1 Introduction to Emotional Disturbance and Behavioral Disorders

Phone calls from school . . . disapproving looks from relatives and friends . . . difficulty finding someone for him or her to play with . . . always seems to be in "trouble" . . . or perhaps, is frequently alone, both on the playground and at home . . . rarely talks or plays with brothers and sisters. People are concerned about a child. Yet what can be done? What do we know? What do we need to know? The reason you are reading this book is that you either suspect or have already been told that your child or one that you know or are working with may have emotional disturbance or behavior disorder (throughout this book, we will refer to this condition using the letters EBD). Many questions and issues have likely crossed your mind. Does this mean that the child is "crazy"? Will the child have to undergo therapy for hours? Days? Years? Will the child have to be hospitalized? Does this mean medication? What does "EBD" mean? This book is designed to respond to these issues.

One of the most confusing and potentially explosive labels that can be attached to a child (and, perhaps, family) is EBD. Its exact impact on the family can only be speculated. A variety of reactions may occur. Compounding the potential family impact is the possible feeling of shame at having a child with emotional or behavioral problems. It is interesting that everyone seems to be an expert on this subject. The purpose of this chapter is to answer some of the initial questions that can cross the minds of those who live or work with children and youth who have EBD. Topics in this chapter will be discussed in more depth throughout the book.

BY ANY OTHER NAME: EMOTIONAL AND BEHAVIORAL DISORDERS

Children and youth who exhibit significant emotional or behavioral problems have been described in many ways. As discussed later in this chapter, there are formal and informal labels for these students. It is critical to understand that many of these individuals exhibit disturbing behaviors because they have a disability. Some individuals may have EBD because of environmental factors, and when the factors change, they may learn to behave in appropriate ways. For example, a child exposed to a traumatic family event, such as a death, may show a reaction that causes others to be concerned. However, when children and youth behave or feel the way they do because it is part of an internal condition that they cannot control, their EBD is a disability.

To better understand this point, it may be helpful to think of other disabilities, such as visual impairment, hearing impairment, or mental retardation. Very few parents or professionals would expect a child who is blind to have vision, or a child who is deaf to hear, or a child who has significant mental retardation to be able to think as normally developing children do. We understand that their disabilities are conditions that these children possess. We do our best to teach them to manage their environments and as much information as we can. We are also tolerant when they have difficulties because of their disabilities. We certainly would not punish a child who possesses one of these disabilities for not being able to do a task that is physically or mentally beyond their capabilities. Can you imagine punishing a child who has a visual impairment because he could not read street signs, or a child with a hearing impairment because she could not sing along with the choir, or a child who has mental retardation because his disability does not allow him to read?

Nevertheless, we do not apply the same rationale to children who have EBD. When they exhibit behaviors that are indicative of their disability, they are often punished! In fact, we seem to spend more time punishing these children and youth than we do teaching them new ways to better navigate their world. Granted, the behaviors exhibited by children with EBD are more troublesome to the people around them, and we normally expect children to behave appropriately, or we punish them. But it must be understood that many of these children will never be "normal," similar to children with other disabilities. Consequently, they will not learn to behave by being punished. Furthermore, they will learn (very quickly) that their disability, no matter that they cannot control it, makes people (even those who love them) disapprove of them. Given these aspects of their disability, it is not surprising that the outlook for many of these children is

not promising. We hope you will acquire information and learn many approaches from this book that will allow you and children who have EBD to better meet the challenges related to their disability.

POSSIBLE CAUSES OF EMOTIONAL DISTURBANCE AND BEHAVIORAL DISORDERS

EBD may be explained by (a) biological factors, such as genetics, brain damage or dysfunction, malnutrition and allergies, temperament, or physical illness; (b) family factors, such as the family definition and structure, family interaction, family influences on school success and failure, and external pressures affecting families; and (c) school factors, such as deficiencies in the ability of school personnel to accommodate students' variable intelligence, academic achievement, and social skills (Kauffman, 2001). Feelings and questions regarding causation are normal and are experienced by many parents and caregivers. Exploring and understanding these reactions is extremely important and may help both you and the child avoid secondary problems.

