Chapter 11
Contact with Schools: Objectives, Limits, and Care

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According to Regra (2000), the children's clinic is a therapeutic process that covers more than one client: besides the child, it also involves his/her parents. However, a basic aspect of behavior analysis is the understanding of the individual's behaviors as a product of interaction with the environment (Todorov, 2007). Thus, when it comes to children, the concept of environment is expanded and extended to the school context, as an important environment where they spend much of the day. Therefore, the goal of the child behavioral clinic also includes changing the child's behavioral relationships and reinforcement contingencies within the school environment in order to enable the client's social and academic aspects.

Considering this important partnership, the therapist's contact with schools is essential, even when the referral for care has arisen from a need by parents or other professionals/specialists who have evaluated and/or are also monitoring the child. For example, a child with oral language alteration may already be assisted by a specialist who works in this area (in Brazil, they are usually speech therapists), and another child with school issues may have the complementary monitoring of a psycho-pedagogist or school psychologist. In this way, when we begin our work, it is a fundamental part of the process to establish contact with the network of professionals who accompany the client, in order to understand the reason for referral, how they have acted, and what the scope of their therapeutic planning is (Hunter & Dunders, 2007). If the therapeutic work was a referral from the school, it is worth knowing all the elements that will be important for the behavioral clinic identified by the school.

As this chapter focuses on exploring the aims, limits, and care of school contact, we will focus more on this important participant in the child's network. Contact

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with the school has two main objectives. The first is to raise important elements for the functional analysis. As school is one of the main learning and socialization environments for children, it is a space in which they develop behaviors related to organization, responsibility, and academic skills. Thus, the data brought by school professionals are essential to broaden the understanding of our client's functioning. Through this contact, we seek to identify his behavioral components and understand how relationships are established between the child and his peers, as well as behaviors involving learning processes and study habits. We aim to investigate how, when, and if the teaching process occurs, in its various contingencies (Prado et al., 2012). Understanding the child's attitude in the classroom and outside it, respect for rules and peers, involvement in academic activities, the concentration time required and performed by the child in various activities, and his/her attitude when facing challenging and improvised situations are some of the important behaviors that help the therapist to establish a functional analysis (Sidman, 2006).

The second objective is more related to networking, which aims to strengthen the partnership between school-therapist-client-family (and the other possible professionals that make up the network). Studies for over a decade have reinforced positive effects on student development and learning when this family-school network is integrated (Smith et al., 2020). The partnership improves academic performance as well as social, emotional, and behavioral experiences (Sheridan & Gutkin, 2000). Expanding this network to include the therapist as part of that partnership makes this process even more supportive. In many cases, complaints may refer to lack of commitment, difficulties in the academic sphere, or inappropriate behaviors in the school environment, which, to be managed, necessarily need support and exposure to this environment. For example, if we consider the case of a student who presents academic difficulties, or even a confirmed diagnosis of dyslexia, depending on the complaint and the complexity of the picture, it is necessary to co-construct, with the various participants in the network, possible adaptations or support that will allow this student to be better accommodated to the school environment. It is necessary that this decision is also shared with the client and his family, so that it can then be discussed and adapted by the school. We can also consider a second scenario, in which the client has difficulty socializing with his peers. In this case, again, it is important that the network partnership is well established, to consider how much the school can contribute (either with more direct interventions or observations from a distance) to expand the positive models of interaction that will be offered to the child and his peers.

The initial contact with the school team can be made at different times. In certain contexts, it is suggested that it occurs at the very beginning of the therapeutic process, concomitant with the initial sessions with the family and child, always after their consent. This usually occurs when the child has been referred at the school's request, so contact is usually established in the first weeks of care, even if there is not yet a fully formulated therapeutic plan. In these cases, the visit aims to establish an initial relationship, in which we listen to the school staff (much more than taking ready-made guidelines), to understand their pedagogical proposal, as well as their view on the student: the main complaints and description of behaviors (desirable

and undesirable) presented in that environment. Only after this meeting, we began to formulate a plan that also includes goals for the school context (Meltzer, 2010).

