Promoting Health *and* Emotional Well-Being *in* Your Classroom

Fifth Edition

Randy M. Page | Tana S. Page

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Preface

This *Fifth Edition* of *Promoting Health and Emotional Well-Being in Your Classroom* is a solid, exciting, enjoyable, relevant, and cost-efficient textbook for those who want to make a significant difference in the lives of young people. It has been designed to provide pre-service and current teachers with all of the information and tools needed to be effective at promoting healthy life choices. Those working with elementary or secondary students will greatly benefit from studying and applying the contents of this text.

The framework of this text is based on the National Health Education Standards and the Centers for Disease Control and Prevention's six risk behaviors. Chapters 1 and 2 are foundation chapters that focus on characteristics and practices of highly effective teachers and professionals. Chapters 3, 4, and 5 address the life skills called for in the National Health Education Standards; these skills are essential for emotional well-being and avoidance of risky behaviors. Chapters 6, 7, 8, and 9 look carefully at the CDC's six risk behaviors and discuss how to effectively promote healthy behaviors. Chapter 10 concludes the text by addressing the critical issues that those working with adolescents should be prepared to deal with.

The design of this text facilitates sound, simplified health instruction planning. We present the life skills at the beginning of the text so that you can integrate these skills into the risk behavior topics that follow. With this organization, health instruction can be condensed into four units: healthy eating and physical activity; tobacco, drugs, and alcohol; sex education; and safety and violence prevention. You can address disease, community, and personal health issues within these four units. A fifth unit on mental health, which encompasses all of the life skills, also can be used. We are not proposing that all health instruction be organized in this manner, but this simplified structure facilitates easy adaptation into other curricular frameworks and makes it easier for new teachers to organize their health instruction. Most important, this framework ensures that the most essential content is addressed.

This edition "has it all" while remaining small enough to easily fit in your hand. The writing style is warm and engaging, and you will find its content immediately relevant—both personally and professionally. The text includes the following items:

- A story at the beginning of each chapter to help you focus on the subject.
- An application exercise in each chapter for you to review your knowledge, habits, and attitudes regarding chapter content.
- Health Education Curriculum Analysis Tool (HECAT) guidelines and modules.
- Twenty-first century skills.
- Up-to-date facts and figures regarding health risks and behaviors; each chapter identifies why its content is relevant and important.
- More than 275 interactive assessment and learning activities, more than half of which are new to this *Fifth Edition*. Each risk behavior chapter includes activities for advocacy, family and community involvement, and integration into core subjects including math, language arts, and social studies.
- Referrals to free downloadable lesson plans and teaching resources for every grade level in each risk behavior chapter.
- Referrals to free web-accessible teaching resources—including videos, games, fact sheets, interactive programs, posters, and handouts—in each risk behavior chapter.
- Chapter review questions.
- Online **Instructor Resources**, including PowerPoint presentations, TestBank questions, sample syllabus, and additional assigments and activities. Contact your sales representative for more information.

Promoting Health and Emotional Well-Being in Your Classroom, Fifth Edition, examines a myriad of issues facing today's students. We hope that the guidance and resources in this book leave you feeling empowered and inspired to make a difference in the lives of young people. We wish you success as you apply these tools and skills in your classroom.

Acknowledgments

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1

Teaching to Make a Difference

Cipher in the Snow

It started with tragedy on a biting cold February morning. I was driving behind the Milford Corners Bus as I did most snowy mornings on my way to school. It veered and stopped short at the hotel, which it had no business doing, and I was annoyed as I had to come to an unexpected stop. A boy lurched out of the bus, reeled, stumbled, and collapsed on the snowbank at the curb. The bus driver and I reached him at the same moment. His thin, hollow face was white, even against the snow.

"He's dead," the driver whispered.

It didn't register for a minute. I glanced quickly at the scared young faces staring down at us from the school bus. "A doctor! Quick! I'll phone from the hotel. . ."

"No use. I tell you he's dead." The driver looked down at the boy's still form. "He never even said he felt bad," he muttered, "just tapped me on the shoulder and said, real quiet, 'I'm sorry, I have to get off at the hotel.' That's all. Polite and apologizing like."

At school, the giggling, shuffling morning noise quieted as the news went down the halls. I passed a huddle of girls. "Who was it? Who dropped dead on the way to school?" I heard one of them half-whisper.

"Don't know his name; some kid from Milford Corners," was the reply.

It was like that in the faculty room and the principal's office. "I'd appreciate your going out to tell the parents," the principal told me. "They haven't a phone and, anyway, somebody from school should go there in person. I'll cover your classes."

"Why me?" I asked. "Wouldn't it be better if you did it?"

"I didn't know the boy," the principal admitted levelly. "And in last year's sophomore personalities column I note that you were listed as his favorite teacher."

I drove through the snow and cold down the bad canyon road to the Evans' place and thought about the boy, Cliff Evans. His favorite teacher! I thought. He hasn't spoken two words to me in two years! I could see him in my mind's eye all right, sitting back there in the last seat in my afternoon literature class. He came in the room by himself and left by himself. "Cliff Evans," I muttered to myself, "a boy who never talked." I thought a minute. "A boy who never smiled. I never saw him smile once."

The big ranch kitchen was clean and warm. I blurted out my news somehow. Mrs. Evans reached blindly toward a chair. "He never said anything about bein' ailin'."

His step-father snorted. "He ain't said nothin' about anything since I moved in here."

Mrs. Evans pushed a pan to the back of the stove and began to untie her apron. "Now hold on," her husband snapped. "I got to have breakfast before I go to town.

Nothin' we can do now anyway. If Cliff hadn't been so dumb he'd have told us he didn't feel good."

After school I sat in the office and stared bleakly at the records spread out before me. I was to close the file and write the obituary for the school paper. The almost bare sheets mocked the effort. Cliff Evans, white, never legally adopted by his stepfather, five young half-brothers and sisters. These meager strands of information and the list of D grades were all the records had to offer.

Cliff Evans had silently come in the school door in the mornings and gone out the school door in the evenings, and that was all. He had never belonged to a club. He had never played on a team. He had never held an office. As far as I could tell he had never done one happy, noisy kid thing. He had never been anybody at all.

How do you go about making a boy into a zero? The grade school records showed me. The first- and second-grade teachers' annotations read "sweet, shy child," "timid but eager." Then, the third-grade note had opened the attack. Some teacher had written in a good, firm hand, "Cliff won't talk. Uncooperative. Slow learner." The other academic sheep had followed with "dull," "slow-witted," "low IQ." They became correct. The boy's IQ score in the ninth grade was listed at 83. But his IQ in the third grade had been 106. The score didn't go under 100 until the seventh grade. Even shy, timid, sweet children have resilience. It takes time to break them.

I stomped to the typewriter and wrote a savage report pointing out what education had done to Cliff Evans. I slapped a copy on the principal's desk and another in the sad, dog-eared file. I banged the typewriter and slammed the file and crashed the door shut, but I didn't feel much better. A little boy kept walking after me, a little boy with a peaked, pale face; a skinny body in faded jeans; and big eyes that had looked and searched for a long time and then had become veiled.

I could guess how many times he'd been chosen last to play sides in a game, how many whispered child conversations had excluded him, how many times he hadn't been asked. I could see and hear the faces and voices that said over and over, "You're dumb. You're a nothing, Cliff Evans."

A child is a believing creature. Cliff undoubtedly believed them. Suddenly it seemed clear to me: When finally there was nothing left at all for Cliff Evans, he collapsed on a snowbank and went away. The doctor might list "heart failure" as the cause of death, but that wouldn't change my mind.

We couldn't find 10 students in the school who had known Cliff well enough to attend the funeral as his friends. So, the student body officers and a committee from the junior class went as a group to the church, being politely sad. I attended the services with them, and sat through it with a lump of cold lead in my chest and a big resolve growing through me.

I've never forgotten Cliff Evans nor that resolve. He has been my challenge year after year, class after class. I look up and down the rows carefully each September at the unfamiliar faces. I look for veiled eyes or bodies scrounged into a seat in an alien world. "Look, kids," I say silently. "I may not do anything else for you this year, but not one of you is going to come out of here a nobody. I'll work or fight to the bitter end doing battle with society and the school board, but I won't have one of you coming out of here thinking himself into a zero."

Most of the time—not always, but most of the time—I've succeeded.

Source: Written by J. E. Mizer. Cipher in the snow. *NEA Journal.* 1964;50:8–10. Reprinted with permission. A movie of this story also exists and has the same title.

The potential for having a positive influence upon students is great, as is the need. Between the ages of 6 and 17, young people spend more time at school with their teachers than with their parents. Although it is an unrealistic expectation to succeed in helping every "Cliff Evans" feel better about himself or herself, there are countless young people who have been, and are yet to be, touched by a special teacher who makes a big difference in their lives. The purpose of this chapter is to give you information and insights into how to be such a teacher.

You Can Make a Difference

Education is all about influencing others. **Figure 1-1** depicts our **pyramid of influence** as teachers. It is interesting to note that even though most of our coursework in preparation for entering the teaching profession centers on the tip of the pyramid, it is the least influential area. We spend a great deal of energy learning how to write effective objectives and lesson plans, prepare materials, present information, and evaluate student learning. These are vitally important skills for educators. More vital and perhaps overlooked are the larger two areas of the pyramid. The foundation for influencing others is modeling, that is, being an example of what we are trying to teach. This includes the obvious, such as a teacher reading while having students do silent sustained reading or being a nonsmoker while discussing the harmful effects of tobacco. It also includes less obvious and, unfortunately, sometimes negative acts such as modeling dislike for things or people. The large midsection of the pyramid of influence deals with interacting with or relating to students. Our ability to influence here is exemplified by the saying "I don't care how much you know until I know how much you care." This chapter looks in depth at the bottom two sections of the pyramid. Chapter 2 is devoted to the top section.

Now that we have discussed our pyramid of influence, we need to consider our circle of influence. Have you ever stopped to think about your circle of influence? To better understand the concept, do the following activity. Use a

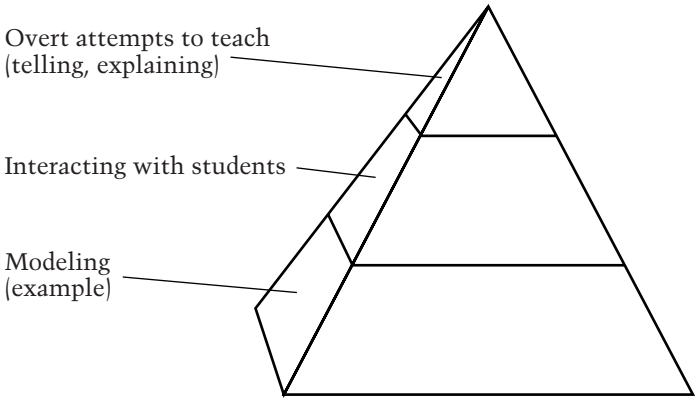

FIGURE 1-1 A teacher's pyramid of influence.
Source: Adapted from Covey SR. *Principle Centered Leadership.* New York: Fireside; 1990, p. 120.

sheet of paper and draw a large circle and label it your **circle of concern** (see **Figure 1-2**). Inside the circle write everything you are concerned about—from world peace to what you are going to eat for your next meal. Your circle might contain items such as these: kids living in dysfunctional situations, teen pregnancy, hatred, violence, bigotry, drug abuse, poverty, apathy, conflicts with roommates or family members, car problems, money for next semester, lack of parking on campus, an egotistical professor, a family member's health, obtaining a meaningful position within your career, paying bills, meeting deadlines, lack of time, or finding a soul mate. You will find that you can probably easily fill the entire circle with your specific concerns.

Next, draw a smaller circle within this large circle. Label this as your **circle of influence**. This smaller circle represents what you have control over—what you can influence. Now, think about the items within your circle of concern and ask yourself the following questions: Which of these concerns can you personally influence? Which items belong in the circle of influence and which belong in the outer circle of concern? Finally, and most important, ask yourself, "Where do I put most of my efforts, thoughts, and actions? Are they within my circle of influence or within my circle of concern?"

Proactive people (see Chapter 3) focus their thoughts and activities inside their circle of influence. They spend their time and energy on things they can do something about, and as a result their circle of influence naturally grows over time. **Reactive people**, on the other hand, spend most of their time in their circle of concern. They focus on the weaknesses of other people, problems in their environment, and circumstances over which they have no control. Their focus creates blaming and accusing attitudes as well as feelings of victimization. Focusing on one's circle of concern causes one's circle of influence to shrink for lack of attention.[1]

Teachers often deeply feel the effects of social problems on a very personal level. Within their own classrooms they witness the devastating effects of

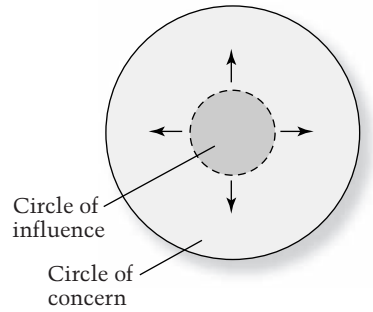

FIGURE 1-2 A teacher's circle of concern and influence.
Source: Adapted from Covey SR. *The Eighth Habit: From Effectiveness to Greatness*. New York: Free Press; 2004, p. 132.

dysfunctional homes, poverty, drugs, violence, teen pregnancy, and other problems affecting our communities and society. Because teachers care about people, they are prone to have very large circles of concern. However, focusing more on one's circle of concern rather than on the inner circle of influence can create feelings of being overwhelmed, disempowered, and "burned out." Novice teachers are especially susceptible to becoming fixated upon their circle of concern as they begin dealing with students and their problems.

Spanish Harlem (New York City) junior high teacher Bill Hall provides an excellent example of how one teacher made a positive difference in the lives of his students by being circle-of-influence focused.[2] It would have been easy for Bill to fall into the trap of being circle-of-concern focused. He taught in a neighborhood where infant mortality rates were high, the average male life expectancy was even less than in Bangladesh, and where language and a few walls separated the stark contrast of poverty and affluence. Rather than focusing on these conditions, Bill placed his energy on what he could do, his circle of influence. Bill organized an after-school chess club to help students better learn English. Many of his students had recently arrived from Central and South America, Pakistan, and Hong Kong and could speak only minimal English. This chess club became known as the Royal Knights of Harlem.

The members of the club not only learned English, but grew in confidence as they came to see themselves through Bill's eyes. Their schoolwork improved as they became more proficient at chess. In its first year, the club finished third at the state finals in Syracuse, becoming eligible for the junior high school finals in California. Bill raised funds to fly the team to California, where they finished seventeenth out of 109 teams in the national competition. Then, his team met a girl from the Soviet Union who was the Women's World Champion. The team reasoned that if this girl could come all the way from Russia, why couldn't they go there? The team traveled to Russia with the help of corporate sponsors, particularly Pepsi-Cola. There, the Royal Knights of Harlem won about half of their matches and uncovered a homegrown advantage in the special event of speed chess. Remember, these were not chess protégés, but rather students who were selected for their need to learn English.

Bill never dreamed that all of this would happen within a few short years of starting the chess club. Neither did he foresee the day that his junior high auditorium would be chosen by a Soviet dance troupe as the site of a New York performance because of his chess club's tour in Russia. But all of this did happen because Bill chose to be circle-of-influence focused. As time passed, his circle of influence naturally grew. When the Royal Knights were asked by one interviewer what they were doing before Bill Hall and chess playing had come into their lives, one boy said, "Hanging out in the street and feeling like shit." "Taking lunch money from younger kids and a few drugs now and then," admitted another. "Just laying on my bed, reading comics, and getting yelled at by my father for being lazy," said a third. When asked if there was anything in their schoolbooks that made a difference, one explained to the agreement of all, "Not until Mr. Hall thought we were smart and then we were."[2(p.139)]

They were smart and Bill Hall helped them discover their potential. Others too came to realize it. Just before graduating from junior high, these Royal Knights members received numerous offers from high schools to join their "gifted" student programs. One private school from California even provided a full-ride scholarship. At the time of junior high graduation, club members were convinced they could do anything and had career aspirations of law, accounting, teaching, and computer science.

It is common for educators to wish that we could take our students out of less than ideal circumstances. But this is rarely possible. Bill Hall made a difference by working within his circle of influence—by showing his students that they had the power within them to rise above their circumstances. We can all expand our ability to influence, and thus make a difference, by focusing on what we can do—not on what others should be doing.

Modeling: Personal and Professional Characteristics of Effective Teachers

The importance of modeling healthy and ethical behaviors cannot be overemphasized. Modeling is a major means by which skills are taught and learned. Observing how others act provides a pattern for youth to follow when in similar circumstances. Next to parents, educators, whose behavior patterns are watched and imitated, are often the most influential adults in a young person's life. Students often learn more from what we do than what we say. The way an educator reacts to frustration or stress can make a lasting impression on a young person. Both displays of positive coping skills as well as negative responses have modeling effects. Therefore, educators must give serious attention to their emotional health and to their own practices and skills.

Consider what behaviors you model, what you might be teaching students. Do you model healthy behaviors including eating lots of fruits and vegetables, watching your weight, and being physically active? Do you abstain from tobacco

and other drug abuse? Do you consistently wear a seat belt? Do you model professional ethical behaviors including acting with integrity, respect, and confidentiality? Do you refrain from gossip and negative discussion of others, including students? Do you interact with students with sensitivity to their needs and diversity? Reviewing the characteristics in **Box 1-1** will help you assess the characteristics you model to your students.

Interacting with Students

How we interact with students affects the degree of our influence in and out of the classroom. Frank O'Malley, an English professor at Notre Dame for four decades, was a teacher who made a difference in the lives of his students. He taught reading, writing—and caring. At the beginning of each semester he would memorize each student's name and have everyone submit a brief autobiography so that he could understand each student better. He focused on the fact that as a teacher he was assisting the growth of unique minds and spirits. He read each paper closely and covered each with red-inked comments of both criticism and praise. He taught his students to exceed their own expectations under his prodding. He gave them a vision of great literature, but also a vision of how they could excel.[3]

1–1
In the Classroom

Characteristics of Effective Teachers

Effective teachers:

- Are caring, warm, and very interested in students' total well-being.
- Are organized, prepared, and clear.
- Have deep preparation in and infectious enthusiasm for the subject and teaching.
- Maintain high standards of conduct and create a sense of belonging.
- Have high academic expectations for students and are able to inspire and motivate students effectively with their expectations.
- Make course work relevant, meaningful, and important to students.
- Use a variety of teaching methods and are creative in helping students learn.
- Inject humor.
- Demonstrate a willingness to admit mistakes.
- Demonstrate fairness in grading and respect in their interactions.

We need more Frank O'Malleys in education today, teachers who know and care for each of their students (not just the standouts), teachers who set high behavior and academic standards for all their students and who take the time and energy to help students achieve that higher expectation. As William Glasser said, "When you study great teachers . . you will learn much more from their caring and hard work than from their style."[4(p.38)]

While serving as Secretary of Education, William Bennett took the sound advice of his wife to get out of his office and get into the schools. He chose to visit schools weekly that had been identified as exemplary. These schools were located in all sorts of settings, including many from poorly funded inner cities. Bennett visited these schools for the purpose of finding out why they were successful. Two children at Garrison Elementary School in the South Bronx summed up Bennett's findings for what makes for a successful school when they told him they went to "America's greatest school" because (1)"there's no messin' around, (2) there's no foolin' around, and (3) everybody loves you."[5(p.75)] Research has consistently shown what these two children knew, that effective teachers and schools interact with students in ways that (1) create high academic expectations, (2) maintain high behavioral expectations, and (3) communicate a feeling of love, belonging, and community.

Teachers who make a difference interact with students in ways that create high academic and behavioral expectations and that communicate a feeling of love and belonging.

The importance of **connectedness**, a belief by students that the adults and peers at their school care about their learning and about them as individuals, cannot be overemphasized. Students who feel connected to their school are more likely to engage in healthy behaviors and succeed academically. In particular, connected students are less likely to use alcohol and other drugs, miss school, have sex at an early age, or be involved in violence or behaviors that increase their risk for injury (such as drinking and driving).[6]

Expectations

Expectations can lead people to form negative or positive self-fulfilling prophecies. **Self-fulfilling prophecies** are expectations about future behavior and performance that emanate from labels and self-image. Children who are labeled "dumb" are likely to live up to that expectation, just as children labeled "bright" are likely to prove that prophecy correct.

A teacher can formulate labels and expectations for new students even before the beginning of an academic year. A label can form in a teacher's mind through subconscious stereotyping or prejudices based on attractiveness, ethnicity, socioeconomic level, or gender. Teachers can also attach labels to students based on discussions with previous teachers, school administrators, students, or parents. The reputations that older siblings establish in school get passed on to younger brothers and sisters. School records of performance and teachers' impressions are also sources of predetermined labels. Cliff Evans, in the story at the beginning of this chapter, is an example of the tragic effect negative labels and expectations can have.

Rosenthal and Jacobson conducted some of the early work relating teacher expectations to student performance and behavior in school.[7] Students in an elementary school were given the "Test for Intellectual Blooming." In each of the classes, an average of 20% of the children were identified as having test scores that suggested they would show unusual academic gains during the school year. The identified children had actually been picked at random from the total population taking the test. Eight months later all the children in the school were retested. Those children whom the teachers expected to show greater intellectual growth had significantly higher scores than other children in the school. This resulted, apparently, from the teachers interacting more positively and favorably with the "brighter" children.

Although Rosenthal's original expectancy research has been criticized for shortcomings in design and methodology, none of the criticisms have denied that teacher expectations have a significant influence on student performance, a fact supported by many subsequent studies. Hamachek cites studies that demonstrate that teachers tend to expect, and therefore get, the same performance from younger siblings that they had come to expect from older brothers and sisters.[8] Hamachek also reviews how children whose IQs have been overestimated by teachers showed higher reading achievement. This was especially true of first-grade teachers who expected the girls to outperform the boys. Teachers

who did not have this expectation found no significant difference between the sexes in aptitude for learning to read.

Physical attractiveness also influences teacher expectations and interactions. Teachers are more likely to interact with and respond more positively to attractive children. Some research studies show that even the academic grades assigned to students are influenced by the attractiveness of the students. An example of this is when athletes receive higher grades than their schoolwork merits.

Physical attractiveness also affects how students interact with each other. Early in life children learn the high value that society places on beauty. Popular children's stories (e.g., *The Ugly Duckling*, *Sleeping Beauty*, *Rudolph the Red-Nosed Reindeer*, *Dumbo the Elephant*, *Snow White and the Seven Dwarfs*, and *Cinderella*) reinforce this value, showing the errors of this way of thinking. Unattractive children are often mocked and teased by other children. During adolescence—a period of rapid changes in body appearance, form, and size—youth often become fixated on physical appearance. They want to look like the media images of firm, sleek, beautiful bodies displayed everywhere. This is a time when peer perceptions become dominant, when expectations for conformity are intense, and deviations are not easily tolerated.

Teachers must be careful with the nonverbal messages they send to their students concerning their students' competence and lovableness. First, teachers have to be honest with themselves about any negative feelings or expectations they have. Although you would never dream of telling a student he or she is "dumb" or "ugly," these perceptions can be communicated nonverbally without your even knowing it. Communication experts tell us that more than half of what we communicate is conveyed by our body posture and facial expressions, and that the tone of voice is by far the most important part of our verbal message.

As a teacher, you should take a hard look at the expectations you have for your students. Strive to remove negative labels that have been established by previous experiences, teachers, or older siblings, and try to replace negative expectations with positive ones. It is critical to realize that many children in our school systems have rarely or have never been viewed in a positive light by a significant adult. The likelihood of positive performance in children increases as they feel warmth from others and believe that they are regarded as capable.

Discipline

Erroneously, discipline is often thought to be synonymous with punishment. The true purpose of **discipline**, however, is the training of self-control. Feeling in control helps children develop self-esteem. Having and maintaining classroom policies and procedures (e.g., when and how to speak, leave your seat, line up, turn in homework, do make-up work) helps students learn self-discipline.

Self-control is best learned from people who exemplify it. Therefore, the key to positive and effective discipline lies in the character of the teacher. Disciplinary efforts tend to be unfair and ineffective when teachers display angry or harsh behavior. Teachers with unstructured classrooms and who do not enforce class-

room rules nurture unpleasant and unruly environments. Successful teachers create structured environments and demonstrate warm, friendly attitudes toward students. They have an air of self-assurance that demands respect and have well-defined behavioral expectations of their students. Such teachers have classroom environments wherein students are comfortable and ready to learn.

Teacher Behavior We usually think of discipline in terms of student conduct. Before addressing student behavior, please carefully review these rules for teacher behavior that effective teachers live by.

Teachers' 10 Commandments

1. Know students' names. Call students by name, become familiar with their interests and talents, and show respect for each student.
2. Ask, "So what?" when preparing lessons. Make learning and the subject matter relevant, challenging, and fun to students.
3. Establish and maintain routines and procedures for taking attendance, opening class, and so on. Begin class promptly.
4. Use the three Fs for good discipline: be firm, fair, and friendly.
5. Don't expect problems; don't look for them. Expect students to be competent, capable, and eager to learn. It is better to be proven wrong than to have students live up to negative expectations.
6. When problems arise, handle them immediately and consistently before they escalate into larger ones. For example, you can walk toward, stop, and look at or call a misbehaving student by his or her last name. Don't use major "artillery" for minor infractions.
7. Avoid sarcasm, ridicule, and belittling remarks, and help students do likewise.
8. Correct students in private whenever possible.
9. Involve students in the setting of individual academic goals.
10. Encourage hydraulic-lift experiences in and out of the classroom.

Student Behavior Now let us address behavioral expectations for students. Clearly defining rules for student behavior at the beginning of the academic year gives students a sense of security and can curtail discipline problems. It has been said that cows in a new pasture will seek out the fences to see how far they can roam. So it is with students. For this reason, it is imperative that teachers clearly define the boundaries. It is inevitable that some students will test the "fences" to see how strong they are (whether the teacher will in fact enforce the established rules). A student contract is often useful in establishing classroom rules. **Box 1-2** contains an example of a student behavior contract that has been used

1-2
In the Classroom

Classroom Policy and Procedure

1. Bring pencil/pen and notebook daily.
2. When you have been absent, it is *your* responsibility to follow established procedures to acquire missed information, turn in assignments, and make up tests.
3. Be in your seat when the bell rings, or have a late excuse.
4. The bell does not dismiss students; I do.
5. Take care of drinks and restroom needs during class changes.
6. Sharpening of pencils is to be done before class, never during a lecture or discussion.
7. Do **not** touch any equipment unless I authorize you to do so.
8. If you are failing in your course work or are not turning in assignments, I will notify your parents.
9. No student is prejudged. That is, I do not read student files beforehand to see who and what problems may be coming in. I assume all students are capable of A work. I also assume that no student is a behavioral problem. If there are any such problem students, those persons will have to show me and the class who they are. Problems, should there be any, will be dealt with accordingly.
10. These behaviors will result in points being subtracted from your grades:
    a. Excessive talking
    b. Disruptive/disrespectful behavior
    c. Failure to follow instructions
    d. Unexcused tardiness

Student Contract

I have listened to and read the classroom policy and procedure regarding citizenship, behavior, and course work. I agree to adhere to this contract and understand that each violation will result in losing 5 points. This will be reflected in my final grade.

Signed: _____

Date: _____

in a junior high setting. Note item 9. The teacher who developed and used this form felt this was the most important item on it.

Many teachers believe that students are more willing to follow rules that they help to make. It is often helpful to involve students in a discussion about classroom rules on the first day of class. Encouraging their input enhances the

children's sense of having some control. Rules can be printed on a large sheet of paper and hung in a prominent place in the classroom. The process by which rules are developed is perhaps not as important as making sure that they are clearly defined from the beginning and that they are consistently and fairly enforced.

Creating a Warm Emotional Climate

As was stressed earlier in the chapter, effective teachers are able to create classrooms where students feel love, like they belong, and that there is a sense of community. Effective teachers not only exemplify a caring positive attitude toward each student, they insist their students interact with each other in the same way. They teach their students how to treat one another with respect and genuine regard.

Put-down or harassment-type comments and behaviors can destroy the positive emotional climate of a school faster than almost anything else. How often have you heard comments such as "He is so dumb!" "I hate her!" "That is so gay!" "What a nerd!" or "Drop dead!" Children are obvious and to the point with their put-downs. As we grow older we become more subtle and sophisticated, but are equally cutting: "I would never think of doing that . .", "He is nice, but . .". Sexual harassment, bigotry, bullying, giving the silent treatment, and excluding people are also pervasive forms of put-down behavior.

It is very important to understand why we and our students might spend so much time and energy trying to undermine others. We put others down in a futile effort to raise our own insecure sense of worth. This behavior can be visually depicted with a teeter-totter or see-saw (**Figure 1-3**). It is as though we were sitting on a teeter-totter and looking for someone to sit on the other end. If we put that individual down, we feel "up," or on a higher level. Feeling superior to others is a false "high" and very short lived. Have you ever been elevated on a real teeter-totter and had the other person get off? You come crashing down in the same way when you figuratively teeter-totter. Then, we look around for someone else to put down, to once again raise our relative sense of worth. This behavior can have addictive qualities and become so pervasive that one's teeter-totter moves with fanlike rapidity. Adolescence is typically a time of rapid change and insecurity. As a result, this stage of life is particularly vulnerable to frequent "**teeter-tottering**."

Teeter-tottering can easily become epidemic in the classroom—and teachers are not immune. This type of behavior naturally occurs in schools because we have become a society that is very proficient at put-downs. TV programs often glamorize put-down behaviors, and "putting someone in their place" is depicted as very "cool." Young people mimic being "cool" by gossiping, spreading malicious rumors, writing nasty e-mails, and excluding the "noncool." In too many homes put-downs are the predominant form of communication. Some children have become so calloused by this type of behavior that they don't even recognize its harmful effects.

How do we break out of the **teeter-totter syndrome**? First, we have to realize when we are caught up in it. Just as we take our temperature to see if we are

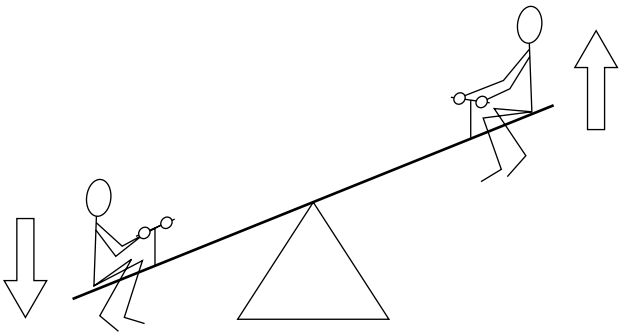

FIGURE 1-3 Teeter-tottering. Teeter-tottering is putting another down in an effort to feel better about yourself.

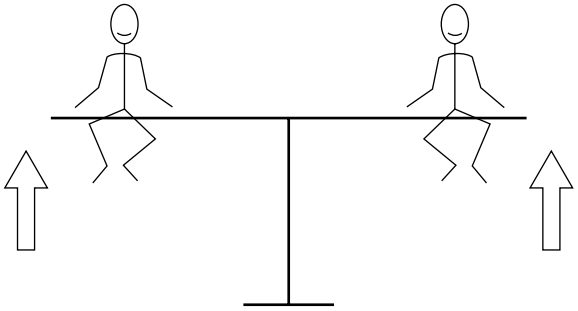

FIGURE 1-4 Hydraulic lift. When you lift another, you too are lifted.

ill, so we can check our emotional health by observing how often we teeter-totter. Students can easily monitor their own put-down behaviors when taught the principle depicted in Figure 1-3. Draw this simple diagram on the board and discuss how teeter-tottering works, or, more accurately, how it does not work. Students don't appreciate being put down and are very willing to give up teeter-tottering to create a classroom where they feel emotionally safe and accepted. Your classroom can be designated as a teeter-totter–free zone. This does not mean that teeter tottering will immediately disappear, but you can just make a teeter-totter hand motion whenever you overhear a put-down. Students appreciate this reminder and will quickly comply with the rule. They appreciate being in an emotionally save environment.

As we work at eliminating put-downs we need to replace teeter-tottering remarks with hydraulic lifts (**Figure 1-4**). A **hydraulic lift** is the act of raising someone else with kind acts or comments. When we are kind to another person we cannot help but feel better about ourselves. It is as if we were sitting on a hydraulic lift. As we show kindness, we rise along with whomever we are trying to lift. This positive action creates a genuine "high" and a more lasting sense of self-worth.

Helping children learn self-control by replacing teeter-totters with hydraulic lifts greatly enhances the emotional climate of any classroom and alleviates

1-3
Application Exercise

Marks on You

This activity was inspired by a very wise mother whose very popular, smart teenage daughter was critically injured in an auto–pedestrian accident. Joni's friends were supportive for months, but had moved on by the time she returned to school a year and a half later. She found herself in special education classes instead of honors courses and quickly became depressed and withdrawn. Her mother helped her become happy again by having her change her focus from herself to others. She asked Joni to make a mark on the back of her hand every time she was able to make someone smile. After school Joni would tell her mother about each mark on her hand.

Doing the following will help you see yourself more clearly and help you identify your teeter-totter and hydraulic lift patterns. For four or more days make a small mark on your left hand for all "teeter-tottering" remarks/acts/thoughts and do the same on your right hand for all "hydraulic lift" remarks/acts/thoughts. If you don't want to mark your hands, keep a tally on a 3 × 5 card. At the end of each day tally up both types of marks and write a summary of what occurred. At the end of the four or more days write a reaction paper explaining what you observed and learned by doing this exercise.

many discipline problems as well. There are many ways teachers can assign students to practice being kind to each other (see **Box 1-3,** Box 3-4, and Box 3-5 in Chapter 3).

Sensitivity to Diversity

We live in an exciting world where diversity of peoples and cultures abounds. In our public schools today, about 45% of the students are minority (Hispanic: 21.1%, African American: 16.6%, Asian/Pacific Islander: 4.6%, and American Indian/Alaska Native: 1.2%). This is double what it was in 1970.[9] As educators, we must model sensitivity to diversity for our students and strive to view individuals from various cultures from their perspectives rather than from our perspectives. We must be sensitive to students struggling to learn a new language and adapt to a new culture. How we treat each student affects our relationship with every other student in the classroom. Being respectful and positive creates classroom climates of understanding and sensitivity to diverse cultures, ethnicities, races, and needs.

How a teacher interacts with just one student influences that teacher's relationship with each student in the classroom.

Ethnocentric, racist, or stereotypic attitudes held by teachers and students serve as critical barriers to learning and establishing sensitivity toward various cultures and ethnic groups. **Ethnocentricity** involves an attitude that one's own ethnic group or culture is better than others, or failure to recognize the existence or validity of other ethnic/cultural groups and their customs, values, beliefs, and norms. **Racism** expresses an attitude that defines certain cultural or ethnic groups as inherently inferior to others and legitimately subject to exploitation, discrimination, and various types of abuse. **Stereotypes** reflect conscious or unconscious attribution of exaggerated characteristics and/or oversimplified opinions, attitudes, or judgments regarding members of a given ethnic group or culture. A **prejudice** is a negative attitude toward a specific group based on comparison using the individual's own group as a positive reference point. Teachers have a professional responsibility to not let personal attitudes, stereotypes, and prejudices interfere with their teaching. For example, a teacher raised in one cultural group may have stereotypes or prejudices against another cultural group. This teacher would need to overcome these stereotypes and prejudices to teach students of this cultural group successfully. Of course, stereotypes and prejudices are not confined to cultural or ethnic groups. For example, some may have stereotypes and prejudices for impaired individuals, the aged, or for a variety of conditions or types of people.

Teachers can build cultural and ethnic sensitivity in a variety of ways. Teachers should strive to display appropriate interpersonal skills, including showing warmth, respect, sincerity, concern, and caring for people of all cultures. Beyond this, it is critical to develop cross-cultural understanding in the

communities where we serve and live. Recognizing culturally determined viewpoints and standards of behavior, including specific knowledge of and respect for differences, is important. Beyond developing personal cross-cultural understanding, emphasis should be given in the curriculum to cross-cultural competency for students.

It is also important to pay attention to culturally/ethnically appropriate learning and problem-solving styles. This involves recognition that a variety of strategies and approaches can be employed to complete a given task. To an extent, learning and problem-solving styles are culturally determined and a variety of approaches should be encouraged. Learning is also facilitated by appropriate style, manner, and content of communication for a particular cultural group. This includes the use of ethnically and culturally appropriate nonverbal skills such as eye contact, body language, and physical closeness.

Special Concerns for Teachers

It is easy to become overwhelmed while working with the many students who have special needs. Many of these needs are complex problems that pose multiple difficulties in the lives of the affected children and for the school systems of which they are a part. Schools often have various staff in place to help students with special needs, such as guidance counselors, psychologists, learning specialists, social workers, special education teachers, and school nurses. A key to success in working with students with special needs seems to be the ability of these personnel and teachers to work together in a supportive team approach. The support given to those with special needs also benefits the entire student body as they learn from the adults' modeled behaviors and attitudes.

Emotional Concerns

An example of emotional concerns present in schools and how a supportive team approach can help comes from Francis Scott Key Elementary and Middle School in Baltimore, Maryland, where Melissa Grady works as a mental health therapist. Grady sees four dozen children every week, some for the first time and others she's been counseling for years. Some are victims of sexual or physical abuse, have witnessed domestic violence, or have dysfunctional parents who suffer from drug addiction or alcoholism. Others have been traumatized by family disruptions such as divorce or unstable living arrangements.

"The huge thing is a lack of parental guidance," says Grady. "Its symptomatic of society. The children are not getting enough of what they need at home, they're not being taught the coping skills, the social skills. So, of course, all that's spilling out into the school system and the children are unavailable to learn or are disrupting others."[10]

Melissa Grady set up a student-support team consisting of herself, a school psychologist, a counselor, a social worker, and teachers representing the elementary and middle schools. The team meets once a week to review the academic

performance and special needs of the student body. They are proactive in looking out for students in need, such as those who are acting out, depressed, withdrawn, or displaying sudden changes in behavior or significant decline in grades or attendance. When a child with a special need is identified, the student-support team arranges one-on-one sessions with the student, parent meetings and counseling, and adequate follow-up. This consistent, vigilant student-support team effort is responsible for helping students improve their grades and cope with a variety of special needs. Teachers at the schools are thrilled that the student support team is in place and have seen a reduction in the severity of discipline problems. A seasoned teacher at the school, who has taught at seven other schools, commented, "You can really teach here."

In coming chapters you will read more about how to deal with various emotional concerns in your classroom, including depression, family stress, and divorce (Chapter 4); eating disorders (Chapter 6); substance abuse and addiction for individuals and families (Chapter 7); abuse and neglect (Chapter 9); and suicide, self-injury, and terminal illness (Chapter 10). You will hopefully be able to set up student-support teams in the schools where you teach that will help you better meet the emotional concerns of your students.

Infectious Health Conditions

Today we gratefully have immunizations (see **Box 1-4**) for many of the communicable diseases that debilitated and killed our ancestors, but we are still vulnerable. The H1N1 virus (swine flu) outbreak that originated in Mexico in April 2009 highlighted how concerned scientists are that a microbe will one day emerge that is as devastating as the 1918 virus flu pandemic that killed 50 million people worldwide.[11] Influenza viruses and other microorganisms are constantly mutating. Every year scientists try to predict which new strains of flu viruses will be problematic and formulate flu shots to help us be prepared. Unfortunately, indiscriminate use of antibiotics here and abroad creates a breeding ground for the growth of drug-resistant microorganisms, "super germs." We need to be careful personally not to abuse antibiotics and to teach our students that antibiotics don't help when we are infected with viruses.[12] We also need to model and teach vigilant habits of hand washing and covering our mouths with something other than our hands when we sneeze or cough. Students need to understand that it is important to stay at home when they are sick so that they do not spread their illness to others. We need to develop the practice of disinfecting commonly touched items in the classroom and teach students not to share combs and hats. Practicing these behaviors helps deter spreading many illnesses in the classroom, including colds, influenza, strep throat, conjunctivitis, diarrhea, impetigo, and lice.

Students of all ages need to be reminded of the importance of frequently washing their hands.

1–4
Background on . . .

Recommended Immunization Schedule

The Department of Health and Human Services at the CDC recommends (2009) that children receive the following immunizations by the time they enter school:

- **Hepatitis B**
- **Rotavirus**
- **Diphtheria, tetanus, pertussis (DTaP)**
- ***Haemophilus influenzae* type b (Hib)**
- **Inactivated poliovirus (IPV)**
- **Measles, mumps, rubella (MMR)**
- **Varicella**

The following are recommended for certain high-risk groups:

- **Pneumococcal (PCV)**
- **Hepatitis A**
- **Meningococcal (MCV)**

Influenza vaccination is recommended yearly.

For children age 11 or 12, the following immunizations are recommended:

- **Tetanus, diphtheria, pertussis (Tdap)**
- **Human papillomavirus (HPV)**
- Meningococcal (MCV)

The Centers for Disease Control and Prevention (CDC) has issued the following guidelines for precautions against the spread of viruses. Following and teaching these measures will minimize the spread of infectious diseases in schools.

- *Avoid close contact.* Avoid close contact with people who are sick; keep your distance from others to protect them from getting sick too.
- *Stay home when you are sick.* If possible, stay home from work, school, and errands when you are sick. You will help prevent others from catching your illness.
- *Cover your mouth and nose.* Cover your mouth and nose with a tissue when coughing or sneezing. It may prevent those around you from getting sick.
- *Clean your hands.* Washing your hands often will help protect you from germs.
- *Avoid touching your eyes, nose, or mouth.* Germs are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.
- *Practice other good health habits.* Get plenty of sleep, be physically active, manage your stress, drink plenty of fluids, and eat nutritious food.

Chronic Health Conditions

The term **chronic** refers to illnesses or conditions that are long-lasting. When a person has a chronic illness, the symptoms of the illness may be reduced or even go away for periods of time, but the person still has the same underlying condition.

Most teachers will encounter children with chronic health conditions in their classroom because more than 5 million school-age youth are affected by chronic health conditions.[13] The chronic health conditions most commonly seen in students are asthma, diabetes, epilepsy, cerebral palsy, heart disease, cancer, and spina bifida. Another chronic health condition of concern in children is HIV/AIDS. You can read more on common chronic health conditions in **Box 1-5**.

Children with chronic health conditions have special challenges and concerns. They want to be like everyone else and worry about being rejected by their classmates. They worry about being teased and excluded. In addition to these worries, they must cope with the effects of the illness and the treatments that they undergo. Often these factors make it difficult to put all of their energy into schoolwork. On the other hand, teachers worry about these students and about their own competence in responding appropriately to any medical emergencies that might arise in the classroom. What should I do if an epileptic child has a seizure in my classroom? What should I do if a diabetic child has a diabetic emergency? It is critical, then, that school personnel working with students with chronic health conditions have an understanding of the various health conditions and emergency management procedures of their students. The following are some tips:

Many children have chronic health conditions, such as diabetes, that require taking medication at home and at school.

- ❖ Your attitude of kindness, empathy, and acceptance toward others generates similar attitudes in the classroom. Your students will watch you and model your behavior.
- ❖ Know the protocol for possible emergencies. Make sure that the school nurse provides you with sufficient information about the medical conditions of students in your classroom.
- ❖ Be sensitive to when not to show concern, like when a child with cystic fibrosis is coughing. The cough is important to clear the lungs. Paying too much attention to a symptom often makes it worse and reinforces a child's sense of shame.
- ❖ Children with medical problems are often overly sensitive. Don't perceive their behavior as babyish or immature or a serious emotional problem. By reinforcing positive age-appropriate behavior, you are most likely to increase it.

When school personnel, parents, and health professionals work in partnership and in a creative manner, having children with chronic health conditions in the classroom can be a stimulus for the growth of everyone in the classroom environment. An example of this is a second-grade student with spina bifida who asked for classmates to receive orientation about his disease after classmates teased him when he had urine leakage. During the session, classmates asked many questions, including whether he would have children and whether he would live. Because of the careful preparation and support, he was not surprised by the questions and could answer them honestly. Once the children understood his condition he was seen as "normal" and accepted with no further teasing.

1–5
Background on . . .

Common Chronic Health Conditions in Children

Asthma, the most common chronic disease of childhood, is an illness that periodically causes breathing difficulties that result from the constriction of the airways in the lungs.

Diabetes is a disease in which the body does not absorb the sugar in food as a result of the failure of the pancreas gland to produce the hormone insulin.

Epilepsy is a general term used to describe different types of seizure disorders or temporary disruptions of electrical impulses in the brain that result in seizures.

Cerebral palsy is a term used to describe a group of chronic conditions caused by damage to the brain that affects body movements and muscle coordination. The damage usually occurs during fetal development or during infancy, but it can also occur before, during, or shortly following birth.

Congenital heart disease is the result of a defect in the heart that is present at birth, whereas **acquired heart disease** develops during childhood, usually as the result of a viral or bacterial infection.

Cancer refers to several diseases in which cells grow out of control, develop abnormal sizes and shapes, destroy neighboring cells, and can spread to other organs and tissues. Leukemia, lymphoma, and brain cancer are the most common childhood cancers.

Spina bifida is a birth defect resulting from the incorrect development of the spinal cord that can leave the spinal cord exposed after birth.

Learning Disabilities

A **learning disability** is a disorder that affects a person's ability either to interpret what he or she sees and hears or to link information from different parts of the brain. These limitations can show up in many ways: as specific difficulties with spoken and written language, coordination, self-control, or attention. They can impede learning to read or write, do math, or learn other important skills. They can also affect student behavior, how students perceive themselves, and how students interact with classmates.

It is not exactly clear how many students experience learning disabilities. Some experts estimate that roughly 1 child in every 100 of school-age children has some form of learning disability; others estimate almost one-third. What is

clear is that many more boys than girls are affected. There are many kinds of learning disabilities including speech and language disorders (difficulty in producing or interpreting communication), academic skills disorders (reading, writing, or arithmetic skill problems), and miscellaneous learning disabilities (fine motor skills problems, nonverbal learning disorder, and others).

Teachers can help children with learning disabilities by first recognizing the problem. All too often children with learning disabilities are labeled dumb or unmotivated. It is essential that these children be identified early, before they begin to see themselves as stupid and failing. Be suspicious if a fairly bright child has trouble learning certain skills. You can make a referral to a school counselor or special education instructor. Every school district has its policy for screening learning disabilities. With the right help, most children with learning disabilities can overcome them. It is helpful to remember the following famous people who had learning disabilities: Albert Einstein, Thomas Edison, Nelson Rockefeller, Ludwig van Beethoven, Winston Churchill, Bruce Jenner, George Patton, Leonardo da Vinci, and Woodrow Wilson. Be mindful that as you interact with students with learning disabilities that you are in fact teaching all of your students attitudes and behaviors that they will mirror. You can facilitate your students learning compassion and understanding for individuals with learning disabilities by doing the activities in **Box 1-6**.

Students with learning disabilities are likely to feel stress and frustration while doing schoolwork.

Activities for Creating a Positive Classroom Environment

For each of the following activities, we have identified the likely appropriate grade level(s) for use:

P = primary, kindergarten through third grade
I = intermediate, fourth through sixth grade
J = junior high
H = high school

Susan Boyle

Play a clip of Susan Boyle's performance on the TV show *Britain's Got Talent*. Discuss the audience's reaction before and after she sang—how and why their judgment of her changed. She touches us because we can all in some way identify with her. Discuss how we all might not be able to sing, but we all have talents, and that we all benefit when we encourage each other to develop our unique talents. (P, I, J, H)

Admirable Graffiti

Wrap your classroom door with construction paper. Tell students that they can write on the door whenever they want to record an admired action or attitude they have observed in one of their classmates. (P, I, J, H)

Positive Tattle Telling

- Have students draw and display posters showing good things (helping, comforting, complimenting, being kind) that they catch somebody doing.
- Have students write good things that they catch classmates doing on pieces of paper and place the papers in a "tattle box." Read the papers at the end of the day or week.
- Include parents by having them catch and record their child doing good at home. Parents can then share through e-mail, letters, or phone interviews. (P, I)

Empathy for Those with Learning Disabilities

- Have students try to write a sentence with the hand they normally don't use for writing.
- Have students hold a piece of paper up to a mirror and try to write their names, a short story, or do a math problem while only looking in the mirror.
- Retype a story or text page with all the *b* and *d*, *c* and e, and *m* and *n* letters switched. Have students try to read it quickly.
- Give students a timed math quiz where all the numbers have been written on their papers in mirror image format. (P, I)

(You can find many additional hydraulic-lift-type activities in Box 3-4 in Chapter 3.)

Attention Deficit Hyperactivity Disorder **Attention deficit hyperactivity disorder** (ADHD) is a common, chronic behavioral disorder characterized by inattention, hyperactivity, and impulsivity. **Inattention** is described as failure to finish tasks started, easy distractibility, seeming lack of attention, and difficulty concentrating on tasks requiring sustained attention. **Hyperactivity** is described as difficulty staying seated and sitting still, and excessive running or climbing. **Impulsivity** is described as acting before thinking, difficulty taking turns, problems organizing work, and constant shifting from one activity to another.

ADHD is believed to affect 5% to 10% of school-age children worldwide. On average, at least one child in each classroom needs help with this disorder. It is diagnosed three times more frequently in boys than in girls. There are some controversies over the prevalence of the ADHD diagnosis and drug treatment. The diagnosis is commonly made by a health professional who "draws a line" on a continuum scale of normal behavior indicating that he or she perceives the child's behavior to be extreme. Many recommend additional psychological testing to look for and confirm cognitive impairment in making the diagnosis.[14]

The cause of ADHD is unknown. There is some evidence, however, that ADHD is the result of a developmental failure in the brain circuitry that controls attention, inhibition, and self-control, with dopamine playing a role. There is no known cure for ADHD. Hyperactivity and impulsivity decrease with age, but problems with inattentiveness persist. About two-thirds of children with ADHD continue to exhibit significant levels of inattentiveness and impairment into adolescence.[14]

Helping Students with ADHD Children with ADHD have a variety of needs.* Some children are too hyperactive or inattentive to function in a regular classroom, even with medication and a behavior management plan. Such children may be placed in a special education class for all or part of the day. In some schools, the special education teacher teams with the classroom teacher to meet each child's unique needs. However, most children are able to stay in the regular classroom. Whenever possible, educators prefer not to segregate children, but to let them learn along with their peers.

Children with ADHD often need some special accommodations to help them learn. For example, the teacher may seat the child in an area with few distractions, provide an area where the child can move around and release excess energy, or establish a clearly posted system of rules and reward appropriate behavior. Sometimes just keeping a card or a picture on the desk can serve as a visual reminder to use the right school behavior, like raising a hand instead of shouting out, or staying in a seat instead of wandering around the room. Giving a child with ADHD extra time on tests can make the difference between his or her passing and failing, and gives the student a fairer chance to show what has been learned. Reviewing instructions or writing assignments on the board, and

* This section is adapted from National Institute of Mental Health, *Attention Deficit Hyperactivity Disorder* (NIH Publication No. 96-3572), 2002. Available at http://www.nimh.nih.gov/publicat/adhd.cfm.

even listing the books and materials they will need for the task, may make it possible for disorganized, inattentive children to complete their work. Many of the strategies of special education are simply good teaching methods. Telling students in advance what they will learn, providing visual aids, and giving written as well as oral instructions are all ways to help students focus and remember the key parts of the lesson.

Students with ADHD often need to learn techniques for monitoring and controlling their own attention and behavior. For example, students can be taught alternatives for what to do when they lose track of what they are supposed to be doing—look for instructions on the blackboard, raise their hand, or quietly ask another child. The process of finding alternatives to interrupting the teacher makes a student more self-sufficient and cooperative. And because there is less interrupting, a student begins to get more praise than reprimands. **Box 1-7** contains resources that can help you become more effective at teaching students with ADHD.

1–7
In the Classroom

Resources for Teaching Students with ADHD

Check out the following Web resources to find information about teaching and working with students with ADHD.

- *Teach and Reach Students with Attention Deficit Disorders: The Educator's Handbook and Resource Guide* is available at http://www.adda-sr.org/Spanish/teachand%20reach.htm.
- "Strategies for ADD/ADHD Students" can be accessed at http://www.atozteacherstuff.com/pages/4007.shtml.
- "Strategies for the Older Child with ADHD" can be located at http://www.drpaul.com/behaviour/adhdclas.html.
- "30 Ideas for Teaching Children with Attention-Deficit/Hyperactivity Disorder" can be found at http://www.kellybear.com/TeacherArticles/TeacherTip49.html.
- *Teaching Children with Attention Deficit/Hyperactivity Disorder* can be accessed at http://ericec.org/digests/e569.html.
- *Suggested Classroom Interventions for Children with ADD and Learning Disabilities* can be located at http://www.childdevelopmentinfo.com/learning/teacher.shtml.
- "Teaching Hyperactive Children" can be accessed at http://www.school-for-champions.com/education/hyperactive.htm.
- ADD in School (http://www.addinschool.com) is a comprehensive website that provides teachers with classroom interventions and tips for working with youth with ADHD in elementary and secondary schools.

Drug Treatment for ADHD Stimulant drug treatment has been found to be very effective at helping those with ADHD concentrate, but there are some questions about the efficacy of using these drugs over the long term.[14] Stimulants such as **Ritalin** (methylphenidate) and **Dexedrine** (dextroamphetamine) have been used for some time. Newer drug formulations, such as **Adderall** (a combination of four amphetamines, including Dexedrine) and **Concerta** (methylphenidate extended-release tablets), are popular because of their longer-acting properties. These pills can be taken by a child or adolescent once a day, instead of two or three times a day, eliminating the need for a dose to be taken at school.

As with all medications, there is the potential for side effects. While on these medications, some children may lose weight, have less appetite, and temporarily grow more slowly. Others may have problems falling asleep. Other side effects can include irritability, agitation, nervousness, and periods of sadness. Serious side effects include facial tics and muscle twitching. Most of the side effects that do occur can often be handled by reducing the dosage.

One important concern about stimulant drugs is their potential for abuse. When these powerful stimulant drugs are abused, abusers have suffered psychotic episodes, violent behavior, and severe psychological dependence on the stimulant. Stimulants used to treat ADHD are classified by the Drug Enforcement Agency (DEA) as Schedule II drugs, the most highly addictive drugs that are still legal. According to the DEA, drugs to treat ADHD rank among today's most-stolen prescriptions and most-abused legal drugs. Most abusers, DEA officials say, are kids. Most dealers are kids who are prescribed the drugs to treat ADHD. Parents of ADHD children have also been found to abuse the stimulant drugs.

Key Terms

pyramid of influence 4
circle of concern 5
circle of influence 5
proactive people 5
reactive people 5
connectedness 10
self-fulfilling prophecies 10
discipline 11
teeter-tottering 14
teeter-totter syndrome 14
hydraulic lift 15
ethnocentricity 17
racism 17
stereotypes 17
prejudice 17
hepatitis B 20
rotavirus 20
diphtheria, tetanus, pertussis (DTaP) 20
Haemophilus influenzae type b (Hib) 20
inactivated poliovirus (IPV) 20
measles, mumps, rubella (MMR) 20
varicella 20
pneumococcal (PCV) 20
hepatitis A 20
meningococcal (MCV) 20
tetanus, diphtheria, pertussis (Tdap) 20
human papillomavirus (HPV) 20
chronic 21
asthma 23
diabetes 23
epilepsy 23

Review Exercise

1. Define, differentiate, and discuss the key terms and their relative importance in this chapter.
2. Identify and discuss the three major areas of a teacher's pyramid of influence.
3. Discuss the principle behind the circle of concern and the circle of influence and cite some examples from the chapter. What can you specifically do to enlarge your circle of influence?
4. Describe the characteristics of effective teachers, including the healthy and ethical behaviors they model. What do you exemplify and what do you need to work on?
5. Summarize the three key characteristics of exemplary classrooms.
6. Discuss how teachers who make a difference interact with students.
7. Identify the Teachers' 10 Commandments.
8. Discuss ways teachers can diminish put-downs and encourage kindness in the classroom.
9. Describe how you can celebrate diversity in your classroom and be ethnically sensitive.
10. Explain how schools can best meet the emotional concerns of students.
11. Identify the immunizations that are recommended for school-age children and the things that teachers can do to minimize the spread of infectious disease.
12. Identify the chronic health conditions teachers are most likely to encounter in students and what teachers can do to help children with chronic health problems.
13. Describe various learning disabilities and how teachers can help students with learning disabilities.
14. Discuss controversies associated with ADHD and accommodations teachers can make for children with ADHD.

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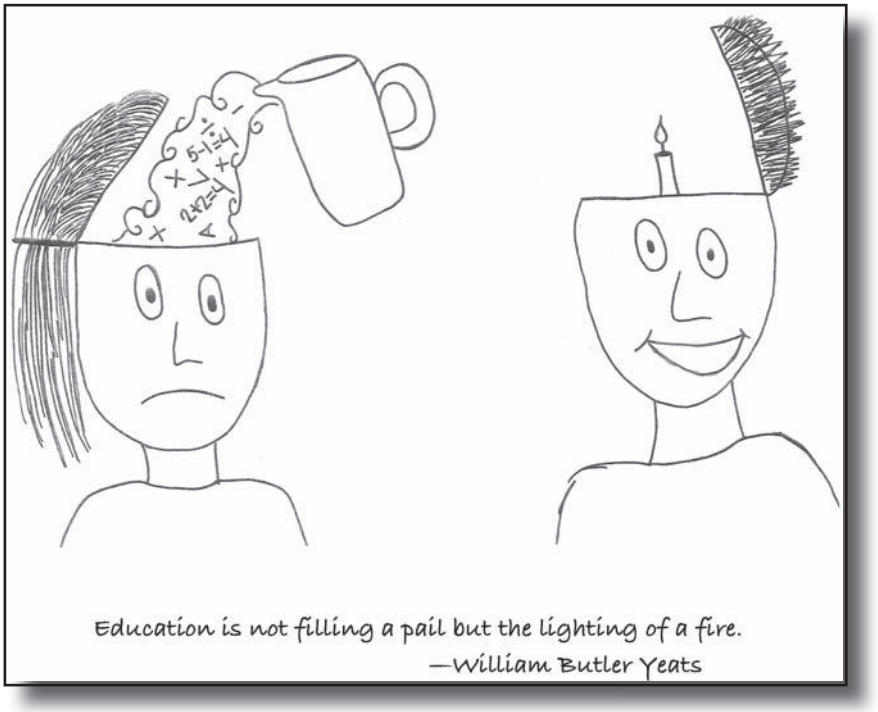
2

Teaching Today's Students



Education is not filling a pail but the lighting of a fire.
—William Butler Yeats

Consider…

- *No matter how well planned, how interesting, stimulating, colorful or relevant the lesson, if the teacher does all the interacting with the material, the teacher's, not the student's, brain will grow.—Pat Wolfe*
- *I like a teacher who gives you something to take home to think about besides homework.—Lily Tomlin as "Edith Ann"*
- *The mediocre teacher tells. The good teacher explains. The superior teacher demonstrates. The great teacher inspires.—William Arthur Ward*
- *A good teacher is like a candle—it consumes itself to light the way for others. —Author unknown*
- *The task of the excellent teacher is to stimulate "apparently ordinary" people to unusual effort. The tough problem is not in identifying winners: it is in making winners out of ordinary people.—Patricia Cross*
- *A teacher affects generations yet unborn.—Author unknown*

Understanding Today's Learners

The world has radically changed, and technology is driving much of the change that we see. When many of today's teachers were schoolchildren, the primary sources of information were encyclopedias and libraries. Today the Internet is the major source of information. With the Internet and other new technologies, many questions can be answered in just a matter of seconds. Today's students visit Google more often than the library. Just as modern technology has already altered our world drastically, it is certain that there are many more changes to come in the future. These changes have major implications for the teaching profession. Current educational practices and strategies must keep up with our evolving world.

Today's learners are often referred to as "digital natives." Digital natives process and deal with information differently from how previous generations do.[1] Rather than having a linear thought process, they tend to piece information together from different sources in a "hypertext" fashion, jumping around between multiple sources. Digital natives also tend to be more visual and interpret and develop images with ease. Their visual–spatial skills seem to be well developed because of experience with video and virtual games. Digital natives learn better through discovery than simply being told information. Other key characteristics of digital natives are their ability to shift their attention rapidly from one task to another and how they often choose not to pay attention to things that don't interest them.

Children's media and technology exposure affects how their brain works. A brain's wiring is structured according to the stimuli it is exposed to. Today's young people are literally "wired" differently from previous generations because they have been exposed to different kinds of stimuli. This evolution of brain wiring changes will likely continue as new generations become exposed to different forms of digital media at even younger ages. Diana Oblinger[2] describes how today's learners generally are comfortable using new technology; being constantly connected to information and other people; prefer experiential or "hands-on learning"; expect immediate results; and are very social. She makes the point that today's learners feel comfortable connecting and socializing in ways that earlier generations would never have considered (e.g., MySpace, Facebook, Bebo, other social network websites). Earlier generations were educated through a very hierarchical method of learning in which a teacher taught (told) students the information that they were to learn. Today's learners, instead, prefer a more lateral approach to learning. This means that the learners learn from peers and nontraditional sources such as the Internet and other media. According to Oblinger, many of today's kids prefer to get their hands on things, figure out problems and processes on their own, and go through the "messy" process of learning from experience.

As a result of brain-imaging studies conducted by Jay Giedd of the National Institute of Mental Health, much has been learned in recent years about how children's brains develop.[3] This research is the culmination of the examination

Digital natives learn best through discovery, and the brain learns better through social interaction.

of the brains of thousands of children and teenagers using high-powered magnetic resonance imaging (MRI) taken at 2-year intervals. The MRI studies counter a belief previously held by most scientists that, because the brain reaches adult size by age 11 or 12 (a 6-year-old's brain is 90% to 95% of its adult size), the brain is fully developed by age 12.[4] We now know that extensive structural changes in the brain take place throughout the adolescent years and the brain does not become fully mature until individuals are in their 20s. The brain's gray matter thickens until about age 11 in girls and age 12½ in boys, and then begins thinning out until the early 20s. The **gray matter** contains nerve cells and dendrites that branch out and form connections with other nerve cells to send nerve signals (messages) throughout the brain. On the other hand, the white matter in the brain thickens. The **white matter** is made up of myelin sheaths, which cover and insulate the axons and make nerve signal transmissions faster and more efficient. Thus, the "pruning away" of gray matter and proliferation of white matter during the adolescent years means fewer but faster nerve connections in the brain, or a more efficient brain. Later in this chapter, you learn how neural connections or synapses that are exercised are retained, whereas those that aren't are lost.

It is important for teachers to realize that the brains of teenage students are immature and not fully developed. The last region of the brain to undergo the maturation process of proliferation and pruning of neural pathways is the prefrontal cortex. The **prefrontal cortex** is the region of the brain, located behind the forehead, where reasoning, planning, organization of thoughts, weighing the consequences of actions, suppressing impulses, and other "executive" functions take place. Adolescent specialist Laurence Steinberg stresses that some of these functions in the prefrontal cortex mature ahead of others. In the teen brain, the systems that regulate logic and reasoning develop ahead of those regulating impulse and emotions.[5] He points out that as a result, adolescents are vulnerable to risky and dangerous behaviors because developmentally they lack the full capacity to control themselves. The prefrontal cortex of the adult brain, unlike the teenage brain, is able to perceive that the negative outcomes of a risky behavior outweigh any potential thrill. These developmental characteristics make teens prone to poor decision making.

Twenty-First-Century Skills

Success in the 21st century requires different skills than were required for successful living in previous centuries. The Partnership for the 21st Century Skills was formed in 2002 to create a model of learning for this millennium that incorporates 21st-century skills into our systems of education. The partnership is a public–private collaboration of business, education, community, and government that serves as a catalyst to position 21st-century skills at the center of the U.S. K–12 education. The partnership recognizes that there is a gap between the knowledge and skills that students learn in school and the knowledge and skills that they need to succeed as effective citizens and workers in the 21st century.

The partnership pushes schools to infuse 21st-century skills into their teaching and learning to prepare children for effective living in this century.

The partnership presents a framework of 21st-century teaching and learning that focuses on student outcomes and support systems to help students master these outcomes.[6] The outcomes are a blending of specific skills, content knowledge, expertise, and literacies that students will need to succeed in work and life in the 21st century. The framework includes a wide range of outcomes such as thinking critically, problem solving, communicating clearly, collaborating with others, thinking creatively, working collaboratively with others, adapting to change, managing goals and time, being self-directed learners, practicing information literacy and media literacy, and applying technology. The partnership also identifies the following core subjects and 21st-century themes as essential for students in this century: English, reading, or language arts; mathematics; science; foreign languages; civics; government; economics; arts; history; and geography. The partnership also advocates that schools go beyond "a focus on basic competency in core subjects to promoting understanding of academic content at much higher levels" by weaving the following 21st-century interdisciplinary themes into core subjects: global awareness; financial, economic, business, and entrepreneurial literacy; civic literacy; and health literacy.[6] According to the partnership, **health literacy** involves the following:

- Obtaining, interpreting, and understanding basic health information and services and using such information and services in ways that are health enhancing
- Understanding preventive physical and mental health measures, including proper diet, nutrition, exercise, risk avoidance, and stress reduction
- Using available information to make appropriate health-related decisions
- Establishing and monitoring personal and family health goals
- Understanding national and international public health and safety issues

This book supports teachers in helping their students achieve many of the 21st-century skills. For example, we emphasize problem solving, goal setting, and communication skills in Chapter 3, and then again in later chapters. Media and information literacy is the focus of Chapter 5 and is again highlighted in later chapters. Further, you should recognize that the interdisciplinary theme of health literacy is a major focus of this book.

Teaching in the Twenty-First Century It is time to abandon the notion that a lecture and reading assignment are enough for students to learn. The role of today's teacher is much more than that of being an expert dispensing facts and information. Teachers need to be co-participants with students in the learning process and take into account the characteristics of today's students as they plan and deliver learning activities. Some describe that the role of the teacher is changing from being a "sage on a stage" to more of a "guide on the side."

Twenty-first-century teachers need to realize that significant learning does not result from absorbing specific information that is delivered (told) to them. Instead, it is more about facilitating students' involvement in learning through exploration and firsthand experience. Teaching approaches need to emphasize less memorizing of material and emphasize more on making connections, thinking through issues, and solving problems. Rodgers et al.[7] describe that 21st-century learners prefer working in teams in peer-to-peer situations, performing visual and kinesthetic activities over reading and listening activities, learning things that matter, and being challenged to reach their own results and conclusion.

Innovative teachers are savvy about technological devices and how they pervade the lives of today's youth, and they use technology and multimedia in ways that enhance student learning. When it comes to technology, teachers can creatively apply numerous possibilities in classroom learning activities including blogs, wikis, threaded discussion boards, chats, videoconferencing, cell phones, and new technologies that will continue to emerge. New and emerging technology creates exciting possibilities for student learning. It provides for almost infinite and rapid access to information and also allows for students to be connected inside and outside of the classroom, to develop multimedia projects, and to learn experientially.

Learning Styles

Effective teachers strive to understand how their students learn best. They teach with the brain in mind (see the next section) and take into account their students' learning styles and multiple intelligences. All students do not learn best in the same ways. One type of learning style relates to one's preference for taking in information. There are visual, auditory, and kinesthetic learning styles that relate to this preference. A **visual learning style** means that a person has a preference for information presented in visual format or through observation such as pictures, diagrams, demonstrations, displays, handouts, video, and flipcharts. An **auditory learning style** means a preference for receiving information through listening to speech and sound such as spoken instructions and songs. A **kinesthetic learning style** means a preference for learning through touching or manipulating things, through physical movement or practical hands-on experiences. Some students have a very strong preferred learning style for taking in information, but many people are multimodal, meaning they use a blend of two or all three of these learning styles. It is important for students to understand that there is no best learning style and that there are different types of learning that are best for one's preferences.

Other types of learning styles relate to the manner in which individuals process the information that they receive. One dimension of processing information is global versus sequential. A **global learning style** is a preference or tendency for seeing the "big picture" before "putting all the pieces together." Once global learners have an overview or holistic sense of what is being learned and

its relevance, they are then able to focus on details or smaller concepts related to the whole. A **sequential learning style** is a preference for "putting together the pieces" to understand the "big picture." Learning sequentially is taking small steps and focusing on one task at a time. These learners are sometimes called linear learners.

Another dimension of processing information is abstract versus concrete. An **abstract learning style** is a preference for visualizing or conceptualizing ideas, which are intangible (cannot actually be seen). A **concrete learning style** is a preference for understanding things that can be seen, heard, or touched. A concrete learner is often excellent in processing factual information but may have difficulty understanding abstract ideas.

What we mention about learning styles in this section represents only a small portion of all of the various learning styles that have been identified. What is most important is for teachers to use a wide variety of instructional strategies to address the diverse learning styles of learners. Whenever possible, offer students choices about how to learn.

Howard Gardner's theory of multiple intelligences[8] provides teachers with a framework that can help them avoid focusing too much on teaching only to students with high linguistic and mathematical abilities. Gardner notes that students who are not good at either linguistic or mathematical abilities have not traditionally received much attention from teachers, have been left behind, and have lost interest in learning. His theory is that people have different intelligences or abilities, in addition to linguistic and mathematical intelligences, and that these unique ways of thinking and learning need to be given equal attention. The eight intelligences that should be given attention by teachers are listed here:

- *Linguistic intelligence*. The ability to read, write, and communicate with words
- *Logical-mathematical intelligence*. The ability to reason and calculate, to think things through in a logical, systematic manner
- *Visual-spatial intelligence*. The ability to think in pictures and visualize future results
- *Musical intelligence*. The ability to make or compose music, to sing well, or understand and appreciate music
- *Bodily-kinesthetic intelligence*. The ability to use one's body skillfully to solve problems, create products, or present ideas and emotions
- *Interpersonal (social) intelligence*. The ability to work effectively with others, to relate to other people, and to display empathy and understanding
- *Intrapersonal intelligence*. The ability to self-analyze and reflect, or, in actuality, the capacity to know one's self. In other words, to be able to con-

template and assess strengths and weaknesses, to review behavior and feelings, and to make plans and set goals

- *Naturalist intelligence*. The ability to find meanings and patterns in nature and the world

Armstrong explains how to plan for teaching for the eight intelligences:

> To get started, put the topic of whatever you're interested in teaching or learning about in the center of a blank sheet of paper, and draw eight straight lines or "spokes" radiating out from this topic. Label each line with a different intelligence. Then start brainstorming ideas for teaching or learning that topic and write down ideas next to each intelligence (this is a spatial-linguistic approach of brainstorming; you might want to do this in other ways as well, using a tape-recorder, having a group brainstorming session, etc.).[9]

Teaching with the Brain in Mind

Until recently, little was known about the workings of the brain and how people learn. Knowledge about the brain and how it learns is rapidly accumulating. Scientific tools such as magnetic resonance imaging (MRI), computerized axial tomography (CAT), and positron emission tomography (PET) have led to important discoveries about the human brain.

Research from several scientific disciplines has contributed to a virtual revolution of knowledge about the human brain and human learning. Findings from this research create exciting opportunities for educators to apply this information in ways that best help students learn.

One of the most interesting findings from brain research is that learning changes the structure of the brain. In essence, the brain "rewires" itself in response to new stimulation and experiences. Learning experiences cause nerve cells in the brain to create new synapses or junctions through which information passes from one nerve cell (neuron) to another. A baby is born with only a small proportion of the trillions of synapses that he or she will eventually have. Many of the synapses that will eventually be formed after birth are the result of what is learned. Other changes in the brain, such as increased capillary (tiny blood vessel) development and neuron-supported cell growth, are associated with learning.[10]

Our brains are designed to take in a large variety of stimuli from our five senses—sight, hearing, smell, touch, and taste. In response to the stimuli we experience, we develop neural networks or connections among neurons through which the neurons communicate with each other. This communication allows our brains to interpret and respond to sensory stimuli. These neural connections, often described as neural pathways, are strengthened when they are frequently used or stimulated. New experiences (learning) cause new neural pathways to form—a process known as **neural branching**. However, when neural pathways are not stimulated or are infrequently used, they atrophy and cease to function. Neuroscientists call the process of the withering away of neural pathways **neural**

pruning. Another important term is **brain plasticity**. Scientists use this term to describe the ability of neural networks to continue to generate and to modify themselves throughout life.[11]

The important point here is that the brain's capacity to develop neural pathways (plasticity) depends critically on how much it is used. The brain adapts continually whenever something new is learned. Changes in the brain occur as a function of use—use it or lose it, so to speak. Experiences early in life, when the number of connections between brain cells starts to increase rapidly, are important to optimal brain development.[12] In the early years of life, it is important that the brain be adequately stimulated through interactions with both people and the environment. Children with stronger and more connected neural pathways are more likely to have greater learning ability, higher levels of motivation, and accelerated readiness to begin school.[11] Learning occurs at all ages, and the brain appears to maintain its plasticity for life.[12]

The physical structure of the brain changes spontaneously and automatically in response to learning. We do not need to be taught to learn; learning is a natural and innate response to experience. Our brains are continually searching for meaning. The brain's craving for meaning is automatic. The search for meaning occurs through patterning as the brain attempts to discern and understand events in its environment. The brain creates neural connections or associations with what is already known to be personally meaningful. Unless new information carries meaning for us, we are unlikely to make use of it.[13]

Relaxed Alertness

Emotions profoundly affect the brain's ability to learn. Positive emotions such as happiness, enthusiasm, hope, and optimism can facilitate children's learning. Learning in a pleasant environment may stimulate the flow of chemicals in the brain that stimulate the areas of the brain most responsible for learning.

An optimal emotional state for student learning has been described as **relaxed alertness.** According to Caine and associates:

> Relaxed alertness is a state of mind where a student feels competent and confident and is interested or intrinsically motivated. Relaxed alertness is also a state that is present in classrooms and learning environments in which emotional and social competence is the goal. Such an environment allows all students ongoing opportunities to experience competence and confidence accompanied by motivation linked to personal goals and motivation.[14(p.5)]

On the other hand, when students feel threatened, chemicals released in the brain cause the brain to **downshift** so that students are less able to engage in intellectual tasks or form memories. The term *downshift* in this context means that the more primitive and emotional parts of the brain begin to dominate when a threat is perceived. Teachers should understand that situations that create anxiety or threat in the lives of students create downshifting and decrease the students' ability to learn. With this in mind, you should pay special attention to building a classroom environment and relationships with your students that

minimize threat and anxiety so that your students can feel a sense of relaxed alertness.

Your classroom should be a place where students feel safe and secure. Pay special attention to the way that you manage your classroom and consider whether there are things that you do that might create threat or anxiety. Seek to eliminate those things that might create such feelings. Help students who appear anxious or threatened to deal with their feelings. Realize that a student cannot simply shut off or turn on emotions to learn better. Many live in situations that are highly stressful. Some are affected by major threats, such as the illness of a family member, poverty, child abuse, or community violence, which can take a toll on learning ability. Children with such major threats need help, and you can be instrumental in linking them with needed assistance and resources. As a school teacher, you can consult counselors, school nurses, and other available professional resources. Follow school and district policies in seeking help for children suffering from serious threatening conditions.

"So What?"

We have described how the brain innately searches for and constructs meaning. The brain responds differently to what it considers to be meaningless versus meaningful information.[9] Facts about various topics that are learned in isolation are usually soon forgotten by students. However, information that has meaning is retained. We have found in our experience that when we can help students answer the question "So what?" concerning a particular topic, student learning is better. It is our responsibility to help our students understand why what we are discussing in class is personally relevant and meaningful. Both teachers and students should be able to answer the "So what?" question. Our lessons and learning activities should strive to relate material to students in a personal way and to connect to prior learning and experiences. There should be more focus on the quality of the information that is taught and less focus on covering large amounts of material that may be meaningless to students.

Active Learning

The notion that the brain is an empty vessel waiting to sponge up information or have informative material poured into it is false. Learners are not passive recipients of information. Learning requires more than the efficient delivery and dissemination of information into students' minds (passive learning).

The human brain is an information-processing organ, and it learns best through experience. It is able to learn more and retain learning longer if the learner acquires the learning in an active rather than passive manner. Active learning engages students in doing things and thinking about the things that they are doing. You can use many active learning strategies in your teaching to engage students actively. Examples of in-class active learning strategies are debates, role-playing, simulations, dramatizations, and learning centers. Outside of class, active learning examples include service learning, health fairs, and

several types of creative projects. An important and frequently neglected ingredient of active learning is giving students time and encouragement to process and think about the meaning of their learning experiences. Give students opportunities to reflect on what they are learning, the value of what they are learning, how they are learning, and what else needs to be learned. You can do this by creating opportunities for students to engage in self-reflection, such as writing in a journal, or to engage with a teacher or others. Reflection and active processing of learning allow for deeper understanding and meaningfulness of learning experiences.

Individuals learn best when they are immersed in meaningful, compelling experiences. Some schools believe that the teacher's job is to create multisensory real-life learning environments that fully immerse students in learning experiences. This active learning approach is often referred to as **orchestrated immersion**.[14] The key is for students to be "immersed" in rich and complex environments as a way of life, not just for a short time a day per subject. Orchestrated immersion implies that the teacher becomes the conductor or the architect, designing experiences that will lead students to make meaningful connections. The teacher then helps students with the active processing of the experiences as a basis for making them a meaningful learning event. The teacher's role here is much different from the traditional scenario in which the teacher dominates by talking and holding the students' attention. Students who become immersed in learning experiences often become engrossed in learning without regard for time.

The optimal tension level for learning is high challenge and low threat.

RAD Teaching

Judy Willis, a teacher and neuroscientist, proposes that we take into account three main brain systems when preparing lessons and planning for instruction. She identifies the three systems with the acronym **RAD**, which stands for reticular activating system (RAS), amygdala, and dopamine. The **reticular activating system (RAS)** is located in the brainstem and has the job of filtering stimuli (sensory messages) coming into the brain. It determines which information gains entry to the conscious, thinking brain or instead is relayed to automatic response centers. According to Willis, there are billions of bits of sensory information available every second, but only a few thousand can pass through this unconscious RAS filter. The RAS gives priority to stimuli that is novel. From a survival standpoint this makes sense: the brain needs to know what has changed in the environment in case it represents a threat. For example, a quick change in the environment rapidly gets our attention—lights turned off and on, a person entering a classroom when everyone is seated. Because the RAS is geared to let things that are novel and surprising capture our attention, novelty and surprise should be incorporated into teaching strategies. Willis points out that listening to lectures and doing drills and worksheets are not novel experiences, so "do not have the sensory excitement to power through the RAS brain filters."[15] In addition to novelty and surprise, multisensory learning experiences are a good way to get and maintain students' attention.

The **amygdala** has been likened to a switch because it determines whether information is sent to the thinking areas of the brain or instead is sent to

The brain's natural way of learning is through problem solving.

reactive areas of the brain. When a student is relaxed, the information can flow more easily to the higher cognitive areas of the brain for processing and reflection. The optimum state for this flow of information is relaxed alertness, as discussed earlier in the chapter. However, Willis explains, if students are stressed, bored, or frustrated "by lessons beyond their level of understanding or by lessons about things they have already mastered, the amygdala directs the input to the unconscious, involuntary, reactive brain." In this emotional state, the brain is in survival mode and is ready to react with "fight, flight, or freeze so no long-term memories are created."[15]

Dopamine is a brain chemical (neurotransmitter) that is released during pleasurable experiences. Dopamine increases the brain's attention to the pleasurable activity and builds strong memories of the experience. The implication here is that when you incorporate pleasurable, joyful learning activities, dopamine may be released in students' brains and help them pay attention and create long-term memories of what they learn.[15]

Other Considerations

You must consider many things when teaching with the brain in mind; because of space constraints, we mention only a few more. One of these is that the brain learns better through social interaction than it does when working alone. Yet, in many classrooms we see the students sitting quietly in rows, working independently with little or no social interaction. Teachers can offer students learning activities that allow students to work together toward a common goal. Cooperative learning activities can help students learn communication and social skills at the same time that they are working toward a learning goal. Cooperative learning activities also foster a sense of being a member of a learning community and encourage meaningful discussion and reflection. Many students find that learning is more enjoyable when they have the opportunity to learn through social interaction.

The brain is poor at nonstop attention. It takes a high level of neural energy for students to concentrate and focus intensely. This is particularly true for direct instruction. The attention spans of most students are brief. According to Jensen, author of *Teaching with the Brain in Mind*, the appropriate amount of direct instruction for children in grades 3 to 5 is 8 to 12 minutes; for those in grades 6 to 8, 12 to 15 minutes; and for those in grades 9 to 12, 12 to 15 minutes.[16] The brain's store of neural energy is quickly depleted by episodes of paying attention. If not given time for rest or diversion, the brain loses the ability to focus and concentrate. For this reason, provide students with breaks, alternative learning strategies, and changes in topics to shift the emphasis of concentration.

Jensen asserts that one of the smartest things that teachers can do is to keep students active.[13] He explains that activity keeps their energy levels up and provides the brain with the oxygen-rich blood needed for highest performance. Physical activity either before or after learning also releases chemicals that

Being physically active keeps energy levels up and enhances long-term memory.

enhance long-term memory. He warns that teachers who insist that students remain seated during the entire class period are not promoting optimal conditions for learning. He suggests using drama and role-plays, energizers, quick games, and stretching to physically invigorate students during learning. If students feel drowsy, they should be allowed to stand at the back of the room for a few minutes and do some stretching in a manner that does not distract other class members. Jensen encourages teachers to give students settling time and rest after a learning session.[16] This affords students a chance for the information to settle and for learning to take root.

Teaching Health Effectively

Health education is integral to the primary mission of schools. It provides young people with the knowledge and skills they need to become successful learners and healthy and productive adults. Health education is a fundamental part of an overall school health program. A critical objective for improving our nation's health is increasing the number of schools that provide health education on key health problems facing young people.[17]

Traditionally health education has been organized around 10 content areas: mental/emotional health; substance use and abuse; healthy eating and physical activity; personal health; safety and first aid; consumer health; community health; disease prevention and control; family life/human sexuality; and

environmental health. Time constraints make it impossible, at both the elementary and secondary levels, for teachers to address all of these areas effectively. Another problem with this organization is that it usually creates a focus on content with an emphasis on knowledge rather than on skills acquisition and healthy behavior. For these reasons we designed this text using a different approach for health instruction that emphasizes the National Health Education Standards with life skills and the **Centers for Disease Control and Prevention (CDC)** categories of risk behaviors. This text correlates all of these elements and makes it possible for teachers to focus on the critical areas and teach protective life skills that research has shown to be effective. This section discusses the National Health Education Standards (NHES) and the CDC's six categories of risk behaviors. Being familiar with this information can help you prioritize what you address in your health education teaching and teach for impact. This section also discusses other topics important to teaching health education including state and district guidelines, the Health Education Curriculum Analysis Tool (NECAT), and the coordinated school health program (CSHP).

National Health Education Standards and Life Skills

The **National Health Education Standards (NHES)** are written expectations for what students should know and be able to do by grades 2, 5, 8, and 12 to promote personal, family, and community health. The standards provide a framework for curriculum development and selection, instruction, and student assessment in health education. The standards with performance indicators for each standard and grade can be accessed at http://www.cdc.gov/HealthyYouth/SHER/standards/index.htm.

The National Health Education Standards help school systems move toward a more skills-based rather than content-based approach to health education. Many contemporary health education programs strive to empower students with life skills that they can take away from the classroom and apply in real-life settings. For example, they focus on teaching young people decision-making skills and strengthening the ability to communicate these decisions to others who might try to influence them to engage in a risky health behavior. Here are the eight national health education standards with key words in italic type that indicate life skills:

- *Standard 1.* Students will comprehend concepts related to health promotion and disease prevention to enhance health.
- *Standard 2.* Students will *analyze* the influence of family, peers, culture, media, technology, and other factors on health behaviors.
- *Standard 3.* Students will demonstrate the ability to *access* valid information and products and services to enhance health.
- *Standard 4.* Students will demonstrate the ability to use *interpersonal communication* skills to enhance health and avoid or reduce health risks.

- *Standard 5.* Students will demonstrate the ability to use *decision-making skills* to enhance health.
- *Standard 6.* Students will demonstrate the ability to use *goal setting skills* to enhance health.
- *Standard 7.* Students will demonstrate the ability to *practice* health-enhancing behaviors and avoid or reduce risks.
- *Standard 8.* Students will demonstrate the ability to *advocate* for personal, family, and community health.

The **World Health Organization (WHO)** also advocates skill-based health education. Individuals who possess these skills are likely to adopt and sustain a healthy lifestyle during their school years and throughout the rest of their lives. The WHO stresses that skill-based health education has been shown by research to reduce the chances of young people engaging in delinquent behavior and interpersonal violence; delay the onset of using alcohol, tobacco, and other drugs; prevent peer rejection and bullying; and improve academic performance.[18]

Three entire chapters of this book are devoted to helping you understand and know how to teach your students essential life skills that will protect them from risk behaviors. Chapter 3 looks at four groups of skills: self-awareness and self-evaluation skills; communication and interpersonal skills; goal setting and self-management skills; and decision-making and problem-solving skills. Chapter 4 addresses stress reduction and stress management skills. Chapter 5 is devoted to media and information literacy skills. We placed these skill-based chapters at the beginning of the text so that you are familiar with key life skills and can incorporate them into your instructional plans for the risk behaviors that are addressed in later chapters.

CDC's Categories of Risk Behavior

Looking at national statistics and trends can also help us prioritize what we take time to teach in our classrooms. More than two-thirds of all deaths among youth and young adults ages 10 to 24 years result from only four causes. Can you name those causes? If you said motor vehicle crashes, other unintentional injuries, homicide, and suicide, you would be correct. But these deaths are only part of the picture we should be examining. Almost two-thirds of deaths of those older than age 25 occur from cardiovascular disease and cancer. Many of these diseases are the result of behaviors, such as poor diet, lack of physical activity, and cigarette smoking, that are established early in life. In addition to these deaths, many school-age youth suffer from nonfatal illness or injury, social problems, and lower quality of life as a result of health risk behavior choices. Unfortunately, many school-age youth experience unintended pregnancy, sexually transmitted infections (STIs), and type 2 diabetes.

The CDC has identified that a high proportion of deaths, illnesses, and injuries in the United States result from six categories of risk behavior (see **Figure 2-1**).

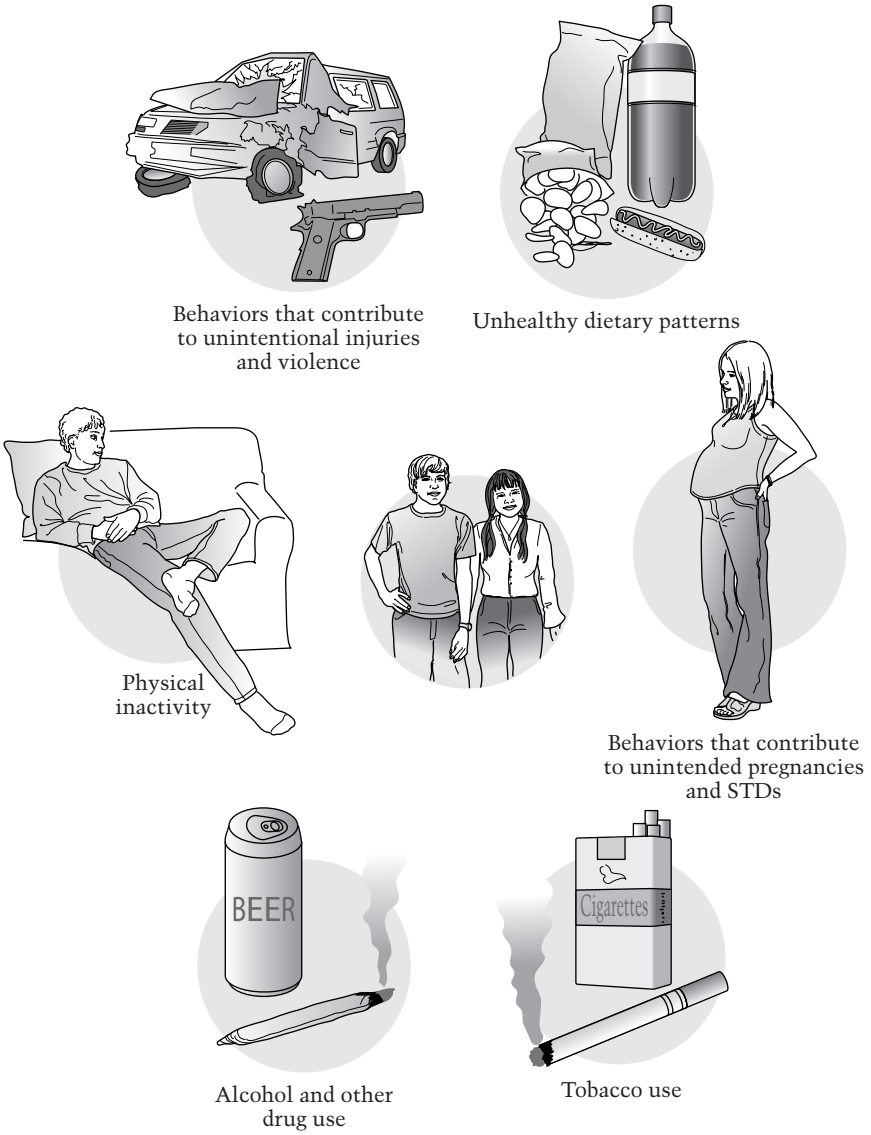


FIGURE 2-1 Six categories of risk behavior.

2-1
Application Exercise

Web Tools

This exercise helps you become familiar with tools you can use in planning your health instruction. The Youth Risk Behavior Survey is a biannual school survey in grades 9 through 12 conducted by the CDC. Becoming familiar with your state's data and how they compare to national averages can help you identify what you need to emphasize in your classroom. Go to http://www.cdc.gov/HealthyYouth. On the HealthyYouth website under the Data & Statistics heading, click YRBBS. Under Fact Sheets, click Comparisons Between State & National Results. Click a state of your choice. Consider the various risk behaviors and data. Answer these questions:

1. What data surprised you the most?
2. How did your state compare to national data?
3. How can you use the Youth Risk Behavior Survey in your teaching?

Snoop around the Healthy Youth website some more and identify at least five additional documents or resources that could help you teach health concepts.

We believe that every teacher, regardless of teaching discipline and grade level, should understand how these risk behaviors adversely affect the lives of youth (see **Box 2-1**). It is our conviction that every teacher can be a part of their school's effort to educate youth about these risks and participate in school-based efforts to promote healthy lifestyles among students. Success in these endeavors requires participation from educators representing all disciplines and all grade levels. Chapters 6, 7, 8, and 9 of this text address the CDC's risk factors in detail. Unhealthy dietary patterns and physical inactivity are addressed in Chapter 6. Tobacco, alcohol, and other drug use are examined in Chapter 7. The behaviors that contribute to unintended pregnancy and STIs, including HIV infection, are the focus of Chapter 8. Behaviors that contribute to unintentional injuries and violence are addressed in Chapter 9.

State and District Guidelines

In addition to taking into consideration the NHES and the CDC's risk behaviors, it is important that you look at available state and district guidelines. These guidelines are often created with an awareness of the particular needs of the students in an area. Community attitudes and problems can also play a part in the development of these guidelines. Many states and school districts provide health education scope and sequence plans that identify the concepts that are to be emphasized at each grade level. A teacher can better judge what students

have already been exposed to when these guides are followed. Scope and sequence guides also help teachers identify what they need to address in their class and how their instruction might be reemphasized in coming years. You can find examples of state health education standards, curricula, and guidelines by using Google to search these topics for the locations where you plan to teach.

Health Education Curriculum Analysis Tool

The **Health Education Curriculum Analysis Tool (HECAT)** is an assessment tool you can use to examine or plan your school health education curricula.* It was developed by CDC and is based on the National Health Education Standards, the CDC's categories of risk behavior, and Characteristics of Effective Health Education Curricula. The HECAT can help schools select or develop effective health education curricula and improve the delivery of health education (**Box 2-2**). Modules are available to help you analyze curricula that address alcohol and other drugs, healthy eating, mental and emotional health, personal health and wellness, physical activity, safety, sexual health, tobacco, and violence prevention. The HECAT is customizable to meet local community needs and conform to the curriculum requirements of a state or school district.

2-2
In the Classroom

Health Education Curriculum

The Health Education Curriculum Analysis Tool (HECAT) can help you plan for health instruction at various grade levels. The following content areas have been identified as essential parts of health education by HECAT. You can see where this text emphasizes each area. You can access grade-specific modules on topic areas at http://www.cdc.gov/HealthyYouth/HECAT/index.htm.

Promoting mental and emotional health	Chapters 3, 4, and 5
Promoting personal health and wellness	Chapters 3, 4, and 5
Promoting healthy eating	Chapter 6
Promoting physical activity	Chapter 6
Promoting a tobacco-free lifestyle	Chapter 7
Promoting an alcohol- and other drug-free lifestyle	Chapter 7
Promoting sexual health	Chapter 8
Promoting safety	Chapter 9
Preventing violence	Chapter 9

* This section is taken from a prepublication document of *National Health Education Standards, PreK–12*. American Cancer Society. December 2005–April 2006: 25, msp. 30.

You can use the HECAT to benefit your schools, school districts, and states in the following ways:

- Ensure a complete, thorough, and consistent review of a health education curriculum is performed.
- Clarify what should be included in a health education curriculum.
- Ensure that the curriculum is aligned with research-based practices, the National Health Education Standards, and CDC's Characteristics of Effective Health Education Curricula.
- Identify instructional strategies that improve teaching and student learning.
- Implement a high-quality curriculum that is affordable and feasible in your schools.
- Provide sound and defensible justification for curriculum decisions to parents, school board members, and other people interested in health education in your community or state.

Characteristics of Effective Health Education Curricula

Reviews of effective programs and curricula and input from experts in the field of health education have identified characteristics of effective health education curricula. The HECAT was designed to be consistent with the characteristics that emanate from this research. An effective health education curriculum includes the following 14 characteristics:

- Focuses on clear health goals and related behavioral outcomes
- Is research-based and theory-driven
- Addresses individual values and group norms that support health-enhancing behaviors
- Focuses on increasing personal perceptions of risk and harmfulness of engaging in specific health-risk behaviors and reinforcing protective factors
- Addresses social pressures and influences
- Builds personal competence, social competence, and self-efficacy by addressing skills
- Provides functional health knowledge that is basic, accurate, and directly contributes to health-promoting decisions and behaviors
- Uses strategies designed to personalize information and engage students
- Provides age-appropriate and developmentally appropriate information, learning strategies, teaching methods, and materials

- Incorporates learning strategies, teaching methods, and materials that are culturally inclusive
- Provides adequate time for instruction and learning
- Provides opportunities to reinforce skills and positive health behaviors
- Provides opportunities to make positive connections with influential others
- Includes teacher information and plans for professional development and training that enhance effectiveness of instruction and student learning

Coordinated School Health Program

For your health education to reach its maximum effectiveness, it needs to be supported by others. It is important for you to consider who you can get to help you (fellow faculty members, cafeteria workers, parents, local church groups) and how you can motivate them to action. The CDC advises that schools by themselves cannot, and should not be expected to, address the serious health and social problems that affect our nation and communities. Families, health care workers, the media, religious organizations, community organizations that serve youth, and young people themselves also must be systematically involved. However, schools can provide a critical facility in which many agencies can work together to maintain the well-being of young people. Health education is an integral part of the **coordinated school health program (CSHP)**. The CDC describes each of the seven other interactive components of the CSHP as follows (see **Figure 2-2**):[14]

- *Physical education*. A planned, sequential K–12 curriculum that provides cognitive content and learning experiences in a variety of activity areas such as basic movement skills; physical fitness; rhythms and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics. Quality physical education should promote, through a variety of planned physical activities, each student's optimal physical, mental, emotional, and social development and should promote activities and sports that all students enjoy and can pursue throughout their lives. Qualified, trained teachers teach physical activity.
- *Health services.* Services provided for students to appraise, protect, and promote health. These services are designed to ensure access and/or referral to primary health care services, foster appropriate use of primary health care services, prevent and control communicable disease and other health problems, provide emergency care for illness or injury, promote and provide optimum sanitary conditions for a safe school facility and school environment, and provide educational and counseling opportunities for promoting and maintaining individual, family, and community health. Qualified professionals such as physicians, nurses, dentists, health educators, and other allied health personnel provide these services.

