

Students With Emotional Disturbances: How Can School Counselors Serve?

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### Abstract

Students with Emotional Disturbances (ED) possess unique characteristics that require additional care from school counselors, teachers, and other school personnel. Information pertaining to the prevalence of ED among students and the common characteristics of students with ED is reviewed. Additionally, ideas and effective approaches that will aid school counselors in meeting the various needs of these students are presented. The purpose of the presented information is to broaden the skill repertoire of school counselors and to enhance the level of service they provide to students with ED.

### Students with Emotional Disturbances: How Can School Counselors Serve?

Students with Emotional Disturbances (ED) possess unique characteristics that require additional care from school counselors, teachers, and other school personnel. The preparation and additional training that many school counselors receive in the realms of career, personal/social, and academic concerns of students can aid in helping school counselors provide services to students with ED. In addition to this training, the following information associated with the prevalence of ED among students, common characteristics of students with ED, and effective approaches to meet the needs of students with ED may assist in broadening the skills possessed by school counselors and enhance the services they provide to students with ED.

In 2001 - 2002, special education and related services were provided to 482,702 United States (U.S.) students with ED (U.S. Department of Education, 2004). Because of the historical practice of under-identifying students with ED, this number may represent only a small fraction of students with ED (U.S. Department of Education, n.d.). It is estimated that 1.3 to 3.8 million students could be identified with serious ED (Kansas Career and Technical Education Resource Center [KCTERC], n.d.). Therefore, school counselors are likely to serve many unidentified students with mild to severe ED. The Individuals with Disabilities Education Act (IDEA) described ED as

...a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance—(a) an inability to learn that cannot be explained by intellectual, sensory, or health factors, (b) an inability to build or maintain satisfactory interpersonal relationships with peers and

teachers, (c) inappropriate types of behavior or feelings under normal circumstances, (d) general pervasive mood of unhappiness or depression, or (e) a tendency to develop physical symptoms or fears associated with personal or school problems. The IDEA requires that the characteristic(s) must be evidenced frequently and intensely, as well as have a negative impact on students' academic functioning. An additional requirement under the IDEA includes schizophrenia as an emotional disturbance, but does not include children who are socially maladjusted unless it is determined that they have an emotional disturbance (IDEA, 2004; Sect. 300.8[c] 4 [i, ii]).

Students with ED often have disorders classified in the Diagnostic and Statistical Manual of Mental Disorders – 4<sup>th</sup> edition – text revision (DSM-IV-TR) such as adjustment disorder, generalized anxiety disorder, attention-deficient/hyperactivity disorder, obsessive compulsive disorder, or depression and often experience serious disturbances in functionality (Reddy, 2001; Erk, 2004; Gacono & Hughes, 2004). Students who meet the eligibility criteria for ED typically experience significant behavioral, social-emotional, and academic difficulties in a multitude of settings (Reddy). Students classified with ED have serious, long-term, learning deficits that are not linked to other disability categories such as mental retardation, learning disabilities, hearing/vision problems, or traumatic brain injury (Connecticut Department of Education, 1997). It is challenging to determine whether difficulties in learning are the result of ED or vice versa. In either case, it is apparent that students classified as ED struggle in school and have many barriers that impede their success (Melton, 2004).

In addition to inherent characteristics, ED may result from external factors. Young, Merchant, and Wilder (2004) outlined internal characteristics as well as three external factors that may increase children's risk for emotional and behavioral disorders. The external factors include (a) family characteristics such as poverty, family violence, lack of rules, and inconsistent or coercive parenting; (b) school characteristics such as non-clarified or inappropriate expectations or lack of individualized and appropriate instruction; and (c) cultural conditions such as the negative influence of peer groups or the media (e.g., gangs, pornography, and violence).

Society's increasing promotion of aggression (Walker, Colvin, & Ramsey, 1995) to solve problems may decrease students' abilities to form interpersonal connections. Students who handle conflicts with aggression may lead to stressful educational environments (Young et al., 2004), thus increasing the anxiety experienced by students. Additionally, discrimination may play a factor. Minority students and students in poverty are more likely to be classified with emotional or behavioral disturbances (Young et al.).

