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Mental Health and School Psychology

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Indiana State University



**A Proposed Collaboration Between
School Psychology Programs and
Local School Systems for Delivery of
Comprehensive Mental Health
Services**

One of the primary responsibilities of a school psychologist is to encourage healthy mental development for students in a school system. Addressing wellness promotion, especially by being resourceful in crisis prevention and intervention, is essential for effective service delivery (Ysselydyke, Dawson, Lehr, Reschly, Reynolds, & Telzrow, 1997). A valuable commodity to a community is a school psychologist who possesses knowledge in designing and implementing (*Continued...*)



mental health initiatives that promote interpersonal skills, problem-solving abilities, and emotional security for children and adolescents. For a psychologist to serve the school community, understanding the progression of program implementation is necessary for programmatic success.

In devising a mental health initiative, it is paramount to create a foundation for positive discipline, academic success, mental health, and emotional wellness through a caring school environment (Dwyer & Osher, 2000). The establishment of a schoolwide foundation consists of building partnerships with community agencies, families, and school personnel. It also consists of the adoption of evidence-supported programs and curriculums. Effective planning emphasizes: a supportive school community; the teaching of appropriate behaviors and social problem-solving skills; the implementing of positive behavior support systems; and providing appropriate academic instruction (Dwyer & Osher, 2000). The results of such prevention planning would minimize unacceptable behaviors, and reinforce healthy mental development. Examples of governmental programs that have been research-supported are:

Developing Social and Emotional Competence and Problem-Solving Skills

1. *Resolving Conflict Creatively Program (RCCP)* – a school-based prevention program that begins in kindergarten and continues through the 12th grade. This is the largest and longest-running initiative in the United States. RCCP is designed to promote constructive conflict resolution and positive intergroup relations.
2. *Promoting Alternative Thinking Strategies (PATHS)* – a

classroom-based curriculum for kindergarten through the 5th grade. This curriculum is designed to prevent aggression and problem behaviors by developing students' social and emotional competence and problem-solving skills.

Comprehensive Schoolwide Prevention and Intervention Programs that Provide Positive Support

1. *Project ACHIEVE* – a schoolwide prevention and early intervention program for students in elementary and middle schools that emphasizes student performance in social skills and conflict resolution, improving student academic progress, promoting a positive school climate, and increasing parental involvement and support.
2. *Positive Behavioral Interventions and Supports (PBIS)* – a comprehensive schoolwide prevention and intervention program that promotes behavioral support to students, especially students with chronic behavioral problems, and consultation support to teachers.
3. *First Steps to Success* – an early intervention program designed to address the emotional needs of kindergarten children who have antisocial or aggressive behavioral problems. The program includes a screening process, a classroom-based skills curriculum called CLASS, and a family intervention program (HomeBase).
4. *Positive Adolescent Choices Training (PACT)* – a violence curriculum designed to be implemented in an (cont...)



intensive, small group setting with African American middle and high school students. This curriculum emphasizes training in violence-risk education, anger management, and prosocial skills that are culturally congruent.

In addition to building a foundation that provides support to all students, it is also necessary to create early intervention services for students who are at risk for academic and behavioral difficulties. These students continue to experience difficulties despite prevention activities. Identifying signals and warnings are essential in reaching children and adolescents who are prone to violent behaviors or emotional difficulties. According to Dwyer and Osher (2000), these warning signs consist of:

- Social withdrawal.
- Excessive feelings of isolation or being alone.
- Excessive feelings of rejection.
- Being a victim of violence.
- Feelings of being picked on and persecuted.
- Low school interest and poor academic performance.
- Expression of violence in writing and drawings.
- Uncontrolled anger.
- Patterns of impulsive and chronic hitting, intimidating, and bullying behaviors.
- History of discipline problems.
- History of violent and aggressive behavior.
- Intolerance for differences and prejudicial attitudes.
- Drug use and alcohol use.
- Affiliation with gangs.
- Inappropriate access to, possession of, and use of firearms.
- Serious threats of violence (also an imminent warning sign).

The next level of program design consists of providing comprehensive, intensive, and culturally appropriate, child and family-focused services (Dwyer & Osher, 2000). At this level, students may have significant disorders and impairments that involve special education services, mental health agencies, families, alternative programs and schools. Establishing special support teams that assist in coordinating intensive interventions for students and their families would facilitate communication in service delivery and ensure appropriation of services. Examples of such services include case management, psychiatric care, day treatment, self-help and support groups, therapeutic foster care, family-based counseling, and individual counseling.

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To implement such programs requires financial support. Responding to tragedies that have exacerbated students' feelings of safety and security, the U.S. Departments of Education, Health and Human Services, and Justice have provided funding for the design and implementation of programs and curricula that promote social skills, family strengthening, and emotional resilience. The Safe Schools/Healthy Students Initiative is designed to enhance the collaborate efforts of educational, mental health, social service, law enforcement, and juvenile justice system services.

According to the Safe & Drug Free Schools Program's (1999) Annual Report on School Safety, 54 partnerships from across the nation received grants from this initiative. In April 2000, another 23 partnerships in 18 states received funding. Based on these reports, the number of (cont...)



programs receiving funding is increasing. As of June 2001, there are fifty-two doctoral-level school psychology programs, and 139 total graduate school psychology programs in the United States (National Association of School Psychologists [NASP], 2001). Although it is unknown how many of the governmental funded programs are a collaborative effort with school psychology graduate programs and local school communities, there is more school psychology training programs than intervention programs the Safe Schools/Healthy Students Initiative is funding. An effort of this sort would prove to be a rather feasible option for training purposes and for accessibility to mental health services. Not only could a joint venture serve as a training forum for future school psychologists, but children and adolescents would also benefit from receiving mental health service delivery – especially services that exceed beyond assessment and recommendations for intervention.