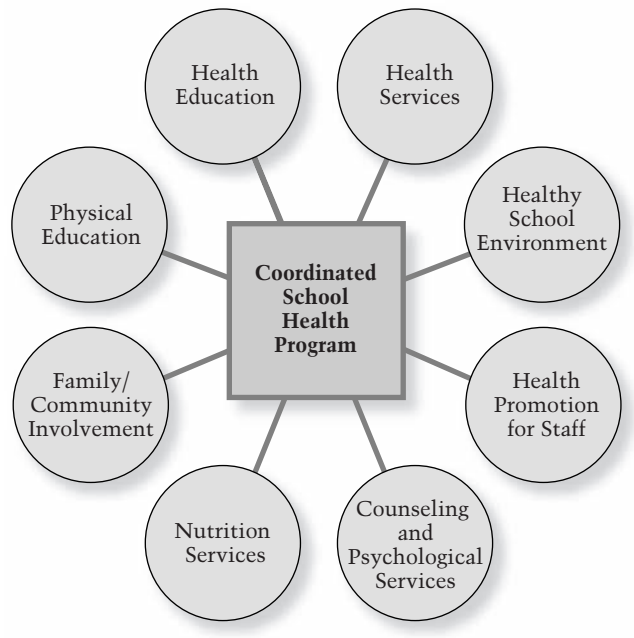


FIGURE 2-2 Eight interactive components of the coordinated school health program.

- *Nutrition services.* Access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students. School nutrition programs reflect the U.S. Dietary Guidelines for Americans and other criteria to achieve nutrition integrity. The school nutrition services offer students a learning laboratory for classroom nutrition and health education, and serve as a resource for linkages with nutrition-related community services. Qualified child nutrition professionals provide these services.
- *Counseling and psychological services.* Services provided to improve students' mental, emotional, and social health. These services include individual and group assessments, interventions, and referrals. Organizational assessment and consultation skills of counselors and psychologists contribute not only to the health of students but also to the health of the school environment. Professionals such as certified school counselors, psychologists, and social workers provide these services.
- *Healthy school environment.* The physical and aesthetic surroundings and the psychosocial climate and culture of the school. Factors that influence the physical environment include the school building and the area surrounding it, any biological or chemical agents that are detrimental to health, and

physical conditions such as temperature, noise, and lighting. The psychological environment includes the physical, emotional, and social conditions that affect the well-being of students and staff.

- *Health promotion for staff.* Opportunities for school staff to improve their health status through activities such as health assessments, health education, and health-related fitness activities. These opportunities encourage school staff to pursue a healthy lifestyle that contributes to their improved health status, improved morale, and a greater personal commitment to the school's overall coordinated health program. This personal commitment often transfers into greater commitment to the health of students and creates positive role modeling. Health promotion activities have improved productivity, decreased absenteeism, and reduced health insurance costs.
- *Family/community involvement.* An integrated school, parent, and community approach for enhancing the health and well-being of students. School health advisory councils, coalitions, and broadly based constituencies for school health can build support for school health program efforts. Schools actively solicit parent involvement and engage community resources and services to respond more effectively to the health-related needs of students.

You might find yourself in a school where there is either no coordinated school health program or where a program is only minimally established. Understanding the interactive components of the CSHP can help you see the possibilities for your school and also help you to enlist others in your school and community to become involved in organizing to support your students to make healthy behavior choices.

School Health Advisory Councils

A **School Health Advisory Council (SHAC)** is a group of individuals selected from segments of the community who act collectively in advising the school district about aspects of the coordinated school health program. Members of a SHAC are usually appointed by the school district to advise the school district. The members of a SHAC are usually drawn from the following groups of people: parents, school teachers, school administrators, students, health care professionals, members of the business community, law enforcement representatives, and representatives of nonprofit health organizations or other community organizations. The School Health Program of the Texas Department of State Health Services has produced a guide for building a successful SHAC that is available at http://www.dshs.state.tx.us/schoolhealth/SHACGuide2007.pdf.

Teaching for Behavior Change

Health education that provides information for the sole purpose of improving knowledge of factual information is incomplete and inadequate. It is important

in health education to go beyond the cognitive level and address health determinants, social factors, attitudes, values, norms, and skills that influence specific health-related behaviors. Instruction that addresses the determinants of behavior is more likely to achieve longer lasting results.[19]

The following sections briefly introduce some of the key health behavior theories and models that explain determinants of and influences on health-related behaviors among youth. Reviewing each of these models can give you great insights into how to help your students make needed health behavior changes.

Health Belief Model

The **Health Belief Model** is one of the first theories of health behavior and has been used extensively in public health practice. It was developed by social psychologists originally to understand why individuals failed to take advantage of public health services such as immunizations and screenings for tuberculosis. The model identifies six factors that influence individuals to act in ways that help improve their health:

- **Perceived susceptibility.** Belief that he or she is susceptible to a disease, injury, or other poor health condition (e.g., lung cancer, motor vehicle injury, loss of teeth).
- **Perceived severity.** Belief that the condition has serious consequences (e.g., death, bodily injury, pain, suffering, loss of job, embarrassment or shame).
- **Perceived benefits.** Belief that taking an action (e.g., not smoking, participating in physical activity) will reduce personal susceptibility to the condition or its severity.
- **Perceived barriers.** The obstacles that get in a person's way of taking an action (e.g., not smoking, participating in physical activity).
- **Cues to action.** Factors that prompt action (e.g., seeing an anti-smoking television spot, an invitation from a friend to exercise).
- **Self-efficacy.** This sixth factor was later added to the model and is discussed in the following section on social cognitive theory.

You can design health education lessons to address each of these six factors. Lessons can help students to realize the seriousness of prevalent health conditions and the connection between the condition and personal behavior (perceived susceptibility and perceived severity). Lessons can also stress the perceived benefits of various health behaviors. It is important to stress that the benefits often go beyond reduction of disease or injury risk. For example, you can stress the social and personal appearance benefits of not smoking cigarettes when discussing tobacco smoking. Young people who do not smoke are not subject to yellow stains on their teeth or bad breath and stinky clothing from cigarette

smoke. Health lessons that address perceived benefits and cues to action are helpful because they address important influences on health behavior.

Social Cognitive Theory

Social cognitive theory (SCT) is particularly valuable in explaining health behavior in youth because it emphasizes the important influence of the social environment on personal behavior. SCT identifies that people learn and are influenced by watching what others do. Observational learning (modeling) helps individuals acquire specific behaviors. Modeling, of course, can either be positive or negative. The modeling of health-enhancing behaviors by teachers, other adults, and peers is a positive force in young people's lives. On the other hand, the modeling of health risky behaviors such as cigarette smoking or weapon-carrying can exert a strong negative influence on behavior.

SCT introduces the concept that reinforcements (rewards) affect whether or not a person will repeat a behavior. Positive reinforcements increase a person's likelihood of repeating the behavior, while negative reinforcements motivate a person to stop a behavior to eliminate the negative stimulus. A good example of this is when the driver of an automobile hears a beeping alarm as a reminder to fasten a seat belt. An important point is that reinforcements can be either internal or external. Internal rewards are things that people do to reward themselves whereas external rewards are provided by other people or the environment.

Children learn from watching and imitating others. The importance of adults modeling healthy behaviors cannot be overemphasized.

Self-efficacy is a component of many health behavior theories and is, according to SCT, the most important personal factor in behavior change. **Self-efficacy** is confidence in one's ability to perform a health action or behavior and to overcome barriers resistant to taking the action. Research shows that health behaviors such as not smoking, physical exercise, dieting, condom use, dental hygiene, seat belt use, breast self-examination, and others are highly associated with a person's level of perceived self-efficacy.[20] Self-efficacy is important to behavior change because it indicates the amount of effort an individual is willing to make to change a health behavior and the person's persistence in continuing to strive for health despite obstacles, barriers, and setbacks.

Given the importance of self-efficacy in determining health behavior, you might ask, "What can teachers do to help boost their students' self-efficacy to engage and perform certain health behaviors?" Margolis and McCabe[21] suggest that teachers focus on the following four areas to help their students develop high-perceived self-efficacy:

- Provide *mastery experiences* in which students experience success. Success boosts self-efficacy, whereas failures can destroy self-efficacy.
- Provide *vicarious experiences* for students to observe a peer succeed in performing an action or behavior. By observing a peer succeed, students can strengthen their belief in their own abilities.
- Provide *verbal persuasion* to encourage students to make their best effort while guiding the student in performing the behavior.
- Foster a *positive emotional state* for encouraging self-efficacy. Teachers can exude enthusiasm about engaging in health behaviors and help to reduce stress and anxiety surrounding the practice of these behaviors.

Theory of Planned Behavior

The **theory of planned behavior** examines the relationship between health behavior and beliefs, attitudes, and intentions. It is very similar to the theory of reasoned action. In both of these theories, behavioral intention is the most important determinant of health behavior. **Behavioral intention** is the perceived likelihood of performing a behavior. Behavioral intention is influenced by a person's *attitude* toward performing a behavior and by the *subjective norm*. **Attitude** is a person's evaluation of the health behavior. The **subjective norm** consists of beliefs about whether key people approve or disapprove of the behavior. According to the theory, individuals behave in a way that gains approval from these key people. The theory of planned behavior also includes a factor called perceived behavioral control. **Perceived behavioral control** is similar to self-efficacy and is the belief that one has, and can exercise, control over performing the behavior.

It is important to provide students with lessons that examine their subjective norms about various health behaviors. Subjective norms are largely

determined by normative beliefs. **Normative beliefs** are an individual's perception of a particular behavior. Research shows that young people who simply overestimate the prevalence of smoking among their peers, as with other health risk behaviors such as alcohol and drug use, are more likely to engage in these behaviors.[22,23] Research also shows that media portrayals of smoking, often shown in a glamorous and positive light, contribute to false impressions of high smoking prevalence.[24] Teachers need to address normative beliefs to correct the belief that many students have that risky behaviors, such as smoking, drug use, and early sexual activity, among their peers are normal and frequent. You can do this by providing feedback of survey data showing actual prevalence rates. Correcting misperceptions (e.g., overestimations) of the prevalence of risky behaviors is an important preventive strategy that teachers can implement in most classrooms.

Stages of Change Model

The basic premise of the **Stages of Change Model** is that behavior change is a process, not an event. As a person attempts to change a behavior, he or she moves through the following five stages:

- **Precontemplation.** A person has no intention of taking action or making a behavior change within the next 6 months.
- **Contemplation.** A person intends to take action in the next 6 months.
- **Preparation.** A person intends to take action within the next 30 days and has taken some steps in that direction.
- **Action.** A person has changed behavior for less than 6 months.
- **Maintenance.** A person has changed behavior for more than 6 months.

The Stages of Change Model has been applied to a variety of individual health behaviors. The model is circular, not linear. This means that people do not systematically progress from one stage to the next. Instead, they may enter the change process at any stage, relapse to an earlier stage, and begin the process once more. They may cycle through this process repeatedly, and the process can stop at any point.

A key concept of this model is that people in the different stages have different health education needs and benefit from different messages and interventions depending on which stage they are currently in. When planning health education lessons about physical activity, for example, it is important to consider different messages and strategies for students who have no intention of becoming physically active (precontemplation), are considering becoming active soon (contemplation), are preparing to become active (preparation), have recently become physically active (action), and have been active long periods of time (maintenance). Design lessons should take into consideration students who have attempted to be physically active but whose efforts have failed (relapse).

These students need support to work through relapse and again move into action.

An example of a strategy based on the Stages of Change Model was developed by Brinley, Barrar, and Cotugna[25] for encouraging high school students to increase fruit and vegetable consumption. Classroom teachers distributed a "staging questionnaire" to determine students' stage of change in terms of eating the recommended intake of five or more servings of fruits and vegetables daily. Students were then assigned to a group based on their stage of change classification. Each group of students attended a stage-appropriate program on increasing fruit and vegetable consumption that was tailored to that group. For example, the focus for students in the precontemplation stage was "consciousness raising" in which the benefits and reasons for eating fruits and vegetables were explained and obstacles to this behavior were explored. Those in the preparation stage were asked to make the commitment to change and were guided with tips, tools, and techniques to begin changing their behavior. Stage-specific action sheets were also created for the students to complete during these health education lessons. This example reminds us that often it is a good idea to take into account the various stages of change in our health education instruction.

Key Terms

gray matter 34
white matter 34
prefrontal cortex 34
health literacy 35
visual learning style 36
auditory learning style 36
kinesthetic learning style 36
global learning style 36
sequential learning style 37
abstract learning style 37
concrete learning style 37
neural branching 38
neural pruning 38
brain plasticity 39
relaxed alertness 39
downshift 39
orchestrated immersion 41
RAD 42
reticular activating system (RAS) 42
amygdala 42
dopamine 43
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theory of planned behavior 56
behavioral intention 56
attitude 56
subjective norm 56

perceived behavioral control 56
normative beliefs 57
stages of change model 57
precontemplation 57
contemplation 57
preparation 57
action 57
maintenance 57

Review Exercise

1. Define and explain the relative importance of each of the key terms in the context of this chapter.
2. Identify the various characteristics of today's learners and explain how digital natives differ from previous generations.
3. Describe the wide range of student outcomes that are part of the Partnership for the 21st Century Skills.
4. Illustrate how the role of the teacher is changing and how savvy 21st-century instructors use technology and multimedia.
5. Differentiate the various learning styles, including styles for taking in information and processing information.
6. Identify Gardner's eight intelligences and provide examples of each.
7. Describe how our brains respond to stimuli (and lack of stimuli) and the practices teachers can do to best facilitate learning in the brain.
8. Explain the RAD system and the implications it has for preparing lessons and planning for instruction.
9. Discuss cooperative learning, nonstop attention, and quietly sitting in desks as they relate to brain learning.
10. Describe how health education has been traditionally organized, and how and why it is organized as it is in this textbook.
11. State the various skills that are in the National Health Education Standards and explain why skill-based health education is so important.
12. Name the CDC's categories of risk behaviors and explain the relative importance of each category.
13. Identify the characteristics of an effective health education curriculum.
14. Name and discuss the eight categories of the coordinated school health program.
15. Differentiate the various key health theories and models. Identify the health education implications of each.

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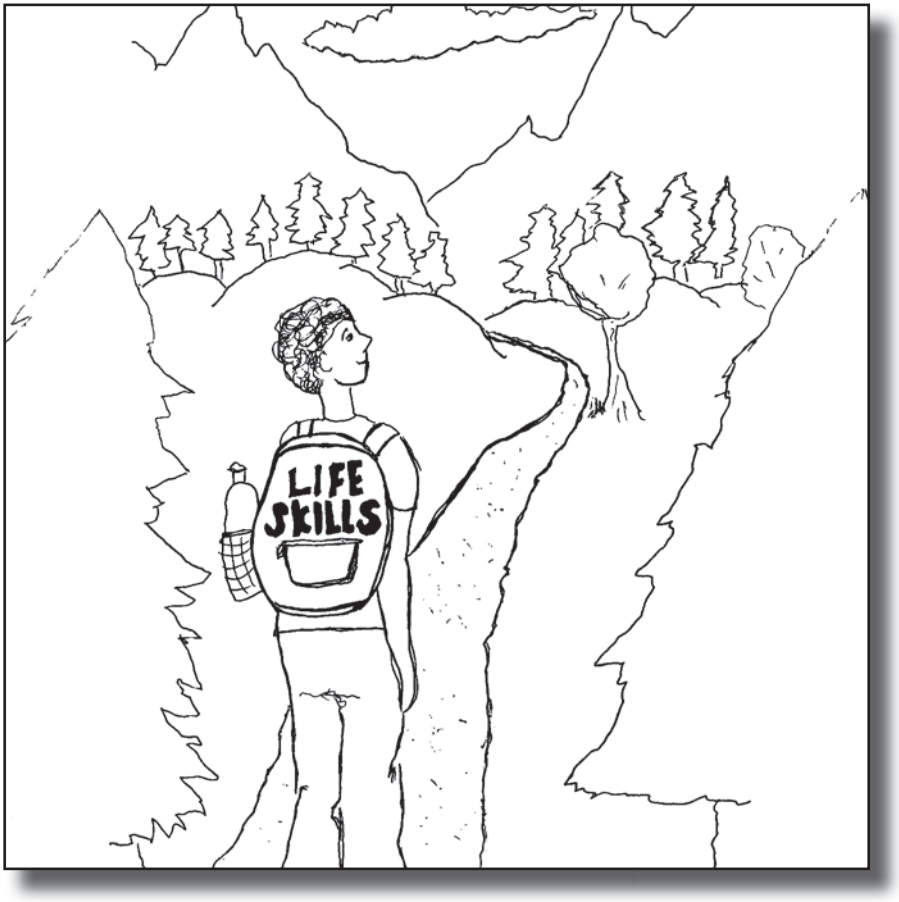
3

Life Skills



Teaching What Really Matters

On my very first day of teaching a fight broke out. It was just before sixth period sophomore slow-track English. As I entered my room I found two boys tussling on the floor. "Listen, you retard!" yelled the kid on the bottom. "I didn't take your stuff!"

The fight was quickly broken up. After class I detained Joe, who had apparently started the fight. With a flat voice and dead eyes he said, "Teach, don't waste your time on us. We're the retards of the school."

That entire night I couldn't get Joe's face and comment out of my mind. I tossed and turned in bed wondering if I really wanted to be a teacher. Finally, I knew what to do.

The following day I stood at the front of my sixth period class and looked each student in the eye. I then turned and wrote DRAHCIR on the board.

I said, "That's my first name. Can anyone please tell me what it is?"

They laughed and said I had a really weird name. I then turned and wrote RICHARD on the board. A couple of students blurted out my name and several gave me a funny look. They were suspicious and wondered if I was playing a joke on them.

I said, "Yes, Richard is my first name. I have a learning disability—something called dyslexia. In elementary school I had trouble writing my own name correctly. I couldn't spell and numbers got all jumbled up in my head. I was labeled retarded—RICKY RETARDED. I can clearly remember people calling me that and the way it made me feel."

"So how'd ya become a teacher?" asked a student in the front row.

I replied, "I hate negative labels. I love to learn and I'm not stupid. That's what my classes are all about, discovering just how smart you are and loving to learn. If you like the label 'retard,' you don't belong in here. Go see the guidance counselor and transfer out. But you have to know that I don't see any 'retards' in here. Now, this class isn't going to be a piece of cake. We're going to work hard, very hard. You're going to catch up and graduate and I'm sure some of you will go onto college. I'm not joking, and I'm not threatening you. I'm just making you a promise. I don't want to ever hear the word 'retard' again! Is that clear?"

No one transferred out and it wasn't long before the students began to believe more in themselves. As they came to expect more of themselves, they worked harder and harder, pushing themselves to catch up to their peers. We all learned a great deal about English literature that year, but so much more about life. While studying classics like The Grapes of Wrath and To Kill a Mockingbird, we discussed the need for taking responsibility for our actions, choices and consequences, and the need for setting life goals. We likened the characters' situations to similar problems they faced and

practiced problem-solving methods, how to resolve conflicts, and other communication and relationship-building skills. We discussed various labels people carry, how those labels affect people's behavior, and how negative labels can be overcome.

All of them did graduate and five of them, including Joe, earned scholarships to college. I'm now in my twenty-third year of teaching. I laugh whenever I think back on my first day in the classroom and how, for a night, I wondered if I really wanted to be a teacher. What could I possibly do that would be more rewarding than trying to make a difference in young people's lives by teaching them the skills that really matter?

Source: Adapted from J. Connolly. Don't waste your time with those kids. In: Kane PR, ed. *The First Year of Teaching: Real World Stories from America's Teachers.* New York: Walker; 1991.

There are thousands of skills young people need today to help them successfully confront their problems, pressures, concerns, and challenges.[1] **Life skills** are abilities and behaviors that enable individuals to deal effectively with the demands and challenges of everyday life. This chapter addresses four major categories of life skills: self-awareness and self-evaluation; communication and interpersonal; goal setting and self-management; and decision making and problem solving.

The **World Health Organization (WHO)** highlights the critical importance of life skills in the healthy development of young people, from their earliest years through childhood, adolescence, and into young adulthood (also see **Box 3-1**):

> These skills have an effect on the ability of young people to protect themselves from health threats, build competencies to adopt positive behaviours, and foster healthy relationships. Life skills have been tied to specific health choices, such as choosing not to use tobacco, eating a healthy diet, or making safer and informed choices about relationships. Different life skills are emphasized depending on the purpose and topic. For instance, critical thinking and decision-making skills are important for analyzing and resisting peer and media influences to use tobacco; interpersonal communication skills are needed to negotiate alternatives to risky sexual behaviour.[2(p.9)]

Our National Health Education Standards also call for life skill education. Six of the eight national standards are skill based. Standard 2 requires the skill of analyzing the influence of family, peers, culture, media, and so on. Standard 3 deals with the skill of accessing valid information. Standard 4 calls for interpersonal communication skills. Standard 5 is about decision-making skills. Standard 6 addresses goal-setting skills, and Standard 8 addresses advocacy skills.

This chapter provides the content and tools for teaching these vital life skills in your classroom. Steps for teaching a new skill are provided and numerous boxed inserts contain teaching activities that help you teach the skills in an engaging way. Later chapters address additional life skills, how to teach those skills, and how to reinforce the skills you learn about in this chapter.

3-1
Background on . . .

Skill-Based Health Education

According to the World Health Organization (WHO), skill-based health education focuses on developing the knowledge, attitudes, values, and life skills that young people need to make and act on the most appropriate and positive health-related decisions. Individuals who possess these skills are likely to adopt and sustain a healthy lifestyle during their school years and throughout the rest of their lives. The WHO stresses that skill-based health education has been shown by research to achieve the following:

- Reduce the chances of young people engaging in delinquent behavior and interpersonal violence
- Delay the onset of using alcohol, tobacco, and other drugs
- Prevent peer rejection and bullying
- Teach anger control
- Promote positive social adjustment and reduce emotional disorders
- Improve health-related behaviors and self-esteem
- Improve academic performance

Source: World Health Organization. *Skills for Health* (Information Series on School Health Document 9). Geneva, Switzerland: WHO; 2003.

Teaching Life Skills

Life skills development can be taught in all curricular areas in schools—English, social studies, science, math, and others. In health education, life skills are fundamental tools that teachers use to help young people avoid health risk behaviors—specifically, the six categories of risk behaviors introduced in Chapter 2 (see Figure 2-1). **Box 3-2** contains recommendations for teaching life skills as part of mental and emotional health. When teaching a life skill it is very helpful to include these steps:

1. *Sell it*. Create a desire in the students to become proficient in the skill and an appreciation for the value of the skill. Answer "So what?" Help students understand why the skill is important in their lives and is useful to them personally. Explain how it can help prevent problems and what can happen when a person lacks the skill.
2. *Explain it*. Explain what the skill entails or the steps required to perform the skill. Use a simple visual aid to help explain.

3. *Demonstrate it*. Show how to do/perform the skill. If there are steps, demonstrate each one slowly and clearly so that the learners can easily follow you and gain confidence in their ability to practice the skill.
4. *Coach it*. Guide students as they practice the skill. Give feedback to help them feel comfortable and confident. Be especially sensitive to the fact that some students will need more time and practice to learn and demonstrate the skill.
5. *Apply it*. Help students to apply the skill in a real-world setting. Assign students to demonstrate the skill to someone else so that they become the teacher.

3–2
Background on . . .

HECAT Recommendations for Mental and Emotional Health

HECAT is a curriculum analysis tool. It helps teachers, school districts, and states review their curricula to see whether they meet National Health Education Standards and the CDC's characteristics of Effective Health Education Curricula. It can be accessed at http://www.cdc.gov/healthyyouth/HECAT.

The following are overview recommendations for mental and emotional health, including key life skills. Specific and more detailed grade-level recommendations can be found at the website. You can review the following points to help clarify what you want to teach your students. Also note that many mental health concepts are included in other chapters: Chapter 1, teeter tottering and hydraulic lifts; Chapter 4, stress management and depression; Chapter 5, media; and Chapter 10, suicide and death. Emotional issues are also common denominators in the four risk behavior chapters (6, 7, 8, and 9). The title of this book acknowledges the fact that emotional well-being is a core element in every health issue.

A pre-K–12 mental and emotional health curriculum should enable students to:

- Express feelings in a healthy way.
- Engage in activities that are mentally and emotionally healthy.
- Prevent and manage conflict and stress in healthy ways.
- Use self-control and impulse-control strategies to promote health.
- Seek help for troublesome feelings.
- Express empathy for others.
- Carry out personal responsibilities.
- Establish and maintain healthy relationships.
- Get an appropriate amount of sleep and rest.

3-3
Application Exercise

My Favorite Activities

Review all of the teaching activities in this chapter that facilitate teaching self-awareness and self-evaluation skills (Box 3-4), communication and interpersonal skills (Box 3-5), goal-setting and self-management skills (Box 3-6), and decision-making and problem-solving skills (Box 3-7). Choose two or more activities from each of these boxes that you would like to use in your classroom. As you read the various activities think about modifications you could make so that an activity is more in line with your teaching style or can better help you reach a particular goal. Also reflect on how you could apply the steps for teaching life skills found on pages 64–65 to the activities you choose to use.

In **Box 3-3**, you can find an application exercise called My Favorite Activities in which you review the numerous activities within this chapter that can help you teach life skills to your students. As you read each activity consider how you can include each of the preceding steps while using the activity in your classroom.

Self-Awareness and Self-Evaluation Skills

A foundational life skill is being self-aware. **Self-awareness** includes recognizing and understanding our perceptions, values, emotions, habits, and the impact our behavior has on others. Being self-aware is a progressive process that is tied to our cognitive development, our having skills to effectively see ourselves, and our willingness and desire to become self-aware. People who lack self-awareness fail to consider or understand their own emotions, do not reflect on their personal reactions, and do not recognize or acknowledge how their behaviors affect others.

How well do you understand your "selves"? This section defines, explains, and differentiates many *self* terms including self-esteem, self-image, self-worth, ideal-self, Pygmalion-self, and self-efficacy. Understanding each of these selves will help you teach and personally apply self-awareness and self-evaluation more effectively. **Figure 3-1** provides an overview of our different selves. The three-way mirror illustrates two major influences on how we see ourselves. Also notice the waves in the mirror. These waves represent our perceptions. At times, our perceptions are more distorted than at other times, such as on "blue days." Consequently, how we view ourselves is dynamic and ever changing. **Self-esteem** is the evaluative component of self-image, or the positive or negative

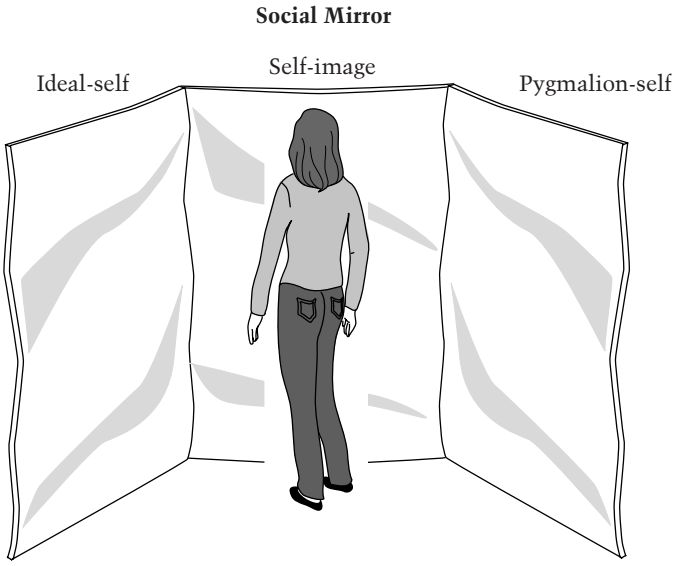


FIGURE 3-1 Understanding our "selves."

manner in which a person judges herself or himself. It is a product of what we perceive ourselves to be (**self-image**), how we want to be (**ideal-self**), and the expectations that we perceive others have for us (**Pygmalion-self**). Often our sense of worth is influenced by how competent we perceive ourselves to be, if we feel we belong in a group(s) that we esteem, and if we feel we have something we can contribute.

Self-Esteem

For 30 years, self-esteem curricula have been used to try and "inject" self-esteem into students to improve their scholastic performance. These curricula have included activities such as generously praising students for any effort they make and having students chant self-affirming statements such as "I'm great!" Unfortunately, these widespread educational efforts got the cart before the horse. Researcher and author Jean M. Twenge elaborates:

> There is a small correlation between self-esteem and grades. However, self-esteem does not cause high grades—instead, high grades cause higher self-esteem. Nor does high self-esteem protect against teen pregnancy, juvenile delinquency, alcoholism, drug abuse, or chronic welfare dependency. Several comprehensive reviews of the research literature by different authors have all concluded that self-esteem doesn't cause much of anything. Even the book sponsored by the California Task Force to Promote Self-Esteem and Personal and Social Responsibility, which spent a quarter of a million dollars trying to raise Californians' self-esteem, found that self-esteem isn't linked to academic achievement, good behavior, or any other outcome the Task Force was formed to address.[3(p.65)]

Believing self-esteem can somehow be injected into students and that self-esteem comes before accomplishment are two of the prominent myths generated by the self-esteem movement. Other self-esteem myths include the notions that narcissism and self-centeredness are self-esteem, and that one should always feel good about oneself. The perpetuation of these erroneous and unhealthy ideas by teachers, parents, media, and society has fostered a generation that tends to feel good about mediocre performance, wants to be praised constantly, and is self-focused.[3] Teachers report that their students badger them for high grades and often have an unrealistic view of their performance (consider some contestants trying out for *American Idol*).

Research now indicates that self-control is a better predictor of success than self-esteem is. Self-control is correlated with earning better grades, finishing more years of education, and being less likely to use drugs and less likely to become pregnant.[3] Students experience a healthy rise in self-esteem when they exhibit self-control, do their very best work, and interact in positive ways with others. Teachers best nurture self-esteem by helping students learn self-discipline and by maintaining high academic and behavioral expectations for students.

Self-Worth

The term **self-worth** is related to a person's self-esteem. Worth identifies the immense value and potential that every person has. Our "sense" of worth may vary, but not our potential nor our value as a human being. Self-worth is best understood when we are "other" rather than "self" focused, when we see our own value because we recognize the value of those around us.

If we define our worth from a comparative view, we experience **conditional worth** where we feel worth only when we think we are somehow better than others. Consider what happens to the beautiful when beauty fades, is blemished, or altered. Plastic surgery is currently used as a form of psychotherapy for individuals whose sense of self-worth depends on their appearance. The suicides resulting from the stock market crash of 1929 attest to the sensed loss of self-worth because of lost wealth. A common denominator among children and adolescents likely to attempt or commit suicide is a very low sense of self-worth. Young people who base their sense of self-worth on conditional factors are vulnerable to feelings of worthlessness when there is failure or disappointment.

A classic example demonstrating **unconditional self-worth** is Ann Jillian. Ann is a celebrated actress and singer who developed breast cancer. She was one of the first celebrities to publicly discuss her battle with breast cancer and she did so to help others suffering from cancer or other life calamities. It took great courage to disclose the loss of her breasts from the cancer, especially when you consider that she works in an occupation where a woman's figure is deemed as or more important than talent. Unconditional self-worth such as that displayed by Ann in her desire to help others can help us meet life's challenges and gives us a firm foundation that allows us to work at achieving without fear of failure. Unconditional self-worth is nurtured when teachers and students interact with

one another in positive building ways like those discussed in Chapter 1 and in this chapter. Having and offering unconditional regard for every student is one of the most difficult, but most powerful, attributes a teacher can develop.

Ideal-Self

Ideal-self is our perception of what we want to be. Ideal-self involves every aspect of our being, including physical characteristics, mental abilities, emotional and social skills, and moral standards. Ideal-self is based on the expectations that we have for ourselves. These expectations are shaped through relationships and interactions with family members, peers, and others. The media also affect ideal-self through the messages and images to which we are exposed.

The aspect of ideal-self that youth tend to focus on most is their physical characteristics. This is particularly true for teenagers. Our *physical ideal* is what we perceive as the perfect body—our image of what we believe is the perfect height, weight, body build, coloring, facial features, and so forth. This ideal is tremendously shaped by the numerous media images we see of beautiful people, airbrushed to perfection, on television, in movies, in magazines, and on billboards. If we do not look like these people, it is easy to form the impression that we are less than ideal. Yet, the truth is that very few are capable of living up to these ideals. Even models report that there are things they don't like about their bodies. Therefore, the physical ideal that should be stressed is having a physically fit and healthy body. This is a healthy, achievable physical ideal.

Although certain physical characteristics cannot be changed, moral characteristics can be attained. For example, everyone has the capacity to be honest, respectful, responsible, hard-working, and compassionate. These characteristics are not usually aspired to or sought after unless a young person receives guidance and nurturing from adults. Too many youths idealize low moral characteristics (e.g., disrespect, disregard for the law, cruelty). In other words, the ideal-self of many young persons (what they aspire to be) includes low moral character. How can we help youth to want to incorporate moral characteristics into their ideal-self? The following sections on hero identification and character and values education address this question.

Hero Identification Heroes are simply people that we admire. The people we choose to admire shape our perception of what we want to be (ideal-self). They provide a standard against which to measure ourselves. Thus, identifying one's heroes gives great insight into one's ideal-self. Think about who you truly admire. What is it that you admire about them? You will probably think of several heroes. Some may be people that you know intimately such as family members or friends. Others might be people you have come to "know" through books or media images. Consider how your heroes affect your life. How much do you attempt to emulate their traits that you find desirable?

How much do you think children and adolescents emulate the people they admire? If you ask children and adolescents who their heroes are, many will

report celebrities—sports figures, actors, musicians, or other media stars. We are a culture fixated on celebrity status and our appetite for reading about their extreme, chaotic, dysfunctional behavior is insatiable. Magazines such as *People*, *In Touch*, and *US Weekly* regularly double their readership and millions of viewers tune in nightly to shows like *Entertainment Tonight* and *Hollywood Insider*. Young people are constantly exposed to images of and news about Britney Spears, Lindsay Lohan, Paris Hilton, and others. The drinking and drug use, wanton self-exposure, pornographic behavior, and revolving-door love lives of these celebrities provide unhealthy role models for our youth. Unfortunately, many young people's ideal-selves have been shaped by celebrity narcissism.[4]

Young people need to be exposed to heroes of high moral character in literature, history, science, in our communities, nation, and world—heroes who have channeled their energy into positive activities that benefit the community, who have made healthy decisions to reach a constructive outcome.[5] Being exposed to many different types of heroes helps youth form ideal-selves with high character qualities. It prompts young people to ask themselves if they have the various traits exemplified and inspires them to develop these traits.

Share your heroes with your students. Highlight the admired characteristics of the heroes you discuss with your students. Explain why the characteristics are important to you and how the hero may have developed these characteristics. Ask your students to interview their parents, relatives, neighbors, or others about their heroes. Instruct your students to listen carefully and identify the admirable qualities these adults' heroes demonstrate. You can also have your students search local newspapers, the Web, and magazines for articles that might identify some individuals who have acted in heroic (admirable) ways. As you do these activities, make a large lettered list of the admirable character traits identified and display this list in a prominent location. In class discussions as the semester proceeds continue to highlight admirable character traits that come to light in what your class reads or studies. The more exposure students have to examples of high character, the more likely they are to make those characteristics part of their ideal.

Character and Values Education The very first readers (elementary level books) used in public education in this nation were full of stories that taught morals—"the moral of the story is . .".In the 1960s, educators stopped teaching morals. It was a time of cultural divide and distrust and the sentiment was that values could not be taught because everyone's values were so different. In the absence of values education a new approach of having students "clarify" their personal values became popular. In **values clarification**, students were not taught values, but lead through exercises that were to help them clarify their own personal values. Perhaps you have been exposed to a values clarification exercise such as imagining you are on a lifeboat with 10 other people. You only have water and food for 4 people and are asked what you would do. In values clarification exercises like this, teachers were instructed not to influence students' values by expressing their own. While conducting these exercises, it

often became apparent that some students lacked moral values—they were amoral. Students would sometimes say things like, "Throw all the old people overboard; who needs them?"

The idea that values could not and should not be taught in the classroom persisted until the 1980s when Tomas Lickona[6] helped educators recognize that respect and responsibility are two fundamental values necessary for any society to exist. We all share these values regardless of our political, religious, or social affiliations. A movement for character- and values-based curricula emerged and has grown to where today many state educational standards require character/values education curricula. The political divide that once removed values education in schools has been replaced with one that calls for it. An example of this is President Barack Obama's inaugural address:

> Those values upon which our success depends—hard work and honesty, courage and fair play, tolerance and curiosity, loyalty and patriotism—these things are old. These things are true. They have been the quiet force of progress throughout our history. What is demanded then is a return to these truths. What is required of us now is a new era of responsibility.[7]

Character education is the deliberate effort to help people understand, care about, and act upon core ethical values—to incorporate them into their ideal-self. Thomas Lickona explains that good character

> consists of knowing the good, desiring the good, and doing the good—habits of the mind, habits of the heart, and habits of action. All three are necessary for leading a moral life; all three make up moral maturity. When we think about the kind of character we want for our children, it's clear that we want them to be able to judge what is right, care deeply about what is right, and then do what they believe to be right—even in the face of pressure from without and temptation from within.[6(p.51)]

Therefore, character education consists of teaching students "the good," motivating them to desire "the good," and inspiring actions of good character. Lickona labels these three components of character education *moral knowing*, *moral feeling*, and *moral action*. Effective character education programs require intentional, proactive, and comprehensive approaches that promote core values in all aspects of school life. Schools that take a comprehensive approach to character education do the following:[8]

- Publicly stand for core ethical values, including respect, responsibility, trustworthiness, fairness, diligence, self-control, caring, and courage
- Define these values in terms of observable behavior
- Model these values at every opportunity
- Celebrate their occurrence in and outside of school
- Study them and teach their application to everyday life, including all parts of the school environment (e.g., classrooms, corridors, cafeteria, playing field, school bus)

- ❖ Hold all school members, adults and students alike, accountable to standards of conduct consistent with the school's professed core values

Schools with effective character education programs provide students with repeated opportunities for moral action geared to help them develop their intrinsic motivation. To be successful, character education must take place in a school environment that is caring and academically challenging and supportive of all students. Parents and community members must be recruited by the school and made full partners in the character-building effort.

Pygmalion-Self

You may be familiar with the Greek myth of Pygmalion, a sculptor who created an ivory statue of a beautiful young maiden. His creation was so realistic and beautiful that he fell in love with it. In recognition of Pygmalion's strong affection for the ivory maiden, Aphrodite, the goddess of love, turned the statue into a live maiden. Using the theme from this myth, George Bernard Shaw wrote a play entitled *Pygmalion*, upon which the film *My Fair Lady* is based. The play and film portray the relationship between a young flower girl, Eliza Dolittle, and a professor. Professor Higgins's determination and expectations transform Eliza from a flower girl into a lovely lady of high society. The powerful influence of expectations of others on behavior and self-esteem has been dubbed the **Pygmalion effect**. A common expression illustrating the power of the Pygmalion effect goes like this:

I am not what I think I am.
I am not what you think I am.
I am what I think you think I am.

Pygmalion-self is our perception of what we believe other people think of us. Thus, Pygmalion-self is precisely what the preceding expression exclaims: "I am what I think you think I am." Eliza Dolittle became the lady Professor Higgins thought she could be. Take a moment to consider your Pygmalion-self. What perceptions do significant people in your life have of you? How are you affected and shaped by these perceptions? Pygmalion-self perceptions can be negative, positive, or even neutral. Can you think of ways in which you have been negatively and positively affected by your Pygmalion-self perceptions?

Relationships and interactions from several individuals contribute to a young person's sense of Pygmalion-self, including family, teachers, peers, friends, coaches, and neighbors. However, Pygmalion-self is also highly specific to each relationship and interaction. For example, it is common for a teenager to feel low regard from certain peers and yet feel high regard from other peers.

Pygmalion-self-perceptions are prone to inaccuracy. Consider the following case. Melissa wholly believes that one of her teachers thinks she is "dumb" and incorporates this perception into her Pygmalion-self. In reality, the teacher considers Melissa as a slightly above average student. Melissa's perception affects her schoolwork and her relationship with the teacher. Misperceiving the percep-

tions of others is a common problem associated with Pygmalion-self. The self-evaluation section in this chapter addresses how to help students accurately evaluate their Pygmalion-self.

Too often individuals accept certain labels that have been "placed" on them. Students need to learn how to reject negative scripting imposed on them by others. Students and teachers also need to develop the habit of being Pygmalion positive to one another. Self-efficacy is fostered in a Pygmalion-positive environment. **Self-efficacy** is believing you can succeed at a particular task. Students who believe they can learn, do so. Students with low self-efficacy for math find math very difficult. How a teacher and classmates interact with a student affects that student's self efficacy for learning in that setting and in the future. Chapter 1 also addresses Pygmalion effect in the classroom in the section titled "Interacting with Students."

Self-Evaluation

Now that we have looked at our many "selves" and reviewed the importance of character and values, we are ready to look at self-evaluation. **Self-evaluation** includes reflecting on how we view and treat others, on our ideal-self and Pygmalion-self, on our strengths and weaknesses, and on our habits and values. A key in self-evaluation is the ability to take a nonemotive third-person view of ourselves. What we mean by this is seeing ourselves through the eyes of another person while maintaining a nonjudgmental state. This is a skill that can be learned. The following examples illustrate the need for more accurate self-evaluation.

Marie works hard in school and recently earned a 94% on a test. Upon reviewing her corrected test, she remarked, "I really messed up on the test!" Michael is very agile and proficient in sports, the "athlete of the family." He does moderately well in school but not as well as his older brother, the "brain of the family." Therefore, he feels that he is dumb. These two young people have trouble evaluating themselves accurately. Being able to see oneself accurately is not an easy task, but it is an important life skill.

Teachers can assist students in evaluating themselves more realistically by first helping them develop an awareness of their ideal-self and Pygmalion-self. A variety of activities can help students answer the questions "How do I wish I were?" (ideal-self) and "How do others see me?" (Pygmalion-self). Part of this awareness entails recognizing how our self-perceptions have been influenced over the years by the media, peers, parents, siblings, and teachers. Teachers can be especially effective in providing these kinds of insights through lecture, discussion, and learning activities. Once students recognize all of these influences it is easier for them to evaluate the accuracy of their self perceptions. They can also determine whether their ideal-self is what they really want it to be, and if they care to accept the Pygmalion-self imposed on them by others.

In the earlier example, Marie was able to accurately identify that she earned a high score on a test, but unrealistically evaluated her efforts as a failure because

her ideal-self demanded perfection. Perfection is an unrealistic foundation for self-evaluation. One of the general characteristics of individuals with negative self-concepts is that they make unrealistically high demands of themselves, they tend to judge themselves on the basis of unattainable goals of perfection. Marie can be helped to see how her ideal-self has demanded perfection and that it would be healthful for her change that aspect of her ideal-self.

In the case of Michael, he had accepted a label as part of his identity. He accurately assessed himself as talented in athletics but inaccurately believed he could not be both athletic and intellectual. Assigning labels and roles to relatives is common in families. Parents often place labels such as "the musician," "the brain," or "the athlete" on their children in an effort to reinforce talents they see in them. Unfortunately, parents don't realize that placing the label on one child sometimes discourages siblings from developing potential in the same area. Another unfortunate consequence of labeling is that it makes the labeled person focus on the labeled trait to the exclusion of other talents or interests that he or she might have. By coming to realize how his family label has affected his self-image, Michael is not likely to suddenly perceive himself as being smart. However, he might wonder if he could be smarter than he had thought. He may challenge himself to see if he is capable of more than he had once believed.

Teachers are not in a position to counsel each student and individually review their self-perceptions. They can, however, help students become more aware of their "selves," question negative labels, foster Pygmalion-positive interactions, promote value development, give honest feedback and help students see their shortcomings, and challenge students to become all that they are capable of being. Helping students honestly and effectively complete self-evaluations of their schoolwork is one way teachers can promote self evaluation skills. Carefully review all the teaching activities in **Box 3-4** for ideas on how you can help your students develop self-awareness and self-evaluation skills.

3-4
In the Classroom

Assessment and Learning Activities for Self-Awareness and Self-Evaluation Skills

The following activities can help you assess and teach your students self-awareness and self-evaluation life skills. Each activity identifies the most likely appropriate grade level(s) for use. Also see Box 1-6 in Chapter 1 for related activities.

(*continues*)

P = primary, kindergarten through third grade
I = intermediate, fourth through sixth grade
J = junior high
H = high school

You can embellish or modify these activities to fit your teaching objectives, styles, and students. For instance, we have observed a teacher very successfully modify and use the activities indicated for the primary level in her high school class. She says teenagers like to act "cool" but are really little kids at heart. Remember to use the suggested steps for teaching life skills on pages 64–65 when you develop these activities into lesson plans. As you review these and the other activities in this chapter, take time to think about how you could use them as part of units addressing risky behaviors.

Getting to Know Me

Have students write endings to complete statements like the following as a self-awareness exercise. Encourage depth and honesty by assuring them that their answers are for their eyes only. (I, J, H)

1. I hate . . .
2. I wish . . .
3. I fear . . .
4. I love . . .
5. I want most to be . . .
6. I am most cheerful when . . .
7. I am interested in . . .
8. When bullied, I . . .
9. When I am the center of attention, I . . .
10. When I feel awkward, I . . .
11. When given responsibility, I . . .
12. When I want to show I like someone, I . . .
13. When I am angry, I . . .
14. When others put me down, I . . .
15. When I am under a lot of stress, I . . .

Reflective Writing

Have students keep a daily journal for a designated time period. Their journal entries could be about their feelings, perceptions, dreams, goals, decisions, habits, strengths, and weaknesses—you determine the prompts according to your teaching objective. (I, J, H)

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Fingerprints

Help each child make a set of fingerprints. Have them compare fingerprints with other children. Point out the differences and discuss how each person is unique and lovable. Students can also draw eyes, ears, hair, and so forth on their fingerprints and then compare their drawings. Have students frame their fingerprints and keep them on their desks as a reminder of their uniqueness. (P)

Classroom Stars and Sun Spots

Make a bulletin board of dark blue paper with a yellow moon in one corner. Have each student make a star, sign it, and write a positive personal quality. You may have to help them identify these qualities. Display all of the students' stars on the bulletin board.

A variation of this is to prepare or have students prepare one paper or cardboard sun (circle with perimeter lines for rays) for each student. Cut a hole in the center of each sun and have each student place one of their school pictures in their "frame." Then, you, the student, or classmates can write special things about each individual on the sun's rays. (P, I)

I Am Good At . . .

Have each student draw a picture to complete this sentence: "I am good at . .". Ask students to show and explain their drawings to the class. Model and help the students give each other positive feedback especially to any shy or insecure student. (P, I, J)

Eggs of Praise and Fortune Cookies

At Easter time, give every student in the class a plastic egg with a message in it that recognizes talents, abilities, or positive behavior you have observed. At Chinese New Year, give every student a fortune cookie that contains positive messages. The point of the activity is to enhance the student's Pygmalion-self. An alteration that creates a hydraulic lift exercise is to have students write the messages in the eggs or cookies. (P, I, J, H)

Who Is This?

Place a baby picture of a student on a bulletin board with the caption, "Who is this important person?" Highlight information about this student—place of birth, hobbies, number of siblings, favorite foods, and so on. Make efforts to spotlight students who

(*continues*)

need recognition or be sure to spotlight every student throughout the school year. Use this activity to help the students see one another's unique worth. (P, I, J)

Slide Show

Throughout the school year, take photographs of the students as they engage in various learning activities. Toward the end of the year, set aside time for students to view the slides, to give and receive positive comments, and to recall shared experiences. (P, I)

King/Queen for a Day

On birthdays or some other day, honor each student by having him or her wear a crown and cape and sit in front of the class. Have the other students write and/or illustrate some positive characteristic they have observed in the honored student. Make these writings and drawings into a "book" and place each student's book in the classroom library to be read by the class during free reading time. (P, I)

Pygmalion-Self

Have students complete each of the following phrases with at least two answers, preferably in paragraph form. (I, J, H)

1. My closest friend thinks I am . . .
2. My classmates think I am . . .
3. My parents think I am . . .
4. A stranger's first impression of me might include . . .

Me Inside and Out

Place on the floor a large sheet of paper that is folded so that it is double thick. Instruct students to lie down on the paper and then have someone trace around them. Cut out the figure. Have students color their figures to show how they look, both front and back. Put the two pictures together and staple around the figure, leaving part of one leg open. Request parents to make a list of all the good qualities they see in their child and have the students bring these lists to school. Create lists for those students whose parents did not comply. Have students write each characteristic on the back of a different piece of scrap paper, crumble the scrap papers and stuff them into the open leg and then staple the leg shut. Display everyone's paper dolls and discuss what the students are like inside and out. This activity can help you foster positive Pygmalion-self and character development. (P, I)

(*continues*)

(*continued*)

Labels I Wear

On slips of cardstock write positive and negative labels people "wear." Have a student stand in the front of the class and tape one or more of the labels to his or her clothing. Discuss how a person might become labeled whatever you have indicated. Have other students come forward and "wear" the other card stock slips. Discuss how we can choose to "wear" labels placed on us or we can choose to discard and disregard labels others try to give us. (I, J, H)

Coat of Arms

On drawing paper, ask students to draw a large shield and then design a personal coat of arms with symbols representing their personal talents, traits, values, and/or aspirations. Reassure students that this activity is not an evaluation of artistic ability, but is an exercise to help them explore who they think they are and who they want to become. (I, J, H)

My Hero

Have students write papers on a person they greatly admire in the world and why. Have the class share their heroes and make a cumulative list of their heroes' admirable attributes. Display this list and challenge the class to look for these attributes in each other. (I, J, H)

Ask your students to interview their parents, relatives, neighbors, or others about their heroes. Instruct your students to listen carefully and identify the admirable qualities these adults' heroes demonstrate. You can also have your students search local newspapers, the Web, and magazines for articles that might identify some individuals who have acted in heroic (admirable) ways. As you do these activities make a large lettered list of the admirable character traits identified and display this list in a prominent location. In class discussions as the semester proceeds, continue to highlight admirable character traits that come to light in what your class reads or studies. The more exposure students have to examples of high character, the more likely they are to make those characteristics part of their ideal.

Repeated Pats on the Back

Have students pin a blank piece of paper on their backs. Every student is to write one positive thing about each classmate on his or her back. You should participate as well. When everyone has written on everyone else's backs, have the students return to their seats, take the papers off their backs, and quietly read the comments. Discuss how it felt to have others write on their backs and how the comments made

(*continues*)

them feel. (Comments may be shallow and superficial, such as "nice shoes.") Create as a class a list of admirable characteristics (e.g., hardworking, honest, loyal). Display these characteristics in large print on cardstock taped high around the perimeter of the classroom walls. Tell your students that they will be giving each other a "pat on the back" again in a couple of weeks or more. Challenge your students to look for the characteristics you have displayed on the walls in one another and be prepared to give each other more meaningful "pats." Be sure to follow through and repeat the activity. (I, J, H)

Me and Maslow

Have students draw Maslow's hierarchy of needs, label the levels, describe someone they have observed personally or otherwise at each level, identify where they believe they are, and identify things they could do to advance toward self-actualization. (J, H)

Strengths and Weaknesses

Discuss the Wiseman's Prayer: "God grant me the strength to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference." Assign students to write a paper finishing the following sentences. (I, J, H)

1. My most important strengths are . . (Consider health, creativity, common sense, good habits, natural ability, integrity, skills, etc.)
2. My most serious handicaps are . . (Consider bad habits, bad temper, moodiness, antisocial tendencies, poor ways of problem solving, etc.)
3. Things I can change for the better are . . .
4. Things I am going to have to accept are . . .

Communication and Interpersonal Skills

Understanding the principles of effective communication is helpful in developing and maintaining interpersonal relationships. Communication skills consist of effectively sending and interpreting messages including expressing your needs and being an advocate for others. Interpersonal relationship skills include communication skills and many additional abilities for establishing, building, and maintaining healthy relationships.

Sending and Interpreting Messages

We communicate in many ways. The saying "Actions speak louder than words" refers to the importance of **body language** in communication. Actors understand

the importance of body language in communicating emotion. When happiness, disappointment, disbelief, or other emotions are displayed on the screen, they are done so primarily through body language. Body language includes facial expressions; posture while standing, sitting, and walking; how close we are to others; and the amount and type of eye contact made.

The tone of voice used is also an important part of sending and interpreting messages. Take a simple statement such as "You are really good at math" and see how many messages you can express changing your voice and inflection. Can you express praise, ridicule, and scorn without changing the wording of the statement?

When we send mixed messages others have trouble interpreting our message. **Mixed messages** are sent when spoken words and body language or tone of voice do not match. For instance, a little boy said to his teacher, "You don't like fourth-grade boys, do you?" His teacher responded, "I love fourth-grade boys." The little guy then said, "I wish you would tell your face that." When we receive a mixed message we tend to believe the nonverbal over the spoken message.

"I" Messages Effective communication is enhanced when we take responsibility for our feelings. All too often we convey blame to others for our feelings ("You make me so mad!"). Instead, we should take responsibility for our emotions and convey them as such. For example, a student who is upset with his father for forgetting to come to his soccer game shouts out in frustration, "You're so wrapped up in your work that you don't care about anybody else in this family!" The father may resent such a strong statement and an argument may ensue. Instead, assume that this student takes responsibility for his feelings and says, "Dad, when you didn't come to my game, I felt like you didn't care about me." This statement would encourage open communication because it describes true feelings and because the father is more likely to respond positively without becoming defensive. When we own our feelings and thoughts we use **"I" messages** and say, "This is how I feel," "This is how I see it," "This is what I think."

Listening Listening is the most powerful communication skill that most of us don't even consider. After all, we were blessed with two ears and only one mouth. The most common listening mistakes include telling similar stories, giving unsolicited advice or solutions, and taking the message personally so that we aren't hearing objectively.

Listening can be passive or active. In **passive listening**, an individual attentively listens without talking and without directing the speaker in any nonverbal way. Passive listening can be effective when you want the speakers to feel free to develop and express thoughts without concern for evaluation or intrusion from you as a listener.

Active listening requires a great deal more mental and physical effort and energy than passive listening. It involves giving complete attention to what an individual is communicating. Through active listening, a listener conveys understanding and caring to another person, using either verbal or nonverbal means.

Listening is the most important communication skill.

Active listening requires that you not think about the experiences and insights you want to add to a conversation, but instead "listen" with your eyes, ears, and heart. Verbal responses focus on what the other is saying and convey sympathy, respect, acceptance, and encouragement; for example: "I understand," "What happened then?" "Is that right?" and "That's wonderful!" You can also show you care and understand by using **reflective listening**. Reflective listening consists of paraphrasing ("Are you saying that . .?"), comparing ("Was it like . .?"), verbalizing unexpressed feelings ("Did it make you feel . .?"), and by seeking more information ("Tell me more about . .").

Electronic Communication Cell phones and the Web have greatly increased our opportunities to communicate with each other, but they have also created communication problems. Who hasn't been annoyed by someone's cell phone going off at an inappropriate time? Students need to be repeatedly taught cell phone etiquette and guidelines for appropriate use of the Web. Problems can arise even when these instruments are used correctly. Many have noted that young adults have lost the skill of conversation because most of their communication has been through mini messages via text or e-mail. Maybe you too have seen young people sitting side by side texting each other rather than talking to one another. The lost art of conversation becomes very apparent when

young people want to begin their lives together. Trying to work through the many needed adjustments is particularly difficult when the individuals have not had years of practice communicating and working out problems face to face.

Assertiveness and Advocacy

People tend to express opinions and feelings in one of three communication styles: passive, aggressive, or assertive (see **Figure 3-2**). We act according to each of these three styles on certain occasions, depending on our situations. However, if we generally respond in one of these styles, then we can be classified as passive, aggressive, or assertive. Our goal is to model and help our students become assertive. Those who are **passive** tend to hold back their true feelings and go along with the other person or persons. They are timid, reserved, and unable to assert their rights. **Aggressive** individuals take charge of almost all situations and express their opinions, beliefs, and values with little or no regard for others. Their messages may be threatening or disrespectful. **Assertive** persons carefully express their true feelings in ways that do not threaten or make others

	Assertive	Passive	Aggressive
Speaking Behaviors	Speaks clearly and confidently with eye contact	Mumbles, nervous, avoids eye contact	Yells or refuses to speak; points finger, glares, uses physical force
Evaluations	Expresses appreciation and respect	Criticizes self and is always apologizing	Criticizes, never compliments
Focus	Uses "I" messages to communicate	Hopes the other person will guess his or her feelings	Uses "you" messages to blame
Problem Solving	Seeks compromise	Gives in to others	Wants his or her own way
Listening Behaviors	Uses active listening skills	Silent, rarely speaks	Interrupts, is sarcastic
Emotions	Tries to understand other's feelings	Denies own feelings and makes excuses	Makes fun of others, uses name-calling

FIGURE 3-2 Communication styles.

feel anxious. They speak their minds and invite others to do likewise. Assertive individuals are especially skilled at using "I" messages and reflective listening.

The ability to recognize and appropriately communicate our emotions is an integral part of being assertive. Young children especially find it difficult to articulate what they are feeling and can act out aggressively when they are angry. A child might yell, "Mommy, I hate you!" when he truly loves his mother, but at that moment is frustrated and doesn't know how to express his emotion or his needs. Children and adolescents can learn to recognize what they are feeling, develop the vocabulary to express it, and then know how to communicate it so that their needs will be met.

Advocacy is a group of skills that is built upon assertiveness and includes being able to make requests, encourage others, and express opinions. As students become more proficient at this skill they are able to influence other people's thoughts, attitudes, and actions. Advocates support other people in how they interact with them and in helping them express their needs. Students who develop the skill of advocacy are able to express and support a position with accurate information and adapt and deliver a message to a specific target audience. Advocacy skills help students promote their own well-being and that of their family and community.

Empathy

Being able to recognize the emotions of other people is a fundamental people skill and a precursor to having empathy. **Empathy** is the ability to recognize emotions of others and have the sensitivity to understand how those emotions can make someone feel. People who are empathetic are more tuned to the subtle social signals of others. They have, so to speak, a social antenna. Individuals who can "read" others are often identified as "star" employees by coworkers. They are able to work well with others, cooperatively solving problems and creating synergistic energy. Conversely, those who have a hard time tuning into others find establishing and maintaining relationships difficult. They can become loners or bullies. Another person's emotions are often displayed through body language, which serves as a means of communicating feelings. For example, in your mind you can probably picture the body language of someone who is sad or depressed. Other emotions invoke discernible body responses. Teach your students to recognize these responses. Through the use of video clips and pictures, students can learn to interpret the facial expressions and body movements of characters. You can also teach these concepts by having students role-play different emotions. Or have students play charades in which different emotions are acted out and the students guess the emotion that is displayed. You can also teach empathy by discussing what people might have felt in historical settings, in fictional settings, or in real-life situations observed on the news or in daily interactions. Recognizing emotions and empathizing with others are skills some children learn quickly, whereas others need considerably more help.

Relationship Building

Positive interpersonal relationships form the basis for filling many human needs. Relationships with significant others can alleviate loneliness, secure stimulation, establish contact for self-knowledge, and provide a means of sharing joy and pain. Young people often lack the skills to initiate and maintain satisfying relationships, resolve conflict, and deal with the deterioration or dissolution of relationships.

Intimate friendships do not develop immediately, but are built as they progress gradually through a series of stages. Understanding these stages and the skills necessary for their development and maintenance can help students build meaningful friendships. It can also help them strengthen family bonds.

In the first stage, initial **contact** is made and basic information is exchanged ("Hi, my name is Brittany"). Physical appearance often plays an important initial role. Other important factors are personal qualities such as friendliness, warmth, and openness. Classroom activities can help students develop and refine skills in initiating conversation and relationships. Students should learn about their tendencies to label and make premature judgments based on physical appearance. This knowledge helps them to develop greater empathy and appreciation for their classmates and others. Learning about the processes of nonverbal communication helps students to analyze and interpret the messages they send and receive during the contact stage.

The **acquaintance stage** entails a commitment to get to know another person better and to become more open with this person. Feelings and emotions are shared, but only in a preliminary way. Relationships often abort during this stage when one person is unable to open up to the other, or opens up too much too soon. It is helpful for students to be aware of levels of communication. Communication ranges from a level of small talk ("That's a great shirt you're wearing") to the sharing of ideas ("Why don't we try doing it this way?") to self-disclosure ("I'm having trouble getting along with my mom").

The **intimacy stage** is characterized by a further commitment to another person. Becoming a best friend, boyfriend, or girlfriend are examples of this type of relationship. Intimacy is reserved for very few people at any one time. Children, for example, often have best friends to the exclusion of playing with others. Deep feelings and emotions are exchanged by intimates that are not shared with others outside this bond.

Having a best friend helps children learn intimacy skills. However, such strong bonding should not and does not mean excluding all others. Students can be taught how harmful cliques can be to others and to themselves. Charity can be fostered for all class members as they are encouraged to interact with each other.

The **deterioration stage** is experienced when individuals begin to feel that the relationship may not be as important as they once thought or when the parties grow apart. Less time is spent together, awkward silences may occur, communication is not as open, and physical contact is not as frequent. Conflicts

Young people need skills to build and maintain healthy relationships, resolve conflicts, and solve problems.

are more likely and reconciliation more difficult than earlier in the relationship. Conflicts often go unresolved because there is an inclination not to bother with reconciliation. When efforts are not taken to alter these events, deterioration can progress to dissolution of the relationship.

Deterioration is sometimes a natural, healthy way for individuals to grow apart. Children and adolescents need to learn how to gracefully stop being a best friend with someone or to "break up" with a girlfriend or boyfriend. Unfortunately, all too often youth become cruel in their efforts. Role-playing and effective communication skills can help students learn to be kind in this stage.

Even though the deterioration stage is sometimes healthy, there are times when relationships crumble that could and should have been maintained. Family ties and relationships are especially vulnerable if left in the deterioration stage. Coming to understand mixed messages by appropriately using "I" messages, engaging in active listening, and being appropriately assertive can assist individuals in resolving conflicts.

Students can be asked to take a good, long look at the health of some of their most important interpersonal relationships. They can ask themselves, "What needs to be improved? How can I make it better?"

A relationship **dissolves** when bonds are severed that once united individuals. Sometimes roles are redefined, such as from boyfriend or girlfriend to "just friends." At other times, so many negative emotions are present between

individuals that they purposely avoid each another. Divorce is the outcome of a marriage that has reached this stage. Pain, bitterness, anger, rage, frustration, betrayal, and hurt are a few of the negative emotions that can result when a relationship dissolves. Many students have experienced some of these negative emotions as a result of dissolved relationships with peers or family members. Discussions of how to handle these negative emotions or avoid them in future experiences can be helpful.

Relationship Bank Account Covey gives great insight into how we can develop and maintain strong relationships.[9] He likens personal relationships to a **relationship bank account**. We have a different "bank account" with everyone we know, and we need to consciously make many deposits in accounts if we want them to remain "fiscally sound." Whether our relationship with another is at the low- or high-quality end of the relationship continuum depends on the amount of deposits and withdrawals we have made in that account. High-quality relationships have accounts with abundant funds. When a person makes an occasional withdrawal, such as being unsympathetic, not keeping a promise, or disciplining a child, the relationship survives fine because there were enough "funds" to cover the withdrawal. Relationships at the low-quality end of the relationship continuum have minimal funds or have been run into bankruptcy. Such relationships are full of conflict and animosity. The only way to correct such accounts is to minimize withdrawals and make steady generous deposits over time. Covey identifies six major types of deposits we can make: understanding the individual, small courtesies and kindnesses, keeping commitments, clarifying expectations, showing personal integrity, and apologizing sincerely. We now take a closer look at each type of deposit. Monetary types of deposits have been linked to these relationship deposits in an effort to help us remember them.

1. *Understanding the individual* (showing *interest*) entails recognizing what is important to that person and taking interest in it. A teenage boy may not be interested in the stock market, but occasionally reading the financial section of the newspaper and discussing it with his father who is a stockbroker will make large deposits in their joint intimacy account.

2. *Small courtesies and kindnesses* (small *change*) are often underrated, but the relationship funds banked by notes, winks, hugs, tired-feet massages, opening doors, and saying thank you quickly add up. These small acts demonstrate appreciation and that the other person's physical and emotional states are important to us.

3. *Keeping our commitments* (*credit card*) means doing what we say we will when we say we will. A boy who promises to attend his girlfriend's game but doesn't makes a withdrawal. A 12-year-old boy who promises to mow the yard when he comes home from school and does so without further reminders makes a deposit. A teacher who takes promised disciplinary action makes both a withdrawal and a deposit, thus breaking even.

4. *Clarifying expectations* (*check*) is critically important in avoiding contention and hurt feelings. We can easily encounter daily conflicts when we try to read others' minds or expect them to read ours. A mother's idea of a clean room may be much different from that of her child's. A newlywed woman's perception of sharing the housecleaning chores may be different from her husband's. A father picking up his daughter at the mall may expect her to be waiting somewhere different from where she is. A teacher's perception of an A-quality report may be different from his students. Clearly communicating our expectations helps us strengthen our relationships.

5. *Showing personal integrity* (*gold*) means demonstrating character in all our actions and relationships. For instance, if a person speaks ill of someone not present, we may wonder what that person says about us behind our back. How we treat one person can affect our relationship with 30. A young man once said to his youth leader, "You know how you are always telling us you love us? I didn't believe you until today." The leader asked what had made the difference. The young man replied, "I've always tried to be real good around you. I figured if you knew the real me you wouldn't love me. Today Johnny messed up real bad and you wouldn't let the rest of us crawl all over him. You loved Johnny even when he didn't deserve it. That's when I knew you loved me."

6. *Apologizing sincerely* (*cash*) when we have intentionally or unintentionally made a mistake is one of the surest and fastest ways of strengthening a relationship. Unfortunately, our pride often holds us back from saying, "I'm sorry . ." Our mistake turns into a relationship deficit when it could have easily become a relationship asset. See **Box 3-5** for ideas on how to teach the relationship bank account in your classroom as well as for additional activities for learning to better read people.

3–5
In the Classroom

Assessment and Learning Activities for Communication and Interpersonal Skills

The following activities can help your students develop communication skills and strengthen their interpersonal relationships as well as help you assess how proficient your students are at these skills. As you modify and develop these activities

(*continues*)

(*continued*)

in your lesson plans, be sure to remember the suggested steps for teaching life skills on pages 64–65.

Understanding with Feedback

Draw a geometric diagram on a three-by-five card. Give the card to one student and have him or her describe the diagram to the class without using hand gestures or allowing for clarifying questions. Have the class members try to draw what they think was described to them. Compare the students' drawings with the original. Repeat the exercise with a different diagram and student describer. This time encourage students to ask clarifying questions. This exercise illustrates the need for active listening. (I, J, H)

Gossip

Whisper a message into a student's ear. Have that student repeat the message by whispering it in another student's ear. Continue this process until the message has been passed through the class. Have the last student to hear the message repeat it out loud and check to see if it is the original message. This activity illustrates how there can be problems with sending and receiving messages. (P, I)

Body Language

Introduce the concept of body language with music or video clip from *The Little Mermaid*. With the students, identify various types of nonverbal messages (e.g., arms crossed, sitting forward or lounging back, palms opened or clenched, direct or indirect eye contact, amount of space between participants, voice inflections). Discuss how mixed messages can be given when verbal and nonverbal language do not agree. (I, J, H)

Emotional Charades

Have students act out different emotions, utilizing only nonverbal language. This activity can be used to help younger children identify and then label different emotions, demonstrate how emotions affect behavior, and demonstrate concepts in nonverbal communication. (P, I, J, H)

(*continues*)

Concentration

Have students mentally do a lengthy dictated arithmetic problem such as:

$$5 + 2 - 3 + 8 + 10 - 11 + 4 + 25 - 10 + 50 = ?$$

Make the point that listening in conversations takes concentration as well. Have students pair up, and then have one person listen while the other discusses a topic such as "the happiest moment of my life" or "the most important person in the world." Ask the listener to summarize what the speaker said. (I, J, H)

Sociogram

Have the class break into groups of five to eight persons. Have the groups discuss a question (e.g., Why are some people constantly putting down others? or What are some things that cause communication to fail?). As the group discusses the topic, a ball of string is passed from one speaker to the next, unraveling as it goes. Only the person holding the ball of string can speak. When another person wants to speak, the ball is passed and the string unravels more. After a few minutes, a sociogram will be revealed to the group. Group members can see who is dominating the conversation and they can include those who have not yet spoken. Repeat the exercise with another topic and challenge the students to do a better job of including everyone who wants to speak. (I, J, H)

Pictures of Emotions

Have students cut out pictures of people showing various emotions. Make a bulletin board. Discuss possible reasons for the feelings that are expressed. You can also include animal pictures. (P)

No Sound Track

Play an unfamiliar TV or DVD clip in class with the sound turned off. Ask the students to provide the dialogue of the situation they see on the screen based on how they read the actors' faces and body language. Discuss the various emotions they saw the actors display. (P, I, J, H)

(*continues*)

(*continued*)

Faces of Emotions

Have students try to match these pictures with the following emotions, or have them play charades trying to depict each of the emotions:

Anger	Distrust	Frustration	Pride
Confusion	Embarrassment	Happiness	Sadness
Contentment	Excitement	Indifference	Satisfaction
Determination	Fear	Love	Worry

(*continues*)

Emotional Log

Have students keep a 2-day log of the emotions they observe in the people around them. For each observation have the students write how and why these people felt as they did. (I, J, H)

Show-and-Tell

For show-and-tell, have everyone share an incident such as their most frightening experience, most embarrassing experience, or a time they were really hurt. Sharing can help them realize that others sometimes feel as they do and can help them be empathetic to others' feelings. You can also discuss how to deal effectively with these and other situations. (P, I)

I Feel . . .

Have students complete sentences such as the following to help them recognize their own feelings and better understand others. (I, J, H)

When nothing seems to go right, I feel . . .
When someone laughs at me, I feel . . .
When I do a good job on something, I feel . . .
When I am afraid, I feel . . .

Relationship Bank Accounts

Make various relationship "banks" by wrapping empty cereal boxes in paper with a picture of different types of people on the front of each bank to represent who the account is with (parent, teacher, friend, sibling). Create deposit slips using the pictures here. Divide the class into as many groups as you have banks. Give each group a sheet of deposit slips and have them write examples of "deposits" that could be made in their bank (for example, show interest in Mom's hobby, tell her thank you for dinner, take the garbage out, check when she wants you home, not talk bad about her to friends, apologize for not cleaning up your mess). Have each group share their examples of deposits as they place them in their banks. Distribute a new sheet of deposit slips to each student, and then have them choose a family member and write deposits they can make to strengthen that relationship. (P, I, J, H)

Here are some examples of deposits a teacher can make for a student:

Showing **interest** (Asking about her hobbies)

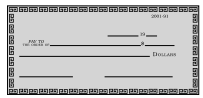
(*continues*)

(*continued*)

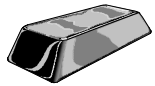
Small **change**—acts of kindness (Thanking her for collecting assignments)

Good **credit**—keeping commitments (Looking up the answer to her question)

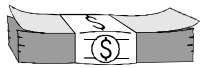
Checking expectations (Clarifying assignment grading criterion)



Pure **gold**—showing integrity (Not negatively talking about others)



Cash—apologizing (Apologizing for making a grading error)



Good Friend Recipe

As a class brainstorm the characteristics of good friends. Add those characteristics you want to emphasize. Have small groups create a "good friend recipe." Display the recipes on a bulletin board. (I, J, H)

Let's Do Dinner

Notify parents ahead of time, and then assign students to have a sit-down dinner with their family at least three times in one week. Instruct the families not to have any media on during the dinner and to try and eliminate any interruptions—that it is a time to eat and communicate with each other. Consider assigning topics for dinner conversation (world news, parents' experiences). At the end of the week have students write a reflection paper on this activity. (I, J, H)

Random Acts of Kindness

Celebrate the "Random Acts of Kindness Week" the second week of February (or anytime).

(*continues*)

Discuss examples you and your students have experienced or given. Discuss how random acts of kindness for strangers are good, random acts of kindness for friends and family are better, and sustained acts of kindness for friends and family are best. (P, I, J, H)

Label Headbands

Carefully select four or more labels according to your classroom needs or your teaching objective (i.e., jock, popular, academic, Goth). Make headbands of these labels. Place your students into groups so that each group has one of each label. Don't let students know what their label says as you place headbands on them. Be sure to give students labels that are not characteristics of them. Instruct the students to do a group activity such as putting a puzzle together or discussing an issue. Tell them to interact with each other according to their labels. After the assigned activity have students guess what their labels are, discuss how they felt with that label, explore why we stereotype people, and discuss how we can change the negative ways we interact with others into more supportive ways. (I, J, H)

I Do Care

Have the students individually make a list of the most important people in their lives. Have them write down ways to show these people that they care about them (e.g., inquire about their activities, listen carefully, show appreciation and affection) and a list of things the students do that might make these people feel they do not care (don't listen, talk only about self, interrupt, criticize, break promises, never show appreciation or affection). Have the students choose one person from their list and then keep a log of their interactions with that person for a week. Challenge students to make a conscious effort to increase the ways they show this individual that they care. (J, H)

Goal-Setting and Self-Management Skills

Goal setting and self-management are key life skills needed for emotional well-being. We will first look at goal setting. Even very young children can be taught how to set and achieve realistic goals and thus realize the joy that comes from these experiences. Four-year-olds naturally set goals such as learning to tie their shoes and dressing themselves. As children grow and mature they need direction in the kinds of goals they should set and in how to reach long-term goals.

Students can learn to see their academic progress in terms of goal setting and achievement rather than reactions to assignments given by teachers. All too often students are not involved in the setting of their academic goals. Teachers, curriculum committees, and others set standards for students to achieve. If students do not feel ownership for these standards, they can easily rationalize

their lack of accomplishment (e.g., "The teacher expected too much," "The goal was set too high," or "No one should be required to do so much"). When students are involved in the goal-setting process, however, using such defense mechanisms is more difficult and accomplishments are personally felt, generating new motivation and enthusiasm.

Students can benefit by learning different types of goals to set, how to set them, and the process of reaching them. A key to setting goals is to base them on past performance and to differentiate between long-term and short-term goals. Individuals with negative self-concepts tend to set their goals either unrealistically low or unrealistically high. Either way, the results are perceived as failure. Children also tend to set unrealistically high goals; they don't feel comfortable with low goals. Teachers who have worked on goal-setting techniques have reported that children, when asked how many times they will try to respond correctly, usually set goals that are high in relation to past performance. The most reasonable type of goal setting is to make the goal slightly higher than previous performances. For many students, this may be at a level far below the long-term goal for which they and their teacher are aiming, but this shorter-term goal is attainable. Goals that are not attainable do not contribute to long-term commitment and performance. One way teachers can handle this tendency to set unrealistically high goals is by charting a child's goal as long-term, with smaller, more easily achieved short-term goals identified as stepping stones. As the child focuses on and obtains the first short-term goal, a sense of competency is felt along with motivation for taking the next step.

As students work toward goals they have set, they need to evaluate their progress and deal with any failures. Students can be helped to see failure to meet a goal as an opportunity to learn more about how to set goals. Students can ask and answer "Was the goal unrealistic?" and "Should the goal have been set lower, and if so, what are some shorter-term goals that would lead up to it?" with a teacher's help. Students' efforts toward obtaining goals should also be part of the evaluation process.

The following steps are involved in setting and achieving goals:

1. *Identify your goal in writing*. If it is not written, it is just a wish.
2. *Identify resources* that can help you reach the goal.
3. *Map out goal achievement*—short-range goals necessary to achieve the major goal.
4. *Work* toward the goal and *adjust* your map as needed.
5. *Achieve and evaluate*. What did you learn? What went well? What could you do differently to be more successful when you purse your next goal?

Being Proactive

Taking responsibility for our life, for our actions and choices, is another key life skill for living a happy healthful life. Three prominent theories of determinism

—genetic, psychic, and environmental—state that factors beyond our control are *responsible* for our behavior. Genetic determinism basically says that "It's your grandpa's fault"; it's in your DNA, it's in your nature. Psychic determinism says "It's your parents' fault"; it's your upbringing, your childhood experiences, or emotional scripting that makes you who you are. Environmental determinism says "It's your boss's, spouse's, or the economy's fault." In other words, someone or something in the environment is responsible for your situation.

We do not deny the influence that genetic, psychic, and environmental factors have on human behavior. However, we want to bring to your attention the concept of **proactivity**, which rejects the view that people and organizations are *controlled* by genetic, historical, or environmental forces. Covey explains: "As human beings, we are responsible for our own lives. Our behavior is a function of our decisions, not our conditions. We can subordinate feelings to values."[9] Highly proactive people "do not blame circumstances, conditions, or conditioning for their behavior. Their behavior is a product of their own conscious choice, based on values, rather than a product of their conditions, based on feelings."[9(p.71)] The concept of being proactive emphasizes taking personal responsibility for behavior.

A classic example comes from the life of Victor Frankl, a Jewish psychologist incarcerated in Auschwitz during World War II. While standing naked, alone, and stripped of all his earthly possessions and family, Frankl envisioned that he had only one freedom left: the freedom to choose his responses. This realization led to the choice to forgive his captors. His forgiveness was not the result of benevolence; rather, he knew that holding on to hatred and resentment would destroy him. He continued to develop his freedom of response as the weeks and months dragged on. While digging ditches, marching, and enduring countless persecutions, he envisioned himself in the future, lecturing to university students on the lessons he learned in the concentration camp. In time, Frankl developed more freedom than his captors. Although they had more liberty, he had more freedom.

Another wonderful example of being proactive comes from the courageous life of Christopher Reeve. He was an acclaimed, tall, athletic actor who won stardom for his role as Superman. In 1995, he was fully paralyzed after a fluke fall during an equestrian competition. At age 52, in October 2004, he died from a heart attack brought on by complications of his paralysis. During his years as a quadriplegic, Mr. Reeve displayed remarkable proactive behaviors. Rather than allow his situation to control him, he chose to take control over his life and to be happy. He reported that on most nights he would dream of walking, sailing, and playing with his children, and then awake in the morning to the reality of his paralysis. He would fight the anguish and sense of loss by immediately trying to shake it off and focus on what he could do. What he did do is quite a legacy. He became a major force, mobilizing scientists to find a way of reversing paralysis, something most had thought impossible until he began orchestrating the effort.

Reactive or Proactive In every circumstance in life we have the choice to be reactive or proactive. **Reactive** people are more or less controlled by circumstance

Christopher Reeve was truly a "Superman" for the way he chose to live his life after becoming a quadriplegic.

or the environment. If they are treated well, they tend to feel and act "good." If they are treated badly, they feel bad and are defensive. Reactive people build their emotional lives around the behavior of others, believing that love is a feeling, bestowed upon them like cupids' arrows. On the other hand, proactive people such as Victor Frankl and Christopher Reeve "carry their own weather" with them. This means that they choose, to a large extent, how they are going to respond. They are value driven, having a carefully selected and internalized value code. Proactive people have the ability to subordinate an impulse to a value. This is the essence of proactivity—choosing how to act rather than being acted upon by circumstance, environment, or even impulse.

If you want to gauge your proactive versus reactive thinking, observe patterns in what you say to others. Reactive language contains statements such as "There's nothing I can do," "She makes me so mad," "That's just the way I am," "I have to do it," "I can't," and "If only . .".Proactive thinking is identified with statements such as "I can . . ," "I control . . ," "I choose . . ," and "I will . .". You can help students substitute "I can't" with "I will" and "I have to" with "I choose to."

We urge you to emphasize the powerful principle of proactivity as you teach students. Individuals do not happen to just "fall into" proactive thinking. It takes self-awareness, effort, and the building of character to achieve this way of thinking and living. You can help your students develop proactive living through

modeling this behavior in your interactions with them. Insist that they take responsibility for their own actions; do not allow them to blame their behavior on someone else. Help your students develop a proactive thinking and speaking style.

Impulse Control and Delayed Gratification **Impulse control** and **delayed gratification** are practiced by proactive people and lay the foundation for every accomplishment, from staying on a diet to pursuing a medical degree. Conversely, those having problems with impulse control and delayed gratification are more likely to drop out of school, become pregnant as teenagers, abuse drugs, and end up in jail. We live in a world saturated with advertisements whose messages tell us that we can have what we want *now*, that we deserve it and should have it *now*. This is not an environment conducive to helping us control our impulses and delay our gratification.

Teachers can help children learn self-discipline rather than act impulsively. Simple classroom structure such as not getting a drink of water until a designated time, not speaking in class until called upon, and staying seated until the teacher dismisses the class helps students learn self-management. Established procedures help teachers help students learn self-discipline. When a student doesn't follow an established procedure, the teacher just asks the student to identify the correct procedure and then do it. Some children need repetitive reminders and opportunities to practice correct procedures, but that is alright. Each time the student practices getting it right, he or she is practicing self-mastery with the teacher acting as a coach. Classrooms can also offer opportunities to learn delayed gratification when students achieve a natural reward after hard work and effort.

Anger Management

We all experience anger, frustration, insecurity, and other negative emotions from time to time. Knowing how to deal with these emotions and appropriately calm ourselves are critical life skills. It is important to talk to young people about anger. Too often, children and adolescents come to believe that it is inappropriate to feel anger. Teachers can reinforce that anger is a normal emotion that can be expressed in constructive ways. Stress to students that they are responsible for managing their anger.

To better manage their anger students need to become aware of how they experience and traditionally express their anger. They should recognize that there are physical responses to anger. Anger creates tension and stress. Building tension causes a release of hormones into the bloodstream that prepare the body for fight or flight. The heart beats faster, there is an increase in blood pressure, and breathing quickens. More blood is sent to the muscles, and these muscles become tense in anticipation of an emergency. Verbal responses to anger might include making sarcastic remarks, raising one's voice, and making put-downs. Recognizing these physical and verbal signals is important so that students can

make decisions about how to respond to their anger before it takes over. They also need to become aware of which thoughts and/or situations trigger them to feel anger.

Self-control is an important aspect of anger management. Teachers need to emphasize that one's behavioral response to anger is a choice. Behavioral responses such as physical aggression or verbal explosions are destructive. **Box 3-6** contains many teaching strategies for helping students learn how to manage their anger as well as activities related to goal setting.

3-6
In the Classroom

Assessment and Learning Activities for Goal-Setting and Self-Management Skills

Let's Think About It

Display the following thoughts on bulletin boards to stimulate class discussions. (J, H)

- The poor man is not he who is without a cent, but he who is without a dream.
- What will I wish a month, a year, or 5 years from now that I had done today?
- No man has become a failure without his own consent.
- No man has ever climbed the ladder of success with his hands in his pockets.
- There are two kinds of people that never amount to much. Those who can't do what they are told, and those who can do nothing else.
- Too many people itch for what they want without scratching for it.
- You can eat an elephant if you just eat him one bite at a time.
- Life by the inch is a cinch, but life by the yard is hard.
- Success comes in cans, not in can'ts.
- Success consists of getting up just one more time than you fall.

Stepping Stones

Teach goal setting by using the analogy of needing to cross a river. The other bank represents the goal you want to achieve. Stepping stones in the water represent steps needed to get to the goal. Identify several age-appropriate goals students might have and needed steps for accomplishing those goals. Draw a river with stepping stones. As you discuss each goal, write the steps to the goal on the stepping stones. Divide students into groups. Give each group two or more goals. Instruct the groups to draw a river for each goal and identify and label the stepping stones needed to reach each goal.

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Wishes to Reality

Have students write five things they wish to accomplish in the next 3 months. Ask them to choose one wish and work that wish through the first four of the six goal-setting steps included in this chapter. When they are finished, have students break into small groups and review each other's work for help in identifying aspects they may have overlooked. Challenge students to work toward their goals and support each other. Occasionally, have the small groups review their individual progress. At the end of 3 months, have students turn in a paper regarding the project. (I, J, H)

Class Goal

As a class, set one or more class goals. These can be academic or behavioral. Help students write the goal, based on past performance, and have it be short range. Work through the goal-setting steps with the students, being sure to evaluate and then follow up with additional goals. (I, J, H)

Individual Academic Goal

Have each student, in conference or in writing, set a goal relevant to the class subject material. Review the goals set to see that they are based on past performance and that they are short range. If any goal does not meet these standards, help the student modify it. This is imperative if the student is to achieve the goal. (P, I, J, H)

Teach Study Skills

Sometimes the difference between the good student and the poor student isn't the amount of time spent studying, but the amount of *effective* time spent. Take time in class to teach study skills such as skimming, scanning, using parts of the text, previewing reading material, outlining, note taking, identifying key concepts, memorization techniques, and test taking. (P, I, J, H)

Bury the "I Can'ts"

Have each student list their "I can'ts" on a sheet of paper. Give students time to think and write until they have filled their paper with comments such as "I can't do long division," "I can't sit still very long," "I can't do a cartwheel," "I can't stand vegetables," "I can't stay up late." Be sure and do this activity along with your students: "I can't get the school to give me more funding," "I can't get Justin to complete his homework," "I can't get Jennifer's mother to come in for a conference."

After 10 or so minutes, have the students put their pieces of paper into a shoe box that has been decorated to look like a coffin. Add your sheet of "I can'ts" to the box.

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Lead your students out to the school yard and dig a grave for "I Can't." At the graveside read the following eulogy. If it is not possible to bury the box with your students present, modify this activity to meet your circumstances.

Eulogy

> We have gathered here today to honor the memory of "I Can't." While he was with us on earth, he touched the lives of everyone, some more than others. His name, unfortunately, has been spoken in every public building—schools, city halls, state capitols, and yes, even the White House. We have provided "I Can't" with a final resting place and a headstone that includes his epitaph. He is survived by his brothers and sister, "I Can," "I Will," and "I'm Going to Right Away." They are not as well known as their famous relative and are certainly not as strong and powerful yet. Perhaps someday, with your help, they will make an even bigger mark on the world. May "I Can't" rest in peace and may everyone present pick up their lives and move forward in his absence. Amen.

After the funeral, cut out a large tombstone from butcher paper and write "I Can't" at the top, put RIP in the middle, and write the date at the bottom. Display this tombstone all year as a reminder for when a student forgets and says "I can't." When this happens, simply point to the tombstone and have your student rephrase his or her statement. (P, I, J, H)

Source: Adapted from C. Moorman. Rest in peace: the "I Can't" funeral. In: *Chicken Soup for the Soul.* Deerfield Beach, Fla: Health Communications; 1993.

Crisis

Ask each student to collect newspaper articles that describe how individuals have acted in crisis situations. Discuss whether these actions were reactive or proactive and why the students think the person acted as he or she did. (I, J, H)

Self-Actualization

Have students review Maslow's hierarchy of needs and examples of self-actualized individuals. Discuss the proactive characteristics these self-actualized people demonstrate. (J, H)

At the Top

Name and give a brief description of various successful individuals. Have students identify possible things these successful individuals had to work for and wait for—how they controlled their impulses and delayed their gratification. (I, J, H)

(*continues*)

Letting Off Steam

Show pictures of steam engines. Explain that steam can be both beneficial (fuel a steam engine) and harmful (burn you). Describe anger as emotional "steam." Discuss where it comes from and the proper and improper times and means of "letting it off." Have students make a simple poster illustrating both destructive and constructive methods of letting off steam. Discuss them and display them on a wall. (P, I, J, H)

Getting a Handle on Anger

Teach the following key anger management skills. The first set of skills concerns what to do long before you find yourself upset. The second group of skills concerns what you can do as soon as you find yourself getting upset. Have a rich class discussion on each skill. Provide examples from your own life and ask students to share as well. (I, J, H)

Before

- *Know yourself.* What makes you angry? What do you usually do with your anger? What thinking patterns lead to your anger? (See the cognitive distortions discussed in Chapter 4.)
- *Develop a relaxation response*. The response could be counting to 10, doing a breathing exercise, singing a song to yourself, or visualizing yourself in a peaceful place—anything that helps you become calmer. (Chapter 4 gives many suggestions for dealing with stress.)
- *Practice using your relaxation response*. Practice looking at situations from other people's perspective. Practice finding something funny in stressful situations. Practice asking yourself, "How big a deal will this seem a week, month, or year from now?"
- *Get connected.* When we feel isolated we tend to get frustrated more easily and are more prone to hostility. Find a confidante, social group, or pet to spend time with.

During

- *Distract yourself.* Relaxation responses distract you from your anger trigger and negative thinking patterns. You can turn on the car radio if you get upset by traffic or pick up a magazine when aggravated by a long line in a grocery store.
- *Effectively communicate*. Explain your point of view using "I" messages.
- *Take 10.* Take a time-out, such as getting a drink of water or taking a walk, and use your extra energy in a productive way. During the time-out, look at your

(*continues*)

(*continued*)

thoughts: Are they rational? Are there cognitive distortions? Try to look at the situation from the other person's point of view.

What Pushes My Buttons?

Ask students to think back over the last year and make a list of every incident they can remember when they got hot under the collar—not just the times they yelled, but all the times they were upset but did or said nothing. As a class make a list on the board of all the "things that make me mad." This will help students recognize their anger triggers. Have them try to identify ways they can better cope with their anger triggers. (I, J, H)

What's My Anger Management Style?

Have students make a list of the last 10 times they were angry. Discuss the following anger mismanagement styles: (J, H)

- *Suppression.* Swallowing the anger and acting passive. Research has shown that people who respond this way have a higher risk for migraines, ulcers, arthritis, hypertension, and breast cancer.
- *Punishing oneself.* Feeling guilty or getting angry at oneself for being angry at others. People who do this may overeat or not eat, get too much or little sleep, or develop addictive behaviors such as alcoholism or overshopping.
- *Exploding.* Going beyond appropriately expressing your feelings, often displacing the anger and using it to try to control others.
- *Sabotaging.* Seeing oneself as the victim and trying to get even.

Suppress Punish self Explode Sabotage

As a class, try to identify TV or movie characters who typically manage anger in these ways. Ask students to think of people they know who typically manage their anger in these ways. Have students think back to the last 10 times they were

(*continues*)

angry and see if they ever mismanaged their anger. Can they identify a pattern for how they typically manage their anger? Discuss healthy ways of dealing with anger, such as the following:

- *Express it*. Use "I" messages and active listening
- *Write a letter*. Express angry feelings but wait before mailing.
- *Burn it off*. Jog, play basketball, chop wood, wash a car, and so on.
- *Distract yourself*. Count to 10, sing a song, make a joke, pick up a magazine, and so on.
- *Look at negative thoughts*.

Anger Log

Have students keep a journal for a week or more of every time they were even a little bit upset. Have them record (1) what triggered the emotion, (2) what their thoughts were while they were upset, and (3) how they managed their emotions. (I, J, H)

Anger News

Share news articles about incidents in which anger was mismanaged. Have students identify the possible anger triggers in the incident. Have students identify what the persons involved might have been thinking at the time of the incident. Have students discuss how they could act to express their anger in a more healthy way if they were in the same situation. Mothers Against Drunk Driving (MADD) is a good example of positively using anger. (J, H)

Stop!

Have students pair up and have each student take 2 minutes to tell their partner about a time when they were really mad, including every detail they can think of. Halfway into the second student's time, yell "Stop!" as loudly as you can. Ask the students who had been talking what they were feeling when you stopped them. What caused them to feel this way? Ask them if their anger had been justified. Ask them to identify various positive ways they could express their anger in this situation. Explain that when they find themselves getting angry it is helpful to yell "Stop!" and ask themselves these questions:

1. What am I feeling? (Frustrated, threatened, insecure, afraid, mistreated, etc.)
2. What is causing me to feel this way?
3. Is my anger justified?
4. Am I still angry?
5. How can I positively express my anger?

(*continues*)

(*continued*)

Repeat the exercise with some volunteers at the front of the class telling about times when they were angry, the class yelling "Stop!" at your signal, and answering the five questions. (J, H)

Role-Play

Have students break into groups and write scenarios for role-play situations using a "top 10 things that make me mad" list. Have student groups take turns drawing a scenario, acting it out first using anger mismanagement styles, and then a second time using healthy anger management techniques. At appropriate times between the role-plays have students identify irrational beliefs, cognitive distortions, or other perceptions that may be contributing to the anger. (J, H)

Decision-Making and Problem-Solving Skills

Problem solving and decision making are very closely related. We first discuss problem solving as a whole and then take a closer look at decision making. We then look at negation and conflict resolution, resilience in a negative environment, and building assets to help students confront and overcome problems.

Problem-solving skills are, unfortunately, seldom seen modeled by young people. On television they see complex problems easily resolved (often with violence) in a 30-minute to 2-hour program. Advertisements are everywhere, convincing them that life should be painfree and enjoyed without any thought of the cost. Today few families eat dinner together more than one or two times per week. With so little family time, children are not in a position to observe their parents confront, handle, and overcome everyday problems. And sadly, in some homes, young people are told that they *are* the problem, not that they *have* a problem.

It is important for students to realize that life is filled with problems for people in all walks of life. Often youth feel they are the only ones with the burdens they carry. Simply discussing the universality of conflicts in people's lives can help students feel less isolated and overwhelmed by their problems. Such discussions help put one's own trials in proper perspective. Looking at other individuals' lives and how they have overcome difficulties can help young people learn to solve problems and overcome obstacles.

Problem-Solving Steps

Problem-solving steps are quite simple. The greatest difficulty comes in the first step—differentiating the problem from the reality. Often we become sidetracked and waste a great deal of time and emotional energy bemoaning the "realities" of a problem and blaming others for its existence. For instance, how often do

we yell about "spilled milk"? The milk on the floor is a reality. How to clean it up is the solvable problem. Being a pregnant teenager is a reality. Securing the welfare of the mother and unborn child is a solvable problem. Once we clearly see what the problem is we can move toward solving it.

Problem-solving steps include the following:

	Correlated Decision-Making Steps
1. Identify the problem and the reality	Describe the situation
2. Explore available resources	List possible decisions
3. Creatively look for alternative solutions	Council with trusted adult
4. Judge the probable consequences of each solution	Evaluate possible consequences
5. Chose and then act on chosen solution	Act on appropriate, responsible decision
6. Evaluate the results	Evaluate

Making Decisions

Young people need help in recognizing how small and major decisions affect their lives now and in the future. Small day-to-day decisions can have a great impact on their health—what they choose to eat, who they choose to spend time with, what they choose to do with their spare time, when they choose to go to bed, how they choose to express their emotions and needs.

