

Overview of Emotional and Behavioral Disorders

Historical Background

A variety of terms have been used to describe abnormal or maladaptive thoughts and behavior in people. Many of them, such as *mental illness* and *psychopathology*, were originally coined to describe adult conditions and, for the most part, have been regarded as too stigmatizing to apply to children. Another, less stigmatizing term, *emotional disturbance*, seen as more appropriate for use with children, appeared in the late 1900s (Reinert, 1972) and was used in the first two editions of this book. During the same period, the label *behaviorally disordered* became popular, particularly with professionals in the field of special education. It was seen as the least stigmatizing label by some (Smith, Wood, & Grimes, 1988), but as misleading by others because it ignored children's emotional conditions. Although these two terms were relatively prominent, they were by no means exclusive, as various states selected their own terminology, such as *emotionally handicapped*, *behaviorally impaired*, and so forth.

In an effort to bring uniform standards to the field, in 1988, the National Mental Health and Special Education Coalition adopted the term *emotional and behavioral disorders* (EBDs). This term has been accepted by a wide variety of professional organizations and, for the most part, is used in this text. However, the field still lacks consensus on definition and terminology. Despite varied terminology, the history of this field records attempts to understand the conditions, thoughts, and behaviors that may currently be subsumed under the labels *mental illness* for adults and *emotional and behavioral disorders* for children and youth. Among the earliest explanations was the notion that individuals whose behavior seemed strange, odd, or vastly different from that of

other people were possessed by either evil or divine spirits. Archaeological evidence suggests that primitive man might have used *trephining*, a surgical technique involving chipping a hole in the skull, to release the evil spirits that robbed people of control over their behavior. (Surprisingly, signs of healing on some of the skulls of these primitive people indicate that they actually survived the treatment; however, we are left to wonder about their mental health.) The march of time and the development of humans from cave dwellers to members of relatively sophisticated civilizations such as those established in ancient China, Egypt, and Greece did little to modify the notion of possession by spirits. However, possession by good spirits, as well as by evil or demonic spirits, was considered a possibility. Bad spirits or demons were cast out by exorcism through use of prayers; magic; or, occasionally, purgatives, usually by a shaman or priest. (The continued use of this practice in current times underscores the ongoing belief in demonology among certain groups.) If a person's behavior signified possession by good spirits, the person was regarded as being chosen or touched by God and was revered as a seer or prophet or as one marked for greatness.

Such ideas prevailed until Hippocrates (ca. 460–377 B.C.), the Greek physician known as the father of medicine, recorded detailed descriptions of abnormal states that he designated as *melancholia*, *mania* (hysteria), and *phrentis* (brain fever). He defined them as forms of physical illness rather than states of demonic possession and attributed them to brain pathology, emphasizing the importance of heredity, as well as actual injury to the head, as causal factors. His classification system was based on clinical observation, a remarkable precursor of modern medical practice. His knowledge of physiology was somewhat lacking, however, and his explanation of illness as due to imbalances among the four bodily humors that he deemed responsible for physical health—yellow bile from the earth, black bile from water, red blood from fire, and mucus from the air—although colorful, was inaccurate. Regardless of these inaccuracies, Hippocrates inaugurated a medical approach to understanding maladaptive behavior and made the study of mental, emotional, and behavioral disorders the concern of physicians. This approach continued to some degree in later Greek and Roman societies, only to give way slowly but surely to the reaffirmation of superstitious belief in demonology that dominated in the Dark Ages of medieval times.

During the Dark (or Middle) Ages (A.D. 500–1500), the medical or physical approach to mental illness was largely lost in Western societies. Although an outstanding Islamic physician, Avicenna (A.D. 980–1037),

produced cogent and humanistic writings regarding illnesses that he referred to as *melancholia*, *epilepsy*, *mania*, and *hysteria*, his work did not influence Western thinking. In Europe, clinical observation and scientific inquiry into abnormal behavior were forgotten, and, as in earlier eras, symptoms of mental illness were thought to be the result of the influence of the devil on the person's spirit or soul. Monks and priests kept voluminous records of the characteristics of various devils that possessed the weak or impious and caused strange or irrational behavior. They were responsible for treating such "possessions" by exorcising the evil spirits. The most benevolent form of treatment involved incantations and pleas for divine forgiveness. Less fortunate sufferers were whipped, stoned, or dunked in ponds, and the hard-core unrepentant were even burned at the stake. The latter treatment was the only known "sure cure," although many miraculous recoveries were attributed to the other approaches.

The dominance of the belief in demonic possession was such that it continued to prevail into the 15th and 16th centuries. In addition to the idea that corporal possession by evil spirits caused madness, the belief grew that the spirits of certain individuals were possessed by Satan and that these persons, called witches, had evil, supernatural powers. These individuals were punished and frequently killed, sometimes in mass exterminations, such as the Inquisition. Often the designation *witch* was applied to the politically rebellious and those rejecting Christianity; however, it also was attached to the mentally ill, much to their detriment. Although the clergy continued to bear the primary responsibility for dealing with the problem, the records of several prominent members of the medical profession of the period reveal that their attitudes were similar to those of the clergy. According to Coleman (1972), one physician, Fernel (1497–1558), reported cases of lycanthropy, the transformation of a human into a werewolf, and another, Plater (1536–1614), described the devil as the source of all mental illness.

