Riverside County Special Education Local Plan Area (SELPA)

Assessment, Identification and Educational Planning for Students with Emotional Disturbance

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Statistics about Emotional Disturbance

The National Academies (2009) report that mental, emotional, and behavioral disorders – which include depression, conduct disorder, and substance abuse – affect large numbers of young people, are a major health threat, and that almost one in five young people has a diagnosable mental, emotional or behavioral disorder. Many of these disorders have life-long effects that include high psychosocial and economic costs, not only for the child but also for their families, schools and communities. Other resources indicate that up to one in ten children may suffer from a serious emotional disturbance, emotionally disturbed children account for approximately one percent of the school age student population, a higher percentage of boys than girls are classified as emotionally disturbed, and 70% of children who have an emotional disturbance do not receive mental health services.

Schools are strategically placed to implement comprehensive prevention interventions for children. Per research cited in Frankford (2007)

- School personnel see the full continuum of young people's mental health needs, from emotional and behavioral disorders to serious emotional disturbance.
- A major set of protective factors for high-risk youth has to do with school, including development of the child's cognitive skills, interactions with peers and adults with pro-social values, and connectedness to school.
- More than three fourths of children who receive any mental health services are seen in the education system; for many, this is the sole source of care.
- The longer adolescents stay in school and the more successful they are in school, the more likely it is that they will not be involved in substance abuse and will not experience mental health problems.
- The less successful students are in school, the more at risk they are for conduct disorders, substance abuse, and engagement in risky behaviors with regard to their health.
- Adolescents with mental health problems and disorders and those who abuse substances are at risk for not staying in school and for having problems in school, which impairs their life outcomes.

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2007) cites research demonstrating that mental health problems often are precursors to delinquency, substance abuse, health-risking sexual behaviors, and school failure. Conclusions drawn from some of the related studies are that:

- Conduct problems predict the initiation of alcohol use as well as greater escalations of alcohol use over time.
- Children in first grade with the combination of hyperactivity and social problem-solving deficits have been found to have a greatly increased rate of drug and alcohol use when they are between 11 and 12 years old.
- Children in first grade with conduct problems, anxiety or depression, or attention deficit–hyperactivity disorder have approximately twice the risk of first tobacco use during fourth through seventh grade than do children without these early emotional disorders.
- Social impairment in childhood is a critical predictor for later substance abuse disorders.
- Children who lack pro-social behavior skills are likely to be rejected by their peers and to gravitate toward other rejected children. These socially isolated peer groups, in turn, promote substance abuse and involvement in antisocial activities.

Neighborhood characteristics and family income can be risk factors that impact young children's social-emotional health and development (National Center for Children in Poverty [NCCP], 2009). References cited indicate young children in low-income neighborhoods are more likely to experience behavioral problems than children living in moderate or affluent neighborhoods. In addition, young children from households with lower levels of family income are more likely to experience behavioral problems that negatively impact their development. NCCP (2009) also cites research that shows that family risk factors, particularly maternal risk factors such as substance use, mental health conditions and domestic violence exposure, can impact parents' ability to support children's development, and may contribute to behavioral problems among young children. Young children with these family risks factors have been found to be two to three times more likely than children without these family risk factors to experience problems with aggression (19% vs. 7%), anxiety and depression (27% vs. 9%) and hyperactivity (19% vs. 7%).

Identification and intervention with students with emotional disturbance is important to lifelong outcomes for these individuals. The Center for Evidence Based Practice: Young Children with Challenging Behaviors (www.challengingbehaviors.org) reports that an estimated 9%-13% of American children and adolescents between the ages of 9 and 17 have serious diagnosable emotional or behavioral health disorders resulting in substantial to extreme impairment. The National Center for Special Education Research (NCSER) has been conducting studies on the early post-school experiences and outcomes for students with different disabilities (youth with learning disabilities or other health impairments, emotional disturbances, intellectual disability or multiple disabilities, hearing or visual impairments). The National Longitudinal Transition Study Wave 2 (NCSER, 2006) found the following for youth with emotional disturbance:

- Students with emotional disturbance reported higher use of alcohol (54%), illegal drugs (36%), marijuana use (44%), and smoking (53%) than all other disability categories.
- Youth with emotional disturbances had the highest dropout rate of any disability categories, with 44% leaving school without finishing.
- Youth with emotional disturbance were the largest group to no longer live with parents (35%) and were the only group to show a significant increase in the likelihood of living in "other" arrangements, including criminal justice or mental health facilities, under legal guardianship, in foster care or homeless.
- Youth in this category had experienced the largest increase in their rate of parenting, with 11% reporting they had or fathered a child.
- One third of these youth had not found a way to become engaged in their community since leaving high school; for those who had, employment was the usual mode of engagement.
- About one in five in youth with emotional disturbances enrolled in any kind of postsecondary education.
- More than three-fourths had been stopped by police other than for a traffic violation, 58% had been arrested at least once, and 43% had been on probation or parole.

Assessment Guidelines

The Riverside County SELPA *Special Education Assessment Procedures* posted on www.rcselpa.org can be reviewed for general assessment information. It is important to consider cultural, English language development, environmental or economic factors. If appropriate, the *Guidelines for Assessing African-American Students* are another helpful resource. The following legal requirements must also be considered:

- A variety of assessment tools and strategies are used to gather relevant functional and developmental information about the child, including information provided by the parent, and information related to enabling the child to be involved in and progress in the general curriculum (or for a preschool child, to participate in appropriate activities). (34 CFR 300.304(b)(2))
- Assessments or measures are administered by trained and knowledgeable personnel in accordance to the instruction provided by the producer of the assessments to insure validity and reliability. Assessments or other evaluation materials include those tailored to assess specific areas of educational need and not merely those that are designed to provide a single general intelligence quotient. Assessment tools should be selected and administered to a child with impaired sensory, manual or speaking skills in a manner in which the assessment results accurately reflect the child‘s aptitude or achievement level or whatever other factors the test purports to measure, rather than reflecting the student‘s impaired sensory, manual or speaking skills (unless those skills are the factors that the test purports to measure). (34 CFR 300.304(c))
- When standardized tests are considered to be invalid for the specific pupil an alternative assessment must be utilized and specified on the assessment plan. (CCR 3030(c)(4)(B) and 3030(j)(4)(B))
- An individual assessment of the pupil's educational needs shall include, but not limited to, all the following: (EC 56320)
    - Testing and assessment materials
        - are selected and administered so as not to be racially, culturally, or sexually discriminatory;
        - are provided and administered in the pupil's primary language or other mode of communication, unless the assessment plan indicates reasons why this provision and administration are not clearly feasible;
        - have been validated for the specific purpose for which they are used;
        - are administered by trained personnel in conformance with the instructions provided by the producer of the tests and other assessment materials;
        - individually administered tests of intellectual or emotional functioning shall be administered by a credentialed school psychologist;
        - include those tailored to assess specific areas of educational need and not merely those which are designed to provide a single general intelligence quotient;
        - are selected and administered to best ensure that when a test administered to a pupil with impaired sensory, manual, or speaking skills produces test results that accurately reflect the pupil's aptitude, achievement level, or any other factors the test purports to measure and not the pupil's impaired sensory, manual, or speaking skills unless those skills are the factors the test purports to measure.
    - No single procedure is used as the sole criterion for determining whether a pupil is an individual with exceptional needs and for determining an appropriate educational program for the pupil.
    - The pupil is assessed in all areas related to the suspected disability.
    - The assessment of a pupil shall be conducted by persons knowledgeable of that disability.

Consider Interventions Attempted

Schools are encouraged to use a Response to Intervention (RtI) process in addition to other measures when evaluating behavior. The RtI process should include the student’s response to academic, behavioral, and other appropriate interventions over time. For example, check if the

local agency has planned and implemented behavior interventions specific to the student. These should be well planned, research based and individualized interventions. Data should demonstrate that the interventions have proven to be ineffective in modifying behaviors, feelings/moods, fear and/or physical symptoms despite well planned and implemented modifications to the plan. Examples include:

- School based counseling or a referral to an outside mental health agency. (For more severe behavioral symptoms a medical and psychiatric referral for evaluation needs to be considered.)
- Student conference with staff administration and/or parents for notification, discussion and consequences for both positive and negative behavior. Using home to school behavior reports/logs (again for both positive and negative behavior) can facilitate communication and keep positive and negative consequences consistent.
- Class wide reinforcement should be consistent in delivery of rewarding desired behaviors and providing consequences for undesired behaviors. A consistently implemented classroom management system can prevent the need for individualized behavior plans.
- Individual in class reinforcement system between the teacher and student. The focus of this plan/contract should be to diminish unwanted behaviors by reinforcing and teaching desired behaviors and distinguishing undesired behaviors (this can be accomplished in a multitude of ways including: clear and consistent behavior expectations, planned ignoring, high to low frequency requests, predictable transitions…)
- Consider a schedule or teacher adjustment (some kids do better at certain times of day and with different personalities). This could include adaptations to curriculum, alteration of pace and instruction as well as teaching study skills. In severe cases a modified day or independent study may be a consideration for BRIEF periods of time while student adjusts to implementation of new interventions.
- Behavior contract with school administrator, counselor or psychologist. A contract based solely on punishing consequences is not likely to be effective. It needs to have positive reinforcements for the student to buy into the contract.
- Positive Behavior Support Plan. This differs from a contract in that it is based on observed behavioral function, a functional behavior assessment, and reinforcement of positive behavior, teaching of replacement behaviors, a consistent reinforcement schedule, as well as frequent data collection/monitoring and revisions.
- Functional Analysis Assessment. This differs from a Behavior Support Plan in that systematic manipulations are utilized in order to identify the true function of the target behavior(s) as well as to provide predictors of the usage of replacement behaviors. This assessment leads to the development of a Positive Behavior Intervention Plan which continues to require teaching of replacement behaviors, a consistent reinforcement schedule as well as frequent data collection/monitoring and revisions.

Identify Areas of Suspected Disability

Answering the following questions with a Yes or No may help the school psychologist identify which area(s) of emotional disturbance need to be targeted in the evaluation process.

I. An inability to learn which cannot be explained by intellectual, sensory or other health factors

- ✓ Is there or has there been Attendance issues?
- ✓ Is there a history of a processing disorder or learning disability?

- ✓ Does the student display a disorder in thought, reasoning, perception, or memory, which can be attributed to an emotional condition?

II. An inability to build or maintain satisfactory relationships with peers and teachers

- ✓ Does the student participate in social activities?
- ✓ Does the student report having friends?
- ✓ Does the student withdraw from peer and/ or adult contact?
- ✓ Is the student unable to initiate or maintain relationships or is he unwilling?
- ✓ Does the student avoid communicating with peers or adults? If so, is the student fearful of peers/adults?
- ✓ Is the problem with peers/adults related to antisocial subgroup behavior?
- ✓ Are conflicts with adults primarily with authority figures, issues of control, and/or power struggles?
- ✓ What is the student's affect? Is it appropriate or is it distorted?
- ✓ Does the student almost always choose solitary activities?
- ✓ Does the student show emotional coldness, detachment, or flattened affectivity?
- ✓ Are the students peer relationships short-lived, anxiety provoking and even chaotic?
- ✓ Are the student's peers alienated by intensity of student's need for attention?
- ✓ Are there constant conflicts and tension in almost all of the student's social relationships?

III. Inappropriate feelings or behaviors under normal circumstances

- ✓ Is the problem with peers/adults related to antisocial subgroup behavior?
- ✓ Are conflicts with adults primarily with authority figures, issues of control, and/or power struggles?
- ✓ What is the student's affect? Is it appropriate or is it distorted?
- ✓ Does the student accept responsibility for their behaviors or do they project blame to others or they confused?
- ✓ Is the student generally anxious or fearful?
- ✓ Does the student have severe mood swings of depression happiness to rage/anger for no apparent reason?
- ✓ Does the student display extreme mood liability or is the behavior the result of a quick temper?
- ✓ Does the student display behaviors associated with a conduct disorder or ODD?
- ✓ Does the student have delusions, auditory or visual hallucinations, disorganized speech, grossly disorganized or catatonic behavior, flat or inappropriate affect?
- ✓ Does the person have control of their behavior?
- ✓ Does the student suspect that others are exploiting, harming, or trying to deceive you?
- ✓ Does the student worry or preoccupied with unjustified doubts about loyalty or trustworthiness of friends?

- ✓ Is the student reluctant to confide in others because of unwarranted fear that information will be used maliciously against them?
- ✓ Does the student perceive attacks on their character or reputation, which are not apparent to others and is quick to react angrily or to counterattack?
- ✓ Does the student read hidden demeaning or threatening meanings into benign remarks or events?
- ✓ Does the student persistently bear grudges and is unforgiving of insults injuries or slights?
- ✓ Does the student display unexplained rage reactions or explosive, unpredictable behavior?
- ✓ Does the student display manic behavior?
- ✓ Does the student display repetitive, ritualistic, stereotyped motions?
- ✓ Is the student oriented to time or place?
- ✓ Does the student display bizarre ideas or statements?
- ✓ Does the student display a lack of contact with reality?
- ✓ Does the student have a sense of reality or is it distorted without regard to self-interest?
- ✓ Does the student display a marked illogical thinking, incoherence, loosening of associations or magical thinking?

IV. General pervasive mood of unhappiness or depression

- ✓ Does the student fail to demonstrate an interest in special events or interesting activities?
- ✓ Is the student overly dependent or impulsively defiant?
- ✓ Is the student generally anxious or fearful?
- ✓ Does the student have severe mood swings of depression happiness to rage/anger for no apparent reason?
- ✓ Do the behaviors appear associated with a conduct disorder or ODD?
- ✓ Does the person have control of their behavior?
- ✓ Does the student have an interest in their usual activities?
- ✓ Does the student display persistent feelings of depression, hopelessness, sadness or irritability?
- ✓ Is the student engaging in extreme self-destructive behavior?
- ✓ Is the student displaying behaviors associated with poor self-esteem or inadequate self-concept (e.g., blames self or inadequacies, real or imagined)?
- ✓ Is the student reporting recurrent thoughts of death or suicide? Does this occur often?
- ✓ Does the student have outburst of over activity or manic behavior?
- ✓ Does the student now have or in the past had problems with any of the following? A poor appetite or overeating; insomnia or hypersomnia; low energy or fatigue; low self-esteem; poor concentration, feelings of hopelessness?

- ✓ Has the student experienced a diminished interest or pleasure in all or almost all activities most of the day, nearly every day? When?
- ✓ Is the student experiencing feelings of hopelessness and sadness? Does this occur often? What are the circumstances they might feel that way?
- ✓ Has the student experienced a significant weight loss or weight gain?
- ✓ Has the student experienced recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation? When?
- ✓ Has the student experienced problems associated with psychomotor agitation or retardation nearly every day (must be observable by others)? When?

V. Tendency to develop physical symptoms or fears associated with personal or school problems

- ✓ Does the student have any physical symptoms or fears associated with personal or school problems?
- ✓ Does the student display-disabling anxiety when talking about school?
- ✓ What does the student say when he/she is questioned about the problem?
- ✓ Has the student experienced panic reactions?
- ✓ Is the student generally anxious and fearful?
- ✓ Are the parents reporting the behavior and has it been observed by an educator?
- ✓ Has the parent sought treatment to determine cause?
- ✓ Also consider if a formal health diagnosis exists.