It is also important for students to ponder the moral aspect of making decisions. Too often choices are made based on what feels good, what others might think of us, or on what everyone else appears to be doing. It is important for students to consider the moral right or wrong of a decision. Getting in the habit of reviewing expectations set by parents, school, church, and community members can help young people make morally correct decisions. Asking "What would happen if everyone in the world did this?" also can identify the moral implications of a decision.

Split-second decisions are often made without thinking, almost like a reflex. Spontaneously deciding which flavor of ice cream to order can be fun, but acting spontaneously in risky situations is not helpful. Even when youth know what is right and wrong they can make a split-second wrong decision if they have not previously decided what to do. Teachers can help students make clear, healthful decisions now and help them recognize that they don't have to make that decision ever again because it has already been made. Risk-reducing decisions like what to do if someone who has been drinking offers you a car ride can be made by students in class and then practiced by role-playing. Teaching stu-

dents to choose their actions based on values rather than reacting to an impulse or circumstance helps them become proactive.

It also is helpful for students to see the thought processes that go into the countless decisions teachers make and the problems they solve each day in the classroom. Teachers can model problem-solving and decision-making skills by sharing with students some of the problems they face and the decisions they must make. Teachers can identify the steps they take in solving their problems and making their decisions. They can also ask their students to help them identify possible solutions and choices. Student involvement in this way helps them feel more responsible, capable, and part of the solution rather than part of the problem.

Conflict Management

Children and adolescents need skills in negotiation and managing conflicts in an appropriate manner. Teaching conflict management skills to young people can help them reduce their risk of perpetrating or being a victim of violence and can help them establish nonviolent behavioral patterns.

Conflict management skills are best learned by children when they are not caught up in the heat of their own conflicts. To be meaningful these skills must be practiced over a wide range of contexts. Young people also need ample opportunity to practice these skills in a trusting and supportive environment. Such an environment helps youth to talk about the conflicts they are having and provides a setting in which classmates can help each other with problem solving. For young children, puppets can be used for role-playing the range of conflict management skills. In teaching conflict management and having students implement it teachers can help students with the following tasks:

- *Understand*.
  - Understand the problem(s) or needs that caused the conflict.
  - See the two sides or viewpoints.
  - See the whole problem and how their behavior contributed.
  - Think of possible consequences if the conflict continues.
- *Negotiate* for a **win–win solution** (where both parties needs are met).
- *Act with integrity* on the planned solution.
- *Reflect* on what was learned and give others ideas on solving conflicts.

Resilience

Some young people thrive even though they live in problem-filled environments. **Resilience** can be defined as succeeding despite serious challenges and adverse circumstances (e.g., neglect; maltreatment; dysfunctional, alcoholic, or drug-dependent families; high levels of family conflict; poverty; physical disability; trauma). It is the process of overcoming negative effects of risk exposure, coping successfully with traumatic experiences, and avoiding the negative trajectories

associated with risks.[10] Although resilience means success in terms of healthy human development and well-being, it does not mean that resilient youth remain unaffected, invulnerable, or unscathed.

We can learn a great deal from resilient children and youth. Studies have been conducted to discover how these children thrive in spite of difficult circumstances. Researchers have looked to find what resilient children have in common. The characteristics they found have been called **protective factors**. Masten points out that results from longitudinal studies of resilient children and youth show that the most important of all protective factors is a strong relationship with a competent, caring, prosocial adult.[11] She also lists the following as critical protective factors: normal cognitive development (e.g., average or better IQ scores, good attention skills, "street smarts"), feelings of self-worth and self-efficacy, feelings of hope and meaningfulness of life, attractiveness to others (in personality or appearance), talents valued by self and others, and faith and religious affiliations. Hopefully, you remember reading about many of these protective factors as part of the other skills discussed earlier in this chapter.

If a high-risk environment is the family itself (e.g., children are growing up in an alcoholic or drug-abusing family), studies suggest that children have a better chance of growing into healthy adulthood if they meet the following criteria.[12] As you read these criteria, think about how you can help the high-risk students in your school develop these attributes.

- Can learn to do one thing well that is valued by themselves, their friends, or their community
- Are required to be helpful as they grow up
- Are able to ask for help for themselves
- Are able to elicit positive responses from others in their environment
- Are able to distance themselves from their dysfunctional families so that the family is not their sole frame of reference
- Are able to bond with some socially valued, positive entity such as a school, community group, church, or another family
- Are able to interact with a caring adult who provides consistent caring responses

Asset Development

Many communities have organized to help young people develop assets that will help them succeed in life. **Asset development** is a movement that focuses on combining life skills with family and community resources. It identifies by name and then tries to increase the positive building blocks in young people's lives. The Search Institute is the major force behind the asset development movement. It has identified 40 different developmental assets that act as protective factors for youth. The Search Institute has divided these 40 assets into two

different groups: 20 external assets and 20 internal assets. The **external assets** include actions that caring adults and communities can take to assist young people in the following areas: supporting and empowering young people; setting boundaries and expectations; and fostering positive and constructive use of young people's time. The 20 **internal assets** concern the positive internal growth and development of young people (life skills), focusing on positive values and identities, social competencies, and commitment to learning. A detailed listing and explanation of the 40 assets along with a teaching curriculum and strategies for them can be found at http://www.search-institute.org.

Research has shown that the more assets youth have, the fewer the risk patterns and the more positive behaviors youth experience. Asset-rich young people are much less likely to abuse alcohol or to experience negative behaviors. Unfortunately, the average young person has less than one-half of the 40 assets. Only 8% of youth are asset rich, that is, having 31 to 40 assets. One in five young people are asset poor, experiencing as few as 0 to 10 assets. Youth have fewer assets as they get older. The least common assets experienced by youth (just 19% to 25%) are a caring school, being treated as valuable resources, reading for pleasure, having their community value youth, and spending time in creative activities.

Often we adults fail to do something about children's problems because we feel overwhelmed as we hear, see, and read about the extent of the problems facing young people today. Asset building says to everyone that we have a role to play, that we can say hello to a teenager, ask youth to help us help others, thank media when positive messages are broadcast about youth, and just smile more at young people. School professionals can help create a caring school climate, ensure there are plentiful after-school programs with lots of physical activity for all children, ensure that young people develop good goal-setting and decision-making skills, and provide opportunities for youth to contribute service and help others. See **Box 3-7** for ideas on how you can teach decision-making and problem-solving skills in your classroom.

3–7
In the Classroom

Assessment and Learning Activities for Decision-Making and Problem-Solving Skills

Decision-Making Styles

Display the following decision-making styles:

- *Reactive decision making.* Allows others to overly influence or make decisions, lacks self-confidence and has a great need to be liked, gives control to others.

(*continues*)

- *Inactive decision making.* Fails to make choices, procrastinates, lacks self-control and direction in life, needs to take responsibility.
- *Proactive decision making.* Follows decision/problem-solving steps; not driven by circumstances; not easily influenced by peers; guided by integrity, honesty, and dignity; in control.

Discuss examples of people who exemplify each of these styles and the consequences for each. Watch for examples to use from popular television programs or movies. You may want to show some clips. Challenge students to become proactive in their decision making. (I, J, H)

Apollo 13

Watch the movie *Apollo 13* and have students take note of the following:

1. The realities—things that have happened that cannot be changed
2. The problems
3. How people act/react to realities and problems
4. How problems are solved (I, J, H)

What They Should Have Done

Collect newspaper articles about people who have made choices with negative effects (e.g., robberies, assaults, cheating, playing with guns). Discuss what early choices might have led to the major decision that resulted in tragedy. Discuss appropriate choices that could have prevented the negative outcome. (P, I, J, H)

"Dear Abby"

Request another class to write a "Dear Abby" letter about some problem they are having. Distribute these letters in your class to small groups and assign the students to answer the letters. Have groups exchange response letters and critique them for their helpfulness. Give the "Abby" letters to the class who wrote "her" about their problems. (I, J, H)

Recall Decision

Have each student write down one decision he or she made during the past 3 months. Have students list the alternatives and identify the decision. Have them evaluate the decision and rethink whether it is the same decision they would make today. (J, H)

Emotions and Decisions

Discuss how emotions can influence the decisions we make by giving several scenarios such as driving while angry or being afraid of what others will think. Ask

(*continues*)

(*continued*)

students to relate personal experiences. Discuss how emotions sometimes prompt people to make unhealthy choices. Discuss how good choices can be made in emotional situations. (J, H)

Thoughts on Thoughts

Make bulletin boards of the following quotes and discuss how our thoughts influence our ability to set and achieve goals, solve problems, make decisions, and resolve conflicts. (I, J, H)

Shakespeare: "There is nothing either good or bad, but thinking makes it so."
Milton: "The mind is its own place, and in itself can make a heaven of hell, a hell of heaven."
Ralph Waldo Emerson: "A man is what he thinks about all day long."
Norman Vincent Peale: "It has been said that thoughts are things, that they actually possess dynamic power. You can actually think yourself into or out of situations. Conditions are created by thoughts far more powerfully than conditions create thoughts."
Dale Carnegie: "Our thoughts make us what we are."
Hugh B. Brown: "You can't think crooked and walk straight."

Kids' Court

Have students brainstorm conflict scenarios that youth often face. From this list, select cases (scenarios) to try in kids' court. Select students to play the roles of the accused, defense attorney, prosecutor, witnesses, jury, and judge. Your role is to serve as moderator to assist students in their various roles. The jury decides on a win–win solution. (I, J, H)

Snow Ball—What Would You Do?

Have students anonymously write down a conflict they have observed or have had with someone. Have students wad up their papers and everyone throw them simultaneously randomly in the air. Have students catch or retrieve a "snow ball," open it, and write how they would handle the problem on the paper. Share and discuss the varied conflicts and suggested win–win solutions. (I, J, H)

Problem-Solving Steps

Have students practice the problem-solving steps by giving them various scenarios and these visual clues. As a class or in small groups, assign students to different roles that represent each step. Have the "explorers" identify available resources

(*continues*)

for solving the problem. Have the "artists" look for creative alternative solutions. Have the "judges" look for probable consequences of the suggested solutions. Have the "warriors" role-play the solution. Be sure to help students first differentiate the problem from the realities of each scenario. Discuss what happens when we apply the steps in the wrong order.

Identify the problem and reality.

Explore available resources.

Creatively look for alternative solutions.

Judge the probate consequences of each solution.

Choose and act.

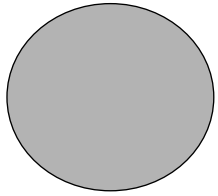
(*continues*)

(*continued*)

Thinking Outside the Box

Here are two exercises that can help your students learn to think more creatively. The first one literally requires thinking "outside" the box. (I, J, H)

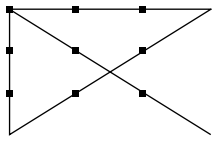
Draw the above dots on the board. Instruct your students to draw similar dots on a paper and then to connect the dots with four lines without lifting their pencils.

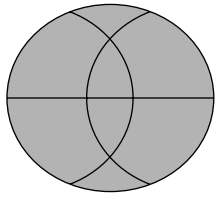


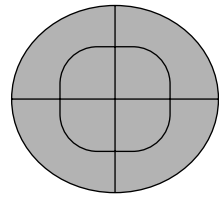
Instruct the students to draw a circle on their papers, pretend it is a pie, and "cut" their pie into 8 pieces using only 3 cuts.

Discuss how we get trapped into "boxed" thinking and need to be creative in looking at ways to solve problems.

Answers to the puzzles.







Key Terms

life skills 63
World Health Organization (WHO) 63
HECAT 65
self-awareness 66
self-esteem 66
self-image 67
ideal-self 67
Pygmalion-self 67
self-worth 68
conditional worth 68
unconditional self-worth 68
values clarification 70
character education 71
Pygmalion effect 72
self-efficacy 73
self-evaluation 73
body language 79
mixed messages 80
"I" messages 80
passive listening 80
active listening 80
reflective listening 81
passive 82
aggressive 82
assertive 82
advocacy 83
empathy 83
contact 84
acquaintance stage 84
intimacy stage 84
deterioration stage 84
dissolves 85
relationship bank account 86
proactivity 95
reactive 95
impulse control 97
delayed gratification 97
win–win solution 106
resilience 106
protective factors 107
asset development 107
external assets 108
internal assets 108

Review Exercise

1. Define and explain the relative importance of each of the key terms in the context of this chapter.
2. Explain why the WHO advocates life skills.
3. Describe the steps for teaching a life skill.
4. Describe a person lacking self-awareness. Describe what is necessary for a person to be self-aware.
5. Describe self-esteem myths and the problems these myths have generated.
6. Summarize how teachers can best nurture self-esteem.
7. Describe how teachers can best foster a sense of worth in their students.
8. Explain how teachers can help students develop full moral ideal-selves.
9. Give examples of Pygmalion-positive and -negative scripting.
10. Enumerate how teachers can help students review their self-perceptions.
11. Discuss the important communication and interpersonal skills covered in this chapter.
12. Discuss each of the types of relationship bank deposits and provide an example of each.
13. Describe ways teachers can teach goal-setting skills.

14. Give examples of proactive individuals in this chapter, and explain how teachers can help students learn to be more proactive.
15. Discuss impulse control and delayed gratification as they relate to health and how teachers can help students learn these skills.
16. Describe the various anger management styles and explain how teachers can help students learn anger management skills.
17. Identify and differentiate decision-making and problem-solving steps. Explain how teachers can teach problem-solving and decision-making skills.
18. Identify key concepts of conflict management and describe how teachers can help students better manage conflicts.
19. Describe the attributes of resilient youth.
20. Summarize how teachers can help students develop more assets.

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4

Dealing with Stress

Stress Journal

It's been a bad day. All of my teachers just dumped tons of homework, like they got together and decided now was the time to make life miserable for us. I swear, each of them thinks their class is the only class in the world, and most of the stuff is irrelevant and just a bunch of busy work. Err, and the test I took today, I studied my head off, but you'd never know by my grade. The questions were worded weird and Mr. Warrick asked stuff that wasn't even on his study guide!! Errrr, I'm really, really mad about that!!!! Then, there's the drama with my friends. . . . Katie is mad at Jennifer, Brad dumped Emily, and somehow I'm in the middle of it all, and no matter what I do someone's going to end up mad at me. Worst of all, I'm broke, like pockets turned inside out broke, and Mom won't give me any money. Ugggggg.

All children and adolescents have stress in their lives. Growth and maturation are partially brought about by encountering and effectively coping with stress. Unfortunately, many children and adolescents react to family, school, and other pressures and demands in unhealthy ways. For instance, they might engage in risky behaviors that could lead to injuries, eating disorders, drug dependence, or pregnancy. This chapter gives insights into the many stressors you and school-age children face and offers suggestions for how you and your students can better deal with your stress.

Understanding the Nature of Stress

The term **stress** was first used in its current physiological and psychological sense by Hans Selye, a pioneer in the study of stress.[1] He defined stress as "the nonspecific response of the body to any demand made upon it." Selye coined the term **stressor** to refer to specific or nonspecific situations or demands that cause stress. Stressors may be specific (e.g., conflict between a child and teacher, giving an oral report in class, or nearly being hit by a car while crossing the street), but the response is a generalized physiological response. This generalized response is known as the **General Adaptation Syndrome (GAS)**, which consists of the following three stages (also see **Figure 4-1**):

1. *Alarm.* The body initially responds to a stressor (whether real or imagined) by preparing for a physiological emergency. This response has been referred to as the **fight-or-flight response** because the body is prepared for an emergency. Some of these physiological responses are increased respiration and heart rate, sweaty palms, muscle tension, pupil dilation, and an increase in blood flow to the heart and skeletal muscles (see **Figure 4-2**).

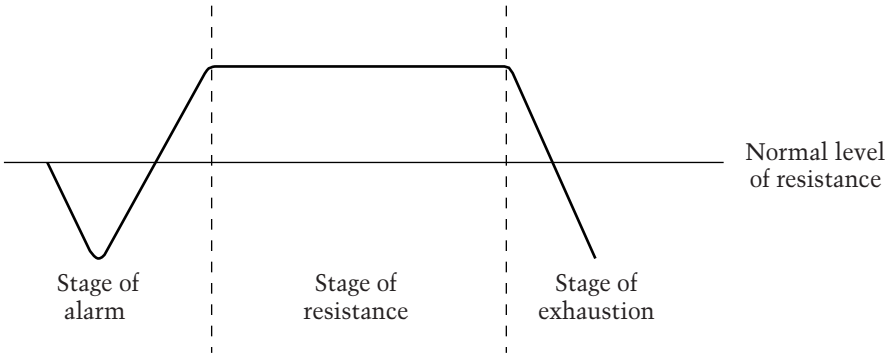

FIGURE 4-1 Three phases of GAS. In the stage of alarm, the body's normal resistance to stress is lowered from the first interactions with the stressor; in the stage of resistance, the body adapts to the continued presence of the stressor and resistance increases; in the stage of exhaustion, the body loses its ability to resist the stressor and becomes exhausted.

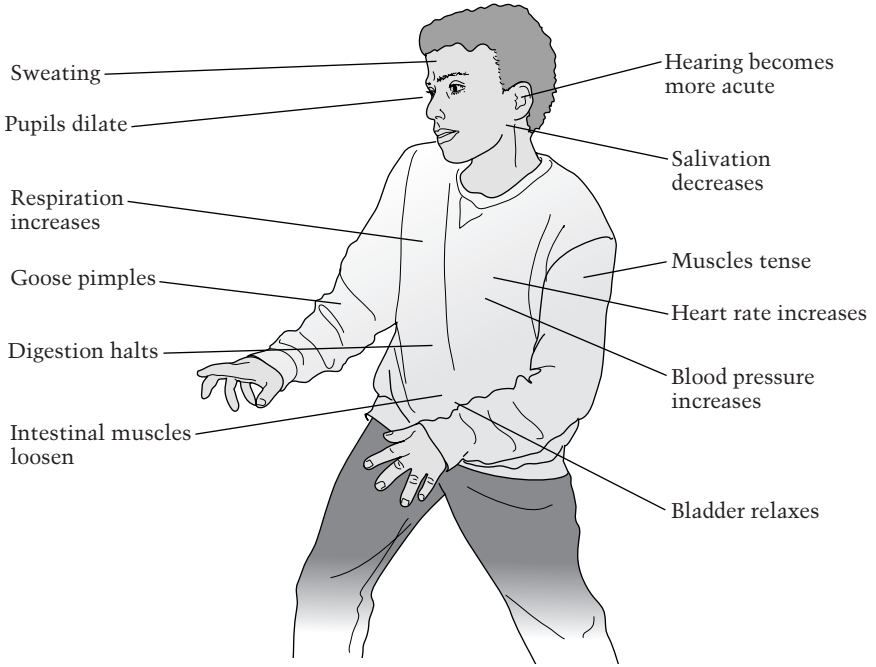

FIGURE 4-2 The fight-or-flight response.

2. *Resistance.* During this stage, the body uses its energy reserves to attempt to return to normal internal activity, or **homeostasis**.
3. *Exhaustion.* Long-term exposure to a specific stressor or a combination of stressors can lead to a depletion of the energy required to return to homeostasis. If this happens, the signs of the alarm stage return. During this stage, physical or emotional disease may be initiated.

We have all experienced alarm from time to time. Imagine yourself carelessly crossing a street when you suddenly realize that a speeding car is coming right at you. Your heart pounds, your muscles flex, and you find yourself jumping farther and running faster than you ever thought possible. Your body is in motion before you really have time to think, as it utilizes all its energies for survival. Once you are safely out of the car's path, you take a deep breath and over time your body returns to its former relaxed state. This is an example of **acute stress**, something that is intense and disappears quickly. **Chronic stress**, often not as intense as acute stress, persists over prolonged periods of time (e.g., hours, days, weeks, months).

Our autonomic nervous system is in charge of the fight-or-flight process and consists of the sympathetic and parasympathetic systems. If you think of your body as a car, the **sympathetic** nervous system is the gas and the **parasympathetic** system is the brakes. Both systems are partially active at all times but with only one dominating. This means that you cannot be physically aroused and relaxed at the same time. The many stressors we experience today sometimes put us in a chronic state of alarm where we are constantly applying the gas and not taking the time to brake. All too often days, weeks, and even months pass without our relaxing—returning to a state of homeostasis.

The endocrine system plays a major role in stress with the pituitary, thyroid, and adrenal glands secreting hormones that target certain organs. These hormones affect metabolism, blood pressure, gastrointestinal activity, sleep, and many other things. For example, cortisol is a hormone released from the adrenal cortex and facilitates the metabolism of fats for energy. During stress, increased levels of cortisol are produced that in turn increase the amount of cholesterol in the blood. This cholesterol provides energy needed for "fight or flight," but we usually don't "burn" if off because of our inactive life styles. Increased cholesterol levels can facilitate plaque buildup in our blood vessels.

Disease and Stress

Stress creates changes in our nervous and endocrine systems and then manifests itself in our bodies as tension headaches, backaches, insomnia, and heart disease. As was just discussed, stress can elevate cholesterol and in turn plaque buildup in blood vessels and heart disease. Stress can also play a role in the onset or aggravation of migraine headaches, asthma, hay fever, ulcers, diarrhea, constipation, eczema, allergies, influenza, and even the common cold. Cancer, lupus, and diabetes have also been found to be linked to stress (**Table 4-1**).

TABLE 4-1 Diseases and Conditions Caused or Aggravated by Stress

Accident proneness	Musculoskeletal disorders
Anorexia nervosa	Low back pain
Bulimia	Migraine headache
Cancer	Tension-type headache
Cardiovascular disorders	Muscle tension
Constipation	Obesity
Diabetes	Pain
Diarrhea	Psychological disorder
Gastrointestinal disorders	Respiratory disorders
Menstrual irregularities	Asthma
	Hay fever
	Skin disorders
	Ulcer

Stress causes physiological changes that tend to weaken the immune system. When the immune system becomes compromised, the body is vulnerable to disease. The **immune system** is a complex set of organs—highly specialized cells and the lymphatic system—all of which work together to clear infection from the body. Lymphatic vessels and lymph nodes carry **lymph**, a transparent fluid containing white blood cells, chiefly lymphocytes. Lymph bathes the tissues of the body, and the lymphatic vessels collect it and move it back into the blood circulation. Lymphocytes are transported to tissues throughout the body, where they act as sentries on the lookout for foreign antigens. The two major classes of lymphocytes are B cells and T cells. **B cells** produce antibodies that circulate in the blood and lymph streams and attach to foreign antigens to mark them for destruction by other immune cells. Certain **T cells**, which also patrol the blood and lymph for foreign invaders, can do more than mark the antigens; they attack and destroy diseased cells they recognize as foreign. T cells also orchestrate, regulate, and coordinate the overall immune response.[2]

Understanding Your Stress

Before you read any further, take a few minutes to identify what things stress you right now and then rank order your stressors (see **Box 4-1**). After you do this, try and identify how you psychologically respond to your stress (become irritable, depressed, sullen, eat . . .) and how you physically respond to your stress (get a headache, get tight neck or back muscles, unable to sleep . . .).

If you are like most people, your top three stressors are related to time, money, and relationships. You may have discovered while doing the Marks on You exercise found in Box 1-3 that you do a lot more teeter-tottering when you are under stress. Anger and resentment are two other common psychological

4–1
Application Exercise

Personal Stress Management Plan

Before you can effectively help your students manage their stress, you need to assess and improve your stress management skills. This exercise helps you identify your stress, how you deal with your stress, and how you can better manage your stress. Do the following in order:

1. Make a list of your top five stressors.
2. Identify triggers for each of these stressors.
3. Identify how you physically respond to your stressors.
4. Identify how you psychologically respond to your stressors.
5. Create a personal stress management plan:
   a. Identify specific things you will do to reduce the amount of stress you experience.
   b. Identify one stress coping skill you will practice.
   c. Identify how you will relax.
6. Put your plan into action for one full week.

responses to stress. Perhaps you "carry" your stress in tight neck, shoulder, or back muscles. Being self-aware of your stressors and how you psychologically and physically respond to your stress can help you identify how you can better manage your stress.

New research indicates that men and women under stress fundamentally cope differently. Different parts of the brain activate for men and women when they are faced with performance-related stress. Men's brain activity response is often characterized as "fight-or-flight," whereas women's brain activity is characterized as "tend-and-befriend."[3] Perhaps you have noticed these differences. Women tend to want to reach out to others and talk through their stress. Men, on the other hand, tend to become quiet, withdrawn, and cope with the stress on their own. Understanding these fundamental differences is helpful in maintaining good relationships.

Cognitive Distortions

Your thinking patterns play a major role in the amount of stress you experience. We experience stress when we perceive something as stressful. For instance, having a "bad hair day" may be perceived as terribly embarrassing by one teenage girl and mildly annoying by another. Uncooperative hair doesn't cause stress, but thinking that one's hair must be perfect does.

You are undoubtedly like most people and have some distorted thinking patterns that exacerbate the amount of stress you feel. Your students, particularly adolescents, are also prone to **distorted thinking patterns**. Review these categories of distorted thinking and see if any of them seem familiar—if they describe you or someone you know.[4]

- **All-or-nothing thinking.** Anything less than perfection is a failure. Evaluating in extreme black-or-white categories. "I spilled my glass . . . the dinner was a disaster." "I got a 93% on the test . . . I blew it!" "If part of me is bad, I'm all bad."
- **Jumping to conclusions.** Conclusions are not tested but are based on hunches, intuition, and experiences. There are two types: mind reading—"She did that on purpose!" or "My teachers don't like me"—and fortune telling—"Those parents wouldn't come if I asked them to" or "I'd blow it if I tried."
- **Overgeneralizing.** Thinking in a negative pattern. Key words are *always* and *never*. "I always make that mistake." "He never listens."
- **Filtering.** Dwelling on the negative details or aspects of a situation to the exclusion of all other details and concluding that the whole situation is negative. "That kid has ruined my whole day." "How can I concentrate when my hair looks terrible!"
- **Discounting the positive.** Accomplishments are the result of luck or are not really meaningful. "He got lucky." "Anybody could have done it."
- **Labeling.** Giving oneself or another a label based on imperfections, as though a single word could completely describe a complex human being. "I'm so stupid." "He's an idiot."
- **Magnification.** Thinking that something is so horrible or so awful that one cannot bear it. In the process one feels helpless and pathetic. "I can't take this anymore!" "He's driving me nuts!"
- **Emotive reasoning.** Thinking that feelings are reality. "I feel inadequate; . . . therefore I am inadequate."
- **Blaming.** Feeling that others are responsible when in fact we are. "She *makes* me so mad."
- **Self-blame.** Accepting responsibility for things we actually have no control over. "If I were a better mother. . . ." "It's all my fault my parents are getting a divorce."

Once we are aware of our thoughts, we can evaluate them for their validity and can reevaluate a stressful situation with a broader perspective. We can also check and fine-tune our expectations. Recognizing our negative thinking patterns can also be a powerful means of gaining control over our emotions and soothing ourselves. By changing our thinking patterns, we can change what we

feel. Take the example of Ann, a very conscientious young driver who drives her parents' new car to school. Ann is in the habit of swearing under her breath at inconsiderate drivers on the road. As a result, she often arrives at her destination exasperated, tense, and angry. In class she learns how negative thoughts can produce negative emotions and takes the challenge to think positively of those she perceives to have wronged her. On her way home, a car pulls out in front of her and she has to slam on the brakes to avoid a collision. Just as she is about to burst forth with colorful language, she remembers her resolve and, instead, says out loud, "I . . . I . . . I . . . I bless you to get wherever you are going safely!" Immediately she starts laughing, feeling relaxed, calm, and even happy. Ann had been in the habit of thinking others were thoughtless, self-centered, reckless drivers out to put a ding in her parents' new car and get her in trouble. In actuality, poor drivers like the one who pulled out in front of her might be confused, distracted, or ill. When Ann blessed the other driver she in effect blessed herself.

Understanding Your Students' Stress

Once more, before you read any further, take a few minutes and try and remember what things stressed you in elementary school, in junior high, and in high school. What were you most concerned about? What made you mad? What fears did you have? Perhaps your memories paint a picture of the "good ole days" where you had little stress, or maybe you recall painful events or interactions and vivid fears (see **Box 4-2**). Can you remember what stressors some of your classmates had in their lives? Your memories can help you recognize what might be causing stress for your students and give you insight into how to help them.

4-2
Background on . . .

Basic Human Fears

Fear is a major source of stress for people of all ages. Following are the six basic human fears. Perceptive teachers recognize these fears in their students, create classrooms that minimize fear, provide opportunities for students to express their fears in a safe setting, and give students skills for meeting and overcoming some of their fears.

Fear of failure
Fear of rejection
Fear of the unknown
Fear of isolation
Fear of losing control
Fear of death

Recess and physical education classes can offer students a chance to release the stress that often builds up in an academic environment.

Although stress is a natural part of life and necessary for growth and development, it can be overwhelming, and young people can respond in negative ways. Some examples of less serious reactions are fatigue, headaches, stomach problems, mood swings, and poor attention span. More serious reactions include behavioral problems, depression, mental illness, unhealthy behaviors, and suicide.

Day-to-Day Hassles

It is important that educators acknowledge that it is not only major life events or highly stressful environments that take a toll on the lives of young people. Day-to-day problems and irritants have a cumulative effect and can be

destructive as well. Examples of daily hassles that concern young people are physical appearance and peer acceptance, homework assignments and tests, and misplacing or losing things. Repeated minor hassles can add up to a major stress reaction.

Economic Stressors

The community economic climate in which young people grow up greatly affects the amount of stress they experience. Living in poverty or crowded housing, being exposed to a pervasive drug culture and periodic street violence, and attending poor schools are all highly stressful. Economic downturns can be very stressful for young people particularly when the adults in their lives encounter frustrations and do not have good stress management skills. Unemployment, debt, and diminished funds can put a family in a state of crisis. Bad economic news by itself can create stress for young people if they worry about things like their parent's job security, the possibility of friends having to move away, not being able to go to college, or not being able to get a good-paying job someday.

Immigration

One in five children in the United States lives in an immigrant family. These children have stressors that children of native-born parents do not have, including adapting to cultural norms that may differ from those of their parents and learning a language that may not be spoken at home. Poverty is another prevalent factor for these children, with a disproportionate number of them being the poorest of the poor. They may be ineligible for food stamps, and their families may experience a great deal of stress in obtaining and paying for food. They are less likely to receive public assistance, including Medicaid, than other low-income children. As a result, they may not seek out health care and may suffer from untreated health problems. Immigration poses additional stresses on children and families, including the loss of support systems; anxiety, depression, or grief associated with migration and acculturation; and trauma from events that preceded or occurred during their migration.[5]

Natural Calamities

Fires, hurricanes, tornadoes, earthquakes, and a host of other natural disasters can be very stressful for children, adolescents, and their families. Evacuating before or riding out a natural disaster is very stressful in and of itself. That stress is greatly compounded if a person's home, school, or community is damaged or destroyed. Following the devastation of a natural disaster, most young people are able to cope over time with the help of parents and other caring adults. The severity of a child's or adolescent's reaction to the disaster depends on the degree of exposure, personal injury, or need to relocate.

Teachers play a vital role in helping affected school-age children cope and recover. When natural disasters hit an area, teachers and schools can do several things to help meet students' needs. School personnel can do the following:[6]

- Identify the unique needs of every student whose home has been destroyed or damaged and try and connect their families with supportive resource agencies.
- Create a list of phone numbers and addresses of students who have to relocate so that classmates can be in contact with them.
- Listen—provide a variety of opportunities for students to discuss the event and how they are coping, understanding that it is normal for them to discuss it repeatedly.
- Use art, music, drama, and play to help students express their emotions.
- Integrate the natural disaster event into subject areas studied, such as science, math, and history.

Home-Based Stress

The home environment can give children a sense of belonging and structure, provide appropriate role models, and teach communication and social skills, all of which buffer the degree of stress children experience. In the home, youngsters initially learn stress-coping techniques that are modeled by parents, other adults in the household, and older siblings. Unfortunately, some young people's homes are stress filled and are places where they see adults handle stress in unproductive and unhealthy ways.

Overscheduling The American lifestyle is often characterized as being "on the go." It has almost become an American norm for parents to enlist their children in every extracurricular activity they can fit into their schedule. Some children are constantly on the go because their scheduled activities serve as baby-sitters for their working parents. From predawn until late at night, children and adolescents participate in team sports; take music, art, and dance lessons; attend school, scouting, and other youth group activities; and give community service.

Children and adolescents can benefit from the social skills often developed in play. When a child goes out to play the child has to find someone to be with, convince that person to play, negotiate what to play, teach others how to play, help enforce the rules, and decide when to stop. Being overloaded with extracurricular activities prevents these activities and can have a greater negative impact than positive impact on development.[7]

Family life in the fast lane can leave both children and parents exhausted and irritable. Some schools have instituted "family nights" to try to give students and their parents time to relax and enjoy one another's company. On these family nights, no homework is assigned and no school activities are scheduled. Parents have become proactive in some communities, stating that "enough is

enough." These parents have organized themselves and taken petitions to local youth sports programs, schools, and community officials requesting that these institutions schedule their activities in a more family-friendly manner.

Lack of Sleep Many Americans, both children and adults, get less sleep than they need. On average we sleep 1 hour less than we need on weeknights and 30 minutes less than what we need on weekend nights. By the end of the year we are short 338 hours. **Sleep deprivation** is the result, and the lack of sleep can be very stressful. Stress is experienced when we don't have the energy and alertness we need to concentrate and interact effectively with others. Lack of sleep also causes physical stress on the body, especially when sleep deprivation becomes a way of life. Poor academic performance, unintentional injury, and obesity have been associated with shorter sleep durations.

Many adults and children become sleep deprived from staying up late at night watching TV programs or movies. Others become fixated on computer games or Internet surfing. Parents who let their children fall asleep in front of the television compound the problem.

Young people also become sleep deprived as they try to cram 28 hours of living into 24 hours. Many adolescents, in an effort to gain an edge in getting into a highly rated university, sign up for every possible school sport and activity while trying to earn top grades and give community service. When these youth finally try to go to bed they are often too wired to fall asleep.

Sleep experts say that elementary through high school aged kids need 9 to 11 hours of sleep a night, and yet the vast majority do not meet these recommendations. One study found that 90% of adolescents said they slept less than 9 hours on most school nights, and that 10% reported less than 6 hours each weeknight. These students reported their lack of sleep made them tired in the day, made it hard for them to pay attention, contributed to their earning lower grades, and increased their stress levels and problems of getting along with others.[8]

School districts in a few states have shifted their schedules to give teens a little more time to sleep before school begins. Those who oppose such moves argue that a later starting time plays havoc on work, bus, after-school, and extracurricular activity schedules. The end result might be teenagers getting to bed even later, nullifying the desired outcome of more sleep.

Home Alone Being home alone can be stressful for children. The number of children home alone without direct adult supervision has mushroomed in the last 20 years as the number of single-parent households and the number of families in which both parents are employed outside of the home have dramatically increased.

Children left home alone are at risk for a variety of problems. Sometimes children who are routinely left to care for themselves are more fearful than those who receive adult supervision. Two prevalent fears are that someone will break into their home and hurt them while they are alone or that older siblings will

harm them. Children home alone may also be more lonely and bored than supervised children are. There is some indication that children who are unsupervised over large periods of time are at higher risk for having personality problems and depression during adolescence and adulthood. Children left unsupervised are also at increased risk of sexual abuse and accidents. Conversely, sometimes children who look after themselves achieve greater self-confidence and independence than those who are supervised.

Media Exposure We often think of relaxing in front of the television set, but viewing television programs and watching DVDs might not be as relaxing as we think. The amount and type of TV programming a young person watches influence the amount of stress he or she feels. Disturbing news reports of criminal activity, wars, natural disasters, and economic woes are stressful. Violent acts depicted in movies, TV shows, and video games can be distressful. Nightmares and night terrors can result from viewing troubling images. There is also evidence that heavy TV viewing is linked to depression, anxiety, and obesity.

Parental Conflict Parental conflict can arise from numerous situations, including financial problems, alcoholism, adultery, abuse, and selfishness. Rarely is a child responsible for marital discord, but children almost always feel somehow responsible. Children experience high levels of stress as they deal with their parents' fights and their own misplaced guilt.

Separation and Divorce Parental separation can be traumatic and creates stressful situations for children and adolescents. Separation can occur when a parent is deployed by the military or leaves to look for employment. Whatever the reason for separation, psychological separation is more traumatic for a child than physical separation from a parent. Separation from siblings can also be significantly stressful.

Approximately half the families in this country have undergone the pain of marital separation, with 60% of those partings affecting children. In addition to the stress of separation parental divorce has been linked in children to delinquency, psychological disturbance, hostility and acting-out behavior, low self-esteem, low evaluation of families, early home leaving, and poor self-restraint and social adjustment. When a parent remarries, children have to contend with a new series of adjustments, such as having a new parental figure in the home, feeling conflicting loyalties between biological parents and stepparents, and dealing with new routines, responsibilities, and personal space issues. All of these adjustments are intensified when stepsiblings are involved. Children of parents granted joint custody must also make the monumental adjustments of living in two different households. For many children of divorced families, school represents the only stable part of their environment. Educators and school personnel should be prepared to assess the student's behavior for signs of stress and recognize the signs of emotional problems.

The child's age at the time of the divorce directly influences his or her feelings and reactions. *Preschoolers* may become frightened about the divorce because they fear being deserted. As a result, they may be anxious about leaving their homes to attend school. Regression is also a common response to divorce among preschoolers. Lapses in accomplished developmental tasks, such as toilet training or self-dressing, may occur. Retreats to the use of security symbols, such as dolls and blankets, are likely to occur as well. In addition, children may blame themselves for causing the divorce and experience guilt as a result.

The most striking reaction among *young school-age children* is sadness, which is characterized by crying and sobbing. Fear is likely to be present, as are yearnings to be with the separated parent and feelings of conflict in loyalty to parents.

Intense anger is often a response to divorce among *older school-age children*. Interestingly, children in this age group are apt to respond to this anger with vigorous physical activity. This is quite unlike younger children, who become depressed and do not feel like participating in physical activity. Older children also have a shaken sense of identity and quite often will choose to ally themselves with one parent rather than the other.

Dysfunctional Families Children reared in **dysfunctional families** are exposed to many childhood stressors, such as parental alcoholism or drug dependency, mental illness, ineffective parenting skills, and poor communication patterns. Alcoholic parents often place unreasonable demands upon their children, such as the following: to keep secrecy about the alcoholic's behavior, to take responsibility for the alcoholic, to neither acknowledge nor express their own feelings, to accept the blame for their parent's drinking, and to provide emotional support and companionship for the alcoholic's spouse. (A detailed discussion of children of alcoholics is provided in Chapter 7.)

Poor Health and Death Chronic or acute health problems experienced by a sibling or a parent can be stressful for young people. They worry about the future, the pain the loved one is experiencing, and about their own health—will they get sick too? Sometimes they become the caregiver and have nursing responsibilities. Often they take on additional household duties such as cleaning, cooking, and caring for siblings.

The death of a parent or loved one represents a tremendously stressful life event for a child or adolescent. Acceptance of the death often takes many months to a few years. Reactions depend largely upon a child's age and developmental level. Fortunately, most children survive a parent's death with only minor emotional scars, but effective coping is assisted greatly by supportive adults. (A more detailed discussion of children and death is provided in Chapter 10.)

Problems at home or downshifting from perceived threats at school decrease a student's ability to learn.

School-Based Stress

The school environment presents a number of conditions and situations that can evoke stress in children and adolescents. Examples of stressors encountered in the school environment include teacher attitudes, behavior, personality, and mannerisms; English being a second language; peer pressures and harassment; homework; grading and evaluation; competition and academic pressure; length of the school day; and extracurricular activities. Competitive stress occurs when teachers place emphasis upon competition in school situations. When teachers overemphasize competition and the need to finish first, unnecessary stress is created in the lives of students. Boredom is another school stressor. Polls taken often reveal that on a given day across the nation half of teens surveyed say they primarily feel bored while in class. Bullying is a major stressor for far too many school-age youth. You can read more about bullying and how to prevent it in Chapter 9. **Box 4-3** provides assistance in recognizing stress in students.

Early Grades Children in kindergarten, first grade, and second grade often feel a great deal of stress about schoolwork, understanding work assignments, and completing creative projects correctly. After schoolwork stressors, the greatest source of worry to these youngsters is peer relationships. Peer relationship stressors include peer pressure, friendships, sharing, playing, and arguing. Other prominent stressors for this age are personal injury or loss (getting hurt, pushed, or kicked; theft; emergency drills; destruction or loss of personal belongings) and loss of personal comfort, space, or time (school schedule, homework interfering

4-3
In the Classroom

Recognizing Stress in Students

The following checklist may help you identify students who are experiencing excessive stress. Students with several of these signs or symptoms may need referral to appropriate counseling professionals. These signs appear in children who have experienced a loss (e.g., parental separation or divorce, death of a loved one) or are having difficulty at home or school (e.g., rejection by classmates, difficulty with schoolwork, parental drug dependency). The more signs or symptoms a child has, the greater the likelihood of a stress-related or stress-induced problem. Children who are suffering great levels of stress exhibit it in their patterns of behavior. Often, they:

_____ Complain of headaches
_____ Complain frequently of an upset stomach
_____ Have out-of-control crying episodes
_____ Show evidence of not getting enough sleep
_____ Exhibit general tiredness
_____ Frequently appear irritable
_____ Appear restless
_____ Exhibit loss of appetite
_____ Have difficulty paying attention in class
_____ Tend to be physically aggressive with other children
_____ Easily become upset by changes
_____ Tend to quit tasks that are difficult
_____ Display difficulty concentrating
_____ Appear to lack emotion
_____ Seem depressed
_____ Lack self-confidence

with personal time, loss of recess time, noise in lunchroom, changing classes, teacher not present or absent).

Middle and Upper Grades Older children and adolescents also experience stress over schoolwork caused by being bored, not understanding the material, not having enough time in the day for homework, or worrying about grades. The more prominent school-related stressors for adolescents are social rejection and fear of exposure in public. Losing friends, being ignored socially, feeling rejected, speaking in public, and making mistakes are examples of stress-provoking fears among adolescents. Anxiety over these fears can lead some students to regressive

and/or self-destructive behaviors, school phobia, academic difficulty, and withdrawal. As a result, parents, teachers, counselors, and school administrators should assist adolescents in identifying and coping with these fears.

Teachers Teachers can also experience stress in the school environment. Their stress is greatly intensified when they feel unsafe, unsupported, overworked, or out of control. Persistent long-term school-related stress can facilitate teacher **burnout**—a condition in which teachers become emotionally exhausted and ineffective. Chapter 1 gives insight into how to create a supportive school environment and effective classroom discipline. The stress reduction, coping, and relaxation skills in this chapter can help teachers as well as students better deal with the stress they experience at school. **Box 4-4** provides suggestions for reducing stress at school.

4-4
In the Classroom

Reducing Stress at School

Teachers can do the following things to reduce the amount of stress they and their students experience in school:

- Establish and maintain classroom routines, procedures, and rules.
- Avoid using a harsh voice or screaming. When problems arise, handle them immediately and consistently. Try to correct students in private.
- Facilitate appropriate humor.
- Create a supportive culture by maintaining the class/school as a teeter-totter-free zone and facilitating hydraulic-lift experiences between students.
- Monitor hallway, schoolyard, and lunchroom activities.
- Use a variety of teaching methods and provide a break in concentration at least every 20 minutes.
- Remember that a degree of stress enhances academic performance, but that too much anxiety impairs functioning.
- Coordinate with other teachers and try to avoid giving major tests on the same days.
- Create a mechanism for students to obtain needed help for homework assignments.
- Institute family-friendly nights free of homework and where parents are encouraged to keep media turned off and to participate in family-based activities.
- Contact the parents of any student who is persistently tired.
- Teach students stress-reducing, coping, and relaxation skills. Provide them opportunities to practice these skills.

Understanding Depressive Disorders in Children and Adolescents

Stress and depression are strongly correlated. Stress can be a contributing factor in the onset of depression and those suffering from depression experience enhanced stress. A **depressive disorder** is an illness that involves the body, mood, and thoughts. It affects the way one eats and sleeps, the way one feels about oneself, and the way one thinks about things. A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better. Without treatment, symptoms can last for weeks, months, or years, but appropriate treatment, including learning stress management skills, can help most people who suffer from depression.

Only in the past two decades has depression in children been taken very seriously. The depressed child may pretend to be sick, refuse to go to school, cling to a parent, or worry that the parent may die. Older children may sulk, get into trouble at school, be negative and grouchy, and feel misunderstood. Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child is just going through a temporary "phase" or is suffering from depression. Sometimes the parents become worried about how the child's behavior has changed, or a teacher notices that a student does not seem to be himself or herself.

Depressive disorders can have far-reaching effects on the functioning and adjustment of young people. Among both children and adolescents, depressive disorders confer an increased risk for illness and interpersonal and psychosocial difficulties that persist long after the depressive episode is resolved; in adolescents there is also an increased risk for substance abuse and suicidal behavior. Unfortunately, these disorders often go unrecognized by families, school personnel, and health care professionals alike. Signs of depressive disorders in young people are often viewed as normal mood swings typical of a particular developmental stage. In addition, health care professionals may be reluctant to permanently label a young person with a mental illness diagnosis. Yet early diagnosis and treatment of depressive disorders are critical to healthy emotional, social, and behavioral development.

The National Institute of Mental Health (NIMH) reports that research indicates that the onset of depression is occurring earlier in life today than in past decades.[9] Further, depression that occurs early in life often persists, recurs, and continues into adulthood. Depression in youth may also predict more severe illness in adult life. Depression in young people often co-occurs with other mental disorders, most commonly anxiety, disruptive behavior, or substance abuse disorders, and with physical illnesses, such as diabetes.

Types of Depressive Disorders

Depressive disorders include major depressive disorder (unipolar depression), dysthymic disorder (chronic, mild depression), and bipolar disorder (manic-depressive disorder).

Major Depressive Disorder **Major depression** is manifested by a combination of symptoms that interfere with a person's ability to work, study, sleep, eat, and enjoy activities the person once thought were pleasurable. Recognition and diagnosis of this disorder in youth may be more difficult for several reasons. The way symptoms are expressed varies with a young person's developmental stage. In addition, children and young adolescents with depression may have difficulty in properly identifying and describing their internal emotional or mood states. For example, instead of communicating how bad they feel, they may act out and be irritable toward others, which may be interpreted simply as misbehavior or disobedience. Parents are even less likely to identify major depression in their adolescents than are adolescents themselves.

Although the recovery rate from a single episode of major depression in children and adolescents is quite high, episodes are likely to recur. In addition, youth with dysthymic disorder are at risk for developing major depression. Prompt identification and treatment of depression can reduce its duration and severity and the associated impairment in functioning.

Dysthymic Disorder (Dysthymia) A less severe type of depression, **dysthymia**, involves long-term, chronic symptoms that do not disable, but keep one from functioning well or from feeling good. This less severe yet typically more chronic form of depression is diagnosed when depressed mood persists for at least one year in children and adolescents and is accompanied by at least two other symptoms of major depression. Dysthymia is associated with an increased risk for developing major depressive disorder, bipolar disorder, and substance abuse. Treatment of dysthymia may prevent the deterioration to more severe illness. If dysthymia is suspected in a young person, the youth should be referred to a mental health specialist for a comprehensive diagnostic evaluation and appropriate treatment.

Bipolar Disorder Although rare in young children, **bipolar disorder**—also known as manic-depressive illness—can appear in both children and adolescents. Bipolar disorder, which involves unusual shifts in mood, energy, and functioning, may begin with either manic, depressive, or mixed manic and depressive symptoms. It is more likely to affect the children of parents who have the disorder. Twenty percent to 40% of adolescents with major depression develop bipolar disorder within five years after depression onset.

Seasonal Affective Disorder **Seasonal affective disorder (SAD)** occurs in certain people who are especially vulnerable to depression on a seasonal basis. They become depressed during winter months and then feel much better in spring and summer when the days are longer and the amount of sunlight increases. SAD has been recognized in children and adolescents, but it is more commonly diagnosed in adults. Gazing into intense fluorescent lights (phototherapy) helps many people who suffer from SAD during the winter months.

Risk Factors

In childhood, boys and girls appear to be at equal risk for depressive disorders; however, during adolescence, girls are twice as likely as boys to develop depression. Children who have major depression are more likely to have a family history of the disorder (often a parent who experienced depression at an early age) than those suffering with adolescent- or adult-onset depression. Adolescents with depression are also likely to have a family history of depression.

Assisting Young People Who Are Depressed

Depression is one of the most overlooked and untreated disorders of children and adolescents. It can be difficult to recognize depression in young people, particularly because they are likely to mask their feelings with behaviors not usually identified with depression, such as aggression, sexual promiscuity, academic failure, abuse of alcohol and other drugs, running away, and accident-proneness. The presence of one or several of the following indicators warrants investigation for possible depression:

- ❖ Feelings of sadness, hopelessness, and worry
- ❖ Negative feelings of self-worth
- ❖ Inability to concentrate or easily distracted
- ❖ Inattentiveness and listlessness
- ❖ Decreased academic performance or drop in grades
- ❖ Frequent absences from school
- ❖ Daydreaming
- ❖ Withdrawn or sullen behavior
- ❖ Social isolation
- ❖ Quick reaction with tears to any kind of pressure
- ❖ Inability to maintain energy level or complete ordinary tasks
- ❖ Complaints of tiredness
- ❖ Decreased appetite
- ❖ Disruptive behavior inside and outside the classroom
- ❖ Low frustration tolerance
- ❖ Frequent complaints of physical symptoms or illness

Accurate, early recognition of these signals is essential for effective intervention. Unrecognized depression may escalate to suicidal thoughts and attempts. Because teachers are on the "front line" they may be the first to observe signs

of depression. Suspected depression should be discussed with parents and a trained health professional such as a school counselor, psychologist, or nurse. Severely depressed children and adolescents need professional counseling and treatment.

Depressed children need a supportive relationship with the classroom teacher and integration into normal class processes. Supportive relationships with other students are also helpful. Depressed children have many strengths that can be mobilized and released when they feel that they have a friend. By attending to the problems of depression, teachers can provide lasting and significant benefits to the lives of their students. Schlozman presents the following advice for classroom teachers concerning childhood and adolescent depression:[10]

- While making allowances for normal fluctuation in mood, teachers should be vigilant in watching for signs and symptoms of depression in their students. They may be the first to notice when a student begins to act depressed.
- When a student is displaying signs and symptoms indicative of depression, a teacher should meet with the guidance counselor or school psychologist to discuss options for further investigation or referral. Teachers and counselors should make appropriate referrals through the proper school channels.
- Teachers need to be aware that depressed students often feel as if they have little to contribute. A teacher can help by showing confidence, respect, and faith in a depressed student's abilities and by not doing things in the classroom that would raise the student's anxiety. For example, when a teacher asks questions for which there is no clearly correct answer, a depressed student may be more likely to participate in a classroom discussion.
- Another way to increase a depressed student's confidence is to have the student assist younger or less able students in some way.
- Help young people who are depressed in forming a connection with a trusted teacher or other adult. This is often central to a young person's recovery from depression.
- When depressed students have difficulty discussing their feelings, it might be helpful for them to identify with literary or historical figures and use them to explore their own feelings.

It is critical that educators recognize that none of the suggestions for helping depressed students in the classroom should substitute for the appropriate diagnostic evaluation and treatment of depression. Treatment for depressive disorders in children and adolescents often involves short-term psychotherapy, medication, or both, and interventions involving the home or school environment.[11]

Stress Reduction Skills

There are thousands of skills adults and young people can develop to reduce the amount of stress they experience in life, ranging from simple skills such as being able to tie your shoes to more complex skills like being able to fix a computer problem. Because most people's top stressors are related to time, money, and interpersonal relationships, this section addresses these areas. (Interpersonal skills are addressed in Chapter 3.) This section also considers study and test taking skills, rest and sleep, and giving and serving. Practicing these stress reduction skills makes anyone's life more enjoyable. **Box 4-5** contains teaching activities you can do in your classroom to help your students develop and practice stress reduction skills.

Time Management

Time management entails several skills, including the following:

- ❖ Prioritizing what you want and need to do with your time
- ❖ Organizing yourself
- ❖ Being self-disciplined

Prioritizing entails identifying and then doing the most important things first. Identifying what is most important is generally fairly simple, the difficulty comes in maintaining the self-discipline to accomplish what we know we should do first. Becoming organized can be a complex skill for students to learn. In an effort to help students be more organized some schools provide students with

Day planners can help students organize and prioritize their time.

day-planners that contain calendars for students to record dates of tests and when major assignments are due. These planners also provide students an organized means of keeping track of daily assignments and homework. When planners are not provided, teachers can help students develop their own.

Teachers also can help students develop time management skills by teaching them how to break down a large assignment into steps with self-imposed due dates. For example, if a paper is due on February 20, a self-imposed rough draft due date of February 13 and a second draft due date of February 17 can be charted. Students who want minimal stress can also make their final due date one day earlier than that given by the teacher. Completing the work early prevents stress caused by rushing to complete an assignment at the last moment or from a computer or printer breakdown. Model the skill of time mapping for your students by displaying your unit plans or teaching calendar.

Money Management

The following are money management tips from financial experts. Following these recommendations will greatly reduce the amount of stress experienced in life. As you review the tips, consider how relevant they are in your life. Reflect on how you can teach and reinforce these principles in your classroom.

1. Pay yourself first—save!
2. Set financial goals and use a budget.
   Budgeting is distasteful when used to keep us from what we want.
   Budgeting is liberating when used to help us get what we want.
3. Avoid debt like the plague.
   Perform plastic surgery (cut up credit cards).
   Get out of debt.
   Use debt only for things that grow in value over time.
4. Do without and use creativity.
   Shop infrequently and avoid the mall.
   Determine the "use cost" of an item before deciding to buy it. (A $5 shirt worn only once has a use cost of $5. A $30 shirt worn 30 times has a use cost of $1. Which is the better buy?)
   Do not expect to have what your parents have—now.
   Eat at home, buy in bulk, and cook from scratch.
   Help people move—you recognize your junk better by having to lift others'.
5. Have appropriate amounts of insurance (e.g., health, car, home, life).
6. Work toward home ownership. Buy modestly—not the max you can borrow.
7. Both partners in a relationship are responsible for finances.
   Set financial goals and make a budget together.
   Divide money management chores.

Each person has a personal slush fund (amount determined by the budget) that can be spent any way that person wants and does not have to be reported to the partner.

Study and Test-Taking Skills

Students can read without gaining any meaning from what they read, missing the major and supporting ideas. Knowing how to read a textbook is an important study skill for all students to learn. Students can be taught to first scan a chapter's major headings and quickly identify the major concepts and important facts or principles. Younger students can practice this skill by first looking at pictures and trying to guess what the story is about. Students also need to develop the habit of reviewing key terms and questions before actually reading a chapter. Learning how to outline a chapter and use a glossary are other important study skills.

One of the best ways to learn how to take tests is to learn how to construct them. Having to write multiple-choice, matching, short answer, and essay questions from given content helps students identify which material lends itself to the different kinds of questions. Constructing tests can also help students identify key concepts and facts. Reviewing good test-taking practices such as scanning the entire test, circling key words such as *not*, and eliminating obviously wrong possible answers are additional test-taking skills. It is also very helpful for students to learn how to relax in an exam by using diaphragmatic breathing (discussed later in this chapter). This can help them overcome anxiety-induced mental blocks.

Rest and Sleep

Getting adequate rest and sleep reduces the amount of stress an individual experiences and helps a person better cope with everyday hassles. Inadequate rest and sleep can lead to chronic fatigue, inability to concentrate, nervousness, and irritability. Stress reactions in young people are also often linked to sleeping problems or insomnia. Encourage your students to get the rest and sleep they need, especially during times of rapid growth.

Giving and Serving

Those who give and serve are happier, experience less stress, have greater productivity, and live longer. The acts of giving and serving change us biochemically: we produce fewer stress hormones and more feel-good chemicals like dopamine. The **helper's high** is a euphoric physically measurable phenomenon. It makes people feel energized, like getting what some call a spiritual buzz. Donating our time or money seems to act as an antidote to stress, chronic pain, and insomnia. Giving has been shown to activate the feel-good chemicals like dopamine in the brain. Brain scans have shown that pleasure centers of the brain are more activated by giving than by receiving something. Just watching others give and serve can be stress reducing.[12]

4–5
In the Classroom

Assessment and Learning Activities for Stress Reduction Skills

First Things First

Demonstrate the concept that we need to do the most important things first with the following demonstration. Display a wide-mouth glass, four or five large rocks, pebbles, sand, and a glass of water. Ask students what you should put into the jar first? Proceed to fill the jar (rocks, pebbles, sand, and water in order). Explain that time works the same way. If we don't do the most important things first, we won't find time. Have the class identify their "rocks." They might say homework, piano practicing, or chores. Pass out a day or week time-planning sheet and have the students block out the time for their most important things first on their charts.

(*Source:* From Covey SR, Merrill AR, Merrill RR. *First Things First.* New York: Simon & Schuster; 1994.) (I, M, H)

Where Does the Money Go?

Have students brainstorm a list of things they spend money on (food, clothes, entertainment, transportation). Make up and tell a story about a student who had a certain amount of money and how he unwisely overspent and didn't have enough funds for what he really wanted. Have students develop a budget for this fictional student. Have students identify something they really want but for which they need to save. Give each student a 3- by 5-inch card and have them draw or paste a picture of the thing they need to save money for. Instruct them to create columns on the other side of the card for categories of things they typically spend money on. Have them identify how much money they typically have each month and then determine how much they can afford to spend in each category and still save for what they want. Instruct them to carry their card and record on it every purchase they make for one month. At the end of the month, review the budget cards, evaluate, and adjust the budget as needed. Reward the class's biggest saver. (I, M, H)

Book Chase

Help students learn textbook reading skills (scanning; skimming; using index, glossary, and table of contents) by breaking students into groups. Be sure stronger-skilled students are in each group. Tell students that they are going to have a

(*continues*)

(*continued*)

competition to see which group can find the answer to questions in their text the quickest. The first group to have every member with their finger on the page with the answer in their book raised high over their head wins that question. Group the questions so that the same text reading skill is repeatedly practiced. (I, M, H)

Surprise Quiz

Announce an unexpected pop quiz and proceed to give it. Stop after a number of questions and ask how the students feel. Discuss their physical and psychological reactions to learning about the quiz and then during the quiz. Discuss things they can do in the future to minimize stress (study and do homework) and relax (diaphragmatic breathing). (I, J, H)

Sleep Log Competition

Create a graphic like those used in telethons to raise money. Have students daily "fill in" the number of hours of sleep they got the night before. Have a contest with another class to see who can "log" the most sleep in a week. The winning class can wear their pajamas to school as a prize. This activity helps create a positive social norm for getting a good night's rest. (P, I, J, H)

Spare Change

Help students experience the helper's high by having them choose a charity, family, or individual that they would like to help. Get a large jar or other container and encourage students to deposit their spare change in it. Have a delegation from the class deliver the raised funds. An example of this is "Pennies for Peace." You can read more about it at http://www.penniesforpeace.org. (P, I, J, H)

Secret Elves

As a class, do a "sub for Santa" or other similar activity for someone in need, such as raking a widow's leaves. Students could even do secret acts of service for each other or for members of their family. (P, I, J, H)

Volunteer

Research volunteer opportunities in your community and make a list of places where your students can donate time. Volunteer as a class or create incentives (i.e., assignment, extra points) for students to volunteer on their own or in teams. (I, J, H)

(*continues*)

Altruistic Quotes

Post quotes like the following on bulletin boards and discuss them in class. (I, J, H)

"Only a life lived for others is worth living." —Albert Einstein

"Life's most persistent and urgent question is, what are you doing for others?" —Martin Luther King, Jr.

"I don't know what your destiny will be, but one thing I know: The only ones among you who will be truly happy are those who have sought and found how to serve."—Albert Schweitzer

Stress Coping Skills

Stress **coping skills** are things that help us effectively deal with difficult circumstances or times in our lives. Children and young people can learn to be effective copers. Effective copers are likely to have role models whom they emulate and from whom they learn specific coping skills. In addition, effective copers have people they can turn to for support, encouragement, and advice. They are able to trust and to maintain important interpersonal relationships and friendships. Children with effective coping skills are able to enjoy play, smile and laugh, and have relaxed bodies. Successfully encountering and coping with stressful life situations brings about a sense of competence. Optimism is a characteristic of those who effectively cope with stress. Teachers can do a number of things to help their students cope with stressful situations in the classroom (see **Box 4-6**). Some additional coping strategies are discussed in this section.

Restructuring Your Thinking

The first step in changing negative self-talk to more healthful thoughts is becoming aware of our inner monologues. Writing them down, talking out loud, or placing a bean in our shoe are some things we can do to remind us to evaluate our thought patterns. The Marks on You activity in Box 1-3 can also help a person become aware of his or her thinking patterns. As we try and pay closer attention we can watch for "red flag" words including *should*, *must*, *always*, and *never*. We can also notice our emotions and ask ourselves questions such as, "Why do I feel this way? What am I telling myself about this situation?" Once we are aware of negative self-talk there are several things we can do:

1. Reevaluate the situation. Step back and look at it with a broader perspective.
2. Check and fine-tune our expectations. Are they realistic? Are they shared?
3. Distract ourselves with music, exercise, reading, playing, laughter. . . .
4. Get quiet and listen for our own inner wisdom that gives us insight.

5. Act ourselves into a new way of thinking such as smiling first to become happy.

The old advice of counting to 10 in a frustrating situation can be very helpful, especially if during that time we evaluate why we are frustrated, check any thinking patterns that add to our frustration, and determine whether the situation is worth getting upset over. Humor can especially be helpful in a frustrating situation. One family has a rule that they can argue about anything, but when doing so they must lie down beside each other and sing their hostilities to one another. This family has discovered that arguments handled in this way soon turn into giggling sessions. Additional anger and conflict management skills are located in Chapter 3.

Humor

Perhaps nothing dissipates the stress response more quickly than humor. Humor can reduce pain, diffuse anger and anxiety, buffer the amount of stress experienced, and give one a sense of power in the middle of chaos. Here is a true story that exemplifies this. A man we know was unexpectedly laid off and unable to find comparable employment for more than a year. Just two weeks after becoming unemployed he awoke to discover his home was on fire. He was able to get his family safely out and retrieve his car from the garage, but nothing else was salvaged. A month after having his home burn to the ground, his car, the one he had saved from the fire, was totaled. He and his entire family were in the car on a congested freeway when they were struck from behind by a driver who failed to slow down when the traffic came to a standstill. The family was propelled into a barrel pit, and rolled several times in the car before it stopped with the tires in the air. Miraculously no one was injured in either the car accident or home fire. Equally miraculous is the fact that no one in the family developed a health problem as a result of all the stress experienced in the traumatic events and from battling insurance companies, hunting for new housing and employment, and grieving lost possessions. The fact that they continued to enjoy good health despite all their stress was in part a result of their use of humor. The father was in the habit of using humor to cope with stress. For instance, as the fire fighters were running toward the front door to try and save some of the house, he yelled out to them, "Don't forget to wipe your feet!"

Learning to not take life too seriously, to laugh at one's own shortcomings, and to look for humor in everyday situations are enormously helpful in managing stress. You can help your students enlarge their funny bone by studying and trying to use various types of humor. As you read through these, consider if you ever use them. Look for examples of each in the comic section of your newspaper. Create a "humor file" you can turn to when stress builds in your classroom.

- **Parody.** Imitating something or someone for comical effect. This is the type of humor used at celebrity roasts.

- **Satire.** A written expression of personal or social inadequacies. Dave Barry is a popular satirist.
- **Slapstick.** Physical humor such as being hit in the face by a pie or falling on a banana peel.
- **Absurdity.** Using two or more concepts that result in a stupid, ludicrous, or ridiculous perception. The *Far Side* comic strip is based on absurd humor.
- **Irony.** When two concepts or events are paired to mean the opposite of the expected outcome, such as ordering a highly caloric meal and then a diet drink.
- **Puns.** Playing with words that have more than one meaning or connotation. Young children particularly like this kind of humor.
- **Black Humor.** Poking fun at death, often as a means of dealing with fears. Cancer patients and sometimes gravestone epitaphs provide examples.
- **Sarcasm.** A biting jab that is often followed by the remark, "I'm just kidding." It might be clever, but it induces rather than reduces stress.

As we use humor in the classroom it is important to help students differentiate humor from ridicule. Carefully review the differences contained in **Figure 4-3**. Humor reduces stress and facilitates learning. Laughing at someone else's expense does not. This truth can be emphasized by discussing the teeter-totter syndrome and hydraulic-lift principle addressed in Chapter 1. Putting someone else down to try and elevate ourselves never makes us feel better for very long.

Journal Writing

Keeping a journal not only helps students develop writing skills, but also helps them identify and express their emotions. Encourage students to keep a stress

Laughing with	Laughing at
1. Going for jocular	1. Going for jugular
2. Caring and empathy	2. Contempt and insensitivity
3. Builds confidence	3. Destroys confidence
4. Involves people in fun	4. Excludes some people
5. Laughing at self	5. Being the butt of a joke
6. Amusing	6. Abusing, offends
7. Supportive	7. Sarcastic
8. Builds bridges	8. Divides people
9. Pokes fun at universal human foibles	9. Reinforces stereotypes by singling out a particular group as the "butt"

FIGURE 4-3 Humor versus ridicule.

journal of the stressors they encounter during the day. Writing such a journal can teach children to the following skills:

- To identify specific situations at home and school that are stressful
- To describe feelings and reactions to stressors
- To learn how to avoid certain stressors in their environment
- To gain insight into how to cope or confront stressors
- To provide feedback about efforts to avoid and control stress

Play

Play serves as an important stress management tool in the lives of children. Through play, they can symbolically reenact and solve problems as well as relieve tension. Preschool- and kindergarten-age children particularly need time to play to facilitate brain and emotional/social skill development. Play helps young people learn natural consequences, and understanding natural consequences helps children develop what is often referred to as common sense.

Physical Exertion

One of the best ways to help students handle stress is to provide opportunities for regular physical activity. Sports, games, dance, and other activities can serve as a diversion from stressors. When students play hard they forget about other things that are bothering them. Exercise also helps students relax by releasing excess muscle tension, by causing fight-or-flight stress hormones to be metabolized, and by encouraging the body to release endorphins. Endorphins, which are chemicals produced by the body, are closely related to opium and create a feeling of well-being. Exercise also increases the amount of oxygenated blood reaching the brain and facilitates learning.

4-6
In the Classroom

Assessment and Learning Activities for Stress Coping Skills

Marks on You

This activity is written as an application exercise in Box 1-3. It provides great insight into negative thinking patterns. It can be adapted to check for various cognitive distortions. (I, J, H)

(*continues*)

Rescript It

Play a video or TV clip(s) of a character demonstrating a cognitive distortion. Have your students rescript how that character could more healthfully look at the situation. (P, I, J, H)

Talk It Out

Talking about our stressors helps us cope better by helping us feel understood, cared about, and not isolated. It can also open the opportunity for others to share their healthful coping habits. Facilitate students talking about their stress by placing them in small groups and asking them to respond to statements such as "What stresses you out?" (J, H)

Lighten Your Load

Teach the importance of forgiving in stress reducing with this object lesson. Forgiving doesn't mean saying, "What you did was OK," but rather, "I'm not going to waste any more time and energy on . . ." Have students brainstorm examples of offenses or grudges that are hard to forgive. Write their ideas on rocks or cans of food. Fill a backpack with labeled rocks or food cans and have a student wear the pack for one day including at recess or during physical education class. Have the student share how the pack affected his or her day. Discuss how forgiveness lightens your load—it's something you do for you. Take the rocks or cans out of the pack one by one and discuss how a person could go about forgiving each offense.

Fear and Shadow Games

Using ordinary objects, turn out the lights and use a spotlight to show the frightening shadows these objects can make. Involve students by asking them to suggest other objects that cast shadows. Discuss fear of the dark and how they have or might be able to overcome their fear. (P, I)

Joke of the Day

After reviewing the various types of humor, encourage students to bring in examples they find to share in class. Be sure to instruct them first on what constitutes respectful, healthful humor. (I, J, H)

Caption That

Collect a series of funny baby pictures from off the Web. As you show your students each picture, have them try to come up with funny captions for it. (I, J, H)

(*continues*)

(*continued*)

Humor File

Have students create their own personal humor file of things that make them laugh. Their file can contain stories or drawings about personal experiences, clipped cartoons, jokes, quotes, or pictures. Encourage students to use their file to help them when they need to lighten up. (P, I, J, H)

Mini Vacation

When stress builds in the classroom have the students make a funny face or do a funny dance—anything for a distraction or to add humor to the situation. Taking a "mini vacation" can reduce the amount of anxiety the students feel. (P, I)

Keep a Journal

Have students keep a stress journal for a week or two. Have them record their various experiences, the emotions they felt, and what they were thinking at the time. Also have them keep track of how much sleep they got each night. This activity will give them great insight into what stresses them and how they handle it. Have them read their own journal entries and check for thinking distortions. Ask them to evaluate whether a lack of sleep is affecting how much stress they experience. (I, J, H)

Play It Out

Use role-play, puppets, or other imaginary play with stuffed toys to help students express their feelings and work through difficult situations. (P, I,)

Play with Me

Go outside with your students and play kickball or another organized game with them. As you play, teach your students about the benefits of physical exertion for coping with stress. (P, I)

Burn It Off

Provide appropriate ways for students to release energy created by the adrenaline released during stressful situations. This could be running in place, taking a walk, or having an early recess. (P, I)

Web Search

Many stress coping resources can be found on the Web. Have a class competition to see who can find the best site.

Relaxation Skills

Relaxation skills are activities that help the body return to a relaxed state—homeostasis. They can be used to deal with an intense stressor or with the effects of cumulative stress effectively. Although some relaxation techniques require special training or equipment (e.g., yoga, tai chi, biofeedback), those reviewed here are relatively easy to teach and are highly effective. People can use the various skills independently, but often combine them in relaxation exercises such as deep breathing and visualizing a restful scene while listening to music.

Diaphragmatic Breathing

Diaphragmatic breathing is controlled deep breathing using the lower abdomen rather than expanding the upper chest area. It is exhibited by people deep in sleep when the stomach distends as the diaphragm expands. While awake, we often expand our chests rather than use our diaphragm to breath. Expanding the chest area drives the sympathetic nervous system. When pressure is taken off of the thoracic area (chest), the sympathetic drive decreases and the parasympathetic drive overrides the sympathetic system, resulting in homeostasis. Diaphragmatic breathing to relax can be used in any setting and is particularly helpful in diminishing the amount of pain we experience. Learning to relax with breathing is a major part of the Lamaze natural childbirth method.

Normally, we breathe without thought, but diaphragmatic breathing requires concentration. When our minds wander, as they will, we simply bring our thoughts back to our breath. Noting what repeatedly pops into our thoughts while we are doing breathing exercises helps us become aware of our thinking patterns and facilitates **cognitive restructuring**. These are some exercises you and your students can practice:

1. While doing diaphragmatic breathing, notice which of your nostrils is dominant—one almost always is. Try and reverse it to make the other nostril dominate.
2. Place your hands on your abdomen and visualize your diaphragmatic breathing like riding a wave. The wave is the expansion and contraction of the stomach area.
3. Visualize yourself repeatedly inhaling clean, crisp mountain air and exhaling dark, cloudy smoke that represents all your stress, including frustration and other negative feelings.

Autogenic Training

Autogenic training entails learning to reverse or minimize the stress response using conscious thoughts. It is a means of exerting a degree of control over our respiratory, circulatory, and muscular systems. Your students can quickly learn

the principles, but it might take a few weeks of practice for them to feel the effects fully. Two elements are key to autogenic training:

1. Learning to make your body feel heavy.
2. Learning to make your body parts, or your entire body, feel warm.

The feelings of heaviness and warmth are key indicators that our parasympathetic nervous system has taken charge and our bodies are beginning to return to a state of homeostasis. Do you remember what you did when you were little and your parents said it was time to go to bed, but you didn't want to go? Did you become limp whenever they tried to pick you up? Instinctively, you were trying to make yourself heavy and this heavy sensation is what you want to feel in autogenic training. Warmth can be generated by simply thinking to yourself, "My arms and hands feel warm." Thoughts can direct our circulatory system to send more blood to a given area of our body or to the surface tissues of our entire body. The redirection of blood flow creates the sensation of warmth. Learning to warm parts of our bodies generally takes more practice than learning to become heavy.

Visualization/Imagery

Mental imagery allows us to forget about stressors and achieve a relaxed state by visualizing a pleasant situation. Visualized scenes that induce relaxation are quiet, peaceful, and warm. Imagined water in the form of a mountain stream, lake, river, or ocean also encourages relaxation. Visualizing oneself performing a physical task such as an athletic move to perfection can be relaxing as well.

It is often helpful for students with persistent test anxiety to practice mental imagery in combination with breathing and autogenic training. Have them get into a relaxed state and then imagine themselves taking a test while maintaining that relaxed state. They can also use mental imagery just before taking a test to help become relaxed.

Progressive Muscular Relaxation

Progressive muscular relaxation is a technique used to help people become aware of the difference between relaxation and tension in body parts. Stress can cause muscle tension in various locations of the body, such as the neck, shoulders, and back. Young people can learn **progressive relaxation** by tensing and relaxing muscles in one set of muscles after another. See **Box 4-7** for an example of a progressive relaxation exercise that you can use in the classroom.

Music and Art

Music can alter our moods and either relax or excite us. Have you ever noticed the type of music played in elevators? This acoustic slow-tempo music is piped

into elevators to help people better cope with the stresses of being with strangers in a small, confined space while rapidly ascending or descending. Young people usually prefer fast-paced energizing music, but teachers can help students identify more tranquil forms of music to listen to while coping with stress.

Drawing, painting, and other artwork in a relaxed setting can facilitate a state of homeostasis. Some athletes find it therapeutic to color between venues at major athletic competitions. Art can also be an effective tool for expressing thoughts, feelings, and perceptions. Teachers can use art to get a glimpse of what their students are thinking and feeling. Children draw or paint their mental perceptions of school experiences, family experiences, and themselves. They draw what they know and feel, rather than what they see. A teacher cannot really understand a student's drawing until the artist explains it. When you have students draw, do not praise any completed work (praise implies judgment of the worth or value of the student), instead say something like, "You've worked hard on this drawing" (to convey acceptance of feelings) and "Tell me about your drawing" (to gain insight). As a student responds, note what each part of the drawing represents according to what the student communicates about it (verbally and nonverbally). If a student draws a disturbing picture or pattern of pictures, and your impressions are supported by interactions with the student, relay your concerns to a school counselor or psychologist. Psychological and emotional evacuation through art is very complex. **Table 4-2** provides some general guidelines for interpreting a drawing. **Figures 4-4** to **4-6** provide examples of children's artwork for inspection. You can see additional children's artwork in Chapter 10.

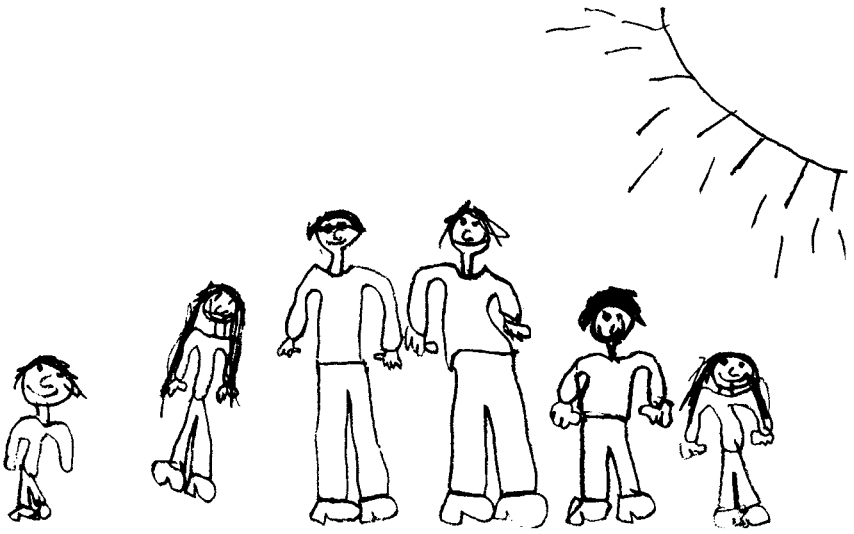

FIGURE 4-4 This drawing shows how a happy, adjusted 8-year-old boy saw his family.

TABLE 4-2 Guidelines for Interpreting Artwork

Characteristics	Feeling Indicated
Colors Predominately Used (if child has choice)	
White	Overwhelming object or experience
Black or purple	Depressed feeling
Warm, light colors	Happy mood
Yellow	Cheerful
Red or orange	Excited or anxious
Green	Refreshed
Blue	Calm
Darker colors	Unhappy, sad
Overall General Impression	
Lightly or hesitantly drawn	Inadequacy
Darkly or heavily lined drawing	Unexpressed anger
Compartmentalized picture	Isolation, insecurity
Scribbling over or erasing part or all	Anxiety over what was revealed in drawing
Figures tiny in comparison to paper	Insecurity, withdrawal
Figures large	Competence, security
Significance of Figures or Parts of Drawing	
Shaded or omitted part(s)	Anxiety over function or symbolic importance of part(s)
Exaggerated or oversized part(s)	Feeling (e.g., power or lack of power) proportional to person or object drawn exaggerated or oversized; exaggerated or oversized object or person is more powerful
Omitted hands or legs	Painful or worrisome anxiety, inadequacy, insecurity
Indication of Family Relations	
Size of each member and order in which members drawn	Largest denotes most powerful
Position of members in relation to closest relationship	Those closest to each other denote those with each other
Omission of self or placement of one member far away from others	Does not feel part of family
Similarity of expressions or clothes of members	The more similar, the stronger the relationship
Family members without hands and/or not standing firmly on ground	Helpless or ineffective

Source: Adapted from Servonsky J, Opas SR. *Nursing Management of Children.* Sudbury, Mass: Jones and Bartlett; 1987.

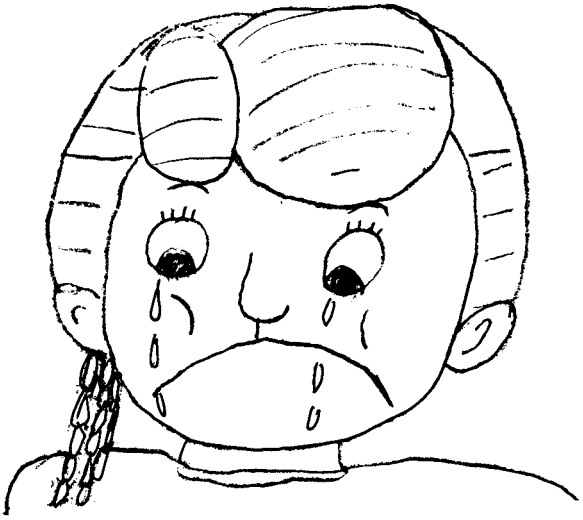

FIGURE 4-5 A 10-year-old girl drew this picture when she was "feeling sad" one day. Note the detail and largeness of the figure.

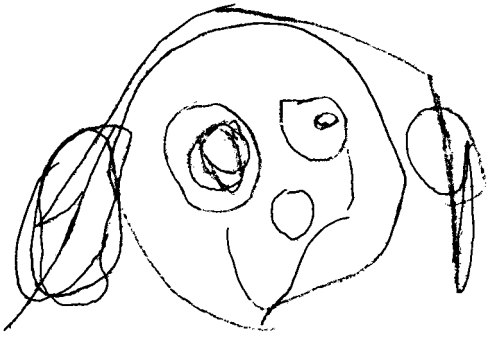

FIGURE 4-6 A self-portrait by a 5-year-old. The child was very happy yet chose to draw with black and brown colors, stating, "I like these colors on this paper. They show up!"

4–7
In the Classroom

Assessment and Learning Activities for Relaxation Skills

Meditative Relaxation

Move desks if necessary and have your students lay down on the floor. Play soft tranquil music that does not have lyrics. Very slowly, instruct the students as follows:

> Close your eyes. Take a deep breath and let it out slowly. Imagine yourself lying someplace that is soft, quiet, and filled with sunlight. This sunlight is very yellow and pleasantly warm. Feel the warmth of the sunlight. Notice how this warm yellow light covers you like a blanket. The warm yellow rays warm your face, your arms, your body, your legs, and your feet. Stretch in the light and then totally relax. Your entire body is relaxed. You feel warm, heavy, and relaxed. (P, I, J, H)

Google It

You can access many simple relaxation/meditative exercises and soothing music you can use in your classroom by doing Google searches.

Progressive Relaxation

I. *Concentrate on breathing.* Instruct your students to sit quietly with their eyes closed and with one of their hands on their abdomen. Tell them to take a deep breath and try to completely fill their lungs by using their diaphragm muscle. Then, have them exhale slowly. Instruct them to concentrate on their breathing for a few minutes, noticing the rhythmic flow of air as it enters and leaves their body. Have your students visualize that the air coming into their lungs is white, clean, and pure, and that the air they are exhaling is dark and filled with any negative emotion they might be feeling. (I, J, H)

II. *Go limp.* After students have concentrated solely on their breathing, instruct them to turn their attention to the amount of tension they feel in their back, shoulders, and neck. Ask them to try to relax the muscles in this area of the body. Remind them of how, as a small child, they went totally limp when they didn't want someone to pick them up. Have them try to duplicate this feeling of going totally limp. (P, I, J, H)

III. *Progressive exercise.* Explain that we often do not realize the amount of muscle tension we have in our body. As we become more aware of it we can better relax. When we relax our body, our mind usually follows and relaxes as well. Follow the order outlined below to take your students through a progressive

(*continues*)

relaxation exercise. Instruct your students to tense the muscle group identified to 100% of their ability for about 5 seconds and then to relax for about 15 seconds. Then, tense the same muscle group to 75% and relax, 30% and relax, 10% and relax. This will help the students identify the amount of tension they are experiencing in each muscle group and the difference between the various degrees of tension and relaxation. This type of relaxation technique is especially helpful for "hyper" individuals who find it difficult to relax by just sitting still. (I, J, H)

Follow this sequence:

1. Back, shoulders, and neck
2. Face and scalp
3. Arms and hands
4. Chest and stomach
5. Legs and feet

Sweet-Sweet Music

Have students close their eyes and use mental imaging while listening to soothing music.

Discuss what types of music are truly stress reducing and why. Play soft music in the background while students work on assignments. (P, I, J, H)

Drawing How I Feel

Ask students to draw a picture of how they feel right now. When the pictures are completed, discuss the following questions: What colors did you use and why? What is the size of the picture in relation to the paper? What were you thinking about as you were drawing? Have your feelings changed since completing the picture? If so, why? (P, I, J, H)

Key Terms

stress 116
stressor 116
General Adaptation Syndrome (GAS) 116
fight-or-flight response 116
homeostasis 118
acute stress 118
chronic stress 118
sympathetic 118
parasympathetic 118
immune system 119
lymph 119
B cells 119
T cells 119
distorted thinking patterns 121
all-or-nothing thinking 121
jumping to conclusions 121
overgeneralizing 121

filtering 121
discounting the positive 121
labeling 121
magnification 121
emotive reasoning 121
blaming 121
self-blame 121
sleep deprivation 126
dysfunctional families 128
burnout 131
depressive disorder 132
major depression 133
dysthymia 133
bipolar disorder 133
seasonal affective disorder (SAD) 133
helper's high 138
coping skills 141
parody 142
satire 143
slapstick 143
absurdity 143
irony 143
puns 143
black humor 143
sarcasm 143
diaphragmatic breathing 147
cognitive restructuring 147
autogenic training 147
mental imagery 148
progressive relaxation 148

Review Exercise

1. Define, differentiate, and explain the relative importance of each key term in the chapter.
2. Describe GAS and explain the physiological changes that come with stress.
3. Explain how disease and stress are linked and how stress affects the immune system.
4. Summarize the major stressors most adults deal with.
5. Discuss common cognitive distortions that increase stress and give an example of each.
6. Give examples of day-to-day hassles, economic-related stress, and immigration-related stress your students may experience.
7. Explain what a teacher can do to help meet students' needs following a natural disaster.
8. Discuss the various home-based stressors and what educators can do to help students appropriately deal with them.
9. Discuss school-based stress various age groups experience and identify ways teachers can reduce the amount of stress students and teachers experience at school.
10. Identify signs that may indicate a child is suffering from excessive stress.
11. Discuss the prevalence and signs of depressive disorders in children and adolescents.
12. Describe what teachers can do to help depressed students.
13. Identify the various stress reduction skills, explain how/why each works, and explain how teachers can help students learn these skills.
14. Identify the various stress coping skills, explain how/why each works, and identify how teachers can help students learn these skills.

15. Identify the various relaxation skills, explain why they work, and describe how each is effectively done.

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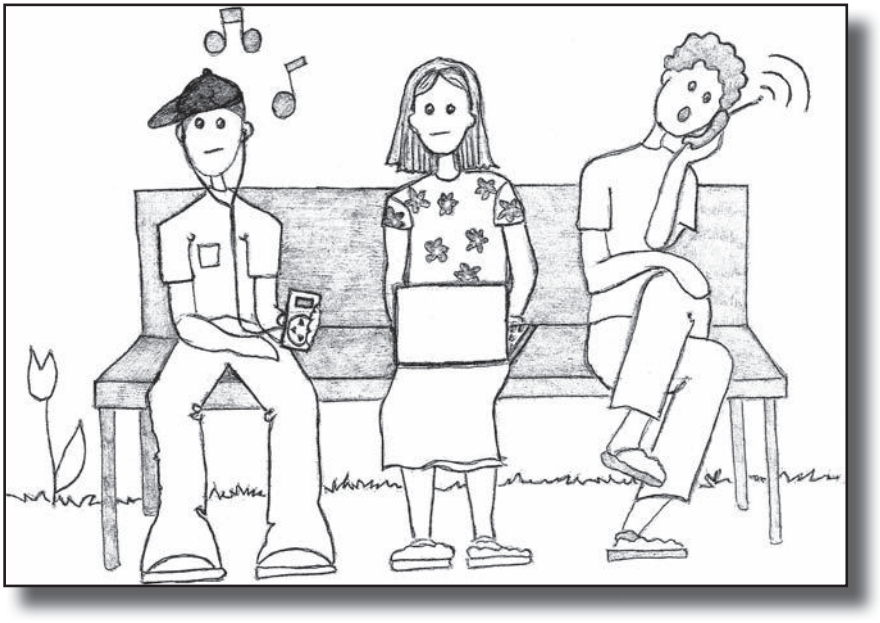
5

Media Literacy Skills



The Other Parent

James Steyer wrote a thought-provoking book entitled The Other Parent: The Inside Story of the Media's Effect on Our Children. Have you ever thought of the media as the "other parent"? Unfortunately, the media do serve as another parent by being a force that shapes children's minds and reality, sets expectations, influences behavior, defines self-image, and dictates interests, choices, and values. In actuality, this other parent is composed of a handful of large media corporations that includes such giants as Time Warner, News Corporation, Disney, Viacom, Vivendi, and Sony. Sadly, these corporations are not concerned about children's well-being. Rather, they are in the business to maximize profits. It's all about money—short-term profit.

One way that these media conglomerates maximize profits is through cross-promotions between branded properties and products—movies, TV shows, videos, merchandise, theme parks, books, magazines, music, and on and on. This means that no one dares stand up and question or challenge the decency and merit of what someone produces within their mega-structured corporate family. The conglomerates also censure their own network news programs and magazine articles to protect and promote their own interests. A common practice is to minimize or kill stories that might offend advertisers. Can you expect to get an objective story about the health effects of alcohol from a network or magazine whose parent company receives large revenues from the beer and liquor industry? It is interesting to see the attitude that the CEOs of media corporations take when it comes to their own children. Many will not allow their own children to see or hear the smut that they produce and market for other people's kids. Media literacy education needs to be offered in every school, from grade school on up, to help our children healthfully deal with the other parent's influence for good and bad.

The term **media** refers to forms of communication that transmit messages. There are many different forms of media: movies, television, radio, the World Wide Web, video games, billboards, magazines, newspapers, CDs, bumper stickers, T-shirts and caps, and packaging all bring us messages. Media messages can influence how we act, what we think, what our roles and expectations in life are, and what we buy. The average U.S. child (ages 8 to 18 years) uses the media for about 44 hours per week. That's clearly more time than most students spend in class or doing their homework.[1]

Today's youth need media and information literacy skills to deal with the vast amounts of information available today. Information is doubling every 5.5 years, technical information doubles every 2 years, and the amount of electronic information doubles every hour.[2] Two of the National Health Education

Media-literate youth understand that media messages are produced by someone with an agenda to sell, persuade, or change behavior.

Standards call for these skills (Standard 3: Students will analyze the influence of media and technology on health behaviors, and Standard 4: Students will demonstrate the ability to access valid information and products and services to enhance health). An entire chapter in this book is devoted to the media and information skills because of their importance and because they apply to every health content area. Being able to access valid information, manage media exposure, analyze and evaluate media messages, and be able to create media are media literacy skills addressed in this chapter.

Concerns about Media Exposure

Much of what the media bring to us in the way of messages is good and positive. Unfortunately, this is not always the case; some of the messages conveyed through media do not promote well-being, good health, and safety. For instance, many young people view media depicting, promoting, condoning, or glamorizing violence, alcohol and other drug use, unrealistic expectations about physical appearance and body image, unhealthy eating habits, and sexual promiscuity. Advertisements frequently use women's and men's bodies to sell products, often in a seductive manner. During the course of childhood and adolescence, young people are likely exposed to hundreds of thousands of advertisements telling them that they don't measure up unless they look or act in a certain way. Too often, people of color are stereotyped and adults are portrayed as incompetent or stupid.

Media "sells" values, attitudes, beliefs, and behaviors. Thousands of studies have shown a relationship between media violence and aggressive behavior. Many have also shown a cause-and-effect relationship between exposure to violence in media and violent behavior. The American Academy of Pediatrics states that more than 1,000 studies attest to a causal connection between media violence and aggressive behavior in children. The threat of children imitating the behavior they see on the screen is real and grave.

Another troubling aspect of media is exposure to ugly, consistently dysfunctional images and messages. Many programs on the air celebrate dysfunctionality by rejecting and making fun of the very things that make civilized life possible: discipline, self-control, hard work, delayed gratification, faith, and a commitment to family and spouse. All too often, television and movie writers and producers opt for the dollar-laden low road, competing to see who can get away with the most first and what old taboos can be broken. Media literacy involves scrutinizing not only the underlying messages of advertisements but also those of the programs one watches.

Unfortunately, our media-saturated lives can negatively affect the development of young people's social skills and relationships. Text messaging, e-mail, and Twitter do not provide young people opportunity to learn how to communicate effectively face to face their thoughts and needs, and to listen and respond to one another with empathy and social skill. Problems arise when families are involved with media and don't take time to talk to each other. At night, parents and children can each be involved with different media—reading the newspaper, watching TV, listening to an iPod, texting, playing a videogame, or surfing the Web. In an evening, family members can be in the same room and spend just one minute communicating with one another.

Consumerism is another media concern. Please take the time to do the application exercise found in **Box 5-1**.

5–1
Application Exercise

Consuming Kids

Watch the trailer to the movie *Consuming Kids: The Commercialization of Childhood* (found at http://www.commercialfreechildhood.org), and answer these five questions:

How and why has advertising to children changed?
What is the goal of advertising to children?
What is the basic consumer identity?
How do advertisers appeal to boys and girls and shape their sex roles?
How is advertising to children changing our society and health?

Media Use by Youth

Exposure to media usually starts early in life. Susan Villani notes that TV viewing often begins before age 2 years.[3] Television shows such as *Teletubbies* have been specifically designed to appeal to infants and toddlers. This has caused considerable concern about the use of the television by parents and caretakers as an alternative to human interaction from parents, other adults, and other children. Another trend of concern that she notes is the rapid proliferation of DVD players and the expansion of cable television and movie channels. This has increased the amount of programming available for young people to see and has blurred the distinction between television and movie programming. It has also made the viewing of extremely violent and sexually explicit movies accessible for millions of youth right in their own homes, often in their bedrooms because so many have their own TV sets.

It is interesting that medical associations such as the American Academy of Pediatrics advocate that health care professionals assess children's media exposure as part of routine medical practice. Villani makes the following recommendations for health care professionals based on an extensive review of the literature on the impact of media on children and adolescents:

> Health care professionals, and particularly child and adolescent psychiatrists, should incorporate a media history into the standard evaluation of children and adolescents. With the growing evidence that certain media use is included as a risk factor for acting out violently, as well as for other high-risk behaviors, the standard of practice has evolved over the past decade to warrant incorporation of the media history into everyday clinical practice. For adolescents, this needs to include careful questioning about musical preferences and the meaning of the music to the adolescents.
>
> This should extend to actively educating parents about the potential dangers of the television as an "electronic baby-sitter" for young children, televisions in children's bedrooms, prolonged periods spent playing violent video games, and the risks of unsupervised Internet use. The challenge to adults who deal with children, either personally as parents or professionally, will be to monitor media use in ways that foster curiosity and the positive aspects of the ability of media to teach, yet simultaneously protect children from spending too much time with media at the expense of human interactions, from being overexposed to material that cannot be adequately processed or understood, and from having their value systems shaped in negative ways by media content. The cost of ignoring the impact of the media on children and adolescents will be enormous, both in absolute dollars and the immeasurable cost of human pain and suffering.[3(p.399)]

Generation M

A Kaiser Family Foundation study labeled the current generation of young people as **Generation M**, where *M* stands for media.[1] The study found that exposure to several forms of media and the use of media devices is widespread and

Young people have media-saturated lives with few rules on media use from parents.

pervasive in the lives of today's young people. Today's young people (ages 8 to 18 years) spend on average 7 hours a day with media (4 watching TV/videos/DVDs; about 2 listening to music; more than 1 hour on the computer doing something other than schoolwork; about 50 minutes playing video games). The time they spend with media far outweighs time hanging out with parents (2 hours and 17 minutes), hanging out with peers (2 hours and 16 minutes), in physical activity (1 hour and 25 minutes), pursuing hobbies or other activities, and doing homework (50 minutes). In a typical day, a majority of young people report watching TV (81%), listening to the radio (74%), and using a computer (54%).

Other findings from the Kaiser Family Foundation study show that young people have media-saturated lives. Many children's homes and even their bedrooms have evolved into multimedia centers with TVs, cable or satellite hookups, computers, music players, and video game consoles. Consider the following facts and statistics about media use:

- The typical youth lives in a home with more than 3 TVs, 3 DVD players, 3 music players, 2 video game consoles, and 1 computer.
- Two thirds (68%) have a TV in their bedroom, and nearly one third (31%) have a computer in their room.

- More than 8 in 10 young people have cable or satellite TV service in their home, and 55% of youth get premium channels at home. Many young people have access to these channels in their bedroom.
- One in five (20%) young people have Internet access in their bedrooms.
- Almost two thirds (65%) have a music player of some sort, and half have a handheld video game player.
- Having the TV on during meals is typical for 63% of young people, and having the TV on most of the time is true for 51%.
- Young people with a TV in their bedroom spend almost 1.5 hours more in a typical day watching TV than those without a set in their room.

The multimedia environment in young people's homes contributes to a generation of media multitaskers. Nearly one third of youth say that they talk on the phone, surf the Web, instant message, watch TV, or listen to music most of the time while doing their homework.

