The Effects of Psychopharmacology on EBD-labeled children in an Educational Setting

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Abstract

This paper examines the effects of psychopharmacology in emotional behavioral disorder labeled children in a federally supported school setting. The paper will explore: (1) the impact of and side effects from medication, the role of therapy in medicated children; (2) the correlation of progress in children when combined with medication; educator’s understanding and education on the effects of medication on students in the classroom; (4) comprehension of the Diagnostic Statistical Manual (DSM); (5) and an Adlerian perspective on how to treat EBD-labeled children in an educational setting. These questions lead to a conclusion that it is not only important for educators to understand the rapid increase in the use of prescription medications, such as antipsychotics and stimulants in an EBD setting, but also equally important, that educators understand that the effects of the medications and their consistent use is vital. DSM diagnosis definitions and classifications are outside educators’ training and expertise. Educators can better prepare academic and behavioral interventions during the school day if educators are educated as partners in collaboration and co-management with other providers, then the best interests of students are served. Examples of these supports and providers are parents, Physicians, Psychiatrist, Therapist, Social Workers, after school programs, Personal Care Attendants (PCA), county workers, case managers, and any other service provider the child may be working with. In conclusion, the most effective long-term prognosis for EBD-labeled children with severe emotional and behavioral disorders is a combination of both medication and psychotherapy in partnership with all stakeholders.
Dedications and Acknowledgments

It is important for me to communicate and give gratitude to those who have helped me in researching and understanding this important subject. First, I would like to thank my family for their continued support and patience in allowing me the time and energy that this project has required. Throughout my journey, my parents and children have displayed continued encouragement.

This paper is dedicated to the many students with whom I have had the pleasure of working. The children of River East Therapeutic and Treatment School have been my motivating force in researching and understanding how this very impactful subject influences their daily lives as well as their ability to learn. My time spent observing and mentoring children in an educational setting, along with the various staff I had the pleasure of working beside, have inspired me to advocate for those who cannot advocate for themselves. It is my intent to seek justice for them in my continued research in this field.
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The Effects of Psychopharmacology on EBD-labeled children in an Educational Setting

Children in emotional behavioral disorder (EBD) setting schools are more and more often medicated with psychotropic medications. Often and increasingly these children are consuming a cocktail of medications to minimize the mental health and behavioral symptoms they regularly face. This recent trend in medicating children as early as preschool, presents many questions, various dilemmas and opportunities. Expectantly, it will set in motion conversations surrounding mental health in public school education (Donatelli et al., 1994).

The first part of this paper discusses the definitions of key concepts addressed throughout the document. Specifically the paper addresses, (1) what designated level of EBD-labeled children are being addressed, (2) what psychopharmacology is being used, (3) the type of educational setting EBD-labeled children face each school day, (4) who the educators are, and (5) an Adlerian view of misbehaving children.

Key Concepts

Emotional Behavioral Disorders

Emotional Behavioral Disorders are defined by the federal government as a child exhibiting one or more of the following characteristics to a marked degree for a long duration of time that adversely affects their education:

1. Difficulty to learn that cannot be explained by intellect, sensory, or health factors
2. Difficulty to build or maintain satisfactory interpersonal relationships with peers and teachers
3. Inappropriate types of behavior (acting out against self or others) or feelings (expresses the need to harm self or others, low self-worth, etc.) under normal circumstances

4. A general pervasive mood of unhappiness or depression

5. A tendency to develop physical symptoms or fears associated with personal or school problems. (Child with a disability, Code of Federal Regulations, Title 34, Section 300.8(c)(4) et seq.)

This paper will be focusing on the population most acutely affected by the EBD school setting. These are children are elementary age (i.e. 5-12 years old), with a few mentions of both preschool and adolescents as well.

**Psychopharmacology**

For the purpose of this paper Psychopharmacology refers to the use of psychotropic medications used by children and adolescents. The effects medications have on moods, behaviors, thoughts, and sensations will be reviewed in this paper. For all intents and purposes, psychopharmacology refers to the use of psychotropic drugs to treat psychological illnesses.

**Polypharmacy**

Polypharmacy is the use of multiple medications to treat psychiatric symptoms regarding mental illness.

