Communicating About and With Learners Diagnosed With Emotional or Behavioral Disorders

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Abstract: This paper provides strategies for communicating about and with learners diagnosed with emotional or behavioral disorders. Based on educator interviews, the author discusses ways to communicate about learners through Response to Intervention models from two Midwestern school districts. The models provide ideas for identifying and monitoring learners who may have emotional or behavioral disorders. Instruments used in data collection are provided. The paper applies communication principles suggested by a survey of scholarly research to generate ideas about communicating with learners who may be diagnosed with emotional or behavioral disorders.

Communicating About and With Learners Diagnosed With Emotional or Behavioral Disorders

Certain communication behaviors—such as inappropriate communication initiation, response, or expression—may be an early signal that an emotional or behavioral problem exists. For some students and their families, a label of emotional or behavioral disorder is devastating with negative life-altering consequences. For others, the identification begins a series of interventions that enable the learner to achieve educational opportunities and life goals. In this paper, we will look at how we communicate "about" learners with emotional or behavioral disorders regarding measurement and data collection. Then we will examine how we communicate "with" learners who may have emotional or behavioral disorders.

Using Response-to-Intervention (RtI) to Communicate About Learners With Emotional or Behavioral Disorders

Educators and parents need effective assessment procedures for communicating about learners who may have emotional or behavioral disorders. Overton suggests that there are three basic types of data collection through observation (2006, p. 193-194). The teacher may want to record a baseline, and then collect additional data to determine progress toward goals and for re-evaluation purposes.

1. Indirect Observation. Indirect observation uses the observations of others through "interviewing the classroom teacher and parents, reviewing data in the school records, completing behavioral rating scales, checklists."

2. Direct or Descriptive Observation (e.g., checklists, teacher data, or behavior charts, event recording, interval recording, anecdotal recording, duration recording, latency recording, and inter-response time). Target behaviors are behaviors that require the teacher to intervene to improve the academic or social learning context. When recording events, the teacher will want to note the frequency of target behavior. When recording intervals, the teacher will want to indicate samples of behaviors by looking at behaviors for brief intervals over a period of time. When recording anecdotes, the teacher will want to make note of behaviors and communication during a specific period of time.

When recording duration, the teacher will want to make note of the length of time of a behavior. When recording latency, the teacher will want to indicate the length of time between the stimulus and response. When recording inter-response time, the teacher may want to record the amount of time between target behaviors.

3. Functional Assessment Interviews. These interviews with teachers, parents, and the student are motivated by the need to formulate a hypothesis about the function, meaning, or motivation of the target behavior. The student may be asked to discuss his or her feelings or worries about any relevant topic.

Response/Responsiveness to Interventions (RtI). A negotiable assessment procedure that enables intervention without labeling is the Response-to-Intervention (RtI) model. RtI refers to individual, comprehensive, student-centered assessment models that apply a problem-solving framework. Instruction and assessment are combined to identify and address a student's learning difficulties. Under IDEA 2004, a Response-to-Intervention (RtI) model is an option for any school district. By emphasizing finding educational supports that work, the exact diagnosis regarding an emotional or behavioral disorder becomes unnecessary to implementing steps that improve student learning (Deshler, Mellard, Tollefson, & Byrd, 2005).

This conference emphasizes the importance of data collection as a means of improving services to students who may be diagnosed with emotional or behavioral disorders. The evaluation and Individual Education Plan (IEP) process must be data driven in order to determine (a) the category of disability, (b) the present levels of performance, (c) special education and related services, (d) modifications to allow the child to meet IEP goals and participate in general education, and (e) the student’s progress. Effective collection and analysis of data are crucial concerns. Overton (2006) suggested an array of potential assessment problems that can introduce bias and error and jeopardize results (p. 94).

- Failure to establish rapport with examinee.
- Failure to follow standard test administration protocols.
- Failure to interpret measure correctly.
- Failure to record diagnosis-relevant behaviors during the examination.
- Failure to record or score correctly.
- Use of measures intended for other purposes.
- Use of measures required by school administration, without consideration of appropriateness.
- Use of the most popular instrument.
- Use of the quickest or easiest instrument.

The potential for misidentification is a serious problem. At the heart of the federal government's principle of nondiscriminatory evaluation is the fact that culturally and linguistically diverse (CLD) students tend to be inappropriately represented in special education and related services. In some cases, culturally diverse students may be under-represented because the school district is afraid of lawsuits over misdiagnosis. In other cases, culture and language differences contribute to misdiagnosis so students who are CLD are over-represented in special education and related services. Robertson and Kushner (1994) reported the following information about students who were African American:

- 16% of the total U.S. student population.
- 32% of students in programs for mild mental retardation (MMR).
- 29% in programs for moderate mental retardation.
- 24% in programs for serious emotional disturbance (SED).

