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.

Children's behaviors exist on a continuum, and there is no specific line that separates troubling behavior from a serious emotional problem. Rather, a problem can range from mild to serious. A child is said to have a specific "diagnosis" or "disorder" when his or her behaviors occur frequently and are severe. A diagnosis represents a "best guess" based on a child's behaviors that he or she has a specific mental health disorder and not just a problem that all children might have from time to time. Research on the cause of emotional disorders has shown that the way the brain receives and processes information is different for children with some types of disorders than for those who do not have those problems. However, this is not true for all children with emotional disorders.

There have been many recent advances in understanding the emotional problems of children and adolescents. As technologies are developed to study the central nervous system and the relationships between brain chemistry and behavior, the research is providing new understanding of how and why some children develop emotional disorders. Still interviews with the child, parents or other family members remain one of the most important sources of information to help professionals arrive at a diagnosis.

A diagnosis of a mental health disorder will be based on one of several classification systems used in the United States. The most familiar system is the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. The DSM-IV contains descriptions of specific behavioral characteristics that are used to determine whether a child or adult has an emotional or mental disorder. The criteria that establishes the presence of a mental health disorder are subject to interpretation that may vary from professional to professional. Cultural and subjective criteria such as race, socioeconomic status, or the behaviors of the child's parents at the time of evaluation have an effect on professional opinion, as does the training of the professional and his or her years of experience.

A DSM-IV diagnosis serves several purposes. First, it may establish the presence of a specific mental health problem which has an accepted treatment standard, such as the use of medication in treating depression. Second, a formal diagnosis may be required for insurance or Medicaid reimbursement. A diagnosis for a child may mean that insurance may cover the costs of services the child needs but would not be eligible for without the diagnosis.

Parents should bring up issues they believe may influence their child's diagnosis during the evaluation. These influences must be considered by the evaluator in making a diagnosis. Generally, determining whether a child has a biologically based mental illness, a behavioral problem or an emotional disorder is not as important to a family as determining what interventions are the most useful to help support their child. What an evaluation should yield,

regardless of whether a child's problems result in a diagnosed disorder or something less definitive, is a set of recommendations for how to support him or her in developing necessary skills.

The question about whether a child needs help should not depend on whether he or she has a diagnosis. A problem does not disappear simply because it is not severe enough to meet the criteria for a diagnosis. Parents should insist on a list of specific written recommendations for how to help their child as a result of any evaluation.

The DSM IV, for instance, lists eighteen separate characteristics of behavior attributed to attention deficit hyperactivity disorder (ADHD). If a child shows six signs of inattention or six signs of hyperactivity and impulsivity, he or she may be given a clinical diagnosis of ADHD. This means that the mental health professional working with the child believes that the child has a medically-based problem and may recommend a specific therapy, such as medication. But the characteristics by which ADHD is diagnosed are also open to interpretation. What does it mean to say that a child is "often distracted by extraneous stimuli?" How often is often? What does *distracted* by mean? And what happens to the child who shows only five signs of inattention and therefore does not have ADHD, but is still failing in school and is unable to stay focused on his or her work?

Different professionals view emotional and behavioral disorders in different ways. Their outlook—and their treatment plan—is usually shaped by their training, their experience, and their philosophy about the origins of a child's problems. Though the philosophical orientation or direction may not seem important to parents who are frantically seeking a way to locate help for their child, it is still recommended that parents discuss such beliefs with professionals they contact. Since the treatment program for a child will stem from the professional's philosophy, parents should be sure they agree with "where the professional is coming from," as well as with the methods used by the professional to help their child. Otherwise, their cooperation in the treatment process may be compromised. When seeking a treatment program for a child, parents may also want to seek a second opinion if they disagree with the approach suggested by the first mental health professional.

The following examples of emotional and behavioral disorders are from the DSM-IV diagnostic criteria. This list is not comprehensive, but is included to give parents examples of emotional disorders affecting children and youth.

Adjustment Disorders describe 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. The symptoms, which must occur within three months of a stressful event or change, and last no more than six months after the stressor ends, are: marked distress, in excess of what would be expected from exposure to the event(s), or an impairment in social or school functioning. There are many kinds of behaviors associated with different types of adjustment disorders, ranging from fear or anxiety to truancy, vandalism, or fighting. Adjustment disorders are relatively common, ranging from 5% to 20%.

Anxiety Disorders are a large family of disorders (school phobia, posttraumatic stress disorder, avoidant disorder, obsessive-compulsive disorder, panic disorder, panic attack, etc.) where the main feature is exaggerated anxiety. Anxiety disorders may be expressed as physical symptoms, (headaches or stomach aches), as disorders in conduct (work refusal, etc.) or as inappropriate emotional responses, such as giggling or crying. Anxiety occurs in all children as a temporary reaction to stressful experiences at home or in school. When anxiety is intense and persistent, interfering with the child's functioning, it may become deemed as an Anxiety Disorder.