In other cases, when the central complaint is not directly related to the school environment, contact with the school may be made some time after the initial sessions with the parents and child. In this case, the therapist already has relevant data and can combine them with the aspects brought by the school or add new behaviors presented by the client to his planning, considering the different environments and variables. It is very common for the child to present undesirable behaviors in the family environment but not at school. For example, parents may complain that the child is very aggressive and defiant when at home, but in some cases, this behavior is not evidenced at school. The opposite may also occur – although it is less frequent – of parents claiming that the child presents behaviors at school that they do not observe in everyday situations.

Let us illustrate with the case of Mary, a 9-year-old girl whose family sought therapy because the school claimed that the child was withdrawn and not very participatory in group activities (with her classmates) and vehemently avoided situations of highlighting and exposure during classes when the teacher requested her participation. According to the parents, Mary was an extremely communicative and outgoing girl, and her attitudes did not match the complaints, although they noticed more restlessness and tension during homework assignments. In this case, it was important to strengthen the relationship with the school to understand the reason for such behaviors and subsequently explain to the parents the contingencies that led Mary to react in such a way.

As already mentioned, when the therapist makes the first (or any) contact with the school, it is essential that the parents are in agreement and have consented, as they are the clients and responsible for the child. In general, they usually understand the importance of this approach with the school; however, there are some exceptions, in which families resist the contact. In these cases, it is important to respect the family's opinion and gradually justify it, reinforcing the importance of the link with the school for the best progress of the case.

When parents consent to this communication, in most cases, the ideal is to seek the educational guidance team, or school psychologist, which monitors aspects related to the psychosocial development of students. Some schools do not have this team in their structure to meet the demands, and, in this case, the contact is made directly with the educational manager or with the school board. When we are working with children attending Elementary I, whenever possible, it is also interesting to request the participation of the class teacher. In some cases, the school has a support department for inclusive students, and contact can also be made with other professionals (specialists) who are part of this therapeutic network.

Contact with the school should be made, however, in a very cautious manner, aiming at the confidential aspects of both parties. As mentioned, the clinician needs to remember that his clients are the child and his parents and that aspects revealed to the school may harm the family. Thus, in some cases, it is also necessary to have the family's permission to share personal information of family functioning, and, if

denied, the therapist must consent to this choice. In these cases, the focus should be on behaviors related to the learning environment.

Similarly, relevant information brought by the school should be passed on to parents only with the consent of the school professionals and with care not to expose third parties, such as teachers, coordinators, and the like. It is also worth reinforcing that, according to the association's code of ethics, any report prepared by the clinician, which contains information regarding the child and his/her family, can only be sent to the school with the family's consent. Therefore, it is essential that the parents read and authorize the sharing of the document before it is sent. If they choose not to share certain information, the clinician can make a brief report version to deliver to the school and a second, more extensive version to share with specialists and doctors who may eventually follow up on the case. It is also suggested that the clinician be careful not to disclose information contained in the reports prepared by him or herself or by other professionals who evaluated the client, in case this sharing has been denied by the family members.

The frequency with which you will contact the school varies from case to case. It is important to note that, even if the child does not present issues related to academic performance or undesirable behaviors at school, it is important to maintain telephone contact from time to time, coupled with a few face-to-face meetings per year.

However, in cases where the school is directly related to the complaint, contact with it should happen more frequently, since part of the therapeutic goals involves this physical and social environment. Take case 2, for example: Nate is referred to therapy at the school's request, with parental consent. The school reports that the client has been exhibiting separation anxiety disorder, not being able to attend school every day of the week nor during the entire school term.