Heathfield and Clark (2004) suggested that children and adolescents are under increased pressure resulting from "poverty, child abuse and neglect, substance abuse, and violence in our communities" (p. 912) which may increase the need for mental health services. School responses to misbehavior in the forms of expulsion and suspension have aided in increasing the intensity of emotional disturbances in students (Dwyer, 2002). By using these approaches schools are not addressing problem behaviors and are not providing proactive and preventative interventions for students classified with ED (Heathfield & Clark). Additionally, students may react negatively to their environment when it is ill-equipped to effectively meet their needs (Dwyer).

The U.S. Department of Health and Human Services (1998) reported that when compared to students with other disabilities, students with serious ED have lower grades, more absences, and more failed classes. Additionally, students with ED drop out of school more frequently and do not meet minimum competencies on exams by comparison. Their graduation rate (42%) falls 29 percentage points below other students (KCTERC, n.d.). The poor academic performance of students with ED may be related to the depletion of internal resources. The energy used to meet emotional demands leaves little to meet academic and social needs (Theodore, Akin-Little, and Little, 2004).

Students with ED may internalize and externalize emotions that could manifest in feelings and behaviors that are not appropriate for their age and are not explained biologically or physiologically (Connecticut Department of Education, 1997; Kehle, Bray, Theodore, Zhou, & McCoach, 2004). For example, internalized emotions include depression, withdrawal, anxiety, excessive fear (National Information Center for Children and Youth with Disabilities, 2004), excessive remorse, feelings of inadequacy, or guilt (Clarizio, 1992). They may have auditory or visual hallucinations, somatization, or gastrointestinal or cardiopulmonary difficulties. Hyperventilation and avoidance of activity due to extreme anxiety is not uncommon (KCTERC, n.d.). Behaviors associated with externalized emotions include aggression, temper tantrums, impulsiveness (KCTERC; National Information Center for Children and Youth with Disabilities), noncompliance, or destructiveness (Epstein, Cullinan, & Rosemier, 1983). Whereas behaviors associated with externalized emotions may be associated with ED, Clarizio noted that individuals with ED were uncomfortable receiving attention and were

restrained and subdued more frequently. When compared to others, students with ED often appeared more sad, lonely, or depressed (Cullinan, Osborne, & Epstein, 2004; Miller, 1994).

Students with ED may be unable to build or maintain satisfactory interpersonal relationships with others (National Information Center for Children and Youth with Disabilities, 2004). They may have difficulty in communicating verbally and non-verbally and experience trouble expressing sympathy, warmth, or empathy toward others. When placed in situations with culturally similar students they act inappropriately or incongruently with social norms. They sometimes express unhappiness or depression through aggression, irritability, or withdrawal. They may also engage in inappropriate touching and other offensive behaviors which negatively impact friendships. These feelings and behaviors are not temporary or situation specific, but span all life situations (Connecticut Department of Education, 1997). Furthermore, students with ED exhibit poor coping skills and have preferences for few transitions and habitual events (Clarizio, 1992; National Information Center for Children and Youth with Disabilities).

It is clear that students with ED face many academic, career, and personal/social challenges. Unfortunately only a small percentage of students with these difficulties are identified as such. Many students with ED have difficulties in the personal/social domain. School counselors are one of a few school professionals equipped to work with students in the personal/social domain; therefore, it is appropriate that school counselors work with students with ED, whether officially identified or not.

### Suggestions for Practice

Roberts et al. (1998) suggested that in order to become more effective in serving students with serious ED, more training and experience is needed by mental health professionals. Myers (2005) found that school counselors desire additional knowledge and training for work with students who have disabilities. In addition to formal research, anecdotal evidence exists as well. We often receive requests for information, preparation, and training regarding students with ED from school counseling master's students, on-site supervisors, principals, and special education teachers.

Following are systemic approaches and specific techniques that will provide school counselors with more information and serve as catalysts for additional training and supervision. Hopefully, these will enable school counselors to better meet the needs of students with ED and those who are unidentified but exhibit the characteristics. Suggestions include proven school-based interventions and modifications of interventions used by teachers or community counselors. The modifications are made so interventions have more utility for school counselors.

Because students with ED may have one or more emotional disorders, we do not suggest the approaches will meet the needs of all students in all instances, but rather that school counselors purposely choose approaches that will help in meeting the individual needs of students with ED. Some suggestions may be effective in addressing more than one characteristic of ED. The success of interventions is dependent on the school environment, the skill level of the counselor, and the level of support provided from administrators, teachers, parents, and the community. Additionally, the level of

student cooperation, commitment, and ability will have a direct impact on the effectiveness of the interventions (Cullinan et al., 2004).