Obsessive-Compulsive Disorder (OCD) which occurs at a rate of 2.5% means a child has recurrent and persistent obsessions or compulsions that are time consuming or cause marked distress or significant impairment. Obsessions are persistent thoughts, impulses, or images that are intrusive and inappropriate (repeated doubts, requirements to have things in a specific order, aggressive impulses, etc.). **Compulsions** are repeated behaviors or mental acts (hand washing, checking, praying, counting, repeating words silently, etc.) that have the intent of reducing stress or anxiety. Many children with OCD may know that their behaviors are extreme or unnecessary, but are so driven to complete their routines that they are unable to stop.

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. The symptoms must occur within one month after exposure to the stressful event. Responses in children include intense fear, helplessness, difficulty falling asleep, nightmares, persistent re-experiencing of the event, numbing of general responsiveness, or increased arousal. Young children with PTSD may repeat their experience in daily play activities, or may lose recently acquired skills, such as toilet training or expressive language skills.

Selective Mutism (formerly called Elective-Mutism) 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. Selective mutism interferes with a child's educational achievement and social communication. Onset of Selective Mutism usually occurs before the age of five, but may not be evaluated until a child enters school for the first time. The disorder is regarded as relatively rare, and usually lasts for a period of a few months, although a few children have been known not to speak in school during their entire school career.

Attention Deficit / Hyperactivity Disorder is a condition; affecting 3%-5% of children, where the child shows symptoms of inattention that are not consistent with his or her developmental level. The essential feature of Attention Deficit Hyperactivity Disorder is "a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development." A few doctors have written articles on ADHD in early childhood, and some suggest that signs of the disorder can be detected in infancy. Most physicians prefer to wait until a clear pattern of inattentive behaviors emerge that affect school or home performance before attempting to diagnose ADHD. Medications, such as Ritalin or Dexedrine, or a combination of these and other medicines have been very successful in treating ADHD.

Oppositional Defiant Disorder. The central feature of oppositional defiant disorder (ODD), which occurs at rates of 2 to 16%, is "a recurrent pattern of negativistic, defiant, disobedient and hostile behaviors towards authority figures, lasting for at least six months…" The disruptive behaviors of a child or adolescent with ODD are of a less severe nature than those with Conduct Disorder, and typically do not include aggression toward people or animals, destruction of property, or a pattern of theft or deceit. Typical behaviors include arguing with adults, defying or refusing to follow adult directions, deliberately annoying people, blaming others, or being spiteful or vindictive.

Conduct Disorder, which affects between 6% and 16% of boys and 2% to 9% of girls, has as the essential feature "a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate social norms or rules are violated." Children with Conduct Disorder often have a pattern of staying out late despite parental objections, running away from home, or being truant from school. Children with Conduct Disorder may bully or

threaten others or may be physically cruel to animal and people. Conduct Disorder is often associated with an early onset of sexual behavior, drinking, smoking, and reckless and risk-taking acts.

Anorexia Nervosa can be thought of as a "distorted body image" disorder, since many adolescents who have Anorexia see themselves as overweight and unattractive. In Anorexia Nervosa, the individual refuses to maintain a minimally normal body weight, is intensely afraid of gaining weight, and has no realistic idea of the shape and size of his or her body. Signs of anorexia nervosa include extremely low body weight, dry skin, hair loss, depressive symptoms, constipation, low blood pressure, and bizarre behaviors, such as hiding food or binge eating.

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. Essential features are binge eating and compensatory methods to prevent weight gain. Bulimia Nervosa symptoms include the loss of menstruation, fatigue or muscle weakness, gastrointestinal problems or intolerance of cold weather. Depressive symptoms may follow a binge and purge episode.

Bipolar Disorder (Manic Depressive Disorder) has symptoms that include an alternating pattern of emotional highs and emotional lows or depression. The essential feature of Bipolar 1 Disorder is "a clinical course that is characterized by the occurrence of one or more Manic Episodes (a distinct period during which there is an abnormally and persistently elevated, expansive or irritable mood), or Mixed Episodes (a period of time lasting at least one week in which the criteria are met both for a Manic Episode and a Depressive Episode nearly every day)." There are six different types of Bipolar 1 Disorder, reflecting variations in manic and depressive symptoms.

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. Depression may be manifested in continuing irritability or inability to get along with others, and not just in the depressed affect. In **Dysthymic Disorder**, the depressed mood must be present for more days than not over a period of at least two years. Dysthymic Disorder and Major Depressive Disorder are differentiated based on severity, chronicity, and persistence. Usually, Major Depressive Disorder can be distinguished from the person's usual functioning, whereas Dysthymic Disorder is characterized by chronic, less severe depressive symptoms that have been present for many years.

