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Special Topics, Special Challenges

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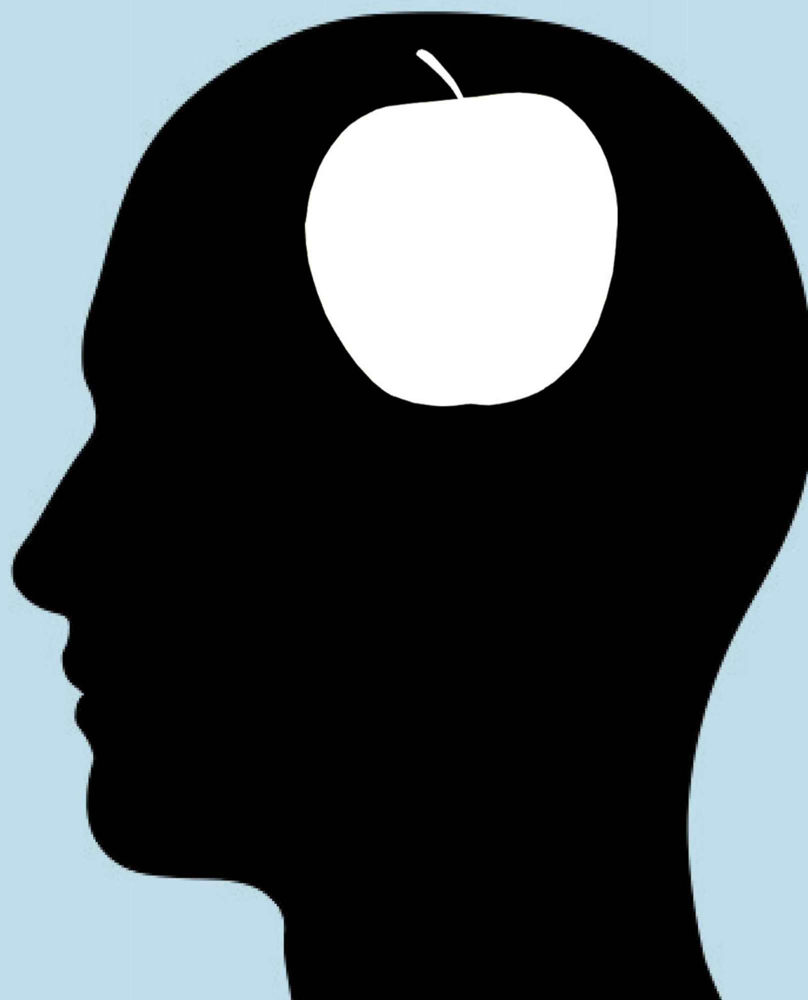

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(Volume 2)

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FOREWORD

As a leader in the field of school mental health for nearly 20 years, I continue to be alarmed by the number of youth falling behind academically in the United States. Achievement rates are abysmal, as only 42% of 4th graders are proficient in math and 34% in reading; whereas only 36% of 8th graders are proficient in math and reading (NAEP, 2014). Nearly 20% of youth today do not graduate from high school (DePaoli *et al.*, 2015) and estimates suggest that 7,000 youth drop out of school each day (Balfanz *et al.*, 2009). Youth living in poverty, of color, involved in special education, and those who are English-Language-Learners are at highest risk for dropping out and in turn poor outcomes (DePaoli *et al.*, 2015).

The implications are clear. Many youth, especially those most vulnerable, are inadequately prepared to be employable in today's global economy. As a result, these young people often succumb to the pressures of gangs and other social ills, suffer the consequences of the pipeline-to-prison, and often become over-reliant on government-funded social programs. In addition to the loss of human capital, there also are broader implications for society-at-large. A high school dropout costs the public over $200,000 in government spending over the course of their life (Levin *et al.*, 2007). Further, poor educational outcomes overall make it difficult to attract and retain corporate investments, further lowering tax revenues thereby decreasing public investments in neighborhoods and escalating risk and marginalization (Amos, 2008; Cardichon & Lovell, 2015).

So why are so many youth falling behind?

Many students come to school with multiple barriers to learning that impede their academic achievement and healthy development. For instance, between 14-20% of children and adolescents experience a mental, emotional, or behavioral disorder each year (National Research Council and Institute of Medicine, 2009). One of every 88 children (and 1 in 54 boys) in the United States have autism spectrum disorders (CDC, 2012). Estimates suggest that 1 in 5 youth are lacking in age-appropriate life/social skills (Blumberg, Carle, O'Connor, Moore, & Lippman, 2008). As a result, many youth are lacking in the social and behavioral pre-requisite skills necessary for success in school and life.

Still others suffer from additional risk factors that increase the likelihood for poor outcomes. Over half of all students in the public education system are living in poverty (DePaoli *et al.*, 2015). One of every 58 children is a victim of child abuse and/or neglect each year (Sedlak *et al.*, 2010). Sixty percent of youth have been exposed to violence in their homes and communities in the past year (Finkelhor *et al.*, 2009). Poverty, trauma, and its correlates impact student learning, and also are known to have detrimental long-term negative

employment, health, and mental health impacts (Felitti & Anda, 2009; Felitti *et al.*, 1997). Youth today simply are exposed to too much risk.

Given the rising prevalence of needs among youth and associated demands placed on the education system, there has been a significant movement toward the adoption of school-family-community partnership models that maximize resources in support of school success (Anderson-Butcher, 2004; Anderson-Butcher *et al.*, 2008). In particular, school mental health (SMH) programs and approaches have become increasingly common (*e.g.*, Weist, Lindsey, Moore, & Slade, 2006; Weist, 2003; Weist *et al.*, 2003; Mellin & Weist, 2011), and have shown promise toward promoting positive academic, health, and mental health outcomes among youth (*e.g.*, Hoagwood, Olin, Kerker, Kratochwill, Crowe, & Saka, 2007; Kutash & Duchnowski, 2011; Suldo *et al.*, 2014; Wilson & Lipsky, 2007). SMH approaches involve universal, school-wide mental health promotion and prevention, assessment, early intervention, and linkage, and intensive interventions/treatment to support the health, mental health, and academic learning of youth today.

The evolution of SMH and other approaches, along with the growing needs among youth today, both necessitate that professionals working in and with schools develop new and expanded competencies to support student learning and development. In fact, the Mental Health-Education Integration Consortium (MHEDIC), a national network of academicians, state and agency-level administrators, and practitioners of which I Chair, has called for enhancement of both pre-service preparation programs and professional development opportunities across multiple disciplines. MHEDIC leaders also are envisioning new SMH competencies for educators (Ball & Anderson-Butcher, 2014; Western *et al.*, 2010), school mental health professionals (Anderson-Butcher *et al.*, 2014; Ball *et al.*, 2010), and others working in interdisciplinary school teams and settings (Iachini *et al.*, 2013; Mellin *et al.*, 2011; Michael *et al.*, 2014).

Priorities are clear. Educators and others working in and with schools simply need to be better prepared to support young people today who come from increasing levels of risk, often have unaddressed health and mental health needs, and often are falling behind. They need to understand the challenges and issues facing young people today (especially those from diverse backgrounds), be knowledgeable of and skilled in evidence-based practices across the learning support continuum, and be motivated to work collectively on behalf of young people today.

To do this work, the field needs resources to utilize in pre-service preparation and training programs, as well as resources to support professional development and capacity-building efforts for those already working in and with schools. This book, Volume II of Mental Health Promotion in Schools (Special Topics, Special Challenges) published by Bentham Science

and edited by Raymond J. Waller, builds upon the first Volume (Foundations) and serves as a primary resource to promote competencies among those working in school mental health. He discusses this more specifically below.

As such, I am honored to provide the introduction to this book, as it promises to serve as an excellent and unique resource for educators and others who wish to broaden their impact on student learning and development (especially among those with "special challenges'), who aspire to ensure all youth graduate from high school and successfully transition to adulthood, and who hope to further make a difference in the lives of youth today especially those that are most vulnerable.