All was not bleak, however, as toward the latter part of the Middle Ages and the beginning of the Renaissance, voices attributing bizarre or maladaptive behaviors to mental disorder of some type began to be raised once again. In the mid-16th century, Johann Weyer (1515–1588), a German physician, published *The Deception of Demons*, in which he argued that many so-called witches were mentally sick. Similarly, an Englishman, Reginald Scott (1538–1599), wrote *The Discoverie of Witchcraft* in 1584 to deny that spirits cause mental disorder. Neither of these individuals was honored in his lifetime, but the ideas of both eventually prevailed. As time passed, the "radical" ideas of these physicians

coincided to some degree with certain aspects of the theories generated by several philosophers depicting the existence of “mind” as distinct from “soul,” thereby directing attention away from the notions of spiritual causation or possession. Thomas Hobbes (1588–1679), John Locke (1632–1704), and George Berkeley (1685–1753) were influential in developing the concept of mental functions. Unfortunately, these emerging and reemerging ideas were of little immediate benefit to the “possessed” members of the population, who continued to be purged of their sins or, in a more “enlightened” vein, confined to institutions whose names evoke images of horror.

Early asylums or “madhouses” were similar to jails in that patients were often shackled or chained to walls or confined to crowded cells. One of the earliest of these institutions, St. Mary of Bethlehem (commonly referred to as Bedlam) was established by Henry VIII in London in 1547. Even today, the name denotes wild, chaotic conditions. Other “bedlams” were established in other countries throughout the 17th and 18th centuries. Patients lived in their own excrement, eating slop. Often for small fees paid to wardens, members of the public were permitted to view the “animals.” Although conditions improved in the 19th century, the use of physical restraints, straitjackets, electrical shocks, and so forth, did not represent humane treatment.

Even though the path to humane treatment of mentally disordered persons was not smooth, as the domination of the clergy began to wane in the 17th century and the notion of possession weakened, the stage was set for dramatic reforms in the 18th century that began to alter these inhumane conditions and eventually returned the study of emotional disturbance to the purview of the physician. Philippe Pinel (1745–1826), a French physician who became director of Bicêtre Hospital after the French Revolution, is famous for unchaining the mental patients and advocating more humane forms of treatment. His approach, known later as *moral treatment*, was successful and influenced the work of his associates and students, the most important of whom was Jean Itard (1775–1838). Itard’s classic book, *The Wild Boy of Aveyron*, reported his efforts to educate Victor, a boy who had been abandoned in a forest and whose behaviors were indicative of mental illness and mental retardation. In turn, Itard’s work influenced educators such as Edward Seguin and Maria Montessori and helped establish teaching as an important component of treatment.

In America, the famous physician Benjamin Rush (1745–1813), recognized as the father of American psychiatry, argued for more hu-

man treatment of the mentally ill. He deplored the use of corporal punishment and stressed the importance of education. Owing in part to his influence, troubled individuals were seen increasingly as sick and not solely responsible for their behavior, and their treatment improved. Rush's work increased the use of Pinel's moral therapy in the United States' asylums in the early 19th century.

In the 19th century, the view of emotional and behavioral disorders (EBDs) as illnesses of the mind became firmly entrenched. Humanists such as Dorothea Dix (1802–1887) campaigned for appropriate services. Dix is credited with establishing the mental hygiene movement in America by garnering public support and funding for the establishment of mental hospitals throughout the country. Simultaneously, physicians began to pay increased attention to conscientious observation of their patients' behavior. They looked for common symptoms as clues to the origins of mental illness and formed schools of psychiatric treatment. Ambroise-Auguste Liebault (1823–1904), a French physician, founded the Nancy School and with his colleagues, particularly Hippolyte Bernheim (1837–1919), developed psychotherapy as a form of treatment. This school emphasized the relationship between patients' symptomology and their suggestibility, a premise that provided the foundation for the concept of functional illness, which is described later.

A rival point of view flourished at the Salpêtrière School, operated by Jean-Martin Charcot (1825–1893). These physicians believed that disturbed symptoms were attributable to organic malfunctions or physical disease.

In addition, a more enlightened approach toward the use of education in the treatment of emotionally troubled persons continued to spread, with schooling provided within asylums for the "insane." Many of the teaching strategies used during this period have remained as cornerstones of special education. These strategies include individualized assessment and instruction, sequenced learning, structured activities, and multisensory approaches.

In Germany, Emil Kraepelin (1856–1926) solidified the mental illness concept by developing a classification system of mental diseases according to distinct clusters of symptoms. He identified two major psychoses, *manic-depressive* and *dementia praecox* (in current terminology, *schizophrenia*). He also created two categories of disease, *endogenous* and *exogenous*. Endogenous maladies are of internal origin and are caused by some type of biological malfunction, such as brain damage or

genetic defects. Exogenous illnesses are of external origin and are unrelated to biological factors.

During this period, the scientific method was being applied to the study of behavior. In 1879, Wilhelm Wundt (1832–1920) established the first experimental psychology laboratory at the University of Leipzig and developed experimental methodology that was later used to investigate behavior throughout the world. In the United States and England, empirical research involving hypothesis formation, observation, quantitative measurement, and controlled experimentation was undertaken by men like Gustav Fechner (1801–1887) and Sir Francis Galton (1822–1911). The significance of this movement is that it introduced an alternative to medical studies of pathological behavior by investigating normal behavior. It also placed importance on proof through measurement, an idea that was not part of the largely intuitive approach to the study of behavior undertaken in clinical or medical settings at that time.

