

The SAGE Handbook of
**Emotional and
Behavioral
Difficulties**



Second edition

Edited by
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How We Prevent the Prevention of EBD in Education

James M. Kauffman

Preventing emotional and behavioral disorders or difficulties (EBD) is a very popular idea. Nearly everyone pays lip service to the idea of prevention, but few are willing to implement preventive measures (Kauffman, 1999, 2010, 2011). Prevention is often stymied by arguments for nontreatment, even though most people will acknowledge that prevention makes eminent sense from both a moral and an economic perspective. Many educators look with disfavor on preemptive treatment in the absence of severe difficulties and reject the treatment of comparatively minor problems. No one says that only extreme and protracted educational difficulties warrant intervention, yet early intervention is often sidestepped. Reporters Warner (2010) and Earley (2006) have described how the needs of children with attention deficit-hyperactivity disorder (ADHD) and other mental health difficulties are typically ignored, dashing any hope of prevention.

The seriousness of early-onset EBD and the prospects of adult dysfunction for children who have EBD should not be overlooked. Most of the students who are eventually found to need special education for EBD have had difficulties for many years (see Forness, Freeman, Paparella, Kauffman, & Walker, 2012). We should rightfully be concerned about problems left to fester in youngsters because eventually they are likely to trigger more severe disorders in adulthood.

Long periods of untreated illness may also be harmful to those with less severe disorders. Preclinical studies suggest that neural 'kindling' can cause untreated psychiatric disorders to become more frequent, severe, spontaneous, and treatment refractory... In addition,

epidemiological studies suggest that school failure, teenage child-bearing, unstable employment, early marriage, marital violence, and marital instability are associated with early-onset untreated mental disorder. (Wang et al., 2005, pp. 610–11)

Nevertheless, the typical response to the need for treatment of EBD in children is to demur. True, we need to be aware of the danger of false positives – false identification or over diagnosis – but the data simply do not support the notion that this is a major problem. The data do indicate very clearly that the false negative – failure or refusal to identify children having serious difficulties needing special education – is a real and present danger (Forness et al., 2012).

Another way of looking at this problem is what we do about early intervention. Do we actually provide the early intervention that we know we should? In a consensus statement about early intervention, researchers said:

- When children with significant problems are neither identified in a timely way nor given appropriate education and treatment, their problems tend to be long lasting, requiring more intensive services and resources over time. Moreover, when the challenging behavior of young children is not addressed in an appropriate and timely way, the future likelihood increases for poor academic outcomes, peer rejection, adult mental health concerns, and adverse effects on their families, their service providers, and their communities.
- Although some systems and tools for early identification of children with challenging behaviors are available, the actual identification of these children and provision of appropriate services are very low. (Dunlap et al., 2006, p. 33)

Why the antipathy toward prevention of EBD? I suggest several reasons for antipathy, but perhaps it begins with a failure to come to grips with the nature of prevention itself.

Specter (2009) has pointed out that if we see something, then we have not prevented it; we never see what we prevent. Thus, making the case that something has been prevented demands hypothesizing what would have occurred had preventive action not been taken (Kauffman, 1999). Prevention is defined by what is avoided – what does *not* happen – which leads many people to misunderstand how to assess it. True, prosocial behavior is desirable, and prevention may entail increasing prosocial conduct. However, an increase in prosocial behavior does not help us judge the success of prevention. *Successful prevention is defined by the nonoccurrence of maladaptive behavior – the behavior to be prevented, not by the occurrence of prosocial behavior.*

Part of the problem is also likely due to a misunderstanding of this fact because it is related to three levels of prevention. *Primary prevention* keeps a phenomenon (in this case, EBD) from occurring at all. If EBD occurs at all, then it has not been prevented; primary prevention failed and it is too late to suggest primary prevention for that case. *Secondary prevention* applies to EBD that has occurred and is designed to keep EBD from getting worse or, if possible, to correct or reverse it. It is not designed for advanced, exceedingly complicated difficulties. When a difficulty has gotten out of hand and complications are serious, it is too late in that case to practice secondary prevention. *Tertiary prevention* is

designed for difficulties that have reached an advanced stage and threaten to overwhelm the individual or others or to produce serious complications. The goal is simply to 'keep a lid' on the difficulty, to minimize its threat. *Prevention requires anticipation of what is to be prevented; it looks forward to what would be likely to happen without prevention, not backward at what has happened.*

Prevention of EBD in schools is practiced occasionally, particularly secondary and tertiary prevention. But prevention of EBD is not a pervasive concern in schools, particularly primary and secondary prevention. Tertiary prevention is far more common in schools. It is a response to a perceived crisis, and it often devolves into harsh punishment. People may become so frustrated or angry about extreme EBD that they recommend not just containment but punishment. In part, primary and secondary prevention are not widely practiced because of public attitudes toward children and their schooling. However, professionals' attitudes often preclude primary and secondary prevention and contribute to public antipathy toward all but tertiary prevention.

