



Handling Common Emotionally Based Behavior Problems

Aden¹ moves constantly. His time on task is measured in seconds. Although he can describe the correct behavior for a situation, he rarely *performs* the appropriate behavior when he should do so.

Olivia delights in arguing minor points until adults give up, and often raises her voice to get her way. During disagreements, she brings up issues from the past that she perceives as unfair as if they applied to the current debate. When teachers redirect her behavior, she counter-attacks (e.g., when asked to clean her desk, she counters that the teacher always bosses her around).

Andy refuses to engage in new activities, declaring that he won't be able to do them correctly. He avoids groups and conversations with others. When his behavior is redirected (which is rare), he becomes tearful. Instead of playing at recess, he sits mournfully on the ground watching the other children because he thinks he might accidentally break the rules of the games.

The Individuals with Disabilities Education Act (IDEA), a federal law in the United States, classifies these symptoms under the heading of *emotional disturbance*. The term refers to a chronic condition that adversely affects the child's educational performance and results in one or more of the following: (1) significant difficulties with learning, (2) problems negotiating relationships, (3) inappropriate behavior or feelings for the context, (4) feeling unhappy most of the time, or (5) becoming sick or fearful about typical home or school problems.²

In American public schools, individualized education plans identify how school staff will help children with emotional difficulties learn skills to cope with, manage, or resolve the diffi-

culties. Recognizing that these are children of God, teachers in Adventist schools have a higher calling than a federal mandate to serve them. This article will (1) identify essential characteristics of attention deficit/hyperactivity disorder, oppositional defiant disorder, and generalized anxiety disorder; (2) offer interventions teachers can use to address each condition; and (3) describe behaviors and symptoms that require referral.

Attention Deficit/Hyperactivity Disorder (ADHD)

About five percent of children worldwide have ADHD.³ Aden exhibits essential characteristics of ADHD: excessive, driven activity; attention easily distracted by noise, movement, or other sensory stimuli; and a tendency to do the first thing that comes to mind without thought of consequences or whether an alternative action would be more appropriate.⁴ Because humans have innate needs for competence and control, children with ADHD are often frustrated with their own limited self-control, which leaves them feeling incompetent and helpless.

Children with ADHD do not initially possess the needed level of internal self-control to consistently respond appropriately to others and situations; therefore, interventions for ADHD are designed to improve their self-regulation. Initial interventions such as point charts use adult-imposed external controls that eventually become internalized. Having the child self-monitor his or her level of activity and then linking various (lower) levels to privileges that are naturally attractive to the child can often be helpful because self-awareness creates the possibility of self-control. The most successful interventions use just two or three specific target behaviors for the child to monitor, such as (1) stay in

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his or her seat, (2) hands on the assigned work, and (3) eyes on the assigned work (which is both an activity issue *and* an attention issue). Self-monitoring can be done by the child using a teacher-made chart. With an external prompt (from the teacher or a timer), the student places a checkmark for every five-minute period during which the target behavior was present the *whole* time. Over time, the student will begin to self-monitor his or her own behavior. (Here is a link to a sample chart and additional details: <http://www.andrews.edu/~coffen/self-monitoring-chart.doc>.) Five-minute intervals can be accomplished with count-down timers (on watches or kitchen timers) that repeat intervals of time, pre-recorded CDs with beeps every five minutes (see <http://www.andrews.edu/~coffen/audiotimer.htm> for more information), software programs, or devices like the WatchMinder II (<http://watchminder.com>). At the end of each class period, the teacher records a star for each non-overlapping group of three checks.