Autistic Disorder 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. Children with Autism may fail to develop relationships with peers of the same age, and may have no interest in establishing friendships. The impairment in communication (both verbal and nonverbal) is severe for some children with this disorder.

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 is frequently manifest in young adulthood. The symptoms may also occur in younger children. There are a number of subtypes of schizophrenia, including Paranoid Type, Disorganized Type, Catatonic Type, Residual Type, and Undifferentiated Type. The lifetime prevalence of Schizophrenia is estimated at between 0.5% and 1%.

Tourette's Disorder occurs in approximately 4-5 individuals per 10,000. 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. During this period, there is never a tic-free period of more than 3 consecutive months. Chronic Motor or Vocal Tic Disorder includes either motor ties or vocal tics, but not both as in Tourette's Disorder. Transient Tic Disorder includes either single or multiple motor tics many times a day for at least four weeks, but for no longer than 12 months. This can occur as either a single episode or as recurrent episodes over time.

Seriously Emotionally Disturbed, or SED, is not a DSM-IV medical diagnosis, but a label that public schools may use when children, due to their behaviors, are in need of special education services. School professionals may or may not use diagnostic classification systems as part of this determination. The school's responsibility is to provide services for students with emotional or behavioral disorders or mental illnesses under the special education category of SED (many states have chosen to use a "different" label such as Emotional or Behavioral Disorder (EBD), to describe this special education service category), when their emotional or behavioral problems are so severe that they cannot succeed without help.

Functional Behavioral Assessment and Positive Interventions: What Parents Need to Know

Many children have inappropriate behaviors that are part of their disability. These behaviors may make it difficult to learn, cause harm to the child or others, or isolate a child from his or her peers. Some children have behaviors that they can't control, such as tics for a child with Tourette syndrome or self-harming behaviors for some children with developmental disabilities. Some children may be sad or anxious. Others simply have not learned positive ways to have their needs met. In any of these instances, the behaviors interfere with the children's ability to learn the skills they need to be successful.

We *can* teach appropriate behavior skills to children! To do so, we need to understand problem behaviors, such as where they occur and what purpose they serve for a child. The process of learning about how children develop problem behaviors is called *functional behavioral assessment (FBA).* If we learn about the behaviors and know when and where they are likely to happen, we can plan positive strategies to teach new behaviors. These strategies are called *positive behavioral interventions*. Teachers and parents will use the information from an FBA to help a child learn new skills. The goal is to teach children how to manage their own behaviors.

This overview will help parents understand functional behavioral assessment and positive interventions. You have a very important role in this assessment, because you have information about your child that no one else has. When you understand the process, you can work effectively with the rest of the team. You will have the tools to make decisions when functional behavioral assessment is proposed for your child. What you know about your child will be used to help develop effective instruction.

Thinking about behavior

Adults often have two different approaches to dealing with problem behaviors. These different approaches are based on different beliefs. One belief is that the child *is a problem*, and the other is that the child *has a problem*.

The child is a problem

Billy is a 12-year-old sixth-grade student. He refuses to do his schoolwork, and then his teacher does not know what to do. He becomes angry when the teacher reminds him to get to work. He screams, swears, and even throws his work on the floor so the teacher will leave him alone. The teacher may think Billy is lazy, mean, or disrespectful. The teacher may feel angry or threatened. Adults who are angry often use punishment or threats: "Do it or else." We do not always realize that children do not think about their problem behaviors the way we do.

When we punish often, children may see us as un-caring. Some may come to fear or avoid us. Others may become even louder and angrier because of the punishment. Children who do not back down when arguing with adults often receive increasingly harsh punishments. Many adults think children should not be permitted to win disagreements. Children, on the other hand, often say things they do not really mean because they are angry. They may refuse to give up even if they lose privileges or are suspended from school.

When a child is suspended from school for problem behaviors, some people think of it as "good medicine for bad behavior." They think the removal teaches the child a lesson and that the child will change the problem behaviors as a result.

But what if that child does not like going to school? He or she may learn that using problem behaviors is a good way to earn a vacation from school. The child may actually want what we think is a punishment.

The child has a problem

Billy, the 12-year-old described earlier, has behaviors that need to change. Let's assume we have assessment data that give a clearer picture of Billy. We find that he reads at a second-grade level. He was sexually abused at age three by a neighbor. Billy is angry over his parents' recent divorce and continuing custody battle. He is worried about where he will live.

Clearly Billy's problem behaviors must change. They are serious and interfere with learning. What we decide to do about the behavior, however, comes from how we feel about it and whether we believe it is willful. That is where functional behavioral assessment comes in. It can help us to identify *why* Billy is frustrated and angry, so we can help him to learn the skills he needs. A reasonable person would have a hard time believing that punishment alone could help Billy succeed.

