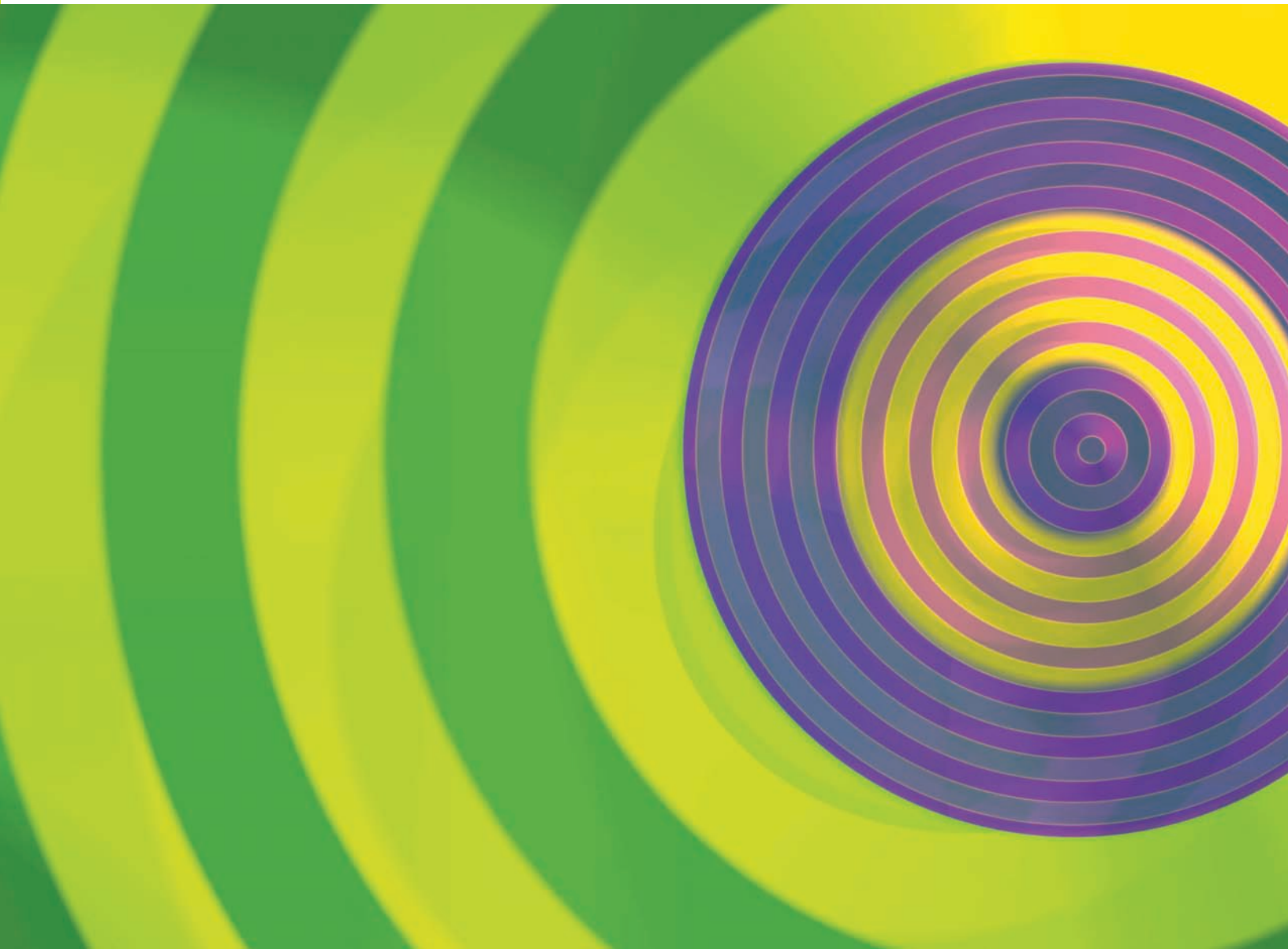


Pearson New International Edition



Learners with Mild Disabilities
A Characteristics Approach
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The definition broadens the interpretation of educational performance to include all areas of functioning in a school context. This helps ensure that services will be available to those who are able to maintain passing grades despite significant emotional and behavioral disorders. It recognizes the holistic nature of the school experience and considers a learner's social, vocational, and personal adjustment as important as academic achievement.