The 20th century saw the study of emotionally disturbed conditions revolutionized by the impact of many diverse theoretical perspectives and social movements. Attention turned to helping children who engaged in antisocial or criminal behavior. Beginning in 1909 with the establishment of the Juvenile Psychopathic Institute, Dr. William Healy, Augusta Bronner, Grace Fernald, and Julia Lathrop pioneered the study of repeat juvenile delinquents. Alfred Binet and Theodore Simon furthered the idea of using standardized laboratory methods to measure behavior by developing a test to predict school success, which gained popularity as an intelligence test—The Stanford-Binet Test (1905). Arnold Gesell opened the Clinic for Child Development at Yale University, and the idea of mental health programs in public schools was advanced. Leo Kanner (1943) described early infantile autism, and Loretta Bender helped organize an education program for the children with schizophrenia whom she treated at Bellevue Psychiatric Hospital in New York. In the 1940s, Bruno Bettelheim, Fritz Redl, and their associates developed and expanded the principles of the “therapeutic milieu” for working with seriously disturbed and aggressive children, which provided the foundation for milieu or ecological therapy. Alfred Strauss and Laura Lehtinen published *Psychopathology and Education of the Brain-Injured Child* (1947), a seminal work that delineated the characteristics that interfere with children’s ability to learn (inattentiveness, hyperactivity, distractibility, volatility) and provided the basis for the structured classroom model. In the early 1960s, William Cruickshank and colleagues adapted the structured approach to experimental classrooms for chil-

dren with behavior problems in *A Teaching Method for Brain-Injured and Hyperactive Children* (Cruickshank, Bentzen, Raatzburg, & Tannhauser, 1961). The structured model for classroom instruction was expanded by Norris Haring and E. Lakin Phillips in 1963 in *Educating Emotionally Disturbed Children*.

In 1960, Pearl Berkowitz and Esther Rothman coauthored *The Disturbed Child*, which advocated a modified psychoanalytic approach to the instruction of emotionally disturbed children. Also in the 1960s, Nicholas Hobbs organized Project Re-ED (an acronym for the Re-Education of Emotionally Disturbed children), an ecologically based model for residential schools for seriously disturbed children, and Frank Hewett developed the concept of the engineered classroom, which advocated a behavioral approach to education. Finally, in 1965, Nicholas Long, William Morse, and Ruth Newman published *Conflict in the Classroom*, a classic book that presented diverse theoretical views about the identification and education of children with emotional disorders.

The years between 1970 and 2005 are most notable for the federal legislation designed to protect the rights of the disabled and disadvantaged. In 1975, P.L. 94-142, the Education for All Handicapped Children Act, was passed. This landmark law, which mandated services for children with disabilities, was amended in 1983 and 1986 to extend its provisions to preschool children and mandate greater attention to successful outcomes for children and youth with emotional and behavioral disorders. In 1990, P.L. 101-476, the Individuals With Disabilities Education Act (IDEA), was passed (and amended in 1991, 1997, and 2004). This law was important for persons with emotional and behavioral disorders because it specified conditions for removing them from public school for disciplinary reasons without denying them access to alternate educational opportunities. It also mandated functional behavioral assessment (FBA) and behavior intervention plans (BIPs) for them. The most controversial of these laws, the No Child Left Behind Act, P.L. 107-110, was passed in 2001. Although the purpose of this law was to improve the level of instruction in schools, its application has generated severe criticism from multiple sources for its stringent and unrealistic testing mandates, inadequate funding for mandated activities, and rigid prescription of services.

Despite the controversy inevitably generated by federal mandates, in the late 20th and early 21st centuries, the federal government became a major player in the movement to provide services for persons with disabilities. Although the implementation of the laws enacted has not always produced constructive outcomes, at least these laws reflect an

increased national concern with the issue of educating children and youth with emotional and behavioral disorders.

Throughout the 20th century, numerous individuals and fields of study influenced our understanding of persons with emotional and behavioral disorders and provided new approaches to their treatment, including Sigmund Freud and his disciples and their involvement in the psychoanalytic movement, the growth of the humanistic movement, the emergence of cognitive psychology, the contributions of Harry Stack Sullivan (1953) and the interpersonal theorists, the information gleaned from sociology and social psychology that emphasized the importance of various cultural forces on behavior, the impact of behavioral theory, and the continued research into genetic and biochemical causes of EBDs. As information from these multiple avenues of study contributed to greater interest in the emotional and behavioral problems of children and youth, a variety of organizations designed to serve this population has evolved. The earliest organization, the Council for Exceptional Children (CEC), was formed in 1922. An important division of the CEC, the Council for Children with Behavioral Disorders, was formed in 1964 and was followed by the Autism Society of America, formed in 1965; the National Mental Health and Special Education Coalition, created in 1987 by a jointure of the National Mental Health Association and the Council for Exceptional Children; and the Federation of Families for Children's Mental Health, established in 1989.

In addition, numerous journals have appeared to present increasingly sophisticated position papers and research results on emotional and behavioral disorders and related topics. Included in their number are *Exceptional Children*, *Journal of Emotional and Behavioral Disorders*, *Behavior Disorders*, *The Journal of Special Education*, *Remedial and Special Education*, *Journal of Autism and Developmental Disorders*, *Journal of Applied Behavioral Analysis*, *Intervention in School and Clinic*, *Journal of Abnormal Child Psychology*, *Journal of Child and Family Studies*, and *Journal of Positive Behavior Interventions*, among others.

Of course, the availability of information does not always translate readily into practice, and those professionals working most closely with emotionally troubled children deplore the seemingly slow progress; including inadequate services, shortsighted or haphazard school-based planning, and at-risk children who are not identified or who are identified only after their problems have become so severe that they can no longer be overlooked. Indeed, as we progress in the 21st century, practitioners in the field are still faced with the challenge of addressing several clearly delineated issues: prevention, placement, instruction, and definition.

