

CHAPTER 2

THEMES AND DIMENSIONS OF EMOTIONAL AND BEHAVIORAL DISORDERS

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ABSTRACT

Students with emotional and behavioral disorders (EBD) are one of the most underserved populations in today's schools (Kauffman, Mock, & Simpson, 2011). Many of these students also have additional disabilities in conjunction with an EBD identification, such as Learning Disabilities (LD), Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), or Obsessive Compulsive Disorder (OCD), among other psychiatric disorders (Henley, Ramsey, & Algozzine, 2009; Kauffman, 2005).

Because the identification of EBD examines behaviors that tend to be more subjective in nature than other disabilities and because these pervasive behaviors are manifested in a variety of forms, EBD is one of the most misidentified disability categories (Skiba, Poloni-Staudinger, Gallini, Simmons, & Feggins-Azziz, 2006). For students with EBD, the behavior(s) they exhibit contribute to learning difficulties in multiple academic and functional areas. This chapter provides in-depth information on the common characteristics and behavioral dimensions of this

population. Additionally, the in-school performance and long-term outcomes of students with EBD are discussed.

Keywords: EBD; characteristics; dimensions; outcomes; behaviors

Students with emotional and behavioral disorders (EBD) are one of the most underserved populations in today's schools (Kauffman, Mock, & Simpson, 2011). Many of these students also have additional disabilities in conjunction with an EBD identification, such as Learning Disabilities (LD), Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), or Obsessive Compulsive Disorder (OCD), among other psychiatric disorders (Henley, Ramsey, & Algozzine, 2009; Kauffman, 2005).

Because the identification of EBD examines behaviors that tend to be more subjective in nature than other disabilities, it is also one of the most misidentified disability categories (Skiba, Poloni-Staudinger, Gallini, Simmons, & Feggins-Azziz, 2006). The pervasive behaviors exhibited by these students take on a vast array of forms, such as: (a) aggression, (b) self-injury, (c) social withdrawal, (d) excessive fear or anxiety, (e) impulsivity (f) immaturity, (g) social skill deficits, and (h) poor peer and adult relationships. For students with EBD, the behavior(s) they exhibit contribute to learning difficulties in multiple academic areas. This chapter will provide in-depth information on the common characteristics and behavioral dimensions of this population. Additionally, the in-school performance and long-term outcomes of students with EBD will be discussed.

WHAT CONSTITUTES IDENTIFICATION OF EBD UNDER IDEA?

In order to fully understand the characteristics of students who become identified with EBD, it is important to examine the actual definition under law by which students may be eligible. The Individuals with Disabilities Education Improvement Act (IDEA) amendments of 2004 defines the disability category of *emotional disturbance* as:

a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: (a) an inability to learn which 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 pervasive mood of unhappiness or depression, (e) a tendency to develop physical symptoms or fears associated with personal or school problems ... includes schizophrenia ... does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance. (§ 300.8 [a][4][i])

This 2004 revision to IDEA uses the term *emotional disturbance* to describe students with emotional and/or behavioral disorders (EBD). Previous versions of IDEA used the term *serious emotional disturbance*, but *serious* was dropped in 1999 when the regulations for the 1997 version of IDEA were created (U.S. Department of Education, 1999). With this change to the disability term, the government made it clear that the definition was not changed; specifically, the U.S. Department of Education (1999, p. 12,542) stated, “[It] is intended to have no substantive or legal significance. It is intended strictly to eliminate the pejorative connotation of the term ‘serious’.”

Though the terms used to refer to students with EBD have changed over the years, the definition in itself has remained consistent. Although many students have probably experienced social maladjustment, withdrawal, or anxiety at moments in their educational lives, the law states that to be identified with a true disability in this category, a student must exhibit one or more behaviors to the extent that it significantly impacts his or her academic performance. Additionally, the behavior or behaviors for which the student is being referred must either be intense in nature and/or have evidence of occurrence over a long period of time. More in-depth information on the actual identification process of students suspected of having EBD can be found in Chapter 3 of this book.

