Social/Emotional Evaluations:

Identifying Emotional Disturbance

PAR Staff

PAR

Executive Summary

Students with an emotional disturbance (ED) can be difficult to assess and identify due to the unique and diverse nature of the disorder. The federal criteria for ED was written in 1957, which makes it outdated. Additionally, the criteria contains some subjective terms, further hindering a clinician's ability to accurately provide services for these students. The task of assisting these students becomes even more muddled when considering whether the issues arise from social maladjustment. For insight on this complicated issue, PAR interviewed experts in the field about the use of instruments that have been useful in gathering the data needed for clinicians to make confident and informed decisions about ED eligibility.

What is ED?

An emotional disturbance (ED) or an emotional disorder is characterized by emotional problems that affect a child's educational performance (Greene, 2019). According to Greene, this broad definition can include children with mood disorders, anxiety problems, serious relationship deficits, chronic behavior problems, and psychosis. Children with an ED may also have comorbidities, such as social maladjustment (SM), learning disabilities, or attention-deficit hyperactivity disorder (ADHD; Greene, 2019). More specifically, students with an ED are defined as those who meet the federal criteria presented in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) defined in the Assistance to States for the Education of Children with Disabilities program (34 C.F.R., §300.7, 2002).

History of ED Prevalence

In the 2001-2002 school year, there were 6.3 million students in special education programs. Of these, 473,663 were classified as emotionally disturbed, according to the National Center for Education Statistics (Hoffman, 2003)—a number that had increased 18.4% from the previous 10 years (1991-1992). By 2002, ED had become the fourth-most prevalent of the 13 exceptionalities served by special education, and there was every indication that an increase in both number and proportion for this group would continue to occur. Instead, the statistics showed a decline. By the 2011-2012 school year, only 373,000 students were classified as having an ED (Keaton, 2013). It appeared the numbers were dwindling.

Yet, recent research has reported that parents and caregivers of more than 8 million school-aged children ages 4 to 17 years have sought help from a mental health professional or school staff member about their child's emotional or behavioral difficulties (Simpson, Cohen, Pastor, & Reuben, 2008). What accounts for the disparity between those asking for help and those receiving services? How do we account for what appears to be an underidentification of ED in the schools? What can we put in place to stop the decline and get those who require help the services they need?

Case Examples

The three following cases exemplify the diversity and difficulty inherent with evaluating students who have been referred for a comprehensive assessment due to academic and/or behavioral concerns.

Katherine is an 8-year-old girl who attends public school. Following a traumatic event, she began to insist on wearing a helmet to school and during class. When school personnel requested she remove the helmet, she adamantly refused, expressing fear that the ceiling would fall and they would all be killed. Her mother reports similar disruptions at home. Katherine's grades have dropped to Ds and Fs. She has become disruptive in class and is having problems socializing with peers. She cries frequently and has most recently expressed a desire to stay home from school. Katherine's parents and teacher requested an evaluation to determine if she meets criteria for ED and is in need of services.

Brian is a 15-year-old adolescent who was expelled from his last school for calling in a bomb threat. The administration at his home school considers him occasionally volatile and "a constant liar." His mother confirms the lying and additionally reports daily fights between Brian and her live-in boyfriend. She states that "he hangs with a bad crowd and his behavior is out of control." Brian's teachers describe him as a "loner" who appears sad throughout the school day. His grades have dropped from Bs to Ds and Fs. School personnel referred Brian for an evaluation to determine if he meets criteria for ED or if his behaviors are consistent with social maladjustment.

Jeremy is a fifth grader who currently receives special education services under the category of ED and other health impairment (OHI). One year after his initial ED diagnosis, he was diagnosed with autism spectrum disorder (ASD). His original ED eligibility was based on violent behavior in kindergarten and first grade. Once it became evident that his violent outbursts were related to characteristics associated with his ASD diagnosis and appropriate interventions were put into place, Jeremy was able to function more effectively at school. His grades are above average, and he has not experienced any behavioral outbursts since second grade. His parents are planning to place him in a private school and have requested an evaluation to eliminate the ED diagnosis. They, along with school administration and teachers, believe the OHI eligibility is the most appropriate.

