UNDERSTANDING BEHAVIOR DISORDERS: THEIR PERCEPTION, ACCEPTANCE, AND TREATMENT- A CROSS-CULTURAL COMPARISON BETWEEN INDIA AND THE UNITED STATES

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The purpose of this study was to explore the perceptions, identification and treatment of students with behavior problems or disorders in India and the United States. Participants in the study were students and teachers in the United States and India. A qualitative approach included in-depth interviews and participant observations. These were conducted in classrooms both in India and the United States with teachers, students, and their parents/guardians. Data analysis reflected ongoing reflective journals, audio and video recordings, still photographs, and collections of ethnographic information which were gathered during interviews and observations by the researcher. Findings indicated that there were several factors i.e., family backgrounds, socioeconomics, environments, peer influence, cultural practices, societal expectations, and cultural gaps between home and school which influenced teachers' perceptions and understanding of behavior problems and disorders in the United States and India. Implications for educators and recommendation of future research are included.

Cross-cultural research is a relevant means of obtaining important information especially within the field of education. Cross-cultural studies can help differentiate the universal and culture-specific aspects of psychological phenomenon (Triandis, 1994), particularly relevant to perceptions and treatment of problem behaviors. To date, few *cross-cultural* studies have been conducted dealing with EBD, especially in determining how cultural perceptions or beliefs may affect the definition, identification, and treatment of EBD. Cross-cultural research between two countries, the United States and India, can yield information about perceptions of and successful approaches to behavioral problems that would be important information for U.S. educators.

Definition of Culture

According to Diller and Moule (2005), culture is *a lens through which life is perceived. Each culture through its differences (in language, values, personality and family patterns, worldview, sense of time and space, and rules of interaction) generates different phenomologically different experiences of reality* (p. 5). The Council for Anthropology and Education (2007) acknowledged that culture is intimately related to language and affects the organization of learning and pedagogical practice, evaluative procedures and rules of schools, as well as instructional activities and curriculum. Thus, culture dictates perceptions, which influence practices**.**

Special Education Services in India and United States

Before 1960, both the United States and India provided segregated services to children with disabilities, but gradually both countries have changed and improved the quality of special services. In the United States, students with disabilities have the right to be educated in the least restrictive environment (LRE) which was first defined in 1975 under Public Law 94-142. Vaughn, Bos, and Schumm (2007) described the least restrictive environment (as defined by IDEA) as *the setting most like that of non-disabled students that*

also meets each child's educational needs (p. 4). The LRE requires that all students with disabilities receive an education in a setting which allows the student to develop his or her highest potential in an environment with non-disabled peers as appropriate (Smith, Polloway, Patton & Dowdy, 1995; Hardman, Drew, Egan & Wolf, 1990). Data from the 27th Annual Report to Congress (U.S. Department of Education, 2005) indicated that the percentage of students with emotional disturbance receiving special education services outside the regular class for more than 60% of the day has decreased from 35% in 1994 to 30% in 2003; the percentage of students with emotional disturbance being served in separate public facilities has decreased from 8% to 6.5%.

In India, a country with over 3,000 years of civilization, the Indian people have been accustomed to dealing with disabilities in a natural psychotherapeutic way rather than depending on western medicine; disabilities were traditionally accepted as misfortune. After gaining independence from the Moghal and British empires, however, the general public in India learned to ignore the conventional thinking and accepted individuals with disabilities. Up until 1972, no school services for students with disabilities existed. Currently, India recognizes several categories of disabilities, however, EBD is not one of them. In 1947 the Government of India began an initiative in the education and rehabilitation of persons with disabilities. However progress was slow until the entire disability sector received a boost in 1981 with the declaration of the International Year of the Disabled Persons by the United Nations (Singh, 2004). According to Singh (2004), the 1992 Rehabilitation Council of India (RCI) Act was amended in 2000 to make the Council more broad based by including important duties such as the promotion of research in rehabilitation and special education. This also included maintaining uniformity in the definitions of various disabilities in conformity with the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (Singh, 2004). The identification of behavior disorders, however, was not recognized.