### *Systemic Approaches for School Counselors*

The American School Counselor Association (ASCA; 2004) suggested that school counselors be “committed to helping all students realize their potential and make adequate yearly progress despite challenges that may result from identified disabilities and other special needs” (p. 1). This commitment often mandates that school counselors serve as primary providers of mental health services to students. Schools and specifically school counselors often form the front line in helping students who meet the criteria for ED. Burns et al. (1995) found that between 70 and 80 percent of children received their only mental health services from school professionals such as school counselors and school psychologists. Given that schools are primary providers, school counselors must be skilled in addressing the personal and social needs of students with ED in addition to academic needs. Suggested systemic practices for school counselors include taking early intervention and prevention measures, collaborating with other school professionals, and acting to remove barriers to student success. A list of systemic interventions reviewed is provided in Figure 1.

Figure 1

### *Systemic Approaches for Students with ED*

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#### Early Intervention

- Classroom guidance (ASCA, 2005; Baker, 1994; Melton, 2004)
- RECAP program (Han, Catron, Weiss, & Marciel, 2005)

- Reducing environment risk-factors (American Academy of Pediatrics Committee on School Health, 2004)
- Teacher and staff inservices on emotional disturbances (Melton, 2004) and crisis management (Field & Seligman, 2004)

#### Collaboration and Teaming

- Collaborative-independent model of collaboration (Bemak, Carpenter & King-Sears, 1998)
- Transdisciplinary teams (Carpenter, King-Sears, & Keys, 1998)
- Parent coaches (Young, Merchant, & Wilder, 2004)

#### Advocacy

- Advocacy counseling (Green & McCollum, 2004)
- Parent advocacy training (Field & Seligman, 2004)
- Special education advocacy (Fiedler, 2000)

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*Early intervention.* It is suggested that early detection and proactive management of behaviors result in more positive outcomes for students with ED (Heathfield & Clark, 2004; Melton, 2004). These suggestions are in direct contrast to the reactive stance taken by many schools today. Service is typically provided to students only after they demonstrate behaviors associated with ED or after significant problems are experienced (Noam & Hermann, 2002). Furthermore, reactive services focus on behavior elimination rather than teaching more appropriate behaviors that are useful in a multitude of settings (e.g., playgrounds, homes, classrooms; Heathfield & Clark; Howell, 1985).

School counselors are in the unique position to promote healthy social-emotional development and provide preventative education through classroom guidance and program coordination. They can take leadership roles by working in collaboration with special education teachers to establish formalized identification methods for students with ED. Classroom guidance can be used to teach essential skills such as problem-solving, conflict resolution, and basic social skills. It can also be used to stress the importance of school attendance, retention, and class and test preparation (ASCA, 2005; Melton, 2004). Baker (1994) described proactive interventions whereby school counselors plan and implement psychosocial lessons as part of the school curriculum. School counselors establish goals, activities, and evaluations similar to those of teachers. Han, Catron, Weiss, and Marciel (2005) found that teachers reported significant improvement in pre-K students' internalizing and externalizing emotional problems, cooperation levels, and assertive behaviors after taking part in a modified RECAP (Reaching Educators, Children, and Parents) program. The 9-month program was used to increase students' social and problem solving skills and to decrease internalizing and externalizing behaviors. It included a weekly training and consultation meeting, a teacher-delivered curriculum, a behavior management system, and a bi-weekly parent group.

Effectively coordinated school counseling programs help school districts meet the compliance requirements of IDEA regarding prevention and early identification of behavior problems (IDEA, 2004, Sect. 613[f]). Preventative methods help reduce long-term academic and behavioral effects, lower the severity of the disorder, and lower the costs associated with long-term treatment (Bricker, Davis, & Squires, 2004; Campbell &

Ewing, 1990; Hester, Baltodano, Gable, Tonelson, & Hendrickson, 2003; Sinclair, Christenson, & Evelo, 1998).

Prevention is the first tier of a three-tiered model for school-based mental health services presented by the American Academy of Pediatrics' Committee on School Health (2004). The prevention tier includes more global approaches for addressing the mental health needs of all students. The second tier involves more specific and targeted services for highly to moderately functioning students who have at least one mental health need. The third tier includes programs and interventions that serve students with severe mental health needs. Prevention includes programs and services that may reduce the environmental risk factors within schools and communities that contribute to poor student mental health. Likewise, the implemented programs and services also aid in increasing factors that may aid in preventing poor student mental health such as helping students to form positive connections in the school environment through relationships and varied academic and curricular activities and publicizing and enforcing behavioral expectations, rules, and discipline policies.