While many programs are currently receiving funding from a variety of sources, and are providing an array of services to local schools, the challenge would be for students to enhance leaderships skills in assisting with the organization of a comprehensive service delivery by partaking in the grant writing process, collaborating with a multidisciplinary team, and devising interventions for prevention, early intervention, and intensive intervention. Graduate training programs that offer unique opportunities for students to acquire such knowledge and skills in comprehensive mental health delivery to local schools may improve the accessibility of services to children and adolescents. True, a commitment of this magnitude would require a significant amount of effort, but the benefits sowed by such work would be insurmountable. It would promote healthy mental and emotional development, decrease school violence, and

strengthen interpersonal relationships. This would certainly be an ideal worth achieving. Ψ

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**UPCOMING Chat with
“Legends of
Psychology”:
Alan and Nadeen
Kaufman!**
Details, page 13



**Be sure to attend this year's NASP
Convention in Chicago, IL
February 26 - March 2, 2002!**

SASP will be having a get together on Tuesday, February 28, 2002 from 6-9PM where you can meet various SASP officers and graduate students from across the nation. E-mail SASP President Dave Shriberg at dshriberg@yahoo.com or SASP Communications Chair Alex Beaujean at abeaujean@ureach.com.

**Mental Health Practices in the
Schools: Advocating for System
Reform**

Paula Fleming, Kami N. Paris, Connie Brooks, Christine Davis, and Sara Svoboda
University of Missouri—Columbia

The mental health of children and adolescents has received increased attention over the course of the last decade. Mounting evidence exists that suggests greater numbers of our nation's children and adolescents are experiencing significant difficulties in meeting the challenges of development (Greenberg, Domitrovich, & Bumbarger, 2000). It has been estimated that 12 million children living in the United States have a diagnosed mental illness (Burke, personal communication, 2000) and that approximately one in five

Author Note: Correspondence concerning this article should be addressed to Jim Koller, Center for the Advancement of Mental Health Practices in the Schools, Department of Educational & Counseling Psychology, University of Missouri—Columbia, 16 Hill Hall, Columbia, MO 65211. E-mail: KollerJ@missouri.edu.

children will experience symptoms of a significant emotional problem during the course of a year (Adelman & Taylor,

2000b). While the prevention of mental disorders in children and adolescents has become a growing priority for federal and state agencies (Greenberg, et al., 2000), the gap between children who need mental health services and those that receive services remains quite large (Wiest, 1999). To help meet the growing mental health needs of our nation's children, policymakers and mental health professionals are looking to expand the current mental health services offered in schools.

However, one might ask why it is necessary for the school to serve as the site for addressing the mental health issues of children? Strapped with tight budgets, it seems that it would be difficult for schools to bear the additional financial responsibility of providing mental health services (Poole, 1997). Nonetheless, providing services in the schools offers a number of advantages. The first is access. Friedman, Katz-Leavy, Mandersheid, and Shondheimer (1996) found that of the children who do seek mental health services, 70 to 80 percent do so in school settings. This ease of accessibility to services can significantly increase utilization (Burns, et al., 1995; Costello, et al., 1996; Weiss, Catron, Harris, & Phung, 1999). When a student seeks support for mental health issues in a school setting, the probability of experiencing the potential stigma associated with needing such support is significantly reduced. This represents an additional benefit for school-based mental health services. Furthermore, when schools proactively confront the mental health issues of students, the opportunities for prevention are increased (Weist, 1999). Finally, when students experience positive mental health, they are more likely to succeed in school. The Carnegie Council Task Force on Education of Young Adolescents (1989) issued this statement, "School systems are not responsible for meeting every need of their students. But (*cont...*)



when the need directly affects learning, the school must meet the challenge” (p. 61). If we accept this statement as valid then it becomes more appropriate to ask why are schools *not* providing these services?

For it to become acceptable and expected practice for schools to respond to the mental health issues of students, it will be necessary to advocate for systemic reform and to heed Adelman and Taylor’s (1998) suggestion for a shift in perspective, policy, research, and practice. For schools to successfully address mental health issues they must adopt the basic assumption that such issues directly affect student learning and student outcomes. It is necessary to understand that all students can benefit from interventions that focus on the enhancement of emotional and social development and that such activities are essential for those students manifesting severe and pervasive problems (Adelman & Taylor, 2000b). One must take the stance that facilitating healthy social and emotional development of students will correlate with increased academic success and that an environment that impedes this development will limit achievement.

To date, comprehensive mental health programs in schools are rare. Those that do exist tend to be underdeveloped and function in isolation (Taylor & Adelman, 2000b). Analyses of current national policy and practice reveal that no cohesive policy vision exists, and that pupil services and school health programs do not have high status in the educational hierarchy or in current health and education initiatives. The continuing trend is for schools and districts to treat mental health programs as desirable but not essential. When services do exist they tend to be fragmented leading to inefficient and ineffective services. It appears that attempts to respond to mental health issues in the schools have

not generated the type of reform necessary for the comprehensive, multifaceted approach that is needed to meet the needs of students (Adelman & Taylor, 2000b).

Central to systemic reform is the introduction of policies and strategies that can decrease fragmentation by integrating the efforts of school, home, and community (Adelman & Taylor, 1998). School psychologists have the expertise to be instrumental in this process. By expanding existing roles and functions, we can provide a vital leadership role in the movement

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towards addressing mental health issues in the schools. Without abandoning our traditional involvement in assessment and diagnosis, we can further facilitate services through a variety of avenues.

