Competency 1.0  Understand major theories of educational psychology as they relate to emotional disabilities.

THEORIES OF BEHAVIOR AND EMOTIONAL DIFFICULTIES

Over the years, the study of emotional and behavioral problems has been based on many different theoretical viewpoints.

The biophysical perspective emphasizes the relationship between physical and biological factors, including body chemistry and genetics, and that of behavior. Drug therapy, with careful monitoring between school, home, and physician, is building.

Sigmund Freud’s structural theory believed that the id, ego, and superego act as a system of checks and balances on behavior. The id is the pleasure seeking, impulsive force that is dominant in childhood. The superego is the conscience, which represents moral and ethical beliefs. The ego mediates between the id and the superego. The ego guides actions by taking into account the natural consequences of behavior.

The psychodynamic approach underscores the need to understand why students are disruptive. It emphasizes the connection between how a student feels and how a student acts.

The psychoeducational framework is developmental in nature. It integrates clinical insights in behavior with practical methods for managing behavior. Treatment emerged from the need to merge behavior management with psychodynamic theory.

The behaviorist position views observable behavior as the critical element. Treatment strategies are focused on modifying environmental factors that reinforce appropriate behavior. The key points of behavioral theory and practice are summarized as follows:

1. Behaviorists view inappropriate and appropriate behavior as learned. Behavior is a response to a person’s interaction with the environment.

2. Learning occurs when environmental conditions reinforce a specific behavior. Reinforcement takes several forms, including imitation, modeling, and operant conditioning (i.e. consequences that shape behavior).
3. Inappropriate behavior is learned through environmental conditioning and new, appropriate behaviors can be learned with proper reinforcement.

4. Effective implementation of behavior treatments in classrooms requires observable descriptions of behavior to be changed, targeting of new behaviors, systematic application of reinforcers, and collection of pre- and post-data to determine treatment effectiveness. (Henley, Ramsey, & Algozzine, 1993, 125).

The Ecological Model promotes the idea that children are influenced by many different environments and that any attempt to help children with behavior or emotional problems must focus on all key elements in a youngster’s life.

Typically, a combination of these treatment approaches is used in many classrooms. For instance, one student may be taking medication to facilitate concentration and adequate attention span. Other students may be participating in a token system designed to reinforce task completion, while yet others are actively involved in a class meeting or discussion session. The difference treatments reflect the various assumptions that people have about behavior disorders.

CHILD AND ADOLESCENT PSYCHOLOGY

The study of psychology can be broken into four processes (Hockenbury and Hockenbury, 2002) of learning: memory, intelligence and mental abilities, motivation, and emotions.

Although learning and intelligence play a significant role in many students with emotional disturbances, the additional and differing component is motivation and emotions.

Nature vs. Nurture The never ending question of those who study human behavior is nature vs. nurture. Is the individual born with certain behavioral tendencies, or is the person reacting to his environment and therefore learning behaviors throughout childhood and adulthood?

Founders of psychological theory include:

1. **Freud** who believed that behaviors stemmed from early experiences in childhood and were often sexual in nature.

2. **Darwin** who believed that behavior is a functional adaptation to the environment and is passed from generation to generation.

3. **Pavlov** who believed that behavior can be conditioned through reinforcers. Pavlov is known for his experiments with dogs.
4. Leipzig who studied sensory and perceptual processes and their impact on behavior.

5. Watson and Skinner who studied behaviorism.

Impact of an Emotional Disturbance in the Educational Setting Please refer to Competency 2.0 and Competency 3.0.

Common Medications Used to Treat Emotional Disturbance—Students with emotional disorders may take some of the following medications:

- Antidepressants—There are three different classes of antidepressants that students may take.
  - Selective serotonin-reuptake inhibitors (SSRIs). The SSRIs block certain receptors from absorbing serotonin. Over time, SSRIs may cause changes in brain chemistry. The side effects of SSRIs include dry mouth, insomnia or restless sleep, increased sweating, and nausea. It can also cause mood swings in people with bipolar disorders.
  - Tricyclic antidepressants. They are considered good for treating depression and obsessive-compulsive behavior. They cause similar side effects to the SSRIs such as sedation, tremor, seizures, dry mouth, light sensitivity, and mood swings in people with bipolar disorders.
  - Monoamine oxidase inhibitors (MAOIs). They are not as widely used as the other two types because many have unpleasant and life-threatening interactions with many other drugs, including common over-the-counter medications. People taking MAOIs must also follow a special diet, because these medications interact with many foods. The list of foods to avoid includes chocolate, aged cheeses, as well as many more.

