Five:
Positive Behavioral Interventions
(4 Hours)**

DRAFT

Instructor Guide

Section Five: Unit Goal: Positive Behavioral Interventions and Supports, Conflict Resolution Techniques, and Restorative Justice

5.1 Unit Goal: Discussion of Positive Behavioral Interventions and Supports in the school-based environment.

Positive Behavioral Interventions and Supports (PBIS) is an evidence-based, data-driven framework proven to reduce disciplinary incidents, increase a school's sense of safety and support improved academic outcomes. The major premise of PBIS is like any other academic course of study, behaviors are learned and should be taught. By directly teaching expected behaviors, students are better able to understand the behavioral expectations. PBIS was originally developed as a way to work with students with developmental disabilities. It was an alternative to punishment-based interventions. Over time, this concept has been applied to the larger school community. All students do better when the whole school environment supports positive behavior, and readily benefit from such an environment.

5.1.1 List the core components of schoolwide Positive Behavioral Interventions and Supports concept

- Teaching behaviors that are expected: direct instruction in specific student behaviors that demonstrate respect, responsibility, and safety.
- Modeling those behaviors
- Consistently recognizing and rewarding the behaviors when they occur: generous quantities of positive adult/teacher attention and reinforcement to students for demonstrating positive behaviors, and
- Consistently enforcing meaningful consequences for behavior intervention: predictable consequences for behavior infractions that are delivered consistently by all staff. Consequences are not primarily punitive in nature but an opportunity for a student to learn from their mistake. The consequences are used on a continuum matched with the intensity of the behavior.

5.1.2 Describe the multi-tiered approach to the Positive Behavioral Interventions and Support approach

PBIS is a proactive approach to establishing the behavioral supports and social culture needed for all students to achieve social, emotional, and academic success. The primary focus is on creating and sustaining primary tier (school-wide), secondary tier (classroom), and tertiary tier (individual) systems of support that improves the child's whole being. The result is making problem behavior less effective and desired behavior more functional.

5.1.3 List reasons for employing a whole-school approach to Positive Behavioral interventions and Supports approach

The desired outcome to achieve academic and behavioral success has to be the consensus goal for the entire campus. This process cannot be limited to one tier or for “those kids”, but should be utilized to shift the entire mindset of the community or school as a whole.

- A healthy, balanced implementation plan will allow for meaningful conversations between students and adults to accomplish lasting achievements.
- Administration and staff must model the process at every level
- Students are given room to grow and fail within the process
- Equality and value is developed and established from within
- Teachers have more time to teach and students to learn.

5.1.4 Apply the concept of Positive Behavioral Interventions and Supports to a student behavior example.

Instructor Note: Utilize an example of your choice to depict the utilization of the PBIS model. Here is an example:

Without the use of the PBIS model: A student in the back of the classroom throws a spitball. The teacher reacts by scolding the student or sending them to the principal’s office. After the student is punished, they are expected to follow the class rules....but do they? If the behavior continues, the punishment might increase.

With the PBIS model: The focus is now on preventing problems. Students learn about appropriate classroom behavior and social skills from the beginning of the year just like any other subject. Role-play may be used and students are praised consistently for good behavior. Teachers look at minor infractions and try to alleviate the possibility of them escalating. The same student throws the spitball. The strategy used might include a break time or a peer mentor. The strategy changes as needed. Discipline is the focus, not punishment.

Lead the class in a role-play of this exercise.

5.2 Unit Goal: Discussion of Conflict Resolution Techniques in a school-based environment

The effect of aggressive behavior on the classroom environment is significant. Studies show that the majority of teachers feel that aggressive students undermine learning in the classroom and that academic achievement would improve tremendously if these issues were addressed. Evidence suggests that we can help alleviate these destructive behaviors by providing the knowledge and skills needed to settle disputes peaceably. Conflict resolution education can help bring about significant reductions in suspensions, disciplinary referrals, academic reductions, fighting and disputes.

