

## *Defining Emotional or Behavioral Disorders: The Quest for Affirmation*

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The high incidence, mild disabilities (specific learning disability (LD), mental retardation (MR), emotional disturbance (ED)) represent the largest group of students receiving special education in the United States. Yet, these categories have failed to achieve consensus about the way they should be defined. Both LD (see Kavale and Forness, 2000) and MR (see MacMillan et al., 1993) continue to experience contentious debate about definition. Similarly, ED is experiencing tensions about definition (see Kavale et al., 1996). Basically, the definitions offered lack precision and this creates vague boundary conditions among categories. Consequently, the high-incidence, mild disabilities tend to demonstrate more similarities than differences, which makes it difficult to reliably differentiate among them (Hallahan and Kauffman, 1977). The lack of clear definition means that any single classification does not possess validity because it will not yield groups whose characteristics are known from the assigned labels (Zigler and Hodapp, 1986).

For ED, definitional problems are compounded by the different social contexts where they are used. An ED label is assigned through cultural rules that demonstrate considerable variability across contexts and make the process inherently subjective (Forness, 1996). The result is a high

degree of 'clinical judgment' in ED designation (Smith et al., 1988). At best, ED definitions describe a general population, but encounter difficulty when applied to individual cases because a uniform interpretation is lacking.

## **DEFINITIONS OF EMOTIONAL OR BEHAVIORAL DISORDERS**

Many definitions of ED have been offered, but none has successfully resolved perceived problems and achieved consensus. Any ED definition stresses that the behaviors in question meet three criteria: severity, frequency, chronicity. Within the context of these criteria, the federal ED definition in the Individuals with Disabilities Education Act (IDEA) stipulates five characteristics:

- 1 An inability to learn which cannot be explained by intellectual, sensory, and health factors.
- 2 An inability to build or maintain satisfactory 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.

The characteristics stipulated in the ED definition have their origin in Bower's (1960) definition of 'emotionally handicapped'. From its codification in 1975, there was dissatisfaction with the IDEA definition because of its inherent vagueness and imprecision. The decision-making structure created was simply too subjective. For example, what is an inability to learn? Does it refer to only academic learning or can social learning be included? How exactly are satisfactory interpersonal relationships defined? What are normal conditions? When is unhappiness pervasive?

The IDEA definition possessed other difficulties. First, from 1975 to 1997, the condition being defined was 'seriously emotionally disturbed' (SED), which made it the only federal category to include an indication about severity level and potential problems when dealing with 'mild' problems (Forness, 1990). Second, an initial statement about characteristics being demonstrated over a long period of time and to a marked degree was extended to include 'which adversely affects educational performance'. This phrase seems unnecessary since the first stipulated characteristic deals

directly with educational performance ('an inability to learn') (Forness, 1992a). Additionally, what if a student, for example, only manifests the 'inability to learn' criterion? The possible confounding with the LD classification seems evident (Forness et al., 1983). An emphasis on educational performance could potentially work against a student who, for example, demonstrated 'a general pervasive mood of unhappiness or depression' but no academic problems.

The most problematic aspect of the federal definition was a statement indicating who was included and who was excluded. The definition included children who were schizophrenic, which was compatible with the SED nomenclature. In subsequent reauthorizations, the federal definition was modified to exclude students with autism who were classified under 'Other Health Impairments' because of its presumed biophysical origin (Forness and Kavale, 1984). In 1990, autism was made a separate category.