In this case, the clinician will need to establish frequent contact with the school to develop systematic exposures that enable Nate's return to the school environment, relying on family participation when necessary. In this scenario, it may be necessary to observe the child's interaction in his school environment. To assist in this process, before making the observation in loco, the school may be provided with a behavior assessment tool that will help guide which behaviors will be analyzed during the visit. There are a number of behavior observation scales, and some even have more than one version for the people accompanying the client.

For example, this is the case of the SNAP-IV scale (Matos et al., 2006), aimed at investigating signs and symptoms of ADHD, which has one version to be completed by the client and another for parents and/or school staff (teachers and coordinators). Another suggestion is the SDQ (Strengths and Difficulties Questionnaire), which assesses the behavioral characteristics of children and adolescents, as well as the presence of symptoms leading to the diagnosis of psychiatric disorders (Saur, 2012).

It is essential for therapists to be clear about which signs and symptoms they want to explore, in order to define the best scale to be used, which they can fill in themselves during their visit to the school. In situations where the therapist needs to investigate very specific aspects, the therapist can prepare his/her own questionnaire (which will be more qualitative in nature), listing the aspects he/she intends to

understand via the school. You can also formulate an observation script with the behaviors you wish to observe during your visit and record how often the client emits them. In this case, one way would be to list behaviors expected by the child in the school environment, such as "relates to peers," "is asked by others," and "responds to verbal requests," evaluating whether "he emits these behaviors with or without intervention," "how often," etc.

Let us analyze another example, which will be called case 3: Joseph is referred to therapy by his parents for presenting behavioral issues in the family environment. He is described as an aggressive child who confronts his parents, fights a lot with his younger brother, and eventually has "tantrums" when he is contradicted. When contacting the school, the report is that the client does not present disruptive behaviors, respects rules imposed without questioning, delivers the activities on time, and has a good relationship with peers and teachers and coordination.

According to the brief report, it can be noted that, in all the cases illustrated above, contact with the school is necessary; however, in the third case, the focus of monitoring differs from the first two, in which the school environment presents aversive contingencies that trigger inappropriate behavior. Thus, in this last example, contact with another environment (other than the family) helps to confirm that the child has more adaptive repertoires, which reinforces the need to guide the family, offering as models chains of contingencies similar to those of the school. Contact with the school, in this case, despite being an important part of the partnership, does not need to occur in the same frequency as in the previous examples, because the priority interventions should take place in the family environment. In cases 1 and 2, however, the analyst aims to observe (in loco) and understand why the stimuli presented in the school environment evoke poorly adaptive behavior as a consequence. In these scenarios, therapist-school contact should occur more frequently and systematically, to observe not only what the student does but also the relationships between his behavior, the aspects that precede it, and those that arise as a consequence of the environment, promoting his learning, both in the physical and social spheres (Prado et al., 2012).

Let's reflect back on the first case, considering that Mary has exhibited avoidance behaviors during situations of greater exposure in the classroom. After some time of follow-up, the therapist began to observe that such behaviors were the consequence of a significant school deficit, especially in activities involving reading and writing. Thus, she referred the child to a complementary neuropsychological multidisciplinary evaluation, which further investigated the child's cognitive and behavioral profile, focusing on learning processes. The evaluation data confirmed a specific reading learning disorder, also known as dyslexia, pointing to a significant deficit in reading and writing skills (alteration in reading fluency and comprehension, phonological and orthographic changes – when reading and writing), in operational memory tasks (requiring mental manipulation), and those involving greater phonological processing and rapid *automatic* naming (RAN tasks), with a slow response to intervention when compared to the client's level of intelligence and schooling (Cruz-Rodrigues, et al., 2014; Shaywitz & Shaywitz, 2005; American Psychiatric Association, 2013; Piza et al., 2009).