One such avenue is to increase recognition for one our most influential resources-the classroom teacher. Much has been said as to what policy makers, administrators, mental health professionals, and community agencies should or could do to facilitate the integration of mental health into the schools. Though some solutions have been offered, little has been said about the vital role of the teacher. Teachers have the most direct contact with students and are in the best position to identify those children and adolescents in need of intervention. But are teachers currently prepared to do this? Abdal-Haqq (1993) suggests that teachers not only need to be capable of identifying students in need of services, but that they must also be equipped to handle mental health problems manifested in the classroom. Teachers need to know how to utilize support services and how to take part in collaborative relationships. (*cont...*)

Research implicates the need for teachers to view themselves as part of a team effort in serving students and that this team must include teachers of both regular and special education. Without involving teachers in the process, our efforts to promote mental health practices in the schools will likely be futile.

Whether or not teachers are prepared or willing to meet the challenge of addressing the mental health needs of students' remains unclear. A national survey conducted by the National Center for Educational Statistics (2001) reported that of the teachers who have direct contact with students with special needs, only 32% feel adequately prepared to address such needs. In the area of pre-service teacher education, the vast majority of educators are not provided with the appropriate knowledge base to

...preventing systemic change through inadequate professional preparation and insufficient professional development programs in the areas of mental health (Adelman & Taylor, 2000a).

recognize and intervene in regard to the mental health issues of students. The general psychology course required to earn a bachelors degree in education has historically offered little insight into how to handle common real-life classroom situations such as student motivation, bullying, depression, stress, anger management, behavior management, and a multitude of other concerns and behaviors faced by teachers. Presently, no consistent theoretical or practical knowledge base exists in pre-service education training for the mental health needs of children (M. D. Weist, personal communication, 2000). This results in a lack of preparedness to meet the demands of today's classrooms.

Institutions of higher education play a role in preventing systemic

change through inadequate professional preparation and insufficient professional development programs in the areas of mental health (Adelman & Taylor, 2000a). Well-intentioned policy makers can design innovative and collaborative school-based mental health programs; yet, if teacher education is not a part of reform efforts, is it realistic to expect the programs to be successful? It seems that school-based mental health programs will result in nothing more than a "band-aid fix" if we fail to change the underlying philosophy and skills of the most vital component to a child's education—teachers.

The next question that must be asked is whose job is it to facilitate changing teacher education to reflect this new emphasis on mental health? Though the effort should enlist the help of multiple disciplines, the role of school psychologists should not be overlooked. While school-based practitioners continue to report spending more than half of their time engaged in the traditional assessment role, many are looking for ways to expand their breadth of services by dedicating more of their time to consultation, prevention, and intervention efforts (Reschly & Wilson as cited in Fagan & Wise, 1994). In addition, school psychologists are taking a closer look at the mental health issues faced by students and are undertaking an instrumental role in the development of school-based mental health services. Educating teachers about mental health issues at the pre-service level is an exciting new way to further expand the role of school psychologists. Integrating training to deal with mental health issues into undergraduate curriculum is a powerful way to embed positive mental health practices into a new teacher ideology.

The University of Missouri-Columbia is currently developing efforts to make mental health central to the training of both school psychologists and teachers. (*cont...*)



The Center for the Advancement of Mental Health Practices in the Schools

In response to the increased awareness for the need of mental health services in school settings, state and federal agencies have begun collaborative efforts at reconceptualizing service delivery models. The Missouri Department of Mental Health has united with the University of Missouri-Columbia to form a unique partnership that seeks to enhance the training of school psychologists and teachers as well as to improve school-based mental health practices in Missouri. The development of the Center for the Advancement of Mental Health Practices in the Schools is a direct result of this partnership. This center strives to achieve three goals: (1) to promote the awareness of positive mental health practices which impact school systems, (2) to increase the knowledge of school personnel and their role in preventing mental health problems through positive mental health practices, and (3) to provide school personnel and other mental health providers the skills to positively interface with mental health issues.

Working in collaboration with the University of Missouri's Department of Educational and Counseling Psychology, the Center is designing an innovative "psychology for teachers" course. The aim of this course is to better prepare tomorrow's educators by relating educational and psychological theory to the mental health issues that are prevalent in today's educational environment. This course will be offered for the first time in January 2002 and will serve as the first step in an attempt to integrate positive mental health practices into the education curriculum at various levels. A Masters degree in Curriculum and Instruction with an emphasis in mental health is currently being developed.

In addition to pre-service course work, the Center will provide opportunities for in-service training. These opportunities will be available to administrators, classroom teachers and other school personnel with the purpose of disseminating information regarding mental health issues in the schools and to introduce strategies for handling such issues. These programs may be tailored to meet the needs identified by the specific school district. Currently, the Center is designing workshops and tailor-made stress reduction programs as the staff are acutely aware of the demands placed on teachers and the consequences these demands can have on a teacher's own mental and physical well-being.

The School Psychology program at the University of Missouri—Columbia, housed in the Department of Educational and Counseling Psychology, is also reaping the benefits of the University's collaboration with the State Department of Mental Health. Students in the program are now afforded the opportunity to interface with the mental health field instead of limiting their experience to school settings. A course in behavior therapy was recently expanded to include applied experiences in mental health settings, where students are given the opportunity to design and implement behavioral interventions. Practicum and internship sites at mental health facilities are also available to students in the school psychology program. To further augment student training, professionals from the Department of Mental Health frequently provide instruction on issues relevant to the mental health of children and adolescents. These same professionals serve as valuable resources to school psychology students by maintaining an open door policy for student consultation.
(cont...)