At home, each star is associated with a small amount of a privilege. Because parental involvement is associated with better child behavior, parental implementation of privileges at home has the added benefit of increasing parental involvement with the child's school life. Teachers and parents can help the child notice the good feelings experienced when he or she exercises self-control and note how he or she got that to happen, which helps develop self-regulation. When the child gets 80 to 90 percent of the possible checkmarks, the external motivation can be gradually discontinued by extending the time periods from five-minute to six- or 10-minute intervals, or by replacing one target behavior with a different one.⁵

Self-monitoring can also help improve children's **attention span**. Another option for enhancing attention is to break tasks into segments. Since success is one of the best motivators, segmenting a task provides multiple success experiences that can motivate the child to focus on the task. For example, the teacher can ask the child to predict how long it will take him or her to correctly solve the first five of 20 math problems, and then the next five, and so on until all 20 have been completed. Beating the clock can be motivating because it creates a sense of competence, control, and success.⁶

Breaking a longer assignment, such as writing a paper, into very specific steps can also be helpful. For example, the teacher could print out the steps and have the child check off each one as it is accomplished: (1) Pick a topic; (2) Create an outline; (3) Generate a title; and (4) Write a first sentence that tells something interesting about the topic, etc.⁷

Related to breaking a task into segments is narrowing the child's field of vision to focus on a specific component of the task. Children with ADHD become overwhelmed when facing a page full of problems because they do not see it as a series of tasks, but as something they have to do all at once. However, by covering up (with blank paper or card stock) all but the current row or the current problem, the child regulates his or her own attention and feels less overwhelmed by having a small section on which to focus. Similarly, when reading, the child can move his or her finger under the words as they are read,

which focuses attention and also makes productive and focused use of the child's tendency to move.⁸

One of the most powerful methods for reducing **impulsivity** is positive practice. Children with ADHD struggle to quickly identify an appropriate behavior because of their underdeveloped short-term planning skills. But teaching self-regulation also involves planning for the long term. Positive practice is a long-term plan for promoting appropriate behaviors at the point they are required. Habitual behaviors "slip out" without conscious thought because they are over-practiced. Impulsive inappropriate behaviors (typically social blunders) indicate an area where the appropriate behavior is not yet habitual. If a child is simply punished (scolded, put in time out, denied privileges), only the inappropriate behavior has been practiced. For punishment to achieve the desired goal, the next time the child thinks about doing the inappropriate behavior, he or she must inhibit the behavior long enough to think, "The last time I did X, I got punished and I didn't like that, so I'll do W, Y, or Z this time." Children with ADHD are not good at inhibiting a response or at instantly identifying alternatives. Thus, what "slips out" is the most-practiced behavior—and up to this point, that has been the inappropriate behavior. So, positive practice requires using role play to help the child to perform the "correct" behavior more frequently than the "incorrect" behavior.

Briefly, the steps for positive practice are as follows:

1. When the child engages in an inappropriate behavior, move him or her out of the situation. When the child's emotions have calmed, implement a "cooling-off" period (positive practice will *not* work when a child is angry, and anger is a likely response to being pulled aside).

2. Ask the child what he or she could have done differently that would have made things go better. It builds competence when a child can think of ideas himself or herself, but a youngster with ADHD may need adult help to brainstorm at least three ideas (more is better).

3. Next, the adult role plays each part in the initial situation except the child's role. The child must choose a better solution to act out than the ones used in the past.

4. When the child uses an appropriate behavior, the adult role plays a positive outcome and offers praise for using a more constructive solution.

5. The role play is done three times so that the appropriate behavior is practiced more times than the inappropriate behavior, thus increasing the chances that the positive behavior will "slip out" in the future. Another option for positive practice: Teachers create common social scenarios and practice positive responses *before* the problem arises. This can be done with the whole class as a part of the curriculum, such as presenting problem scenarios and having children try out different social responses in role plays.⁹ (See <http://www.andrews.edu/~coffen/pos-practice.pdf> for more details.)

A few final points: Do not take away recess (research shows that physical activity, like recess, is associated with increased on-task behaviors).¹⁰ Move closer to the child, or drop the child's name into your lecture to restore attention ("As I was

saying to Aden earlier...”). Remind the class about your behavioral expectations before the start of an activity, and privately commend or note the compliance of the child with ADHD shortly after the activity begins.¹¹

Oppositional Defiant Disorder (ODD)

An estimated three percent of children worldwide have ODD.¹² Unlike ADHD, ODD may not occur in both home and school settings.