Although schizophrenia was included, the SED definition 'does not include children who are socially maladjusted, unless it is demonstrated that they are seriously emotionally disturbed.' Since social maladjustment was not given specification in the law, it came to be defined in terms of disruptive and antisocial behavior (Forness, 1992b). Generally, such behavior is often equated with conduct disorder (CD) characterized by a persistent pattern of behavior violating basic rights of others or age-appropriate social rules (APA, 1994). Symptoms include a variety of aggressive, destructive, dishonest, or noncompliant behaviors (Kazdin, 1995). Given these parameters, it seems illogical to exclude students because their problems are considered to be 'merely' CD (Center, 1990) while the actual underlying emotional disorders may not be recognized because the more evident 'social maladjustment' is excluded (Forness, 1992b). Clearly, social maladjustment may be evidenced in the federal definitional criteria (especially b and/or c) which, in fact, were originally meant to be indicators of social maladjustment (Bower, 1982). Thus, strict adherence to the federal definition would seem to exclude children on the basis for which they might be included and thus enable schools to *not* serve children with significant behavioral problems (Cline, 1990).

An enduring problem continued to surround terminology. The Council for Children with Behavioral Disorders (CCBD) endorsed the term 'behavior disorder' in place of 'emotional disturbance'. The advantages were seen in a) focusing attention on clearly observable aspects of the problem (that is, disordered behavior), b) no suggestion about any particular theoretical perspective, and c) less stigma (Huntze, 1985). The concern about stigmatization was supported by findings that the label 'behaviorally disordered' implied less negative connotations to teachers

than did 'emotionally disturbed' (Feldman et al., 1983). Nevertheless, the longstanding definition of emotional disturbance suggested that terminology should include the possibility that a student may have emotional or behavioral problems or both (Forness and Kavale, 1997).

In 1992, a definition of emotional or behavioral disorder (E/BD) was proposed by the National Mental Health and Special Education Coalition (see Forness and Knitzer, 1992). The definition reads as follows:

- (i) The term emotional or behavioral disorder means a disability characterized by behavioral or emotional responses in school programs so different from appropriate age, cultural, or ethnic norm that the responses adversely affect educational performance, including academic, social, vocational, and personal skills. Such a disability
  - (A) is more than a temporary, expected response to stressful events in the environment.
  - (B) is consistently exhibited in two different settings, at least one of which is school-related; and
  - (C) is unresponsive to direct intervention in general education, or the child's condition is such that general education interventions would be insufficient.
- (ii) Emotional and behavioral disorders can co-exist with other disabilities.
- (iii) This category may include children or youth with schizophrenic disorders, affective disorder, anxiety disorder, or other sustained disorders of conduct or adjustment where they adversely affect educational performance in accordance with section (i). (Forness and Knitzer, 1992)

The definition resolves many problems by 1) recognizing that disorders of emotion and behavior can occur separately or in combination, 2) recognizing cultural and ethnic differences, 3) eliminating minor or transient problems, 4) recognizing that problems exhibited outside of school are important, 5) recognizing the possibility of multiple disabilities, and 6) eliminating arbitrary exclusions (Forness and Kavale, 2000).

Although the E/BD definition provides a more comprehensive perspective, eligibility remains predicated primarily on impaired educational performance. This places the definition in a special education context, but the E/BD phenomenon may also be the province of other agencies with different definitional perspectives (Forness, 1996). For example, the *Diagnostic and Statistical Manual of Mental Disorders-IV* (DSM-IV) focuses on the psychiatric bases of 'mental disorder' which is 'conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual' (APA, 1994: xxi). The E/BD concept thus becomes far more generalized, which introduces greater problems in determining eligibility. Across agencies, there exists the possibility that a student might be found eligible in one system yet not meet criteria provided

in a different agency definition (Forness and Kavale, 1997). School and mental health agencies thus operate in a parallel rather than a cooperative or interactive manner (Mattison and Forness, 1995). Consequently, special education and mental health diagnostic categories may not be concordant (Sinclair et al., 1985).