How concerned are parents about generation M's media use? A study by the Kaiser Family Foundation[4] indicates that about two thirds of parents say they "closely" monitor their children's media use, are "very" concerned that children in this country are exposed to too much inappropriate content in the media, and favor government regulations to limit TV content during early evening hours. Minority parents express the most concern. About half of parents said they use movie ratings, but very few (16%) have ever used the V-Chip to block TV content and more than half didn't even know about V-Chips. Many parents still don't understand TV ratings and 90% thought FV (fantasy violence) stood for "family viewing."

A slightly different version of parental involvement in TV viewing is depicted in another study[1] where the majority of young people said their parents did not impose any rules about TV watching, and of those who do have rules, only 20% said that the rules were enforced most of the time. Only 14% of youth said they have rules about how much TV they can watch, and only 13% have rules about which TV shows they can watch. Only 12% reported parental involvement in their video game selection.

Encouraging parents to remove TVs from their children's bedrooms may be one of the most helpful things an educator can do in regards to media literacy. Increased time in front of a television screen is associated with many poor health behaviors. Adolescents with a bedroom television report spending more time watching TV, less time involved in physical activity, poorer dietary habits, fewer family meals, and poorer school performance.[5] The presence of a TV in the bedrooms of preteen youth has been found to be a stronger predictor of obesity than the amount of time spent watching TV.[6]

The Internet

Children and adolescents are frequently on the Internet. The time young people spend online is devoted to social networking, playing games, surfing the Web,

doing homework, and shopping. Many are immersed in technology and are able to write blogs, instant message, and even create video games. However, many are not as Internet proficient as they think. Too frequently they access information that is inaccurate, paste together reports rather than write them from information they find, and unknowingly cite sources that are highly biased.

Social Networking Sites such as Facebook and MySpace are part of the interactive Web that allows users to upload and create content in profiles. These **social networking** sites are very popular with young people. They contain contact information for registered users and may incorporate blogs, podcasts, and photos. These sites provide the ability to build a network of friends either by inviting people to join the service or finding other registered users with similar interests. Social networking services can help users find other people with shared interests, share good news, and help people stay connected. Unfortunately, sexual predators use these sites, and sexually explicit material can be posted. Cyberspace bullying is an additional concern of social networking. Users need to understand that even though these sites can feel like private areas, they are public forums. Youth need to be reminded not to put any information online that they wouldn't mind having on a billboard for everyone to see.

Concerns about Internet Use Nearly three out of four parents (73%) say they know "a lot" about what their kids are doing online. Most parents whose children are online say that they check their children's instant messaging buddy lists, review their children's profiles on social networking sites, and look to see what websites their children have visited. Forty percent of the parents who have children using the Internet at home say they use parental controls to block access to certain websites. However, youth report in another study that only 23% of their parents have rules for how long they can use the computer and for what they can do on the computer.[4]

The studies indicate that many young people are accessing the Internet unsupervised. Many are online when their parents are not home or gain access outside of their home. Some have Internet connections in their bedrooms and many have Internet access through cell phones. Although its wealth of information makes the Internet a valuable resource, students need to learn to avoid certain problems. For instance, some websites try to pry into young people's private lives by using games and special promotions as bait to capture names, ages, and addresses. Spending inordinate amounts of time online is another problem. Internet use can have addictive qualities, where hours seem like minutes, and can cause problems as relationships and responsibilities are ignored. Chat rooms are especially bad in this way.

One of the most serious concerns about unsupervised Internet use by children and teens is the potential for becoming involved with a sexual predator who tries to "groom" them for sex. Grooming can involve flattery, sympathy, gifts, money, or offers for modeling jobs over extended periods of time. The

predator tries to manipulate the victim to feel loved or just comfortable enough to want to meet them in person.

Another major concern is the easy, sometimes accidental, access to pornography on the Internet by young people. Wireless handheld devices such as video cell phones, iPods, iPhones, personal digital assistants (PDAs), and PlayStations and other video game consoles can be conduits for pornography available on the Internet. There is a need for educating youths about appropriate use of cell phones, e-mail, and social networking. They need to understand that once information or images are shared electronically, they can be passed an infinite number of times. Minors need to know that in many states they too can be found guilty of misdemeanor or more serious charges for sending pornographic materials electronically. Pornography is a $57 billion worldwide industry, including $12 billion in the United States alone. Its revenue exceeds the combined revenues of all professional baseball, football, and basketball franchises and the combined revenues of ABC, CBS, and NBC. Its distortions can affect teenagers' attitudes about sexuality and can be addictive with the same devastating effects on relationships and families as other addictions. Many addicts report getting hooked at a very early age and that kicking a pornography addiction is like trying to overcome a cocaine addiction. All addictions change brain structures critical to decision making, learning, and memory and behavior control. This may help to explain the compulsive and destructive behaviors present in all addictions.[7]

There are even concerns about using the Internet for academic endeavors. These concerns are identified by respected educator Alan November:

> For many students, the Web is the dominant medium and the place they most likely go to find information. Unfortunately, many students accept information that looks authentic as the "truth," and this is one of the dangers of researching on the Web—especially since anyone can publish almost anything they want.[8(p.vii)]

Online Safety Tips Teachers can share the following online safety tips with students and their parents; these tips can be taken home as part of an assignment that generates family discussion.

- Place computers in an open, frequently accessed area of the home (i.e., family room) so that others can easily see the screen.
- Do not allow Internet access in bedrooms.
- Establish clear ground rules for Internet use (e.g., when, where, how long, what sites can or cannot be accessed).
- Tell parents all screen names, e-mail addresses, and addresses of blogs and profiles students use. Parents and students frequently visit these sites together and discuss what is seen.
- Never make plans to meet an online acquaintance face to face.

- ❖ Post only information that you are comfortable allowing others to see (e.g., parents, future employers).
- ❖ Make sure screen names and sites do not say too much about you, such as your full name, age, home town, school, or job.
- ❖ Consider not posting photos of yourself. They can be altered or broadcast in ways you may not be happy about.
- ❖ Do not respond to dangerous or offensive communications such as e-mail or chat (anything or anyone who has made you feel uncomfortable or scared).
- ❖ Immediately tell an adult if you ever feel threatened by someone or uncomfortable because of something online.
- ❖ Avoid flirting with strangers online because you never know who you are really dealing with.
- ❖ Immediately turn off a computer if you accidentally access a pornographic site. Some pornographic sites disable the user's ability to escape when using normal key functions such as ESC (escape) and instead bring up additional windows containing pornographic images.

Advertising Power

The average American is exposed to about 3,000 advertisements per day through television, radio, magazines, newspapers, billboards, and on objects we often don't consider advertising, such as logos on clothing. These ads sell us much more than products: they influence our perceptions of ourselves and the world around us. They teach us attitudes, beliefs, and values without our noticing it.

We have been conditioned into believing that a media program (e.g., a television show) is brought to us by a sponsoring company ("Today's game is brought to you by Brand X"). The truth is, however, the opposite. We, the potential consumers, are in reality the products being sold. The program (television show, radio broadcast, magazine article, website) exists for the purpose of rounding up an audience to see and hear the advertisements. The reason that a television program or magazine exists is to sell the products that are advertised through the medium.

Noted advertising expert Jean Kilbourne explains more about the purpose of media:

> Make no mistake: The primary purpose of the mass media is to sell audiences to advertisers. *We* are the product. Although people are much more sophisticated about advertising now than even a few years ago, most are still shocked to learn this.
>
> Magazines, newspapers, and radio and television programs round us up, rather like cattle, and producers and publishers then sell us to advertisers, usually through ads placed in advertising and industry publications. "The people you want, we've got all wrapped up for you," declares *The Chicago Tribune* in an ad

Ads are everywhere, selling us much more than their products, including warped perceptions, attitudes, values, and unhealthy behaviors.

> placed in *Advertising Age*, the major publication of the advertising industry, which pictures several people, all neatly boxed according to income level.
>
> Although we like to think of advertising as unimportant, it is in fact the most important aspect of the mass media. It is the point. Advertising supports more than 60 percent of magazine and newspaper production and almost 100 percent of the electronic media. Over $40 billion a year in ad revenue is generated for television and radio and over $30 billion for magazines and newspapers. As one ABC executive said, "The network is paying affiliates to carry network commercials, not programs. What we are is a distribution system for Procter & Gamble." And the CEO of Westinghouse Electric, owner of CBS, said, "We're here to serve advertisers. That's our raison d'être."[9(p.34–35)]

In this "ad-vironment," it is common to hear people say that they just ignore the ads. However, it is impossible to filter out the amount of advertising to which we are constantly exposed, especially when advertisements are carefully designed to affect us with every detail planned, researched, and pilot tested. The power of advertising is evidenced by the fact that lots of people pay lots of money for numerous highly advertised products. Today's grocery stores stock about

24,000 items, up from about 9,000 a decade ago. Have you ever wondered why so many people are willing to buy a bottle of water worth two cents and pay $1.50 for it? More than buying the product itself (the water), they are buying the values that advertising has attached to the product (e.g., being hip). There is an old Madison Avenue saying that "You don't drink the beer; you drink the advertising."

Most advertising is based on two fundamental messages. First, you should be dissatisfied with yourself. Second, purchasing the product being pushed is the only way to resolve this dissatisfaction. We are bombarded with ads saying that our hair is too oily, our breath stinks, or that we have body odor. Purchasing shampoos, mouthwashes, and deodorants is the solution to these dissatisfactions. Ads make us feel insecure about our weight, appearance, and ability to attract lovers—the list goes on and on. Eating this cereal, taking this over-the-counter product, and drinking this beer are presented as solutions to these insecurities. Advertising has the capacity to influence people to believe that their life and worth are defined by what they possess. If you are feeling ugly, have a beer. If you think you are not sexy, buy the breath mint, perfume, designer clothing, or automobile that promises you the magical transformation of making you sexy. People who feel empty or who suffer from a sense of low self-worth are most vulnerable to advertisements. If individuals harbor negative feelings about themselves, they are more likely to turn to products promising to resolve these feelings. It is a sad fact that teenagers raised in disrupted families exhibit higher levels of compulsive consumption than those raised in intact families.

Companies spend lots of money advertising their products and services. Millions are spent producing a single commercial, and a great deal more money is spent on airing it. It cost, on average, $3 million to air a 30-second commercial during the 2009 Super Bowl game. The average cost in 2009 to air a 30-second TV spot during Fox's *American Idol* was $630,000 and during ABC's *Desperate Housewives* was $251,000. Remember, these are the costs of airing a single 30-second commercial just one time—think about how many times you see the same commercial repeatedly aired and then consider how much companies spend on their advertising campaigns.

Because advertising is a business with billions of dollars at stake, advertisers do extensive research to be sure they are spending their money effectively. An ad is the end product of a complex and very costly process. Many specialists are involved, and they might spend months putting together all of the components to make an effective advertisement. Everything has been planned in detail—every image, word, scene, sound, camera angle, and detail in the background. The specialists involved in constructing an advertisement include writers, researchers, editors, psychologists, photographers, camera crews, actors, models, and artists. The costs involved in production can easily go into millions of dollars for a single advertisement. Check out the attention-getting and persuasion tactics advertisers use in **Box 5-2**.

5-2
Background on . . .

Attention-Getting and Persuasion Tactics

The following are appeals advertisers use to get our attention and persuade us to purchase their products:

- *Humor.* Associating humor with a particular product.
- *Sex.* Creating an emotional arousal that is transferred to a product or program.
- *Shock.* Getting an audience's attention by having something unexpected happen.
- *Urgency.* Stressing the need to act immediately so that you don't miss out.
- *Put-downs.* Putting down a product or person to appear superior.
- *Repetition.* Repeating names, slogans, images, or music to create an association with the product and creating a likelihood you will buy it.
- *Endorsements.* Using celebrities, cartoon characters, or "people who know."
- *Self-centeredness.* Emphasizing *you:* "you deserve it," or " you are worth it."
- *Everyone's doing it.* Inviting you to join in because you don't want to be a loser.
- *Progress.* Emphasizing that a product is "new and improved."
- *Scientific evidence.* Giving results of "scientific" studies or surveys to boost your confidence in a product.

Ad Creep

In many ways we are increasingly becoming invaded by ads. They seem to be everywhere: in schools, airport lounges, doctors' offices, movie theaters, hospitals, gas stations, elevators, convenience stores, on the Internet, on fruit, on ATMs, on people's apparel, on restroom walls, on the sides of buildings, pressed into the sand on beaches, and in countless other places. Cars, taxis, and buses sporting ads have also become moving commercials. **Ad creep** is a popular term to explain the expansion of advertising space to nontraditional locations or spaces. Ad creep reflects how marketers are attempting to find new ways to stick ads in front of our noses in an effort to get our attention.

Ambient Advertising Many forms of advertising contribute to ad creep. **Ambient advertising** is the general placement of ads in public places. One form of ambient advertising is **place-based advertising**, or coercing captive viewers to watch video ads; examples are the ads frequently aired before movies, on public transportation, on ATMs, on gas pumps, in doctors' offices, and in airport waiting areas. The selling of **naming rights** to public spaces has heightened the amount of ambient advertising and ad creep in many communities.

Companies have purchased naming rights to such public spaces as sporting arenas, theaters, parks, schools, museums, and subway systems. This practice is enticing for cities and counties, which view it as a way of increasing revenue without raising taxes.

Digital Advertising **Digital (virtual) advertising** is using computer technology to add logos or products to scenes; the computer-generated material is superimposed on a live video feed or inserted into a completed movie or TV show. This form of ad creep is common in TV coverage of sporting events, where ads are digitally inserted onto the billboards, sideboards, and playing surfaces in arenas and stadiums. If you watch the World Series on TV, you will probably notice that the advertising space behind home plate changes to a different ad each inning of the game. This is a classic example of digital or virtual advertising. Another example is the insertion of a particular brand of cookies in front of actors in a syndicated version of a TV show in which the cookies did not appear in the original airing.

Product Placement **Product placement** is when advertisers pay to have their product included in movies, TV shows, museum exhibits, or other forms of media and culture. Usually the product placement involves placing a product in highly visible situations in the context of a program. Product placement is believed by some to be more effective than traditional commercial spots because it sneaks by a viewer's critical thinking processes.[10] Most recently released movies and many TV programs contain several product placements. A variant of product placement is *advertisement placement*, in which an advertisement for the product (rather than the product itself) is seen in the movie or television series.

Product placements are a growing source of controversy. Many people are of the opinion that product placement has grown out of control and become too pervasive. There is concern that most product placements are inherently deceptive (people do not realize they are, in fact, advertisements) and are not fully or clearly disclosed. Consumer groups advocate for full disclosure of all product placement arrangements so that consumers are notified of these embedded advertisements before and during a television program. Media outlets argue that restrictions on product placements are an infringement of freedom of speech rights. Some European nations sharply restrict or ban product placement on television.

Undercover Marketing **Undercover marketing**—marketing in which people do not realize that that they are being marketed to—seems to be creeping into our lives. One form of undercover marketing is for a marketing company to pay an actor to use a particular product in a very visible way in a location where potential consumers are congregated. For example, a company marketing a new cigarette brand might employ an attractive-looking woman to go to a bar, strike

up conversations with customers, hand out samples of the cigarette, and in the process, extol the virtues of the brand she is smoking. The people she talks to do not know that she is a paid actor who is working to sell cigarettes; they view her as just another patron of the bar. In another example, a "tourist" might ask strangers, "Excuse me, do you mind taking a picture of me?" The tourist then tells the picture taker how cool the camera is and mentions all of its awesome features.

The goal of an undercover campaign is to generate **buzz**, or peer-to-peer word of mouth. Because buzz spreads from person to person in a seemingly spontaneous manner, buzz marketing is also sometimes called **viral marketing**: somebody tells two friends, who then tell four friends, and so on, until the infection takes hold. Other names for this type of advertising or marketing are **stealth marketing** and **roach baiting**.

Buzz Marketing **Buzz marketing** campaigns identify key influential young people opinion leaders and get them to spread information about a product to their peers through instant messaging, social networking sites, and blogs. An example of a successful buzz marketing campaign is Procter & Gamble's **Tremor**, which uses 280,000 teens as part of its "Tremor Crew." The Tremor Crew helps spread the word about Procter & Gamble brands among teens through sleepovers, by cell phones, by e-mail, and at school. They do it for free, and no parental consent is obtained during the application process. Tremor's teens are now being used by other companies to talk up their brands as well. Coca-Cola, Valvoline, CoverGirl cosmetics, shampoos, milk, Toyota cars, and movies have used Tremor's recruits.[11]

Another marketing firm that targets young people through buzz marketing is the **Girls Intelligence Agency (GIA)**, which promotes its "Slumber Party in a Box." This campaign attracts girls ages 8 to 13 years. Potential marketers are told of the value of having "40,000 secret agent influencers and their closest friends." Companies who use the Girls Intelligence Agency use these girls to form focus groups for their products and see their product spread through the lucrative multibillion female youth market. This approach raises some controversial issues. Do these girls understand that they are being used and that marketers are exploiting their friendships? Ad creep has thus reached a point where the advertising culture is so ingrained that children may be unable to tell if their friends are advertisements in disguise.

Mobile Marketing and Viral Video Today cell phones make **mobile marketing** possible and give advertising agencies direct access to youth. Soon young people will increasingly receive phone calls when they are near particular stores and restaurants with pitches that try to get them to come in and buy something spontaneously. Markets have also taken advantage of the popular short online videos. They now use **viral videos** to promote brands sometimes overtly and sometimes in disguise on video sharing services like YouTube.

Targeting Kids

To the corporate world, kids are big business. American companies spend $15 billion a year on marketing and advertising to children under the age of 12.[12] Each year, the average child sees about 40,000 ads on television alone.[13]

Advertisers aim not only at the billions of dollars that kids spend each year, but also at the billions of dollars that adults spend on kids—an amount that might be 10 times as high. The fact that kids influence between 25% and 40% of household purchases has made all kinds of companies—from automakers to airlines—aim their advertisements at youth. Marketers also know that when brand allegiances are formed in childhood, the customer usually remains loyal to the product for many years to come. Thus, marketers try to win a child so that they can enjoy that enduring loyalty. Children begin developing brand preferences in early childhood, even before entering school. This lucrative kids' market has spurred a proliferation of television channels (e.g., Nickelodeon, Fox Kids Network, Disney Channel, Cartoon Network) and websites to advertise products and services to young people.

Vulnerability of Children

Parents and teachers need to be aware that children are particularly vulnerable to advertising. Young children are unable to distinguish advertising from regular programs. By age 5 or 6, most children are able to comprehend the distinction between an advertisement and a program, but that doesn't mean they understand that the purpose of an advertisement is to sell. Children consider the advertisements they view as entertaining or informational in nature (see Box 5-2). They also have a high degree of trust in advertisements. Around the age of 7 or 8, most children begin to understand the selling intent of advertisements. With the development of more conceptual thinking, children around age 12 can recognize the motivation of advertisers, the source of an advertisement, and the strategies used to persuade. Increasing consumer experience allows most teenagers to become fairly critical and skeptical of advertising.[14]

School-Based Marketing

Advertisements are even in our schools where we see them on bulletin boards, scoreboards, book covers, and educational materials bearing corporate logos. Schools use curricular materials that are produced by the Coca-Cola Company and Pizza Hut. School buses and school athletic fields are decorated with ads. Incentives, promotions, and contests are other frequently used in-school marketing devices. Channel One, a daily ad-bearing TV news program containing 2 minutes of ads for every 12 minutes of programming, is aired in more than 12,000 schools. Schools who participate in Channel One receive televisions and VCRs in exchange for the school's commitment to show its news program, with

advertisements aimed at students, at some point in each school day. Many parents and educators object to the Channel One program, but for schools with limited budgets it is difficult to pass up the offer of free TVs and VCRs in every classroom. Channel One promises its advertisers "the largest teen audience around" and "the undivided attention of millions of teenagers for 12 minutes a day." Some communities, such as the Nashville and Seattle public schools, have expelled Channel One in an effort to reduce commercial intrusion in their schools.[10]

Schools are vulnerable to allowing companies to cash in on kids in an attempt to solve financial difficulties. For example, Coca-Cola has entered into several "partnerships" with schools in which the company gives schools large sums of money in exchange for a long-term contract giving Coca-Cola exclusive rights to school vending machines. Tax monies can only be stretched so far; therefore, financially strapped schools are often willing to enter into ventures with generous commercial sponsors. These sponsors willingly provide numerous enhancements (e.g., computers, educational materials, TV monitors) that a school might not otherwise be able to afford. Sadly, in the process, children gain more access to vending machines selling fatty foods and sugary soft drinks, are exposed to an increasing number of advertisements and corporate logos, and learn from corporate-sponsored lessons and curricula. Is it any wonder that today's students drink twice as much soda as milk and that the diets of many are full of junk foods?

School children form a captive audience for school-based marketing, and the campaigns carry an implied school endorsement. Students are especially vulnerable to these marketing tactics because they believe that what they are exposed to at school is good for them. School-based advertising creates a blurred line between education and propaganda. For this reason, students need to learn to analyze, interpret, and evaluate all of the messages contained in an advertisement, even those to which they are exposed at school. It is hoped that more schools will make efforts to become advertising-free schools. This requires significant, ongoing community commitment and involvement. Parents and taxpayers have to support the effort to provide an advertising-free environment for school children. It requires a strict policy and replacing lost corporate contributions with large donations of time, talent, and money.

Internet Marketing

Marketing on the Internet is an advertising strategy that is increasingly targeting children and teens.[15] Young people are an ideal target group for Internet advertisers because they stay online for longer periods of time than adults do, participate in a wider range of online activities, and are more likely to adapt quickly to new technology and accommodate those changes.[11] Internet marketing allows advertisers direct, usually unmonitored or parent-free access to children. Online

marketing activities are largely unregulated. In comparison to other forms of media, the Internet is the least regulated. This allows websites directed at children to use insidious and manipulative marketing techniques. Even countries that prohibit broadcast advertising to children, such as Sweden and Norway, find that these efforts are undermined by Internet marketing.

Companies targeting children find Internet advertising an attractive and cost-effective way of reaching young people with their marketing messages. In comparison to television advertising, Internet advertising is inexpensive. Websites are relatively cheap to create, can remain online for months, and are not subject to the high costs associated with television advertising.

A common online marketing strategy is the creation of **branded environments**, or websites designed specifically for kids with content that features a commercial product or brand.[9] These commercial websites are designed with children and teenagers in mind. They entice children with such features as interactive games and activities, contests and competitions, prizes and other incentives, clubs, sports sponsorship, animated characters, "kids-only" zones, and online chat communities. Website marketing allows children to interact directly with a company and can be used to collect personal data from children (e.g., e-mail addresses for themselves and their friends) and extract marketing information (e.g., from having children vote on new flavors or packaging designs). Prizes or incentives are sometimes promised to children who share the e-mail addresses of their friends. Such sites also feature online stores or links to websites that are created to make direct sales. Some websites have created "digital wallets" that allow a parent to use a credit card to place a set amount of money into a child's online account. Many youth who surf the Web have no trouble finding the websites for alcohol and tobacco companies, which are appealing and enticing to young people.

Information Literacy Skills

Information literacy is the set of skills that allows us to find, evaluate, and use the information we need and filter out the information we don't need. What respected educator Alan November says in *Web Literacy for Educators* illustrates the importance of information literacy in the lives of students:

> The Internet is the most powerful, convenient, and potentially manipulative medium ever invented. It can give you any version of the truth you are looking for. Not only does information expand and change every day, the rules for finding information also change.[8(p.vii)]

One of the most important aspects of being a wise consumer is being able to determine if information is reliable—is it accurate and truthful? A key in determining the reliability of information is to ask if the purpose of those providing the information is to inform rather than to sell. If the information is provided to persuade people that they need to purchase a specific product or service, it is probably not reliable. Reliable health information is provided by

individuals or organizations for the purpose of helping people make informed decisions and encourage healthy behaviors.

The source of the information is another clue about the reliability of the information. Be suspicious of organizations or individuals who might profit from the information they provide or who seems to have a particular "agenda." Any organization or individual with a vested interest in a particular product or service may present information that is biased toward that particular interest. For instance, what biases might be purported in a brochure about nutrition and health created by the manufacture of a line of vitamin and mineral products? What messages about nutrition and health might be promoted by a trade association made up of beef producers or owners of fast-food restaurants? What bias is apparent when the sponsor of an educational pamphlet about treatment of depression recommends treatment with a specific drug produced by the same company?

Reliable health information is based solely on scientific research and information, and not on mere opinion. The information is more likely to be accurate if credible health professionals and health organizations agree with it. Unreliable information, however, is sometimes presented in a way to convince you that it corresponds with established medical knowledge. Headline news and media reports of health issues have often been criticized for attributing too much certainty to research findings, for premature representation of findings as breakthroughs, and for being alarmist, incomplete, or inaccurate. Be aware of health information that attempts to arouse feelings of fear or anxiety. Ask if the information or advice is plausible and commonsensical, or whether it is wishful thinking or sensationalism.

Evaluating Information on the Internet

The quality of information on the Internet varies from highly credible to very poor. No one regulates the information on the Internet and anyone can set up a home page and claim anything. Wrong and misleading information can harm someone or cause people to become worried, distraught, or paranoid. Here are some good questions for evaluating the reliability of information found on Internet sites: Are advertisements mixed in with content? Does it promise miracle cures or unbelievable results? Does the site ask you to give personal information, but not promise to keep it private? Does the site fail to link to other reliable health information? Does the information on the site contradict what you have learned from a physician or a reputable health organization? Also be wary of information found on bulletin boards, in chat rooms, in forwarded messages, and in e-mail messages.

Tip-Offs to Rip-Offs Being a wise consumer also requires information literacy skills. Young people need help in learning how to differentiate between products and services that enhance health and those that do not. The **Food and Drug Administration (FDA)** has identified some tip-offs to health fraud rip-offs. The

FDA suggests that you look for the following phrases and gimmicks used to catch your attention and gain your trust[16]:

- Quick fixes
- "Natural" or "nontoxic"
- Promises of easy weight loss
- "One product does it all" or claims that the product is an effective remedy for a wide range of ailments
- Personal testimonials
- Undocumented case histories of people who claim dramatic results
- Health care providers that may be unlicensed or lack other appropriate credentials
- Meaningless medical jargon
- "Satisfaction guaranteed" or "money-back guarantees"
- "Time-tested" or "new-found treatment"
- Claims of a "scientific breakthrough," "miraculous cure," "exclusive product," "secret ingredient," or "ancient remedy"
- Paranoid accusations
- Claims that the product is available only from one source

Sources of Reliable Health Information There are many sources of reliable health information. Many federal, state, and local government agencies that focus on health-related issues maintain printed materials and websites that have reliable information. The Centers for Disease Control and Prevention (CDC) is an excellent source for reliable information on numerous health topics. The Food and Drug Administration (FDA) regulates foods, drugs, and medical devices and also serves as an information resource on numerous health topics. The **Consumer Product Safety Commission (CPSC), Federal Trade Commission (FTC)**, and the **National Health Information Center (NHIC)** are additional federal government agencies that provide valuable health information.

Other good sources of health information are voluntary health agencies and professional health organizations. Examples of voluntary health agencies include the American Cancer Society, American Heart Association, and the American Diabetes Association. Examples of professional health organizations include the American Medical Association (AMA), American Public Health Association (APHA), and the American Academy of Pediatrics. These organizations produce and circulate publications and also offer websites that provide sources of quality health information. See **Box 5-3** for information literacy teaching activity ideas and **Box 5-4** for free resources including lesson plans and video clips.

5-3
In the Classroom

Assessment and Learning Activities for Information Literacy

The following are activity ideas that you can adapt for assessment and use at many grade levels (indicated as in previous chapters). As you read these consider how you could integrate teaching media and information skills into various content areas such as math, social studies, drug education, and nutrition.

Scavenger Hunt

Encourage students to bring laptop computers and cell phones to class one day. Divide students into teams and have them compete to see who can be the first to find answers to questions you pose on a subject you are currently studying. Have them search the Internet or call someone who can help. Review their sources for reliability. (I, J, H)

Website Evaluation

As a class, visit several websites that offer information on a topic. Have students evaluate the site by answering these questions: Is this information presented to sell anything? Is the source of the information biased? Does the source of the information stand to profit in some way? (J, H)

News Analysis

Review with students news articles online or in newspapers that are examples of arousing fear or anxiety, wishful thinking, sensationalism, reporting on single studies. Discuss why news sources contain this type of material and why we need to be wary of it. (J, H)

Wise Consumer

Have students evaluate ads they find online or at the back of magazines for questionable products using the information discussed in the section titled "Tip-Offs to Rip-Offs" earlier in the chapter. (P, I, J, H)

Online Health Info

As a class, use Google to search for information on health topics. Review the sites identified and declare them either as reliable or unreliable. (J, H)

5-4
Background on . . .

Free Resources for Teaching Media and Information Literacy

You can find lesson and curriculum plans on media and information literacy for elementary, middle, and high school levels at these websites:

- The Alliance for a Media Literate America: http://www.medialit.org/reading_room/rr4_lessonplan.php
- Media lesson plans for math, science, social studies, and language arts: http://www.amlainfo.org/lesson-plans
- National Association for Media Literacy Education: http://www.amlainfo.org/meal-resources
- The Media Awareness Network: http://www.media-awareness.ca/english/teachers/index.cfm
- Media Literacy for Drug Prevention: http://www.nytimes.com/learning/teachers/NIE/medialiteracy
- Media-Smart Youth: http://www.nichd.nih.gov/msy/msy.htm

You can locate materials for teaching media and information literacy at these websites:

- Web-based game with teacher's guide that teaches kids how to spot online marketing strategies, protect their personal information, and avoid online predators. Privacy Playground: http://www.media-awareness.ca/english/games/privacy_playground
- Streaming videos on and for media literacy education. The Media Literacy Clearinghouse provides a very large link bank to Teacher Tube, Media Ed Foundation, PBS, YouTube, and others. Categories include Advertizing, Alcohol, Big Media, Body Image, Career Education: http://www.frankwbaker.com/streaming_ml.htm
- Filmmaking resources for educators who want to integrate media production into the classroom: http://www.frankwbaker.com/recent_trends_in_the_use_of_media.htm

Media Literacy Skills

Media literacy refers to the skills needed to manage, analyze, evaluate, and create media messages. To be media literate is to be able to discriminately use and critically interpret one's media environment.

Discussions of media should help students to recognize both the good and bad in media consumption. It is important not to demonize media. Lynda

Bergsma stresses that media literacy is not media bashing.[17] She recognizes that youth culture is closely identified with media and pop culture. As such, she encourages adults to validate and acknowledge young people's experiences with their media culture. This will help youth accept and apply media literacy skills to the messages that they consume. Bergsma also makes the following recommendations for helping students develop media literacy skills:[18]

- Teachers and parents should develop familiarity with youth media and culture. Watch the movies that your students are watching, listen to their music, look at the websites they visit, and become familiar with the magazines that are popular. You can learn a lot about the media from your students.
- Teachers and parents must become media literate themselves before they can guide the development of media literacy in their students and children.
- Start media literacy efforts as early as possible. Parents should start teaching media literacy as soon as children start watching TV. Media literacy should be introduced into school curricula in kindergarten.
- Media literacy efforts should be integrated in several curricular areas. Media literacy is especially appropriate in health, language arts, and social studies but also has a place in math, science, geography, history, and other classes (see **Box 5-5**).
- Help students to become involved in media production. Media literacy skills are internalized when students have opportunities to create and produce media.

Manage Exposure

Parents are ultimately responsible for monitoring and controlling their children's media use. Teachers can help parents by providing them with information and by helping their students understand the importance of viewing guidelines. Media literacy skills can be shared with parents at back to school night, special events, or through school newsletters sent home. Most parents want help with putting parameters on their children's media use and find school-initiated programs and shared information very helpful. These parents appreciate being able to say to their children, "Your teacher told me about research that says you should not have a TV in your bedroom because . . ."

Parents also appreciate learning more about media control tools and research about media use. For instance, most parents would appreciate knowing that the American Academy of Pediatrics recommends that parents avoid TV viewing for children under the age of 2 years.[19] The academy stresses that research on early brain development shows that babies and toddlers have a critical need for direct interactions with parents and other significant caregivers for healthy brain growth and the development of optimal social, emotional, and cognitive skills.

As a result, exposing young children to TV programs should be discouraged. This is counter to the conception that a majority of parents have that baby videos positively affect development.

Limit Use Several guidelines can help parents appropriately limit the amount of time their children spend in front of a screen. Of course the ultimate goal is for students to develop good media habits and gain the self-control needed to limit their own media use. Parents also need to be encouraged to model this and all other media literacy skills. Here are some recommended guidelines for wisely limiting media use:

1. Create an electronic media-free environment in children's bedrooms.
2. Create a television (and computer, video game, MP3 player, etc.) allowance. Determine the appropriate total hours per week for viewing and develop a media time budget for these hours.
3. Have cell phones turned off during school hours, and have a texting and talking time budget for after school.
4. Have a rule that children must finish homework and chores before watching TV.

Cyberspace can be a dangerous place where media literacy skills are vital. Teachers can help by sharing safety tips with students and parents.

5. Do not allow children to eat in front of the television set. The increased rate of obesity in childhood and adolescence is closely correlated with sedentary activities such as watching TV and eating the advertised junk food. Eating while watching TV is a double whammy that contributes to overweight and obesity.
6. Have media-free time each day at dinner time or other time to facilitate family members interacting more meaningfully with each other.

Make Positive Media Choices Teachers can encourage students and families to make positive media choices and be instrumental in facilitating this. Teachers can talk about upcoming historical, scientific, geographic, and similar programs in class and can encourage students to watch these programs at home with their families. Classroom discussions can include research about the detrimental effects of viewing violent acts and the probable real-life consequences of disrespectful and immoral behaviors often glamorized or made to appear humorous on the screen. Here are a few guidelines for helping parents and children make positive media choices:

1. Preselect the programs to be viewed. Look for age-appropriate programs that are fair in their treatment of people, are not violent, do not display sexual images or themes, do not use vulgar language, and do not display other inappropriate behavior or messages.
2. Immediately turn off the TV at the end of a program. Do not allow yourself to be sucked in to watch the following program or to begin channel surfing.
3. Watch TV as a family and analyze together the program and advertisement content by discussing the following:
   - ❖ What is "real" and "unreal" in the scenes
   - ❖ The actors' behaviors and dialogue and what would be the real-life consequences of their actions
   - ❖ Underlying messages or morals, including those that might not have been intended by the writers
   - ❖ Why the advertisers chose to run their ads during that program

Select Creative Alternatives Teachers can encourage parents and students to better use their time spent in front of a screen. Often parents need encouragement and good ideas to break the habit of using television, video games, and computers as electronic baby-sitters. Teachers can emphasize alternative activities such as physical activity, crafts, hobbies, and visits to museums. Teachers can encourage parents to be good role models by selectively using media and limiting their own choices, thereby allowing children to observe healthy use of media, such as reading a book or newspaper.

Analyze and Evaluate

Questioning media messages lies at the heart of media literacy. Young people need to question media and begin with the premise that media messages are produced by someone with an agenda to sell to them, persuade them, or change their behavior. Teaching young people to ask fundamental questions about media helps to demystify media's power and gives them tools to understand the deeply rooted ways in which media influence thoughts and behaviors. Five basic questions can help students analyze media messages:

- Who created this message?
- Why was this message produced?
- What attitudes, values, beliefs, and lifestyles are included and omitted?
- Who is the target population for this message?
- How was this message constructed?

Who It is important for students to recognize that those who author messages make choices about the message they create. Their agendas, biases, and points of view become part of the message even to some degree when they try to remain impartial. Asking "Who wrote this article, script, or lyrics?" and "what personal biases, lifestyles, or agendas are evident?" helps students become more critical consumers of media.

Students also need to recognize that most of the media that we consume is created by a handful of powerful industries. As much as 90% of media outlets is owned by the transnational corporations of Time Warner, News Corporation, Disney, Viacom, Vivendi, and Sony.[20] Many people, for instance, think of Disney as a theme park and cable television channel without realizing Disney also owns the ABC network; nine cable channels including ESPN, A&E, and Lifetime; six production and distribution companies; five music labels; five magazine publishing groups; sports teams; television and radio stations; and newspapers. Media conglomerates like Disney create media products and then use all their media outlets to promote their products. We are usually totally unaware of this cross promotion. For instance, talk shows promote the movies, television programs, music, and celebrities employed by their parent corporation. Media conglomerates also own major food and beverage industries. This means that our mass media is not as diverse as it might seem on first glance. Helping young people understand who produces the media they consume helps them identify how these companies have worked to shape their perceptions of the world, and then challenge some of the perceptions and thinking patterns they have acquired from media.

Why Students need to understand that all media exists to make a profit. This is obvious for a music CD purchase, but is less obvious when buying a newspaper. We tend to think we are paying for the newspaper when in fact more than 70%

of the newspaper production costs are covered by advertisements. More than 60% of magazine costs and almost 100% of electronic media costs are covered by advertisements. This means that the advertisements are the most important part of the media. Media messages in whatever form exist to gather an audience and put that audience in a receptive mood to hear/see the advertisements. This facilitates a major emphasis on materialism and consumption in media. Because maximizing profits is the main goal of the media corporations, concerns about our society's health and well-being may become lost. For instance, corporations gaining huge revenues from alcohol advertisements are not likely to create messages in print or video that expose the large-scale devastating impact of alcohol consumption on society.[19]

Have you ever examined the amount of advertisements in a magazine compared with its editorial content? What you will find for most magazines is that they are essentially catalogs of advertised products with a few stories sprinkled in, and those stories are often advertisements as well in disguise. This is particularly true of teen and women's magazines. The stories contained in magazines are influenced tremendously by the advertisers. Magazines that carry tobacco advertisements do not run stories about the health effects of cigarettes any more than magazines bearing alcohol advertisements carry stories about the tragedies of alcohol abuse.

What Students need to understand that "What is being sold?" refers to much more than the products being advertized. Programs as well as advertisements portray or "sell" attitudes, values, beliefs, and lifestyles. Media messages shape our perceptions and understanding of the world. Important questions that help identify what is being sold include: What lifestyles does this media program portray? What value messages does this media product convey? What attitudes are modeled? What does this message want me to believe? What is this program doing to try and make me receptive to the advertized products? What healthy or unhealthy habits are being modeled? What messages are being left out (what is not being told) and why?

A question that can help students identify underlying messages in programs, songs, games, and advertisements is, "What was the moral of the story?" or "What was the moral of the message?" One professor asked his class this question after showing them the classic movie *Butch Cassidy and the Sundance Kid*. When no one responded, he asked, "Wasn't it that they didn't have to kill anyone until they went straight?" The class had to think about that for a moment, and then all agreed that they had absorbed this moral message without observing it. They hadn't consciously thought about it until the professor pointed it out. Media messages are usually designed so that we don't think about them. How often have you and your students picked up on these underlying messages in the TV programs or movies you've seen? (Parents and all adults are dumb. It's cool to be a rebel. Possessions make us happy. Don't trust the establishment. Putting others in their place is very cool. Love just happens—it's something you fall into.)

Help students analyze underlying messages in advertisements by critically questioning the validity of those messages. "If I buy this product, will imaginary playmates appear, making my life fun and exciting? Will it solve all my problems, make me popular, or make me thin and beautiful? Does this toy really do all the things it is shown to do and do all the accessories come with it? Will using this product really help make people of the opposite sex find me more desirable or sexy?"

Target Who is the target population for this message? What audience is the program trying to draw in? At which age, gender, race, socioeconomic group is this program aimed? What kinds of things are being advertised during this program? Identifying the target audience of a program helps students better identify and analyze what is being "sold," both in terms of the advertised products and the attitudes, values, and beliefs being modeled to increase the target population's receptivity to those advertisements. Additional key questions to ask related to target population include, "How might different people interpret this message differently?" and "What concerns are there for this message being seen by an unintended audience such as young children?"

The "prime" target population for advertisers is often career working single adults because this population has the most discretionary money to spend. The television program *Friends*, for instance, was developed to pull in and advertise to this population. Many believe that *Friends* and other programs like it actually influenced the expansion of this demographic in society today. The lifestyle sold on *Friends* was "bought" by many teenage viewers who are young adults today. Our society currently has more young adults than ever before who are choosing to "hang out" like their favorite TV characters rather than marry like their parents and grandparents did.

How Students need to understand that media messages are very carefully constructed. In advertisements, every detail is created first on a storyboard where each second and camera angle is mapped out. Directors take hundreds of takes on each segment to try to capture the perfect image that will entice us to buy the product. Messages are pilot tested to groups and reworked to be the most influential message psychological research and money can produce.

Here are some questions to help students identify how a message has been constructed: How does this media product make me feel? What emotions did this media product tap? What did the media product's producers do to catch, capture, and keep my attention? What special effects does the media product use? Which persuasive techniques is this media product using? One of the best ways for students to understand how messages are constructed is to assign them to create their own media program or advertisement. Box 5-2 identifies tactics that writers and producers use to get our attention and try to influence us to spend money on their products. Students become more aware of these tactics when they use them to create their own media messages.

Check out the free resources, including lesson plans and video clips, available on media literacy in Box 5-4. Review the media literacy teaching activity ideas in Box 5-5 and consider how these and other ideas can be incorporated into language arts, math, social studies, and various health topics including nutrition, drugs, sexuality, violence, and safety.

5–5 In the Classroom

Assessment and Learning Activities for Media Literacy

The following are teaching activity ideas that you can adapt for assessment and use at many grade levels (indicated as in previous chapters). Be sure to get approval before playing for students any advertisements, video clips, or streaming videos. As you read these consider how you could integrate teaching media and information skills into various content areas such as math, social studies, drug education, and nutrition.

Media Apples

Insert a nail into the bottom side of a beautiful apple. Remove the nail and rub it on decaying fruit or vegetables. Reinsert the nail into the apple. A few days later, show the students the apple. Discuss the attractiveness of the apple. Cut the apple in half, exposing its unattractive insides. Ask the students, "How is this apple like some media?" Discuss the hidden negative messages contained in programs and commercials. (P, I, J, H)

Are the Top 10 Really Good?

Ask students to identify their favorite movies and TV shows. List the top 10 on the board. Ask students to identify healthy and unhealthy and moral and immoral behaviors that characters model in each. Chart these behaviors on the board. Ask students how they think watching these shows might influence them and whether they think watching each of these shows is a good or a bad idea for younger siblings. (P, I, J, H)

Did You Hear That?

Select a popular album that contains objectionable material. Review this album at a website, such as http://www.pluggedinonline.com/music. In a class discussion, ask

(*continues*)

(*continued*)

students if they can identify all the objectionable material on the album. Share with them what the review said and discuss why it found certain things objectionable. (P, I, J, H)

Talking Back

Identify unhealthy messages and modeling in programs by showing a TV or movie clip in class. While you are running the clip, talk back to the characters in the scene. For instance, during an action scene, you could say, "Yeah, right, like I'm going to believe you can do that and it's OK—nobody gets hurt." Show additional scenes and invite the students to yell things at the screen. Challenge students to talk back to their TV for a week whenever they see unhealthy behaviors modeled. (P, I, J)

Advertisements That Get into Your Head

Divide students into small groups. Have them identify 10 different advertising jingles or slogans that have stuck in their mind. Sharing examples can help them get started. Have the small groups share their slogans with the class and have the class try to identify the products for each. (I, J, H)

TV Ad Analysis

Videotape television commercials. You might want to record only commercials aired after school, on Saturday mornings, during prime time, or during athletic events. Show these in class and discuss which industries choose to run their ads at these various times and why. Analyze each ad using the questions on page 160 of this chapter. (P, I, J, H)

Magazine Analysis

Have students bring a copy of one of their favorite magazines to class. In groups, have students analyze the magazines by answering these questions:

1. *Hook*. What did the magazine producers do to the cover to hook the audience into looking at and buying the magazine?
2. *Ad space*. What percentage of total space is devoted to editorial stories and how much to advertisements? Watch for stories that are really ads. How many ads are in the magazine? What are they for? What do these advertisements tell you about the magazine's target audience?
3. *Images*. Describe the major characteristics (gender, appearance, age, race, ethnicity, behavior, and other characteristics) of the people shown in the magazine's content and ads.

(*continues*)

4. *Messages*. What unhealthy or poor value messages are presented by the magazine? Were any contradictory messages given, such as an article on dieting placed next to an ad or recipe for high-calorie food?
5. *Overall*. What do you believe is the overall message portrayed by this magazine? (I, J, H)

Advertisement Log

Have students be on the lookout for and make a log of all the ambient advertising, digital or virtual advertising, and product placements they can find during 1 to 3 days. Have students share their lists and create an inclusive list on the board. Discuss what they found, including the location and perceived effectiveness of the ads. (I, J, H)

Ad Spoof

Have students take a print ad and construct a spoof of the ad that expresses something that is misleading or is a half-truth in the ad. Alcohol, tobacco, fast food, beauty and appearance, and weight-control products are good materials for this assignment. Have students show their ad spoofs to the class and explain what they are exposing in their spoof. (I, J, H)

Pull the Plug

Challenge students to give up TV, DVDs, and video games for one week. Prepare by discussing alternatives to these things. During the designated week, provide motivation and encouragement. Consider including the PTA and/or families in the challenge. When the experiment is over, have students write essays on the experience. (P, I, J, H)

Billboard Review

Have students create a list of all the billboards they see during a typical week. Make a chart or grid showing how many times each billboard is looked at by students in the class. Discuss the types of products advertised in this way in their community and why promoters might be choosing this form of advertising. Discuss the validity and persuasiveness of each billboard. (P, I, J)

Am I Influenced?

Have students identify what they have spent their money on in the past week or month. Here is how a hundred 9- to 14-year-olds filled out a survey on what they spent their money on:

(*continues*)

(*continued*)

74 bought food (mostly snacks).
17 bought clothes or accessories.
14 bought magazines or comics; toys, stickers, or games; movie tickets; or arcade games.
13 bought gifts.
12 bought music or movie rentals.
11 bought sneakers and footwear.
11 bought grooming products.

Discuss how various forms of advertisements might influence what students spend their money on. (I, J, H)

Information Safety Tips

Teachers can aid in the development of students' media literacy by sharing the following online safety tips with students and their families:

- Establish clear ground rules for Internet use before subscribing to online services.
- Place computers in the family room or another open area of your home.
- Never give out personal information online, especially in chat rooms and on bulletin boards.
- Never plan a face-to-face meeting with online acquaintances.
- Do not respond to offensive or dangerous e-mail, chat, or other communications.
- Immediately turn off the computer if a pornographic site is accidentally accessed. Some pornographic sites disable the user's ability to escape using normal key functions such as ESC (escape) and instead open additional windows containing pornographic images. (P, I, J, H)

Advocate Letter

Have students write and send an e-mail message or letter to the producer of a movie, TV program, or advertisement that they find offensive. The letter could do any or all of the following: clearly express their opinion; document any supporting evidence for their position; and make one or more requests of the producer. (I, J, H)

Key Terms

media 158
Generation M 161
social networking 164
ad creep 169
ambient advertising 169
place-based advertising 169
naming rights 169
digital (virtual) advertising 170
product placement 170
undercover marketing 170
buzz 171
viral marketing 171
stealth marketing 171
roach baiting 171
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Tremor 171
Girls Intelligence Agency (GIA) 171
mobile marketing 171
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branded environments 174
information literacy 174
Food and Drug Administration (FDA) 175
Consumer Product Safety Commission (CPSC) 176
Federal Trade Commission (FTC) 176
National Health Information Center (NHIC) 176
media literacy 178

Review Exercise

1. Define, differentiate, and discuss the key terms and their relative importance in this chapter.
2. Explain why media and information literacy skills are important and how they are a part of health, math, social studies, and English curricula.
3. Identify and discuss the various concerns about media exposure.
4. Describe Generation M's media use habits and parental involvement in media choices.
5. Identify the skills and concerns connected with children and adolescent Internet use.
6. Discuss the "ad-vironment's" purpose, importance, and influential power.
7. Describe how and why ad creep takes place.
8. Explain why and how corporations target kids with advertising and the many concerns about advertising to children.
9. Describe why and how school-based marketing takes place and the concerns about it.
10. Describe Internet marketing prevalence, tactics, and concerns about it.
11. Discuss how a person can determine the reliability of information including key questions to review and tip-offs to rip-offs.
12. Identify the recommendations by Bergsma for helping students develop media literacy skills.
13. Discuss the key concepts for managing media exposure.
14. Identify and discuss the key questions for analyzing and evaluating media.
15. Identify resources and teaching activities that can help you teach media literacy to your students.

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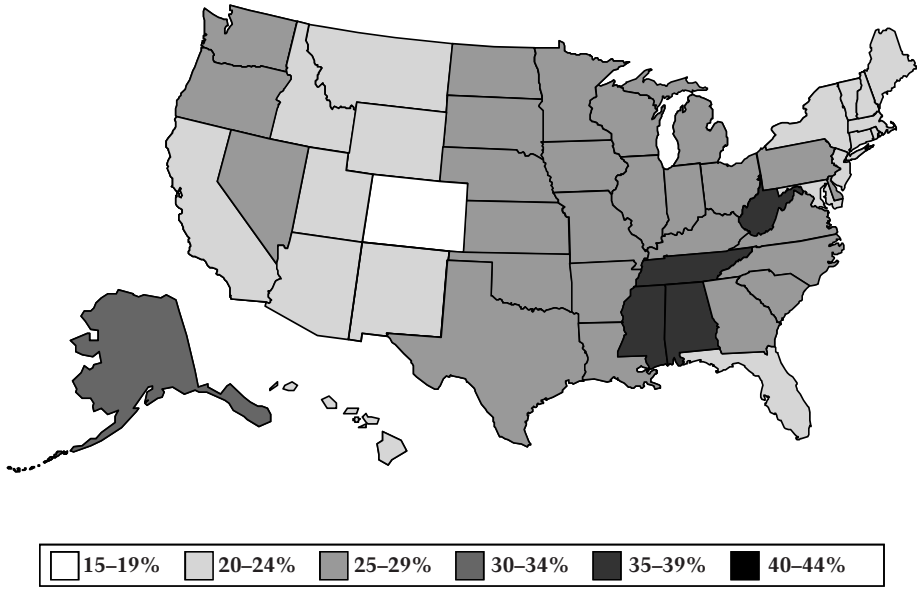
6

Promoting Healthy Eating and Physical Activity

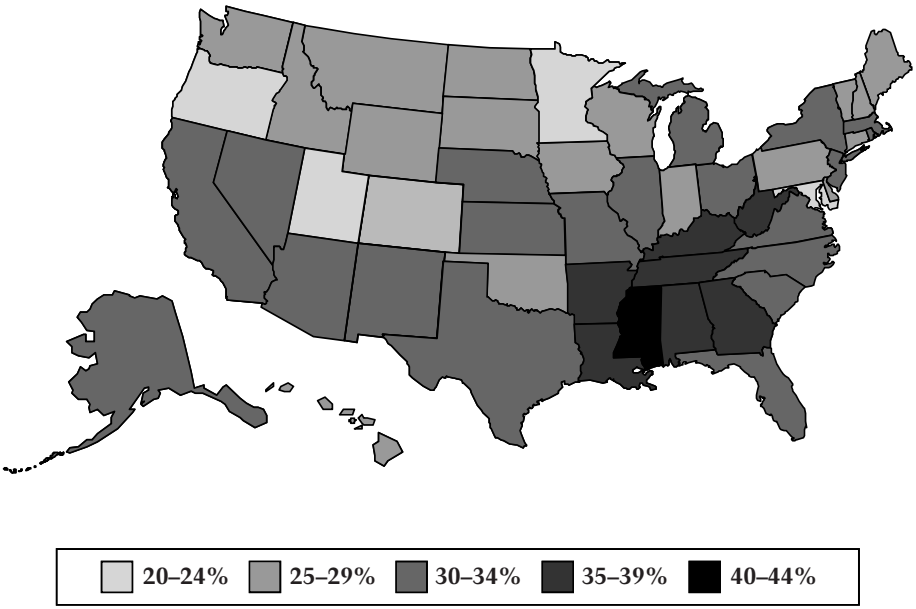
How Fat Are We?

Being fat has become the norm. The 2009 report released by Trust for America's Health and the Robert Johnson Foundation indicates that obesity in the United States is continuing to rise along with weight-related medical costs. See the two maps that follow. The first map indicates adult obesity rates, and the second map depicts childhood obesity and overweight rates for youths ages 10 to 17. The precise data for each state is available at http://healthyamericans.org/reports/obesity2009. The Centers for Disease Control and Prevention (CDC) also has a PowerPoint presentation titled "Obesity Trends Maps" that graphically demonstrates how the United States is progressively becoming fatter (available at http://www.cdc.gov/obesity/data/trends.html).

Adult Obesity Rates



Childhood Obesity and Overweight Rates



Eating and physical activity patterns are critical aspects of health and well-being. These patterns not only contribute to a young person's current health but also are important to his or her future health status as an adult. Healthy eating patterns and regular physical activity promote optimal health, growth, and development in childhood and adolescence and reduce the risk for chronic disease in adulthood (e.g., coronary heart disease, cancer, stroke). The eating and physical activity patterns established in youth often extend into adulthood. The purpose of this chapter is to help teachers recognize their potential in helping students adopt and establish lifelong healthy eating behaviors and physical activity patterns. This chapter examines how patterns of eating and physical activity contribute to health and well-being and explains what teachers can do to help young people establish these healthy habits. Be sure to take the time to complete the application exercise in **Box 6-1**.

6-1
Application Exercise

Diet and Activity Analysis

For 3 days, keep a detailed record of everything you eat and all the time you spend in physical activity (try to not change your normal patterns for this record). Visit and study the MyPyramid.gov website. Analyze your 3-day diet and physical activity record using the website's resources. Determine your body mass index (BMI). Write a summary of what you have learned about your eating and activity patterns that includes recommendations of changes you should make.

Overweight and Obesity Trends

The prevalence of overweight children ages 6 to 11 years has more than doubled in the past 20 years and among adolescents ages 12 to 19 it has more than tripled (**Figure 6-1**).[1] In children and adolescents ages 2 through 19 years, those classified

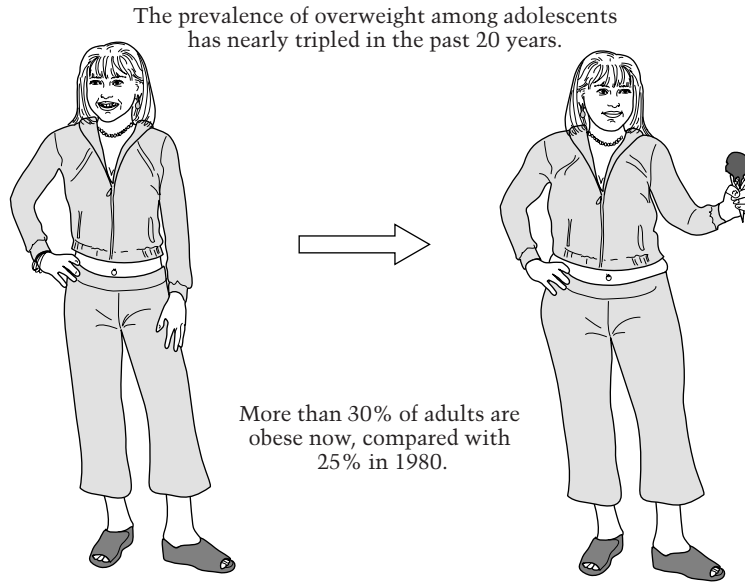


FIGURE 6-1 Overweight youths.

Being overweight in childhood and adolescence is associated with:

- Type 2 diabetes
- Elevated blood cholesterol levels
- High blood pressure
- Increased adult mortality
- Psychological stress
- Exclusion and discrimination
- Other health problems

FIGURE 6-2 Problems associated with being overweight.

as either overweight or obese is 32%.[2] The percentage of very young overweight and obese children is particularly alarming. One study found that almost 1 in 5 American 4-year-olds is obese—that is more than half a million 4-year-olds. This study also found higher rates of obesity among minority preschool children: American Indians (31.2%), Hispanics (22%), and blacks (21%).[3]

It is important to have a clear understanding of the terms *overweight* and *obese* to comprehend weight-related statistics. **Overweight** often is defined in health studies as having a **body mass index (BMI)** of 25 to 29.9, and being **obese** as having a BMI of 30 or higher. Body mass index is computed by multiplying a person's weight in pounds by 703 and then dividing that number by a person's height in inches squared. You can find a BMI calculator for adults and children at http://www.keepkidshealthy.com/welcome/bmicalculator.html.

Unfortunately, the "American way of life" that lead to our nation's weight gain is spreading around the world, creating a pandemic often referred to as **globesity**. The dramatic increase in the prevalence of overweight and obesity among both children and adults has prompted health organizations and officials to warn of coming health problems and health care costs (**Figure 6-2**). A former surgeon general, David Satcher, said, "Left unabated, overweight and obesity may soon cause as much preventable disease and death as cigarette smoking."[4] We now look at the factors that led to and that continue to promote overweight and obesity in children and adults.

Physical Inactivity

Children don't get the amount of incidental physical activity that they used to obtain. In past generations, children were likely to run to the store on errands for a parent, walk to school, or bike to sports team practices. Forty years ago, half of all kids walked to school. Today's children are not likely to walk to

FIGURE 6-3 This bike is broken . . . its motor is inside watching TV.

school: only 10% do. Even among kids who live within a mile of school, fewer than one third walk. One reason for this is that walking to school is not safe for some children. In many areas where children live, sidewalks, if they exist, usually end at the entrance to a subdivision or housing area. Modern suburban design often brings subdivision streets to connect to high-traffic roadways, which makes walking and biking dangerous. Many schools are located on busy highways or in areas that are dangerous for children to travel by foot or by bicycle unassisted.

Today's children grow up in homes with televisions, computers, VCRs, and DVD, CD, and video game players. They spend more time using these entertainment devices than they do in play or physical activity (**Figure 6-3**). Parents' worries about children's safety keep many children indoors instead of outdoors playing games or sports, walking, or biking. This is particularly true in inner cities, where youth have higher overweight and obesity rates than those in other areas. Data from the National Youth Risk Behavior Surveillance System (YRBBS) indicate that on an average school day 35% of high school students watched TV for 3 or more hours and that 25% played video games or were on the computer (for things other than homework) for 3 or more hours.

Physical inactivity among young people is a serious cause for concern. A pattern of inactivity may persist throughout youth and into adulthood. Physically inactive individuals are likely to miss out on the many health benefits enjoyed by those who are physically fit. The National YRBSS 2007 data reveal that 65% of U.S. high school students did not meet recommended levels of physical activity, 46% did not attend physical education classes, and 70% did not attend physical education classes daily.[9]

The number of students enrolled in daily physical education classes and the percentage of time students spend in moderate or vigorous physical activity during physical education classes have decreased over the past 20 years. This decline is largely attributed to the emphasis on testing and giving more time to core subjects. The childhood obesity epidemic, however, has made school administrators and state legislators recognize the need for increased physical education in schools. Changing school policies to promote physical activity to prevent obesity in youth has also been called for by *Healthy People 2010*,[5] the Institute of Medicine,[6] the Council on Sports Medicine, and the Council on School

Only about half of young people in the United States participate regularly in vigorous physical activity, and participation rates decline as youth grow older.

Health.[7] Unfortunately, limited fiscal resources often impede needed changes. For example, in Oregon the typical elementary student gets just 12 minutes a day of physical education, less than half the daily 30 minutes that the legislature set as a target. A bill passed in 2007 included aiming for an average of 30 minutes of daily PE class for elementary pupils and 45 minutes a day for middle-schoolers. Officials said the failure to meet their goals was a result of not having enough gyms, the fact that the gyms that exist are too small, and the fact that the schools can't afford to hire enough PE teachers.[8]

Too Many Calories

Today we are consuming many more calories than we did just a few decades ago. This is in part because of the abundance of inexpensive food available. The portion sizes of today are often double to four times the size that were considered normal 20 years ago, creating a phenomenon known as **portion distortion**. For instance, bagels today are typically 6 inches in diameter and contain 350 calories. Twenty years ago, they were only 3 inches in diameter and contained 140

We have become used to supersized portions that are often four times the size served three decades ago.

calories. The size of hamburgers, sodas, and servings of French fries are often double to quadruple the size served 30 years ago. Portions have ballooned in grocery stores and bakeries and at home as well. Cookbook recipes provide much larger serving portions than in the past, and the plates and bowls we use are larger than the ones our grandparents used.

We are not only eating more, we are eating more calorie-dense foods both at home and out—foods such as hamburgers, pizza, chips, and soft drinks. Restaurants know what sells best, and that, unfortunately, is calorie-dense food. For instance, when Burger King introduced its Enormous Omelet Sandwich, which consisted of two slices of cheese, two eggs, three strips of bacon, and a sausage patty, its breakfast sales jumped by 20%. When Pizza Hut got cheesier with a triple-cheese stuffed-crust pizza, that item alone took in 20% of the chain's business within 4 days.

Poor eating habits also play a role in weight gain and can cause health problems even for those who do not become overweight. Some of the poor dietary habits often displayed by young people are skipping meals (especially breakfast); dieting; avoiding nutritious foods such as milk, fruits, or vegetables out of dislike; and frequently eating fast food and other low-nutritive, high-energy foods and drinks (**Figure 6-4**). Less than 25% of youth say they eat the recommended amount of fruits and vegetables a day and more than 33% report drinking soda or pop daily.[9] The snack foods typically consumed by adoles-

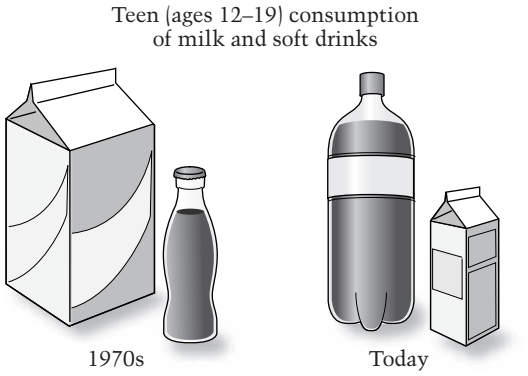


FIGURE 6-4 Liquid candy. Soda has become our drink of choice. Drinking less milk and more soda can lead to dental decay and other health problems. A 12-ounce can of nondiet cola has about 10 teaspoons of sugar, 150 calories, and no other nutritive value. Schools often promote soda consumption by entering into contracts to sell soft drink products in their vending machines.

cents are high in fat, cholesterol, sugar, and sodium and lack real nutritive value.

Family and Social Factors

Today's children and adolescents frequently decide what to eat with little adult supervision. The increase in one-parent families or families having two working parents, along with the availability of convenience foods and fast-food restaurants in the community and in the school cafeteria, inhibit the ability of parents to monitor their children's eating habits. Psychosocial developmental changes such as the desire for independence and identity, concern for appearance, and peer acceptance play a role in youths' food choices. Family background, increased independence and mobility, and money for discretionary spending on food products also influence eating habits.

Today almost half of the money Americans spend on food is spent at restaurants. We choose to eat out more for three main reasons: our fast-paced lifestyle; the relatively low cost of fast food; and our appetite for fatty, salty, and sweet food. Eating out has become such a way of life that many young adults have minimal to no cooking skills. Even poor people living in inner cities eat a great deal of cheap fast food. McDonalds, Burger King, and other fast-food outlets are much more plentiful in inner cities than are grocery stores. Often the only option for buying groceries in "rough" neighborhoods is small convenience stores that offer limited or no fruits, vegetables, and other healthy food items. See **Box 6-2** for some teaching activity ideas on analyzing food messages and choices.

6-2
In the Classroom

Assessment and Learning Activities for Analyzing Food Messages and Choices

The following are teaching activity ideas that you can adapt for assessment in many grade levels (indicated as in previous chapters). Be sure to also consider the skills and activities in Chapter 5, Media Literacy Skills, for use in a unit promoting healthy eating and physical activity.

Food Commercial Analysis

Record and then play food commercials aired Saturday morning or after school. Have students analyze each ad: Who produced the ad? What techniques were used to grab and maintain attention? Were any negative messages given? What attitudes, values, beliefs, or lifestyles were "sold" in the ad? (P, I, J, H)

Fast Food Analysis

Identify the calorie and fat intake for common fast-food meals. Print pictures of the foods and display the fat content of each by placing tablespoons of shortening on a plate by the picture (1 TB shortening = 12 grams of fat). You can find an Internet tool that will help you access fast food information at http://www.statesman.com/health/content/shared/health/tools/fastfood.html. (P, I, J, H)

Junk Food Analysis

An alteration to the preceding activity is to display the amount of sugar as well as fat in snacks and soda (4 g of sugar = 1 tsp of sugar, or 1 sugar cube). (P, I, J, H)

Good Menu Choice

Have students practice making healthy choices from a variety of restaurant menus you have collected in person or on the Internet. (P, I, J, H)

Assessment

Have students analyze their or a fictional student's diet and physical activity using the MyPyramid Tracker tool. You can access the tool at http://www.mypyramidtracker.gov. (I, J, H)

(*continues*)

Portion Distortion

Have students prepare PowerPoint presentations on how much food servings have grown and how many calories are contained in common foods. (Do a Google image search for "portion distortion" or "portion size.") (P, I, J)

Media Use and Marketing Concerns

Sedentary leisure activities, such as television watching, playing video games, and personal computing, have contributed to the increasing prevalence of overweight in the United States.[10] Numerous international studies show that media use is contributing to the current epidemic of obesity worldwide.[11] These sedentary activities take time away from participation in energy-expending physical activities. Studies have documented that the adolescents who are frequent viewers of television participate in physical activity less than their peers who watch less television.[12] Television viewing is also associated with snacking on high-energy, low-nutrient foods. The scientific literature documents that food marketing to children is massive; has expanded in number and venues; is composed almost entirely of messages for nutrient-poor, calorie-dense foods; has harmful effects; and increasingly is global.[13] Advertisements targeting kids encourage preferences for high-fat, high-sugar food and is considered a contributing factor in childhood obesity. Half of all advertisements aimed at kids are for food. Ads for candy and snacks loaded with fat and sugar comprise 34%, followed by cereal (28%) and fast foods (10%).[14] Only 2% of all advertising by food manufacturers is for fruits, vegetables, grains, or beans.

The U.S. food industry is the second largest advertiser in the American economy, and it targets children and teenagers because of their vulnerability and spending power. Food advertisements are now much more prevalent and sophisticated than in the past. Ads often include a push to a website and tie-ins to games, toys, and TV and movie characters. Advertisers know that children and teens spend billions of dollars of their own money on snacks, beverages, and fast food each year. It is also estimated that children influence almost three quarters of their families' food and beverage purchases. Advertisement campaigns have been designed to help children know how to pester their parents into buying what they want. Ads are also designed to create brand loyalty. For instance, McDonalds has run ads suggesting that children can be started on fast foods (e.g., hamburgers, fries, shakes) at a very young age. These ploys certainly work because every month more than 90% of children in the United States eat at McDonalds.

Unhealthy food choices are also marketed to children at the point of sale. Product package design represents a $100 billion a year industry. Walking down a cereal aisle of a grocery store reveals the various advertising appeals used to create visual appeal, attract children's attention, and build brand loyalty. Retail

studies have shown that up to 85% of all consumer purchases are made on impulse, and packaging design has a great deal to do with impulse purchases made by or influenced by children.[15] Restaurants offer another venue for points of sale to children by offering playgrounds, cartoon characters, and kids' meals that include toy giveaways.

The Internet is increasingly used to market food to children as well. Companies sponsor websites with online games where branded food products are embedded features. Identification characters or spokes characters are the main focus of the games. Players spend their time focused on the embedded product without being aware that they are staring at an advertisement the entire time they are playing a game. The websites are designed to display combinations of sound, music, animation, and eye-catching colors and visual images. Almost three quarters of food-sponsored websites initiate interpersonal interaction with friends that create viral marketing.[16]

We have always had food marketing to children, but the sophistication and amount of advertising to children have profoundly increased. One common method of TV food marketing to children is to depict food as having a drug-like property. Eating the product is associated with exaggerated pleasure (euphoric highs), kaleidoscopic colors (visual hallucinations), taking extreme measures to obtain the food (needing a fix), and loss of control over the food product (addiction). Making connections or associations of food and mood alteration and addictive behavior to sell products to children is seen by many as irresponsible and potentially harmful.[17]

As food advertising to children has come under increased scrutiny, many, including health professionals, health agencies, policymakers in Congress, and the Federal Trade Commission (FTC), have called for mandated changes.[14] In response, U.S. food and media industries have tried to quiet the controversial storm and arrest the call for mandated change by proposing their own voluntary initiatives. The food and advertising industries have also funded research to question the accuracy of studies that draw a link between commercials and obesity.

Marketing Junk Food in Schools

In the past, the primary source of foods for students at schools was school lunch. Today, school lunch represents a smaller part of the school food environment because many schools now provide increased food options: foods are for sale in vending machines, school stores, and snack bars; and à la carte foods are for sale in the cafeteria. In addition, less nutritious options are now available to students at younger ages than ever before. The increased availability of low-nutritive foods at schools appears to be a major cause of poor eating habits in youth.[18]

With increasing financial pressures and limited resources, schools often put nutrition at the bottom of the priority list. School foodservice programs must often now be completely financially self-supporting because of declining allocations for operating budgets. As a result, many schools are compensating for the

Whether vending machines belong in school buildings is a hotly debated topic.

loss of funds from budget cuts by increasing the sale of à la carte foods and fast-food options. For many schools, entering into contracts with food or beverage marketers has become a source of additional income. A recent trend is for school districts to negotiate exclusive "pouring contracts" with soft drink companies. Many of these contracts have provisions to increase the percentage of profits schools receive when sales volume increases. This is a substantial incentive for schools to promote soft drink consumption by adding vending machines, increasing the times they are available, and marketing the products to students.[18]

Marketing Body Image

It is pretty hard not to be affected by the media's constant message that "Thin is in!" By the time a girl is 17, she is likely to have seen 250,000 commercials and advertisements through the media, many of which emphasize the importance of beauty and physical attractiveness and use thinness as a standard of beauty. However, the women portrayed in almost every ad are not typical of normal, healthy women. Fashion models weigh substantially less than the average women, and it has been estimated that a young woman in the United States has only a 1% chance of being as thin as a supermodel.

The apparent motive of advertisers in purposefully normalizing unrealistically thin bodies in ads is to create an unattainable desire that drives product purchase and consumption. In other words, when individuals realize that their own bodies are not in line with the desired or ideal body shape, they become anxious, frustrated, and disappointed. The overriding message is that we need

Young girls "buy" media messages about beauty, love, success, and acceptability.

to change something about ourselves to be accepted, loved, or successful and that the correct change is to buy the advertised product.

The dissatisfaction with body image that the media help to create leads to increased purchasing of products, but wreaks havoc on the psyches and well-being of many. Girls who spend their time reading women's magazines with lots of female-oriented advertisements are more likely to feel bad about their appearance and to obsess over their physical appearance as a measure of their worth than those who do not read these magazines. Is it any wonder, then, that three quarters of normal-weight women think they are overweight and that 9 of 10 women overestimate their body size? Health experts are concerned that depicting thin models in ads may lead girls into unhealthy weight-control habits because the ideal they are seeking to emulate is unattainable for many and unhealthy for most.

The women featured in the media have become slimmer and slimmer. A few years ago, *People* magazine ran an article about this trend entitled "How Thin Is Too Thin?" that depicted several famous actresses (Heather Locklear, Jennifer Aniston, Lara Flynn Boyle, Victoria Beckham, Calista Flockhart, Courtney Cox Arquette, Helen Hunt, Paula Devicq, Gwyneth Paltrow, Kelly Ripa, and others) before and after they had become excessively thin. The article noted the impact that these stars' appearances has on young people:

> "We're seeing quite an increase in inquiries [from parents and therapists] about girls 9, 10, and 11 years old trying to emulate their favorite stars," says Adrienne Ressler, body-image specialist at the Renfrew Center in Coconut Creek, Fla. "For adolescents, the ideal for the person they want to be when they grow up is either

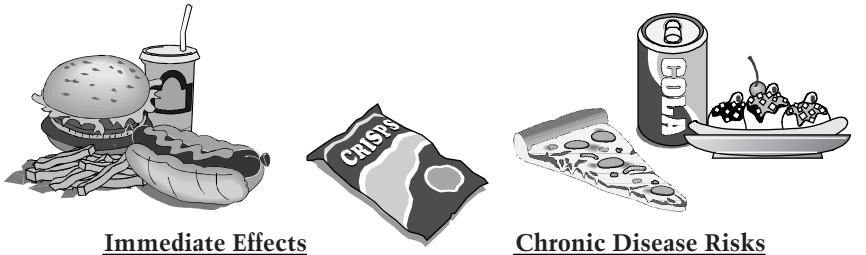
a movie star, TV actress or supermodel, and the emphasis is very much on external appearance. Our patients would die—and practically do—to look like Calista Flockhart. They say, 'I want to look like her. I want to *be* her.' "[19(p.120)]

Problems Related to Unhealthy Eating and Inactivity

There are many problems and consequences of overweight, obesity, and undernutrition in school-age youth (**Figure 6-5**). Risk factors for heart disease, such as high cholesterol and high blood pressure, occur with increased frequency in overweight children and adolescents compared with children who maintain a healthy weight. The consequences of being overweight go beyond disease. Children who are overweight or obese feel tremendous psychological pain as a result of their condition. They are likely to suffer from a poor self-image and feelings of inferiority and rejection. They are often teased, ridiculed, and left out of games, athletics, and other activities. The rejection and isolation that results from this treatment is a source of intense frustration and may cause a child to withdraw, act out, and overeat.

Substantial weight gain in very young girls can sometimes trigger premature puberty, as early as age 8 or 9 years in some girls. Puberty then triggers additional weight gain. About 2 years later, a young girl begins menstruation and soon reaches full height. If extra weight gain triggers premature puberty, a young girl often loses inches in height that she would otherwise have achieved, missing the opportunity for her height to catch up or for her to "grow into" the added weight.

Undernutrition also causes problems. Many students start school with no breakfast or an inadequate breakfast. Skipping breakfast is not limited to children who live in poverty. Many children who can afford breakfast go to school



Immediate Effects
- Undernutrition
- Iron deficiency anemia
- Overweight and obesity
- Unsafe weight-loss methods
- Eating disorders
- Dental caries

Chronic Disease Risks
- Coronary heart disease
- Cancer
- Stroke
- Diabetes
- High blood pressure
- Overweight
- Osteoporosis

FIGURE 6-5 Effects of unhealthy eating patterns.

without eating breakfast. Those who skip breakfast do so for a variety of reasons. Some say that they don't have time to eat breakfast before leaving for school. Others say that they don't feel hungry when they wake up. Often, parents have left for work or are too busy to prepare breakfast. Even those children who eat before leaving the house may become hungry long before lunch time. A long bus ride requires some children to leave home early, so their breakfast may wear off by midmorning.

Starting the school day hungry puts students at a disadvantage. The physical symptoms of hunger include stomach pain, headache, muscle tension, muscle fatigue, and sleepiness. The emotional and psychological effects include anxiety, nervousness, anger, aggression, indecisiveness, and confusion. Teachers see the results of these symptoms. The hunger interferes with students' ability to learn and to perform academically and socially.

Undernutrition can have lasting effects on children's cognitive development and school performance. Chronically undernourished children attain lower scores on standardized achievement tests, especially tests of language ability.

Adolescent girls are at higher risk of failing to meet nutritional requirements than are boys. The overwhelming desire by many adolescent girls to be thin can create energy and nutritional inadequacies. Adolescent boys on the whole consume greater amounts of food than girls and are less likely to suffer nutritional deficiencies. Adolescent girls are at high risk for **iron-deficiency anemia** because of inadequate intake of foods high in iron and vitamin C, which helps the body absorb iron. Lacking sufficient iron, the young person's body has reduced ability to produce hemoglobin. Hemoglobin is needed to carry oxygen in the blood. Girls with iron-deficiency anemia have difficulty paying attention and suffer from fatigue. They are also vulnerable to infections.

Unsafe Weight-Loss Methods

Being overweight, fearing weight gain, and feeling pressure to be thin lead many young people to practice unsafe weight-loss methods. Dieting attempts often begin in elementary school. In 2007, 45% of students reported that they were trying to lose weight.[21]

A nationwide survey found that during the 30 days preceding the survey, 12.3% of students went without eating for 24 hours or more; 4.5% had vomited or taken laxatives to lose weight; and 6.3% had taken diet pills, powders, or liquids without a doctor's advice.[22]

The **unsafe weight-loss methods** of skipping meals, fasting for long periods of time, taking diet pills, using laxatives, inducing vomiting after meals, and going on crash diets can be problematic. Deliberately restricting food intake over long periods can lead to poor growth, delayed sexual development, and eating disorders. **Eating disorders** are food-related means by which individuals attempt to relieve emotional problems, such as low self-esteem, lack of social acceptance, fear of rejection, and the inability to express feelings in appropriate ways. Often, eating disorders begin as youth use unsafe weight-loss methods and then keep using those methods to try and solve their emotional problems.

Young girls are susceptible to eating disorders just before or just after puberty. The emergence of an eating disorder may be an unconscious effort to delay physical maturing. Stress also triggers eating disorders. Stressful life events that may trigger eating disorders include moving, parental divorce or death, a broken love relationship, or ridicule by others that the individual is fat or becoming fat.

Smoking is an unsafe means that some young people use to regulate weight. Concern about weight gain is a major issue among young women smokers. Adolescents, and in particular adolescent girls, who diet or who are concerned about their weight have a higher rate of cigarette smoking than do nondieters or girls having few weight concerns. Teens who smoke cigarettes are also more likely than are nonsmoking teens to report trying to lose weight by self-induced vomiting, taking diet pills, and using laxatives.[20] Teachers need to inform children and adolescents that the health consequences of smoking outweigh any anticipated or realized effects of smoking on weight control. Because slenderness is highly prized, adolescents may be willing to overlook the very serious long-term consequences of smoking (e.g., emphysema, lung cancer) to achieve or maintain a desirable body weight.

Box 6-3 contains information on how to lose weight safely.

6-3
Background on . . .

Safe Weight-Loss Methods

Safe and effective weight-loss programs should include the following components:

- Healthy eating plans that reduce calories but do not forbid specific foods or food groups.
- Tips to increase moderate-intensity physical activity.
- Tips on healthy behavior changes that also keep your cultural needs in mind.
- Slow and steady weight loss. Depending on your starting weight, experts recommend losing weight at a rate of ½ to 2 lbs per week. Weight loss may be faster at the start of a program.
- Medical care if you are planning to lose weight by following a special formula diet, such as a very low calorie (1,200 calories or less) diet.
- A plan to keep the weight off after you have lost it.

Note: To take off 1 pound per week, you will need to reduce calories (the amount of food you eat) by 500 per day. (One pound of body fat equals about 3,500 calories.) Try eating 250 calories less per day and exercising enough to burn 250 calories—by walking about 2.5 miles each day. The easiest way to cut back on calories is to watch your portion sizes.

Anorexia Nervosa

Anorexia nervosa is a serious psychological disorder that affects many more females than males. This disorder is characterized by having a body weight at least 15% below normal weight for age and height, an intense fear of gaining weight or becoming fat, and body image distortion. Also, menstrual periods are often absent in females with anorexia. A central feature of anorexia nervosa in adolescents is the issue of control. By controlling one's weight through obsessive dieting, an anorexic feels she is able to gain greater control over her life. Anorexia nervosa can be fatal. It is sometimes necessary to hospitalize severe cases to prevent death. Death is usually a result of kidney failure or heart shrinkage.

Anorexics do not lack appetite, but refuse to eat, hungry or not. For anorexics, the idea of becoming fat creates intense fear and disgust. As the self-starvation progresses, they frequently experience behavioral and mood changes. Normal perception of what their bone and skin frames look like becomes distorted. Even though they are emaciated, they typically feel too fat. This is in part because of where females lose weight first—in the upper body. As their chests shrink their hips appear to grow. They also mistake the sensation of food in their digestive track as fat. Anorexics suffer fatigue and may be sensitive to cold. Skin becomes dry and grayish. In advanced stages of the disease, a fine, downy covering of hair appears all over the body, which is the body's attempt to provide a thermal padding for lost fat layers.

Anorexics come from all socioeconomic levels and are frequently high achievers. However, it is common for grade point averages and other signs of high achievement to decline as the anorexia progresses. Anorexics have an overwhelming need to please their parents and teachers. Parents are often shocked at their child's starvation tactics because they are contrary to the usual good behavior and obedience that are characteristic of the child. Anorexic children usually conform to rules at home and outside of the home. This conforming is often to the point of losing self-esteem and the capacity for independent thought.

Bulimia

Bulimia is an eating disorder that consists of gorging on food, followed by self-induced vomiting or purging. This behavioral disorder may be part of anorexia nervosa or may constitute a distinct, separate disorder. As with anorexia nervosa, most persons with bulimic behaviors are female. Unlike anorexia nervosa, which typically emerges during early and middle adolescence, bulimia is most likely to occur during the late teenage years or early twenties.

Bulimic people are usually aware of their abnormal eating habits and fear not being able to control their eating. Food-binging episodes are followed by efforts to control weight through dieting, fasting, or purging. These efforts include vomiting, compulsive exercising, or the use of laxatives, diuretics, enemas, and weight-reducing drugs (e.g., amphetamines). Food binges are often responses to intense emotions such as depression, anger, loneliness, stress, and feelings of inadequacy. Binges serve to tranquilize or calm these negative feel-

ings. Bulimics consume as many as 1,000 to 10,000 calories or more per binge. Self-induced vomiting produces a sense of relief and often a feeling of euphoria. Vomiting episodes are often described by bulimic persons in sexual terms, ascribing to the vomiting an orgasmic quality. The resulting relief and euphoria are often associated with a sense of calmness, relaxation, and tiredness. These feelings, however, are short-lived and replaced by disgust, guilt, shame, and self-condemnation. A progression to more serious feelings of depression, hopelessness, and suicidal ideation is also common.

Although most bulimics maintain normal body weight, bulimia carries the risk of serious medical complications. Kidney impairment and heart irregularities may develop. In addition, the stomach or esophagus may rupture in response to binging or purging episodes. Chronic hoarseness, premature facial wrinkles, electrolyte disturbances, and hemorrhages in the conjunctiva of the eye are other complications. Tooth decay and erosion result from regurgitation of acidic gastric contents. Syrup of ipecac, an over-the-counter drug used for inducing vomiting in poison victims, is sometimes abused by bulimics to purge after food binges. Repeated use of syrup of ipecac can cause irreversible heart damage. One famous victim of syrup of ipecac abuse was Karen Carpenter, a popular singer and performer during the 1970s. **Box 6-4** has some teaching activity ideas for body image and weight management.

6-4
In the Classroom

Assessment and Learning Activities for Body Image and Weight Management

Be sure to also consider the skills and activities in Chapter 4, Dealing with Stress, that are related to weight management and check out related resources in Box 6-7.

Magazine Look

In magazines they often read, have students do a count analysis of all the pictures of people. Have them count the images by gender, race, weight, physical attractiveness, and perceived socioeconomic status. Have students identify attitudes, values, beliefs, and lifestyles projected by these images. Discuss how they have been influenced by similar images. (I, J, H)

(*continues*)

(*continued*)

Double Messages

Have students look in magazines and on magazine covers for double messages, such as a picture of a fattening dessert right next to an article on dieting. Discuss why editors place double messages side by side. (I, J, H)

Model of Health

Have a healthy body image ad campaign competition in which students create their own slogans, public service announcements, and postures. Review the Dove company's "Campaign for Real Beauty Worldwide" at http://www.campaignforrealbeauty.com, but be sure to identify that this is a marketing tool. (I, J, H)

BMI Calculator

Have students calculate the body mass index for fictional students, themselves, or family members by using the BMI Calculator at http://www.keepkidshealthy.com/welcome/bmicalculator.html. (I, J, H)

Fire Analogy

Liken burning calories to building a fire. Discuss how logs won't burn if you simply try and light them with a match. Explain how fat (like a log) won't burn all by itself. Fat needs glucose to burn. Liken sugar to paper chains. Simple sugars are small chains, complex carbohydrates are long paper chains, and glucose is a single link broken off of a chain. Simple sugars are broken down very quickly, long complex carbohydrates take hours to break down. When we eat a lot of simple sugars, they are broken down quickly and our blood sugar spikes. Insulin is released and soon our blood sugar drops dramatically, creating cravings for more sugar. When we eat complex carbohydrates, they are broken down slowly, which maintains a moderate rise in our blood sugar over a long period of time and facilitates the "burning" of fat. When we go on crash diets, we often don't have glucose in our blood and can't burn fat. Instead, we lose muscle, which does not require glucose to burn. When we "burn up" our muscles, we reduce the number of "fires" we can set because all calories are burned in our muscles. (I, J, H)

Fad Diets

Assign student groups to research various fad diets at http://www.faddiet.com/. This site is humorous as well as informative. Diet book reviews can be found at http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/media_8815_ENU_HTML.htm. (I, J, H)

Diseases Related to Unhealthy Eating and Inactivity

Health experts note that the number of deaths from obesity, overweight, and lack of physical activity is more than the number killed annually by pneumonia, motor vehicle accidents, and airline crashes combined. Overweight and obesity are associated with type 2 diabetes, heart disease, high blood pressure, certain types of cancer, stroke, arthritis, breathing problems, and psychological disorders such as depression. Unhealthy eating patterns are also associated with osteoporosis, dental decay, anemia, and poor academic performance. The eating practices that contribute to disease are established early in life. Young people who have unhealthy eating habits tend to maintain these habits as they age. For this reason, it is critical that children and adolescents are taught healthy eating patterns before poor habits become firmly established.

Diabetes

The United States is experiencing an epidemic of diabetes. Health experts attribute the epidemic to the rise in obesity rates among adults and children. The Centers for Disease Control and Prevention (CDC) warns that one in three U.S. children born in 2000 risk becoming diabetic unless people start eating less and exercising more. In the past 10 years, the number of diagnosed cases of diabetes has risen by nearly half and is expected to rise an additional 165% by 2050.

Type 2 diabetes is a diet-related chronic disease that can develop during childhood or adolescence and has been a disease that primarily affected adults. In fact, it used to be called *adult-onset diabetes* because it occurred mostly in

Our current epidemic of diabetes is related to inactivity and obesity.

men and women older than age 50. But now it is showing up at an increasing rate among children, especially those who are obese and physically inactive. A decade ago, pediatricians would have been surprised to see a case of type 2 diabetes in a child.

In type 2 diabetes, the pancreas is usually producing enough insulin, but for unknown reasons the body cannot use the insulin effectively, a condition called **insulin resistance**. After several years, the insulin production decreases. Uncontrolled blood sugar can injure blood vessels, leading to serious health problems. If not treated, type 2 diabetes can cause serious and even life-threatening conditions, such as blindness, kidney disease, nerve damage, and heart disease. Children and adolescents diagnosed with type 2 diabetes have a longer time in which to develop these complications than individuals who develop the disease later in life. It appears that type 2 diabetes is a more aggressive disease when it occurs at a young age, increasing risk of complications.

Among children, cases have occurred in early childhood, but the peak age for diagnosis usually occurs after the onset of puberty. Changes in hormone levels during puberty can cause insulin resistance and decreased insulin action.

The symptoms of type 2 diabetes develop gradually. They are not as sudden in onset as in **type 1 diabetes**. Some people have no symptoms. Symptoms may include fatigue or nausea, frequent urination, unusual thirst, weight loss, blurred vision, frequent infections, and slow healing of wounds or sores.

Coronary Heart Disease

Poor eating habits can contribute to the development of coronary heart disease, stroke, and high blood pressure. Heart disease is caused by narrowing of the coronary arteries that feed the heart. Like any muscle, the heart needs a constant supply of oxygen and nutrients, which are carried to it by the blood in the coronary arteries. When the coronary arteries become narrowed or clogged by cholesterol and fat deposits—a process called **atherosclerosis**—and cannot supply enough blood to the heart, the result is coronary heart disease.

Cholesterol is a waxy, fatlike substance that occurs naturally in all parts of the body and that our bodies need to function normally. It is present in cell walls and membranes everywhere in the body, including the brain, nerves, muscle, skin, liver, intestines, and heart. Our bodies use cholesterol to produce many hormones, vitamin D, and the bile acids that help to digest fat. It takes only a small amount of cholesterol in the blood to meet these needs. If a person has too much cholesterol in the bloodstream, however, the excess is deposited in arteries, including the coronary arteries, where it contributes to the narrowing and blockages that cause the signs and symptoms of heart disease.[23]

Arthrosclerosis can begin as early as childhood and adolescence. If not enough oxygen-carrying blood reaches the heart, the individual may experience chest pain called **angina**. If the blood supply to a portion of the heart is completely cut off by total blockage of a coronary artery, the result is a **heart attack**. This is usually the result of a sudden closure of the artery by a blood clot forming on top of a previous narrowing.

Cancer

Researchers agree that poor diets and sedentary lifestyles are among the most important contributors to cancer risk. At least one third of all cancer deaths are linked to poor diet, physical inactivity, and carrying excess weight. Except for quitting smoking, the best way to cut your risk of cancer is to achieve and maintain a healthy weight, to be physically active on a regular basis, and to make healthy food choices. Being active helps with weight control and can also reduce your cancer risk by influencing hormone levels and your immune system. Eating *at least* five servings of vegetables (including legumes) and fruits each day, especially those with the most color (a sign of high nutrient content), provides antioxidants and many other substances that work together to lower risk of several cancers, including cancers of the lung, mouth, esophagus, stomach, and colon. Eating whole grains adds fiber to the diet that helps prevent constipation, dilutes hazardous carcinogenic substances, and provides an environment conducive to "friendly" bacteria. Cutting back on processed meats such as hot dogs, bologna, and luncheon meat, and red meats such as beef, pork, and lamb may help reduce the risk of colon and prostate cancers.[24]

Osteoporosis

The National Osteoporosis Foundation defines **osteoporosis** as a disease in which bones become fragile and more likely to break. Osteoporosis is often called a silent disease because bone loss occurs without symptoms. The first symptom may be a fracture or a collapsed vertebra in the spine. When vertebrae collapse, the result is severe back pain, loss of height, or spinal deformities and stooped posture. The risk of osteoporosis increases with age if you are female, and may be, in part, hereditary. Caucasian and Asian women are more likely to develop osteoporosis than are African American and Hispanic women. Small-boned and thin women are at the greatest risk, and early menopause increases the risk of developing osteoporosis. Smoking cigarettes, drinking alcohol, consuming an inadequate amount of calcium, and getting little or no weight-bearing exercise are lifestyle factors that increase risk.

Consuming enough calcium is particularly important during childhood, adolescence, and young adulthood to reduce risk of osteoporosis. Adolescent females consume less **calcium** than is recommended by health experts. It is recommended that they consume at least 1,200 mg of calcium per day. This helps bones to reach their maximum density. To meet this recommendation, girls need to consume a minimum of three servings daily of milk or yogurt. With almost half of an adult's bone mass being formed during the teen years, the inadequate calcium intakes among children and adolescents are a serious concern. Young females who consume inadequate amounts of dietary calcium are at increased risk for osteoporosis in later life.

Young people need to understand that bones become stronger and denser when the demands of physical activity are placed on them. **Weight-bearing exercises** are those in which your bones and muscles work against gravity, such as

jogging, walking, climbing stairs, dancing, and playing soccer. **Resistance exercises** use muscular strength to improve muscle mass and strengthen bone, such as the use of free weights and weight machines. The National Osteoporosis Foundation recommends these two types of exercise for building and maintaining bone mass and density.

Dental Decay

According to the CDC, **dental decay** is one of the most common chronic infectious diseases among U.S. children. This preventable health problem begins early: 17% of children ages 2 to 4 years have already had dental decay. By the age of 8, approximately 52% of children have experienced decay, and by the age of 17, dental decay affects 78% of children. Among low-income children, almost 50% of tooth decay remains untreated and may result in pain, dysfunction, underweight, and poor appearance—problems that can greatly reduce a child's capacity to succeed in the educational environment.[22]

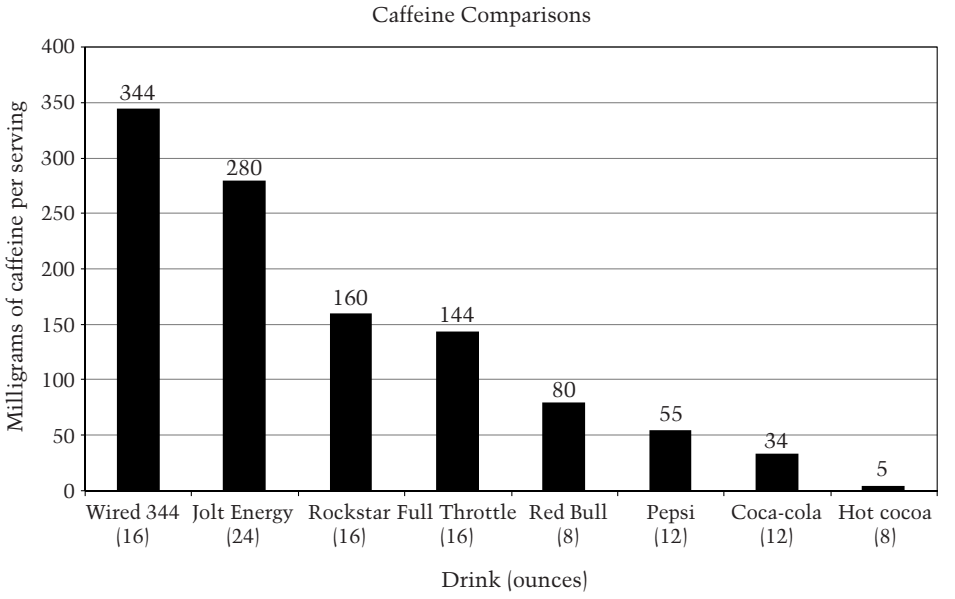
Dietary habits often contribute to the development of dental caries in children. Sticky, sweet food is very bad for teeth because it maintains high sugar levels in the mouth, and is very likely to cause tooth decay. There is also a positive correlation between soft drink consumption and dental decay. In many carbonated beverages, the sugar content can equal 10 teaspoons per 12 ounces! Most carbonated beverages contain phosphoric acid, citric acid, and carbonic acid that leads to chemical erosion of teeth.[25] See **Box 6-5** for information on carbonated and uncarbonated beverages with caffeine statistics. Also, see **Box 6-6** for an idea of how you help students understand soda's impact on teeth.

6-5
Background on . . .

The Energy Drink Buzz

Energy drinks are one of the nation's fastest growing markets and have some professionals worried about the health implications. Some of the stronger drinks contain more than three times the physician-recommended daily limit on caffeine intake in a single can. The Food and Drug Administration does not regulate the amount of caffeine in soft drinks. Additionally troublesome is the fact that new products such as Sparks contain both caffeine and alcohol. These products look like other energy drinks and there is concern that these drinks will accidentally or intentionally get into the hands of minors.

(*continues*)



You can find out how much caffeine is in all types of drinks at http://www.energyfiend.com/the-caffeine-database

Source: Adapted from Energy Fiend. Caffeine Contents of Drinks. Available at http://www.energyfiend.com/the-caffeine-database. Accessed September 18, 2009.

