PRESCRIPTIONS FOR CHILDREN WITH PSYCHOLOGICAL AND PSYCHIATRIC PROBLEMS

A CONSULTANT'S DESK REFERENCE

FOURTH EDITION

David F. Bogacki, Ralph F. Blanco,
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Fourth Edition

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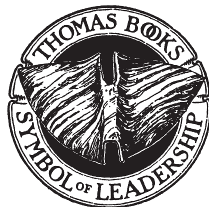

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PREFACE

The first edition, *Prescriptions for Children with Learning and Adjustment Problems*, was published in 1972 (Blanco) and was created to fill a specific need of school and clinical psychologists, guidance counselors, social workers, school personnel, and graduate students in those fields. It became apparent to the author that there were insufficient references dealing with intervention techniques and treatment for troubled children with mental and physical problems. Although there were many books and articles dealing with diagnostic instruments, too few dealt with a wide variety of treatments in school and clinical settings. Of course, treatment plans now include psychotherapy, with various theoretical foundations, along with behavior modification, cognitive behavior therapy, group therapy, psychiatric intervention, etc. Unfortunately, several of these effective treatments are not yet available in school settings, even though most children who are disabled need multiple interventions at one time. It is clear to those who render professional services that they need to use effective and practical prescriptions for not only the children, but also for the children's parents. It was apparent in earlier times that psychology was long on diagnosis but short on treatment.

As an example of thoroughness of the science of medicine with its long history, the *Merck Manual of Diagnosis and Therapy* contains a dazzling compilation of medical symptoms, diagnoses, and respective treatments written by physicians for physicians. Their often-revised desk reference is invaluable to medical doctors. Not only do physicians use the book, but also many related professionals refer to it for critical information. Other references could be offered such as *The Pediatric Patient and Current Therapy: Approved Methods of Treatment for the Practicing Physician.* Fortunately now, computerized medical information is easily assessable and, to a lesser extent, some quality information is computerized in psychology as well. Handbooks and desk references, used to refresh one's memory bank, still have value in the profession office.

In the professions of psychology and education, regarding children's symptoms, diagnoses, and treatments, a similar desk reference is absent.

In brief, the mission of the author's first edition was to accumulate appropriate psychological and educational prescriptions, strategies, and treatment

plans for children and adolescents. A nationwide survey was developed through grants from Temple University (the author's base) and the Department of Health, Education and Welfare, Bureau of Education for the Handicapped in Washington, D.C. The author attempted to entice experienced psychologists who were members of the Division of School Psychology of the American Psychological Association to contribute to a special survey. They were asked to write their "best prescriptions and recommendations" for school-age children and adolescents who manifested a wide range of symptoms of behavior, learning, emotional and physical problems. Each psychologist received:

1. A cover letter explaining the purpose of the survey from the then president of Division 16 (School Psychology).
2. An extensive list of symptoms from a psychiatric listing to identify problem areas of school children.
3. Instructions on how to respond to the survey.
4. A personal data sheet regarding their academic and professional backgrounds.
5. The author's then-unpublished "Fifty Recommendations to Aid Exceptional Children" as a model for their prescriptions.
6. After they sent their contributions, they then received an additional "One Hundred Recommendations to Aid Exceptional Children."
7. Later, all the contributors received a notice of a forthcoming book with their edited recommendations.

All the 146 contributors were listed in the first edition. All had earned a Ph.D., Ed.D. or master's degree plus considerable field experience with children, parents and teachers. The survey resulted in obtaining over 3,000 prescriptions which were then edited for clarity. (For current readers interested in the methodology and details of the survey, it is suggested that they search in the Library of Congress for Catalog Card Number 72-75908, ISBN 0-398-02533-7, a copy of the first edition). Temple University and the Department of Health, Education and Welfare received one-half of the ensuing royalties. The third edition (1988) was rewritten and significantly enhanced by co-author, David F. Bogacki, Ph.D.

During the initial research effort, a small, unpublished study was undertaken at Temple University that sought the reactions of special education teachers in two classes to the written reports of their school psychologists. Their responses are below:

1. The school psychologist does not suggest methods of approach to remedy the individual child's problems, and thus, I get no real help.