Children with severe behavior problems are recognized as juvenile delinquents under the Juvenile Justice Act (House of Parliament, India, 2000). Behavior problems are addressed in juvenile courts which have been set up in different geographic areas. Once juvenile delinquents (children who come into conflict with the law or those who are described as orphans or abandoned) in India are charged with a criminal act, they may be placed in the juvenile home, the observation home, or the special home (Mookherjee, 1994).

Defintions of EBD

In the United States, the current definition for EBD is similar to that used in the early 1960's (Ysseldyke, Algozzine, & Thurlow, 2000), though the terminology of *serious emotional disturbance* was replaced in IDEA 1997 by *emotional disturbance* to eliminate the negative connotation of *serious* (Knoblauch & Sorenson, 1998). Students with emotional disturbance in the United States are identified based on the following characteristics: (a) an inability to learn regardless of intellectual, sensory, or health factors; (b) an inability to build satisfactory relationships with peers and teachers; (c) inappropriate types of behaviors or feelings under normal circumstances; (d) depression or mood swings; or (e) the development of physical problems or personal fears. The term also included individuals with schizophrenia and autism, but does not include socially maladjusted children unless they were considered seriously emotionally disturbed (U.S. Department of Education, 1998). This definition, however, has faced criticism for its vagueness, redundancy, lack of empirical support, and ambiguity (see Cullinan, 2005).

Disproportionality

In the United States *secondary students with emotional disturbance are more likely to be male, black, and to live in poverty than secondary students in the general population* (p. xiv, U.S. Department of Education, 2005). For the past decade, many concerns have been expressed regarding the disproportionality of students placed in special education, particularly those identified as EBD. Research indicated that this is due to institutional racism, stereotypes, cultural incompetence, racial bias, and inequitable discipline policies (Lehr & McComas, 2006). Some have suggested that students who *stand out* from the norm are more likely to be labeled by educators as having EBD even though their behavior is similar to that of their white peers (Oswald, Coutinho, & Best, 2002). Teacher perceptions on behavior play a powerful role in referring students to be identified with EBD. These perceptions of student behavior are influenced by gender, ethnicity, and socioeconomic status (Casteel, 2000). Thus, it is imperative that teachers develop cultural competency to bridge cultural discontinuity between teachers, students, and families (Osher et al.,

2007; Diller & Moule, 2005). Cultural competency involves educating students in the context of minority status, respecting culturally defined needs of diverse populations, acknowledging that culture shapes behavior, and recognizing that thought-patterns from diverse cultures are equally valid, though different, and influence student perceptions (Cross, Bazron, Dennis, & Isaacs, 1989). Finally, Oswald and Coutinho (2006) explained that students from diverse ethnic backgrounds may have higher prevalence of disability *not because they 'stand out' but because of the inherent stress of living as a member of a minority group* (p. 3). With the understanding that stress is associated with living as a minority member within a homogenous community, supports can be developed to help students from diverse backgrounds cope with this stress as an effort to reduce disability prevalence (Oswald & Coutinho, 2006).

Cultural competency has been a recommended policy in the field to battle the misidentification and inappropriate treatment of children of color (Cross et al., 1989; U.S. Dept. of Education, 1994). For example, the Office of Special Education Programs reported valuing and addressing diversity as a target strategy to effectively meet the needs of students with EBD. The target strategy goal included "to encourage culturally competent and linguistically appropriate exchanges and collaborations among families, professionals, students, and communities. These collaborations should foster equitable outcomes for all students and result in the identification and provision of services that are responsive to issues of race, culture, gender, and social and economic status" (U.S Department of Education, 1994, Strategic Target 3, ¶1). Despite these efforts, disproportionality continues to exist in the EBD category in the United States, forcing educational leadership to examine the quality and effectiveness of how practitioners are prepared to operate in culturally diverse settings.