There is rarely a simple cause of EBD. In fact, it may be best to understand the significant difference between diagnosing physical problems and mental health problems. With regard to physical problems, it is believed that a "cause" needs to be discovered, which will then be followed by the best treatment, which will hopefully result in a "cure." However, for schools, cause is not as important as the behaviors that are currently being exhibited. Within schools, what is stressed is the intensity, duration, and level of impairment associated with the behaviors. Furthermore, although some behaviors can be cured, many other disorders that have longer durations must be managed and the people habilitated to their conditions.

Diagnosis may occur at any time in an individual's life, as emotional problems can surface at any age. In fact, it is common for all of us to be emotionally disturbed occasionally, as evidenced in bouts of severe anger, depression, or extreme frustration. Complex factors, such as a student's environment, a deeply rooted psychological problem, or a biophysical imbalance, may each contribute to different feelings or behavioral problems. Furthermore, there may be several factors interacting with one another, such as a biophysical imbalance that coincides with a family crisis.

Briefly, when the *environment* is considered to be a major contributor to students' problems, many questions are explored: What is happening at home? Is the home culturally different from the school, resulting in behaviors being accepted at home and not at school? Are the economic conditions at home significantly less favorable than those of others, preventing equal participation in school activities (play sports having

fees, etc.)? And do the significant people (teachers, community, relatives) in children's lives create problems of differing expectations? In other words, identification of disturbing behaviors may be a result of the degree of flexibility and tolerance the concerned members of the child's environment demonstrate as well as myriad other factors.

Deeply rooted psychological problems involve uneven or deficient personality development, as reflected in pathological (repeated, long-term) behavioral difficulties. Traditionally, most behavioral problems have been perceived as the result of a disturbed psyche. One form of these behavioral problems is *phobias.* Phobias are extreme fears and anxieties that prevent people from behaving more or less normally or appropriately in everyday situations. Like other types of disturbances, phobias may be temporary or long term.

In the 1950s, '60s, and '70s, much of the thought and practice in school psychology was heavily influenced by psychological theory. In recent years, the psychological theory of disturbance has become less popular, especially when school-based disturbances (problems that only surface in the schools) were considered. This is primarily due to the rather inefficient process normally associated with the psychological approach—it takes a long time before results are apparent. Most teachers believe that they don't have the time and, perhaps, expertise to effectively use the counseling techniques associated with these approaches. Nevertheless, community-based mental health agencies are often able to effectively use this approach.

A *biophysical imbalance* or medical problem implies that the students' problems are internally based. That is, the students cannot change their behaviors at will because of a biophysical problem. Many theories suggest that prenatal (before birth) or perinatal (around the time of birth) illnesses, unusually long childbirth, heredity, or inappropriate levels of certain body chemicals may contribute to or cause emotional disorders. As with other areas of disturbance, much controversy and debate surround these theories of direct links to specific emotional or behavioral disturbance.

Whatever the cause or label, it is important that both professionals and families understand the exact nature of the problem. What is meant by a given label in a particular case? What is the child doing to be labeled, and, more important, what can the child do, and what are some realistic behavioral expectations? When unclear about the manner in which the term *emotional disturbance* is being used, families are encouraged to ask for clarification, especially if causation is implied. Remember that it is sometimes difficult to discern between a psychological and a biophysical cause. This may have a considerable impact on the intervention chosen (e.g., counseling therapy or medication). Concerned individuals have the right to know as much as possible. A more detailed discussion of causation or etiology will follow in Chapter 3.

A focus on blame will rarely help anybody and, in many cases, may hinder a child's progress. It is critical not to blame a child in relation to his or her EBD. For example, a teacher once commented about a child, "He's smart enough to behave better." This raises a very important point. Intelligence may have little to do with the occurrence of emotional problems. Although it is natural to feel frustration when a smart child seemingly should know better, being smart doesn't necessarily mean health. Many very intelligent people have emotional problems.

INCIDENCE

Incidence, or the number of children and adolescents identified as having EBD, is a subject of major controversy among professionals. As there is confusion regarding the definition of the problem, it follows that the percentage of students who are labeled EBD will vary according to the group or individual doing the labeling. This is not surprising in view of the range of behaviors, ages, circumstances, duration, and intensity of many problem behaviors.