2. Reports are too sketchy for specific recommendations and do not tell me what to do to change the situation.
3. Should list specific weaknesses of the child with suggestions on helping the child develop.
4. I get only an “official label.” The psychologist only described the problems; what about ideas to help the child?

The same teachers also indicated:

1. The psychologist is not given enough time to counsel the teacher since there aren’t enough psychologists to go around; they have too many cases and are overworked.
2. My school psychologist is really capable.
3. Some psychologists would like to spend time in developing remedial programs.

A disappointing litany of written prescriptions illustrates the problems of certain school psychologists in their reports after assessing the children who were referred for evaluation:

1. This boy has a weak ego. He has not had adequate opportunity for growing pains. Give him an opportunity to make mistakes.
2. Time, patience, and a manifest faith in this girl would seem to be a good beginning in helping her to respond to her environment.
3. There is evidence of disorientation and disorganization. Give him library books to take home. This should help a lot.
4. Mary may be a slow learner due to her lack of intellect. Help her.
5. He needs experiences to regain a feeling of self-worth. There are either neurological, emotional, or family problems present; the parents should let him be independent.
6. Provide the child every opportunity for success. Meet the child’s needs. The teacher should offer various methods of instruction to aid academic work.

Since the publications of the third edition of *Prescriptions for Children* approximately 30,000 copies of the book have been sold, mainly to school and clinical psychologists, counselors, special education personnel, and graduate students. Hundreds of notes and letters sent to the authors revealed the appreciation of readers. Many have requested an expanded edition to include a greater array of prescriptions for children who are disabled with a focus on children in preschool and who are developmentally delayed, plus ideas for professionals in private practice. Obviously, no reference book in applied

psychology can equal the stature and scope of the previously noted *Merck Manual of Diagnosis and Therapy* for medical personnel. The discipline of medicine has developed an incredible and enviable knowledge base for action. Scientific psychology, by comparison, even with its remarkable gains over the past 50 years, has the proverbial "long way to go" in contributing to the three goals of science: understanding, prediction and control.

Certainly, none of the listed prescriptions are guaranteed to minimize symptoms. A treatment plan that may seem initially appropriate may later have to be adjusted or discarded. It depends on the therapist's judgment and other variables. Knowing these conditions, the professional should regard all treatment considerations as suspect, as experimental, and as subject to change without notice, or at least as far as the facts allow. An analogy here relates to penicillin in that this medication has been extremely beneficial for most people with specific medical problems, but sometimes harmful to others.

Experienced psychologists know that even the best prescriptive intervention will be ineffective if the teacher, parent or primary caregiver dealing with the child who is disabled is resistant to changes or too reluctant to help the child. It is essential that an excellent relationship be present for success. This often can be accomplished by using the following abbreviated consulting approaches: expert listening, the manifestations of caring behavior, the reflection of feeling tone, the recognition of the complicated aspects of the case, and the regarding of the other professions on a co-equal basis. Such consulting skills are not easy to learn and certainly do not minimize the problems in every case.

R.F.B.

THE ISSUE OF VALIDITY

It is appropriate to discuss, briefly, the efficacy of the specific recommendations in the book. Portions of the suggestions already have been experimentally or clinically verified utilizing behavior modification techniques. Additionally, they are valid for some circumstances and not others, and their appropriateness is dependent on professional judgment, and then the results of actual application. Naturally, each case is different. What is a sensible treatment approach for one child may be unthinkable for another. Counseling may be effective with a depressed child who has lost a parent, but residential care may be mandatory for another with self-destructive behavior or severe drug addiction.

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A NOTE ON GENDER SELECTION FOR PRONOUNS

The authors have decided, for the sake of grammatical simplicity, to refer to the child who is exceptional or disabled as "he" rather than the more accurate pronouns of "he" or "she." Males, rather than females, more often are represented in most handicapping or debilitating conditions (with exceptions such as anorexia nervosa, bulimia, etc.). Also, since prescriptions are focused more often at the primary and elementary grades than at middle or secondary levels, and since most teachers are females at the earlier grade levels, the term "she" for the teacher has been consistently used rather than the words "he" or "she." We trust that the reader will accept the adjustment.

