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## Emotional or Behavioral Disorders

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Emotional or

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Emotional or

## Emotional or Behavioral Disorders

If surveyed across several generations, casual inquirers would not be hard-pressed to discover differing attitudes about current behavior challenges in schools today. While many structures have been established and documents written, one cannot deny the changes in focus that are now required to accommodate new attitudes and behaviors in many children in our public education system. The Individuals with Disabilities Education Act maintains a formal definition of Emotional and Behavioral Disorders (EBD) which led to this disorder being included in the list of IEP-warranted classifications. Children who exhibit symptoms within the listed criteria often are identified as demonstrating predominately externalizing behaviors (the most common) or internalizing behaviors (Heward, 2009). Getting out of seat, yelling, blurting out, hitting, fighting, complaining, excessive arguing, lying, stealing, non-compliance and destruction of property are some examples of externalizing behaviors. Contrarily, internalizing behaviors may include limited peer interactions, daydreaming, fantasies, fear of certain things, frequent complaints of being sick or hurt and feelings of depression (Heward, 2009).

### Definitions and Diagnosis of Emotional or Behavioral Disorders (EBD)

There have been several attempts to establish a comprehensive definition for this disability but most have met with varying amounts of criticism. Two basic approaches to defining and understanding EBD are referred to as the Disease Model and the Dimensional Model (Rutherford, Quinn, & Mathur, 2004). The Disease Model (often evaluated using criteria established in the *Diagnostic and Statistical Manual of Mental Disorders*) considers EBD as a

## Emotional or

collection of distressing behaviors, thoughts, and emotions that differ from “normality.” A person either *has* or *does not have* the disorder based on the number of symptoms that meet the established criteria. In the Dimensional Model (sometimes called the Empirical Model), this disability is looked at across a spectrum of sorts. It assumes that all children behave inappropriately at times and that the duration, severity, and frequency are what help to determine a need for intervention. A common tool used to identify persons under this philosophy is the Achenbach System of Empirically Based Assessment (ASEBA). (See Figure 1 for a comparison of correlative EBD criteria). For the purpose of this paper, however, the IDEA definition and criteria will be what collected information is weighed against. The category most children with an EBD will receive an IEP for is that of Emotional Disturbance (ED). The IDEA definition requires that a student be offered interventions if they meet one or more of the following identifiers and that this adversely affects educational performance, has existed for a long period of time *and* to a marked degree:

- An inability to learn which cannot be explained by intellectual, sensory, and health factors;
- An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
- Inappropriate types of behavior or feelings under normal circumstances;
- A general pervasive mood of unhappiness or depression; or
- A tendency to develop physical symptoms or fears associated with personal or school problems (Heward, 2009, p. 214).

Emotional or

### Medical and Psychological Considerations

Unfortunately, the prevalence of children diagnosed with EBD is rising. According to Kauffman (2005) most studies indicate “that between 3% and 10% of children have emotional or behavioral problems that are sufficiently serious and persistent to warrant intervention” (as cited in Heward, 2009, p. 221). Two areas are consistently blamed for this disorder and include biological factors (which include brain disorders, genetics, and temperament) and environmental factors (across the spectrums of home, school and community)(Heward, 2009). It is clear that behavior disorders interfere with education and that it impairs a child’s ability to learn, wears out teachers and can readily (without intervention) become a lifelong problem. Until very recent years, most of the research related to interventions for this population has focused primarily on behavioral/psychosocial interventions. However, more recent advances have been made in child and adolescent psychopharmacology. These findings, according to Konopasek and Forness (2004) are “advances which suggest that psychopharmacologic treatment may even exceed the effectiveness of psychosocial intervention” (p. 352). High levels of collaboration between the educational system, the family and the medical community are believed to be the key to effectively utilizing new information related to combining medications and psychosocial interventions for the greatest benefit to the child (Rutherford et al., 2004).

Emotional or

## Effective Educational Methods/Interventions

Many people have opinions or circumstances that are to blame for EBD as well as ideas on what it would take to “fix” EBD. Just ask any grandparent and one will hear a broad range of proposed interventions. While these self-dubbed “professionals” may speak with certainty, it has only been in recent years that true, empirically-based research has been collected. The three areas of empirically-based interventions that will be mentioned in this paper include, Functional Behavioral Assessments (FBA), additional Behavioral Intervention Plans (BIPs) and Schoolwide Positive Behavior Supports (PBS).