The Difficulty with ED Eligibility

As seen in the previous case examples, students with emotional disturbance are a unique and diverse population, making them particularly difficult to assess and identify. Whether determining, changing, or removing

eligibility, clinicians usually have an idea of who needs help emotionally. However, determining whether a student qualifies for special education services within the IDEA category of ED can be complicated.

One of the greatest challenges in determining eligibility services involves the social maladjustment/emotional disturbance dichotomy. The term *socially maladjusted* (SM) has not been defined by IDEA. The federal definition of ED, which has been virtually unchanged since it was written in 1957, leaves the operationalization of the criteria set forth by IDEA to individuals and organizations in the field. State and local educational agencies are also responsible for implementing special education services.

To further complicate matters, we have only recently begun to question the longstanding belief that SM students externalize their behaviors, while ED students internalize their behaviors. However, since ED was defined in 1957, neuroscience has shown that "brain differences underlie both internalizing and externalizing behaviors," says Richard M. Marshall, EdD, PhD, author of the Pediatric Behavior Rating Scale (PBRS; Marshall & Wilkinson, 2010). "From a neurobiological perspective, therefore, the only difference between the two is the expression of behavior. There is little evidence that students with externalizing behaviors are any more capable of controlling their emotions or behavior than students with internalizing disorders. Yet students with internalizing disorders are provided with interventions, while students with externalizing behaviors are punished."

In addition to the difficulties defining and determining SM versus ED, the federal criteria defined in the Assistance to States for the Education of Children with Disabilities (34 C.F.R., §300.7, 2002) includes two potential areas of ED eligibility that are very broad and have no clinical definition:

- *"An inability to build and maintain satisfactory interpersonal relationships with peers and teachers."*

- *"Inappropriate types of behavior or feelings under normal circumstances."*

Also, the Office of Special Education Programs (OSEP) has never provided official guidelines for potential exclusionary criteria for an ED diagnosis such as severity, educational impact, and duration. Although some feedback on these issues has been provided, no formal guidelines have been published. The federal definition does allude to some clinical conditions (e.g., depression, anxiety, schizophrenia), but it doesn't provide guidelines for how these conditions should be diagnosed.

Finally, we cannot negate the fact that in the past, psychologists lacked psychometrically sound instruments to provide the hard data needed to substantiate a well-informed decision in regard to ED eligibility.

PAR Asks the Experts

Clearly, school staff members often have difficulties when it comes to assessing a student who may have an ED; getting hard data to back up the decision can be just as difficult. PAR spoke with experts in the field about the use of various instruments that have proven to be useful in gathering the hard data needed in order to make an informed decision about ED eligibility.

Behavior Rating Inventory of Executive Function, Second Edition (BRIEF2)

Peter K. Isquith, PhD, is a practicing developmental neuropsychologist and coauthor of the BRIEF2 and the BRIEF2 Interpretive Guide.

PAR: *Why would it be helpful to include a measure of executive functioning in the assessment of a student being evaluated for ED eligibility?*

PI: In general, the purpose of including the BRIEF2 when asking about ED is to know whether or not the child actually has an emotional disturbance or if his or her self-regulation gives that appearance. So, if a child is referred who has frequent severe tantrums, we want to know if this is an emotional disturbance or if it is part of a broader self-regulatory deficit. That is, is the child melting down because he or she truly experiences emotional distress, or is he or she doing so because of poor global self-regulation? To answer this, I would want to look at two things:

- *Is there evidence of an actual emotional concern? Does the child exhibit mood problems, anxiety, or other emotional issues?*

- *Does the child's self-regulation have an impact on other domains, including attention, language, and behavior? That is, is he or she physically, motorically, attentionally, and/or verbally impulsive or poorly regulated?*

If the first answer is yes, then there is likely an emotional disturbance. But if it is no, then there may be a self-regulatory issue that is more broad. By using the BRIEF2, clinicians can quickly learn if a student is impulsive or poorly regulated in other domains. A BRIEF2 profile with high

Inhibit and Emotional Control scales suggests that the child is more globally disinhibited. If it is primarily the Emotional Control scale that's elevated, and there is an emotional concern like mood problems, then it may be more of an emotional disturbance.