RISK FACTORS FOR DEVELOPING EBD

One of the most common terms used in the field of education to describe students who do not achieve academically or socially when compared to their same-age peers is “at risk.” Even though states are given the opportunity to define for themselves what it means to be at risk, some salient characteristics are evident across the nation. Lane and Menzies (2003) described students at risk, as those who “deviate from normative performance” (p. 431) in an academic, behavior, and/or social domain, which results in problems with learning and behavior. At-risk students are also characterized as children living in poverty, English Language Learners (ELL), migratory students, neglected and delinquent children, homeless children, immigrant students, teen parents, refugee children, or ethnically identified students (U.S. Department of Education, 1994).

Researchers have further defined the meaning of "at risk" with specific regard to behavioral concerns. For example, Severson, Walker, Hope-Doolittle, Kratochwill, and Gresham (2007) define behaviorally at-risk students as those "(a) who are on a trajectory to later destructive outcomes due to risk factor exposure in the first five years of life and (b) who present moderate to severe behavioral challenges to their teachers, peers, and sometimes primary caregivers" (p. 194). These behavioral risk factors have been defined as "events that occur at the child, family, and environmental levels that increase the probability of diagnosis or the severity of a serious emotional disturbance (e.g., physical abuse, sexual abuse, family violence, and drug-alcohol abuse; family history of mental illness, violence, or drug-alcohol abuse)" (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 1998).

Much research has been conducted on such potential risk factors in children for developing EBD. Some of the most salient environmental risk factors associated with the development of chronic behavior problems identified in the literature include (a) poverty, (b) subjection to domestic violence, and (c) child maltreatment (Conroy & Brown, 2004). Nelson, Stage, Duppong-Hurley, Synhorst, and Epstein (2007) found five factors that were most predictive of problem behavior including (a) externalizing behaviors, (b) internalizing behaviors, (c) child maladjustment, (d) family functioning, and (e) maternal depression. Without effective early interventions, these at-risk students are likely to experience increased difficulty with social adjustment and in meeting academic and behavior expectations; many eventually become eligible for EBD as a result (Farmer et al., 2008).

CHARACTERISTICS OF STUDENTS WITH EBD

Externalizing/Internalizing Behaviors

Externalizing and/or internalizing behavior problems are typically the two broad categories used to describe the type of behaviors students with EBD might exhibit (Furlong, Morrison, & Jimerson, 2004; Gresham & Kern, 2004). Externalizing types of behaviors are more visible and disruptive. Within this broad category, conduct disorder (CD), ADHD, and ODD are discussed due to the interrelatedness among them and because they are characterized by behavioral difficulties linked to aggressive, noncompliant, and violent behavior that severely affect students' performance in school and at home (Furlong et al., 2004; Kauffman, 2005).

CD typically encompasses an array of antisocial behaviors that impede students' abilities to follow major social rules and behave according to social expectations. According to the American Psychiatric Association (APA, 2000, pp. 98–99) a student diagnosed with CDs should exhibit a pattern of behaviors that violate social rules and the rights of others. Students might manifest at least three of the following behaviors within a year (with at least one behavior present in the past six months): (a) aggression to people or animals in the form of bullying, threatening, fighting, using a weapon, or cruelty; (b) destruction of property in the form of fire setting, vandalism; (c) deceitfulness, lying, or stealing; and (d) serious violations of rules, such as running away from home, school truancy, or staying out of home despite parental objections. CD is classified by age of onset and those students who manifest the “childhood-onset type” (i.e., CD types of behaviors before age 10 years), will most likely continue to develop a severe impairment and have worse prognosis in comparison to students who manifest CD types of behaviors after age 10 years, that is the “adolescent-onset type” (Eddy, Reid, & Curry, 2002; Walker, Ramsey, & Gresham, 2004).

ODD and ADHD are other types of disorders that are commonly associated with CD. In fact, the coexistence of CD with ADHD and ODD is very high (Kauffman, 2005). Studies have shown that many children and youngsters with a CD diagnosis manifested ODD types of behaviors early on (Eddy et al., 2002). Moreover, according to the *Diagnostic and Statistical Manual of Mental Disorders, Text Revisions, Fourth Edition (DSM-IV-TR)* (APA, 2000) if a child does not meet the criteria for CD, but exhibits defiant, angry, hostile, irritable, or spiteful behaviors they might be diagnosed with ODD. However, if children or adolescents exhibit a persistent pattern in which social rules and the rights of others are violated, then they might be diagnosed with CD. Following are the criteria the DSM-IV-TR (APA, 2000, p. 102) established for the diagnosis of ODD with four or more of the following behaviors frequently present during at least six months: (a) loses temper easily; (b) argues with adults; (c) is noncompliant; (d) annoys people deliberately; (e) blames others for his/her misbehavior; (f) is irritable and easily annoyed by others; (g) shows anger and resentfulness; (h) is spiteful or vindictive.