Conclusion

To effectively deliver mental health services in the schools will require a shift in perspective, policy, research, and practice (Adelman & Taylor, 1998). Every individual involved in the education of our nation's children will need to embrace the ideology that mental health issues can have a significant impact on a child's educational experience. To fulfill our obligation to educate all children we must provide resources that enhance mental health and address psychosocial, emotional, and behavioral deficits. It must be understood that services promoting healthy development are crucial for preventing mental health and psychosocial problems (Adelman & Taylor, 2000b) and that for those children and adolescents already exhibiting emotional and behavioral concerns these services become essential. Research findings have consistently supported that service accessibility and use are significantly increased by the presence of school-based counseling services and that the majority of children who receive mental health services do so in the school setting (Burns, et al., 1995; Costello, et al., 1996; Weiss, et al., 1999). This further supports the justification for mental health service delivery in the schools.

Providing mental health services in the schools is a challenging undertaking and requires collaboration and cooperation at all levels. Policy makers must understand the need and advocate for funding; administrators must understand the need and advocate for mental health service delivery in their districts; and teachers, counselors, school psychologists and other school personnel must understand the need and work together to meet the needs of their students. School psychologists are in a unique position to significantly influence this process and provide

leadership in policy reform and service delivery. By taking a leadership position in meeting the challenge of providing mental health services in the schools, school psychologist will have the opportunity to further expand their role and function. One way this leadership role has been embraced is through the development of the Center for the Advancement of Mental Health Practices in the Schools. Activities proposed by Center staff are directly focused on cultivating the shifts in perspective, policy, research, and practice needed for the development of a more effective and meaningful model of mental health service delivery in the schools. Ψ

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Wanted: Local Chapter News

Local chapters are invited to send in information regarding chapter activities. abeaujean@ureach.com



SASP Chapter Updates

Caroline McKnight

University of South Carolina

After a few years' hiatus, the University of South Carolina (USC) has reinstated its SASP chapter and is looking forward to a successful year. With many new members, representing every incoming class since 1998, we are off to a great start.

While still in the preliminary planning stages, we have several goals on which we are currently focusing. First, in the spring we will be speaking with undergraduates majoring in psychology and other related fields about the profession of school psychology. Our goal is to "get the word out" about school psychology and clear up any misconceptions about the field. Second, as a chapter, we will be joining forces with USC's Diversity Committee and Psychology Graduate Student Associate (PGSA) in making the interview process for prospective students more student-friendly. As we all remember, interviewing for graduate school can be stress-filled and anxiety-ridden. We hope to make the experience for all prospective students, and later, incoming students, a comfortable and worthwhile experience. Last, we would like to make student involvement more visible and active in NASP. Although we are in the beginning stages of this significant endeavor, we feel it is an important goal and one that could help bridge connections between NASP and APA. The SASP chapter at USC is pleased to be back and look forward to working with such a fine group of students. If other chapters have any suggestions or would like to work together on any projects, please email Caroline McKnight at cgmcknight@sc.edu. Ψ



Karyn Ciappa, Membership Chair

Hoffstra University



STRESS: A new conceptualization

Why do we call it STRESS? Because that's what it is; a state of mental or emotional strain or suspense; "s/he suffered from fatigue and emotional tension". Let's think what it would be like to

Start a Treatment of Relaxation for new Energy by tapping Support Systems.

Conflicts and difficulties are a natural part of everyone's life. This is something we all try to understand, however, when it comes down to it, we each have our own definitions for stress. The question then is, just what or how much is too much? Answering this question honestly and thoroughly can take from two minutes to as long as is needed. Once we have reached this point, a point in which we might often need to revisit, we are on our way to the next step, that of managing our stress.

Stress Management is an

essential skill needed to handle the stress of everyday life. Below I offer some tips on managing stress and working at feeling relaxed. Remember these tips are only user friendly if they work for the user.

- Take a mini vacation (a 15-30 minute vacation). During this time, turn off all distractions, and with every breath in, focus the energy at a different part of the body, and with every breath out, imagine that you are releasing any stress or tension that may be lingering in that area.
- Get in touch with yourself, feel your emotions, talk to yourself about what is going on in your life. If needed, talk to your journal, and record your feelings for later checkups. One's self can often be one's best support system.
- Sweat a little! Exercise your mind! Exercise your body!
- Humor is a wonderful stress reducer, it's true, laughter releases tension, so go laugh a little!
- Tap your support systems. There is an old saying that "a problem shared is a problem halved." It is unnecessary to lug around needless burdens.

Each bullet completed is reward in itself.Ψ

SASP Chats

SASP Would like to thank Drs. Jack Cummings, Steve Little, and Rick Short for their participation in September's online chat and Dr. Mary Henning-Stout for her online chat in October.

Contact Information for Local University/College SASP Chapter

We are a current chapter of the Student Affiliates in School Psychology (SASP), the student organization of Division 16 (School Psychology) of the American Psychological Association. Below is our most updated contact information.

University/College Name _____

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Phone _____

Local president/chair _____

Year in program _____ email address _____

President/chair-elect _____

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Please submit contact information sheet to: Karyn Ciappa, Membership Chair, SASP,
128 Roosevelt Blvd. Long Beach, NY 11561 Karpsy@aol.com

*Join Student Affiliates in School Psychology
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*If you are interested in either starting a local chapter
or learning how you can be involved in the only
professional organization designed specifically for
students in school psychology, please contact:*

Karyn Ciappa, Membership Chair, SASP,

128 Roosevelt Blvd.

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Chat with Legends of Psychology: Alan and Nadeen Kaufman!