Dawn Anderson-Butcher
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PREFACE

School mental health promotion has grown rapidly from an idea and acknowledgement that schools, by virtue of the eminent role they hold in children's education, development, and socialization, had the potential to serve as a foundational locus for active programming in which policies and practices in schools purposefully engaged in promoting student mental health. This emerged from several observations among those of us working in K-12 settings including:

- **Some practices commonly seen in schools imposed psychological risk, such as some punitive disciplinary approaches,**
- **Schools have been identified as a best practice forum in health promotion,**
- **The dichotomy between mental health and physical health is nonexistent-so in order to improve one, you must address people holistically and include both, and**
- **Intentionally promoting mental health is highly correlated with positive school outcomes such as reducing undesirable behaviors, increasing engagement with the school community, and improving academic outcomes.**

School mental health promotion has evolved to the current standing of an international practice and academic emphasis in its own right, with texts (*e.g.* Waller, 2006 & Waller, 2012) and academic journals (e. g. *Advances in School Mental Health Promotion*) as well as support by prestigious centers of research and practice (National Center for Mental Health in Schools at UCLA and Clifford Beers Foundation).

Several approaches were contemplated pertaining to the direction and outcome desired with the second volume in this series, *Mental Health Promotion in Schools,* before concluding that the logical follow-up to the first volume, *Foundations,* as well as the best contribution would be *Special Topics, Special Challenges.*

This volume is intended to provide the reader with unique situations and student groups that were selected based on three desired outcomes. These were offering the reader discussion and school mental health promotion topics that:

- **Were universal in scope,**
- **Could be easily generalized to broader educational practice, and/or**
- **Involved situations or student groups that are not typically considered as potential benefactors of school mental health promotion practices.**

I would like to express sincere and deep gratitude for the overwhelmingly positive response and participation of the experts who contributed their time and knowledge in generously supporting this work. Distinguished international scholars from Volume I including Howard Adelman, Linda Taylor, Mark Weist, Dawn Anderson-Butcher, Elise Capella, and Steven Little are joined in Volume II by the expertise of, among others, John Miller, Kathleen Rudasill, Bruce Thyer, S.A. Moore and R.C. Mitchell, and Elizabeth Mellin.

To the reader, I convey the collective knowledge and experience of the contributing authors. I also extend the invitation of feedback on the volumes already available as well as identified areas of inquiry that you would find essential as we complete subsequent volumes.

Most importantly, I hope that the material in Volumes I and II have buttressed in some way your practice interest and efforts in this important topic.

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DEDICATION

For Amy E. Cox, friend and co-worker, who so rapidly has become an indispensable team member-a role that just as rapidly may lose its lustre with dawning awareness that she is, essentially, the team;

For the ongoing generosity of so much expertise from such esteemed colleagues, who are both near and far in proximity, but who are always near in mission;

For the patient perseverance of Asma Ahmed and Bentham Science;

For my very good friends William Warnock and Greg Ruediger, for the pricelessness of having their friendship and counsel;

For Sarah and Emily, who bring so much to the world that six book dedications is the minimum acceptable;

For Jackson and Charlotte, because a person has never achieved a level of growth so optimal that they are not improved by coercion to develop higher levels of patience and humility; and

For Moki and Toby, because they are better than I am and know it and share it charitably and frequently, but even so, accept me with unflagging acceptance and enthusiasm at no more personal expense than a bite of chicken jerky.

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CHAPTER 1

Restorative Justice and Transdisciplinary Praxis: An Investigation in Ontario Schools and a Framework for Moving Forward in School Mental Health Promotion

S. A. Moore and **R. C. Mitchell**[*]

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Abstract: Schools are, for many nations, among the most enduring societal institutions. As such, they serve as repositories of wisdom, learning, and tradition. Tradition can be of incalculable cultural value, but can also serve as a functional barrier in some cases. Promotion of mental health in schools is a violation of traditional thought for many. This chapter discusses transdisciplinary praxis as a functional framework within which needs of contemporary students can be effectively addressed. This framework involves abandonment of the punitive practices, exclusion, and deficiency based assessment traditional in many schools and in juvenile justice in favour of restorative justice, community building, and considering behaviour within environmental context. Restorative practices have garnered such support so rapidly that some leading universities now offer graduate degrees in their study and implementation.

Keywords: *Diagnostic and Statistical Manual of Mental Disorders* (DSM), Medical model, Praxis, Resilience, Restorative practices, Transdisciplinarity.

INTRODUCTION AND CONTEXT

This chapter presents a thematic analysis of preliminary findings from a 2013 school-based restorative justice study in Ontario, Canada. The dataset included a systematic review of legal, policy documents, qualitative and quantitative results

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contributed by 300 participants from 60 schools in 14 rural and urban districts across southern Ontario near the capital city of Toronto. In 2012, the *Safe and Accepting Schools Branch* of Ontario's Ministry of Education invited a provincially based organization known as the Restorative Practices Consortium to suggest means to expand their discourse with multiple school boards in their region, and one of us (Moore) was invited as a consultant to carry out the study. The challenges were accepted and involved the designing of a multi-faceted, evidence-based investigation that articulated the following main aims:

- **To ascertain foremost practices for fruitful application of restorative practices within schools congruently, accurately, and systematically,**
- **To ascertain impediments to engagement of these practices congruently, accurately, and systematically, and**
- **Wide dissemination of empirical findings to facilitate greater and more effective implementation of restorative practices province-wide.**

In previous careers, we had engaged with children, young people, their families and caregivers in frontline practice within British Columbia's mental health, youth justice, educational and child welfare systems before moving to research, teaching and tenure at a mid-sized Ontario university. A number of scholarly outcomes ensued for us as we translated professionally based knowledge into theoretically and pedagogically congruent research and teaching programs.

First and foremost we adopted the Greek term praxis to delimit our work, a term commonly adopted by critical educators inspired by Paulo Freire's (1970, 1999) teaching and learning philosophy. This term is defined as any endeavour that coalesces theorizing and application, and deliberation with deed, for emancipatory purposes. Secondly, a *transdisciplinary* point-of-view has shaped our research projects in response to the fragmentation and disciplinary myopia we encountered over the course of our careers with thousands of young people (Mitchell, 2003, 2007, 2013; Mitchell and Moore, 2012; Moore and Mitchell, 2008, 2009, 2011a, b; Moore, 2004, 2008, Moore, Tulk, and Mitchell, 2005). Leavy (2011) astutely acknowledges that transdisciplinary research practices have emerged within the context of "a confluence of extraordinary changes within and beyond the academy" (p. 36; also Pinker, 2011 and his counterintuitive thesis), and many of

these changes are reflected in our chapter.

The chapter has taken shape during a time of increasing uncertainty for the promotion of well-being of children and young people in Canadian schools - one being fanned in no small part by numerous high-profile suicides of young people after social media ‘cyber-bullying’ and related events (CBC News, 2013a, b). A public inquiry into the custodial suicide of nineteen-year-old Ashley Smith (Richard, 2008) - first incarcerated when she was fourteen years old - as well as the recent release of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) have further fomented the controversy surrounding how various professionals can further well-being within and beyond schools (American Psychiatric Association, 2013).

The DSM-5 was 16 years in the making, comprising more than 800 pages in length (Moffitt, Arseneault, Jaffee, Kim-Cohen, Koenen, Odgers, Slutske, and Viding, 2008) and framing the dominant discourse within child and youth mental health across educational and youth justice settings in both Canada and the US. Released in May of 2013, a shift was made from a multiaxial system to a dimensional structure for assessment, and the aim of this new modus is to encourage additional specific communication regarding diagnoses and to consider clients in the context of a system or continuum of functioning.

The transformation was argued as a move away from a previous DSM focus on pre-existing categories within which to cast clients (*i.e.* to fit clients in a therapeutic box rather than understanding the person’s experiences in context). This evolution includes a greater developmental sensitivity and a consideration of differences due to the intersections of culture, psychosocial, and environmental factors affecting functioning, contended Leigh (2009). This widespread framework for understanding behavioural difficulties and affective challenges occurring within young people’s lives is also being roundly but fairly critiqued for displaying numerous theoretical and cultural shortcomings.

CHAPTER 2

Students with Disabilities: Reversing a History of School as a Risk to Mental Health

Sheryl R. Matney* and **Joel P. Willis**

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Abstract: Persons with disabilities have, throughout history, been exposed to segregation, harassment, and brutal maltreatment. Few opportunities existed whereby meaningful community involvement was a viable option. Over the course of centuries, little changed for far too many. Legislation rapidly snowballed over the past hundred years, decreasing persecution and, even more recently promoting individual rights and access rather than minimizing mistreatment. School legislation and compulsory education have arguably had more impact on improving outcomes for youth with disabilities than any other political or social realm, and have recently moved from the older philosophy of mainstreaming to the current model of inclusion. This reflects a significant improvement, but has to be fully implemented *in vivo* or *in vitro*.

