When Universal Approaches and Prevention Services Are Not Enough: The Importance of Understanding the Stigmatization of Special Education for Students with EBD
A Response to Kauffman and Badar

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We want people to care about young people's EBD and to see EBD as undesirable but to see it as a treatable condition and to support more effective ways of treating it.

—Kauffman and Badar, 2014, p. 26

This quote from Kauffman and Badar's paper titled "How We Might Make Special Education for Students with Emotional or Behavioral Disorders Less Stigmatizing" is central to their discussion and provides a critical message to the field of special education for students with emotional and behavioral disorders (EBD). Implicit in this sentence are two concepts one might think go without saying: (a) youth who experience EBD have a condition that negatively impacts development and contributes to long-term adjustment problems; and (b) there is a need for intensive and comprehensive intervention to help foster adaptation and promote more positive outcomes in youth with EBD. Further, a logical extension of these two concepts is that programs designed to effectively support the education and treatment of youth with EBD are desirable and provide an important service that enhances the lives of these students and their families. Yet, as Kauffman and Badar suggest in the title and summarize in the article, identifying youth as having EBD and providing treatment for them is viewed to be stigmatizing by many people, which, in turn, has constrained both the support and use of special education and related services for EBD.

I began working with children and young adults with disabilities and EBD in the early 1980s. When I first began, I thought this was difficult and emotionally demanding work, but I also found it to be highly rewarding and personally satisfying. Most notably, I thought this was very important work—the kind of work that makes a meaningful difference in the lives of others and the kind of work that others view as both extremely necessary and invaluable. Over the years, I've found many aspects of being in the field of special education for youth with EBD to be challenging, but I have remained steadfast in my sense that this is important work. However, I no longer think many others outside of the field hold this work in high esteem. Further, I have been mystified by events, practices, and policies that, in the name of protecting youth with EBD from stigmatization, have resulted in creating additional obstacles and challenges for children and adolescents I view as being highly misunderstood and vulnerable to extremely poor outcomes. In their article, Kauffman and Badar take the issue of stigmatization head-on and instead of trying to avoid it or act like it should go away, they help us to see why we need to understand and systematically work to reduce its impact on special education for youth with EBD.

In this commentary, I build from Kauffman and Badar's article to examine the issue of stigmatization from four perspectives. First, I consider how efforts to avoid stigmatization may be related to current approaches to address emotional and behavioral problems in the general population. Second, I summarize my views of what has been lost in the field of special education by efforts to avoid stigmatizing youth with EBD. From this backdrop, I explore how the suggestions offered by Kauffman and Badar can help realize the promise of special education for students with EBD. I conclude with a discussion of the need to bridge the constructs of research and caring within the concept of community in treating youth with EBD.

Avoiding Stigmatization by Addressing EBD as a General Population Issue

In the past few decades, several advances have been made that are related to understanding the development of EBD. Further,
there has been considerable progress in terms of the establishment of effective interventions to prevent and reduce the impact of emotional and behavioral problems within the general population by improving behavioral and mental health support services in school settings. These advances are highly welcomed and provide an important foundation for enhancing the treatment of students with EBD. However, in some ways, progress in the field may be supported by concerns about stigmatization, and these concerns and corresponding efforts to avoid stigma may have an unintended consequence of leveraging attention and resources away from students with chronic EBD and the intensive treatment they need.

Developmental Psychopathology and Preventive Interventions to Reduce EBD

Developmental psychopathology is the study of the interplay between biological, psychological, and social-contextual aspects of normal and abnormal development (Cichetti & Toth, 2009). Typically, research in developmental psychopathology uses longitudinal analytic frameworks to clarify processes and pathways that contribute to maladaptive outcomes over the life course, and that also distinguish problematic outcomes from adaptive ones (Bergman & Magnusson, 1997; Robins & Rutter, 1992). By identifying factors that contribute to adjustment problems and elucidating how these factors come together and can be modified in development, research in developmental psychopathology provides a strong foundation for the establishment of interventions to prevent and treat EBD (Cicchetti & Toth, 2009; Walker & Sprague, 1999a).

Research on risk factors and pathways that lead to EBD have been incorporated into prevention programs, but less work has focused on using developmental frameworks to guide treatment for youth who meet criteria for EBD (Forness, 2003; Walker & Sprague, 1999b). Leveraging developmental information to prevent rather than treat EBD involves a less complex level of intervention. Most prevention programs build from a cascade model which posits that the development of disorder involves multiple factors operating across multiple systems such that EBD emerges as problems accumulate and spread to other factors and systems (Masten & Cicchetti, 2010). From this vantage, intervention should start early in the developmental pathway to prevent the cumulative consequences of risk by stopping the spread of problems prior to the manifestation of disorder (Mrazek & Haggerty, 1994; Reid, 1993). With cascade models of prevention, the goal of intervention is to identify risks for EBD prior to or as they emerge and to intervene before they become chronic disorders (e.g., Conduct Problems Prevention Research Group, 1999; Dunlap et al., 2006; Jones, Brown, & Aber, 2011; Walker et al., 2009).