### Functional Behavioral Assessments

In 2004, the Individuals with Disability Education Improvement Act (IDEIA) stated that IEP team members must “address the behavioral needs of students with disabilities when their behavior impedes their learning or the learning of others” (Sonick & Ardoin, 2010, p. 153). These teams are then required to address the unwanted behavior using behavior intervention plans that have been developed as a result of a Functional Behavior Assessment (Sonick & Ardoin, 2010). According to O’Neill et al. (1997), “Functional assessment is a process for gathering information that can be used to maximize the effectiveness and efficiency of behavioral support (p. 3).” The underlying premise that warrants an FBA is that all behavior occurs for a reason and serves a specific function for the child. (Adams & Dunsmuit, 2009) Lane and colleagues (2009) believe that these interventions are highly individualized and focus on the reasons *why* problem behaviors occur. FBA should include four stages: collecting data,

Emotional or

developing a hypothesis, testing the hypothesis, and developing interventions based on the tested hypothesis (Solnick & Ardoin, 2010). Typically, an operant learning behavior model is used to collect data and follows an Antecedent (A), Behavior (B), Consequence (C) approach. Most behaviors can be classified as an attempt to GAIN something, AVOID something, or fulfill a sensory need and once this is identified, a personal and highly effective intervention can be considered.

McLaren and Nelson (2009) conducted a study that was done using an FBA approach to develop behavior interventions for three students in a Head Start Program. Their goal was to see if a behavioral intervention plan that was created from a FBA would be effective in reducing unwanted behavior for young children and to identify if the teachers would feel that the interventions were acceptable and feasible. Initially, the authors implemented phase one which included teacher interviews and informal data collection to determine behavior challenges (target behaviors) of three boys. Phase 2 included the use of observation and scatterplots to record the times and frequency that the targeted behaviors occurred in a way that recorded student's strengths, interests, dislikes, etc. Information was then broken down into an A-B-C chart. One student, for example, named Anthony had a target behavior defined as "touching another child with his arms or feet in an inappropriate or harmful manner" (McLaren & Nelson, 2009, p. 5). The scatterplot helped to determine that Anthony's **A**ntecedent was walking around the room during free play and a peer sitting on the floor in the block center. Anthony's **B**ehavior included reaching down to peer and hitting him on the back. Anthony then moved away and looked at peer. The **C**onsequence was no reaction from the

## Emotional or

peer. There were several additional examples of similar scenarios recorded which were carried over into Phase 3, hypothesis development. It was hypothesized that Anthony was acting out in an effort to GAIN peer attention. Therefore, a new target behavior or replacement behavior was developed. For Anthony, this was that “during unstructured play and transition periods, Anthony will use non-harmful touching, gestures, or verbal communication... to obtain peer attention and initiate peer interaction” (McLaren & Nelson, 2009, p. 9). From this point, the process included incorporating a Behavioral Intervention Plan which is discussed in the next section. At the end of this study, Anthony’s teacher was asked to complete the Treatment Acceptability Rating Form—Revised (TARF-R) in order to evaluate her approval of the intervention. Anthony’s teacher’s rating was 95%, indicating that she found the intervention to be successful and accessible. It was determined that using an FBA to identify motivators and then to incorporate positive elements and strengths into an intervention in the classroom was effective.