ADHD is thought to affect 3–5% of school-age children in the United States (American Psychiatric Association, 2000). The DSM-IV-TR (APA, 2000, p. 87) establishes three types of ADHD: (a) inattentive type, where the main difficulty is an inability to stay focused on a task or activity; (b) hyperactive-impulsive type, where the person acts impulsively and is very active (e.g., fidget, run around constantly, and cannot play quietly); and (c) combined type, where the person is inattentive, impulsive, and excessively

active. Boys are more likely to be diagnosed with ADHD than girls and tend to display more externalizing types of behaviors as well (Abikoff et al., 2002).

Under IDEA, ADHD is classified under the other health impairments (OHI) category. However, according to Special Education Elementary Longitudinal (SEELS) data, the prevalence of ADHD in other special education categories is high, especially for LD and ED. Fifty percent of students with ADHD qualified for the LD category and 60% for the ED category. Due to the coexistence of this disorder with ODD, CD, and other psychiatric disorders students with ADHD are more likely to receive special education services under the ED category (Schnoes, Reid, Wagner, & Marder, 2006).

Internalizing behavior problems are manifest when a student turns inward in social or emotional conflict (Henley et al., 2009). Contrary to externalizing type of behaviors, students who suffer from internalizing types of behaviors will frequently go unnoticed. There are several types of internalizing disorders: (a) anxiety-related disorders; (b) mood disorders; and (c) suicidal ideation or planning (Gresham & Kern, 2004).

Anxiety-related disorders are typically co-morbid with CD and depression (Kauffman, 2005). Within anxiety disorders some of the major disorders are: (a) separation anxiety; (b) obsessive-compulsive disorder; (c) selective mutism; and (d) posttraumatic stress disorders.

Separation anxiety is a disorder in which children become excessively fearful and nervous when separated from home or loved ones. For this disorder to be diagnosed, children have to exhibit severe and persistent separation anxiety that impedes their ability to function in social and academic contexts. To be diagnosed, three or more of the following characteristics must be present for at least four weeks: (a) excessive distress when separated from home or important figures; (b) worry about losing major subjects of attachment or an event that might cause them to be detached from loved ones; (c) fear about being left alone; (d) refusal to go to sleep or sleep away from home if significant figures are not present; (e) nightmares about separations; and (f) physical symptoms (e.g., crying, headaches, nausea, and vomiting) when they know they will be separated from loved ones (APA, 2000, p. 125).

Obsessive-compulsive disorder is another type of anxiety disorder in which individuals engage in a cycle of repetitive thoughts, fears, or an obsession in regard to nonrelated real-life problems. For instance, obsessions might be related to fear of contamination by germs, repeated doubts, urge to have things in order, or aggressive impulses and images. These obsessions are difficult to control and cause individuals to engage in patterns of routines (compulsions) in an attempt to make the obsessive thought to go away. They might wash hands constantly, arrange things in a

certain order, count or repeat words in silence, or frequently check things (e.g., oven turned off, and door locked) that they associate with harm or danger (Gresham & Kern, 2004).

Selective mutism is a disorder in which children exhibit a persistent failure to speak in social settings. This disorder is rare as it occurs in less than 1% of the school-age population. These children know how to have normal conversations, but they choose to communicate only with certain individuals. They are to some degree socially withdrawn, exhibit compulsive traits, negativism, and temper tantrums that severely affect social and school functioning (APA, 2000, p. 125; Kauffman, 2005).

Post-Traumatic Stress Disorder (PTSD) is an anxiety disorder that can develop after a person has been exposed to life-change events or ordeals (e.g., accidents, natural disasters, and violent personal assaults) in which grave physical harm or near-death experience occurred or had the potential for occurring. People who suffer from PTSD will develop intense fear, helplessness, and horror. Symptoms might manifest in irritability or anger, difficulties with sleep, inability to concentrate, and obsessive worry (APA, 2000).