Risk for EBD is distributed on a continuum from very low to very high. For a typical (low or moderate) level of risk, universal primary prevention is often effective. For high risk, only individually designed, intensive, comprehensive, sustained interventions have a good chance of success. More important, at every location on the continuum of risk, we know that '*prevention means early intervention*' (Kamps & Tankersley, 1996, p. 42). Early intervention means supporting adaptive behavior, identifying signs of incipient problems, and resolving problems by intervening early in patterns of recurrent misconduct (Kauffman, Bantz, & McCullough, 2002; Kauffman, Pullen, Mostert, & Trent, 2011; Walker, Ramsey, & Gresham, 2004). The characteristics most clearly signaling higher risk for EBD are academic failure, hyperaggression, peer rejection, or association with deviant peers (Kauffman & Landrum, 2013). No research supports allowing risk-elevating problems to become severe before intervening. The most effective early intervention is early in two ways: (1) *earlier rather than later in the child's life* and (2) *earlier rather than later in behavioral sequences leading to increasingly maladaptive conduct*. Special education needs to be more proactive in preventing difficulties, but being proactive requires providing more and earlier services to more children, which is contrary to biases against preemptive action.

PREVENTION-PREVENTING BEHAVIOR

Special educators, psychologists, and others involved in children's mental health programs do not set out to prevent prevention deliberately, but they often engage in behavior and encourage attitudes that make prevention impossible. These individuals are not malicious (see Kauffman, 2009), but their well-intentioned decisions often have the effect of stopping prevention in its tracks. I describe 10 ways of undercutting prevention, which are not mutually exclusive but complementary.

1. Show Greater Concern for Labeling and Stigma than for Prevention

Probably the most frequent and fervid objection to early intervention is that the child will be labeled and stigmatized (see Kauffman, 2010, 2013). Universal interventions that apply to all, regardless of their behavior, can be implemented without labeling an individual. However, no other interventions are possible without labels. Either all students are treated the same or some are treated differently. Any student who is singled out and treated differently is inevitably labeled. Communication about individual differences is impossible without labels for differences. And, if a label for EBD does not indicate what is wrong – if it describes EBD as something desirable – then it is a cruel hoax (Anastasiou & Kauffman, 2011; Kauffman, 2013).

Most children with EBD are already labeled informally by their peers, receiving the *label du jour* for misfits. Formal labeling by professionals may help avoid misunderstanding and rejection. Eventually, many of those with EBD are labeled unequivocally because their deviance becomes so outrageous that it can no longer be denied. Then they become clients of a variety of social systems, often including not only special education but also mental health and juvenile justice. Their social spoilage is assured by the fact that they did not have early and corrective treatment. Ironically, the horror people express for labels for comparatively benign problems heightens the stigma of labels and fosters the eventual use of more demeaning labels for severe social deviance. Helping people understand the meaning of labels may be a better choice than trying to avoid the labels we have (see Jamison, 1995; Kauffman, 2013).

2. Object to a Medical Model and to Failure-Driven Services

Some critics of special education object to a medical model and call it failure-driven. However, special education is much more aligned with the legal model than with the medical model (see Kauffman, 2007). But, to the extent that either law or medicine is preventive, it is driven by failure – actual failure or the anticipation of it. Safety laws are designed to prevent the failures we call accidents. Preventive medicine is designed to prevent the failures we call illness or injury and their complications. The complaint that special education and related services are badly structured because they are failure-driven is simply illogical. *Prevention is by definition, regardless of the profession in which it is practiced, designed to avoid initial failure or further failure and complications and is, therefore, failure-driven by necessity.*

3. Choose False Negatives Over False Positives

Every known attempt to practice prevention results in errors, which is to say that no preventive program in any field yields perfect predictions, although some are

more accurate than others and greater accuracy is always desirable. Every known prevention strategy produces false positives and false negatives, and one type of error must be weighed against the other. In medicine, a false negative (overlooking pathology or failing to prevent it) is the primary concern. False positives (diagnosing pathology where none exists or inoculation against disease that would not occur) are not taken lightly, but the primary concern of the physician is not missing pathology and not failing to prevent it. In law, quite the opposite applies – it is the false positive (false conviction or false accusation) that is the horror most assiduously avoided, not the false negative (false acquittal or failure to rightly accuse). Special education seems to be more like law in its horror of false positives and preference for false negatives (see Kauffman, 2007).