5.2.1 Discuss the central focus of the conflict resolution concept.

Conflict resolution programs can assist schools in promoting both a student's behavioral change as well as the systemic change necessary for a safe learning environment. The ability to resolve disputes effectively and nonviolently is central to the peaceful expression of human rights. Teaching students to express their concerns peacefully and to seek resolution to conflicts that take common interests and human dignity in account, promotes responsible citizenship.

Schools can be places where students prepare for their future roles as parents, community leaders, and productive members of the workforce. Conflict resolution skills are primary to these endeavors. The ability to resolve complex issues depends on how people deal with each other on a daily basis through an understanding of how to reach consensus, as well as how to disagree productively.

5.2.2 List types of conflicts that arise in the school environment

Conflict arises from discord. Conflict in and of itself is not necessarily negative. It is the response to the conflict that changes it into either a destructive experience or a constructive challenge. Since conflict is a part of life it is important to learn how to respond to it constructively.

Conflicts in general arise out of differences. The two largest categories of these differences include:

- Cultural conflicts: based on differences in national origin or ethnicity
- Social conflicts: based on gender, sexual orientation, class, and physical and mental abilities

Reaction to differences are complex and often take the form of prejudice, discrimination, and harassment. Conflict resolution education programs provide a structure for addressing these issues by promoting respect and acceptance through learning new ways to communicate and understand one another's differences.

“The best school-based violence prevention programs seek to do more than reach the individual child. They instead try to change the total school environment, to create a safe community that lives by a credo of nonviolence.” (William DeJong, Harvard School of Public Health)

5.2.3 List the three main components to the conflict resolution structure and discuss the fundamental challenge in engaging students in learning conflict resolution techniques

Conflict resolution education includes primarily learning the following techniques:

- Negotiation
- Mediation
- Consensus decision-making, which allows for exploration of peaceful solutions to conflict.

Negotiation: a problem solving process where two students involved in a dispute meet face-to-face to work together, unassisted, to resolve the dispute.

Mediation: a problem solving process where two students in a dispute meet face to face to resolve the dispute assisted by a third party called a “negotiator.”

Consensus decision-making: this is a group problem solving process where all students in the dispute resolve the dispute by designing a plan of action that all students can live with or at least support. This may or may not be facilitated by a neutral third party.

Instructor Note: Review the above conflict resolution components through class role play. Utilize a scenario depicting a common conflict between students. Discuss the fact that when conflict arises, students have two choices: to continue the conflict or to problem-solve. The problem-solving strategies of conflict resolution address needs and create opportunities for those needs to be satisfied. But when they choose to continue the conflict, no one’s needs are met.

The fundamental challenge in teaching conflict resolution skills to students lies in being able to engage them in learning the skills and processes. By learning these skills and processes it will further enable them to resolve and manage conflict effectively. But ultimately when they experience success with negotiation, mediation, and consensus decision-making in school, they are more likely to use these processes in other environs. This results in the amount of conflict incidences and the intensity of the incidences diminishing.

5.2.4 List reasons for establishing a conflict resolution program

There are many positive reasons why the conflict resolution program could be advantageous in your school. Such as:

- The problem-solving process of learning negotiation, mediation, and consensus decision-making can improve the school climate.
- Conflict resolution strategies can reduce violence, vandalism, chronic school absences, and suspensions.
- Shifting the responsibility for solving nonviolent conflicts to students frees teachers and administrators more to teaching and less on discipline.
- Conflict resolution techniques are a more effective behavior management technique than detention, suspension, and expulsion.
- Conflict resolution education increases skills in listening, critical thinking, and problem solving.
- Conflict resolution education emphasizes seeing other points of view and resolving differences peacefully.

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National Education Association (2015)

5.3 Unit Goal: Discussion of restorative justice technique and its ability to build healthy relationships between parents, students, staff and Law Enforcement/School Resource Officers.