The phrase "more than a transient, expected response to stresses in the learner's environment" indicates that special education services should be reserved for students whose problems are unlikely to be resolved by standard school counseling services and other typically available interventions and who require more intensive services. As described in Bower's description of the levels of severity of emotional disorders, the coalition recognized that special education services were most appropriate for learners identified by Bower (1960) as being in levels 3, 4, or 5 (see again *Spotlight on History* 6.1).

In requiring that the behaviors be "exhibited in at least two different settings," the coalition sought to prevent the identification of a learner based on the idiosyncratic referral of a single person. If the problem behavior is apparent only in one setting, it is more reasonable to study that setting for the answer rather than to place the child in special education. The requirement that the problem behavior be unresponsive to interventions applied in general education was included to underscore the importance of providing effective instructional environments in general education for all children. When Congress added the concept of response to intervention to IDEA in the 2004 reauthorization, it underscored the belief that only when the best that general education can offer in terms of interventions is insufficient is it appropriate to look to special education.

The statement that emotional or behavioral disorders may exist along with such conditions as learning disabilities, intellectual disabilities, speech impairments, substance abuse, and recognized psychiatric diagnoses was included to ensure that all learners, regardless of their classification, would have access to services designed to help them develop behaviors that are personally satisfying and socially acceptable. IDEA 1997 and 2004 recognized this principle as well in requiring that individualized education programs include individualized behavior intervention plans for all students whose behavior is problematic, regardless of a learner's disability classification.

Although the coalition's definition is not fully in force in IDEA, it is nevertheless useful for teachers and other professionals who work with these students to consider the points made in the proposed definition. Special education services will likely be more effective with such students if we collect the information as specified in the coalition definition. Specifically, the routine practice of evaluating students' behaviors from a contextual basis, from a perspective that recognizes the ecological nature of emotional and behavioral disorders, and of determining cultural and age normative behaviors will provide useful data to guide intervention planning (Elliott, Gresham, Frank, & Beddow, 2008; Forness & Kavale, 2000). Using the results of intervention attempts as diagnostic information is now supported in IDEA. Recognition of the possible coexistence of this disorder with other disabilities will allow schools to serve such youngsters earlier and more fully.

ASSESSMENT AND IDENTIFICATION ISSUES

A major reason for the debate about definition in this field is that emotional or behavioral disorders do not exist outside a social context (Elkind, 1998; McIntyre, 1993, 1996; Murray & Greenberg, 2006). Emotional or behavioral disorders exist only to the extent that behavior or emotions are unacceptable or unsatisfying in a particular contextual environment. Any identification of an emotional or behavioral disorder can be made only by comparing an individual's characteristics with existing cultural rules or norms. What is disturbed behavior at one developmental stage or in one context might be considered quite typical and even expected in another. For example, hitting and knocking peers down is generally considered inappropriate, unless the student is on a football team. Only to the extent that a behavior is seen as significantly different from behaviors expected of typical peers and as a threat to the stability, safety, or values of the

individual, society, or community is the behavior (and by extension, the person) appropriately considered to be disordered.

Sensory, physical, or intellectual deficits are viewed for the most part as varying along a single dimension, and there are established instruments to measure the degree of functioning and, by extension, the level of deficit. The presence of an emotional or behavioral disorder, on the other hand, can be inferred only by comparing the behavior of the individual to that of others in the social context. It is also important to distinguish between difference and pathology. Although marked differences in behavior may signal a disorder or pathology, the same behaviors may be present in students who are behaving in a manner consistent with cultural norms. It is critical to ask if there are alternative explanations for the behavior.