Harvard (2001) studies show this trend has continued with inappropriate special education placements for minorities, sometimes at a rate of four times what one would expect. In some cases,

language and cultural differences may cause learners to be undiagnosed or incorrectly diagnosed regarding their eligibility for special education and related services (Baca & Cervantes, 2004**;** Case & Taylor, 2005). The over-representation of CLD learners in programs for special education, for example, suggests that inappropriate assessment may be influencing the process (Artiles, Rueda, Salazar, & Higareda, 2005).

Although some educators may worry that RtI may become an excuse for not providing services, when used as intended, RtI allows services to begin during a time of evolving diagnosis. Given the potential for misdiagnosis and mislabeling, RtI can simply focus on helping the student and monitoring progress. Through Responsiveness-to-Interventions (RtI), the general education teacher may work with other educators to employ research-based strategies to help students who later may be diagnosed eligible for special education services. When diagnosed eligible for special education services, IDEA-2004 still requires the student receive instruction in the least restrictive environment, so that educators can benefit from learning strategies that may work to both assess and remediate problems.

Blue Valley, Kansas and North Kansas City, Missouri are two school districts currently using an RtI approach to identify and monitor students with special needs. Although some scholars may question the research base behind RtI, the approach has been used in Kansas for 20 years under different names. RtI started as pre-assessment to screen students who may qualify for special education or related services. Originally, the Kansas approach was coordinated through the state. Now with the advent of IDEA 2004 law, a discrepancy model is nonessential to the identification of students for special education and related services. Before the law, however, Blue Valley School District did not use a true discrepancy or test-and-place model. Apparently, the federal government liked what was coming out of Kansas, which may have been part of the impetus in the change in the 2004 law. The RtI process seems to work, although it is constantly evolving as educators seek to make the process work more effectively. Under the IDEA 2004, RtI seems like a positive direction for the

future. By examining a general model at the high school level, one can see the basics of how RtI may operate.

Identification. Typically in student assessment, a general education teacher raises a concern. Although I have not seen data on who initiates an evaluation request, the educators I talked to suggested that the teachers probably initiate request more requests than other people involved with the child. In some contexts, the teachers are quick to seek assistance. By the time a student reaches high school, referrals where the teachers have done nothing are rare. In some school systems, teachers can pull up grades from other teachers when they are concerned about a student failing a course. They can see if it's a wider problem or a single subject problem, which helps in trying to analyze a possible problem.

In RtI, educators look more to classroom assessments as a start of the process. An administrator recently questioned a teacher about the role of homework as an indicator of potential problems, for example. The teacher may use standardized testing or regular classroom assessment as a signal that a problem may exist.

In RtI, educators typically look at the history of child and what has happened over time. In high school, for example, there is much evidence over the child's history. With RtI, a teacher might go to inactive files when a teacher had a problem with a particular student. The current teacher may seek the answer to several questions. What did the teachers say? What were the themes? What were the teacher comments? Documentation may help the teacher obtain an analysis of what's happening right now. This process may put the teacher on a path of figuring out what is happening now through gathering more information. Data collection helps everyone because educators can look at everything educators tried with the student. The RtI process can make that happen. Traditionally, a lot of RtI work is done before referral, but the initial interventions do not always have documentation. Regulations require the documentation, so educators do that now. RtI is a learning situation, where educators find what works and start gathering the information before the meeting phase.

Interventions. When using RtI, the teachers seek to answer the following question: What interventions make a difference for the student? The idea is that when there appears to be a problem, the teacher tries research-based strategies designed to help the student. In RtI, the teachers evaluate, try, evaluate, and try again, by using interventions they hope will work for the student all the way along.

With the large number of students each teacher has at the high school level, for example, individualized data collection may be unrealistic for RtI. If the general education teacher has a gut feeling there is a problem, however, the teacher can keep a file, call the parent, and try strategies. Of course, teachers have their gradebooks as a data collection method, and in RtI, typically teachers start writing down the modifications they use. Anything that works is noted and the information is communicated to other teachers. The RtI approach can be totally implemented away from a test and place model or RtI can be used in conjunction with formal testing procedures.

In RtI, the teachers may review the student's progress with interventions every once and a while to see if the interventions continues to make a difference. Before any student coming up for special education or related services will go through RtI before they are evaluated. Ideally, once completed the RtI process, the evaluation will be minimal because there will be extensive information and data collection as part of the RtI process.

The RtI team uses input from all teachers, nurse, administrator, counselor, social worker, and parent. The team members seek information from the parent and student so there is input if not they are not invited. In elementary schools, RtI commonly tries reading interventions. All students receive all kinds of assessment, so the team decides whether students need more direct support along the way. At this point, the general education teacher may have exhausted typical options.