When we have healthy relationships it creates an environment conducive for learning, decreases crime in our schools, and promotes positive interactions between all stakeholders. The goal of the Cross Cultural Connections Sessions is to create safer schools by creating a village mindset. Restorative Justice Practices were adopted from Native Indians and African cultures that utilized “circles” to repair harm within their communities. The idea was that instead of expelling people from their communities, they used the “circle” process to keep people in community through support and accountability. Part of this process required understanding of other individuals. This understanding was gained by listening to and learning from one another. We often misunderstand one another based upon the fact that we have different cultural norms. By creating a space for Community Building and Healing, we come to understand other cultures by listening to them.

5.3.1 Participants will participate in a group discussion on the concept of restorative justice and its positive involvement in school discipline.

CROSS CULTURAL CONNECTEDNESS THROUGH COMMUNITY BUILDING

1. Cultural Connections:

In this track, School Resource Officers and community members go through sessions that will help to break down barriers of assumptions, identify privilege, learn to have intentional conversations, learn about other cultures, solve conflict, repair harm, de-escalate and build relationships. In addition, School Resource Officers will learn how to interact in circles with adolescence and teens in schools that are living in the urban context in order to develop trust and promote open communication with parents, staff, supports staff and community members.

2. Community Building Circles:

This process allows parents to build relationships with Law Enforcement and School Resource Officers that patrol their children’s schools, give them an opportunity to problem solve with the parents in their community and decrease the likelihood of crime on their campuses. This is an opportunity for community and law enforcement to learn how to have positive interactions with one another. These circles are designed to be ongoing which will allow each officer on a school campus to participate.

Who Should Organize the Community Building Circles?

Ideally, these circles should be organized by parents in partnership with service providers on a school campus (Principal, teachers, SRO, students and support staff).

How do we get parents involved?

It is recommended that you use parent support team meetings on the school campus as an opportunity to introduce the idea of the restorative justice process and for parent/community volunteers to lead circles and to train parents in your district on the process of mobilizing to support the success of a school campus by creating a caring environment on the campus.

What is the Circle?

The circle is a structured process for organizing effective communication, relationship building, decision making, and conflict resolution. The process creates a space apart from our normal ways of being together. The circle embodies and nurtures a philosophy of relationship and interconnectedness that can guide us in all circumstances-in circles and outside of circles.

The Circle is an intentional space designed to:

- Support participants in bringing forward their “core self” – to help them conduct themselves based on the values that represent who they are when they are at their best;
- Make visible our interconnectedness even in the face of very serious differences;
- Recognize and access the gifts of every participant;
- Elicit individual and collective wisdom;
- Engage participants in all aspects of the human experience- mental, physical, emotional and spiritual or meaning-making; and
- Practice value-based behavior when it might feel risky to do so. The more people practice this behavior in circle, the more these habits are strengthened to carry the behavior into other parts of their lives.

What is the Circle Practice?

What, then, does the circle look like? Visually you will see:

- Participants seated in a circle, preferably with no furniture in the middle
- A centerpiece, which creates a central focus for participants

- An opening ceremony that marks the beginning of the special space of the circle
- An object, called a talking piece, that is passed from person to person to regulate the flow of dialogue (who speaks and when)
- A closing ceremony that marks the end of the special space of the circle

Essential Elements of Constructing the Circle

The circle keeper uses the following elements to design the circle. Together, these elements create the space for all participants to speak their truth respectfully to one another on an equal basis and to seek a deeper understanding of themselves and others.

Creating the Space:

- Talking Piece- The talking piece allows the one holding it to speak without interruption. Everyone else should be deep listening (listening is the most important part of this process).
- Centerpiece- Circle Keepers use a centerpiece to create a focal point that supports speaking from the heart and listening from the heart. The centerpiece usually sits on the floor in the center of the open space inside the circle of chairs. Sub-consciously reminds us of why we are here. It should be set up according to the event.
- Refreshments- What better way to have a conversation?

