THE CARLAT REPORT CHILD PSYCHIATRY

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UNBIASED INFORMATION FOR CHILD PSYCHIATRISTS

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Editor-in-Chief

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IN THIS ISSUE

Schools and Psychiatry

Learning objectives for this issue:
1. Describe the impact of bullying and the steps you can take to help a child or adolescent who is the victim. **2.** Summarize some of the ways that child psychiatrists can help teachers manage the behavior of challenging students. **3.** Detail how you can combine the use of medications and behavioral techniques to help children struggling with behavior issues at school.

Bullying in Schools: A Primer

When most of us went to school, we knew who the bullies were, and we knew who got bullied, but the problem was not discussed much. Things have changed since then. With media coverage of suicides attributable to bullying, we now realize that the phenomenon is potentially deadly.

Bullying is generally defined as an aggressive, intentional act carried out by an individual or a group, repeatedly over time, and aimed at a victim who can't easily defend him or herself. It can take various forms. It can be physical (an assault), verbal (a threat), relational

Continued on page 2

In Summary

- Half of all children are bullied at some point during their school years.
- Your routine history taking in children should always include explicit questions about bullying.
- The consequences can be serious, including anxiety, depression, lowered self-esteem, loneliness, self-harm, and suicidality.

Q&A With the Expert

Helping Teachers Help Your Patients

Jessica Minahan, MEd, BCBA

Director of Behavioral Services, Neuropsychology & Education Services for Children and Adolescents, Newton, MA
Adjunct Professor, Boston University

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

CCPR: The book you co-authored with child psychiatrist Nancy Rappaport, MD, (see companion interview "Combining Medications and Behavioral Techniques in Schools" on p. 5) *The Behavior Code*, describes techniques teachers can use to better manage the behavior of challenging students. Why was this book needed?

Ms. Minahan: If you look at the statistics, at least a quarter of kids age 13–18 have been diagnosed with anxiety in their lifetime. Of those with emotional behavioral disabilities, 48% are dropping out of school as early as ninth grade, 58% had been arrested, and only 30% were employed after high school. So there are all these kids with behavioral problems in the classroom, and yet teachers have very little training in how to deal with them. The typical master's in education program includes only one class in behavioral intervention.

CCPR: Are there typical struggles that teachers encounter?

Ms. Minahan: As a board-certified behavior analyst and special educator, I've consulted with schools in different settings and have shared some techniques to help

Continued on page 3

Bullying in Schools: A Primer

Continued from page 1

(socially isolating the victim), indirect (spreading rumors), or cyber (such as via social media and texting).

Bullying is common, with half of all children experiencing it at some point during their school years, peaking in middle school years (Pergolizzi F et al, *Int J Adolesc Med Health* 2011;23(1):11–18). The National Education Association has estimated that each day more than 160,000 children stay home from school because of bullying.

The Impact of Bullying

There have been a number of studies on the psychological effects of bullying. They have consistently shown a correlation between being frequently bullied and being more likely—by about two-fold—to experience anxiety, depression, lowered self-esteem, loneliness, self-harm, and suicidality (Kaltiala-Heino R et al, *J Adolesc* 2000;23(6):661–674; Wolke D & Lereya St, *Arch Dis Child* 2015;Epub ahead of print). And while we tend to have little sympathy for the bullies, they suffer high rates of depression, are often victims of abuse or bullying themselves, and are at risk for substance abuse.

Asking about bullying should be an explicit part of your routine history since many children will not spontaneously report these experiences. In one survey, up to 50% of kids said they would never or only rarely tell their parents or teachers, likely because of shame or fear of retaliation (Radford L et al, *Child Abuse Negl* 2013;37(10):801–813). Kids with developmental problems, such as autism, are at particularly high risk to be bullied. See "Types of Bullying and Questions to Ask Victims" below for more on specific types of bullying and questions you may ask children if you suspect they are a victim. You'll want to probe for more details from kids who tell you that bullying is a significant problem.

What You Can Do

How do you "treat" bullying? Clearly, it is not an individual disorder but is a problem in the child's environment. While you can treat secondary symptoms of depression and anxiety using your usual combinations of medications and therapy, in order to stop the bullying you will have to understand the context and work with the parents and the school.