Screening and Evaluation. By the time RtI reaches a level of more traditional evaluation procedures, the teachers have collected data about what they have done, what interventions were tried, what interventions work, how the interventions worked, and therefore what special education or 504

services are necessary. Teachers are well-informed about the student because they gathered data throughout the process. This feature of RtI is positive. The problem is that depending on individual teachers or individual school building abilities, the number or type of interventions may be quite limited. The possible interventions available to students seem to be less at lower educational levels, particularly elementary and middle schools. Although the RtI motto may be "Do whatever it takes." The work often falls back on the individual teachers to do, which limits the effectiveness of RtI to the individual teacher's skills at using research-based interventions and collecting appropriate data about the effectiveness of the interventions. As one educator explained about RtI, when the teacher lacks the ability to create and implement various interventions, the RtI model may fall apart for that teacher's students.

Student Eligible, IEP Developed, Section 504, or Not? Typically in RtI, assessment is made up of a team of individuals. Once at a more formal assessment level stage, the team has most of the data collected. The team involves multiple people, such as an occupational therapist and transition specialist at a high school. In RtI, there is an emphasis on authentic and informal assessment.

Some educators think the RtI approach can delay or even undermine needed services. Other educators think the RtI approach may accept more kids on IEP than when the discrepancy model was used because an intervention model can work. For some students, RtI has opened up services they might have been denied services. That can be positive or negative. RtI might be easier for students as they get older, when labels create problems.

Using Communication Skills Training to Communicate With Learners with Emotional or Behavioral Disorders

A student's communication ability is the single best predictor of school success because of the correlation between communication skills and positive peer relationships and academic achievement (Sage, 2001, p. 423). Effective communication strategies are crucial to everyone, but for learners

diagnosed with emotional or behavioral disorders, communication interactions take on special significance.

Children diagnosed with emotional disturbances often live in homes with **multiple risk factors for poor life outcomes**, while facing multiple impairments, including poor communication skills (Wagner, Kutash, Duchnowski, Epstein, & Sumi). There appears to be a significant gap between identification of a problem and the beginning of special education services. In addition, these students have a high rate of suspension, expulsion, and unstable school environment. Further, the parents appear to have to work harder to obtain services, and these parents feel less satisfied with those services than are other parents of children diagnosed with disabilities. The Wagner, Kutash, Duchnowski, Epstein, and Sumi survey suggested that more than a quarter of these students may have difficulty with expressive language, and a greater number have difficulty with receptive language and interactive rules of communication. The continuation of communication problems throughout high school suggests "an ongoing need to develop effective interventions in this domain" (p. 91).

Although social skill training is commonly used with students diagnosed with emotional and behavioral disorders, often the training provides **little or no real behavioral change**. There are social skills curricula available for teaching students who are diagnosed with special needs (Kerr & Nelson, 2006). Students who lack social skills are at risk for other problems, such as aggression, peer rejection, poor academic achievement, isolation, difficulty with employment, mental illness, and incarceration (Maag, 2005). Unfortunately, social skills training often fails the student. Does social skills training fail to affect the student positively or does social skills training lacks something the learner needs? In his meta-analysis of research on the topic, .Maag suggested three **key problems that may contribute to the limited success in social skills training**: (a) lack of appropriate behavioral assessment, (b) training needs to match the reasons for social failures, and (c) peer acceptance is needed to achieve social competence. Although the generalizability of Emotional and Behavior Disorder (EBD) research

may be problematic, the use of instructions, modeling, rehearsal, role playing, and reinforcement seem to have value for students with emotional or behavioral disorders (Maag).

Another possible explanation for the difficulty of teaching social skills may revolve around the nature of the student's diagnosis. Jobe and Harrow reviewed research on the outcomes of **schizophrenia** treatment and found the disorder to have "relatively poor outcome." Longitudinal studies appear more optimist than previous research indicating that some subgroups had extended periods of recovery. Not all patients experienced a "downhill course." There appears to be a more heterogeneous outcome than previously thought. The potential for suicide is a danger, particularly in the first 10 to 12 years of the disorder. Patients with schizophrenia showed poorer courses than people with other psychiatric disorders. Equal to the importance of the treatment is "the personal strengths, the developmental achievements, and the resiliency of individual patients" (p. 892).

The relatives of people with **bipolar disorder** typically use better communication strategies than relatives of people with schizophrenia. These strategies focus on social interaction and quality interaction. This more positive communication may be because the problems associated with people diagnosed with bipolar disorder are easier to deal with than schizophrenia (Chakrabarti & Gill, 2002). Effective communication is essential in managing bipolar spectrum disorder (Lewis, 2005). According to Lewis, at least 4% of the US population has a bipolar disorder, which typically begins in adolescence or early adulthood. "Its impact on education can affect lifetime earnings" (p. 34). The disorder can affect social skills, relationships with family, friends, and employers. Lish, Dime-Meenan, Whybrow, Price, and Hirschfeld found that 70% of people diagnosed with bipolar disorder were previously misdiagnosed. Lewis (2005) suggested that patients diagnosed with bipolar disorder need to be actively involved in the treatment process in order to receive the best possible results. In a review of current research, Berk, Berk, & Castle (2004) describe the serious consequences of bipolar disorder. The severe, chronic, and cyclical nature of bipolar disorder can affect a person throughout his or her life. Early death is a potential outcome because the suicide rate is "12 times higher than the

general population" (p. 505). Although medication is helpful, difficulty in following medical prescriptions and treatment plans contributes to the gap between efficacy and effectiveness. For people diagnosed with bipolar disorder, adherence is typically partial or intermittent (Lingam & Scott, 2002).