As part of prevention and early identification programs, faculty and school staff should be educated on how to identify and serve students with ED. Often students with ED are overlooked because many do not exhibit symptoms and/or behaviors and they seldom disrupt the classroom environment or call attention to themselves (Heathfield & Clark, 2004). Yet, the high incidence of suicide or injury among this population makes early identification even more important. For these reasons it may be helpful for school counselors, in collaboration with special education teachers, to provide in-service training to faculty and staff related to the signs of emotional disturbances (Melton,

2004). They may also want to make themselves more available for consultation with staff regarding questions about students' behaviors or social deficits. Furthermore, school counselors may need to familiarize themselves with and educate other school personnel about crisis management policies. If no such policies exist, school counselors may assist in the development of such policies (Field & Seligman, 2004).

*Collaboration and teaming.* There is a growing call for more integration of services that address the needs of and provide support for all students (ASCA, 2005; U.S. Department of Health and Human Services, 1999.). Because of budgetary limitations and questions about effectiveness, the number of students who use mental health centers and inpatient facilities has decreased. This increases the importance of collaboration between schools and agencies. It also increases the need for the integration of mental health services within schools (Curtis, Ronan, & Borduin, 2004; Farley & Zimit, 1991; Heathfield & Clark, 2004; National Information Center for Children and Youth with Disabilities, 2004; Roberts, Jacobs, Puddy, Nyre, & Vernberg, 2003).

Models of collaboration address the needs of students with ED and their families. In order to be effective, collaboration should occur across many environments (e.g., home, school, etc.) and should include parents or guardians, teachers, community members, school resource officers, school nurses, school social workers, and school psychologists (ASCA, 2005; Vernberg, Jacobs, Nyre, Puddy, & Roberts, 2004). Keys, Bemak, Carpenter, and King-Sears (1998) suggested using a *collaborative-independent* model for consultation. Doing so does not delineate any one person as the expert on a student, but all interested parties contribute their unique knowledge and perspectives. When this is done effectively, all stakeholders share information and ideas with all of the

other stakeholders. They suggested that this model has utility in providing for collaboration among many different professionals and organizations.

Multisystemic treatment and collaboration allows for continuous monitoring and effective treatment of student behavior and academic performance (Landrum, Tankersley, & Kauffman, 2003). School counselors can also collaborate with other school professionals to help create programs and learning environments that enhance direct instruction and remediation activities provided by teachers and peers (Penno, Frank, & Wacker, 2000).

Carpenter, King-Sears, and Keys (1998) described school counselors' roles in coordinating transdisciplinary teams in working for students with disabilities. They stated "coordinated, cooperative, and collaborative activities exist during all stages of assessment, planning, intervention, and evaluation" (p. 4) and may involve a number of service providers such as school counselors, parents, teachers, and community counselors. In transdisciplinary teams, school counselors may serve in the role of collaborator, community liaison, family liaison, case manager, group process facilitator, or counselor. Goals for students are developed jointly; however, team members work individually or in groups to help students meet these goals. In using this approach, school counselors are more likely to provide collaborative interventions in natural settings, such as on the playground or in the classroom. The roles of team members are not compartmentalized but are integrated in order to avoid overlapping services. All members are accountable for maintaining communication and goal completion.

Young et al. (2004) suggested the use of parent coaches in order to increase collaboration between schools and primary caregivers and to serve students in multiple

environments which may increase success. Coaches meet weekly with parents to support them as they learn and utilize positive parenting skills (e.g., training and providing remediation in social skill development, providing positive reinforcement, and instructing appropriately). During the training, parents and students use role-plays to practice strategies. Home visits during times that parents believe are most challenging may also be utilized for coaches to gain a better understanding and to provide suggestions to improve interactions between parents and children.

*Advocacy.* According to ASCA (2004), school counselors should advocate for students with special needs in schools and the community. Advocacy performed by school counselors involves removing systemic barriers to academic, emotional, and social achievement (ASCA, 2005). Green and McCollum (2004) described advocacy counseling as a group of behaviors that includes identifying and helping marginalized students; creating programs that empower students, parents, and guardians to effectively utilize school and community resources; and discovering and taking advantage of school and community resources. Additional considerations for school counselors developing advocacy approaches include cultural issues (Oswald, Coutinho, Best, & Singh, 1999) and socio-economic status (Heathfield & Clark, 2004).