Statement of the Problem

In India disabilities are defined as handicaps that are divided into four categories: physical, visual, hearing, and mental (Misra, 1996). Unlike the United States, the category behavior disorder is not considered a disability in Indian culture. The implications are: (a) there are no behavior problems among children in India, (b) Indian society does not recognize behavior problems as disabilities or it defines *behavior* problems differently, (c) behavior is perceived as the responsibility of someone other than the school's, or (d) behavior problems which do exist are so well accommodated that they do not merit additional attention. Thus, a cross-cultural study would help determine how and why behavior is perceived and treated differently between two countries.

Purpose

This research was aimed to investigate the process of cultural understanding toward teachers', parents', and students' perception and acceptance of behavior disorders. The main purpose of the study was to qualitatively characterize the factors that influence society's perception, acceptance or recognition and treatment of behavior disorders.

Method

The research design for this study is based on qualitative inquiry. A *field theory approach* (Kleiner & Okeke, 1991) enhances the role of psychological and cognitive processes in understanding a wide range of social behaviors representing an individual's (or group) way of perceiving and organizing or reacting to the environment. This approach acknowledges that numerous variables act simultaneously on the population being studied at any given point in time including social structure, culture, and psychological factors.

Setting

Two settings were chosen in order to perform the comparison of perceptions. The first setting of India included observations in two residential for facilities for students with behavioral issues. Observations took place at a residential juvenile center for boys in India which provides academic, vocational, recreational, and rehabilitation programs for children from grades k-12 and who have mild or moderate behavior problems. Research observations also took place at a residential home for girls in India that provides academic, social, and behavioral services for females between the ages of 5 and 15.

The second setting observed was a U.S. high school in New Mexico. Because it **was** a public school, only two classrooms were selected for observation. This high school served approximately 30 students who were identified as having behavior disorders.

Participants
The subjects of this study include teachers, parents and students affiliated with both residential settings in India and the high school in New Mexico. The subjects in India came from diverse linguistic and socioeconomic backgrounds. The students ranged in age from 12 to 17 years old. The students in New Mexico ranged in age from 14 to 18 years old. They primarily came from Hispanic and Anglo cultures and were from low socioeconomic backgrounds. The parents and teachers either lived and/or worked in the southern part of New Mexico.

Five to six students (three girls and two boys from the U.S. and four boys and two girls from India) were selected from each of the school settings as participants for this study. For the entire study approximately 12-15 subjects were utilized in each setting. In India, 6 students, 5 teachers, and 1 parent participated. In the United States, 5 students, 5 teachers, and 5 parent/guardians were involved in the study. Table 1 provides a summary of demographic information.

Table 1
Demographic Information of Study Participants

	Teachers	Parents	Students
Gender			
Male	*n* = 2	n = 0	n = 6
Female	n = 8	n = 6	n = 5
Race			
White	n = 3	n = 1	n = 1
Hispanic	n = 1	n = 3	n = 3
African American	n = 6	n = 1	n = 6
Asian Indian		n =1	n =1
Other			
United States	n = 5	n = 5	n = 5
India	n = 5	n = 1	n = 6
Total	n = 10	n = 6	n = 11

Data Collection
This qualitative, ethnographic study included participant observations and interviews with parents, students and teachers. Several types of data were gathered which included in-depth interviews, non-participant observations, participant observations, reflective journals, and a formal review of available literature.

The in-depth interviews aimed to develop an understanding of perspectives **of** behavior disorders? The researcher used open-ended questions with the subjects over a 30-45 minute period. In-depth interviews were conducted with each participating teacher, student and parent. The interview focused on participants' knowledge, views, perceptions and understanding of behavior disorders.

In India, non-participant observations were conducted in the five different classrooms. This type of observation allowed for a greater building of rapport between the researcher and all participants. In the U.S., by contrast, participant observations were used. The focus of these observations was sometimes student-centered, teacher-centered, and/or whole-class-centered.

The reflective journal included the researcher's personal thoughts and questions related to the study. These were reflected upon during and after each site visit. The reflective journal was an important tool in identifying and exploring themes as they emerged from the data.