By implication, then, any assessment of the nature or degree of disordered behavior will be subjective (MacMillan, 1998; McIntyre, 1996). Educators can improve the objectivity of the process by rigorously defining and describing the applicable cultural norms, rules, and expectations and by developing instruments to describe the person exhibiting the problem behaviors as objectively as possible. By comparing the normative behaviors to the observed behaviors, we determine the extent of the discrepancies and increase the likelihood of developing a helpful intervention program. Because one of the conceptual biases used against these students is that their behavioral excesses are volitional, we must also attempt to determine the degree to which a student is making a choice to engage in those behaviors and the extent to which the student could adopt other behaviors if desired (Merrell & Walker, 2004; Peacock Hill Working Group, 1991; Theodore et al., 2004). If it appears that the learner is choosing the problem behavior, it behooves teachers and parents to ask why. What need does the behavior fill for the child? Functional behavioral assessments also are important in determining the function of a particular behavioral pattern for the individual (Barnhill, 2005; McIntosh, 2008; Ryan et al., 2003).

Such a process might begin by using an adaptation of Wood's (1982) model of behavioral assessment, which suggests that problem behaviors be considered from five perspectives:

- **The disturber element:** Who is the focus of the problem? What do we know about the child? What is the learner's gender, age, race, language(s), economic background, sexual orientation? Are there age, cultural, or ethnic norms that help explain (not excuse) the behavior? Are there other disabilities present? What is the home environment like?
- **The problem behavior element:** How do we describe the behavior? How often does it occur? What are the antecedent and consequent events around the behavior?
- **The setting element:** Where does the behavior occur? What are the characteristics of that setting? What are the characteristics of those settings where the behavior does not occur?
- **The disturbed element:** Who regards this behavior as a problem? Who is bothered by the behavior? What are the characteristics of the person(s) who regard the behavior as a problem, or of those who do not see it as a problem?
- **The functional element:** What goal or need does the behavior appear to help the individual meet; are there alternatives available to allow the child to meet that need?

From this starting point and from the general principles of nondiscriminatory evaluation, it is apparent that the only legitimate process for identifying students with emotional or behavioral disorders is a multiphasic one (Elliott et al., 2008; Marchant et al., 2009). Batteries of psychoeducational instruments alone are rarely of much help in identifying the core issues of a problem behavior or in planning interventions. Appropriate use of such instruments means that the evaluator recognizes that the information value of these instruments becomes apparent only as we collect information from a variety of other sources, including observations.

Behavior rating scales—such as the Behavior Assessment System for Children, Second Edition (BASC-2; C. R. Reynolds & Kamphaus, 2004), Burks Behavior Rating Scales (BBRS-2; Burks, 2006), the Child Behavior Checklist (CBCL; Achenbach, 2001), the Social Skills Rating System (SSRS; Gresham & Elliott, 1990), the Social Skills Improvement System (SSIS; Gresham & Elliott, 2008), and the Behavioral and Emotional Rating Scale (BERS-2; Epstein,

2004)—provide information about the *informants' perceptions* of the extent of the problem behaviors (Fennerty, Lambert, & Majsterek, 2000). A rating scale completed only by the referring person is likely to reflect only the idiosyncratic views of that individual. When a rating scale is completed independently by several individuals who know the child well, one can begin to have more confidence in the results. Rating scales that also provide support to intervention planning are said to have treatment validity as well (Elliott et al., 2008).

Interviewing can also be a valuable source of information. Information can be gathered from parents, teachers, peers, siblings, and even from the learner. Using open-ended questions and seeking clarification of the information obtained can result in information that is rich in diagnostic value and that can lead to more effective interventions. Each interview provides significant information in itself, but when the information from all of these sources is “triangulated,” a more accurate understanding of the problem emerges (Spradley, 1979).

Direct observation in a variety of settings and by multiple observers is essential. The observer needs to collect information on the frequency, duration, intensity, and patterns of the behavior. The observer can compare the nature of the problem behavior with the normative behaviors of peers in the same setting. Identifying antecedents and consequences of the behavior helps add meaning to the description of disturbing behaviors and also guides intervention planning. Observing in more than one setting helps sort out the contextual factors that may be involved (Marchant et al., 2009). Accurate recording of observed behaviors is essential in describing the problem behavior and in evaluating the effect of a particular intervention after implementation.

