The Relationship-Driven Classroom

The most importance force in the relationship-driven classroom model, of course, is the relationship. The emphasis in the classroom is not on obedience but on appropriate social interaction. The goal is for appropriate social interaction to generate appropriate behavior. For this model to work, relationships become an important part of classroom structure. The relationship between the teacher and the child and the relationship between the children are the two most important components of this model. Proactive moves are made to ensure that the classroom, once filled with children, will engender appropriate relationships.

It usually takes about 8 weeks for relationships between the teacher and child and the relationships between the students to begin to gel. The interceding period is taken up with boundaries testing, getting acquainted, and fear reduction. It also takes that long for routine to become familiar and for separate individuals in the group to become a whole.
To examine any approach it is worth considering the *how, who, what, where, and when* of it:

- How is the approach to maladaptive behavior conceptualized?
- Who is perceived as having responsibility for the problem?
- What has to happen in order for change to take place?
- Where does responsibility for change lie?
- When does the change take place?

In the relationship-driven classroom model, inappropriate behavior is seen as a teaching opportunity. A very large amount of misbehavior occurs because the child simply does not know to behave differently, because he has misconceptions about how he should behave, or because he has misconceptions about himself. These situations are not corrective occasions. They are teaching opportunities. Functional behavior is taught actively via the teacher–child relationship and latterly peer to peer in order to give children experience of the appropriate behaviors they are to use.

In the relationship-driven classroom, problems are co-owned. It’s not your fault, it’s not my fault, and we are working on this together. Responsibility is shared or interconnected. The child and the teacher are on the same team against the inappropriate behavior. Throughout the entire paradigm of the relationship-driven model this is the goal. It’s the teacher and the child on one team against the behavior. It is never the teacher on one team against the child and his or her behavior.

For change to take place, the teacher must first form a relationship with the child. This is the only context in which change can take place. The cornerstone of this relational approach is commitment. It is the unequivocal commitment of one individual to another that evokes positive change. Children have to have this type of relationship if they are going to move forward. They need the esteem that comes only from knowing others care about them and that others value them sufficiently to commit to them. They need to know that while significant others
may have been unable to provide this type of commitment, it
does not mean they are unworthy of it.

In One Child, Torey changes Sheila’s behavior by forming a
relationship between them. Sheila changes because it matters
to Torey that she change. This relationship gave her the energy
to try to change that she didn’t manage before because it now
mattered to Torey. Although Sheila was able to internalize her
changes eventually, in the beginning the change happened
because of the interface between the two of them and because
Torey made it apparent that it was important to her that Sheila
change.

In the relationship-driven classroom, responsibility for
change is shared. As a consequence, responsibility for change
drifts away from individuals, away from individual ownership
of problems, and away from individual change to the relation-
ship interface and how the teacher and child relate. It is the
child’s and the teacher’s responsibility to sort the problem out,
and there are many things teachers can do to help ranging from
teaching, role modeling, therapy, and supervision to just plain,
good old caring. An amazing amount of change can be brought
about by one single person caring enough about one single other.

Finally, in the relationship-driven classroom model, change
is present oriented because relationships can only exist in the
present. If the relationship is in the past, you can’t change
anything, can you? If the relationship is in the future you
can’t change anything. So change within a relationship-driven
model is happening right now. This model uses a relationship-
oriented vocabulary. It tends to use words like sense, love, accep-
tance, tolerance, nonjudgmental, understanding, commitment, and
helpful.

Since relationships can only exist in the present, what you
are working on now is what is being changed. Change is open-
edended. You do not know the outcome. And no one can know
the outcome. Consequently, you remain hopeful in this model
because none of us knows what really can happen. None of
us can see the future. And because of this present orientation
there is considerable room for flexibility because you’re always
present. You are always monitoring what is happening, and
you can change if it is necessary.
THE TEST FOR TRUTH

The new gold standard for evidence is that an idea from one field fits with ideas drawn from other realms of experience. This is called consilience by philosophers of science (Wilson, 1998, as cited in Brendtro, Mitchell, & McCall, 2009). Consilience links findings from separate fields to discover simpler universal principles. Consilience requires that truth be tested against the multiple perspectives of science, experience, and universal human values. When we tap varied perspectives, the big picture becomes clear.

A relationship-driven classroom model meets the test of consilience. It is supported by related knowledge from (1) natural science, (2) social science, (3) practice expertise, (4) the voices of youth and their families, and (5) universal values of respect and human dignity.

To start, biological science reveals that the brains of children have inbuilt attachment programs which strongly motivate them to seek out positive bonds with caring adults (Cozolino, 2006). The need for attachment permeates all of our relationships; it is designed into our DNA (Szalavitz & Perry, 2010).