6-6 In the Classroom

Pop Rot Experiments

Soak an egg in a glass of soda pop for 3 days. Have students observe how the enamel of the shell changes. You can also soak teeth (obtained from students or a dentist) in pop and another set in milk in a fridge for a week or more, and then compare the teeth. (P, I, J, H)

Promoting Healthy Eating and Physical Activity

Schools are an ideal setting for encouraging healthy eating and physical activity.* Instruction, programs, and services that promote wise food choices and lifelong physical activity can be provided in schools as well as opportunities for practicing healthy eating and engaging in physical activity. In **Box 6-7**, you can find lists of free teaching resources for healthy eating, including where you can obtain lesson plans and materials.

6-7
In the Classroom

Free Resources for Teaching Healthy Eating and Physical Activity

You can find lesson plans on nutrition and physical activity for elementary, middle, and high school levels at these websites:

- USDA: http://teamnutrition.usda.gov/resources/mypyramidclassroom.html
- Dairy Council/Nutrition Explorations:
  http://school.discoveryeducation.com/lessonplans/programs/mypyramid/
  http://www.nutritionexplorations.org/educators/main.asp
- Media-Smart Youth: http://www.nichd.nih.gov/msy/msy.htm
- A to Z Teacher Stuff: http://www.atozteacherstuff.com/Lesson_Plans/
- Discovery Education: http://schoolnew.discoveryeducation.com/
- Utah Education Network: http://www.uen.org/curriculumsearch/SearchResults.do;jsessionid=1181BE81F214EA1781332B2B77E35E56
- Nebraska Department of Education:
  http://www.nde.state.ne.us/PEHealth/conferences.html

You can access materials for teaching nutrition and physical activity at these websites:

- National Dairy Council, Nutrition Explorations:
  http://www.nutritionexplorations.org/educators/main.asp
  Age-appropriate concepts (guide for progression of teaching)

(*continues*)

* Much of the information in this section is from the following guideline reports from the Centers for Disease Control and Prevention: "Guidelines for School Health Programs to Promote Lifelong Healthly Eating," *Morbidity and Mortality Weekly Report*, 45(RR-9), 1996, and "Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People," *Morbidity and Mortality Weekly Report*, 46(RR-6), 1997.

Nutrition FAQs (answers to frequently asked questions)
Internet classroom (sites for teacher and students)
Fun food games for kids

http://www.nutritionexplorations.org/catalog/parents.asp
Materials for both elementary and secondary levels, including brochures, cardboard photographs, and postures

- USDA's Eat Smart. Play Hard:
  http://teamnutrition.usda.gov/Resources/eatsmartactivitysheets.html
  Activity sheets, bookmarks, comics, and stickers
- USDA's MyPyramid for Kids Classroom Materials:
  http://teamnutrition.usda.gov/resources/mypyramidclassroom.html
  Worksheets, CD with game, postures, tips for families
- University of Maryland Baltimore: Mouth Power: http://www.mouthpower.org/
  Interactive self-tutorial site for young people
- Intermountain Health Care: http://intermountainlive.org/Pages/home.aspx
  Fun and thought-provoking video commercials

Supportive School Environment

A supportive school environment reinforces the promotion of lifelong healthy eating and physical activity for its students. Schools should serve healthy school lunches and breakfasts to reinforce health education lessons about healthy eating. Lessons about the importance of physical activity should be reinforced by making school spaces and facilities for activity available to young people. School-based interventions have been shown to have significant effects on weight management goals.[26]

The availability of healthy and appealing foods in school cafeterias, vending machines, school stores, and at school functions (e.g., athletic competitions, special events) sends a message about the value that the school community places on healthy eating. For this reason, schools should discourage the serving and sale of foods high in fat, calories, sodium, and added sugars (e.g., candy, chips, soda) on school grounds. Many schools sell junk food as part of fund-raising activities and as a means to provide revenue for school programs. These sales send the message that it is acceptable to compromise health for financial reasons. These efforts also undermine the messages on healthy eating given in health education classes.

Another way that health messages are undermined is when teachers use food for rewarding students or exercise as a punishment. Some teachers give candy or other sweets as a reward for good behavior or as prizes for games and competitions. If food is served in classrooms, teachers should see that healthy snacks and treats are served and that consideration is given to possible food

allergies, religious prohibitions, and safe food handling. Making students who misbehave or fail to meet expectations run laps or do other exercises is an inappropriate use of physical activity. School personnel should not force students to participate in physical activity or withhold opportunities as a punishment. This may lead young people to create negative associations with physical activity.

Teachers and other school personnel who practice healthy behaviors are positive role models for students. Health promotion programs for school faculty and staff help foster healthy habits among school personnel. These programs have many benefits for the individuals who participate as well as the school system itself. Teachers who participate in school-based health promotion programs are absent from work less and report higher levels of job satisfaction. Participants in health promotion programs have improved levels of physical fitness, lower levels of body fat and blood pressure, and are better able to cope with stress.

An additional way to increase support for healthy eating and physical activity is by providing adequate time for health education and for physical activity. Sufficient time for teaching nutrition concepts and helping students develop healthy eating behaviors and skills must be built into the curriculum. Also, adequate time should be provided within physical education classes, during recess, and immediately before and after school for physical activity. School personnel should encourage students to be physically active during these times.

School Personnel Collaboration

The efficacy of good nutrition and fitness education is enhanced when teachers and other school personnel coordinate their efforts and collaborate with each other. Foodservice personnel can serve as guest speakers in classes focusing on nutrition topics. Physical education teachers are great resources for promoting physical fitness. Counselors can give guidance for teaching behavioral skills associated with healthy lifestyle issues. Many schools plan health fairs, and school nurses and the professionals mentioned in this section are great resources when it comes to planning such an event or similar activities.

Here are some more specific ways that school foodservice personnel can promote healthy eating:

- Invite classes to visit the cafeteria kitchen and learn how to prepare healthy foods.
- Involve students in planning the school menu and preparing recipes.
- Offer healthy foods that reinforce classroom lessons.
- Place nutrition posters and flyers in the school cafeteria.
- Display nutrition information about available foods and give students opportunities to practice the food analysis and selection skills learned in the classroom.

Parental Involvement

The attitudes and behaviors of parents and caretakers directly influence children's and adolescents' food and activity choices. The influence of parents may be stronger for elementary children than it is for secondary students, but parental influence is still an important factor at any age. Helping parents modify their children's eating behaviors may be one of the most effective ways to improve the eating behaviors of students. As well, parents' physical activity patterns are certain to influence their children's decision to be active.

Teachers can involve parents in ways that do not require their attendance at school. Here are some ideas of how schools can involve parents in promoting healthy eating:

- Send nutrition education materials and cafeteria menus home with students.
- Ask parents to send healthy snacks to school.
- Invite parents and other family members periodically to eat with their children in the cafeteria.
- Invite families to attend exhibitions of student nutrition projects at health fairs.
- Offer nutrition education workshops and screening services.
- Assign nutrition education homework that students can do with their families (e.g., reading and interpreting food labels, reading nutrition-related newsletters, preparing healthy recipes).

To involve parents in encouraging physical activity, teachers can assign homework to students that must be done with their parents and can provide flyers designed for parents that contain information and strategies for promoting physical activity in the family. Parents can also serve on school health advisory councils. Parents can influence the quality and quantity of comprehensive school health education and daily physical education in schools by advocating for these programs within the schools their children attend. Parents can also serve as volunteer coaches or leaders of extracurricular physical activity programs and community sports and recreation programs. **Box 6-8** has ideas on how you can help your students reach out to their family or the community and become an advocate for healthy eating and physical activity.

Community Involvement

Schools can engage community resources and services to respond to the nutritional and physical activity needs of students through advisory councils or through direct contact with community organizations. Schools can also participate in community-based nutrition education and physical activity promotion campaigns sponsored by public health agencies or voluntary organizations.

Students are most likely to adopt healthy behaviors if they receive consistent messages through multiple channels (e.g., home, school, community, media) and from multiple sources (e.g., parents, peers, teachers, health professionals, media).

The Brownsville Farmer's Market in Texas serves as an excellent example of community involvement in nutrition education. The market is a collaborative effort to provide locally grown produce and increase the awareness of chronic disease associated with obesity. The Hispanic community in the valley has twice the national average of diabetes. The market, with funds from a grant from the Texas Department of State Health Services, provides low-income families with $10 vouchers to purchase fresh fruits and vegetables. The market also gives health care experts the opportunity to educate shoppers on nutrition, obesity, and diabetes.[27]

Schools should establish links with qualified public health and nutrition professionals who can provide screening, referral, and counseling for nutrition problems; inform families about supplemental nutrition services available in the community, such as WIC (Women, Infants, and Children), food stamps, and local food pantries; and implement nutrition education and health promotion activities for school faculty, other staff, school board members, and parents. These links can help resolve nutritional problems that can impair a student's capacity to learn, demonstrate the value placed on good nutrition for the entire school community, and help adults serve as role models for school-age youth.

6-8
In the Classroom

Advocacy, Outreach, and Integration Activities

Fun Run/Walk

Sponsor a schoolwide fun run. Ask parents and the PTA to participate. Invite local high school track team members to run with and encourage individuals as they participate. Have preparation "training" activities. Have participants make their own time goals for the course and celebrate each participant's involvement. (P, I)

Food Drive

Sponsor a school or community food drive for a local food bank. Have students be physically active as they collect and deliver the food. (P, I, J, H)

(*continues*)

Cultural Food Fair

Work with your school's PTA and sponsor a school food fair highlighting healthy ethnic foods found in your area or from around the globe. Have the fair celebrate various cultures and "tastes." Invite parents and local ethnic restaurants to participate. (P, I, J)

Integration ideas for teaching nutrition and physical activity in other content areas include these:

Math. Do math story problems using food labels (http://www.cfsan.fda.gov/~dms/foodlab.html). Calculate family food budgets and savings from eating at home and cooking from scratch. Compare costs of eating fruits versus eating other dessert choices. Calculate the yearly cost of habitually drinking soda or eating some junk food items. Do heart rate and breathing rates at rest and after exertion, and then calculate norms, means, and averages. (I, J, H)

Language arts. Create brochures on dieting tips using http://www.checkyourhealth.org/nutrition/food_plans.htm as a resource. Write poems or songs about healthy food choices. Write stories, case histories, or mini dramas about physical activity. (I, J, H)

Social studies. Discuss and/or research globesity, culture and food, war and food, food production and distribution, government farm subsidies, world food trade and embargos, historical perspectives on physical activity and food including its availability, preparation, and preservation. (I, J, H)

Teaching Healthy Eating and Physical Activity

Education about healthy eating and physical activity should aim to help students develop the knowledge, attitudes, and behaviors they need to establish and maintain patterns of healthy eating and physical activity. The curriculum needs to focus on the relationship between personal behavior and health. Lessons and classroom learning activities should stress the importance of combining regular physical activity with sound nutrition practices as part of an overall healthy lifestyle. **Box 6-9** identifies the Health Education Curriculum Analysis Tool–recommended guidelines for a healthy eating and a physical activity curriculum.

Children and adolescents need to have a clear understanding of nutrition and physical activity concepts. Students need to gain a content knowledge on things such as nutrients, digestion, dietary recommendations, causes of weight gain, safe weight loss, health benefits of physical activity, physical fitness,

and so forth. Students also need to develop behavioral skills that enable them to adopt healthy behaviors. Goal setting and decision making are two essential skills that enable students to adopt and maintain a healthy lifestyle that includes regular physical activity and choosing healthy foods. Students will also benefit from learning skills for how to identify and manage barriers to their goals.

Teachers need to recognize that skill acquisition and development require providing students multiple opportunities to practice, master, and develop confidence in a new behavior. Give your students opportunities to analyze their eating and activity patterns (self-assessment), set realistic goals for changes in their personal behaviors (goal setting), monitor their progress in reaching those goals (self-monitoring), and reward themselves for achieving their goals (reinforcement). Teach your students to critically analyze socioenvironmental influences—including media and advertising—on food selection and decisions about physical activity, to resist negative social pressures, and to develop social support for healthy behaviors.

Health education for healthy eating and physical activity is most appealing to students when it incorporates learning strategies that emphasize active learning and making learning fun. Health-enhancing behaviors are best promoted through participatory activities rather than passively in the form of lectures, worksheets, or books and other textual materials. Learning activities should be designed to emphasize the positive, appealing aspects of healthy eating and physical activity patterns rather than the negative consequences of unhealthy eating or sedentary living. Students should have opportunities to experiment with healthy behaviors. You can give students opportunities to taste healthy foods and to try out new physical activities or sports. Use hands-on practice to help students develop practical skills and self-confidence in preparing foods, planning meals, reading food labels, and making healthy food choices.

It is important to emphasize the benefits of adopting healthy food and physical activity choices. The benefits that may have the strongest appeal to young people are those that are most immediate and tied to their present aspirations. Information about how healthy eating and regular physical activity might prevent heart disease in later adulthood might not have the same impact as short-term benefits such as improved physical appearance, sense of personal control and independence, and improved capacity for physical activities.

Education about healthy eating and physical activity is not limited to health education classes. This information can be integrated into many other school subjects. For example, math lessons can analyze nutrient intake or calculate exercise heart rates. Reading lessons can feature reading material about many topics relating to eating and physical activity. Social studies lessons can examine topics such as how obese people are often treated poorly in society or how changes in our society in the past century have contributed to a more sedentary way of life and differences in food availability.

6-9
In the Classroom

HECAT Recommendations for Promoting Healthy Eating and Physical Activity

Health Education Curriculum Analysis Tool (HECAT) is, as the name suggests, a curriculum analysis tool. It can help teachers, school districts, and states review their curricula to see whether those curricula meet National Health Education Standards and the CDC's Characteristics of an Effective Health Education Curriculum. Following are overview recommendations for healthy eating and physical activity curricula. You can find specific and more detailed grade-level recommendations (by grades 2, 5, and 8) at http://www.cdc.gov/healthyyouth/HECAT/.

A pre-K–12 healthy eating curriculum should enable students to do the following:

- Eat a variety of whole grain products, fruits and vegetables, and fat-free or low-fat milk or equivalent milk products every day.
- Eat the appropriate number of servings from each food group every day.
- Choose foods that provide ample amounts of vitamins and minerals.
- Eat the appropriate amounts of foods that are high in fiber.
- Drink plenty of water.
- Limit foods and beverages high in added or processed sugars.
- Limit the intake of fat, avoiding foods with saturated and trans fats.
- Eat breakfast every day.
- Eat healthy snacks.
- Eat healthy foods when dining out.
- Prepare food in healthful ways.
- Balance caloric intake with caloric expenditure.
- Follow a plan for healthy weight management.

And do these as part of a personal health and wellness curriculum:

- Brush and floss teeth daily.
- Practice behaviors that prevent foodborne illnesses.
- Practice behaviors that prevent chronic diseases.
- Seek out health care professionals for appropriate screenings and examinations.

(*continues*)

(*continued*)

- Seek out help for chronic diseases and conditions.
- Prevent health problems that result from fads or trends.

A pre-K–12 physical activity curriculum should enable students to do the following:

- Engage in moderate to vigorous physical activity for at least 60 minutes every day.
- Regularly engage in physical activities that enhance cardiorespiratory endurance, flexibility, muscle endurance, and muscle strength.
- Engage in warm-up and cool-down activities before and after exercise.
- Drink plenty of water before, during, and after physical activity.
- Avoid injury during physical activity.

MyPyramid

The U.S. Department of Agriculture (USDA) created MyPyramid to help people make healthful food and physical activity choices. **MyPyramid** symbolizes a personalized approach to healthy eating and physical activity. The symbol reminds consumers to make healthy food choices and to be active every day. Moderation, proportionality, and variety are represented by the six bands in the pyramid depicting the five food groups and oil.

Activity is represented by the steps and the person climbing them, as a reminder of the importance of daily physical activity (see **Figure 6-6**). **Table 6-1** identifies the amount of food from each food group that a person should eat dependent upon the number of calories that person consumes.

The USDA also created a website for the MyPyramid food guidance system that includes resources and tools for following the system. The site encourages individuals to follow daily food intake recommendations based on their age, size, and physical activity. With the MyPyramid Tracker tool, you can evaluate your current diet and physical activity pattern. This interactive Web-based tool can help you and students compare current dietary habits and physical activity to health recommendations. You enter the foods that you eat and your physical activities for a day so that you can learn how well you are balancing the calories eaten and the calories burned. MyPyramid Tracker provides each user with detailed, personalized results. MyPyramid also has resources for teachers, steps to healthier weight, pregnancy and breastfeeding, and preschoolers. You can access the MyPyramid website at http://www.mypyramid.gov. You can find teaching activity ideas for eating healthy and getting physical activity in **Box 6-10**.

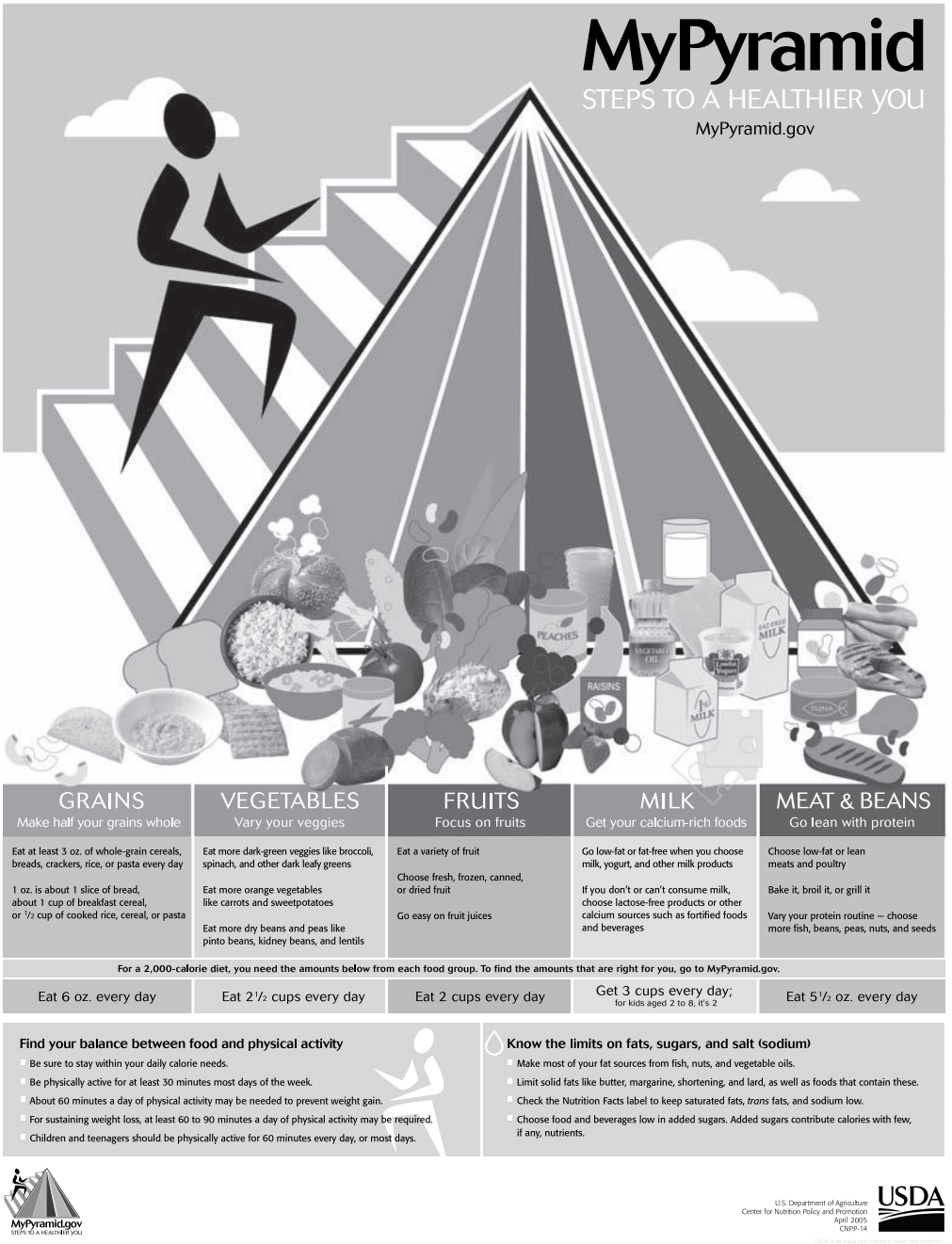


FIGURE 6-6 MyPyramid: Steps to a healthier you.
Source: U.S. Department of Agriculture. http://www.MyPyramid.gov.

TABLE 6-1 Food Intake Patterns

The suggested amounts of food to consume from the basic food groups, subgroups, and oils to meet recommended nutrient intakes at 12 different calorie levels. Nutrient and energy contributions from each group are calculated according to the nutrient-dense forms of foods in each group (e.g., lean meats and fat-free milk). The table also shows the discretionary calorie allowance that can be accommodated within each calorie level, in addition to the suggested amounts of nutrient-dense forms of foods in each group.

Daily Amount of Food from Each Group per Week												
Calorie Level[1]	1,000	1,200	1,400	1,600	1,800	2,000	2,200	2,400	2,600	2,800	3,000	3,200
Fruits[2]	1 cup	1 cup	1.5 cups	1.5 cups	1.5 cups	2 cups	2 cups	2 cups	2 cups	2.5 cups	2.5 cups	2.5 cups
Vegetables[3]	1 cup	1.5 cups	1.5 cups	2 cups	2.5 cups	2.5 cups	3 cups	3 cups	3.5 cups	3.5 cups	4 cups	4 cups
Grains[4]	3 oz-eq	4 oz-eq	5 oz-eq	5 oz-eq	6 oz-eq	6 oz-eq	7 oz-eq	8 oz-eq	9 oz-eq	10 oz-eq	10 oz-eq	10 oz-eq
Meat and Beans[5]	2 oz-eq	3 oz-eq	4 oz-eq	5 oz-eq	5 oz-eq	5.5 oz-eq	6 oz-eq	6.5 oz-eq	6.5 oz-eq	7 oz-eq	7 oz-eq	7 oz-eq
Milk[6]	2 cups	2 cups	2 cups	3 cups	3 cups	3 cups	3 cups	3 cups	3 cups	3 cups	3 cups	3 cups
Oils[7]	3 tsp	4 tsp	4 tsp	5 tsp	5 tsp	6 tsp	6 tsp	7 tsp	8 tsp	8 tsp	10 tsp	11 tsp
Discretionary Calorie Allowance[8]	165	171	171	132	195	267	290	362	410	426	512	648

1 Calorie Levels are set across a wide range to accommodate the needs of different individuals. The attached table "Estimated Daily Calorie Needs" can be used to help assign individuals to the food intake pattern at a particular calorie level.

2 Fruit Group includes all fresh, frozen, canned, and dried fruits and fruit juices. In general, 1 cup of fruit or 100% fruit juice, or 1/2 cup of dried fruit can be considered as 1 cup from the fruit group.

3 Vegetable Group includes all fresh, frozen, canned, and dried vegetables and vegetable juices. In general, 1 cup of raw or cooked vegetables or vegetable juice, or 2 cups of raw leafy greens can be considered as 1 cup from the vegetable group.

Vegetable Subgroup Amounts per Week												
Calorie Level	1,000	1,200	1,400	1,600	1,800	2,000	2,200	2,400	2,600	2,800	3,000	3,200
Dark green veg.	1 c/wk	1.5 c/wk	1.5 c/wk	2 c/wk	3 c/wk	3 c/wk	3 c/wk	3 c/wk	3 c/wk	3 c/wk	3 c/wk	3 c/wk
Orange veg.	0.5 c/wk	1 c/wk	1 c/wk	1.5 c/wk	2 c/wk	2 c/wk	2 c/wk	2 c/wk	2.5 c/wk	2.5 c/wk	2.5 c/wk	2.5 c/wk
Legumes	0.5 c/wk	1 c/wk	1 c/wk	2.5 c/wk	3 c/wk	3 c/wk	3 c/wk	3 c/wk	3.5 c/wk	3.5 c/wk	3.5 c/wk	3.5 c/wk
Starchy veg.	1.5 c/wk	2.5 c/wk	2.5 c/wk	2.5 c/wk	3 c/wk	3 c/wk	6 c/wk	6 c/wk	7 c/wk	7 c/wk	9 c/wk	9 c/wk
Other veg.	3.5 c/wk	4.5 c/wk	4.5 c/wk	5.5 c/wk	6.5 c/wk	6.5 c/wk	7 c/wk	7 c/wk	8.5 c/wk	8.5 c/wk	10 c/wk	10 c/wk

4 Grains Group includes all foods made from wheat, rice, oats, cornmeal, barley, such as bread, pasta, oatmeal, breakfast cereals, tortillas, and grits. In general, 1 slice of bread, 1 cup of ready-to-eat cereal, or 1/2 cup of cooked rice, pasta, or cooked cereal can be considered as 1 ounce equivalent from the grains group. At **least half of all grains consumed should be whole grains**.

5 Meat and Beans Group in general, 1 ounce of lean meat, poultry, or fish, 1 egg, 1 Tbsp. peanut butter, 1/4 cup cooked dry beans, or 1/2 ounce of nuts or seeds can be considered as 1 ounce equivalent from the meat and beans group.

6 Milk Group includes all fluid milk products and foods made from milk that retain their calcium content, such as yogurt and cheese. Foods made from milk that have little to no calcium, such as cream cheese, cream, and butter, are not part of the group. Most milk group choices should be fat-free or low-fat. In general, 1 cup of milk or yogurt, 1 1/2 ounces of natural cheese, or 2 ounces of processed cheese can be considered as 1 cup from the milk group.

7 Oils Group include fats from many different plants and from fish that are liquid at room temperature, such as canola, corn, olive, soybean, and sunflower oil. Some foods are naturally high in oils, like nuts, olives, some fish, and avocados. Foods that are mainly oil include mayonnaise, certain salad dressings, and soft margarine.

8 Discretionary Calorie Allowance is the remaining amount of calories in a food intake pattern after accounting for the calories needed for all food groups—using forms of foods that are fat-free or low-fat and with no added sugars.

(*continues*)

TABLE 6-1 (*continued*)
Estimated Daily Calorie Needs
To determine which food intake pattern to use for an individual, the following chart gives an estimate of individual calorie needs. The calorie range for each age/sex group is based on physical activity level, from sedentary to active.

	Calorie Range
Children	Sedentary→Active
2–3 years	1,000→1,400
Females	
4–8 years	1,200→1,800
9–13	1,600→2,200
14–18	1,800→2,400
19–30	2,000→2,400
31–50	1,800→2,200
51+	1,600→2,200
Males	
4–8 years	1,400→2,000
9–13	1,800→2,600
14–18	2,200→3,200
19–30	2,400→3,000
31–50	2,200→3,000
51+	2,000→2,800

Sedentary means a lifestyle that includes only the light physical activity associated with typical day-to-day life.
Active means a lifestyle that includes physical activity equivalent to walking more than 3 miles per day at 3 to 4 miles per hour, in addition to the light physical activity associated with typical day-to-day life.
Source: U.S. Department of Agriculture. http://www.MyPyramid.gov.

Physical Fitness Curricula

One of the main goals of school physical education is to help students develop an active lifestyle that will persist into and throughout adulthood. Curricula should emphasize knowledge about the benefits of physical activity and the recommended amounts and types of physical activity. Physical education should help students develop the attitudes, motor skills, behavioral skills, and confidence they need to engage in lifelong physical activity. Physical education should emphasize skills for lifetime physical activities such as dancing, strength training, jogging, swimming, bicycling, cross-country skiing, walking, and hiking.

Physical fitness is another main goal of physical education. **Physical fitness** is a state of well-being that allows individuals to perform daily activities with vigor, participate in a variety of physical activities, and reduce their risks for health problems. Five basic components of fitness are important for good health: *cardiorespiratory endurance*, *muscular strength*, *muscular endurance*, *flexibility*, and *body composition* (percentage of body fat). A second set of attributes,

referred to as sport- or skill-related physical fitness attributes, includes *power*, *speed*, *agility*, *balance*, and *reaction time*. Although skill-related fitness attributes are not essential for maintaining physical health, they are important for athletic performance or physically demanding jobs such as military service and emergency and rescue service.

Physical activity promotion needs to emphasize the benefits of an active lifestyle. Regular participation in physical activity in childhood and adolescence provides many benefits including building and maintaining healthy bones, muscles, and joints; controlling weight; and reducing fat. Regular physical activity also prevents or delays the development of high blood pressure and helps reduce blood pressure in some adolescents with hypertension.[28]

Physical activity affects more than the physical dimension of health. Emotional health is improved through participation in physical activity. Physical activity reduces anxiety, reduces depression, improves self-esteem, and increases the ability to respond to stress.[29] A study by Page and Tucker found that adolescents who participate infrequently in physical activity experience more loneliness, shyness, and hopelessness than do their more active peers.[30] Another study by Page and colleagues showed that elementary children who are lonely are less physically fit than children who are not lonely.[31] Students who participate in interscholastic sports are less likely to be regular or heavy smokers or to use drugs and are more likely to stay in school and have good conduct and high academic achievement than are nonparticipants. Sports and physical activity programs can introduce young people to skills such as teamwork, self-discipline, sportsmanship, leadership, and socialization. Lack of recreational activity, on the other hand, may contribute to making young people more vulnerable to gangs, drugs, and violence.

Physical activity guidelines for children provide parents and youth leaders with information regarding appropriate physical activity for preadolescent children.[32] The following are the recommendations for children ages 5 to 12 years:

- Children should accumulate at least 60 minutes, and up to several hours, of age-appropriate physical activity on all or most days of the week. This daily accumulation should include moderate and vigorous physical activity, with the majority of the time being spent in activity that is intermittent in nature.
- Children should participate in several bouts of physical activity lasting 15 minutes or more each day.
- Children should participate each day in a variety of age-appropriate physical activities designed to achieve optimal health, wellness, fitness, and performance benefits.
- Extended periods (periods of 2 hours or more) of inactivity are discouraged for children, especially during the daytime hours.

Guidelines for adolescents recommend the following:[32]

- Adolescents should be physically active daily, or nearly every day, for at least 30 minutes as part of play, games, sports, work, transportation, recreation, physical education, or planned exercise, in the context of family, school, and community activities.
- Adolescents should engage in three or more sessions per week of activities that last 20 minutes or more and that require moderate to vigorous levels of exertion.

A useful way to help young people meet physical activity guidelines is to implement the award programs of the President's Council on Physical Fitness and Sports. For a young person to meet the President's Challenge, he or she must reach a set of physical performance standards. The President's Active Lifestyle Award (PALA), on the other hand, is based on participation rather than performance. To receive the PALA, youth ages 6 to 17 years must participate in 60 minutes of physical activity a day for at least 5 days per week, for a total of 6 weeks. This is consistent with the 60-minute physical activity guideline for children. The program also allows youth to achieve the award by accumulating at least 13,000 steps recorded on a pedometer for males or 11,000 steps for females.[33] However, some fitness experts assert that higher step counts than those recommended by the PALA standards might be required to achieve good health.[32]

6-10
In the Classroom

Assessment and Learning Activities for Eating Healthy and Physical Activity

Be sure to check out the free lesson plans and materials identified in Box 6-9 when planning a unit on promoting healthy eating and physical activity.

Nutrients and Nutritional Labeling

Lunch Sack

Place three different foods into three lunch sacks and label the sacks 1, 2, and 3. For instance, put a box of pectin in sack 1, dog food in sack 2, and a cup of soup in sack 3. Let students know exactly what is in each sack by showing them the lists of ingredients in each food, but not the food, and ask students which lunch they want. Have students identify which sack they want and try to guess what is inside.

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This is a good activity to introduce the question "Do you know what you're eating?" (I, J, H)

Label Match

Play a matching game where students have to match food labels with the appropriate products. Students can provide the labels from packages of foods they commonly eat at home. A variation is to play Nutrient Match, where students match vitamins and minerals with their functions or rich food sources. (I, J, H)

Serving Size?

Ask a student to pour the amount of cold cereal he or she typically eats into a bowl. Measure the amount poured in a measuring cup. Compare the student's serving size to that indicated on the food label. Display pictures of portion distortion found on an image search on the Web. Discuss how package labels sometime indicate abnormally small serving sizes to conceal calorie, fat, and/or sugar counts. (P, I, J, H)

Label Dissection and Comparison

Discuss each part of a food label (http://www.cfsan.fda.gov/~dms/foodlab.html), and then have students compare food labels of similar foods such as various cold cereals, different types of milk, snack foods, and various juices. Make a game of identifying the most healthful food products. (I, J, H)

House Analogy

Discuss the various sizes and styles of homes and the common materials they are built from. Discuss the various healthy sizes of bodies and the common nutrients they are built from (wood/bricks = proteins; fuel = carbohydrates; chemical compounds = vitamins and minerals). Discuss what happens when not enough of the right materials are available for building a home, a body. (P, I, J, H)

Eat More Vegetables, Fruits, Complex Carbohydrates

A to Z

In teams, have students try a fruit that begins with every letter of the alphabet. This same exercise can be done with vegetables. Have students identify which of

(*continues*)

the foods on their lists they have eaten. A great resource for this activity is provided by the CDC at http://www.fruitsandveggiesmatter.gov/. (P, I, J, H)

Top 10

Generate a list of fruits, vegetables, and fruit juices. Have students try to identify the top 10 nutritious fruits (or veggies, etc.). Have students research which are the most nutrient dense using the Web at http://www.whfoods.com/foodstoc.php. (P, I, J, H)

Fear Factor

Have a fun new food-tasting challenge somewhat like the TV show *Fear Factor*. Contact the produce sections of local grocery stores to see if they will provide you with samples of fruits and vegetables. (P, I, J, H)

Grow a Garden

Follow Michelle Obama's example and plant, harvest, and eat vegetables from a garden your class grows. Recruit the PTA to help with this project. (P, I)

MyPyramid Fill-In

Have students record everything they or their family eats on a laminated MyPyramid chart hung on their fridge. Keeping record on the chart prompts us to eat well. (P, I, J, H)

Marketing Competition

Have students compete in developing a marketing campaign for healthy eating or increased physical activity (i.e., eating more fruits and vegetables, drinking less pop, walking to school more). Encourage students to study and use marketing techniques. (I, J, H)

Food Preparation

Menu Planner

Have students plan a day or more of menus to meet their healthy eating goals using the Menu Planner at http://www.mypyramidtracker.gov/planner. (I, J, H)

(*continues*)

(*continued*)

Recipe Alterations

Have students' families experiment with healthy alterations to their favorite recipes. This is fun to do for Thanksgiving dinners. (P, I, J, H)

Cookbook

Have students work with their parents to come up with healthy recipes that can be included in a classroom cookbook. (P, I, J)

Food Safety

Cafeteria Tour

Tour the school's cafeteria and learn about all the precautions those who work there must make to ensure food safety. Discuss how school menus are planned. (P, I)

Restaurant Inspection

Check the Web for restaurant alerts in your area. Invite a restaurant inspector to be a classroom guest speaker. (J, H)

Physical Activities

Walk to School

Read about steps for a successful walk-to-school day, a "walking school bus," and safe routes to school initiatives at http://utahwalks.org/index.php?option=com_content&task=blogcategory&id=22&Itemid=43. (P, I)

Personal Trainer

Have students analyze their physical activity habits and needs using the tool at http://www.mypyramidtracker.gov/. Working in pairs, have students develop personalized activity plans, and then act as trainers for one another as they carry out the plans over a designated time period. Trainers encourage, motivate, check up on, and do some activities with their "client." (J, H)

(*continues*)

Map Quest

Make a class goal of walking/running to a given location such as the state capitol building. Each day, have students add up how far they collectively walked or ran. Mark their mileage on a map on the classroom wall showing the total distance from your school to your goal location. (P, J)

President's Challenge

Use the free Fitness File software to manage group testing and tracking at http://www.presidentschallenge.org/educators/fitness_file/login/login_coord.aspx. (J, H)

PSA Benefits

Have students create public service announcements for the radio that highlight the benefits of physical activity. (I, J, H)

Energizers

You can find descriptions of activities that get kids moving in the classroom for elementary and middle school students at http://www.ncpe4me.com/energizers.html. (P, I, J)

Key Terms

overweight 195
body mass index (BMI) 195
obese 195
globesity 195
portion distortion 197
undernutrition 205
iron-deficiency anemia 206
unsafe weight-loss methods 206
eating disorders 206
anorexia nervosa 208
bulimia 208
type 2 diabetes 211
insulin resistance 212
type 1 diabetes 212
atherosclerosis 212
cholesterol 212
angina 212
heart attack 212
osteoporosis 213
calcium 213
weight-bearing exercises 213
resistance exercises 214
dental decay 214
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Review Exercise

1. Define and explain the relative importance of each of the key terms in the context of this chapter.
2. Identify the prevalence of overweight and obesity in children, adults, and minorities.
3. Discuss the various factors in our society that have led to our physical inactivity.
4. Discuss the various factors that have led to our consuming too many calories.
5. Discuss the various family and social factors that contribute to poor eating habits.
6. Identify the numerous concerns about media use and food marketing.
7. Summarize why and how junk food is marketed in schools.
8. Explain why advertisers use very thin actresses and models and the possible impacts this can have on females.
9. Identify the many problems related to unhealthy eating and inactivity.
10. Describe various unsafe and safe weight-loss methods.
11. Describe signs, triggers, and risks of eating disorders.
12. Discuss the epidemic of diabetes. Describe signs and symptoms of diabetes and differentiate between type 1 and type 2 diabetes.
13. Explain the connection between diet and coronary heart disease, cancer, osteoporosis, and dental decay.
14. Summarize the elements of a supportive school environment for promoting healthy eating and physical activity.
15. Identify ways school personnel can collaborate for enhancing good nutrition and fitness education.
16. Give examples of parental and community involvement in promoting healthy eating and physical activity.
17. Summarize the aims and methods for effectively teaching good nutrition and physical activity.
18. Reproduce the MyPyramid and indicate the daily amount of food from each food group a person consuming 2,000 calories a day should eat.
19. Discuss the goals, needs, and guidelines for physical fitness curricula.
20. Identify many different teaching resources and activities that can help you teach to the recommended HECAT guidelines for healthy eating and physical activity.

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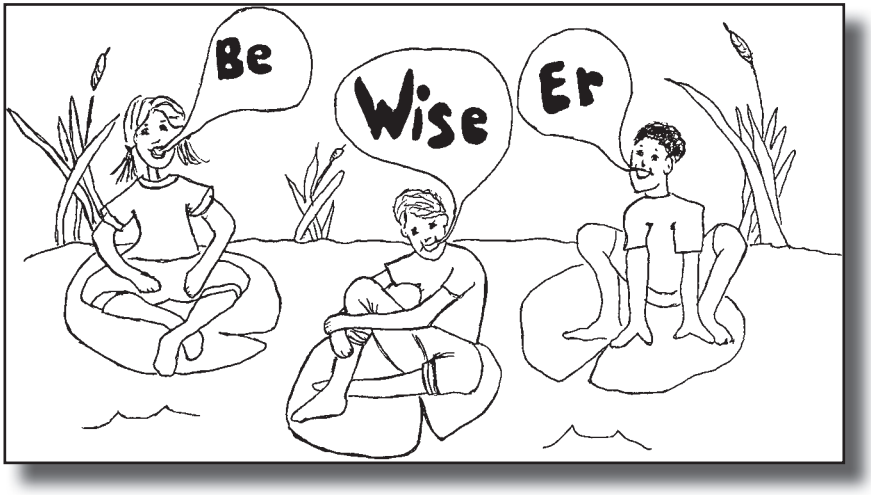
7

Promoting a Tobacco-Free and Drug-Free Lifestyle



Once Upon a Time . . . My Story

The following was turned in by a university student in a personal health class. The assignment was to write a short story about a family suffering from alcoholism.

Once upon a time there lived a family of six—a mom, an alcoholic (Dad), and four children. The mother was kind of crazy trying to keep up with her alcoholic husband. She loved him, so in her eyes she had to drink along with him to prove her love to him.

Out of the four kids there was only one family hero. She was 16 at the time, but she had to grow up a lot faster than she ever expected. She took care of the two younger children and covered up the alcoholic's mistakes constantly. She took care of everything because she had to become the mother and father and still keep up with her own life.

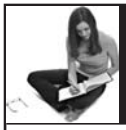
The other two girls in the family were labeled between a scapegoat and the family mascot or clown. They were the reason the alcoholic dad lost four jobs and was drinking his life away. Yet, at times they brought relief to the family due to their humor.

The youngest child was the lost child of the family. He fit all the classic characteristics of a lost child. He died at age 15 due to someone choosing a life in the bottle over his family.

This is a true story. It's my story.

Alcohol and other drugs are facts of life in most communities. The use of psychoactive substances by children and adolescents is a national problem that demands the attention of all professionals who work with young people. (Do the Application Exercise in **Box 7-1** to assess how substance abuse "costs" you.) Substance use poses many problems for young people. Youthful substance users are vulnerable to life-threatening accidents and injuries. Substance abuse is the major cause for most of the premature life lost and morbidity seen in adolescents in the United States and many other nations as well. The Centers for Disease Control and Prevention (CDC) reports that three quarters of unintentional injuries (the leading cause of death in adolescents) among adolescents are directly or indirectly related to substance abuse.

Substance users are often impulsive and engage in risk-taking behavior and illegal activity that increases risk of injury and serious medical consequences. Young people who use drugs often expose themselves to sexually transmitted diseases, including HIV infection. The effects of psychoactive drugs erode emotional, social, and cognitive development in youth, making it difficult to face developmental challenges during adolescence and in later stages of life. Involvement with substances interferes with school achievement and contrib-



7–1
Application Exercise

Personal Cost Analysis

Try to determine what tobacco, alcohol, and other drug abuse costs you (even if you don't use these products) by answering these questions.

1. Who do I know has been harmed by tobacco (first or second hand)? How much does my (or others') tobacco habit cost annually (purchases, additional insurance premiums, dry cleaning, health care)? How much of my medical and insurance costs are assessed to cover others' tobacco use?
2. Who do I know has been harmed by alcohol? How has my or others' alcohol consumption affected my relationships, attitudes, and productivity? How much does my (or others') alcohol consumption cost annually (purchase prices, lost days of work, increased auto insurance, repair costs)?
3. Who do I know has been harmed by prescription or other drug abuse? How has drug abuse affected my home, work, and community? How much does my (or others') drug abuse cost annually (purchase prices, accidents, lost productivity, legal fees, medical fees)?

utes to school dropout and truancy. School systems are adversely affected by substance use. Students under the influence of psychoactive substances cannot learn, and teachers cannot teach such students. Substance-using students alter the learning environment for everyone in a school.

Compared with non-substance-using youths, teenage substance users:

- Have a greater chance of getting into trouble with parents, friends, and teachers
- Have a greater chance of engaging in problematic behavior, such as truancy, vandalism, petty theft, and property damage
- Have a greater chance of not learning many of the emotional and social skills necessary for a safe and productive life
- Have a greater chance of causing an accident or injury to themselves or others
- Have a greater chance of engaging in sexual behavior that can put them at risk of unintended pregnancy and sexually transmitted diseases
- Have a greater chance of progressing to heavy use and drug dependency

Monitoring Substance Use Trends

Three major national surveys provide data on substance use among youths. Websites make the data from these surveys readily available and allow you to follow trends in substance use. There are some limitations to the data available. It takes a great deal of time to collect and analyze the information and the data are usually one to two years old by the time they are available. Another limitation is that the data does not represent every young person. For instance, those who have dropped out and students not in school the day a survey is conducted will not be represented in the data set. Even with these limitations, you can learn a great deal by monitoring substance use trends.

The **Monitoring the Future (MTF)** study is an annual survey funded by the National Institute on Drug Abuse that measures the extent of drug use among high school seniors, tenth graders, and eighth graders. The goal of the survey is to collect data on 30-day, annual, and lifetime drug use among students in these grade levels. This survey has been conducted every year since 1974. The MTF website is http://monitoringthefuture.org.

The **National Survey on Drug Use and Health (NSDUH)**, sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), is the primary source of statistical information on illicit drug use in the U.S. population aged 12 years and older. Formerly known as the National Household Survey on Drug Abuse, the survey collects data in household interviews, currently using computer-assisted self-administration for drug-related items. The data from this survey are available at https://nsduhweb.rti.org.

The **Youth Risk Behavior Survey (YRBS)**, part of the U.S. Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System, is a school survey that collects data from students in grades 9 through 12. The survey includes questions on a wide variety of health-related risk behaviors, including tobacco, alcohol, and other drug use. The YRBS website is at http://www.cdc.gov/HealthyYouth/yrbs.

The following key summary findings from the 2008 MTF study illustrate drug use trends and the type of data available to you on these websites:[1]

- *Alcohol.* Alcohol use remains extremely widespread among today's teenagers. Nearly three quarters of students (72%) have consumed alcohol (more than just a few sips) by the end of high school, and about two fifths (39%) have done so by eighth grade. In fact, more than half (55%) of twelfth graders and nearly a fifth (18%) of eighth graders in 2008 report having been drunk at least once in their life. There was a modest increase in binge drinking (defined as having five or more drinks in a row at least once in the past 2 weeks) in the early and mid-1990s. Fortunately, binge drinking rates leveled off 7 to 10 years ago, and in 2002 a drop in drinking and drunkenness began to appear in all grades. Gradual declines have continued in the years since. The longer-term trend data available for twelfth graders show that alcohol usage rates, and binge drinking in particular, are now substantially below peak levels in the early 1980s.

- *Cigarettes.* Nearly half (45%) of American young people have tried cigarettes by twelfth grade, and 1 out of 5 (20%) twelfth graders are current smokers. Even as early as eighth grade, 1 in 5 (21%) have tried cigarettes, and 1 in 15 (7%) has already become a current smoker. Fortunately, there has been some real improvement in these smoking statistics over the last 11 to 12 years, following a dramatic increase earlier in the 1990s. Some of that improvement was simply regaining lost ground, but by 2008, cigarette use reached the lowest levels recorded in the life of the study, going back 33 years in the case of twelfth graders. It is particularly encouraging that, after seeming to end a couple of years ago, the decline in use is now continuing.

- *Smokeless tobacco.* Smokeless tobacco use had also been in decline continuing into the early 2000s, but the decline appears to have ended in all grades. The 30-day prevalence rates for smokeless tobacco are now just under 10% for males, down by about half from peak levels.

- *Psychotherapeutic drugs.* Psychotherapeutic drugs now make up a larger part of the nation's overall drug problem. It seems likely that young people are less concerned about the dangers of using these drugs outside of a medical regimen because they are widely used for legitimate purposes. (The low levels of perceived risk for sedatives and amphetamines observed among twelfth graders illustrates this point.) Also, prescription psychotherapeutic drugs are now being advertised directly to the consumer, which implies both that they are in widespread use and that they can be used with low risk.

- *Illicit drugs.* Today, nearly half (47%) have tried an illicit drug by the time they finish high school. If inhalant use is included in the definition of illicit drug use, more than a quarter (28%) have done so as early as eighth grade—when most students are only 13 or 14 years old. One in four (25%) have used some illicit drug other than marijuana by the end of twelfth grade, and 18% of all twelfth graders reported doing so during the 12 months prior to the survey. Various stimulant drugs (amphetamines, Ritalin [methylphenidate], methamphetamine, crystal methamphetamine) have experienced a continued gradual downward trend in use while most illicit drug use trends hold steady.

- *Marijuana.* Marijuana use steadily climbed in the 1990s, and usage peaked in 1999 when nearly 27% of students reported smoking it in the preceding month. Between 2000 and 2005, marijuana use dropped and has now leveled off with nearly 20% of high school youths reporting using it one or more times during the month preceding the survey.

- *Population density*. Crack and heroin use generally have not been concentrated in urban areas, as is commonly believed, meaning that no parents should assume that their children are immune to drug threats simply because they do not live in a city.

- *Socioeconomic level*. In the lower grades, drug use has declined faster among students from more educated families. Rates of binge drinking are roughly equivalent across the social classes in the upper grades.
- *Race/ethnicity*. Among the most dramatic and interesting subgroup differences are those found among the three largest racial/ethnic groups—whites, African Americans, and Hispanics. Contrary to popular assumption, African American students have substantially lower rates of use of most licit and illicit drugs than do whites. These include any illicit drug, alcohol, and cigarettes. In fact, African Americans' use of cigarettes has historically been dramatically lower than whites' use. Hispanic students have rates of use that tend to fall between the other two groups. Hispanics do have the highest reported rates of use for some drugs in twelfth grade—crack, heroin taken with a needle, and crystal methamphetamine. In eighth grade, they tend to come out highest of the three racial/ethnic groups on nearly all classes of drugs (amphetamines being the major exception). One possible explanation for this change in ranking between the eighth and twelfth grades may lie in the considerably higher school dropout rates of Hispanic youths. Thus, more of the drug-prone segment of that ethnic group may leave school before twelfth grade compared to the other two racial/ethnic groups. Another explanation could be that Hispanics are more precocious in their initiation of these types of behaviors.

It is very important that, despite the considerable progress made in the past decade, educators, parents, and the entire nation not be lulled into complacency. To some degree this happened in the early 1990s, after the considerable improvements of the 1980s. In the 1990s, attention to the problem of drug use nearly disappeared from national news coverage, and many governmental and nongovernmental institutions withdrew attention and programmatic support, which likely helped to set the stage for the costly relapse in the drug epidemic of the 1990s.

Media Promotion of Alcohol and Tobacco Use

Alcohol and tobacco companies spend billions of dollars each year promoting their products through advertisements and other means. These industries proclaim that they do not target children and adolescents and that they are not in the business of recruiting new users. In your mind, do the following facts refute or support this claim?

- Beer and tobacco companies need young consumers because they would suffer enormous financial losses if underage drinking and tobacco use stopped. Between 2001 and 2007, youths ages 12 to 20 were 22 times more likely to see an alcohol product advertisement than an alcohol industry–funded "responsibility" advertisement. The alcohol industry does not really want everyone to drink "responsibly" because if a magic wand could cure alcoholism, the alcohol industry's revenues would be cut in half.

- Youth exposure to alcohol advertising on television has risen by 38% since 2001. More than 40% of this exposure comes from ads placed on youth-oriented programming, that is, programs with disproportionately large audiences of 12- to 20-year-olds. Almost two thirds of these placements were on cable television, 53% were for beer, and 41% were for distilled spirits.[2]
- Beer and liquor companies deliberately target young people through sponsoring "extreme" sporting events such as snowboarding, mountain biking, and inline skating that especially appeal to youths and in which many of the contestants are teenagers. These companies also sell related sports paraphernalia with beer company brand logos. In one snowboarding competition, contestants wore Captain Morgan bibs until a parent complained.[3] One third of teenagers own tobacco-brand promotional items sporting tobacco company logos, such as T-shirts, backpacks, hats, and CD players.
- Alcohol and tobacco companies design Internet websites that are particularly attractive to underage audiences, featuring popular music, games, contests, animations, and downloads.
- Nearly 90% of teen smokers smoke one of the three most heavily advertised brands of cigarettes: Marlboro, Camel, and Newport.
- Tobacco companies have developed and marketed "starter products" that have special appeal to youths, such as smokeless tobacco products with cherry flavoring.

Our "ad-environment" is full of alcohol messages designed for children and adolescents to see.

These points highlight the fact that the alcohol and tobacco industries do target kids and use the media as a major tool to do so. One of their main tactics is to make it look like "everyone is doing it." They pay TV and movie producers large sums of money to have actors hold, talk about, and consume their products on screen. New research shows that witnessing smoking scenes in movies may be the leading cause of smoking among teenagers. In addition, there is abundant research that attests to the impact of alcohol and cigarette advertising on teenagers' use of those products.[3]

Advertisements and product placements for alcohol and tobacco often use the following appeals: happiness, maturity, sex appeal, healthy athletic appearance, slim body, freedom, social acceptance, romance, and escape. What is interesting is that these products actually promote the exact opposite. Advertisers know this, so they sell a lie. Another disturbing practice is to use humor to depict behaviors associated with alcoholism (e.g., lying, stealing, hiding, hitting, having alcohol as more important than family relationships). We laugh and without conscious thought take in the message that hitting someone is OK, normal, even "cool." One commercial can seem funny, but looking at the progression of ads by Budweiser, for instance, reveals the real intent of the alcohol company to normalize alcoholic behavior.

The Philip Morris Company, maker of Marlboro cigarettes, created the "Youth Smoking Prevention Program" media campaign in 1998 to counter the fervor of accusations that they were trying to target young people in their advertisements. This program used the slogan "Think. Don't Smoke." A study in the *American Journal of Public Health* concluded that youths exposed to the "Think. Don't Smoke" advertisements were actually more open to the idea of smoking.[4] They were less likely to deny that cigarettes cause harmful diseases and to say that they want cigarette companies to go out of business in the future. They were more likely to say that they would smoke in the future. Now Philip Morris has television spots that urge parents to warn their children against smoking. It appears these advertisements are also a sham. Research shows that increased exposure by teenagers to these ads is correlated with stronger intention to smoke.[5]

The same year that Phillip Morris began the "Think. Don't Smoke" campaign, the American Legacy Foundation began its very successful "truth" ad campaign. The first truth ads included media images of young people placing 1,200 body bags at the door of a cigarette company office building and cowboys leading horses with body bags over the saddle. Teenagers exposed to the "truth" counter marketing ads showed an increase in antitobacco attitudes and beliefs. It is not surprising that the American Legacy ads were more effective tobacco prevention tools than the Philip Morris campaign. The "Think. Don't Smoke" ads were very careful not to make the connection between cigarettes and death or to point out the devious tactics of the cigarette companies in marketing a lethal, deadly product to young people. The truth ad campaign illustrates how the media can be an effective tool for smoking prevention when hard-hitting, truthful messages are aired.

Another media vehicle for promoting alcohol and tobacco is movies. Many popular movies show likeable and charismatic characters using and enjoying tobacco and alcohol products. Movie scenes showing stars using alcohol, cigarettes, or cigars are in many ways an advertisement for one of these addictive products. Young people are susceptible to this influence. Studies show that kids who see stars smoking in films are more likely to start smoking and have higher receptivity to the idea of smoking.[6,7] This is particularly concerning given the fact that adolescents are three times more likely to go to the movies than adults are.

During the 1990s, there was a marked increase in smoking in movies. Cigarette smoking has become so pervasive in movies that the vast majority of popular films in the last decade show people smoking. According to the Smoke Free Movies website (http://www.smokefreemovies.ucsf.edu), of America's 25 top-grossing movies each year, 9 in 10 dramatize use of tobacco. More than 1 in 4 depicts a particular brand of cigarettes. Eighty percent of the time, the featured brands are the same ones most heavily advertised in other media (e.g., billboards, magazines). Marlboro cigarettes have been featured in at least 28 of Hollywood's top-grossing movies in the past decade.

Smokers are frequently lead characters in movies and are usually likeable, rebellious, attractive, and successful. Women are often displayed smoking to convey sex appeal, power, emotional control, and body-image control. Males smoke to portray masculinity, power, prestige, authority, and male bonding.[8] To see a list of current movies that contain smoking, visit http://www.scenesmoking.org.

Television is another medium that routinely portrays the use of alcohol and tobacco in the programs shown. Seven of 10 prime-time TV programs have scenes of alcohol use, averaging 3.5 scenes an hour, and the music videos most popular with teens show 4.2 drinking episodes per hour.[9] Television shows also frequently feature smoking at high levels. And, of course, most movies eventually show up on cable and network television so that young people view thousands of media depictions of alcohol and tobacco use in their own homes and, increasingly, on their own bedroom TV sets.

The surgeon general in 2007 in a "Call to Action to Prevent and Reduce Underage Drinking" stated that the alcohol industry has a public responsibility relating to the marketing of its product because its use is illegal for more than 80 million underage Americans. That responsibility can be fulfilled through products and advertising design and placement that meet the following criteria:[10(pp.43–44)]

- The message adolescents receive through the billions of dollars spent on industry advertising and responsibility campaigns does not portray alcohol as an appropriate rite of passage from childhood to adulthood or as an essential element in achieving popularity, social success, or a fulfilling life.
- The placement of alcohol advertising, promotions, and other means of marketing do not disproportionately expose youths to messages about alcohol.

- ❖ No alcohol product is designed or advertised to disproportionately appeal to youths or to influence youths by sending the message that its consumption is an appropriate way for minors to learn to drink or that any form of alcohol is acceptable for drinking by those under the age of 21.
- ❖ The content and design of industry websites and Internet alcohol advertising do not especially attract or appeal to adolescents or others under the legal drinking age.

The surgeon general also said that the entertainment and media industries have a responsibility to the public in the way they choose to depict alcohol use, especially by those under the age of 21, in motion pictures, television programming, music, and video games. That responsibility can be fulfilled by creating and distributing entertainment that follows these guidelines:[10(pp.44–45)]

- ❖ Does not glamorize underage alcohol use.
- ❖ Does not present any form of underage drinking in a favorable light, especially when entertainment products are targeted toward underage audiences or likely to be viewed or heard by them.
- ❖ Seeks to present a balanced portrayal of alcohol use, including its attendant risks.
- ❖ Avoids gratuitous portrayals of alcohol use in motion pictures and television shows that target children as a major audience. This is important because children's expectations toward alcohol and its use are, in part, based on what they see on the screen.

In **Box 7-2**, you can find teaching activity ideas for helping your students learn how to analyze media messages about tobacco and alcohol.

7-2
In the Classroom

Assessment and Learning Activities for Analyzing Drug Media Messages

The following are teaching activity ideas that you can adapt for assessment in many grade levels (indicated as in previous chapters). Be sure also to consider the skills and activities in Chapter 5, Media Literacy Skills, when analyzing influences on tobacco, alcohol, and drug use.

(*continues*)

TV Observation

Assign students to count the number of alcoholic beverages consumed by television characters during a certain time period. (P, I, J, H)

Picture That

Have students draw pictures or play charades that depict the reasons why people use drugs. Discuss alternatives for reducing stress, gaining confidence, having fun, fitting in, becoming relaxed, and so on.

TRUTH

Have students check out the antitobacco clips at http://www.thetruth.com and make a list of the reasons why people smoke.

Take a Survey

Get permission from school administrators, and then conduct a schoolwide survey on tobacco, alcohol, and drug consumption. Have students compare your data with national and individual state data at http://apps.nccd.cdc.gov/yrbss. Discuss overestimations and normative perceptions.

Anti Posters

Have students design and make antitobacco, antidrug, or underage drinking posters. Encourage parental involvement. Posters could illustrate short-term or long-term harmful effects and be a spoof on a real ad. Hang the posters around the school and have all students vote on their favorites. Award the creators of the top three posters. (P, I, J, H)

Ad Deconstruction

Have students deconstruct tobacco and alcohol ads they view on TV, in magazines, or on billboards. For each ad, have students identify: (1) who the target audience is; (2) what the "hooks" are (techniques used to get attention and create appeal; (3) what emotional associations are made (happiness, maturity, sex, body image, success, security, independence, power, adventure, escape, romance, love and belonging, etc.); (4) what messages are conveyed overtly and subtly; (5) the types of models or actors used and why they were selected; (6) the behaviors the ad tries to create or shape; (7) important facts that were omitted; (8) the estimated number of people the ad reached and an estimate of the average number of expo-

(*continues*)

(*continued*)

sures per person (frequency); (9) minute details that were choreographed into the ad showing that a great deal of time and money went into the ad's construction. (I, J, H)

Commercial Creation

Review common advertising appeals and have students use these strategies to write commercials against tobacco, alcohol, and other drug use. (P, I, J, H)

Substance Abuse Prevention Education

Next to the family, schools are the primary societal institution serving young people, so it is vital that schools assume some responsibility for substance abuse prevention. Substance abuse interferes with school goals by disrupting the educational process. Schools employ personnel who have the necessary skills to plan and implement programs to prevent substance abuse. Schools also provide important access to youths.

At the same time, substance abuse is a family and community problem; therefore, it is unrealistic to expect the schools alone to solve drug abuse problems. The responsibility for the well-being of children and for assisting in substance abuse prevention is shared by all individuals and institutions affected by substance abuse: parents, students, school staff, communities, professional organizations, colleges, businesses, policymakers, the media, social services, health care professionals, and mental health agencies. Effective prevention programs evolve only with the collaboration of these groups in developing coordinated and comprehensive efforts.

Information-Based Strategies

Most substance abuse education programs in the 1960s and 1970s relied solely on information about the legal and medical consequences of drug use as a prevention strategy. These programs often used scare tactics in an effort to change attitudes and behavior regarding substance use and abuse. It was common for drug prevention programs to invite into the classroom local police to tell stories about drug abusers and the troubles that drug abuse made in their lives. Police officers would place emphasis upon showing young people what drugs looked like and maybe even demonstrating what burning marijuana smelled like. The rationale was that children would then know what to avoid. Another common strategy for schools was to invite former addicts to explain to children how easy it is to get hooked on drugs and the horrible life that results from addiction.

Scary antidrug films were also shown to young people to scare them away from using drugs. Scare tactics and testimonials are not the most effective means of changing attitudes and behaviors. Listeners tend to quickly forget negative information and often disregard warnings as "that doesn't apply to me" or "they're just trying to scare me."

Information-only-based strategies assume that if students understand that drugs are harmful, they would avoid experimentation and drug use. Information-only approaches are ineffective because information is only one of the many factors that govern an individual's decision to use or not use substances. However, sound information about drugs and their effects and consequences is fundamental to substance abuse prevention efforts. Information provides the foundation for effective substance prevention programs.

Information about how specific substances produce immediate effects (e.g., yellow stains on teeth, bad breath from cigarette smoking) is more effective than information about the possible long-term consequences (e.g., lung cancer, emphysema). Regardless of the focus or strategy of a program, any information presented in a substance abuse prevention program must be accurate.

Normative Education

It is typical for young people to overestimate the prevalence of tobacco, alcohol, and other drug use among their peers. Consequently, a critical component of a substance abuse prevention program should be clearing up misconceptions often portrayed in the media about "everybody is drinking, smoking, or doing drugs." This approach is sometimes referred to as **normative education**. Students gain more accurate perceptions when they are provided with information concerning drug use prevalence rates among their peers from national and local surveys. This information is then compared with their own estimates of drug use. Misconceptions can also be cleared up when students organize and conduct surveys of drug use in their school and community. Research shows that normative education, which posits that drug use is not the norm, is an effective strategy in lowering substance abuse behavior.[11] This research also showed refusal skills and enhancing competence in personal and social skills to be effective strategies in reducing drug use among youths.

Resistance Strategies

Peer group acceptance and identification are major concerns of young people. Peer pressure to use various substances or engage in other health-risky behavior can be great for many young people. Therefore, teaching upper-elementary-specific, middle-school-specific, and high-school-specific skills to resist peer pressure may be effective in deterring substance use and abuse. A typical refusal skills technique includes a film or video depicting the various social pressures students are likely to encounter from peers, media, and others. After "inoculation," or exposure to these anticipated pressures ("germs"), students brainstorm and discuss possible refusals to the pressures. Role-play is then used to practice

and rehearse these skills. These skills can assist young people not only to refuse pressure from peers and others, but also to resist the persuasive influence of advertising. Students are then better able to recognize the appeals in ads and formulate counterarguments to them.

Personal and Social Skills Training and Enhancement Approaches

Educators must realize that youths do not begin to use substances simply because they lack knowledge about drugs and their consequences. Rather, several cognitive, affective, and environmental factors influence substance use and abuse. In addition to peer and media pressure, factors such as poor self-concept, anxiety, low social confidence, external locus of control, impulsivity, and low assertiveness increase the risk of substance use. The recognition that problem behaviors, including substance abuse, result from an interplay of these personal and social factors has led to the development of effective prevention programs such as the Life Skills Training program. The program deals directly with the interpersonal and social factors that promote drug use by teaching general self-management and social competence skills. The Life Skills Training program includes teaching the following:[12]

- General problem-solving and decision-making skills
- Critical thinking skills for resisting peer and media influences
- Skills for increasing self-control and self-esteem (e.g., self-appraisal, goal setting, self-monitoring, self-reinforcement)
- Adaptive coping strategies for relieving stress and anxiety through the use of cognitive coping skills or behavioral relaxation techniques
- Skills for communicating effectively (e.g., how to avoid misunderstandings by being specific, paraphrasing, asking clarifying questions)
- Skills for overcoming shyness
- Skills for meeting new people and developing healthy friendships
- Conversational skills
- Complimenting skills
- General assertiveness skills

Skills training requires instruction, demonstration, feedback, and reinforcement. Adequate classroom time must be devoted to practicing the skills (behavioral rehearsal) as well as to extended practice outside of class through behavioral homework assignments. The Life Skills Training program has been shown effectively to reduce drug use behavior, particularly when the training is followed by booster sessions to reinforce retention of personal and social skills. In **Box 7-3**, you can find chapter numbers and page numbers for where to find information and teaching activities on social skills for reducing drug use behavior.

7-3
In the Classroom

Social Skills Teaching Activities

You can access teaching activities in the designated chapters (and pages) that build social skills needed for living a drug-free lifestyle.

Problem Solving and Decision Making	Chapter 3	Pages 104–112
Self-Control and Goal Setting	Chapter 3	Pages 93–104
Coping and Relaxation	Chapter 4	Pages 141–153
Communication and Relationship Building	Chapter 3	Pages 79–93

Peer Approaches

Many youth substance abuse prevention programs utilize exemplary peer leaders. The rationale for using peer leaders is that they often have higher credibility with young people than do teachers or other adults. Peer leaders may lead discussions in classroom or group settings or serve as facilitators of skills training by demonstrating skills taught in prevention programs (e.g., refusal skills). Peer leaders also serve as role models who do not use drugs. Peer leaders can be about the same age as prevention program participants or may be older students who work with younger students. **Peer tutors** are usually older students who teach younger students about drugs and how to resist pressures to use them.

Peer counselors are exemplary students who have received specific training in how to listen, avoid making judgments, maintain confidentiality, and be supportive of others. Peer counselors make themselves available to their peers who need to discuss problems, and then refer students with serious problems to an appropriate professional or school staff member.

Some advocate peer-led programs are more effective in preventing and reducing high-risk behavior than teacher-led programs are. This may be explained by the fact that peers have more social information than teachers and other adults do. Further, modeling appropriate behaviors outside of school, where youths use substances, may explain the effectiveness of peer-led programs. To ensure successful implementation of peer approaches, it is imperative that school administrators and personnel provide extensive support, guidance, and training.

Drug-Free Activities and Alternatives to Drugs

We can assume that some children and adolescents take drugs to achieve an altered state of consciousness. As a result, some substance abuse prevention programs teach and/or provide youths with opportunities to achieve "natural

highs" or altered states of consciousness through drug-free activities. Stimulating, relaxing, creative, or growth-enhancing activities such as meditation, exercise, sports, or performing arts are used as alternatives to drugs (see **Box 7-4**). Service projects in which youths volunteer to assist people in need also serve as alternatives to substance abuse activities.

7-4
In the Classroom

Drug-Free Healthy-High Teaching Activities

Delicious Drink Recipes

Have students collect recipes for nonalcoholic beverages. Prepare and try some of the recipes in class. (I, J, H)

Quick and Easy Ideas

Have students brainstorm and discuss ideas for things bored kids could do that are quick and easy. Offer prizes for suggestions such as the most creative, most fun, most likely to be done. Here are some ideas to get the activity started: buy a cheap model at the store and put it together; eat cornflakes by candlelight; watch TV without the sound on and figure out the plot and supply your own dialogue; bake cookies, bread, or some other item. (I, J, H)

Outdoor Activities

In groups, have students compete to see who can come up with the most ideas for outdoor drug-free fun. After giving them time, have groups take turns writing their ideas on the board. These are some ideas you might want to contribute: create a treasure hunt for teams or each other; make and fly kites; create sidewalk chalk drawings; slide down a grassy slope on a block of ice; slide down a mowed hay hill on cardboard; do gravestone rubbing by placing a plank piece of paper on an illegible headstone and rub chalk over the paper until you can read it; play Frisbee football or golf; climb trees at the park; play water-balloon volleyball or baseball. (I, J, H)

Service Ideas

Review with students the following service ideas and ask students to make their own suggestions. Challenge students to act on one of the ideas within the following

(*continues*)

week and provide incentive for doing so: plan a date for other couples and then be their chauffeurs, chefs, waiters, and so forth; have a candlelit dinner ready for someone at a park, hilltop, or elsewhere; bake cookies for someone who could use a tender touch—a crabby neighbor, a shut-in, someone feeling low; read stories to children in the hospital or elsewhere; take flowers or goodies to new mothers at the hospital; baby-sit for a young married couple so that they can go out on a date. (I, J, H)

Get a Little Crazy

Ask for student volunteers to do the following activities over a weekend, week, or month. Have students report on how it went and any suggestions they have for improving the activity. Emphasize how much fun kids can have without alcohol or drugs. Here are some ideas: have a Christmas party in July; have a marathon dinner; have a three-armed dinner (pairs tie one of their arms together and then make some part of the dinner—dessert, salad, main course); visit travel agencies and pretend you are planning a trip (compete to see who can come up with the best vacation for a predetermined time and budget, and then get together over treats to determine who won); pretend to be tourists and do local sight-seeing and take pictures or videos; have a hairdo party where the boys do the girls' hair (have an awards ceremony and don't forget to videotape); play hide-and-seek at the mall; build sand castles (get sand at a cement company and put it into wading pools); take lawn chairs to the side of the road and hold up cards with numbers 1–10 to rate the cars going by; go on a "sound" scavenger hunt. (I, J, H)

Student Assistance Programs

These programs, modeled after employee assistance programs in business and industry, provide professional counseling to students at risk for substance abuse or other problems. In addition, these programs can provide intervention for students already abusing substances and can refer students and their families to outside agencies and professionals. Student assistance programs are partnerships among people inside and outside of schools (e.g., substance abuse and mental health treatment professionals, businesses, law enforcement personnel) and can serve communities in the following ways:

- Provide substance abuse education to teachers, students, and parents
- Help identify youths with problems Accept self-referral of students and referral by teachers, parents, and peers of youths needing evaluation and/or services

- ❖ Help students and families find and use community resources
- ❖ Conduct discussion groups to allow youths troubled by substance abuse (or other problems) to talk about their concerns
- ❖ Conduct reentry groups for students returning to school after receiving treatment for substance abuse

Parent Approaches

A variety of parent approaches has been used in substance abuse prevention programs. Information programs strive to give parents basic information about drugs and the impact they have on health and society. Programs on parenting skills assist parents in learning and developing personal and interpersonal skills that may serve to prevent drug abuse in the family. For example, parents refine skills in communicating with children, decision making, setting goals and limits, and even how and when to say no to their children. These important skills can improve weak family relationships and poor family communication, which are often found in families where youths use drugs.

Parent support groups help parents to cope with drug problems in their homes and neighborhoods. Parents meet to gain mutual support by discussing problem solving, communication skills, parenting and child-management skills/

A simple recipe for raising substance-free children: frequent family dinners. Children who eat with their families are less likely to smoke, drink, or use drugs.

strategies, and ways to take action against drug problems. These groups often provide supervision for young people's activities that are free of alcohol and other drugs.

Some of the most promising drug prevention programs are those in which parents, students, schools, and communities join together to send a firm, clear message that the use of alcohol and other drugs will not be tolerated. Parents should be encouraged to visit their children's school and learn how substance abuse education is being taught. Parents can evaluate substance abuse education programs by asking questions: Are the faculty members trained to teach about alcohol and other drug use? Is drug education a regular part of the curriculum or limited to a special week? Is it taught through the health class, or do all teachers incorporate drug education into their subject area? Do children in every grade receive drug education, or is it limited to selected grades? Is there a component for parents? Do drug education materials contain a clear message that alcohol and other drug use is wrong and harmful? Is the information accurate and up-to-date? Does the school have referral sources for students who need special help?

Parents can help their children to remain drug free by supporting community efforts to give young people healthy alternatives. Alcohol- and drug-free proms and other school-based celebrations are growing in popularity around the country. Parents can help to organize such events, solicit contributions, and serve as chaperones.

School-Based Programs That Work

The drug education that students receive in schools varies considerably from school district to school district. Drug education is sometimes delivered as early as kindergarten; in other districts, it may not be delivered until late elementary, middle school, or junior high. Sometimes drug education is designed to stand alone as a course, whereas sometimes it is integrated into a health education, family life, or life skills course. It may be taught by a school's own teachers or may be taught by outside personnel (e.g., police officers). Some school districts purchase drug education curricula from commercial vendors. Others develop their own curricula and materials.

The most widely used drug education program is Drug Abuse Resistance Education (DARE). DARE began in 1983 in Los Angeles and is found today in more than three quarters of all school districts in the United States. The program is taught by police officers to students mainly in fifth or sixth grade. The effectiveness of this program was challenged by a study in the *Journal of Consulting and Clinical Psychology* showing that DARE did not affect adolescents' rate of experimentation with drugs.[13] The authors of this study suggested that one reason DARE may not have been effective was because it emphasized the role of peer pressure in drug use. Many young people may be motivated to use drugs by other factors, such as curiosity or thrill seeking. Also, DARE may teach

children drug resistance skills years before they need them. DARE has been criticized for asserting that drug abuse is more prevalent or normal than it is in reality. As a result of studies showing the ineffectiveness of DARE, many dropped the program. Since then, changes have been made to the DARE curriculum to reach older grades, to have less reliance on lecturing to students and more emphasis on discussion within groups, and to include the message that not everyone uses drugs.

Only a handful of school drug prevention programs have been subjected to rigorous scientific evaluation and meet high standards for effectiveness. These programs are highlighted and described on the Web at http://www.preventionnet.com. The second edition of the National Institute on Drug Abuse publication *Preventing Drug Use Among Children and Adolescents: A Research-Based Guide*[14] identifies what research has found to be the principles of effective substance abuse prevention. These principles state that prevention programs should have the following characteristics:

- ❖ Enhance protective factors and move toward reversing or reducing known risk factors.
- ❖ Target all forms of drug abuse.
- ❖ Include skills to resist drugs when offered, strengthen personal commitments against drug use, and increase social competency (e.g., in communications, peer relationships, self-efficacy, assertiveness).
- ❖ Include interactive methods, such as peer discussion groups, rather than didactic teaching techniques alone.
- ❖ Be family-focused prevention and include a component for parents or caregivers that reinforces what the children are learning.
- ❖ Be long term, over the school career, with repeat interventions to reinforce the original prevention goals.
- ❖ Reach all youth populations and specific subpopulations at risk for drug abuse, such as children with behavior problems or learning disabilities, and those who are potential dropouts.
- ❖ Be adapted to address the specific nature of the drug abuse problem in the local community. The higher the level of risk of the target population, the more intensive the prevention effort must be and the earlier it must begin.
- ❖ Be age-specific, developmentally appropriate, and culturally sensitive.

Substance Abuse Prevention Curricula

Substance abuse curricula must present a clear and consistent message that the use of alcohol, tobacco, and other illicit drugs is unhealthy and harmful. Curricula should be designed to promote healthy, safe, and responsible attitudes and

behavior. It is critical that curricula be sensitive to the specific needs of the local school and community in terms of cultural appropriateness and local substance abuse problems. Developmental considerations should also be carefully taken into account when designing and organizing substance abuse curricula. **Box 7-5** contains the HECAT Recommendations for Promoting a Tobacco-Free and Drug-Free Lifestyle. **Box 7-6** identifies where you can find free lesson plans and materials for teaching drug prevention.

7-5
Background on . . .

HECAT Recommendations for Promoting a Tobacco-Free and Drug-Free Lifestyle

HECAT is a curriculum analysis tool. It helps teachers, school districts, and states review their curricula to see whether they meet National Health Education Standards and the CDC's Characteristics of Effective Health Education Curricula. You can access HECAT at http://www.cdc.gov/healthyyouth/HECAT. Following are overview guidelines. You can find specific and more detailed grade-level recommendations (by grade 2, 5, and 8) for promoting a tobacco-free and other drug-free lifestyle at the website.

A pre-K–12 tobacco-free curriculum should enable students to:

- Avoid using (or experimenting with) any form of tobacco.
- Avoid second-hand smoke.
- Support others to be tobacco free, including supporting a tobacco-free environment.
- Seek help for stopping the use of tobacco for self and others.
- Quit using tobacco if already using.

A pre-K–12 alcohol and other drug-free curriculum should enable students to:

- Use over-the-counter and prescription drugs properly and safely.
- Avoid experimentation with alcohol and other drugs.
- Avoid the use of alcohol.
- Avoid the use of illegal drugs.
- Avoid driving while under the influence of alcohol and other drugs.
- Avoid riding in a car with a driver who is under the influence of alcohol or other drugs.
- Quit using alcohol and other drugs if already using.
- Seek help for stopping the use of alcohol and other drugs (for self and others).

7-6
In the Classroom

Free Resources for Teaching a Tobacco-Free and Drug-Free Lifestyle

You can locate lesson and curriculum plans on media and information literacy for elementary, middle, and high school levels at these websites:

- Media Literacy for Drug Prevention: A Unit for Middle School Educators: http://www.nytimes.com/learning/teachers/NIE/medialiteracy
- National Institute on Drug Abuse: http://backtoschool.drugabuse.gov/curricula.html
- Center for Substance Abuse Prevention: http://toosmarttostart.samhsa.gov/educators/teachin/Default.aspx#materials
- A to Z Teacher Stuff: http://www.atozteacherstuff.com/Lesson_Plans
- teAchnology: http://teach-nology.com/teachers/lesson_plans/health/substance
- Discovery Education: http://school.discoveryeducation.com/lessonplans/health.html#k-5
  http://school.discoveryeducation.com/lessonplans/health.html#6-8
  http://school.discoveryeducation.com/lessonplans/health.html#9-12
- Utah Education Network: http://www.uen.org/curriculumsearch/SearchResults.do;jsessionid=1181BE81F214EA1781332B2B77E35E56
- Nebraska Department of Education: http://www.nde.state.ne.us/PEHealth/conferences.html

You can find materials for teaching media and information literacy at these websites:

- The truth smoking prevention campaign: http://www.thetruth.com
  Videos, games, fact sheets, infections blog
- The American Lung Association: http://www.lungusa.org
  Multimedia library with public service announcements (PSAs), photographs, and sound bites
- Youth Risk Behavior Survey: http://apps.nccd.cdc.gov/yrbss/HealthTopic.asp
  Current statistics and fact sheets
- U.S. Drug Enforcement Administration: http://www.dea.gov/index.htm
  News releases and multimedia library with photos and videos
- National Institute on Drug Abuse (NIDA): http://backtoschool.drugabuse.gov/curricula.html
  Scholastic classroom magazine, extension activities, poster, CD-ROMs

(*continues*)

- NDIA for Teens: http://backtoschool.drugabuse.gov
  Brain games, real stories, new media, facts, teaching guides, ask Dr. NIDA
- It's My Life: http://pbskids.org/itsmylife/body/index.html
  Self-tutorial interactive information on alcohol for young people
- The Cool Spot: Peer Pressure: http://www.thecoolspot.gov
  Interactive site using superhero-looking illustrations
- The National Association for Children of Alcoholics: http://www.nacoa.net
  Children of Alcoholics: A Kit for Educators
- Center for Substance Abuse Prevention: http://toosmarttostart.samhsa.gov/educators/teachin/Default.aspx#materials
  Worksheets, puzzles, family pages, postures, media package

Developmental Considerations

Age and developmental abilities play a role in being susceptible to abusing substances and able to understand associated dangers. Educators need to consider their students' developmental levels as they prepare teaching strategies and curricula for promoting a drug-free lifestyle.

Grades K–3 The knowledge gained in grades K–3 should be the foundation for all future substance abuse prevention education. Much of the early health education experience for children should emphasize wellness. **Wellness** is an approach that stresses the positive physical, social, and emotional benefits of being healthy and acting safely. Wellness is a key concept in developing young children's determination to avoid drugs. At this age, children should also begin to develop a sense of responsibility toward themselves and others, including the responsibility to tell adults if something is wrong.

Substance abuse prevention education for this age group should discuss alcohol, tobacco, marijuana, cocaine, Ecstasy, and methamphetamine. Children should also be introduced to the dangers of inhalants because inhalant abuse may be one of the first forms of drug abuse with which children experiment. A special effort should be made to counter the myths that marijuana and other substances are not harmful. K–3 students should learn how to identify a responsible adult through homework assignments involving parents and through classroom presentations by police officers, school nurses, doctors, clergy, and human service professionals. Parents can participate in homework assignments by identifying family rules for behavior, conducting safety checks, and helping with class assignments. Having parents sign homework assignments is a good way to involve them and keep them informed of what is going on in class.

At the early elementary level, instruction may include both formal curricula and other types of classroom activity, including songs and skits and the use of

character props such as puppets, cartoon characters, and clowns. These are particularly useful for relaying messages about safety, personal health, and dangerous substances. Skits enable children to practice resistance skills by acting out scenarios in which they encounter dangerous substances or situations. Songs encapsulate important information in an easily remembered form. Some packaged curricula incorporate standardized songs and skits; teachers often enjoy creating their own.

Grades 4–6 In grades 4–6, peer influences continue to grow. Because of an expanding world of friends and experiences, older elementary school children have a particular need to deal with increased pressures. Some in this age group may experiment with tobacco, alcohol, and other drugs. Therefore, they need more information, more analysis of why people use drugs, stronger motivation to avoid drugs, and specific skills for avoiding drug use. In particular, children in the upper elementary grades need specific strategies for resisting pressures.

Curricula at these grade levels should emphasize personal safety. Children in grades 4–6 have more freedom than younger children do, may travel alone to and from school and other local destinations, and may be left alone part of the day. Personal safety lessons can include using the "buddy" system of always traveling in groups or at least in pairs, why to avoid certain routes, how to get help (such as through the local emergency telephone number), and how to answer the telephone or door.

It is important to help children understand rules and laws at this age level. They should learn about society's interest in protecting people from dangerous substances and behavior. They need to understand that they have certain rights—the right to be safe, to learn, and to say no. Along with these rights come duties and responsibilities.

Within the classroom, students in the upper elementary grades benefit from hands-on learning experiences. Students can build models to illustrate health lessons, such as showing how drugs affect the circulatory or respiratory system. Teachers can assign independent research projects that promote critical thinking about substance use. Students can prepare class projects that reflect real-life events, such as mock television interviews or press conferences. These are just a few examples of hands-on learning experiences. Can you think of others?

Middle/Junior High School (Grades 7–9) The onset of adolescence creates new challenges for substance abuse prevention. The natural desire for peer acceptance may become a significant cause of anxiety and concern for the adolescent. As a result, the influence of peer pressure to use drugs may become intense. The desire to appear mature and independent rapidly emerges during the middle/junior high school years. Access to tobacco, alcohol, and other drugs is often readily available for many in this age group. Also, changing bodies and developing minds are very vulnerable to the damaging effects of psychoactive substances.

Adolescents often possess a sense of personal invulnerability ("It can't happen to me"), together with a great insecurity about personal attractiveness

and social responsibility. For these reasons, emphasizing that alcohol, tobacco, and other drug use can immediately affect their appearance, coordination, thinking, and behavior can be an effective teaching strategy. Nothing gets the attention of junior high school students like knowing that they may look ridiculous, smell bad, not be capable of playing sports, become unattractive, or not develop physically and sexually. Suggestions that drugs can impair one's chances of getting into college and succeeding in a career begin to have a powerful impact at this age. And, particularly in view of the many other strains on today's families, young teenagers are likely to pay close attention to discussions of how drug use impairs family relationships.

Most adolescents understand that they are gradually gaining freedom; they should also understand that this means greater accountability for their actions. Accordingly, at this grade level, curricula should emphasize personal responsibility, awareness of the law, and penalties for law-breaking. As students begin dating, contemplate college and career, and anticipate a driver's license and other aspects of adulthood, the time is right for introducing training for adult responsibilities.

Because middle and junior high school students will probably be exposed to people who use drugs and who pressure them to do so, they need to be familiar with support resources. The curriculum should make students aware of what these services are and how they function. Students should learn that they are not responsible for creating or curing another's problem, but that there are responsible adults and services to which it is proper to turn to for help.

Middle and junior high school students often become involved in school-sponsored social events and activities. The organization and supervision of these activities (such as bands, athletics, clubs, and student organizations) should focus on making and keeping them drug free. Students at this age also benefit from field trips, guest presentations, and research assignments. For example, students in these grades might visit a hospital, might hear presentations from personnel working with drug addicts, and might cooperate on developing class-wide research projects involving different media.

High School (Grades 10–12) Students in these grades are beginning the transition to adulthood, and it can be a confusing time for them. Even though they are obtaining licenses to drive and preparing for work and postsecondary education, most high-schoolers are still minors under the law. Alcohol and other drugs are illegal for them. Substance abuse prevention education faces the challenge of motivating these students to continue resisting illicit substances and of helping them behave responsibly as they prepare to assume new roles in society.

Students in high school are in the process of establishing themselves in the world. Thus, it is essential that the lessons of substance abuse prevention education carry over into students' lives outside of class. Among the aspects of increasing responsibility that should be stressed are the importance of serving as positive role models for younger children, realizing one's responsibility in the

workplace, and understanding how substance abuse affects personal growth and professional success.

Some curricula use high school students as peer leaders. Peer leaders make presentations to students in lower grades and serve as "buddies" to younger children. Peer leadership can be very effective in motivating older students. However, peer leaders need close supervision and monitoring by teachers and school personnel. Student leaders should be drug free and well trained. They should be trained to refer any problems to teachers or other school officials. Properly supervised, peer leaders can help maintain communication and reduce the likelihood of tragedy during a critical period in students' lives.

Special Education Students Physically and mentally, special education students may be more susceptible to pressure to use drugs than other children are. They are vulnerable to exploitation, may have low self-esteem, and may feel an intense need for acceptance. For these reasons, they may not understand the risk without careful instruction. It is incumbent upon school personnel to teach them sound prevention principles and to make sure that they get their full share of prevention education.

Educators also need to recognize that many physically and mentally impaired students must rely upon medicines to treat their health conditions. They are psychologically sensitive to implications that there is something wrong with them because they rely on medication. They may also be very sensitive to substance abuse prevention education when their impairment is the product of, or is affected by, their parents' use of dangerous drugs.

High-Risk Students

High-risk students are those who are at high risk of becoming substance users or who are already abusing drugs. High-risk students include students in the following situations:

- ❖ Drop out of school or suffer academic failure
- ❖ Become pregnant
- ❖ Are economically disadvantaged
- ❖ Are children of an alcohol or other drug abuser
- ❖ Are victims of physical, sexual, or psychological abuse
- ❖ Have committed violent or delinquent acts
- ❖ Have attempted suicide
- ❖ Have substance-abusing friends

Curricula for high-risk students should present drug education early and in a form appropriate for a child's age and experience. Resistance training and lesson plans should pay attention to the total environment in which such children live. If they have not begun using drugs, prevention-oriented education can

be useful. Recovering users can also benefit from a positively presented message about drug-free lifestyles. Children who are using drugs, recovering, or dealing with the addictions of family members and friends need to learn and be constantly reminded that addiction does not end when formal treatment ends; addiction cannot be cured but can effectively be treated and controlled.

Both children who are recovering and those who are subject to high-risk environments need support services outside the curriculum. **Support groups** are an effective method of in-school or out-of-school assistance for students and staff. These are confidential discussion and counseling sessions led by professionals or trained volunteers. Nonusers may find such groups helpful in dealing with friends who use drugs and with home problems such as the addictions of parents or siblings. For recovering users, support groups can reinforce their determination to stay off drugs, while helping fulfill the terms of their conditional reentry to school.

Infusion of Substance Abuse Prevention Education into the Curriculum

Schools often have limited time for prevention education in the curriculum. One solution to this problem is to infuse substance abuse prevention into other curricular subjects (**Box 7-7**). Substance abuse prevention education can be integrated into virtually every other subject in the curriculum. For example:

- *Math* classes can use statistics to describe the financial and human costs of substance abuse.
- *Science* classes can explore the chemical characteristics and physiological effects of specific drugs.
- *Visual arts* and *English* classes can discuss media pressures and advertising techniques and explore ways to resist these pressures.
- *Social studies* classes can discuss the effects of substance abuse on society and individuals.
- *Physical education* classes and coaches can discuss the effects of anabolic steroids.

7-7
In the Classroom

Advocacy, Outreach, and Integration Activities

These are a few examples of how you can: help your students be advocates; reach out and involve families, the school, or community; and infuse drug-free lifestyle concepts into other subjects.

(*continues*)

(*continued*)

Award Badges

Design awards, badges, or plaques and give them to tobacco users (students and adults) who have reduced or quit their tobacco habits. (P, I, J, H)

SADD

Have students organize their own chapter of Students Against Drunk Driving. (H)

Public Service Announcement

Have students write and record a public service announcement for radio about the dangers of drinking and driving. Have them submit announcements to local radio stations. (I, J, H)

Bumper Stickers

Have students create bumper stickers with strong messages against tobacco, alcohol, or other drug use. (I, J, H)

Letters

Have students write a letter to a hypothetical friend to persuade him or her to stop smoking or obtain help in overcoming a drug abuse problem. (I, J, H)

Service Support Speaker

Have a representative from a detoxification unit , Alateen, or Al-Anon speak about available services for alcoholics and members of the alcoholic family. (H)

AA or Other Meetings

Have students attend and report on Alcoholics Anonymous, Al-Anon, or Alateen meetings. (H)

MADD

Have a representative from MADD, Mothers Against Drunk Driving, speak to your class about the organization and the problem of drinking and driving. (J, H)

(*continues*)

Additional Ideas

Integration ideas for teaching a drug-free lifestyle in other content areas include the following:

Math. Have students calculate the cost of smoking one pack of cigarettes every day for 1 year. Compare the cost to a stereo system or other items students would enjoy buying. Have students go "shopping" from catalogs or newspaper ads with the money they could save from not smoking 1, 2, 5, or 10 years. Calculate the additional cost smokers pay for car and home insurance, medical care, laundry, and home cleaning. (I, J, H)

Language Arts. Check in your school library for books that deal with tobacco, alcohol, or drug abuse. Read these stories in class or have students read them as an assignment or for extra credit. Have student write stories about families dealing with a substance abuse. Have students answer letters to a "Dear Abby" about a substance abuse problem. (I, J, H)

Social Studies. Have students research and report on U.S. legislation and aid to support the tobacco industry. Have students check on passive smoking laws. Assign students to interview employees in public buildings and other work environments affected by the legislation. Have students research and report on the results of state lawsuits against tobacco companies in the past decade. Discuss the costs of smoking to all Americans in terms of medical care, lost work productivity, and loss of lives. (J, H)

Substance Abuse Problems

Any drug, legal or illegal, can be abused. Using a substance for purposes other than those intended by the manufacturer is drug abuse. Teen substance abuse overall has declined since the 1990s, but that is not true of prescription pain killers. The abuse of addictive narcotic painkillers that imitate morphine has continued to grow. The number of teens who reported using OxyContin (oxycodone) increased 30% between 2002 and 2006, and the number continues to rise. Educators, parents, and others can never become complacent about the potential for youth substance abuse. Even if statistics indicate improvements in some areas, others remain problematic and there is always the threat of another epidemic outbreak. Too many youths today are and will become caught in a web of addiction—that of their own or that of a loved one. This section discusses

many abused substances and provides resources you can use in your classroom to promote a drug-free lifestyle. In **Box 7-8**, you can find many activity ideas you can use while promoting a tobacco and drug-free lifestyle in your classroom.

7-8
In the Classroom

Assessment and Learning Activities for a Tobacco-Free and Drug-Free Lifestyle

Be sure to also check out the resources (lesson plans and materials) identified in Box 7-6 when you make plans for teaching about tobacco, alcohol, or drugs.

Human Beans

Count out 1,214 pinto or kidney beans and place them in a glass jar. Give each student a handful of bean, but not all of the beans in the jar. Explain that these are "human beans" and that students are to try and guess how many people die each day in the United States. Have students count their beans and take turns placing them in an empty jar until they think they have the right number. Say, "No, not yet," when they stop prematurely. Keep a running total of the number of beans placed in the jar. After they have all placed their beans in the jar add the remaining ones you held in reserve. Discuss the devastating effects of tobacco on human life and suffering. (P, I, J, H)

Legally Drunk

Have students calculate how many drinks it would take individuals of various weights to become legally drunk. Discuss the role of food in the stomach, alcoholic content of beverages, and other factors in blood alcohol levels. (I, J, H)

Clean Up

Initiate a school clean-up campaign and log the effects of smoking on the property and facilities. (J, H)

Body Part Skit

Write a skit in which each student plays the part of a different body organ and expresses how tobacco, alcohol, or other drugs affects it. (I, J, H)

(*continues*)

Warning Labels

Have students design warning labels about fetal alcohol syndrome to place on all alcoholic beverages. (I, J, H)

Bulletin Boards

Have students develop bulletin boards illustrating (1) alcohol's cost to society in terms of fatalities, medical costs, job absenteeism, job loss, decreased productivity, and family life; (2) the short- and long-term effects of alcohol on the body; and (3) how drug abuse (tobacco, alcohol, and others) affects family life, social life, schoolwork, and the economy. (P, I, J, H)

Walk the Line

Have students walk a taped line and discuss whether they would want to ride with a driver who could not do this. (P, I, J, H)

What's This?

Display three white mixtures (e.g., laundry detergents, salt, sugars, rat poisons, baking powder, soda) and ask the students which they want. Discuss how drugs are cut and that a person buying drugs on the street doesn't know what he or she is getting. (P, I, J, H)

Impaired

Have two students compete to see who can complete some simple tasks such as buttoning up a shirt, tying a shoe, and threading a needle first. Have one student wear gloves and sunglasses smeared with petroleum jelly. Discuss how alcohol impairs a person's ability to do simple tasks and the dangers that can result from those impairments to the drinker and those around.

Tobacco Use

Most cigarette smokers begin smoking during their teen years.* In fact, 80% of adult smokers started smoking before the age of 18. Every day of the year, more than 3,600 young people initiate cigarette smoking and an estimated 1,100 become daily cigarette smokers (see **Figure 7-1**). More than 6.4 million children living today will die prematurely because of their decision as children or teenagers to smoke cigarettes.

* Unless otherwise noted, the facts and statistics cited in this section are from the CDC's Tobacco Information and Prevention Source website (http://www.cdc.gov/tobacco).

FIGURE 7-1 Early onset of smoking.
Source: Centers for Disease Control and Prevention. Smoking and Tobacco Use Fact Sheet. Available at http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking. Accessed August 21, 2009.

Nicotine

When a person inhales cigarette smoke, the **nicotine** in the smoke is rapidly absorbed into the blood and starts affecting the brain within 7 seconds. In the brain, nicotine activates the same reward system as do other drugs of abuse, such as cocaine or amphetamine, although to a lesser degree. Nicotine's action on this reward system is believed to be responsible for drug-induced feelings of pleasure and, over time, addiction. Nicotine also has the effect of increasing alertness and enhancing mental performance. In the cardiovascular system, nicotine increases heart rate and blood pressure and restricts blood flow to the heart muscle. The drug stimulates the release of the hormone epinephrine, which further stimulates the nervous system and is responsible for part of the "kick" from nicotine. It also promotes the release of the hormone beta-endorphin, which inhibits pain.

People addicted to nicotine experience withdrawal when they stop smoking. This withdrawal involves symptoms such as anger, anxiety, depressed mood, difficulty concentrating, increased appetite, and craving for nicotine. Most of these symptoms subside within 3 to 4 weeks, except for the craving and hunger, which may persist for months.