Issues in the 21st Century

Prevention

Professionals associated with special education (e.g., Bower, 1961, 1981; Heck, 1940; Kanner, 1943) have long espoused the value of early intervention, that is, preventing the onset of a problem or identifying and trying to solve the problem before it becomes worse. The word *early* in this context does not refer to the age of the child, but to the age of the problem. As educators have learned more about children's emotional disorders, it has become increasingly obvious that, unlike fine wine, children's disorders usually do not improve with age. Whelan (1998) points out that identifying problems before they mushroom into serious disorders not only makes good sense from a humanistic perspective but also is cost effective. It is far less costly to spend a relatively small amount of money on preventive activities (e.g., screening children for problems, observing potentially problematic behaviors, or conferencing with parents) than it is to fund children's placements in private residential schools or psychiatric facilities.

There is great agreement about the wisdom of preventing the development of EBDs; however, there is considerable confusion about how this might be accomplished. Whelan (1998) recommended that schools expand their responsibility in this area from school- or curriculum-based programs (secondary approaches) to more essential primary services such as prenatal care, medical care, nutrition, and protection from abuse. Although unifying responsibility for services might solve problems associated with multiple agencies providing fragmented or insufficient care, many individuals regard this type of solution as impractical and difficult to accomplish (Bickman, Heflinger, Lambert, & Summerfelt, 1996; Kauffman, 2005; Knapp, 1995).

Cullinan (2007) drew from information supplied by the Institute of Medicine, an organization that focuses on health issues, to offer several approaches to the issue of prevention. One classification system includes primary, secondary, and tertiary levels or stages of the disease's progress. At the *primary* stage, the disease is prevented from occurring. The *secondary* level is designed to reduce the number of cases that might occur, and the *tertiary* level involves reducing the seriousness of the cases that do exist. This type of categorization system works well with physical diseases, such as measles, but it appears unsuited for use with the variety of conditions associated with EBDs.

An alternate approach discussed by Cullinan (2007) also presents three forms of prevention: universal, selective, and indicated. *Universal prevention* is applied to everyone in a large group (e.g., every student in the school). *Selective prevention* is conducted with a defined group at risk to develop EBDs because they have certain biological or psychosocial characteristics. *Indicated prevention* is directed at individuals who show early signs of the condition and is designed to reduce the severity of the problem.

Examples of universal prevention in schools are programs that teach good classroom and school management skills, pro-social competencies, conflict resolution, and substance abuse prevention (Cullinan, 2007). Ideas and strategies to improve classroom management are readily available (see the Interventions chapters of this book in Part III for detailed discussions). Some specific examples are also provided by Bos and Vaughn (2006); Emmer, Evertson, and Worsham (2006); Friend and Bursuck (2006); Polloway, Patton, and Serna (2005); Strout (2005); and Swanson (2005). Examples of school management programs are presented by Leedy, Bates, and Safran (2004) and Peterson, Miller, and Skiba (2004).

Programs to teach pro-social competencies may involve empathy lessons, social problem solving, and anger management, whereas programs to resolve conflicts usually teach students to recognize and manage emotions, empathize with others, and use problem-solving skills (Cullinan, 2007). Drug prevention programs present information about drugs and teach social problem-solving skills. A popular example is *Life Skills Training* (Botvin & Dusenbury, 1987; Botvin, Griffin, Diaz, & Ifill-Williams, 2001).

Selective prevention for high-risk children is synonymous with early intervention. These activities involve improving school readiness, including basic academics, and teaching appropriate school conduct to young children in an effort to forestall the development of academic and behavioral problems (Conroy, Hendrickson, & Hester, 2004).

Indicated prevention is for students whose problems are early forms of an EBD (Cullinan, 2007). *Check & Connect* is an example of an indicated program for adolescents who have behavior problems and inadequate home support (Christenson & Havsy, 2004; Sinclair, Christenson, & Thurlow, 2005).

Although a large body of information about preventive programs is available, Kauffman (1997) points out that schools have not been particularly successful in implementing programs addressing the prevention of EBDs. He identifies multiple reasons for school avoidance of preventive programs, including (a) the belief that children with EBDs are

just going through a phase that they will outgrow, (b) the social stigma associated with disability labeling, (c) the false-positive outcomes of some identification tools, (d) the possibility of discrimination against minority groups, (e) the cost of preventive programs, (f) the belief that experts outside the school are best qualified to identify children at risk to develop EBDs, and (g) the fear that screening for EBDs might anger parents. For any number of reasons, children identified for special services tend to have severe, long-existing problems (Duncan, Forness, & Hartsough, 1995). Kauffman and Landrum (2000) note that despite knowledge of the dangers of ignoring easily identified signs of EBDs, prevention remains only a “rhetorical reality” (p. 124), and they are not hopeful that the reluctance to take preventive action will diminish in the 21st century.

Placement

The availability of appropriate placements for children and youth with EBDs emerges as a surprising problem for the 21st century. Many special educators thought this issue was settled with the passage of IDEA and the regulations that mandated a continuum of alternative placements for children with disabilities. Children would be served in the *least restrictive environment*, that is, the placement closest to the general education classroom that best met each child’s needs. The least restrictive environment might be general education classrooms with supporting services, resource rooms in general education schools, self-contained special classes with mainstreaming in general education classes, special day schools, day programs at residential schools or hospitals, residential schools or inpatient hospitals, homebound instruction, or schools in juvenile detention centers and prisons (Kauffman & Smucker, 1995). Also, any child’s placement or least restrictive environment might change as the child’s needs change.