Except in the most severe cases, it is extremely difficult to arrive at an exact number of individuals who have EBD. The U.S. Department of Education (1996) reported that 1% of the kindergarten-through-12th-grade student population have EBD. Yet many states are hard-pressed to officially identify 1% of their population this way. Professionals in this field believe that these numbers are very low (Center & Obringer, 1987; Forness, 1991; Kauffman, 2001; Paul & Epanchin, 1991). It was estimated in a report by the Surgeon General (U.S. Department of Health and Human Services, 1999) that about 20% of all children have mental disorders, with at least mild functional impairment. Friedman, Katz-Levey, Manderschied, and Sondheimer (1996) suggested that 5% to 9% of those students would qualify for special education, a number far greater than is currently being served. As will be discussed later, many people have differing ideas about the definition of EBD. Consequently, the number of children so identified varies. Also, there may be other factors that enable or hinder identification of these children and youth.

Various groups have estimated percentages of behaviorally disordered and emotionally disturbed children ranging from 1% to 40% of the school-age population (see Zionts, 1996). In comparison, public school administrators believe that the number of children and youth so classified is approximately 3% to 6%, whereas teachers have contended that between 10% and 40% of their students have problems severe enough to warrant professional attention. These discrepancies are compounded by the fact that some students who exhibit maladaptive behaviors at school do not exhibit them at home. Furthermore, it is often difficult to determine

if a child's problems are going to be short-lived (growing pains) or if they will drastically affect the long-term emotional growth of the child.

To determine if a child's problems are, in fact, growing pains, one must understand how other children of a similar age behave and express their emotions. By definition, a child is an individual who is not fully developed: cognitively, physically, socially, and emotionally. Therefore, it is important to be aware of behaviors that are common to particular age groups. One study suggested that one third to one half of 8-year-olds may be identified as overactive and restless. Again, it is when a child is significantly different from peers that concern should arise.

Henley, Ramsey, and Algozzine (1999) perhaps said it best when they contended that students who are "seriously emotionally disturbed are identified by their severe deficits in perception, communication and behavior. Such behaviors as delusions and lack of affect are marked examples of the extreme behavioral disturbances in seriously emotionally disturbed students" (p. 115). Complicating matters is the identification of more males, African Americans, and those who are economically disadvantaged than one would find statistically in the population (U.S. Department of Education, 1998).

SERIOUS EMOTIONAL DISTURBANCE OR BEHAVIORAL DISORDERS OR EBD: WHAT'S THE DIFFERENCE?

Much of the time, there's no difference in behaviors; the only difference is in the labels. In this regard, it might be helpful to distinguish between two types of labels: official labels, which are used on official documents and heard in such formal environments as school and clinics, and informal labels, which may occur in private or maybe only in one's thoughts! Prior to discussing these labels, one must remember that there is also a controversy regarding the diagnosis (how one is identified and labeled) as EBD. As mentioned earlier, at least three different views exist regarding cause. Diagnostic test results are frequently less valid than usual due to the child's behaviors during the testing situation.

The first official label is often given to a disturbing child by school personnel. Labels for a child's behavior may vary vastly depending on the state of residence. Frequently used labels include *serious emotionally disturbed, emotionally impaired, behaviorally disordered, conduct disordered, socially maladjusted,* or the more general *educationally handicapped*. The official label applied by the federal government is *emotionally disturbed*. This label is used when identifying and providing special educational services for children and youth who have EBD.

The foregoing labels usually have the same meaning for both educators and parents. That is, they are used to identify and describe

students who have significant social, behavioral, or emotional differences when compared to their normally developing peers. Much time and energy are spent on determining the most appropriate label. We believe that it is the manner in which the labels are used (e.g., socially excluding certain groups of children), not the labels themselves, that causes problems. As of this writing, labels are required for children to receive special education services and, hopefully, appropriate treatments.

For children and youth who exhibit extremely different (or deviant) behaviors, the word *severely* may be attached to their labels, such as *severely emotionally disturbed*. Severely emotionally disturbed students often cannot handle the rigors of a regular classroom setting, requiring instead a specialized classroom in a public school or another alternative setting. Regardless of the label, it is important to remember that the focus should be on the child. These children are probably more similar to other children than dissimilar. They have good days and bad days, as is the case with their peers—and the rest of us.

What Are Informal Labels?