Health Consequences of Smoking

Smoking damages nearly every organ in the human body, is linked to at least 15 different cancers, and accounts for some 30% of all cancer deaths. In the

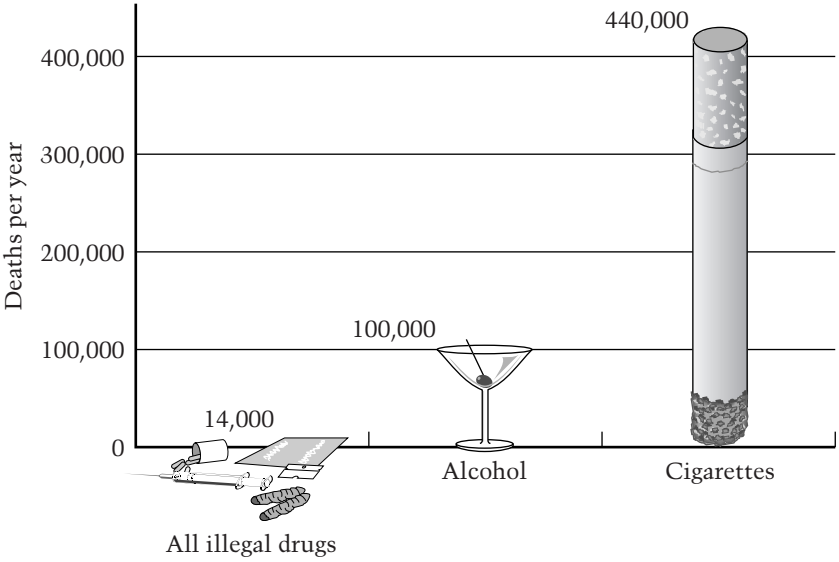


FIGURE 7-2 Deaths per year from substance abuse.

United States, cigarette smoking is responsible for about one in five deaths annually, or about 443,000 deaths per year. An estimated 49,000 of these deaths are the result of second-hand smoke. This is more than 1,200 deaths per day (see **Figures 7-2 and 7-3**). This clearly makes cigarette smoking the leading preventable cause of death in the United States. Cigarette smoking kills more people than does AIDS, alcohol abuse, illegal drug abuse, car crashes, murders, suicides, and fires—combined (see **Figure 7-4**). On average, smoking reduces a person's life 13 to 14 years.

Health studies have clearly documented that smoking cigarettes causes heart disease, lung and esophageal cancer, and chronic lung disease. Cigarette smoking contributes to cancer of the bladder, pancreas, and kidney. Studies have also demonstrated that women who use tobacco during pregnancy are more likely to have adverse birth outcomes, including low-birthweight babies. Low birthweight is a leading cause of death among infants. Studies also indicate that nonsmokers are adversely affected by environmental tobacco smoke. Researchers have identified more than 4,000 chemical compounds in tobacco smoke; of these, at least 43 cause cancer in humans and animals. Each year, because of exposure to environmental tobacco smoke, an estimated 3,000 nonsmoking Americans die of lung cancer, and 300,000 children suffer from lower respiratory tract infections.

In addition to the long-term consequences of cigarette smoking (e.g., lung cancer, emphysema, coronary heart disease), smoking has short-term consequences for young people who smoke. These include respiratory and

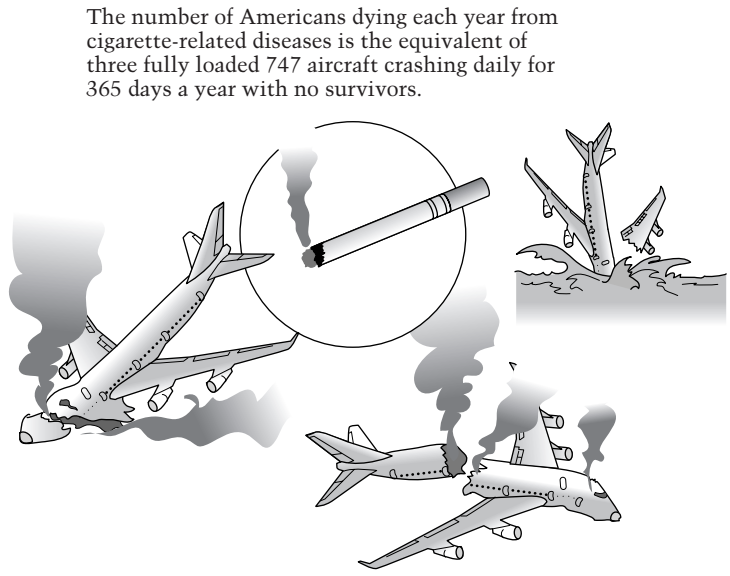


FIGURE 7-3 Daily deaths from cigarettes.
Source: Centers for Disease Control and Prevention. Smoking and Tobacco Use. Available at http://www.cdc.gov/tobacco. Accessed August 21, 2009.

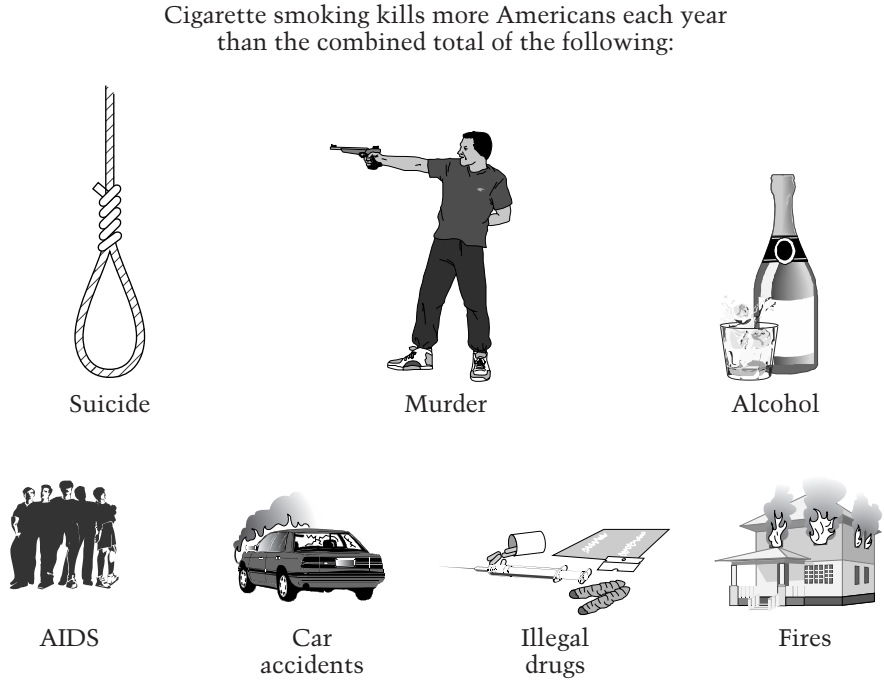


FIGURE 7-4 Cigarettes kill …
Source: Centers for Disease Control and Prevention. Smoking and Tobacco Use. Available at http://www.cdc.gov/tobacco. Accessed August 21, 2009.

nonrespiratory effects, addiction to nicotine, and the associated risk of other drug use. Health effects of cigarette smoking for young people include the following consequences:

- Cigarette smokers have a lower level of lung function than do those persons who have never smoked, and smoking reduces the rate of lung growth.
- Smoking affects young people's physical fitness, both performance and endurance, even among young people trained in competitive running.
- Among young people, regular smoking is responsible for coughs and increased frequency and severity of respiratory illnesses. Teenage smokers suffer from shortness of breath almost three times as often as teens who don't smoke do, and they produce phlegm more than twice as often as do teens who don't smoke.
- Teens who smoke are 3 times more likely than nonsmokers to use alcohol, 8 times more likely to use marijuana, and 22 times more likely to use cocaine, and also are at increased risk of engaging in other risky behaviors, such as fighting and unprotected sex.
- Smoking may be a marker for underlying mental health problems, such as depression, among adolescents. Teenage smokers are more likely to have seen a doctor or other health professionals for an emotional or psychological complaint.

Cigarette and Cigar Smoking in Youth

Results from the 2007 National Youth Tobacco Survey show that 20% of high school students and approximately 6% of middle school students were current cigarette smokers. Among racial and ethnic subgroups, approximately 23% of white, 17% of Hispanic, and 12% of African American high school students were current cigarette smokers.

Cigar use (in the past 30 days) was reported by 19% of high school boys and 8% of high school girls. Among high school students, the use of bidis and kreteks in the past 30 days was 3%, and 2% for middle school students. **Bidis** are thin, unfiltered cigarettes produced in India that are wrapped in brown leaves and tied with a short length of thread. They come in different flavors, including strawberry, chocolate, almond, and root beer. They are sold in tobacco specialty stores and frequently in health food stores as well. Although some people claim that bidis are a safe alternative to regular cigarettes, this is not true. Bidi smoke contains higher levels of carbon monoxide, nicotine, and tar than cigarette smoke does. The fact that bidis are filterless means that more of the cancer-causing agent, tar, goes directly to the smoker's system. **Kreteks** are clove cigarettes that are sometimes mistaken for bidis. They are made in Indonesia and contain tobacco and clove. The clove deadens sensation in the lungs, making it easier to inhale smoke deep into the lungs.

Cigarette Smoking and Girls

Smoking has long been the leading cause of preventable death and disease among women. Many women do not realize that lung cancer, once rare among women, surpassed breast cancer in the late 1980s as the leading cause of female cancer death. Cigarette smoking—once thought of as an almost exclusively male behavior—is now nearly as high among women as men (22% of young women smoke). Almost as many teenage girls (19%) smoke as teenage boys (21%). More than 22 million adult women and at least 1.5 million adolescent girls in the United States currently smoke cigarettes. As a result, smoking-related diseases cause the premature death of approximately 165,000 American women per year.

Girls who take up smoking often hope smoking will help them lose weight or keep them from getting fat.

Cigarette smoking poses additional health risks to women besides lung cancer. There is also evidence that women who smoke have increased risks for liver and colorectal cancer and for cancers of the pancreas and kidney. In addition to causing lung and other cancers, lung disease, coronary heart disease, and stroke and increasing risk for osteoporosis, smoking affects a woman's appearance. Long-term smoking causes the skin to age prematurely and lose its elasticity, the nails and teeth to turn yellow, and the breath to smell foul. Females might be more susceptible to the addictive properties of nicotine and might clear nicotine at a slower rate from their bodies than males do. In addition, females seem to be more susceptible to the effects of tobacco carcinogens than men are.

Women who smoke or who live with a smoker face unique health effects related to reproductive health, including problems related to pregnancy, oral contraceptive use, menstrual function, and cancers of the cervix and bladder. Young women need to be alerted to the facts that smoking can impair fertility and the production and implantation of ova and can contribute to early pregnancy loss. Further, smoking appears to cause irregular menstrual cycles and increased menstrual discomfort. Women who smoke also have an earlier menopause, which may increase their risk of osteoporosis, heart disease, and other conditions for which estrogen provides a protective effect. Cigarette smoking also increases the risk of pregnancy complications. Women who smoke are more likely to experience bleeding and to have low-birthweight babies. The risk of sudden infant death syndrome (SIDS) is also increased when a woman smokes. Women who smoke and who have children put them at risk of serious health problems. Children exposed to their mother's secondhand smoke have more frequent infections, including colds and flu, ear infections, and lower respiratory infections such as bronchitis and pneumonia. Secondhand smoke has been shown to cause new cases of asthma, as well as to make existing cases of asthma worse.

Smokeless Tobacco Use

The use of **chewing tobacco** and **snuff** delivers nicotine to the central nervous system. Although nicotine is absorbed more slowly through the mouth than the lungs, the blood nicotine levels of smokeless tobacco users are similar to those of cigarette smokers. Like cigarette smoking, smokeless tobacco use can lead to dependency on nicotine and result in withdrawal symptoms. Nicotine is a psychoactive substance that causes changes in mood and feeling and can produce **euphoria** or exaggerated feelings of well-being. Therefore, smokeless tobacco products, like cigarettes, are addictive substances.

The fact that smokeless tobacco products can be addicting is of great concern because of the high prevalence of use among young people, particularly males. An estimated 13% of males in high school were current smokeless tobacco users in 2007. In some parts of the United States, much higher rates of adolescent males use smokeless tobacco. Student athletes are at high risk of smokeless tobacco use.

Smokeless tobacco users are more likely than nonusing youth to have family members who use smokeless tobacco and are not as likely to encounter parental disapproval of the practice. Use by friends and among peers is an important influence on a young person's decision to chew tobacco or use snuff. In fact, pressure from peers is cited by young smokeless tobacco users as the primary reason for initiating use. However, continuation of use is most often attributed to enjoyment of the taste and "being hooked." The use and portrayal of use by role models (particularly professional athletes) is also a powerful influence.

Some youths and adults believe that smokeless tobacco is a safe alternative to smoking cigarettes because it is not likely to cause lung cancer. However, chewing tobacco and snuff contain potent carcinogens that have been shown to cause cancer in animals. Oral cancers occur several times more frequently in smokeless tobacco users than in nonusers.

An inspection inside a snuff dipper's or tobacco chewer's mouth often reveals an abnormally thickened, wrinkled, and whitish patch of tissue. These **oral leukoplakias** occur at the site where the tobacco is held in the mouth as a result of direct irritation and contact with tobacco juice. Some leukoplakias transform into precancerous and cancerous lesions in the mouth, throat, esophagus, or on the tongue or lip.

Smokeless tobacco use can lead to serious dental problems because the gums tend to recede from the teeth in areas near where the tobacco is held in the mouth. The bare roots are then more susceptible to decay and more sensitive to cold, heat, air, certain foods, and chemicals. Smokeless tobacco contains sugar, which can increase tooth decay. Abrasion of the enamel of teeth, as well as staining of teeth, may occur as a result of tobacco use. Bad breath is another problem of chewing and "dipping."

Tobacco Use Prevention and Cessation Programs in Schools

Successful programs to prevent tobacco use (as well as other substance abuse problems) address multiple psychosocial factors related to tobacco use among children and adolescents. The psychosocial factors that need to be addressed include the following:

- *Immediate and long-term undesirable physiologic, cosmetic, and social consequences*. Educators should help students understand that tobacco use can result in decreased stamina, stained teeth, foul-smelling breath and clothes, exacerbation of asthma, and ostracism by nonsmoking peers.
- *Social norms regarding tobacco use*. Educators should use a variety of educational techniques to decrease the social acceptability of tobacco use, highlight existing antitobacco norms, and help students understand that most adolescents do not smoke.
- *Reasons that adolescents say they smoke.* Educators should help students understand that some adolescents smoke because they believe it will help them be accepted by peers, appear mature, or cope with stress. Educators

should help students develop other more positive means to attain such goals.

- *Social influences that promote tobacco use*. Educators should help students develop skills in recognizing and refuting tobacco-promotion messages from the media, adults, and peers.
- *Behavioral skills for resisting social influences that promote tobacco use*. Educators should help students develop refusal skills through direct instruction, modeling, rehearsal, and reinforcement, and should coach them to help others develop these skills.
- *General and personal skills*. Educators should help students develop necessary assertiveness, communication, goal-setting, and problem-solving skills that may enable them to avoid both tobacco use and other health-risky behaviors.

Schools should address these psychosocial factors at developmentally appropriate ages. Particular instructional concepts should be provided for students in early elementary school, junior high or middle school, and senior high school.

Successful tobacco use prevention programs develop and enforce a school policy on tobacco use. A school policy on tobacco use must be consistent with state and local laws. Further, the CDC recommends that a policy should include the following elements:

- Prohibitions against tobacco use by students, all school staff, parents, visitors on school property, in school vehicles, and at school-sponsored functions away from school property
- Prohibitions against tobacco advertising in school buildings, at school functions, and in school publications
- A requirement that all students receive instruction on avoiding tobacco use
- Provisions for students and all school staff to have access to programs to help them quit using tobacco
- Procedures for communicating the policy to students, school staff, parents or families, visitors, and the community
- Provisions for enforcing the policy

To ensure broad support for school policies on tobacco use, representatives of relevant groups, such as students, parents, school staff, and school board members, should participate in developing and implementing the policy. Clearly articulated policies, applied fairly and consistently, can help students decide not to use tobacco. Policies that prohibit tobacco use on school property, require prevention education, and provide access to cessation programs rather than solely instituting punitive measures are most effective in reducing tobacco use among students.

Effective cessation programs for adolescents may already be available in the community through the local health department or voluntary health agency (e.g., American Cancer Society, American Heart Association, American Lung Association). Schools should identify available resources in the community and provide referral and follow-up services to students. If cessation programs for youth are not available, such programs may be jointly sponsored by the school and the local health department, voluntary health agency or other community health providers, or interested organizations (e.g., churches or civic clubs).

Alcohol Use

Alcohol is a central nervous system depressant. Alcohol hinders coordination, slows reaction time, dulls senses, and blocks memory functions. It affects virtually every organ in the body, and chronic use can lead to numerous preventable consequences, including serious injuries, alcoholism, and chronic disease. Heavy drinking can increase the risk for certain cancers, especially those of the liver, esophagus, throat, and larynx (voice box). It can also cause liver cirrhosis, immune system problems, brain damage, and harm to the fetus during pregnancy (see **Box 7-9**). In addition, drinking increases the risk of death from automobile crashes, recreational accidents, and on-the-job accidents, and increases the likelihood of homicide and suicide (see **Figure 7-5**).

Although it is illegal for anyone under the age of 21 to purchase, possess, and consume alcohol, many young people do drink. In addition to breaking the law, young people are particularly vulnerable to the various problems that

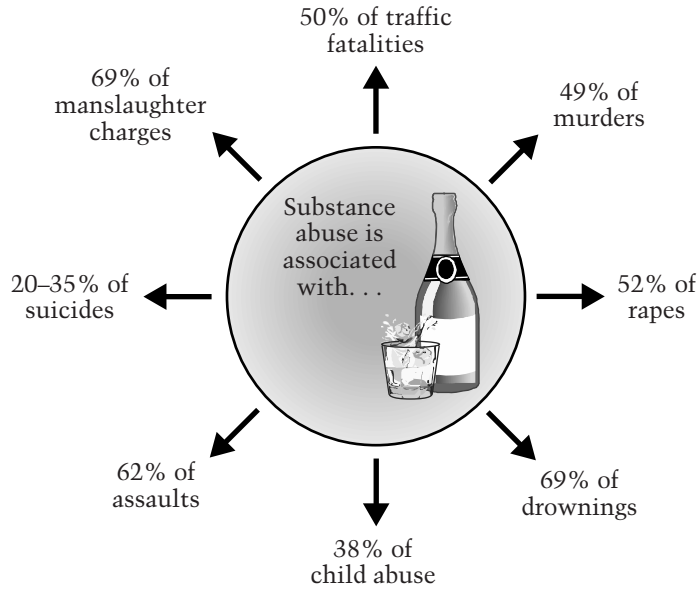


FIGURE 7-5 Problems associated with substance abuse.

7-9
Background on . . .

Fetal Alcohol Spectrum Disorder

According to the Children's Research Triangle,

> for the past thirty years, a child whose mother drank alcohol during pregnancy, but who had only partial or no apparent expression of physical features of alcohol exposure was said to have Fetal Alcohol Effects (FAE). These children may have had minimal to moderate facial changes or no changes at all, but usually had some problems in intellectual, behavioral, or emotional development. These difficulties had a significant impact on learning and long-term development. Over the past few years, research has demonstrated that children with so-called FAE have significant structural and functional changes in the brain, even though there is little if any overt physical manifestation of the alcohol exposure. Currently, there is a move to replace the terms Fetal Alcohol Syndrome and Fetal Alcohol Effects with the more global term Fetal Alcohol Spectrum Disorder (FASD). This is the term we prefer to use because it emphasizes the wide continuum of devastating clinical effects that can occur when a woman drinks alcohol during pregnancy. In addition, we have found that many children who have significant brain dysfunction and abnormal facial features achieve normal growth patterns once they move into a stable foster or adoptive home.

Source: Children's Research Triangle. FASD. Available at http://www.childstudy.org/fasd. Accessed August 12, 2009.

alcohol can cause. Among young people, alcohol use is linked to troubles with law enforcement authorities and academics, property destruction, physical fighting, and a host of other problems. Alcohol lowers inhibitions and impairs judgment, which can lead to risky behaviors, including practicing unprotected sex. This can lead to acquiring HIV/AIDS as well as other sexually transmitted diseases and unwanted pregnancy. Driving ability is seriously hampered when combined with alcohol use. Approximately 40% of motor vehicle fatalities among teenagers are alcohol related. Many drownings and other injuries among young people are also alcohol related. Alcohol abuse is responsible for more than 100,000 deaths in the United States each year.[15]

Results from the 2007 Youth Risk Behavior Survey show that a large proportion of high school students are at risk of alcohol-related injuries and consequences. About 3 in 10 high school students nationwide report riding one or more times in the past month with a driver who had been drinking alcohol. Thirteen percent of male and 8.1% of female high school students reported that in the past

month they drove a vehicle one or more times after drinking alcohol. Almost one fourth of students who were currently sexually active said that they had used alcohol or other drugs at last sexual intercourse. Seventy-five percent of high school students have had at least one drink of alcohol during their lifetime, and 44.7% have drunk alcohol in the past month. Twenty-six percent of students have had five or more drinks of alcohol (episodic heavy drinking) on at least one occasion in the past month. Overall, male students (28%) were more likely than female students (24%) to report episodic heavy drinking.

Alcoholism

Alcoholism is best explained as a complex, progressive disease. It involves a progressive preoccupation with drinking that leads to physical, mental, social, and/or economic dysfunction. The complexity of alcoholism results from various causes and factors—genetic, psychological, familial, and social—many of which are not clearly understood. Alcoholism usually has the following characteristics:

- *Craving.* A strong need, or compulsion, to drink
- *Loss of control.* The frequent inability to stop drinking once a person has begun
- *Physical dependence.* The occurrence of withdrawal symptoms, such as nausea, sweating, shakiness, and anxiety, when alcohol use is stopped after a period of heavy drinking (these symptoms are usually relieved by drinking alcohol or by taking another sedative drug)
- *Tolerance.* The need for increasing amounts of alcohol to get "high"

Adolescents, in comparison to adults, appear to be more susceptible or vulnerable to alcoholism. The disease of alcoholism shows a more accelerated progression in adolescents than that observed in adults. By the time parents, health providers, or school personnel become aware of the problem, an adolescent may have a serious drinking problem.

Signs and Symptoms of Youth Alcoholism and Problem Drinking

Increases in youth alcoholism and problem drinking may be partly the result of the following factors:

- Easy availability of alcoholic beverages
- Alcohol advertisements on television and in print media
- Exposure to parental and adult problem drinkers
- Toleration by parents of drinking and drunkenness
- Growing use of alcohol to cope with the pressures and conflicts of adolescence

- ❖ Cultural ambivalence about alcohol and drugs
- ❖ Few strict controls for the social use of alcohol or against the abuse of alcohol

It is important for educators to be aware of the signs and symptoms of youth alcoholism, which include the following:

- ❖ The tendency to drink in secret or to hide one's level of consumption
- ❖ Guilt about drinking
- ❖ Drinking in response to worry, depression, tiredness, and so forth
- ❖ Increasing tolerance to alcohol (need to increase consumption to achieve desired effect)
- ❖ Alcoholic blackouts (periods of alcohol-induced amnesia)
- ❖ Increasing the frequency and amount of drinking
- ❖ Continuance of drinking after others have stopped
- ❖ Lying about one's drinking
- ❖ Preoccupation with procuring and maintaining a supply of alcohol
- ❖ Gulping drinks
- ❖ Early-morning drinking
- ❖ Early-morning tremors
- ❖ Difficulty managing money
- ❖ Changes in eating behavior
- ❖ Withdrawal symptoms when efforts are made to stop drinking (these include restlessness, tremors, insomnia, depression, mental confusion, and in severe cases hallucinations and convulsions)

In addition to these warning signs of alcoholism, young alcoholics often demonstrate indirectly related behaviors that are observable by teachers and parents, such as these:

- ❖ Impulsive behavior
- ❖ Lying to teachers and parents
- ❖ Declining grades
- ❖ Sudden decrease in handwriting skills
- ❖ Absences from and tardiness in school
- ❖ Decreased attention span

- ❖ Inability to cope with frustration
- ❖ Change from one peer group to another
- ❖ Irritability with others
- ❖ Suspiciousness of others
- ❖ Rebelliousness
- ❖ Difficulty completing projects and assignments

Addiction in the Family

Addiction to alcohol or other drugs has tragic effects not only upon the addict but also upon the children of addicts. There are an estimated 28 million children of alcoholics in the United States. About one in five adult Americans lived with an alcoholic while growing up. An average of five students in every classroom come from a home with a parent who has a substance addiction.

Children raised in substance-abusing families have different life experiences than children raised in non-substance-abusing families. It is important, however, to realize that children raised in other types of dysfunctional families may have similar stressors as do the children raised in families of substance-abusing parents.

The impact of substance abuse and addiction is immense and affects the entire family. Excessive parental substance abuse contributes to a family environment of chaos, unpredictability, anxiety, tension, and denial, in which the primary needs of children are not met. Children of addicts often feel great responsibility and guilt for their parents' substance abuse behavior. They are told by parents or given subtle messages that "if they were better, dad (or mom) wouldn't be so angry and drink so much."

Unpredictability results because children are confused by the difference between the intoxicated and sober behavior of a parent. Promises made by an intoxicated parent are likely to be forgotten when the parent is sober, or vice versa. Confusion and unpredictability also result when a certain action is praised one day and then ignored or punished the next.

Parental substance abuse breeds low self-esteem in children and insecurity about parents' love. Substance abuse by a parent is often equated with not being loved. "If Mommy really loved me, she wouldn't drink." Children may also be angry with a non-substance-abusing parent who does not protect them from the violent addicted parent.

Children of addicts have reason to fear for their own safety as well as that of their addicted parent. They have concerns about being in an accident when driving with an intoxicated parent or of having the home catch on fire because a parent passed out while holding a lit cigarette. They realize that a frequently intoxicated parent could lose control of the car while driving home late at night or become seriously injured in many other ways. Children are also terrified of the arguments between parents that typify the addict home. They may have

suffered abuse at the hands of an addicted parent or are fearful that they will become victims of abusive behavior.

We now take a closer look at how alcohol abuse affects the family. Many of the following observations made about an alcoholic family can also be made of families with other substance abuse problems.

Effects of Growing Up in an Alcoholic Family Three rules characterize an alcoholic family: "don't talk," "don't trust," and "don't feel." Children learn to not talk about the alcoholism in the family to anyone outside and, therefore, they "don't talk." Because the reactions of the alcoholic parent cannot be predicted or trusted, they "don't trust." And as children see painful feelings avoided or numbed through the use of alcohol, they learn to "not feel," and use denial to escape emotional pain.

Important messages for children of an addicted parent to hear include the following:

- *Alcoholism/drug dependency is a sickness*. You didn't cause it and you can't control it.
- *You can't make it better*. You can't cure it.
- *You deserve help for yourself*.
- *You are not alone*.
- *There are safe people and places that can help*.
- *There is hope*.

To cope and survive in their alcoholic environments, children often assume roles that represent particular and rigid ways of relating to other family members and the outside world. The four roles assumed by children in alcoholic families are discussed next, along with classroom strategies for dealing with children of alcoholics.

Family Hero The **family hero** is often, but not always, the eldest child. The role of the hero is to make up for the deficits in the family, diverting attention from the alcoholic by achieving or overachieving in schoolwork, athletics, music, or other pursuits. They are often very responsible with a drive or compulsion to achieve. Perhaps they are attempting to show the world that the family must be problem-free and functional to have produced such an exceptional child.

These children often assume unfulfilled parenting responsibilities within the family. Family heroes are usually well-behaved children but may seem bossy or parental in their relationships with other children. They are frequently labeled the "teacher's pet" by other children. These children assume leadership roles and tend to "take charge" in group activities rather than participate as equal members or followers. They may volunteer often and have a strong need for

There are three rules that characterize an alcoholic family: "Don't talk," "Don't trust," and "Don't feel."

attention and approval from adults. Family heroes are not likely to be recognized as needing attention from school personnel because they seem so well adjusted and because of their achievements.

As adults, family heroes are prone to becoming compulsive overachievers who have an insatiable drive to always be on top. Therefore, they tend to become workaholics and perfectionists. In addition, they are likely to suffer physical problems, probably related to the stress created from their constant striving to achieve and succeed. The adult family hero often relies on drugs and alcohol to sustain the highly straining lifestyle. Family heroes who are not dependent on alcohol or other substances often marry spouses who are chemically dependent,

weak, sick, or otherwise dependent. When a family hero marries a chemically dependent person, he or she becomes the chief enabler of the chemically dependent partner.

Despite all the achievements, an adult family hero often feels a deep sense of failure because the accomplishments and brilliant performances did not make the alcoholic parent stop drinking. She or he does not know how to relax or play, having spent years "mothering" and attending to the needs of parents, spouses, and others. A sense of failure also arises with the realization that the hero is continually meeting other peoples' needs while ignoring his or her own, is often taken advantage of, and does not know how to stop it.

The family hero needs to learn how to ask for help, how to follow and negotiate, how to identify and meet his or her own needs, how to relax and have fun, and how to balance work and play. To facilitate this, teachers can do the following:

- Limit classroom responsibilities of the child
- Give positive attention at times when the child is not achieving
- Give attention to the child when he or she participates as a follower rather than as a leader in an activity
- Help the child understand that it is all right to make mistakes
- Suggest to the child that he or she pay attention to his or her own needs
- Teach relaxation techniques such as progressive relaxation, imagery, exercise, and biofeedback
- Do not allow the child to monopolize class discussions or always be the first to volunteer or answer a question
- Validate the child's worth based on being himself or herself, not on doing or achieving
- Help the child balance work and play by organizing and participating in social and recreational activities

The Scapegoat Often described as the problem child because he or she displays rebelliousness, irresponsibility, breaking rules, talking back to parents and school workers, and acting out, the **scapegoat** relies strongly on peers and tends to blame others. Acting out is often through substance abuse, but may be through other delinquent or problem behaviors, such as criminal activity, sexual promiscuity, or other high-risk activities. The scapegoat serves to divert attention from the alcoholic parent, in essence, allowing the outside world to believe that the family is fine, but the scapegoat is just a problem child and troublemaker.

The scapegoat often comes to the attention of school personnel because of the manifested behaviors and attitudes. Children serving this role are very difficult and frustrating to have in class. They neglect schoolwork, are disruptive,

talk back to teachers, and break rules. Teachers are likely to feel as if they have tried everything to deal with a scapegoat child, with no success, and to feel tremendous frustration about how to deal with the child.

Scapegoats are very vulnerable to addiction to alcohol and other substances as teenagers and adults. Engagement in substance abuse and other high-risk behaviors increases the likelihood of such consequences as early pregnancy, accidental death, suicide, disease, and trouble with the law.

The scapegoat needs to learn how to express anger in a constructive manner, to forgive himself or herself, and to take responsibility for his or her mistakes but not those of others. In addition, the scapegoat needs to learn activities that will bring positive attention and social skills that will allow friendships. Teachers can assist the scapegoat by doing the following:

- ❖ Stressing the importance of personal responsibility for the child's actions and not allowing the child to blame others
- ❖ Giving affirmations to the child when he or she takes responsibility
- ❖ Applying logical consequences when the child misbehaves
- ❖ Developing an understanding of the child's behavioral and attitudinal patterns, to avoid getting angry at the child's behavior
- ❖ Providing suggestions for developing social skills, and working with the school counselor to provide this training
- ❖ Not treating the child in a special manner
- ❖ Not taking the child's behavior personally
- ❖ Not agreeing with the child's blaming and complaints about others

The Lost Child The **lost child** often acts withdrawn and shy as well as tends to be quiet, to have few friends, and to seldom cause problems. He or she likes to work alone at school and often is creative in nonverbal ways, such as art, music, and writing. The lost child typically daydreams and fantasizes to escape painful reality. Teachers frequently overlook a lost child because this student does not demand attention and rarely misbehaves. The lost child also may fade into the family woodwork, never causing any trouble or calling attention to himself or herself, thereby being the one child in the family that the parents do not have to worry about.

The difficulty that lost children have in interpersonal and social relationships remains as they become adults. Lack of social skills, combined with low self-esteem and shyness, contributes to dissatisfying interpersonal and marital relationships in adulthood. Inability to deal with conflicts sends the lost child into further social withdrawal and avoidance, resulting in loneliness that is often coped with inappropriately through substance abuse.

The lost child needs to realize that he or she is important and deserves attention, deserves to get what he or she wants and needs, must recognize and

own feelings, can initiate activities, and can make personal choices. Teachers can help lost children by doing the following:

- Taking an inventory of students in your classroom who are lonely or whose name you cannot consistently recall
- Making efforts to notice and attend to the child
- Finding out more about the child's interests and talents
- On a one-to-one basis encouraging the child's creativity, talents, and academic progress
- Assisting the child in developing relationships with other children in the classroom
- Having the child work in small groups frequently to build social trust and confidence
- Making a point of calling on the child in class, not allowing him or her to remain silent
- Not allowing other children in the class, siblings, or parents to take care of the child by talking and answering for him or her
- Redirecting fantasy and daydreaming activities into appropriate and creative channels, such as writing or artwork
- Not being overly sympathetic to the child

The Mascot or Clown The **mascot** or family clown diverts attention from the alcoholic parent and reduces family tension by being cute or funny. In school, this child makes repeated and constant attempts to be funny or get attention and is often suspected of hyperactivity, and as a result comes to the attention of the school counselor or nurse.

The "job" of mascot becomes a full-time role that mascots do not seem to outgrow even as adults. There is the constant need to be the clown, yet unhappiness underlies continual attempts to be humorous or funny. Unfortunately, many mascots turn to alcohol and other drugs to deal with their deep feelings of sadness and depression.

The mascot needs to learn how to receive attention, praise, and help from others in appropriate manners, how to deal with conflict and solve problems, and recognize and accept feelings. Classroom teachers can assist the mascot by doing the following:

- Giving attention to the child when he or she is not attempting to be funny or exhibiting attention-getting behaviors
- Reinforcing to the rest of the class the importance of not paying attention to the child's misbehavior
- Giving the child classroom jobs or tasks that require responsibility

- ❖ Discussing the importance of appropriate behavior with the child in brief, one-to-one discussions
- ❖ Encouraging an appropriate sense of humor
- ❖ Not laughing at the mascot's attempts to be funny
- ❖ Remembering that the mascot's behavior is an effort to mask fear and depression

Al-Anon and Alateen

Al-Anon is a fellowship of people who have been affected by the alcohol abuse of someone. Al-Anon members meet in small groups to harness the strength and hope of others who have lived with alcoholism. Al-Anon provides an opportunity in which individuals can learn from the experience of others who have lived in similar situations. **Alateen** meetings are similar to Al-Anon meetings except that Alateen is restricted to people under age 20 who live, or have lived, with someone who abuses alcohol. Alateen meetings include one or two Al-Anon sponsors. Young people who are living with a person with an alcohol problem, or who have lived with an alcohol abuser in the past, should be encouraged to attend an Alateen meeting. They will find other young people who have faced similar experiences. You can obtain further information about Al-Anon and Alateen from the Al-Anon and Alateen website at http://www.al-anon.alateen.org.

Other Drugs of Abuse

Oxycodone

Oxycodone is a very strong narcotic pain reliever similar to morphine. It is an effective pain reliever for mild to moderate pain, chronic pain, and for treatment of terminal cancer pain. It is designed so that the oxycodone is slowly released over time, allowing it to be used twice daily. Oxycodone (also known by the brand name OxyContin) is abused for its narcotic effects. Rather than ingesting the pill as indicated, abusers use other methods of taking the drug. Abusers crush oxycodone tablets to release all the narcotic in the drug at once and produce an intense, heroin-like high. Once the tablets are crushed, abusers either snort them or dissolve them in liquid for injection.

As was discussed earlier, the nonmedical use of oxycodone and other pain relievers is a growing problem. Prescription pills don't look dangerous; they appear harmless like the medicines people are accustomed to taking such as Tylenol or Advil. This is the mindset of many teens. According to the 2008 report *Prescription for Danger* from the Office of National Drug Control Policy, one third of teens believe there's "nothing wrong" with using prescription medicines without a prescription once in a while.[16] This is the fatal mistake that leads to addiction. Family members' and friends' medicine cabinets are usually the original source. Addicts try to supply themselves by scamming physicians

for prescriptions, stealing from unsuspecting acquaintances, and buying the drug on the street. Pharmacies have had to increase security measures because of the burglaries for oxycodone and other narcotic pain relief pills such as hydrocodone (Vicodin, Lortab). Addicts are prone to move onto heroin because heroin is so much cheaper to buy on the street.

Cocaine

Cocaine is a strong stimulant derived from the leaves of the coca bush. The coca bush grows in the Andean Mountain region of South America (Colombia, Peru, Bolivia). Coca leaves are processed into cocaine hydrochloride, a white crystalline powder that is inhaled through the nose ("snorted") or injected. When inhaled, cocaine's effects peak in 15 to 20 minutes and disappear in 60 to 90 minutes. When injected intravenously, the result is an intense high that crests in 3 to 5 minutes and wanes over 30 to 40 minutes. Another form of cocaine is "crack" cocaine. **Crack cocaine** is made by processing cocaine hydrochloride to a base state with baking soda and water. Crack cocaine looks like slivers of soap but has the general texture of porcelain. It is smoked in a pipe and produces an intense cocaine high.

Cocaine directly stimulates the reward centers of the brain, producing intense feelings of euphoria. When the euphoria and excitement of the initial cocaine high taper off, the user slides into a physiological depression, a "let-down" feeling with dullness, tenseness, and edginess. A user wants to take cocaine again in an effort to counteract these let-down feelings. This causes a cycle of using cocaine to achieve euphoria and to ward off the negative feelings associated with coming down from its effects.

Daily or binge users undergo profound personality changes. They become confused, anxious, and depressed. They are short-tempered and grow suspicious of friends, loved ones, and other associates. Their thinking is impaired; they have difficulty concentrating and remembering things. They experience weakness and lassitude. They neglect work and other responsibilities. They lose interest in food and sex. Some become aggressive, and some experience panic attacks. The more of the drug they use, the more profound their symptoms.

In some cases, where consumption of cocaine is frequent or the dose is high, or both, users suffer a partial or total break with reality, or cocaine psychosis. The cocaine psychotic has delusions and may become paranoid, sometimes reacting violently against those he or she imagines are persecuting him or her. Many have visual, auditory, or tactile hallucinations (one of the most common is "coke bugs," or **formication**, the sensation of insects crawling under the skin). Cocaine psychosis can continue for days, weeks, or months. Severe cases require hospitalization and antipsychotic medications.

Cocaine use can cause chest pain and irregular heartbeat, and can worsen preexisting coronary heart disease and bring on a heart attack. Because cocaine increases acute blood pressure, it can cause blood vessels in the brain to rupture and cause strokes. Cocaine may also damage the walls of arteries. Those who

inject cocaine, or any other drug for that matter, are at high risk of infection from contaminated needles. HIV, hepatitis B, and hepatitis C are some of the infections that can be spread from contaminated needles.

Another serious risk associated with cocaine use is seizures. Cocaine has been known to induce epilepsy even in those with no previous signs of it.

Methamphetamine

Methamphetamine is a powerful central nervous system stimulant. Methamphetamine is made easily in clandestine laboratories with over-the-counter ingredients (e.g., ephedrine, pseudoephedrine). Methamphetamine is commonly known as "**speed**," "**meth**," "**chalk**," "**crystal**," "**crank**," "**fire**," and "**glass**." Methamphetamine comes in many forms and can be smoked, snorted, orally ingested, or injected. Immediately after smoking the drug or injecting it intravenously, the user experiences an intense rush, or "flash," that lasts only a few minutes and is described as extremely pleasurable. Snorting or oral ingestion produces euphoria, but not the intense rush obtained by smoking or injections. Snorting produces effects within 3 to 5 minutes, and oral ingestion produces effects within 15 to 20 minutes.

Methamphetamine produces pronounced effects on the central nervous system: increased activity and wakefulness, increased physical activity, decreased appetite, and a general sense of well-being. The effects of methamphetamine can last 6 to 8 hours or longer. After the initial rush, there is typically a state of high agitation that in some individuals can lead to violent or irrational behavior.

As with similar stimulants (e.g., cocaine), methamphetamine most often is used in a binge and crash pattern. In an effort to obtain desired effects, users may take higher doses of the drug, take it more frequently, or change their method of drug intake. In some cases, users forgo food and sleep while binging on the drug or on a "run." After the binge or run, a user "crashes." During the crash, the user may sleep for more than 24 hours and become depressed and hungry and feel intense craving for the drug.

Methamphetamine has toxic effects. It has been shown to damage nerve terminals in the dopamine-containing regions of the brain. High doses can elevate body temperature to dangerous, sometimes lethal, levels, as well as cause convulsions. Abuse can lead to inflammation of the heart lining, increased blood pressure, rapid and irregular heartbeat, and strokes in the brain. If methamphetamine is injected, there is increased risk of HIV, hepatitis B, and hepatitis C transmission. This is particularly true for individuals who inject the drug and share injection equipment.

Long-time users exhibit symptoms that can include violent behavior, anxiety, confusion, and insomnia. They also can display a number of psychotic features, including paranoia, auditory hallucinations, mood disturbances, and delusions (for example, the sensation of insects creeping on the skin, called *formication*). The paranoia can result in homicidal as well as suicidal thoughts.

In the 1980s, "**ice**," a smokable form of methamphetamine, came into use. Ice is a large, usually clear crystal of high purity that is smoked in a glass pipe

like crack cocaine. The smoke is odorless, leaves a residue that can be resmoked, and produces effects that may continue for 12 hours or more.

In addition to the dangers of methamphetamine abuse, the manufacturing process presents its own hazards. The production of methamphetamine requires the use of hazardous chemicals, many of which are corrosive or flammable. The vapors that are created in the chemical reaction attack mucous membranes, skin, eyes, and the respiratory tract. Some chemicals react dangerously with water, and some can cause fire or explosion. Methamphetamine manufacturing results in a great deal of hazardous waste. The manufacture of 1 pound of methamphetamine results in 6 pounds of waste. This waste includes corrosive liquids, acid vapors, heavy metals, solvents, and other harmful materials that can cause disfigurement or death when contact is made with skin or breathed into the lungs. Lab operators almost always dump this waste illegally in ways that severely damage the environment. National parks and other preserved sites have been adversely affected.

Heroin

Heroin is a narcotic drug that is processed from morphine, a naturally occurring substance extracted from the seed pod of the opium poppy. It is typically sold as a white or brownish powder or as the black, sticky substance known on the streets as "**black tar heroin**." Most street heroin is cut with other drugs or with substances such as sugar, starch, powdered milk, or quinine. Street heroin can also be cut with strychnine or other poisons. Because heroin abusers do not know the actual strength of the drug or its true contents, they are at risk of overdose or death. Heroin also poses special problems because of transmission of HIV and other diseases that can occur from sharing needles or other injection equipment.

Heroin is usually injected, sniffed/snorted, or smoked. Typically, a heroin abuser may inject up to four times a day. It is particularly addictive because it enters the brain so rapidly. With heroin, the rush is usually accompanied by a warm flushing of the skin, dry mouth, and a heavy feeling in the extremities, which may be accompanied by nausea, vomiting, and severe itching. After the initial effects, abusers will be drowsy for several hours. Mental function is clouded by heroin's effect on the central nervous system. Heart rate and blood pressure slow. Breathing is also severely slowed, sometimes to the point of death. As mentioned, heroin overdose is a particular risk on the street, where the amount and purity of the drug cannot be accurately determined.

Heroin use can rapidly progress to addiction. As with abusers of any addictive drug, heroin abusers generally spend more and more time and energy obtaining and using the drug. Once addicted, the heroin abuser's primary purpose in life becomes seeking and using drugs. The drugs literally change the brain. Physical dependence develops with higher doses of the drugs. With **physical dependence**, the body adapts to the presence of the drug, and **withdrawal symptoms** occur if use is reduced abruptly. Withdrawal may occur within a few hours after the last time the drug is taken. Symptoms of heroin withdrawal include

restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps ("**cold turkey**"), and leg muscle spasms. Taking methadone can prevent withdrawal. As a result, methadone is used in treating heroin addiction.

Marijuana and Cannabis

Marijuana is the dried, shredded flowers and leaves of the hemp plant *Cannabis sativa*. There are hundreds of slang terms for marijuana, including "pot," "herb," "weed," "boom," "Mary Jane," and "chronic." It usually is smoked as a cigarette (called a *joint* or *nail*) or in a pipe or bong. In recent years, it has appeared in **blunts**, which are cigars that have been emptied of tobacco and refilled with marijuana. Some users mix marijuana into foods or use it to brew tea.

THC (which is short for delta-9-tetrahydrocannabinol) is the chemical that accounts for the major psychoactive effects of marijuana. THC is found most abundantly in the upper leaves, bracts, and flowers of the resin-producing variety of the plant. The dried leaves (marijuana) average from 3% to 5% THC. However, through special breeding marijuana may yield greater amounts of THC (7% or higher). **Hashish**, which is the dried and pressed flowers and resins, has up to 12% THC. **Hashish oil**, a crude extract of hashish, has up to 60% THC. THC tends to remain stored for long periods of time in the body. Complete elimination of THC can take up to 30 days.

A typical marijuana high may last 2 to 3 hours. The user experiences an altered perception of space and time. Marijuana adversely affects judgment, complex motor skills, and physical coordination. These effects make driving a car dangerous and increase the possibility of many types of accidents (see **Box 7-10**). Using marijuana can also impair one's judgment regarding decision making about sex. Sexual activity places young people at risk for unplanned pregnancy and sexually transmitted diseases, including HIV infection. Marijuana users are also likely to experience difficulty in thinking and problem solving. There is concern that regular use of marijuana by young people may impair psychological and physical maturation and development. Apathy, lack of concern for the future, and the loss of motivation have been seen in some heavy users.

There is much concern about the effects of smoking marijuana on the lungs because it is usually taken through smoking. A marijuana smoker is likely to experience many of the same respiratory problems that tobacco smokers have. However, marijuana is typically inhaled more deeply and held in the lungs for a longer period of time than tobacco smoke is. These inhalation practices are likely to increase the risk of respiratory problems. As a result, marijuana smokers may have daily cough and phlegm, symptoms of chronic bronchitis, and more frequent chest colds. There is concern that marijuana smoke contains carcinogens that could increase the risk of lung cancer.

Several thousand people are treated each year for marijuana dependency. Marijuana's effects on the brain and those produced by such highly addictive drugs as alcohol, heroin, cocaine, and nicotine are quite similar (see **Box 7-11**).

7-10
Background on . . .

Dangers of Drugged Driving

Many education campaigns have been designed to inform the public about the dangers of driving under the influence of alcohol; however, it's also important to recognize that driving under the influence of drugs can be as dangerous as driving drunk.

Research shows that driving under the influence of certain drugs can impair one's motor skills, reaction time, and judgment. Although alcohol has long been recognized as a road hazard, public health officials and others are increasingly realizing that driving under the influence of drugs is a serious public safety threat as well.

Some drugs, both legal and illegal, that act on the brain can alter an individual's perception, attention, balance, and coordination—all critical components required for safe driving. For example, THC, the active ingredient in marijuana, can negatively affect coordination, memory, and judgment. As a result, a driver high on marijuana may not be able to react appropriately to unpredictable traffic conditions.

Prescription drugs also may impair drivers. In fact, many prescription drugs come with warnings against the operation of machinery (including cars and other vehicles) for a specified period of time after taking the drug.

Young drivers are particularly at risk for a number of reasons. The *Monitoring the Future* survey indicates that in 2004, 12.7% of high school seniors reported driving under the influence of marijuana, and 13.2% reported driving under the influence of alcohol in the 2 weeks prior to completing the survey. Also, it is generally accepted that because teens are the least experienced drivers as a group, they have a higher risk of being involved in an accident compared with more experienced drivers. When lack of experience is combined with the use of marijuana or other substances that affect cognitive and motor abilities, the results can be tragic. Unfortunately, there is no widely available roadside testing device that can quickly detect drugs in a driver's system.

Source: National Institute on Drug Abuse. Message from the Director: Drugged Driving Can Be Harmful to Your Health. August 2005. Available at http://www.drugabuse.gov/about/welcome/messageddriving805.html. Accessed August 12, 2009.

7–11
Background on . . .

Drugs and the Brain

The brain's job is to process information. Brain cells called *neurons* receive and send messages to and from other neurons. There are billions of neurons in the human brain, each with as many as a thousand threadlike branches that reach out to other neurons.

In a neuron, a message is an electrical impulse. The electrical message travels along the sending branch, or *axon*, of the neuron. When the message reaches the end of the axon, it causes the release of a chemical called a *neurotransmitter*. The chemical travels across a tiny gap, or *synapse*, to other neurons.

Specialized molecules called *receptors* on the receiving neuron pick up the chemical. The branches on the receiving end of a neuron are called *dendrites*. Receptors there have special shapes so that they can collect only one kind of neurotransmitter.

In the dendrite, the neurotransmitter starts an electrical impulse. Its work done, the chemical is released back into the synapse. The neurotransmitter then is broken down or is reabsorbed into the sending neuron.

Neurons in your brain release many different neurotransmitters as you go about your day thinking, feeling, reacting, breathing, and digesting. When you learn new information or a new skill, your brain builds more axons and dendrites first, as a tree grows roots and branches. With more branches, neurons can communicate and send their messages more efficiently.

Some drugs work in the brain because they have a similar size and shape as natural neurotransmitters. In the brain in the right amount or dose, these drugs lock onto receptors and start an unnatural chain reaction of electrical charges, causing neurons to release large amounts of their own neurotransmitter.

Some drugs lock onto the neuron and act like a pump so that the neuron releases more neurotransmitter. Other drugs block reabsorption or reuptake and cause unnatural floods of neurotransmitter.

All drugs of abuse, such as nicotine, cocaine, and marijuana, primarily affect the brain's limbic system. Scientists call this the "reward" system. Normally, the limbic system responds to pleasurable experiences by releasing the neurotransmitter dopamine, which creates feelings of pleasure.

Source: Adapted from National Institute on Drug Abuse. Facts on Drugs: The Brain and Addiction. 2005. Available at http://teens.drugabuse.gov/facts/facts_brain1.asp#top. Accessed August 12, 2009.

Marijuana seems to affect the brain's reward systems in much the same way as these other addictive substances. These actions in the brain keep users desiring to repeat the use of marijuana. When heavy users of marijuana abruptly stop taking the drug, they are likely to feel anxiety and other negative emotions. Individuals may keep using marijuana in an effort to avoid these feelings. Many teenagers who seek treatment for drug dependency report being addicted to marijuana.

Club Drugs

Club drugs is a general term for a number of illicit drugs, primarily synthetic, that are most commonly encountered at nightclubs and "raves." The drugs include MDMA, ketamine, GHB, Rohypnol, LSD, PCP, methamphetamine, and, to a lesser extent, psilocybin mushrooms. This section on club drugs discusses MDMA, LSD, PCP, and psilocybin mushrooms. Ketamine, GHB, and Rohypnol, which are popular on the club and rave scene, are discussed in the following section ("Date-Rape Drugs") because they are also used as date-rape agents. Methamphetamine is discussed earlier in this chapter.

One reason that these drugs have gained popularity is the false perception that they are not as harmful or as addictive as mainstream drugs such as cocaine and heroin. A serious danger surrounding many of these club drugs is that users are often unaware of what is contained in the pills that they acquire. Look-alike substances, such as paramethoxyamphetamine (PMA) and dextromethorphan (DXM), are sometime sold as MDMA. These substances can cause a dangerous rise in body temperature and have resulted in the death of some who unknowingly took them in pills they believed to be Ecstasy (MDMA). MDMA tablets may also contain other substances, such as ketamine, PCP, caffeine, ephedrine, or methamphetamine.

MDMA MDMA is the most popular of the club drugs. There is widespread abuse of MDMA, most commonly known as Ecstasy, in many areas of the United States. **MDMA**, **Ecstasy**, or "**e**" is a synthetic, psychoactive substance possessing stimulant and mild hallucinogenic properties. Known as the "hug drug" or "feel good" drug, it reduces inhibitions, eliminates anxiety, and produces feelings of empathy for others. In addition to chemical stimulation, the drug reportedly suppresses the need to eat, drink, or sleep. This enables club-scene users to endure all-night and sometimes 2- to 3-day parties. Although it can be snorted, injected, or rectally inserted, MDMA is usually taken orally in tablet form, and its effects last approximately 4 to 6 hours.

An MDMA overdose is characterized by a rapid heartbeat, high blood pressure, faintness, muscle cramping, panic attacks, and, in more severe cases, loss of consciousness or seizures. One of the side effects of the drug is jaw muscle tension and teeth grinding. As a consequence, MDMA users will often suck on pacifiers to help relieve the tension. The most critical, life-threatening response to MDMA is hyperthermia, or excessive body heat. Recent reports of MDMA-

related deaths were associated with core body temperatures ranging from 107 to 109°F. Many rave clubs now provide cooling centers or cold showers so that participants can lower their body temperatures.

There is evidence that Ecstasy causes damage to the neurons (nerve cells) that utilize serotonin to communicate with other neurons in the brain, and that recreational MDMA users risk permanent brain damage that may manifest itself in depression, anxiety, memory loss, learning difficulties, sleep disorders, sexual dysfunction, and other neuropsychiatric disorders. In addition to the dangers posed by MDMA, incidents involving look-alike tablets containing substances such as PMA, methamphetamine, and methamphetamine/ketamine are increasing. Tablets containing MDMA in combination with other illicit drugs, such as phencyclidine (PCP), have also been encountered. Users are unaware of the dangers posed by these drugs and unknowingly ingest potentially dangerous or even lethal amounts. In 2000 alone, PMA was associated with three deaths in Chicago and six deaths in central Florida.

LSD **LSD** (lysergic acid diethylamide) is a potent hallucinogenic drug. One liquid ounce contains about 300,000 human doses. It is a colorless, odorless, and tasteless compound. The liquid is dropped onto blotter paper ("blotter acid") or made into tiny colored pills ("microdots"). LSD is taken orally, and its effects generally last 8 to 12 hours.

Usually, the user feels the first effects of the drug 30 to 90 minutes after taking it. LSD's physiological effects include sweating, an increase in blood pressure and heart rate, and an enlargement (dilation) of the pupils of the eye. Other effects that a user may experience include increased body temperature, loss of appetite, sleeplessness, dry mouth, and tremors.

Users refer to their experience with LSD as a "trip." The effects of LSD are unpredictable. They depend on the amount taken; the user's personality, mood, and expectations; and the surroundings in which the drug is used.

LSD is perhaps best known for its effects in altering perceptions. Psychologically, a user may experience delusional thinking and hallucinations. **Hallucinations** are alterations of vision and other senses. Some users experience **synesthesia**, which is a crossing of the senses—seeing sounds or hearing colors. An LSD user may have opposite feelings at the same time, such as elation and depression or relaxation and tension. For many users, the sense of time is distorted, and hours may be perceived as much longer increments of time—perhaps days, weeks, or even years. The drug can alter perceptions to such an extent that the user engages in bizarre behavior. There have been instances in which users have jumped off a tall building or into a body of water. Another bizarre effect is the sensation that one's body is distorted or even coming apart. An LSD trip can be pleasant or terrifying; there is no way of predicting the outcome of a trip. A "**bad trip**" refers to an LSD experience accompanied by severe, terrifying thoughts and feelings. Fatal and serious accidents have occurred during bad trips.

Many LSD users experience flashbacks. A **flashback** is a recurrence of certain aspects of a person's LSD experience without the user having taken the drug

again. Flashbacks occur suddenly, often without warning, and may occur within a few days or more than a year after LSD use.

PCP On the street, **PCP** (phencyclidine) has many names, including "angel dust," "PeaCe Pill," "cadillac," "crystal joints," "superpot," "superweed," "monkey weed," and "horse tranquilizer." PCP is often substituted for, and sold as, LSD and mescaline on the street.

PCP was first used in pill form, but now is most often snorted like cocaine or mixed with tobacco, marijuana, or parsley and then smoked. Some users inject PCP into their veins, and others swallow it in a liquid form.

PCP has depressant, stimulant, hallucinogenic, and analgesic properties. Quite a combination! The effects of the drug on the central nervous system vary greatly. At low doses the most prominent effect is similar to that of alcohol intoxication, with generalized numbness and reduced sensitivity to pain. As the amount of PCP increases, the person becomes more insensitive and may become fully anesthetized. Large doses cause coma, convulsions, and death.

Common effects include flushing, excessive sweating, and a blank stare. The size of the pupils is not affected by PCP. At higher doses side-to-side eye movements (**nystagmus**), double vision, muscular incoordination, dizziness, nausea, and vomiting may occur. Also, tremors, jerky movements, and grand mal and prolonged seizures may follow high doses.

PCP's psychological effects are unpredictable. Any combination of the following may occur with use: mood fluctuations, distortions in thinking, exaggerated sense of well-being, exhilaration, sedation, drunkenness, delusions, auditory and visual hallucinations, and violent behavior.

In some users, PCP causes psychotic reactions that last for weeks or months. Some researchers believe that permanent brain damage can result from PCP use. The withdrawal effects associated with chronic PCP use include anxiety, depression, and short-term memory difficulties.

Psilocybin Mushrooms Although they are not as popular as the synthetic drugs, **psilocybin mushrooms** are encountered at raves and clubs and are used by high school and college students. Mushrooms can be ingested alone or in combination with alcohol or illegal drugs. The mushrooms can be soaked or boiled in water to make tea, and often are cooked and added to other foods to mask their bitter taste. The physical effects of the mushrooms appear within 20 minutes of ingestion and last approximately 6 hours. These effects include nausea, vomiting, muscle weakness, yawning, drowsiness, tearing, facial flushing, enlarged pupils, sweating, and lack of coordination. Other physical effects include dizziness, diarrhea, dry mouth, and restlessness.

The psychological and physical effects of the drug include changes to audio, visual, and tactile senses. Colors reportedly appear brighter, and users report a crossing of the senses, such as seeing a sound and hearing a color. Users often report a sense of detachment from their body and a greater feeling of unity with their surroundings. Furthermore, the high is described as a more natural

sensation than that supplied by synthetic hallucinogens. A large dose of the drug produces hallucinations and an inability to discern fantasy from reality. This sometimes leads to panic reactions and psychosis. No evidence of physical dependence exists, although tolerance does develop when mushrooms are ingested continuously over a short period of time. Individuals tolerant to LSD also show tolerance to mushrooms.

Date-Rape Drugs

Certain drugs are being used to incapacitate individuals and thereby facilitate sexual assault. The drugs that are used most frequently as date-rape drugs are Rohypnol, GHB, and ketamine. These substances are typically slipped into a victim's beverage at a party or bar while a drink is left unattended or the person is distracted. After ingestion, the victim feels disoriented and may appear drunk. This leaves the victim very vulnerable, and the perpetrator often volunteers to drive the victim home. Hours later, a victim may wake up in unfamiliar surroundings with little or no memory of what has happened.

Rohypnol **Rohypnol** (flunitrazepam) is a powerful sedative-hypnotic in the same class of drugs as Valium (diazepam). It is 10 times stronger than Valium. Rohypnol has never been approved for medical use in the United States. It is illegal to possess in the United States but is available as a prescription drug in several countries, including Mexico. Much of the Rohypnol that comes into the United States comes from Mexico. Rohypnol has been linked to several sexual assaults. It is known on the street as "roofies," "roachies," "rib," "forget pill," and "mind-erasers."

GHB **GHB** (gamma hydroxybutyric acid) is another drug with high potential for abuse as a date-rape drug. GHB acts powerfully as a central nervous system depressant, taking effect within 15 minutes. Its effects are similar to Rohypnol, causing dizziness, confusion, overwhelming drowsiness, and unconsciousness. Victims often cannot remember events that occur after the drug is ingested. It is easily obtained and can be manufactured by amateur "basement" chemists. It comes in liquid form and can be easily slipped into drinks because it is colorless and odorless. However, it may be detected because it has a slightly salty taste. Several deaths have been attributed to GHB abuse. GHB is also known by the following names: "Georgia Home Boy," "Grievous Bodily Harm" (GBH), "Liquid X," "Easy Lay," "G," and "Bedtime Scoop."

Ketamine **Ketamine** is a legal drug in the United States that is approved for use as a veterinary anesthetic. It produces a dissociative effect similar to the drug PCP. Ingestion of ketamine causes hallucinations and feelings of being separated from one's body. Amnesia and dreamlike memories make it difficult for a date-rape victim to remember whether a sexual assault was real or imagined. An unsuspecting victim of date rape could easily be given a dangerous overdose of this drug. Taking too high a dose of ketamine can cause the heart to stop.

The main source of ketamine for illegal use is through stealing the drug from veterinary clinics. "Special K," "K," "Vitamin K," and "Bump" are street names for ketamine.

Alcohol Perpetrators of sexual assault now have new drugs to add to their arsenal of date-rape drugs. Yet alcohol has been used for many years as a date-rape agent. A majority of victims of date rape are drunk or have been drinking when the assault occurs. Alcohol is a central nervous system depressant. Drinking alcohol can impair judgment and cause disorientation. Drinking large amounts of alcohol can cause a person to pass out. These effects place a young person at high risk of being taken advantage of sexually.

Protection Against Date-Rape Drugs A date-rape drug can be slipped into any type of beverage. For this reason, young people should be taught not to drink any beverage that they did not open for themselves. This may require a person to refrain from drinking from a container that is passed around or from a punch bowl. Young people should also be instructed never to leave a drink unattended. Drinks that were left unattended are best discarded rather than drunk. When offered a drink at a party or social event, the person should go to where the drink is opened, carefully watch it being poured, and then carry the drink himself or herself. Warn young people to avoid drinking a beverage that has an unusual taste or appearance (e.g., salty taste, excessive foam, unexplained residue). Also, warn young people not to accept rides home from strangers.

Inhalants

Substances inhaled to induce psychoactive effects, such as euphoria or intoxication, can be classified into three basic groups: volatile solvents, aerosols, and anesthetics. The **volatile solvents** include the chemical components (e.g., toluene, acetone, benzene) of commercial products such as plastic (model) cement, fingernail polish removers, paint thinners, gasoline, kerosene, typewriter correction fluid, and lighter fluid. **Aerosols** are products discharged by the propellant force of compressed gas. Chemicals in the aerosol products and the propellant can be toxic. Many abused aerosols contain gases of chlorinated or fluorinated hydrocarbons, nitrous oxide, and vinyl chloride. Various aerosol products are abused, including hair sprays, spray paints, cooking sprays, and Freon gas. Many aerosols and volatile solvents are extremely poisonous and can damage body organs and systems.

Anesthetics include ether, chloroform, nitrous oxide, halothane, and related gases. Nitrous oxide (laughing gas) is the most widely used; it is available as an anesthetic and commercially as a tracer gas to detect pipe leaks, as a whipped-cream propellant, and as a pressurized product to reduce preignition in racing cars.

Children commonly abuse the volatile solvents and aerosols. There are two major types of young inhalant abusers: experimenters, or transitional users, who

either quit using or move on to other drugs, and chronic abusers. Chronic abuse is usually limited to those who have limited access to more popular mind-altering substances, such as the young and the very poor. Inhalant experimentation is widespread among the young. Chronic inhalant abuse is often related to parental alcoholism and neglect or abuse.

Frequently, the abused substance is emptied or sprayed into a plastic or paper bag, which is held tightly over the nose and mouth, and the fumes are inhaled. A cloth may be dipped in a liquid solvent, or the active solvent may be applied to the cloth, which is then held against the nose and/or mouth.

Many hazards are associated with inhalant abuse. Each inhaled substance carries different hazards. Because these substances are often poisonous, long-term (e.g., brain damage, hepatitis) or short-term damage to body tissues and organs is possible. Fatal overdoses occur when the central nervous system is depressed to the point that breathing stops. The risk of accidents is high because these substances often affect reasoning, orientation, and muscle coordination. Suffocation and asphyxiation can also occur.

Anabolic Steroids

Anabolic steroids are synthetic derivatives of the male hormone testosterone. The full name is *androgenic* (promoting masculine characteristics) *anabolic* (building) *steroids* (the class of drugs). These derivatives of testosterone promote the growth of skeletal muscle and increase lean body mass. Anabolic steroids were first abused by athletes seeking to improve performance.

Today, athletes and others use anabolic steroids to enhance performance and also to improve physical appearance. Anabolic steroids are seldom prescribed by physicians today. Current legitimate medical uses are limited to certain kinds of anemia, severe burns, and some types of breast cancer.

Because these drugs produce increases in lean muscle mass, strength, and ability to train longer and harder, athletes in a variety of sports are attracted to these substances in hopes of enhancing athletic performance and improving physique. Young people are attracted to anabolic steroids in efforts to accelerate their physical development.

Anabolic steroids are taken orally or injected, and athletes and other abusers take them typically in cycles of weeks or months, rather than continuously, in patterns called cycling.

Cycling involves taking multiple doses of steroids over a specific period of time, stopping for a period, and starting again. In addition, users frequently combine several different types of steroids to maximize their effectiveness while minimizing negative effects, a process known as **stacking**. Steroids are produced in tablet or capsule form for oral ingestion or as a liquid for intramuscular injection. Those who inject anabolic steroids run the risk of contracting or transmitting hepatitis or the HIV virus that leads to AIDS.

Steroid users subject themselves to serious side effects and hazards, many of which yet remain unknown, particularly when high doses are used over long

periods of time. Some side effects appear quickly, such as trembling, acne, jaundice (yellowish pigmentation of skin, tissues, and body fluids), fluid retention, and high blood pressure. Others, such as heart attack and strokes, may not show up for years.

A major concern of anabolic steroid use is the impact upon physical growth and development. Among adolescents, anabolic steroids can prematurely halt growth through premature skeletal maturation and accelerated pubertal changes.

In males, use of steroids can cause shrinking of the testicles, reduced sperm count, infertility, baldness, and development of breasts. In females, irreversible masculine traits can develop along with breast reduction and sterility. Females using anabolic steroids may also experience growth of facial hair, changes in or cessation of the menstrual cycle, enlargement of the clitoris, and deepened voice.

Aggression and other psychiatric side effects may result from anabolic steroid abuse. Many users report feeling good about themselves while on anabolic steroids, but researchers report that anabolic steroid abuse can cause wild mood swings, including manic-like symptoms, which lead to violent, even homicidal, episodes. Depression is often seen when the drugs are stopped and may contribute to steroid dependence. Users may suffer from paranoid jealousy, extreme irritability, delusions, and impaired judgment stemming from feelings of invincibility.

Signs of steroid use include quick weight and muscle gains (if steroids are used in conjunction with weight training); behavioral changes, particularly increased aggressiveness and combativeness; jaundice; purple or red spots on the body; swelling of feet or lower legs; trembling; unexplained darkening of the skin; acne; and persistent breath odor.

Drug Injection and Disease Transmission

Increased HIV and hepatitis B and C transmission is a likely consequences of drug abuse, particularly in individuals who inject the drug and share injection equipment. Infection with HIV and other infectious diseases is spread among injection drug users primarily through the reuse of contaminated syringes, needles, or other paraphernalia by more than one person. Drug abusers can then pass on these infections to sexual partners and children. In nearly one third of Americans infected with HIV, injection drug use is a risk factor, making drug abuse the fastest growing vector for the spread of HIV in the nation.

Key Terms

Monitoring the Future (MTF) 240
National Survey on Drug Use and Health (NSDUH) 240
Youth Risk Behavior Survey (YRBS) 240
normative education 249
peer tutors 251
peer counselors 251
wellness 259
high-risk students 262

support groups 263
nicotine 268
bidis 271
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family hero 281
scapegoat 283
lost child 284
mascot 285
Al-Anon 286
Alateen 286
oxycodone 286
cocaine 287
crack cocaine 287
formication 287
methamphetamine 288
speed 288
meth 288
chalk 288
crystal 288
crank 288
fire 288
glass 288
ice 288
heroin 289
black tar heroin 289
physical dependence 289
withdrawal symptoms 289
cold turkey 290
marijuana 290
blunts 290
THC 290
hashish 290
hashish oil 290
club drugs 293
MDMA 293
Ecstasy 293
e 293
LSD 294
hallucinations 294
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bad trip 294
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PCP 295
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psilocybin mushrooms 295
Rohypnol 296
GHB 296
ketamine 296
volatile solvents 297
aerosols 297
anesthetics 297
anabolic steroids 298
cycling 298
stacking 298

Review Exercise

1. Define and explain the relative importance of each of the key terms in the context of this chapter.
2. Discuss the various problems that accompany use of psychoactive substances and the characteristics of young substance abusers.
3. Summarize the key findings of the 2008 MTF report and discuss the implications for education and attention on drug use.
4. Give examples of how media promote alcohol and tobacco use and evidence of marketing to youth.
5. Discuss the effectiveness of antismoking campaigns by the tobacco industry and others.

6. Identify the key components of the surgeon general's Call to Action to Prevent and Reduce Underage Drinking.
7. Summarize each of the substance abuse prevention strategies, paying particular attention to how each is effectively carried out.
8. Identify the principles of effective substance abuse prevention programs.
9. Identify the recommended topics and focus for substance abuse prevention education at various grade levels.
10. Discuss the substance abuse prevention curricular and support needs of high-risk students.
11. Describe the various means by which substance abuse prevention can be infused into the curriculum of subjects other than health.
12. Summarize the important facts, figures, and concepts about tobacco use regarding nicotine; health consequences of smoking; cigarette and cigar smoking in youth; cigarette smoking and girls; smokeless tobacco use; tobacco use prevention; and cessation programs in schools.
13. Identify additional health risks girls who smoke have and explain why females might be more susceptible to tobacco addiction and effects.
14. Discuss the problems and statistics associated with alcohol use among young people.
15. Discuss causes, characteristics, youth to adult comparisons, and signs and symptoms of alcoholism.
16. Discuss the statistics, impact, and effects of growing up in a family where one or more individuals has an addiction.
17. Explain the roles children of alcoholics take on and specific things teachers can do to help children acting in each role.
18. Identify the administration, effects, hazards, and any street names for the following drugs: cocaine, methamphetamine, heroin, oxycodone, marijuana, MDMA, LSD, PCP, psilocybin mushrooms, Rohypnol, GHB, ketamine, aerosols, and anabolic steroids.
19. Name diseases associated with drug abuse and explain how they are transmitted.
20. Identify resources and teaching activities you can use that will help you promote a tobacco-free and drug-free lifestyle in your classroom.

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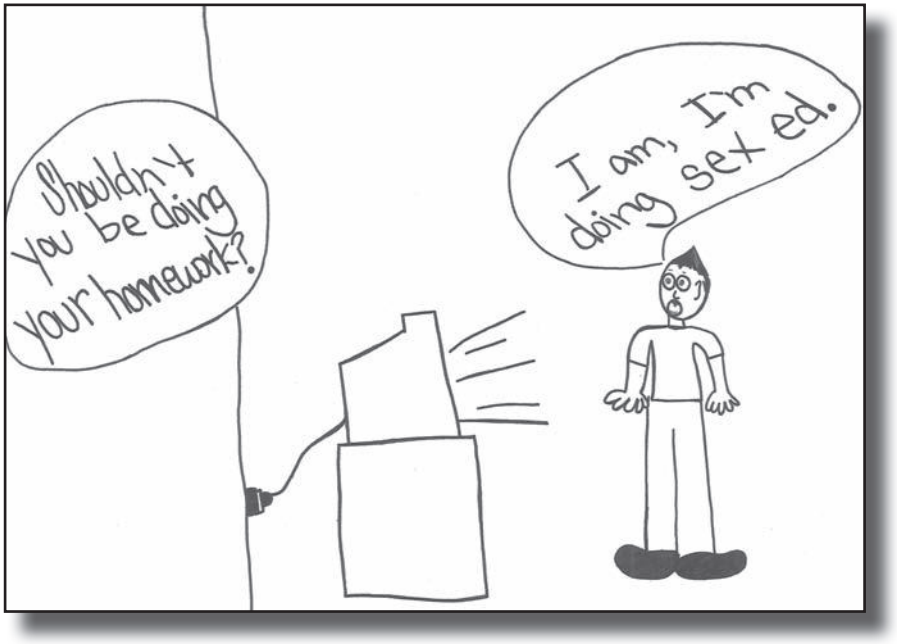
8

Promoting Sexual Health



In Your Opinion

The following are polled answers to the question: Should condoms be made available on high school campuses?

Yolanda Jackson, high school student. Sure. Almost everyone I know is sexually active. What's the big deal? Having condoms available won't make kids do it more, but might help them be more responsible. AIDS is scary, but pregnancy is the real problem. Four of my friends have already had babies.

Edith Rollings, teacher. No. I'm all for responsible sex education, which, in my opinion, should be abstinence education. Giving out condoms in high schools is going too far. It's like telling kids to not drink and drive and then giving them a beer.

Earl Richardson, teacher. No. Sex is more prevalent and more dangerous than when I was a kid, but the problem isn't obtaining condoms. We could easily get them back then and so can kids now. Kids have trouble remembering to use condoms, not get them. They don't need a free handout at school.

Tie Owyang, high school student. No. I think the real answer is in having TV condom advertisements. I guess some people are scared of erotic commercials, but what's the difference between that and movie previews or MTV?

Susan Nelson, mother and PTA member. Yes. Let's face it, TV is this nation's biggest sex educator. I know some parents who are dead set against sex education in the schools, but don't monitor the TV shows or movies their kids watch. Kids need help, especially now that sex is so dangerous. Few kids find that help at home, so let the schools do it.

Gary Sorenson, principal. I know school districts in Seattle, New York City, Chicago, Baltimore, and Los Angeles are distributing condoms in their high schools. I don't think that we are ready for that here, but then this is a question for the school board to answer.

Adolescence is a developmental time period that is largely about forging a personal identity. During adolescence, youths undergo the process of puberty and attain physiological sexual maturation. Most adolescents are extremely sensitive about their physical appearance and many are confused about issues of sexual activity. Adolescents feel newly developed biological sexual urges and impulses. There is much in society to arouse these feelings. Sex is pervasive in advertising, on television shows, in movies and videos, and in other forms of media. Parents and schools encourage abstinence from sexual activity at the same time that the mass media glamorize sex. Peer pressure about sexual activity can be either negative or positive. For example, it is common for youths to report feeling pressure from peers to experiment and engage in early

sexual activity. Yet, on the other hand, some youths say that they feel support for sexual abstinence from peers. Religious and cultural beliefs also exert strong influence on decisions about sexual activity. Young people observe that the issues surrounding youth sexual activity are emotionally charged and evoke a wide range of opinions and reactions from teens, parents, and educators.

In the midst of such confusion, young people must make decisions about their involvement in sexual activity. Young people face developmental challenges in making decisions. Teens and preteens often lack the maturity, experience, and range of options that adults have when making decisions about sexual activity. They have a tendency to engage in short-range thinking, focusing more upon present desires than on long-term consequences of decisions. Also, it is common for young people to feel a strong sense of personal invulnerability. As a result, they do not perceive the need to avoid risks. These factors help explain why a high percentage of young people engage in sexual behaviors that place them at great risk for unintended pregnancy and acquiring sexually transmitted infections (STIs), including human immunodeficiency virus (HIV) infection.

Teenage Sexual Activity

Results from **Youth Risk Behavior Surveys** show that sexual activity begins early for many teens. The percentage of high school students who initiated sexual intercourse before 13 years of age is about 7% and almost a third have had intercourse by the ninth grade. Between 1990 and 2005, the percentage of students who had ever had sexual intercourse significantly decreased when the rates dropped from 54% to 47%. The 2007 Youth Risk Behavior Survey reported that 48% of high schools students had ever had sexual intercourse, 35% were currently sexually active, and about 15% had had sexual intercourse with four or more partners. Sixty percent used a condom during last sexual intercourse and about 16% said they used birth control before. Additional data available on the CDC website indicate, unfortunately, that the number of teenagers giving birth is on the rise again for the first time in 15 years. Data also show an increase in sexually transmitted infections among young people.[1]

Teen pregnancy and sexual intercourse are not the only sexual behaviors of concern. Results from a recent survey commissioned by the National Campaign to Prevent Teen and Unplanned Pregnancy show that 21% of teen girls and 18% of boys have sent/posted nude or seminude images of themselves. Sexually suggestive messages (text, e-mail, instant messages) are even more prevalent than sexually suggestive images. Nearly 40% of all teens say that they have sent or posted sexually suggestive messages. Nearly 50% say that they have received such messages.[2]

Media and Sexual Content Concerns

American media, both programming and advertising, are highly sexualized in their content. The American Psychological Association estimates that the

Nearly two thirds of young people have television sets in their bedrooms. This is concerning in light of the amount and type of sexual content portrayed during nighttime programming.

average young viewer is exposed to 14,000 sexual references and innuendos per year on television alone. This number does not come close to the many other sexual messages conveyed through exposure to other media, including movies, music, magazines, billboards, radio, and the World Wide Web. Television, movies, and music videos now routinely air images that were taboo not too many years ago. Programs created for adult audiences are often viewed by children. The Nielsen Ratings found that the television show *Desperate Housewives* was the most popular broadcast network TV show for kids ages 9 to 12 years.

The amount of sexual material, including sexually violent material, has dramatically increased since past decades. Studies by the Kaiser Family Foundation show that there are eight sexual incidents per hour during the "family hour" on television (7–9 P.M.), which is a fourfold increase since the mid-1970s. Programs aimed for teenager audiences were the most frequent offenders, and very few scenes contained any information related to the risks and responsibilities of sexual activity.[3]

Advertisers have also increasingly used sexual titillation to attract the attention of potential customers, with much of the sexual imagery and depiction bordering on what would have been considered pornography a decade ago. Sexual images and themes are used in an attempt to grab the consumer's attention. Images of sexy bodies used to sell products are seen almost everywhere in our environment, from the corner store magazine covers, to billboards, to posters plastered anywhere and everywhere.

Given the heavy dose of sexual messages that young people receive through media sources, the entertainment industry is our nation's primary source of sex education. This is a scary fact when you consider what is often portrayed during a typical week of network TV fare. There also has been a proliferation of cable TV channels and movie channels into the homes of many families—bringing more seductiveness to young people, often in their own bedrooms. The inappropriateness of much of what is on the popular media is even more disconcerting in light of the fact that young teens (ages 13 to 15) rank entertainment media as their top source of information about sexuality and sexual health.[4] It is interesting to note that although many of our school-based sex education programs promote abstinence to avert problems such as unintended pregnancy and sexually transmitted infections, our media mock abstinence as a choice.

Research has been conducted to see how sexualized media affects young people. Four longitudinal studies have linked exposure to sexy media to an earlier onset of sexual intercourse, and another study has linked early exposure of sexy media to teenage pregnancy.[5] One study followed teens over time and found that the teens who were exposed to high levels of television sexual content (90th percentile) were twice as likely to become pregnant in the 3 following years than those with lower levels of exposure (10th percentile).[6] See **Box 8-1** for activities to analyze media influence.

8–1
In the Classroom

Assessment and Learning Activities for Analyzing Media Influence

The following are teaching activity ideas that you can adapt for assessment in many grade levels (indicated as in previous chapters.) Be sure also to review the additional skills and activities in Chapter 5, Media Literacy Skills.

Counterfeits of Love

Use the following chart to help you discuss the differences between lust, infatuation, and love with your students. Discuss how literature and the media often portray lust and infatuation as love. Talk about the many relationship problems that develop from believing the love myths perpetuated by fictional characters in books and on the screen. (I, J, H)

(*continues*)

(*continued*)

Lust	Infatuation	Love
Visceral.	Cupid's arrow—fall into and out of it. No control over it.	Takes time, develops, not discovered. Is something you do, not something that happens to you.
Self-centered, predatory. Uses other person as an object.	Self-gratifying—someone you want to be seen with, or fear of being left behind or missing out (everyone else is paired up).	Deep concern for the welfare of the loved one. True love gives.
Can consume thoughts, comments, and activities. Focuses on "stimuli," not person.	Feelings based on illusions and idealizations; exaggerations of other's good points.	Feelings based on reality—mature love sees more, not less, but because it sees more, it is willing to see less.
Varying states of physical arousal.	Loss of appetite; hard to concentrate. Can be short-tempered and irritable.	Eat, study, excel because you want to be your best for the other.
No desire for relationship other than for physical gratification.	Insecure; in love with being loved; jealousy.	Happy because you are sure and secure.
Tells lies in order to get sex.	Disagree easily. Focused on love feeling rather than on coming to deeply know and understand the other.	Readiness to listen to and understand other's perspective.
Lacks self-control or restraint.	Feel like must have sex or marry to cement relationship.	Recognize sex is a natural part of love, but have sexual restraint to prevent consequences for self and loved one and don't want sex to get in the way of developing the relationship. Marriage and sex can wait till the right time.

TV Analysis

Assign various students to watch different TV channels for specific blocks of time during one week. (Use wisdom and care in making these assignments.) Have the students record the number and types of sexual material presented on the pro-

(*continues*)

gramming and commercials. Combine all the student's reports into a graph format for an analysis of one week. Discuss the amount and appropriateness of the sexual material presented in light of the time of day and probable audience; the messages "taught" or "caught" from such material, the misconceptions and myths perpetuated, the demographics of those involved in sexual behaviors in contrast to real life (married vs. single, etc.), and the relative number of negative consequences of sexual behaviors depicted. Have students write letters of concern to the advertisers of programs they found troubling, or to the companies whose advertising was found distasteful. (J, H)

Understanding Adolescent Sexual Development

Today, adolescents are maturing physically at an earlier age than did previous generations (see **Figure 8-1**). This increases the likelihood that they will not have been exposed to sexual education before they experience changes caused by their own sexual development. It also increases the period of sexual exploration between puberty and marriage. Moreover, youths 10 to 12 years of age may be physically mature, but their still-limited cognitive reasoning abilities make providing information about, or discussing, sexuality issues all the more challenging. Moreover, their emotional or social development may not be keeping pace with their new physical maturity.

By the time most youths reach the age of 13 or 14, they have some sense of their body image and have developed a general sense of their self-worth, for better or for worse. At that age, most of that sense of self is related to how their parents, teachers, other significant adults, and peers have treated them. Clearly, young people do not grow up in isolation. They do so in families, schools, and communities. The culture of each affects young people's self-perception, their decision making, their behavior, and their view of the future.

Youths also are socialized regarding their sexual development through a range of cultural images and messages from their parents, their religious advisors, the media, and their peers. Yet, this socialization is more random than that which occurs in most other areas. Consider the example of teaching young people to brush their teeth, a dissimilar activity but relevant in terms of the discipline necessary to maintain a healthy lifestyle. Parents teach their children about brushing their teeth at a relatively early age, and then spend considerable time coaching youngsters to develop the habit of brushing at least twice a day.

In the area of sexuality, almost the reverse happens. The cultural norms regarding sexuality tend to limit open discussion. Even in close families, parents often do not display physical affection, and most do not talk with their children about relationships or intimacy. Young people, therefore, have few role models with regard to relationships and little exposure to appropriate sexual behavior.

- Signs of sexual development in girls appear at younger ages today than in the past.
- One in seven white girls starts to develop breasts or pubic hair by age 8.
- Nearly one of every two African American girls shows these signs by the age of 8.
- Early sexual maturation causes pressures that young girls are not prepared to handle—pressure to act like teenagers or even adults.
- Early maturing girls have to cope with pressures from boys who are interested in them sexually.
- Scientists have not figured out with certainty what's causing early sexual maturation.
- Some scientists believe it may be due in part to the increase in obesity—overweight girls tend to mature earlier,and very thin girls, such as those with anorexia nervosa,tend to mature later than normal.
- Some scientists believe that seeing sexualized messages in the media and elsewhere might trigger brain chemicals that "jumpstart" sexual development.

FIGURE 8-1 Teens before their time.
Source: Adapted from Lemonick M. Teens before their time. *Time*. 2000;156(18):66–74.

When introduced to sexuality education and concepts such as reserving sexual activity for a loving relationship later in life, young people can grasp these ideas intellectually, but often they do not have an experiential or real-life frame of reference.

Promoting Responsible Sexual Decisions

All young people need careful guidance about making decisions about sexual activity. They need the skills necessary to successfully avoid dangerous or risky behavior. It is critical for young people to recognize the dangers they may encounter and to be taught negotiation and decision-making skills. Then, adequate time must be given to young people and their peers to practice those skills. In addition, young people need to develop a sense of personal responsibility to protect both themselves and others from risky behavior. They need to know that they are valued and have worth as individuals so that they will feel important enough to protect themselves.

The most appropriate and effective place for this guidance is from loving parents. The role of parents is vital to the successful development of children and adolescents. It is a difficult job that requires support and assistance from educational institutions and community agencies. Unfortunately, many young people do not have adults in their lives who can effectively provide the nurturing

and guidance that they need. Some of these young people are particularly vulnerable to involvement in sexual activity that places them at risk of unintended pregnancy and infection with sexually transmitted infections. For this reason, schools must play an active and vital role in teaching young people how to make responsible decisions about sexual activity.

Sex Education

Sexuality education, when done properly, reflects the needs of the community. **Sex education** programs need to be locally determined and consistent with parental and community values. Therefore, those who teach sex education must not only be familiar with the subject matter, but must also be sensitive to the attitudes of their students, the parents of students, community groups, and school administrators. They must examine their own personal attitudes toward sensitive and controversial topics and be prepared for how students, parents, and administrators might react to these issues. They must be thoroughly familiar with state and district policies regarding the teaching of sex education.

Most states require that public schools teach some form of sex or STI/HIV education. The current status of individual states' policies regarding sex education is posted at http://www.guttmacher.org/statecenter. This information is frequently updated to reflect changes in state policies regarding sex education and other family life issues. Most states place requirements on how abstinence or contraception should be handled when included in a school district's curriculum. One aspect of whether students receive instruction on sex or STIs/HIV is the existence of parental consent requirements. These are sometimes called "opt-out" clauses and they allow parents to remove students from instruction that the parents find objectionable.[7] See **Box 8-2** for HECAT recommendations for sex education.

Some sex education teachers encounter negative reactions from parents or community groups opposing certain sex education topics. However, when parents are provided the opportunity to visit the school to learn what will be addressed through the sex education curriculum (and how it will be taught), most parents welcome support in helping their children develop healthy relationships that are based on information, choice, respect, and responsibility. Most parents support the teaching of sex education in schools.

Effective sex education is much more than teaching about pregnancy and sexually transmitted infections (see **Box 8-3**). It requires going beyond just providing accurate information. To help young people, sex education must assist them in their decision-making process. It must also offer life skills training (e.g., communication skills, negotiation skills, refusal skills, relationship skills) that helps young people avert

8-2
Background on . . .

HECAT Recommendations for Sex Education Curriculum

Health Education Curriculum Analysis Tool (HECAT) is a curriculum analysis tool that can help teachers, school districts, and states review their curricula to see whether they meet National Health Education Standards and the CDC's Characteristics of Effective Health Education Curricula. Following are overview recommendations for sex education curricula. You can find more specific and detailed grade-level recommendations (by grades 2, 5, and 8) at http://www.cdc.gov/healthyyouth/HECAT.

A pre-K–12 sexual health curriculum should enable students to:

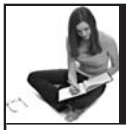
- ☐ Establish and maintain healthy relationships
- ☐ Practice and maintain sexual abstinence
- ☐ Seek support to be sexually abstinent
- ☐ Avoid pressuring others to engage in sexual behaviors
- ☐ Return to sexual abstinence if sexually active
- ☐ Support others to avoid sexual risk behaviors
- ☐ Seek health care professionals to promote sexual health

Additional risk-reduction outcomes not addressed in a risk-avoidance curriculum are:

- ☐ Limit the number of sexual partners if sexually active.*
- ☐ Use condoms consistently and correctly if sexually active.*
- ☐ Use birth control consistently and correctly if sexually active.*

adverse consequences from sexual activity and fosters healthy development. To do this, educational programs must present both the risks of involvement in sexual activity and the specific actions young people can take to avoid these risks. Particular emphasis must be given to helping youths build relationship skills because relationships are the context in which sexual activity occurs. Learning activities should also address media influences on sexual behavior because the media are a strong and pervasive influence on youths.

Effective sexual education programs also help young people to examine the risks of becoming sexually active within the context of planning for their future. Sex education programs take into account the cognitive developmental level of students and the various capacities of students at each particular grade level. Sufficient time must be devoted to building student trust because the issues



8-3
Application Exercise

Self-Inventory

Teaching sex education is challenging because of the breadth and range of topics. Review the following topics and reflect on how (1) comfortable and (2) prepared you feel you are to teach each area.

- Reproductive anatomy and physiology (e.g., male and female reproductive systems, menstruation, nocturnal emissions)
- Sexual development (e.g., physiological development [puberty], psychological development, cultural and societal influences, sex roles)
- Human reproduction (e.g., fertilization and conception, prenatal development, pregnancy, childbirth)
- Family life issues (e.g., parent–child relationships, parenting skills, marriage, divorce, single parenting)
- Relationships and interpersonal skills, including decision making, assertiveness, and peer refusal skills
- Responsibility regarding sexual activity, including addressing abstinence and how to resist pressures to become prematurely involved in sexual activity
- Contraception and/or birth control
- HIV infection and other sexually transmitted infections
- Sexual abuse and assault (e.g., date rape, incest, child sexual abuse, sexual harassment)
- Controversial issues (e.g., abortion, homosexuality, pornography)

addressed in sex education programs are more complex and personal than in any other area of the curricula. Specialized support and/or immediate referral to such support must be in place for youths who, as a result, disclose sexual abuse or other serious problems.

Abstinence Education

Abstinence from sex is often stressed in school-based sex education programs because it is the most effective way to prevent unintended pregnancy and sexually transmitted infections, including HIV. The Centers for Disease Control and Prevention (CDC) states that "abstinence from vaginal, anal, and oral intercourse is the only 100% effective way to prevent HIV, other STIs, and pregnancy. The correct and consistent use of a male latex condom can reduce the risk of STI transmission, including HIV infection. However, no protective method is

100% effective, and condom use cannot guarantee absolute protection against any STI or pregnancy."[8]

Engaging in early sexual activity can also delay emotional and personal development and limit opportunities for young people to build a strong future. For all of these reasons, **abstinence education** is emphasized in most school-based sex education programs. However, there is considerable debate and lack of agreement about how to carry out abstinence education. Some sex education programs are broadly classified as "abstinence-only," whereas others are categorized as "abstinence-plus." **Abstinence-only education** generally teaches abstinence from all sexual activity as the only appropriate option for unmarried people. These programs often do not teach about contraception or condom use or, if discussed, do not provide detailed information. **Abstinence-plus education** emphasizes the benefits of abstinence while also teaching about contraception and disease-prevention methods, including condom and contraceptive use. Abstinence-plus programs are also sometimes referred to as **comprehensive sex education**.[9] Educators can reinforce abstinence as a healthy choice by addressing normative expectations. Young people tend to think "everyone's doing it," but research indicates that many young people are choosing to be abstinent. The following sections look at how abstinence education is often carried out.

Health Concerns Because of concerns about sexually transmitted infections and HIV, as well as teenage pregnancy, educators are choosing to emphasize abstinence from sexual intercourse to lower the health risks and prevent disease.

Emotional Concerns Choosing to abstain from sexual activity gives youths the time and freedom to discover who they are and make long-range goals for the future, rather than becoming caught up in defining themselves in terms of a dating game. Abstinence gives youths time to learn how to develop quality relationships rather than superficial ones based primarily on physical drives. Abstinence also helps youths develop social skills, discover healthful ways of expressing emotions and needs, gain time to focus on developmental tasks, and develop character as they learn self-control, delayed gratification, respect for self and others, and responsibility for their own actions. Abstinence also protects them from the emotional baggage that can come with promiscuity.

Parent–Child Communication Communication between parents and their children is an important factor in deterring sexual activity among teenagers. Many school, community, and religious groups offer parent–child sexuality classes. These classes help parents articulate the value they put on abstinence and help them to define, with their teens, exactly what they want them to abstain from and why. It is interesting that many parents who have resisted sexuality education for their children often support classes that include them. Such programs provide activities that increase parent–child communication about sexuality and give opportunities for parents to share expectations and values with their children. (Chapter 3 includes additional information on communication skills.)

Refusal Skills Teenagers report that the pressures to engage in sexual activity are strong. Many curricula provide **refusal skills** activities to teach young people to resist this pressure. Many of these skills are also useful in resisting pressures to engage in other health-risky behaviors (e.g., substance use). Resisting the pressure to engage in sexual activity with someone a young person cares for is much more difficult than refusing sex from a "creep." Young people should be taught that pressure may also come from someone they like and/or find attractive. This requires stronger commitment and adherence to personal values. (Refusal skills are also discussed in Chapter 7.)

Decision-Making Skills Youths need to understand that they are responsible for their own behavior and that it carries consequences, both favorable and unfavorable. Unfortunately, many young people do not see this link between personal behavior and behavioral consequences for their life goals. Providing opportunities for youths to grapple with decision making often leads to the determination that delaying sexual activity is best for their futures. (Specific guidelines and teaching activities regarding decision-making skills can be found in Chapter 3.)

Goal-Setting Skills As young people mature, they develop the cognitive ability to begin analyzing their feelings and developing their own sense of self. They begin to understand what is in their best interest, not only for today but for the future. When young people receive guidance in setting and working toward goals that will ensure a bright future, they understand that an adverse consequence from engaging in sexual activity (e.g., unintended pregnancy, HIV infection) could prevent them from achieving those goals. This focus on the future is central to effective prevention education and should be at the core of all related activities. Discussions of how engaging in sexual activity can damage future opportunities are central to promoting abstinence as a healthful choice. (Chapter 3 provides additional information on goal setting, and **Box 8-4** contains assessment activity ideas for sex education and human development.)

8-4
In the Classroom

Assessment and Learning Activities for Sexual Health

These are a few ideas for activities you can use in your classroom while teaching sex education and human development. Be sure also to include the life skills in Chapters 3, 4, and 5 when planning your curriculum. These skills are vital compo-

(*continues*)

(*continued*)

nents of promoting sexual health. Also check out the numerous lesson plans and materials you can access that are listed in Box 8-5.

Healthy Relationships

Burnt Cake

Bake two cakes, one as directed and one on much higher heat. Use the cakes as an object lesson to initiate what happens when young people try to grow up too fast (they or others "turn up the heat"). You could also leave out one or more of the key ingredients in one cake and then liken the various ingredients to skills needed for growing up and having healthy relationships. (I, J, H)

Warning Signs

On the back of printed warning signs write a characteristic of an unhealthy relationship (jealousy, lying, possessiveness, neediness, lust). Discuss examples of these warning signs that adolescents have seen live or in the media. Discuss how to get out of an unhealthy relationship. (I, J, H)

Human Development

Timing

Set three or more alarm clocks to go off during class at random times. Turn each off as they go off, but don't say anything until the final alarm sounds. Students will be eager to know what it's all about. Explain how puberty is "set to go off" at different times (ages) in different people. Have everyone line up shortest to tallest. Tell the students to rearrange themselves to the height they think they will be at age 20. (I, J)

Body Image

Talk about how the media influences our body image. Streaming videos such as the Dove ad deconstruction and Killing Me Softly can be found on the Media Literacy Clearinghouse link bank at http://www.frankwbaker.com/streaming_ml.htm. Be sure to get administrative clearance before using any video in class. (I, J, H)

Birth Video

Show the miracle of birth. Nova offers an hour-long program divided into eight chapters at http://www.pbs.org/wgbh/nova/miracle/program.html. (J, H)

(*continues*)

Waste Days

On and around holidays it is often difficult to keep students academically focused. Try out these activities on the following holidays: (P, I, J, H)

Halloween. Memorize bones and then have a tag test using a decoration skeleton that is intact or taken apart. Assemble various X-rays in a class window. Build a model of the spinal cord and nerves using empty spools of thread and string. Discover what muscle groups do by stretching large rubber bands across the body where the muscles are located.