Collaborative Communication. Research suggests that a collaborative approach between the parties involved—e.g., physician-patient--may provide the needed support for people diagnosed with bipolar disorder (Berk, Berk, & Castle). There may be stages of the acceptance of a diagnosis that require different a move from a paternalistic to autonomous choice model as the person diagnosed with bipolar disorder takes management of his or her own care (p. 506). A collaboration model is comparable to the approach used for leading adolescents to adulthood, as individuals become more autonomous. The kinds of approaches that showed a positive correlation with treatment success may offer insight into appropriate communication approaches for students diagnosed with behavioral disorders. Heru, Ryan, and Vlastos (2004) suggested that family functioning—including their communication--profoundly influenced a person's ability to deal with a family member diagnosed with a mood disorder. An adult-to-adult approach to problem solving—instead of parent-child—may prompt healthier coping skills (Heru, Ryan, & Vlastos).

The use of communication-based intervention strategies is not new. The meta-analysis by Berk, Berk, & Castle suggested an array promising communication strategies that also may be helpful for the special education teacher. Of course medical treatment is different from appropriate classroom behavior, so while research suggests these strategies may be appropriate for bipolar disorder, the inferential leap to application with students with emotional and behavioral disorders in the classroom may or may not be appropriate. As we consider an array of **possible interventions**, however, these strategies may prove useful.

- Using interventions that help the person put his or her request into words.

- Using interventions that provide information and support that may help the person to integrate appropriate behavior into the self-concept.
- Using interventions that support autonomy for appropriate decision-making.
- Using a relationship-centered intervention that provides a balance between providing information, feedback, and support and total autonomy.
- Using a flexible approach to intervention, which is based on the desires and personality of the student.
- Using collaboration, which may improve student satisfaction.
- Using empathic listening to understand the student's requests.
- Using interventions to enhance social supports and positive interpersonal relationships.
- Using optimism, which has a positive effect.
- Using encouragement to participate in enjoyable activities.
- Using effective communication, including clear instructions and active listening.
- Using interventions that off social support.
- Using interventions that encourage the favorable influence of others.
- Using interventions that help the student recognize negative consequences.
- Using intervention strategies that dispel misconceptions and improve insight.

Communication and Social Skills Strategies for Students with Disabilities

When it comes to teaching students appropriate communication behaviors for the classroom, parents and teachers may gain insight in what teachers expect of students, from the research of Beebe-Frankenberger, Lane, Bocian, Gresham, and MacMillan (2005). Although **parents rated *self-control* and *responsibility*** as essential for success, **teachers rated *cooperative behaviors* as essential** for success in school. In another study of K-12 teachers, however, Lane, Wehby, and Cooley (2006)

found that teachers considered a student's self-control essential for success. In fact, **high school special education teachers rated *self-control*** higher than did other teachers.

These findings seem particularly important, given that students who exhibit "confrontational and disruptive behavior patterns. . . often exhibit some combination of oppositional, noncompliant aggressive, inattentive, impulsive, or hyperactive behaviors" (Gresham, Lane, & Beebe-Frankenberger, 2005, p. 721). **Four behavioral expectations appear crucial to K-12 teachers**, which require student behavioral compliance:

1. Produces correct school work.
2. Ignores peer distractions when doing class work.
3. Easily makes transition from one activity to another.
4. Finishes class assignments within time limits.

In addition, **secondary teachers also value** the following:

1. Attends to your instructions.
2. Uses time appropriately.
3. Complies with your directions (Beebe-Frankenberger, Lane, Bocian, Gresham, & MacMillan, 2005)..

Relatively few researchers have focused on **using conversation** to facilitate more effective student behaviors (Dwairy, 2005, p. 144). Problem-solving conversation may be used successfully with students who have behavioral or emotional disorders. The procedure of this kind of conversation has steps reminiscent of Dewey's reflective thinking and other typical problem-solving communication procedures. In this case, the idea is to use these steps when adults communicate with students, but the steps also could provide ideas for a sequence of communication skills that can be used to teach the student how to solve problems with others (Dwairy, 2005).

1. **Listen to the other person.** A comfortable environment, positive nonverbal communication, and using I statements ("I heard that . . . ") may support the listening process.

2. **Use probing to re-evaluate the problem.** Directness, reframing, and interpretation can support this stage.
3. **Explore alternatives.** Brainstorming about the logical sequence of consequences may support the exploration. Feedback, directives, and advice from the adult may be helpful.
4. **Set up a plan.** The responsibilities of each person need to be clarified as part of the plan.
5. **Follow up on the success of the plan** can be accomplished at another time (Dwairy, 2005).