Mood disorders are mental health problems that have many characteristics and dimensions. For instance, they may involve an array of extreme emotions from the feeling of unhappiness or anguish to a state of euphoria. Often times these emotions are not in proportion to actual circumstances. Depression is one major mood disorder that affects children and adolescents. According to the APA (2000) a major depressive disorder is characterized by one or more depressive episodes that would cause the person to lose interest in all activities. Depression usually manifest by the following characteristics: feeling down, unworthy, guilty, helpless, restless, irritable, lethargic, increased or decrease in sleep, inability to concentrate or remember, increase or decrease in appetite, and thoughts of death or suicide. In children, a major depressive disorder is typically characterized by irritability rather than sadness. The co-occurrence of depression with anxiety disorders and CDs is high (Gresham & Kern, 2004; Kauffman, 2005). Dysthymic disorder is another depressive disorder. In children and adolescents it manifests by irritability and, during a year period, they experience two or more of the following characteristics without the symptoms for more than two months at a time: (a) poor appetite or overeating, (b) sleeping problems; (c) fatigue or low energy; (d) hopelessness and low self-esteem; and (e) lack of concentration and difficulty making decisions (APA, 2000).

Suicidal behavior is a major health concern as it is the third leading cause of death for 10- to 24-year-olds. Males commit suicide five times more than female youth (American Association of Suicidology, 2010). Children and

adolescents who are depressed are at a greater risk to commit suicide (Kauffman, 2005). Some warning signs include: (a) talks about suicide or no reason to live; (b) withdrawn from friends and social activities; (c) experience a recent severe loss; (d) drastic changes in behavior (e.g., loss of interest in hobbies and activities and in personal appearance, increase use of alcohol and drugs); (e) give away possessions and make final arrangements; and (f) depression (e.g., feelings of helplessness and hopelessness).

Without doubt, the types of externalizing and internalizing behaviors children and youth might exhibit is vast. Both present unique challenges in the education and treatment of children with EBD in school settings as they also influence and impact language, processing ability, and overall academic performance.

Language Skills and Processing Ability

The types of externalizing and internalizing behaviors that students with EBD experience can not only co-occur among each other, but they can also influence students' language skills and processing speed. Research has shown that language deficits and EBD frequently coexist (Benner, Nelson, & Epstein, 2002; Nelson, Benner, & Rogers-Adkinson, 2003), that the presence of externalizing type of behaviors tend to accentuate students' expressive language deficits (Nelson, Benner, & Cheney, 2005) as well as their academic fluency deficits (Benner, Allor, & Mooney, 2008).

In a literature review of 26 quantitative studies, spanning from 1993 to 1996 (Benner et al., 2002) examined the (a) prevalence and types of language deficits (e.g., receptive, expressive, and pragmatic) in children with EBD and (b) the prevalence of EBD in children diagnosed with language deficits. The sample included 2,358 children with EBD and 438 without EBD between the ages of 4 and 19 years. Researchers reported that an average of 71% of children with EBD experienced significant language deficits. When looking at language deficits by type, the majority of students experienced pragmatic deficits, followed by expressive deficits, and lastly receptive deficits. Finally, approximately 57% of children with language deficits also experienced EBD.

In a similar study, Nelson et al. (2003) Nelson, Benner, and Rogers-Adkinson (2003) conducted a cross-sectional study that included a sample of 152 students, in grades K-12, in an urban school district in the Midwest. The purpose was to further investigate the characteristics of students with co-morbid EBD and language deficits. Findings revealed that 45% of the sample selected had some type of language deficit. Specifically, 32% of children and 54% of adolescents experienced difficulties with receptive and expressive

language. Additionally, across age groups, students who exhibited EBD and language deficits were more likely to have severe expressive language deficits. Further, these students exhibited mild to moderate achievement deficits in reading, mathematics, and written language.

Nelson et al. (2005) examined deficits in language skills across age and gender for a random sample of 166 students with EBD, in public school settings, across grades K-12. They also examined the specific types of problem behaviors that were related to deficits in language skills. Findings revealed that gender did not influence language deficits across grade levels (boys and girls experienced similar expressive and receptive language deficits); however, they were more likely to experience more expressive, rather than receptive, language deficits. Moreover, type of behavior did influence the type of language deficit. Those students who exhibited externalizing behaviors were more likely than students who exhibited internalizing behaviors to experience expressive language deficits (Nelson et al., 2005).