Thanksgiving. Trace where Thanksgiving dinner goes (digestive system).

Valentine's Day. Discover the similarities between a valentine heart and a real heart (divide it in two and then across the top = the two upper atria and the two lower ventricles). Make a huge diagram of a heart using an old sheet or plastic table cloth and an overhead projector. Have students draw for a chance to be a red blood cell traveling through the heart.

Risks and Responsibilities of Sexual Activity

Wheel of Misfortune

Divide the class into groups. Have each group design a "Wheel of Misfortune" game based on the TV program *Wheel of Fortune*. Instruct students to design their wheels so that they contain physical and emotional problems associated with premature sexual involvement. (I, J, H)

Pass the Cookie

Hold up two cookies. Ask one or more students to wait in the hall. While they are gone have every student take turns holding one of the cookies and doing anything they want to it except change its appearance. Invite those in the hall to come back in. Explain what happened in their absence. Ask them to identify which of the two cookies they would like to eat. Discuss how this object lesson is like HIV or STI transmission. (I, J, H)

Flour Tote

Have students carry around a 10-pound bag of flour (baby) everywhere they go for one or more days. Explore other ways of making this time resemble being responsible for a real baby. Discuss what was learned. (J, H)

(*continues*)

(*continued*)

Abstinence

Great Comebacks

Ask the class to identify and list on the board 10 or more examples of sexual pressure (e.g., "Don't worry, I'll take care of everything," "Nobody will know but us," "If you love me . . ."). Divide the class into pairs. Have each pair come up with a great comeback for each of the listed pressures (e.g., "If you love me . . ."—"If you loved me, you wouldn't pressure me!"). Have class members share their comebacks. Write the best comebacks next to their corresponding pressures on the board. (I, J, H)

Everybody's Not Doing It

(Read "Normative Education" on page 249 in Chapter 7.) Poll students to determine what percentage of their peers they believe are sexually active. Discuss how and why youths often overestimate the number of adolescents who are sexually active. Discuss the true figures. (You can find national figures at http://www.cdc.gov/HealthyYouth/yrbs/index.htm.) Discuss why many youths choose to be or become sexually inactive. (J, H)

Life Line

Give each student seven small pieces of paper (3- by 5-inch). Have students write at the top of each of their papers their name, a future age (e.g., 18, 23, 28, 35, 45, 55, 65), and what they want to be doing or have accomplished by the indicated age. Have the students clip their "age papers" to a life line made by stringing a clothesline or similar cord from one end of the classroom to the other. Encourage students to read one another's papers as they are clipping theirs up. Discuss how decisions made in their adolescence can affect the rest of their lives. (I, J, H)

Drawing the Line

Create a sexual continuum on the board ranging from holding hands to intercourse. Ask the students to mentally draw a line on the continuum that they do not want to cross at this point in their lives. Tell the following two stories to impress upon students the importance of "drawing the line" early, way before the point they don't want to cross. After telling the stories, discuss safety rules for "flying well above the trees" and staying far away from "dangerous cliffs." Such rules might include "date in groups" and "avoid being alone with the other person." (J, H)

(*continues*)

Story 1. In World War II some pilots participated in "tree topping" to impress others with their flying skills. They would fly close enough to break off the very tips of trees. This practice became prohibited because of the number of planes that ended up in the trees. A new safety rule was set in place so that the minimum altitude at which a pilot could fly was well above the trees.

Story 2. A company was interviewing truck drivers for hauling precious cargo across a mountain pass. When asked about a particularly hazardous curve on a steep cliff, one applicant said, "I could take that corner going 60 miles an hour while driving on the outside shoulder." A second applicant said, "I would gear down, and drive slowly and as close as possible to the hill side of the road." Which of the two applicants would you hire to drive your precious cargo?

Virginity Pledges

As part of a larger sex education program, give students the opportunity to pledge "I won't" until swearing "I do." These can be written documents that students sign on the dotted line. Those who have been sexually active can pledge to become sexually inactive. (I, J, H)

Good Clean Fun

Youths need alternative activities to avoid sexual pressures and situations. Many such activities are listed in Box 7-4. Review these suggestions and ask students for additional ideas that provide good clean fun. (I, J, H) Many additional activities that would be relevant in a sex education program can be found in Chapter 2. These activities can be altered to meet specific needs.

HIV Prevention Education

Most states mandate HIV prevention education in schools. Health experts urge that education about HIV should start in early elementary school and at home so that children can grow up knowing how to protect themselves against HIV infection. They further emphasize that HIV prevention education should be offered in the context of a comprehensive school health education program (grades K–12). In addition to simply providing information about HIV transmission, students should be provided with opportunities to develop skills for decision making and resisting personal and social pressures.

School-based programs are critical for reaching youths before behaviors are established. Because risk behaviors do not exist independently, topics such as HIV, STIs, unintended pregnancy, tobacco, nutrition, and physical activity

What do children know about AIDS? Education about AIDS should start in elementary school with information about HIV transmission and developing skills for making decisions and resisting pressure.

should be integrated and ongoing for all students in kindergarten through high school. The specific scope and content of these school health programs should be locally determined and consistent with parental and community values. Research has clearly shown that the most effective programs are comprehensive ones that include a focus on delaying sexual behavior and provide information on how sexually active young people can protect themselves.[10]

Kindergarten Through Third Grade Kindergarten through third grade is the time for educators to establish a foundation for a more detailed discussion of sexuality in later grades. Children should be encouraged to feel positive about their bodies. It also is important for them to know about their body parts and the differences between girls and boys. The primary goal during the early elementary years should be to dispel the fear of AIDS. To do this, teachers can tell students that young children rarely get AIDS. Teachers should also communicate that there is no need to worry about playing with children who have family members with AIDS or have AIDS themselves. They cannot get the disease from playing with these children. Because children at this age are interested in germs and how disease is spread, teachers can discuss HIV as one of many diseases. They can answer questions about AIDS directly and simply; responses can be limited to questions asked by students. Children should be warned not to play with hypodermic needles that they may find in neighborhoods or elsewhere. They should also be taught to avoid contact with other people's

blood and the importance of cleaning up bodily fluids in a safe manner. Educators can also discuss having compassion for those living with AIDS.

Upper Elementary Grades Children in upper elementary grades should be provided with basic information about human sexuality. They will need help understanding puberty and the associated changes in their bodies. Part of this understanding is affirming that their bodies will have natural sexual feelings. Children should be urged to examine and affirm their own family values about sexuality. Upper elementary level children need to have answers to their questions about AIDS and HIV prevention. It is appropriate at this age level to begin discussing the ways HIV is transmitted (e.g., sexual intercourse, sharing needles). Students should also recognize that alcohol and other drugs can increase the risk of infection by lowering a person's ability to act responsibly.

Secondary Level At the secondary level, the major emphasis of HIV prevention education should be to teach students to protect themselves and others from infection with HIV. Information about HIV prevention should focus on healthy behaviors rather than on the medical aspects of the disease. Students should clearly understand that they have a right to abstain from sexual intercourse and to postpone becoming sexually active. Adolescents should be taught that abstaining from sexual activity is the best way to prevent HIV infection. It should be stressed to secondary students that alcohol and other drugs influence individuals to make very poor choices. HIV prevention education needs to allow students to examine and confirm their own values. Decisions can be reinforced by providing adequate opportunities to rehearse resisting peer and social pressure to engage in risky behaviors. Questions about HIV must always be answered honestly and factually.

Educators should not assume that all students will choose to abstain from sexual activity and/or substance use. For these students, proper information concerning risk reduction (e.g., using condoms, avoiding injecting drugs) should be provided. Still, these behaviors must never be condoned by school personnel. It is important to stress that young people do not have to continue their risky behavior. High-risk youths should be offered assistance in changing their risky behavior patterns.

Effective HIV prevention must take place over the course of many years and be developmentally appropriate. Teachers should strive to provide information about HIV prevention clearly and in sufficient detail for each grade level. Students should also be encouraged to ask questions and be given the opportunity to ask questions anonymously. HIV prevention education should also include discussion of critical social issues associated with HIV infection (e.g., civil liberties, protection of public health, health care costs, compassionate care of HIV-infected people) and teach skills that will enable students to continue to evaluate HIV-related issues.

HIV prevention is too important to be left to health educators alone. All teachers and school personnel who work with young people should receive HIV

prevention information as part of inservice and preservice training. In this way, all school personnel can effectively and sensitively assist in HIV prevention efforts. **Box 8-5** lists where free lesson plans, curriculum guides, and materials for promoting sexual health are available.

8–5
In the Classroom

Free Resources for Teaching Sexual Health

You can find lesson plans on sexual health and human development for elementary, middle, and high school levels at these websites:

- Discovery Education: http://school.discoveryeducation.com/lessonplans/programs/humandev
  http://school.discoveryeducation.com/lessonplans/health.html#k-5
  http://school.discoveryeducation.com/lessonplans/health.html#6-8
  http://school.discoveryeducation.com/lessonplans/health.html#9-12
- Teacher Planet: http://www.teacherplanet.com/; click on H—Human Body
- Utah Education Network: http://www.uen.org/curriculumsearch/SearchResults.do;jsessionid=1181BE81F214EA1781332B2B77E35E56
- Nebraska Department of Education: http://www.nde.state.ne.us/PEHealth/conferences.html
- Alberta Government: http://www.teachingsexualhealth.ca

You can access materials for teaching sexual health and human development at these websites:

- The National Campaign to Prevent Teen and Unplanned Pregnancy: http://www.teenpregnancy.org
  Examples of teen pregnancy in the media, audio and video clips, PowerPoint presentations
- StayTeen.org: http://www.stayteen.org/quiz
  "What would you do?" Quiz
- The National Campaign to Prevent Teen and Unplanned Pregnancy: http://www.thenationalcampaign.org/tooyoung
  Too Young Educational Video
- Kaiser Family Foundation: http://www.kff.org/youthhivstds/3040-02.cfm
  Fact sheet
- Prongo.com: http://prongo.com/human/game.html
  Human Body Quiz Game

Contraceptives

Young people who are sexually active need to make decisions about the use of **contraceptives**. Talking about contraceptives in schools raises many concerns and points of view. Many argue that teaching about contraceptives is necessary because many unmarried adolescents are already sexually active. However, many teachers feel uncomfortable discussing sexual matters in the classroom, and many concerned parents, community groups, and religious organizations promote the idea that it is immoral or irresponsible to suggest the use of contraceptives to young people. Further, it is difficult to get sexually active adolescents to regularly and properly use contraception because all methods require planning. It should be pointed out that school programs that promote contraceptives do not lead to an increase in sexual activity.

Successful contraception for sexually active teens requires the performance and foreplanning of a complex sequence of behaviors. First, a young person must admit that he or she is sexually active and then he or she can make decisions about contraception use. The teen must learn relevant information about conception and contraception and must evaluate contraceptive methods in terms of personal advantages and disadvantages. The youth also must evaluate the barriers to obtaining and using needed contraceptives. A teen using contraception will need to acquire the contraceptive method. This usually requires a public acquisition, such as purchasing condoms at a store or visiting a health department or health clinic. Once the teen has obtained contraceptives, the adolescent must consistently and correctly use the chosen contraceptive. Often, this requires action prior to each instance of sexual intercourse. A difficult task for most young people is engaging in presex discussions and negotiations of contraception with a partner.

Anticipating sexual activity, consistently practicing contraception, acquiring contraceptives, and persuading partners to behave in a certain way are difficult tasks for adults, let alone teens, considering the cognitive inability of many adolescents to consider and plan for future outcomes. Educators should consider using simulations to teach young people these skills. Simulations should allow students to make decisions about sex, social life, relationships, school, and work and then "live" with the consequences of their choices in all areas of their life. Perhaps such exercises can succeed in extending the time orientation of adolescents to a point where they can envision the outcomes of choices and weigh decisions more thoughtfully.

Some areas of the country now offer contraceptive services through school-based clinics. The presence of school-based clinics in schools does not appear to increase the rates of sexual activity among students attending the schools.

Controversial Issues

Most states have guidelines or mandates on how controversial sex education issues are to be (or not to be) addressed in the classroom. The importance of

educators becoming familiar with state and school district policies regarding the teaching of sex education cannot be overemphasized. Knowing the policies helps educators plan curricula as well as know best how to respond to questions or comments that arise in class.

Perhaps the most emotionally and politically charged health issues today center around **lesbian, gay, bisexual, and transgender (LGBT)** people. The LGBT community wants their way of life seen as normal and natural while the opposing view sees homosexuality as deviant behavior. Students often voice these opposing views at school, in or out of class, and can become combative and militant in their expression. It is important for teachers to teach and model how to respectfully disagree. **Respectfully disagreeing** with someone entails letting the other person voice her point of view without interruption and voicing your perspective without demeaning those you disagree with. Unfortunately, disagreeing respectfully is not often modeled in the media where emotionally charged and derogatory comments "sell" news. It is important to help students see that bashing or harassing anyone (gay or ultraconservative) is unacceptable.

A related issue is how to handle personal questions about sexual orientation. It is not uncommon for an adolescent to question his or her sexual orientation and seek the advice of a trusted teacher. There are two helpful points teachers can share with students in a situation like this. First, let the student know that it is not uncommon for girls to have "girl crushes" on a girl and for boys to have "boy crushes" on boys. Young people often feel a strong attraction to someone they admire or esteem. These feelings do not necessarily mean that they are lesbian or gay. It is also helpful for students to know that it is common for adolescents to be aroused by sexuality in general, whether from a same or other gender source. For instance, a 14-year-old boy might become aroused while checking in the boys' locker room to see how he compares with classmates. His arousal does not necessarily mean that he has homosexual tendencies. Second, teachers can emphasize the need for teenagers to remain sexually abstinent for reasons beyond avoiding pregnancy and STIs. Teens need time to develop socially and emotionally and come to know who they are. Premature sexual involvement can present a major roadblock in their psychosocial maturation.

Abortion is another hotly debated topic in this society and a controversial sex education issue. In states and school districts where it is included in the curricula, it is important for educators to identify the arguments and facts given both for and against abortion. Some teachers have found it helpful to poll students for their perspective and then assign them to debate the opposite point of view. This helps students focus on facts and arguments rather than on being argumentative. It also helps them develop critical thinking and research skills.

Pornography can be controversial in two respects. First, there are differing perspectives on what constitutes pornography, and second, there are differing views on how harmful viewing pornography is. However, there is no controversy over children and adolescents being the subject of pornographic images or being solicited to pornographic sites. Students need to know how to protect themselves from pornographic producers and distributors, including other youths

who electronically share pornographic materials. The American Psychological Association reports that pornography can warp a teenager's perspective on sexuality.[11] Students need to be warned that viewing pornography can warp their attitudes and expectations about sex and mess up their relationships. For example, girls can be affected by viewing unattainable body images and hypersexualized behavior, and perceiving the message presented in pornography that the female body is an object for pleasing others.

Peer-Led Prevention Programs

Peer education is a highly effective prevention strategy with youths. **Peer education** uses exemplary young people as credible prevention messengers to promote healthy lifestyles among other young people. Peer educators can present material about the risks of sexual activity in ways that are highly relevant to young people. Adolescents often find prevention messages more believable when they are delivered by their peers.

Peer-led prevention efforts are popular at many schools. However, many more such efforts utilizing peer educators are needed. An example of an innovative peer-led prevention effort is the Sex Can Wait program. High school students are trained to work with middle school students. They teach self-respect and give concrete reasons for remaining abstinent. Instead of just telling the middle school students why they shouldn't have sex, the older teens also tell them how to say no. They perform skits emphasizing this message and assist the younger students in practicing ways of saying no to sexual activity. The program also has benefits for the peer educators. It teaches leadership and reinforces the skills that can keep them from falling to peer pressure to have sex. When teens make a public commitment not to have sex, it reinforces their decision to remain abstinent.

Teen Parenthood Programs

Teens who have been sexually active, become pregnant, and choose to bear their babies need a considerable amount of support and help with making decisions. Educators must make comprehensive efforts to assist pregnant teens in ensuring adequate prenatal, obstetric, and pediatric care to prevent adverse consequences associated with pregnancy and childbirth. Young teens with children usually need training in parenting skills and programs to help keep them in school so that they can finish their high school degree and meet other educational and career goals. These young people need to learn skills to prevent subsequent unintended pregnancies as well. Both the adolescent mother and adolescent father share many of these needs.

Programs for Out-of-School Youths

School-based programs do not reach all youths at risk. Those adolescents not in school—because they have graduated or dropped out—need to be reached with the same kind of basic information that schools provide to all others. Many youths at very high risk for STIs, HIV infection, and unintended pregnancy, such

as homeless or runaway youths, juvenile offenders, or school dropouts, can be reached only through intensive community-based programs. Integrating prevention programs with ongoing community efforts to provide shelter, medical care, or other services to out-of-school youths is essential. Schools can play an important role in supporting these programs and referring students who drop out to these programs and services. **Box 8-6** includes assessment and learning activities to help students become advocates.

8-6
In the Classroom

Advocacy, Outreach, and Integration Activities

These are a few examples of how you can help your students be advocates for sexual health by reaching out and involving families, the school, or community, and how you can infuse other subjects with sexual health concepts.

Family Dinner

Assign students a project that has to be completed during family dinner and takes more than one night to complete. It could be a questionnaire that reveals previously unknown information (where did you have your first kiss?). The objective is to encourage family meal time, discussion, and stronger family ties.

Walk in Her Heels

Sponsor a schoolwide day where every "caring" male wears a pair of girls' shoes to school. In classes, discuss what new perspectives on women's issues this activity gives.

Integration ideas for teaching sexual health in other content areas include the following:

Math: Have students compute the costs of having a baby (medical, food, diapers, clothes, etc.). Cost-related information can be found at http://www.teenageparent.org/english/costofbaby2B.html.

Language Arts: Have students develop a brochure on a STI that contains information on cause, facts, statistics, and treatment. Students can get the needed information at http://www.cdc.gov/std.

Social Studies: Have students identify and discuss the role marriage has played in societies through time. Why have cultures and governments cared so much about marriage? What economic and social problems are associated with single women raising children?

Problems Associated with Youth Sexual Activity

The following sections examine in depth the risks of youth sexual activity.

Emotional Consequences

Even if promiscuous youths escape the harsh consequences of sexual activity—pregnancy, HIV infection, or an STI—they can experience negative emotional consequences. This is evidenced by the numerous young adults who state they wish they would have waited longer before becoming sexually active. It can take years for individuals to overcome the emotional baggage of early-age sexual activity. Some never completely overcome lingering emotional effects. Following are 10 possible emotional dangers of premature sexual involvement[12]:

1. *Worry about pregnancy and STIs.* Sexually active young people can experience a great deal of stress over the possibility of being pregnant or having contracted an STI. Receiving a negative pregnancy or STI screening test can relieve their fears, but the stress reemerges at their next sexual encounter. Many youths don't get screened but remain sexually active, turning this stress into a chronic condition.

2. *Regret and self-recrimination*. Young women often report feeling used, stupid, and cheap after sexual encounters. Girls are especially vulnerable to this because they are more likely to think of sex as a way of "showing they care." They may become physically intimate in an effort to try to "keep the guy," but become ignored or "dumped." Giving one's self for nothing can be emotionally devastating. Youths can also regret losing their virginity as they realize sex isn't exactly what it is hyped to be.

3. *Guilt*. Many people report having a guilty conscience about having sex. This can come from not living up to religious expectations or from seeing the pain they have caused in others. Guilt can also come from knowing that their parents would be upset if they knew the teen was having sex. Parents can be crippled by guilt regarding their own early sexual activity. Their reluctance to be hypocritical can keep them from advising their children about the dangers of premature sexual involvement.

4. *Loss of self-respect and self-esteem*. Discovering that one is pregnant or has contracted an STI can have a monumental impact on one's sense of confidence and worth. Casual sex also can lower self-esteem. An oppressive cycle can develop of casual sex leading to lowered self-esteem leading to more casual sex. When people treat other people as objects, they not only hurt them but also lose respect for themselves. Getting drunk and having sex with someone not remembered later or having sex for a sexual conquest results in a loss of self-respect for both parties.

5. *Corruption of character and the debasement of sex.* People corrupt their characters and debase their sexuality when they treat others as sexual objects

and exploit them for their own pleasure. The breakdown of the character traits of self-control and delayed gratification are major factors in many of the sex-related problems plaguing society: pornography, sexual harassment, sexual abuse, infidelity in marriage, and rape. Character is also corrupted when people tell lies to get sex. Lies can range from "I love you" to "I've never had a sexually transmitted infection."

The debasement of sex is too often seen on school campuses. In school hallways, students can be heard using profane language. Teenage boys clubs have been reported to exist in which members compete to see how many girls they can have sex with. Elementary schoolchildren have been found playing sexual contact games in which points are earned by touching another's private parts. And sadly, many young people have stated that forced sex is permissible if a man and woman have been dating for 6 months or more.

6. *Shaken trust and fear of commitment*. Individuals who feel betrayed or used after breaking up from a sexual relationship can experience difficulty in future relationships. Girls can see guys as interested in just one thing and wonder if anyone will ever love and accept them without demanding sex to earn that love. Boys can also feel a loss of trust and a fear of commitment. Some young men report engaging in one-night stands because they are afraid of falling in love.

7. *Rage over betrayal*. Sex can create an emotional bond that hurts terribly when broken. Rage and violence can result when an individual feels betrayed. News networks often report on the violent acts of former lovers.

8. *Depression and suicide*. The emotional pain caused by a terminated sexual relationship can be enormous, especially if one of the partners thought it was "the real thing." Sometimes the emotional turmoil of a broken relationship can lead to deep depression. Depression in turn can lead to suicide. Rage turned inward has also resulted in suicide.

9. *Ruined relationships*. Sex can turn a good relationship bad. It can quickly become the focal point, block other means of communicating love, and stunt the balanced growth of a relationship.

10. *Stunting personal development*. Some young people have used sex, like alcohol and drugs, ineffectively to try to cope with life's pressures. Teens caught up in intense sexual relationships thwart their individual growth and sense of identity. They are focusing on one thing when they need to be forming friendships with others, developing skills and interests, and taking on larger social responsibilities. Promiscuous youths can have trouble expressing and meeting their own needs and the needs of others. They can also have trouble setting long-range goals and creating a plan for their lives.

Unintended Teen Pregnancy

International comparisons show that U.S. teen pregnancy and teen birth rates are the second highest among 46 countries in the developed world.[13] At one time, they were the highest. The decline in teen pregnancy rates in the United States between 1990 and 2005 was primarily because of an increase in the use of contraception and because teens were having less sex.[14] There is concern that the national teen pregnancy rate spikes in 2006 and 2007 may reveal an escalating trend. The National Campaign to Prevent Teen Pregnancy reports that three in 10 girls in the United States become pregnant at least once before they reach age 20. These numbers are even higher for certain population segments: 51% of African teenagers and 53% of Hispanic teenagers become pregnant before age 20. Currently, there are about 730,000 pregnancies and 400,000 teen births annually in the United States (see **Figure 8-2** and **Box 8-7**).[15]

More than 80% of teen pregnancies are unplanned, meaning they occurred sooner than desired or were not wanted at any time. In addition to becoming sexually active, lack of contraceptive use is a major cause of teenage preg-

Thirty-four percent of girls become pregnant at least once before age 20—the vast majority are unintended pregnancies.

Every year more than 830,000 adolescents become pregnent. U.S. teen pregnancy and birth, STIs, and abortion rates are considerably higher than in other developed countries.

FIGURE 8-2 Teen pregnancy—a U.S. problem.
Source: Centers for Disease Control and Prevention. Preventing Teen Pregnancy. Available at http://www.cdc.gov/ReproductiveHealth/AdolescentR. Accessed September 21, 2009.

nancy. Sexually active adolescents are reluctant to use contraceptives for the following reasons:

- ❖ They do not believe they could conceive.
- ❖ They do not expect to have intercourse.
- ❖ They want to keep their sexual activity private.
- ❖ They are embarrassed to discuss sexual matters with others (e.g., partners, friends, parents, counselors, physicians, health care providers).
- ❖ They believe that using condoms takes all the pleasure out of intercourse.
- ❖ They believe that birth control decisions are female decisions.
- ❖ They believe myths such as the following:
  You can't get pregnant the first time you have intercourse.
  You can't get pregnant if you are standing during intercourse.
  You can't get pregnant if a girl is still having her period.
  You can't get pregnant if a boy withdraws in time.
  You can't get pregnant if you douche afterward.
  You can't get pregnant if you use foam afterward.
  You can't get pregnant if you take a birth control pill afterward.

There are other reasons that teens become pregnant besides failure to use contraception. Some desire to have a baby as a sign of maturity or even as a type of status symbol. Some teens view motherhood as a way of achieving love or feeling needed by someone else. Others use pregnancy as a means of escaping

8-7
Background on . . .

Teen Pregnancy

The following provide details on why teen pregnancy is bad for the mother, the child, and all of us.

Teen pregnancy is bad for the mother because:

- Future prospects for teenagers decline significantly if they have a baby.
- There are serious health risks for adolescents who have babies.
- Teen pregnancy is closely linked to poverty and single parenthood.

Teen pregnancy is bad for the child because:

- Children born to teen mothers suffer from higher rates of low birthweight and related health problems.
- Children of teens often have insufficient health care.
- Children of teen mothers often receive inadequate parenting.
- Children with adolescent parents often fall victim to abuse and neglect.
- Children of teenagers often suffer from poor school performance.

Teen pregnancy is bad for us all because:

- The United States leads the fully industrialized world in teen pregnancy and birth rates.
- Teen pregnancy costs society billions of dollars a year.
- Teen pregnancy hurts the business community's bottom line.

Source: Adapted from National Campaign to Prevent Teen and Unplanned Pregnancy. Teen Pregnancy—So What? February 2004. Available at http://www.thenationalcampaign.org/media/jls.aspx. Accessed August 25, 2009.

an unhappy or abusive family situation. Teen mothers can obtain federal and state aid to support their babies through such programs as Medicaid, Aid to Families with Dependent Children (AFDC), and food stamps.

Serious consequences are associated with teenage pregnancy. Babies carried by teenage mothers are at high risk for complications of pregnancy, birth, and infant development. The pregnancy outcomes of teenagers who receive good prenatal care are no different from those of older women. The problem is that pregnant adolescents, and particularly young adolescents, are much less likely to receive that care. As a result, pregnant adolescents are more likely to give birth to premature and low-birthweight infants. The babies born to adolescents are at risk for decreased rates of growth and intellectual development, and are susceptible to infections, injuries, and violence. Teens who become mothers are often poor and dependent on public assistance for their economic support.

Teen mothering is associated with a plethora of problems. Daughters of teenage mothers often become teenage mothers themselves.

The consequences for a teen mother or father often include the following:

- Early dropout from school
- Poor academic performance and achievement
- Increased economic needs resulting from the presence of a baby
- Decreased ability to earn and provide because of lack of education
- Increased likelihood of teenage girl being a single parent and staying a single parent
- Increased likelihood of repeat pregnancies
- Limited life options for teen parents and children reared by teen parents

Teen girls who have babies are likely to become pregnant again in the short-term future. About one fourth of teen mothers have a second child within 24 months of the first.[15] Children of teen mothers are also at increased risk for being teen parents themselves. These children are at increased risk for dropping out of school as adolescents. Approximately 55% of teen pregnancies end up in birth; 14% end up in a miscarriage, and 31% in abortion. In most states, teens who give birth can legally place their child for adoption without parental consent and involvement, but only a small percentage of these babies are placed in adoptive homes.

Diseases Associated with Youth Sexual Activity

HIV Infection

Young people in the United States are at persistent risk for HIV infection. This risk is especially notable for youths of minority races and ethnicities. Infection with **human immunodeficiency virus (HIV)** is the most frightening potential consequence of youth sexual activity. HIV is the cause of AIDS (acquired immunodeficiency syndrome). This virus attacks the cells of the immune system so that the body loses its ability to fight infection and certain cancers. As a result, people with AIDS are susceptible to life-threatening diseases, called **opportunistic diseases**, which are caused by pathogens that do not cause illness in healthy people.

The most common means of transmitting HIV from person to person is through sexual contact with an infected partner. During sexual contact, HIV can enter the body through the lining of the vagina, vulva, penis, rectum, or mouth. Another common means of transmitting HIV is the sharing of needles or syringes used to inject drugs. Transmission occurs when needles or syringes are contaminated with minute quantities of blood from someone infected with HIV.

Young people are at greatest risk of HIV infection if they have unprotected sex outside of a mutually monogamous relationship between two HIV-negative individuals, use injection drugs, or use alcohol or other drugs that impair their decision-making abilities. Those who have many different sex partners and who inject illicit drugs into their bloodstream are at even greater risk. Individuals with other sexually transmitted infections (e.g., chlamydia, herpes) are at increased susceptibility of acquiring HIV infection during sex with an infected partner.

HIV-infected females can pass the virus to their fetuses during pregnancy or birth. About one fourth of HIV-infected females who do not receive treatment pass the infection to their babies. The virus can also be passed to the baby through breast milk after delivery. The chances of passing HIV to a baby are greatly reduced if the mother is given the drug AZT during pregnancy.

Concerns that HIV can be transmitted through casual contact are unfounded. The virus is not spread through the sharing of food utensils, towels and bedding, swimming pools, telephones, or toilet seats. Closed-mouth kissing does not carry risk of HIV transmission. However, health authorities advise against open-mouthed kissing ("French" kissing) with an infected person because of the possibility of contact with blood. HIV also is not spread by biting insects such as mosquitoes or bedbugs.

Sexually Transmitted Infections

Sexually transmitted infections (STIs) continue to be a problem for American youths. According to the CDC, one fourth of the reported STI cases each year occur among teenagers (see **Box 8-8** for information on disease-causing agents). One in two sexually active persons will contact an STI by age 25.[16] Many of

8-8
Background on . . .

Disease-Causing Microbes

Microbes are organisms too tiny to be seen without a microscope. They are abundant and can be found everywhere—in air, soil, water, plants, animals, and the human body. Many microbes are essential for healthy life and we could not exist without them, but some cause disease. Most microbes belong to one of four major groups: bacteria, viruses, fungi, or protozoa.

Viruses are among the smallest microbes. Viruses are not cells. They consist of one or more molecules of DNA or RNA, which contain the virus's genes surrounded by a protein coat. Viruses can be rod shaped, sphere shaped, or multisided. They have no way to reproduce on their own. They infect cells and take over their reproductive machinery to reproduce. Viral diseases can be very difficult to treat because viruses live inside the body's cells, where they are protected from medicines in the bloodstream. Only a few antiviral medicines are available to prevent and treat viral infections and diseases. Antibiotics are not effective against viruses.

There are thousands of types of **bacteria**. Bacteria are single-celled organisms that are much larger than viruses, but still too small to be seen without a microscope. Under a microscope, bacteria look like balls, rods, or spirals. They are capable of reproducing on their own and often have threadlike structures, called *flagella*, which help them to move around. Bacteria often produce disease by releasing toxins into the body. Bacterial diseases are sometimes effectively treated by antibiotic drugs. However, there is increasing concern about antimicrobial resistance. Some bacteria are becoming resistant to the killing effects of these drugs. This has become a very serious problem, especially in hospital settings.

There are millions of types of **fungi** in our environment. Those most familiar to us are mushrooms, yeast, mold, and mildew. Fungi also live in or on the human body. Many do not cause disease, but there are those that do cause disease. Diseases caused by fungi are called *mycoses*. Antifungal medicines are available to treat fungal infections of the skin as well as those within the body.

Protozoa are microscopic one-celled animals that come in many shapes and sizes. Protozoal infections are difficult to treat because drugs that destroy the protozoa may also destroy human cells.

The following table displays sexually transmitted infections (STIs) by type of microbe.

Viral STIs	Bacterial STIs	Fungal STI	Protozoal STI
HIV/AIDS	Syphilis	Candidiasis	Trichomoniasis
Genital warts	Gonorrhea		
Genital herpes	Chlamydia		
Hepatitis B			

these young people will suffer long-term health consequences as a result. The high rate of sexual activity among young people increases the likelihood of being exposed, infected, or transmitting a host of infectious diseases.

There are now more than 25 known sexually transmitted infections. Many of these diseases are passed from one person to another unknowingly because the carrier may not feel ill or may come to feel ill after he or she has already passed the disease to unknowing victims. Some diseases regarded as STIs can be transmitted through other means (e.g., from a mother to an unborn or newborn child, through blood transfusions, by sharing contaminated needles). The primary means of transmission of these diseases, however, is through sexual contact. Therefore, the most effective means of prevention is to avoid sexual contact.

Young people who are sexually active put themselves at high risk of acquiring a sexually transmitted infection. The greater the number of partners with whom an individual has sexual contact, the greater the risk of developing an STI. *Safe sex* refers to sexual practices that are important in preventing the spread of STIs. One safe-sex practice is the use of a condom during sexual activity. This reduces but does not eliminate the risk of STI transmission from one partner to another. Use of nonoxynol-9, a common ingredient in spermicidal jellies and foams, in combination with a condom reduces the risk of spreading an STI from one person to another during sexual intercourse. Avoiding other practices, such as oral-genital and anal-genital contact, also reduces the risk of contracting an STI.

Young people who are sexually active should seriously consider the risks of developing an STI and consider postponing sexual contact. They should also know the potential signs and symptoms of STIs. If any of the following are present, early medical advice and treatment should be sought:

- Any unusual discharges from the genitals
- Pain in the genital area
- Burning sensation in or around the genitals (especially during urination)
- Sores on or near the genitals
- Frequent urination
- Lower abdominal pain
- Itching around the genital or anal area
- Growths or warts in the genital area

Common STIs Among Teens

Teens are at high risk for acquiring most STIs. Teenagers and young adults are more likely than any other age groups to have multiple sex partners and to engage in unprotected sex. Also, young females are likely to choose sexual partners older than themselves.

Chlamydia and gonorrhea are the most common curable STIs among teens and the rates of infection for both are climbing. **Chlamydia** is the result of a bacterial infection and is the most common sexually transmitted infection in the United States today. Forty percent of all chlamydia cases are reported among 15- to 19-year-old adolescents.[17] Read more on chlamydia in **Box 8-9**. **Gonorrhea**, also a bacterial infection, is one of the oldest and most widespread sexually

8–9
Background on . . .

Chlamydia

Chlamydia is the most frequently reported bacterial sexually transmitted infection in the United States. Chlamydia can be transmitted during vaginal, anal, or oral sex. Chlamydia can also be passed from an infected mother to her baby during vaginal childbirth. Chlamydia is known as a "silent" disease because about three quarters of infected women and about half of infected men have no symptoms. If symptoms do occur, they usually appear within 1 to 3 weeks after exposure. If untreated, chlamydial infections can progress to serious reproductive and other health problems with both short-term and long-term consequences. Like the disease itself, the damage that chlamydia causes is often silent.

In women, untreated infection can spread into the uterus or fallopian tubes and cause pelvic inflammatory disease (PID). This happens in up to 40% of women with untreated chlamydia. PID can cause permanent damage to the fallopian tubes, uterus, and surrounding tissues. The damage can lead to chronic pelvic pain, infertility, and potentially fatal ectopic pregnancy (pregnancy outside the uterus). Women infected with chlamydia are up to five times more likely to become infected with HIV, if exposed.

To help prevent the serious consequences of chlamydia, screening at least annually for chlamydia is recommended for all sexually active women age 25 years and younger. An annual screening test also is recommended for older women with risk factors for chlamydia (a new sex partner or multiple sex partners). All pregnant women should have a screening test for chlamydia.

Complications among men are rare. Infection sometimes spreads to the epididymis (a tube that carries sperm from the testis), causing pain, fever, and, rarely, sterility.

An estimated 2.8 million Americans are infected with chlamydia each year. Women are frequently reinfected if their sex partners are not treated.

Source: Centers for Disease Control and Prevention. Chlamydia—CDC Fact Sheet. Available at http://www.cdc.gov/std/chlamydia/STDFact-Chlamydia.htm. Accessed August 24, 2009.

transmitted infections. Chlamydia and gonorrhea produce similar symptoms, and most females with these infections are asymptomatic and unaware that they are infected. These bacterial infections can easily be treated with antibiotics if detected early enough. However, if these diseases remain undetected and untreated, they can result in severe health consequences later in life, including pelvic inflammatory disease (PID), a major infection of the entire female reproductive tract that can lead to permanent sterility or even death. Babies born to females with chlamydial or gonorrheal infections can acquire serious eye infections that lead to blindness.

An increasing number of individuals acquire genital herpes or genital warts, both viral STIs, during the teenage years. **Genital herpes** is a viral infection caused by a herpes simplex virus that cannot be cured. These viruses are very contagious, and their resulting infection is characterized by recurrent and unpredictable outbreaks. Herpes infection results in painful, blister-like sores that may appear on the sex organs, the mouth, or the face. Although the sores go away, the herpes virus remains in the body, so the sores reappear periodically throughout the person's lifetime. The herpes virus can be spread from a mother to her baby during vaginal delivery and can be fatal to the baby. **Genital warts** are the result of infection with the **human papillomavirus (HPV)**. They cause considerable discomfort and embarrassment for an infected person. They are highly contagious and can easily spread to a sexual partner and to a baby during delivery. Females with genital herpes and genital warts are at higher risk for having cervical cancer in their lifetimes than those who have not been infected.

In 2006, the FDA approved the Gardasil vaccine for girls and women ages 9 through 26. This vaccine prevents infection with the types of HPV that cause most cases of cervical cancer and genital warts. It is important to note that this vaccine does not provide any protection for other STIs including chlamydia and gonorrhea. The CDC's Advisory Committee on Immunization Practices recommends that girls ages 11 and 12 receive the three-dose vaccination. Gardasil is also recommended for girls and women ages 13 through 26 years who have not yet been vaccinated or who have not received all three doses.

Syphilis, hepatitis B, and chancroid are STIs that are declining among teens and other age groups. **Syphilis** is a bacterial infection that when detected early can be treated effectively with antibiotic drugs. However, untreated syphilis can cause destructive effects in the body and even birth defects in a developing baby if a pregnant female carries the infection. Infection with **hepatitis B virus** can cause serious viral infection of the liver.

Hepatitis B is preventable through vaccination. **Chancroid** is a highly infectious STI caused by a bacterium that can cause ulcers in the genitals or painful swelling in the groin area, or both. Chancroid can be effectively treated with antibiotics.

Other STIs that teens may acquire include trichomoniasis, candidiasis, and pubic lice. **Trichomoniasis** is a common STI caused by a protozoal organism. This organism can also be spread by towels, sheets, and other objects because the protozoan can remain alive on external objects for up to 1.5 hours. **Candidiasis**

is caused by *Candida albicans*, a yeastlike fungus that creates intense vaginal itching and burning sensations. **Pubic lice**, known as "crabs," are parasites that are spread by sexual contact. These lice attach to the pubic hair and feed on the blood of a host.

Key Terms

Youth Risk Behavior Surveys 305
sex education 311
abstinence education 314
abstinence-only education 314
abstinence-plus education 314
comprehensive sex education 314
refusal skills 315
contraceptives 323
lesbian, gay, bisexual, and transgender (LGBT) 324
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pubic lice 338

Review Exercise

1. Define and explain the relative importance of each of the key terms in the context of this chapter.
2. Summarize the rates, trends, and concerns for teenage sexual activity.
3. Discuss the prevalence of sexual content in media, including trends, concerns, and effects.
4. Describe the sexual development of adolescents, including physical and cognitive maturation amid social, family, and cultural influences.
5. Discuss laws and regulations governing sex education and explain the difference between abstinence-only and comprehensive sex education.
6. Identify the numerous topics often included in sex education. Note the six sections highlighting how abstinence education is often carried out.
7. Identify what should be taught regarding HIV in kindergarten through third grade, upper elementary, and secondary grades.
8. Enumerate the arguments for and against teaching about contraceptives in school.

9. Identify the controversial sex education issues and explain how you would handle each in your classroom.
10. Describe the components and benefits of peer-led prevention programs, teen parenthood programs, and programs for out-of-school youth.
11. Discuss the negative emotional consequences associated with premature sexual involvement.
12. Discuss teen pregnancy, including trends, causes, and consequences.
13. Discuss the rates, trends, risks, and concerns regarding STIs and teenagers.
14. Identify the common STIs and explain each one's type of microbe, signs and symptoms, and possible protective measures.
15. Identify lesson plans, materials, and teaching activities you will use to promote sexual health in your classroom.

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9

Promoting Safety and Violence Prevention

Posted August 1

Today my brother got hit by a truck while on a bike. It was the most terrifying thing of my life. My little 15-year-old brother (I am 17) got hit by a truck. He was not wearing a helmet and lucky for him the truck flew him almost 6 feet to the ditch with a soft landing. He is currently still in the hospital after being sent to another for a CAT scan. Except for some very nerve wracking spells of low blood pressure, very high temperature, and dizziness he's been talking and stuff just fine. I am seriously gonna promote the use of helmets a lot more. I am very terrified for him, but am grateful for the nurses and doctors that worked on him.

Source: Bicycle Helmet Safety Institute.

This chapter addresses the leading cause of death and disability for school-age youth. Injuries can be classified as either intentional (resulting from violence) or unintentional. Unintentional injuries are often called "accidents," even though many of the situations that cause injuries can be prevented. Motor vehicle crashes, drowning, poisoning, fires and burns, falls, sports- and recreation-related injuries, firearm-related injuries, choking, and suffocation are major causes of unintentional injuries. Types of violence are assault, sexual violence, rape, child maltreatment, dating and domestic violence, homicide, suicide, and self-inflicted injuries.

Injury-related causes account for about two thirds of all deaths among children and adolescents. The leading causes of injury deaths in school-age youth are motor vehicle crashes, homicide, and suicide. Motor vehicle crashes are the leading cause of death throughout childhood and adolescence. Homicide is the second leading cause of death among adolescents ages 15 to 19 years and the fourth leading cause of death among children ages 5 to 14 years. Suicide is rare among children ages 5 to 9 years but is the third leading cause of death among adolescents ages 10 to 19 years. In addition to deaths, injuries cause enormous suffering in the lives and families of young people, such as pain, emergency room visits, hospitalizations, disability, fear, and other negative emotional consequences. Injuries also cause billions of dollars in medical costs. **Table 9-1** identifies risky behaviors that contribute to injury and death.

Safety Concerns

Young people face many safety concerns including motor and pedestrian accidents, fire/burns, drowning, poisoning, and falls.* This section reviews data that

* Statistics in this section come from the Centers for Disease Control and Prevention/YRBS and Injury, Violence, and Safety websites unless otherwise indicated.

TABLE 9-1 Trends in the Prevalence of Behaviors That Contribute to Unintentional Injury, National YRBS: 1991–2007*

1991	1993	1995	1997	1999	2001	2003	2005	2007	Changes from 1991–2007[1]	Change from 2005–2007[2]
Rarely or never wore a seat belt (When riding in a car driven by someone else)										
25.9 (20.8–31.7)[3]	19.1 (16.6–21.9)	21.7 (18.4–25.4)	19.3 (16.0–23.0)	16.4 (13.7–19.4)	14.1 (12.5–15.9)	18.2 (14.3–22.9)	10.2 (8.5–12.1)	11.1 (8.9–13.8)	Decreased, 1991–2007	No change
Rarely or never wore a bicycle helmet (Among students who had ridden a bicycle during the 12 months before the survey)										
96.2 (94.8–97.2)	92.8 (89.9–94.9)	92.8 (91.1–94.3)	88.4 (83.2–92.1)	85.3 (81.3–88.6)	84.7 (81.4–87.5)	85.9 (82.3–88.9)	83.4 (79.8–86.5)	85.1 (82.3–87.6)	Decreased, 1991–2001 No change, 2001–2007	No change
Rode with a driver who had been drinking alcohol (In a car or other vehicle one or more times during the 30 days before the survey)										
39.9 (37.7–42.2)	35.3 (32.7–38.1)	38.8 (35.0–42.7)	36.6 (34.4–38.8)	33.1 (30.8–35.4)	30.7 (28.7–32.8)	30.2 (28.1–32.5)	28.5 (26.5–30.5)	29.1 (27.2–31.2)	Decreased, 1991–2007	No change
Drove when drinking alcohol (A car or other vehicle one or more times during the 30 days before the survey)										
16.7 (14.9–18.7)	13.5 (11.7–15.6)	15.4 (12.3–19.1)	16.9 (14.3–19.9)	13.1 (11.9–14.3)	13.3 (11.8–14.8)	12.1 (10.8–13.4)	9.9 (8.9–11.0)	10.5 (9.3–11.9)	No change, 1991–1997 Decreased, 1997–2007	No change

[1] Based on trend analyses using a logistic regression model controlling for sex, race/ethnicity, and grade.
[2] Based on t-test analyses, $p < .05$.
[3] 95% confidence interval.
* The national Youth Risk Behavior Survey (YRBS) monitors priority health risk behaviors that contribute to the leading causes of death, disability, and social problems among youths and adults in the United States. The national YRBS is conducted every 2 years during the spring semester and provides data representative of 9th- through 12th-grade students in public and private schools throughout the United States
Source: Centers for Disease Control and Prevention/YRBS. National Trends in Risk Behavior. Available at http://www.cdc.gov/HealthyYouth/yrbs/trends.htm. Accessed September 18, 2009.

help put in perspective the various risks. As you consider these facts, think about what you can do as a teacher to limit your students' risks for unintentional injury. **Box 9-1** identifies many free resources for addressing the safety risks discussed in this section, and **Box 9-2** offers an application exercise for teachers to access whether they are ready to deal with emergencies in the classroom.

Motor vehicle injuries are the nation's top safety concern. In fact, vehicle injuries are the greatest public health problem facing children today. Among children and adolescents ages 5 to 19 years, 70% of unintentional injury deaths are the result of motor vehicle crashes. That means that on average each day 4 children die and 504 others are injured. Alcohol plays a large role in this devastation. Approximately 25% of motor vehicle crashes involve drinking drivers, and about 68% occur while the child is riding with the drinking driver. The prevalence of riding with someone who has been drinking is highlighted by Youth Risk Behavior Survey (YRBS) data that indicate that during the 30 days preceding the survey, 30% of students said they had ridden with a driver who had been drinking alcohol, and 12% said that they had personally driven after drinking alcohol.

Wearing seat belts and using booster seats saves lives. Among children younger than age 5, in 2006, an estimated 425 lives were saved by car and booster seat use. Restraint use among young children often depends upon the driver's seat belt use. Almost 40% of children riding with unbelted drivers were themselves unrestrained. When riding in a car driven by someone else 18% of youths say they rarely or never wear seat belts. Traffic-related injuries also include those sustained while walking, riding a bicycle, or riding a motorcycle. For the past decade, each year more than 700 children have died from injuries sustained while walking, more than 500 of these while walking in traffic.[1]

In 2005, 29% of motor vehicle–related deaths were bicyclists. The most serious bicycle-related injuries are head injuries. Wearing a bicycle helmet is as important as wearing a seat belt, yet more than 85% of high school age youths say they rarely or never wear bike helmets. Younger children are more compliant than are adolescents for using bicycle helmets.

Drowning is the third leading cause of injury death for children ages 5 to 14. On average, 15 people drown each day from swimming or boating-related incidents. More than one in four fatal drowning victims are children 14 years and younger. For every child who dies from drowning, another four receive emergency department care and survive but might suffer brain damage. The fatal drowning rate of African American children ages 5 to 14 is 3.2 times that of white children in the same age range. For American Indian and Alaskan Native children, the fatal drowning rate is 2.4 times higher than for white children.

Poisoning is the second leading cause of unintentional injury–related death in the home. Each year approximately 2.4 million people—more than half under age 6—swallow or have contact with a poisonous substance. Children are involved in 75% of all poison control center cases. The American Association of Poison Control Centers (AAPCC) estimates that 70% of accidental poisonings

are preventable. Generally, poisonings in the home break down as follows: kitchen (41%), bathroom (21%), bedroom (12%), all other places (26%).

Other leading causes of unintentional injury deaths for children ages 5 to 19 years include fire/burns and falls. Fire kills more Americans than all natural disasters combined and more than three fourths of all civilian fire deaths occur in homes. More than 1 million serious sports-related injuries occur each year to adolescents ages 10 to 17 years.

Approximately 4 million children and adolescents are injured at school each year. Playgrounds are often the site of these injuries. About 45% of playground-related injuries are sever/fractures, internal injuries, concussions, and dislocations. More injuries occur on climbers than on any other equipment. On home playgrounds, swings are responsible for most injuries. Poorly planned and poorly maintained playgrounds present higher hazards for injury.

9-1
In the Classroom

Free Resources for Teaching Safety

You can find lesson plans, materials, and information for elementary, middle, and high school levels at the following websites.

For Multiple Safety Topics

- Lesson Plan Central: http://lessonplancentral.com/lessons/Health/Safety/index.htm
  Lesson plans, web quests, worksheets, student link and clipart
- The CDC: http://www.cdc.gov/HomeandRecreationalSafety/index.html
  Fact sheets, podcasts, alerts, updates, and safety week or month
- Kidd Safety: http://www.cpsc.gov/KIDS/kids.html
  Quiz about safety at home and outdoors. Posters, bicycle safety tips.
- CodeRedRover: http://www.coderedrover.org/index.html
  Interactive fun website for younger children

Road Safety (Auto, Bus, Bike, and Pedestrian)

- AARP Driver Safety Online Course: http://www.aarp.org/families/driver_safety/driver_safety_online_course.html
- Tips for Teachers: Road Safety Lesson Plans: http://www.essortment.com/family/roadsafetyeduc_sugl.htm

(*continues*)

(*continued*)

- CDC's "Walk to School Day": http://cdc.gov/MotorVehicleSafety/Pedestrian_Safety/walk_to_school.html
- National Bike Safety Network: http://www.cdc.gov/ncipc/bike

Water and Outdoor Safety

- City of San Diego: http://www.sandiego.gov/lifeguards/safety/lesson.shtml
- Lesson plan, crossword puzzle, video, activity book
- U.S. Environmental Protection Agency Sun Wise Program: http://epa.gov/sunwise/
  Interactive pages for schools, students, and communities

Chemical/Poison Safety

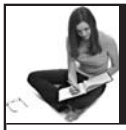
- Environmental Protection Agency: http://epa.gov/kidshometour/toxic.htm
  Information about pesticides and toxic chemicals used around the house and what to do in the case of an accident. An online "home tour" of pesticides and toxic substances in a typical kitchen, garage, laundry room, bathroom, and bedroom.
- University of Utah Poison Control Center: http://uuhsc.utah.edu/poison/publiced/poisonsafety.htm
  Lesson plans for pre-K–6th grade

Fire Safety

- U.S. Fire Administration for Kids: http://www.usfa.fema.gov/kids/html/index.shtm
  Lesson plans (escape planning, home fire safety, smoke alarms), information, games, crossword puzzles, coloring pages, word search, hazard house, matching game, and become a Jr. Fire Marshal
- A to Z Teacher Stuff: http://www.atozteacherstuff.com/Themes/Fire_Safety
  Lesson plans, activity ideas, crafts, songs, experiments, student links

Natural Disaster Preparation

- FEMA for Kids: Get Ready, Get Set: http://www.fema.gov/kids/ready.htm
  Helps kids put together a disaster supply kit, set up a family disaster plan, understand what they might feel in a disaster, pet protection, stories about prepared kids, Project IMPACT (a community damage mitigation program)



9-2
Application Exercise

What Would You Do?

The following are scenarios you might someday find yourself in. After reading each scenario answer, "What would you do?" as quickly as possible, as if you had to act right then without having time to think. When you are finished, evaluate your answers. Check available resources in the chapter for insights into how you could better handle each situation.

1. You awake in the middle of the night to smell smoke.
2. A student has passed out in your class and may be having a seizure.
3. You turn a corner and see students fighting and no other adult is visible.
4. A student has a black eye and bruised arm and simply says she tripped.

Understanding Youth Violence

Media reports often contain sobering details of school shootings, hazing, gang activities, suicide, and other examples of youth violence. Such violence leaves young people and their families to cope with injury, disability, and death. It leaves lasting scars on victims, perpetrators, and their families and friends. Youth violence is an ongoing, troubling, and pervasive problem afflicting every community (see **Table 9-2**).

Youth violence includes aggressive behaviors such as verbal abuse, bullying, hitting, slapping, or fist fighting. These behaviors have significant consequences and can leave emotional scars but do not generally result in serious physical injury or death. Youth violence also includes serious violent and delinquent acts committed by and against youth, such as aggravated assault, robbery, rape, and homicide.

Consider the following facts about youth violence in the United States:

- The U.S. child homicide rate is five times higher than the rate of 25 other industrialized countries combined.
- African American, Hispanic, and American Indian adolescent males suffer from higher homicide rates than do white, non-Hispanic males.
- About one in five female high school students has reported being physically or sexually abused by a dating partner, and females who have experienced dating violence are more likely to engage in substance use, unhealthy weight-control practices, and sexual risk behaviors; to have ever been pregnant; and to have considered or attempted suicide.

TABLE 9-2 Trends in the Prevalence of Behaviors That Contribute to Violence, National YRBS: 1991–2007*

1991	1993	1995	1997	1999	2001	2003	2005	2007	Changes from 1991–2007[1]	Change from 2005–2007[2]
Carried a weapon (For example, a gun, knife, or club on at least 1 day during the 30 days before the survey)										
26.1 (23.7–28.5)[3]	22.1 (19.8–24.6)	20.0 (18.8–21.4)	18.3 (16.5–20.2)	17.3 (15.4–19.3)	17.4 (15.5–19.5)	17.1 (15.4–19.0)	18.5 (16.9–20.2)	18.0 (16.3–19.8)	Decreased, 1991–1999 No change, 1999–2007	No change
Carried a gun (On at least 1 day during the 30 days before the survey)										
NA[4]	7.9 (6.7–9.3)	7.6 (6.5–8.7)	5.9 (5.1–6.8)	4.9 (3.8–6.3)	5.7 (4.8–6.8)	6.1 (5.1–7.2)	5.4 (4.6–6.3)	5.2 (4.4–6.0)	Decreased, 1993–1999 No change, 1999–2007	No change
In a physical fight (One or more times during the 12 months before the survey)										
42.5 (40.0–45.0)	41.8 (39.8–43.8)	38.7 (36.5–40.9)	36.6 (34.7–38.7)	35.7 (33.4–38.1)	33.2 (31.8–34.7)	33.0 (31.1–35.1)	35.9 (34.3–37.4)	35.5 (34.0–37.1)	Decreased, 1991–2003 Increased, 2003–2007	No change
Injured in a physical fight with injuries that had to be treated by a doctor or nurse (One or more times during the 12 months before the survey)										
4.4 (3.6–5.3)	4.0 (3.2–5.0)	4.2 (3.6–4.8)	3.5 (3.0–4.1)	4.0 (3.3–4.8)	4.0 (3.6–4.5)	4.2 (3.4–5.3)	3.6 (3.2–4.0)	4.2 (3.7–4.7)	No change, 1991–2007	No change

[1] Based on trend analyses using a logistic regression model controlling for sex, race/ethnicity, and grade.
[2] Based on t-test analyses, $p < .05$.
[3] 95% confidence interval.
[4] Not available.
* The national Youth Risk Behavior Survey (YRBS) monitors priority health risk behaviors that contribute to the leading causes of death, disability, and social problems among youths and adults in the United States. The national YRBS is conducted every 2 years during the spring semester and provides data representative of 9th- through 12th-grade students in public and private schools throughout the United States.
Source: Centers for Disease Control and Prevention/YRBS. National Trends in Risk Behavior. Available at http://www.cdc.gov/HealthyYouth/yrbs/trends.htm. Accessed September 18, 2009.

- ❖ The trauma associated with witnessing or being a victim of violence can adversely affect the ability of students to learn.
- ❖ Being the victim of child abuse increases the likelihood that young persons will engage in health risk behaviors, including suicidal behavior and delinquent and aggressive behaviors in adolescence.
- ❖ Being victimized as a child increases the risk for victimizing others in adulthood.

There are several factors to consider in understanding why children and adolescents exhibit violent behavior. Awareness of these factors enables educators and parents to develop and implement strategies to reduce and prevent violent behavior. This section reviews the following contributing factors: family, media, substance use, access to weapons, personal and peer characteristics, and gang involvement.

Family Factors

Violence is often a learned response to conflict and frustration. This explains why violent children often come from violent families. Within these families, violence is modeled by parents and other family members as a problem-solving strategy. Therefore, children have ample opportunities to observe parents attempt to resolve conflict by violent means. Through this modeling of violent behavior, children learn to solve their personal conflicts and stress by violent means.

Lack of appropriate parenting is also often an important factor in the development of violent behavior. A lack of parental monitoring and discipline, poor supervision, inconsistent rule application, and aversive interactions are likely to be present within parent–child interactions of families of children exhibiting violent behavior. Family rejection also increases the likelihood of long-term violent behavior. Conversely, good parental and family relationships are associated with reduced risk of adolescent violent behavior.

Exposure to Media Violence

A large proportion of the media that children and adolescents are exposed to includes acts of violence. It is estimated that by the age of 18, the average young person will have viewed 200,000 acts of violence on television alone. Many television programs contain interpersonal violence—and much of this violence is portrayed in an entertaining or glamorized manner with little to no depiction of realistic pain or harm. The suffering, loss, and sadness of victims and perpetrators are rarely shown. Rather, most violence in the media is used for entertainment in an attempt to provide immediate visceral thrills to those who view it.

American films are the most violent in the world. It is not uncommon for a young person viewing a major motion film to see numerous people shot, stabbed, crushed, punched, slapped, raped, maimed, or blown up during the

course of the movie. It is clear that children learn to be violent by the steady diet of violence they consume from films and TV.

Children's shows and music videos often depict violence. In fact, the level of violence during Saturday morning cartoons is higher than the level of violence during the prime-time viewing hours. There are 3 to 5 violent acts per hour in prime time versus 20 to 25 per hour on Saturday mornings.

The high occurrence of violence on television greatly exceeds the actual rate of violent behavior in our society. This clearly dispels the myth that television programming is a reflection of what is going on in society. On the other hand, what is portrayed on television appears to be shaping behavioral patterns with respect to violence. Television often teaches children that violence is an acceptable response to anger or frustration.

It is not just television and movies that expose young people to violence. Much of the music that young people listen to contains lyrics with violent messages. The lyrics of many rap and heavy metal songs expose young people to themes such as suicide, sexual violence, murder, Satanism, and substance abuse. Many songs glorify violence and other harmful behaviors and have become increasingly explicit in the past two decades. "Gangsta rap" involves many references to violence, weapons, sex, and drug use, and several major rap artists have been charged with violent crimes in real life. The celebrity status of these rap artists seems to glamorize their violent behavior and condone the violent messages in their music. Music videos, particularly those shown on MTV, often contain violence, sexism, suicide, and substance abuse. Watching music videos is a popular pastime for many preteens and teenagers; as a result, they are frequently exposed to violence through this medium.

Violent video games are popular among children and adolescents. This games may pose greater risks than passively watching violence on television or in a move. Game players are more likely to identify with violent characters that respond to their directions. This identification increases a player's ability to learn and retain the aggressive thoughts and behaviors they see portrayed in the game. Research suggests that exposure to violent video games increases angry and hostile feelings in players and decreases compassionate feelings for others with whom they interact.[2] Unfortunately, restrictive age and violent-content labels seem to increase the attractiveness of video games for both boys and girls. Almost two thirds of youngsters have played *Grand Theft Auto*, a video game that contains extremely violent content.[3]

Influence of Media Violence Few researchers bother any longer to debate that bloodshed on TV and in the movies has an effect on kids who witness it.[4] According to the American Academy of Pediatrics (AAP), more than 3,500 research studies have examined the relationship between media violence and violent behavior; all but 18 have shown a positive relationship.[5] The strongest single correlate with violent behavior is previous exposure to violence. As a result, health care professionals are increasingly recognizing that exposure to media violence can cause violent behavior to occur.

Violence often is a learned response to conflict and frustration.

The AAP alerts parents and those who work with children that media violence affects children in the following ways:[6]

- Increasing aggressiveness and antisocial behavior
- Increasing their fear of becoming victims
- Making them less sensitive to violence and to victims of violence
- Increasing their appetite for more violence in entertainment and in real life

Children and adolescents who view violence may mirror conflict resolution techniques they see on television and in movies. Viewing aggressive acts on television increases aggressive behavior among children, particularly among those children most inclined to aggression initially. In particular, there is a strong relationship between heavy television viewing and aggression during preschool years. Children whose parents use physical punishment are more likely to be aggressive themselves or to become more aggressive after exposure to television violence.

Children younger than 8 years cannot discriminate between fantasy and reality. As such, they are particularly vulnerable to adopting as reality the values and attitudes that are portrayed in the media they watch.

The AAP stresses that media violence is associated with a variety of physical and mental health problems for children and adolescents, including aggressive

behavior, desensitization to violence, fear, depression, nightmares, and sleep disturbances. David Grossman, a military expert on the effects of violence, relates the following story told to him by a woman who called him when he was a guest on a radio call-in show:

> My 13-year-old boy spent the night with a neighbor. After that night, he started having nightmares. I got him to admit what the nightmares were about. While he was at the neighbor's house, they watched splatter movies all night: people cutting people up with chain saws and stuff like that.
>
> I called the neighbors and told them, "Listen: you are sick people. I wouldn't feel any different about you if you had given my son pornography or alcohol. And I'm not going to have anything further to do with you or your son—and neither is anybody else in this neighborhood, if I have anything to do with it—until you stop what you're doing."[7(p.15)]

David Grossman commented on this story by saying, "That's powerful. That's censure, not censorship. We ought to have the moral courage to censure people who think that violence is legitimate entertainment."

Substance Use and Abuse

Alcohol and drug use increase the potential for violent behavior and victimization by reducing behavioral inhibitions and facilitating aggressive responses. Alcohol and other drugs can make people feel more aggressive and powerful, yet less able to control themselves and less aware of the consequences of actions. The abuse of drugs is also strongly associated with violent crimes (see Figure 7-5).

Immediate Access to Weapons

The immediate accessibility of a weapon is another critical factor that increases the potential for violent behavior affecting both the carrier and others. The proliferation of guns and the relative ease with which young people acquire them appear to be some of the most potent factors accounting for episodes of lethal youth violence. Carrying a weapon, especially a firearm, greatly increases the possibility for escalation of violence and potential for its use. Weapon-carrying behavior for some youths may be a defensive strategy in response to the profound fear of being a victim of a violent act. However, research has shown that weapon carrying among youths appears to be more closely associated with criminal activity, delinquency, and aggressiveness than with purely defensive behavior. Handgun ownership by high school youth is associated with gang membership, selling and using drugs, interpersonal violence, being convicted of crimes, school truancy, and either suspension or expulsion from school. Gun carrying among junior high students is also strongly linked with indicators of serious delinquency, such as having been arrested.[8,9]

Law enforcement officials note that firearms are easily accessible to many young people, which can be particularly dangerous for young people (see

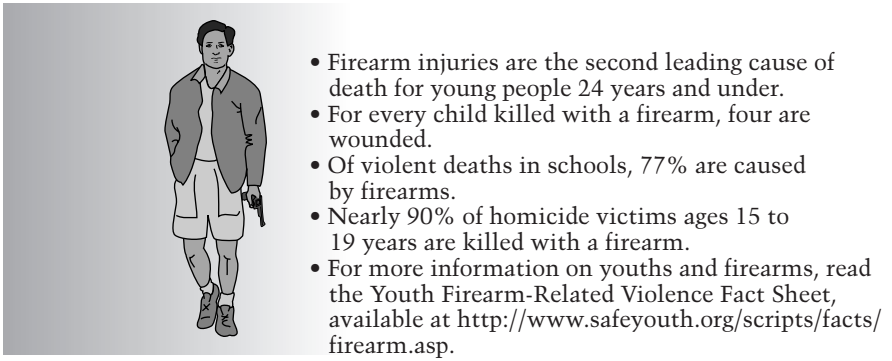


FIGURE 9-1 Firearm injuries.

Figure 9-1). Some have access to guns in their homes. Youths can readily borrow guns from friends, buy them by proxy, steal them, or even rent them. On the street, often youths can purchase guns quite inexpensively. Young people often use guns for solving seemingly trite problems. Guns are also increasingly being used by young people against older or larger children or teens who have a history of bullying or intimidating them. Thus, guns are used as an "equalizer," an equalizer that can readily be obtained by many youths.

Personal and Peer Characteristics

It is common for young people who behave violently and aggressively to engage in other high-risk behaviors (e.g., alcohol abuse, illicit drug use, sexual promiscuity). Thus, youths who display violent behavior also share the following characteristics with youths engaging in other high-risk behaviors:

- ❖ Early initiation of delinquent behavior
- ❖ Lack of parental support and guidance
- ❖ School failure
- ❖ Inability to resist peer influences

Violent children and adolescents often seem not to fit in with "mainstream" peers. They may feel rejected or isolated as a result of their displays of aggressive behavior. Or they may have become aggressive in response to feeling left out or different. These feelings may be compounded by difficulties in learning. Early academic skill deficits and difficulty cause school failure and frustration. Thus, those experiencing this frustration do not "bond" to the school culture. Instead, they are more apt to bond with peers who are likewise experiencing school failure and who do not fit in with mainstream peers. Attachment to these peers often reinforces participation in violent behaviors and increases the likelihood of alienation from prosocial peers and institutions (e.g., school,

church, youth groups). These factors also heighten the likelihood of gang involvement.

Gang Involvement

Youth gang members are often actively involved in violent crime and behavior. Not only are gang members more likely to be involved in violent criminal activity as youths, but gang membership can prolong a youth's involvement with violence into adulthood. Most youth gang members are male. However, there is concern that females are increasingly becoming involved in gangs.

Young people are attracted to gangs for many reasons. The primary attraction of gangs, however, is their ability to respond to youth needs that are not otherwise being met. For many youths, gangs become an extended family of sorts or even a surrogate family, where the banding together provides a sense of security. The gang also provides some youths with a sense of identity, belonging, power, and protection. Thus, young people lacking a sense of security are vulnerable to gang involvement. Among those feeling powerless and lacking control, gang activities become an outlet for their anger.

Large cities have historically had problems with juvenile gangs, but now their appearance in smaller cities, towns, suburbs, and even rural communities is a concern. The emergence of gangs in smaller populations is to the result of several factors. One may be the changes some small towns and rural areas are experiencing with newly arrived racial or ethnic groups. Immigrant youth often experience difficulty merging with the dominant youth group. They may feel different or ostracized, may have language barriers, and may feel alienation toward their parents' "old ways." They may band together in groups to create a social group where they are understood and where they can maintain a strong ethnic identity. This does not mean, however, that all immigrant youth groups or other bands of youths are gangs.

For a number of the following reasons, some communities have jumped to the mistaken conclusion that gangs are present: the visibility of racial or ethnic groups on street corners or at shopping malls; the faddish wearing of clothing styles and colors commonly worn by gang members; local groups of youths imitating big-city gangs in an attempt to gain popularity and acceptance among their peers; and isolated incidents of ganglike activity (e.g., graffiti, arrest of a nonlocal gang member). It is reassuring to note that in smaller communities, in most cases, a gang problem is short-lived, dissipating as quickly as it develops. Small towns and rural areas simply do not have a large enough population base to sustain a gang as members are arrested or drop out. In cities with typically longer-standing gang problems, about half of the youth who join leave the gang within a year.[10]

Box 9-3 discusses the continuum of gangs, from troublesome to criminal. Gangs are a symptom of deeper community problems. These problems have to be addressed and resolved to dissolve ganglike activities. The following community conditions often precede the transition of typical youth groups into established gangs:

9–3
Background on . . .

The Continuum of Troublesome and Criminal Groups

Troublesome youth groups. Young people who hang out together at places such as malls and may be involved in minor forms of delinquency.

Delinquent groups. A small number of friends who commit delinquent acts such as vandalism or burglaries.

Subculture youth groups. Groups such as "goths," "straight edgers," and "anarchists," which are not gangs but have special interests.

Taggers. Graffiti vandals. They are often called gang members but typically only engage in graffiti contests.

School-based gangs. Groups of young people that may function as a gang only at school.

Street-based gangs. Semistructured groups of adolescents and young adults who engage in delinquent and criminal behavior.

Drug gangs. Groups loosely organized for drug-trafficking operations; they are generally led by young and older adults but sometimes include adolescents.

Adult criminal organizations. Small groups of adults that engage in lucrative criminal activity primarily for economic reasons.

Source: Adapted from Howell JC. *Preventing and Reducing Juvenile Delinquency: A Comprehensive Framework*. Thousand Oaks, Calif: Sage Publications; 2003:80.

- ❖ Families or schools or both being ineffective and alienating
- ❖ Adolescents having a great deal of free time not consumed by other healthy activities
- ❖ Limited access to appealing career lines
- ❖ Having a place to congregate, such as a well-defined neighborhood

Violence and Learning Potential

Beyond the obvious threat that violence poses to children's personal safety, violence also poses another potential problem for youth. The threat of violence can adversely interfere with a child's development and learning potential. When children constantly confront the threat of violence at home, school, and/or in the community, they must learn to protect themselves by setting up defenses against their fears. These defenses take considerable emotional energy, robbing from the energy needed for other developmental tasks, including learning in school.

The presence of violence in the home is often associated with feelings of guilt and responsibility by children and consequent feelings of being bad or worthless. These feelings are not compatible with a child's potential for learning and commonly result in the feeling that one is incapable of learning. This, in turn, contributes to a lack of motivation to achieve in school.

Children who face the threat of violence, or who have suffered trauma from violence, have difficulty seeing themselves in meaningful future roles. Children who cannot perceive a positive and secure future for themselves are unable to give serious attention and energy to the tasks of learning and socialization. The unpredictability of violence contributes to a sense of little or no control over one's life. Such a sense of helplessness interferes with the development of autonomy, which is essential for healthy growth and maturation.

Bullying in Schools

Bullying is a form of violence that needs to be addressed because it is a prevalent form of violence among youth and can have long-lasting consequences. **Box 9-4** contains Web links to free lesson plans and materials for addressing bullying and other violence issues. **Bullying** is the repeated infliction or attempted infliction of injury, discomfort, or humiliation on a weaker student by one or more students with more power. The term *bullying* encompasses a wide range of physical or verbal behaviors of an aggressive nature, including threatening, humiliating, insulting, teasing, harassing, abusing physically and verbally, and mobbing. Bullying differs from normal quarreling, teasing, childhood "rough play," or conflict because it is prolonged and there is a power differential between the bully and the victim (e.g., bullies are often physically larger and stronger). Bullies find enjoyment in harassing the same victims. Most bullying goes unreported because victims feel that nothing will be done and that they might receive greater retaliation the next time. Also, others watching bullying may fear reporting it because they might lose their social status or also become victims.

Bullies tend to pick on those who appear vulnerable in one way or another. Students who are perceived as different in some way or who don't seem to fit in are at increased risk. Children who are fatter or skinnier, wear glasses or braces, have speech impediments, have a learning or physical disability, or differ in other personal characteristics are common victims of bullying. Victims usually are passive, anxious, sensitive, quiet, easily intimidated; avoid confrontation; and have a difficult time defending and standing up for themselves. They tend to have few friends they can rely upon to help them stand up to the harassment they receive. Gay, lesbian, and bisexual students and those perceived to be gay by their peers are often targeted by bullies for repeated verbal abuse and physical assault.

Victims of bullying suffer humiliation, insecurity, and loss of self-esteem. They may suffer physical injury as a result of the bullying. It is hard for children to concentrate on schoolwork if they are being bullied, and academic perfor-

mance can suffer as a result. They may develop a fear of going to school and attempt to avoid school altogether. They may avoid public areas of the school, such as the cafeteria, restrooms, playground, or school buses, to stay clear of bullies. They might not participate in extracurricular activities because of the same fear. Students who are repeatedly victims of such abuse and assaults are at increased risk for mental health problems such as depression or suicide. Some retaliate to the enduring abuse in a violent way. Being a victim of severe bullying has been noted in the news media as a contributing factor in shootings at Columbine High School in Littleton, Colorado, in 1999, and Santana High School in Santee, California, in 2001, and in other acts of youth violence.[11] The psychological scars from being bullied often last into adulthood.

Children and adolescents who bully thrive on controlling and dominating others. They achieve a sense of accomplishment and esteem from causing weaker students distress or harm. They have often been victims of physical abuse or bullying themselves. Bullying is often the beginning of antisocial and rule-breaking behavior that can extend into adulthood. Those who bully are also involved in other forms of antisocial behavior such as vandalism, shoplifting, skipping and dropping out of school, fighting, and the use of alcohol and other drugs. Bullying behavior in childhood or adolescence is also linked with participation in criminal behavior as adults.[11] Students who bully need intervention in an effort to prevent serious academic, social, emotional, and legal difficulties for them and their families.

Schools should not condone or tolerate bullying. They can actively work to stop and prevent bullying behavior. School staff, students, and parents can work together to raise awareness about bullying, improve peer relations, intervene to stop intimidation, develop clear rules against bullying behavior and support and protect victims. A highly effective bullying prevention program achieved reductions in bullying among elementary, middle, and junior high school students by instituting the following measures:[11]

- Determination of the nature and prevalence of the school's bullying problem by surveying students anonymously
- Increased supervision of students during breaks
- Schoolwide assemblies to discuss bullying
- Regular classroom meetings with students to discuss bullying
- Establishment and enforcement of classroom rules against bullying
- Staff intervention with bullies, victims, and their parents to ensure that the bullying stops

Lumsden makes some other suggestions for preventing and counteracting bullying:[10]

- Developing and distributing a written antibullying policy to everyone in the school community that sends the message that bullying will not be toler-

ated, and then fairly and consistently applying the policy (some states are now mandating policies)

- ❖ Mapping a school's "hot spots" for bullying incidents so that supervision can be concentrated where it is needed most
- ❖ Asking teachers to stand in the doorways of their classrooms during passing time so that the halls are well supervised
- ❖ Teaching bullies positive behavior through modeling, coaching, prompting, praise, and other forms of reinforcement
- ❖ Teaching students social skills, conflict management, anger management, and character education
- ❖ Using role-play situations in which counselors present students with provocative situations and help them recognize the difference between a "hot response" and a "cool response"
- ❖ Having students sign antiteasing or antibullying pledges
- ❖ Sending bystanders of bullying situations to after-school mediation
- ❖ Having students and their parents sign contracts at the beginning of the school year acknowledging that they understand it is unacceptable to ridicule, taunt, or attempt to hurt other students
- ❖ Teaching respect and nonviolence beginning in elementary school

Cyber-Bullying

With the recent explosion in technology, youths can use electronic media to embarrass, harass, or threaten their peers. Increasing numbers of teens and preteens are becoming victims of this new form of violence. Although many different terms—such as **cyber-bullying**, *Internet harassment*, and *Internet bullying*—have been used to describe this type of violence, **electronic aggression** is the term that most accurately captures all types of violence that occur electronically. Like traditional forms of youth violence, electronic aggression is associated with emotional distress and creates problems at school.[12] Nancy Willard (2007), director of the Center for Safe and Responsible Internet Use, identifies the various forms that cyber-bullying takes:[13]

- ❖ *Flaming.* Sending angry, rude, or vulgar messages directed at a person or persons either privately or to an online group
- ❖ *Harassment.* Repeatedly sending a person offensive messages
- ❖ *Cyberstalking.* Harassment that is highly intimidating or includes threats of harm
- ❖ *Denigration (put-downs).* Sending to others or posting harmful, untrue, or cruel statements about a person

- *Masquerading.* Pretending to be someone else and sending or posting material that makes that person look bad or places that person in potential danger
- *Outing and trickery.* Sending or posting material about a person that contains sensitive, private, or embarrassing information, including forwarding private messages or images; engaging in tricks to solicit embarrassing information that is then made public
- *Exclusion.* Actions that specifically and intentionally exclude a person from an online group, such as exclusion from an instant messaging buddies list

It is very likely that the rates of electronic aggression will increase as technology becomes more affordable and sophisticated. Often cyber-bullying goes unreported because victims are afraid of making perpetrators more angry and fear that they will be bullied even more. The Internet can provide anonymity for those sending or posting electronic aggression. Unlike schoolyard bullying, cyber-bully victims may not know who is attacking them. A victim of schoolyard bullying can try to get a teacher or peer to help, but in the electronic world, a victim is often alone when responding to aggressive e-mail or text messages. A student's only defense may be to turn off the electronic communication device. If the electronic aggression takes the form of a posted message or embarrassing picture on a public website, the victim may have no defense.

Teachers, school administrators, and parents need to work together to reduce the occurrence and negative impact of electronic aggression. Working collaboratively, they can develop policies, explore available programs, offer training, and talk to youth about the issue.

9-4
In the Classroom

Free Resources for Violence and Bully Prevention

You can find lesson plans, materials, and information on violence prevention for elementary, middle, and high school levels at the following websites:

- Goodcharacter.com: http://www.goodcharacter.com/BCBC/Preventing Conflicts.html
  How to stop fights, discussion questions, student activities, writing assignments, video
- Lesson Planet: http://www.lessonplanet.com/search?keywords=violence
- National Youth Violence Prevention Resource Center: http://www.safeyouth.org

(*continues*)

(*continued*)

Tools to facilitate discussion with children, resolve conflicts nonviolently, stop bullying, prevent teen suicide, and end violence committed by and against young people. Fact sheets, best practices documents, statistics, profiles of promising programs. The Resource Center also operates a call center (1-866-SAFEYOUTH; 1-866-723-3968).

- National Youth Gang Center: http://www.iir.com/nygc
  Links to studies, analysis, and reports on gangs, successful prevention programs, strategies for gang prevention and intervention, and documents to assist law enforcement.
- Stop Bullying Now: http://www.stopbullyingnow.hrsa.gov
  Information on bullying, what kids can do, webisodes, games, and links to interact with experts. Resources for adults include How You Can Help; Guide to Using Materials; All About Bullying: Cyberbullying: Tip Sheets; Catalog of Resources: Partnerships; and Parents and Family. School-based antibullying programs and information on state laws on bullying.
- Videos on media violence: http://www.frankwbaker.com/streaming_ml.htm

Preventing Injury and Violence

Schools are a strategic setting for preventing violence and unintentional injury. Schools have the responsibility for providing a safe and violence-free environment for all school-age youths, school personnel, and others on school premises. Educators can also counter violence by providing students and families with violence prevention curricula. Intervention for troubled youth must also be addressed in such a way that there is adequate support in getting help for these youth. Schools can teach students the skills needed to promote safety and reduce their risk for unintentional injuries and violence throughout their lives (see Box 9-4).

It is important to note that the solution to violence does not just rest with schools. Solutions must be engineered that are community-wide and coordinated. This effort requires a shared responsibility between schools, families, courts, law enforcement, community agencies, community churches, businesses, and the broader community.

Safe and Violence-Free School Environment

Safety and violence prevention begins by making sure the school campus is a safe and caring place. All students have a right to a safe and protective school environment. Compared to home and other settings, school is one of the safest places where young people spend their time. However, the tragic episodes of violence that have occurred on school campuses across the nation point out that

no school and community can afford to be complacent about making and keeping schools safe. Schools must commit to policies that ensure a maximum effort to keep schools safe for students, staff, and others on school premises.

School Security Measures Schools must ensure that weapons are not carried onto school premises and that students remain safe at school. In recent years, far too many violent episodes involving weapons on school campuses have led to tragedy. Providing a safe and violence-free school requires school districts to consider such provisions and controls as locker searches, security guards or police who patrol school premises, and possibly metal detectors that students must pass before entry. Some schools have eliminated lockers altogether. Some schools employ uniformed security guards and/or install hallway cameras to monitor students. Some school systems have created separate alternative schools for young people with a history of violent and abusive behavior.

A Safe Physical Environment The physical condition of the school building has an impact on student attitude, behavior, and motivation to achieve. Typically, there tend to be more incidents of fighting and violence in school buildings that are dirty, too cold or too hot, filled with graffiti, in need of repair, or unsanitary. To ensure a safe physical environment regular safety and hazard assessments need to be made. Structures, equipment, and grounds need to be maintained. All student activities need to be actively supervised.

A Safe Social Environment The social climate of a school can promote safety and prevent unintentional injury, violence, and suicide. To ensure a safe social climate school personnel need to establish a supportive environment that does not tolerate harassment or bullying. High academic standards need to be maintained and students' connectedness to school needs be encouraged. School personnel must develop, implement, and enforce written policies including disciplinary policies. School programs and policies need to be assessed at regular intervals.

Discipline and Dress Codes School officials may consider discipline and dress codes as strategies to curb violence. Administrators, teachers, parents, and students must craft these codes collaboratively, and the district's legal staff must review them so that they are in accordance with state law. An effective discipline and dress code clearly explains to students what behavior is acceptable and the policies for dealing with students who break the rules. Discipline and dress codes must be firmly, fairly, and consistently implemented and enforced. Every student, parent, and teacher must be given a copy of a discipline or dress code.

Safety and Hazard Assessments The CDC recommends that schools consider doing a comprehensive safety assessment at least annually. More frequent assessments (e.g., monthly) are needed for some areas of the school, particularly playgrounds and sports fields. One person can be given the responsibility for

identifying hazards and ensuring maintenance of the school environment. Procedures for reporting hazards to the responsible person should be developed and publicized. Sufficient funding is necessary to support inspection, repair, and upgrades as needed.

Identification of Warning Signs of School Violence Earlier, this chapter presented several early warning signs of violence. An important aspect of effective violence prevention is having school personnel who are trained to recognize these signs. Schools should take special care in training all school personnel to understand and identify early warning signs. This is critical because these early warning signs can signal a troubled child and indicate that a student may need help. They may also indicate that the child is prone to violence toward self or others. When early warning signs are observed, teachers should be concerned, but should not overreact and jump to conclusions. In no way should early warning signs be used to exclude, isolate, or punish a child. Neither should children be inappropriately labeled or stigmatized because they exhibit a set of early warning indicators.

When educators observe **early warning signs**, their first and foremost responsibility should be to get timely help for a child. They should immediately speak to available professionals such as school psychologists, social workers, counselors, and nurses. Referrals to outside agencies or professionals may be necessary. School administrators can help facilitate this. Educators must keep in mind that all referrals to outside agencies based on early warning signs must be kept confidential and be made with parental consent (except referrals for suspected child abuse or neglect).

Educators can increase their ability to recognize early warning signs by establishing close, caring, and supportive relationships with students. This requires getting to know students well enough to be aware of their needs, feelings, attitudes, and behavior patterns.

Unlike early warning signs, **imminent warning signs** indicate that a student is very close to behaving in a way that is potentially dangerous to self and/or others. Imminent warning signs require an immediate response. No single warning sign can predict that a dangerous act will occur. Rather, imminent warning signs usually are presented as a sequence of overt, serious, hostile behaviors or threats directed at peers, staff, or other individuals. Usually imminent warning signs are evident to more than one staff member, as well as to the child's family. Imminent warning signs may include the following:

- ❖ Serious physical fighting with peers or family members
- ❖ Severe destruction of property
- ❖ Severe rage for seemingly minor reasons
- ❖ Detailed threats of lethal violence
- ❖ Possession and/or use of firearms and other weapons
- ❖ Other self-injurious behaviors or threats of suicide

When warning signs indicate that danger is imminent, safety must always be the first and foremost consideration. Action must be taken immediately. Immediate intervention by school authorities and possibly law enforcement officers is needed whenever a child exhibits the following behaviors:

- Presents a detailed plan (time, place, method) to harm or kill others, particularly if the child has a history of aggression or has attempted to carry out threats in the past
- Carries a weapon, particularly a firearm, and has threatened to use it

In situations where students present other threatening behaviors, parents should be informed of the concerns immediately. Schools also have the responsibility to seek assistance from appropriate agencies such as child and family services and community mental health. These responses should reflect school board policies.

Curricular Approaches to Safety and Violence Prevention

A variety of educational approaches are used in schools to prevent violence. Curricula have been developed for various grade levels that seek to increase knowledge about violence, encourage nonviolent attitudes, and instill interpersonal skills that reduce the propensity for violent behavior (see **Box 9-5**). Various school-based educational interventions have been designed to modify such behavioral factors associated with violent behavior as weapon carrying, poor anger management, ineffective conflict management, poor communication skills, and substance use.

9–5
Background on . . .

HECAT Recommendations for Promoting Safety and Violence Prevention

The Health Education Curriculum Analysis Tool (HECAT) is a curriculum analysis tool that can help teachers, school districts, and states review their curricula to see whether they meet National Health Education Standards and the CDC's Characteristics of Effective Health Education Curricula. Following are overview recommendations for safety and violence prevention. You can find specific and more detailed grade-level recommendations (by grades 2, 5, and 8) at http://www.cdc.gov/healthyyouth/HECAT.

(*continues*)

(*continued*)

A K–12 safety or unintentional injury prevention curriculum should enable students to do the following:

- Use appropriate seat restraints when riding in a motor vehicle
- Sit in the back seat of the vehicle when age appropriate
- Avoid using alcohol and other drugs when driving a motor vehicle
- Avoid riding in a car with a driver who is under the influence of alcohol or other drugs
- Use appropriate safety equipment
- Refuse to engage in or encourage others to engage in risky behaviors
- Practice safety rules and procedures to avoid injury
- Plan ahead to avoid dangerous situations and injuries
- Seek help for poisoning, sudden illness, and injuries
- Provide immediate help to others with a sudden illness or injury

Related personal health and wellness recommendations include these:

- Prevent vision and hearing loss
- Prevent damage from the sun

A pre-K–12 violence prevention curriculum should enable students to do the following:

- Engage in positive, helpful behaviors
- Manage interpersonal conflict in nonviolent ways
- Manage emotional distress in nonviolent ways
- Avoid bullying, being a bystander to bullying, or being a victim of bullying
- Avoid engaging in violence, including coercion, exploitation, physical fighting, and rape
- Avoid situations where violence is likely to occur
- Avoid associating with others who are involved in or who encourage violence or criminal activity
- Get help to prevent or stop violence including harassment, abuse, bullying, hazing, fighting, and hate crimes
- Get help to address inappropriate touching
- Get help to stop being subjected to violence or physical abuse
- Get help for self or others who are in danger of hurting themselves

Educational Efforts Safety and violence prevention curricula and instruction can be important components of school efforts to prevent violence and unintentional injuries. In addition to health classes, schools can infuse unintentional injury and violence prevention content into various disciplines, including family and consumer education, physical education, driver education, vocational

education, and other curricular areas. Programs and curricula can focus on building skills that students will need throughout their lives. Youths displaying aggressive and violent behavior usually have personal and social skill deficiencies in many areas. For this reason, educators should consider a skills training approach when selecting or developing violence prevention and reduction curricula and programs including anger and conflict management skills. Personal and social skills are best taught through approaches that incorporate modeling, role-playing, performance feedback, and adequate time for practicing the skills. Specific skills that can help prevent unintentional injuries and violence include the following:

- Problem solving
- Decision making
- Impulse control
- Communication (asking for help, initiating and carrying on a conversation, listening to others, giving compliments, saying thank you, and showing appreciation)
- Empathy (recognizing feelings, empathizing with others' feelings)
- Refusal/resistance skills (dealing with peer and group pressure or being left out)
- Conflict management (apologizing, resolving conflict, negotiating)
- Stress management (dealing with embarrassment)
- Anger management (responding to teasing)
- Parenting skills

Students can learn about effective unintentional injury and violence prevention strategies that affect individual behavior, the environment, injury-causing agents, social norms, legislation, and policy. Examples include seatbelts, child safety seats, bicycle helmets, minimum drinking age legislation, graduated driver licensing legislation, smoke alarms, mentoring programs, and parenting education. Students can also learn the first aid and cardiopulmonary resuscitation (CPR) skills needed to treat injuries and other emergencies.

Schools can work with communities to increase the availability of early childhood education for those at increased risk. Students who come to school lacking important social and emotional skills often fall behind their academically better prepared peers and are at increased risk for behavioral, emotional, academic, and social development problems. Early childhood education for children at risk has been demonstrated to decrease unintentional injury, violence and delinquency, and educational difficulties.

Schools can teach students how to prevent injuries that can occur on school property and at home, at work, and in the community. Specific topics might include the following:

- Motor vehicles
- Pedestrians
- Bicycles
- Playground safety
- Firearms
- Fires and burns
- Drowning
- Poisoning
- Suicide
- Dating violence, sexual assault, and harassment
- Family violence, child abuse and neglect
- Bullying, hate crimes, and other violence

Students can learn developmentally appropriate basic emergency lifesaving skills (e.g., going for adult help, performing first aid and CPR) so that they are prepared to respond to various injury situations.

Schools can involve families, community members, and community resources in the learning process. Unintentional injury and violence prevention skills can be incorporated into community-based programs (e.g., service learning, volunteering, and community development projects). Parents and family

Peers modeling injury prevention behaviors help other students acquire and maintain those same behaviors.

members can be involved through family-based education strategies (e.g., family homework assignments) or through programs that bring adults into schools (e.g., mentoring). Programs that focus on involving youth (e.g., mediation, tutoring, peer-led classroom activities, and advocacy groups such as Students Against Destructive Decisions [SADD]; 4-H; and Family, Career, and Community Leaders of America) can also increase student involvement in unintentional injury and violence prevention.

Educators must take into account developmentally appropriate educational strategies. Young children might not fully understand abstract concepts or different perspectives; for example, young children might think a driver can see them and will stop just because the child can see the car approaching. Unintentional injury and violence prevention education for young students might focus on concrete experiences (e.g., practice in safely crossing a street or resolving conflicts).

More abstract associations among behaviors, environment, and injury risk become appropriate as students approach middle school. Although families still play an important role, peer pressure to engage in risky behaviors can be an even stronger motivator. By the time children enter middle school, they can understand and act on the connection between their behaviors and injury.

During late adolescence, children prepare to make the transition to the adult world. Intimate relationships and work begin to take on increased importance. Therefore, unintentional injury and violence prevention education for middle and high school students can focus on helping students assess the effect of behavior and environment on safety, setting goals for reducing risks for unintentional injury and violence, and advocating for safe behaviors with peers and younger students.

Educational programs should be appropriate to the culture of the community in which they are located. Educators can consider issues of social class, race, ethnicity, language, sexual orientation, and physical ability when choosing and implementing prevention strategies. Educational efforts might need to be tailored for students with special needs. Activities that promote tolerance and respect for differences are critical. Involving students in developing and implementing programs can help ensure their relevance. Obtaining input from student members of various cultural groups is essential. Educational activities can help students understand social influences on health- and safety-related behaviors and how to resist cultural, media, and peer pressure to make unsafe choices.

Effective Violence Prevention Programs The most highly effective violence prevention programs combine components that address both individual risks and environmental conditions, particularly building individual skills and competencies, parent effectiveness training, improving the social climate of the school, and changes in type and level of involvement with peer groups. In schools, interventions that target change in the social context appear to be more effective on average than those that attempt to change individual attitudes, skills, and risk behaviors. Involvement with delinquent peers and gang

membership are two of the most powerful predictors of violence, yet few interventions have been developed to address these problems. Another factor relating to effectiveness is the quality of program implementation. Many programs are ineffective not because their strategy is misguided, but because the quality of implementation is poor. **Box 9-6** describes activities for violence prevention.

9-6
In the Classroom

Assessment and Learning Activities for Safety Promotion and Violence Prevention

These are a few ideas for activities you can use while addressing safety and violence prevention. You will also find key life skills here that are important components of safety and violence prevention curricula and can be located in other chapters. You can locate free lesson plans and materials you might want to use in Boxes 9-1 and 9-4.

Road Safety

Buckle Up, Egg Head

Roll a large plastic car into a wall with an egg sitting in the driver's seat. First have the egg taped in simulating wearing a safety belt. The second time do it with no tape. You might want to cover the floor with plastic. (P, I, J, H)

Bike Rodeo

Create a bike "obstacle course" with simulated hazards on the playground. (P, I)

Safety Check

Have students conduct a seat belt and other safety behavior observational survey before and after school. (P, I, J, H)

Melon Drop

Draw a face on a cantaloupe and then put it in an old bike helmet. Drop the helmet onto the ground so that the helmet takes the impact. The cantaloupe usually sur-

(*continues*)

vives the fall, but the helmet will lose its strength integrity and should not be worn for protection in the future. Drop the cantaloupe without the helmet—use a plastic tarp. (P, I, J, H)

Home Safety

Safety Fair

As a class or school, design a safety fair with booths and activities for various safety topics. Here are a few possibilities: fire extinguisher use; stop, drop, and roll relay; spot the hazards; first aid station, and blindfold smoky room demonstration. Invite other classes to participate and learn from your expert students. (I, J, H)

Song Writers' Competition

Have students write safety-related lyrics to familiar tunes on assigned safety issues. Have groups perform and vote on the best song for teaching safety concepts. (I, J, H)

Safetymercial

Have students create and record a 30-second spot that could be aired as a public safety commercial. Skits could be performed instead of videotaping. (I, J, H)

Poison Collage

Have students create a collage of pictures of poisonous household materials with a Mr. Yuck stick proximately displayed and the local poison control phone number. (P, I)

Outdoor Safety

Face Paint

Compete to see who can apply sun block on the face, arms, and legs in the most creative way. (I, J, H)

Safety Signs

Have students design and display original safety signs. (I, J, H)

(*continues*)

(*continued*)

ABCs of Summer Safety

Have students come up with a summer safety concept for every letter of the alphabet. (P, I)

Mock Disaster

Have students participate in mock disaster training by local fire departments, or create their own mock disaster scenarios and rehearse appropriate first responders actions. (J, H)

Violence Safety

Family Feud

Play a game similar to the TV version of *Family Feud* where students guess violence-related statistics ("Survey says …"). Take time to discuss the relevance and implications of the statistics. (I, J, H)

What's My Line?

This is another game based on an old TV show where contestants try to guess the identity of the mystery guest. Have the "mystery student" take the role of a victim of violence. Use the activity to spring board discussion. (I, J, H)

Out of the Hat

Have students take turns drawing a violence/bully-related scenario out of a hat, and then enact it in front of the class. (I, J, H)

Life Skills

These life skills have been identified as key components of safety and violence prevention curricula. In the boxes indicated you will find related teaching activities.

Problem solving	(Box 3-7 in Chapter 3)
Decision making	(Box 3-7 in Chapter 3)
Impulse control	(Box 3-6 in Chapter 3)
Communication	(Box 3-4 in Chapter 3)
Empathy	(Box 3-4 in Chapter 3)
Resistance skills	(Boxes 3-4, 7-4, and 8-4)
Conflict management	(Box 3-7 in Chapter 3)

(*continues*)

Stress management	(Boxes 4-1, 4-5, 4-6, 4-7 in Chapter 4)
Anger management	(Box 3-6 in Chapter 3)
Parenting skills	(Boxes 8-4 and 8-6 in Chapter 8)

Advocacy and Outreach Ideas

Fire Fighters

Arrange for a field trip to a local fire station or for a fire truck to visit your school.

Women's Shelter

Have a representative from a local women's shelter come and talk about domestic violence and emphasize where and how to get help.

PSA

In conjunction with a local TV or radio station, have students develop and air safety promotion or violence prevention public service announcement.

Integration into Other Subjects

Math. Create graphs to show related statistics.

Language Arts. Write a caption for related photographs, create word searches or cross word puzzles, write safety books, and illustrate them with clip art.

Social Studies. Research relative safety and violence risks and in various cultures or at various times in history.