Forgan and Gonzalez-DeHass (2004) suggested that social skills instruction can improve student behavior, but most teachers believe there is too little time to focus on behavioral instruction. Instead, the teachers feel pressured to focus on academics. This need prompts Forgan and Gonzalez-DeHass to suggest **combing behavioral and academic instruction together.** Children's literature can, in fact, give students an opportunity for **bibliotheraphy** by providing scenarios for problems and language use models. Students can discuss the literature examples regarding appropriate communication behaviors as part of social skill training. Harriott and Martin (2004) also found success in using literature to teach social and communication skills. The same strategy can be used through television program and film examples.

Children with disabilities typically have more difficulty communicating, **greater likelihood of communication breakdowns, and fewer strategies to repair their communication problems** (Keen, 2003). Relatively little research has addressed the need for teaching communication repair strategies to students with disabilities (Keen, 2003, p. 53). To **repair a communication breakdown, students need intentionality (*goal directedness*), perspective-taking (*empathy*), and effective verbal and nonverbal (*word and non-word*) responses**. All of us are prone to the fight or flight response when we are challenged, but one might expect students with behavioral or emotional disorders to react by protesting or abandoning attempts their repair communication. Teachers and parents may be able to use this model of communication repair as a way of offering students communication strategies (Keen, 2003).

Students who lack social skills are at risk for other problems, such as aggression, peer rejection, poor academic achievement, isolation, difficulty with employment, mental illness, and incarceration (Maag, 2005). Unfortunately, social skills training often meets with little behavioral change in the student. In his meta-analysis of research on the topic, .Maag suggested three key problems: (a) lack of appropriate behavioral assessment, (b) training needs to match the reasons for social failures, (c) peer acceptance is needed to achieve social competence. Although the generalizability of Emotional and Behavior Disorder (EBD) research appears problematic, the use of instructions, modeling, rehearsal, role playing, and reinforcement seem to have value (Maag).

Students with disabilities who have problems with social skills face an array of potential difficulties, including **mental health problems, peer or teacher rejection, and low academic achievement** (Miller, Lane, & Wehby, 2005). Miller, Lane, and Wehby suggested that a key problem in the lack of success in teaching social skills is failure to assess what the student's problems and strengths and determine where skills or motivation are missing, before teaching the appropriate social skills. Social skills curriculum exist, and students can learn through modeling, practice, and coaching may be effective. Whatever the instructional strategy, appropriate feedback is essential. In their study, Miller, Lane, and Wehby (2005) observed a decrease in inappropriate behaviors after social skills training. Children with emotional and behavioral disorders are more likely to demonstrate social skills "that impede their relationships with peers and adults. These strained relationships contribute, in part, to an often negative educational experience, given that social competence is essential to working well with peers and negotiating relationships with adults. Despite improvements, some students failed to show positive behavioral changes, while others actually showed negative changes. Possible explanations might be a need for more individualized instruction. When talking about negative communication behaviors, for example, a student lacking appropriate skills or motivation might actually learn additional negative communication strategies (Miller, Lane, & Wehby, 2005).

Pierce, Reid, and Epstein (2004) reviewed the literature on the topic of using teacher interventions to improve learning in students with emotional or behavioral disorders. It seems logical that interventions that worked would be published, while interventions that failed would have more difficulty being published. Perhaps a lack of comparative data is not such a problem for teachers who are looking for new strategies because through the interventions supported by research in this research review, teachers have a repertoire of interventions they can use. The interventions are as follows:

Successful Intervention Strategies (Pierce, Reid, & Epstein, 2004).

1. Academic contracting
2. Adjust task difficulty
3. Adjusting presentation and point delivery rate (faster rate)
4. Bonus contingency in token program
5. Child choice of task
6. Choice making opportunities
7. Contingency reinforcers
8. Incorporating student interest
9. Individual curricular modifications
10. Inter-trial interval duration (short & immediate intervention)
11. Life space interviewing
12. Mnemonic instruction
13. Modeling, rehearsal, and feedback
14. Personalized system of instruction
15. Previewing
16. Rate change—slow or fast-presentation during taped words
17. Sequential prompting
18. Story mapping

19. Structured academic tasks
20. Structured instructional system about school survival skills
21. Taped words and drill instruction
22. Teach test-taking skills
23. Teacher planning strategies
24. Teacher vs. child control of choice of task & reinforcement
25. Time delay strategy
26. Token reinforcement system
27. Trial-and error strategy
28. Use of free time
29. Verbalize math problems
30. Written feedback (Pierce, Reid, & Epstein, 2004).

Ryan, Reid, and Epstein (2004). discussed **peer-mediated interventions** that may be used with students who are diagnosed with emotional or behavioral disorders. The following research-based peer-mediated strategies were found to have positive learning effects (Ryan, Reid, & Epstein, 2004).