Evaluation Strategies

As in any evaluation, the assessment team members must use professional judgment in selecting the battery of tools and instruments to be utilized with an individual child. The evaluation of behavioral-emotional functioning is conducted by a multi-disciplinary team, including a certificated or licensed psychologist. Each team member has information to contribute about the student, particularly about the frequency, intensity or duration of maladaptive behaviors or deficits in coping skills and emotional functioning. A behavioral-emotional evaluation includes the information about the unique personal attributes of the student and describes any distinctive patterns of behavior which characterize the student's personal feelings, attitudes, moods, perceptions, thought processes, and significant personality traits. Typically the evaluation includes records review, interviews with the student and parent, learning history, and behavioral observations with special consideration given to evaluation of disorders of thought, memory, judgment, and /or time-place orientation as appropriate. An individual intellectual evaluation shall be given when academic or learning deficits is suspected. In addition, the evaluation includes background data, checklists or rating scales, and an assessment of:

- the learning environment, including curriculum and task demands;
- academic strengths and weaknesses, including written and oral language and information from individualized achievement assessment;
- present levels of academic functioning; and
- vocational needs (for students age 14 and older).

Including family members' knowledge of their child can enhance the reliability and validity of the screening and assessment process (Yates, Ostrosky, Cheatham, Fellig, Shaffer, & Santos, 2008). Some of the benefits of family involvement in screening and assessing social-emotional competence are listed below:

1. Utilizing families' knowledge as a source of information about their children's social-emotional skills is valuable to the assessment process.
2. Involving families in the assessment process can lead to a better understanding of the child's social emotional skills.
3. Encouraging families to be active members on assessment teams can help them learn about their child's social-emotional strengths and needs.
4. Increasing families' presence and participation in the assessment process can help children establish trust and rapport with members of the assessment team.

Records Review. It is important to review the student's cumulative file and prior school assessments. In addition, look for evaluations conducted by other agencies such as the Department of Mental or Behavioral Health and Regional Center. Interview the parent and seek consent to request private mental health documents from a psychiatrist, psychologist, family therapist or clinical social work and/or authorization for a mental health hospital to release records to the evaluator.

Interviews. In regards to identification of emotional disturbance, structured or unstructured interviews are important in obtaining information about the student's medical and developmental history, social-emotional functioning, educational progress or history, and community involvement. The family is a critical component in identifying home environmental factors that may be impacting the child's behavior. Although not standardized, a formal interview format may provide relevant information. A sample Student Interview Form that has demonstrated success as part of the process in identifying emotional disturbance in included as Appendix A. There is also a sample Parent Interview Form included as Appendix B.

Observations. Systematic observation is completed in the child's environment and yields data critical to any evaluation procedure as it increases the chance of making correct assumptions. Observations must reflect multiple settings and time periods. Observations require a greater degree of planning and execution beyond merely watching a child perform within a particular setting and summarizing one's opinions about the child's behavior. Observations of children and youth should not be conducted for the sole purpose of meeting a procedural requirement. Rather, observations should be designed to address a specific purpose, need or question. A Behavioral Checklist Observation Form designed specifically for evaluations focused on identification of emotional disturbance is included herein as Appendix C. It is important to write observations as descriptive statements rather than subjective, inferential statements as noted in the following table.

Behavioral Descriptive Statements	Behavioral Inferential Statements
• The child was observed tapping his pencil and starring out the window	• The child was day dreaming
• The child or youth kicked his desk	• The child or youth was frustrated
• The child or youth refused a teacher directive to return to seat.	• The child or youth was oppositional
• During this observation the child passed a spelling test with 19/20 words correct.	• The child does not appear to have any difficulties with spelling.

It is important that observations be conducted to gather demonstration *of* the behaviors not information *about* the behavior. The interpretation of the behavior should occur after the data is collected and analyzed.

Projective Techniques. Projective tests require specialized training, adherence to administration criteria, and analytical interpretation of results. School psychologists may or may not feel they have the knowledge and skills to do this type of assessment based on their preparation training program.

Adaptive and Behavior Rating Scales. Rating scales are used to identify characteristics of emotional disturbance, to identify the extent of behaviors (intensity, frequency), and to reflect the observations of those who regularly engage with the individual (e.g., teacher, parent). Rating scales may be completed by anyone who knows the child. It should be understood that rating scales are not exact and should be used in conjunction with other methods of collecting data. Some rating scales provide for self-reporting measures, which allows the child to express inner feelings and perceptions of his/her behavior. See Appendix D for a list of potential behavior rating scales for different grade levels.

Standardized Assessments. There are a variety of inventories that have been standardized to assess for personality and/or specific mental health problems (e.g., anxiety, depression). Appendix E provides a list of appropriate personality tests for different grade levels. In addition, Appendix F provides an emotional functioning assessment overview of tools to use to evaluate specific areas of concern.

Identification of Emotional Disturbance

Emotional disturbance is difficult to define. In many cases the application of the definition is subjective. Children with emotional difficulties often lack the ability to behave in an acceptable manner consistently in a social environment such as school. Typically the reason for a referral for a mental health type of intervention is the student's behavior, emotionality and/or social competence. It is not important to specifically define those three terms, and it is not necessary to delineate which one, two, or three apply to an individual student. The student may have needs in any or all of the areas. The key concept is the underlying issue is not based solely on a communication disorder, cognitive limitations, or learning problems. The child may have an academic deficit but it is as a result of underlying social and/or emotional and/or behavioral issues. This concept has not changed.

Most children with other primary disability conditions have needs that can met with the lower level of behavioral, emotional and/or social interventions while those with more frequency, intensity or duration of difficulties need more intensive services. For example, one of the most intensive need eligibility categories is the federal IDEA definition of emotional disturbance. For special education eligibility purposes, this 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 child'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 general pervasive mood of unhappiness or depression;*
5) *A tendency to develop physical symptoms or fears associated with personal or school problems.*

Emotional or behavioral disorders can be divided into externalizing behaviors and internalizing behaviors. Per Smith (2011), externalizing behaviors constitute an acting-out style that could be described as aggressive, impulsive, coercive, and noncompliant. Internalizing behaviors are typical of an inhibited style that could be described as withdrawn, lonely, depressed, and anxious. Students who exhibit externalizing and internalizing behaviors, respectively, are the two main groups of students with emotional or behavioral disorders, but they do not account for all of the conditions that result in placement in this special education category. The following table defines and explains some of the common externalizing and internalizing behaviors seen in special education students.

Externalizing Behaviors	Internalizing Behaviors
Violates basic rights of others	Exhibits painful shyness
Violates societal norms or rules	Is teased by peers
Has tantrums	Is neglected by peers
Steals; causes property loss or damage	Is depressed
Is hostile or defiant; argues	Is anorexic
Ignores teachers' reprimands	Is bulimic
Demonstrates obsessive/compulsive behaviors	Is socially withdrawn
Causes or threatens physical harm to people or animals	Tends to be suicidal
Uses lewd or obscene gestures	Has unfounded fears and phobias
Is hyperactive	Tends to have low self-esteem
	Has excessive worries; Panics

Many children who do not have emotional disturbances may display some of these same behaviors at various times during their development. However, when children have an emotional disturbance, these behaviors continue over long periods of time. Their behavior thus signals that they are not coping with their environment or peers.

The determination of emotional disturbance should not be the result of a temporary traumatic event in the life of a child. Careful consideration should be given to the immediate influences that the child is subjected to in his environment. Also inappropriate behaviors of emotionally disturbed children should be observable in several settings including home and school and charted to determine the frequency. Typically emotionally disturbed children may also exhibit a number of other psychiatric disorders. The determination of disability shall not be made solely because the student's behavior violates the school's discipline code, because the student is involved with a state court or social service agency, or because the student is socially maladjusted, unless the IEP team determines that the student has an emotional disturbance (Massachusetts Department of Elementary and Secondary Education, 2006). The Maine Administrators of Services for Children with Disabilities Behavior Task Force (1999), North Dakota (2007) and Wisconsin Department of Public Instruction (2010) developed guidelines for the identification of this disability by further clarifying each of these descriptors as follows.

An Inability to Learn That Cannot Be Explained By Intellectual, Physical, or Health Factors

In essence, the student cannot learn in a general education classroom as demonstrated by failure to attain a satisfactory rate of educational progress, which cannot be explained by intellectual, sensory, health, cultural, or linguistic factors. This category requires that a student have so severe an emotional disability that he/she cannot learn despite appropriate educational interventions. Inability to learn should not be confused with an unwillingness or disinterest in learning. Basic definitions of inability to learn may include the following:

- incapable, unable, cannot, lacks the power or capacity to learn;
- cannot make academic gains when causes such as learning disability, mental retardation, and lack of motivation are eliminated.

Aspects of the student's thoughts, feelings, and behaviors should be examined to determine if they produce incapacity to learn in the normal school environment, under non-special education interventions. The differential assessment should rule out social/cultural issues, nonattendance, and motivation (e.g. the student refuses to complete homework as part of a pattern of disinterest in learning), as primary factors interfering with the student's ability to learn. A student with emotional disability may exhibit discrepant achievement due to anxiety, pervasive depression, and/or reality distortion. These underlying thoughts and feelings may manifest themselves in behaviors associated with being disorganized, quitting or giving up easily, difficulty retaining material, learning to some extent but achievement scores significantly different than potential.

An Inability to Build or Maintain Satisfactory Interpersonal Relationships with Peers and Teachers

Satisfactory interpersonal relationships include, but are not limited to, the ability to demonstrate sympathy, warmth, and empathy towards others; to establish and maintain friendships; to be constructively assertive; and to work and play independently. This characteristic requires documentation that the student is unable to initiate or to maintain satisfactory interpersonal relationships with peers and adults in multiple settings, at least one of which is educational. Examples of unsatisfactory student characteristics may include behaviors, such as, physical or verbal aggression, lack of affect, disorganized/distorted emotions toward others, demands for attention, or withdrawal from social interactions. These should be considered when observing the student’s interactions with peers and adults.

Through an analysis of the information obtained, the evaluator will need to determine that the student has been unable to establish meaningful and/or satisfactory interpersonal relationships with peers and teachers. This inability exists primarily because of the severity of the emotional disability. Inability should be distinguished from an unwillingness to form relationships that others consider appropriate. It is not an issue of getting along with others. It is a question of whether the student has an impairment that negatively affects his/her ability to interact with others (e.g. demonstrating warmth and sympathy toward others, initiating positive interactions, enjoying working and playing with others, etc.).

Other disabilities may result in the lack of social skills that could otherwise be systematically taught to the student. The lack of social skills alone or as the result of another disabling condition does not make a student eligible under this category. A differential diagnosis needs to rule out other factors such as social maladjustment or social immaturity as being responsible for

the impairment. A student with emotional disability may exhibit one or more of the following characteristics:

- Has no friends at home, at school or in the community;
- Does not voluntarily play, socialize, or engage in recreation or structured activities with others;
- Avoids talking with teachers and peers, or is selectively mute;
- Is excessively physically or verbally aggressive when others approach him/her; alienates others through consistently hostile or detached (uncaring) behaviors;
- Shows lack of affect, disorganized emotions toward others, or auditory/visual hallucinations which negatively affect relationships with others;
- Displays consistent anxiety-based or fear-driven avoidance of meaningful school-based social interactions;
- Exhibits withdrawal, isolation and/or bizarre interactive patterns suggesting behaviors symptomatic of schizophrenia, social phobic reactions, depression, obsessive-compulsive disorders, etc.;
- Seeks excessive approval from others through abusive, self-humiliating and/or immature actions;
- Seeks negative attention by being ostracized, punished, humiliated, and/or hurt by others.

The following behaviors may be seen in students with emotional disturbance:

- Excessively controlling
- Is too easily influenced by peers
- Uses/manipulates others
- Lacks trust in others or is fearful of others
- Wants constant attention or approval
- Difficulty attaching to others
- Exhibits inappropriate sexual behavior
- Ignored or rejected by peers
- Is too easily influenced by peers
- Excessively dependent
- Inability to interact with a group/play by the rules
- Sees self as a victim
- Difficulty separating from caregivers
- Overly affectionate
- Lack of social awareness—may not understand social conventions or behavioral expectations

Inappropriate Types of Behaviors or Feelings under Normal Circumstances

Inappropriate behaviors or feelings refer to those behaviors that make the student appear strange or unusual compared to others in the same situation. Inappropriate behavior can be withdrawn, deviant, or bizarre behavior, not just aggressive or acting-out behavior. Some children express their inappropriate behavior or feelings through confused verbalizations, fantasizing, preoccupation with emotional conflict in their art work, written expression, or other outlets. Developmental norms and comparisons with peers in similar circumstances should be used to judge whether the behaviors are inappropriate or unusual. This category does not include behaviors that would be described as solely oppositional or conduct disordered in nature. It also does not include behaviors that are willful and understood by the student. It does include behaviors that are bizarre or psychotic, such as compulsions, hallucinations, preoccupations, delusions, ritualistic body movements, or severe mood swings, as well as exaggerated forms of other problems. A student in this category may exhibit one or more of the following characteristics:

- Reacts catastrophically to everyday occurrences;
- Lacks appropriate fear reactions;
- Shows flat, blunted, distorted, or excessive affect;
- Engages in bizarre verbalizations, peculiar posturing or ritualistic behavior;
- Engages in self-mutilation;
- Demonstrates manic reactions or manic behaviors, such as unexplained euphoria, racing thoughts, and excessive activity;
- Has delusions, such as believing that his/her thoughts are controlled by someone else or having unfounded feelings of persecution, over-exaggeration of ability, or feeling that situations or discussions always refer to him/her even with evidence to the contrary;
- Has hallucinations, such as hearing things that are not there or seeing things that are not there;
- Has obsessions, such as persistent, recurrent, or intrusive thoughts that cannot be controlled;
- Displays extreme changes or shifts in mood or feelings;
- Displays unexplained rage reactions or violent temper tantrums;
- Dwells in a fantasy life or seems to be out of touch with reality;
- Displays regressive behaviors and/or unacceptable social behaviors under stress, such as temper tantrums, excessive or uncontrollable crying, wetting pants or soiling;
- Laughs or cries inappropriately in ordinary or common social or academic situations;
- Uses disjointed verbal communication in which ideas are not logically related to the content of the discussion;
- Displays extreme social withdrawal;
- Behaves aggressively in a manner that seems unprovoked or extreme for the circumstance, such as physically attacking other children for unclear or unjustified reasons;
- Expresses unusual and unprovoked sexual behaviors, such as public masturbation or attempts to fondle teachers or peers.

Such characteristics may manifest themselves in the following behaviors:

- Limited or excessive self-control
- Low self-esteem and/or distorted self-concept
- Inappropriately laughs or cries
- Overreacts
- Refuses to respond to others
- Inability to make changes or transitions
- Appears remorseless
- Lacks empathy
- Disorganized or scattered thought processes
- Wide mood swings
- Low frustration tolerance, emotional overreactions, and impulsivity
- Rapid changes in behavior or mood
- Limited ability to predict consequences of behavior
- Lies, cheats, steals
- Refuses to do school work
- Non-compliant or passive-aggressive
- Exhibits flat affect
- Lack of assertiveness
- Overly perfectionistic or hard on self
- Becomes defensive without provocation
- Excessive emotional responses
- Extreme responses to changes in routine or schedule

Once it is established that the inappropriate behaviors are significantly deviant, it also must be determined that they are due to an emotional condition. The evaluator(s) must determine whether the student's inappropriate responses are occurring "under normal circumstances."

When considering “normal circumstances,” one should take into account whether a student’s home or school situation is disrupted by stress, recent changes, or unexpected events. However, such evidence does not preclude an eligibility determination.

A General Pervasive Mood of Unhappiness or Depression

To meet this criteria the student must demonstrate actual, symptoms of depression. Depressive symptomology typically involves changes in four major areas: affective, motivational, physical and motor functioning, and/or cognition. The student's manifestation of unhappiness or depression must be pervasive, chronic, and observable in the school setting. This means that it must have become a protracted state that has persisted beyond the time usually expected for reactions to a specific traumatic event or situation.