As the research was conducted and new issues or themes were identified, the researcher continued exploration of the literature. The literature review continued throughout the study as the researcher collected, analyzed and attempted to interpret the meaning of the data.

Results

After analyzing the interview tapes, observation notes, and reflective journal, several themes related to perception, acceptance, and treatment of behavior disorders in India and the United States emerged. The four primary themes were related to **)**: 1) definitions of behavior problems or disorders in children and youth in India and in the United States, 2) responsibility for treating children and youth with behavior problems and disorders in India and the United States, 3) cultural construction of the concept of behavior problems or disorders and their treatment in the classroom in India and the United States, and 4) causes of behavioral problems and disorders in children and youth in India and the United States.

Definitions

The parent/guardians and teachers in the United States represented diverse cultural backgrounds. Three parent/guardians and one teacher were Hispanic Americans, one parent was Asian American, one teacher was Indian American, and one parent/guardian and three teachers were Anglo. When asked *Is your child identified with EBD?* individuals of Hispanic, Asian, Indian, and Anglo American origin responded with the comments provided in Table 2.

Table 2
Comments from Parents of Diverse Cultural Backgrounds Responding to the Question, "Is your child identified with EBD?"

Cultural Background	Comments
Parents from Hispanic Origin	
Parent 1	1) "No, because the term doesn't exist."
Parent 2	2) "No and Yes. No, because not in Mexico or in Native American culture. Yes, because, I am born and brought in the U.S., and the term exists in that country."
Parent 3	3) "No, the term doesn't exist."
Parent 4	4) "No, because the term doesn't exist."
Parent from Asian Origin	"No because they don't have such term."
Parent from Indian Origin	"No, because the term doesn't exist." (Indian American)
Parents from Anglo Origin	
Parent 1	"Yes."
Parent 2	"Yes, it is the part of the legal term to identify SED/BD."
Parent 3	"Yes, it is part of the special education law."
Parent 4	"Yes, it is the part of the special education law."

Table 3 summarizes the information regarding the identification of behavior disorders within their own culture. It is important to note that answers did not differ between parents/guardians or teachers. Answers were only different based on cultural perspectiv**es**.

Table 3
Parent and Teacher Perception of the EBD Label by Culture within the United States: Responses to "Are Children Identified as EBD within your Culture?"

Culture	Yes	No	Other (Yes & No)
Hispanic		*n* = 3	*n* = 1
White	*n* = 4		
Indian American		*n* = 1	
Asian American		*n* = 1	

Teachers and parents in India were not asked if children were identified as EBD in their culture because a specific definition for emotional problems and behavior disorders did not exist in India. However, they were asked to state their own personal definition of behavior problems. One teacher stated that she believed the children she served had mild and moderate behavior problems, but that they were not born with the condition. This teacher expressed that the problems developed from their environment and the environment they grew up in. Another teacher agreed that the behavior problems were not something with which the child was born. She said, *Today's children are more independent. . . .When parents and society want to mold them based on their expectations, conflict arises. Most of these children did not have any structured life and guidance in their childhood.* All teachers interviewed from India agreed that behavior disorders are not the result of some congenital anomaly, but that the only contribution to EBD was environmental. They also agreed that these children exhibited negative behavior as the result of poverty, negligence, lack of structure and lack of education within the family.

Responsibility for Treatment

Because family background and other home issues are often viewed as contributing factors to behavior disorders, the primary responsibility for treating individuals with these problems lies with the schools and teachers. It was intriguing to find the differences in understanding that how these schools serve children labeled as having behavior problems or disorders.

The classroom activities involving students who are identified with behavior disorders in the United States were different than for the students in India. Not only did the teachers interact differently with these students, but also they were treated differently by their regular education teachers, non-disabled peers, administrators and school staff. The label *BD* impedes some regular teachers from including these students in their classrooms; some administrators often blame the students for misconduct, and they are the first ones to be blamed for any gang violence.