High-profile cases of school violence highlight the need for prevention in the minds of the public and many professionals, but these cases are probably not the most important. Less riveting but much more important are the less highly visible and more common antisocial acts, the acts that are often ignored and lead to false negative decisions. These often do not cause public outrage, and often there is no intimation that they are psychopathological. Coercion, bullying, disruption, social isolation, and threatening behavior are examples of conduct that should induce preventive action by educators, but often educators do not take preventive action because they fear the false positives.

Effective secondary prevention requires us to intervene at the earliest stages of misconduct, not wait until acceleration has begun (see Kauffman et al., 2002; Kauffman, Pullen, et al., 2011). Early, preventive action requires recognizing the precursors of more serious difficulties. Smith and Churchill (2002) described how functional analysis of precursor behaviors was important in preventing more serious difficulties. Yet, educators are often unwilling to intervene in precursor behavior (e.g., aggressive talk and talk of aggression) because such talk is not always followed immediately by aggressive acts. Youngsters themselves or their parents or observers may complain about restriction or repression when teachers take preemptive action based on precursor behaviors, further strengthening the tendency to circumvent early intervention. Hence, false negatives are far more common than are false positives.

4. Propose a 'Paradigm Shift' that Blocks Prevention

A popular 'paradigm shift' obviates the need for classification of students. Its champions suggest that all students can be taught well without distinguishably different instruction or behavior management because everyone will be treated individually and no one will need to be considered a 'special' case. In the 'new paradigm', prevention is pervasive but imperceptible. But we cannot prevent what we are unwilling to say is different from the typical or normative, nor can we practice anything other than primary prevention if we are unwilling to categorize interventions as special (see Kauffman, 2011; Kauffman, Nelson,

Simpson, & Mock, 2011; Sasso, 2007). In short, special education is rendered very *not* special by a paradigm that suggests general education should teach *all* children well (see Zigmond & Kloo, 2011).

A 'paradigm shift' might attack the scientific bases of special education practices, suggesting that alternative, non-scientific paradigms are morally superior (see Kauffman, 2011; Sasso, 2007). This gambit undermines applied behavior analysis research, leaving a vacuum into which punitive 'craft knowledge' may be drawn. Although craft may well be important, it must be based on a science of education, not simply left to intuition or assertion. Prevention is thwarted by any 'paradigm shift' that (1) condemns singling out individuals for special treatment or (2) rejects the legitimacy or superiority of science for figuring things out. Such a shift puts prevention in reverse. It is regressive, requiring the denial and distortion of what we know and the adulation of wilful ignorance (see Anastasiou & Kauffman, 2011; Kauffman, 2011; Kauffman & Sasso, 2006a, 2006b; Sasso, 2001, 2007).

5. Call Special Education Ineffective

Sometimes special education's ineffectiveness has been merely intimated, not stated directly. Sometimes the claim that special education has not 'worked' or cannot work as intended is made directly and unequivocally (e.g., Bolick, 2001; Gartner & Lipsky, 1989). Special education is seen by some as second rate and demeaning to those it serves, as a malicious enterprise (see Kauffman, 2009 for discussion of this charge). If one concludes that on balance special education is ineffective, then preventive intervention at any level, if it involves special education, is a hoax. One should therefore do everything possible to keep children out of special education, and to keep them in general education, where they are assumed to be better off.

The conclusion that, on balance, special education does more harm than good is not justified by a logical analysis of the data (Kauffman, 2009). But here is a logical conclusion: to the extent that we believe that special education is ineffective, our preventive efforts as special educators are undermined.

6. Misconstrue Least Restrictive Environment and Least Intrusive Intervention

Restriction has social costs, as does nonrestriction. Enthusiasm for minimally restrictive environments hides the fact that minimum restriction in the present may require greater restriction later. A minimally restrictive environment is not necessarily the place in which people without disabilities thrive, and some environments, thought to be more restrictive, apparently facilitate the social and academic learning of students with EBD more than environments considered less restrictive (see Brigham & Kauffman, 1998; Crockett & Kauffman, 1999; Kauffman & Brigham, 2009; Kauffman, Bruce, & Lloyd, 2012).