In order to create a sense of belonging, an advocacy initiative should include students with ED in all counseling program activities rather than only in those targeted at special education students (Myers, 2005). School counselors may also recognize and aid in rectifying inequalities, help students recover lost credits, and assist students in finding appropriate curricular and extracurricular opportunities in their schools (Christenson & Thurlow, 2004; Green & McCollum, 2004; Melton, 2004). In addition,

Field and Seligman (2004) suggested that school counselors extend advocacy activities to the home to ensure that parents better understand how to serve their children.

Fiedler (2000) proposed a five-step model for those advocating for special education students and their families. The first step, *Problem Definition*, includes developing an accurate description of the problem and how to solve it. The second step, *Information Sharing*, involves all parties advocating for a student or group of students sharing what pertinent information they may have. In this step it is essential for school counselors to be aware of as many resources as possible. *Action Planning*, the third step, involves examining (a) the definition of the problem and the desired outcomes, (b) all information, (c) the benefits of the outcomes to the student, (d) a list of the possible adversaries to the plan, (e) a list of strategies, the order of the steps, and a time line for completion, and (f) alternative activities should the plan fail. During the fourth step, *Assertive Action*, plans are carried out. The final step, *Follow-up*, includes monitoring change and making adjustments should they be needed. The number of actions that could be taken utilizing this model is limitless.

#### *Specific Interventions for School Counselors*

The following specific approaches and techniques will enable school counselors to address students' needs in particular elements of the five criteria classification areas of ED in individual and small group counseling. Individual counseling is best utilized when a personalized, more goal-focused approach is needed. Group counseling is more efficient because it allows counselors to meet the needs of larger numbers of students (Cook & Weldon, 2006) and may help students with ED to feel less isolated from peers and gain a sense of belonging with their group members (McWhirter,

Shepard, & Hunt-Morse, 2004). Regardless of the intervention chosen, school counselors should use basic counseling skills (e.g., attending behaviors, questions, and reflections) and generate an atmosphere of empathy, unconditional positive regard, and congruence (Rogers, 1957).

Interventions can address behaviors manifested from internalized and externalized emotions ranging from physical aggression to social withdrawal. Internalized emotions rarely disrupt the school environment, but can have a detrimental effect on students. Therefore, it is equally important to intervene with students who internalize emotions in the form of withdrawal or anxiety as it is with those who externalize emotions in the form of aggressive behaviors (Tarver-Behring & Spagna, 2004; Heathfield & Clark, 2004). The specific interventions highlighted utilize behavioral and cognitive behavioral approaches and include peer involvement and social and coping skills training.

*Behavioral and cognitive behavioral approaches.* Behavioral interventions are most successful with students exhibiting inappropriate externalized emotions. These methods attempt to increase appropriate behaviors and decrease and eventually eliminate inappropriate behaviors (Orton, 1997). Gagnon and Leone (2005) found that day treatment and residential schools that serve elementary-age children with emotional and behavioral disorders rely primarily on a behavioral philosophy.

Behavior therapy first involves identifying antecedents or causes of inappropriate behaviors. Once antecedents are identified, positive reinforcement, negative reinforcement, punishment, or response cost can be used to replace inappropriate behaviors with more appropriate ones. In order for this approach to be successful,

school counselors must determine which reinforcers are most appropriate for each student (Orton, 1997). Ultimately, extrinsic rewards or consequences are replaced with intrinsic rewards. Students realize that life is better, school is more pleasant, teachers and parents are more cooperative, and peers are more accepting when they behave appropriately (Thompson, Rudolph, & Henderson, 2004).

Because of their complementary nature, cognitive behavioral approaches may be used with, rather than instead of, behavioral approaches. Cognitive behavioral approaches encompass interventions to address not only behavioral change but also to restructure irrational beliefs which are often antecedents to inappropriate behaviors (Thompson, Rudolph, & Henderson, 2004). Students can benefit from the aspects of cognitive behavioral approaches that rely more on concrete reasoning such as modeling, behavioral rehearsal/role-playing, and self-monitoring (Orton, 1997).

Adolescent students may benefit from more traditional cognitive behavioral interventions such as challenging and restructuring irrational beliefs. Challenging and restructuring irrational beliefs help students identify their unique cognitive distortions. It may be helpful to provide a list of common distortions that promote inappropriate behaviors. Examples include self-defeating beliefs like “I should” or “I must”, predicting catastrophic consequences for every situation, and constant self-deprecation (Cook & Weldon, 2006; Ellis, 1996).