**Sunday, April 4, 2002 at
4 p.m. (Eastern time).**
<http://www.saspweb.org/eforum.html>

The American Psychological Association's Division 16 Student Affiliates of School Psychology (SASP) cordially invites you to an online chat with Drs. Alan and Nadeen Kaufman! They will be chatting with school psychology graduate students from across the nation on Sunday, March 17, 2002 at 4 p.m. (Eastern time).

Brief Biographies:

Alan Kaufman, Ph.D. (Professor of Psychology, Yale University School of Medicine, Child Study Center) earned his A.B. degree from the University of Pennsylvania in 1965; M.A. in Educational Psychology from Columbia University in 1967; and Ph.D. from Columbia University in 1970 (under Robert L. Thorndike).

While Assistant Director at The Psychological Corporation from 1968 to 1974, Alan worked closely with David Wechsler on the revision of the Wechsler Intelligence Scale for Children (WISC) and supervised the standardization of the revised version—the WISC-R. He also collaborated with Dorothea McCarthy in the development and standardization of the McCarthy Scales of Children's Abilities. From the mid-1970s to the present Alan has had several university affiliations prior to his current Yale position, most notably the University of Georgia (1974–1979) and University of Alabama (1984–1995).

Nadeen Kaufman, Ed.D. (Lecturer, Yale University School of Medicine, Child Study Center) earned her B.S. in Education from Hofstra University in 1965; M.A. in Educational Psychology from Columbia University in 1972; Ed.M. in Learning and Reading Disabilities from Columbia University in 1975; and Ed.D. in Special Education from Columbia University in 1978 (under Margaret Jo Shepherd).

Nadeen is a researcher, clinician, and university trainer of clinical and school psychologists who has founded several clinics for the psychoeducational assessment of children and adults (including clinics at Mesa Vista Hospital and the California School of Professional Psychology, both in San Diego). Immediately prior to Yale, she was Professor at California School of Professional Psychology. During her career, she has worked as an elementary school teacher, teacher of learning disabled children, school psychologist, psychoeducational diagnostician, clinic director, and university professor.

Together, the Kaufmans have authored over 150 articles, chapters, and books, as well as numerous assessment instruments including the Kaufman Assessment Battery for Children (K-ABC), the Kaufman Brief Intelligence Test (K-BIT), the Kaufman Functional Academic Skills Test (K-FAST), the Kaufman Survey of Early Academic and Language Skills (K-SEALS), the Kaufman Short Neuropsychological Assessment Procedure (K-SNAP), the Kaufman Test of Educational Achievement (K-TEA), and the Kaufman Adolescent and Adult Intelligence Test (KAIT).

Chat sponsored by the American Psychological Association's Division 16 Student Affiliates of School Psychology (SASP). If you have any questions, feel free to contact Alex Beaujean at abeaujean@ureach.com or your local SASP chapter. Ψ



Mental Health Problems in the Learning Disabled Population: A Literature Review

**A. Alexander Beaujean,
Communications Chair**

*University of Missouri-
Columbia*



The diagnosis of a learning disability typically sets into motion a set of academic and school structure modifications. These interventions have a heavy emphasis on the academic needs. However, what can be done to prevent complications beyond these needs? (Morrison & Cosden, 1997, p. 56).

Far too often, the diagnosis of a learning disability (hereafter referred to as LD) sets into motion a set of academic and school structure modifications that have a heavy emphasis on academic needs. However, little is done to prevent complications beyond academics. This is unfortunate because there is much literature to indicate that a learning disability not only affects academics, but also has a big influence on emotional, social, and personal components of the individual with the LD.

Definition

Experts in the field often find an etiology for LD in the neurological processes of the affected individual. Such neurological abnormalities can cause difficulties in understanding, perceiving, thinking, and a host of other academic struggles. As Rourke (1989, as cited in Rourke & Fuerst, 1996) points out though, "it is possible that emotional disturbances and other adaptive deficiencies may arise from the same patterns of central processing assets and deficits that generate the manifestations of academic and social LD" (p. 278).

Cruickshank (1983) stated that that when one defines LDs in terms of

remediation or solely based on academic deficiencies, little, if anything, is accomplished. It is only when the LD definition encompasses the neurological basis, and when the subsequent programming reflects the definition, that children will prosper and remediation will be appropriate.

When one views LDs as a central processing problems, it becomes much easier to see the far-reaching ramifications. One simply does not have a problem doing math (or decoding text, or writing, or perceiving non-verbal cues, etc.); instead, one has a neurological dysfunction that manifests itself in a variety of different areas, one of which might be solving rote mathematical problems (or decoding written symbols, or perceiving non-verbal cues, etc.).

Autonomy and Motivation

Deci, Hodges, Peirson, and Tomassone (1992), found that students' self-perceptions and perceptions of the social context, relevant to competence in attaining desired outcomes and autonomous regulation, showed meaningful patterns in their LD populations. Further, these motivational factors predicted achievement and adjustment.

Student-self perceptions tend to correlate in ways that one would expect from self-determination theory (see Deci & Ryan, 1985 for further explanation of self-determination theory). Students with LD typically experience a large number of failures, and thus often feel incompetent. Therefore, it is not surprising that their feelings of competence are central predictors of their adjustment and achievement.

Deci et al. (1992) found that there is some evidence that support of perceived autonomy in the home and classroom, along with the involvement of the significant adults, promotes greater internal motivation, achievement, and adjustment. The authors suggest that controlling the context for children with an LD (e.g., the special education environment) may have (*cont...*)

some benefit, there could also be some unintended costs, such as interference with the students' development of self-regulation and poorer achievement and adjustment.

