WHAT IS AN EMOTIONAL OR BEHAVIORAL DISORDER?

Although childhood is generally regarded as a carefree time of life, many children and adolescents experience emotional difficulties growing up. Identifying an emotional or behavioral disorder is difficult for many reasons. For instance, it cannot be stated with certainty that something "goes wrong" in the brain, causing a child to act in a particular way. Contrary to early psychiatric theories, it is impossible to conclude that a mother or father did something wrong early in a child's life, causing an emotional or behavioral disorder. The question of who or what is responsible for a child's problems has given way to an understanding that the combinations of factors affecting development – biological, environmental, psychological- are almost limitless.

EBD is an overarching umbrella for many disorders. The following examples of emotional and behavioral disorders are not comprehensive, which is why it can be difficult to correctly diagnose a child with an EBD because the list is so extensive.

Adjustment Disorders- This describes emotional or behavioral symptoms that children may exhibit when they are unable, for a time, to appropriately adapt to stressful events or changes in their lives.

Anxiety Disorders- These disorders are a large family of exaggerated anxiety including but not limited to: school phobia, posttraumatic stress disorder, panic attacks, etc.

Obsessive-Compulsive Disorder- OCD occurs when a child has recurrent and persistent obsessions or compulsions that are time consuming or cause marked distress or significant impairment.

Post-Traumatic Stress Disorder- PTSD can develop following exposure to an extremely traumatic event or series of events in a child's life, or witnessing or learning about a death or injury to someone close to the child.

Selective Mutism- This occurs when a child or adolescent persistently fails to speak in specific social situations such as at school or with playmates, where speaking is expected.

Attention Deficit/ Hyperactivity Disorder- ADHD simply is where the child shows symptoms of inattention that are not consistent with their developmental level.

Oppositional Defiant Disorder- The central feature of oppositional defiant disorder is a recurrent pattern of negativistic, defiant, disobedient and hostile behaviors towards authority figures, lasting for at least six months.

Conduct Disorder- Has the essential feature of a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate social norms or rules are violated.

Anorexia Nervosa- This can be thought of as a distorted body image disorder, since many adolescents who have Anorexia see themselves as overweight and unattractive.

Bulimia Nervosa- Is characterized by episodes of binge and purge behaviors, where the person will eat enormous amounts of food, then induce vomiting, abuse laxatives, fast, or follow an austere diet to balance the effects of dramatic overeating.

Bipolar Disorder- Otherwise known as Manic Depressive has symptoms that include an alternating pattern of emotional highs and emotional lows or depression.

Major Depressive Disorder- Occurs when a child has a series of two or more major depressive episodes, with at least a two-month interval between them.

Autistic Disorder- This is a pervasive developmental disorder, characterized by the presence of markedly abnormal or impaired development in social interaction and communication, and a markedly restricted level of activities or interests.

Schizophrenia- Is a serious emotional disorder characterized by loss of contact with environment and personality changes. Hallucinations and delusions, disorganized speech, or catatonic behavior often exist as symptoms of this disorder, which frequently manifest in young adulthood.

Tourette's Disorder- The disorder includes both multiple motor tics and one or more vocal tics, which occur many times per day, nearly every day, or intermittently throughout a period of more than one year.

Seriously Emotionally Disturbed- SED is a label that public schools may use when children, due to their behaviors, are in need of special education services.

PSYCHOLOGY OF EMOTIONAL OR BEHAVIORAL DISORDERS:

Summary of Emotional Development[*] from Birth- 12 years of age.

Age	Emotional Expressions/Regulations	Emotional Understandings
0-6 months	• All primary emotions appear. • Attempts to regulate negative emotions by sucking or turning away are observed.	• Discriminates such facial expressions as happiness, anger, and sadness.
7-12 months	• Primary emotions such as anger, fear, and sadness become more apparent.	• Recognition of others' primary emotions improves.
1-3 years	• Secondary (self-conscious) emotions appear.	• Toddlers begin to talk about and play-act emotions.
3-6 years	• Some masking of emotions and compliance with simple display rules.	• Empathetic responding becomes more common.
6-12 years	• Compliance with display rules improves.	• Children integrate internal and external cues to understand others' emotions.

This chart is not a comprehensive model of the entire process of emotional development. For further information research child and developmental psychology, theories on emotional development. Other information to also consider is adolescent psychology texts which address similar topics for ages 13-21.

Another important model is the development of aggression. A pioneering study done by Florence Goodenough (1931)[**] asked parents to keep diaries in which they would record the details of their child's (ages 2-5 years of age) angry outbursts. Her study found that unfocused temper tantrums became less and less common between ages 2-3, because children began to physically retaliate (e.g. hitting or kicking) when playmates frustrated or attacked them. Between the ages of 3-5, physical aggression began to slowly decline, but was replaced by verbal aggression (e.g. name calling or teasing) usually brought on by toys and other possessions.

Furthering the study by Florence Goodenough, Willard Hartup (1974) found the 4-7 years olds also have hostile exchanges, still centered on toys; there are more aggressive outbursts with a goal to primarily invoke harm as an adversary. Boys particularly take this stance, as they perceive this behavior as normal.

Although, aggression is considered a normal attribute of behavior, extreme cases can alienate students to anti-social contact with their peers. Individuals with moody, ill-tempered, and aggressive behavior can be a fairly good predictor of future aggressiveness.