**Educational Setting**

In this paper, educational setting refers to the school the children attend and the school’s federalized category relates to the severity of emotional and behavioral disorders of the children. The setting I will be referencing is a Federal IV setting, which by definition, is the most severely impaired children in a public school setting (Katsiyannis & Zhang, 2002). This type of program
provides direct care and education for children with severe conflicts and challenges in previous public school settings. These students have met the federal guidelines to be considered eligible for services under the protection of special education services. All students classified as EBD have an Individualized Education Plan (IEP) (Child with a disability, Code of Federal Regulations, Title 34, Section 300.8(c) (4) et seq.).

**Educator**

The term educator is a catchall for those individuals directly involved in the care, treatment, and education of the students as referenced in the paper. The definition includes teachers, paraprofessionals, mental health practitioners, social workers, administrators, and any other personnel who directly support the students on a regular daily basis in the school (Kubiszyn, 1994).

**Social Interest**

A term described by Alfred Adler as community feeling: not self-interest or regard (Ansbacher & Ansbacher, 1964). Social interest is discussed in the context of this paper by how it relates to the children’s *goals of misbehavior* (Dreikurs, 1964). It includes the educational environment in which these children are to be educated. The community and family system surrounding these children will also be a part of the social interest discussed throughout.

**Access and Understanding of Mental Health for Families of EBD-Labeled Children**

**Lack of Understanding**

Access to mental health services for parents is varied and wait lists are long, delaying care that many parents desperately seek. For instance, high turnover rates of mental health staff often disrupt the continuity of care and support (Honigfeld & Pidano, 2012). Additionally, families with a desire for psychosocial treatments are often left on their own to navigate their
children’s care. As explained by Honigfeld & Pidano, “Due to payers unwillingness to fund efforts to streamline mental health services, thereby creating co-management of mental health care” (2012, p. 2).

**Financial Implications**

There is often health care coverage for medication, but not always for therapy (Johnston & Parents, 2011). Therefore, many families are limited to seeking medication, as a means to the management of their child’s mental health needs. “Behavioral Health care organizations, have an incentive to reduce utilization of psychosocial treatment (and hospitalization), but they are unaffected by the use of psychotropic medications” (Parens & Johnston, 2011, p. 25).

Many times due to behavioral HMO restrictions, parental training, which has been proven effective, is not covered by health insurance. Parens and Johnston (2011) state, “Every step in children’s mental health care is compromised, from assessing the child’s needs to providing information on treatment choices, accessing treatments, and monitoring the effectiveness of which each treatments are provided (Parens & Johnston, 2011, p. 27).

**Alternatives to Medication**

There is a desperate need for parents to be properly educated regarding the options for assessing and treating their children (Guo & Hussey, 2003). Diagnosis, prognosis, treatment plans, and medications are all topics of education that parents have interest in understanding (Robold, 2002). Alternatives to mediation such as yoga, acupuncture, and therapy should also be easily accessible to those who seek them. Access to options for the mental health needs of children, must be readily available to parents to promote proper decision making when addressing their child’s mental health needs.
Long Term Affects of Medication Usage in Children

Research

A child’s brain is an evolving organism, which no one, including physicians, can fully comprehend (Bowman, Hall, Ley, & Frankenberger, 2006). While research continues, there is little knowledge about the long-term effects of psychotropic medication on a child’s brain. It is often thought that continued long-term use of psychotropic medications can lead to dependence, whereas discontinued use can lead to a relapse or worsening of symptoms (Gardner, et al., 2007).

Research highlights the sensitivity of the developing brain. Synaptic density, dopamine receptor density, and cerebral metabolic rates peak in the first 3 years of life and decline over subsequent decades. This highlights the potential central nervous system sensitivity to exogenous factors including medications (Gardner et al., 2007, p. 307).

Regrettably, studies reviewing effectiveness of medical treatments in children are missing from current texts and therefore several key issues remain unmeasured. For example combined use of anti-anxiety, anti-psychotic, and anti-seizure medications, as well as other combinations of medications, otherwise referred to as polypharmacy (Bauer, Burns & Ingersoll, 2004).

Ethical Implications to Research.

There are also ethical implications to research on the long-term effects of medication use in children (Block, 2006). Those ethical dangers and dilemmas are barriers to research including obtaining informed consent from children to conduct research (Johnston & Parents, 2011). Although there are several barriers to conducting long-term research on the effects of psychotropic medication in children, there appears to be a priority in medicine to investigate these effects in children more recently (Curry, 2006). In 2002, there was a renewal law called, “Better Pharmaceuticals for Children Law” (Curry, 2006). Although such bills increase the rigor
with which drugs must be tested before being prescribed for children, these bills do not contribute to the debate over whether psychotropic drug interventions are the best choice for children (Bauer et al., 2004).