- Stimulants – They are often prescribed to help with attention deficit disorder and attention deficit hyperactivity disorder. The drugs can have many side effects including agitation, restlessness, aggressive behavior, dizziness, insomnia, headache, or tremor.

- Anti-anxiety medication (tranquilizer)- In the case of severe anxiety these may be prescribed. Most tranquilizers have a potential for addiction and abuse. They tend to be sedating, and can cause a variety of unpleasant side effects, including blurred vision, confusion, sleepiness, and tremors.

If educators are aware of the types of medication that their students are taking along with the myriad of side effects they will be able to respond more positively when some of the side effects of the medication change their students behavior, response rate, and attention span.
COMMON TREATMENT APPROACHES AND EDUCATIONAL PRACTICES
FOR STUDENTS WITH EMOTIONAL DISTURBANCE

1. **Psychodynamic Approach to Psychology** is based on Freud's theory of the unconscious on behavior. It was a popular approach to treatment for emotional disturbance in the mid twentieth century. This form of therapy may still be used in some clinical settings, but in the educational realm it has largely been replaced by other therapies.

2. **Behavioral Approach to Psychology** includes considerations of antecedents (where the behavior happens and what is happening prior to the behavior), the behavior, how the behavior is addressed by school personnel (consequences), and if the behavior changes. A significant consideration is why the student exhibits the inappropriate behavior and what the desired behavior would be.

3. **Sociological Approach to Psychology** addresses factors in the student’s environment which may be contributors to his emotional disturbance.

   For example, a child who comes from a home in which extreme physical neglect was a condition, the child may exhibit hoarding of food from the cafeteria (due to lack of food in the home).

   Likewise a student who has been physically abused may be distrustful of others (particularly adults) and cringe or duck when a physical movement (even something like a move to pick up a book) is done in their direction. In this approach the student is involved in activities to learn trust and that not all personal interactions are dysfunctional.

Please also refer to Competencies 11.0, 12.0, and 13.0 for additional classroom strategies.
Competency 2.0  Understand learning processes and the significance of disabilities for learning.

The teacher of special needs students must have a thorough understanding of the content matter that is taught from kindergarten through twelfth grade for two important reasons. First, she will be instructing students whose functioning abilities can span all grade levels, and second, she must be able to use specialized instruction in order to teach content in required subject areas.

The actual content and sequence of concepts learners with special needs must be taught are the same as those used with the regular student; however, special learning strategies, techniques, and approaches must be utilized. For instance, task sequences must be analyzed and broken down into a hierarchy of subskills for students with learning difficulties and emotional disorders. Often it is helpful when the content is made meaningful to learners and when skills are taught in a firsthand, functional manner.

The content areas of reading, vocabulary, decoding skills, comprehension, math problem solving, fact mastery, computational operations, reasoning, verbal problem solving, language arts, and social skills training are broad in scope. They entail a specific instructional sequence all learners must follow and are basic to being able to succeed in other subject areas. However, being able to plan, predict, diagnose, and assess the instructional content appropriate for individual learners necessitates a full and complete understanding by the special educator of sequential skills hierarchies, the development of learners with special needs.

Jean Piaget recognized the importance of structuring thinking in order to learn. According to this theory, each person approaches the learning task with an existing cognitive structure or schemata. The learner adapts to the environment and structures new knowledge in two complimentary ways:

- **Assimilation.** Learners incorporate new experiences into their already existing cognitive structure. New experiences provide practice and strengthen their existing cognitive structures. For example, a child learns that balls are objects, which can be grasped and thrown.

- **Accommodation.** Learners focus on the new gestures of a learning task, thereby changing, or modifying their cognitive structures as the child grasps balls of differing sized, textures, and firmness, he learns that balls are different, and that some objects that look like balls cannot be thrown.
The cognitive stages outlined by Piaget are:

1. **Sensorimotor intelligence** - birth to 18 months. The child differentiates himself from the rest of the world and learns object constancy.

2. **Preoperational thought, representational thinking** - 18 months to 4-5 years. Private symbols and representations precede language, which begins during this stage. Children are still unable to take another person’s view of things.

3. **Preoperational thought, intuitional thinking** - 5 - 7 years. The child begins to understand conservation of amount, quantity, number, and weight. He can attend to more than one aspect of an object at one time and begins to understand the reversibility of some operations, though he cannot explain personal conclusions.