Pediatric Behavior Rating Scale (PBRS)

Richard Marshall, EdD, PhD, Richard Marshall, EdD, PhD, is a licensed school psychologist specializing in pediatric and adolescent neuropsychology. In addition to the PBRS, published in 2008, he is the author of 2011's The Middle School Mind: Growing Pains in Early Adolescent Brains.

PAR: *How does the PBRS fit into the diagnosis of ED?*

RM: Two gaps in practice prompted us to develop the PBRS. The first was that the assessment instrument available at the time had few, if any, items about rage attacks, irritability, assaultive aggression, and other symptoms associated with early onset bipolar disorder. Hence, despite significantly abnormal behaviors, results of assessments were often within normal limits because they failed to capture symptoms of interest. So, our first goal was to include these new behaviors into parent and teacher ratings.

The second gap was that symptom overlap between ADHD and early onset bipolar disorder made it difficult to differentiate between the two. The problem is that the standard treatment for ADHD—stimulant medication—induces mania in individuals with bipolar disorder. Thus, diagnosis accuracy is paramount.

What we learned from the PBRS norming sample was that students with ADHD and bipolar disorder produce a similar pattern of scores, but stud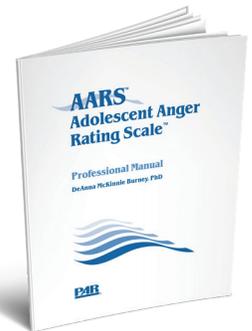ents with bipolar disorder produce a higher level of scores. That is, both groups have similar symptoms, but individuals with bipolar disorder have more serious symptoms. Thus, the PBRS can assist clinicians in differentiating individuals with mood disorders from those with ADHD.

PAR: *Decades of research in cognitive neuroscience, combined with changes in our understanding and classification of mental illness in children, impels us to continually reevaluate theory and practice. Formulated more than a half-century ago, the idea of social maladjustment is one of those policies in desperate need of revision. In 1957, the idea of being able to identify students who were socially maladjusted may have seemed reasonable.*

RM: There are two problems with this idea. First, the government has never defined social maladjustment and states (and practitioners) have been left without clear ways of differentiating students who are or are not socially maladjusted. Second, without a clear definition, the concept of social maladjustment has created what Frank Gresham refers to as a "false dichotomy" that is used to exclude students from receiving interventions that would help them and to which they are entitled.

Adolescent Anger Rating Scale (AARS)

Darla DeCarlo, PsyS, has been a clinical assessment consultant with PAR for more than a decade. She is a licensed mental health counselor and certified school psychologist in the state of Florida.

PAR: *Can you speak about your use of the AARS in ED evaluations?*

DD: Within the context of assessing those students referred for behavior-related evaluations, I found the AARS to be a great compliment to the various other instruments I used during the evaluation process. Making an ED determination is a sensitive issue and I wanted as much hard data as possible to help me make a well-informed decision. The AARS allowed me to assess a student's level of anger and his or her response to anger through a self-report. Limited instruments are able to give clinicians information that can help them look at the ED/SM issue. The AARS helped me identify students who were at risk for diagnoses of conduct disorder, oppositional defiant disorder, or ADHD. Combine these results with results on the Emotional Disturbance Decision Tree (EDDT) and other instruments, and I was able to get a good picture (not to mention some hard data) on whether SM factored into the student's issues.

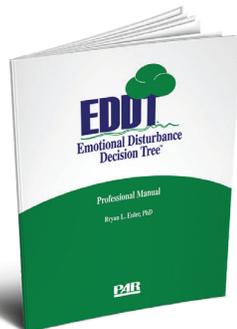**PAR:** *What about interventions? Does the AARS help with that in any way?*

DD: Anger control, as defined by the AARS, "is a proactive cognitive behavioral method used to respond to reactive and/or instrumental provocations. Adolescents who display high levels of anger

control utilize the cognitive processes and skills necessary to manage anger related behaviors" (Burney, 2001).