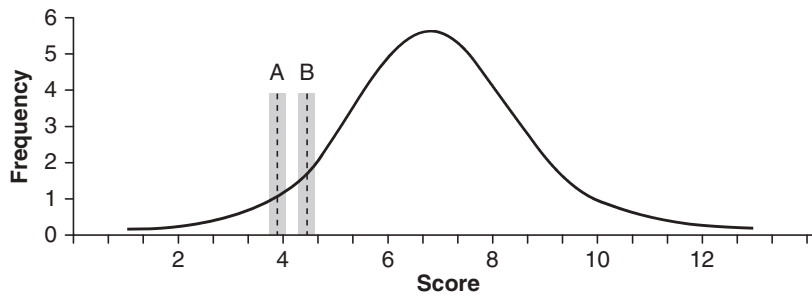


Figure 36.1 Near-normal statistical distribution of a continuously distributed variable

The least restrictive environments and least intrusive interventions can be implemented earliest in a pattern of behavior leading to more serious misconduct (Walker et al., 2004). However, after misbehavior has accelerated, the *formerly* least restrictive or intrusive is very unlikely to be effective. Emphasis on minimizing intrusion and restriction without careful attention to the behavior pattern results in a chain of increasingly intrusive and restrictive but decreasingly effective interventions. Prevention requires addressing the precursors of more serious misconduct. Keeping environments least restrictive and interventions least intrusive *in the long term* requires something counterintuitive and typically judged desirable in a medical model but unacceptable in a legal model – intervening earlier to avert maladaptive behavior by anticipating it, rather than waiting for the misbehavior to occur.

7. Protest the Percentage Served by Special Education and Uncertainty in Identification

A commonly heard opinion is that children are overdiagnosed and that special education has grown too large, not only in the percentage of time, effort, and money schools spend on it but also in the percentage of the school population receiving it. A common related opinion is that we are uncertain about just which children should be identified and that many are misidentified as needing special education. These views are extraordinarily problematic because *far* less than half of the youngsters with EBD have been identified for special education, and they are typically identified only after they have had serious problems for many years (Forness et al., 2012; Kauffman & Landrum, 2013). Prevention in an underserved population requires serving more individuals, not fewer. This is illustrated in Figure 36.1, which depicts a near-normal statistical distribution of a continuously distributed variable. Assuming that it represents measurement of social behavior, such that deviant or unacceptable behavior is represented by the left tail of the curve and that greater distance from the central tendency means greater social deviance, moving the criterion for identification closer to the central tendency necessarily designates a greater number of individuals. For example, moving the

criterion for intervention from A to B (i.e., from more to less deviant behavior) shows that an increase in the number of individuals included is inevitable. The gray areas paralleling lines A and B represent hypothetical measurement error – uncertainty that the individuals identified actually *should* be identified. The uncertainty will apply to a greater number of individuals when the criterion for EBD is moved from A to B.

Figure 36.2 is an approximation of the relationship between number of individuals and a given level of severity of EBD. Assume that a higher score (on the X axis) indicates greater social deviancy or more severe difficulty. Then, regardless of the slope of the line (straight or curved, steep or gradual), moving the criterion for intervention to less severe difficulties – moving right to left (e.g., from A to B or C) – includes a greater number of individuals (or a greater proportion of the population). The conclusion that prevention inevitably requires serving more individuals, at least initially, is a logical outcome of the observation that prevention means early intervention – intervening before problems become so severe and catching problems in their earlier stages. This statistical, mathematical phenomenon does not require speculation, merely knowledge of the relatively simple mathematics involved (Kauffman & Lloyd, 2011).

8. Complain that Special Education Already Costs Too Much

Most law-makers and voters are concerned about immediate cost, not long-term cost. But concern for lowering cost by denying services may actually increase the eventual cost of responding to social deviancy. In fact, economic analyses suggest that cutting effective services is very costly in the long term. Long-term follow-up programs of early intervention for young children at high risk of school difficulties show about a 2:1 ratio of long-term savings. The savings include increased tax revenues from people who are employed, decreased reliance on social welfare, reduced costs for services like special education, emergency medical care, and stays in homeless shelters, and lowered costs for criminal justice.