Second, social science research in both teaching and therapy shows the power of relationships. Teachers with varied teaching styles can be successful if they develop positive relationships with their students (Morse, 2008; Pianata, 1999; Vitto, 2003). Likewise, a common element within all forms of effective psychotherapy and counseling is a respectful, valuing, and empathetic bond between therapist and client (Corey, 2000; Hubble, Duncan, & Miller, 1999). Psychiatrists and psychologists call such a relationship between the therapist and client the therapeutic alliance. A similar bond—a pedagogical alliance—between teacher and student is similarly powerful (Danforth & Smith, 2005).

Third, practice expertise from the successful experiences and the collective wisdom of youth care work pioneers demonstrates the power of relationships. The hallmark action research of Fritz Redl, David Wineman, Nicholas Hobbs, and William Morse, early leaders in the education of children with
emotional disturbances, shows that real behavior change is facilitated by relationships (Brendtro, 2008). Nicholas Long (2008), coauthor of six editions of *Conflict in the Classroom* with Morse, states that “if we are not successful in developing interpersonal bonds with youth, then all subsequent treatment and pedagogical techniques are mechanical. It is like racing a car engine without any oil. It is not going very far before it heats up and shuts down” (p. 57).

Fourth, experience includes not only practice expertise but also the often ignored firsthand knowledge from youth and their families. Werner and Smith (1992) studied Hawaiian children with multiple risk factors (poverty, strained parental relationships, and poor role models) for 40 years. They found that one out of three of these children developed into competent adults. They then studied the children who were able to succeed despite living with much stress and adversity and identified factors that were present in these successful children; these factors form the basis of resilience. Werner and Smith found, among other things, that these children often credited a favorite teacher who went beyond academics and became a mentor, confidant, and positive role model for personal identification.

Likewise, a national survey of 12,118 adolescents by Resnick et al. (1997), in an article titled “Protecting Adolescents from Harm,” found having an adult who was supportive to them was the strongest protective factor. The adult was someone the youth could count on for understanding, advice, and support. Teachers were among those adults mentioned most frequently as the source of this support. Families of troubled youngsters also consistently reported that what was significant about residential programs serving their children was that workers made them feel like they were important, like they cared (Garfat, 2010).

And finally, values of human dignity motivate us to create caring environments where all young persons are treated with respect and given the opportunity to fully develop their potential (Seita, Mitchell, & Tobin, 1996). Humans are innately disposed to treat others the way they want to be treated. This,
of course, is the golden rule, which is universal across all major religions.

**Control-Driven Classrooms**

Given the consilience of these views about the tremendous power of relationships, it is puzzling why relationships have not been a central focus in classrooms for emotional and behavioral disorders in recent decades. Since the 1970s, there has been a marked shift away from milieu models toward models which favor control. This preoccupation with control was first reported by Knitzer, Steinberg, and Fleish (1990) in their national investigation into programs for emotionally disturbed children; the self-contained classrooms they studied were dominated by *curriculums of control*. The curriculum emphasis was often on behavioral management first with a central concern on behavioral point and level systems. These behavior modification systems seemed largely designed to help maintain silence in the classroom, not to teach children how better to manage their anger, sadness, or impulses. Similar observations about this preoccupation with control have been made by numerous scholars who observed classrooms for emotional and behavioral disorders in North America (Brendtro & Brokenleg, 2007; Brendtro, Brokenleg, & Van Bockern, 2002; Cambone, 1994; Danforth & Smith, 2005; Morse, 2008; Nichols, 2007, VanderVen, 2009).

Most current American programs are based on two philosophical approaches, both of which emphasize control—the behavioral model and the market or business model.

**Behavioral Model**

This approach to dealing with behavioral problems comes from the scientific community. It takes its philosophical base from B. F. Skinner’s research in the 1940s, 1950s, and 1960s wherein all behavior is conceptualized as resulting from external, discreet, observable *A-B-C chains* comprised of an
antecedent to the behavior, the behavior itself, and the consequence of the behavior. The jargon is that of the laboratory: observation and data.

In the early years of this model, special education classrooms were regarded as types of laboratories, using strict scientific methods to discern antecedent behaviors and alter outcomes by strict manipulation of positive or negative consequences. Latterly, many classrooms established in using behavioral models have segued into the market model through use of token economies and now operate on a cross-breed version of these two models.

In this approach, responsibility for the problem is externalized. A child behaves the way he does because externally observable, discreet antecedents are causing externally observable, discreet behavior. Responsibility for change in this model is thus also external. Behavioral change is initiated, imposed, and controlled by others; and while the child may have the chance for input, responsibility is generally externalized to the point that the child’s cooperation, permission, or even knowledge of the proceedings is not necessary. This external orientation of responsibility means that behaviorism is a control model (e.g., others control the factors responsible for bringing about acceptable behavior).