Positive Behavioral Interventions

Positive: characterized by or displaying approval, acceptance, or affirmation.
Behavior: what we do.
Intervention: an action that changes a course of events.
(Adapted from *Merriam Webster's Tenth Collegiate Dictionary.*)

The 1997 Individuals with Disabilities Education Act (IDEA) regulations state:

The IEP team shall, in the case of a child whose behavior impedes his or her learning or that of others, consider, where appropriate, strategies, including positive behavioral interventions, strategies, and supports that address that behavior.
IDEA 300.346(2)(i)

Positive behavioral interventions are used *before* problem behaviors occur. To develop positive interventions, the team must understand why a child has problem behaviors and what strategies might be helpful. Many different strategies can be used to reduce problem behaviors in school: changing where a child sits in the classroom, adjusting the schoolwork, rewarding the child for positive behaviors. The child's teacher may speak in a different tone of voice to help the child remain calm. Adults may try to keep calm when the child is angry. The goal is to stop or reduce the problem behaviors so that punishment does not become necessary.

Here is an example: The teacher knows that Mary is more likely to argue with the teacher when she sits next to Mark. If the teacher thinks Mary argues because she wants Mark to notice her, there are several things the teacher can do. She can separate Mary and Mark so that Mary does not try so hard to get his attention. She can also teach Mary more positive ways to gain Mark's attention and provide positive reinforcement for using the new behaviors.

Behaviors are governed by their consequences

John has a fight (behavior) and is suspended from school (consequence). If John loves school and can control the behavior, the consequence is negative because he has to give up something he wants (school). If John dislikes school, however, he may see that same consequence as positive. He may learn that fighting is a good way to be sent home. The next time John does not want to be in school, what behavior is he likely to use?

Many of us have learned to deal with problem behaviors by doing nothing until they occur. After a child uses the behaviors, we punish. Punishment does not teach new skills, though. Its goal is to stop problem behaviors from continuing. If we do not teach a child what to do instead, the child will probably continue to misbehave. Any time a child uses a behavior that is successful in meeting a need, the behavior is likely to be repeated. The behavior serves a *function* for the child.

Most people agree that we need to have consequences for problem behaviors. We must also focus on teaching the positive behavior skills we would like to see. If we can understand the function of problem behaviors, we can teach a child more positive behaviors that serve the same function, and the problem behaviors are no longer needed.

What is functional behavioral assessment?

Functional behavioral assessment (FBA) is a process for collecting information. The data the team collects are used to help determine why problem behaviors occur. The data will also help identify ways to address the behaviors. Functional behavioral assessment data are used to develop a positive behavioral intervention plan. The Individuals with Disabilities Education Act specifically requires an FBA whenever a child with a disability has his or her current placement changed for disciplinary reasons. This does not mean that we should not think about FBA at other times, too.

The evaluation requirements of IDEA make it clear that children must be evaluated in "all areas related to the suspected disability." This means that if your child has problem behaviors that are not improving, your child may need an evaluation to examine the behaviors more closely. You may request an FBA at any time if your child's problem behaviors are becoming worse, or when the team cannot explain to you why the problem behaviors occur.

There are many reasons a child might misbehave. Some have to do with the nature of the child, such as allergies to dust, foods, or plants. A sinus infection, headache, or toothache can also lead to problem behaviors. Some children have a medical diagnosis, such as bipolar disorder or attention-deficit/hyper-activity disorder that affects behavior. The team's responsibility is to collect data to help it understand why a child has problem behaviors.

The people who complete the functional behavioral assessment use different ways to collect data. School staff may interview you and your child. They observe your child in different settings, such as the lunchroom or classroom, or on the playground. They gather reports from teachers and others. The team reviews your child's records, including any assessments you would like to share.

The results of this process should lead to a *hypothesis* about why problem behaviors occur. A hypothesis is an educated guess, based on the data the team has gathered. Assessment results are used to develop a positive behavior intervention plan.

Behaviors are context-related

Most behaviors are related to their context. This means that behaviors often result from what is happening in the child's world or environment. These are just a few of the factors that may lead to problem behaviors:

- a disagreement between children
- the number of children in a classroom
- the quality of peer relationships
- the size of the classroom
- medicine changes
- the difficulty of schoolwork

Other things, such as who is present and what their expectations are, also affect behaviors. Behaviors may also be a problem when a child is emotionally upset and cannot handle the demands of the environment.

