American School
AMERICAN SCHOOL BOARD JOURNAL • THE SOURCE FOR SCHOOL LEADERS

Aug. 27, 2007

Shrink-Rap

A Day in the Life of a School Psychiatrist

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Problems start at home.

A mother was making breakfast for her son, but did not hear him getting ready for school. She knocked on his bedroom door to inquire, and he announced through the door, “I’m not going to school today!”

“Why not, she replied?

He answered, “First, I don’t like school. Second, the teachers do not like me. Third, kids make fun of me.”

She responded, “Well, I’ll tell you why you are going to school today. First, school is good for you. Second, you’re 56 years old. Third, you’re the dean of the college!”

Anyone working in a school probably has, at one time or another, shared the son’s feelings. But “school refusal,” the term psychiatrists use to describe the phenomenon, is commonly encountered in young students, most typically younger pupils afraid to separate from their parents.

School refusal, however, is just one of many psychiatric conditions that become apparent in the classroom, on the playground, or during after-school activities. What teacher or principal has not confronted the challenge of attention deficit hyperactivity disorder (ADHD), anorexia, depression, oppositional defiant disorder, or self-mutilating behaviors? Among junior high and high school students, substance abuse is so prevalent it merits its own sentence.

Schools devise various strategies to help students and families cope with a range of emotional and behavioral problems that make learning more difficult, but is the educational system sufficiently well equipped for the task?

Psychiatric epidemiologists – those who study patterns of disease – believe most psychiatric conditions that adults suffer from were in fact diagnosed in childhood. It is no surprise that, according to a 2003 study by the Substance Abuse and Mental Health Service Association, 87 percent of schools throughout the United States deliver some sort of mental health service, even if it is just referring kids to outside providers. However, the same study indicated that, when the going gets tough, only 2 percent of these school systems have an “in-house” psychiatrist to consult.

What kinds of questions would school administrators ask a child psychiatrist, namely a medical doctor trained in the diagnosis and treatment of emotional and behavioral disorders? What does a child psychiatrist actually do in a school? As a board certified child psychiatrist who has consulted in numerous school systems, I’ve put together a composite that represents a typical morning in a

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school system. It shows how such consultants can be helpful to schools while also being cost-effective. Names and details have been altered to ensure anonymity.

Sometimes zebras appear in school…

8 a.m. I arrive at Brookside Elementary to observe a first-grader, Matthew, whose teacher complains that he is disruptive in class and is not paying attention. His eyes wander, and his mind seems to follow. Concerns about ADHD abound. I spend 25 minutes observing the child in language arts and then at recess.

I am struck by the staring spells, both indoors and out, that the teacher pointed out. This could be ADHD, although kids with the disorder usually pay attention to things that are interesting to them, such as games at recess. Perhaps this boy is suffering from a type of seizure disorder that consists of such staring spells. I talk with the school psychologist and suggest that the parents confer with a child neurologist who can make this diagnosis with an electroencephalogram (EEG). This is an important distinction because seizures and ADHD are treated quite differently.

A significant contribution that psychiatrists sometimes make, in addition to the expertise provided by school psychologists, is their medical perspective. Psychiatrists complete four years of medical school prior to specializing in psychiatry, so it's our job, for example, to look at a child who is inattentive and raise the possibility of iron deficiency, or lead toxicity, or a seizure disorder, any of which can mimic ADHD. Teenage depression is even harder to just "snap out of" when a low blood cell count (anemia) or poor thyroid gland function is the culprit.

There's an adage in medicine: "If it looks like a horse and sounds like a horse, it's a horse, not a zebra." So, what looks like depression usually is. Nevertheless, sometimes zebras appear in school.

When old-fashioned etiquette fails….

8:35 a.m. Deirdre is a seventh-grader at my second stop, Sherwin Middle School, where I arrive for her 9 a.m. individual educational plan (IEP) meeting. Deirdre seems unmotivated to learn and is withdrawn, despondent, and occasionally oppositional with teachers.

During the meeting, the mother shares that her daughter is being treated by a therapist and a psychiatrist for depression. Having seen this child in class the week before, I agree with the diagnosis, and believe that my observations would influence the girl's psychiatrist to increase the frequency of psychotherapy visits, the medication she is taking, or both.

Because the psychiatrist has not returned a couple of phone calls from the school psychologist, I agree to call him myself, because sometimes "doc-to-doc" contact seems to happen a bit faster. Facilitating more efficient, effective contacts between schools and outside clinicians is an important part of my work and can be a huge time-saver for overworked teachers, clinical staff, and administrators.

I will tell Deirdre's psychiatrist the school staff's relevant observations so his treatment will be based on complete information. I will also ask him for suggestions, based on his knowledge of Deirdre and her family, that would help school staff educate her more successfully.

Whose side am I on, anyway?

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10:05 a.m. While cruising to Deerfield Elementary School to talk with a principal and teacher about Trevor, a third-grader in a special needs class, I demolish the apple that ricocheted around the front seat of my car. The principal and teacher disagree about how best to respond to behavioral outbursts.

In an effort to convince the child that throwing objects in the classroom will not be tolerated, the special needs teacher sends the child to the front office for a reprimand. The principal believes the best approach, rather than punishing the child, is for Trevor to resume his work in the office until the child is calm enough to return to the classroom. At times the student seems to enjoy the individual attention he receives from other staff in the front office, and it seems the outbursts are occurring with increasing frequency.

Parents, meanwhile, are concerned about their son's loss of class time, and have petitioned the school to place the student in an out-of-district classroom. I suggest to the teacher and principal that we meet first to hammer out a consistent behavioral plan. At the same time, I know that this very seasoned teacher resents being undermined by a fairly junior principal. Equally relevant is that the principal, who wields a mild-mannered, flexible leadership style, believes the teacher is responding to the student with knee-jerk rigidity. The three of us set up a time for the following week.

To Muster Trust

11:15 am. Last stop for the morning is Charlemagne High School. The problem is not the child, classroom, teacher, or principal. The question is about academic placement from an irate parent who believes her daughter, Carla, is not getting sufficient accommodations for her learning disability in the resource room where she spends a good part of her day.

At least, that's how the principal presents the problem. The underlying issue for the 33-year-old mother of this 16-year-old is her own traumatic memories of her high school experience, which culminated in repeating 10th grade and ultimately dropping out in her junior year. No matter how accommodating the school has been, the staff's efforts are not enough to override the colossal lack of trust. The education of this woman's daughter is merely the vehicle by which to express anger and frustration.

In an initial meeting with the mother, I use my status as an outsider to acknowledge the validity of her traumatic memories. I tell her the school has brought me in because they want to be sure that they are doing right by her daughter. I state that I do not have a quick fix and tell the mother that she and I will need to meet a few more times, with other school staff, to develop a workable solution.

This arrangement does not feel like the brush-off she was expecting from a busy psychiatrist. She leaves our meeting with just a little less distrust than before.

What can you learn?

The above travelogue is typical of my days as a consultant to school systems. My functions include acting as the bearer of medical and psychiatric information; working as a liaison with outside clinicians; helping school staff communicate better; and leveraging my outsider status with those suspicious of the establishment.

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This last function is an important reason school systems pay my fee. If they divert just one child from an unnecessary out-of-district placement, I've been more than cost-effective.

Of course, helping kids and staff find more success in school is the real incentive for me to keep doing the work I do. Because psychiatrists are reputed to talk about mothers – their own and everyone else's – I'll conform to that mold and conclude by stating that I'll never tell mine that I don't want to go to school!

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