Shaffer defines two types of aggressors, *Proactive Aggressors:* highly aggressive children who find aggressive acts easy to perform and who rely heavily on aggression as a means of solving social problems or achieving other personal objectives. *Reactive Aggressors:* children who display high levels of hostile, retaliatory aggression because they over attribute hostile intents to others and can't control their angers long enough to seek nonaggressive solutions to social problems.

As individuals we are quick to point out the home situation as a place to blame, for one's behavior. Patterson (1982) found no explanation for "out of control" behavior by focusing solely on the home situation. Instead, a combination of an atypical family environment that was characterized by a social climate that *they had helped to create.* [***]

Further study recommended, Dodge's Social Information Processing Theory of Aggression.

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[*] Shaffer, David R. (1999). *Developmental psychology: Childhood and adolescence*. 5th ed. Detroit: Brooks/Cole Publishing Company.

[**] Goodenough, Florence (1931). *Anger in young children.* Minneapolis: University of Minnesota Press.

[***] Patterson, G.R. (1982). *Coercive family processes.* Eugene, OR: Castilla Press.

Overview of Chapter 4

It is very important for educators today to know about EBD, as most of the diagnosed students spend at least half their day in general education classrooms. The federal government's definition of "emotionally disturbed" students can help a teacher in referring a student to special education.

(i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance including:
   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 and teachers;
   c. Inappropriate types of behavior or feelings under normal circumstances;
   d. A general passive mood of unhappiness or depression; or
   e. A tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) The term includes children who are schizophrenic. The term does not include children who are socially maladjusted, unless it is determined that they are emotionally disturbed.

*From Individuals with Disabilities Education Act

- The rate of incidence in the classroom tends to be 3-6 percent of the student population, with less than 1% receiving special education. Within the diagnosed population, males outnumber females 8:1.
- Behaviors can either be internalized or externalized, characteristics include:
  - Conduct disorders and aggression (physical and emotional abuse towards others and objects, serious rule breaking)
  - Hyperactivity
  - Socialized aggression (routinely engaging in anti-social behavior)
  - Pervasive developmental disorder (expressing unusual, unbelievable ideas)
  - Immaturity (absent-minded, cannot finish tasks, poor concentration, daydreaming)
  - Depression
  - Anxiety-withdrawal (extreme worrying, accompanied by withdrawing from others)
- Not much is known about the causes of EBD, except that it stems from both environmental and genetic factors.
- Different types of treatment exist:
  - Stimulants include; Cyclert, Ritalin, Dexedrine, and Benzedrine
  - Antidepressants include; Elavil, Tofranil, and Prozac
  - Antipsychotics include; Haldol, Thorazine, Mellaril, Navane, and Stelazine
  - Lithium can also be used with mood disorders
- How can a student's behavior be identified as a case of EBD? It is a difficult task since there are many labels under the umbrella of being labeled EBD, but some clues can be found:
  - Social and behavioral problems are unusual for the age of the student
  - Abnormal occurrence of emotional symptoms; withdrawal, mood swings, depression, whining, etc.
  - Frequent display of several symptoms
  - Low self esteem, antisocial, often sad or lonely
  - Consistently harmful to others without remorse
  - Behavior continues even after many interventions
  - Lack of pride or self-satisfaction
- Although all of the above symptoms seem to occur within a child's life, it is the extreme cases that would justify needing help, and should be referred to specialized services.
- **What can be done in the classroom to help an EBD student?**
  - **Maintain an organized physical environment** (uncluttered, accessible materials, good lighting, low noise level, clean area, personal space for each student, posted schedule, rules posted)
  - **Establish positive relationships**, trust is very important to the EBD student
  - **Enforce desirable behaviors** (this can be aided with a behavior contract)
  - **Practice conflict resolution skills and promote self-control**
  - **Adapting instruction** by allowing each student to succeed at small tasks

Suggestions for promoting change usually involve small steps, such as timing positive interactions to see if the time of the incidence can increase each episode. Also, establishing personal goals by using note cards and keeping them visible for the student.

Interviews

I interviewed Jesse Denzer, an 11th grade student with Emotional Behavior Disorder (EBD), and also his teacher Barb Lieske, a high school Special Education teacher who works with Jesse and other students with EBD.

Here are a few questions and answers from the interview with Jesse.

Q: Do you feel different from other students?

A: Yeah, nobody else expresses their opinion. They just let the teacher scream and yell at them even when they know it is wrong. I will share every opinion with you. If you piss me off, I will tell you that you are pissing me off. I do not talk behind people's backs. I will straight up tell you to your face what I don't like about you.

Q: What suggestions would you give to teachers that would help you work better in a classroom setting?

A: If a kid has an attitude problem when they come into your class, the teacher should give an attitude to the student or else things will erupt. Also, always listen to the whole story, do not just judge on previous experiences. Also, if you really want me to work hard, there should be cigarette breaks, yeah, cigarette breaks.

Here are a few questions and answers from the interview with Barb.

Q: What is the most difficult aspect of working with students with EBD?

A: Constantly dealing with negativity. Also, the lack of positive attitudes day after day. It gets very straining.

Q: What is the most rewarding aspect of your job?

A: Developing personal relationships with the students. Also, when you see improvement, learning, and growing is very rewarding. Also, anytime something goes well in the classroom.

Q: What teaching strategies do you find work well with students with EBD?

A: Direct instruction. One-on-one. The students do not do well with independent activities. You also need to change your teaching instruction so it is not always the same. You can't fall into the same routine everyday. The students need change.

Quick Reference for EBD

Emily Dressen
Heidi Hennen
Rob Jeppson
Patrick Lambertz
Lisa Simonet

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