### Behavior Intervention Plans

One behavior intervention (McLaren & Nelson, 2009) is to collect data, form a hypothesis and implement strengths for instigating appropriate replacement behaviors. In Anthony’s case, the intervention was implemented during classroom clean up and center time. The teacher or assistant teacher would invite Anthony to play with him/her during center time and model interactions with other children as well as invite Anthony to help with simple cleaning up tasks, incorporating peers when possible. This intervention was easy to incorporate,



Emotional or

was cost free and the data indicate that it was successful in decreasing Anthony's aggressive behaviors due to positive peer interactions instead. "Behavior problems are a well-documented and an ever-increasing challenge facing educators and effective behavior management strategies that meet these challenges and promote safety for students and adults are of significant interest for educators nationally" (Wheatley et al., 2009, p. 551). Numerous schools across the country are beginning to implement school-wide interventions and there have been many models established that attempt to distinguish between varying levels of supports that are needed. According to Nelson et al. (2009), these models are found in the schools (primary, secondary, and tertiary tiers), in the public health arena (response-to-intervention model), and in the behavioral health field (coordinated with levels of risk referred to as universal, selected, and indicated). The overarching commonality between these models is that there are interventions that can be done for the total population, intensified a bit for a smaller population group (who thereby receive two levels of supports) and built on further for a higher risk population, now receiving three levels of intervention.

One example of an intervention done for all students is the Classwide Function-Based Intervention Team Program (CW-FIT) which is a multi-level group contingency program that is described by Wills et al. (2010). For students who aren't responsive at the primary-level, a secondary level is used and students who do not respond to level two become candidates for level three. The CW-FIT incorporates several components which include teaching (clearly defining desirable skills), extinction (eliminating or minimizing social reinforcement for problem behavior), rewards (group and individual contingencies) and self and/or peer management.

## Emotional or

The primary skills addressed include, gaining the teacher's attention appropriately, following directions and ignoring inappropriate behavior. While this paper cannot explore the detailed events, the outcomes of the intervention included increased on-task behaviors and a decrease in inappropriate behaviors that were class-wide.

Self-monitoring and self-evaluation are also methods of intervention that are growing in popularity. One study by Menzies, Lane, and Lee (2009) addressed the metacognitive strategies of self-monitoring, self-evaluation, self-instruction, goal setting, and strategy instruction and believe that behavior problems arise when students are unable to be successful due to problems in metacognition. They refer to this as "thinking about thinking" and focus on helping a student break down tasks and analyze a problem until a solution is found. The self-monitoring process is broken down into five steps. These steps include, identifying the target behavior (blurting out), creating a simple self-recording data sheet (chart where student marks the times he blurted out), teaching the student the procedures to self-monitor (how to complete the form), using data collected (initially to form a baseline and then to track student progress), and lastly, maintenance and follow-up (prompts are faded as student success increases).

Whitby and Miller (2009) described how an innovative software program, eKidTools, was used to create programs that addressed the behavioral needs of children in general education classrooms. This program uses a variety of kid-friendly charts (many the child can customize for his own needs) to encourage self-monitoring and self-management. As a child

Emotional or

becomes more proficient using his prescribed strategy, he moves along a continuum from external control procedures (adults providing the rules and structures) to a shared control environment and ultimately to personal responsibility. One example that was explained was the Fair-Pair Countoon (Whitby & Miller, 2009). This assumes the philosophy that in order to extinguish one behavior, another one must be added in its place. A small chart/card is created via the computer program that has columns to document, for example, what Michael *does*, how many times (numbers 1-20) and what Michael *should do* instead, and how many times (numbers 1-20). Michael's Fair Pair Countoon can be taped to his desk and he can cross off numbers to record how many times he blurts out and contrarily, how many times he is successful in raising his hand instead. There are also point sheet templates, Stop, Think and Do Plan templates, and Star Countoon Card templates available on the website. (eKidTools.missouri.edu) and an address where a thumb drive with all the templates can be ordered to be used on multiple computers.

### Positive Behavior Supports

“An enormous contribution of research based on behaviorism has been the development of a positive, supportive approach to behavioral problems....Today this idea is being extended to an approach to school discipline known as Schoolwide Positive Behavior Support (SWPBS)” (Nelson & Kauffman, 2009, p. 37). The premise is that instead of just targeting the 10% who act out the most, it is to everyone's advantage to begin at a level that impacts the entire student body. The first and overarching characteristic of an effective PBS

## Emotional or

system is for the staff of the school to have a shared vision. Barriers, roadblocks and predictable behavior patterns must be discussed and predicted by the staff regarding when, where, and under what conditions the problematic behaviors are likely to occur (Rutherford et al., 2004). Secondly, the school administration must be in full support of the intervention which leads to a mandatory level of collaboration. The primary element of the PBS then becomes the agreed-upon set of academic and social expectations. This typically focuses on five (or less) positively stated behaviors that are posted around the school and then broken down further into guidelines specific to each classroom. Communication of these expectations to students is pivotal and should be done in a variety of creative ways. Agreed upon rewards/reinforcers and disciplinary policies must be fairly and equally applied by all staff, including the administration. “Inconsistency...is known to decrease the effectiveness of a well-designed and well-intended program” (Rutherford et al., 2004, p. 491). The social and academic outcomes for this relatively new intervention have been monumental.