Behaviors serve a function

Problem behaviors usually serve a function, or purpose, for the child. Sometimes we see problem behaviors when a substitute teacher is in the classroom. In this case, we must be careful not to assume that the child doesn't like the teacher or that the child wants to show off for friends. Perhaps the child likes his or her regular teacher and is upset when she is not there. Or the child may be anxious about what to expect with a new teacher. A child who is upset about having a new teacher may use problem behaviors in order to be placed in a less stressful setting. Some children would rather be in a time-out space than in their classroom.

Unfortunately, consequences that improve the behaviors of most students do not work with all. Sending a child to the principal's office, for example, can be ineffective if the consequence does not address the complex function of a child's behavior.

What a child does (the behavior) and *why* a child does it (the function) may be unrelated. Skipping school and getting good grades are two very different behaviors. Yet they may serve the same function for different children—gaining adult attention. Two children may both want to be noticed by their parents; one may study hard to have good grades while the other skips class. They do very different things to get the attention they want. While the function of both behaviors is positive (parent attention), skipping class is not an acceptable way to be noticed.

Behaviors are influenced by events in the environment (antecedents)

What happens in an environment affects behavior. The size of a classroom, the number of students, transitions, or early morning bus incidents are all antecedents that might affect a child's behavior.

It is important to know what leads to both positive and negative behaviors. If teachers and parents understand the conditions that lead to problem behaviors, then changing the conditions may reduce the need for the behaviors. Positive teaching strategies such as providing structure, routine, and rewards for appropriate behaviors help to increase positive behavior skills.

Steps in conducting a functional behavioral assessment

The Individuals with Disabilities Education Act does not define how a functional behavioral assessment is done. The process may vary with the needs of each child. However, several specific steps are always part of this kind of assessment. The process begins with identifying the specific behaviors that must change.

If a child has many problem behaviors, it will be important to focus on the most serious one or two behaviors. The problem behaviors are described in a way that helps everyone to understand exactly what the behaviors are. These are typical steps:

1. ***Identify and agree on the behavior(s)*** that most need to change.
2. ***Determine where the behaviors occur and where they do not.*** Identify what may contribute to the behaviors. The team will ask these kinds of questions:
    - What is unique about the environments where behaviors are not a concern?
    - What is different in the places where the problem behaviors do occur? Could they be related to how the child and teacher get along? Does the number of other students or the work a child is asked to do cause the problem? Could the time of day or a child's mood affect the behaviors? Was there a bus problem or a disagreement in the hallway?
    - Are the behaviors likely to occur in a specific set of circumstances or a specific setting? What events seem to support the problem behaviors?
3. ***Collect data*** on the child's performance from as many sources as possible.
4. ***Develop a hypothesis*** about why problem behaviors occur (the function of the behaviors). A hypothesis is an educated guess, based on data. It helps predict where and why problem behaviors are most likely to occur, and where and why they are least likely to occur.
5. ***Identify other behaviors that can be taught*** that will serve the same function for the child.
6. ***Test the hypothesis.*** The team develops and uses positive behavioral interventions that are written into the child's IEP or behavior intervention plan.
7. ***Evaluate the success of the interventions***. Change or fine-tune as needed.

If children have behaviors that place them or others in danger, they may need a crisis intervention plan. Crisis interventions should be developed before they are needed. The team should decide what behaviors are crises and what they (and the child) will do in a crisis. By having a plan that guides actions, teachers can help children through difficult emotional situations.

Behavior intervention plan

An effective behavior intervention plan (often called a behavior support plan or positive intervention plan) is used to teach or reinforce positive behaviors. Typically, a child's team develops the plan. It usually includes:

- skills training to increase appropriate behavior
- changes that will be made in classrooms or other environments to reduce or eliminate problem behaviors
- strategies to replace problem behaviors with appropriate behaviors that serve the same function for the child
- supports for the child to use the appropriate behaviors

A positive behavior intervention plan is *not* a plan to determine what happens to a student who violates a rule or code of conduct. That would be more appropriately called a discipline plan or a punishment plan.

School discipline policies

The IEP team determines whether the school discipline policies need to be amended for a child, or whether the consequences need to be different from those written into the policy. This decision should be based on evaluation and a review of the records, including the discipline records or any manifestation determination review(s) that have been completed by the school. A child's IEP or behavior intervention plan should focus on teaching skills.

Sometimes school discipline policies are not successful in correcting problem behaviors. That is, the child does not learn what the school staff intended through the use of punishments such as suspension. The child may learn instead that problem behaviors are useful in meeting a need, such as being noticed by peers. When this is true, it is difficult to defend punishment, by itself, as effective in changing problem behaviors.

One of the most useful questions parents can ask when they have concerns about the discipline recommendations for their child is "Where are the data that support the recommendations?" Special education decisions are based on data. If school staff wants to use a specific discipline procedure, they should check for data that support the use of the procedure. For instance, if your child has been repeatedly suspended from school for a problem behavior, has suspension taught your child the skills he or she needs to learn?