The relationship between processing ability (i.e., the rate with which a student is able to process information automatically and rapidly), has also been examined in regard to the contribution to the externalizing, internalizing, and attention problems of students with EBD. Benner et al. (2008) conducted a cross-sectional study of 133 students with EBD, in grades K-12, to assess the frequency of fluency deficits in reading, mathematics, writing, academic skills, and language in students with EBD. Results showed that more than half of the sample (57%) evidenced an academic processing deficit. Students with fluency deficits in reading, math, and writing evidenced more externalizing and attention problems than did students who evidenced academic skills or language deficits. This study found that academic fluency deficits have a greater impact on social adjustment than language or academic skills of students with EBD.

Social Skills Deficits

Social competence is considered a necessity in order for students to lead successful and healthy lives both in school and beyond. The ability of a child to apply appropriate verbal and nonverbal social responses, such as eye-contact, posture, social distance, voice, volume, handling conflict, expressing feelings, and cooperating with peers and adults allows him or her to gain the social competence necessary to create and maintain positive interpersonal relationships with peers, family, and adults (Gresham, Sugai, & Horner, 2001; Gresham, Van, & Cook, 2006; Spence, 2003). Gresham et al. (2001) define

social skills from a conceptualized standpoint by stating, "social skills are the specific behaviors that an individual uses to perform competently or successfully on particular social tasks" (p. 333).

In alignment with this definition, today's education focuses on promoting social competence of all students. Although many students are fluent in the ability to interact with peers and adults and perform socially appropriate behaviors, other students may not naturally possess these capabilities. Students with disabilities are one population of students for which this statement is highly accurate. In fact, more than 70% of youth with disabilities have deficits in social interaction and communication skills (Wagner, Newman, Cameto, Levine, & Garza, 2006). Students with EBD are at the forefront of this disparaging statistic, especially when compared to their same-age, typically developing peers. By definition, students with EBD often experience social skills deficits that lead to inappropriate peer and adult interactions, as well as social withdrawal and poor academic achievement in the educational setting (Christensen, Young, & Marchant, 2007; Gresham, et al., 2001). For these students, simple exposure to social settings alone is an insufficient remedy. The acquisition of appropriate social skills for students with EBD often require more direct and systematic instructional approaches that often take the form of an integrated multimodel involving modeling, behavior rehearsal/role-play, immediate feedback, and reinforcement (Chen, 2006; Spence, 2003). Without such explicit social skill instruction, students with EBD continue on a trajectory of school failure and poor post-school outcomes in employment, education, independent living, and social and leisurely activities.

WHO AND WHERE ARE STUDENTS WITH EBD: NATIONAL PERSPECTIVE

Now that the most salient characteristics of students with EBD have been identified and explained, it is important to examine the current status and trends of these students within the national context.

Representation of Students with EBD

According to the U.S. Department of Education (2009), national data indicate that of the 6,608,446 students with disabilities, ages 6 through 21 years, receiving special education services, a total of 405,475 were classified

under the EBD category. Many factors influence the social and academic progress for these students. Three longitudinal studies funded by the Office of Special Education Programs (OSEP), Special Education Elementary Longitudinal Study (SEELS); National Longitudinal Transition Study-2 (NLTS2); and the Study of State and Local Implementation and Impact of IDEA (SLIIDEA) provide a comprehensive perspective on students with EBD across grade levels (Bradley, Doolittle, & Bartolotta, 2008; Bradley, Henderson, & Monfore, 2004; Wagner et al., 2006). Findings from these longitudinal studies are discussed in more detail below.

Demographics of Students with EBD

Approximately 8% of special education students are identified with EBD as their primary disability. The majority of those are male. Specifically, an astounding 80% of elementary and middle school children and 76% of secondary school youth with EBD are male. Across racial and ethnic backgrounds of the EBD population, 57% of elementary and middle school children are White, 27% African American, and 12% Hispanic (Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005). These percentages indicate a disproportionate representation of African Americans identified as EBD. In fact, the National Research Council & Committee on Minority Representation in Special Education (NRC, 2002) reported that African American students are 1.92 times more likely than Caucasian students to be labeled with EBD. Further, African American students make up 17% of the total school population but disproportionately represent 27% of the students with EBD (NRC, 2002). Socioeconomic status is also a factor associated with students with EBD, as 33% of elementary and middle school children with EBD are living in poverty compared with 16% of students in the general education population (Wagner et al., 2005). Additionally, students with EBD are more likely to live with one parent, in foster care, or in another alternative living arrangement (Cullinan, Epstein, & Sabornie, 1992; Wagner, 1995).