The behavioral model is future oriented. Change takes place when the inappropriate A-B-C chain is broken and a new, more appropriate one put in its place. Normally this is done by altering consequences. There is virtually no flexibility in this model when it comes up against exceptions or situations where it needs to adapt in the present. The strict adherence to discerning, then manipulating the A-B-C chain, and observing results means adaptation can only take place in the future, after the prescribed A-B-C chain has been completed and observed to fail.

**Market or Business Model**

This approach to dealing with behavioral problems comes from the business world. The special education classroom is
regarded as a management economy. Behaviors become a commodity. The jargon of this model is that of the business place: assessment, contracts, goals, and accountability.

In this approach, responsibility for the problem becomes an issue of *ownership*. Responsibility moves from an abstract concept to a concrete possession. Identifying the owner of the problem by default identifies the behavior as a discreet, observable entity, rather than leaving open the possibility that responsibility is shared or interconnected. Once ownership is determined, then trading begins. Behaviors are controlled and changed by being assessed and valued. Contracts are then drawn up with clear, concrete goals of change in exchange for something of equal value by another party.

Responsibility for change in this model is external. Behavioral change is normally initiated, imposed, and controlled by others, and there is little scope for the child to do more than agree to the conditions of the contracts, although the occasional good or creative bargainer can increase his pay off. This approach is thus also a control model, focusing on the use of external control to bring about acceptable behavior.

The market model also tends to be *future oriented*. Change takes place when goals or targets are reached, and these always exist in the future. So this approach focuses on what the child *will* be doing. Consequently, there is limited flexibility when this model comes up against exceptions or situations where it needs to adapt because the payoff is in the future and to vary from a contract is to break it.

**MEDICAL MODEL**

The other common approach to behavioral problems is, as the name implies, derived from the medical world. The special education classroom in this instance is regarded as a place of treatment. Behaviors become symptoms of illness. The jargon of this model is that of the medical world: disease, genetic disorder, intervention, and prescription.
Responsibility for the problem is a mirror opposite to the market model in that it is characterized by complete lack of ownership. Responsibility is depersonalized to the point where it becomes an act of God, nature, or genes.

Behaviors are controlled by prescribed drugs and therapies. Responsibility for change in this model is externalized. The child is a victim of something completely beyond her control. Consequently, this too is a control model, where acceptable behavior is achieved through the external control of medical intervention.

The medical model tends to be past oriented. This approach focuses on dealing with an irrevocable event or events, such as genetic makeup or organic dysfunction, which have already occurred. This model has limited flexibility when coming up against exceptions or situations where it needs to adapt, as it is largely restricted to prescribing a different drug. The time frame required for some drug withdrawal further restricts its flexibility.

Perceived as the embodiment of rational thought and the building block of intellectual and economic advancement in the post-Sputnik era, science has become a philosophical force in its own right. Scientific theory, reduced to its most basic, involves identifying a problem, forming a hypothesis, and then objectively testing it as a way of determining the nature of reality. The results are thus regarded as reality. All three of these models share this scientific philosophy and are valued for their scientific traits of being clean, objective, and accountable.

The problem arises when we try to apply scientific theory to people. As convenient as it would be if humans had no internal environment to contend with, this isn’t a possibility, and unfortunately, there is no way to objectively observe what is going on inside a person’s head. We can observe what goes in. We can observe what comes out. We cannot, however, observe what is happening in between. The only mind we have direct access to is our own, and even that is often heavily clouded by subjective perception. We have absolutely no access to other people’s minds. This hidden area, this one place we cannot directly,
scientifically observe, often then results in what we call *under-determination*. This means, in essence, that whatever objectively collected data we come up with about someone reflects less than the total amount of information there is about that person because we do not have full access to all aspects of the equation. Consequently, for whatever conclusion we draw about the cause of a particular behavior or how best to change it, there will always be other equally valid and possibly incompatible conclusions that could be drawn.

For example, we might have a child who has been placed in a behavioral management class due to serious problems with concentration and attention. If we are following the behavioral model, we will observe the child and count how many times he gets out of his seat to determine there is a legitimate problem. We will then identify the A-B-C chain. Antecedent behavior is when the teacher hands out worksheets. Behavior is when the child gets up out of his chair to sharpen a pencil, talks to kids next to him, goes to look at stuff on the bulletin board, and so on. Consequence is that he doesn't get his work done. An appropriate intervention under this model would be to alter the consequence. For instance, if he doesn't get his worksheet done, he doesn't go out to recess.