Feelings of unhappiness or depression are considered natural reactions when they are the response to traumatic events such as parental divorce or the death of a family member. Such reactions need to be evaluated in the context of the situation in which they occur with special attention given to the intensity and duration. If the reactions appear to be of mild or moderate intensity, of short duration and closely tied to a specific situation, then they should be addressed by utilizing non-special education interventions, such as individual counseling or referral for mental health services outside of school.

If the unhappiness or depression seems unusually intense or has generalized to other situations, then this could indicate an emotional disability. Serious talk about death or a genuine desire to die or commit suicide would indicate a severe reaction that needs to be addressed immediately through referral to a mental health professional. If suicidal thought or depression persists then this could be indicative of an emotional disability. A student in this category may exhibit one or more of the following characteristics:

- Seems constantly unhappy, sad, depressed and/or hopeless;
- Has lost interest in and/or pleasure in activities, pastimes or social relations;
- Displays major changes in eating patterns and weight level when not dieting;
- Demonstrates loss of energy, is frequently fatigued/over-tired, and/or is experiencing insomnia or hypersomnia;
- Acts excessively agitated or is unusually over or under-active compared to previous behavior;
- Manifests feelings of worthlessness or inferiority, through repeated self-denigration;
- Expresses feelings of excessive or inappropriate guilt;
- Shows prolonged periods of crying and confusion about the reason for crying;
- Seems to feel little or no emotion or is emotionally unresponsive;
- Has recurrent thoughts of death or desires to be dead;
- Engages in suicidal ideation and/or attempts to harm self;
- Displays outbursts of uncontrollable and excessive anger, frustration, or irritability which are changes from previous behavior;
- Exhibits diminished ability to think or concentrate, such as memory difficulty or indecisiveness, that is not associated with marked loosening of associations or incoherence;
- Loss of interest in socialization or preferred activities.

These characteristics may manifest themselves in the following ways:

- Listless or apathetic
- Overly pessimistic
- Hides
- Anxious habits such as nail biting or hair pulling
- Preoccupied
- Insomnia or hypersomnia nearly every day
- Volatile temper or excessive anger
- Depressed or irritable mood most of the time
- Fatigue or diminished energy nearly every day
- Thinks/ talks repeatedly of suicide
- Preoccupied with negative feelings
- Runs away from home
- Expresses feelings of worthlessness, hopelessness
- Obsessive/compulsive
- Lacks or loss of interest in surroundings, activities, etc.
- Blames self; extremely self-critical
- Unexpected changes in weight or appetite
- Feelings of excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness, nearly every day

A Tendency to Develop Physical Symptoms or Fears Associated with Personal or School Problems

This category represents physical symptoms or fears that develop as reactions to emotional problems that have no known medical cause. Biological or medical conditions such as allergies, neurological syndromes and effects of medications should be ruled out. Also, since it is common to manifest physical reactions to stress and tension, it is important to demonstrate that the physical symptoms and fear are excessive and chronic.
Fears may range from incapacitating feelings of anxiety to specific and severe phobic reactions and panic attacks. Typically such feelings and reactions are irrational and persistent to the degree that the student engages in consistent avoidance behavior in regard to the person or object of his/her fear. The inability to avoid the object or circumstance will usually result in severe anxiety or panic attacks. Generally children can describe their fears but cannot give a meaningful explanation to them. True school phobia [termed Separation Anxiety Disorder in DSM-IV] may fit under this category. The evaluation must clearly differentiate between school phobia and truancy. A student in this category may exhibit one or more of the following characteristics:

- Complains of physical problems without known medical cause, such as aches and pains, headaches, nausea, problems with eyes, rashes, stomachaches, cramps or vomiting;
- Displays physical reactions that appear specifically linked to stress or conflict, such as increased heart rate, sweating palms, or tremors;
- Shows physical reactions or behaviors that are not under voluntary control, such as tics, eye blinking, or unusual vocalizations that are not related to physical conditions;
- Has persistent and irrational fear of specific objects, situations, or activities that result in compulsive and/or avoidance behavior;
- Expresses excessive fear of going to school;
- Has irrational fear that catastrophe or harm will occur to self, parent, or other important person, or fears a parent/adult will leave home and never return;
- Worries excessively about learning or school performance to the point where somatic complaints are evident and/or result in the inability to function/perform;
- May be preoccupied with morbid beliefs or thoughts;
- Excessively fearful in response to new situations, certain people or groups, certain classes or activities.

These concerns may manifest themselves in the following behaviors:

- Excessive absences, tardiness, truancy
- Refusal to attend school ("school phobic")
- Unusual sleeping or eating patterns
- Accident prone
- Fearful of getting hurt or rejected
- Flinches or cowers
- Self-mutilation and/or eating disorder
- Frequent requests to visit the health office
- Auditory or visual hallucinations
- Psychosomatic illnesses
- Constant complaint of being picked on
- Neglects self-care and hygiene

Demonstrated Over a Long Period of Time

The qualifier "a long period of time" requires that the student must exhibit one or more of the behavioral characteristics long enough to be considered chronic. This means that the behavioral characteristics are manifested over a long period of time (e.g. 6 months or longer), displayed via high frequency of occurrences over a short period of time, or through multiple acute episodes that may be the culmination of underlying emotional problems. Such differential time periods may be appropriate to consider in relation to the chronological age of the student or the intensity of the problem. For example, shorter duration might be considered for young children rather than for adolescents. Shorter time periods might be appropriate for acute problems that demand immediate interventions. A letter written by the Office of Special Education Programs in 1989 (*Letter to Anonymous,* EHLR 213;247) stating that a generally acceptable definition of "a long period of time" is a range of time from two to nine months, assuming preliminary interventions have been implemented and proven ineffective during that period (North Dakota, 2007). The qualifier "a long period of time" excludes episodic emotional or behavioral disturbances that are transitory and would be expected to subside over time under normal circumstances. Examples of short term responses to situational stressors would include reactions to traumatic events, such as death in the family, divorce, illness, birth of a sibling, a family move or financial crisis. In these types of situations, it is necessary to determine that the problems have continued beyond the expected time limits for normal adjustment.

Demonstrated to a Marked Degree

"To a marked degree" is a limiting condition that actually comprises two separate components, both of which must be present for the condition to be met:

- **Pervasiveness** — Students should demonstrate the characteristics of their disability across most settings (i.e. school, home, community). Problems should be observed and documented by several members of the school staff or in more than one class in order to verify that they are pervasive in the school environment and not confined to a single setting or relationship. *If problems exist primarily in the home or community but not in the school environment, then the student should not be considered a student with emotional disability.*
- **Severity / Intensity** — These terms refer to the demonstration of problem behaviors in an overt, acute and observable manner. Manifestations of the problem behaviors must be clearly apparent to school staff and others who are familiar with the student and not solely documented in psychological assessments or clinical settings. However, psychological evaluations should be used to help verify the presence and severity of the emotional disability.

In determining this qualifier, evidence of the behavior should be observed by more than one person across a variety of settings and environments. It should occur in noticeable, predictable

patterns, and be considered significant in rate, frequency, intensity, or duration. The problem behaviors must be more severe or frequent than the normally expected range of behavior for individuals of the same age, gender, and cultural group. Finally, the problem behaviors have not been changed or improved after implementation of at least two planned and documented interventions applied in the school setting prior to referral. Behavioral characteristics should not be a secondary manifestation attributable to substance abuse, medication, or a general medical condition (e.g., hypothyroidism). The behavior is not the result of a developmental phase or due to ethnic or cultural issues. Normative comparisons can be obtained through the use of standardized measures, criterion and statistically based measures, and/or the use of developmentally based evaluations.

That Adversely Affects the Child's Educational Performance

Manifestations of the emotional problems must result in an impairment of the student's ability to learn and/or perform the academic or daily living tasks required in his or her educational program. It is necessary to demonstrate that it is the manifestation of the student's emotional problems -- and not some other condition (e.g. a learning disability, limited cognitive ability, etc.) -- that impacts educational performance. Adverse educational performance can be defined as measurable achievement that is significantly lower than one would reasonably expect for that student's level of cognitive functioning and that results in the inability to make educational progress. It can be demonstrated by any of the following:

- Inability to pass from grade to grade, or to pass several academic courses in a given year;
- Work samples that show abnormal thought processes and/or an inability to complete tasks;
- Curriculum or portfolio based information that clearly demonstrates a rate of academic progress that is noticeably slower than that of the student's peers and slower than what would have been predicted for that student based on his/her intellectual ability;
- Standardized achievement scores that are approximately one and a half standard deviations below the student's expected achievement based on intellectual ability;
- Inability to attend, concentrate, follow class discussions and/or participate appropriately in educational activities, resulting from such things as bizarre thought processes or out-of control emotions;
- Serious, recurring disciplinary problems that are emotionally based and that interfere with educational performance.

From another perspective, the behavior significantly impacts a student’s educational progress, taking into consideration academic performance and/or social emotional growth. Academic performance includes things such as an inability to take on what is expected at the age level, sudden changes in grades, inconsistent performance, spending excessive time or energy to complete assignments to maintain grades, or excessive energy to maintain effort in the classroom. Social emotional growth may include difficulties in the areas of social relationships, personal adjustment (self-esteem and self-concept), self-care, and vocational skills. Considerations in this area generally include the frequency, duration and intensity of the behavior in comparison to peers. It also can include consideration of whether the behavior adversely affects the education of others.

The purpose of evaluation and reevaluation is not only to determine whether the child has a disability, but also to establish the educational needs of the child. The “adversely affects a child’s progress” part of the definition is the first step in determining those needs.

- **Academic progress**—traditional measures of school progress: report card grades, attendance, high school credit accumulation, levels of achievement compared to potential, performance on standardized tests such as statewide or district-wide assessments, meeting expectations for processing information and learning. A student *need not be failing academically* to meet the definition of emotional disturbance, since there are five other need areas that may be descriptive of behaviors associated with such a diagnosis.
- **Social Competence**—Social skills and adaptive behaviors which enable students to meet environmental demands and assume responsibility for his/her and others' welfare are elements of social competence which is one aspect of educational performance. Since social development is a necessary and critical component of a student's educational performance, deficits in social competence which impair one's ability to form and maintain interpersonal relationships with adults and peers may qualify the student for emotional disability services regardless of academic achievement if other identifying criteria are met.
- **Social relationships**—ability to get along with others, to interact with both adults and peers formally and informally, manage one's behavior in a variety of environments, read social cues, initiate and maintain relationships with others, integrate socially into the school and community.
- **Personal adjustment**—ability to handle stress; self-concept and self-esteem issues; and how the student feels about himself/herself.
- **Classroom adjustment / Prevocational skills**—skills related to the ability to function and succeed in classroom settings, set goals, follow classroom and school rules, attend regularly and arrive on time, comply with requests, bring materials to class, work in large and small groups, perform on classroom assignments and tests, organizational and study skills, note taking if appropriate to grade level, keeping an assignment notebook if appropriate, keep track of long term assignments, accept feedback and correction, work independently, skill at "being a student".
- **Self-care**—as it relates to emotional disturbance, self-care is a performance deficit: the student *knows* the basic self-care concepts but is not *demonstrating* those skills. The student may exhibit a lack of personal care to an extent that prevents or significantly impairs his/her ability to interact with others. This may include students with eating disorders, those who exhibit self-mutilating behaviors, who are self-destructive, or engage in dangerous thrill-seeking behaviors. This area of need is not the same as adaptive skill behavior included under the eligibility criteria for a cognitive disability.
- **Vocational skills**—skills that should be incorporated into transition planning. Rather than teaching job skills or how to apply to post-secondary education programs, this area focuses on the student's ability to manage his/her personal needs in a work or other post-high school setting, to appropriately apply social skills to those settings, and to demonstrate self-advocacy skills in understanding his/her disability and the ramifications of that disability. For students who have mental health needs, this area may include helping them to identify community resources and to transition from the child/adolescent system to the adult system.

Rule Out Social Maladjustment

"Social maladjustment" is excluded from the category of emotional disturbance unless it is determined that the individual also has an emotional disability. Social maladjustment has been generally accepted as consisting of behaviors that are outside established norms of the majority culture but that may be acceptable to members of the same subculture. It involves a persistent pattern of violating societal norms through such behaviors as truancy, substance abuse,

perpetual struggles with authority, poor motivation for schoolwork, and impulsive and manipulative behavior. Per the Maine model, a student may demonstrate social maladjustment in one or more of the following ways:

- Displays misbehavior that is controlled and understood;
- Usually has intact peer relations;
- Is often a member of a subculture group that is asocial or antisocial;
- Is often skilled at manipulating others;
- Has conflicts primarily with authority figures (e.g. parents, school personnel, police);
- Often displays self-confidence or strong self-identity outside of school situations;
- Tends to be independent and to appear self-assured;
- Appears defiant and oppositional;
- Shows courage, responsibility and imagination but toward undesirable ends;
- Generally reacts toward situations with appropriate affect;
- Lacks appropriate guilt (i.e. underdeveloped conscience) and often blames others for his/her problems though otherwise appears reality oriented;
- Dislikes school except as a place for social contacts;
- Is frequently truant, and/or rebels against rules and structures;
- Is involved with the criminal justice system;
- Frequently avoids school achievement even in areas of competence;
- Has a diagnosis of conduct disorder or a dual diagnosis of conduct disorder and substance abuse.

Per the Wisconsin model, students with social maladjustment display little remorse, seek pleasure, are street-wise, display behavior that is more situational dependent, act tough, and are seen as "a survivor". The individual may hurt self or others as a means to an end, may be viewed as "cool" even if feared, have friends of same age or older. He or she may be described as "bad", seen as unwilling to comply, generally has low achievement, doesn't want help, and blames others. Anger is the most common emotional overreaction and self-reflection is rarely employed. Behaviors may be self-serving, he or she may be manipulative, he or she understands but does not accept general behavioral standards, are usually loyal to a delinquent peer group, and may possibly have family, peer, or neighborhood support for behaviors. Such individuals may appear to have adequate self-esteem, show "macho" or "bravado" behaviors, and have a very superficial sense of self. Two documents have been included herein to help evaluators in this decision making process: *"A Guide to Differentiating Emotional Disturbance and Social Maladjustment"* (Appendix G) and *"A Guide to Differential Diagnosis and Educational Options"* (Appendix H).

Consider Other Disabilities and Disorders

It is the responsibility of the evaluation team members to determine if a student's academic difficulties are primarily caused by emotional disturbance. Many students with emotional problems have a disability complicated by a secondary diagnosis. The co-occurrence of emotional disturbance and other disabilities may intensify a student's behavioral problems and further compromise academic performance. It is important to understand the other characteristics and their implications when designing appropriate social, emotional, behavioral, curricular, and instructional strategies. Students with emotional disturbance who are eligible for services under IDEA may exhibit comorbidity of emotional and behavioral disorders. Such students are at greater risk for substance abuse disorders and negative encounters with the juvenile justice system.

Consider Other Special Education Eligibility Criteria

The IDEA requires that a child be assessed in all areas of suspected disability. This needs to be considered when determining the assessment instruments and strategies to employ, who is involved in the evaluation process, and how the findings are analyzed. Many students with emotional disturbance have a secondary disability or disorder also impacting their educational performance.