Maternal Relationship

Doleys, Cartelli, & Doster (1976) did a fascinating study on maternal interaction with children with a LD, children with a clinic-referred behavioral problem, and children in a control group. They reported that mothers who had a child with an LD gave more rewards and less criticism to their children than the control sample, but they also asked more questions and tended to command and/or criticize their children more. It was mothers in the control group, though, that elicited the highest percentage of compliance from their child (p. 44).

Doleys et al. (1976) found that mothers with an LD child judged their child to be better adjusted (e.g., have fewer problems) than the clinic-referred sample, but judged their children to have more behavior and adjustment problems than the control group (p. 45). Interestingly, the mothers of the LD children said their children's adverse behavior where mainly in inappropriate verbal behavior (arguing, being "sassy," etc.), peer relations, and self-help (e.g., eating behavior, sleeping alone)—behavior deficits *very similar* to those identified by mothers of clinic-referred children. This is interesting because while children in the LD group and children in the clinic-referred group had similar behaviors, the mothers with LD children reported their children to be better adjusted than the clinic-referred children. Doleys et al. suggested that, at least in their study, mothers with a LD child viewed their children's behaviors as a product of their "disability," while the mothers of the clinic-referred children interpreted their children's actions as acts of defiance and/or disobedience (p. 46). In other words, the behaviors between the two groups might not be significantly different, but the mothers with LD children saw them as better adjusted because they were functioning with a disability.

Social Competence and Peer Acceptance

Osman (1987) wrote, "we live in a social world, first and foremost" (p. 112). Children with a LD often inherently lack the proper social skills necessary for effective interpersonal functioning. While the majority of screening and assessment focuses on perceptual, motor, and cognitive capabilities, in most instances interpersonal problems are noted long before people observe academic difficulties.

Gresham (1983, as cited in Osman, 1987) wrote that social problems in LD children occur on three levels. The first reflects poor social cognition or skill deficit, e.g., the individual is unaware of the appropriate behavior in a given situation. Second, some children with LD know how they should behave, but have a performance defect, e.g., their needs interfere with their actions. Third, some children with LD lack the ability to self-monitor/asses their own behavior. They know what they should do and can demonstrate the appropriate behavior, but they may not realize how others perceive them.

...the presence of a LD produces a greater risk for depression and anxiety.

Osman (1987) wrote, while children with LD are a heterogeneous group, there are some common characteristics of many LD children--in varying degrees and combinations. First, they tend to be immature (in thinking, language development, and possibly physically) for their chronological age and their social development often reflects this immaturity. Therefore, older adults often make decisions for these children, which only diminishes their development of self-reliance and self-confidence. Second, LD children are often impulsive, distractible, and have a short attention span. Third, many with perceptual problems tend to misread/misinterpret written symbols, such as numbers or words on page as (*cont...*)

well as misperceive non-verbal communication. Unfortunately, children who misinterpret meaningful nonverbal symbols are at greater risk of expressing themselves poorly with their body language. A subtype of the third characteristic is the LD child that has problems processing language. Translating his/her native tongue is similar to translating a foreign tongue in that he/she has to do it slowly, self-consciously, and word-by-word.

Osman (1987) wrote that the social implications of cognitive deficits and memory problems are cogent in everyday interaction. Children with these problems frequently do not perceive cause and effect, and they might not reach the Piagetian Formal Operations stage until well after adolescence, thus hindering their ability to abstract and analyze situation with consideration. In adolescence, the gap in judgment and social competence becomes more apparent. As the children grow older, the symptoms may change, but the problems continue.

Risk, Resilience, and Adjustment

Morrison and Cosden (1997) reviewed the literature on a number of factors influencing the LD student. Following the developmental psychopathology model, they wrote of risk factors and protective factors, all of which interact with the LD person to bring about the outcome. All of the following comes from Morrison and Cosden (1997), unless otherwise cited.

Emotional Adjustment

There is comorbidity between LD and emotional problems, with LD students and adults tending to score higher on scales of anxiety and depression. As with the population at-large, there is a wide variation in the emotional adjustment of individuals with learning disabilities. The majority of individuals with LD do not have significant emotional problems, but the presence of a LD produces a greater risk for depression and anxiety.

The major protective factors against depression and anxiety are self-esteem and

self-awareness. Additionally, a large correlate with higher self-esteem in the LD population is the perception that one's LD is circumscribed, not global, e.g., it only affects one part of one's being, not the entire person.

Family Adaptation

Family environment can provide both risks and protective factors. Most parents experience a different type of interaction with their LD children than with their non-LD children. Parents with child who has an LD tend to have higher anxiety, and perceive their families as more chaotic as well as report more conflict among family members. The personal characteristics of the children and parents, the family's structure, and the external support available to the family are all factors that can make the family a risk factor or a protective one.

...risk factors and protective factors, all of which interact with the LD person to bring about the outcome

Risk factors are hyperactivity and, particularly with males, the presence of behavior problems. Parental expectations (and consequential disappointment) with the child's academic performance can significantly increase family stress. Other risk factors are if the parents generalize the child's disability to his/her whole being, and there not being a "good fit" between parents and LD child. Feagans et al. (1991, as cited in Morrison and Cosden, 1997) defined "goodness of fit" as parents perceiving more desirable characteristics in their child(ren), than undesirable characteristics.

School dropout

Morrison and Cosden (1997) wrote that school dropout rate is significantly higher in children with and LD, with rates ranging from 33% to 47% being common (Levin et al., 1986, as cited in Morrison & Cosden, 1997; Zigmond & Thornton, 1985, as cited in Morrison & Cosden, 1997). School dropouts are, consequently, at particular risk for extended economic and social disadvantage. (cont...)