The reasons for differences in interactions in the United States and India are dependent upon each society's perception of behavior disorders. Although all teachers do what they think the children need in order to overcome their difficulties, the definition, cause and treatment of EBD are perceived differently. In India, none of the children are labeled as *behavior disordered* because the pressures of survival are seen to be of primary importance; behaviors are secondary.

Cultural Construction

The teachers observed and interviewed in India described students who they thought may have behavioral problems as children who come from low socioeconomic backgrounds, broken families, and families who lack education. The teachers also recognized that cultural expectations and acceptance of certain behavior problems as a disability is reflected in children's behavioral performances. All of the teachers mentioned that since the term behavior disorders does not exist in their culture, they each have accepted different levels of behavior as being developmental style unique to each student. One teacher in India stated, *Culture is not something you remember to practice everyday. It is a part of daily life.*

Within the classes in India, the teachers all noted that behavioral problems are the least important factors to worry about. Most importantly, these teachers wanted to provide these students with a good education. Concerns regarding the provisions of food and shelter weighed more heavily on these teachers than issues surrounding the students' behavior. These students all came from low socioeconomic backgrounds and were merely struggling to survive. One teacher stated, *the development of behaviors is influenced and guided by the environment, family expectations and practices, and values and beliefs*. Based on the interviews and observations in India, it appeared that behavior problems were seen as a part of normal growth and development, and these problems were seen as secondary to issues of survival.

Identifying issues of cultural construction in the United States was a much more complicated task. Though all of the students served by the New Mexico school were in many ways American, many also carried the culture of their family such as having a Hispanic heritage. All five teache**rs'** construction of the meaning of the term behavior disorders differed from each other based on cultural perspectives. However, they all agreed that family environments and childhood upbringing were the common issues that are reflected in behavior problems. Several of the teachers stated that culture has little to no influence on student behavior.

They thought that it was due to how behavior was accepted at home or on the individual students' own personal experiences.
In relation to culture, one teacher did refer to how the *culture gap* can impact perceptions of behavior in schools. This teacher stated, *The cultural gap between their home and school makes a big difference in their performance.* It makes so difficult for these children who are identified as behavior disordered.

Causes
Teachers in India and the United States had varying opinions as to what causes behavior problems and disorders. When interviewed, the teachers from India stated that behavior problems were the result of a complicated childhood, cultural differences, low socioeconomic background, broken family, abusive background, lack of education, and lack of love. Teachers in the United States cited similar views. They stated that behavior problems were the result of a broken home, drug abuse, alcohol abuse, sexual abuse, family background, lack of family education, unhealthy family environment, cultural background, and complicated childhood.

Discussion
The findings of the study indicate that there are a number of variables that influence teachers' perceptions of the abilities and needs of the students with behavior problems or disorders. These variables are unique, yet they share a common role in a teacher's decision-making concerning students who they think may have *behavior disorders*. The term *behavior disorders* is constructed differently because of the factors that influence teachers' (in both countries) decision-making, beliefs, perceptions, teaching preferences and interactional styles.

Results indicate four significant findings. First, the study identifies factors that influenced the teachers' construction of the definition of the terms *behavior problems* or *behavior disorders* All teachers in India and in the United States defined behavior problems or disorders based on their own lives and experiences. In India, problems are defined as common to all human beings and are not considered disabilities. The emphasis is on the need for social and academic growth of each individual. The perception is that different levels of behavior problems should not interfere with the achievement of educational opportunities. In the United States, some teachers related to the cultural and linguistic experiences of their students, but agreed that students are appropriately placed in the special education programs if they are identified by the diagnostician and Individual Education Program (IEP) team as having a behavior disorder. Several teachers in the United States believe that labeling may prohibit students from acting like normal children. Labeling also creates a generalized view of students as *problem children* alienating them from participating and interacting normally with others. With regard to responsibility and cause for behavior problems, all five teachers in the United States agreed that peer pressure, drug/alcohol abuse, gang involvement, and weak family structures are to blame for students' negative behaviors. In India, poor socio-economics, extreme poverty, family problems, and social expectations are considered responsible for causing behavior problems. Unlike in the United States, opportunities to receive special services in India are privileges, not rights.