4. **Concrete Operation** - 7 to 11 years. The child organizes his perceptions and symbols and becomes able to classify and categorize along several dimensions at the same time.

5. **Formal Operations** - 12 years through adulthood. The learner can deal with abstractions, hypothetical situations, and logical thinking.

**Jerome Bruner**, like Jean Piaget, believed knowledge developed in an evolutionary sequence. Bruner suggested knowledge is represented in three forms; enactive, iconic, and symbolic.

1. **Enactive**-Knowledge is initially acquired at the enactive or concrete action level. It is demonstrated through action like throwing a ball or by direct manipulation such as bundling sticks in groups of ten.

2. **Iconic**-The information that is digested and recorded at the enactive stage is recalled in a mental image or seen in a visual representation at the iconic level. Knowledge at this level has a visual or perceptual organization; it is communicated by pictures and forms. An example of iconic knowledge is the mental manipulation of images of concrete objects such as solving math problems by picturing ones, tens, and hundreds units.

3. **Symbolic**-Finally, the information reaches the symbolic level through spoken words of written symbols. This type of knowledge represents information about concrete and semi concrete situations in a symbolic manner. “The use of symbols allows for easy problem-solving actions” (Thornton, Tucker, Dossey, & Bazik, 1983, p. 86). The highest and most formalized level is symbolic knowledge. An example would be the use of symbols in the form of numerals to calculate the answer to a specified mathematical operation. A correspondence between the stages proposed by Piaget and the levels described by Bruner are shown in Figure 7-1.
Both Piaget and Bruner dealt with language as it related to cognitive growth. Bruner theorized that once children begin to acquire language, they use it further shape their thoughts.

Piaget proposed that language is acquired as children take in or assimilate the language in the environment, and then modify it with their knowledge and ideas. What language is assimilated is directly influenced by each child’s reasoning processes.

Children’s language becomes more sophisticated with age because they are able to understand more complex language, and thus modify it with more complex ideas. The primary educational implication for the developmental learning movement through theorized stages is its element of predictability.

Some students move through developmental stages or levels at a slower or faster pace than others. What students learn depends on their existing cognitive structure, language development, and the experiences and knowledge that they bring to the learning situation. It is important that entry level skills be diagnosed, and that students be able to use the knowledge, experiences, and skills they already possess in learning situations.

**Figure 2-1 Developmental Stages and Levels**

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<thead>
<tr>
<th></th>
<th>PIAGET</th>
<th>BRUNER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensorimotor, concrete knowledge stage</td>
<td>Enactive, concrete action level</td>
<td></td>
</tr>
<tr>
<td>Perceptually bound knowledge</td>
<td>Iconic, visual, or perceptual</td>
<td></td>
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<tr>
<td>Preoperational or concrete Operations Stages</td>
<td>Organization Level</td>
<td></td>
</tr>
<tr>
<td>Formal or symbolic stages</td>
<td>Symbolic Level</td>
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**EFFECTIVE LEARNING METHOD AND STRATEGY CONSIDERATIONS OF LEARNING FOR THE STUDENT WITH AN EMOTIONAL DISTURBANCE**

**Communication of Expectations**- It is important that the emotionally disturbed student (even more than other students) have an understanding of the expectations of a lesson. These expectations should include general behavior, participation in the lesson, communication with peers and educators, and the type of learning assessment that will be used (in-class worksheet, homework, project, etc.) These expectations may be listed in some type of checklist as a visual reminder to the student.

**Physical Presentation of Learning**- While many students enjoy a visually stimulating learning environment, this may not be appropriate for the student with an emotional disturbance who is easily distracted. A classroom divider or study cubicle may help the student(s) stay focused on the task at hand. The materials used should be specific to the lesson. It is important materials be sturdy as they may take more than usual wear-and-tear in the special education classroom.
Learning Activities- Activities should address the student’s optimum learning mode (visual, auditory, kinesthetic). The student should also be taught study strategies of preview, consideration of prior knowledge, attention to new information, and review in preparation for assessment (test or other demonstration of knowledge gained).

Feedback- All learners need feedback on their participation in the learning environment. In the case of the emotionally disturbed student, it is crucial that the feedback be consistent and address the expectations initially set forth.

Positive feedback is important for addressing the student’s self esteem (often an area of deficit in the student with emotional disturbance). It should be recognized that positive feedback should include a type that is recognized by the student (token physical rewards or activities) as well as the increased use of the sought after socially accepted feedback (positive comments, grades).