1. Class-wide Peer Tutoring
2. Cooperative Learning
3. Cross-Age Tutoring
4. Peer Tutoring
5. Peer-Assisted Learning Strategies
6. Peer Assessment
7. Peer Modeling
8. Peer Reinforcement

Research suggests that all types of peer-mediated interventions can have positive outcomes for students diagnosed with emotional or behavioral disorders (Ryan, Reid, & Epstein, 2004).

Students who exhibit oppositional and defiant behaviors for six months show a consistently manipulative or noncompliant pattern (Salend & Sylvestre, 2005). Behaviors may include angering easily, arguing with others, becoming annoyed easily, blaming others, cursing, feeling frustrated easily, losing temper, refusal to comply with rules, seeking attention, seeming to enjoy annoying or bothering others, showing poor self-esteem. Labeling these students suggests the problem lies in the student instead of the education system and may limit the way others interact with the student. Communication strategies that may enhance the student's learn are improved family collaboration and communication, social skills instruction, attribution training, relationship building, and increased awareness of verbal and nonverbal communication. Educators may benefit from perceiving family members as a resource as they share important information about the student. For example, "an effective intervention for students who exhibit opposition and defiant classroom behaviors is a home-school contract in which teachers communication with the student's family regarding behavior in school and families reinforce the child's improved behavior" (p. 33). Social skills instruction can help students collaborate in groups, respond to others, and make friends. Role-playing, feedback, student reflection, social skills curricula, bibliotherapy, and practice, for example, are potentially effective research-based interventions (Salend & Sylvestre, 2005).

Attribution theory suggests that when something goes wrong for us, we tend to blame circumstances (Salend & Sylvestre, 2005). When something goes wrong for other people, we tend to blame the person involved. Teachers can help students to use attribution more appropriately through dialog pages and helping students to understand the consequences of their behaviors. Teachers can talk with students about how effort affects performance, how failure is a step in learning, and taking responsibility for mistakes. To **enhance rapport and relationship building** with students, research suggests (Salend & Sylvestre, 2005):

- Complimenting students.

- Discussing topics of interest to students.
- Greeting students by name.
- Informally interacting with students.
- Recognizing special events, such as birthdays.
- Sharing teacher interests.
- Showing emotional support.
- Showing interest in a student's personal life.
- Showing kindness.
- Using activities where students excel.

In their analysis of research studies, Vaughn, Kim, Morris Sloan, Hughes, Elbaum, and Sridhar (2003) categorized interventions into the following:

- Prompting.
- Rehearsal or practice.
- Play-related intervention.
- Free-play generalization.
- Reinforcement of appropriate social skills.
- Modeling of social skills.
- Social skills related to storytelling.
- Direct instruction.
- Imitation.
- Time out.

"In general, interventions that included modeling, play-related activities, rehearsal/ practice, and/or prompting were associated with positive social outcomes for children with disabilities" (p. 12). For young children, the best results seemed to come when social skills interventions were combined with

general education instruction. Modeling, practice, and prompting appear crucial to student success. Children with disability need explicit instruction through explicit modeling of what and how to use social skills, systematic prompting, and extensive practice (Vaughn, Kim, Morris Sloan, Hughes, Elbaum, & Sridhar, 2003).

One final area about communication seems particularly importance for students with emotional and behavioral disorders, and that is the area of student **resilience**. Increased communication effectiveness may facilitate resilience in students with behavior disorders. Galambos and Leadbeater (2000), for example, identified resilience of adolescents in high-risk circumstances—including adolescents who are members of minority groups as those diagnoses with disabilities--as a current research trend in the field. Although resilience has been studied since the early 1970s, a research shift has included urban youth in recent years (D'Imperio, Dubow, & Ippolito, 2000). Urban youth have typical stressors and additional chronic stress caused by poverty, physical danger, and other factors. Neighborhood disadvantage is correlated with behavioral maladjustment, for example (D'Imperio, Dubow, & Ippolito, 2000). Resilience, which is the ability to adapt to threatening circumstances, is affected by stressor exposure and competence (D'Imperio, Dubow, & Ippolito, 2000). Suggested correlates with resilience include intellect, personal attributes, coping skills, social supports, family support, and extra-familial support. Resilient children cope by problem-solving, rethinking the effect of the challenge, and believe they had the internal fortitude to affect the problem. Coping skills enable the individual to exert control over chaos. Avoidance seems to have the opposite effect.