Keywords: Compulsory education, Inclusion, Least restrictive environment, Mainstreaming, Medical model, Normality, Self-efficacy.

INTRODUCTION

Students with disabilities often experience low self-esteem, apprehension and depression among other psychosocial issues (Hurwitz & Weston, 2010). Emotional, behavioral, and social problems create conditions that can impede the child's ability to be successful in the academic setting. Schools that intentionally provide a positive environment for all students benefit in ways that include increased academic achievement, decreases in problem behaviors, improved

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relationships connectedness among school community members, and increased positive school and classroom climates (Hurwitz & Weston, 2010).

The School Environment – Climate and Community

A school is more than a building where teaching and learning are the only activities taking place. Schools provide social and emotional growth opportunities nestled within a community of its own. Educators, administrators, students and other personnel can be engaged in activities designed to improve the overall culture of a school. These activities may strengthen relationships between students and teachers, foster feelings of shared purpose, inclusion, caring and mutual investment (Great Schools Partnerships, 2013). In our view, the term school community is affected by all experiences afforded to stakeholders such as learning, playing, eating, resting, helping, governing, competing, and other activities taking place in a school setting.

It is imperative for students with disabilities to feel a sense of belonging and acceptance within their school community. When describing a school community, often the defining criteria involves a group of people who are associated with each other and share common values about the education of children (Redding, 1991).

Of course, a school community promotes academic learning, but it also provides an environment where social, emotional, ethical and community development of students occurs. School communities should create an environment where everyone is welcomed and supported socially, emotionally, physically, and intellectually (National School Climate Center, 2013). School climate has been described as the quality and character of school life and is based on norms, values and expectations that support people:

- **feeling socially, emotionally, and physically safe,**
- **being engaged and respected,**
- **working together to develop, live and contribute to a shared vision,**
- **modelling and nurturing attitudes that emphasize benefits and satisfaction gained from learning, and**
- **each person contributing to the operations of the school and the care of the**

physical environment (Definition developed by the National School Climate Council).

Of what ultimate benefit is discussion about the school community, school climate and overall environment of the school and how does this relate to children with disabilities and mental health? In the quest for understanding the experiences of people with disabilities, it is important to review the history and cultural background of disability. Many disability advocates value the teaching of disability history and culture because, as George Santayana (1905) asserted, people who cannot remember the past are condemned to repeat the past. A brief historical synopsis of separateness and exclusion is presented and sets the stage for examining the attitudinal barriers students with disabilities face in a school community and the community at large.

Historical Overview: The Legacy of Discrimination and Ostracism

Throughout history, individuals with disabilities have been the subject of discrimination resulting from negative attitudes within society. Many of these negative attitudes stem from subtle cultural factors that determine standards of normality within a society. Individuals who do not meet the preferred standards are marginalized if not excluded from participation within society (Boswell, Hamner, Knight, Glacoff, & McChesney, 2012; Braddock & Parrish, 2001; Fox, & Marini, 2012; Taylor & Searl, 2001).

Examples of this exclusion and marginalization are well documented in literature throughout history and describe the unfair and sometimes inhumane treatment of those with disabilities. In his 1684 book The Practice of Physick: Two Discourses Concerning the Soul of Brutes, Thomas Willis described the ‘insane’ as animal-like, humans who had descended to a brutish state. The most effective treatment for the insane, according to Willis, was torture and torment (Scull, 1989).

CHAPTER 3

Children's Temperament at School and in the Classroom

Kathleen Moritz Rudasill*, **Kate Sirota, Mary Kralemann, Amanda Prokasky, Kenji Madison** and **Victoria J. Molfese**

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Abstract: Temperament is arguably one of the most important childhood traits about which educators should be thoroughly versed. Childhood temperament is linked with, among other outcomes, three that are essential to school success: behavioral responses, academic performance, and social interaction. It also plays a compelling role in long-term mental health. This chapter describes the range of temperamental manifestations and offers suggestions for promoting temperamental factors to support resilience rather than foster risk.

Keywords: Activity, Adaptability, Behavioral inhibition, Distractibility, Externalizing behavior, Goodness-of-fit, Internalizing behavior, Reactivity, Regulation.

INTRODUCTION

Variations in children's characteristics are universally acknowledged by teachers. In addition to widely supported differences in cognitive ability, children differ in the ways that they approach learning, follow directions, are interested in and attend to class activities, engage with peers, and interact with teachers. These differences are often rooted in temperament, defined as biologically based individual differences in thinking, feeling, and behaving in the environment (Duckworth & Allred, 2012). Although developmentally dynamic (*i.e.*, tempera-

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mental reactions to the environment change with advancing development), temperament is relatively stable through childhood and adolescence (Caspi & Silva, 1995; Kagan, Resnick *et al.*, 1988; Resnick *et al.*, 1986; Rimm-Kaufman & Kagan, 2005; Rothbart & Posner, 2005). Temperament is also multi-dimensional, encompassing characteristics such as activity, persistence, shyness, inhibition, and attention, and provides the foundation for personality, which extends to values, morals, beliefs and social cognition (Rothbart & Bates, 2006).

Like personality, temperament both influences and is influenced by the environment, making it an important aspect to consider when studying school environments. Indeed, children's temperament has been linked to their mental health, academic success, and social outcomes, both directly and indirectly *via* forces in schools (such as peers and teachers) that facilitate or prevent certain outcomes (*e.g.*, Degnan, Almas, & Fox, 2010; Martin & Holbrook, 1985; Rudasill & Rimm-Kaufman, 2009).

The modern era of temperament research began in the 1970s with the landmark New York Longitudinal Study by Alexander Thomas and Stella Chess. Inspired by their own children, Thomas and Chess (1977) conducted in-depth observations of infants, noting the individual differences in their behavior. They identified nine temperament dimensions: activity, rhythmicity, adaptability, approach-withdrawal, threshold to responsiveness, intensity, mood, distractibility, and attention/task persistence. Using these dimensions, Thomas and Chess were able to classify approximately 60% of children into one of three types: easy, difficult, and slow to warm up. Easy children were characterized by positive mood, high regulation, low to moderate intensity of reaction, high adaptability, and positive approach. In contrast, difficult children were described as being high in intensity of reaction, withdrawn in new situations, and slow to adapt and adjust to new routines.

Finally, slow to warm up children were characterized as displaying low levels of activity, withdrawing from new or unfamiliar stimuli, being slow to adapt and negative in mood, and responding to situations with low intensity of reaction (Thomas, Chess, & Birch, 1970). Thomas and Chess (1977) were quick to stress that no temperament type was better or worse than another; rather, positive

adjustment depended on the *goodness-of-fit* between a child's temperament and environment. For example, a difficult child may thrive in a supportive environment with sensitive and responsive parenting, whereas an easy child may be overlooked because he or she does not demand much from parents or the environment.

Other scholars have explored temperament, resulting in variations and refinements in its conceptualization. For example, Buss and Plomin (1975) identified four dimensions of temperament: emotionality, activity, sociability and impulsivity, while Goldsmith conceptualized temperament as differences in emotionality, and Kagan examined behavioral inhibition in toddlers and connections to later shyness (Merivelde & De Pauw, 2012). Rothbart and colleagues developed one of the most widely used frameworks for temperament, conceptualizing it as being comprised of reactive and regulatory components (Rothbart & Bates, 2006). The notion of temperament as both reactive and regulatory has been useful for reconciling nuances in conceptualizations of temperament, as well as for applying temperament concepts in settings such as school. For these reasons, Rothbart's temperament framework is described in detail below.