Response to Intervention

IDEA 2004 provided an additional perspective for identifying learners with emotional and behavioral disorders. Using the concept of response to intervention (RTI), schools today are encouraged to use a process of successively more intensive, evidence-based interventions in the special education referral and identification process. Gresham (1991, 2005) has long proposed using RTI as a means of determining the presence and severity of an emotional or behavioral disorder. He suggested that students with emotional or behavioral disorders can appropriately be described as those whose problem behaviors are resistant to change even when they are provided with well-designed school-based interventions. Factors that affect resistance to intervention include the severity and chronicity of the behavior, as well as the ease with which behavioral changes generalize outside the treatment setting.

Severity (“to a marked degree”) includes such factors as the topology, intensity, and frequency of the behavior. If the strength of initial interventions proves insufficient to significantly alter the behavior, then the individual may appropriately be identified as having an emotional or behavioral disorder (Nevin, 1988). Chronicity (“over a long period of time”) is a key criterion in both IDEA and *DSM-IV-TR* criteria. Gresham (2005) concurs with the Mental Health and Special Education Coalition that use of chronicity as a criterion is appropriate only when it is applied to long-standing problem behaviors that persist in the face of validated intervention protocols and procedures designed to change behavior. If no valid attempts have been made to alter the behavior within the general education setting, we need to consider whether the real problem is a lack of effective interventions. Marchant and colleagues (2009) proposed the implementation of strong universal interventions (e.g., schoolwide positive behavioral interventions and supports) as a primary prevention strategy.

Many severe behaviors can also be characterized by a failure to achieve generalization of behavioral change. Some behaviors may respond to intervention in highly structured training settings, only to return to previous levels in nonintervention settings. Such behaviors should be viewed as resistant and will require longer periods of intervention, including careful and explicit generalization training and fading. Students with less severe behavioral problems will more easily maintain and generalize the changes following intervention activities.

ON THE WEB

The **National Association of School Psychologists** (www.nasponline.org) provides a variety of resources, including position papers on issues related to identifying and serving children and youth with emotional or behavioral disorders.

ON THE WEB

The **Technical Assistance Center on Positive Behavioral Interventions and Supports** (www.pbis.org), established by the Office of Special Education Programs, U.S. Department of Education, provides information and technical assistance for identifying, adapting, and sustaining effective schoolwide disciplinary practices.

In considering the use of RTI as a diagnostic tool, Gresham (1991, 2005) also reminded educators that the response to any intervention needs to be evaluated with respect to treatment effectiveness, strength, and integrity. Failure to respond to an inadequate intervention tells us nothing about the learner. IDEA 2004 reminds us that treatment plans must have research supporting their effectiveness. Interventions must also be implemented at a level of treatment strength that is appropriate to the individual's needs, the behavior, and the setting or environment. Treatment integrity refers to how well the intervention is implemented. This factor is clearly affected by available resources and staff time, as well as staff training in the strategy. Treatment integrity, another key attribute, must be carefully documented if the results are to be viewed as valid indicators of change or resistance to the intervention. Poorly implemented treatments are unlikely to be effective, tell us nothing about the nature of a child's emotional or behavioral problems, and are of little diagnostic use.

LEVELS OF SEVERITY

As previously discussed, IDEA identifies in this category only those students who have more serious levels of emotional disturbance. However, students logically fall on a continuum of severity with respect to their emotional or behavioral disorders. As Bower (1960) delineated in his classic definitional work, these disorders may manifest themselves as transient or temporary problems with limited impact or as more pervasive problem behaviors requiring more intensive interventions. He further defined the five levels of impact according to the intensity of needed services (see once again Spotlight on History 6.1), beginning with those problems that require only temporary support and structure within general education and the home to resolve them. As the level of severity increases, problem behaviors may require interventions by special education and support personnel for extended periods of time to maintain the student in school programs. Bower's most severe level of disability is characterized by the need for residential or homebound services, when the disorders are so serious that school programs are not appropriate until some progress on the behavior is achieved. As we saw in Nicki's story, the level of disability can change over time, depending on the efficacy of the interventions provided (Gresham, 2005).