Zero-tolerance policies

Many school districts have zero-tolerance policies that provide immediate negative consequences for specific behaviors. Such policies simply do not provide effective consequences for all children who violate them. If a child with a disability violates a zero-tolerance policy, the consequence may or may not be effective, given that child's needs. Consequences for problem behaviors must not discriminate against a child based on his or her disability. The IEP team is responsible for determining whether exceptions need to be made to the written school district discipline policy for a student, or whether the student needs a different consequence for misbehaviors than is written into the school discipline policies. Instructional goals may need to be written into the IEP to help remediate the problems a child is having in following school discipline policies.

While some administrators may not want to make exceptions to schoolwide discipline policies established for all students, exceptions are sometimes necessary. Some students who are unable to conform their behavior to the school expectations may need to have individualized consequences that will be more effective in supporting positive behaviors.

In the U.S. legal system, the consequences for breaking a law are generally based on an evaluation of the events around the violation. Yet schools often have one discipline standard for all students regardless of individual needs. They may use the same consequences for all students. Parents must carefully examine school policies to help determine whether modifications need to be made to meet the needs of their child.

Examples of behavioral intervention strategies

Schools use the following common strategies to help reduce problem behaviors and teach children positive behavioral skills.

Stop, Relax, and Think teaches children how to think about the problem they are having and find a solution. Children learn the steps:

1. Define the problem.
2. Decide who "owns" the problem.
3. Think of as many solutions as possible to solve the problem.
4. Select a solution to try.
5. Use the solution.
6. Evaluate its success.

After children understand the steps, role-play and practice can help the process become habit. Helping children to recognize their own response to stress (clenched hands, voice tone, etc.) may become part of the instruction needed to use this strategy effectively.

Planned ignoring is useful in stopping behaviors that are annoying. For example, it is useful for students who yell or interrupt the class to attract the teacher's attention or that of students who are not prepared for class. Planned ignoring acknowledges that children's problem behaviors serve a function. If the purpose of a problem behavior is to gain adult attention, then not providing attention means that the behavior does not work. The behavior lessens over time and eventually disappears. Ignoring nonserious behavior is especially useful for parents when their child is having a tantrum for attention. Many adults find it difficult to ignore behaviors, however, especially if the behaviors interrupt what the adult is doing. Also, attention-seeking behaviors often get worse before they eventually go away. Planned ignoring is not suitable for behaviors that are extremely disruptive. It also may not work if other children laugh at the problem behaviors the adult is trying to ignore. Some behaviors, including those that are unsafe or that include peer issues such as arguing, can grow quickly into more serious behaviors. It may not be possible to ignore these kinds of behaviors. Planned ignoring should *never* be used for unsafe behaviors. As children grow older and want attention more from their friends than from adults, planned ignoring is less useful.

Preventive cueing (also called signal interference) lets a child know when he or she is doing something that is not acceptable. Teachers or parents can frown, shake their head, make eye contact, point to a seat for a wandering child, or snap their fingers, to let the child know he or she needs to pay attention or to stop the problem behaviors. When using preventive cueing it is important not to smile or look pleased with a child. Preventive cueing may be used in steps, depending on the behaviors and how often they occur or how serious they are. For instance, a hand motion may work the first time or two, but it may need to be combined with eye contact or a shake of the head for the next offense.

Proximity control means that a teacher or adult moves closer to the child in a gentle way. If the teacher does not get the child's attention by using cues, then he or she may move closer to the student or give the lesson while standing near the child's desk.

Touch control, meaning touch that is not resisted, is a nonverbal guided intervention. It is used to direct a student toward positive behavior. For example, a teacher may gently place a hand on a child's shoulder to steer the child back to his or her desk. Touch control should never be used with children who react angrily or when school policy does not permit its use. If a child's records show that he or she has a history of violence, has been abused or maltreated, is anxious, or has a mental illness or psychosis, touch control should not be used, unless specifically agreed to by a physician or psychologist.

Humor directed either at the teacher or the situation—*never* at the child—can defuse tensions as well as redirect children. Humor must *never* be used to demean a child or be used in a manner that might encourage others in the class to ridicule the child.

Nonverbal warnings give a child the opportunity to regain control without being singled out for a verbal reprimand. For example, a teacher might place a colored warning cue card or a note on a desk as he or she moves through the room, or hold up the number of fingers that corresponds to the rule being challenged.

Discipline privately. Many children see it as a challenge when teachers attempt to discipline them in front of their peers. Children rarely lose these challenges, even when adults use negative consequences. Young people can gain stature from peers by publicly refusing to obey a teacher. A child is more likely to accept discipline if his or her peers are not watching the process.