What I like about the instrument is that it qualifies the type of anger the student is displaying and then gives the clinician information about whether or not the student displays anger control or even has the capacity for anger control. As a school psychologist, I needed to know if the student already had the skills to follow through with some of the possible interventions we might put in place or if we needed to teach him or her some skills before attempting the intervention. For example, something as simple as telling a student to count to 10 or walk away when he or she feels anger escalating may seem like an easy task, but not all students recognize the physiological symptoms associated with their outbursts. Therefore, asking them to recognize the symptoms and then act by calming themselves is pointless. I have seen this mistake many times, and have made the mistake myself by suggesting what I thought was a useful and effective intervention, only to find out later that the intervention failed simply because the student did not possess the skills to perform the task. The AARS gave me information that helped guard against making this type of mistake.

Emotional Disturbance Decision Tree (EDDT)

Bryan Euler, PhD, author of the EDDT as well as the EDDT Parent Form and the EDDT Self-Report Form, has a background in clinical and counseling psychology, special education, and rehabilitation counseling. He has decades of experience as a school psychologist working in urban and rural settings with multicultural student populations.

PAR: *Can you describe the overall benefits of the EDDT system and what makes it unique from other instruments?*

BE: The EDDT series was designed to map directly onto the IDEA criteria for emotional disturbance, which are different from and broader than constructs such as depression or conduct. The federal criteria are, some might say, unfortunately wide and "fuzzy," rather than clean-cut. The EDDT scales are written to address these broad domains thoroughly and help school psychologists apply the unwieldy criteria. The EDDT also includes an SM scale. Since students who are only SM are not ED eligible, the EDDT is useful

in ruling out these students and in identifying those for whom both conditions may be present.

This can be helpful with program decisions so children or adolescents who are primarily "fragile" are not placed in classrooms with those who have both depression/anxiety and severe aggression. The EDDT also has an Educational Impact scale, which helps to document that the student's social–emotional and behavioral issues are having educational effects, which IDEA requires for eligibility. All of the EDDT forms include a Severity scale, which helps to gauge this and guide service design.

The EDDT Parent and Self-Report forms also include Resiliency and Motivation scales, which help to identify a student's strengths and determine what may most effectively modify his or her behavior. The presence of all these factors in the EDDT scales is intended to facilitate the actual practice of school psychology with ED and related problems.

PAR: *Why is it important to have multiple informants as part of an evaluation?*

BE: Having multiple informants is, in effect, one way of having multiple data sources. Multiple data sources add incremental validity, or accuracy, to evaluations as well as breadth of perspective. A rough analogy might be to lab tests, which are often done in panels, or multiples, rather than in singles, to help with insight, efficiency, and decisions.

PAR: *What are the benefits of having the student perspective as part of an evaluation with multiple informants?*

BE: Having a student's perspective on his or her behavior and social–emotional adjustment is a critical but sometimes overlooked component of assessment, especially for ED and ADHD evaluations. If only teacher anecdotal reports, teacher-completed ratings, and behavior observations are used, this vastly increases the chance that the evaluation will be skewed toward externalized behavior like aggression and rule-breaking. Internal factors such as depression or anxiety, which may be causing the behavior, will be deemphasized, if noted at all. Research corroborates that if teachers rate a student and ratings are also obtained from the parent and the child, the teacher results tend to highlight difficult, disruptive behavior, while other ratings may result in other insights. Relatedly, in children and adolescents, depression is often primarily manifest in irritability or anger rather than sadness. If there is no observable sadness and only problem behavior, teacher ratings

may understandably focus on what stands out to them and complicates classroom management.