**Diagnostic and Statistical Manual (DSM) Criteria**

The vagueness of classifications of medication in the Diagnostic and Statistical Manual fourth edition is concerning especially when considering the diagnosing and treatment of children (American Psychiatric Association Ed., 2000). Notably, “Drugs are classified in relation to the disease processes they are tested on even if the disease process is ill defined” (Bauer et al., 2004, p. 3). It is well understood that the DSM-IV criteria for diagnosis are not well proven in the reliability and validity of children (Bauer, Burns, & Ingersoll, 2004). Poor or misdiagnosis only further complicates the challenges mental health providers experience in their assessment and treatment of EBD-labeled children. The process of diagnosing EBD-labeled children is necessary because it streamlines the prescription of treatment, including therapy and medication. Although the model used to diagnose children is flawed and continues to challenge clinicians, it is important to have diagnostic categories so that clinicians, researchers, and physicians have concrete criterion to work with when collaboratively treating a child (Parens & Johnston, 2011). According to Parens and Johnston (2011), there are six possible issues to diagnosing children to determine if a psychiatric disorder is present. Those six issues are as follows:

1. Heterogeneity within the diagnostic categories, meaning children experiencing different symptoms can receive the same diagnosis.

2. Overlap between diagnostic categories exists. For example children with the same symptoms often are diagnosed differently.
(3) Symptoms of the same disorder can look very different in children and adults. There is a section of the DSM-IV that has disorders that are primarily diagnosed in infancy and childhood. Far more often, the diagnosis comes from an adaptation for a disorder meant for adults.

(4) Careful diagnosis requires both identification of symptoms and level of impairment. A diagnosis is only warranted when the symptoms create significant impairment.

(5) The basic flaw of the DMS is that it fails to take into context the symptoms. For example, depression when in the context of the death of a loved one can trigger intense sadness. This person could often be mistaken as being depressed when their emotions are due to an event and are in appropriate response to a tragic event.

(6) Diagnosing children is that symptoms and impairments are dimensional, and children’s brains are still developing (Paren & Johnston, 2011, p. 16). These are six potential issues clinicians and practitioners face every day when dealing with diagnosing based on DSM-IV criteria.

In a recent study (2014), the mental health DSM-IV disorders most affecting students in an EBD educational settings are as follows in descending order:

(1) 57.1% ADHD
(2) 50.6% oppositional defiant disorder (ODD)/conduct disorder (CD)
(3) 28.6% depressive disorder
(4) 20.8% pervasive development disorder (PDD)
5) 13% anxiety disorder
(6) 7.8% psychotic disorder
(7) 3.9% other
Further, comorbidity was present in 67.5% of students in the study (Mattison, Michel, & Rundberg-Rivera, 2014, p. 3-5).

**Side Effects of Medication During the School Day**

**Educators Understanding of Side Effects**

In EBD school settings Bowman et al., (2006) estimate that as many as 77% of students were identified as having one or more psychiatric disorders and 21% were said to have more than one psychiatric disorder. Approximately 65% of the elementary students in the EBD setting were recognized as receiving psychotropic medications. Of that amount, 15% were acknowledged as being prescribed more than one psychiatric medication. Astoundingly, 6.2% were identified as receiving three or more medications simultaneously to treat psychiatric disorders (Bowman et al., 2006). Thus, it is imperative that educators both recognize and understand the effects of the medications (or lack thereof,) on students during school hours.

Of the medications prescribed to children for mental health disorders, atypical antipsychotics were the most widely used (49.4%) followed by, stimulants (33.8%), (28.6%) for mood stabilizers and (28.6%) for selective serotonin reuptake inhibitors (SSRIs). It was impossible, even for researchers, to measure and monitor the side effects of the participants, due to the high level of comorbidity. Though there is awareness that side effects are present, to be able to assign them to one medication over the other when they are taken simultaneously makes it almost impossible (Mattison et al., 2014).

Side effects such as jitteriness, tiredness, frequent trips to the bathroom, headaches, stomach aches, rashes, joint pain, dry mouth, and dizziness are all common during the school day (Konopasek & Schoenfeld, 2007). It is important for educators to understand how side effects may have profound influences on a student’s performance, comfort, and attitudes during the
school day (Konopasek & Schoenfeld, 2007). Although educators can plan to provide education based on expected behaviors, adjusting attitudes and awareness surrounding medications in not only important for the management of the classroom, but the overall academic success of the individual student.