Informal labels are oftentimes more of a problem for children and youth than formal labels. Informal labels are automatically attached to a person's behavior when it is very different from what is expected. People may label either the behavior or the person as "weird," and so forth. That is, some individuals may label a person's essence rather than a particular behavior, especially when the behavior is unusual in a negative way. In other words, if someone does something that is not normally accepted, he or she might be thought of as being crazy, hyper, or bad.

HOW PROFESSIONALS VIEW LABELS

Although the preceding information holds true for the way most practitioners view EBD, some practitioners and researchers believe that a label gives some very specific information about the cause of an individual's problems. Generally speaking, they believe that when students are labeled as emotionally disturbed, they may have deeply rooted psychological problems that call for an intervention program of psychotherapy. Or they may have a biophysical cause, and collaboration with medical personnel may be necessary, possibly resulting in the prescription of medications.

In contrast, if students are labeled *behaviorally disordered*, their problems may be observable and thought of as more easily identified, and an effective intervention program is thought to be more readily designed and implemented by teachers and parents. According to the Individuals

with Disabilities Education Act ([IDEA], 1997), both approaches may be implemented, depending on the needs of the student.

IDENTIFICATION OF EBD

Three factors are often considered when determining if a child is disturbed: intensity, pattern, and duration of behavior.

- *Intensity* refers to the severity of the child's problem. How does it get in the way of the child's (or society's) goals? How much does it draw attention from others? For obvious reasons, this factor is the easiest to identify.
- *Pattern* refers to the times when the problems occur. Do problems only occur during the school day? Only during math class? At bedtime? Answers to these questions may yield very helpful diagnostic and remediation information.
- *Duration* refers to the length of time the child's problem has been present. For example, some school districts require a 3-month duration before they suggest that a child has an emotional or behavioral problem.

Bower (1969) proposed a developmental continuum for identifying emotional disturbance in children and youth, and his work has served as the foundation for the definition of EBD. Although this definition is problematic for teachers and psychologists, it nonetheless serves as a useful reference point because it speaks to the kinds of support these students may require in school or at home or both:

Stage 1: Children who experience and demonstrate the normal problems of everyday living, growing, exploration, and reality testing

Stage 2: Children who develop a greater number and degree of symptoms of emotional problems as a result of crises or traumatic experiences

Stage 3: Children in whom symptoms persist to some extent beyond normal expectation but who can adjust adequately to school

Stage 4: Children with fixed and recurring symptoms of emotional disturbance who can, with help, maintain some positive relationships in a school setting

Stage 5: Children with fixed and recurring symptoms of emotional difficulties who are best educated in a residential school setting or temporarily in a home setting

Clearly, by referring to these five stages, almost any child who is different from what is considered normal may be labeled EBD. A closer look at these stages suggests that according to Stage 1, most children exhibit disturbing behaviors sometime in their childhood. Thus parents, educators, and other professionals should be careful not to overreact to an isolated disturbing event in a child's life. Furthermore, it is currently less likely that students in Stage 5 will be placed in a residential school setting than it was in Bower's day—1969!

BEHAVIORS THAT FIT INTO EDUCATIONAL STAGES

As an alternative to the Bower model, Forness and Knitzer (1992) proposed the following definition, which has been adopted by many organizations (but not the federal law), such as the Council for Children with Behavior Disorders and Head Start:

> I. The term emotional or behavior disorder means a disability characterized by behavioral or emotional responses in school programs so different from appropriate age, cultural, or ethnic norms that they adversely affect educational performance, including academic, social, vocational or personal skills, and which:
>
> (a) is more than a temporary, expected response to stressful events in the environment;
>
> (b) is consistently exhibited in two different settings, at one of which is school related; and
>
> (c) persists despite individualized interventions within the education program, unless in the judgments of the team, the child's or youth's history indicates that such interventions would not be effective.
>
> Emotional or behavioral disorders can co-exist with other disabilities.
>
> II. This category may include children or youth that are with schizophrenic disorders, affective disorders, anxiety disorders, or other sustained disturbances of conduct or adjustment when they adversely affect educational performance in accordance with section I. (p. 13)

One important message associated with these definitions is that the term *emotional disturbance* (or *behavioral disorder, social maladjustment, emotional handicap*, etc.) may be extremely general and ambiguous. It can mean a variety of things to different people. Many research studies have found that the term has different meanings for parents, teachers, counselors, principals, doctors, and even the child's friends. In this context, the following two vignettes illustrate how difficult it is to identify and understand emotional disturbance and behavioral disorders:

Sally has been a very pleasant student in her 5th-grade classroom all year. She is attractive, well-mannered, and does well in school. She sits in the front row and smiles appropriately, answers questions, and participates in group discussions. She is an only child, and her parents have traditionally taken an active interest in her school progress. She is extremely close to her mother.