Given this diagnostic confirmation, the behavior analyst can act as case manager and resume meetings with the school coordinator, reinforcing the areas of greater cognitive and behavioral weakness confirmed by the evaluation, and then establish new therapeutic goals (together with the coordinator), aiming to expand the educators' knowledge and conduct about the case (Hunter & Dunders, 2007). When a solid partnership is established between therapist and school, it is possible to collaboratively build strategies that will reduce aversive behaviors while promoting the expansion, consolidation, and refinement of new behaviors acquired and more appropriate to the student.

In this particular example, it is known that psychoeducation is a fundamental stage of the process, since students with learning disorders can often be misunderstood and misinterpreted by parents and school staff, because they usually show notorious discrepancy in expressing and understanding information orally, when compared to the quality of their production and written language. In addition, students with school difficulties (whether or not they have a confirmed diagnosis) often adopt behaviors of indifference, avoidance, and evasion (being seen as "lazy" or "sloppy") or even arrogance in the face of "not knowing."

Thus, understanding the functioning profile of these individuals helps the network of parents-specialists-school to design specific and more appropriate strategies for the client, allowing more appropriate and less aversive contingencies to be modeled that access the client's true knowledge and potential. For example, again considering case 1 (Mary), after diagnostic confirmation, the behavior analyst met again with the specialists (in this case, the neuropsychologist), parents, and client to present the proposals for adaptation that she would like to suggest to the school team. Based on the multidisciplinary assessment, it was observed that the student would benefit from facilitating strategies for reading and textual comprehension, for example, the use of rubrics or summaries (prompts) with guiding questions and steps for problem-solving (plan, organize, and self-monitor production); bold keywords in texts/sentences to hold her attention; the study through short activities, with repetition of content; and audiovisual support (when possible) to assist the absorption of content and quality of performance. It was also considered the reduction of more complex/longer statements, fractioned into smaller parts to help her reflect on the content, stimulating abilities to plan her action before executing it. Another suggestion was that Mary should take tests in quieter environments and have ample time, allowing breaks when a drop in performance or increase in anxiety was observed.

Upon exposing such guidelines to the client and her parents, Mary reported that she would not like to take all the tests in another setting. In this case, the therapist realized that such a strategy would increase her aversion to the assessment context (where the client felt "very different from her peers"). In this case, therapist and client agreed with the school that she would only take some of the tests (concerning the subjects in which she had more difficulty) outside the classroom. This example demonstrates that it is essential for the behavior analyst to know his client and be able to identify the contingencies that increase or decrease a behavior so that

strategies and interventions are carefully chosen, avoiding "ready-made" orientations that prioritize the diagnosis and not the client's profile (Barkley, 2012).

Furthermore, it is important that the behavior analyst also deepens his/her knowledge of the most frequent neurodevelopmental disorders so that, when necessary, he/she can also suggest adaptations and accessibility focused on teaching technologies (Hunter and Dunders, 2007). Integrating their knowledge about the client's behavioral profile with specific characteristics of these childhood conditions will allow professionals to offer more realistic, personalized, and fundamental strategies to expand and adapt teaching methods that may include complementary resources, such as audiovisual proposals and computer tools (Prado et al., 2012).

Finally, it is worth noting that when reflecting on school guidelines, it is essential to consider the school's profile, as well as its openness and flexibility in accepting external suggestions. In Marina's case in particular, the specialists had established a good link with the school team, so they knew that such adaptations would be possible and well accepted. However, there are situations where, unfortunately, the school staff are less willing to discuss suggestions proposed by specialists. In these cases, it is important to respect this space, but clearly expose the student's needs, as well as the contingencies that increase his/her inappropriate behaviors. Special care should be taken not to wear out the relationship between the family/student and the school, aiming to strengthen the bond of this network. However, it is also the role of the behavior analyst to consider, realistically, how well the school is prepared to receive and work with the student's needs.

In short, working with children and adolescents requires establishing a bridge with the school and family, as these are the most important environments of socialization for the child. In addition, numerous studies and case reports have confirmed that the success of clinical evolution is very much related to good partnership work, even when the initial complaint did not come from the school.

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