In some situations, decisive action by the school, such as disciplining the perpetrator, may essentially solve the problem. But in more subtle bullying situations, the child may need training in social skills. These can include basic interaction skills (smiling, making eye contact, listening), and coaching on how to join a group activity, how to take turns or share, how to problem-solve when disagreements come up, and how to stand up for oneself. Social skills training has been shown to have a positive impact, particularly in middle and high school kids (Braddock BA et al, *Clin Pediatr* (Phila) 2015;Epub ahead of print). Having a few close friends can improve self-esteem and decrease anxiety and depressive symptoms, so learning these skills to help form connections with peers can be effective.

Continued on page 8

Types of Bullying and Questions to Ask Victims

If you suspect a child or adolescent is a victim of bullying, ask questions to determine the extent of the problem.

Direct bullying:

- Have you been threatened or blackmailed, or have your things been stolen?
- Do you get insulted or called nasty names?
- Do you have nasty tricks played on you to make you look ridiculous?
- Are you ever hit, shoved around, or beaten up?

Relational bullying (damaging relationships between friends and destroying status in groups to hurt or upset someone):

- Do other kids leave you out of get-togethers, parties, trips or groups, just to make you feel bad?
- Do kids ignore you or tell you they don't want to be your friend?
- Do kids tell nasty lies, rumors, or stories about you?

Cyberbullying:

- Do other kids forward your private email, instant messages, or text messages to someone else or post them where others can see them?
- Do other kids spread rumors about you online?
- Do you get threatening or aggressive emails, instant messages, or text messages from other kids?
- Do other kids post embarrassing pictures of you online without your permission?

Note: You can also ask the same kinds of questions of kids who are the bullying perpetrators by adjusting the phrasing appropriately.

Source: Adapted from Wolke D & Lereya St, *Arch Dis Child* 2015;Epub ahead of print.

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This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists and other health care professionals with an interest in the diagnosis and treatment of psychiatric disorders.

Expert Interview: Ms. Minahan
Continued from page 1

teachers become more effective. I coauthored the book with Nancy Rappaport because she is heavily involved in consulting for the Cambridge (MA) school system, and we both found that teachers were struggling with certain kids—specifically students with anxiety-related, oppositional, withdrawn, or sexualized behaviors.

CCPR: What is meant by the 'Behavior Code'?

Ms. Minahan: The idea is that behavior is not simply a problem that needs to be rewarded or punished, but that it is a code that the child is using to communicate something. If we can crack that code, we can be more effective in helping these kids to change. *The Behavior Code* also takes complex clinical information and translates it into practical strategies a teacher can easily understand and implement in a busy classroom.

CCPR: What's the problem with the methods of behavioral management currently used?

Ms. Minahan: Our traditional techniques, based on rewards and consequences, can exacerbate some students with social/emotional challenges. For example, teachers will often say, "If you turn in your homework every day you can earn recess time," or other similar rewards. If a child isn't doing the work, the teacher might say, "You're fooling around, you need to get your work done or you'll stay in for recess." The problem with that approach is that it misses skill building. If the child has anxiety, not doing the work is a "can't" issue rather than a "won't" issue. They need skills rather than consequences. One of the skills is initiation—anxious kids get overwhelmed with starting a task, and teachers need to teach them initiation skills. Other kids will start, hit one bump in the road, and stop working. Those kids need to learn persistence skills. Without teaching these skills, work avoidance will persist or become more entrenched.

CCPR: Sounds like an interesting approach. What kinds of kids does your method target?

Ms. Minahan: As I mentioned, we found that teachers are struggling with four types of kids: those with anxiety issues, oppositional behavior, withdrawn behavior (who are often depressed), and kids with sexualized behavior. For each type of kid we've put together suggestions for behavioral interventions that we've called the FAIR plan—F is for understanding the *function* of behavior, A is for *accommodations*, I is for *interaction strategies*, and R is for *response strategies*.

CCPR: I love the FAIR mnemonic. Can we unpack these components a bit?