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Grateful acknowledgment is given to the Group for Advancement of Psychiatry for permission to reproduce a portion of their Symptom List in Psychopathological Disorders in Childhood: Theoretical Considerations and a Proposed Classification, Report No. 62, 1996, and to the American Psychiatric Association for portions of the diagnostic nomenclature from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV: APA, 1994).

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PRESCRIPTIONS FOR CHILDREN WITH PSYCHOLOGICAL AND PSYCHIATRIC PROBLEMS

Chapter 1

USING THE CDR PROFESSIONALLY

A. PROCEDURAL GUIDELINES FOR DIAGNOSTIC EVALUATION

The procedures employed for psychological assessment, treatment, education, or counseling largely depend on the view of "human nature" to which one adheres. Treatment recommendations follow directly from presuppositions and conceptions of normal and abnormal behavior, personality development, human motivation, and causation.

Assessment of underlying personality provides little information that can be used for a selection of a particular therapeutic treatment (Peterson, 1968) or educational strategy (Blanco, 1978; Hewett, 1968). The failure of assessment and diagnosis to be related precisely to treatment has been a great concern of psychologists (Kanfer & Phillips, 1970; Goldstein & Hersen, 1984).

While the authors have found through their clinical experiences that behavioral approaches provide more clinical utility in arriving at prescriptive interventions, other models for viewing the etiology of educational or emotional dysfunction are not discarded, nor are they contraindicated for use. Rather, emphasis is placed on environmental, situational, and social determinants that influence behavior as judged by the clinician or consultant on the particular case. In addition to behavioral interventions, there also are a number of recommendations derived from need theory, as well as from a psychodynamic viewpoint.

It is believed that a general adherence to the following diagnostic procedures and practices will increase the value of the prescriptions contained in this volume. The sequence of the procedures may be varied as consequences require.

Comprehensive diagnostic assessment is mainly reserved for complicated and critical problems rather than minor ones. It also is true that expert consultation without psychometric assessment in casework may resolve problems and change behaviors that were earlier believed to require nothing less than

full evaluation and major therapeutic intervention. When diagnostic work is necessary, however, a step-by-step listing may be helpful to the psychologist-in-training in structuring plans for assessment and may guide clinicians in using the prescriptions for greatest advantage. A comprehensive evaluation requires that the clinician:

1. Obtain extensive information and data about the problems with the referred child via the referring agent or a comprehensive referral form, but reserve special consideration about the motives and biases of the referring agent. Determine the problem behaviors as precisely as possible, and obtain baseline measures when appropriate.
2. Gather relevant school data about the child through a personal study of longitudinal and cross-sectional information in cumulative folders, as well as from past and present teachers, administrators, and counselors. Learn much from the teacher through her perceptions and attitudes. This review of observations ordinarily includes reports of quantitative and qualitative information about learning strengths and disabilities, social and personal characteristics, special problems, family concerns, and test scores of intelligence and achievement to help create diagnostic hypotheses.
3. Secure written permission of the parents to begin a comprehensive psycho-educational assessment of their child, should such an evaluation be deemed necessary. Obtain parents' signatures on Release of Information forms so that an exchange of information may begin with the child's physician and any social agencies assisting the family. Investigate sensory and physical contributions to the child's problems.
4. Observe the child in his classroom. At the elementary level, determine the teacher's expectations through interview, her specific approaches to the child in the class, the social roles operating, and the general learning atmosphere of the class, school, and community. Record normal as well as atypical behavior of the referred child. Do not focus on the pathology alone. At the secondary level, consult with guidance and administrative personnel about the scope and intensity of the problem as revealed to them by teachers.
5. Interview both parents to determine their (1) perceptions of the child, (2) aspirations for him, (3) plans for his future, and (4) problems concerning him and his adjustment and learning. Obtain an extensive social, educational, and occupational history on both parents. Obtain a detailed developmental history that is both medically, psychologically, and educationally relevant. Determine how the parents have helped or hindered the child. Communicate to them that the clinician is their advocate as well as their child's. Grasp their respective value systems,

as this will be extremely important in recommending certain prescriptive interventions that must be reasonably congruent with their style and belief system.

