Special-needs Children and Mental Health

Brandon[1] is in 4th grade. He often interrupts other students, rarely follows instructions, and almost never works calmly at his desk. He seldom turns in any of his classwork, and his assignments are often found crushed inside the back of his desk. Papers, pencils, and other objects he collects can be found littering the 5-foot perimeter around his desk. What is going on with Brandon? How can he be helped?

Carmen is a 3rd grader. She has difficulty reading. She cannot sound out words and often will make up words based on the first letter and/or the context. Although the teacher has placed her with a parent-volunteer who is willing to give her special tutoring in this area, Carmen frequently misses the sessions. According to her mother, she often complains of stomachaches and cries when she has to leave for school. Sometimes the "fight" over going to school is so intense that Carmen's mother decides to keep her home for the day, stating that this at least seems to help the stomachache. What might be going on with Carmen? How can she be helped?

Jake, a 9th grader, signed up for the volleyball intramural games, but his mood suddenly changed one month into the school year, and he has missed six of the nine games in the past three weeks. Lately, he seems sad and sluggish. Various teachers have heard him say, "I wish I could stop everything" or "I'm so stupid" in class or in the halls. He eats alone in the cafeteria and seems uncommonly burdened. Almost every day, after arriving home from school, he stays in his room, and his mom reports that he isn't sleeping well. His parents and teachers are concerned about his wellbeing. What might be happening with Jake? How can he be helped?

BY NANCY CARBONELL

What do these stories have in common? They are representative of many students who experience learning difficulties while at the same time struggling with mental or emotional issues. Special-needs teachers see children like Brandon, Carmen, and Jake in their classrooms every day. It is estimated that in the U.S., 37 percent of children with special needs also need mental-health care.[2] That is approximately one in every three special-needs students! This is particularly challenging for teachers whose training did not include how to deal with children experiencing mental-health issues.[3]

Helping children with mental-health issues dovetails well with the philosophy of Seventh-day Adventist education, which emphasizes the balanced development of the whole person.[4] Ellen G. White wrote: "A comprehensive education is needed—an education that will demand from parents and teachers such thought and effort as mere instruction in the sciences does not require. Something more is called for than the culture of the intellect. Education is not complete unless the body, the mind, and the heart are equally educated."[5] Acknowledging the psychological wellbeing of each child and ensuring his or her wholistic development to the fullest potential God desires are aspects Christian educators dare not ignore.

Research shows that although teachers are not always comfortable with the role of gatekeeper, they realize that it is their responsibility to be aware and supportive of students with mental-health needs. This has often led them to recognize that they must initiate needed interventions.[6] Clearly, more attention and training are needed to educate teachers on how better to assess and access the appropriate mental-health care children need.

This article will identify and review three mental-health disorders commonly found among children: Attention Deficit/Hyperactivity Disorder (ADHD), Separation Anxiety Disorder (SAD), and Major Depression Disorder (MDD). It will discuss the findings of what causes each disorder, the diagnosis frequently given, and treatment options available. The article will also review and discuss symptoms that would warrant teacher referral of such students for mental-health care.

Attention Deficit/Hyperactivity Disorder

Attention Deficit/Hyperactivity Disorder (ADHD) is one of the most prevalent disorders among school-aged children. ADHD affects three to seven percent of school-age children in the United States and is more prevalent among boys.[7] Symptoms are often apparent by 3 to 6 years of age[8] but become prominent once a child reaches school age. The danger lies not only in the affected child's inability to do well academically, but also in his or her difficulty in developing healthy social interactions with peers. Brandon's story describes well what ADHD looks like in a school setting. Although much research is still being conducted to determine what factors may be tied to ADHD (such as mother's use of tobacco and alcohol during pregnancy, exposure to toxins [i.e.. lead], low birth weight, premature delivery, and brain injury), studies suggest that genetics also play a part.[9] Children diagnosed with ADHD typically have a parent, sibling. or close relative with ADHD.

Children with ADHD may exhibit the following behaviors:

- inattention;
- inability to follow instructions;
- incessant talking;
- easily distracted from schoolwork or play;
- chronic forgetfulness;
- inability to stay seated;
- obliviousness to what is happening around them;
- impulsivity, acting and speaking without thinking;
- trouble taking turns;
- interrupting others.