Five Elements of the Circle: Seating of all participants in a circle (preferably without any tables)

- Opening Ceremony- The birth of the circle, dictates the pace, and sets the mood for the conversation.
- Ice Breakers- Can be used for introductions and as a creative way to build relationships, involves peer interaction, movement, and relevant exercises
- Values – Consensus based regulations that the circle has agreed to uphold. Each participant discusses the values that are important to them and those they want to bring to the dialogue, they lay the foundation of the circle space in values. The values should be written and placed visibly within the circle. The guidelines describe the behaviors that the participants feel will make the space safe for them to speak their truth.
- Body- Why we are here!
- Close- The ceremonial ending that connects us to our next steps as participants in circle

Guiding Questions: Effective questions framed to:

- Encourage participants to speak from their own lived experiences
- Invite participants to share stories from their lives
- Focus on feelings and impacts rather than of facts
- Help participants transition from discussing difficult or painful events to discussing what can be done now to make things better.

Questions should never invite attacks on another individual or group. Asking participants to respond using “I” statements rather than “you” statements is sometimes helpful.

Closing Ceremony:

- Closings acknowledge the efforts of the circle. They affirm the interconnectedness of those present. They convey a sense of hope for the future, and they prepare participants to return to ordinary space of their lives. Openings and closings are designed to fit the nature of the particular group.

Role of the Circle Keeper:

- Assists the group in creating and maintaining a collective space in which each participant feels safe enough to speak honestly and openly without disrespecting anyone.
- Leads the group through the process of identifying their values and guidelines and by supporting proper use of the talking piece.
- Initiates a space that is respectful and safe
- The keeper is in a relationship of caring about the wellbeing of every member of the circle. Keepers do this not from a detached place but as an equal participant in the circle.
- Keeper sets the time and place, extends invitations, prepares all parties, selects talking piece and centerpiece, plans opening and closing ceremonies and formulates some guiding questions.

Circle Keeper Tips:

- Invite someone to bring a talking piece
- Provide an array of talking pieces for circle members to choose from;
- Invite one or more participants to do an opening and closing ceremony
- Invite circle members to bring or create items for the center piece

Challenges in Circle:

- Take a break when needed and check in with anyone who seems to be struggling
- After coming back from break, you might ask participants to look again at the values and review the guidelines before renewing the dialogue
- If you are uncertain about where the circle should go next, it is okay to say, “I’m not sure where we should go from here,” and then pass the talking piece
- Trust that someone in the group may have a helpful idea. This technique allows you to demonstrate that leadership is a shared responsibility in the circle
- It is okay to ask for help from the circle
- It is important for circle keepers to make it safe for participants to share if it isn’t working for them. This requires humility and openness to feedback

Planning the Specifics of the Circle: Put together a circle by answering the following questions

- Who will be part of the circle?
- What time?
- Where?
- What will be the talking piece?
- What will be in the center?
- What opening ceremony will be used?
- What questions will be used to generate values for the circle?
- What questions will be used for an introduction or check in round?
- Is there a need for further relationship building before getting into the issues? If so, how will that be done?
- What questions(s) will be used to begin the dialogue about the key issues?
- What further questions might be useful if the group is not getting deeply enough into the issues?
- What closing ceremony will be used?

Suggested Questions for further cultural discussions when that is the basis of the conflict:

Tell a story about racism- when you felt it or observed it.

Tell us a story about the most important experience that shaped you into the woman you are today?

Tell a story about a time when someone of another culture made an assumption about your culture (cause) and it caused you harm (effect). How did that make you feel?

How can we ensure that this conversation today doesn't end here, but continues and becomes part of our lives?

In a **single sentence**, using the beginning statement “**I WILL...**” please share what **YOU** are willing to do to help make **OUR** community one in which assumptions and pre-judgment don't affect **OUR** relationships with one another.

What difference would it make (in your friendships, families, our community, the broader current culture, etc.) if the diversity was more of a reality in our life?

What are some ways we can celebrate our differences to communicate an attitude of acceptance?

Why does having deep friends of a different race matter so much?

5.3.2 Identify effective communication tools to utilize when participating in a “circle” activity.

Getting the right point across:

Effective Communication is defined as verbal speech or other methods of relaying information that get a point across.

When using this definition, the primary goal of communication is for the other person to receive the message that I am attempting to convey.