### **The problem of definition**

The lack of precision in the ED definition creates potential confounding with other categories and LD provides a prime example. The LD definition clearly focuses on 'an inability to learn' manifested in significant academic underachievement (Kavale and Forness, 2000). Additionally, the LD definition also includes an exclusion clause indicating that the learning problems 'cannot be explained by intellectual, sensory, or health factors.' The definitions thus share many common features. In fact, large-scale evaluations have demonstrated the similarities in the academic deficits manifested by students with ED and LD (Stone and Rowley, 1964; Forness et al., 1983). Similarly, students with LD often tend to demonstrate behavioral difficulties closely resembling those found in students with ED (Epstein et al., 1983; McConaughy and Ritter, 1985). This is particularly the case for social skill deficits which are manifested by a majority of students with LD (Kavale and Forness, 1996) and led the Interagency Committee on Learning Disabilities definition of LD to include social skill deficits as a primary LD (see Kavanagh and Truss, 1988). Forness and Kavale (1991) pointed out the logical dilemma of diagnosing LD without the historically important academic deficits but, more importantly, the confounding it would cause with ED because social skill deficits are conceptually closer to ED than LD. Thus, the boundaries between ED and LD are imprecise and analyses generally fail to find clear distinctions between these categories (for example, Epstein and Cullinan, 1983; Fessler et al., 1991; Scruggs and Mastropieri, 1986).

### **Balkanization in special education**

The difficulties in defining ED may not be related solely to a lack of precision, but rather in isolating the nature of a particular condition when there is a strong possibility that it may possess characteristics similar to other related conditions. The dilemma becomes one of how best to disentangle the conditions of interest from overlapping conditions (Achenbach, 1990/1991). For example, suppose that almost all individuals meeting criteria for condition X, 50 percent also meet criteria for condition Y, and

40 percent meet criteria for condition Z; substantial overlap exists between conditions Y and Z. Similarly, suppose there is also a high probability that almost all individuals who meet criteria for condition Z will meet criteria for condition X, while 25 percent will meet criteria for condition Y. Given these relationships, the question becomes: Do these relatively independent conditions represent phenotypic manifestations of the same underlying disorder or are they co-morbid conditions that co-exist in the same individual?

The tendency has been to view diagnostic categories as relatively independent conditions ignoring the possibility that they are co-morbid conditions (Tankersley and Landrum, 1997). This tendency has resulted in periodic calls to make each discrete disorder a separate category of special education.

The process of creating new special education categories has been likened to the geopolitical process of Balkanization where a region divides into smaller (and often antagonistic) units (Forness and Kavale, 1994). Balkanization generally begins with the recognition of a separate identity for an ethnic people, followed by movement to create a separate government to better accommodate the group's needs, and often introduces a process of 'ethnic cleansing' to ensure that only select individuals are included in the newly created state. Five disorders exemplify the Balkanization of special education because they either have become new categories or have seen serious efforts to establish them as separate categories. These disorders are: attention deficit hyperactivity disorder; traumatic brain injury; fetal alcohol syndrome; post-traumatic stress syndrome; and fragile X syndrome. When these 'new' behavior disorders are examined in relation to specific problem areas (for example, below-average IQ, language impairment, underachievement, inattention, conduct disorder, depressive disorder, anxiety disorder), significant overlap exists across the five disorders. In fact, there appears to be more symptom variability *within* disorders than across disorders. These 'new' disorders also demonstrate a great deal in common with the existing ED and LD categories. Consequently, confounding among disorders is probable and the Balkanization process may only waste valuable resources in attempting to determine eligibility for ever more circumscribed categories.

### **Attention deficit hyperactivity disorder**

Among the 'new' behavior disorders, attention deficit hyperactivity disorder (ADHD) is perhaps most problematic because it illustrates how the issue of co-occurrence tends to be a confounding factor.

The ADHD concept emanated from the study of brain injury whose sequelae might include inattention, hyperactivity, and impulsivity

(Barkley, 1998). Over time, the ADHD concept has witnessed substantial changes in nomenclature and criteria, but the concept remains an ill-defined constellation of behaviors that calls into question its validity as a distinct diagnostic entity (Prior and Sanson, 1986).

