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Medicated students and mystified teachers

By Nancy Schnog

Here's a scene that 20 years teaching English never quite prepared me for. It's 10 a.m., the end of a short break between classes on a bright fall morning. My 11th-graders trickle into literature class, chatting while finishing off peanut butter bars and sugar doughnuts.

In marches a perfectly likable young person who announces to all within earshot: "Good morning, Ms. Schnog. Oh, I can't study today. I didn't take my meds."

"Ummm," I utter, before falling mute. What now? Give a mini-lesson on Benjamin Franklin and the power of the will? Introduce Mary Baker Eddy's concept of mind over matter? Grin neutrally or disapprovingly?

Uncertain how to proceed, I intone something half-baked, sprinkled with cheery uplift. "Of course you can." Pause and stammer. "Drugs don't control us." The less-than-three-minute exchange trails off into an apologetic retreat, as I mumble about my fear of side-effects and my wish for simpler times.

There it was: the "teachable moment," an occasion to bring this student to a powerful insight about educational responsibility. And I was making a mess of it.

So over the summer I decided to do what I tell my students to do when they confront a perplexing question: Research it. I started with Judith Warner's recent book, "We've Got Issues: Parents and Children in the Age of Medication," which explores the complicated matter of parents' decisions to medicate their children. (I knew some of this complexity personally, having once been told to give Ritalin to my child.) Warner shows how parents are buffeted between pro-medication advice and anti-medication warnings. The book helped me accept that, no matter one's own preferences — mine used to tend toward the anti-medication end of the spectrum — medical interventions into learning are here to stay.

Then I sought the expertise of Nancy Rappaport, a child-and-adolescent psychiatrist and professor at Harvard Medical School. She said she sees more educators being asked to manage the "emotional and diagnostic world of kids." For most of them, it's uncharted territory.

She made clear that students deserve privacy and that it's not the place of teachers to get involved with — or make judgments about — medical challenges. But that doesn't mean teachers can't do anything.

They can respect boundaries and still foster discussions about “the art of self-care.” Sleep, nutrition, exercise, relaxation — none of this should be outside their scope. But when some teachers must spend every moment preparing students for standardized exams, it’s hard to imagine them detouring into a serious discussion about a good night’s sleep and three square meals a day.

Rappaport understands this. But, she says, teachers and administrators need to confront today’s medical realities and make time for them in the curriculum. Conversations with students will flow more readily, she believes, as teachers learn more about psychotropic drugs and their side effects and grasp more fully the biases that they may have regarding these treatments.

Still, I wondered about the in-the-moment exchange — what to say to the student in front of me whose pill is in the kitchen. Here I got help from parent educator Annie Fox, a San Francisco-based school consultant. She says disarming a student’s “I can’t study because I forgot my meds” demands a teacher’s direct response. You have to try to solve the problem and set a precedent for similar exchanges. Fox advises teachers to plan reminder tactics with students — an automatic e-mail or a strategically placed sticky note — and urge personal responsibility (no blaming Mom or Dad).

But teachers can go deeper. It is up to them, Fox says, to help students understand what they’re capable of, so they can perform daily to the best of their ability.

Still, many families decide to keep children’s medical and psychological information private. What is right for families, however, can translate into challenges for teachers: another degree of separation from the whole child and an obstacle to making nuanced assessments of the entire class.

To better understand the responsibilities of teachers facing these murky conditions, I turned to William Stixrud, a specialist in the evaluation of children with learning disabilities and a lecturer at George Washington University School of Medicine. Stixrud shifted my focus, drawing connections between kids on medication and adolescents at large. He argues that while schools have been quick to accommodate pharmaceutical treatments, they have been slower to address the pressures in teens’ lives that add to the ranks of those seeking medical solutions. “No discussion of medication is complete,” he told me, “without a discussion of the many kids who wouldn’t need them if the lifestyle adults structured wasn’t so brain-unfriendly.”

Stixrud’s list of what schools could offer to help teens includes later school start times; homework policies that reduce assignments at night, when mental efficiency is low; balancing course loads to keep stress manageable; and physical outlets, such as exercise and meditation, that help students manage tension. These changes would, in Stixrud’s words, “make kids happier, learn better and have fewer mental problems.”

We’re several weeks into a new school year now, and I’m better prepared for the day I hear another student say: “I can’t study because I didn’t take my meds.” I shouldn’t shy away from that conversation. I’m not going to pry or overstep the bounds of privacy, but I’m not just going to stand there and stammer.

My summer project has morphed into a project for this fall: designing strategies for my students to better understand their own study habits and capacities for perseverance and resiliency. I am using exploratory exercises such as free-writing assignments and learning diaries to help my students think about how they can do their best work. It’s a good lesson for everyone: learning to be ready to learn, even on the bad days.

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