Constructive criticism should also be consistent with the initial expectations. The educator of the emotionally disturbed student should remember that often these children have come from abusive situations or that they (as a result of the specific disturbance) may react inappropriately to typical direction or comment.

Generalization of Material Learned- It is especially true in the classroom with emotionally disturbed students that generalization of learning be given consideration. Because of the isolated learning environment students may not see the carry over into other subjects or into daily living and their environment. Activities and outings that address such generalizations are helpful for this to occur and for participation in the community.

Generalization of Learning into the Inclusive Classroom- When possible (according to the student’s emotional readiness) the student should be given opportunities to participate in related (or more fully inclusive) learning activities in the general education classroom. Initial opportunities related to a unit of study might include watching a video, attending an assembly or speaker presentation, going on a field trip, participation in daily class, or presenting a project via display or verbal presentation.

Learning Motivators for the Emotionally Disturbed Student- All students need motivators to stay on task behaviorally and academically. The special educator of the emotionally disturbed may employ a number of motivators or rewards for her students. These may include token rewards of candy or trinkets or free time for a desired activity such as time on the computer or drawing. If the motivators address student interest as well as reflect the study at hand two goals have been accomplished. For example, if studying multiplication consider a computer game that can be used as a motivator that will also give the student additional practice.
Competency 3.0 Understand types and characteristics of emotional disabilities.

*Emotional disturbance* is defined 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 student's educational performance:

1. An inability to learn that cannot be explained by intellectual, sensory, or health factors.
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
3. Inappropriate types of behavior or feelings under normal circumstances.
4. A generally pervasive mood of unhappiness or depression.
5. A tendency to develop physical symptoms or fears associated with personal or school problems.
6. The term includes schizophrenia.
7. The term does not apply to students who are socially maladjusted, unless it is determined that they have an emotional disturbance.

The term *emotional disturbance* covers a range of disorders with varying severity. These are outlined in the Diagnostic and Statistical Manual of Mental Disorders (also referred to as the DSM).

Children with emotional handicaps or behavioral disorders are not always easy to identify. It is, of course, easy to identify the acting-out child who is constantly fighting, who cannot stay on task for more than a few minutes, or who shouts obscenities when angry. It is not always easy to identify the child who internalizes his or her problems, on the other hand, or may appear to be the "model" student, but suffers from depression, shyness, or fears. Unless the problem becomes severe enough to impact school performance, the internalizing child may go for long periods without being identified or served.

Studies of children with behavioral and emotional disorders, share some general characteristics:

*Lower academic performance:* While it is true some emotionally disturbed children have above average IQ scores, the majority are behind their peers in measures of intelligence and school achievement. Most score in the "slow learner" or "mildly mentally retarded" range on IQ tests, averaging about 90. Many have learning problems that exacerbate their acting out or "giving-up" behavior. As the child enters secondary school, the gap between her and nonhandicapped peers widens until the child may be as many as 2 to 4 years behind in reading and/or math skills. Children with severe degrees of impairment may be unable to be tested with any degree of reliability or validity in the results.
**Social skills deficits:** Students with deficits may be uncooperative, selfish in dealing with others, unaware of what to do in social situations, or ignorant of the consequences of their actions. This may be a combination of lack of prior training, lack of opportunities to interact, and dysfunctional value systems and beliefs learned from their family.

**Classroom behaviors:** Often, classroom behavior is highly disruptive to the classroom setting. Emotionally disturbed children are often out of their seat or running around the room, hitting, fighting, or disturbing their classmates, stealing or destroying property, defiant and noncompliant, and/or verbally disruptive. They do not follow directions and often do not complete assignments.

**Aggressive behaviors:** Aggressive children often fight or instigate their peers to strike back at them. Aggressiveness may also take the form of vandalism or destruction of property. Aggressive children may also engage in verbal abuse.

**Delinquency:** As emotionally disturbed/acting-out children enter adolescence, they may become involved in socialized aggression (i.e. gang membership) and delinquency. Delinquency is a legal term, rather than a medical, and describes truancy, and actions that would be criminal if they were committed by adults. Of course, not every delinquent is classified as emotionally disturbed, but children with behavioral and emotional disorders are especially at risk for becoming delinquent because of their problems at school (the primary place for socializing with peers), deficits in social skills that may make them unpopular at school, and/or dysfunctional homes.