While all children may engage in one or more of these actions from time to time, those with ADHD engage in such behaviors frequently or at excessive levels. Such behavior occurs over an extended period of time and in varied settings, such as home, school, and church.

Children with ADHD are particularly challenging in the classroom. Teachers may feel impatient and annoyed about repeating instructions or reminding wanderers to return to their seats. Unfortunately, these behaviors can lead to teacher/child interactions that are predominately negative and punitive. Actions that further alienate the child (making him or her sit in the hallway for extended periods of time), or taking away certain privileges that most children need and enjoy (recess, free-time activities, etc.) only contribute to the child's conviction that "My teacher hates me!"

ADHD traits may also lead to trouble with classmates—being bullish at play, breaking things, loud and impulsive behavior, inability to "play fair" with classmates, etc. Thus, school is often perceived as a hostile place by children with ADHD.

Diagnosis of ADHD

A child showing such ADHD symptoms needs to be referred to a mental-health professional (the family physician or the school's health professional). These persons will collect observational information from various adults in the child's life such as teachers, parents, and caretakers, and also from the child's family history, using questionnaires that assess ADHD behaviors.[10]

Interventions for ADHD

Although ADHD can't be cured and often continues into adulthood, it can be managed successfully, and some symptoms may actually decrease with age.[11] A number of therapies (e.g., cognitive, occupational, biofeedback, herbal, vitamins, food supplements) have been used in ADHD management, although no evidence-based studies exist to prove their effectiveness.[12] The best course is to consult a trained mental-health provider who is able to work with and monitor the child, parents, and teacher.[13]

Behavioral therapy and cognitive-

behavioral therapy have been found to be successful in dealing with both behavior and thought patterns that result in ADHD behavior.[14] The counselor/psychologist teaches the child various skills—interacting with others, problem solving, and self-monitoring—to cultivate the desired behavior and minimize impulsive and inattentive behaviors. The counselor often includes parents in the treatment process so that the family becomes aware of ADHD issues and learns to address the symptoms effectively.

Affirmation Is Preferable to Sanctions

In the classroom, teachers can help ADHD children through preventative classroom modifications, particularly in special-education classes since those tend to have fewer children and utilize one-on-one teaching approaches. These strategies might include sitting the child close to the teacher's desk and away from windows, doors, and other obvious distractions (class pets, pencil sharpeners, etc.), or allowing the child to take breaks as needed, and perhaps structuring the break so the child is asked to be the teacher's helper to take messages to the office or turn in the lunch count. Children love helping in this way. Some children with ADHD also concentrate better if they are allowed to have outlets for their excess energy in order to stay on task. For example, being allowed to pace in the back while thinking or keeping their hands moving by squeezing "stress balls" as they work on an assignment.

It is important for teachers to establish and enforce clear and consistent classroom rules and redirect the ADHD child's energy toward a goal or task when he or she gets off task and to focus on the child's successes in the classroom rather than the problems he or she "causes." Research[15] has revealed that ADHD children are best motivated by rewards and affirmations. Openly praising the child for the good job done and positively reinforcing with a token or star on a chart provide affirmation, and constitute powerful tools for teachers. The teacher can also affirm the child by asking him or her to hand out homework, collect assignments, or assist in decorating a bulletin board. Positive moments help build self-esteem, help motivate on-task behavior, and foster a good relationship between the teacher and the child.

Strengthening the parent-teacher relationship is also critical to resolving students' school problems.[16] When teachers have ongoing positive communication with parents, home and school can work together to help children complete academic tasks consistently and successfully. Teachers can support parents by providing teacher-student contracts that allow the student to complete unfinished work at home, send home daily or weekly reports on how the child is doing, and the assignments that still need to be completed.

Clinical practice guidelines[17] involving diagnosis, evaluation, and treatment of ADHD in children and adolescents recommend that medication be used only when behavioral interventions are not available or when significant room for improvement exists following effective implementation of behavioral interventions. Pharmacological interventions have been shown to increase the brain's production of certain neurotransmitters that activate the parts of the brain dealing with impulsivity and attentiveness. It is imperative that parents and physicians work together to monitor medications and their side effects, and obtain periodic assessment of their effectiveness.