6. Begin the first contact with the child being respectfully sensitive to their initial apprehensions, values, and concerns. Complete the appropriate testing, suited to the essential problems earlier stated, especially if these relate to intelligence, achievement, perception, personality, and development; conduct an in-depth clinical interview. Verify, refute, or refine the original diagnostic hypotheses.
7. Integrate the data to determine the most comprehensive and specific psycho-educational diagnosis with a grasp of etiological conditions and with reference to both quantitative and qualitative information. Recognize that most cases not only have multiple problems; they also have multiple diagnoses and multiple treatments.
8. The primary purpose of a diagnostic evaluation is to create unique recommendations to minimize, modify, or extinguish the problems and contributing factors, thus enhancing the probability of changing ineffective or maladaptive behavior or learning. These first prescriptions should arise from the clinician's own resources: experience, theory, practice, and relevant text and journals suitable to the child's problems.

B. THE SELECTION OF PRESCRIPTIONS FROM THE CDR

9. The next important step is to isolate the correct chapter and subheadings in the CDR relevant to the child's behavior disorder, symptom complex, or diagnosis. From these terms, select the section relating to treatment for that specific problem from the Table of Contents or Index. Become familiar with the general content of each chapter in terms of interventions, and attempt to apply them after refinement for the particular case (e.g., age, sex, ability, family value system, achievement). As noted earlier, the Table of Contents has been organized in such a way as to follow the current classification scheme of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 2013 of the American Psychiatric Association as well as the special education classification system used by most school psychologists. Thus, those who are familiar with these classification schemes will be familiar with the appropriate chapter headings or diagnostic classification to help readily locate specific recommendations for a given problem. For those not so familiar with DSM-V, they should have little difficulty with familiarizing themselves with the major diagnostic categories that reflect various behavioral problems.

Once the appropriate section relating to the treatment for that difficulty has been located in the Table of Contents or Index, disregard recommendations that may be administratively convenient but inappropriate for the child. Omit those that are not reasonably congruent with the values of the home and school personnel.

10. Next, discuss the recommendations selected and their educational implications with school personnel; encourage understanding of the child's problems and contributing factors while developing additional prescriptions in the continuing relationship with the teacher and administrator.
11. While meeting with both parents, discuss the original problems, contributing factors, test scores, and a meaningful interpretation of the diagnosis in language that the parents are able to understand. Do not attempt to teach them scientific terminology at the feedback session. Explain the unique recommendations appropriate to the child and to them in an effort to develop their acceptance and future implementation. Listen to their objections and refine those recommendations that are unsuitable from their perspective.
12. Write a comprehensive psychological report, noting baseline behaviors, a summary of the highlights listed in the previous steps, the diagnostic impressions and the prescriptions determined to be acceptable in the school and home. Recognize that this report is a legal document that can be read by the parents, subpoenaed in court, and possibly seen by the child in later years. Followup with the case extensively.

Consistent with the *Ethical Standards of Psychologists* (APA, 2010), psychologists only recommend interventions that are consistent with their training and experience. It is not advisable to prescribe interventions that the psychologist or another professional (e.g., tutor, physician, teacher) does not have the experience or capability to implement directly. Thus, one measure of a psychologist's skill level is the number of prescriptive interventions he/she or a responsible colleague can effectively carry out. Of equal importance is the consultant's ability to teach interventions to others involved in the child's overall treatment. Lastly, monitor, revise, and continuously fine-tune prescriptive interventions throughout the overall course of treatment.

The authors have a firm professional belief that consultants assume responsibility for the implementation and follow-up of all recommendations made during the consulting process. To this end, recommendations should be consistent with the level of expertise and the ability to carry out a prescribed intervention by the parent, teacher, or others involved in treating the child.