Often when we think about communicating effectively, we think about the things that we can say in order for others to understand us. We often don't think about the things that we can do to help others understand the messages we are attempting to convey.

Effective Listening skills are the ability to actively understand information provided by the speaker, and display interest in the topic discussed.

Introspective thinking is the examination of one's own conscious thoughts and feelings.

When I am thinking introspectively, I am processing what I am hearing from others in a way that begins to change me. I begin to identify thoughts within myself that could potentially be toxic towards other individuals or people groups.

Empathetic Listening is paying attention to another person with emotional identification, compassion, feeling, insight. One basic principle is to “seek to understand, before being understood.”

The old saying that people really don't care how much you know until they know how much you care is true.

In restorative justice we foster relationships that matter by developing empathy for the people who are a part of our community. This is done through the act of listening to one another's stories. Every person that we interact with has a story to tell.

The Power of Story Telling: Tell a story about a time that you attempted to communicate with someone and they totally misunderstood what you were saying? What thoughts came to your mind about the other individual?

Tell a story about a time when you misunderstood what someone else was attempting to say to you? What thoughts came to your mind about the other individual?

5.3.3 Participants will employ the restorative justice technique to scenarios depicting the restorative circles technique.

Instructor Note:

Utilization of the documentary "Chasing Smoke" or similar viewings of the "circle" process will be helpful in educating participants on what to expect in the scenario activity to follow.

Lead group in a participation of a "circle" activity. If instructor does not have appropriate experience in conducting this activity, a subject matter expert should be contacted to assist in this section.

Activity:

Community Building Circle Exercise

"Getting the RIGHT point across"

Purpose: *The goal in the opening circle is to introduce ourselves and begin to build community with those who we will spend the next few hours with. In this circle we will discuss our values and belief system as well as build a consensus around guidelines to establish a healthy space to meet our needs, grow and learn.*

Materials: *Talking Piece, Center Piece, Sticker Name Badges, Paper, Pens/Markers, Tissue, and Index Cards ***

Estimated time for community building circle is 30min. Facilitator should explain the following and answer each round/question first:

- Talking Piece- The talking piece allows the one holding it to speak without interruption. Everyone else should be deeply listening (listening is the most important part of this process).
- Centerpiece- Circle Keepers use a centerpiece to create a focal point that supports speaking from the heart and listening from the heart. The centerpiece usually sits on the floor in the center of the open space inside the circle of chairs. Sub-consciously reminds us of why we are here. It should be set up according to the event.

 **OPENING: The birth of the circle, dictates the pace, and sets the mood for the conversation.**

Read Quote to Circle: "Culture is the Arts elevated to a set of beliefs" ~ Thomas Wolfe

 **ICE BREAKER: Can be used for introductions and as a creative way to build relationships, involves peer interaction, movement, and relevant exercises**

Q: What was/is your nickname growing up, who gave the name to you and why?

*** Write the name on your name badge.*

*** If a participant does not have a nickname, the community (circle) will give him/her a nickname.*

 **VALUES: Consensus based regulations that the circle has agreed to uphold. Each participant discusses the values that are important to them and those they want to bring to the dialogue, they lay the foundation of the circle space in values. The values should be written and placed visibly within the circle. The guidelines describe the behaviors that the participants feel will make the space safe for them to speak their truth.**

Q: What is one word to define your commonly held standards of what is acceptable or unacceptable, important or unimportant, right or wrong, workable or unworkable, etc., in a community or society?

*** Ask each participant to write the word on their index card, pass the talking piece around so that everyone will have the opportunity to share about what they wrote and why. Then place the index card in the center of the circle.*

 **BODY: Why we are here!**

*** During this round you will ask one question at a time in each round. Answer the question first then pass the talking piece to the person next to you and allow them to answer Q1 until the circle is complete. Do the same for Q2.*

Q1: Tell a story about a time that you attempted to communicate with someone and they totally misunderstood what you were saying? What thoughts came to your mind about the other individual?

Q2: Tell a story about a time when you misunderstood what someone else was attempting to say to you? What thoughts came to your mind about the other individual?