The issue of appropriate placements for children with EBDs has become contentious because of the emergence of what is best described as the “full inclusion” movement. The term *full inclusion* refers to placing all children with special needs in general education classrooms and is an outgrowth of the “regular education initiative,” which holds that this type of arrangement is beneficial for *all* children with disabilities (Stainback & Stainback, 1991; Van Dyke, Stallings, & Colley, 1995). Unlike the concept of least restrictive environment, inclusion ignores the issue of the child’s specific educational needs. The assumption is made that the value of socializing with and learning from students in general

education classes transcends any benefits that might be gained from more restrictive placements, regardless of special needs. Also, unlike mainstreaming, which provides students with combinations of special placements and placements in the general education classroom, full inclusion provides only the general education placement for all students.

Ironically, the notion of full inclusion has gained wide acceptance in the schools. Costs associated with the education of children with disabilities may have influenced this level of acceptance. When general classroom educators bear the primary responsibility for educating children who might otherwise require the services of special educators in alternate placements, costs are reduced. However, many concerned parents have been persuaded by the advocates of this movement that efforts to deny a child full inclusion violate basic rights to equal education and they demand full inclusion placements. Also, some educators are committed to the idea that every child's special needs can be met best in a well-run general education classroom.

The controversy over this issue is extensive. Opponents of the idea of full inclusion for all children are particularly concerned about the welfare of children with EBDs (Diamond, 1993; Kauffman & Lloyd, 1995; Morse, 1994). *The Illusion of Full Inclusion*, edited by Kauffman and Hallahan (2005), explores this issue fully and offers particularly cogent arguments against the premise that all students with disabilities should be educated solely in general education classrooms. Other professionals (e.g., Bateman & Chard, 1995; Mock & Kauffman, 2002; Yell, 1998) are concerned with the illegality involved in ignoring the mandate from IDEA to provide a continuum of placements.

The issue of appropriate placements for students with disabilities is further complicated by the school's responsibility to provide educational environments for secondary-level students that will help them make successful transitions from school to work or to higher level educational placements (Cheney & Bullis, 2004). Some school districts have attempted to fulfill this obligation by providing extra help to students with disabilities who are enrolled in college preparatory courses. Often, however, the students do not perform at a level that makes them viable candidates for success in higher education settings. Other school districts offer children with disabilities a less demanding curriculum, a solution that makes them vulnerable to charges of discrimination. In still other cases, a curriculum that integrates academic study with specific vocational training is used. This type of arrangement is most attractive to students who are interested in employment rather than additional education after graduation from high school.

Unfortunately, the literature suggests that existing transitional programs for students with disabilities often are not successful. Myles and Simpson (1998) reported that the school dropout rate for young people with EBDs ranges from 39% to 47%. Also, the National Organization on Disability/Harris Survey of Americans With Disabilities (Harris & Associates, 1994) found that these individuals tend to be unemployed or underemployed. Those who find jobs often are underpaid. Employment opportunities are limited by inadequate interpersonal skills, academic skills, and specific vocational training (Clark, Carlson, Fisher, Cook, & D'Alonzo, 1991). Similar problems reduce the probability of success at postsecondary education, even when supportive or remedial services are provided.

In reporting the results of the National Longitudinal Transition Study, funded by the federal government, the U.S. Department of Education (1995) noted that regardless of type, transition programs are effective only when students succeed in them. This conclusion suggests that secondary schools need to have a variety of placement options for students with disabilities and that individual students should be encouraged to select the option that best meets his or her specific needs. Halpern (1994) believes that students can make better decisions about their options for the future when transitional programs begin no later than age 14.

Instruction

In 1990, Knitzer, Steinberg, and Fleisch published *At the Schoolhouse Door: An Examination of Programs and Policies for Children With Behavioral and Emotional Problems*. This report was a compilation of data collected through national surveys of various organizations and agencies that provided services to children identified as having emotional and behavioral disorders. This document did much to reveal the appalling dearth of coordinated services and the absence of strategies for improving the mental health of these children. It also increased concern over the quality of instruction being provided in special education programs designed to meet the special needs of this population. In particular, the investigation revealed that the majority of special education classes concentrated almost exclusively on controlling aggressive or acting-out behavior and devoted little attention to improving academic skills and teaching social skills.

Since the publication of the work of Knitzer and colleagues (1990), special educators have placed great emphasis on the importance of effective instruction as a prerequisite for sound behavior management

(Kauffman, Mostert, Trent, & Hallahan, 2002; Kerr & Nelson, 2002; Lane, 2004). Instruction that is meaningful to the students and provides them with the opportunity to succeed often prevents behavior problems from occurring. When problems do occur, instruction that focuses on problem solving to develop better social skills is often effective (Polsgrove & Smith, 2004). Chapter 7: Educational Therapy, found later in this book, discusses these issues in detail.

Definition

Defining the term *emotional and behavioral disorder* appears like a simple task, but, in fact, it has confounded experts for years for a variety of reasons. First, expert opinions vary with their professional training, philosophical outlook, and experience. For example, a psychoanalytically oriented psychiatrist and a special educator can be expected to have different perspectives about what defines an EBD. Second, experts have different reasons for developing definitions. State and federal governments may be primarily concerned with behavioral indices that facilitate identification of individuals with an EBD and care little about causal factors. Even those individuals with a common purpose may disagree about the behavioral indices. Third, the term *emotional and behavioral disorder* represents an umbrella category for a number of diverse conditions that defy simple definitions. Finally, even the most basic definition of the term invites argument because its implementation depends on the subjective judgments of those who interpret it.