The difficulty in defining ADHD creates the possibility of substantial overlap with related conditions (Silver, 1990). For example, the exact association between ADHD and LD is difficult to specify because comorbidity rates have been found to range from 10 percent to 90 percent (for example, Biederman et al., 1991; Bussing et al., 1998; Marshall et al., 1997). A similar relationship exists between ADHD and CD (Gresham et al., 1998; Reeves et al., 1987). The situation is further complicated by a strong association between CD and LD (Hunt and Cohen, 1984). Cantwell and Baker (1987) found a large proportion of an LD sample also had some type of psychiatric diagnosis, with the most common being ADHD (40 percent) followed by CD (9 percent). Thus, although ADHD, LD, and CD can occur independently, there is a high probability that they may also co-occur, which raises questions about the nature of the associations: Are they subtypes of the same disorder? Does one predispose an individual to another? Do they share a common etiology that produces distinct syndromes? Until answers are forthcoming, precise definitions are not likely to be achieved (Forness and Kavale, 2002).

## **Emotional disorders and LD**

There appears to be an association between emotional disorders (for example, anxiety, depression, mood disorders) and LD (Weinberg and Rehmet, 1983). For example, among LD samples, depressive symptoms can range from 26 percent to 36 percent (Wright-Strawderman and Watson, 1992). Forness (1988) found, in a sample of children diagnosed with depression, that 57 percent revealed co-morbidity in the form of a secondary diagnosis of ADHD, ED, or LD. Similar findings about co-morbidity were found when the primary diagnosis was ADHD (Sinclair et al., 1985) or CD (Forness et al., 1993). With respect to anxiety and mood disorders, in an LD sample, Cantwell and Baker (1987) found mood disorder more common than anxiety disorder at diagnosis (17 percent vs. 2 percent) but, at follow-up, anxiety was present at a higher rate than mood disorder (25 percent vs. 10 percent).

## **CD and ED**

The co-morbidity issue is critical for ED because the failure to recognize co-occurrence may decrease the likelihood of a student being found eligible

for special education. Recall that the federal definition stipulates that a student may not be considered for the ED category if the primary problem is viewed as social maladjustment. Yet, when social maladjustment is placed in the context of CD, it represents one of the most prevalent and most enduring of all psychiatric conditions (Offord and Bennett, 1994). Consequently, it would be advantageous to view CD as a 'complex' disorder where overt CD is co-morbid with other psychiatric disorders (Forness et al., 1993).

Forness et al. (1994) described how complex CD might be symptomatic of other underlying psychiatric disorders. There exists the possibility that the two major behaviors associated with CD (that is, not paying attention and disrupting classroom activities) may not be recognized as expressions of co-morbid disorders such as ADHD (Cantwell, 1996), mood disorder (Kovacs, 1996), anxiety disorder (Bernstein and Borchardt, 1991), or even schizophrenic disorder (Volkmer, 1996). For example, in mood disorder (such as depression) inattention may derive from diminished ability to concentrate, while disruptive behavior may derive from the primary symptom of irritability.

Forness et al. (1994) estimated the prevalence for 'complex' CD (that is, CD plus one of four psychiatric disorders) to be more than half (2.3 percent) of the prevalence for CD itself, which is generally viewed as approximately 4 percent. Complex CD may also be associated with other disorders, such as LD, especially if social skill deficits are present (San Miguel et al., 1996). Additional possible disorders include physical and sexual abuse (Cicchetti and Toth, 1995) and post-traumatic stress disorder (APA, 1994), whose sequelae often mimic CD symptomology. These possibilities were validated by findings showing that, in a large ED group, nearly two-thirds had a CD diagnosis and two-thirds of this group also had another co-morbid psychiatric diagnosis (Greenbaum et al., 1996). Thus, 'complex' CD may be more prevalent than 'simple' CD.