Kortering et al. (1992, as cited in Morrison and Cosden, 1997) found that the major risk factors for school dropout were district-initiated interruptions (e.g., suspensions and/or expulsions), school transfers, and lack of family intactness. The most cogent protective factor was the lure of success in post-graduation employment outweighing the perpetual feelings of failure and discouragement in school. Interestingly, Bartnick and Parkay (1991, as cited in Morrison & Cosden, 1997) reported that special education--where many LD students are placed--had less "holding power" than general education programs.

Juvenile Delinquency

Berman (1974, as cited in Morrison & Cosden, 1997) reported that as many as 50% of young offenders had evidence of a LD. Larosn (1988, as cited in Morrison & Cosden, 1997) reported that LD youth were adjudicated twice as often as their non-LD peers and had a greater likelihood of recidivism and parole failure.

Poor judgment and impulsiveness seem to be significant risk factors in recidivism among delinquents with a LD. Not surprisingly, the association between delinquency and LD is strongest when hyperactivity and conduct disorder are also present. Additionally, school failure seems to be a significant predictor of later delinquency.

Acting as a protective factor is the perceived improvement of academic skills and its subsequent reduction of psychological stress.

...the association between delinquency and LD is strongest when hyperactivity and conduct disorder are also present.

LD as a risk factor

Morrison and Cosden (1997) concluded their literature review by stating it is best to consider LD a risk factor that, when interacting with other factors (e.g., hyperactivity, family structure, etc.), can make an individual more susceptible to various adverse outcomes. They write:

Children and adolescents with learning disabilities are exposed to the same challenges in society as other children. However, the existence of a learning disability, combined with significant stressors in the family, school and community, puts the individual with learning disabilities at greater risk for negative emotional, familial, and societal outcomes (p. 54).

Adaptive Behavior

DeLoach, Earl, Brown, Poplin, and Warner (1981, as cited in Weller, Strawser, & Buchanan, 1985) found that teachers were able to accurately bifurcate their students with LD into severe and mild/moderate subgroups. The teachers reported that they made their determinations based upon two factors: academic performance and adaptive behavior. The differences between the mild and severe groups included: (a) need for intensive, alternative instruction; (b) difficulties in transferring learned concepts across instructional contexts; (c) lack of facility with language and poor quality/organization of thinking and comprehension; and (d) difficulties in applying academic skills to real-life needs (p. 200). Taken to its logical conclusion, it would seem that DeLoach et al.'s research gives reason to believe that the ability/achievement discrepancy alone is insufficient to designate a continuum of severity, and that criteria *other* than learning difficulties should be used to designate the severity of an LD.

Weller et al. (1985) wrote that their research has indicated that students with mild LD tend to function age-appropriately in the various adaptive behavior domains. The only common significant abnormal function was that they tended to make snap judgments and direct anger at individuals other than themselves—behavior that many in the non-LD population display. Unfortunately, students at the other end of the LD spectrum--those with severe (*cont...*)

LD--tend not to function very highly in their adaptive behavior. They often use ineffective problem solving strategies, need excessive motivation, have difficulty using and understanding humor, excessively divulge personal information, and have a poor understanding of cause and effect. According to teacher ratings, difficulties in academics, linguistics, psycholinguistics, and visual motor abilities were present in conjunction with the adaptive behavior problems (p. 202).

Conclusion

From this brief literature review, it seems obvious that there is more than an academic component to the amalgam of characteristics labeled Learning Disability. Unfortunately, in "real life" other components are often not addressed, and, if they are, then only in a cursory manner. It is this author's belief that the lack of complete diagnosis (and subsequent incomplete treatment) is one cause for much of the negligible progress made with many LD students. It seems to be valid hypothesis that when psychologists and teachers begin to assess the complete student (including cognitive, achievement *and* various mental health aspects) that working ameliorations will begin to surface, which will subsequently lead to better, and more permanent, change and help for the LD student. Ψ

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SASP: CALL FOR PROPOSALS

SASP Convention Affairs announces the "Call for Proposals" for the 2002 SASP Convention which will be held during the 110th Annual APA Convention August 24th to August 28th in Chicago, Illinois. This year's convention will be addressing professional development issues related to internship, grant writing, and cultural diversity. Convention activities this year will include a formal address by our keynote speaker, presentations, and a reception. Abstracts for proposed presentations or symposia on areas related to these topics will be considered for the SASP Convention if received by MARCH 17, 2002. This "Call for Proposals" is open to all SASP members and graduate students in School Psychology.

GUIDELINES FOR PROPOSAL SUBMISSION

Types of Sessions: The following are descriptions of all of the types of sessions that can be held at the convention.

Individual Presentations:

Abstracts submitted to SASP will be grouped together by topic. Time allotments for presentations shall be determined by the division's program chairperson in collaboration with the presenter.

Symposia or Panel Discussions:

A symposium or panel discussion is a focused session in which participants present their views about a common theme, issue, or question. This format consists of an introduction by the chairperson followed by the participant's presentations, a discussion between participants and audience, and concludes with a summary by the chairperson. This format is not a paper-reading session. Participants should prepare well in advance so that the chairperson can prepare a coherent summary, highlighting the essential points.

GENERAL INSTRUCTIONS FOR ALL PROPOSALS

- Submissions are classified as either individual presentations, symposia.
- A cover sheet, provided in this Call, must be submitted with a proposal.
- A summary on 8-1/2 x 11-inch paper, one side only, double-spaced, of the proposed presentation or program must accompany the cover sheet.
- Paper and symposia submissions should include five copies of a 300-500 general summary or abstract.
- Titles of presentations must not exceed 10 words.
- Accommodation request. Please indicate any accommodations for a physical disability that would facilitate your participation.
- Participants are reminded to adhere to APA's principles of ethics with regard to avoiding sexism, racism, and so forth in presentations. Specific suggestions for avoiding sexist language are on pages 50-51 of the Publication Manual of the American Psychological Association, 4th Edition.
- Notification of Proposal Status. With each proposal, include a contact's e-mail address. Presenters and discussants will be notified in this manner.