Although many children with EBD exhibit problems at an early age (Knitzer, 1996), students are usually identified later than those with other disabilities, despite the availability of valid and reliable screening tools. In fact, according to NLTS-2 (2004) data, more than half of all secondary school students identified with EBD do not begin receiving services until age nine years. Research suggests that behavioral and emotional problems identified during adolescence can often be linked to early childhood behavioral patterns (Hinshaw, Lahey, & Hart, 1993; Walker, Colvin, & Ramsey, 1995).

EDUCATIONAL AND LONG-TERM OUTCOMES OF STUDENTS WITH EBD

Although many of the previously described behavioral dimensions are common across students with disabilities, much of the research examining the academic achievement for this group yields highly variable results (Reid, Gonzalez, Nordness, Trout, & Epstein, 2004; Wiley et al., 2008). Though statements can be made regarding the overall educational outcomes of this group, many studies have found that characteristics such as school income and educational placement are also significant indicators of academic performance deficits of students with EBD (e.g., Lane, Wehby, Little, & Cooley, 2005a, 2005b; Wiley et al., 2008). The academic performance and post-school outcomes for these students are discussed in more detail below.

Overall Intelligence

Much research has been dedicated to examining the intelligibility of students with EBD when compared to students with other disabilities and to their peers without disabilities. The majority of studies have concluded that students with EBD tend to fall in the low-average range (i.e., mean IQ of 96) when compared to their peers without disabilities (Kauffman, 2005). The results of a meta-analysis conducted by Sabornie, Cullinan, Osborne, and Brock (2005) also echo similar results when comparing IQ to two other disability categories, LD and Mild Intellectual Disabilities (MID). The authors found 58 studies that matched their inclusion criteria and included all necessary data to run analyses. The participants in the studies ranged from preschool to 12th grade, and school placements included general education classrooms, resource rooms, and self-contained settings. The results indicated that the IQ scores of students with EBD were similar to students with LD (i.e., average to low-average range). Further, there was a large statistically significant difference (i.e., $ES = -2.17$) between students with EBD and students with MID, indicating that students with EBD had higher IQ scores.

Academic Performance

Despite the large number of studies that indicate students with EBD have general cognitive abilities in the average and low-average ranges, this group consistently has the worst outcomes across all academic domains (Bradley

et al., 2004, 2008). In fact, the majority of students with EBD are functioning at least one or more grade levels below the one in which they are assigned (Cullinan, 2007). Extant research on students with EBD has been conducted in an effort to better understand the variables that significantly affect the academic performance of this student population. For example, in an extensive literature review of academic research trends and performance of students with EBD that spanned almost 40 years (i.e., 1961–2000) Trout, Nordess, Pierce, and Epstein (2003) found that students with EBD were performing below grade level in all included studies. Specifically, these students showed below-grade level performance in the areas of reading, mathematics, and written expression.

Reid et al. (2004) found similar results in a meta-analysis conducted on the academic status of students with EBD. Results of this study suggested that 75% of students with EBD across the included 25 studies had overall academic achievement below the mean when compared to students without disabilities. Additionally, the authors found that students with EBD performed lower in all academic areas compared to their peers without disabilities, especially in spelling and mathematics.

Wagner et al. (2005) examined conducted bivariate and multivariate analyses on existing SEELS data to examine how students with EBD differ in academic performance, among other measures, when compared to other disability categories. The authors found that, in reading, 61.2% of students with EBD have percentile scores in the bottom quartile (i.e., lowest scoring 25% of children in the general population). Further, 24.5% score in the second quartile, 9.2% in the third, and only 5.1% in the top quartile. Though scores in mathematics calculation for students with EBD were better than those in reading, they were still considerably below students in the general population. Specifically, 43% of students with EBD scored in the lowest quartile, 30% in the second, 18.8% in the third, and only 8.1% in the top quartile. These scores are comparable to student with MID, autism, and multiple disabilities.

In a recent study, investigating the academic performance of students with EBD, Lane, Barton-Arwood, Nelson, and Wehby (2008) found that both elementary and secondary students with EBD performed below the 25th percentile in reading, mathematics, and written expression. Moreover, as students became more fluent in reading, their reading comprehension skills failed to improve.