Patton (1995) outlined a seven-session sequence approach for teaching rational behavior skills to middle school students with behavioral and emotional disturbances. While the approach contains seven sessions, Patton suggests that it may take several weeks for students to exhibit success in the skill areas for some sessions. In completing

the seven sessions students obtain knowledge and skills such as creating and controlling of emotions; identifying and changing irrational thoughts, feelings, and behaviors; and practicing and self-monitoring of new rational habits in multiple settings (e.g., school, home, community).

With behavioral and cognitive behavioral approaches, genuine and targeted praise may be effective in motivating students to improve behaviors (Latham, 1998) and in increasing on-task behaviors of students with emotional and behavioral disorders (Sutherland, Wehby, & Copeland, 2000). Sutherland & Wehby (2001) found that teachers were three times more likely to reprimand than praise students with emotional and behavioral disorders. Kalis, Vannest, and Parker (2007) described contingent praise as "...praise given as a consequence of a specific required or expected behavior such as correct completion of assigned work, effort, appropriate attendance or social behavior" (p. 20). Praise should reflect the behaviors associated with the effort rather than an evaluation of the product. Examples of praise statements include "I like the way Jason raised his hand to ask permission to sharpen his pencil", "I like the way you shaded that part of the drawing", or "you did a great job answering the questions in group today" (Kalis, et al.). Non-evaluative praise is similar to encouragement described by Dinkmeyer, McKay, and Dinkmeyer (1989) in which adults provide feedback to students regarding effort and improvement. Examples of statements of encouragement include "You put a lot of energy into your drawing" and "you seem to enjoy writing poems." A list of specific interventions reviewed is provided in Figure 2.

## Figure 2

*Specific Interventions for Students with ED*

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## Peer Involvement

- Peer Pairing (Pelsma, Hawes, Costello, & Richard, 2004)
- Modeling (Orton, 1997; Thompson, Rudolph, & Henderson, 2004)
- Peer tutoring (Melton, 2004; Ryan, Epstein, & Reid, 2004)
- Small Groups (Young, Merchant, & Wilder, 2004)
- Behavior-practice groups (Thompson & Henderson, 2007)

## Social Skills Training

- Targeted Social Skills Training (Cook & Weldon, 2006; Landrum, Tankersley & Kauffman, 2003)
- Behavioral contracts (Tarver-Behring & Spagna, 2004)
- Self-monitoring cards (Young, Merchant, & Wilder, 2004)
- Non-verbal expression training (Cooley & Triemer, 2002)
- Self-modeling (Kehle, Clark, Jenson, & Wampold, 1986)
- Assertiveness training (Cook & Weldon, 2006; Huxley, n.d.)
- Dialogue journaling (Regen, 2003)

## Coping Skills Training

- Stress inoculation (Michenbaum, 1985)
- Worry Log (Leahy & Holland, 2000)
- Progressive muscle relaxation (Allen, 2002)
- Halting and refocusing techniques (Knapp & Jongsma, Jr., 2002)

- Umbrella technique (Hobson & Thompson, 1996)
  - Relaxation and Imagery (Cheung, 2006; Gilman & Chard, 2007)
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*Peer Involvement.* A number of researchers describe the benefits of using peers in counseling for students. Pelsma, Hawes, Costello, and Richard (2004) described the practice of pairing students with and without disabilities. These relationships were facilitated by school counselors and have been shown to improve the self-esteem as well as the interpersonal skills of students with disabilities. This common behavioral approach involves modeling and allows for an easier transfer of skills because it provides students with examples of appropriate behavior in real-life settings. To be most effective, models should be of the same age and gender as the student with ED. Modeling should involve multiple exposures of real life situations rather than the typical film or video exposure of one episode (Orton, 1997; Thompson, et al., 2004).

Ryan, Epstein, and Reid (2004) along with Melton (2004) reported that interventions involving peers as tutors or cooperative learners were successful in increasing academic success. In some cases students with ED were utilized as tutors for younger students or as peer-mediators. It has been suggested that these types of roles help students with ED gain a sense of accomplishment, experience a boost in self-esteem, and improve behavior and academic outcomes (Frey & George-Nichols, 2003; Gable & Arllen, 1994; Ryan, et al.).