### **ED, LD, co-morbidity, and diagnostic validity**

The failure to recognize co-morbidity may produce negative consequences related to the validity of individual diagnoses and the effectiveness of intervention efforts. Given the nature of the federal definitions for ED and LD, the issue of co-morbidity is not usually addressed in school assessments, which increases the potential for misclassification or no classification (that is, not being found eligible). On the intervention side, the treatment approaches suggested, although seemingly appropriate for the primary problem, may not be comprehensive or focused enough to effect possible

disorders accompanying the primary symptomatology. For example, in a group of children diagnosed with depression or CD, special education eligibility was most likely when there was co-morbid LD (Forness, 1988; Forness et al., 1993). Thus, with depressive disorder or CD as a primary diagnosis, special education eligibility appears predicated, to a significant extent, on the presence of severely compromised educational performance (that is, LD).

The question of eligibility must be placed in the context of problems in identifying LD related primarily to the reliance on an IQ-achievement discrepancy, which means that the learning problems associated with psychiatric disorders may not actually be 'true' LD but are labeled as such (Kavale and Forness, 1995). For example, Forness et al. (1993) studied a group that was equally divided between a 'pure' ADHD group and a 'mixed' ADHD group (that is, concurrent with CD) and found them similar with respect to IQ levels, but the 'mixed' group was more impaired academically, which meant greater likelihood of an LD diagnosis because of the presence of a significant IQ-achievement discrepancy.

For ED, Duncan et al. (1995) found a significant delay before an ED classification was established. For a large ED sample, although some psychiatric intervention began at mean age 6.4 years, special education referral usually for LD did not begin until mean age 7.8 years, while the final ED placement did not occur until mean age 10.4 years. About half the sample had concurrent disruptive and anti-social behaviors which may have provided a barrier to appropriate identification because of the 'social maladjustment' exclusion found in the ED definition. Thus, the initial school action for an ED sample was usually for other problems (for example, LD), and perhaps five years passed until there was appropriate special education placement (that is, ED). Similarly, Del'Homme et al. (1996) found a relatively small proportion of referrals for students with solely behavior problems as opposed to combined (behavioral and academic) problems, suggesting that potential ED was under-identified either because the focus was on academic difficulties (that is, LD) or because the behavioral problems were related to disruptive and antisocial behavior (that is, CD) and hence excluded from ED consideration.

The potential for disregarding the significance of ED was also found by Lopez et al. (1996), who tracked 150 students in grades 2 to 4 meeting strict research-based criteria for ED, ADHD, and LD. Findings showed that 37 percent of ADHD and 50 percent of ED students were placed in an LD program, but only 9 percent of ADHD and none of the ED group were considered for ED placement. In fact, only *one* student out of 55 with ADHD or ED who might reasonably be expected to receive ED services actually received them. Why were 54 placed in a seemingly inappropriate program? It appears that the 'social maladjustment' exclusion criterion for

ED meant that such students were placed in LD programs in order to provide at least some special education services. The LD program, however, may be inappropriate because they usually lack an emphasis on remediating the behavior problems prominent in ED or ADHD (Forness et al., 1996).

## CONCLUSION

The definition of ED in US federal law remains contentious. Although positive modifications have been made, the ED definition still does not provide a clear and unencumbered view of the phenomenon. Consequently, the ED definition has not been applied rigorously and systematically, resulting in much imprecision in the classification process.

A prime contributor to the imprecision is a failure to recognize comorbidity, the co-occurrence of two or more conditions in the same individual. For ED, a major source of confounding is the LD category which possesses its own definitional problems, especially when social skill deficits are primary in discussing LD status. The situation for ED becomes further complicated by increasing recognition that ADHD, CD, and psychiatric diagnoses (for example, depressive disorder, mood disorder, anxiety disorder) may co-occur in complex associations that may cause one or more of these conditions to be overlooked.

The failure to acknowledge the co-existence of independent disorders has resulted in definitions of single disorders that are imprecise. The concurrent disorders may be primary or secondary, but not considering the many possibilities may adversely influence the diagnostic process by resulting in either misclassification or, more serious, no classification.

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