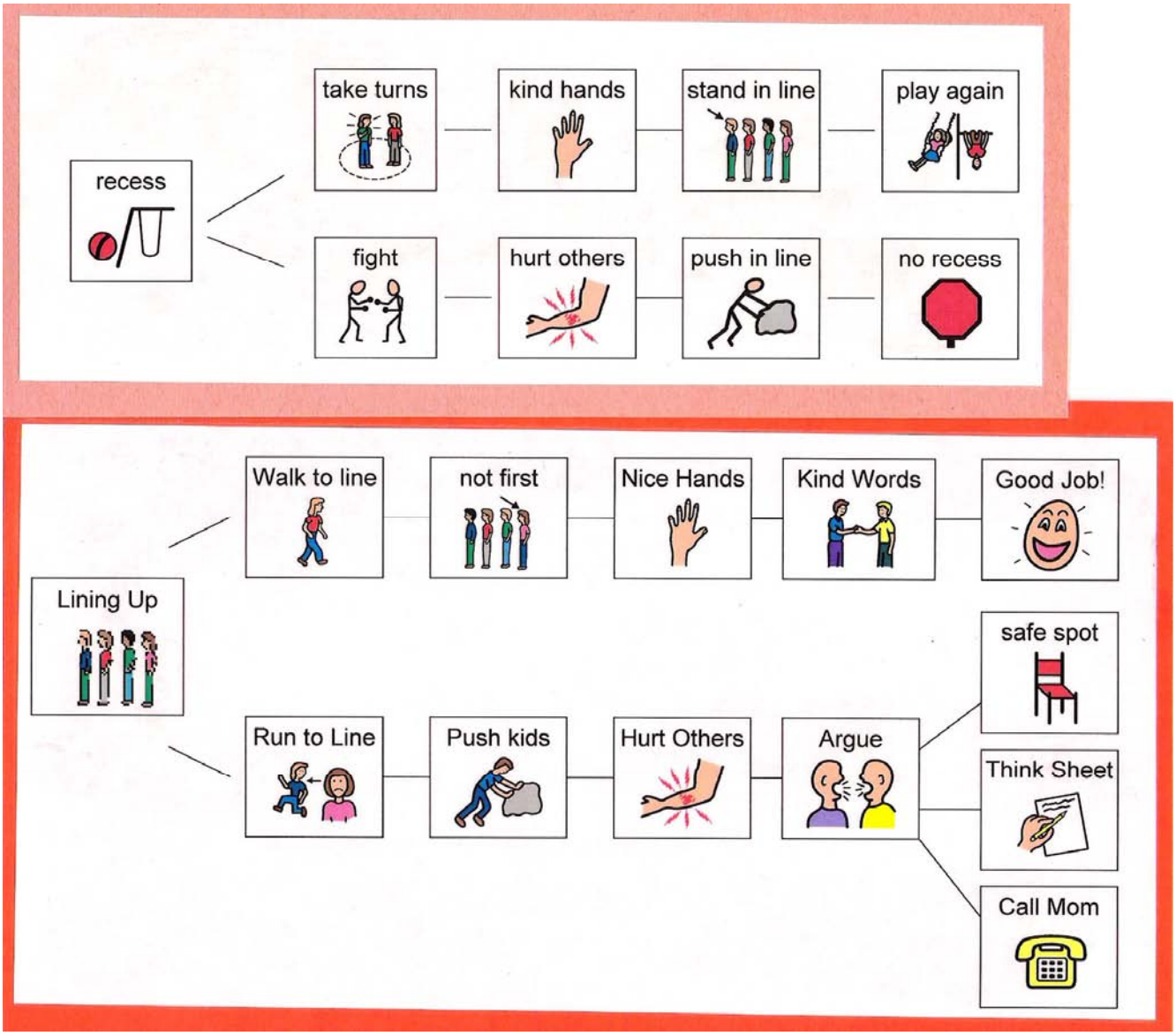
Conclusions

Based on the RtI procedures of two area school districts, the approach does have potential for communication about and service of students who may have emotional or behavioral disorders. Careful oversight of interventions for elementary and middle school may be needed to ensure that students are served well. In addition, teacher training of research-based interventions and data collection methods will be useful to make sure students are served well.

Learning effective communication skills can have a positive effect on students with emotional or behavioral disorders (Nelson, Benner, Neill, & Stage, 2006). Communication skills training is an area of intervention that affects social and academic success for students with disabilities. By generating individualized communication scripts, a ten step process seems to address crucial elements shown in the research literature. The **Ten-Step Strategy for Building Communication Responses** includes the following:

1. Protest if positive.
2. Run only for a moment.
3. Consider your goal.
4. Show empathy.
5. Use a positive face, eyes, and body.
6. Use explaining words.
7. Seek or give forgiveness.
8. Ask for a model.
9. Notice a teacher's prompt.
10. Practice talking well.

The teacher may find this procedure useful alone or in combination with other communication scripts. See appendices for examples. This script by J. J. Collins, for example, show the high road and the low road, for example, show students a path of consequences about *recess* and *lining up*.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hurt others
push in line
no recess
Lining Up
Walk to line
not first
Nice Hands
Kind Words
Good Job!
Run to Line
Push kids
Hurt Others
Argue
safe spot
Think Sheet
Call Mom

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Appedix A: Aitken's Ten-Step Strategy for Building Communication Responses

Problem	**1. Protest if positive.**	**2. Run only for a moment.**	**3. Consider your goal**	**4. Show empathy**	**5. Use a positive face, eyes, & body**	**6. Use explaining words**	**7. Seek or give forgiveness**	**8. Ask for a model**
								