Reactivity

Reactivity refers to the intensity of an individual's reaction to environmental stimuli; a highly reactive child may be more prone to excitement, fear, or frustration than a less reactive child (Rothbart & Jones, 1998). In short, highly reactive children experience life intensely; they may become very excited about an upcoming event, get easily frustrated from a small setback, or seem anxious when meeting someone new. An individual's level of reactivity is manifested both emotionally and behaviorally (Rothbart & Bates, 2006). Emotional reactivity describes feelings (*e.g.*, anxiety, fear, joy) associated with an environmental stimulus, and behavioral reactivity describes the response to that feeling (*e.g.*, crying, social reticence, approach). Reactivity is evident in infancy and predicts

CHAPTER 4

Adolescent Pregnancy: Rejecting Preference *via* 'Profiles in Courage' in Policy and Practice

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Abstract: Ideally, best practice methods are built upon an edifice of informed policy guided by the low star of serving student best interests. Unfortunately, such a stalwart foundation is non-existent for many psychosocial and educational initiatives. In fact, it is lamentably common for policy to be constructed on a sand dune comprised of presumption, special interests, or intuition. Unfortunately, innumerable examples exist to warn us that human behavior is frequently counterintuitive, increasing the risk of policy decisions guided by presumption or face validity. While abstinence-only efforts to reduce adolescent pregnancy and associated adverse outcomes sometimes occurring as a result of high risk sexual behavior might have initially been defended as plausible, the evidence is compelling that such efforts are ineffective compared with other methods. Pregnancy and risk reduction policy and practice supported by empirical inquiry are discussed, and this issue is presented as an example actually and conceptually representative of divergence of public policy from the body of scientific knowledge.

Keywords: Abstinence, Contraceptives, Peer education, Sexual activity, Sexually transmitted infections.

INTRODUCTION

Prior to the invention and wide accessibility of the automobile, a would-be traveler desiring either greater convenience or alacrity than was offered by their

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own feet often resorted to transport by horse. When this traveler did not own a horse, she might charter the use of a horse by a stable owner, the historical equivalent of a contemporary would-be traveler renting an automobile. A stable owner of distal repute was Thomas Hobson

(Webber & Feinsilber, 1990) of Cambridge, England. A potential customer of Hobson's might survey the equestrian options available for hire and specify their preference for the animal they desired, but their stated preference did not impact the outcome. Hobson, in apparent contradiction of the idea that the customer is always right, had a rigorous practice of personally choosing the horse he leased so that he could rotate the use of his animals, thereby avoiding the overuse of his best animals. This arcane business practice gained so much attention that it became a narrative and literary term that continues to be used today; thus, audiences hearing the term *Hobson's choice* know that, for all practical purposes, the conveyed meaning is that one has no choice at all (The Phrase Finder, 2015).

Perhaps the contemporaneous practice equivalent of Hobson's choice involves those domains of psychosocial and educational practice in which the scientific knowledge base is at variance with public policy and programming. When public funding supports one primary method or program, administrators have the option of providing any programs deemed appropriate-and 'appropriate' options tend to align themselves with the legislated funding stream-or tend to cease operation. Historically there are innumerable illustrations of these occurrences in the US. An excellent example includes pregnancy prevention, legislation and incentives based on abstinence-only approaches to reducing teen pregnancy. This chapter will therefore discuss teen pregnancy rates *vis-à-vis* contradictions between policy and practice and the role that preference of the body politic or of special interest groups therein can play in influencing implementation of effective practices.

Description of Teen Sexual Behaviors and Pregnancy in the United States

The national Youth Risk Behavior Survey (YRBS) is a tool that the Centers for Disease Control and Prevention (CDC) uses to monitor health risk behaviors of students in grades 9-12. Among recent findings from this survey, 46.8% of high school students in the US reported that they have had sexual intercourse (CDC,

2014), although this reflects a decrease from the 1991 rate of 54.1%.

Perhaps a more important question to ask adolescents is *whether they are* currently sexually active. The indicators on the YRBS fail to capture this information, asking instead whether the student has had sexual intercourse in the past three months. Although the rate of current sexual activity reported by high school students is currently lower than much of the history for which records were kept, "a significant decrease among black students, where the proportion who are sexually active declined from 59% in 1991 to 42% in 2013" (Child Trends, 2014, p. 2). Traditionally, it has been thought that males had higher rates of sexually activity; however, recent findings indicate that 12th grade females report having a higher rate of sexual activity (50.7%) than any other group (Child Trends, 2014).

Risks

Unprotected sexual activity among adolescents can lead to myriad consequences, from unplanned pregnancies to the contracting of sexually transmitted infections (STIs). Protection during first sexual contact has decreased, but unprotected teen sex is still far too prevalent (see Table **1**).

According to the Alan Guttmacher Institute (AGI, 2014), almost half of those diagnosed annually with STIs are under the age of 24. More alarmingly, the Office of Adolescent Health (2014) has released the statement that "four in 10 sexually active teen girls have had an STD that can cause infertility and even death" (para 1).

Due to findings such as these, the CDC also collects data on condom usage. Although data is collected on other methods of birth control, only condom usage is directly associated with the reduction of STIs (see Table **2**). The CDC found that slightly more than half (59.1%) of the adolescents surveyed in YRBS 2013 stated that either the respondent or their partner used a condom during last sexual intercourse. This reflects a significant increase in condom usage since 1991 (46.2%), but unfortunately indicates a *drop* in condom usage since 2003 (63.0%) (see Table **2**).

CHAPTER 5

Creating Safer Environments for Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth and Families: Opportunities for School Mental Health Promotion

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Abstract: As schools reflect the sociopolitical climate of the country, educators and school mental health professionals are increasingly attending to the school climate for lesbian, gay, bisexual, a nd transgender (LGBT) youth as well as children raised in LGBT-headed households. This chapter provides school mental health professionals and educators with a summary of LGBT issues common in school settings as well as concomitant impacts on the mental health of LGBT students and families. Lastly, this chapter offers pragmatic thoughts for creating safer school environments that promote mental health for all students.

Keywords: Bisexual, Coming out, Discrimination, Diversity, Gay, Harassment, Lesbian, Sexual identity, Sexual orientation, Stigma, Transgender.

INTRODUCTION

Schools, which are responsible for creating safe environments for all students to learn and grow, often mirror the sociopolitical climate of our country. Debates about same-sex marriage and second parent adoption as well as news stories of suicides related to anti-gay bullying permeate both the households in which children live as well as the schools they attend. Our national dialogue about the

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civil rights of lesbian, gay, bisexual, and transgender (LGBT) persons is also occurring in schools where there is increasing reflection on, and attention to, the school climate for LGBT youth and families.

The positioning of schools within these sociopolitical debates urges school mental health professionals and educators to consider the role they play in creating safer school environments for all students and their families. Many same-sex parents and sexual minority youth encounter an unwelcome school climate and face difficulties in their school communities (Kosciw & Diaz, 2008). Findings from the 2011 National School Climate Survey indicated that many LGBT students are targets of physical and verbal harassment and discrimination throughout the school day (Kosciw *et al.*, 2012).

As the political and social debates ensue, they will pervade classrooms and affect children with a LGBT parent. In fact, recent studies have suggested that the school related experiences of LGBT parents are often similar to the experiences of LGBT students; a negative school climate also affects LGBT parents and their children (Kosciw & Diaz, 2008; Kozik-Rosabal, 2000; Lamme & Lamme, 2002). There is an obvious relationship between school contextual factors such as school climate and psychosocial health of students and families. A negative school climate has been linked to:

- **LGBT youth suicide (Morrison & L'Heureux, 2001),**
- **escalation of depression, increased absenteeism (Kosciw *et al.*, 2012), and**
- **additional undesirable educational outcomes (Mayberry, 2006).**

All school mental health professionals and educators are ethically obligated to meet the needs of all students, sexual orientation notwithstanding. Many professional ethical standards clearly articulate the role of school counselors, psychologists, and social workers in addressing the health outcomes of LGBT youth by assisting in the creation of a respectful climate free of discrimination (ACA, 2005; ASCA, 2007; Tomaszewski, 2002; NASP, 2011).

School mental health professionals should likewise be advocates for all students. Their multiple roles allow them to communicate with students, parents,

administrators, teachers, and staff and, in turn, offer support, help develop an inclusive climate, prevent bullying and victimization, affect change at the institutional level, and promote acceptance of diversity. The purpose of this chapter is to provide information about the mental health needs and related opportunities for school mental health promotion of LGBT youth and children in LGBT-headed households in school settings. We will begin with an overview of what is known about the school experiences of LGBT youth in both elementary and secondary schools, and about children from LGBT-headed households. Opportunities and suggestions for mental health promotion strategies that best support LGBT youth and families are also offered.