Positive phrasing lets children know the positive results for using appropriate behaviors. As simple as it sounds, this can be difficult. Teachers and parents are used to focusing on misbehavior. Warning children about a negative response to problem behaviors often seems easier than describing the positive impact of positive behaviors. Compare the difference between positive phrasing and negative phrasing:

> *Positive phrasing:* "If you finish your reading by recess, we can all go outside together and play a game."
>
> *Negative phrasing:* "If you do not finish your reading by recess, you will have to stay inside until it's done."

Positive phrasing helps children learn that positive behaviors lead to positive outcomes. This, in turn, can help them gain control of their behaviors.

I-messages, described by Thomas Gordon in his 1974 book *Teacher Effectiveness Training,* helps children learn about how their problem behaviors affect others. It also demonstrates the importance of taking responsibility for one's own behavior. For example, parents or teachers will use language like "I'm upset when . . ." not "You are bad when . . ." When a child has a good relationship with parents and teachers, I-messages can help him or her to understand how the problem behaviors affect adults. If the child dislikes the teacher, though, using I-statements can be a problem. It may even help the child to more effectively annoy the teacher.

Behavior shaping acknowledges that not all children can do everything at 100 percent. If a child does not turn in papers daily, expecting that papers will be turned in 100 percent of the time is not realistic. By rewarding small gains and reinforcing the gains as they occur, children learn how to stick with a task and to improve the skill.

Clear routines and expectations let children know what comes next in their school day, reducing anxiety or fear. Teachers who post and review the rules daily establish expectations for behavior during the day.

For additional information on positive behavioral interventions and functional behavioral assessment as well as related topics, contact the following:

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What Parents Need to Know About Teens with Disabilities and their Rights to Transition Services While Incarcerated

When compared to the rest of the population, youth with emotional, behavioral, learning and developmental disabilities are overrepresented in the juvenile and the adult corrections system. Between 25% to 75% of all young offenders are known to have at least one disability. Many others are never identified or are misdiagnosed, and, as a result, do not receive the remediation and services that could help them. The most common disabilities identified in this population include attention deficit hyperactivity disorder, depression, learning disabilities, developmental disabilities, and conduct disorder. Often, youth have more than one disability. If they are undiagnosed, and inadequately treated the disabilities can be a continuing source of frustration and anger that perpetuate a cycle of failure and delinquency.

Teens with disabilities in the delinquency system?

Many youth have contact with the juvenile justice system by the time they reach transition age. Youth who have entered the system at young age are more likely to continue to engage in delinquency. Youth with disabilities are more often suspended, expelled, or referred to court for disability related behaviors. Delinquency is associated with poor academic skills and school dropout. Youth ages 14-18 show a marked increase in school dropout rates. Often they drop out of school because of frustration with their school experiences.

Behaviors including poorly developed social skills, impulsive behaviors, risk taking behavior susceptibility to negative peer pressure, and greater difficulty learning in school are common to many young offenders.

African American youth are overrepresented in special education programs in the public schools and in the delinquency system. They are incarcerated at five times the rate for white youth, and they are less likely to have an attorney representing them in juvenile court proceedings.

Transition services that should be provided in the juvenile justice system

Youth with disabilities ages 14-21 are eligible for transition (post high school) services under the Individuals with Disabilities Education Act (IDEA). They have the right to a free, appropriate public education (FAPE) including special education and related services, wherever they live or attend school. This includes juvenile correctional placements and with certain exceptions, adult correctional facilities.

If your son or daughter has never been identified as having a disability, but is experiencing frustration in school, is truant, or has other difficulties, you can ask in writing for an evaluation. The correctional facility is obligated to consider your request and to determine if your child has special needs.

It is important that your child's educational records including the Individual Education Program (IEP) or section 504 (of the Rehabilitation Act of 1973) plans be forwarded to the correctional facility other rights to be aware of:

- Parent involvement remains a basic principle of the IDEA, even if the youth is incarcerated.
- Until age 18 parents/guardians of incarcerated youth should be involved in the development of their child's Individualized Education Program (IEP).
- After age 18 parents or guardians can remain involved with the permission from the young adult.

- When parents or guardians are not able to attend IEP meetings in a correctional facility, they can participate through telephone conferencing. When parents or guardians are not available to participate in the IEP process, surrogate parents can be appointed.

- The surrogate parent cannot be an employee of any agency that might have a conflict of interest with the provision of special education services. (probation officer, special ed teacher).

- If a youth has dropped out or changed school districts repeatedly, a new IEP or 504 plan must be developed to replace outdated programs.

- When a youth is transferred to a correctional facility, an IEP or 504 plan that identifies the transition services he or she needs in the correctional facility must be developed.

- Licensed personnel including special education teachers, psychologists, social workers or mental health professionals, should provide transition (post high school) services.