A second major finding indicates that all teachers do not integrate children's cultural, linguistic, and familial experiences into the curriculum. In many cases, they only consider issues of culture, language, and family if they are obvious factors in the child's difficulties. The positive or negative influences of such experiences are often overlooked by some teachers and left outside the classroom. In the present study, in the U.S., one student's family problems were overlooked by the regular education teacher, resulting in placement in a special behavior disorder program. However, in India, one student's family problems were considered a part of his misbehaviors and he was treated with care, nurture, and integrity in order to strengthen his academic, social, and behavior performances.

A third finding is the differences in classroom activities involving students who are identified with *behavior problems or disorders* in the United States and India. Not only did the teachers interact differently with these students, but also they were treated differently by the regular education teacher, non-disabled peers, administrators, and school staff. The reasons for the differences in interactions in the United States and India are dependent upon each society's perception of behavior disorders.

Finally, the lack of parent involvement in the decision-making of a child's program placement may influence the program to be unsuccessful. Three out of five parents in the United States were unhappy about their child's placement in the *behavior disorder* program. According to these parents, their children may have some social, emotional behavior problems, but not to such a degree as to label them. Three parents were also frustrated with the teacher's lack of understanding of their family and cultural backgrounds prior to referral to the BD program. The lack of communication between parents and teachers generates confusion and misunderstanding which impacts the success of the school program.

Implication/Recommendations

The implications of the findings of this study are addressed within two areas of education: (a) pre-referral intervention and (b) pre-service and in-service training. Pre-referral is often viewed as the most critical period prior to a teacher's referral of a student to a special education placement. A teacher's individual beliefs, biases, attitudes, and practices are important issues in his/her classroom activities. The validity of a student's appropriate referral depends on teachers' knowledge and understanding of the child's problems and difficulties. While the question of pre-referral is irrelevant in India since children are not labeled with BD, several implications for pre-referral interventions are applicable in the United States. In most schools in the U.S., the regular classroom teacher most often makes the initial referral, then the Child Study Team helps make the final decision about processing the referral. Classroom teachers and members of the child's study team need to be aware of the following:

1. Pre-referral strategies must take into account the teacher's construction of the meaning of the term *behavior disorders* and the factors that influence those constructions. These factors may include teachers' attitudes, beliefs, biases, teaching practices, expectations, and consideration of culture and family.
2. The student's social and emotional backgrounds may influence a student's behavioral performances.
3. The personal and professional experiences of individuals working with the students may impact their views of effectiveness of special education programs, thereby affecting their decisions concerning special education referral.
4. Parent involvement in important and crucial prior to referring the child for a special education program. Since parents are the most important source of students' personal, social, and emotional information, their views may differ than those of the teachers.
5. Careful attention must be paid to classroom interventions (both behavioral and academic modifications) based on the child's individual needs.
6. Special education personnel need to be more involved in observation and implementation of modifications. Specifically, special education teachers can be utilized collaboratively during the child study period as the regular education teachers try to implement modifications.
7. Teachers should reflect on their own teaching practices in order to determine ways in which they can make changes in their teaching rather than attempting to make changes in the student's life. Teachers must be willing to adapt their teaching to their students rather than adapt their students to their teaching.
8. Teachers' classroom activities may have a possible impact in teacher-student, and student-student interaction, especially the students who may have social, emotional, and behavior problems that conflict with classroom interactions.
9. Teachers must be aware of their own expectations that they convey through their classroom discourses regarding their students' behavior, social interaction, knowledge, and learning. Furthermore, they should realize the effect of these expectations has on their students, especially those who may have social, emotional behavior problems.
10. Prior to labeling or referring these children for a special education BD program, teacher must understand that each child is different from others and their ration of proper behavior performances may vary. Therefore, all behavior problems are not disabilities. They can be a statement of inadequate performance or a product of the environment.