**Withdrawn behaviors:** Children who manifest withdrawn behaviors may consistently act in an immature fashion or prefer younger children as playmates. They may daydream or complain of being sick in order to “escape” to the clinic, cry, cling to the teacher, ignore other’s attempt to interact, or suffer from fears or depression.

**Gender:** Many more boys than girls are identified as having emotional and behavioral problems, especially hyperactivity and Attention Deficit Disorder, autism, childhood psychosis and problems with undercontrol (aggression, socialized aggression). Girls, on the other hand, have more problems with overcontrol (i.e. withdrawal and phobias). Boys are much more prevalent than girls in problems with mental retardation and language and learning disabilities.

**Age Characteristics:** When they enter adolescence, girls tend to experience affective or emotional disorders such as anorexia, depression, bulimia, and anxiety at twice the rate of boys, which mirrors the adult prevalence pattern.
**Family Characteristics:** Having a child with an emotional or behavioral disorder does not automatically mean the family is dysfunctional. However, there are family factors that create or contribute to the development of behavior disorders and emotional disturbance.

- Abuse and neglect
- Lack of appropriate supervision
- Lax, punitive, and/or lack of discipline
- High rates of negative types of interaction among family members
- Lack of parental concern and interest
- Negative adult role models
- Lack of proper health care and/or nutrition
- Disruption in the family

**EMOTIONAL DISTURBANCES IN THE SPECIAL EDUCATION CLASSROOM**

Although some emotional disturbances do not appear until late adolescence or adulthood, others begin in childhood. Severe emotional disturbances are often treated with medication and therapy. In addition, these students may receive services from the school social worker and are often receiving educational services in a special education program.

Several emotional disturbances that may be present in the special education classroom are outlined below. This is not by any means an all-encompassing list, but reflects many disorders a typical Special Education Teacher may encounter throughout her career.

**Anxiety Disorders** - The National Institute of Mental Health divides this area of mental illness into five kinds: Generalized Anxiety Disorder, Obsessive-Compulsive Disorder (OCD), Panic Disorder, Post-Traumatic Stress Disorder (PTSD), and social phobia. Some individuals with anxiety disorders may also have ADHD.

**Bipolar Disorder (Manic Depression)** - The National Institute of Mental Health describes children and adolescents with bipolar disorder as having frequent and severe mood swings between mania and depression. Many individuals with bipolar disorder are suicidal.

Bipolar disorder is more common in children of individuals who are bipolar, but many bipolar individuals do not have parents who suffer from the illness. This mental illness can also be characterized by aggression and irritability.
Schizophrenia and psychotic behaviors: Children may have bizarre delusions, hallucinations, incoherent thoughts, and disconnected thinking. Schizophrenia typically manifests itself between the ages of 15 and 45, and the younger the onset, the more severe the disorder. These behaviors usually require intensive treatment beyond the scope of the regular classroom setting.

Autism: This behavior appears very early in childhood. It is associated with brain damage and severe language impairment. Six common features of autism are:

- **Apparent sensory deficit** – The child may appear not to see, hear, or react to a stimulus, then react in an extreme fashion to a seemingly insignificant stimulus.
- **Severe affect isolation**—The child does not respond to the usual signs of affection such as smiles and hugs.
- **Self-stimulation** – Stereotyped behavior takes the form of repeated or ritualistic actions that make no sense to others, such as hand flapping, rocking, staring at objects, humming the same sounds for hours at a time.
- **Tantrums and self-injurious behavior (SIB)** – Autistic children may bite themselves, pull their hair, bang their heads, or hit themselves. They can throw severe tantrums, and direct aggression and destructive behavior toward others.
- **Echolalia**—also known as “parrot talk.” The autistic child may repeat what is played on television, for example, or respond to others by repeating what was said to him. Alternatively, he may simply not speak at all.
- **Severe deficits in behavior and self-care skills**. Autistic children may behave like children much younger than themselves.

DETERMINATION OF ELIGIBILITY FOR SPECIAL EDUCATION DUE TO EMOTIONAL DISTURBANCE

The classroom teacher, other school personnel, and the student’s family will be first to see the impact of a suspected emotional disturbance. (See Competency 1.0). However, determination of a mental illness must be diagnosed by a psychiatrist or psychologist. (See Competency 6.0) Typically, the school psychologist will test for academic delays and behavioral patterns that impede progress in the school setting. (See Competency 2.0).