- **Autism.** Autism is a complex developmental disability that causes problems with social interaction and communication. Symptoms usually start before age three and can cause delays or problems in many different skills that develop from infancy to adulthood. Different people with autism can have very different symptoms. One person may have mild symptoms, while another may have serious symptoms. But they both have an autism spectrum disorder. Per California Code of Regulations Title 5 Section 3030(g), an individual qualifies for special education when he/she exhibits any combination of the following autistic-like behaviors, to include but not limited to: (1) An inability to use oral language for appropriate communication. (2) A history of extreme withdrawal or relating to people inappropriately and continued impairment in social interaction from infancy through early childhood. (3) An obsession to maintain sameness. (4) Extreme preoccupation with objects or inappropriate use of objects or both. (5) Extreme resistance to controls. (6) Displays peculiar motoric mannerisms and motility patterns. (7) Self-stimulating, ritualistic behavior.

A review of existing studies done by Connor (1999) shows those young children with high functioning autism could be contrasted with children with Asperger syndrome on a range of developmental disorder symptoms, notably those concerned with socialization and communication, and standard measures of language skill. Both groups showed impaired executive functioning skills. While the Asperger group performed significantly better on theory of mind and verbal memory tasks, such children are more likely to have disorganized thought processes, focus upon their internal experiences, and have more complicated fantasy lives.

A study by Tonge, Brereton, Gray, and Einfeld (1999) aimed to determine whether there were differences in behavioral and emotional disturbance between children and adolescents with high-functioning autism and Asperger syndrome. It was found that children and adolescents with Asperger's disorder presented with higher levels of psychopathology than those with high-functioning autism, were more disruptive, antisocial and anxious, and had more problems with social relationships. The authors considered their finding of extreme symptoms of anxiety and disruptive behavior in the Asperger group of particular clinical relevance and noted that these problems are potentially open to cognitive behavioral interventions and psychopharmacological treatment. They argue that young people with Asperger's disorder require at least equivalent levels of clinical service, educational assistance, and social and family support as those with high-functioning autism.

- **Intellectual Disability.** Until Rosa's Law was signed into law by President Obama in October 2010, IDEA used the term "mental retardation" instead of "intellectual disability." Rosa's Law changed the term to be used in future to "intellectual disability." The definition itself, however, did not change. Accordingly, "intellectual disability" is defined as "…significantly sub-average general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period, that adversely affects a child's educational performance" [34 CFR §300.8(c)(6)]. Research by Emerson (2003) suggests that: (1) rates for conduct disorders, anxiety disorders, attention deficit hyperactivity disorder and pervasive developmental disorders are higher among children with intellectual disabilities than among their non-intellectually disabled peers; (2) there were no statistically significant differences between

children with and without intellectual disabilities with regard to rates of depressive disorders, eating disorders or psychosis. Such students need goals/objectives and services that address all their needs.

- **Other Health Impairment due to Attention Deficit.** A diagnosis of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) by itself does not entitle a student to special education services. However, such students may qualify for services under other health impairment, specific learning disability, and/or emotional disturbance. ADD is described as ADHD without the hyperactivity and is characterized by excessive daydreaming, frequent staring, cognitive sluggishness, lethargy, confusion, memory problems and social reticence. Student often blurt out answers before questions have been completed, have problems waiting their turn and may frequently and unwittingly interrupt or intrude on others.

The behavior of students with ADHD is characterized by poor sustained attention, impaired impulse control, an inability to delay gratification and excessive task-irrelevant activity. Students may often fidget with their hands or feet, appear restless, leave their seat in the classroom or in other situations in which remaining seated is expected, may run about or climb excessively in situations where it is inappropriate, have difficulty playing or engaging in leisure activities quietly and may often talk excessively. Students with ADHD find it difficult to plan and control their behavior. They often seem unaware of danger and have a tendency to rush into things. They also find listening to, remembering and following through on instructions difficult and fail to finish school work. Students are often reluctant to engage in activities that require prolonged effort, are easily distracted by extraneous stimuli and often have difficulty organizing materials required for participating in learning tasks. Students with ADHD have difficulty with sustained play and are often disliked by their peers because of their aggression, impulsiveness and inability to take responsibility for their actions. The incidence of symptoms tends to decline in adolescence and adulthood but the disorder persists. Students with ADHD are often on medical treatment to mitigate the impact of the disorder on their daily lives.

- **Specific Learning Disability**. Often students with emotional issues are originally diagnosed as learning disabled. Such students demonstrate a disorder in one or more of the basic psychological processes involved in understanding or using language, spoken or written, which may manifest itself in an impaired ability to listen, think, speak, read, write, spell, or do mathematical calculations, and have a severe discrepancy between intellectual disability and achievement in one or more academic areas; the basic psychological processes include attention, visual processing, sensory-motor skills, and cognitive skills including association, conceptualization, and expression (Title 5, Section 3030(j)). Typically academic achievement for these students includes the student's level of competence in materials and subject matter explicitly taught in school and is measured by standardized achievement tests.

Other Mental Health Diagnoses

It is **NOT** the responsibility of a school psychologist to make a specific mental health diagnosis as it is outside his or her scope of practice. However, it is important that school psychologists understand the characteristics of different mental health disorders to help them in their analysis of the data obtained through the identification of emotional disturbance process. A diagnosis determined by a mental health expert using the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revised (DSM-IV-TR) does not automatically make a student eligible for special education as emotionally disturbed. One must apply the IDEA eligibility criteria to assessment results to make this determination. In most situations the clinical diagnosis of a mental disorder is not sufficient to establish the existence for legal purposes of a mental disability. Additional information about the individual's functional impairments and how these affect the particular abilities in question must be gathered. Per the DSM manual, a

diagnosis does not carry any necessary implications regarding the causes of the individual's mental disorder or its associated impairment.

- **Bipolar Disorders**. Per the Mayo Clinic, bipolar disorders are one of several medical conditions called depressive disorders. Depressive disorders affect the way a person's brain functions. Bipolar disorder goes by many names: manic depression, manic-depressive disorder, manic-depressive illness, bipolar mood disorder, and bipolar affective disorder are medical terms for the same condition. Bipolar disorder is classified into four different types by mental health experts because the symptoms of bipolar disorder show up differently in different people. When doctors know what type someone has, they can tailor treatment to that person's specific needs.

Bipolar disorder often shows up in adolescence, affecting males and females. Kids who have bipolar disorder may experience particularly rapid mood changes and may have some of the other mood-related symptoms such as irritability and high levels of anxiety. Because brain function is involved, the ways people with bipolar disorder think, act, and feel are all affected. This can make it especially difficult for other people to understand their condition. A person with bipolar disorder will go through episodes of mania (highs) and at other times experience episodes of depression (lows). These aren't the normal periods of happiness and sadness that everyone experiences from time to time. Instead, the episodes are intense or severe mood swings, like a pendulum that keeps arcing higher and higher.

Symptoms of mania include: racing speech and thoughts; increased energy; decreased need for sleep; elevated mood and exaggerated optimism; increased physical and mental activity; excessive irritability, aggressive behavior, and impatience; poor judgment; reckless behavior, like excessive spending, making rash decisions, and erratic driving; difficulty concentrating; inflated sense of self-importance. Symptoms of depression include: loss of interest in usual activities; prolonged sad or irritable mood; loss of energy or fatigue; feelings of guilt or worthlessness; sleeping too much or inability to sleep; drop in grades and inability to concentrate; inability to experience pleasure; appetite loss or overeating; anger, worry, and anxiety; thoughts of death or suicide

Episodes of mania or depression may happen irregularly and follow an unpredictable pattern or they may be linked, with a manic episode always following a period of depression, or vice versa. Sometimes episodes have a seasonal pattern. Between episodes, someone with bipolar disorder usually returns to normal (or near-normal) functioning. For some people, though, there is little or no "break period" between their cycles. These mood swing cycles can change slowly or rapidly, with rapid cycling between mania and depression being much more common in women, children, and adolescents. Some people with bipolar disorder turn to alcohol and drugs because they feel temporarily better when they're high. But using alcohol and drugs can have disastrous results for people with bipolar disorder. Substance abuse can actually make the symptoms worse, as well as making the condition hard for doctors to diagnose.

- **Conduct Disorder.** Conduct disorder (CD) typically refers to students whose behaviors are disruptive to the learning process or social interactions of the group. Acting out behavior is generally situation specific rather than pervasive and may be under the student's control if he/she can verbalize the behavior and its purpose. The behavior may be more intense than that of normal students in the same situation, and may be learned, but is less antisocial or purposefully aggressive than that of socially maladjusted students. Incorporating social skills instruction and positive behavior interventions and supports will assist schools in serving students with CD in the least restrictive environment.

Per the Special Education Support Service (SESS, http://www.sess.ie/), CD may at first present as what one may believe to be oppositional defiant disorder (ODD); however, it is more severe and has more socially disruptive and disturbing characteristics. While students with CD may share characteristics similar to the students with ODD they are more physically aggressive and threatening, and appear to lack empathy. Behavior in which the rights of others or age appropriate societal norms are violated is persistent and repetitive. CD is one of the most disruptive and difficult conditions to affect the behavior of students and those with CD have great difficulty following rules and behaving in a socially acceptable way. Typically, CD is not diagnosed until the student is at post-primary level.

Those with CD may be aggressive to people and/or animals and this may be exhibited when the student bullies, threatens or intimidates others, initiates physical fights, uses a dangerous weapon, is physically cruel to people and/or animals, steals while confronting others (e.g. mugging, purse snatching, extortion) and/or forces someone into sexual activity. Students with CD may deliberately set fires and destroy property. Deceitfulness, lying and/or stealing also characterize the student with CD and may present when a student breaks into a house/car, lies and engages in stealing activities such as shoplifting. Serious violation of rules may also be associated with CD and may include truancy from school. It is exceptionally rare for a student to present with CD alone. The student may have some other neuropsychiatric disorder such as attention deficit hyperactivity disorder (ADHD), depression or bipolar disorder. Students with CD may also have Tourette syndrome, learning difficulties, mood disorders, obsessive compulsive disorder (OCD) or other special educational needs.

- **Depression.** Child depression is one of the mental, emotional, and behavior disorders that can appear during childhood and adolescence. Some of the common signs for child depressions are sadness that won't go away, boredom, hopelessness, unexplained irritability or crying, and loss of interest in usual activities. Child depression can lead to school failure, alcohol or other drug use, and even suicide. The depressed child may pretend to be sick, refuse to go to school, cling to a parent, or worry that the parent may die. Older children may sulk, get into trouble at school, be negative, grouchy, and feel misunderstood. Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child is just going through a temporary "phase" or is suffering from depression.

- **Generalized Anxiety Disorder.** Per the Anxiety Disorders of America website (www.adaa.org), this disorder is characterized by persistent, excessive, and unrealistic worry about everyday things. People with the disorder, which is also referred to as GAD, experience exaggerated worry and tension, often expecting the worst, even when there is no apparent reason for concern. They anticipate disaster and are overly concerned about money, health, family, work, or other issues. GAD is diagnosed when a person worries excessively about a variety of everyday problems for at least 6 months. Sometimes just the thought of getting through the day produces anxiety. They don't know how to stop the worry cycle and feel it is beyond their control, even though they usually realize that their anxiety is more intense than the situation warrants. The disorder comes on gradually and can begin across the life cycle, though the risk is highest between childhood and middle age. Although the exact cause of GAD is unknown, there is evidence that biological factors, family background, and life experiences, particularly stressful ones, play a role. Although they may avoid some situations because they have the disorder, some people can have difficulty carrying out the simplest daily activities when their anxiety is severe.

- **Obsessive-Compulsive Disorder**. Often referred to as OCD, obsessive-compulsive disorder is actually considered an anxiety disorder. OCD is characterized by recurrent, unwanted thoughts (obsessions) and/or repetitive behaviors (compulsions). Repetitive behaviors (hand washing, counting, checking, or cleaning) are often performed with the hope of preventing obsessive thoughts or making them go away. Performing these so-called "rituals," however, provides only temporary relief, and not performing them markedly increases anxiety. A large body of scientific evidence suggests that OCD results from a chemical imbalance in the brain. (http://nichy.org)

- **Oppositional Defiant Disorder.** Per the Special Education Support Service (SESS, http://www.sess.ie/), Oppositional Defiant Disorder (ODD) is a psychiatric disorder, the definite causes of which are unknown, although biological and environmental factors may have a role to play. The hallmark of ODD is a recurrent pattern of negative, defiant, disobedient and hostile behavior towards authoritative figures in particular that continues for at least six months, during which four or more of the following are often present:
  - ✓ loses temper
  - ✓ argues with adults
  - ✓ actively defies/refuses to comply with adults' requests or rules
  - ✓ puts the blame for own mistakes or behavior on others
  - ✓ deliberately annoys people
  - ✓ is easily upset or annoyed by others
  - ✓ is angry and resentful
  - ✓ is spiteful and vindictive

Such disturbances cause clinically significant impairment in social, academic, and/or occupational functioning. Students with ODD possess a 'counter-will': the more pressure one applies the greater the opposition. Actions are premeditated and often the student may want confrontation. Typically, in the school situation, the student with ODD will be aggressive and will purposefully bother and irritate others. It is exceptionally rare for a student to present with ODD alone. Usually such students have other neuropsychiatric disorders such as attention deficit hyperactivity disorder, bipolar disorder, conduct disorder, depression, Tourette syndrome, or other special educational needs.

- **Post-Traumatic Stress Disorder (PTSD).** All children exposed to the intense fear and helplessness associated with trauma or death of a loved one may be susceptible to PTSD (http://MayoClinic.com). This should not be diagnosed as an emotional disturbance. Some children experience or witness unusual, sudden and frightening traumatic events such as child abuse, community violence, and/or natural disasters. These events may involve the actual or threatened death or serious injury to the children themselves or to someone they know. Children's PTSD symptoms fall into the following categories:
  - Re-experiencing: Moments when a child seems to replay the event in his/her mind; intrusion of recurrent memories of the event or repetitive play about the event; nightmares
  - Anxiety or Arousal: Disorganized and agitated behavior; irritability or anger; nervousness about everyone and everything around him or her (e.g., when people get too close); jumpy when hearing loud noises; trouble sleeping
  - Avoidance: Trying to avoid thinking or talking about the event; avoidance of thoughts, feelings or places that remind the child of what happened; numbing or lack of emotions; avoiding activities once enjoyed; Hopelessness about the future; memory problems; trouble concentrating; difficulty maintaining close relationships.

- Other behaviors: Regression to earlier behavior, such as clinging, bed-wetting or thumb sucking; difficulty sleeping or concentrating; detachment from others or social withdrawal; excessive use of alcohol or other substances to self-medicate.

- **Psychosis.** Per Special Education Support Service (SESS, http://www.sess.ie/), psychosis can be defined as the presence of disruptions in thinking, accompanied by delusions or hallucinations, along with an alteration in thought processes. A clinical diagnosis is required. While incidents of psychosis amongst students are low, it is important to note that students experience the same range and types of psychotic symptoms as adults. Psychosis is a term that encapsulates different subgroups, the most common being schizophrenia and bipolar disorder.

Warning signs for psychosis may include changes in sleep patterns, withdrawal from family, friends and other social activities, difficulty understanding what others are saying, reticence, hoarding objects or searching through other's belongings, wearing inappropriate combinations of clothes, diminished motivation, decreased ability to concentrate, erratic behavior, paranoia and anxiety. (It is important to note that delusions and hallucinations are quite different to the vivid imagination that many young students have.)

Among students with schizophrenia, internalizing behaviors such as paranoia, anxious thoughts, and suspiciousness are reported to be more common than externalizing acting out behaviors such as temper tantrums, aggression, opposition and hostility. In the student with bipolar disorder, delusions may be characterized by an excited energetic state. There will be increased energy and physical activity, and racing thoughts and speech that may be confused and irrational. Some students may have delusions whereby they think they have special powers. Alternatively, the student may become extremely withdrawn and inactive, possibly not moving or speaking for extended periods.