Ms. Minahan: Sure. And this is something that psychiatrists can think about as they are evaluating kids as well. The *function* of behavior is what we talked about already in terms of the behavior code. What is the child trying to communicate through the behavior? And what is triggering the behavior? We talked about the child who is not getting work done. In that case, the anxious child was communicating that he doesn't think he can do the work at all. *Accommodations* are adjustments in the classroom procedure that may improve behavior. In this case, the accommodation might be that the child gets the math sheet the night before, and the parents can help him get it started in order to reduce the anxiety of getting new work sprung upon him. *Interaction* strategies are ways the teacher can interact with the child to prevent anxiety and confrontation, such as avoiding public praise. Many kids will react poorly to public praise, such as crumpling up their paper after receiving a compliment on it. In these instances, the teacher should create a less obvious way of praising that the student agrees to and is comfortable with. *Response* strategies are back up plans for teachers to have in case these prevention strategies fail, such as reminding the child to use an equivalent but appropriate way to communicate their needs rather than communicating through inappropriate behavior (this is called a replacement behavior). An example would be instead of walking out of the room when frustrated, politely ask for a break.

CCPR: You mentioned the importance of teaching kids skills. What sorts of skills are you talking about?

Ms. Minahan: The five most important skills that are often underdeveloped in students with social emotional disabilities are self-regulation, social skills, positive thinking, flexible thinking, and executive functioning. (See "Five Skills to Help Kids with Problem Behaviors" on p. 6 for more details and examples of each of these skills). Self-regulation is the ability to do an internal check, to understand if you're becoming dysregulated, and to change your own behavior. Many kids don't know how to do this, and they go from zero to 60 before they know it. The common teacher practice is to give a lot of direction at this point. For example, the teacher might say, "Sit up," "Keep your voice down," "Don't slouch." But an alternative strategy is to say, "Can you check yourself?" This is a cue for the child to look down and think, "Am I talking too loud?" or, "I have a pencil in my nose," etc. So instead of trying to stop a specific behavior, the teacher is promoting a skill (self-monitoring/self-regulation), which can be generalized to other behaviors and situations.

CCPR: Let's talk a little bit more about self-regulation. Kids who "rev up" in their behavior can cause problems both at school and at home. What other specific techniques do you have for dealing with these situations?

Ms. Minahan: A lot of kids don't know how to self-calm. We tell kids to calm down and that doesn't usually work. This is especially true when kids get up to a nine or 10 on a one to 10 scale of anxiety and agitation. At that point, the more language you use, the more you are putting kindling on a fire. When you're trying to reason with the kid using language, you're asking him or her to engage in cognition to calm down. But in fact, as we get anxious and agitated our working memory goes down and studies have shown that we can lose the equivalent of up to 13 to 15 IQ points when we are very anxious (Mani A et al, *Science* 2013;341(6149):976–980). That's why it's important to rehearse and practice self-calming with the child when they are calm. For example, a child can practice self-calming in the same green bean bag chair in the back of the classroom repeatedly. Now when the child is upset, telling the child to sit and calm down in the green chair automatically reminds her of those skills. It is also important to remember that kids may need a break from their own anxious thinking at these times.

Continued on page 4

Expert Interview: Ms. Minahan

Continued from page 3

I refer to these types of strategies as cognitive distractions.

CCPR: What are some examples of that?

Ms. Minahan: That will depend on the age of the kid. For older kids, I recommend listening to audiobooks, doing puzzles such as Sudoku, doing Mad Libs word games, or listening to music. For younger kids, I create a basket of activities. These might include hidden picture magazines such as "Where's Waldo." One foolproof activity is to read out loud. For example, one of my seventh grade girls with self-harming behavior records a book for a younger child with dyslexia. She finds that this helps her calm down and take her mind off her worries.

CCPR: So you tailor self-calming behaviors to the child?

Ms. Minahan: Yes, and we recommend that teachers and parents create a calming box or a comfort box. Once you figure out a recipe of calming activities for a particular child, you put those in that box. Children can bring this to school and keep it near their desk or table. You can think of it as an anxiety first aid kit. Teenagers don't want a "comfort box" so we'll recommended that they put things on a keychain. For example, I have a 16-year-old kid, a tough and confrontational guy, who cut a piece of his baby blanket and put it on his keychain. He rubs it when he's in a difficult situation and that enables him to stop and think before he gets into a conflict with a peer. And I have a 17-year-old girl who I met with and we went through fortune cookies and she found a fortune she liked. It said something such as, "You have the power to make changes in your life," and we laminated that fortune and put it on her keychain. She has social anxiety, and when she walks from one class to another, she convinces herself that she will be made fun of by others. Having this fortune on her keychain promotes positive self-talk and helps her make that transition with less anxiety.