Gossip I told a rumor about a person.	Instead of denying, apologize.	Instead of running away, talk to the person.	I want to be worthy of your trust.	Your feelings must have been hurt when you heard people talk about you.	Lean forward. Look in eyes. Concerned look on face.	I shouldn't have told anyone what you told me privately.	I became caught up in the excitement and having people pay attention to me. I apologize. I will not spread rumors.	Will you help me understand when it's okay to talk about other people? Teacher demonstrates with student in reversed role playing.
Criticize I made a judgmental statement that hurt person's feelings.	I said it, but I didn't mean it the way it sounded.	We can talk even though you are angry.	I want to help you feel less hurt.	I have faults, and I know I feel upset when someone criticizes me.	Raised eyebrows. Soft voice.	I made a poor choice of words. I had no business criticizing you. I like you no matter what.	I didn't stop to think about how you would feel about what I said. I'm sorry I said those things because I really care about you.	Will you help me to speak more positively? The teacher models how the words may be said.

Argue I instantly opposed other (e.g., defied an adult).	I saw this differently than you did.	I understand what you're saying, and I will do it.	I want to follow the adult's request.	I feel threatened when people argue with me. I didn't mean to make you upset.	Relaxed face. Allow eyes to blink (no starring). Direct eyes (no looking up).	I realize you want what's best for me.	I find it hard to listen to other people. Will you explain why you want me to do this and help me understand why I should do it?	Will you help me figure out when to wait before I speak? Teacher model an appropriate response.

Problem	**1. Protest if positive.**	**2. Run only for a moment.**	**3. Consider your goal**	**4. Show empathy**	**5. Use a positive face, eyes, & body**	**6. Use explaining words**	**7. Seek or give forgiveness**	**8. Ask for a model**
								
Upset Someone else seems angry with me.	I can talk about what is on my mind--my ideas—without getting mad or calling people bad names.	I can run until I get my thoughts gathered.	I want to be able to speak my mind.	I want to understand your view of the situation. Please explain your thoughts and help me listen to you.	Raise my eyebrows, try to smile, sit up or lean forward.	Help me to understand where you're coming from and I'll do the same for you.	I feel scared when you become upset, so that makes me want to be quiet. Will you tell me what I did wrong so I can understand?	Will you tell me if I do something that threatens our relationship? Teacher model a facial expression and vocal level, while saying words.
Feel Small Other person not listening to me.	I can stand up and say something.	I will only run until I calm down, then I will come back to talk.	I want to make clear each side, so we understand each other.	I know this is very difficult and it's hard. I know how you feel.	Smile, nod head, raise eyebrows, lean forward, chin down, moderate voice.	I want to hear what you have to say, and then I need for you to listen to my point of view.	I haven't figured out how to express myself so you can understand me. What do you need me to tell	Will you help me feel confident to say what I think? Teacher model active listening skills, then

							you?	change roles.
Betrayed I don't trust the other person.	I am worthy of respect.	I can resist the urge to end the relationship.	Gain the feelings of trust back.	I realize everyone makes mistakes. When I violate a person's trust, I feel guilty.	Look at the other in the eyes. Look focused on the words. Listen actively.	I know you didn't mean to hurt me. We can work on building the trust back up together.	I talk to you because I think you care about me. How can we build trust again?	Will you help me figure out what I expect from you? Teacher model the conversation.

Problem	**1. Protest if positive.**	**2. Run only for a moment.**	**3. Consider your goal**	**4. Show empathy**	**5. Use a positive face, eyes, & body**	**6. Use explaining words**	**7. Seek or give forgiveness**	**8. Ask for a model**
								
Silence. Lack of communication.	I can step up to the plate and say what I think.	I can only run until I think of what to say.	Speak up when I don't like what is being said.	You must feel really frustrated because I don't any responses to your comments.	Smile with my eyes. Widen my eyes. Breathe normally.	I am feeling like I don't have a voice when you are talking to me. I can't tell you how I feel because I don't feel like you want to hear what I am saying.	When you say things I don't like, it makes me question who I am and what I think. Will you help me talk up by asking me questions?	Will you explain to me what I should say now? Teacher and student reverse roles so teacher can model.
Bossy: I gave orders without consideration for another.								
Selfish: I refused to cooperate with another.								

Tattled: I betrayed a confidence that got the other person into trouble.								

Appendix B: PROCESS REMINDER

Problem	1. Protest if positive.	2. Run only for a moment.	3. Consider your goal	4. Show empathy	5. Use a positive face, eyes, & body	6. Use explaining words	7. Seek or give forgiveness	8. Ask for a model
								

Appendix C: PROMPTS

Gossip I told a rumor about a person.	**Criticize** I made a judgmental statement that hurt person's feelings.	**Argue** I instantly opposed other (e.g., defied an adult).	**Upset** Someone else seems angry with me.	**Feel Small** Other person not listening to me.	**Betrayed** I don't trust the other person.
Privacy	**Acceptance**	**Respect**	**Speak for myself**	**Listen to one, then the other.**	**Trust**