Most students with psychosis have been assessed as falling within the average range of IQ (Intelligence Quotient) on standardized IQ tests. Thus, if a student with a psychotic disorder is having problems with schoolwork, there might be a number of other possible reasons for this. There may be primary problems implicit in the disorder itself such as some form of learning difficulty. Problems may also stem from coping with delusions or hallucinations, paranoia, attention deficits and hyperactivity, social and emotional problems, low self-esteem, or side effects of medication.

Educational Planning

Educational planning for students with emotional disturbance follows a process that includes review of the assessment report and the IEP team meeting. Key concepts in writing appropriate IEP goals, instructional environment needs, special education program options, least restrictive environment, instructional strategies, and progress monitoring are addressed herein.

Assessment Report

The personnel who assess the student shall prepare a written report of the results of each assessment. The evaluation report must include information about the student's demographic data, the reason for the referral, documented interventions and their affects, and any previous assessment results, including consideration of independent evaluation results, the child's developmental and health history, social and family dynamics including any socio-cultural factors, and school history. Results of tests administered should include (as appropriate) the student's performance in school and the classroom, adaptive behavior functioning, academic

achievement levels, cognitive abilities, psychological processing areas, emotional behavioral functioning, language/communication skills and career/vocational. Documentation that the assessment was administered in student's primary language (EC 56320), a statement regarding the validity of the assessment, and, if an assessment is not conducted under standard conditions, a description of the extent to which it varied from standard conditions should be included. The report shall include, but not be limited to, all the following: (EC 56327).

- Whether the pupil may need special education and related services and the basis for making the determination;
- The relevant behavior noted during the observation of the pupil in an appropriate setting;
- The relationship of that behavior to the pupil's academic and social functioning;
- The educationally relevant health and development, and medical findings, if any;
- For pupils with learning disabilities, whether there is such a discrepancy between achievement and ability that it cannot be corrected without special education and related services;
- A determination concerning the effects of environmental, cultural, or economic disadvantage, where appropriate; and
- The need for specialized services, materials, and equipment for pupils with low incidence disabilities.

A summary and conclusion of the test results along with the recommendations regarding eligibility and placement for special education services is recommended. If making a determination of eligibility, the report must be signed off by all of the multi-disciplinary team members. Include strategies, accommodations and/or modifications the student may need to progress and be involved in the general education curriculum and/or setting based on the evaluation results. Indicate the name(s) and title/position of the multidisciplinary team members who assisted in compiling the evaluation report. A copy of the evaluation report and the documentation of determination of eligibility shall be given to the parent or guardian. (EC 56329 (a)) A sample report template form is included herein in Appendix I.

IMPORTANT NOTE: In making a determination of eligibility, the evaluation team must have documentation – both qualitative and quantitative – of evidence that meets the criteria specified in the definition and be sensitive to the seriousness of the label. When considering a determination of emotional disturbance, careful consideration of benefits and risks associated with a label need to be taken into account, not just for the immediate situation, but for the future as well. Such a label can carry greater potential for negative impact, and we do not want to label children or youth unnecessarily. Labels are necessary at times for receipt of certain services and interventions; but the label itself does not necessarily prescribe the needed intervention strategy. Rather, interventions are based on the strengths and needs of the specific student.

IEP Team Meeting

For best practices and specific procedures regarding preparing for and holding an IEP meeting, see the Riverside County *SELPA IEP Manual and Forms* on www.rcselpa.org. The National Association of School Psychologists (http://www.nasponline.org) has stated the following:

- Because emotional and behavioral disorders have multidimensional facets, interventions for children with these disorders must be multifaceted and comprehensive.
- Interventions should be planned by a team that includes (as appropriate) the parent, the child whenever possible, the school psychologist and other student services personnel, teachers, administrators, and community service providers.

- Intervention plans should take into account the strengths of the child, the family, the child's teacher(s), and the school.
- Children with significant emotional or behavioral disorders often need interventions provided both inside and outside of the school.
- Careful attention to the use of effective discipline practices is critical as children with emotional and behavioral disorders frequently have disruptive behaviors.
- The discipline system in the school should be used to support the student with an emotional and behavior disorder in becoming more effective in school.

Writing Educationally Relevant IEP Goals

Russell (2011) indicates that impacted areas need carefully planned goals for instructional interventions and progress monitoring. Feelings and emotions are not objective or observable. However, they often manifest themselves in behavior that that is observable and teachable. Appendix J (pulled from RCOE, 2004) lists some areas that can be targeted for IEP goals for each of the specific qualifying characteristics.

Students may have many behaviors that need intervention and it is important to prioritize behaviors since it may be impossible to target all behaviors at the same time. When addressing multiple challenging behaviors for intervention, give the highest priority to behaviors that pose a danger to the student or others, damage property, or significantly interfere with the learning environment. Behaviors that are irritating but not dangerous have a lower priority. Consider how increasing or decreasing one behavior will affect other challenging behaviors. Define the behavior in objective, measurable, observable terms. What will we see and/or hear that will tell us if the behavior is being exhibited? For more information, see the Riverside County SELPA *Positive Behavior Supports and Interventions: A Tiered Approach.* In addition, the *Behavior Intervention Case Manager (BICM) Manual* explains Riverside County SELPA certification requirements. Finally, it is important that practitioners are trained in behavior emergency response interventions and the *Behavior Emergency Report* requirements. These documents are all available at www.rcselpa.org.

Instructional Strategy Considerations

Most students avoid tasks if they believe they will fail. Therefore, it is important to ensure that students are not only challenged, but that they are capable of succeeding. Fear of failure is particularly relevant when dealing with students with emotional and behavioral problems, as they often have gaps in their skill levels, or “splinter skills,” that make schoolwork even more difficult. One strategy helpful in building opportunities for success is targeting the necessary skills the student may need to improve upon. Quinn et al. (2000) indicate the key is to predict, modify, or avoid situations in which the student may encounter problems. This procedure, referred to as “pre-correction,” will help the student meet challenges and cope with problems. Predicting where students may have difficulty permits educators to build in instructional supports. Teachers have demonstrated success in increasing academic engagement time utilizing the following strategies:

1. Breaking long presentations into shorter segments;
2. Using interesting visual and auditory presentations to entice students to attend to tasks;
3. Extending the amount of time students are given to complete particular task;
4. Breaking down assignments into smaller ones;
5. Reducing the number of practice items that a student must complete once the student has demonstrated mastery;
6. Helping them learn from mistakes; and

7. Following low-interest activities with high-interest activities (Quinn et al., 2000).

All students, especially students with emotional and behavioral problems, need to know what is expected of them. Teachers can enhance education for all students by establishing a sound classroom management system and by clearly articulating expectations and goals. Educators can discourage challenging behavior by the way they manage space: control the degree of stimulation, delineate space, monitor high traffic areas, and establish a quiet place. Explain rules in positive, concrete terms that describe the behavior that is expected of them (e.g., raising one's hand to be called upon to talk), rather than defining what behavior is not acceptable (e.g., no talking). Similarly, consequences for failing to meet expectations should be logical, fair, predictable, directed at the inappropriate behavior, and, of course, explained before an infraction occurs.

Quinn et al. (2000) provide the following recommendations. Once five or six rules have been stated clearly, it is important to teach students how to follow them. Establishing routines for how things are done and then teaching those routines can help students stay on target in the classroom. Oftentimes, rapport breaks down when teachers need to discipline students; therefore, a teacher should let a student know that it is his or her behavior that is problematic, not the student as an individual. Staff can communicate respect by actively listening, using non-threatening questions, using open-ended questions, and showing personal interest in the student. Students with emotional disturbance are particularly vulnerable to environmental changes such as transitions and to a lack of positive behavioral support during transitions (CECP, 2001). For students with more challenging behaviors, the following classroom strategies cited by Quinn et al. (2000) may be useful:

- Positive Reinforcement: Point systems, stickers, smiles, and public recognition for a job well done. Pair tangible rewards with social reinforcement so that the social reinforcement will ultimately become rewarding and the tangible reinforce can gradually be removed. Reinforce immediately (especially when working with new behaviors or young or immature students), as any delay may result in ambiguity over which behavior is being reinforced. Give a verbal description of the behavior being reinforced so that the student knows exactly which behaviors have led to the reward. Gradually increase the time between the behavior and the reinforcer.
- Behavior Contract: makes a reward depend upon a desired response. Most effective contracts usually contain concrete definitions of expected behavior; positive consequences for demonstrating expected behavior; a statement of everyone's role; and a statement of commitment from everyone involved.
- Token economies (point systems): response contingency systems wherein students are asked to perform appropriate behaviors for which they receive tokens (or points) to be exchanged later for a predetermined reward. As students become proficient in demonstrating acceptable behavior, points are given less frequently. It is sometimes useful for the student to see a visual chart that represents his or her progress toward reaching a goal.
- Punishment: should be only a small part of a behavioral management plan. Three things to consider: (1) Punishment focuses on what the student should not be doing rather than on what he or she should be doing; (2) Punishment often causes emotional reactions, not only from the student whose behavior is being punished, but from other students; and (3) punishment is often the result of student behaviors that are highly frustrating to educators. Punishment should only be considered when the behavior is dangerous to the student or others; every other intervention has been appropriately implemented and

has failed; the student's behavior is so noxious that it prevents him or her from learning or forming meaningful social relationships.

- Time-out: actually refers to "time-out from positive reinforcement." With time-out, all reinforcement ceases and the student is essentially removed from a reinforcing situation. It is especially effective for attention-seeking behaviors. Effective use of time-out requires discussing with the student in advance those behaviors that may lead to a time-out, as well as the proper procedures for going to, being in, and returning from time-out. Time-out should be clearly differentiated from other removal techniques and from places students voluntarily go to when they feel they need time to gain control over themselves or their situation. Effective time-out strategies incorporate a multilevel system of increasing seclusion.
- Teach New Behaviors: by modeling, rehearsing appropriate behavior, role-playing, continuous reinforcement, and prompting.
- Support Appropriate Behaviors: by proximity control, signal interference, redirection, relaxation, talking the student down, humor, and compassion.

Instructional Environment Needs

"Effective instructional strategies assume that educators take into account the strengths and needs of their students when designing any lesson. Like their classmates, *students with emotional and behavioral problems learn best in classrooms characterized by effective instruction and behavior management routines.* As educators know, students benefit most when academic tasks and instructional strategies are carefully designed to engage them and support their learning, and when expectations and rules are clearly communicated to them" (Quinn, Osher, Warger, Hanley, Bader, Hoffman, 2000, p. 31). Russell (2011) provides a program planning matrix for each of the eligibility criteria associated with emotional disturbance. The items listed below are samples and not intended to include all evidence-based interventions.

Criteria 1: For students with an inability to learn which cannot be explained by intellectual, sensory or health factors, the following implications need to be considered in educational planning:

- Calm, nurturing environments, including adults who work with them.
- Avoid criticizing, ridiculing, or trying to reason (argue) with students who are anxious, agitated or escalated.
- Such students need protection from aggressive peers, especially verbal abuses that can become preoccupations that further disable thinking. They also need to have protective supervision because they are easily misled due to impaired reasoning, perception and adaptive function.
- Accommodations for problems with concentration, processing speed, memory, organization, initiating and self-monitoring task completion, etc. may be needed.
- Affective education and adult guided practice for internalizing components of such education may be needed.
- Structured environments in which expectations for learning and behavior are clearly communicated in multiple ways and in concrete, comprehensible language are best.
- Universally available supports such as the following may be helpful: visual checklists, models of finished work products, graphic organizers, task analysis, individualized instruction, visual/nonverbal supports to guide task completion, prompts and redirection strategies, frequent performance feedback, coaching and debriefing, etc.
- Specialized prevocational training with emphasis on interventions to reduce functional impairments at work; more intensive levels or work site supervision.

- School based mental health services, including possible need for psychiatric medication evaluation.

Criteria 2: Students identified with an inability to build or maintain satisfactory interpersonal relationships with peers and teachers will benefit from the following educational components:

- Affective education and adult guided practice for internalizing components of affective education.
- Tier II or III interventions for social difficulties and aggression; especially cognitive-behavioral interventions for social misperceptions.
- Tier II or III interventions for teaching coping and de-escalation strategies including self-monitoring.
- Establishing a positive environment that is supportive and communicates high expectations for all, especially for low performing or uncooperative students.
- Structured environments in which expectations for learning and behavior are clearly communicated in multiple ways and in concrete, comprehensible language are best.
- Universally available supports such as the following may be helpful: task analysis and individualized instruction, visual/nonverbal supports to guide task completion, prompts and redirection strategies, coaching and debriefing, etc.
- Keep difficulty level for group tasks commensurate with skills levels of low performing students.
- Systematically teach social skills, including how to be appropriately assertive rather than aggressive and how to recognize and repair derailed social interactions.
- Use cooperative learning activities in which social interaction skills are taught with adult guided practice to help students internalize them.
- Capitalize on teachable moments: use difficult situations to review causal factors, teach appropriate effective social interaction skills, and reinforce appropriate responses.
- Avoid criticizing, ridiculing, or trying to reason (argue) with students who are anxious, agitated or escalated.
- Communicate genuine interest in acting out students and reinforce their efforts at coping at higher than normal rates.
- School based mental health services, including possible need for psychiatric medication evaluation.

Criteria 3: Students who exhibit inappropriate types of behavior or feelings under normal circumstances may need the following educational components considered in their plan:

- Careful management of environmental variables that frustrate or confuse.
- Direct instruction in self-monitoring skills for moods, social climate, tone of social interactions.
- Accommodations for impaired concentration, memory, organization, and difficulty initiating and self-monitoring task completion: visual checklists or other nonverbal guides, including graphic organization, prompts or nonverbal supports for task initiation difficulties, frequent performance feedback or teach self-monitoring skills/system, “cheat sheets” for memory difficulties, visual models of finished work products.
- Tier II or III interventions for teaching coping strategies.
- Tier II or III interventions for social interaction difficulties, especially cognitive-behavioral interventions for distorted perceptions and social attribution errors.
- Pass system for granting permission to leave the room when escalated.
- Do not try to reason or argue with a student who is agitated or escalated.

- When student behaviors are triggered by difficulty level or complexity, quickly redirect to easier or preferred activity.
- Protect student from interpersonal triggers such as aggressive comments or other indignities.

Criteria 4: For students who display a general pervasive mood of unhappiness or depression, the IEP team needs to consider the following:

- Cognitive-behavioral interventions for distorted perceptions and social attribution errors causing depression.
- Affective education, especially disability awareness and self-advocacy training.
- Accommodations for sleep disorder, concentration problems, unexpected shifts in mood/behavior.
- Social rhythms therapy, especially interventions to normalize sleep-wake cycle.
- Teach self-monitoring tools for moods, social climate, implementation of coping with stressors.
- Accommodations for impaired concentration, memory, organization, and difficulty initiating and self-monitoring task completion: visual checklists or other nonverbal guides, including graphic organization, prompts or nonverbal supports for task initiation difficulties, frequent performance feedback or teach self-monitoring skills/system, “cheat sheets” for memory difficulties, visual models of finished work products.
- Tier II or III interventions for teaching coping.
- School based mental health services may need to include psychiatric evaluation for medication, cognitive-behavioral interventions for distorted perceptions and social attribution errors that increase anxiety/fears, assistance regularizing routine, especially physical activities and sleep schedules, assistance maintaining a social support system.
- Tier II or III interventions for depression and possibly for anxiety.