Separation Anxiety Disorder

The second mental-health disorder commonly experienced by school-aged children is Separation Anxiety Disorder (SAD). Children with SAD often refuse to go to school or to sleep alone. They fear being away from key parental figures in the home, have nightmares about separation, and complain of physical symptoms in anticipation of separation. Carmen's story at the beginning of this article describes well what separation anxiety disorder might look like. In such cases, the child's anxiety leads to exces-

sive worry and stress beyond what is normal for the child's age group. It is natural for many children younger than age 5 or 6 to feel anxious when separated from their caregiver. However, when school-aged children (7 years and up) feel such severe anxiety that they no longer want to go to school or visit friends, or insist on sleeping with their parents rather than in their own room, there is cause for concern. In fact, the key features of this disorder are the non-age-appropriate and excessive nature of the symptoms.[18] In such situations, the anxiety can become so extreme that it impedes the child's desire to engage in new experiences and to discover and learn new things—experiences important in creating self-efficacy in most children.

Children with SAD tend to:

• feel that family members are in danger when separated from them;

• exhibit extreme over-attachment to parent(s);

• shadow parents at home;

• fear sleeping in a dark room alone;

• experience physical symptoms (headaches, stomachaches, dizziness) when anticipating separation;

• whine about going to school, to a friend's house, or a birthday party;

• dislike saying good-bye to parents.

SAD is often inaccurately referred to as "school phobia." In reality, the anxiety actually occurs at the thought of being separated from parents or caregivers. Such children would never leave their caregiver's side if they did not have to. Consequently, they may miss many days of school, which affects their ability to keep up with school work, and also keeps them disconnected and isolated from peers and age-appropriate experiences.[19] To make things worse, parents commonly will try to protect such children by allowing them to stay home if they start complaining of stomachaches or headaches as the time to leave for school draws near. Without intending to do so, such parents actually reinforce the behavior that induces anxiety!

About four percent of children and adolescents have this disorder.[20] The chances for overcoming separation anxiety are best when it is diagnosed and dealt with in the early stages. If untreated, anxiety tends to create and blossom into more anxiety, thus hindering good management or recovery.[21] The teacher's role becomes even more important to the child's wellbeing because the parents themselves may be contributing to the problem by not knowing how to respond appropriately. Although the connection between childhood and adult anxiety is not yet clearly understood, evidence suggests that vulnerability to adult anxiety may manifest itself in childhood.[22] Learning how to deal with anxiety early in childhood is thus advisable and necessary.

Diagnosis of Separation Anxiety Disorder

Research shows that a high percentage of children with SAD have a parent who also experienced separation anxiety in childhood, which suggests that SAD may have a genetic component.[23] This should be taken into account when a teacher shares his or her concerns with the parent so that the child can be properly diagnosed either by a mental-health professional or a physician. A diagnosis is usually made after collecting observational information from interviews with various adults in the child's life, such as teachers, parents, and caregivers.

Interventions for Separation Anxiety Disorder

The teacher's main role in the intervention process is one of informing the parents regarding his or her observations and connecting them and their child with a competent mental-health provider. The sooner the child receives counseling intervention, the better. Studies show that cognitive-behavioral therapy and family interventions appear to be most effective for children aged 7 to 10, while the cognitive-behavioral approach alone is just as helpful for those aged 11 to 14.[24] The early treatment allows the child to learn to manage anxiety in more productive ways before maladaptive patterns become too entrenched.

As mentioned earlier, some studies suggest that families of children with SAD tend to contribute to their children's anxiety issues by being excessively concerned and over-protective.[25] Hence, the importance of involving parents in the intervention process cannot be overstated. By including the parents in the process, they not only learn to better understand how and why their child is interacting with their world in this way, but it will also guide parents on how to calm down and support their child in a way that facilitates success in his or her life. Parents can learn to help their child master appropriate anxiety-managing skills and can assist the child in identifying the signs of an anxiety episode before it spins out of control.