In 1961, Eli Bower made a valiant attempt to define an EBD. His definition, which ignored etiology, contained five characteristics, of which one or more had to be demonstrated to a marked extent and over a period of time. The characteristics and conditions in Bower's definition were accepted by the U.S. Department of Education and included in IDEA. The definitions in IDEA specified that serious emotional disturbance is indicated by problematic behavior in one or more of five characteristic areas (Assistance to States for the Education of Children With Disabilities, 1977, 1985, 1991, 1998, 2002, 34 C.F.R. § 300.7 [b][4]):

- (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors
- (B) An inability to build or maintain satisfactory interpersonal relationships with peers or teachers
- (C) Inappropriate types of behavior or feelings under normal circumstances

- (D) A general or pervasive mood of unhappiness or depression
- (E) A tendency to develop physical symptoms or fears associated with personal or school problems

The (1977) federal regulations departed from Bower by adding a sixth criterion—that an observed behavior problem must adversely affect educational performance—and specified that schizophrenia was included but social maladjustment was not included unless the individual also had an emotional disturbance.

Many critics (e.g., Forness & Kavale, 2000; Kauffman, 2005; Schulz & Turnbull, 1983; Tankersley, Landrum, & Cook, 2004; Wood, 1985) have lamented the inadequacy of the federal definition and criticized it for being ambiguous, excluding the socially maladjusted, having characteristics that were arbitrarily selected and lacked research support, and ignoring characteristics that have research support. Because of widespread discontent, professionals from a variety of associations and advocacy groups came together under the auspices of the National Mental Health and Special Education Coalition in the late 1980s to propose a new definition (Forness & Knitzer, 1992, p. 13):

- I. The term emotional or behavioral 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 least one of which is school-related; and
 - c. persists despite individualized interventions within the education program, unless, in the judgment 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 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.

The foregoing definition appears to be more comprehensive and more detailed than the existing federal effort but has not, as yet, been adopted to replace it. Apparently, any definition would be subject to extensive criticism. However, gaining knowledge about what the term *emotional and behavioral disorders* means should be facilitated by knowledge of the major perspectives and schools of thought on the topic. To that end, this chapter concludes with a discussion of global perspectives that explain EBDs. The major schools of thought about the topic are presented in Chapter 2.

General Perspectives

General perspectives of EBDs reflect three major emphases: disability, deviance, and alienation.

Disability Perspective

Viewing an EBD as a disability primarily reflects a medical point of view. It emphasizes the existence of internal pathological conditions that generate aberrant behaviors. As is true of physical ailments, where specific symptoms (e.g., a stomach pain) may be caused by a particular disorder or disease (e.g., an ulcer), overt behaviors that are detrimental to oneself or to others are symptomatic of underlying, causal disorders. These abnormal behaviors are signals that a person is sick or afflicted and, consequently, are not directly responsible for the person's overt behavior.

From the disability perspective, diagnosis and treatment of EBDs are focused on causal conditions. Aberrant overt behaviors are important in diagnosing an EBD primarily because they are symptoms that help identify (and eventually treat) those underlying causal conditions. Although underlying conditions may be organic or neurological diseases, such as the brain abnormalities found in persons manifesting symptoms of schizophrenia, they also may involve psychological forces shaped by environment and development. Because specific aberrant overt behavioral symptoms may have any of a number of causes, diagnostic efforts must go beyond observing and recording those behaviors and must involve extensive psychiatric, psychological, and psycho-neurological evaluations.

Diagnostic efforts are aided by the existence of systems that classify disorders. From the disability perspective, these disorders are akin to

diseases. The most widely used classification system in the United States, published by the American Psychiatric Association (2000), is the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition, Text Revision (DSM-IV-TR)*. This widely used manual names and describes hundreds of specific mental disorders.

Although the types of disorders presented in the *DSM-IV-TR* that occur in children and youth are discussed later, the extreme popularity of this clinical tool makes a cursory discussion of its organization helpful. The *DSM-IV-TR* presents a multiaxial diagnostic system. Abnormal behavior is divided into two axes: Axis I reports all mental disorders (e.g., conduct disorder, attention deficit/hyperactivity disorder, anxiety disorders, mood disorders) except personality disorders and mental retardation, which are included on Axis II. The separation ensures that the Axis II disorders will not be ignored when they coexist with a disorder listed on Axis I. Axis III codes medical conditions that might affect the disorders listed on Axes I and II (e.g., diabetes might cause depression). Axis IV codes the psychosocial and environmental problems that might influence the diagnosis and treatment of the disorders listed on Axes I and II. Axis V is the Global Assessment of Functioning, which deals with the individual's ability to cope with everyday life.

The diagnostic categories are listed under 18 broad headings, beginning with “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.” The first four categories under this heading are mental retardation, learning disorders, motor skills disorder, and communication disorders. Most of these disorders and those in other categories (e.g., mood disorders) that are applied to children and youth are discussed in Chapter 3.

The *DSM-IV-TR* classification categories illustrate the extent to which, from the disability perspective, EBDs may be thought of as fixed rather than culturally relative conditions. Even though a disorder might have been induced by sociocultural circumstances, once established, it is an abnormal pathological condition diagnosable in any culture. In a similar vein, the existence of an EBD at any specific time does not depend on displays of deviant or aberrant behavior during that time—as when an existing psychosis is not identified until a major disruption occurs.

From the disability perspective, diagnosis and much of the treatment of persons with EBDs is conducted largely by medical personnel. Psychiatrists (physicians who specialize in mental disorders) bear primary responsibility for treatment, although they may be assisted by members of related professions, such as psychiatric social workers or clinical psychologists. A principal component of treatment is drug therapy to control

the symptoms of the disorder. Also, psychotherapy may be conducted. Treatment facilities include mental hospitals, psychiatric facilities, and mental health clinics.