Olivia exhibits essential characteristics of ODD: active defiance of and noncompliance with authority; frequent arguments, tantrums, and hostility; habitual anger and aggression; deliberately annoying others, holding grudges, and denying responsibility.¹³

Children with ODD often do not view their behaviors as problematic.¹⁴ They have a very high tolerance for hostility, yelling, shame, insults, crying, and threats, and seem to enjoy creating a negative environment. When directed to do something, they escalate their negative behavior. If the adult has a lower tolerance for negativity than the child, the adult will withdraw his or her demands of the child and withdraw from the situation to decrease his or her feelings of discomfort. However, giving in increases the child’s use of negative behaviors in the future since they “worked” in the past.

Unlike children with ADHD who need help developing control, children with ODD need a “control vacation.” These children try to manage the world as if they were adults rather than accepting the appropriate levels of control and boundaries that actually help children feel safe. Paradoxically, as grownups enforce fewer and fewer boundaries because of the effort required, children with ODD feel as though adults are taking less and less care of them, so children with ODD escalate their attempts at adult-like control, causing further clashes with authority.¹⁵

Therefore, the essential features of interventions for ODD are to provide the child with as much *appropriate* control and choice as possible while preventing him or her from coercively controlling things in the adult domain. For example, appropriate control offers choices about *how* to complete homework (e.g., at Olivia’s desk or at the work table; by herself or with a group; at home or at school), but not *whether* to complete it.

In contrast, with coercive control, the child escalates his or her negative behavior (tantrums) in attempting to escape a request. The escalation works only when both the child and the adult seek to maximize immediate gains by turning off the other’s aversive behavior as quickly as possible—the child seeks to dismiss the adult’s command, and the adult seeks to end the child’s tantrum. To prevent such power struggles, teachers need to identify effective negative sanctions in advance over which they have complete control (this may require collaboration with parents to implement sanctions at home, e.g., loss of five minutes of TV or video-game time or loss of five minutes of playtime with friends). Sanctions that require child compliance in order to be effective (e.g., sitting on the sidelines during recess, which requires the child to obey this restriction; saying “Sorry,” which requires the child to repeat the required phrase) typically

are ineffective and may generate additional arguments. After the child has been informed of the sanctions, the teacher should make only one request before applying the sanction (e.g., loss of a privilege for five minutes) and should continue applying the sanction (e.g., every two minutes) until the child complies. No deals should be made to delay or lessen the request or sanction since that would mean the child’s arguing and noncompliance effectively reduced the requirements and thus promoted additional arguments and noncompliance.¹⁶

Since these children react to adult demands with actions that they believe will produce the maximum payoffs, sanctions should typically be combined with predetermined and desirable outcomes for appropriate responses (compliance). Any positive outcome (reinforcement) for the child that results from oppositional behaviors must be eliminated, while positive outcomes for prosocial behavior must increase, thus reducing the child’s perception of the “value” of exerting control.

The use of a modified reward system similar to the self-monitoring system described above for ADHD may be helpful. Typically, the teacher should be the one to monitor the target behaviors, at least initially (self-monitoring may be useful later; see the sidebar on daily report cards). Target behaviors should be positively stated (e.g., “Complied with directions the first time asked”). As the child complies more consistently, the length of time between monitoring points can be extended to only once or twice per class period, with privileges adjusted to make success more likely. It is often advisable for the teacher to include a penalty for specific inappropriate behaviors on the monitoring chart, which should be per occurrence rather than per time period. For example, “Argued about directions” could be included on the chart, with the loss of one point each time it occurs (regardless of the amount of time between occurrences), or with the requirement of performing positive practice (the child should have the option of recovering the lost point if he or she performs the practice without complaining).