Small groups may also be helpful to students with ED. Young, et al. (2004) suggested that the school counselor invite the student with ED and two or three peers to a session. The school counselor would introduce a skill (e.g., taking turns, or asking to

participate). Students would then complete games or activities in which they practice the skill while being monitored by the school counselor. Behavior-practice groups work in similarly, but may be exclusive to students with ED. Students are allowed to practice new academic or social skills in a safe environment. The groups also allow for instantaneous reinforcement and corrective feedback (Thompson & Henderson, 2007).

*Social skills training.* School counselors usually receive extensive training that allows them to prepare and implement programs and interventions to help students develop and maintain friendships, resolve conflicts, and increase independence. Landrum et al. (2003) suggested utilizing targeted social skills training that includes student-student or student-teacher interaction in a natural setting to improve the interpersonal relationships of students with emotional or behavioral disturbances. Students can be taught and then allowed to practice basic friendship skills, such as introducing themselves, listening, and making conversations (Cook & Weldon, 2006).

Tarver-Behring and Spagna (2004) suggested the use of behavioral contracts to provide students with specific limits, rules, and expected behaviors. Contracts could be used to increase appropriate social skills such as sharing, maintaining appropriate personal space, and using non-violent means to dispel anger. Contracts include succinct descriptions of privileges for appropriate behaviors and consequences for inappropriate behaviors. Allowing students to have input into contracts will increase the likelihood for success. Should interventions fail to meet stated goals, new interventions are developed. Once effective interventions are found, school counselors can develop plans for behavior maintenance (Thompson et al., 2004). Contracting was originally

discussed for use with parents of adolescents, but can be modified for use by teachers or other school professionals.

Students with ED can monitor behavior on the playground with the use of self-monitoring cards (Young et al., 2004). Students are provided with self-monitoring cards during recess. Cards allow students to record the activity in which they participated and with whom they participated. Additionally there is space for both the student and a supervisor (e.g., teacher, aid, or counselor) to initial if the student displays appropriate behavior such as cooperating and sharing. A point system is used to reward appropriate behavior and agreement between the supervisor and student. For example, if both the student and supervisor believe that the student behaved appropriately, then the student would earn 5 points. If the supervisor believes that the student behaved appropriately, but the student does not then, the student would earn 3 points. If at any time the supervisor witnesses the student acting inappropriately or if both agree behaviors are inappropriate, then the student would receive zero points. The points can then be exchanged for reinforcers specific for that student.

Typically, students with ED experience difficulties in regulating emotions. They may have never learned or have never been able to manage or appropriately express their emotions (Saarni, 1979; Southam-Gerow & Kendall, 2000). Southam-Gerow & Kendall found that youths with anxiety disorders had less of an understanding of changing or hiding emotions than youths without anxiety disorders. They suggested that this understanding influences the development of the disorder and has implications for treatment. Cooley and Triemer (2002) proposed instruction in nonverbal expressions of emotions such as accurately decoding facial expressions and vocal tones in order to

increase understanding of peers and adults. This instruction should include skill development to allow students with ED to respond appropriately to nonverbal cues and to generalize these skills to real-life situations.

Self-modeling may also be a viable option for students with ED. In self-modeling students are videotaped and disruptive behaviors are edited out of the tape. Students are then shown the tapes five or six times over a two week period. Kehle, Clark, Jenson, and Wampold (1986) found that after six weeks this treatment substantially reduced inappropriate behaviors in boys.

Assertiveness training may be a benefit to students with ED. Whereas it is of utmost importance for school counselors to advocate for students who are classified with ED, it is imperative for students to be able to stand up for themselves. When students are not able to verbally express their needs and emotions, these emotions surface in maladaptive ways ranging from physical aggression to social disengagement. Instruction related to assertiveness will enable students to better express their emotions without harming themselves or others (Cook & Weldon, 2006).

Huxley (n.d.) used the acronym K.I.T.E. to help parents teach children to be more assertive. K.I.T.E. has utility for school counselors as well as parents. The “K” represents “Know what you want”. Students should be able to concretely and positively tell others what they would like from them. The “I” represents the use of “I” statements rather than “You” statements when describing hurt feelings or anger. This will aid students in realizing the control they have in certain situations rather than blaming others for their emotions. The “T” represents “Telling others” what you want in a firm voice and repeating it as often as needed. The “E” represents “Expect change and

evaluate effectiveness". It is important to explore the effectiveness of assertive behaviors. If one is proving ineffective, switch to a new one. This evaluation leads to additional skill development in problem solving. Huxley suggested when students come with problems, especially with bullies, it may be helpful to tell them to "Go fly a KITE".