The idea is that behavior is not simply a problem that needs to be rewarded or punished, but that it is a code that the child is using to communicate something.

Jessica Minahan, MEd, BCBA

CCPR: How else can we be helpful in identifying and troubleshooting situations where kids get into difficulty in the school environment?

Ms. Minahan: One helpful way to diagnose difficulties is to think in terms of the major hotspots in school that tend to be most anxiety provoking. The first hotspot is unstructured time, for example, being in the cafeteria and going outside for recess. Studies suggest that bullying is most likely to occur during the unstructured times of the school day, which can contribute to anxiety as well (Farrington DP & Ttofi MM, *Vict Offender* 2009;4(4):321–326). So you can ask parents, "How is he doing at lunch? Do you hear about problems in the cafeteria? Does he get stressed out during lunch? Are there more incidents in the afternoon then in the morning?" Lunch clubs are a great accommodation for students having difficulty in the cafeteria. These clubs are small, structured lunch groups disguised as fun clubs focused on a cool activity such as a "cartooning club." Another major hotspot is transitions. Typically, standard practice for teachers is to do a countdown warning, such as, "Five more minutes and it's time to clean up your snack". However, some kids don't know how to stop an activity. For example, if there's going to be a transition from reading a book to something else, saying, "5-4-3-2-1 close your book," is not going to be helpful for Katie who is inflexible and can't stop reading when she is in the middle of a chapter. Better to say, "In 10 minutes we are going to have to stop reading so try to find a stopping place now." Cue her to put a sticky note that reads "stop" at the end of a dialog or chapter. This will reduce push back when it's time to make the transition to the next activity. Anxious kids in particular have a hard time waiting, making the down-times of the school day problematic. In that situation, it's good to encourage the teacher to prompt the child to do a structured activity, such as doodling or sharpening the classroom pencils until the class transition is over and the next activity is about to start. Explicitly teaching transition skills is helpful, such as teaching the child to avoid activities that are difficult to stop, or as mentioned earlier how to initiate or start an anxiety-provoking task.

CCPR: What are some other hotspots during the school day?

Ms. Minahan: Writing activities are another hotspot because many kids avoid writing. Open-ended writing assignments are especially anxiety provoking. For example, "Write a persuasive essay on Columbus" versus "Name three facts about Columbus." Some kids say from a very early age that they can't write, and one really quick trick to help them is adapted from cognitive behavioral therapy. You take a piece of paper and write a line down the middle, creating two columns. On the left side is "before" and on the right is "after." You ask the child to predict on a scale of 1 to 5 how hard the assignment will be. They will usually say 4 or 5. Then you have them do the assignment, and rate how hard it actually was. The number is almost always much lower. You'd be surprised at how effective this is in improving kids' attitudes about their own abilities. Two other common hot spots are: social demands, such as when a teacher has kids partner up to do group work; and unexpected change, such as having a substitute teacher or a change in schedule. For changes, we recommend doing a heavy preview of any unexpected changes.

CCPR: Any other tips that we might find helpful for challenging kids?

Ms. Minahan: A particularly hard situation is the oppositional angry boy, who tends to bait people into arguments and get into power struggles with teachers all the time. For example, a kids drops his book on the floor next to his desk and doesn't pick it up. A common response is for the teacher to come over, look at him, and say, "Pick it up." This often doesn't work well because both invasion of personal space and eye contact can be provocative. One technique I recommend to teachers is do something that gives the student more time and space. So write a note that says, "Please pick up the book before the end of class," put it on his desk

Continued on page 6

Q&A With the Expert

Combining Medications and Behavioral Techniques in Schools

Nancy Rappaport, MD

Attending Child and Adolescent Psychiatrist, Cambridge Health Alliance,
Director of School-Based Programs
Associate Professor of Psychiatry, Harvard Medical School, Cambridge, MA

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

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

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

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

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

We have too few child psychiatrists who are able or willing to commit their time to helping school staff.