Privileges and costs implemented at home, based on the monitoring chart, could include increased time in a preferred activity, decreased requirements of less-desirable chores, increased privileges, etc. Non-tangible rewards such as attention and praise for compliance should be offered (privately for older students) with the goal that children will learn to praise themselves and thus begin to self-regulate their behavior without external rewards.¹⁷

An alternative explanation for defiant behavior is that children simply have not learned the correct social, cultural, and cognitive skills necessary for smooth social interactions. To address this problem, a teacher could incorporate social-skills training into the curriculum (e.g., during social studies or language arts). Some children lack fundamental social skills like the use of eye contact, smiling, respecting physical space, voice volume and inflection, appropriate content for conversations, and ignoring provocations. Children may also need help with advanced skills, such as reading social cues, starting/ending conversations, giving/receiving compliments, asking/answering questions, expressing emotions, entering a group or conversation, disagreeing with

Example of Daily Report Cards

Daily report cards (DRC) can take very little time (less than five minutes per day) and can be effective in increasing appropriate behaviors.* Here are the basic steps for implementing a DRC system:

1. Pick a few specific behaviors to target (no more than five; two or three is best).
2. State the behavior that the child *should* demonstrate (e.g., “Use calm words to say what you want.”).
3. Determine how frequently you will rate the behavior (at least once a day, preferably two or three times a day to increase the frequency of feedback and chances for success). For example, a system using three ratings per day would rate all targeted behaviors (a) before lunch and recess, (b) during lunch and recess, and (c) after lunch and recess.
4. Create a simple rating chart that uses the same rating scale for each of the targeted behaviors. For example, a five-point rating scale might be:
 - a. 0 = did not demonstrate the behavior at all;
 - b. 1 = demonstrated the behavior very little or only with considerable assistance;
 - c. 2 = demonstrated the behavior about half the time and may have required some assistance;
 - d. 3 = demonstrated the behavior nearly all the time and required very little assistance;
 - e. 4 = demonstrated the behavior all the time and without assistance.
5. In collaboration with parents and student, identify privileges at home that will be associated with the total points earned on the DRC each day. *It is essential, especially early in the implementation of the DRC, that the number of points the child is likely to earn will produce success experiences for him or her.* The criteria can be gradually raised with consistent performance. An example of a menu of incentives for three target behaviors using a 0-4 point scale might be as follows:
 - a. 6-8 pts. = one of the following: 15 minutes of media; 15 minutes with a friend over; 15 minutes of playtime with a parent; 25 cents; 15 minutes of cell phone time;
 - b. 9-11 pts. = one of the following: 30 minutes of media; 30 minutes with a friend over; 20 minutes of playtime with a parent; 50 cents; 30 minutes of cell phone time;
 - c. 12 pts. = one of the following: 60 minutes of media; 60 minutes with a friend over; 30 minutes of playtime with a parent; one dollar; 60 minutes of cell phone time.
6. Send home a copy of the DRC each day. Early in the process, follow up with parents to ensure that the child is receiving the incentives and to troubleshoot any problems.
7. Consider including a weekly and/or monthly reward based on total points over the longer period. The advantage: Even on “bad” days, points that won’t earn a daily incentive will still count toward the weekly/monthly goal and prevent the child from giving up when “bad” days occur. For example, for a weekly reward using three target behaviors and a 0-4 point scale, some options might be:
 - a. 55-60 pts. = invite a friend to a sleepover;
 - b. 50-54 pts. = choose a fast-food restaurant for a weekend meal;
 - c. 45-49 pts. = choose the menu for one of the major weekend meals.

* Sandra Chafouleas, T. Chris Riley-Tillman, and James McDougal, “Good, Bad, or In-Between: How Does the Daily Behavior Report Card Rate?” *Psychology in the Schools* 39:2 (2002):157-169; George DuPaul, Laura Rutherford, and Shelly Hosterman, “Attention-Deficit/Hyperactivity Disorder.” In Richard Morris and Nancy Mather, eds., *Evidence-based Interventions for Students with Learning and Behavioral Challenges* (New York: Taylor & Francis, 2013), pp. 33-58.

others, setting limits on others, anticipating what others are thinking/feeling, and developing empathy. Several helpful social-skills training programs exist that can be incorporated into the curriculum, even at the earliest grade levels (K or Pre-K) and before problems are apparent, including *Skillstreaming* (by Goldstein and McGinnis: <http://www.skillstreaming.com>) and PATHS (by Kusché and Greenberg: <http://www.channing-bete.com/preventionprograms/paths/paths.html>).¹⁸

Children who have not learned appropriate problem-solving skills will need for them to be taught directly. That is, when adults request the child to perform an action that the child views as interfering with his or her personal goals, if the child cannot identify ways to both comply with the request and meet his or her

own goals, then the child is likely to experience strong negative emotions. On the other hand, if the child can identify alternative ways to accomplish his or her goal, negative emotions decrease, and compliance is more likely.