In order to address cultural competency, pre-service and in-service training is needed for the teachers in both India and in the United States by incorporating the following guidelines:

1. Address the issues of global change, individual attitudes, personal beliefs and biases, philosophies of learning, and expectations of teachers during pre-service training. Additionally, these trainings

should expand on personal beliefs regarding culture, behavior, and family which contribute to school experiences. Teachers and administrators must be aware of the impact these factors have on teaching and education decision-making.

2. Provide trainings with sample case studies of students' different states of social-emotional behavioral backgrounds to help generate an understanding of why and how the behaviors of students change. The lack of understanding of a student's background can result in improper referral.
3. Present different ways that educators, parents, and students construct the meaning of the term *behavior disorders*. Encourage ongoing dialogue and critical analysis that helps in developing a common language that effectively describes students' academic or social-emotional behavioral situations.
4. Emphasize the need for teachers' adapting to new teaching styles to meet students' needs rather than expecting students to adapt to teaching styles.
5. Address the issue of different classroom discourses, teaching styles, and communication patterns that may impact the learning environment.
6. Provide training in transdisciplinary collaboration to involve special education personnel and other service providers such as speech therapists, occupational therapists, social workers, physical therapists, and counselors in decision-making at the pre-referral stage. This will increase communication among teachers, administrators, and trained special education personnel.
7. Introduce the concept of individual special needs and special education systems and minimize the misconception of disabilities. The training will help teachers and staffs in India and the U.S. in order to gain a better understanding of the differences between what disabilities are and are not.
8. Address the issue of cultural and linguistic diversity in the U.S. and India and how diversity impacts classroom activities, interactions, and communication.
9. Make the important connection between home and school experiences of children. Incorporating students' cultural, linguistic, and economic background and the role of family members in the educational process will increase communication between parents and teachers, teachers and students, and students and parents. Teachers and administrators need training to involve parents in effective ways. Such training may help prevent inappropriate referral for special education and increase success in both the school and home environment.
10. Provide an opportunity for parents and possibly students to receive training when needed to develop a better knowledge and understanding of the school's and society's expectations. Sometimes parents' lack of knowledge of school policies, classroom activities, and especially the knowledge of their child's special need, create misunderstandings and miscommunication between home and school.

Research Implications

In countries with diverse cultural backgrounds, such as the United States, strides must be taken to adequately prepare teachers in cultural competence, empowering them to become more aware of how to prevent problem behaviors from occurring and how to respond to behaviors. While IDEIA 2004 (U.S. Department of Education, 2004) calls for attention to disproportionate representation by race and ethnicity in special education, an action plan to equip teachers to be culturally competent is missing. Similarly, No Child Left Behind legislation (U.S. Department of Education, 2001) requires teachers to be highly qualified; however, cultural competency is not recognized as a necessary skill for teachers to achieve highly qualified status. In order to adequately address the issue of disproportionality in special education, particularly in EBD, teachers must be adequately trained to recognize how their own perceptions of *inappropriate* behavior **are** mediated by culture.

Overidentification and disproportionate representation of students in EBD categories can be prevented at the stage of pre-referral. Pre-referral strategies must take into account the teacher's construction of EBD as well as the student's social, emotional, and cultural background. Pre-service and in-service trainings must address the following issues: on-going dialogue on how the term *EBD* is constructed among practitioners, exploration of diverse personal beliefs on culture and how these beliefs contribute to school experiences, and guidance on appropriate ways to adapt teaching styles to meet student needs. Finally, preventive approaches to reduce EBD should be embraced. Research has indicated that early identification of academic learning problems may reduce risk for EBD (Lane et al., 2002). Thus, as efforts are made to

improve academic competence for all learners, teachers must be adequately prepared to address diversity in classroom activities, interactions, and communications.

Summary

The finding of this study has critical implications for the understanding of behavior problems or disorders in India and the U.S. Definitions, causes, and classroom practices have both influenced and emerged from the social systems in India and the U.S. The data in the study suggests the need for future research and training exists.

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