Criteria 5: Students who have a tendency to develop physical symptoms or fears associated with personal or school problems may need the following educational considerations:

- Initial referral to pediatrician to check for organicity.
- School based mental health services may need to include a psychiatric medication evaluation, cognitive-behavioral interventions for distorted perceptions and social attribution errors that increase anxiety/fears, systematic desensitization to anxiety provoking aspects of school.
- Calm, nurturing and supportive adults in school.
- Familiar routines, procedures and personnel that soothe anxiety.
- Management of environmental stressors, including interpersonal difficulties.
- Affective education, especially self-advocacy training.
- Tier II or III interventions for teaching coping strategies.
- Teach self-monitoring of anxiety level as well as anxiety reduction techniques.
- Manage demands and expectations for school performance that cause excessive anxiety.

Special Education and Related Service Considerations

When planning interventions, it is important to keep in mind that the ultimate goal is to teach the students skills that will enable them to regulate their own behaviors, including "being better able to control their emotional reactions, adjust to complex social situations, deal with challenging academic and social difficulties, manage anxieties, and achieve personal goals" (Polsgrove & Smith, 2004, p. 400, cited in Bullock & Gable, 2006).

The core special education program of specialized academic instruction is defined as "adapting, as appropriate to the needs of the child with a disability the content, methodology, or delivery of instruction to ensure access of the child to the general curriculum, so that he or she can meet the educational standards within the jurisdiction of the public agency that apply to all children." (34 *CFR* 300.39(b)(3)). Such services can be delivered in any of the following settings, shown in order from least to most restrictive:

- ✓ General Education placement
- ✓ Part-time Special Education placement
- ✓ Special Education placement for a majority of the school day in a district class
- ✓ Special Education placement for a majority of the school day in a specialized District class designed for students with emotional disturbance
- ✓ Special Education placement for a majority of the school day in specialized County-operated class designed for students with emotional disturbance
- ✓ County-Operated Intensive Treatment Program
- ✓ District Operated Alternative to Nonpublic School
- ✓ Nonpublic School placement
- ✓ Residential Placement

In addition to core academic instruction, students with emotional disturbance typically need specific behavioral intervention and direct instruction on socially normative expectations. Behavioral supports may be indicated as IEP goals with a Behavior Contract, Positive Behavior Support Plan (PBSP), or Positive Behavior Intervention Plan (PBIP). Whatever the situation, the following general "rules of thumb" are important to note (State of Connecticut, 1997).

- The teacher should always have a major role in selecting the behavior management system to be employed.
- Parents should be consulted in the employment of specific strategies in that the consistency of parent follow-through where possible makes the employment of such strategies more efficient and long lasting.
- Behavior management strategies should be openly explained to students, parents, teachers, administrators, and other staff to ensure understanding and encourage support.
- There are no panaceas in managing behavior. No approach will always work, and techniques that work with one child may not be effective with another.
- It should be recognized that behavior management procedures follow a continuum ranging from least to most intrusive actions, and less intrusive procedures are preferable.

It is imperative that the level of intervention strategies is carefully planned and discussed with all team members and care providers. As interventions become more intrusive, it is critical that appropriate documentation of plans and strategies takes place prior to implementation of any behavior management strategies. Individuals responsible for implementing these techniques should be able to demonstrate basic knowledge of the principles of behavior management. For more information about how to develop such supports, see the *Riverside County SELPA Positive Behavior Supports and Interventions: A Tiered Approach* available at www.rcselpa.org.

Most students identified as emotionally disturbed also need the support of educationally-based mental health related services. Some students may be successful with Tier I school-wide behavioral systems, others may need Tier II targeted interventions, and a few may need intensive services. Special education mental health related services must be cited in the IEP

and coded according to CASEMIS (CDE, 2011). Such related services are to be provided by a qualified social worker, psychologist, guidance counselor, or other qualified personnel.

510: Individual Counseling: One-to-one counseling, provided by a qualified individual pursuant to an IEP. Counseling may focus on aspects, such as educational, career, personal; or be with parents or staff members on learning problems or guidance programs for students. Individual counseling is expected to supplement the regular guidance and counseling program.

515: Counseling and guidance: Counseling in a group setting, provided by a qualified individual pursuant to an IEP. Group counseling is typically social skills development, but may focus on aspects, such as educational, career, personal; or be with parents or staff members on learning problems or guidance programs for students. IEP-required group counseling is expected to supplement the regular guidance and counseling program. Guidance services include interpersonal, intrapersonal or family interventions, performed in an individual or group setting by a qualified individual pursuant to an IEP. Specific programs include social skills development, self-esteem building, parent training, and assistance to special education students supervised by staff credentialed to serve special education students. These services are expected to supplement the regular guidance and counseling program.

520: Parent Counseling: Individual or group counseling provided by a qualified individual pursuant to an IEP to assist the parent(s) of special education students in better understanding and meeting their child's needs; may include parenting skills or other pertinent issues. IEP-required parent counseling is expected to supplement the regular guidance and counseling program.

525: Social Work Services: Social Work services, provided pursuant to an IEP by a qualified individual, includes, but are not limited to, preparing a social or developmental history of a child with a disability; group and individual counseling with the child and family; working with those problems in a child's living situation (home, school, and community) that affect the child's adjustment in school; and mobilizing school and community resources to enable the child to learn as effectively as possible in his or her educational program. Social work services are expected to supplement the regular guidance and counseling program.

530: Psychological Services: These services, provided by a credentialed or licensed psychologist pursuant to an IEP, include interpreting assessment results to parents and staff in implementing the IEP; obtaining and interpreting information about child behavior and conditions related to learning; planning programs of individual and group counseling and guidance services for children and parents. These services may include consulting with other staff in planning school programs to meet the special needs of children as indicated in the IEP. IEP-required psychological services are expected to supplement the regular guidance and counseling program.

535: Behavior Intervention Services: A systematic implementation of procedures designed to promote lasting, positive changes in the student's behavior resulting in greater access to a variety of community settings, social contacts, public events, and placement in the least restrictive environment.

540: Day Treatment Services: Structured education, training and support services to address the student’s mental health needs.

545: Residential Treatment Services: A 24-hour out-of-home placement that provides intensive therapeutic services to support the educational program.

Least Restrictive Environment

In discussing program options, consider the following factors: (a) concerns related to current setting/services; (b) school history (e.g., disciplinary history of suspensions/expulsions and findings from manifestation determination meetings, behavioral interventions attempted, and student's attendance (how this change could improve student's attendance); (c) family involvement/background; (d) outside agency involvement; (e) need for extended school year; and least restrictive environment (how the considered change would be an offer of a free appropriate public education in the least restrictive environment).

Per Bullock and Gable (2006), what constitutes the least restrictive environment represents a pupil-specific decision based on the strengths and weaknesses of that individual. For example, the least restrictive setting might be a highly structured, supportive classroom for children with emotional disabilities. In such an environment, a child may be able to thrive, learn new behaviors, and make academic progress, whereas, in a less structured setting, a child might not develop socially and academically as would be expected. While inclusion in general education environments with their non-disabled peers for students with emotional disturbance should be maintained as a goal, the reality is that many students with emotional disturbance have a very difficult time in inclusive classrooms.

Per these authors, this difficulty may be attributed to several factors. Students with so- called externalizing behavior problems (e.g., antisocial, aggressive, acting-out behaviors) are able to disrupt events in any setting. Because no one tolerates disruptive behavior, these students are viewed as "troublemakers" and their behaviors are broadly considered unacceptable in the classroom. In addition there are students that demonstrate behaviors that may range from being distractible, noncompliant, and off-task to fearful, anxious, and socially withdrawn. Students with what are characterized as internalizing behavior problems present unique problems to school personnel. For example, it is often difficult to actively engage these students in learning activities. Many of these students appear to be unmotivated, passive, and disinterested in their schooling, whereas others may seem overanxious, phobic, or social isolates. All across the country, schools are struggling to deliver adequate education and supports for students with emotional and/or behavioral challenges who are placed in the general education classroom. Few general education teachers have the skills to select appropriate strategies and systematically teach students with severe emotional disturbance.

The IEP Team determines the least restrictive environment in which the recommended interventions will be implemented. The assessment information will be the basis for determining which interventions, strategies and/or services will be written into the student's IEP along with goals and objectives. The Connecticut (1997) model emphasizes that decisions stem from consideration of:

1. Education with students without disabilities to the maximum extent appropriate;
2. Removal from the regular education environment only after the use of supplementary aids and services could not be achieved satisfactorily;
3. Where on the continuum of alternative placements the student should be educated;
4. The necessity for aids and supports;
5. Modifications in regular education instruction;
6. The need for a behavioral management plan that considers safety issues and the teaching of new behaviors; and
7. Applicable laws, regulations and school board policies regarding areas such as academic credit, grading, attendance, discipline or suspension/expulsion.

Progress Monitoring

To ensure the appropriate and effective implementation of a student's educational plan, a systematic process for monitoring student performance on an ongoing basis should be developed. This process would delineate ways in which documentation of all student outcomes written in the IEP can be gathered across all educational settings. This process also monitors timelines, provides evidence for continued eligibility, and guides recommendations for program modifications. The State of Connecticut (1997) identified the following purposes for ongoing assessment.

1. First, daily and weekly monitoring of student performance reveals what does and does not work, and often indicates instructional modifications that not only enable students to succeed in one classroom, but are also applicable in other instructional settings in which the students learn (physical education, music, lunch, recess, study hall, another subject area, etc.).
2. Second, when educators have data that describe student performance over a substantial period of time, they are better informed and able to contribute to meetings in which important decisions are made about the proposed educational experiences and programs of their students (e.g., annual reviews, team meetings, IEP Teams, etc.).
3. Third, ongoing assessment provides a record of student performance over a substantial period of time and enables those involved in triennial reviews to make decisions that are based on a substantive data. In other words, the ongoing recording and reviewing of data informs educators as to student performance with respect to the goals, objectives and timelines of the educational plan.
4. Finally, ongoing assessment provides the IEP Team with evidence as to whether the student continues to meet the eligibility criteria for special education and related services.

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Appendix A

Sample Student History Interview Form

NAME: _____ DOB: _____ DATE: _____

LEA: _____ SITE: _____ GRADE: _____ AGE: _____ GENDER: ___

Number of Siblings: _____ Older/Younger? _____ Brothers/Sisters? _____

Taking Medications: Yes No If yes: _____Wear glasses? _____

School you attended for:

K	**1**
2	**3**
4	**5**
6	**7**
8	**9**
10	**11**
12	**Note:**

Current School Subjects and Grades

_____ _____ _____

_____ _____ _____

Why do you believe you are behind academically in school?

_____

_____

Are you depressed? If yes, why do you think so?

_____

_____

Do you have or have you displayed any behavior which you cannot explain?

_____

_____

How do you get along with your mother, father, and each sibling?

_____

_____

Sample Student History Interview Form

How do you feel most of the time?

_____

_____

Describe your fears, what makes you angry, sad, and happy?

_____

_____

_____

Do you get depressed very often? _____

Have feelings of hopelessness and sadness? _____

Does this occur often? _____

What are the circumstances when you might feel that way? _____

_____

Do you have many friends? Yes No Comments: _____

Do you prefer to be by yourself or with your peers? _____

Do you now or have you in the past had problems with:

Having a poor appetite or overeating	Yes	No	Insomnia or hypersomnia	Yes	No
Low energy or fatigue	Yes	No	Low self esteem	Yes	No
Poor concentration	Yes	No	Feelings of hopelessness	Yes	No

Have you now or in the past had a significant weight loss or weight gain when not dieting or decrease or increase in appetite nearly every day? When and for how long?

_____

_____

Have you now or in the past had a diminished ability to think or concentrate, or indecisiveness, nearly every day? When and for how long?

_____

_____

Have you now or in the past had recurrent thoughts of death (not just fear of Dying), recurrent suicidal ideation. When and for how long?

_____

_____

Have you ever been involved with the Juvenile Justice system? If yes, when and for what have you had contacts with legal system?

_____

_____

Have you ever been involved with drugs? If yes when?

Sample Student History Interview Form

_____

_____

Past Drug Use	**Yes**	**No**	**Frequency of Use**	**By self and/or with others**
Marijuana	Yes	No		
Alcohol	Yes	No		
Crystal Meth, Coke	Yes	No		
Other: _____	Yes	No		

Current Drug Use	**Yes**	**No**	**Current Alcohol Use**	**Yes**	**No**
Before school	Yes	No	Before school	Yes	No
During school	Yes	No	During school	Yes	No
After school	Yes	No	After school	Yes	No
Weekends	Yes	No	Weekends	Yes	No
Binges?	Yes	No	Binges?	Yes	No

Why do you use drugs or alcohol?

_____

_____

Are you currently on probation? Yes No Comments: _____

_____

Do you now or have you in the past had problems with:	
Having a poor appetite or overeating?	Yes No
Problems sleeping or sleeping too much?	Yes No
Low energy or fatigue?	Yes No
Poor concentration?	Yes No
Do you/have you intentionally cut on yourself?	Yes No
Do you ever hear things other people do not?	Yes No
Do you ever see things other people do not?	Yes No
Do you have a current girl/boyfriend?	Yes No
Have you ever had a girl/boyfriend?	Yes No
Do you suspect that others are exploiting, harming, or trying to deceiving you?	Yes No
Do you worry or are you preoccupied with unjustified doubts about loyalty or trustworthiness of friends?	Yes No
Do you enjoy close relationships with other people?	Yes No

Sample Student History Interview Form

Current living situation:

Both natural parents	Yes No	Natural mother	Yes No
Natural father	Yes No	Natural mother and stepfather	Yes No
Natural father and stepmother	Yes No	Other:	Yes No

Father's education _____ Father's occupation _____

Mother's education _____ Mother's occupation _____

Somatic concerns present? _____

Are you in special education classes? Yes No

Have you been retained? Yes No

Do you have a history of truancy or skipping classes? Yes No

Do you complete homework assignments? Yes No

Do you participate in extracurricular activities? Yes No

What are your Career Goals? _____

Do you have a quick temper? Yes No

If yes, when does it normally happen? _____

Time spend living in the home?

_____

_____

_____

Is there anything that has not been asked that should be known?

_____

_____

_____

Sample Parent Interview Form

What is the significant problem you are having with your child?

_____

_____

_____

_____

Would you describe your child's self-esteem as low?	Yes	No
Does your child seem to be in a world of their own?	Yes	No
Does your child hear or see things that are not there?	Yes	No
Does your child have problems making and keeping friends?	Yes	No
Has your child wished to die or hurt himself/herself?	Yes	No
Has your child had a problem because of alcohol?	Yes	No
Has your child had a problem because of drug abuse?	Yes	No
Has your child had a problem because of running away?	Yes	No
Has your child had a problem because of suicide threat?	Yes	No
Has your child had a problem because of suicide attempt?	Yes	No
Has your child ever tried to hurt himself/herself?	Yes	No
When confronted with demands, does your child show poor frustration tolerance, a high degree of irritability and often throws temper tantrums?	Yes	No
Would you describe your child as impulsive?	Yes	No
Does your child typically blame others for his/her difficulties and feel they're making unreasonable demands and being unfair?	Yes	No
Is your child highly manipulative and exploitative?	Yes	No
Has your child in the past or now have problems with insomnia or hypersomnia?	Yes	No
Has your child in the past or now have problems with having a poor appetite or overeating?	Yes	No
Has your child in the past or now have problems with low energy or fatigue?	Yes	No
Has your child in the past or now have problems with low self-esteem?	Yes	No
Has your child in the past or now have problems with poor concentration?	Yes	No
Has your child in the past or now have problems with feelings of hopelessness?	Yes	No
Has your child in the past or now, ever suffered a depressed mood most of the day, nearly every day?	Yes	No
Has your child in the past or now, displayed a diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day?	Yes	No
Has your child in the past or now, displayed psychomotor agitation or retardation nearly every day?	Yes	No

Sample Parent Interview Form

Does your child have a history of friendship patterns currently or in the past? Please explain.