The teacher can teach the following steps for problem-solving: (1) Identify the problem; (2) Brainstorm lots of possible solutions (even crazy ones!); (3) Rate each solution on a scale of 1 to 10; (4) Pick the best one, and try it; and (5) If it works, congratulate yourself; if it doesn’t work, pick the next best solution and try it. A class activity illustrating how to complete each step will be helpful for all students and can be used whenever these kinds of difficulties arise. A more-detailed example of the problem-solving process is available at <http://www.andrews.edu/~coffen/problem-solving-steps.pdf>.¹⁹

The most effective response to coercive behavior by children with ODD is to respond with non-hostile, matter-of-fact, non-physical punishment. In the process of responding to the child’s coercion, do not let him or her control the mood, timing, or content of the interaction—that is the adult’s job. If you ask Olivia to clean up her lunch mess and she responds, “You’re so mean—you always tell everyone what to do!” it is tempting to argue with her, but that gives her control over the discussion. Stick to *your* content, timing, and mood by

calmly (*mood*) replying, “Right now I expect you to clean up your lunch (*content*). If you’d like to stay after school (*timing*) to talk about what you can do so I don’t ask you to clean up, that will be fine.” If she still refuses to comply, provide appropriate, punishment-embedded choices (both choices must be acceptable to you): “You may choose to clean up your lunch now, or you will be choosing to clean up your lunch and the rest of the classroom at recess.” Then walk away because if Olivia does not clean up now, that means she is choosing to clean at recess. Further struggles can be handled with the behavior-monitoring plan.²⁰

A few final points: Teachers must be consistent with implementing consequences for all children—children with ODD try to escape limits but are the first to argue about inconsistencies.

Peer Coaching

Peer coaching (which requires little direct teacher involvement once it is implemented) is an intervention that can help students with poor social skills improve their interactions with peers and increase their ability to make friends. Although research on peer coaching is not yet definitive,¹ there is some evidence that it can improve social behaviors. Here are the basic steps to implement one approach to peer coaching (the 31-page primary source provides significantly more detail).²

1. Identify which students would make good coaches (those who regularly follow the rules, demonstrate good social skills, and perform well academically).
2. Once a coach has been selected, provide his or her parents with information about what the child will be expected to do, and obtain informed consent from both the parent and the student who will do the coaching.
3. Identify which students will benefit from having a peer coach. Candidates include children who have difficulty making friends due to impulsive social behaviors that lead to rejection, have difficulty identifying and following through on a goal, have trouble developing a plan for accomplishing a goal, have difficulty sticking with a plan, and are reluctant to try different things when an initial attempt does not meet the goal.
4. Meet with the coach and student together to explain the coach's job—to help the student set goals for making friends and to support him or her in meeting the goals.
5. Collaboratively identify some "friendship goals" on which the student would like to work (e.g., join a game in progress, sit with other students at the lunch table, invite someone to play with him or her, start a conversation, etc.) and write them down.
6. For each coached student, create and maintain a notebook containing his or her "friendship goals" and progress notes.
7. Develop and describe to the coach and student the daily procedure for coaching (as described in the steps below).
8. At the beginning of each school day, have the coach and student meet at a designated time and private place to identify the "friendship goal" for the day. For example, "Play a group game calmly without getting angry when the game doesn't go in my favor, or it seems that others are cheating."
9. At the beginning of the period when the student needs to meet the goal (e.g., recess), the coach will remind the student about the goal.
10. During recess (or other relevant period), the coach will approach the student to offer positive feedback about the student's positive actions in attempting to meet the goal.
11. At the end of the period, the coach and student independently rate the student's success in achieving the goal (1 = did not achieve; 5 = achieved).
12. When the student's rating is within one point of the coach's rating, the highest score is used. If both gave the same rating, the score plus an additional point is used. If the ratings are more than one point apart, no points are received.
13. Throughout the week, check occasionally with the coach and student to troubleshoot any difficulties (remembering that the process is intended to be student mediated).
14. At the end of the week, total the points earned, and allow both the coach and the student to choose a reward from a list of options (rewards can be provided at school or home). Also, send home a letter at the end of the week informing the parents of both the student and the coach about their achievement of the week's goals.