There is no question that mental health needs of EBD-labeled children are complex, difficult to meet. Furthermore the attitude of an educator can assist improvement upon the problems these student experience, or they can actually make the student’s behavior worse (Konopasek & Schoenfeld, 2007). It is important for teachers and educators to carefully watch for potential problems or changes in student’s behavior in an educational setting, and to teach the student accordingly, while being in contact with parents and supports (Konopasek & Schoenfeld, 2007).

Educators often participate in completing behavioral assessments, change classroom instruction due to medication changes, and monitor physical symptoms that interfere with the ability of a child to learn (Parens & Johnston, 2008). Moreover educators receive little to no training. Though medications are palliative and do not change the child’s long term skills and behaviors, they do help management symptoms in the classroom which in turn aid in the ability to teach children with severe mental disorders (Hollon, Stewart, & Strunk, 2006). It is suggested that educators are not particularly well informed in the basics of pharmacology and there is a strong need for training in this area, especially in an EBD school setting (Mattison et al., 2014). Medication education is of the utmost importance because according to Mattison et al., (2014), educators with this knowledge would “become improved reporters to help prescribing Physicians determine the beneficial and side effects of psychotropic medications they are increasing prescribing to youth.” It is noted in one study that the importance of EBD educators to have
adequate knowledge and understanding of DSM-IV disorders of their students, cannot be underestimated. In short, prescribing physicians need educator’s observations of these seriously ill children, in an effort to make timely and appropriate adjustments in medications (Mattison et al., 2014).

**Medication Distribution During School Hours**

Over time there has been an increase in the number and frequency of medications being distributed during school hours (McCarthy, Kelly, Johnson, Roman, & Zimmerman, 2006). What is more one in ten EBD-labeled children has a mental disorder severe enough to impair their level of daily functioning at school (Ryan, Katsiyannis, Losinski & Ellis, 2014). Moreover, up to 6 million children take medications for mental disorders, which continue to increase through time (Center for Health and Healthcare in Schools (CHHS), 2007). Medication helps suppress the impulses and challenges EBD-labeled children are faced with (Ryan et al., 2014). Due to the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973, schools are required to dispense medications, including psychotropic medications, to students when necessary. Although this is a requirement of all schools, there is no guidance or suggestion on how to safely administer or monitor the effects of the medications.

Psychotropic medications are defined as a grouping of drugs or agents prescribed to stabilize or improve behavior, emotions, cognitive functioning, and sleep. These medications are chemical substances that alter the function of the brain, resulting in provisional changes (Ryan et al., 2014). The most common psychotropic medications in EBD settings are antidepressants/SSRIs (for the treatment of depression, obsessive-compulsive and panic disorders, eating and anxiety disorders, and ADHD); stimulants (for ADHD and hyperactivity in developmental disorders); antipsychotics (for psychotic disorders, bipolar and mood disorders,
behavior disorders with severe agitation and aggression, and irritability in autism); antiolytics (for anxiety disorders and insomnia); alpha 2 agonists (for ADHD, Tourette Syndrome, and behavior disorders with severe agitation or aggression); mood stabilizers, including lithium and anticonvulsants (for bipolar disorder, behavior problems with aggression, anger, and severe mood swings), and selective norepinephrine reuptake inhibitors (SNRIs)…(For ADHD; Ryan et al., 2014).

Though psychotropic medications do not cure mental health disorders, they aid students in managing their symptoms for improved emotional and behavioral regulation at school, and assist in the efficacy of academic and behavioral interventions (Katsiyannis & Ryan, 2009). Furthermore, psychotropic medications are often fast acting and can provide relief immediately. Thus, these medications have become common for EBD-labeled children (Ryan et al., 2014). With the aid of these medications for the treatment of mental health disorders in children, there is a substantial decreased probability of children encountering comorbid disorders (Abikoff et al., 2004; Ryan et al., 2014).

Close monitoring of psychotropic medications is critical as all medications pose the potential for harmful side effects (Ryan et al., 2014). Further, there is an increased chance of side effects for off-label medications (Curry et al., 2006). Due to the increase in distribution at school of psychotropic medication it is reasonable to expect educators to understand what side effects they might notice in their students as a result of medication (Ryan et al., 2014).