Now while this has all been scientifically done—child observed, hypothesis of the problem formed, and solution put into place—the hypothesis based on this clean, objective data underdetermines the problem. In reality, this child comes to school each morning on a doughnut and a Coke. His family eats almost exclusively junk food. He’s never made the acquaintance of healthy, nutritious food, and as a consequence, his brain is so deprived of nutrients it isn’t functioning properly. There is no way, however, for us, who are observing the child clinically in the classroom, to determine this is why the kid can’t sit still. As a consequence, our intervention may have an effect, indeed, it may even be very effective in the short term, but it is simply controlling the problem. It’s not changing it.

Now we have a second child in the same class who also suffering serious problems with concentration and attention. If we are following a business model, we observe and identify
the problem to determine the problem. An appropriate intervention would then be to arrange a contract with the child. She will sit in her seat and do Worksheet A, and in return she will be “paid” one star. When she collects five stars, she can choose a small toy.

Again this follows good scientific practice aimed at producing clear-cut, accountable results. But again, in the process it underdetermines the problem. In reality, Child B has a mother at home dying of breast cancer and a father who has sunk into deep depression. She has been shuffled around among relatives, separated from her siblings, and is concerned that they might all be placed in foster care. Consequently, she can’t concentrate for worry and upset at the disruption. All we see upon observing her, however, is a kid who can’t sit still. The contract may be successful in controlling her tendency to get out of her seat but because it has underdetermined the problem, it will not bring about a lasting change in her behavior.

And now we have a third child in the same class who is also suffering serious problems with concentration and attention. If we are following a medical model, we observe and identify the problem. An appropriate intervention is to prescribe a suitable medication for controlling hyperactivity, such as Ritalin.

Yet again, this follows good scientific and medical procedure and is aimed at a clear-cut, accountable result, but yet again, it underdetermines the problem. In reality Child C is being seriously sexually abused by a neighbor. This has made him tense and anxious around his teacher for fear this adult also may hurt him. Moreover, he is very worried about leaving his pet cat alone during school hours, as his abuser has told him the cat will be killed if the abuse is disclosed. All we see on observing him in the classroom and in the doctor’s office, however, is a kid who can’t sit still. The drug may make him physically less inclined to move about, but the problem has been underdetermined, so the drug is simply controlling a symptom. It isn’t changing the problem.

There are three primary shortcomings, which contribute to the failure of all these models in the classroom. The first is an emphasis on control instead of on change. All three models are
designed for behavior management. The presenting, observable problem is treated as if it were the complete problem, and no effort is made to acknowledge, much less address the existence of other interdependent issues, which have created or maintained the behavior but which cannot be empirically observed. The child is simply taught not to do something. While this is a pleasingly clean approach to the messy reality of human emotional behavior, it isn’t particularly effective at teaching the child how to prevent its happening again. Thus, by using these approaches, the emphasis in the special education classroom becomes obedience rather than personal growth.

The second difficulty is an externalization of the behavioral problem. In all three approaches the behavioral problem is seen as something separate and discreet to the individual. This externalization makes it more straightforward to control what is happening because, when it is external, other people and resources can be enlisted in the task. However, it also makes it more difficult to change the behavior because inherent in externalization is the concept that it is outside the control of the person doing it. This weakens a sense of personal responsibility for it. We are responsible for ourselves because only we are ourselves, but our responsibility over other things decreases the further away from us they move.

Another negative aspect of externalization is that it does not allow for linking a behavioral problem with its etiology. Without considering and understanding behavioral etiology, at least to some degree, it is difficult to teach a child how to predict her behavior before it happens and thus learn how to manage impulses, anger, fear, or sadness in order to prevent future problems.

The third difficulty is that focus for a solution is either on the future or in the past rather than on the present. Concentrating on what will happen if the child completes a contract or engages in inappropriate behavior or concentrating on what has happened, which needs the amelioration of drugs or treatment, takes control for change out of the child’s hands simply because the child, like all the rest of us, only exists in the present. For change
to be effective, it must take place now for the very simply reason that now is all we have to work with. Now is the only time the child can behave or not behave, so now is the place he needs to focus his attention in order to prevent misbehavior from occurring rather than on a future goal or a past event or malfunction.

So, perhaps it is time to look at alternatives. Most successful, experienced teachers use a degree of relationship-driven methodology which they will have developed intuitively as part of their teaching strategy. As such, we are unwilling to refer to this relationship-driven methodology as ours. Moreover, saying it is ours immediately produces an us-and-them quality that implies to accept this requires rejection of the other models and thus disallows access to their constructive aspects. On the contrary, we feel the three current models all have much to offer, are helpful to know well and understand, and are entirely appropriate in certain circumstances. Our only complaint with these methodologies is, as expressed by Abraham Maslow’s famous comment, that “if the only tool you have is a hammer, then every problem becomes a nail.” All three apply the same response to every situation. Because we are complex and individual creatures, this one-size-fits-all approach does not allow for the depth, breadth, and flexibility of response required if we want to change the behavior of a diverse group of people rather than simply control it.