Another helpful method is bibliotherapy,[26] a treatment approach used by psychotherapists, which includes carefully selected books and journaling to help treat depression. The therapist may provide parents and teachers with helpful books that provide management skills and strategies for supporting the child at home and at school, such as *Helping Your Anxious Child: A Step-by-Step Guide*.[27] It should be noted, however, that although books and other information sources may help in dealing with children with SAD, these are no substitute for professional mental-health care.[28]

Major Depressive Disorder

While separation anxiety is often seen in younger children, Major Depressive Disorder (MDD) is often triggered as children move into puberty. Chronic feelings of sadness and worthlessness seem to permeate everything the young person does and often rob him or her of the capacity for happiness and joy. The disorder is so pervasive that it can interfere with all aspects of an adolescent's life, causing him or her to skip school, experience difficulty in socializing with friends, and in severe cases, triggering suicidal thoughts. The major signs to look for are:

• changes in mood, either more irritable or more despondent;

• marked, involuntary changes in weight;

• highly critical of self; feelings of worthlessness;

• depression lasting weeks or months;
• unusual sadness and reduced interest in activities once enjoyed (hanging out with friends, participating in sports, etc.);
• thoughts or attempts of suicide;
• changes in sleep patterns;
• fatigue and sluggishness;
• indecisiveness that significantly interferes with day-to-day activities.

Although many factors may be responsible for childhood and adolescent depression, genetics play a key role. Behavioral scientists have found that humans inherit varying levels of vulnerability to depression that cause individuals to respond differently to various stressors in the environment.[29] Children whose close relatives suffer from depression are more likely to be victims. (This is not to say that those without any family history are immune from becoming depressed.)

Depression may also be triggered by traumatic events, such as being attacked by a dog, losing a loved one, ending a relationship, or being the victim of sexual abuse. It can also occur in those who have no family history or have never experienced trauma. Depressive episodes can often be resolved with effective counseling, so finding a mental-health professional who specializes in working with children with this disorder is the most effective approach.

Interventions for Depression

The U.S. Centers for Disease Control and Prevention (CDC) reported that in a 2009 sampling of 16,410 high school youth, 26.1 percent felt sad and hopeless enough to stop their normal activities; 13.8 percent reported they seriously had contemplated suicide during the previous year; 10.9 percent had actually developed a suicide plan; and 6.3 percent had attempted suicide one or more times.[30] Depression is a serious matter, but often by the time the symptoms are recognized, the life of the person affected may be at risk. The suffering and dysfunction caused by mood disorder can harm the child in many ways—developmentally, socially, and academically. Further, depressed youngsters are more at risk than the general population to develop alcohol and legal/illegal substance dependencies and to become suicide risks.[31]

In cases of mild depression, counseling is generally sufficient. For more difficult cases, psychotherapy and medication may be needed. For example, cognitive-behavioral therapy, during which the counselor teaches young people how their thoughts can affect their feelings and behavior and how to replace dysfunctional messages with more rational ones, has been found helpful. Interpersonal therapy seeks to jump-start recovery by focusing on the child's parents, family, and friends in order to assess the positive and negative impact on one another's lives, while encouraging the children to seek out friends and activities they once enjoyed.

If after interviewing the child and parent(s), a mental-health professional suspects that the cause of depression has a genetic component, the child will most likely be referred to a child psychiatrist or medical doctor to receive further evaluation and treatment. The medications that seem most effective are those that increase the supply of certain neurotransmitters, such as serotonin, epinephrine, and dopamine. The use of medications for a child with depression is never an easy decision. Experts, however, believe that the benefits outweigh the risks since untreated depression is a serious threat to teen health and happiness.[32]

If a student displays symptoms of depression, take time to talk with him or her and show an interest in his or her life. If a child or adolescent expresses self-injuring or suicidal thoughts, speak directly to him or her about such thoughts. Some fear that such a direct approach may lead to harmful effects; but in fact, it allows caregivers to assess the seriousness of the depression and how far it has progressed.

In the United States, if an educator suspects that a child is dangerous to self or others, the law requires him or her to contact the parents, guardians, or school counselor, and do everything possible to keep the student safe. Every school should have a clear protocol to follow in such situations, which spells out the steps teachers and staff should follow when they encounter a potentially suicidal student. In the U.S., if such an emergency occurs and the child appears to be suicidal, call the National Suicide Prevention Lifeline (1-800-273-TALK [8255]), 1-800-SUICIDE (1-800-784-2433), or 911. For international resources, visit the International Association for Suicide Prevention Website at http://www.iasp. info/resources/Crisis_Centres.

Conclusion

For the first time since 1960, when the U.S. Government began collecting data on the types of disabilities experienced by children, the top five disabilities affecting youth are mental-health challenges rather than physical problems.[33] The challenges facing families, teachers, and administrators are greater than ever. In today's world, almost 40 percent of all students with special needs will also have a coexisting mental-health disorder!