Although school nurses would be the most obvious choice for the disbursement and management of medications at school, due to the reduced school nurses budgeted and utilized full time in public schools, they are often not the ones disbursing or monitoring medications in public schools, including EBD settings (Academy of Pediatrics, 2009). According to the
National Association of School Nurses (NASN), there is one nurse per 750 students in Minnesota public schools (American Nurses Association, 2010). For this reason school nurses are spread between multiple schools to serve the needs of students with medical and medication needs. Interestingly, there is little written on the effects of inconsistent medication distribution in children with mental health concerns and the possible impacts on mental health and academic progress.

**Medication Side Effects and Impacts on Children in the Classroom**

The three most commonly diagnosed psychiatric disorders in EBD-labeled children are disruptive behavioral disorders, notably oppositional defiant disorder (ODD) and conduct disorder (CD), Attention Deficit Hyperactive Disorder (ADHD), and mood disorders such as, depression, anxiety, and bi-polar (Donatelli, Ellis, Hampton, Landrum, & Singh, 1994). More often then not, the disorders were comorbid; meaning there was more than one diagnosis assigned. Consequently, most students diagnosed with these disorders, have more externalizing behaviors (Donatelli et al., 1994).

Research indicates that it is of particular importance that educators be conversant about the area of psychopharmacology so they can observe drug effects and correspond with physicians (Donatelli et al., 1994). Additionally, research shows that educators are not particularly well informed in the fundamentals of psychopharmacology (Donatelli, et al., 1994). Educators need more immediate familiarity with psychotropic medications to better serve the needs of and plan more effective interventions for their students (Mattison et al., 2014).

Mattison et al. (2014) claims that special educators should be better trained in psychotropic knowledge in order to become improved reporters’ to prescribing physicians to help determine the successes and potential side effects of the medications being prescribed to EBD students.
Teachers and educators understanding the effects, both good and adverse, of medications will not only help aid the prescribing physician, but in a like manner, will be assisting psychiatric researchers assess the impact of medications on children (Mattison et al., 2014). Medications thus far have been proven to reduce the symptoms of mental disorders in children. Unfortunately, there is an increase in risk for adverse effects of medication in children (Griffith & Huefner, 2014). The goal of these medications is to use only as much as any child needs and no more than necessary (Griffith & Huefner, 2014). Educators, including teachers, usually have no training or education on how to monitor the effects of medications in the classroom. There should be a clear protocol to follow regarding things to look for and who, when, and where to report the findings. In addition, teachers and educators need to be aware the side effects of psychotropic medication and be knowledgeable about how the side effects impact students during school so they can better prepare classroom interventions based on anticipated changes in behavior and/or side effects.

**Cohesion and Co-Management**

According to Smith, Katsiyannis, Losinski, and Ryan. (2014) “Not including school staff in the pharmacological process may limit the potential benefits a medication might afford a child, and negatively impact their educational performance” (p. 712). It thus would appear that it is in the best interest of children to have their support systems be as collaborative as possible, so as to provide the best all-encompassing support structure. Not only are educators often the first to notice and indentify the need for assessments and services they are often the ones managing the presenting behaviors and deficits (Smith et al., 2014).

Indeed, optimizing the effects of a psychotropic medication is greatly enhanced by educators, including teachers, collaboration with prescribing physicians and psychiatrist.
Prescribing physicians do not appear to obtain feedback from educators regarding the effects of the medications, except those for ADHD and disruptive behavior disorders (Mattison et al., 2014). Moreover, it is important that prescribing clinicians have a clear picture of the child’s functioning in multiple environments. For instance, Mattison et al. (2014) states, “A student may be stable at school but not at home, and a medication adjustment to calm anger at home may lead to sedation at school and worsening academic performance” (p. 6). Finally, in a survey published in the *International Journal of Special Education*, Bowman et al., 2006 reported that teachers agreed that most EBD-labeled children are more teachable when properly treated with medication.

While parents believe they should be the first and primary contact regarding questions or concerns of medication, they are in support that educators should have an active role in the communication with physicians (Andrews, 1991). It is imperative that all caretakers are observing children and questioning, and noting, any side effects. A multi-environmental observation and communication approach provides a baseline behavior and comparison behavior for the prescribing physician to assist them to manage and properly prescribe medications (Katsiyannis & Ryan, 2009).