PROPOSAL COVER SHEET
2001 SASP Annual Mini-Convention

Fill in all information requested below for all individuals. Submit any additional pages along with this form in order to provide SASP with complete information on all individuals. Information not appearing on this form and its attachments, including degrees and affiliations, will not appear in the Convention Program.

1. TITLE OF PRESENTATION: (Title must not exceed 10 words.)

2. PRINCIPAL (PRESENTING) AUTHOR: First name/Initial/Last name

**Highest educational degree

Complete mailing address: Street/City/State/ZIP

Phone numbers: Office/Home

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Please check membership status: APA Member Division 16 Member
 Nonmember SASP Member

3. COAUTHORS (Please list in order):

Coauthor: First name/Initial/Last name

**Highest educational degree

Professional affiliation/City/State (list only one):

Coauthor: First name/Initial/Last name

**Highest educational degree

Professional affiliation/City/State (list only one):

4. ACCOMMODATION REQUEST: (please specify)

THIS INFORMATION MUST BE RECEIVED BY MARCH 17, 2002

Preferred method of proposal submission is via e-mail.

Send proposal to:

Denise Charles, SASP Convention Chairperson
914 Kussner
Terre Haute, IN 47802
dmc6848@hotmail.com

Call for Nominations for Elected Positions on the SASP Executive Board

As with any organization, active participation is essential to future growth and success. Today, amidst the mass of proposed policy changes, numerous student organizations in other disciplines have responded by increasing their membership and level of involvement. Graduate students in school psychology have an opportunity to do the same by joining SASP and actively contributing to their own training.

Executive members serve one-year terms beginning each August, except for the President-Elect, who serves for two years (first year as President-Elect and second year as President).

General responsibilities and opportunities include: preparing for and traveling to national conventions at least once a year to meet as a full executive board; responding promptly to electronic mail; organizing committees; participating in conference calls, chatroom meetings, and SASP listserv exchanges; voting on new initiatives, policy statements, and important issues; and developing and implementing a variety of projects. Position descriptions are listed below. Should you have any questions, please contact SASP President, Dave Shriberg at dshriberg@yahoo.com. This leadership opportunity can be a life-changing experience!

General elections will take place in the spring for the following positions:

- 1. President-Elect** Helps to oversee and prioritize issues for SASP, while preparing to preside over SASP during the presidential year. The President serves as the primary point of contact and spokesperson for SASP, as an ex-officio member of all SASP subcommittees, and as a liaison to other APA governance groups and Division 16 Executive Board.
- 2. SASP Liaison** Represents training and internship needs of school psychology students by networking with APA and other affiliations; monitors the climate of training environments and advocates appropriately, collaborates with the APAGS and APA Education Directorate on relevant projects; announces relevant workshops and professional opportunities for members; and works to increase the quality of education and training experiences for school psychology students.
- 3. Membership Chair** Assists with the processing of individual and chapter memberships; works closely with the Division 16 Membership Vice President to support membership campaigns and other initiatives; organizes membership information and directs students to SASP committees.
- 4. Communications Chair** Develops and publishes SASP News, the SASP quarterly newsletter; implements various marketing and publicity initiatives to communicate the activities of SASP to members, and helps with facilitating effective information exchange and updating for SASP.
- 5. Convention Chair** Shapes SASP programming for the annual SASP conventions to ensure that timely, relevant, and cutting-edge information is presented; obtains keynote speaker; and works closely with Division 16 regarding convention organization.
- 6. Diversity Affairs Chair** Guide working groups and ad hoc committees that address specific issues of diversity; Establish relationships and joint projects with staff members in the APA Public Interest Directorate and Division 16 Executive Board; serve in various official liaison roles that focus on issues related to diversity, including ethnic heritage, women's issues, ageism, sexual orientation, disability issues, etc.; develop initiatives, programs and resources within SASP that



support diverse students, as appropriate; and advocate for the needs of diverse students within and outside of SASP.

7. Technology Chair Serves as Layout Editor and Publisher of SASP News; updates and revises SASP web site; assists with the electronic development of SASP projects, research, and electronic forum meetings; and serves on the SASP Elections Committee.

Requirements to apply to run for one of the elected positions include the following:

1. You must be an Division 16 student affiliate (which automatically makes you a SASP member).
2. You must submit the following materials **no later than March 17, 2002:**
 - A cover letter indicating the elected position for which you would like to run. Please include your university affiliation, previous degrees, address, phone number, and e-mail address.
 - A brief letter of support from your Department Chair or Program Director confirming your student status, anticipated graduation date, and a statement regarding your leadership potential.
 - A candidate statement of 100 words or less describing your experiences, background, reasons for seeking the particular position, and objectives if elected.

After receipt of materials, they will be forwarded to the SASP Elections Committee (composed of the SASP President, SASP President-Elect, and the SASP Technology Chair) for review and the formation of a slate of qualified candidates. Superior leadership skills, evidence of commitment and responsibility, and potential for effectively representing and advocating for graduate students will be considered when selecting the slate. If selected, the candidate statement will be published in the Summer Newsletter

The deadline for 2002 election materials is March 17, 2002. Please submit nominations electronically to David Shriberg, President, dshriberg@yahoo.com.

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Winter (2)	December 20, 2001	February 20, 2001
Spring (3)	March 8 , 2002	April 16, 2002
Summer(4)	May 24, 2002	July 5, 2002



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