Because of the large amount of time children and young adults spend each day in the school setting, it often becomes the responsibility of the classroom teacher to make an initial identification of which children have mental-health needs that require special assistance. While teachers are key players in guiding the parents and child on how and where to go to obtain effective assessments and interventions for such mental-health concerns, they will need the support of their school administrators and continuing-education courses to obtain appropriate training. Two great resource books are *The Educator's Guide to Mental Health Issues in the Classroom* by Frank Kline and Larry Silver, and *Teaching Kids With Mental Health and Learning Disorders in the Regular Classroom* by Myles Cooley.[34] These are must-reads for all educators who work with children. The authors provide information on the various mental-health and learning problems found among children in the classrooms and give practical suggestions on how to address them.

It is also imperative that administrators and teachers work together to identify nearby mental-health providers who can become a part of their team as they work to help these students. Having good referral services to turn to for consultation or assessment is crucial. While the challenges are great, we also have more knowledge and resources than ever before to face them head on. ✐

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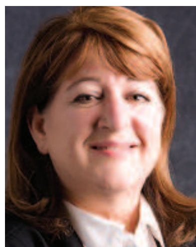

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NOTES AND REFERENCES

1. Names used are pseudonyms.

2. Amanda P. Spears, "The Healthy People 2010 Outcomes for the Care of Children With Special Health Care Needs: An Effective National Policy for Meeting Mental Health Care Needs?" *Maternal & Child Health Journal* 14:3 (2010):401-411.

3. Jenny Cvinar, *Educating Private School Teachers About Issues of Mental Health: A Program Development.* Psy.D. dissertation, The Chicago School of Professional Psychology (2010).

4. General Conference of Seventh-day Adventists, *General Conference Policy Manual* (2003), "Seventh-day Adventist Philosophy of Education—Departmental Policies" (2003): FE 05, FE 10.

5. Ellen G. White, *The Ministry of Healing* (Mountain View, Calif.: Pacific Press Publ. Assn., 1942), p. 398.

6. Robert Roeser and Carol Midgley, "Teachers' Views of Issues Involving Students' Mental Health Issues," *The Elementary School Journal* 98 (1997):115-133: http://www.jstor.org/stable/1002138?seq=1#page_scan_tab_contents. Unless otherwise indicated, all Websites in the endnotes were accessed in September 2015.

7. U.S. Centers for Disease Control and Prevention (CDC), "Youth Risk Behavior Surveillance: 2009," *Mortality Weekly Report* 56:35 (2010):905-908.

8. American Psychiatric Association (APA), *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (2013).

9. Alessandro Serretti and Chiara Fabbri, "Shared Genetics Among Major Psychiatric Disorders," *The Lancet* 381:9875 (2013):1339-1341.

10. C. Keith Conners, *The Conners Rating Scales—Revised* (North Tonowanda, N.Y.: Multi-Health Systems, 1997); Marc S. Atkins, William E. Pelham, and Mark H. Licht, "The Differential Validity of Teacher Ratings of Inattention/Overactivity and Aggression," *Journal of Abnormal Child Psychology* 17:4 (1989):423-435.

11. CDC, *Mortality Weekly Report*, op. cit.

12. Russell A. Barkley, *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment* (New York: Guilford Press, 2014).

13. Estrella Rajwan, Anil Chacko, and Moshe Moeller, "Nonpharmacological Interventions for Preschool ADHD: State of the Evidence and Implications for Practice," *Professional Psychology: Research and Practice* 43:5 (2012):520-526.

14. Steven W. Evans, Julie Sarno Owens, and Nora Bunford, "Evidence-based Psychosocial Treatments for Children and Adolescents With Attention-Deficit/Hyperactivity Disorder," *Journal of Clinical Child & Adolescent Psychology* 43:4 (2014): 527-551. DOI: 10.1080/15374416.2013.850700.

15. Caryn L. Carlson and Leanne Tamm, "Responsiveness of Children With Attention Deficit-Hyperactivity Disorder to Reward and Response Cost: Differential Impact on Performance and Motivation," *Journal of Consulting and Clinical Psychology* 68:1 (February 2000):73-83.

16. Susan M. Sheridan and Thomas R. Kratochwill, *Conjoint Behavioral Consultation: Promoting Family-School Connections and Interventions* (New York: Springer, 2008).