Emotional or behavioral disorders vary in severity from mild to severe. *DSM-IV-TR* (American Psychiatric Association, 2000) generally uses a framework of mild disorders displaying the minimal number of criteria to make the diagnosis, whereas severe disorders are characterized by many behaviors in excess of the minimum. Clarizio and Klein (1995) surveyed school psychologists in an attempt to determine which factors held the most weight in determining the severity of a disorder. Four factors strongly affected their determination of severity: impairment of functioning, physical danger, frequency, and chronicity.

Finally, severity levels can be described by a student's responsiveness or resistance to intervention, as described previously. The more resistant the behavioral condition is to intervention, the more serious the disorder (Gresham, 2005). Failing to employ effective, well-implemented interventions when disorders first manifest themselves in the general education environment may impair our ability to halt the progression in severity, as we saw illustrated in Nicki's story at the beginning of this chapter.

PREVALENCE OF EMOTIONAL OR BEHAVIORAL DISORDERS

Estimates of the number of youngsters affected by emotional and behavioral disorders range widely. Figures ranging from less than 0.5 percent to 30 percent have appeared throughout the literature and in various government reports, with most estimates ranging from 3 percent to 6 percent (Forness & Knitzer, 1992; Gerber, 2005; Gresham, 2005; Kauffman & Landrum, 2009; U.S. Department of Education, 1997b). One federal estimate held that 7–8 percent of all school-age children may have emotional or behavioral disorders severe enough to require treatment and that one-third to one-half of those would be expected to also display academic

difficulties (Forness & Knitzer, 1992; Gerber, 2005; U.S. Department of Education, 1994). These are the students who are believed to be in need of assistance in developing more personally satisfying and socially acceptable behaviors and who may benefit from special education intervention.

According to annual reports to Congress on the implementation of IDEA, however, less than 1 percent of all children are currently served in programs for students with emotional or behavioral disorders (U.S. Department of Education, 2009). Given that the most conservative professional and governmental estimates cite a prevalence rate of 2 percent (Kauffman & Landrum, 2009; U.S. Department of Education, 2001), the fact that special education programs are currently serving significantly less than 1 percent of all children raises serious questions.

IDEA child count data for 2004–2005 also indicate that the percentage of school-age children (ages 6–21) classified as students with emotional or behavioral disorders ranged from a low of 0.12 percent in Arkansas to a high of 1.58 percent in Vermont (U.S. Department of Education, 2009). Within states, districts have historically shown the same variability (U.S. Department of Education, 1994), and a review of state implementation of identification criteria found that about two-thirds of the variance remained unaccounted for (Wright et al., 1990). These observations suggest that there are long-standing problems with the definition itself because an effective definition should generate comparable prevalence rates across comparable settings and time periods.

Another concern with identification rates was identified by the U.S. Department of Education (1994, 2001, 2006b, 2009). The annual reports have repeatedly noted that rates of identification vary significantly across racial, cultural, gender, and socioeconomic groups. Disproportionately high numbers of students from low socioeconomic backgrounds have been identified, and disproportionately low numbers of female students have become classified as having primary emotional disturbances. Rates have varied across racial categories as well (see Table 6.2 and Diversity in Focus 6.1). A task force of the Council for Children with Behavioral Disorders discussed these trends in its position paper on disproportionate representation and culturally sensitive treatment of learners from diverse cultural and linguistic backgrounds (Anderson et al., 2003).

Prevalence by age groups also suggests some interesting comparisons (see Table 6.3). Adolescents account for almost 65 percent of all students with emotional or behavioral disorders, although they account for less than half of all students with disabilities (U.S. Department of Education, 2009). One hypothesis that might explain this finding is that students with milder forms of emotional or behavioral disorders are tolerated within general education when they are younger, but by the time they reach the more turbulent adolescent years, the problems have become serious enough to demand attention and services.