Across the few rigorous economic evaluations done to date, the conclusion that government savings ultimately exceed costs for early intervention programs means that public investment in these programs can be justified. There are additional monetary benefits to society for early interventions, as well as intangible benefits (i.e., well-being) that improve the value of such investments. (Kendziora, 2004, p. 342)

We should take into consideration the reduction in anxiety and suffering that effective early intervention avoids. Prevention seems to be a good idea both morally and economically.

9. Maintain Developmental Over-Optimism

Those who work with young children tend to be overly optimistic about children's development, leading to the assumption that early signs of behavioral

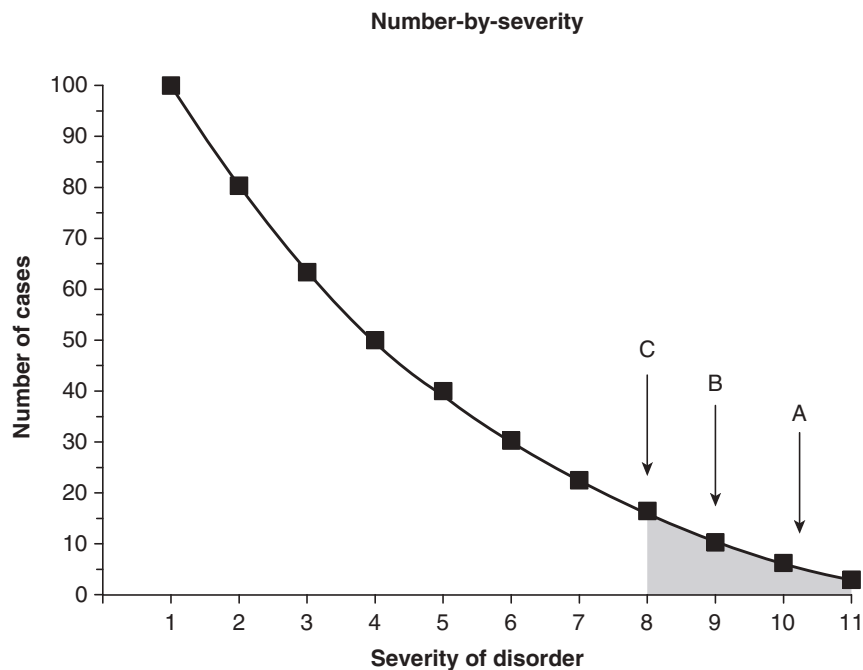


Figure 36.2 Approximation of the assumed relationship between number of individuals and severity of emotional or behavioral difficulties

difficulty do not predict a stable or increasing pattern of maladaptive behavior. Their assumption is that the child will ‘grow out of it’ or improve spontaneously. True, some children do; many do not. But the overly optimistic attitude often means that preventive action – deliberate correction of difficulties – is delayed until the problem is severe.

10. Denounce Disproportionality, Defend Diversity, Deny Deviance

Guilt for past ignorance of or insensitivity toward racial, ethnic, and cultural differences and fear of being accused of such horrors may stop prevention. In the United States, at least, African American children are disproportionately identified as having EBD. Although this phenomenon is poorly understood, it is frequently thought to be the result of racism or insufficient cultural sensitivity. Moreover, diversity has become a matter of such intense concern that educators are often unwilling to see a difficulty, preferring to call it cultural diversity. Linking the civil rights of ethnic minorities with the right to appropriate education of students with disabilities further exacerbates the problem (see Kauffman & Landrum, 2009). The point is, that if we confuse EBD with acceptable diversity or deny its deviance, then we are unlikely to try to prevent it.

CONCLUSION

Preventing EBD is not a unique problem. Prevention, in general, almost always is an up-hill battle (Specter, 2009). Our behavior as educators may be a function of the behavioral and social-cognitive phenomena of delayed negative reinforcement for prevention (in which problems are averted, but long after the fact of preventive action), immediate positive reinforcement for doing things that stymie prevention (social approval of others for doing the 10 things I mentioned that stop prevention), and modeling of prevention-preventing behavior (i.e., 'leaders' provide powerful models of anti-prevention through using the arguments against prevention that I mentioned – see Kauffman, 1999, for further discussion).

The arguments against prevention must be taken seriously because they raise important issues that cannot be dismissed lightly. Ignoring these legitimate concerns carries high cost, regardless of the fact that they are often used to defeat prevention. Ultimately, the cost of failure to practice prevention is even higher. But one cost must be weighed against another, and there isn't a no-cost decision about EBD. Moreover, preventing prevention is understandable when educators receive immediate approbation for their objections to the action required for prevention but long-delayed condemnation for false negative judgments.

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