LGBT Issues in School Settings

LGBT youth and families are vulnerable populations that may encounter many obstacles because of their sexual orientation or gender expression. A surge of recent studies (Kosciw *et al.*, 2012; Kosciw & Diaz, 2008; D'Augelli, Grossman, & Starks, 2006; Bontempo & D'Augelli, 2002) have indicated that many LGBT youth encounter hostile school environments in which students in a sexual minority or children having same-sex parents too often encounter stigma, verbal harassment, and violence. These experiences with victimization are associated with poorer mental health outcomes compared to their heterosexual counterparts (Balsam & Hughes, 2013).

Despite the increase in attention to LGBT issues in secondary schools, particularly concerning bullying, investigations of LGBT youth and families in elementary schools are scarce (Cianciotto & Cahill, 2012). The primary barrier to researching LGBT issues in elementary schools is access; teachers, parents, and guardians have concerns about whether or not young children should be learning about LGBT issues in school-particularly in the early grades, primarily because most adults continue to equate LGBT with sexual behavior rather than relationships. There are also often conflicting opinions and varying perspectives on whether it is the school's responsibility to address such issues (Boyd, 1999).

Regardless of one's view, schools should be held accountable for promoting acceptance of all types of individuals and families, and preventing prejudice and

CHAPTER 6

Student Athletics: Opportunity, Challenge, and the Byzantine Construct 'Body Image'

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Abstract: Student interscholastic sport involvement is often presumed to be a protective factor for participating athletes, and this is no doubt the case for some. This protection derives from influences such as extra privileges, adoration, popularity, and beliefs about future prospects. However, student athletic participation can be a significant risk for others. Risk occurs as a result of significant pressures for low body weight, ideal physique, and coaching methods used. These pressures are different based on gender, and even based on sport of preference. This chapter describes student athletes as a potentially vulnerable population and discusses the risks that can be experienced using the example of increased incidence of eating disorders.

Keywords: Anabolic steroid, Binge, Body image, Body weight, Coach*, Eating disorder, Performance enhancing drugs, Purge, Student athlete.

INTRODUCTION

Christy Henrich, a former gymnast of near-Olympic caliber, died at the age of 22 due to complications of an eating disorder (Pace, 1994). According to her mother, "… 99 percent of what has happened to Christy is because of the sport" (Pace, 1994, para. 9). While sports and sports figures are lauded by society, various exigencies on the athlete may exist that are far from the popular presumption of glamor. Often these stressors include factors such as an exaggeration on winning, poor coach/parent–athlete relationships, and pressure for young people to succeed

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(Holt, Hoar, & Fraser, 2005). In the case of Christy Henrich, an offhanded comment by a judge at a meet was taken to mean she was overweight (Wilstein, 1994). This comment led Henrich to compare herself to the thin Soviet and Romanian gymnasts. As a result, Henrich believed these gymnasts were, in fact, getting better scores due to their size and condition (Wilstein, 1994). Although Henrich sought reassurance from her coach regarding her perceived physical condition of being overweight, it was never given (Wilstein, 1994).

While the Henrich scenario is extreme, body image issues involving the female athlete population occur regularly (Bissell, 2004; Bissell & Zhou, 2004; Mendelson, Mendelson, & White, 2001). Previous investigations have indicated an increased likelihood of eating disorders in athletes participating in sports that accentuate leanness or a low body weight (Byrne & McLean, 2001; Smolak, Murnen, & Ruble, 2000). Since by their very nature, athletes often evaluate themselves in juxtaposition to others, they may tend to compare themselves to others in actual or perceived competitive positions, as evidenced in Christy Henrich's situation (Pace, 1994). For example, Henrich did not ask for reassurance that she was good enough, but rather if she was thin enough, in comparison to the other elite athletes.

The lack of acknowledgement regarding the gravity of eating disorders in athletes – frequently idealized as the healthiest of individuals - has created a health cataclysm for the affected individuals and the people closest to them (Klump, Bulik, Kaye, Treasure, & Tyson, 2008) with potentially life threatening results (Myers, 2006). Yet, some states such as Illinois and New Jersey have been sluggish in recognizing eating disorders as "serious mental illnesses" (SMIs), "biologically based mental illnesses" (BBMIs), or, in the case of children, "serious emotional disturbances" (SEDs) (Klump *et al.*, 2008 p. 97). Such lack of recognition may be due to the perception that individuals afflicted with eating disorders can recover from them independently or volitionally (Crips, Gelder, Rix, Meltzer, & Rowlands, 2000).

The athletic environment offers a distinctive confluence of stressors increasing the potential manifestation of eating pathology. Athletes at elite levels are often under pressure to perform well for a variety of reasons such as living up to parental,

coaching, and spectator expectations. Athletes may be influenced by numerous psychosocial stressors associated with pathological eating including explicit "weight restrictions either by sport or coach, judging criteria that emphasizes thin and stereotypically attractive body builds, performance demands that encourage very low percentage body fat, coaches applying pressure to lose weight and peer pressure" (Zeigler, 2011, para. 8).

Coaches have been found to play an important role in shaping an athlete's experiences in sports. Specifically, the method of providing feedback preferred by coaches may be a primary source of stress and anxiety in sporting experiences (Smith, Zane, & Smoll, 1983; Ntoumanis & Biddle, 1999). When coaches are consistently and negatively critical about performance or emphasize winning to the point of giving most of their attention to only the "best" on the team, student athletes may develop questions about their physical competencies and performances (Brustad, Babke, & Smith, 2001).

Distinct Experience Necessitates Targeted Inquiry

Brownell, Rodin, and Wilmore (1992) identified some personality characteristics related to eating problems that could be descriptive of student athletes:

- **competitiveness,**
- **performance anxiety,**
- **obsessive uneasiness with body image, and**
- **meticulousness.**

Athlete leanness is often perceived as improving functioning during competition against heavier opponents who are presumed to be slower and less formidable rivals (Brownell *et al.*, 1992). The moniker 'lean sports' is often applied to those activities that presume a competitive advantage due to the more slender contestant. Lean sports have been discussed by numerous scholars and include examples such as running, swimming, gymnastics, dancing, and diving (Otis *et al.*, 1997; Smolak, Murnen, & Ruble, 2000). Internalization and pursuit of the thin ideal, endemic to participation in these activities, is a significant risk factor for the onset of problematic eating behaviors (Stice & Shaw, 2002).

CHAPTER 7

Students Coping with Chronic Physical Conditions

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Abstract: Students with chronic physical conditions may experience substantial risk of undesirable outcomes in school. The experience of physical challenges may synergistically affect mental health and school performance. School personnel and families may experience additional stress meeting the needs of students for whom the expertise or resources necessary for care provision is insufficient. Information, support, and effective programming can result in a more desirable outcome for everyone. While often considered synonymous with disability, these are distinct issues.

Keywords: Absenteeism, Chronic illness, Chronic mental condition, Chronic physical condition, Family functioning, Side effects, Suicide, Symptoms.

INTRODUCTION

The number of children and adolescents in the United States living with chronic physical conditions has increased dramatically in the past four decades (Perrin, Bloom, & Gortmaker, 2007). Such conditions can have significant, disparate effects. Though there can be effects on student participation in school, children with chronic physical conditions, like other youth, have the need and the right to be educated:

> Up to 98% of children suffering from a chronic illness, which may have been considered fatal in the past, now reach early adulthood. It is estimated that as many as 30% of school-aged children are affected by a chronic ill-

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> ness. For this population of children, the prevalence of educational and psychological problems is nearly double in comparison with the general population. (Martinez & Ercikan, 2009, p. 391).

Bethell, Read, Blumberg, and Newacheck (2008) estimate the number of children and youth with one or more chronic health conditions range from 12.8% to 19.3%. In a large-scale survey in Minnesota, Barnes, Eisenberg, and Resnick (2010) found that 9.5% of children and youth had a chronic physical health condition, 6.6% had a chronic mental health condition, and 3.0% had co-occurring chronic mental and physical conditions.

Children and adolescents from minority ethnic groups are disproportionately represented among youth with chronic illnesses, and the prognosis of their illnesses are complicated by factors such as poverty and access to quality health care (Perrin *et al.*, 2007; Zylke & DeAngelis, 2007). In a study of 4,746 ethnically diverse middle and high school students, Erickson, Patterson, Wall, and Neumark-Sztainer (2005) found that adolescents who were African American, Native American, or from a mixed-other race grouping were significantly more likely than Caucasian adolescents to report having a chronic health condition. They also found that adolescents from a low socioeconomic status (SES) were significantly more likely to have chronic health conditions than youth from a high socioeconomic level.