Table 6.2 Percentage of Students with Emotional Disturbance, by Race, Compared to Total Populations (2004–2005)

Racial Group	Percentage of Students in Special Education for Emotional Disturbance (Ages 6–21)	Percentage of Total Special Education Population (All Disabilities, Ages 6–21)	Percentage of Total School Population (Ages 6–21)
Black	28.42	20.75	15.08
Hispanic	10.46	16.15	17.65
Asian/Pacific Islander	1.17	2.08	4.10
American Indian/ Alaskan Native	1.52	1.51	.98
White	58.44	59.50	62.19

Source: Data from *28th Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2006* (Vols. 1 and 2, pp. 75, 83, C-10) by U.S. Department of Education, 2009, Washington, DC: USDOE.



DIVERSITY IN FOCUS 6.1

There are long-standing concerns about the disproportionate classification of students of color as having emotional disturbance. African American and Native American students are overrepresented, and Hispanic and Asian students tend to be underrepresented (see Table 6.2). A study of classification rates by Coutinho, Oswald, and Forness (2002) found that the disparity in rates was related to the characteristics of the students (e.g., race and gender) as well as to the characteristics of the community (e.g., poverty). The authors noted that students of color are “disproportionally exposed to potentially toxic environmental influences” (p. 121) and called for local districts to study all the possible contributing factors before deciding on interventions.

However, educators must consider the degree to which culturally relevant behaviors explain behavioral differences and then decide whether those behaviors indicate the need for intervention. The reference to cultural norms was added to the Mental Health and Special Education Coalition definition to address the possibility that learners were being identified as having an emotional disturbance because their behavior and interaction patterns differed from those of their teachers, when those behaviors may, in fact, be normative within their communities. McIntyre (1993) believed that the issue is not that clear-cut, voicing the fear that, under the coalition definition, legitimate emotional or behavioral needs of diverse youngsters (e.g., students of diverse races, economic levels, sexual orientations) might be discounted solely because of their cultural status. It certainly is true that students from such groups should not routinely be placed in programs for students with emotional or behavioral disorders simply because their behaviors differ from those typically expected by teachers. It is also true that young people in such groups may have legitimate needs in developing more personally satisfying and socially acceptable behavioral responses to their environment. To include or to exclude students from services because of their cultural background is to treat them inappropriately. Assessment protocols should consider the degree to which each student’s cultural status is affecting his or her emotional or behavioral responses. That information can then be used to help create a package of services to address those needs appropriately from within that cultural context (Cartledge, 1999).

With all this said, just what is a reasonable estimate of the numbers of children and youth who may need various levels of support for emotional or behavioral disorders? The most generally accepted estimates suggest that 3–6 percent of the school population may require Tier 2 or 3 interventions in any given year, whereas the federal estimates are widely regarded as entirely too conservative (Forness & Knitzer, 1992; Kauffman, Mock, & Simpson, 2007). Using the IDEA projections as the expectation, schools appear to be identifying only those with the most severe disorders, students who are clearly a danger to themselves and others. This leaves unserved and unnoticed many other students who are not *yet* that severe and who might actually be more amenable to interventions. We may be failing to identify those very students who might be more

Table 6.3 Distribution of Students with Emotional Disturbance, by Age Group, Compared to Total Populations (2004–2005)

Age Group	Percentage of Students in Special Education for Emotional Disturbance	Percentage of Total Special Education Population (All Disabilities)	Percentage of Total School Population
3–5	1.19	10.30	15.20
6–11	28.12	40.76	} 63.34
12–17	64.63	44.33	
18–21	6.05	4.61	21.26

Source: Data from *28th Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2006* (Vol. 2, pp. 7, 8, 14, 17, 20, C-1, C-3, C-4, C-5) by U.S. Department of Education, 2009, Washington, DC: USDOE.