Tragically, her mother is in a car accident and subsequently dies. Sally becomes sullen and withdrawn, refusing to go to school. Her father leaves her alone, believing she is undergoing a normal grieving period. However, 10 days pass, and Sally's withdrawn behavior continues. Her father decides that it would be best for her to return to school to help her come out of the depression.

On Sally's return, she quietly moves her seat to the back of the classroom. The teacher tries gently to persuade Sally to participate in class but also understands what Sally must be going through and decides to leave her alone. When the teacher has time, she attempts to counsel Sally. However, no matter what is done to help her, Sally's withdrawn behavior continues. After a meeting with other school professionals, it was decided to let Sally stay in class in the hope that, with time, she will return to her normal self.

Joe has been a pain in the neck to almost everybody he has been in contact with this year. He is unkempt, ill mannered, and a C–D (below average) student. Joe's teacher always seemed to be calling out his name for classroom infractions. His mother was initially responsive to contacts from the school, but she stopped her attempts to cooperate. She admitted to the principal that she was at the end of her rope with Joe at home. Joe's father, although professing concern, worked long hours in his new business and was generally uninvolved with his son.

Suddenly, one day, Joe's mother died. During the next week, Joe, who had been extremely close to his mother, engaged in many tantrums. His father left him alone, believing that this was normal grieving. While taking the week off from work, his father found it very difficult to communicate with Joe. Finally, he decided that Joe should return to school.

On Joe's return to school, he stormed into the classroom, kicking chairs and throwing papers all over the room. He ran to his desk screaming, "I hate her! I hate her! She left me, the bitch! I hate her, I hate her, I hate her!" The teacher tried to quiet Joe, with no success. After a meeting with other school professionals, it was decided that Joe might need special help.

Joe and Sally represent students who may be equally disturbed, yet their behaviors demonstrate that the natures of their disturbances are different. Although undergoing the same type of catastrophic experience, Joe was disturbing and Sally was withdrawn. Consequently, society's reactions to Joe and Sally are different. Although both examples focus on the death of a mother and its effects on children, rarely will the children's reactions be as strong as those portrayed. Nevertheless, in most instances, somebody like Sally will be allowed to continue to act disturbed in her quiet, withdrawn manner. Students like Joe, on the other hand, will most likely be removed from the regular classroom, and treatment may be deemed necessary.

Some people believe that it is only those children who are *disturbing,* such as Joe, who are regularly identified as having EBD. Withdrawn students, such as Sally, are often more difficult to identify and, ultimately, help. As we've mentioned, children are diagnosed as having EBD when their behavior is very different from that of their peers or what is expected of them. The problem behaviors may be recent and short-lived or they may be long-term. The disturbances may be demonstrated in the classroom, where such abstract assignments as reading and writing are required, or only in the home, where tasks are frequently more concrete, such as taking out the garbage, washing dishes, or mowing the lawn.

Refer again to the three factors that generally determine assignment of a label. Both Sally and Joe seem to belong in Bower's (1969) Stage 2. That is, their feelings and behaviors seem to be a result of a one-time traumatic experience. Yet the action that parents and concerned professionals take may influence either child's future emotional growth. It the responsibility of all parties to be careful observers of the behavior of children after a traumatic event occurs.

CHARACTERISTICS OF EMOTIONALLY DISTURBED OR BEHAVIORALLY DISORDERED CHILDREN AND YOUTH

Characteristics of a disturbed child are best described in behavioral terms. Rather than talking about a child as crazy or acting out, a more detailed explanation of specific behaviors and emotions allows all concerned parties to approach the problem with an equal understanding. General categories, such as hyperactive and withdrawn, may be good starting points but give little useful information for diagnosis or treatment options.