**Medication and Therapy**

Managing emotional and behavioral disorders can be accomplished in several ways. One of the paths to treating EBD-labeled children is to eliminate the symptoms as early as possible. Other ways to manage the challenges EBD-labeled children face are medication, psychotherapy, and school-based interventions (Konopasek & Schoenfeld, 2007). Though not widely studied, initial reports indicate the combination of behavior therapy and medication is necessary to produce lasting improvements in the lives of EBD-labeled children (Parens & Johnston, 2011).
For example, one study explained how children labeled as having bipolar disorder and receiving one or more psychotherapy treatment in combination with medication, are more likely to recover from an acute episode than those just taking medication (Cleek et al., 2014). While often times the public pits medical treatment against psychosocial interventions, most disorders respond better to a combination of medication and psychosocial treatments. For one thing, it seems the use of medication quickly reduce the severity of symptoms, allowing parents to engage in psychosocial interventions (Albano et al., 2004). Above all, the two treatments are not in opposition—they are additive and complimentary (Curry et al., 2006).

In fact, according to Hollon, Stewart, and Strunk (2006), “Not only do psychosocial treatments reduce existing distress or improve functioning, they are believed to do so in a manner that produces lasting change over time (p. 286).” Likewise, some therapies have been proven to reduce relapse in children being weaned off of medication” (Lau, Ridgeway, Segal, Soulsby, & Teasdale, 2000, p. 615). In addition, several studies have proven that cognition does not change over time in therapy, however, there does appear to be a change in information processing, such as core beliefs about the self. It is only in recent years that psychosocial interventions have been used adjunctively and research has proven their value (Hollon, Stewart, & Strunk, 2006).

When medication and psychotherapy were compared for effectiveness, “the combination of the two was whoppingly more effective than either one alone” (Carey, 2008, p. A15). In a study released by the New England Journal of Medicine in 2008, research concluded that children with emotional disorders were most likely to recover when using a combination of medication and talk therapy. After reviewing the study in the New England Journal of Medicine, Dr. Sanjiv Kumra, Director of the Child and Adolescent Psychiatry program at the University of Minnesota replied, “It’s surprising that they found such a dramatic difference between
combined treatment and the others” (Carey, 2008, p. A15). Dr. Kkumra’s conclusion was that these findings should bring reassurance to parents regarding both medicating and participating in psychotherapy in combination with their child (Carey, 2008).

An Adlerian Perspective

Childhood Disorders

With regard to the behavior disorders of children, Adler’s conviction is that the difficulty children experience is a result from an, “early-established neurotic disposition, which is based on an early mistake in judgment” (Ansbacher, & Ansbacher, 1964, p. 392). These early dispositions include:

(1) Habit disorders (Adler, 1931). Bad habits are explained as the child’s “clear indications of a development in opposition to the demand of the community.” The child is simply doing “business in the interest of his sense of power by appropriately utilizing and varying his drives” (Ansbacher, & Ansbacher, 1964, p. 387).

(2) Fears (Adler, 1931). According to Adler, fear can attract attention and be built into a child’s lifestyle. Consider for instance, a child’s fear to, “secure their goal of regaining connection with the mother” (Ansbacher & Ansbacher, 1964, p. 389). A child might exhibit this fear by having nightmares at night to bring their mother closer to them.

(3) Stuttering (Adler, 1930). Is defined as the, “conscious control of a function which should operate automatically” (Ansbacher, & Ansbacher, 1964, p. 389) resulting in a child paying too much attention to his speech causing him to stutter.
(4) Overt Aggression (Adler, 1930). “When the desire for self-assertion becomes extraordinarily intense, it will always involve an element of envy.” (Ansbacher, & Ansbacher, 1964, p. 389). This is an example of children wishing others ill will, do harm to others, make trouble, and put others down. The child initiates competition with others.

(5) Daydreaming and Isolation (Adler, 1930). It is explained by Adler as a child’s form of striving through isolation, which often indicates extreme sensitivity. Adler states the child, “has no faith in his ability to achieve success by the usual means, and as a result avoids all means and opportunities for success by the usual means” (Ansbacher & Ansbacher, 1964, pp. 390).

(6) Laziness (Adler, 1930). Adler explains the lazy child may be lazy in an attempt to ease their situation. Thus when a lazy child does something, even minor, it receives exaggerated acknowledgement from others.