Deviance Perspective

From the deviance perspective, EBDs are determined by the extent to which an individual's behavior deviates from the norm. One form of deviation involves breaking social rules. A society establishes rules or standards of appropriate behavior that reflect its values, beliefs, convictions, and traditions. Such rules may be formalized in laws or may be implicit, unspecified criteria for social interaction. For the most part, each member of the society is expected to conform to such rules or risk negative consequences because rule breaking is perceived as harmful to the general welfare. Technically, rules are enforced by the citizenry; the behavior of each citizen is subject to evaluation by every other citizen. When an individual's overt behavior falls outside the limits deemed appropriate, he or she may be labeled as mentally disturbed or, in the case of children or youth, emotionally or behaviorally disordered. These labels represent one of many categories of deviance (juvenile delinquent or criminal are others; Moynihan, 1993).

Just as the *DSM-IV-TR* psychiatric clinical classification system reflects the disability perspective, empirically derived behavioral dimension classification systems reflect the deviance perspective. Empirical classification uses statistical analyses such as factor analysis or cluster analysis to measure patterns of behavior that are related or clustered (intercorrelated). Data about large samples of children's behaviors are gathered with questionnaires, checklists, or rating scales. The correlation of items shows which behaviors tend to cluster together to form a syndrome or behavioral dimension that consists of similar or related problem behaviors. Ideally, problem behaviors on different behavioral dimensions should not be similar or overlapping.

Research consistently identifies two broad behavioral dimensions (Achenbach, 1985; Quay, 1986). One encompasses acting-out behaviors (e.g., fighting, temper tantrums, verbal and physical aggression, disobedience, and destructiveness) and is usually labeled *externalizing* or *undercontrolled* (Achenbach, 1991; Achenbach & Edelbrock, 1989). The second dimension encompasses characteristics such as anxiety, depression, shyness, and social withdrawal and is labeled *internalizing* or *overcontrolled* (Achenbach, 1991; Achenbach & Edelbrock, 1989). Any individual may have problems included in both classifications. For

example, a person might be abnormally aggressive (externalizing) and depressed (internalizing). In addition to these two general dimensions, research has identified a number of more specific or narrow-band syndromes, including hyperactive, delinquent, aggressive, schizoid, socially immature, and somatic behaviors (Achenbach, 1991).

Among the instruments available to measure behavioral dimensions, a comprehensive conglomeration of classification instruments—the *Achenbach System of Empirically Based Assessment* (ASEBA; Achenbach, 1995; Achenbach & McConaughy, 2003)—is widely used and highly researched. It includes the *Child Behavior Checklist* (CBCL; Achenbach, 1991), the *Youth Self-Report* (YSR), and the *Semistructured Clinical Interview for Children and Adolescents* (SCICA; Achenbach & Rescorla, 2001), among other tools. The *Social Skills Rating System—Teacher* (SSRS-T; Gresham & Elliott, 1990) also has been shown to discriminate between groups of children identified as externalizing, internalizing, and hyperactive (Lambros, Ward, Bocain, MacMillan, & Gresham, 1998).

Notably, from a deviance perspective, the emotional and behavioral characteristics measured by these statistically devised instruments are present to some degree in the general population of children and youth. The critical determinant of an EBD is the extent or degree to which an individual who displays these characteristics deviates from the norm.

The issue is not as clear as it may seem, however, because norms in specific subcultures may vary. Behavior deemed deviant in one circumstance might be judged appropriate in another. The environmental circumstances affecting an individual—the social milieu—help define the normalcy of behavior. Such variables are part of the criteria that community members use to judge the appropriateness of behavior. Thus, the deviance perspective of emotional and behavioral disorders is a “social” or “culturally relative” point of view.

To illustrate this perspective, Ullmann and Krasner (1969) noted that behavior could never be viewed as deviant or pathological if it is the norm for a particular society:

A critical example is whether an obedient Nazi concentration camp commander would be considered deviant or abnormal. To the extent that he was responding accurately and successfully to his environment and not breaking its rules, he would not be labeled abnormal. Repulsive as his behavior is to Americans, such repulsion is based on a particular set of values. (p. 15)

From the deviance perspective, the term *emotional and behavioral disorder* is not synonymous with *mental disease* and there is little concern with the underlying pathological conditions that cause atypical or aberrant behavior because the issue of causation is not an important variable in identifying a disorder. An EBD is identified when behavior falls outside a range of socially acceptable normal behavior. Generally, this happens when deviant behaviors occur (a) with excessive frequency, (b) with great consistency, and (c) in unusual abundance. Too many deviant acts displayed too often over too long a time mark an individual's behavior as different from the norm. However, some behaviors deviate so dramatically from societal norms that a single act may indicate that an individual has an EBD. Acts such as murder or attempted suicide are examples of such behavior. Even in these instances, circumstances may indicate normalcy, as in justifiable homicide and suicide to end suffering.

Because EBDs are determined by socially deviant behaviors, they are not fixed conditions. An individual is not either afflicted or well; in fact, the same individual might be construed as disordered in one community or subcommunity and as normal in another, because standards vary. For example, behaviors such as fighting, truancy, use of profanity, and so forth, may be regarded as deviant in one school (subcommunity) and may be regarded as typical in another school (subcommunity). On a broader scale, states, cities, towns, boroughs, and neighborhoods form communities, and each establishes unique, conflicting criteria for deviance. Furthermore, whether behaviors are deemed appropriate or inappropriate may depend on extraneous variables such as an individual's age, gender, race, social class, or education. Also, the type of behavior regarded as deviant fluctuates as societal norms and community attitudes change. Today's deviant act is tomorrow's acceptable behavior.