Child Abuse

Child abuse affects children of all ages, races, and income levels (see **Box 9-7**). According to the National Clearinghouse on Child Abuse and Neglect Information (NCCANCH), most states recognize four major types of child abuse: physical abuse, neglect, emotional abuse, and sexual abuse. Although any form of child abuse may be found separately, they often occur in combination. The following discussion provides definitions and descriptions of the major types of child abuse.

Physical abuse is the infliction of a nonaccidental physical injury upon a child. This may include burning, hitting, punching, shaking, kicking, beating, or otherwise harming a child. It may, however, have been the result of overdiscipline or physical punishment that is inappropriate to the child's age.

9-7
Background on . . .

Child Abuse

Parents Who Abuse Their Children

Most parents don't hurt or neglect their children intentionally. Many were themselves abused or neglected. Very young or inexperienced parents might not know how to take care of their babies or what they can reasonably expect from children at different stages of development. Circumstances that place families under extraordinary stress—for instance, poverty, divorce, sickness, disability—sometimes take their toll in child maltreatment. Parents who abuse alcohol or other drugs are more likely to abuse or neglect their children.

Child Abuse Fatalities

According to the National Clearinghouse on Child Abuse and Neglect Information, child fatalities are the most tragic consequence of maltreatment. In 2003, an estimated 1,500 children died as a result of abuse or neglect. More than three quarters (79%) of children who were killed were younger than 4 years old, 10% were 4 to 7 years old, 5% were 8 to 11 years old, and 6% were 12 to 17 years old. Infant boys (younger than 1 year) had the highest rate of fatalities, with nearly 18 deaths per 100,000 boys of the same age in the national population. Infant girls (younger than 1 year) had a rate of 14 deaths per 100,000. The overall rate of child fatalities was 2 deaths per 100,000 children. More than one third of child fatalities were attributed to neglect. Physical abuse also was a major contributor to fatalities.

Source: National Clearinghouse on Child Abuse and Neglect Information. Available at https://ncadistore.samhsa.gov/catalog/resourceDetails.aspx?ID=257. Accessed August 28, 2009.

Neglect is the failure to provide for a child's basic needs. Neglect can be physical, educational, or emotional. *Physical neglect* can include not providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection (e.g., hat or coat). *Educational neglect* is failure to provide appropriate schooling or special educational needs or allowing excessive truancies. *Psychological neglect* includes not providing emotional support and love, chronic inattention to the child, exposure to spouse abuse, or drug and alcohol abuse.

Emotional abuse is a pattern of behavior that impairs a child's emotional development or sense of self-worth. This may include constant criticism, threats, or rejection, as well as withholding love, support, or guidance. Emotional abuse is often difficult to prove without evidence of harm to the child. Emotional abuse is almost always present when other forms are identified. This form of abuse is also referred to as *emotional maltreatment*.

Sexual abuse is inappropriate adolescent or adult sexual behavior with a child. It includes fondling a child's genitals, making the child fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism, sexual exploitation, or exposure to pornography. To be considered child abuse, these acts have to be committed by a person responsible for the care of a child (e.g., baby-sitter, parent, day-care provider) or related to the child. If a stranger commits these acts, it would be considered sexual assault and handled solely by the police and criminal courts. More information on child sexual abuse is presented later in this section of the chapter.

Many states now provide definitions for **child abandonment** in their child abuse reporting laws. In general, it is considered abandonment of the child when the parent's identity or whereabouts are unknown, the child has been left by the parent in circumstances in which the child suffers serious harm, or the parent has failed to maintain contact with the child or to provide reasonable support for a specified period of time.

Teachers and school administrators are required by law to report suspected abuse to appropriate child protective agencies. Because mandatory reporting statutes vary from state to state, it is imperative that educators become familiar with the specifics of the law within the state where they teach. Information about state child abuse laws is available from the school superintendent's office or the state attorney general's office. Teachers reporting suspected child abuse without malice are generally immune from prosecution for any civil or criminal damages that may result from the report.

Child abuse is frequently identified by school personnel in the classroom or school setting. This is possible because children spend a large part of their day in school, placing teachers and other school personnel in the position of being able to observe the signs and symptoms of abuse. The Carnegie Foundation for the Advancement of Teaching estimates that nearly 90% of teachers see abused or neglected children in their classrooms. However, teachers are often reluctant to report suspected cases of abuse. Reluctance may stem from a variety of reasons, including the following:

- ❖ Fear of getting involved in the situation
- ❖ Concern about interfering with private family relationships and child-rearing practices
- ❖ Anxiety about a parent's potential retaliation
- ❖ Wariness of alienating families
- ❖ Inadequate training regarding child abuse identification and reporting

These factors underscore the necessity of quality inservice and preservice training for school teachers regarding child abuse issues. Inservice and preservice training for teachers (as well as the entire school staff) should consist of the following:

- ❖ Identification and reporting of child abuse
- ❖ Coping with disclosures
- ❖ Legal and ethical issues
- ❖ Family dynamics
- ❖ Interviewing children
- ❖ Confidentiality
- ❖ Implications for child development
- ❖ Treatment approaches

Child Sexual Abuse

Child sexual abuse usually involves the engagement of a child in sexual activity through the use of bribes, subtle deceits, threats, or outright force. Although some child sexual abuse involves sexual intercourse, most cases of child sexual abuse do not. Child sexual abuse can take the form of genital handling, oral-genital contact, sexual abuse of the breasts or anus, or requiring a child to undress and/or look at the genitals of adults. Sexual abuse typically involves less force than adult rape. Children often comply with the wishes of their abusers because of their smallness of physical stature, their innocence, and the persuasive powers of abusers. Sexual contact between relatives is **incest**, often a part of sexual abuse.

In many cases, child sexual abuse is not limited to a single episode. Many children are repeatedly abused and victimized over periods of months or even years. Sexual offenders against children often have abused many children before they are discovered. Those who abuse children are most frequently individuals with whom the child is familiar or acquainted. Often the abuser is a parent or other family relative, neighbor, family friend, baby-sitter, or day-care worker. Child sexual abuse is more likely to occur in the home of the child victim than in any other place. A small percentage of sexual abuse cases involves strangers to the child. Yet, ironically, most child sexual abuse prevention programs focus upon "stranger dangers." Consequently, few children learn about the possibility of assault by a relative or friend.

Those who abuse children very often had been abused themselves as children. Thus, there is a vicious cycle in which the abused grow up to be abusers. Interestingly, boys who are abused are far more likely to turn into eventual offenders, and girls are more likely to produce children who are abused by others (possibly because they tend to associate with males who are abusive).

Abusers also typically have low self-esteem and suffer from poor impulse control. Alcohol abuse is also common among abusers of children. It seems that more prevention efforts should be directed toward helping abused children to not become abusers themselves to break this cycle of abuse. This would entail activities such as assertiveness training, self-esteem enhancement activities, parenting skills development, and substance abuse prevention and treatment.

It is imperative that educators understand that under no circumstances is child sexual abuse ever the fault of an involved child. At the same time, educators should understand that the following characteristics in children may make them more vulnerable to victimization:

- Children who are poorly supervised
- Children whose care is entrusted to someone who has a substance abuse problem
- Children with low self-esteem
- Children who have been taught to blindly obey adults
- Children who are hungry for affection
- Children who are lonely

Reported cases of child sexual abuse represent only the tip of the sexual abuse iceberg. Because sexual abuse is largely a secretive act, most occurrences go unreported. Also, offenders are likely to force, bribe, coerce, threaten, or deceive child victims to prevent them from telling. As a result, it is difficult to determine with certainty the number of children who are sexually abused, and estimates vary widely.

Recognizing and Reporting Child Sexual Abuse Children do not tell supportive adults that they have been or currently are a victim of sexual abuse for many reasons. Some common reasons are that the child:

- Is too young to understand or tell that he or she is being abused
- Is afraid of the offender
- Is concerned about rejection by those he or she reports the abuse to or by the offender
- Is worried that she or he will not be believed
- May find the sexual contact or activity pleasurable
- Is afraid that telling will result in a loss of love
- Is concerned about the effect that telling will have on her or his image or reputation
- May have been bribed or rewarded not to tell
- May receive no attention other than the sexual abuse

Most states require that school officials and employees report any suspected cases of child abuse or neglect. School personnel should follow the reporting procedures of their respective schools and districts to ensure proper reporting. As individuals suspecting abuse, teachers are legally responsible for making certain that the report is made to designated child protective agencies immediately. Those who report in good faith are immune from liability under protection of most state laws. School personnel should be familiar with the indicators of sexual abuse (see **Box 9-8**) so that they can effectively recognize sexual abuse or possible abuse among students.

9-8
In the Classroom

Indicators of Child Sexual Abuse

Physical Indicators

- Sexually transmitted disease in a child of any age
- Pregnancy at 11 or 12, especially with no history of peer socialization
- Evidence of physical trauma to or bleeding from the oral, genital, or anal areas
- Complaints of pain or itching in oral, genital, or anal areas
- Unusual or offensive odors
- Torn or stained clothing
- Extreme passivity during a pelvic exam

Family Indicators

- Extreme paternal dominance, restrictiveness, and/or overprotectiveness
- Family isolated from the community and support systems
- Marked role reversal between mother and child
- History of sexual abuse for either parent
- Substance abuse by either parent or by children
- Other types of violence in the home
- Absent spouse (through chronic illness, depression, divorce, or separation)
- Severe overcrowding
- Complaints about a "seductive" child
- Extreme objection to implementation of child sexual abuse curriculum

(*continues*)

Behavioral Indicators

- Unusual interest in and/or knowledge of sexual acts and language inappropriate to ageor developmental level
- Seductive behavior with classmates, teachers, or other adults
- Acting-out sexual behavior
- Excessive masturbatory behavior
- Attempts to touch the genitals of other children, adults, or animals
- Wearing many layers of clothing, regardless of the weather
- Inappropriate dress, such as tight and/or revealing clothing
- Continual avoidance of bathrooms
- Reluctance to go to a particular place or be with a particular person
- Reluctance to go home and/or constant early arrival at school
- Excessive clinging, fear of being left alone
- Frequent absence and/or constant late arrival at school, especially if the notes are always written by the same person
- Sudden school problems; a marked decline in interest in school
- An abrupt change in behavior or personality
- An abrupt change in behavior in response to personal safety lessons
- Aggression, anger directed everywhere
- Anxiety, irritability, constant inattentiveness
- Regression, frequent withdrawal into fantasy
- Overcompliance, extreme docility
- Compulsive behaviors
- Appearing to have overwhelming responsibilities
- Suicidal threats or gestures
- Use of alcohol and/or other drugs
- Drastic change in appetite
- Sleep disturbances
- Running away from home or attempting to run away
- Denial of a problem with a marked lack of expression
- Lack of affect, extreme absence of expressiveness
- Depression, excessive crying
- Low self-esteem
- Lack of friends, poor relationships with peers
- Reluctance to undress for physical education (PE), continual avoidance of PE
- Indirect hints, allusions to problems at home, fishing for attention

Handling Disclosure Responding to a student's disclosure of sexual abuse presents a difficult and delicate situation for a teacher or school professional. The following guidelines from the Colorado Department of Health and Education can assist teachers in properly handling the disclosure.

Do:

- ❖ Believe the child
- ❖ Find a private place to talk
- ❖ Reassure the child that he or she has done the right thing by reporting
- ❖ Listen to the child
- ❖ Rephrase important thoughts—use the child's vocabulary
- ❖ Tell the child help is available
- ❖ Let the child know you must report to someone who can help him or her
- ❖ Report the incident immediately to appropriate persons or agencies
- ❖ Seek out your own support system

Don't:

- ❖ Promise confidentiality
- ❖ Panic or express shock
- ❖ Ask leading or suggestive questions
- ❖ Make negative comments about the perpetrator
- ❖ Disclose information indiscriminately

In addition, educators must reassure the child that he or she is not at fault and should not take the blame for the abuse. They must determine the child's immediate need safety and ensure that the child will be protected and supported. It is also important for teachers to discuss with the child what will happen when the report is made.

Preventing Child Abuse and Neglect

Recognizing and reporting child maltreatment are important to prevent abuse and neglect from continuing or recurring.* Schools also must be involved in working to prevent maltreatment from ever occurring at all. A school's involvement in prevention can be divided into school-based programs, school–community programs, and individual action on the part of educators.

* This section has been condensed and adapted from Crosson-Tower C. Preventing child abuse and neglect. *The Role of Educators in Preventing and Responding to Child Abuse and Neglect* (Chapter 6). Fairfax, VA: Caliber Associates; 2003. Available at http://catalogue.nla.gov.au/Record/3842282.

School-Based Programs Specifically designed programs provide some prevention efforts, whereas existing school curricula integrate other efforts. Some of the more common areas that prevention activities address or strengthen are the following:

- *Life skills training.* Conflict management, peer mediation, communication, problem-solving skills, and parenting.
- *Socialization skills.* These skills include four skills children and adolescents need to learn to grow into happy, successful adults: (1) Learning how to get their needs met appropriately. Often, maltreated children are not able to express their needs and ask for help. (2) Learning how to express feelings, which enables children to separate these feelings from actions. For example, children must learn that it is acceptable to feel anger toward someone, but it is not appropriate to hit another person. (3) Learning to take responsibility for their actions. (4) Learning how to make decisions and solve problems.
- *Problem-solving and coping skills.* Chapters 3 and 4 address these skills and give suggestions for how to teach them to students.
- *Preparation for parenthood.* To help stop the intergenerational cycle of violence or prevent new cycles of child abuse, many schools have curricula on learning how to parent adequately. To do so, students must be armed with knowledge in three areas: reproductive processes, child development, and parenting skills. Students who are trained to understand what children do at specific ages may be better able to cope as parents. Numerous lessons and exercises exist that teach what is expected of new parents, as well as the social, financial, physical, and psychological implications of sexual activity and potential parenthood.
- *Self-protection training*. This usually includes educating children about what sexual abuse is (e.g., distinguishing among "good," "bad," and "confusing" touches), making children aware of potential abusers, and teaching children what to do when they are abused or feel that they are vulnerable to abuse. Some programs bring in experts to educate the children, whereas others train teachers to conduct the training seminar or to integrate the information into their curriculum. Opinions on such programs vary, however, with some maintaining that they make children feel responsible for their own protection and cause them to feel guilty if they are molested. Programs with a minimum of four sessions have been shown to be the most effective, and active, long-term programs have the most impact on children.
- *School-based programs for families*. These can offer support for at-risk families and support for adolescent parents and their children. After-school care for children and after-school recreation programs for adolescents are a great help for working parents or parents who need relief from child-care

responsibilities. At-risk adolescents often have more problems with their parents, and schools can make efforts to alleviate some stress that mounts between parents and teens.

- *Support for adolescent parents and their children.* Some schools have programs designed for adolescent parents that focus on specific activities and skills to help them stay in school and strengthen their family life. Some schools provide special programs such as child care for the children of adolescent students, whereas others assign special teachers and counselors to monitor and support the students. Some schools also offer these teens training in parenting, birth control, budgeting, child development, and time management.

School–Community Programs Cooperative efforts between schools and the community can be an effective means of preventing child maltreatment. Training and staff development programs for those who work with children should stress identifying, reporting, treating, and preventing child maltreatment; furnish information on professional roles and responsibilities; and offer opportunities for free and frank discussion of mutual interests and problems among professionals in various disciplines. Schools can participate in public awareness programs through parent–teacher groups and other school–community organizations. Schools can offer facilities such as auditoriums or conference rooms to self-help groups, such as Parents Anonymous or Circle of Parents, or for school-sponsored public forums and workshops on child abuse and neglect prevention. Schools can also offer joint school–community adult education programs on such topics as alternative disciplinary methods and early childhood growth and development. School buildings can be made available for day care, crisis care, and after-school care programs operated by social service agencies. School staff can serve as consultants, leaders, and facilitators of these programs. School newsletters can be used to announce them. In addition, school-owned films and books can be lent to other agencies and organizations for training programs and meetings.

Individual Action Although the school as a whole is important in preventing child maltreatment, it is the individual who is often in a position to carry out these efforts. As mentioned previously, reporting suspected child maltreatment is necessary to prevent it from continuing. The attitude of the reporter can affect the progress the family is able to make once the report is filed. The educator who recognizes the strengths of both children and their parents and is supportive and available to the family throughout the investigation, treatment, and rehabilitation process helps the family maintain its dignity and protects the child.

Educators must consider how their actions affect family functioning. For example, if behavior management is a point of contention between parents and their child, a terse note from the school about the child misbehaving in class may increase the child's risk of maltreatment. Instead, it may be better to meet

with the parents to decide together which techniques of behavior management should be used.

If grades are an issue, a parent–teacher conference to discuss academic performance may be a better choice than sending home a report card with a failing grade. Whenever possible, the educator should stress the child's positive performance while suggesting ways to improve any negative aspects. Reiterating the child's faults may reinforce the child's negative self-image and further the parent's view of the child as a disappointment. In contrast, emphasizing the child's assets will increase the child's self-confidence and indicate to the parent that the child is worthwhile, capable, and someone of whom to be proud.

The positive influence of an educator on the life of a child can be significant. As one survivor of an abusive home commented:

> I don't think my fourth grade teacher, Mr. Evans, had any idea what an impact he had on my life. He was my father's opposite and taught me much about how men could be. He was consistent and concerned while my father was drunk or ignored me. He praised me while my father criticized. He prized my mind and my accomplishments; my father cared only about abusing my body. I learned a great deal from that teacher about who I was and that I was an important person. I think I became a teacher myself to be like him, so that I could make a difference for some other child.

Many survivors of child abuse name an educator who made a real difference in their lives by showing that he or she cared.

The actions of these vital educators helped prevent survivors of abusive homes from repeating the negative behaviors from their childhoods. Every educator has the opportunity to make a difference for an abused or neglected child. It is a challenge worth meeting.

Rape

Rape is the act of forcing or coercing someone to have sexual relations against her or his will. Rapes that occur to victims younger than the age of consent are **statutory rape**, whether or not force is involved. The rate of rapes in the United States has increased more in recent years than have any of the other major crimes. Further, experts estimate that only 1 of every 5 to 20 rapes is reported. Not all rape victims are female; males are also frequently rape victims. School-age youth are often involved both as victims and as perpetrators.

There are different types of rape. **Acquaintance rape** involves individuals who know each other casually prior to the rape, including coworkers, neighbors, and friends. **Date rape** occurs between two people who are spending time together with the possibility of building a closer relationship. **Marital rape** occurs between spouses. **Stranger rape** occurs between a victim and offender who had no prior relationship.

Many myths and erroneous perceptions associated with rape persist. These include the following:

- ❖ Victims "ask for" rape by their clothing, behavior, or actions.
- ❖ Males cannot be raped.
- ❖ Old or unattractive women do not get raped.
- ❖ Any victim can resist a rapist if she or he really tries.
- ❖ Victims can be raped only by someone they do not know.
- ❖ Rapists are mentally ill or sexually perverted.
- ❖ Victims secretly want to be raped.
- ❖ Nice people do not get raped.
- ❖ Rapes almost always occur in dark alleys or deserted places.
- ❖ The incidence of rape is overreported.
- ❖ Some victims deserve to get raped.

No one is immune to rape. Rape can happen to anyone regardless of age, social class, educational level, occupation, or race. The most common age range of rape victims is the 13- to 19-year age group, with 14 and 15 years being the most frequent ages. This finding underscores the importance of rape prevention activities within the secondary schools. School-based rape prevention programs, directed toward both male and female students, must emphasize the following points:

- ❖ Counteracting sex role stereotyping
- ❖ Acquaintance and date rape
- ❖ Communication skills
- ❖ Peer violence and pressure
- ❖ Assertiveness behavior
- ❖ Decoding mass media images and values that sanction violence and aggression, especially against women
- ❖ Dispelling readily accepted myths about rape

Rape prevention programs should also inform students of such precautions as the following:

- ❖ Admit that you could be a candidate for rape.
- ❖ Be especially cautious of first dates, blind dates, or of people you meet at a party.
- ❖ Be careful not to establish predictable patterns of movement to and from school or other activities—alter routes frequently.
- ❖ Do not walk alone at night.

- ❖ Walk briskly and with a sense of purpose.
- ❖ Avoid informing telephone callers that you are home alone.
- ❖ Place emergency telephone numbers near the telephone, or better yet, commit them to memory.
- ❖ Keep doors and windows locked securely.
- ❖ Take self-defense classes to assist in preventing assault.

Date Rape

Unfortunately, it is not uncommon for females in this society to have an experience in which a male dating partner forces sex against their will. The aftermath of date rape can be devastating. Victims may experience any or all of the following:

- ❖ Anxiety
- ❖ Sleeplessness
- ❖ Nightmares and/or flashbacks
- ❖ Guilt and feelings of responsibility
- ❖ Lowered self-esteem
- ❖ Questioning of personal judgment
- ❖ Feelings of shame
- ❖ Sense of humiliation
- ❖ Altered attitude toward sex
- ❖ Pregnancy and related decision making (who to tell? who to trust? abort? adopt out? raise the child? leave school? leave work?)
- ❖ Catching AIDS or another sexually transmitted infection
- ❖ Physical and/or verbal battering

To help prevent date rape, secondary curricula should teach students to be cautious of the following dating behaviors or characteristics of dating partners:

- ❖ Lack of respect for women
- ❖ Generalized hostility or anger toward women
- ❖ Lack of concern for partner's feelings or wishes
- ❖ Obsessive jealousy
- ❖ Extreme competitiveness
- ❖ Attempts to induce feelings of guilt if sexual advances are rejected

- ❖ Violent or abusive behavior while drinking
- ❖ Physical roughness
- ❖ An attitude that females are primarily responsible for preventing rape
- ❖ Traditional beliefs about women's roles

In addition, school programs can collaborate with community agencies in the prevention of date rape and dating violence by helping adolescents to do the following[13]:

- ❖ Manage conflict in relationships, including dating
- ❖ Withdraw from a conflict that is getting out of control
- ❖ Deal with jealousy, rejection, and use of alcohol or other drugs in dating relationships
- ❖ Understand sexual signals and communication
- ❖ Understand the extent of dating aggression and date rape
- ❖ Recognize abuse and sexual coercion
- ❖ Become skillful at resisting violence and rape
- ❖ Develop assertiveness skills
- ❖ Obtain self-defense training
- ❖ Debunk rape myths
- ❖ Understand the legitimacy of saying no to unwanted sexual interaction

Key Terms

bullying 356
cyber-bullying 358
electronic aggression 358
early warning signs 362
imminent warning signs 362
physical abuse 371
neglect 372
emotional abuse 373
sexual abuse 373
child abandonment 373
incest 374
rape 381
statutory rape 381
acquaintance rape 381
date rape 381
marital rape 381
stranger rape 381

Review Exercise

1. Define and explain the relative importance of each of the key terms in the context of this chapter.
2. Identify the leading causes of injury and deaths in school-age youths and discuss the risk behaviors associated with each.
3. Discuss family factors common in children and adolescents exhibiting violent behavior.
4. Describe young people's exposure to media violence and summarize the research on the influence of media violence.
5. Summarize the influences of immediate access to weapons, firearm injuries, and the personal and peer characteristics of young people who behave aggressively.
6. Discuss gangs, including why youth become involved, gang activities, sociocultural contributing factors, and the continuum of troublesome and criminal groups.
7. Describe how violence interferes with learning potential.
8. Discuss the prevalence of bullying and cyber-bullying in today's schools, its causes and effects, and the proposed means of preventing and counteracting it.
9. Describe security measures, physical inspections, policies, and discipline that can be put in place to ensure a safe and violence-free school environment.
10. Identify the early warning signs of violence and what a teacher can/should do to see them and respond to them. Identify imminent warning signs of violence and discuss what teachers must do when they are present.
11. Identify the skills and topics that are included in safety and violence prevention curricula.
12. Identify some of the physical, family, and behavioral indicators of child abuse and child sexual abuse. Explain how teachers should report child sexual abuse, including the *dos* and *don'ts* in handling the disclosure.
13. Describe the various programs and actions educators can provide to prevent child abuse and neglect.
14. Identify rape myths, dating behaviors to be cautious of, and other important skills and concepts that need to be included in date rape and dating violence prevention curricula.
15. Identify resources and teaching activities that can be used to teach safety and violence prevention to students.

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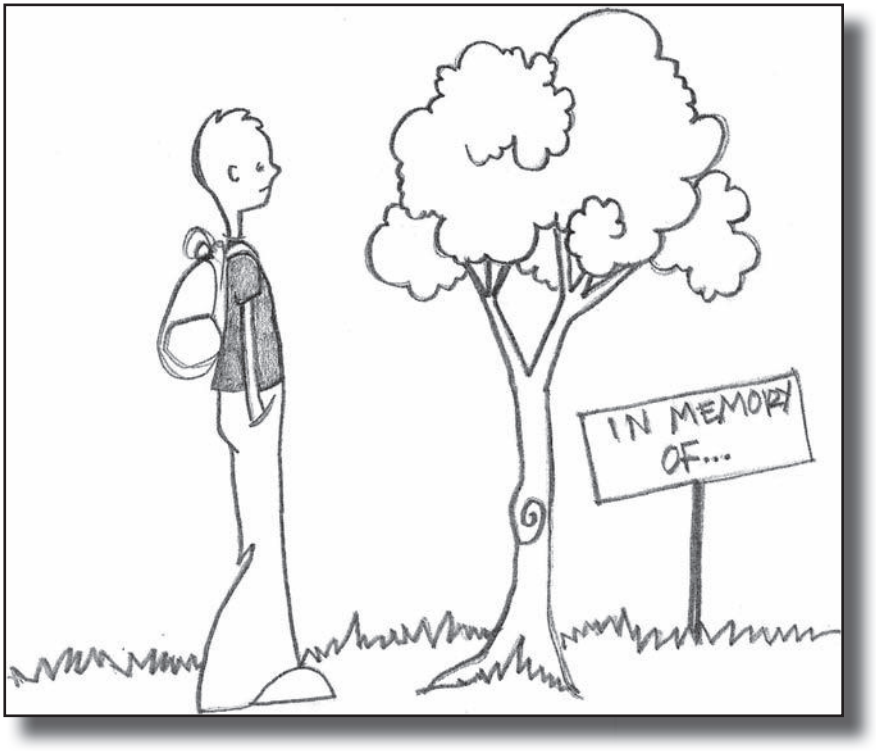
10

Dealing with Crises and Critical Issues



David Disappeared

"When I was in fourth grade the kid that sat in the desk next to mine was killed in an automobile accident. On the school bus Monday morning all the kids were talking about it. When we got to school we found that his desk had mysteriously disappeared and the rows had been rearranged. No adult at school said anything about his death—it was as if David had never existed to them. At recess the kids whispered all kinds of stories about David's death for weeks. Looking back I can see we needed to talk about it and these stories were generated by fears, imagination, and sometimes by wanting to be the center of attention. Because our teacher never spoke of David, we didn't dare ask her about him or the rumors that we were hearing. I never said anything about it to my parents, even though it really affected me. I was scared I might die too and then everyone would forget me."

This chapter addresses some of the more difficult situations educators are called upon to deal with. Every semester students express appreciation for the opportunity to discuss the issues in this chapter. They readily see the importance of becoming prepared now for something they may have to deal with in the future, as individuals and as teachers. This chapter can help educators gain insights into how to prepare for crises and offers classroom tools for dealing with suicide, self-injury, terminal illness, and death.

Crisis Response Plans

Schools need to be responsive to crises and disasters that could affect the school community including environmental disasters (e.g., fires, floods, tornadoes, blizzards, earthquakes) and other situations that threaten safety (e.g., chemical spills, explosions, terroristic acts).* School teachers and administrators also have to be prepared to deal with the serious injury or death of one of their students, a member of a student's family, or a fellow teacher. A school plan dealing with crises can be comprehensive, addressing response needs for multiple types of disasters and emergencies. Plans should include responses for both short- and long-term services.

Many states require districts and schools to have crisis response plans. Schools should review district and state crisis intervention manuals and adapt them to address local needs. The school plan could include the development of a crisis response team with a designated contact person to coordinate the school's response. The plan and team could be developed with input from key members

* This section is adapted and condensed from Centers for Disease Control and Prevention. School health guidelines to prevent unintentional injury and violence. *MMWR.* 2001; 50(RR-22):350.

of the local community, including school administrators; law enforcement; fire and rescue departments; emergency medical services (EMS); mental health agencies; parent–teacher organizations; hospitals; domestic violence shelters; health, social service, and emergency management agencies; rape crisis shelters; the faith community; teachers' unions; and organizations such as the Red Cross. Crisis plans can do the following:

- Assign roles and responsibilities in the event of an emergency to all members of the team and to the broader school community
- Consider the potential need for backup assistance from the district, other schools, or outside groups
- Consider that the crisis might be based in the community and that the school might need to serve as a shelter
- Include plans for dismissing school early, canceling classes, and evacuating students to a safer location
- Include strategies for informing school staff members, families, and the community regarding the school's plans and assignment of responsibilities
- Include procedures for handling suspicious packages or envelopes, including actions to minimize possible exposure to biological or chemical agents and mechanisms for informing law enforcement

Schools often become emergency shelters at times of crises. The school building and school staff can offer both physical and emotional refuge.

A communication system could provide for communicating internally as well as for contacting community resources (e.g., law enforcement) and families in the event of an emergency. Schools can communicate basic emergency procedures to families so that they will know where to report or call for information in the event of a crisis. A communication system can also include methods for families, community members and agencies, students, and others to communicate potential crises to the school. Floor plans might be shared with local law enforcement, fire and rescue, and EMS agencies. Crisis plans can be produced in writing and copies given to all school staff members and all relevant community organizations, even if they do not participate in developing the plan. The plan could be updated annually.

Schools can train faculty, staff members, students, community organization and agency staff members, and the crisis response team regarding the crisis response plan and their individual roles and responsibilities in a crisis. Plans should be practiced regularly and whenever updates are incorporated.

Preparations for a Crisis

Responsiveness during a crisis depends on preparation. In addition to the crisis response plan, schools could have a current list of personnel who are trained and certified to administer first aid and cardiopulmonary resuscitation (CPR); a phone tree for expediting communication with school staff members and families; clothing or badges to signify members of the crisis response team; fact sheets and letters for distributing information regarding the school to the media; an emergency contact list; and a "go box." The go box contains tools and information to be taken to the crisis response post and could include the phone numbers, current lists, and items described previously as well as a bullhorn, a complete list of students, and maps and floor plans that include locations of power and utility connections. A laptop computer and a cell phone or walkie-talkie system could also be made available. The contents of the go box might be reviewed and updated at least annually. Several persons should have access to the go box and know how to use it.

Schools should establish evacuation procedures for moving students to safety, making appropriate provisions for persons with special needs. Adequate transportation should be available to move students to the preestablished safe location, taking into account transportation requirements for students with special needs. Reunion areas should be established for students and families to meet each other. Assigned staff members can manage a standardized procedure for releasing students to family members. This procedure could include keeping records of when each student left school grounds and with whom they left.

Schools can anticipate demands from the media and be proactive in delivering the information that the school wants released to the media. For example, schools can decide in advance what types of information will be released during

a crisis and have templates of press releases already assembled. When a crisis occurs, schools can then control the message that will be released to the media. A school official trained in providing information through the media could be designated to speak to the media. A specific location for media contacts can be assigned. This location and the name of the media contact can be communicated to local media outlets when releasing the school crisis response plan.

Short-Term Responses and Services

Schools should consider reopening as quickly as possible after a crisis has ended. School personnel can be a substantial source of assistance to students. Developmentally appropriate and culturally competent mechanisms are essential for dealing with the psychological consequences of traumatic events in counseling centers, classrooms, and assemblies. Depending on the situation, these mechanisms might involve teachers, administrators, counselors, families, and local safety professionals (e.g., fire fighters after a fire).

After a crisis, grief counselors could be made available to students and staff members on both group and individual levels. The school can communicate with students, families, and staff members regarding recognizing and treating posttraumatic stress disorder.

Depending on the scope of the crisis, all or some of the students and staff members might not be able to return immediately to routine class schedules. Community resources might need to be sought for counseling and psychological services.

In the event of a death, students, families, and staff members should be allowed to grieve. Gatherings or other tributes might be appropriate, except in the case of suicide, where public tributes might increase the risk for copycat suicide attempts. Schools could be proactive in identifying and assisting students who want or need to discuss their feelings. In addition, schools can continue to work with the media so that students and staff members can return to school without disruption and to ensure that the media and the public receive the information they need.

Long-Term Responses and Services

Crises have long-term consequences and should be treated over the long term. Some students might require ongoing counseling and psychological services. Schools can anticipate anniversary dates and other occasions that might be painful for members of the school community and can provide any necessary additional services at these times. Schools should continue to communicate with students, families, and staff members to recognize and treat posttraumatic stress disorder and depression. Schools can teach students coping and grieving strategies that students can use throughout their lifetimes.

Schools can learn from crises. After a crisis affects the school or community, the school crisis response team might meet to analyze the school's response,

consider revisions to the crisis response plan, assess how to prevent future recurrences, and make necessary changes based on lessons learned.

Youth Suicide

Youth suicide is a serious public health problem.* For youths between the ages of 10 and 24 years, suicide is the third leading cause of death. There are also reports of suicide deaths among children younger than the age of 10. Approximately 4,500 young people's lives are lost each year by suicide. The top three methods used in suicides of young people include firearm (46%), suffocation (39%), and poisoning (8%).

Deaths from youth suicide are only part of the problem. More young people survive suicide attempts than actually die. A nationwide survey of youths in grades 9 through 12 in public and private schools in the United States found that 15% of students reported seriously considering suicide, 11% reported creating a plan, and 7% reporting trying to take their own life in the 12 months preceding the survey. Each year, approximately 149,000 youths between the ages of 10 and 24 receive medical care for self-inflicted injuries at emergency departments across the United States.

Suicide affects all youths, but some groups are at higher risk than are others. Boys are more likely than girls to die from suicide. Of the reported suicides in the 10-year to 24-year age group, 83% of the deaths were males and 17% were females. Girls, however, are more likely to report attempting suicide than are boys. Cultural variations in suicide rates also exist, with Native American/Alaskan Native and Hispanic youth having the highest rates of suicide-related fatalities. A nationwide survey of youths in grades 9 through 12 in public and private schools in the United States found Hispanic youth were more likely to report attempting suicide than their black and white, non-Hispanic peers were.

Several factors can put a young person at risk for suicide. However, having the following risk factors does not always mean that suicide will occur:

- History of previous suicide attempts
- Family history of suicide
- History of depression or other mental illness
- Alcohol or drug abuse
- Stressful life event or loss
- Easy access to lethal methods
- Exposure to the suicidal behavior of others
- Incarceration

* The statistics found in this section on suicide are taken from the Centers for Disease Control and Prevention. Suicide Prevention. Available at http://www.cdc.gov/ViolencePrevention/suicide/index.html.

Most people are uncomfortable with the topic of suicide. Too often, victims are blamed, and their families and friends are left stigmatized. As a result, people do not communicate openly about suicide. Thus, an important public health problem is left shrouded in secrecy, which limits the amount of information available to those working to prevent suicide.

Warning Signs of Suicide

An attempted suicide must be taken very seriously. In addition to being a potentially lethal event, it is a risk factor for completed suicide and often an indicator of other problems such as substance abuse, depression, or adjustment and stress reactions.[1] Unfortunately, many youth suicide attempters do not receive medical or psychological treatment following their attempt. Suicide researchers estimate that the number of adolescent suicide attempts may be as high as 50 to 200 times that of completed suicides.[2]

Many signs can indicate suicidal thoughts or behavior in young people. These signs can be grouped in four categories: verbal, behavioral, situational,

Most suicides are planned rather than committed on impulse. Educators should be alert for verbal, behavioral, situational, and depressive symptoms.

and depressive symptoms. Educators should be alert for these signs in the children and adolescents they work with.

Verbal Signs Quite often educators dismiss or overlook direct or indirect statements about suicidal intentions or wishes as not being serious statements. Yet, in fact, these statements do indicate suicidal intentions and should be treated seriously. One of the most dangerous misconceptions about suicide is that people who talk about killing themselves rarely do it. Actually, more than three fourths of all suicide victims mention it beforehand. Most suicides are planned rather than committed on impulse. Statements like the following may indicate suicidal intentions:

- ❖ I wish I were dead.
- ❖ I'm going to kill myself.
- ❖ People (or my family) would be better off without me.
- ❖ Nobody needs me.
- ❖ If (such and such) happens, I am going to kill myself.
- ❖ I just can't go on living anymore.
- ❖ You won't have to worry about me anymore.
- ❖ How do you donate your body to science?
- ❖ Why is there such unhappiness in life?

Behavioral Signs The most serious and predictive sign of suicide is a previous unsuccessful suicide attempt. Any suicide attempt should be considered serious. It is common for some youths to make weak attempts to gain attention. Yet, if these attempts are ignored or not regarded as serious, the individuals may turn to more lethal methods.

"Setting one's affairs in order" is another behavioral sign that needs serious attention and is strongly suggestive of suicidal thoughts. This includes activities such as making arrangements to be a donor of vital body organs and giving away prized possessions. Educators should question any changes in behavior, whether positive or negative. Behavioral signs include the following:

- ❖ Poor adjustment to a recent loss
- ❖ A suicide note that is left in advance
- ❖ A sudden, unexplained recovery from a severe depressive episode
- ❖ Alcohol and other drug abuse
- ❖ Extreme changes in mood or behavior
- ❖ Excessive irritability

- ❖ Feelings of guilt
- ❖ Unexplained crying (particularly if male)
- ❖ Truancy or running away from home
- ❖ Academic difficulty or poor schoolwork
- ❖ Aggressive behavior
- ❖ Promiscuity
- ❖ Self-mutilation
- ❖ Resignation from clubs or other groups
- ❖ Repeated episodes of accidental injury
- ❖ Social isolation or withdrawing from friends

Situational Signs The most important situational signal is family strife. Family disruption by death of a parent or sibling, separation, or divorce is associated with suicidal behavior. Disruption or disorder in the family is frequently associated with alcohol or other drug abuse among parents. Suicidal behavior by an immediate family member is more prevalent among youth suicide attempters than among those who have not attempted suicide. Therefore, suicidal behavior by other family members may serve as a model for coping with stress. Young people growing up with these family models may be more likely to resort to suicide in response to stress. Other situational signs include the following:

- ❖ Loss of a job
- ❖ Loss of a boyfriend or girlfriend
- ❖ A fight with a peer
- ❖ A fight or serious disagreement with a parent
- ❖ Chronic illness
- ❖ Survival of an illness with a disability
- ❖ A move to a new city
- ❖ Academic failure
- ❖ Being caught for a crime, such as shoplifting or vandalism

Depressive Symptoms Depression is strongly associated with youth suicide. Educators should be alert for the signs associated with depression discussed in Chapter 4. Feelings of hopelessness are particularly highly correlated with suicidal ideation and behavior. Therefore, any signs of depression and hopelessness require serious attention (see **Box 10-1**).

10–1
Background on . . .

Resources for Suicide Prevention

A number of organizations focus on suicide prevention. Check their websites for information and resources.

- Centre for Suicide Prevention: http://www.suicideinfo.ca
- Florida Suicide Prevention Coalition: http://www.floridasuicideprevention.org
- Life: Living Is for Everyone: http://www.livingisforeveryone.com.au
- Light for Life Foundation: http://www.yellowribbon.org
- National Strategy for Suicide Prevention: http://mentalhealth.samhsa.gov/SuicidePrevention
- Suicide Awareness/Voices of Education: http://www.save.org
- Suicide Prevention Action Network: http://www.spanusa.org
- Youth Suicide Prevention Program: http://www.yspp.org

Prevention and Intervention

Often, suicidal behavior is a cry for help with problems that seem impossible to solve. Showing that you care and listening are the most critical preventive measures that you can employ. Take warning signs and threats seriously and establish a sense of trust. A student's trust in a teacher often requires confidentiality. This places a great responsibility on the teacher to determine whether the situation warrants informing parents or others. When intervention is necessary, the teacher can advise the student on how to get professional help. It is helpful when teachers serve as a liaison between the school and the professional help.

Daily contact with and knowledge of their students put teachers in an excellent position to detect the warning signs of suicide. Any suspicions about suicide cannot be ignored. It is best to ask a student calmly, "Are you thinking about suicide?" This direct approach helps lower a student's anxiety and lets him or her know that someone cares enough to simply listen.

Teachers should not back away from talking to young persons who disclose that they are considering suicide.[1] By discussing suicide, you are not putting the idea into the student's head or increasing the likelihood of suicidal behavior. An open discussion can help decrease some of the anxiety that they feel and open up the door for seeking help. It also conveys that someone cares about them and wants to help them. A discussion can help them see other options.

By being a concerned listener, you help a young person know that he or she is being taken seriously. Listening conveys to the young person that you care and that he or she is not alone. Failure to listen may be perceived as a sign of an individual's sense of worthlessness.

Teachers must not act shocked if a student discloses that he or she is thinking about suicide. You can help the individual to realize that he or she is not so different because of thinking of suicide in response to problems or stresses. Thoughts of suicide are normal; however, suicidal actions are not. Teachers must take disclosure of suicidal thoughts seriously and not dismiss them lightly. *They must take appropriate action*.

Educators must not attempt to deal with a suicidal person alone. Enlist the support and help of parents, school counselors, and other mental health professionals, clergy, and friends. It is very difficult for students to obtain professional assistance on their own. Therefore, teachers serve a critical role in the referral process. Trust your suspicions that a student may be contemplating suicide and take the appropriate action.

Teachers must not allow themselves to be sworn to secrecy by a suicidal student. You may be confronted by a student who says "I have something important to tell you, but first you must promise not to tell anyone else." Your response should be, "If someone is hurting you or you are considering hurting yourself, I cannot promise that I will not tell anyone else. If it is a personal matter, I will not tell anyone and I will help and support you. However, if it is a problem for which you need assistance from others, I will help you get the help you need."

Young people are often relieved that teachers are willing to help with their problem and that they are comfortable talking about it. In discussing their problems and situation, take a positive approach and help them to see the alternatives to suicide. It is important that they realize that there are choices. Share some strategies that work for you in dealing with stressful situations, failure, loss, and disappointment. Ask them to share with you some strategies that have worked for them in the past. Convey that suicidal thoughts are normal and that they do not need to act upon those thoughts. Suicide is a normal thought, not a normal behavior.

It is important that depressed and unhappy youths understand that most problems solve themselves over time. Help them to get out of the thought pattern that things get worse and worse. Emphasize the temporary nature of most problems. Explain that the immediate crisis will pass in time and that time will help in the healing. Tell them that suicide is a permanent solution to a problem that is usually temporary.

Help the young person develop a network of support. Identify people that he or she can be with and talk with. Sometimes a **contract for life** helps. A contract for life is a formal, written agreement in which suicidal people state that they will ask for help before they hurt themselves. A contract for life should be dated and signed. Educators must never let a contract for life expire without formal acknowledgment. *Young people who pose an immediate suicide risk should never be left alone*.

More schools and school personnel need to be involved in suicide prevention and intervention programs (see **Box 10-2**). Educators must become effective in identifying and helping potential suicide victims. Effective suicide

prevention programs are developed when teachers, school administrators, school staff members, parents, and community agencies become actively involved. **Box 10-3** provides suggested classroom activities for dealing with the topic of suicide.

10–2
Background on . . .

Suicide Prevention

Suicide prevention methods are best used in conjunction with other strategies rather than in isolation. Schools and communities can implement several suicide prevention strategies to counter suicide among students. The following list includes some of these strategies.

- *School-based suicide awareness curricula.* These curricula generally focus on the following areas: dispelling myths and increasing correct knowledge about youth suicide, increasing the ability of students to recognize another student potentially at risk for suicidal behaviors, encouraging troubled students to seek help, and providing students with knowledge concerning school and community resources that are available should they need help or should they encounter a peer who needs help. Lessons about suicide can be incorporated into existing classes such as health, social studies, physical education, and others.
- *Life skills training for youth.* Some schools offer skills training for students as a way to protect young people against depression, hopelessness, and drug abuse—risk factors for suicidal behaviors or thoughts. The skills that might be included are problem-solving skills, social skills, coping skills, and help-seeking strategies.
- *Screening.* This prevention strategy involves efforts to identify students who are potentially at risk for suicide through interviews and self-report questionnaires. Screening can focus on such indicators as depression, hopelessness, psychiatric disorders, substance abuse problems, suicidal ideation, and past suicide attempts. Referrals of students with indications for suicide risk are made to the proper professionals and agencies.
- *Gatekeeper training.* Gatekeeper training refers to education and training for teachers and other school staff (e.g., counselors, coaches) about youth suicide. Because these adults are often in a position to be among the first to detect signs of suicidality and offer assistance to youths in need they are sometimes known as "natural community helpers." Gatekeepers are trained in school policies that relate to dealing with students deemed to be at high risk for suicide and in how to make appropriate referrals for professional help for these students. They are also trained that their role is not to go beyond the gatekeeping role. Mental health counseling needs to be left to trained professionals.

(*continues*)

- *Educating parents*. Schools can provide information to parents about youth suicide warning signs, risk factors, protective factors, community resources, and actions to take following a suicidal crisis. These efforts can be combined with education on other youth risk topics such as alcohol and other drug use. Parents should be alerted about the heightened risk that easy access to firearms in the home poses for youth who are suicidal. Firearms are the most common method of suicidal death in the United States.
- *Crisis centers and hotlines*. Schools can inform students about crisis centers and hotlines, which provide immediate, accessible, and confidential support for individuals in need. These services are often accessible during times when other services are not open or accessible, such as late at night and on weekends.
- *Peer support groups*. A strategy for students potentially at risk for suicidal behaviors is the use of peer support groups. These students are more likely to confide in and feel comfortable with peers rather than adults. Support groups that allow vulnerable students to meet with other students in a comfortable group climate might foster peer relationships and coping skills. These groups may also help alleviate feelings of isolation, loneliness, and hopelessness. Despite the potential benefits of peer support groups, they should not be used as a substitute for professional counseling or therapy.
- *Positive and safe school climate*. Interventions that target the improvement of school climate might have an impact in terms of reducing youth suicide. All students, including those at high risk of suicide, benefit when there is a positive and safe school climate. It is important for students to feel connected to their school.

Sources: Doan J, Roggenbaum S, Lazear K. *Youth Suicide Prevention School-Based Guide—Issue Brief 5: Suicide Prevention Guidelines*. Tampa, Fla: Department of Child and Family Studies, Division of State and Local Support; 2005. And Gould MS, Kramer RA. Youth suicide prevention. *Suicide Life-Threatening Bhvr.* 2001;31(suppl):6–31.

10-3
Background on . . .

Classroom Activities Dealing with Suicide

The following are examples of teaching activities that deal with suicide. This subject is usually addressed at the high school level. These activities help students review the warning signs of suicide, the proper steps to take in prevention and interven-

(*continues*)

(*continued*)

tion, and the importance of life. Be sure to invite your school counselor to participate. It is possible one or more of the students in your class will have experienced the loss of someone close as a result of suicide. You need to be prepared to handle appropriately any emotional needs that may surface.

Lesson Plans

You can find lesson plans on suicide prevention at the SOS Signs of Suicide Suicide Prevention Program for High Schools website at http://www.mentalhealthscreening.org/highschool. It is a school-based program that has shown a reduction in suicide attempts (by 40%) in a randomized controlled study (*American Journal of Public Health*, March 2004). The main teaching tool of the SOS program is a video that teaches students how to identify symptoms of depression and suicidality in themselves or their friends and encourages help seeking. The program's primary objectives are to educate teens that depression is a treatable illness and to equip them to respond to a potential suicide in a friend or family member using the SOS technique. SOS is an action-oriented approach instructing students how to ACT (acknowledge, care, and tell) in the face of this mental health emergency.

Chalk Line

Draw a horizontal line across a chalkboard. Tell the class that this line represents the time line of a person's life. Have the students identify the gender of the person and name the person. Divide the class into three groups. Have one group come up with important events that take place in the "chalk person's" school years. Have the second group identify events in the person's young adult years, and have the third group identify events for midlife and beyond. Give the groups a few minutes to work independently to determine their life events. Then, have the first group come up to the chalk line and mark in the important events, followed by the second group, and finally the third group. Don't be surprised if students mark in both good and bad events. Let them have fun with it. When they are finished, say, "I'm sorry, this was to have been Jane Doe's life, but on (give a specific date and time indicating she died as a teenager) she committed suicide." Draw a very heavy line showing time of death. At this point, the students will most likely become very quiet as they think about all that this fictitious person would have missed out on. This activity can be useful in introducing the topics of suicide and how life should be celebrated.

Letters

Assign students to write a letter to an imaginary friend who is contemplating suicide.

(*continues*)

Speaker

Invite a suicide hotline crisis worker or other mental health specialist to talk with your class about suicide prevention and intervention.

Brainstorm

Have students brainstorm the warning signs of suicide. Discuss how and why each sign makes suicide a likely possibility.

Dos and Don'ts

In small groups, have students compile lists of *dos* and *don'ts* in helping suicidal students. Have each group share its lists with the rest of the class.

Role-Play

Have students role-play situations in which they practice suicide intervention and prevention. Examples of role-play situations include pretending to be a worker at a suicide hotline or responding to a friend who is contemplating suicide. Be sure to guide students in active listening skills and enlisting the help of adults.

Self-Injury

Some young people engage in acts of self-injury. **Self-injury**, also known as *self-harm* or *self-mutilation*, includes deliberate attempts to cause harm to one's own body; the injury is usually enough to cause tissue damage. Any method used to harm oneself might be used in self-injury, such as cutting, hair pulling, skin picking, burning, biting, bone breaking, head banging, self-poisoning, self-strangulation, or limb amputation. Self-injury is not generally an attempt at suicide, but it probably has resulted in deaths when sustained injuries were serious enough to cause fatality. It appears to be more common in girls than in boys. Some studies suggest that self-injury may be practiced by as many as 5% to 9% of people in Western societies.[3]

Why would a young person intentionally harm himself or herself? Self-injury might be used to help someone relieve intense feelings such as anger, sadness, loneliness, shame, guilt, and emotional pain. It is believed that those who cut themselves do so in an attempt to release intense emotional feelings. Some young people troubled by a sense of emotional numbness report that seeing their own blood when they cut themselves helps them to feel alive because they usually feel dead inside. Others report that they injure themselves because

dealing with the physical pain is easier than dealing with emotional pain. Self-injury is also used by some as a way to punish themselves for the guilt, shame, and blame that they carry for an abuse that they have suffered. Some harm themselves out of a sense of self-hatred for themselves and their body. Sometimes, self-injury is an attempt to get attention or a cry for help. But there are self-injurers who go to great extremes to keep their self-injurious behavior a secret. Whatever means is used for self-injury and whatever the reasons behind it, there is usually a release from built-up feelings and emotions. However, the emotional release is only temporary.

Many young people engaging in acts of self-injury have a troubled past. Many have a history of sexual or physical abuse, have emotionally absent parents, come from broken homes, or have substance-abusing parents. It is speculated that these factors could contribute to a young person's using self-injury as a way to cope with or block out the emotional pain resulting from these situations.

The act of cutting or other forms of self-injury are signs of disturbance or emotional difficulty that needs to be recognized. For some, self-injury is a last resort or a coping mechanism keeping them from committing suicide. They are choosing self-injury instead of death. Self-injury often becomes a habit, and some mental health experts describe it as an addiction. One woman who struggled with cutting said that "there was nothing like seeing your own blood dripping off your arm or leg and knowing you control it." Some say they are addicted to the blood, some to the scars, and some to the pain or a mixture of all three. The compulsion to self-injure becomes increasingly more dangerous. A young person self-injures and feels emotional release. Then, the next time he or she is feeling depressed or angry, his or her thoughts turn to self-injury. If the person succumbs to the urge, he or she is perpetuating a cycle of addiction.

Young people suffering from this dangerous behavior need to understand that accepting help is not a sign of weakness, but a sign of strength. Many adults do not understand how to react to someone who is injuring himself or herself. Educators and adults need to not react with shock, but with understanding. They need to understand that self-injury is a coping mechanism. They need to support a young person suffering from self-injury and to help him or her find help from mental health professionals who are trained to deal with this problem. The road to recovery may be long; hopefully, through the recovery process the self-injurer will find understanding from informed adults.

Helping Children and Adolescents Deal with Death

Bereaved children face the arduous tasks of coming to terms with death, grieving, and resuming the appropriate progression toward development of personality. Sensitive and skilled school personnel can help children accomplish these tasks. However, many teachers are either uncomfortable or are inadequately trained to offer appropriate support to bereaved children. These teachers cannot help children resolve their grief in a healthy manner and may even complicate the grieving process. Teachers who are comfortable with their own grief and

prepared to help students play a vital role dealing with death in the classroom (see **Box 10-4**.)

The process of acceptance of a death or loss is often referred to as **grief work**. The death of a loved one, such as a parent or sibling, often requires 2 or more years before grieving is completed. A child's reactions to death depend on his or her age and cognitive developmental level, but resemble adult patterns of mourning. Typically, the initial responses are denial, anger, and anxiety. Later, these feelings are replaced by periods of sadness, despair, and depression. When the child has worked through these feelings, acceptance of the death emerges. **Box 10-5** provides a list of normal emotional, physical, and behavioral reactions to death.

10-4
Application Exercise

Am I Ready?

Take out a blank piece of paper and without much thought draw whatever comes to mind when you think of the word "death." When you are finished, step back and look at your drawing. Ask yourself the following questions:

1. What experience do I have with death?
2. How comfortable am I talking about death and grieving with others?
3. What do I need to do to become more prepared for dealing with a death that affects my students?

10-5
Background on . . .

Bereavement

The following are normal reactions to death. Knowing that these emotions and behaviors are normal can help you and your students work through your grief.

Emotions

- *Shock and numbness*. It seems like a dream.
- *Sadness*. Sadness might come and go over a long period of time, depending on how well you knew the person and how much you depended on him or her.

(*continues*)

(*continued*)

- *Anger.* You might feel anger possibly at those perceived to be responsible, yourself, the world in general, or the person who died.
- *Depression.* You might feel like you are on a rollercoaster of laughing one minute while remembering funny incidents and then immediately feeling depressed again.
- *Guilt.* Regrets about what you did or said to the deceased or what you didn't do or say. Guilt that you are still alive. In time, guilt that you cannot always remember what the person looked like.
- *Fears.* You might experience fear for the future and possibly about getting close to others.
- *Special emotional days.* You might feel highly emotional on special days, such as holidays, death date, anniversaries, birthdays, or other special days.

Physical Sensations

- Fatigue or weakness, like your body is weighted down
- Trouble breathing, like the wind has been knocked out of you
- Dry mouth
- Hallucinations—seeing or hearing the deceased

Behaviors

- Crying at random and at unexpected times
- Withdrawing from others
- Loss of appetite
- Insomnia
- Dreams or nightmares
- Treasuring or avoiding mementos of the deceased
- Absentmindedness or preoccupation
- Reverting to acting like a younger age
- Hostility and aggression, especially in children who do not have other means of expressing their anger and frustration

Age-Related Concepts and Needs

It is important to identify young people's perceptions and needs regarding death (see **Figures 10-1 through 10-4**). For most children, an understanding about death follows an orderly sequence. This sequence begins with total unawareness in very early childhood and progresses through stages to the point where death is conceptualized as final and universal and where abstract thinking about death occurs. Mature concepts about death develop in a progressive, developmental

FIGURE 10-1 When children are simply asked to draw pictures about death, many different perceptions and experiences emerge. This child's grandfather had recently died. Notice the detail of the tears and coffin, and also the missing feet on the people who cannot walk away from the pain.

sequence that generally follows Piaget's model of conceptual development. However, many children attain mature death concepts at younger ages than suggested by Piaget. The comprehension of death concepts such as irreversibility, universality, and cessation of function has been found to vary widely among the chronological ages of children.

Here are 10 needs children have concerning death:[4]

1. *To learn how to mourn*. That is, to go through the process of giving up some of the feelings they have invested in the deceased and go on with the living, to remember, to be touched by the feelings generated by their memories, to struggle with guilt over what they could have done, and to deal with their anger over the loss.
2. *To mourn small losses*. To mourn small losses, such as animals, helps children to deal better with the larger, closer losses.
3. *To be informed about a death*. When they are not told but see parents upset, they may invent their own explanations or blame themselves.
4. *To understand the finality of death*. Because abstract thinking is difficult for young children, they may misunderstand adults who say a deceased person "went away" or is "asleep."
5. *To say good-bye to the deceased.* Children can participate in funerals or viewings, even if only for a few minutes, to say good-bye.

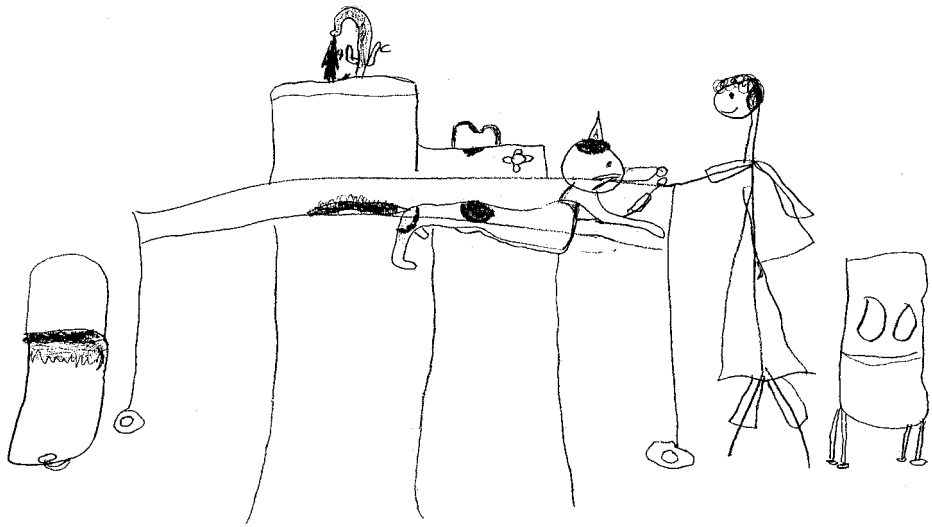


FIGURE 10-2 This child drew about her pet being put to sleep. The child had mixed feelings about this procedure. Notice the smile on the person and the intensity of the water coming out of the faucet.

6. *To work out their feelings and perceptions.* Opportunities to work out their feelings and deal with their perceptions of death come through talking, dramatic playing, reading books, or expressing themselves through the arts.
7. *Reassurance that their parents will take care of themselves and probably won't die until after their children are grown*. It is important that children know that sometimes children die, but only if they are very sick or if there is a bad accident. It is equally important that they understand that almost all children grow up and live to be very old.
8. *To know that everyone will die some day*. It may be hard for adults to be honest about this fact, but if denied, children will not be prepared for dealing with death during their lives.
9. *To be allowed to show their feelings*. Children need to be able to cry, become angry, or laugh uncontrollably. The best approach is for adults to empathize with their feelings.
10. *To feel confident that their questions will be answered honestly and not avoided and that adults will give them answers they can understand*.

Preschool-Age Children Children 3 to 5 years of age tend to see death as gradual and happening only to the very old, and as a departure that is reversible—as they have seen portrayed in cartoons. Many children believe there is a magical power that will bring a deceased person back to life. They are very curious about

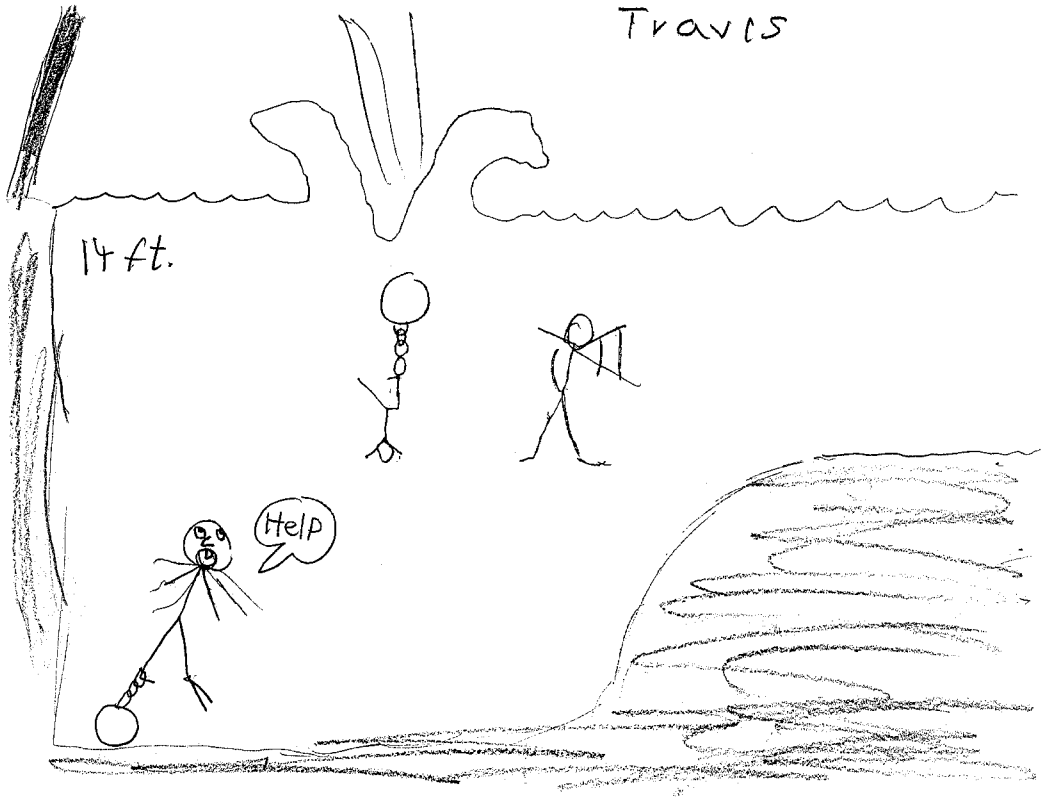


FIGURE 10-3 This child's depiction of death possibly reveals a fear of drowning.

death, which is likely to lead to questions that parents and teachers may find unsettling.

When a deceased person continues to stay away, a child may become angry or hurt. A child may feel that he or she is responsible, believing that a thought or behavior may have caused the death. This evolves as a result of the child's egocentric thinking. Fears of abandonment and anxiety also occur.

Concern about the dead person's physical well-being after death is common. A child is typically concerned with how the dead person will stay warm and get food after burial.

In the mind of a young child, death is associated with a cessation of body functions. A person or animal is considered to be dead when there is no longer any breathing or voluntary movement.

Middle Childhood Early in the middle childhood period (from about first to third grade), death is often personified as a monster, ghost, skeleton, or other predatory form. Because of this conception, children think death can be fought

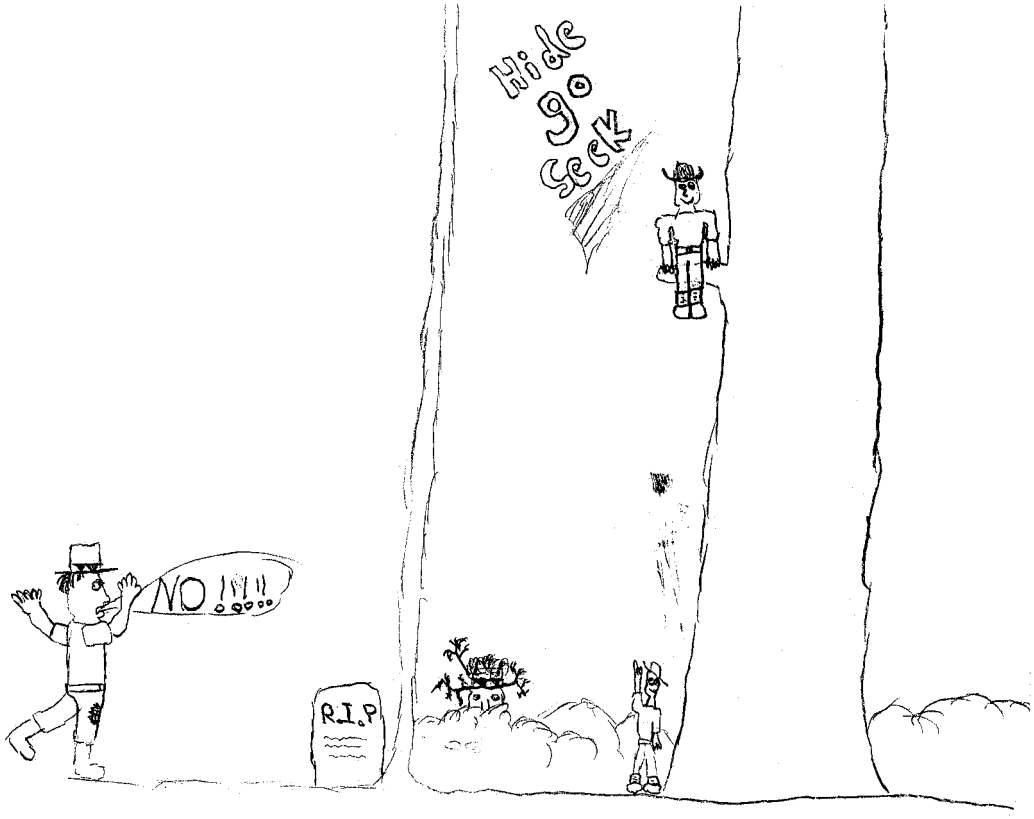


FIGURE 10-4 This child had had no real experience with death and depicted it with cartoons and Halloween images.

and overcome by magic. As a result, children consider themselves to be immortal and believe that only those who are weak or old are susceptible to death.

At about 9 or 10 years of age, children are able to conceptualize that death is final and not reversible. Although death is still an abstract thought, they come to realize that they too will die. Such realizations can create fears and concerns about dying. Such realizations also heighten their interest in the details about dying and the state of the body after death and stimulate questions.

It is common for children to believe that a deceased person can see and hear them. As a result, children may feel pressure to "be perfect" for the deceased. Misunderstandings about death can accelerate fears about dying. The religious beliefs of the family concerning death gain new importance to children as they come to understand the finality of death.

Adolescence Adolescents are capable of comprehending that death is final, irreversible, and universal. This understanding brings concern about personal

mortality. They often defend against the resulting anxiety by denying the possibility of their own death—except as an abstract event in a remote future. Denial serves as a buffer against this anxiety and contributes to an illusion of invulnerability and immortality. These illusions may contribute to risk-taking behaviors such as speeding and reckless driving and drug use.

Adolescents can also formulate abstract ideas about the nature of death. Piaget refers to this developmental period as "the period of formal operations." As such, young people can make generalizations about death beyond what they experience. They formulate their own theologies about life after death as they examine the religious views of their parents and others.

Death of a Parent

About 6 of every 100 children experience the death of one or both parents before the age of 18. The death of a father is twice as likely to occur as the death of a mother. Most parental deaths are sudden. Therefore, children and surviving family members have little opportunity for anticipatory grieving or preparation for the death. Also, a surviving parent is in a state of shock, which makes it very difficult for children to obtain parental assistance and support with their grief.[5]

Responses to the death of a parent may include a host of emotions and behaviors. The death may frighten, stun, shock, bewilder, or overwhelm a child. Also, feelings of guilt, anger, loneliness, helplessness, and abandonment or rejection may occur. Behavioral responses that typically result are aggression, hostility, and noncooperation. Withdrawal and regressive behaviors also occur. Sometimes children experience disturbances in school performance.

Losing a parent in the teen years can be particularly problematic. Well-meaning adults sometimes say things like, "You need to be strong and take care of your family." This denies the teen the opportunity to mourn. Often they experience a sense of guilt or unfinished business if a parent dies while an adolescent, in the normal course of development to gain autonomy, is emotionally and physically pushing the parent away. Adolescents might lack the emotional support they need because the adults in their lives assume that they will find comfort in their friends. This usually doesn't happen unless the teenager's peers have had some experience with grief themselves.[6]

Although a major distress, most children survive the death of a parent without long-lasting effects upon their mental health. The support and care that a child receives from adults after a parent's death is a crucial factor in the healthy acceptance of the death.

When a parental death is sudden, school personnel need to provide support to the child immediately upon return to school. When a child is isolated or feels rejected because of the death, class discussions may help. Class discussions also help other children overcome fears that such a loss will happen to them. When a child did not have an opportunity to say good-bye to a deceased person, the need to do so remains (this often happens when a child was shielded from the death and not allowed to attend the funeral). Counselors can assist by helping

a child write a letter or draw a picture to say good-bye to a loved one. Further, children should be allowed to express their feelings about the death freely. Later psychiatric problems often result from incomplete grief work. School personnel can play a key role in initiating and assisting children in their grief work.

School personnel should be alert for the following behaviors in a bereaved child. According to Brenner, a combination of two or more of these behaviors may indicate the need for additional support, counseling, or therapy:[7]

- Deep and persisting fears that other loved ones will die or that the child himself or herself will die
- Repeated expressions of wanting to die to be with the dead parent
- Angry and violent outbursts combined with feelings of guilt for the parent's death
- Attempted role reversal from depending on the surviving adult to taking care of him or her
- Continual movement; inability to be quiet or to express sad feelings
- Marked reduction in activity by a formerly very active child

Death of a Sibling

The loss of a sibling during childhood is a very traumatic experience. A sibling's death may be more difficult to accept and understand than a parent's death is.

The death of a sibling may be more difficult to accept and understand than a parent's death is.

Because the deceased sibling is close in age, the death represents the reality of a child's or adolescent's mortality. Further, the surviving sibling's need for support may be ignored by others in light of the needs of parents.

Parents' reactions to the sibling's death profoundly influence a child's quest for acceptance of the death. Some parents react by overprotecting surviving children, taking excessive precautions to make sure children are free from any risks. In such cases, a child may have difficulty developing independence as a result of these efforts to restrict the child's vulnerability to perceived danger. This can seriously thwart a child's normal development process.

Some parents may come to idealize the dead child. Consequently, surviving siblings may feel inadequate by comparison to the deceased sibling. Some parents try to recover the loss by unconsciously pressuring a remaining child to take on the personality or behavior of the dead one.

The siblings of a terminally ill child must deal with the stress of witnessing the pain and discomfort of their dying brother or sister. Because the parents must focus upon the overwhelming needs of the dying sibling, other children in the family feel the loss of attention and companionship of their parents. An additional stressor faced by surviving siblings is that parents expect them to be well behaved and to take care of their own needs. Feelings of guilt are common to survivors because they are allowed to go on living while a sibling must die.

When a sister or brother is actively involved in circumstances that lead to a sibling's death, extreme feelings of guilt are likely. Professional help is necessary for such children to gain an understanding of the death and to come to the point that they can forgive themselves. Another concern focuses upon the reactions of the other family members to this sibling. Some have difficulty trusting and forgiving the child. Some direct anger toward the child as other family members deal with the death.

In response to the death of a sibling, it is common for children to experience feelings of shock, confusion, numbness, depression, anger, and loneliness. Thoughts about the dead sister or brother linger. It is common for the surviving siblings to have had thoughts about suicide, to have experienced sleeping and eating disturbances, or to report hallucinations in which a deceased sibling either spoke to them or reappeared to them.

Death of a Pet

The death of a pet is often a child's first experience with death and grief. When a pet dies, children are likely to feel significant sorrow, pain, and grief. It is important for educators not to underestimate the depth of a child's grief. Children love their pets and often consider the pet a member of their family. Pets provide young people companionship, acceptance, emotional support, and unconditional love. Youths often feel responsible for their pets because they feed them, groom them, and clean up after them. When a pet dies, children may blame themselves, their parents, or the veterinarian for not saving the pet. They may feel depressed and frightened that others they love may also leave them.

Children need extra support in dealing with the loss of a pet. Teachers can encourage a child to talk freely about the pet. It is important to be patient because the child may repeatedly return to the topic. During this process, teachers can give the child lots of reassurance and discuss death, dying, and grief honestly. They can use correct terms and avoid euphemisms such as "put to sleep." Children often develop misunderstandings about death and hearing "put to sleep" could make a child become afraid of going to sleep. Educators can also encourage grief work by having the child draw a picture, write a story, or engage in imaginary play about the deceased pet. Sharing personal experiences with grief can reassure the child that sadness is okay and help the child work through his or her feelings.[8]

Providing a Supportive Environment for the Terminally Ill Child

The presence of a terminally ill school-age child or adolescent in school involves and affects many. In addition to the terminally ill child and his or her family, school personnel and students need support as they cope with the situation. (Working with children with chronic illnesses is discussed in Chapter 1.)

Whenever possible, dying children are encouraged to continue to attend school for as long as possible. School provides frequent opportunities for creative expression and art activities, which provide natural outlets for working through the dying process. Schoolwork is often something that terminally ill youngsters can do, so it provides a means through which they can perform successfully. This can be extremely important as a source of maintaining feelings of self-worth. School also allows a terminally ill young person to fulfill social needs.

Of course, the physical limitations of a terminal illness make full-time school attendance difficult, if not impossible. Absences are necessary for treatments and on days when a child feels too ill to attend school. Therefore, arrangements for partial days and homebound teaching support are usually necessary.

When the illness progresses to the point that school attendance is no longer possible, it helps if small groups of classmates visit the child. This maintains contact between the child and his or her class, which can be very supportive to a terminally ill child.

Understanding the Dying Child

Children with terminal conditions come to understand death at younger ages than their same-age healthy peers. Dying children often demonstrate remarkable knowledge about the seriousness of their condition despite attempts by physicians and parents to conceal the child's impending death. Therefore, children do need to be informed that their condition is fatal.

Terminally ill children feel a great deal of anxiety regarding their illness and their future. However, open communication about the illness by medical personnel and family members is associated with lower stress and anxiety levels,

increased relief about their concerns, and improved ability to cope among dying children.

Dying children begin to experience many losses in their lives. They are often separated from their family and school environment for long periods of time as they receive medical care. In the dying process, they may lose hair or undergo disfiguring surgery. Particularly to an adolescent, these changes in physical appearance result in severe blows to self-esteem.

Although school-age children lack the cognitive ability to grieve the loss of their future, adolescents do not. Preparatory grief can be overwhelming and debilitating for adolescents with terminal illness and for their families. **Preparatory grief** typically includes five stages. A person can experience these stages in any order, revisit some stages, go through more than one stage at a time, and skip stages. **Denial** ("No, not me. It can't be true") is often the first stage and works as a buffer to reduce the initial shock of news of a terminal illness. **Anger** and resentment can follow as the realities of the illness can no longer be ignored ("Why did God let this happen?" "Those stupid doctors . . ."). The ill person often attempts **bargaining** with a supreme being for full recovery or more time to delay or prevent the inevitable ("God, I'll do . . . if you . . .). When the person realizes that death is inevitable, they feel a sense of deep **depression**. It should be recognized that this sense of depression and loss is a normal part of preparatory grief, not a mental disorder. With adequate support and time, the dying individual works through the previous stages and comes to **acceptance**. Acceptance is neither a happy nor sad time, but a period of accepting her or his fate. The depression and pain are mostly gone, and it is a time for rest and reflection. Recognizing these stages helps people work through the emotions that come with grief. The preparatory grief of the terminally ill child is best facilitated when supportive adults understand why a dying young person feels and behaves in a particular manner, and then responds to his or her needs.

The Teacher's Role

The classroom teacher can play a special role in the life of a terminally ill child. Bryant describes this role as follows:

> Remember that as a teacher you have a special place. You represent the child's normal world; you are an oasis for him. The doctors and nurses bring shots and machines; the parents hover with tears and anguish. You, however, know the child's work-a-day world. You are part of his business and social community. You, more than many, can maintain a semblance of his former world by your visits, news of the classroom, and occasional work assignments. Your interaction with a dying child can keep him among the living a little longer.[9(p.65)]

The Classmates' Role

Throughout the terminal illness, the child needs to continue to feel included as a member of the class. When possible, classmates should be informed about the terminal illness and guided to deal with the situation in a constructive manner.

Bertoia and Allan explain why this is important:

> By including the child as part of the class throughout the treatment phase and during the course of an illness, the class as a whole can deal with the situation in a positive manner. Generally, class members will become very supportive of the child in class and protective on the playground. When the teacher or child explains something about the disease to class members, their fear of getting the same thing is diminished and the sick child is not isolated. Because family members are frightened by names such as "cancer" or "AIDS," general terms such as "blood disease" can be used. The counselor should get permission from the child's family if the proper name is to be used. Classmates will understand when standards do change and seem unfair because the sick child cannot complete as much work in the assigned time. Class discussions about feelings and behaviors help clarify what is happening in the classroom.[10(p.34)]

Teachers should never ignore questions that classmates have about the illness or the eventual death of their terminally ill classmate. It is important that children have the opportunity to ask questions and to have them answered. Further, the parents of classmates should be informed that their child was exposed to a death so that they can recognize behaviors or other characteristics that indicate their child's grief and mourning. The parents can then help their children in their grief work.

Responding Appropriately to Death

During your teaching career, it is likely that you will have to deal with death in the classroom. Whether a student, fellow teacher, member of the community, or family member of a student dies, it can affect your entire school. This section provides additional insights into how educators can respond appropriately to death. **Box 10-6** lists some resources on the topic.

10-6
In the Classroom

Resources on Death and Dying

There are many resources for helping children and adolescents deal with death and dying.

- Cincinnati Children's Hospital Medical Center's StarShine Hospice provides a list of suggested books about death and grief for preschoolers through adolescents at http://www.cincinnatichildrens.org/svc/alpha/s/hospice/read/default.

(*continues*)

htm. It also has a list of books that help children prepare for hospital and doctor visits.

- Parenting Book Reviews has a page devoted to reviews of books about children and death. It can be located at http://www.pburch.net/books/booksFAQ3_4_death.html.
- Hospice Net has a children's section and information on helping younger people cope with death and funerals. It can be accessed at http://www.hospicenet.org/html/talking.html.
- "Discussing Death with Children" (available at http://kspope.com/therapistas/death.php) provides insights for dealing with death in the classroom as a planned or unexpected event. Included are listening guidelines, classroom considerations, and classroom projects.
- Compassion Books (http://www.compassionbooks.com) is a commercial website with an annotated listing of more than 400 resources to help children and adults through serious illness, death, loss, grief, and bereavement. The books have been reviewed and selected by knowledgeable professionals.

Death of a Student

It is apparent that the children's reactions to the death of a schoolmate can be hindered by the behavior of school personnel. The most powerful hindrance is the teacher's denial of children's capacities to deal with death. Studies reveal that teachers who are open to the painful feelings aroused by death are the best facilitators because they help their classes deal with death as a unit to explore together.[11] Some children need counselors or outside agencies, but the most effective method of handling children's reactions to the death of a schoolmate is within the classroom. The classroom was found to provide the best environment for children to deal with the trauma of a fellow student's death.

Immediately upon the news of a student's (or teacher's) death, the involved teacher(s), principal, school counselor, and school nurse should meet to make a plan of action for talking to classmates about the death, removing the dead student's belongings, working with the family, and for some form of memorial activity.

School personnel should be designated to inform schoolmates of the death, to discuss the death with them, and to answer questions. It is preferable if the classroom teacher, who has an ongoing relationship with the students, is involved in these discussions. When the teacher is too uncomfortable to lead the discussion, it helps if she or he is present while someone else, such as a counselor, leads the discussion. Children should be encouraged to ask questions, and teachers should remain open for questions and comments beyond this initial discussion. Many questions and concerns will surface in the days and weeks that

follow, and teachers should be prepared to deal with them as they arise. Teachers have to acknowledge their feelings about loss so that they can be emotionally available to help their students. By displaying emotions, teachers validate those of their students and provide a model for grieving.

The grief work of schoolmates is facilitated by planning and participating in memorial activities for the deceased child and communicating condolences to family survivors. Children need to express their sorrow and to participate in activities such as attending memorial activities, writing notes or drawing pictures for the bereaved family, and creating a memorial book, bulletin board, or memorial garden.

Suicide

Many children and adolescents die from accidents, suicides, or homicides. When death is the result of suicide, young people need a lot of help in understanding why the suicide occurred. It is common for surviving friends, siblings, and children to feel considerable guilt about something they said or did to the deceased individual, and to feel responsible for the suicide. When this occurs, the young person needs adult support and professional counseling to come to terms with the death and to find relief from this sense of responsibility.

Family survivors of a suicide victim are inclined to feel shame about the death. Many hold religious and personal views in which a person who commits suicide is condemned. These are difficult feelings for family members and friends to work through and require extra support.

In the school setting, teachers can allow students to express emotions surrounding the suicide, especially through classroom discussions of the death and memorial activities. Depressed students, who might view the suicide as a path to follow, need special help.

Survivors of suicide victims need to talk and ventilate their feelings. Listening on the part of friends and school personnel is one of the most important types of support. Survivors must be allowed to relate their feelings over and over if they desire. It is in the relating of their feelings that they begin the healing process. While listening, friends and school personnel should be careful not to place blame or rationalize reasons for the suicide. Educators must affirm survivors' right to feel the way that they do.

Adults should avoid making comments such as these:

- ❖ It was God's will.
- ❖ You must forget her or him.
- ❖ He or she must have been insane.
- ❖ Don't cry.
- ❖ You have other friends.
- ❖ You have other children.
- ❖ I know how you feel.
- ❖ Time will make it easier.

Adults must realize that there is no appropriate timetable for the grief process. Students must be allowed time for recovery, even if it takes months or years.

When Tragedy Comes to School

This section provides an actual account of how a school coped with the tragic death of a student.* Their experience provides an example of all the different needs and issues schools must address in these types of situations.

Coping with the Trauma of a Violent Death

A member of the junior class was murdered one weekend, following a party with friends. She was killed by her boyfriend, a classmate. Both students were well-known and well-liked in the school. As can be imagined, there was considerable anguish and confusion on the part of all who knew them. The student body was stunned, the small New England community shocked.

The loss of their classmate prompted a variety of emotions among the students. After initial shock and grief, our students experienced anger and varying levels of fear and depression. It was not unusual that at times these emotions commingled indiscriminately. The students needed to be guided through this difficult time so they could deal with their grief and the grieving period would be brought to some sort of acceptable closure.

I hope you never have to deal with such a condition. However, if it does occur, perhaps by knowing our experience you may be better able to manage the situation. The following was our reaction and process.

A Meeting with Classes

Each grade level was addressed on the next school day following the tragedy. The first class to meet was the class of the victim. The students were talked to softly and gently, told that their grief was natural and had a purpose. They were told that the grieving period and subsequent time would help to heal the hurt while preserving the memory of their classmate.

Many students were afraid after the tragic event. They envisioned themselves as experiencing the same tragedy. Many said that they were afraid to be alone, or that they were afraid of the dark. They were comforted and urged not to live their lives in fear. The mere statement gave considerable reassurance. Repeated with confidence and conviction, it had a calming effect.

Finally, students were warned to give no credence to rumor. Rumor, whether true or false, has a destabilizing impact on the entire school. One cannot stress this point often enough. Students must be given as much information as possible from credible sources. They should be urged to reject all statements that begin with, "I heard that . . .". In the absence of personal knowledge, they must assume nothing.

The main office, guidance office, and library were set up as in-school information centers. Students were urged to seek factual information there.

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* This section on coping with the trauma of a violent death is taken from Franson JP. When tragedy comes to school: coping with student death. *NASSP Bull.* October 1998:88–91. It is reprinted here with permission.

A Place to Be Apart

Grieving students were allowed a place in the school where they could express their grief. They were often too upset to go to their classes, and needed a place where they could talk, cry, or simply sit and reflect. The library was closed for general use and made available to anyone who needed to be apart from classes or classmates.

A Memorial Service

A memorial service conducted in the school gym had a considerable healing effect. Probably its most significant accomplishment was to bring closure to the period of public grieving, while accelerating the end of personal grieving.

The service was primarily for the students; however, since the parents of the victim did not have a memorial service open to the public, we were able to provide a medium by which friends of the family could participate and express their sentiments. The parents also attended the service, and they, too, were consoled.

The service was held after school and was primarily directed to the students. They had "reserved" seating by the podium. Other guests were given the remaining available seats and bleacher seats. More than 1,000 persons attended.

Journalists from all media were invited to the service, although cameras of all types were prohibited. Advance notice of this restriction was given the media where possible; others were informed of the restrictions at the entrance to the gym. This decision lent much to the dignity and solemnity of the service.

A clergyman known to many of the students delivered the eulogies and the prayers. As principal, I spoke, and at various times during the service, the choir sang.

At the conclusion of the service, there was no rush to leave. People stood around talking quietly. Students hugged each other, cried softly, or otherwise consoled one another. Townspeople came by to talk. They were pleased with the sensitive way in which the school managed events. It was an important part of the healing process. Great care should be taken not to miss this opportunity.

Student Support Services In-House and Out-of-House

When students left the memorial service, they were given a paper that told them how they could find support during the next five days in school, and indefinitely out of school. This information was also posted in the halls and office area.

In school, a hotline and drop-in center were established by the guidance directors. The school was open 24 hours a day for the next five days (which included a long weekend).

The telephone numbers of area emergency services and mental health centers were made available. An area outpatient clinic was also available to provide immediate therapeutic services to those in need.

The hotline was active during the first couple of days of its availability. By the fourth and fifth days, there were only one or two calls. Seemingly, the students who used the outreach opportunities felt satisfied. Others may have found comfort simply in knowing that the help was available.

Bereavement Counseling for Staff

It was important not to overlook the emotional needs of staff members during this time. Teachers often have deep personal ties to their students. We contacted a mental health clinic in a neighboring town and requested the services of their bereavement counselors. (The counselors donated their services.) The counselors came to school and talked to the staff members, explaining the stages of the grieving process and the symptoms that the staff members could expect to see in themselves and in the students. They gave suggestions on how to cope with the different situations. Further, they explained how just their coming together had a therapeutic effect that contributed to the healing process.

The knowledge and comfort that staff members gained in this session contributed greatly to their ability to calm themselves and their students.

Staff and Administrative Presence

The first school day after the tragedy was the most difficult day of all. There was much congregating in the halls, cafeteria, gymnasium, and other places with general access. The professional staff members were visible and accessible to students at every opportunity. Questions were answered. Opinions and solace were given with love, caring, and sensitivity. Nothing would have been more devastating than a "business as usual" approach.

Class time was given up freely for the discussion of events. School rules regarding punctuality were relaxed. A caring and sheltering atmosphere pervaded the school building. The students responded with relief and affection. As mentioned earlier, the staff counseling contributed much toward the effectiveness of staff-student counseling.

Civil Officials

The local police chief and an officer came to school to meet with interested students to explain the sequence of legal events that were to follow. They shared as much information as possible, and further explained the potential consequences for their other classmate.

At the courthouse where the trial was to be held, the district attorney met with a delegation of students to discuss the legal process in homicides. Both meetings provided authoritative information with which students could make personal judgments.

The Media

The media provided one of the thorniest problems during the entire process. While some journalists behaved with sensitivity and in a professional manner, others could best be described as carnivores. The latter sought to sensationalize events and intruded on the grief of students with impunity and without apology.

Journalists have a vested interest in all news, but particularly in the spectacular. A middle ground must be found whereby the school can help them meet their professional responsibilities and yet protect individual privacy.

To this end, on school grounds, all interviews with journalists were done exclusively by school administrators and guidance counselors. Journalists and students were kept apart. Any student interviews initiated by journalists were conducted off school grounds. We did not do this until the second school day

after the tragedy. In that short time, considerable student animosity developed toward the media.

One young-looking female reporter hid herself in the girls' room, eavesdropped on conversations, and printed them in the evening paper out of context. In another incident, our students were photographed in their grief and ended up on the 6:00 news. It was not surprising, then, that the students requested that their privacy be protected. We supported their request wholeheartedly. From that point on, the members of the media behaved much more responsibly.

During the entire process, no student file information was released. There are statutes that prohibit release of private information; however, in the absence of such statutes, it is still a good idea to maintain confidentiality.

Memorial Tributes

Different kinds of memorials were established on behalf of the deceased student. Members of the school and community sent contributions for a memorial scholarship. The company for whom the victim's father worked matched all contributions on a two-for-one basis. It has turned into our largest scholarship award with an endowment of approximately $20,000.

During the week following the girl's death, the school flag was flown at half mast.

Students planted a cherry tree and provided a memorial stone. A dedication ceremony was held for the junior class and all others who wished to participate. The school choir also participated.

A page in the class yearbook was dedicated to the student in memoriam. When the class graduated, the parents, in a private meeting with me, were presented a diploma granted in memoriam.

Strength is supposed to come from adversity. I would have to say that such was the case here. In addition, there was a certain coming together of the school and community as a result of heightened sensitivity by those who sought to comfort and those who sought to be comforted.

We are all changed by the past events and yet we are still the same. We shall never forget that year. But there is comfort in knowing that in this very difficult time, we helped.

Death Education

Education about life and death assists students and teachers in confronting one's own mortality and that of others. This awareness allows the development of the mature perspectives necessary for decision making about matters of life and death. Death education aims to help students find more depth and meaning in family relationships and friendships, to set goals and priorities, and to better understand the feelings of those who experience dying and bereavement. In addition to gaining an understanding of bereavement and grief processes, students practice and acquire listening and communication skills to assist others through grief work. These skills also help in coping with personal losses (see **Box 10-7**). The following are possible areas of study in a death education unit or course:

- The life cycle
- Definitions, causes, and stages of death
- The meaning of death in American society
- Cross-cultural views and practices related to death
- Funeral ceremonies and alternatives
- Bereavement, grief, and mourning
- Cremation
- Cryogenics
- Organ donations and transplants
- Extending condolences to a relative or friend
- Legal and economic aspects of death
- Understanding the dying relative or friend
- Euthanasia

Before a teacher initiates a death education unit, she or he must confront personal feelings about death and come to terms with these feelings. The teacher, of course, must also be knowledgeable about the subject matter.

Death education is controversial in some areas. Some feel uneasy having teachers discuss issues that touch the very core of peoples' personal beliefs. Others contend that teachers are not sufficiently trained to deal with the emotions that come from facing one's own mortality or that emerge from grieving survivors. Before beginning a death education unit, teachers should check to see whether the topic is permitted in state, county, and school guidelines and should consult with the principal.

10-7
In the Classroom

Teaching Loss as a Part of Life

Here are some examples of teaching activities that deal with loss and seeing death as a part of life. The appropriate grade level for each activity is indicated. As you prepare to teach this topic, tell your school counselor about your plans and invite him or her to attend and participate. Be aware that one or more of your students

(*continues*)

(*continued*)

may have recently had someone close to them die. Be prepared to respond appropriately to any unexpected emotions.

Confronting Mortality and Dealing with Bereavement

Falling Leaves

Collect leaves and make a display in the classroom of a variety of shapes, sizes, and colors. Liken them to the uniqueness of individual lives. Discuss the finite nature of life and the reassurance that our world goes on. (P, K, I, J, H)

Pets

Allow children to talk about the death of pets or of relatives. This gives you an opportunity to teach the acceptance of death as part of life. (P, K, I, J)

Literature

Comment on death and loss as it occurs in the literature that you read in the classroom. Discuss how grieving characters act and help your students understand the need for grief work. Reinforce the fact that loss is universal, that it hurts, and that life goes on. (I, J, H)

In the News

Discuss violent deaths that are prominent in local or national news. Help students empathize with grieving families. Teach students safe ways to express verbally or nonverbally any anger they feel. (I, J, H)

Draw

Have students draw a picture entitled "Death." This is a good groundbreaking activity for the subject. It will also give you a quick preview of who has experience with death, who sees it as an abstract cartoon, and who may have fears concerning death. These pictures can then serve as a starting point for discussions on death. (I, J, H)

Panel Discussion

Invite representatives from different religions to discuss their beliefs about death and life after death. Have students prepare questions for panel members in advance. (H)

(*continues*)

Finding Deeper Meaning in Life and Relationships

Obituary

Have students write their own obituaries. The purpose of this activity is to help them identify all the things they want to fill their lives with. It demonstrates the fact that there is a beginning and an end to each of their "stories." Provide your students with examples of actual obituaries from newspapers. Instruct students to select the age and cause of death and to enumerate on their accomplishments and activities. (I, J, H)

Two Years

Have students close their eyes, take a deep breath, and relax. Tell them: "Imagine yourself in your favorite place to be alone, someplace you like to go when you want to think something through. It is very comfortable, warm, and quiet there. You feel very calm and relaxed, and at peace. Your feelings are a little surprising, because you have been told you have only 2 years to live. You have already gone through denial, anger, bargaining, and have come to accept your circumstances. You have come to this special place to think about what it is you want to do with the time you have left. Take a few moments now and visualize what it is you want to do with the 2 years you have left." Give students about 5 minutes to think this through. You may need to occasionally speak, helping them through this visualization. At the end of the visualization, instruct students to take a deep breath, let it out slowly, and to slowly come back to the present and open their eyes. Discuss their visualizations and what they wanted to do with their limited time. This activity helps students identify their priorities in life. It can also help illustrate the point that everyone dies, but not everyone lives. (J, H)

Role-Play

Have students role-play the following situations: talking to a very ill grandparent, talking to a terminally ill friend, asking their healthy parent about their living will or funeral desires, talking to a grieving person, and talking to a person with suicidal thoughts. (I, J, H)

Roots

Have students fill out a family tree with their parents or guardians. In addition to becoming familiar with ancestors' names and dates and places of birth and death, suggest that students inquire about their ancestors' personalities and characteristics. (I, J, H)

(*continues*)

(*continued*)

Decision Making

Funeral

Have students plan and enact a funeral for an imaginary person or animal. (I, J, H)

Other Customs

Have students research other cultures' perspectives of death and funeral customs. Have them also look for changes that have taken place in their own culture over the past 200 years. (I, J, H)

Mortuary

Have students visit a mortuary and report on itemized costs of funerals and other services. (H)

Living Will

After discussing the importance of organ donations and transplants, create a living will as a class. (I, J, H)

Organ Donation

Have students do Internet research on organ donation.

Hospice

Ask a representative from a local hospice to speak to your class about the needs of those with terminal illnesses and about hospice services. (I, J, H)

Key Terms

contract for life 397
self-injury 401
grief work 403
preparatory grief 413
denial 413
anger 413
bargaining 413
depression 413
acceptance 413

Review Exercise

1. Define and explain the relative importance of each of the key terms in the context of this chapter.
2. Summarize the key elements in crises plans, preparations, short-term responses and services, and long-term responses and services.
3. Discuss statistics, risk factors, and warning signs of suicide (e.g., verbal, behavioral, situational, depressive symptoms).
4. Explain in detail what to do when someone confides he or she is thinking about committing suicide.
5. Explain why young people engage in acts of self-injury and how educators should respond.
6. Identify the needs children have concerning death. Explain how children and adolescents perceive death.
7. Describe the possible emotional and behavioral responses a child and adolescent may have to the death of a parent. Identify when additional support, counseling, or therapy may be needed by a student.
8. Enumerate some of the unique emotions, stresses, and needs a student can experience with the death of a sibling and of a pet. Identify how teachers can be helpful in each situation.
9. Describe how schools can provide a supportive environment for a terminally ill child.
10. Identify the needs of a dying child and explain the stages of preparatory grief.
11. Describe the role a teacher and the role classmates can have for a terminally ill student.
12. Describe the best environment for students to deal with the trauma of a fellow student's death. Explain how teachers can help students with their grief work.
13. Discuss the particular needs young people have when dealing with a suicide.
14. Outline how to deal with the needs and issues a school must address after a violent death.
15. Identify resources, lesson plans, materials, and teaching activities you can use in dealing with crises, suicide, self-injury, terminal illness, and death.

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