Newacheck, Stein, Bauman, and Hung (2003) also reported a higher prevalence of health disabilities among African American children compared to Caucasian children, but that the differences were entirely attributable to higher poverty rates among the African American children. It has also been reported that minority and low-SES youth with chronic health conditions are less likely to utilize health services and mental health services (Newacheck, Hung, & Wright, 2002), leading to poorer physical and mental health prognoses.

Occurrence of Affected Youth is Rising

The prevalence of children with medical conditions is increasing. This increase is related to an increase in the incidence rates (particularly with such conditions as asthma and obesity) as well as duration, caused principally by advancements in

medical care. For example, Steck-Silvestri *et al.* (2013) state, “advances in neonatal care have resulted in increased survival rates of extremely low birth weight or very preterm infants” (p. 300). Extremely low birth weight infants are more likely to have:

- **cerebral palsy,**
- **asthma,**
- **low IQ and adaptive functioning, and**
- **motor impairments (Taylor, Drotar, Schluchter, & Hack, 2006),**

and the increased survival rates of extremely low birth weight infants can explain, in part, the increased prevalence of children with these chronic health conditions. Another chronic health condition, congenital heart disease, has seen a one-year survival rate increase from 20% in the 1940s to over 85% today (Warnes *et al.*, 2001). Erickson *et al.* (2005) stated:

> Due to advances in medicine improving the morbidity and mortality of children with chronic health conditions, many of them are surviving through adolescence and into adulthood. Working with these youth to manage their chronic illnesses or disabilities is an increasingly important issue confronting health care providers. Pediatricians and other health care professionals need to be informed and able to assess the psychosocial distress experienced by these adolescents, which very often compounds the management of their chronic health conditions. (p. 181).

Children and adolescents who live with chronic illnesses bear not only the physical corollaries of their illness, but also experience psychological, behavioral, and educational consequences. Erickson *et al.* (2005) suggested that the normal challenges of adolescence combined with the additional stress of living with and managing a chronic health condition contribute to higher levels of both internalizing (*e.g.*, depression, anxiety, self-esteem) and externalizing (*e.g.*, tobacco use, illicit drug use, sexual activity) behavior problems.

Similarly, other researchers found externalizing behavior problems, such as delinquent and aggressive behaviors, and internalizing problems, such as somatic complaints, anxiety, depression, and social withdrawal, among this population

CHAPTER 8

A Review of Sexual Exploitation Risk Factors for Our Children and Ways to Create Positive Classroom and Community Environments

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Abstract: All families experience some degree of discord. When that discord becomes severe and synergistically mediated by environmental challenges such as low performance and disconnectedness at school, students may experience behavioral and psychosocial risks associated too commonly with highly undesirable outcomes. Among the most dangerous example is that students can become targets of recruiters of prostitution by human traffickers, who are often amazingly adept at exploiting the physiological and psychosocial needs of children and adolescents for nurturance and attachment in numerous ways. Predators can immerse disaffected youth into networks so convoluted that recovery is difficult, if not impossible. Engagement with the juvenile justice system is another undesirable outcome for those youth who disaffiliate from peers, family, and the school community, whether by choice, manipulation, or both. Considering the severity of the potential consequences, it is incumbent upon schools to play an assertive role in promoting resilience, connectedness, and engagement in school community membership and fostering school success.

Keywords: Abuse, Drug mule, Dysfunctional family, Human trafficking, Neglect, Organ harvesting, Prostitution, Sexual exploitation.

INTRODUCTION

Human trafficking, sexual exploitation, and prostitution of youth are a 150 billion

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dollar industry in the world today (UNICEF: USA, n.d.). In most cases, the recruiter of children is familiar to the victim – often an intimate or close family member. It is estimated there are 85 million child victims involved in commercial sexual exploitation, hazardous physical labor, and organ harvesting (World Vision, 2015). The major issue fueling the ability of traffickers to operate worldwide is the lack of birth certificates documenting live births (World Vision, 2014). Without this documentation, children are unaccounted for and unrecognized by governments. The *Girls Count Act* is currently pending in the United States Senate and would require registration of all children in order for a nation to receive US Foreign or Domestic Aid.

The gateway to human trafficking of youth appears to depend on a constellation of several risk factors, with the research highlighting several main areas of importance. A previous study done by the authors identified risk factors such as:

- **challenging family systems,**
- **childhood maltreatment,**
- **mental health issues,**
- **poor social skills, and**
- **substandard school performance**

as contributing to becoming the victim of human trafficking, sexual exploitation, and prostitution (Twill, Green, & Traylor, 2010).

This chapter is divided into two sections. In the first section, a brief review of the literature of risk factors will be delineated. Afterward, a discussion concerning the juvenile justice issues related to sexual exploitation will be highlighted. The purpose of the first section is to provide a frame for discussing the complex issues that contribute to human trafficking, sexual exploitation, and juvenile prostitution.

Understanding the life experiences of those at-risk youth gives the reader a better appreciation of the challenges and the necessity to re-think the social construction of the classroom and community as preventative environments. Further, being grounded in this literature will allow readers to assess implications for practice and explore ways to manage the classroom and school experience to optimize

positive influences that can help palliate negative life experiences. The second section will provide suggestions for the creation of positive classroom and school community environments for the purpose of mitigating these risk factors.

Sexual Exploitation Risk Factors for Youth

Twill *et al.* (2010) outlined several categories of risk factors influencing the propensity of juveniles to fall victim to human trafficking, sexual exploitation, and prostitution. The risk factors of negative family systems, childhood abuse and neglect, mental illness, poor social skills, insufficient school performance, and juvenile delinquency seem to be predominant on the list of critical life events favoring the risk of involvement in human trafficking. A review of additional literature corroborates these categories with additional foci on substance abuse and sexually transmitted disease infection complicating the lives of victims (Hudson & Nandy, 2012; Jani & Anstadt, 2013; Murphy, 2010; Surratt, Kurtz, Chen, & Mooss, 2012; Wilson & Widom, 2010).

Negative Family Systems

Negative, unstable, and dysfunctional families systems comprise an assemblage of factors forcing youth to the streets (Tyler, Hoyt, & Whitbeck, 2000). In a study conducted almost twenty years ago, Brannigan and Van Brunschot (1997) reported that juveniles who were prostituted, compared to other students of the same age, were "more likely to characterize parental home life more negatively, to report higher levels of physical abuse, sexual abuse, non-traditional family structures, parental drug and alcohol abuse… [and] higher levels of running away behavior" (p. 350). This study highlights what has now become common knowledge – lack of a solid foundation with nurturing care at a basic level is detrimental to a child's development and growth.

The common belief that human trafficking, sexual exploitation, and prostitution only befell those of lower socioeconomic backgrounds (Estes & Weiner, 2005) is not accurate. Exploiters prey on unsupervised youth in suburban areas, offering friendship, money, and other popular commodities (*e.g.*, cell phones, clothes, and high-end accessories) to lure children away from home and family. Milloy's (2002) study of youth living on the street revealed 75% originated from working

CHAPTER 9

Adopted Children in Schools: A Guide for Educators

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Abstract: Similar to a previous discussion on student athletic participation, adoption is often postulated to be an overwhelmingly protective event. Even more so than in that example, the assumption is, in the following example, likely true. Children who have been adopted do well in many domains of life. Even so, adoption can convey risk to children depending on several factors that are discussed below such as the type of adoption process a child experiences, providing many opportunities for schools to be involved in mental health promotion. Moreover, school practices can convey risk to adopted children, depending on the approach and sensitivity used in presentation. This chapter also, therefore, provides specific examples of how common school exercises that may convey risk can, often with little resource investment, encourage adopted children and facilitate their participation as members of the school community.

Keywords: Adoption, Child welfare, Deprivation, Developmental cognizance, Domestic adoption, Foster care, International adoption, Open adoption.

INTRODUCTION

Adoption is the process by which a child and non-biologically related adult(s) are legally joined in a parent-child relationship. The relationship is permanent and affords the adoptive parent with all responsibilities and rights of a biological parent. In the United States (US), it is estimated that 1.8 million, or approximately 2.5 percent of all children, joined their families through adoption (Vandivere,

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Malm, & Radel, 2009). However, the numbers of lives that intersect with adoption are much greater when you include birth parents, siblings, adoptive parents, close friends, and so forth. Even if a teacher does not have an adopted child in class, it is quite possible that the class includes a child with a relative or friend of someone who was adopted.