(7) Lying and Stealing (Adler, 1930). According to Adler, “Lying is a compensation to keep the inferiority feeling from manifesting itself” (p. 391). The two forms of lying are lying out of fear, and lying to seem superior than they feel. Stealing is explained by Adler as a child’s way to, “escape a stronger person, or a cunning means to catch up with him” (p. 391).

**Treating the Child**

Adler treated children different than adults. When Adler conducted therapy with children, he did so in front of an audience (Adler, 1927). The purpose was that he could help more children if he could help educators in school understand the children they teach. So teachers and
parents of children were often the audience during therapy with children, having an audience it
turns out was therapeutic itself (Ansbacher & Ansbacher, 1964).

Adler’s first goal when working with children was to review the case and “discern basic
underlying facts, which are the goal and guiding idea around which the whole life-style has been
develop and organized” (Ansbacher & Ansbacher, 1964, p. 393). Once Adler understood that,
Adler believed he could then understand that what ever was going on with the child was directly
related to the circumstances. When examining the lifestyle of a difficult child, Adler understood
that all behavior grows from a direction in movement born of misconceptions, or patterns of

The Parents

According to Adler, “Parents are not responsible for all the bad qualities the child shows
(1930, p. 395). Adler further asserts that it is much more impactful to work with the parent than
to blame them. Adler encourages those working with parents to validate their concerns and lift
the burden of critiquing them. Adler stated, “it is impossible to modify an entrenched system
with few words” (Adler, 1930, p. 395).

The Individual Child in School

Adler describes school an intermediate space between home and society (Ansbacher &
Ansbacher, 1964). According to Adler a child at school has an opportunity to correct their,
“mistaken styles of life formed under family upbringing, and the responsibility of preparing the
child’s adjustment to social life” (Adler, 1930, p. 399). Adler viewed the school as a place for a
child to strive for social interest (Ansbacher & Ansbacher, 1964). The educators most important
job is to make sure children are not discouraged at school and if they are discouraged when they
arrive at school to encourage them by empowering them and making the child more independent.
The goal should be to convince the child that can achieve what they have not yet by perseverance, practice, and courage (Ansbacher & Ansbacher, 1964). Adler encourages educators to put tasks in front of the child, which they know the child can accomplish, so they can build self-esteem.

According to Adler (1930), education is the development of the individual through courage and training. Hence, children never have bad intentions instead they are utilizing the useless acts of life in an attempt to be acknowledged. Adler encourages educators not to engage in power struggles with children, but to try to understand their mistaken beliefs (Adler, 1930).

According to Adler, the classroom is a family made up of equal parts (Ansbacher & Ansbacher, 1964). For this reason, Adler insists that children who are difficult are quickly cured of their difficulty simply through social interest with their classmates. Adler insists it is important for educators to know their students intimately. Educators knowing their students will make it much easier to understand the child’s mistaken lifestyle and to create the best classroom environment for the children (Adler, 1931).

**Mistaken Goals of Misbehavior**

Rudolf Dreikurs, a psychiatrist and educator, helped to develop a working model for misbehaving children based on Alfred Adler’s concept of individual psychology in children. Dreikurs organized a group in 1952, named The North American Society of Adlerian Psychology. He led this group until his death in 1972. In *Children: The Challenge* (Dreikurs, 1964) he explains children’s misinterpreted pursuit with *the 4 mistaken goals of misbehavior*. The first of these goals is undue attention. According to Dreikurs, this is always the first of the four mistaken goals to be acted upon. According to Dreikurs (1964), “Influenced by his
mistaken assumption that he has significance only when he is the center of attention, the child develops great skill at attention-getting mechanisms” (p. 58).

The second goal of misbehavior is the struggle for power (Dreikurs, 1964, p. 61). The struggle for power happens when a child uses his power to be defiant in requests of his parents. As a result, the child feels a sense of satisfaction and power from the defiance and feels if they were to follow directions, they would lose their personal value. Dreikurs encourages adults not to get into power struggles with children, which only sharpens the child’s defiance skills and frustrates the adults.

The third mistaken goal of misbehavior is revenge. The consequence and build up of the first two goals, result in retaliation and revenge (Dreikurs, 1964). According to Dreikurs (1964), a child seeks revenge as a means to make themselves feel significant. For this reason, it is the child’s intent to hurt others, as they have been hurt. Consequently, to the child the revenge feels just and is powerful. As a result, the child feels unlikable and discouraged and thus is intent to convince others of their unworthiness.