Nancy Rappaport, MD

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

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

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

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

CCPR: Can you give me an example?

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

Continued on page 7

Expert Interview: Ms. Minahan

Continued from page 4

without making eye contact, then quickly walk away, putting your back to the kid.

CCPR: That's something the teacher can do. How can we work with the boy to help him prevent arguments?

Ms. Minahan: We help the kid create an automatic response to these situations, and I'll rehearse it with him in the office. If he feels that he's getting revved up and about to argue, he can put his hand up and say, "I need a minute," and turn around and walk away. Or he might just shake his head and walk away. If these signals are shared with the parents and teachers ahead of time, they can be very helpful. Another idea is to teach the student to avoid asking yes/no questions. Questions such as, "Can I have a turn on the computer?" can be a set up for disaster if the student is averse to hearing the word "no." The child can learn to avoid asking yes/no questions and instead ask questions that begin with the word when. "When can I have a turn on the computer?" will not be answered with the word "no" which prevents arguing and oppositional reactions.

CCPR: Thank you, Ms. Minahan.

Editor's note: Ms. Minahan is the co-author of *The Behavior Code*, along with our other interviewee in this issue Nancy Rappaport, MD (Cambridge, MA: Harvard Education Press; 2012). Ms. Minahan is also the author of *The Behavior Code Companion (*Cambridge, MA: Harvard Education Press; 2014).

Five Skills to Help Kids with Problem Behaviors

1. **Self-regulation.**
   What it is: Self-calming and managing frustration.
   Examples: Have the child use a vibrating timer and teach them to ask themselves, "Am I paying attention?" or "Am I sitting in my seat?" when it goes off. Biofeedback games, which often include placing a sensor on the child's finger, which is connected to a computer or tablet, can help students choose which coping strategy works for them as evidenced by their heart rate.

2. **Social skills.**
   What it is: Interpreting social cues and understanding other's perspectives, including interaction skills such as smiling, making eye contact, being empathetic, listening to others, and taking turns.
   Examples: Your patient doesn't know how to react when another child hits them on the arm or an unfriendly kid approaches them on the playground. Learning these skills can help children make friends, ease loneliness, and improve their self-esteem.

3. **Positive thinking.**
   What it is: Having positive and realistic thoughts about oneself.
   Examples: Teachers can take photographs of successful moments in the school day and send them home. Another strategy is to create a daily check-in and check-out sheet, where the child writes or states what he is worried about that day and what he thinks is going to be difficult. An end of the day check-out may allow him to see that he was more successful than predicted, enhancing self-esteem.

4. **Flexible thinking.**
   What is it is: The ability to adapt to new situations, improvise, and shift strategies to meet different types of challenges.
   Examples: Parents and teachers can work with riddles and jokes to help a child shift between word meanings. Changing the rules of a game can show a child there are other ways of doing things. Catching kids being flexible and reinforcing them is a great way to see this skill increase (eg, a 'flexibility jar' can be filled with a pom-pom every time the child demonstrates flexibility).

5. **Executive functioning.**
   What it is: Planning and organization skills.
   Examples: Teach kids techniques such as using checklists and how-to lists, breaking long assignments into small chunks, and using visual calendars, time organizers, and mnemonics. Teachers can also project on the board photographs of common routines and directions, such as what one's desk should look like to better prepare for school work.

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

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

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

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

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

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

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Expert Interview: Dr. Rappaport

Continued from page 5

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

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

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

CCPR: Thank you, Dr. Rappaport.

THE CARLAT REPORT: CHILD PSYCHIATRY

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This Issue's Focus:
Schools and Psychiatry

Next Time in *The Carlat Child Psychiatry Report:* Anxiety Disorders

Bullying in Schools: A Primer

Continued from page 2

DR. CARLAT'S VERDICT: Bullying is common, takes many forms, and can have a significant mental health impact for the bully as well as for the victim. Ask about bullying as an explicit part of your routine history since many children will not spontaneously report these experiences. In your work with schools, be clear to school staff that the most effective way to create a healthy school environment for all is not based upon what the principal or teacher says, but, much more importantly, what is done about bullying, once it is reported to the school.

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