 **CLOSING: The ceremonial ending that connects us to our next steps as participants in circle.**

*** Final round, pass the talking piece and allow everyone to reflect until the circle is complete.*

Debrief/Reflection: Ask individuals “What was one thing you had in common with someone in the group that surprised you?”

❖ Ask Participants to keep their “value” index card for future circles exercises throughout this training.

5.3.4 Participants will discuss the process of building positive relationships between adults and students in order to create a healthy atmosphere conducive to teaching and learning.

Building trust by building relationships:

Community Building Participation

Creating a space where students, SRO, teachers, parents, and support staff can interact with one another to build meaningful relationships is the key to changing the climate of a school campus.

Often the barrier that keeps us from creating spaces like this on school campuses is time. Teachers often think that they don't have time to do classroom circles and SROs typically have several other responsibilities on the campus that makes it difficult for them to spend time in community building circles.

Time Well Spent

Spending time in circle will, in most cases, enhance the time that you have on campus. Teachers will be able to teach more class content; students will feel a deeper sense of connection with the teacher and the SRO on their campus because of the relationship that they have developed.

Creating Time: Check-in, Check-up & Check-out Circles are a way to connect with students on your campus in a short period of time. These circles require 10 – 15 minutes three times a week. This is a maximum of 45 minutes a week spent in the classroom building relationships with students that you will interact with a minimum of 40 hours per week.

Check – in Circles quick conversations at the beginning of the week to listen to the student’s most pressing needs. This could involve discussions about weekend experiences, how they are feeling or their goals for that week.

Check – up Circles gives us the opportunity to engage students in conversations about their relationships with family, peers, teachers and community. This is done midway through the week to offer support and accountability to successfully reach their relational and academic goals.

Check – out Circles can be used as a tool to celebrate the wins for the week, encourage self-care for the weekend and dialogue about new goals for the following week.

De-escalating Conversations

Identify ways to build relationships with students who have experienced stress or trauma in their lives. As adults, we often unintentionally re-traumatize students by neglecting to address the root cause of a child’s behavior.

Examples of Traumatizing Situations:

- The removal of a student from his or her home
- The death of a family member
- The death of a peer
- Sexual abuse

De-escalating Chats:

“*De-escalating Chat*” is a very effective tool used to converse with students about their day or a particular situation that may have occurred. This conversation can take place between the students and adult while walking in the hallway, around a track, cafeteria and even in a classroom!

1. Questions to ask the person who has done the harm:
 - What happened?
 - Who else was there/around when it happened?
 - What were you thinking at the time?
 - Who has been affected/upset/harmed by your actions?
 - How do you think they have been affected?

2. Questions to ask the person who has been affected:
 - What was your reaction at the time of the incident?
 - How do you feel about what happened?
 - What did you think at the time?
 - What have you thought about since?
 - How has it upset/hurt/harmed you?
 - What has been the worst or hardest thing for you?
 - What is needed to make it right/to make you feel better?
3. Questions to ask the person who has done the harm:
 - Is there anything else you want to say?
4. Questions to ask the person including any observers:
 - What would you like to see happen to repair the harm?
 - Is that okay? / Do you agree? Is that fair?
 - Is this realistic and achievable?
 - How can we make sure this doesn't happen again?
 - Is there anything I can do to help?
 - Is there anything else you would like to say?
5. Conclusion:
 - Formally record the agreement.
 - Congratulate the students for working it out.
 - Arrange time to follow-up / meet again to see how things are going.
6. Ask each person
 - Is there anything else you would like to say?

Resource: sample questions by www.healthiersf.org/RestorativePractices

5.4 Unit Goal: Utilization of instructional strategies to present information concerning Positive Behavioral Interventions and Supports, Conflict Resolution Techniques, and Restorative Justice Techniques, to the classroom environment

5.4.1 Participants will discuss the application of knowledge obtained in section five to classroom training and student involvement.

Instructor Note:

Involve participants in a discussion concerning how to best instruct this topic section and techniques to utilize to evoke positive student involvement and internalization of information

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