Even if students minimize their depression, anxiety, or social problems, they do sometimes rate one or more of these as "at risk." This can provide a window into subjective emotional pain that may otherwise be obscured. Finally, gathering student-derived data enhances school psychology professional practice. Psychologists who complete child custody or juvenile corrections evaluations gather data directly from the child to facilitate insight, which can also aid in school psychology.

Note: For a comprehensive, step-by-step guide to use of EDDT ratings in the evaluation of emotional disturbance, please read this white paper by Greene and Euler (2018).

Conclusion

Evaluating and identifying students with ED can be a challenging process. However, as described by our experts, the use of proper assessment resources can provide clinicians with a wealth of hard data and insights that can be used to make accurate and confident decisions regarding a student's diagnosis and placement in services. The BRIEF2 can help clinicians distinguish between ED and unrelated problems with self-regulation. The PBRS is useful in distinguishing between individuals with ED and ADHD. The AARS can assist in identifying students with conduct disorder, oppositional defiant disorder, and ADHD, and can additionally provide information about whether certain interventions are right for the student. The EDDT is especially useful in that it contains scales that coincide with the federal criteria—in addition to a social maladjustment scale—and allows for data from multiple informants for a more valid and comprehensive assessment.

As with every evaluation, the instruments we choose in our assessments are important, but even the best instrument is useless without the keen skills of well-trained school staff to properly administer and interpret results with accuracy and precision. The following pages contain additional resources that can aid parents and teachers in helping individuals who may have ED.

Assistance to States for the Education of Children with Disabilities, 34 C.F.R. § 300 (2002).

Burney, D. M. (2001). *Adolescent Anger Rating Scale.* Lutz, FL: PAR.

Greene, J. A., & Euler, B. L. (2018). *Utilizing multiple rater perspectives in emotional disturbance evaluation: A case study with the Emotional Disturbance Decision Tree (EDDT) rating forms* (white paper). Lutz, FL: PAR.

Hoffman, L. M. (2003). *Overview of Public Elementary and Secondary Schools and Districts School Year 2001-02.* Washington, DC: National Center for Education Statistics.

Individuals with Disabilities Education Improvement Act of 2004 (IDEA). Public Law No. 108-446, 118 Stat. 2647.

Keaton, P. (2013). *Selected Statistics From the Common Core of Data: School Year 2011-12.* Washington, DC: National Center for Education Statistics.

Marshall, R. M. & Wilkinson, B. J. (2010). *Pediatric Behavior Rating Scale*. Lutz, FL: PAR.

Simpson, G. A., Cohen, R. A., Pastor, P. N., & Reuben, C. A. (2008). *Use of mental health services in the past 12 months by children aged 4-17 years: United States, 2005-2006*. Hyattsville, MD: National Center for Health Statistics.

Additional resources for parents and teachers

Handbook for Raising an Emotionally Healthy Child

The Middle School Mind: Growing Pains in Early Adolescent Brains

How Children Succeed: Grit, Curiosity, and the Hidden Power of Character

Helping Children Succeed: What Works and Why

The Mental Breakdown Morning Show [video podcast]

Resources for school psychologists

Behavior Rating Inventory of Executive Function, Second Edition (BRIEF2)

The BRIEF2 product page features a video with BRIEF2 coauthor Peter K. Isquith, PhD, as well as links to an informative BRIEF2 fact sheet; sample BRIEF2 Parent, Teacher, and Self-Report form interpretive reports; a sample Parent Form Screening Form Report; and a sample BRIEF2 Summary Report. There's also a BRIEF2 Decision Guide to help determine which BRIEF2 option is best for your practice.

Pediatric Behavior Rating Scale (PBRS)

The PBRS product page features an informative PowerPoint presentation about the PBRS, a sample Parent Score Report, and a Sample Teacher Score Report.

Emotional Disturbance Decision Tree (EDDT)

The EDDT product page includes an informative PowerPoint presentation about the EDDT, an EDDT family fact sheet, and a sample PARiConnect report.

The Adolescent Anger Rating Scale (AARS)

The AARS product page includes a brief overview of the instrument, including its intended purpose, age range, and estimated time of administration. Subscales and normative sample information are also shown.

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