While the purpose of this chapter is to draw attention to the unique needs of adopted children in schools, it is important first to consider the overall well-being among adopted children. Results of a large-scale, representative study of adopted children in the United States indicated that the majority of adopted children are faring well in most areas of their lives (Vandivere, Malm, & Radel, 2009). For example, most adopted children are in excellent physical, emotional, and social health. Compared to non-adopted counterparts, they are more likely to have health insurance, have a parent read to them on a daily basis, and be involved in extra-curricular activities. Importantly, nearly 90% of adoptive parents agreed they would "definitely make the same decision to adopt their child, knowing everything then that they now know about their child" (Vandivere, Malm, & Radel, 2009, p. 5).

Evidently, the majority of adopted children are doing well. However, adopted compared to non-adopted children have a higher number of important, risk congruent outcome measures, including:

- **special health care needs;**
- **developmental and language delays;**
- **mental health difficulties such as attention deficit hyperactivity disorder (ADHD), anxiety, and depression; and**
- **lower levels of educational success, as measured by reading and math scores (Vandivere, Malm, & Radel, 2009; Smith & Riley, 2006; and Harwood, Feng, & Yu, 2013).**

While these outcomes are elevated for only a minority of adopted children, they pose significant challenges for the affected children and their parents.

Of course, adoption in and of itself does not cause problems or school related

difficulties. On the contrary, adopted children often fare much better than do their non-adopted peers on school outcome measures (van IJzendoorn, Juffer, & Poelhuis, 2005). Adopted children, however, face some unique challenges and vulnerabilities in school, some of which are due to pre-adoption privations and others to the nature of adoption as a diverse family formation.

Educators occupy an influential position in all children's lives. Children spend a tremendous amount of time each day in school, and learn not just academics, but also about themselves, their peers, and the world. As important role models for children, teachers often serve as facilitators of the development of self- esteem and self- efficacy. It is in the school setting that adopted children generally first realize that their family "stories" are different from their peers. They begin to hear "important messages regarding adoption that help to shape their identity as adopted persons" (Smith & Riley, 2006, p. 2). Teachers are uniquely situated to impart messages about adoption that are positive and normalizing. Consequently, it is imperative for educators to understand the multiple aspects of adoption. This will, in turn, allow educators to better address and serve adopted children's needs in mental health promotion rather than alienating their family experience.

Multiple Routes to Adoption

The purpose of this chapter is to describe educational, psychosocial, and diversity related issues relevant to the needs of adopted children in schools. We will begin with a brief overview of three types of adoption in the US. In each type, the child follows a different path to his or her permanent home. This will be followed by a discussion of potential areas of concern for adopted children in schools. Next, we will describe guiding principles for responsive and inclusive schools for children who join their families through adoption. We will conclude with a discussion of resources for teachers who would like to know more about adopted children in schools.

Types of Adoption

Because regulations guiding adoption can vary so dramatically by nation, basic descriptive information is provided for the United States for example purposes. Children are adopted through three primary methods in the United States. First,

CHAPTER 10

The Clinically Anxious Student: Evidence-based Approaches to Assessment and Treatment

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Abstract: Although the primary focus of this text is not to provide a reference on mental illness conditions (see preface), this chapter is included for several reasons. First, anxiety disorders are the most common psychosocial diagnoses worldwide, making it a virtual certainty that anyone in the education profession will work with affected students during their career. Second, this chapter provides a foundation that will facilitate appreciation of the content in the succeeding chapter. Third, much of this material links to other chapters herein, and hopefully enhances the understanding that the information throughout the text is intimately and irrevocably interrelated. The psychosocial conditions described can impact individuals along a continuum ranging from impairing to life threatening. Following this discussion is a chapter discussing the intricacies-and necessity-of intervening in the school setting with an anxiety disorder largely unknown, yet not rare.

Keywords: Agoraphobia, Anxiety, Anxiety disorder, Body dysmorphic disorder, Nightmare disorder, Obsessive compulsive disorder, Panic, Phobia, Selective mutism.

INTRODUCTION

Members of the school system face unique opportunities and challenges when working with students with anxiety disorders. This chapter outlines the primary characteristics associated with anxiety, and common clinical diagnoses as delineated by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.;

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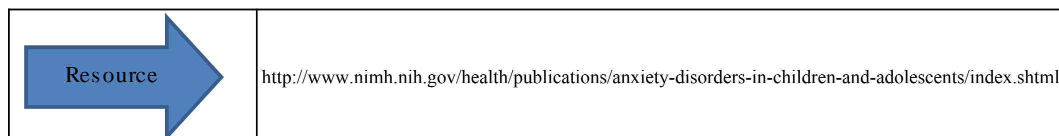
DSM–5; APA (APA), 2013). Further discussion of appropriate assessment and treatment options are presented, as well as indications for referral.

What is Anxiety?

Defining characteristics of anxiety disorders include excessive fears or feelings of anxiety. Though anxiety can be developmentally and situation-appropriate, the National Institute of Mental Health (NIMH) indicates that anxiety disorders develop when symptoms become difficult to manage and subsequently affect daily functioning for at least 6 months (APA, 2013; NIMH, 2014). Differentiation between feelings of fear and anxiety is primarily proximity-related, meaning, fear characterizes a response to a real *or* perceived *imminent* threat. Fear responses are further described by autonomic arousal and escape behaviors. In contrast, anxiety is considered a reaction to a *future* threat likely to elicit muscle tension and associated preparation for possible dangers.

An estimated 40 million Americans over 18 are affected by anxiety each year, with women 60% more likely to experience anxiety than men (NIMH, 2014). Further, approximately 8% of teens responding to a national survey reported having an anxiety disorder, with only 18% indicating they have received mental health care for their anxiety (NIMH, 2014). Anxiety, like other mental health conditions, has a multi-systemic etiology. Interactions between environmental conditions, familial and genetic precursors, and individual characteristics shape the likelihood of an individual developing an anxiety disorder, with no specific antecedent considered the defining cause (NIMH, 2014). These states (*i.e.*, fear and anxiety) are likely to overlap, however, they remain distinct. Additionally, the use of avoidance and escape behaviors may help to reduce fear and anxiety in some individuals (APA, 2013).



Anxiety Overview: Common Clinical Diagnoses

The *DSM-5* outlines 11 specific anxiety disorders, each with unique

characteristics and many with other distinguishing elements subject to further description (*e.g.*, phobia specification, onset) by a qualified mental health clinician (APA, 2013). Several additional conditions (*e.g.*, body dysmorphic disorder, nightmare disorder) are also highlighted due to their increased prevalence in student populations.

Anxiety Disorders

The *DSM-5* indicates that distinguishing among the various anxiety disorders is linked to the object or situation that induces fear or anxiety. Further, though the 6 - month period is considered a guideline for anxiety disorder duration, reduced criterion for duration may be considered with adolescent and child populations. Careful consideration by a qualified mental health clinician, keeping cultural context in mind, can help to determine if the fear or anxiety is considered developmentally appropriate or warrants intervention. Diagnosis of anxiety disorders is only made after assuring substance or medication use is not the primary cause of the fear or anxiety *and* that an additional mental health condition cannot account for the excessive fear or anxiety reactions.

Separation Anxiety Disorder

The primary source of fear and anxiety in separation anxiety disorder (SAD) is removal from the person to whom the individual is attached that exceeds the individual's developmental stage. Symptoms of separation anxiety disorder often present in early childhood, but can persist throughout the life course. Criteria for diagnosis require at least three of several characterizing reactions including recurrent distress or persistent and excessive worry:

- **when separated from major attachment figures,**
- **of possible harms that may befall the attachment figure (*e.g.*, disasters, morbidity, mortality), or**
- **of experiencing a future event (*e.g.*, being involved in an accident, morbidity, mortality)**

that would result in separation from the attachment figure. Refusal to go out and away from the attachment figure, persistent and excessive fear of being alone, and

CHAPTER 11

Social Anxiety Disorder in Schools: The Example of Paruresis

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Abstract: Anxiety disorders affect more members of the global community that any other psychosocial phenomena. Their voluminous impact is not limited to adults; anxiety disorders substantially influence the quality of life of many children and adolescents as well. This chapter diverges in format and intent from previous chapters in that the goal herein is to provide the reader with some of the applied difficulties that can emerge when attempting to intervene in the school setting. This chapter is not built upon the weight of empirical inquiry that defined previous chapters—indeed, that weight of evidence does not exist for the following topic. In order that the reader can appreciate the functional impairment that can be associated with anxiety disorders, a discussion of one type social anxiety disorder is reviewed. Then, in an attempt to illustrate the school effects related to what is perhaps the most common anxiety disorder most have never heard of paruresis and how it results in considerable distress as well as significant intervention challenges. The reader is strongly encouraged to exercise imaginative projection into the complications associated with this disorder in the school environment. Finally, a treatment protocol developed by the senior author is presented for the purpose of conveying the importance of school involvement.