The fourth and last mistaken goal is complete inadequacy. Dreikurs (1964) explains this concept as, “a completely discouraged child who gives up entirely” (p. 63). Because of this feeling, the child is hopeless that his efforts will be futile, so why bother. The goal of inadequacy is acted out, “exaggerating any real or imagined weakness or deficiency, to avoid any task where his expected failure may be even more embarrassing” (Dreikurs, 1964, p. 63).

These four mistaken goals of misbehavior, according to Dreikurs (1964), are always present in disturbing behavior. The goal of the behavior is always for a child to find their place. As adults, we can only do our best to stimulate a child toward improved behavior. We do not always succeed, as children have their own minds and ideas of what they will do. Thus, it is
important that adults do not always assume responsibility for a child’s decisions. In short, “Life consists only of the present moment, and if we do the right thing at this moment, we move toward improvement” Dreikurs (1964, p. 66). The key is for adults to learn to really understand children. The more adults can help children reorient themselves, the more accurate picture of life a child will develop (Dreikurs, 1964).

Other Adlerian concepts’ relating to children Dreikurs explains are those of mutual respect, encouragement, and natural and logical consequences (Ansbacher & Ansbacher, 1964). Mutual respect is the notion that we are all equal human beings, children included (Ansbacher & Ansbacher, 1964). Adults, who show respect and win a child’s respect in return, teach the child to respect themselves and others. Given these points, encouragement implies the acceptance of a child as they are (Dreikurs, 1964). Lastly, natural consequences in lieu of punishment and reward are explained as the direct result of a child’s behavior (Ansbacher & Ansbacher, 1964). In all, logical consequences are a direct and logical consequence of transgression.

In summary, an Adlerian approach to understanding misbehaving children is often what comes naturally when we as adults are in our best mental place (Ansbacher & Ansbacher, 1956). The notions of Adler’s approach are fundamental and stem from a baseline of calmness and the interest in people as individuals, even children. The basis of Adlerian theory is adults must encourage children and lead by example (Ansbacher & Ansbacher, 1964). Adults are encouraged not to lend energy to struggles of power and to empower children by not doing things for them that they can do for themselves. At last, understanding the goals of children and using the concept of mutual respect will allow adults to come from a place of wholeness and use their best judgment with children.
Conclusion

The lack of understanding and education of EBD-labeled children cannot be understated or minimized. These children are often the most challenging and they deserve to learn from the most educated and equipped educators (Kramer et al., 2006). Further, the financial barriers to families are wide and deep. It is essential we better education of parents of all of the options when treating their child. Finally, access to psychotherapy treatment, parallel with medical treatments is not only the best long term prognosis, but also gives families and educators better training and awareness of how to best cope with an often difficult child (Parens & Johnston, 2011).

Given these points, streamlining the mental health process for children, including medication is of the utmost importance. There should be a strong urge on behalf of the public to ensure children dealing with emotional and behavioral disorders receive the full range of services as efficiently as possible. Above all, the recent trend in school violence should bring about the catalyst for such change. The role of medical insurance and healthcare providers needs to be evaluated to ensure that children have financial access to the different forms of treatment needed, without having to wait six months to receive them. Additionally, the power of the drug companies to control the pace to which the effects of medications are studied, has to be investigated. Due to financial incentives for drug manufacturers research on possible adverse effects on innocent children are often overlooked (Parens & Johnston, 2011). There needs to be more regulations in place to manage the control any profitable industry has in the health and well-being of children.

EBD-labeled children are children first. They deserve what all children in society are offered, including access to care that is desperately needed, the most supportive parents who
receive support as well as the most informed and aware teaching staff and tools to ensure their success in school and in greater society. EBD-labeled children are not to be tolerated, but rather to be cared for as equal members of a society. In conclusion, many of the questions that are born of society’s judgment of how people end up, are built upon the backs of children who struggled without proper support from the beginning of life.

**Future Considerations**

The need for research on the effects of medication in children has been referenced in numerous articles by authors writing on this subject as referenced earlier in this paper. The subject of research on psychotropic drug effects on children cannot be dismissed. Thus, there has to be a push from society to ensure that the medications prescribed to children are safe for their developing minds and bodies. Equally important, educating parents, educators, and childcare workers with regard to how these medications affect children and key symptoms to note. On the whole, the need for parents and educators to understand mental health and mentally ill children is critical.
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