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1. Pamela Plumer and Gary Stoner, "The Relative Effects of Classwide Peer Tutoring and Peer Coaching on the Positive Social Behaviors of Children With ADHD," *Journal of Attention Disorders* 9:1 (2005):290-300.
2. Peg Dawson and Richard Guare, *Coaching the ADHD Student* (New York: Multi-Health Systems, 2000).

Discipline and reprimands should be carried out privately; public confrontation is likely to escalate these children's acting-out behaviors. Asking children with ODD for solutions can be appropriately empowering for them and can prevent arguments about solutions being forced on them. If children consistently argue when only one option is presented (e.g., "Clean now."), try offering acceptable choices first (e.g., "Do you want to clean now or in two minutes?") but do not negotiate further. Seek every opportunity to give attention to the child's compliance.

Be sure parents support class rules, or the child will use divide-and-conquer tactics to justify misbehavior. Associate the completion of a command that the child is less likely to follow with one he or she is more likely to follow (e.g., "After you clean up your lunch, please get a ball for recess."). If the child complies with only part of the request, praise that action but restate the expectation or negative sanction. Children with ODD tend to interpret other people's behaviors as intentionally hostile—help them consider that the actions may have been neutral or positive. Webster-Stratton offers teacher-training programs at <http://incredibleyears.com/programs/teacher/> to help teachers promote emotional regulation, problem solving, and prosocial behaviors among their students—skills that should reduce the frequency of oppositional and defiant behaviors in the classroom.²¹

Anxiety

About 6.5 percent of youth worldwide have some type of anxiety disorder, which makes this the most common type of emotional disorder among youth.²² Anxiety can be either very specific (e.g., fear of heights) or very broad (e.g., fear that something bad might happen). Andy exhibits essential characteris-

tics of generalized anxiety disorder (GAD): excessive, difficult-to-control worry about a number of events or activities as well as social withdrawal. Anxiety is typically accompanied by physiological arousal (shaking, rapid heart rate, sweating, muscle tension, shallow/rapid breathing) and catastrophic thoughts.²³

Like children with ODD, children with anxiety seek escape. Unlike children with ODD, they seek to escape the catastrophe they anticipate. Children with anxiety avoid what they fear because they believe that doing so prevents the catastrophe. But

maintaining avoidance means they rarely discover that approaching the situation does *not* produce the catastrophe.²⁴

Therefore, the essential feature of interventions for anxiety is preventing escape so the child learns the catastrophe does not occur. These children need support as they gradually approach the things they fear. One approach is to have children with this disorder make a hierarchical list that starts with the things they fear least and ends with the things they fear most. To motivate children to approach feared things, identify some small incentives they can achieve by approaching what they fear (starting with the least-feared thing to create a success experience, and to show the child that the catastrophic thing does not happen). Refusal to approach a situation should not be rewarded—a child who fears attending school should not be allowed to stay home and play video games. Initially, the child may require an adult's presence to approach the feared thing, but the teacher/aide should gradually remove his or her presence, such as by physically moving farther and farther away.

As the child achieves success with less-feared items, he or she can move up to those more feared. Moving up to the next step may be accompanied by special celebrations at home (e.g., a cookie for the easiest level up to a meal at a favorite restaurant for the highest level).²⁵

Anxiety does *not* rapidly disappear, so the child will have to approach feared things in spite of these feelings. Try brainstorming with the child some strategies that can reduce his or her physiological reactions. Examples: Singing aloud or silently (e.g., *Veggie Tales*' "God Is Bigger Than the Boogie Man"); deep breaths (breathe in through nose, out through mouth); positive self-talk (e.g., "It really is safe. Fear is just trying to trick me."); imagining how a heroic figure would approach the feared thing (e.g., Jesus, Samson, David); squinting and growling at the scary

thing (scare *it!*); replace catastrophic thoughts with vivid images of happy thoughts (e.g., the sights, sounds, smells, tastes, and sensations of heaven or holiday celebrations); pairing the child with a close friend during feared activities. Some children benefit from writing stories about anxiety-provoking situations if they receive adult guidance to ensure that the essays include coping behaviors and have positive conclusions.²⁶