17. American Academy of Pediatrics, "ADHD: Clinical Practice Guidelines for the Diagnosis, Evaluation and Treatment of Attention Deficit/Hyperactivity Disorder in Children and Adolescents," *Pediatrics* 128:5 (2011):1007-1022.

18. Nikole J. Cronk, et al., "Risk for Separation Anxiety Disorder Among Girls: Paternal Absence, Socioeconomic Disadvantage, and Genetic Vulnerability," *The Journal of Abnormal Psychology* 113:2 (May 2004):237-247.

19. Cyd C. Strauss, et al., "Peer Social Status of Children With Anxiety Disorders," *Journal of Consulting and Clinical Psychology* 56:1 (February 1988):137-141.

20. APA, *Diagnostic and Statistical Manual of Mental Disorders,* op. cit.

21. Martin B. Keller, et al., "Chronic Course of Anxiety Disorders in Children and Adolescents," *Journal of the American Academy of Child and Adolescent Psychiatry* 31:4 (1992):595-599.

22. Peter M. Lewinsohn, "Separation Anxiety Disorder in Childhood as a Risk Factor for Future Mental Illness," *Journal of the American Academy of Child and Adolescent Psychiatry* 47:5 (2008):548-555.

23. Paula M. Barrett, Mark R. Dadds, and Ronald M. Rapee, "Family Treatment of Childhood Anxiety: A Controlled Trial," *Journal of Consulting and Clinical Psychology* 64:2 (April 1996):333-342; Vanessa Elise Cobham, *The Role of Parental Anxiety in the Aetiology and Treatment of Childhood Anxiety*, Ph.D. dissertation, University of Queensland (1997); Muniya S. Khanna and Philip C. Kendall, "Exploring the Role of Parent Training in the Treatment of Childhood Anxiety," *Journal of Consulting and Clinical Psychology* 77:5 (2009):981-986.

24. Barrett, Dadds, and Rapee, "Family Treatment of Childhood Anxiety," ibid.

25. Ibid. See also Cobham, *The Role of Parental Anxiety in the Aetiology and Treatment of Childhood Anxiety,* op. cit.; and Khanna and Kendall, "Exploring the Role of Parent Training in the Treatment of Childhood Anxiety," op. cit.

26. American Library Association, "Bibliotheraphy," http://www.ala.org/tools/bibliotherapy.

27. Ronald M. Rapee, et al., *Helping Your Anxious Child,* 2nd ed. (Oakland, Calif.: New Harbinger Publications, Inc., 2008).

28. Ronald M. Rapee, Maree J. Abbott, and Heidi J. Lyneham, "Bibliotherapy for Children With Anxiety Disorders Using Written Materials for Parents: A Randomized Controlled Trial," *Journal of Consulting and Clinical Psychology* 74:3 (2006):436-444.28; Michael Shanahan and Scott M. Hofer, "Social Context in Gene-Environment Interactions: Retrospect and Prospect," *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, Vol. 60, Supplement 1 (March 2005):65-76.

29. CDC, "Youth Risk Behavior Surveillance—United States, 2009" (2010): http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf.

30. Ibid.

31. Jeffery A. Bridge, et al., "Clinical Response and Risk for Reported Suicidal Ideation and Suicide Attempts in Pediatric Antidepressant Treatment: A Meta-analysis of Randomized Controlled Trials," *Journal of the American Medical Association (JAMA)* 297:15 (2007):1683-1696.

32. International Association for Suicide Prevention Resources: Crisis Centers: http://www.iasp.info/resources/Crisis_Centres.

33. Anita Slomski, "Chronic Mental Health Issues in Children Now Loom Larger Than Physical Problems," *Journal of the American Medical Association (JAMA)* 308:3 (2012):223-225.

34. Frank M. Kline and Larry B. Silver, eds., *The Educator's Guide to Mental Health Issues in the Classroom* (Baltimore, Md.: Paul H. Brookes Publ. Co., 2004); and Myles L. Cooley, *Teaching Kids With Mental Health & Learning Disorders in the Regular Classroom: How to Recognize, Understand, and Help Challenged (and Challenging) Students Succeed* (Minneapolis, Minn.: Free Spirit Publishing, Inc., 2007). Both books are available from Amazon.com.