- Services in a transition plan can include academic programs, vocational or technical training, life skills programs, substance abuse and mental health treatment.

- Whenever possible, it is preferable that the IEP meeting include representation from the student's home school district. If a representative of the home district cannot come to the IEP meeting, the district can provide input by phone, mail, or fax.

- If a youth in a correctional facility is not receiving appropriate transition service she or she has have the same rights under the IDEA to mediation and due process that are afforded to families whose youth attend school in the community.

Services that should be provided after a youth leaves a correctional facility

When a youth leaves a correctional facility, he or she will need an aftercare plan. Ideally, planning for release back into the community should begin when a child enters the facility. An aftercare plan for a transition aged youth should include strategies to stay out of trouble, academic goals, incentives for school attendance, vocational and job skills training, mentors, ongoing mental health services, substance abuse classes, and meetings with a probation officer. The aftercare plan should be similar to and may be coordinated with the Transition Plan.

Youth with disabilities sent to adult correctional facilities are entitled to services

Most youth with disabilities under the age of 22 and incarcerated in adult correctional facilities are entitled to special services under the IDEA if hey were identified as eligible and were already receiving transition services through an IEP *prior to* their incarceration. Youth with disabilities in adult correctional facilities may also be entitled to services under the Americans with Disabilities Act (ADA) or 504. Parents should:

- It is easy to be intimidated by the corrections but parents continue to have the right to be involved with their child's education.
- Contact the staff in the correctional facility to let them know that your child is entitled to special education and related services.

For more information:

- The National Center on Education, Disability, and Juvenile Justice is a collaborative research, training, technical assistance and dissemination program designed to develop more effective responses to the needs of youth with disabilities in the juvenile justice system or those at-risk for involvement with the juvenile justice system. Visit www.edjj.org or Contact the Juvenile Justice project of the PACER Center, www.pacer.org, or 1-800-537-2237.

JUVENILE JUSTICE AND YOUTH WITH DISABILITIES SCENARIOS

1. ***Monica is an 18-year-old Native American student whose constant truancy has forced her to drop out of a regular educational setting. She is new to your program and comes with a history of substance abuse, but has no documentation of a disability. You notice that Monica is moody and unfocused in school and often has trouble completing tasks. Monica has a part-time job, but her employer is growing tired of her angry outbursts when given direction. You are concerned that Monica will lose her job, leave your program, and begin using drugs again.***

   Q: 1) What are some possible reasons for Monica's behaviors at school and on the job?

   2) How could you use school, family, or community resources to secure appropriate services for Monica?

   3) What could you do to help Monica be more successful on the job?

2. ***Cho is a 16-year-old Hmong student who has been in this country for 5 years. He appears to be adapting to the American culture, though his parents continue to live according to their country's traditions. Cho has been in your program for about a year and has a history of extreme mood changes, sleeplessness, physical complaints and has attempted to run away from home on several occasions. Cho has a diagnosis of ADD, but your school psychologist suspects bi-polar, and wants Cho reassessed. Cho's parents are not willing to give their permission to have him retested. It is your task to find Cho employment but you are worried that his behaviors will hamper his success.***

   Q: 1) How could you work with Cho's family to make sure your concerns are addressed?

   2) Given the input from the school psychologist, would you change programming strategies for Cho?

   3) How could you work with Cho to help him understand his own disability?

3. ***Jeff is a 17-year-old who was diagnosed with ADHD at the age of 8. A few yeas ago he stopped taking the medication that was helping him manage his disability because he didn't like "being different." Repeated truancy and curfew violations landed Jeff in a small court-ordered correctional treatment program. Jeff's program has lasted longer than expected due to the bad influence of his more sophisticated peers. Jeff's Probation Officer has identified your program as a good option for when Jeff leaves the facility. Among the terms of Jeff's probation will be successful school and employment outcomes. You have agreed to accept Jeff into your program when he is released in a week.***

Q: 1) What type of program structures would you consider implementing to help Jeff be successful in your program?

2) What questions would you ask about Jeff's situations that are not addressed in the description above?

3) What would be your strategy for building work readiness and finding employment for Jeff?

4. ***Shari is a 19-year-old new addition to your program. She has 3 prior arrests for prostitution in the past 14 months and you suspect that she still may be working the streets. She has aged out of juvenile probation and has very little family support. You have access to her last set of school records, which are 4 years old. They indicate that Shari was diagnosed as having an Emotional Behavioral Disorder (EBD). Shari's school attendance was inconsistent and she has never held a regular job.***

Q: 1) What services could you access to address the possibility that she is prostituting again?

2) What would you look for when reviewing her records to help you strategize for her programming and services?

3) What strategies could you use to expose Shari to the world of 'appropriate' employment?