Final Thoughts

Many effective interventions (e.g., medication for ADHD) have not been included here for the following reasons: (1) They are difficult to implement in a classroom setting, (2) teachers and aides will need special training to apply the strategies successfully, or (3) professionals must evaluate the multitude of factors influencing emotionally based behavior problems.

Typically, interventions need to be tried for at least two weeks before changes are made. For acting-out behaviors (e.g., ADHD and ODD), the intervention will often *stop* working after two weeks—but don't stop the intervention! Instead, add an additional cost on top of the incentive intervention.²⁷ The cost can be discontinued when the incentive begins "working" again. For example, if the child claims the privileges don't matter, don't stop using privileges as incentives; instead, implement a greater cost schedule for lack of earning points (e.g., one additional chore if only four points are earned; two chores for only three points, etc.).

Finally, certain symptoms require immediate referral for mental-health services: suicidal ideation (comments about wishing one were not alive or about killing one's self); homicidal ideation (any veiled or direct comments about seriously harming another person); hallucinations (hearing or seeing things that are not there); serious or repeated aggression; drug use; self-harm (e.g., carving on one's arms); and abuse or neglect.

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Useful Websites

1. **The Therapy Advisor Website** offers information in both English and Spanish and is funded in part by the National Institute of Mental Health. From the home page, select the type of content you wish to view (either "practitioner content" or "consumer content") and select the "Child Therapies" option in the sidebar on the left of the page. Then select the type of disorder in which you are interested from the list. Information offered is concise (not overwhelming) but easily understood, and there are links to more detailed information or self-help. Topics covered include a description of the disorder, information about the types of therapies that are effective for treatment, and information about medication. URL: <http://www.therapyadvisor.com>.

2. **The PsyWeb site** offers information about diagnostic symptoms for various disorders and some information about treatment of disorders as well. Use the URL listed at the end of this item to get you to the right section of the site. From that page, select the disorder you are interested in. A description of the disorder and what it looks like is provided in easy-to-understand terms. By following relevant links, information is also available that describes the various types of available treatments and also commonly prescribed medications. URL: <http://www.psyweb.com/Mdisord/jsp/mental.jsp>.

3. **The Center for Mental Health in Schools** at UCLA has produced a document that is full of useful interventions that are well supported by re-

search. There is much useful information in the PDF document, but you will need to be willing to sift through a lot of information in order to find interventions related to a specific problem your student might be having. However, using the table of contents can get you into the right section; then review the title headings carefully to determine if that section will be relevant for the issue at hand. URL: <http://smhp.psych.ucla.edu/pdfdocs/conduct/conduct.pdf>.

If you are willing to click around the Website a bit and willing to spend some time finding what you want, you can check out the main Website for the Center for Mental Health in Schools at UCLA too. URL to main Website: smhp.psych.ucla.edu.

4. The **LD Online Website** has links to articles about specific interventions that teachers can implement with detailed information about how to do the interventions. The emphasis of interventions is for students with ADHD or a Learning Disability. URL: <http://www.ldonline.org>.

5. The articles and resources offered at **Rick Lavoie's Website** are largely targeted to children with learning disabilities, but many (if not most) children with behavioral disorders also have a learning disorder. Many of the articles available at this Website offer specific help that can apply to many children with learning problems, whether those problems are behavioral, emotional, or cognitive. URL: <http://www.ricklavoie.com/gateindex.html>.

All children have needs that must and can be met. These physical, psychological, social and spiritual needs are part of our nature as created by God—He gave us emotions and needs. He gave us other people and Himself to meet those needs. Teachers can help children find appropriate ways to meet those needs. ☞

This article has been peer reviewed.



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NOTES AND REFERENCES

- Names used in this article are pseudonyms.
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