The following behavioral characteristics are intended to explain some of the vague categories that are often used to describe EBD. You are cautioned not to make hasty generalizations based on familiar behaviors in the categories. If an acquaintance exhibits two or three of these

behaviors, it probably does not mean that the person has a major (pathological) problem. As discussed earlier, factors such as the intensity of the emotion and the length of time it is exhibited must be considered when making an appropriate professional diagnosis.

Conduct Disorders

Fights, hits others
Destroys property
Commits crimes against society
Easily frustrated
Steals
Undependable
Boisterous
Truant
Runs away from home
Lies persistently
Abuses substances
Engages in inappropriate sexual activity
Blames others

Attention and Concentration

Can't sit still
Is highly distracted by everything
Has short attention span—may be as short as 20 seconds
Doesn't seem to listen
Is drowsy
Shows lack of interest

Hyperactivity; Attention Deficit

Can't sit still, fidgets
Rushes work
Seems to be talking all the time
May have nervous mannerisms such as twitches
Constantly seeks attention of others
Demonstrates poor organizational skills
Shows lack of goals, direction
Has short attention span
Can't ignore environmental influences
Is impulsive
Excessively climbs on things
Needs consistent supervision

Interrupts others
Has frequent temper tantrums

Withdrawal

Seems tired
Avoids interaction with others
Demonstrates lack of interest
Is depressed, sad
Is passive
Is easily embarrassed
Rarely expresses emotions
Doesn't have self-confidence
Feels inferior to others
Is shy, timid, fearful

Function Disorders

Eating disorders
Voluntary regurgitation
Obesity
Eating inedible objects (habitually)
Refusal to eat
Elimination disorders
Inability to control bladder (no physical reasons)
Inability to control bowels (no physical reasons)

Severe EBD

Illogical thinking
Delusions
Hallucinations
Disjunctive talking
Unusual perceptions
Self-injurious behavior

The purpose of listing these categories is to provide a glossary of behaviors that are often attached to these general and sometimes vague descriptions. Please resist the temptation to become an armchair psychologist. Instead, we encourage you to ask the professionals about the specific characteristics a child is exhibiting when he or she is described as hyperactive, for instance.

A rule of thumb is to decide if the observed behaviors are deviant enough to attract the attention of at least one other person. The behaviors must be significantly apparent and interfering with the student's goals or

environment. Listing these behaviors may aid you in noticing potential signs of trouble. Generally, you should begin to be concerned if changes occur in the child's behavioral pattern. After observations and information have been shared with a concerned parent, two critical questions normally follow:

How much of this information should we share with our child?

A very important point to consider is the child's feelings and perspective. Does he perceive the behavior(s) that are so upsetting to others? By involving children in the various interactions and meetings that take place regarding their problems, some youth may be able to participate in remediation attempts.

Talking with children can sometimes shed light on matters that have been incorrectly perceived or interpreted by others. A knowledge of what a child can handle and consultation with school or counseling personnel can best answer this question.

How will my child be treated at school?

This depends on the type of emotional disturbance or behavioral disorder the child has. If children are demonstrating negative attention-getting behaviors, they are likely receiving negative feedback from their parents, their teachers, and, possibly, their friends.

It doesn't necessarily follow that others will view a child's problems as "new" once they have been identified. If the diagnosis leads to a new educational placement for the child, it may become necessary to help the child cope with the new setting.

SUMMARY

The purpose of this chapter has been to introduce you to a general overview of emotional disturbance and behavioral disorders. Each of the topics discussed will be explored in greater depth in other sections of this book. General issues and questions about the topics were raised so that you might critically examine the everyday problems of working and living with youth who have emotional disturbances and behavior disorders.

Various theories of causation may be useful when trying to understand a child, but it is important to remember that it is extremely difficult to pinpoint any one reason for a child's behavior. Furthermore, the central purpose of determining causation or, for that matter, any diagnosis, is to generate interventions. To merely know why something happens has little use.

Emotional disturbance and *behavioral disorders* mean different things to different people. Parents, friends of the family, neighbors, teachers, school administrators, shopkeepers, and doctors may each have their own "expert" opinions. Therefore, communication about the child's *individual* problem must occur. Most often, it will be your responsibility to insist on getting a clear, understandable message from those concerned. We hope to aid you in that regard.

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