Because socially inappropriate behavior is a critical variable in defining EBD, treatments of identified individuals emphasize teaching socially appropriate behavior, including more acceptable responses to typical interactions that occur in daily living. Therefore, treatment is not the sole purview of the psychiatric or medical community but can be conducted by a variety of individuals who typically interact with the individual, including parents and teachers. Treatment is not confined to hospitals or clinics; it can also take place in a variety of environments, including schools and playgrounds.

Alienation Perspective

The alienation approach to understanding EBDs emerged as a major perspective during the mid-20th century. Unlike both the disability and deviance points of views, this perspective emphasizes the positive aspects of human nature. People are seen as inherently healthy, motivated to fulfill or actualize their potential by living constructive lives and behaving in a socially responsible manner. To maintain a state of positive mental health, each person seeks to engage in meaningful activities in a society that welcomes individual creativity and provides opportunities for self-actualization.

EBDs develop when individuals are frustrated in their quest to fulfill their potential by a materialistic society that equates success in life with money and power, that denies opportunity to persons with different values who refuse to “play the game,” that frustrates creativity by straining human ideas through the sieve of mindless bureaucracy, and that is dominated by its own self-interest. As individuals become increasingly aware of these circumstances, they feel futile, lonely, and alienated from society as a whole and they rebel. Although their behavior may be atypical, in reality they are neither mentally disordered nor engaging in deviant behaviors because they have not learned any better. Their troubled feelings are an understandable response to a materialistic, mechanistic, inhumane society. The identification of these individuals as diseased (disability perspective) or deviant (deviance perspective) serves the purpose of the inhumane society and frequently involves minorities or women who are more likely to be denied opportunities for self-actualization. However, persons who accept the dominant social values are the individuals in grave emotional danger, despite the fact that they are not regarded by themselves or others as socially deviant or psychiatrically disordered.

The issue of whether or not specific behaviors are sufficient to characterize an individual as having an EBD is not germane from this perspective, nor is the question of specific etiology. Efforts to teach a person conforming behavior or to categorize their behaviors are ineffectual because they direct attention away from the societal barriers that hurt individuals. Effective interventions involve recognizing the uniqueness and dignity of every individual and acknowledging the value of their perceptions. Treatment is undertaken by professionals who adhere to a humanistic point of view. Extensive focus is on the environmental forces affecting an individual. Regarding the issue of cultural relativity, the problems affecting the individual transcend specific cultures because most dominant societies share basic inhumane values.

Summary

For the sake of clarity, the three general theoretical perspectives of emotional and behavioral disorders discussed in this chapter have been presented as unique, competing points of view. However, it is more accurate to say that each perspective answers a different question about the topic. The deviance point of view attempts to delineate *how* an individual becomes identified as emotionally disturbed. It depicts the labeling of rule breakers that operates in a particular society. The disability perspective attempts to explain *what types* of emotional disorders exist and *what causes them*. It provides culture-free criteria for the diagnosis of pathological conditions. The alienation perspective explores *why* individuals become emotionally disturbed. It is a global examination of cultural malaise.

Each perspective increases knowledge of emotional and behavioral disorders but also provides reasons for caution. In a positive vein, the deviance perspective emphasizes the arbitrary nature and negative implications of disability labeling. However, the implication that nonconforming behavior is maladaptive and that treatment involves teaching conforming behavior ignores the fact that many nonconformists (e.g., the Wright brothers, Thomas Edison, Albert Einstein) have been responsible for significant social and cultural advances.

Similarly, the disability perspective stresses the importance of a culture-free classification system necessary for the systematic scientific investigation of each disorder that could result in treatments that are more effective. However, most classification categories are descriptive rather than explanatory (e.g., a person is diagnosed as schizophrenic because of his or her behavior). The term *schizophrenia* does not explain what causes the behavior. Finally, the alienation point of view makes much of the inherent goodness of each individual but ignores the reality that some of these inherently good people are responsible for creating destructive societies.

Regardless of which philosophy appears appealing at this point, the stage is set to explore the implications of each position in greater detail. If one regards persons with emotional and behavioral disorders as inherently different from the nondisordered population, then one must determine whether the individual's problem is a biological phenomenon due to faulty genes, neural functioning, or biochemistry or whether the disorder was developed because of environmental stress that activated certain predispositions within the individual.

If one accepts the premise that environmental circumstances determine who will become emotionally and behaviorally disordered, then

one must decide whether those circumstances are viewed most accurately as a sequence of specific interactions between an individual and varied environmental agents or as a total or global phenomenon involving a multitude of sociological variables.



STUDY QUESTIONS

1. Discuss why the term *emotional and behavioral disorder* is difficult to define. Then define it in your own words and use the information in Chapter 1 to determine how each general perspective influenced your definition.
 2. Compare and contrast the disability, deviance, and alienation perspectives of emotional and behavioral disorders.
 3. A 10-year-old child in your class cries frequently, refuses to complete his assignments, and complains often of illness. From an alienation perspective, discuss how you might help the child.
 4. Consider the case of “Son of Sam,” the man from New York who shot and killed or injured several young women and their dates. He reported that God instructed him to kill. At his trial, he was judged sane and sentenced to life imprisonment. From the information in Chapter 1, what perspective influenced that decision?
 5. Choose the perspective in Chapter 1 that you find most plausible, and discuss the reasons for your choice.
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