_____

_____

_____

_____

Does your child have difficulty dealing with authority figures? Please explain.

_____

_____

_____

_____

What is the main problem you are having with your child? Please explain…

_____

_____

_____

_____

Is there a history of a mood of unhappiness or major depression? Please explain.

_____

_____

_____

_____

Is there a history of physical symptoms such as headaches, stomach pains? Please explain.

_____

_____

_____

_____

Other things to add?

_____

_____

_____

Behavior Checklist Observation Form

Type of lesson in which student has greatest success:

❑ Lecture	❑ Oral Reading	❑ Other (describe)
❑ Group Discussion	❑ Learning Center	_____
❑ Written Assignments	❑ Independent Work	_____
❑ Silent Reading	❑ Small Group work	_____

Academic Strengths:

❑ Reading Decoding	❑ Math Computation	❑ Other (describe)
❑ Reading Comprehension	❑ Math Problem Solving	_____
❑ Writing	❑ Science	_____
❑ Spelling	❑ Social Studies & History	_____

Grades Earned to date:

_____ English/Language Arts	_____ Science	_____ Electives
_____ Reading	_____ Social Studies/History	_____
_____ Writing	_____ Physical Education	_____
_____ Math	_____ Art/Music	_____

Does this student have the ability to do better work?

_____ yes, explain: _____

_____ no, explain: _____

Please mark the following behaviors that are typical for this student.

Body Activity

_____ Sits still in chair	_____ Restless/squirming/shifting
_____ Relaxed posture	_____ Tense
_____ Stays in seat when expected	_____ Out of seat and wandering
_____ Average Coordination	_____ Poor coordination
_____ Can remain still during activity	_____ Rocking Swaying
_____ Stays on task in assigned area	_____ Erratic or scattered behavior
_____ Typical movement	_____ Repetitive behavior

Behavior Checklist Observation Form

Attention

_____ Follows directions well
_____ Adequate Attention Span
_____ Completes classwork
_____ Stays on task
_____ Volunteers in class

_____ Does not follow directions
_____ Short attention span
_____ Work is incomplete
_____ Easily distracted
_____ "Day dreams"

Social

_____ Shows leadership
_____ Seeks positive attention
_____ Respects others' property
_____ Keeps hands to self
_____ Follows peers instructions
_____ Other kids like this student
_____ Likes to be part of the group

_____ Usually a follower
_____ Seeks negative attention
_____ Bothers others' property
_____ Frequently touches others
_____ Pushy, dominates others
_____ Other kids avoid this student
_____ Withdrawn and a loner

Frustration

_____ Works persistently, keeps trying
_____ Slow to anger
_____ Even moods
_____ Appears relaxed and comfortable
_____ May pout less than 10 minutes
_____ Ignores others' behavior
_____ Proud of classwork
_____ Attempts to complete work
_____ Readily attacks new work

_____ Gives up easily
_____ Reactive, angers quickly
_____ Rapid mood shifts
_____ Appears nervous
_____ Pouts for 10 or more minutes
_____ Easily angered and explosive
_____ Destroys own work
_____ Easily distracted from classwork
_____ Avoids beginning work

Language Behavior

_____ Appropriate relevant questions or responses
_____ Raises hand to be called upon
_____ Age appropriate vocabulary
_____ Is quiet when working
_____ Understands directions/responses
_____ Responds appropriately socially

_____ Inappropriate or unrelated questions/responses
_____ Speaks out of turn
_____ Immature vocabulary
_____ Talks to self
_____ Will repeat questions/responses
_____ Laughs/whistles/signs inappropriately

Fatigue

_____ Responsive and attentive
_____ Interested in activity
_____ Alert

_____ Lays head on desk
_____ Stretches/yawns
_____ Rubs eyes/sleepy

Behavior Checklist Observation Form

Summary

Number of positive behaviors observed: _____

Number of negative behaviors observed: _____

Areas of strength:

_____

_____

_____

_____

Areas of weakness:

_____

_____

_____

_____

Summarize the student's positive attributes: _____

_____

Summarize the student's negative attributes: _____

_____

Appendix D

Behavior Rating Scales for Different Grade Levels

Behavior Rating Scales	Appropriate Grade Levels			
	K-2	3-5	6-8	9-12
Adolescent Anger Rating Scale (AARS)			x	x
Behavior Assessment System for Children (2nd edition) (BASC-2)	x	x	x	x
Behavior and Emotional Rating Scale (2nd edition) (BERS-2)	x	x	x	x
Behavior Rating Profile (2nd edition) (BRP-2)	x	x	x	x
Burks Behavior Rating Scales (2nd edition) (BBRS-2)	x	x	x	x
Clinical Assessment of Behavior (CAB)	x	x	x	x
Conduct Disorder Scale (CDS)	x	x	x	x
Conners Comprehensive Behavior Rating Scales	x	x	x	x
Conners Early Childhood	x			
Devereaux Behavior Rating Scale – School Form	x	x	x	x
Differential Scales of Social Maladjustment and Emotional Disturbance (DSSMED)	x	x	x	x
Differential Test of Conduct and Emotional Problems (DT/CEP)	x	x	x	x
Emotional Disturbance Decision Tree (EDDT)	x	x	x	x
Hare Psychopathy Checklist: Youth Version			x	x
Preschool and Kindergarten Behavior Scales (2nd edition) (PKBS-2)	x			
Scales for Assessing Emotional Disturbance (2nd edition) (SAED-2)	x	x	x	x
Social-Emotional Dimension Scale (2nd edition) (SEDS-2)	x	x	x	x

Adapted from Tibbetts, T. (in press)

Appendix E

Appropriate Personality Tests for Different Grade Levels

Personality Test	Appropriate Grade Levels			
	K-2	3-5	6-8	9-12
Adolescent Psychopathology Scale (APS)			x	x
Children's Apperception Test	x			
Depression and Anxiety in Youth Scale (DAYS)	x	x	x	x
Draw A Person: Screen Procedure for Emotional Disturbance (DAP:SPED)	x	x	x	x
Educational Apperception Test	x	x	x	
Family Drawings (K-F-D)	x	x	x	x
Hand Test			x	x
Hopelessness Scale	x	x	x	
House-Tree-Person (H-T-P)	x	x	x	x
Jesness Personality Inventory – Revised (JI-R)		x	x	x
Millon Adolescent Clinical Inventory (MACI)			x	x
Minnesota Multiphasic Personality Inventory – Adolescents (MMPS-A)				x
Multidimensional Anxiety Scale for Children (MASC)		x	x	x
Multiscore Depression Inventory – Children (MDI-C)		x	x	x
Multiscore Depression Inventory			x	x
Personality Assessment Inventory – Adolescent (PAI-A)			x	x
Reynolds Adolescent Depression Scale (2nd edition)			x	x
Reynolds Child Depression Scale		x	x	
Roberts Apperception Test for Children (2nd edition)	x	x	x	x
Rorschach Diagnostic Test	x	x	x	x
Thematic Apperception Test		x	x	x

Adapted from Tibbetts, T. (in press)

Emotional Functioning Assessment Overview

I. GENERAL PERSONALITY ASSESSMENT

- Adolescent Psychopathology Scale (APS)
- Jesness Personality Inventory – Revised (JI-R)
- Minnesota Multiphasic Personality Inventory – Adolescent (MMPS-A)
- Personality Assessment Inventory – Adolescent (PAI-A)
- Roberts Apperception Test for Children – 2nd edition (RATC-2)

II. DEPRESSION

- Hopelessness Scale
- Multiscore Depression Inventory [Adolescents] (MDI)
- Multiscore Depression Inventory for Children (MDIC)
- Reynolds Adolescent Depression Scale – 2nd edition (RADS-2)
- Reynolds Child Depression Scale (RCDS)

III. ANXIETY

- Depression and Anxiety Youth Scale (DAYS)
- Multidimensional Anxiety Scale for Children (MASC)
- Revised Children's Manifest Anxiety Scale – 2nd edition (RCMAS-2)

IV. AGGRESSION

- Adolescent Anger Rating Scale (AARS)
- Children's Aggression Scale (CAS)

V. VIOLENCE RISK and PSYCHOPATHOLOGY

- Hare Psychopathology Checklist: Youth Version (PCL:YV)
- Structured Assessment of Violence Risk in Youth (SAVRY)

Adapted from Tibbetts, T. (in press)

A Guide for Differentiating Emotional Disturbance and Social Maladjustment

Appendix G

The special education definition for emotional disturbance (ED) includes an exclusion clause such that a child or youth cannot be found to be ED if the behavior is specifically the result of a social maladjustment. The following chart developed in Texas helps to illustrate how the two can be differentiated.

Emotional Disturbance Using IDEA Definition	**Social Maladjustment**
1. "...condition…" Inappropriate behaviors must be indicative of an emotional condition. The condition is documented by behavior observations, self-report (interviews, questionnaires), projective responses in the following areas: ❑ Feelings are often emotional overreactions including anxiety, depression, and guilt. ❑ Thoughts may be inappropriate to situation, confused, bizarre, tangential, and emotionally overloaded. ❑ Perceptions are often not congruent with usual perceptions of reality and can be confused or overly suspicious. ❑ Behaviors may be idiosyncratic, unusual, bizarre, as well as inappropriate. ❑ Lack of social awareness. Student may not understand or may misinterpret social conventions and behavioral expectations.	1. Inappropriate behaviors which originate in social maladjustment and are not indicative of an emotional condition: ❑ Emotional overreactions may occur only when behavior is criticized and punishment is applied. Anger is the most frequent reaction. ❑ Thoughts are usually practically related to situations. ❑ Perceptions are usually practically related to situations and congruent with other people's perceptions. ❑ Behavior may be goal directed, self-serving, and manipulative. Student acts according to own perception of self-interest (even though others may consider behavior to be self-defeating). ❑ Student usually understands, but chooses not to accept, general social conventions and behavior standards. However, student may accept and follow counter-cultural standards of neighborhood and peer groups.
2. Exhibited "…over a long period of time…" ❑ ED behaviors must be persistent, generalized, inappropriate behaviors over time and situations.	2. Socially maladjusted behaviors may or may not be exhibited over a long time period. ❑ May often be situation-specific rather than occurring in many situations. ❑ Are often not observed until preadolescence or adolescence.
3. "…to a marked degree…" ❑ Serious Problems ❑ Low frequency in peer group	3. Socially maladjusted behaviors: ❑ May or may not be serious. ❑ May occur with higher frequency in delinquent peer group.
4. "…which adversely affects educational performance…" ❑ ED behaviors result in a demonstrable educational need in achievement, grades and/or dysfunctional behaviors in academic situations.	4. Socially maladjusted behaviors: ❑ May or may not have adverse affect on educational performance. ❑ Educational deficits, when present, are often related to truancy, tardiness, work refusal, and occasionally to limited intellect or educational background. ❑ A subgroup of socially maladjusted students have a history of language deficits and lowered verbal intelligence which predisposes them to chronic educational problems and social maladjustment related to lack of success.

A Guide for Differentiating Emotional Disturbance and Social Maladjustment

Appendix G

Associated Characteristics	
Emotional Disturbance	**Social Maladjustment**
1. ED student usually has limited or no social support for inappropriate behavior.	1. Possible home, neighborhood, and/or peer support for socially maladjusted behavior.
2. ED student usually demonstrates limited self-control. ❑ Low frustration tolerance, emotional overreactions, and impulsivity are common. ❑ ED Student often displays limited premeditation or planning and has limited ability to predict consequences of behavior. ❑ Behavior escalates quickly and cool down periods are often needed.	2. Socially maladjusted students have variable rather than limited self-control. They may preplan behavior and may be vigilant in social situations to avoid detection of misbehavior. Misbehavior may be goal-directed, even though the goals may be limited rather than long range. Socially maladjusted students may be able to stop misbehavior quickly if apprehended by authorities.
3. ED behaviors generally are dissocial and have no clear relationship to social morals or law enforcement.	3. Socially maladjusted behaviors are anti-social in that they violate social conventions and often exploit others. Attitudes and behaviors are generally anti-law enforcement: law enforcement officers are seen as interfering with the achievement of their self-interest.
4. Inappropriate behavior is disturbing to the ED student. ❑ May experience anxiety, guilt, depression, distress. ❑ ED student often expresses desires to want to change or improve behavior.	4. Inappropriate behavior is not disturbing to socially maladjusted students. ❑ Limited emotion may be attached to misbehavior. ❑ Socially maladjusted student may have an incentive to continue misbehavior to reach goals.
5. Social relationships are distorted and may be characterized by inappropriate dependence and over-closeness and/or inappropriate rebellion and defiance.	5. Social relationships tend to be superficial and transitory, although loyalty may be given to a delinquent peer group.
6. Self-esteem is usually low and self-concept is usually distorted.	6. Socially maladjusted student may appear to others to have adequate self-esteem and self-concepts; however, feelings of inadequacy often underlie veneer of adequacy. Student may show bravado and “macho” attitudes.
7. ED student is often preoccupied with his/her conflicts and overly self-concerned; however, some ED students translate their problems into behavior immediately and have limited self-awareness.	7. Socially maladjusted students often have a very superficial sense of self and are rarely self-reflective.
8. ED student is more likely to respond to psychotherapeutic interventions.	8. Because of the characteristics mentioned above, including difficulty forming relationships and limited affective development, the socially maladjusted student who is not ED is less likely to respond to psychotherapeutic interventions. Alternative educational programs need to be developed for these students.

Appendix H

A Guide to Differential Diagnosis and Educational Options

Behavior Area	Emotional Disturbance	Socially Maladjusted
School Behavior	Unable to comply with teacher requests; needy or has difficulty asking for help	Unwilling to comply with teacher requests; truancy; rejects help
Attitude Toward School	School is a source of confusion or angst; does much better with structure	Dislikes school, except as a social outlet; rebels against rules and structure
School Attendance	Misses school due to emotional or psychosomatic issues	Misses school due to choice
Educational Performance	Uneven achievement; impaired by anxiety, depression, or emotions	Achievement influenced by truancy, negative attitude toward school, avoidance
Peer Relations and Friendships	Difficulty making friends; ignored or rejected	Accepted by a same delinquent or socio-cultural subgroup
Perceptions of Peers	Perceived as bizarre or odd; often ridiculed	Perceived as cool, tough, charismatic
Social Skills	Poorly developed; immature; difficulty reading social cues; difficulty entering groups	Well developed; well attuned to social cues
Interpersonal Relations	Inability to establish or maintain relationships; withdrawn; social anxiety	Many relations within select peer group; manipulative; lack of honesty in relationships
Interpersonal Dynamics	Poor self-concept; overly dependent; anxious; fearful; mood swings; distorts reality	Inflated self-concept; independent; underdeveloped conscience; blames others; excessive bravado
Locus of Disorder	Affective disorder; internalizing	Conduct disorder, externalizing
Aggression	Hurts self and others as an end	Hurts others as a means to an end
Anxiety	Tense; fearful	Appears relaxed; “cool”
Affective Reactions	Disproportionate reactions, but not under student’s control	Intentional with features of anger and rage; explosive
Conscience	Remorseful; self-critical; overly serious	Little remorse; blaming; non-empathetic
Sense of Reality	Fantasy; naïve; gullible; thought disorders	“Street-wise”; manipulates facts and rules for own benefit
Developmental Appropriateness	Immature; regressive	Age appropriate or above
Risk Taking	Avoids risks; resists making choices	Risk taker; “daredevil”
Substance Abuse	Less likely; may use individually	More likely; peer involvement

Adapted from *Social Maladjustment: A Guide to Differential Diagnosis and Educational Options* (Wayne County Regional Educational Service Agency - Michigan , 2004) – cited in School Psychologist Files.com

Best Practice Guidelines for Evaluation Report On Student with Emotional Disturbance

The following outline is adapted from RCOE (2004) and is suggested for initial ED evaluations. Three year/triennial evaluations should address current behavioral, emotional, health and academic concerns, and may be more summarial in nature.