Even more disconcerting, there is evidence to suggest that academic performance deficits among students with EBD do not tend to improve over time (Anderson, Kutash, & Duchnowski, 2001), and have actually been

shown to get worse as students grow older (Nelson, Benner, Lane, & Smith, 2004). More specifically, Nelson et al. (2004) conducted a cross-sectional study of school-aged students with EBD. The authors found significant differences between children with EBD and adolescents with EBD, with mathematics performance being poorer at adolescent age; reading and writing achievement of these students remained stable across the years.

The Effects of Setting on School Performance

Researchers have been especially interested in determining how academic performance of students with EBD compares across different educational placements. For example, when examining general education classes, resource classes, self-contained classes, and special school settings, Reid et al. (2004) found that students with EBD exhibited academic delays regardless of the instructional setting.

Other evidence, however, suggests the performance of students with EBD varies depending on the setting in which instruction is provided. For example, Lane et al. (2005a) compared the behavioral, social, and academic characteristics of students with EBD educated in self-contained schools versus the characteristics of students with EBD self-contained classrooms within general education schools. Their sample included 72 students with high-incidence disabilities (ED, LD, and ADHD). To assess progress, behavioral rating scales, standardized, and curriculum-based measures were used. Results showed that students who were educated in self-contained classrooms had higher academic skills in reading comprehension, reading fluency, oral language, written language, and mathematics when compared to students educated in self-contained schools. There were no differences, however, in the students' social skills in either setting. Additionally, students with EBD in self-contained classrooms exhibited significantly higher levels of internalizing behaviors than students in self-contained schools.

In another study, Lane et al. (2005b) examined how students with EBD progressed and benefited over time, either in a self-contained school or in a self-contained classroom, from the beginning to the end of the school year. Results showed that students in both settings made limited academic improvement. Across settings, no significant differences were found. Although students educated in the self-contained school experienced modest progress in reading comprehension and oral language skills, they showed significant decreases in writing scores as compared to students educated in

self-contained classrooms. The latter group showed no changes on writing measures.

Long-term Outcomes

When investigating the overall educational and post-school outcomes of students with EBD, results are consistent and stable across time. A plethora of research exists that indicates students with EBD experience the most discouraging outcomes compared to any other group of students (Kauffman, 2005; Walker et al., 2004).

For students with EBD, success during school and beyond is often poor because the many deficits described previously in this chapter impact almost every aspect of daily life. In fact, 44% of students with EBD exit school without finishing; this represents the highest dropout rate among all disability categories (Wagner et al., 2006). Thirty-five percent of young adults with EBD no longer live with parents, and they are the only group among all disability categories to show a significant increase in the likelihood of living in criminal justice or mental health facilities, under legal guardianship, in foster care, or being homeless (Wagner et al., 2006). Additionally, one-third of this specific population lacks the social competence necessary to become actively engaged in their community after leaving high school (Wagner et al., 2006). Individuals with EBD were the largest group among all disability categories to indicate that they see friends often (i.e., at least weekly); however, they are among the least likely to take part in organized community groups, volunteer activities, or to be registered to vote. Finally, more than three-fourths of individuals with EBD have been stopped by police for an offense other than a traffic violation, 58% have been arrested a minimum of one time, and 43% have been on probation or parole (Wagner et al., 2006). These are harrowing post-school statistics for this population.

SUMMARY

The information provided in this chapter captures the multifaceted nature that often characterizes students with EBD. This population of students makes up the smallest percentage of students identified with high incidence disabilities, yet they are the most underserved (Kauffman et al., 2011). Many students who become identified with EBD often exhibit a number of risk factors, such as (a) poverty, (b) subjection to domestic violence, and (c) child

maltreatment (Conroy & Brown, 2004). Although early identification of any disability is critical, students with EBD still tend to be identified years after the behavioral warning signs are exhibited (Knitzer, 1996). Additionally, students with EBD share many common characteristics, including (a) diagnoses of additional disabilities or psych disorders, (b) externalizing and/or internalizing behaviors, (c) social skill deficits, (d) language and processing deficits, (e) low academic performance, and (e) poor long-term outcomes. To address the many complex characteristics and dimensions of students with EBD, it is critical to examine and implement the most effective identification, assessment, and instructional strategies to best meet their needs. These issues are explored more thoroughly in subsequent chapters.

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