### Suggestions for Parents and Teachers

One of the key suggestions, regardless of which interventions are used, is the need for consistency (Rutherford et al., 2004). Some suggestions for teachers include, structuring the classroom in a way that doesn't provoke disruptions, seating students who are likely to act out closer to the teacher, using checklists for monitoring behaviors, and providing rewards and incentives for positive behaviors. It is imperative that all penalties that deal with negative behaviors are clearly stated and consistently and predictably used. One author's suggestions

Emotional or

include areas where parents can improve as well and recommend breaking up long-term goals into shorter-term ones, being consistent with rules, routines and punishments and encouraging children to use self-evaluations related to behaviors they need to improve (Curtis, 2006).

### Discussion

It is estimated that 12% of all children in this country have significant emotional and/or behavioral disorders that negatively affect their academic and social functioning (Nelson et al., 2009). This is not a small percentage! In 2004, the No Child Left Behind Act (NCLB) mandated that evidenced-based methods be used to teach appropriate behaviors to students with learning and behavior problems. This has led to an influx of research being performed, measured, and documented in an effort to identify the most useful tools in order to help these children be successful. That is the good news. Unfortunately, the strain that this adds to unprepared teachers in overcrowded classrooms and the continuing rise in numbers of students affected by EBD is still disheartening.

These proposed methods of intervention are often met with a recurring challenge. Nelson and Kauffman (2009) sum it up well when they state, “We also now know that changing the behavior of children requires, first, a change in the behavior of adult” (p. 38). This is proving to be a much greater challenge than changing the behavior of the student. Sadly, the research indicates that students with EBD continue to be under-identified and demonstrate the poorest outcomes of any population of students in schools (Nelson & Kauffman, 2009). One cannot summarize a topic like this without mentioning the need for *prevention* at the outset.

Emotional or

However, while research, documentation and lobbying is being done in an effort to save these children through prevention, doesn't this bring us back to the most challenging proposal of all? Prevention would indeed require a change in the adults in this culture, regardless of whether or not you blame biology or environment for these issues.

Emotional or

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Emotional or

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Emotional or

Figure 1

ED Definition Terms	DSM-IV Mental Disorders	ASEBA syndromes
An inability to learn that cannot be explained by intellectual, sensory, or health factors.	Learning disorders Communication disorders ADHD – Inattentive Type	Attention problems
An inability to build or maintain satisfactory interpersonal relationships with peers and teachers	No specific DSM disorder but an important part of many	Withdrawn/depressed Social Problems
Inappropriate types of behavior or feeling under normal circumstances	ADHD – hyperactive-impulsive type Conduct disorder Oppositional-defiant disorder Bipolar I disorder Adjustment disorder with disturbance of conduct	Aggressive behavior
A general pervasive mood of unhappiness or depression	Depressive disorders Adjustment disorder with depressed mood Other mental disorders with depressed features	Anxious/depressed Withdrawn/depressed
A tendency to develop physical symptoms or fears associated with personal or school problems	Separation anxiety disorder Anxiety disorders Somatoform disorders	Anxious/depressed Somatic complaints
Schizophrenia (specifically included)	Schizophrenia and most psychotic disorders Mood disorders accompanied by psychotic features	Thought problems
Socially maladjusted (if sole problem, does not qualify as ED)	Conduct disorder Child or adolescent antisocial behavior	Rule-breaking behavior

Adapted from Rutherford, B. R., Quinn, M. M., & Mathur, S. R. (Eds.). (2004). *Handbook of research in emotional and behavioral disorders*. New York: The Guilford Press. p. 44.