Student Name: _____DOB: _____ AGE: _____ GENDER: ___

Grade: _____ School: _____ District: _____

I. REASON FOR REFERRAL

Rationale: A few brief sentences to orIEnt the reader to the nature of the evaluation.

A. Referral Status: State referral source

B. Observations: List observable behaviors of concern, incuding location and frequency.

C. Achievement: Note academic performance, if applicable.

II. BACKGROUND INFORMATION:

Rationale: This section is used to establish if behaviors of concern have existed "over a long period of time" and to a "marked degree." It also provides a necessary global overview of the student's development and problems affecting emotional functioning.

A. Family Status: include family make up, cultural background, language spoken in the home

B. Health Status: include prenatal history, birth history, developmental history, major illnesses, accidents and situational traumas, past hearing and vision results, past history of medications

C. Social History: include significant social events that may have had an impact on the student's emotional development, i.e. foster or group home placement, temporary homelessness, death of a family member, etc.; significant changes in family membership; psychiatric hospitalizations; significant and recurring behavioral and social problems

D. School History: include record of schools attended and dates; attendance history; reports from Student Study Team (SST) meetings and recommendations; behavioral reports, contracts, and specific school interventions attempted; Functional Behavioral and/or Intervention Assessment (FBA/FAA) and supporting Positive Behavior Support or Intervention Plans (PBSP/PBIP); summary of related services received (i.e. speech, counseling, etc.); special education placements including dates and type of program; record of referrals to other agencies (i.e. Mental Health)

E. Other Agency Involvement: date and name of agency referred to; outcomes of referral; statement of current services

F. Parental Concerns and Priorities: summarize from contact with parent before the meeting; add any changes or comments from parent made during the meeting

III. PREVIOUS ASSESSMENTS

Rationale: This section is necessary for establishing baseline information to compare against current test resutls.

Best Practice Guidelines for Evaluation Report On Student with Emotional Disturbance

A. Dates of Assessment: list dates of all prior assessments

B. Types of Assessments: pschoeducational evaluation; private psychological report; psychiatric evaluation; hospital discharge summary

C. Agency Completing Assessment: list the agency name and location for each assessment completed)

IV. CURRENT ASSESSMENT RESULTS

Rationale: The nature of the ED assessment necessitates aa global evaluation of each student. The following identified areas of assessment aare needed to help define if a social emotional condidtioan is "affecting educational performance" and the "pervasiveness" of the disturbance. A comprehensive evaluatin is also needed to gather necessary information to assess if the student does, indeed, qualify for special education services under any one of the state eligibeilty criteria for special education services. Behavioral observations are necessary to impart to the reader the behavioral characteristics of the student. Clinical observations are also important to validate the resultes of formalized testing.

A. Behavioral Observations:

1. Classroom Observation by Psychologist: peer interactions; student's ability to follow teacher direction and class rules; specific behaviors observed affecting learning
2. Behavior During Testing (observations and clinical judgements): appearance and grooming; activity level during testing; attention span, including distractibiltiy; abilty to communicate, including initiation of conversation; ability to cooperate with examiner requests; level of confidence displayed including need for additional time or repeated instructions; general affect or mood; level of mental processing including need for additonal time or repeated instructions; frustration level

B. Procedures Utilized:

1. Requrired statement of ethnicity and gender considerations; statements of procedures for minority students, if applicable; statement of procedures for English Learners , if applicable
2. Effect of cultural, economic, and environmental variables
3. Tests utilized and statement of appropriateness
4. Statement of validity of test results

C. Discussion of Evaluation: cognitive/intellectual development; academic levels; adaptive behavior; language skills; motor skills, if applicable; pre-vocational/vocational skills; social, behavioral, and emotioanl development; student strengths and learning style; curent health status, including medications

V. STATEMENT OF ELIGIBILITY FOR SPECIAL EDUCATION SERVICES UNDER SPECIFICATIONS FOR EMOTIONAL DISTURBANCE:

Eligibility is based on the presence of both A & B.

A. Qualifying condition(s): *(include all that apply; only one is needed).*

1. An inability to learn which cannot be explained by intellectual, sensory, or health factors.
2. An inability to maintain satisfactory interpersonal relationships with peers and teachers.

3. Inappropriate types of behavior or feelings under normal circumstances exhibited in several situations.
4. A general pervasive mood of unhappiness or depression.
5. A tendency to develop physical symptoms or fears associated with personal or school problems.

B. Qualifying Behaviors: *(All three conditions must be met)*

1. Duration of condition must be over a long period of time. "Over a long period of time" has been defined to mean that "the student has a history of ED symptoms that have been exhibited for approximately six consecutive months.
2. Degree of disturbance must be to a marked degree. "To a marked degree" has been interpreted to mean that the ED symptoms occur with frequency and duration in more than one setting; i.e. they are reported in the school, in the home, and in the community.
3. Effect on educational performance must adversely affect educational performance. "Affecting education performance" is defined as those ED characteristics which interfere primarily with social performance or functioning in the school setting. "This functioning may partially but not exclusively be assessed by either reduced work production in the classroom or by lowered norm referrenced academic test scores."

VI. SUMMARY

Rationale: The summary should include all pertinent data compiled in developing the report. A hypothesis should be formulated regarding any disabilty based on eligibility criteria supported and cross-validated by data from all appropriate sources.

An Integrative Summary:

A. referral data, background information, and previous assessments

B. current assessment findings

C. eligibilty for special education services, including disability condition(s) and qualifying behaviors

VII. RECOMMENDATIONS AND CONSIDERATIONS FOR THE IEP TEAM

Rationale: Recommendations are necessary to provide guidelines for any necessary remediation strategies, including student strengths and learning style. This section should also outline behavioral intervention steps to be considered by the IEP team.

Recommend:

A. Possible instructional strategies to be considered

B. Possible behavioral strategies to be considered

C. Suggested special education program needs (e.g., mainstreaming, related services, special education services if applicable)

Report Written By: _____

Sample Goal Areas Based on Criteria for Emotional Disturbance

Criteria & Need Statement: Inability to build or maintain satisfactory interpersonal relationships.

Sample Goal: By 9/5/12, X will cope with disappointment and frustration during interactions with adults and peers by expressing her feelings using a , for 9 of 10 trial days as shown by data/point sheets.

Objective One: By 12/5/11, X will cope with disappointment and frustration during interactions with adults and peers by expressing her feelings using appropriate tone of voice and language with modeling and reminders, for 9 of 10 trial days as shown by data/point sheets.

Objective Two: By 4/5/13, X will cope with disappointment and frustration during interactions with adults and peers by expressing her feelings using appropriate tone of voice and language with two reminders per situation, in 4 out of 5 situations, for 9 of 10 trial days as shown by data/point sheets.

Additional Goal Areas:

- Interact appropriately with peers by maintaining appropriate space and conversation.
- Verbalize consequences within a peer group.
- Initiate and lead group discussions.
- Ignore the behavior of peers who are acting inappropriately.
- Work cooperatively with one or more peers.
- Work cooperatively in a large group or class setting.
- Engage in competition appropriately.
- Respond with self-control to peer provocation (teasing, arguing, and laughing).
- Interact in a group without instigating conflict between group members.
- Establish and maintain eye contact with adults or peers during conversations.
- Initiate positive interactions with peers and adults.
- Use appropriate language when interacting with adults or peers.
- Verbalize feelings appropriately with adults and peers.
- Accept responsibility for actions, attitudes, and decisions in peer and adult interactions.
- Establish and maintain a friendship with an adult or peer.
- Accept constructive criticism appropriately from a peer or adult.
- Accept positive feedback appropriately from an adult or peer.
- Use positive outlets to express anger and frustration without using verbal or physical aggression.
- Use positive alternative behaviors instead of passivity.
- Recognize and respect authority figures at school and in the community.

Sample Goal Areas Based on Criteria for Emotional Disturbance

Criteria & Need Statement: Inability to learn which cannot be adequately explained by intellectual, sensory or health factors.

Sample Goal: By 9/5/12, X will organize, start and complete a task or assignment within a specific time period, in 4 out of 5 situations, for 9 of 10 trial days as shown by point sheets.

Objective One: By 12/5/11, X will organize and a start task or assignment within a specific time period, with two prompts, in 4 out of 5 situations, for 9 of 10 trial days as shown by point sheets.

Objective Two: By 4/5/12, X will organize, start and complete a task or assignment within a specific time period, with two prompts per assignment, in 4 out of 5 situations, for 9 of 10 trial days as shown by point sheets.

Additional Goal Areas:

- Stay on task by sitting in seat quietly and working steadily on assigned task
- Resolve problems and reduce hostility toward authority figures.
- Report upsetting incidents to appropriate persons or authority figures.
- Demonstrate appropriate behaviors during transition times.
- Demonstrate appropriate behaviors on campus.
- Demonstrate appropriate behaviors during unstructured times through the school day.
- Organize and bring classroom/study materials to class.
- Arrive for class on time.
- Remain in assigned seat or area.
- Remain in class during the school day.
- Maintain good attendance.
- Remain in the designated area during activities.
- Follow oral directions from staff with minimal reminders.
- Find acceptable way to use unstructured or free time.
- Follow school and classroom rules with minimal reminders.
- Maintain successful participation in school structure and routine.
- Be responsible for carrying out home-school communication.
- Increase independent on-task behavior.
- Use school property appropriately.
- Remain on campus.
- Turn in assignments when due.
- Begin tasks immediately.

Sample Goal Areas Based on Criteria for Emotional Disturbance

Criteria & Need Statement: Consistent or chronic inappropriate types of behavior or feelings under normal conditions.

Sample Goal: By 9/5/12, X will initiate positive interactions with others during unstructured/free-time in the classroom by approaching a peer and asking him/her to play a game with no prompts two times per day for 9 of 10 trial days as shown by data charts.

Objective One: By 12/5/11, Rafael will initiate positive interactions with others during unstructured/free-time in the classroom by approaching a peer and asking him/her to play a game with modeling and prompts two times per day for 9 of 10 trial days as shown by data charts.

Objective Two: By 4/5/12, Rafael will initiate positive interactions with others during unstructured/free-time in the classroom by approaching a peer and asking him/her to play a game with one prompt two times per day for 9 of 10 trial days as shown by data charts.

Additional Goal Areas:

- Take responsibility for own behavior by accepting consequences with no arguing
- Respond appropriately to positive interactions initiated by others.
- Seek attention from others in an appropriate way.
- Diminish inappropriate attention-seeking behavior.
- Verbalize feelings in an appropriate manner.
- Recognize feelings in others.
- Respond appropriately to and respect feelings in others.
- Increase verbal responses without teacher probing.
- Exhibit appropriate coping behavior in a stressful situation.
- Take responsibility for actions.
- Accept consequences for behavior.
- Handle failure appropriately.
- Cope with disappointment appropriately.
- Accept criticism appropriately.
- Decrease immature behaviors.
- Adjust appropriately to changes in routine.
- Demonstrate a sense of humor when appropriate.
- Distinguish between reality and fantasy in real life situations.
- Practice good grooming habits.
- Accept positive feedback in an appropriate manner.
- Maintain verbal and physical control.

Sample Goal Areas Based on Criteria for Emotional Disturbance

Criteria & Need Statement: Displays pervasive mood of unhappiness or depression

NOTE: two areas are addressed – 1) self-concept and 2) frustration and feelings of unhappiness).

Sample Goal: By 9/5/12, X will increase her self-concept by recognizing and verbalizing positive statements about herself in conversations with peers and staff 3 times per day with one indirect prompt for 9 of 10 trial days as shown by data charts.

Objective One: By 12/5/11, X will increase her self-concept by recognizing and verbalizing positive statements about herself in conversations with peers and staff 3 times per day with modeling and two prompts for 9 of 10 trial days as shown by data charts.

Objective Two: By 4/5/12, X will increase her self-concept by recognizing and verbalizing positive statements about herself in conversations with peers and staff 3 times per day with one direct prompt for 9 of 10 trial days as shown by data charts.

Sample Goal: By 9/5/12, X will demonstrate appropriate ways to decrease frustration and feelings of unhappiness by verbally identifying appropriate methods of dealing with stress during or after a stressful situation, with no prompts, in 4 out of 5 situations for 9 of 10 trial days as shown by data.

Objective One: By 12/5/11, X will demonstrate appropriate ways to decrease frustration and feelings of unhappiness by verbally identifying appropriate methods of dealing with stress after a stressful situation, with discussion and prompts, in 4 out of 5 situations for 9 of 10 trial days as shown by data charts.

Objective Two: By 4/5/12, X will demonstrate appropriate ways to decrease frustration and feelings of unhappiness by verbally identifying appropriate methods of dealing with stress during or after a stressful situation, with two prompts, in 4 out of 5 situations for 9 of 10 trial days as shown by data charts.

Additional Goal Areas:

- Decrease self-persecuting behaviors.
- Recognize and accept one's strengths and weaknesses.
- Set realistic goals for self.
- Demonstrate appropriate eye contact and body posture.
- Use first person pronouns to identify self.
- Identify simple feelings in self.
- Identify simple feelings in others.
- Respond appropriately to positive feedback.
- Respond appropriately to failure.
- Express felt emotions appropriately.
- Actively seek leadership roles.
- Practice good grooming habits.
- Verbalize feelings when in distress.
- Demonstrate appropriate coping skills in stressful situations.
- Decrease test anxiety.
- Decrease worry and anxiety about home and school problems
- Adapt to new situations or changes in routine.

Sample Goal Areas Based on Criteria for Emotional Disturbance

Criteria & Need Statement: Displays tendency to develop physical symptoms, pains or unreasonable fears associated with personal or school problems.

Sample Goal: By 9/5/12, X will reduce physical symptoms or phobias and increase appropriate focus on school work by remaining on task without complaining or verbalizing discomforts for one class period or 45 minutes, with one reminder to earn points on a contract for 9 of 10 trial days as shown by chart data.

Objective One: By 12/5/11, X will reduce physical symptoms or phobias and increase appropriate focus on school work by remaining on task without complaining or verbalizing discomforts for 20 minutes, with one reminder to earn points on a contract for 9 of 10 trial days as shown by chart data.

Objective Two: By 4/5/12, X will reduce physical symptoms or phobias and increase appropriate focus on school work by remaining on task without complaining or verbalizing discomforts for 30 minutes, with one reminder to earn points on a contract for 9 of 10 trial days as shown by chart data.

Additional Goal Areas:

- Reduce phobias and demonstrate his willingness to attempt a new task by accepting written or verbal directions for a new task with a positive remark or clarifying question
- Have only excused absences.
- Have only excused tardies.
- Complain of physical discomfort only when appropriate.
- Remain on task despite perceived or minor discomforts (i.e. room too hot or cold).
- Decrease physical reaction to personal or school problems.
- Reduce inappropriate complaining or whining.
- Reduce inappropriate crying.
- Participate in events at school.
- Demonstrate willingness to attempt a new task.
- Increase motivational level through contracts, charts, points, levels.
- Increase general community functioning skills.
- Answer questions regarding information presented in classroom setting.