Keywords: Anxiety, Cognitive behavior therapy, Parcopresis, Paruresis, Psychogenic urinary retention, Shy bladder syndrome, Social anxiety disorder, Social phobia.

INTRODUCTION

Social anxiety disorder is one of the most commonly occurring mental health

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issues in youth (March & Albano, 1998), with prevalence rates of 8% (Miller, Gold, Laye-Gindhu, Martinez, Yu, & Waechtler, 2011; Neil & Christensen, 2008). However, epidemiological studies in the United States found that only 5.4% of those with social phobia sought treatment (Lipsitz & Schneier, 2000). This chapter includes a review of the literature on social anxiety disorder and social phobia disorder in children, including a discussion of implementation of evidence-based interventions to treat anxiety disorders in school settings. A detailed description of the diagnostic criteria for social anxiety disorder, barriers to treatment, and a rationale for increasing purposeful mental health programming in schools are also discussed.

The DSM-IV-TR and DSM-V use the terms "social phobia" and "social anxiety disorder" interchangeably to describe clinical impairments due to the overwhelming feeling of fear, and therefore, both terms were used in reviewing the literature. Following this literature review, we will examine a specific social phobia – paruresis or shy bladder syndrome – among children and adolescents, the environmental considerations and influences of the school for children with paruresis, encouraging the reader to reflect deeply on the functional impairment that paruresis - a condition defined by such situational specificity (attempting to urinate in the presence of other people), can have on quality of life.

Literature Search Strategy

This literature review consists of systematic reviews, meta-analyses, other evaluations of the literature, experimental and quasi-experimental designs, and case studies with children and adolescents as participants, reported in English language, published in peer-reviewed journals. Keyword terms included: social phobia, social anxiety, anxiety disorder, anxiety, anxious, intervention, treatment, assessment, school*, classroom, youth, children, adolescent, cognitive behavioral, and CBT. Searches were conducted from 1977-2014 on the following databases: ERIC, ScienceDirect, PsycInfo, Education Full Text, Social Work Abstracts, SAGE, Project Muse, JSTOR, Wiley, and Social Sciences Abstracts. Unpublished literature was not included in the review.

Social Anxiety Disorder/Social Phobia Disorder: Overview

According to the American Psychiatric Association (2000), as cited by Kearney (2005), social anxiety disorder is defined as a "severe, irrational fear and avoidance of social interactions and/or situations that involve performance before others, evaluation by others, and possible negative consequences such as embarrassment" (p. 2). The key factors in diagnosing social anxiety disorder as a clinical syndrome is *the degree* to which the fear inhibits everyday functioning *and the extent* to which the individual is distressed by having the fear (Lipsitz & Schneier, 2000).

The diagnostic criteria for social anxiety disorder is different in children than adults in that the anxiety must occur in peer settings and not just during interactions with adults (Spence, Donovan, & Brechman-Touissant, 2000). These authors described how the fear or anxiety may be expressed by children in crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations. According to Hudson and Rapee (2000), as cited by George (2008), social anxiety usually appears after 8 years of age, when individuals have developed the ability to anticipate negative evaluation from others and they begin to experience associated feelings of self-consciousness. This age of onset is not firm, however, and earlier onset can occur. Social anxiety disorder may manifest as school phobia, which is a common, and conspicuous display of anxiety in schools in which children experience severe anxiety regarding the idea of attending school and therefore may leave early or refuse to attend completely (Hudson, & Rapee, 2006).

Symptoms and Risk Factors

Socially anxious children and adolescents exhibit various symptomology that involves fear of negative personal evaluation and avoidance of social situations. Symptoms inhibit, among other outcomes, academic success, and eventually can even result in increasing long-term health risks. The tasks of adjustment and school functioning are immeasurably more difficult for anxious youth and can be manifest or be exhibited through:

CHAPTER 12

Reversing the Outcomes for US Military Families: From Resilience to Risk during a Protracted Armed Conflict

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Abstract: Historically, US military families have shown themselves resilient against numerous risk factors of potentially significant consequence. However, involvement in the longest armed conflict in US historyoften referred to as the war on terror-and concurrent policy changes for service members-has eroded the protection of resiliency for many military families. This chapter concludes the text by discussing these changes, the effects observed on contemporary military families, and confers important considerations for school mental health promotion for the huge student demographic from a military family. A brief summary of this volume is also provided.

Keywords: Combat, Deployment, Family supports, Military, Posttraumatic stress disorder (PTSD), Secondary trauma, War on terror.

INTRODUCTION

It may be tempting to assume that children in military families, due to the nature and potential familial consequences of a martial career, have borne a burden of stressors beyond the scope and imagination of most families, and that these stressors have been an underpinning of undesirable outcomes for children in military families. While military families may have endured an unfair burden for the current and perhaps previous US engagements, many people will be surprised

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to know that, historically, being a member of a military family has not resulted in clear evidence of detriment to the functional capacity of these families. Indeed, though military life can impose compelling challenges, military families have proven highly resilient. For example, though military families relocate at a much higher rate than other families and though frequent moves can have an adverse effect, these moves have not only failed to impose harm, they may have served to *strengthen* children in military families (Kelley et. al, 2003). Succinctly, military families, despite the potential stressors of military life, do *at least* as well as other families on a wide range of investigated outcomes (*e.g.* Eastman, Archer, & Ball, 1990). Or they did.

The circumstances of the US involvement in the conflict often referred to as the war on terror- the longest military engagement undertaken by the US armed forces-has changed the risk burden for many military families. Where resilience historically occurred, hazard has overtaken many. This chapter elucidates some of the changes that have transpired which may be associated with decreasing resilience of military families, variables research suggest can help to buttress these families, and confers suggestions for schools in promoting mental health for their student members of military family units.

Current Status of US Military and their Families

The challenges placed on military families with the conflicts in Iraq and Afghanistan are numerous and complex and have changed the functional outlook for many military families. They have, in many cases, left the professional community with a dearth of empirical evidence to rely upon in guiding policy and practice. Part of the changing outlook for military families may have emerged because the concept of war is so different than it has been in the past, and scant data exists to address the change. The current conflict is of a type of conflict sometimes referred to as extra-systemic wars, which are defined as conflicts between at least one state (*e.g.* the US) and one nonstate (*e.g.* Al Qaeda) actor engaged in conflict transcending recognized borders (Simpson, 2006).

With the war on terror creating the “longest war in United States history” (Lester & Flake, 2013, p. 122), it is a given that our military members and their families

will shoulder the brunt of this millstone as it relates to family functioning within the body politic. Although this is typically the case, the current conflict is unprecedented in placing the encumbrance directly and primarily on military families. While the general public is often encouraged to directly ignore the national status of conflict by political leaders, indirect encouragement for nonmilitary citizens to focus on matters other than armed conflict occurs in daily activities in the form of the absence of larger societal sacrifices observed during previous conflicts such as rationing of goods, growing victory gardens, or increases in domestic tax rates (*e.g*. Victory Gardens, n. d.; Rumbaugh, 2013).

An additional distinction of the current conflict is that it lacks a defined enemy and has no delineated end point, making it in some ways more comparable to 'the war on drugs' than a previous armed engagement (Raz, 2006).

Fig. (1). By Artist: Morley Size: 27"x 19" Publication: [Washington, D.C.] Agriculture Department. War Food Administration. Printer: U.S. Government Printing Office - http://www.art.unt.edu/ntieva/pages/about/newsletters/vol_15/no_1/WarPosterImages.htm, Public Domain, https://commons.wikimedia.org/w/index.php?curid=2030283

New Paradigm, New Scope

There are over two million children with a parent in the military on active duty or in the Guard/Reserves. An additional two million children have a parent that is a combat veteran. Learning how the current conflict affects individuals and families

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