Dialogue journaling (Regan, 2003) may be useful in allowing students with ED to form connections with their teachers and to express themselves through writing. The journal involves a written conversation between teachers and students in which regular communication occurs involving teachers' responses to students' comments and questions. Teachers may also choose to introduce topics or ask questions of students. Dialogue journaling may also be helpful between students and counselors in order to provide information that cannot be obtained through self-reports during counseling sessions or observations.

*Coping skills.* Students who are unable to relate socially often experience alienation. The alienation may result from students' inability to interact effectively with others or it may result from the rejection of peers. Alienation may stifle students' development and serve as a reason for dropping out of school.

Stress inoculation is an intervention that may be used by school counselors to help students cope with alienation, anxiety, and stress. Developed by Michenbaum (1985), this process involves three phases. During the first phase, the conceptual phase, counselors build trusting relationships with clients while exploring the nature of their stress. Counselors help clients begin to understand the underlying thoughts related to their stress and anxiety in particular situations.

In the second phase, the skills acquisition and rehearsal phase, clients acquire knowledge regarding skills and techniques that they can use to cope with stressful or anxiety-producing situations. During this phase, clients gather additional information regarding stressful situations and learn to counter and replace any negative internal dialogue with more positive self-statements. Additional stress-reducing interventions include teaching relaxation techniques and encouraging physical activities.

The third and final phase, application and follow-through, involves applying skills acquired in counseling to real-world situations such as classrooms or home environments. The generalizability of these skills gained in counseling to outside environments is the key to success. During this phase, clients imagine using the skills and techniques in increasingly stressful situations and finally practice the techniques in real-life situations. The process of stress inoculation training provides clients with a set of skills and techniques that are useful in just about any stressful situation (Meichenbaum, 1985).

To reduce anxiety, school counselors may have students keep a *Worry Log* (Leahy & Holland, 2000) to document situations in which they experience anxiety. By analyzing the log, students with ED and school counselors can obtain a better understanding of events that trigger anxiety and develop interventions to address those specific events. In order to reduce anxiety, school counselors may have students learn and practice progressive muscle relaxation in which students are constricting and relaxing muscle groups (Allen, 2002).

School counselors can educate students about methods to refocus and halt inappropriate thoughts or daydreams (e.g., snapping a rubber band on the wrist,

rotating feet or body, reestablishing eye contact, or changing facial expression) that lead to increasing anxiety or depression. (Knapp & Jongsma, Jr., 2002). Additionally, school counselors may have students develop coping statements using the umbrella technique described by Hobson and Thompson (1996). Students write their negative self-statements that lead to increased anxiety and depression onto rain drops and then assign and write positive statements onto sections of an umbrella that may protect them from the negative self-statements (rain drops).

Relaxation training and imagery may also be used to decrease internal distress that may be experienced by students with ED. Relaxation techniques may involve deep and slow diaphragmatic breathing coupled with the reciting of a word such as “calm”, “relax”, or “wonderful” (Cheung, 2006; Gilman & Chard, 2007). Breathing may also be coupled with progressive muscle relaxation (Gilman & Chard) or squeezing and releasing stressballs (Knapp & Jongsma, Jr., 2002). Guided imagery may be used to ease students’ distress. Cheung describes guided imagery as “...being guided into a world of creativity to experience the world from a different perspective” (p. 139). Guided imagery may function to increase concentration or insight, visualize success, or control emotions (Cheung). Students with ED could imagine themselves being successful in the classroom and in personal relationships or as less depressed or anxious. Utilizing these images, school counselors can aid students in creating steps to make these images a reality. Students may also imagine themselves in soothing and pleasant locations. These places may be revisited during times of distress (Grimmer, 2006).

### Conclusion

Many students with ED do not receive services under IDEA because their externalizing behaviors are thought to be related to social maladjustment, a criterion excluded under the classification for ED, or their internalizing behaviors go undetected by faculty and staff (Olympia et al., 2004). In either case, these students as well as all students with ED need the support, understanding, and interventions that school counselors and other school personnel can provide. Utilizing the interventions and strategies provided will aid in addressing the needs and promoting change in students with ED. Additionally, these strategies provide a base from which further research and interventions can be explored and tested.

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