In many respects, the concept of prevention is a hopeful one and suggests the possibility of promoting adaptation. In contrast, treatment may be viewed as acknowledging that a child has a chronic disorder. Researchers and practitioners may view prevention as preferable to treatment and may be concerned about identifying a child for EBD services. This concern may build from three complementary views: (a) identifying a child for services may result in a stigmatizing label, (b) being identified and receiving special education services for EBD may constrain opportunities for growth, and (c) identifying the child for treatment means giving up hope for future adjustment. In some ways, this type of thinking builds from a cascade model of development and does not recognize the potential for developmental adaptation across the life course even in youth who experience disorder. Although the cascade model is an extremely valuable conceptualization of development and is appropriate for guiding the prevention of EBD, special educators and related service providers need to be aware of other models of development. Alternative models are needed to guide treatment that fosters positive adaptation and affirms the potential for special education services to promote more productive and desirable outcomes for youth with EBD.

Schoolwide Positive Behavioral Intervention Supports and School-based Mental Health

In recent years, there has been considerable progress related to supporting students' school adjustment. In response to discipline policies linked to the 1997 reauthorization of the Individual with Disabilities Education Act, Schoolwide Positive Behavioral Intervention Support (SWPBIS) programs have been established to create universal policies, structures, and practices aimed at promoting and reinforcing positive behavior throughout the school.
Community. Based on applied behavior analysis, universal screening, the integration of behavioral and education practices, and a multitiered prevention model, SWPBIS is an organizational framework and set of intervention approaches aimed at enhancing a school's capacity to promote positive behavior in all students (Horner, Sugai, & Anderson, 2010). Large-scale evaluations show that SWPBIS programs reduce student discipline referrals and suspensions (e.g., Bradshaw, Mitchell, & Leaf, 2010). Further, tiered models that merge universal SWPBIS with more selective and individualized interventions show promise for reducing emotional and behavioral difficulties in youth who do not respond to universal approaches (Reinke et al., 2014; Woodbridge et al., 2014).

In addition to SWPBIS programs, there has been a recent emphasis on school-based mental health services (Evans & Weist, 2004; Forness, 2011). Sometimes embedded within or designed to complement SWPBIS, school-based mental health programs may take a variety of forms. Such programs may involve placing mental health resources and professionals in schools to ensure their availability for all youth (e.g., Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008), reframing the roles of school counselors and school social workers to include support for universal and selective mental health services for students (see Mellin, 2009). These programs may also use school and community mental health professionals to provide consultation and coaching interventions to help teachers improve the classroom social interactions between students with behavioral difficulties and their classmates (e.g., Cappella, Jackson, Bilal, Hamre, & Soule, 2011).

Schoolwide Positive Behavioral Intervention Support and school-based mental health provide a critical base for a comprehensive system of services to meet the emotional and behavioral needs of all youth. Consistent with a prevention framework, universal aspects of such a system serve as a foundation to reduce risk factors for emotional and behavioral problems. Universal services not only impact the general population, they provide a structure and culture that is supportive of students who experience emotional and behavioral problems (i.e., students who need Tier 2 or Tier 3 strategies) and they help facilitate the delivery of intensive interventions. On this score, SWPBIS and school-based mental health have the potential to be core components of intensive treatment for students with EBD.

However, when a cascade model of prevention is paired with SWPBIS and school-based mental health services, and when concerns about stigmatization are added to the mix, a potential outcome is that youth who need comprehensive and intensive interventions will not be identified for special education services. One contributing factor to the nonidentification of students for special education is that school professionals may view SWPBIS and school-based mental health as sufficient alternatives for special education services for EBD. A second contributing factor is that emotional and behavioral problems may be viewed as transitory issues to be prevented or “fixed” rather than as a chronic disorder with a developmental trajectory that needs to be realigned with carefully coordinated services (see Farmer & Farmer, 2001). A third contributing factor is the stigmatization of being identified as having EBD and the allied concern that many EBD programs are not effective may result in the belief that placing a student in a special education program will be more harmful than helpful for her or his long-term developmental adjustment and corresponding adulthood outcomes. When these views converge, it is possible that key stakeholders will avoid identifying youth with EBD for special education.

Casualties in the Pursuit of Avoiding Stigmatization

Kauffman and Badar provide a thorough discussion and analysis of problems related to the stigmatization of special education services for EBD. To highlight what is in the balance, I outline three complementary casualties of efforts to avoid stigmatization that I believe coalesce to truncate EBD services and contribute to problematic outcomes for youth who need them.

The Identification of Students who Need EBD Services

As Kauffman and Badar point out, a perpetual issue in the field involves the discrepancy between the number of youth identified for special education for EBD and data on the prevalence of serious and chronic disorders (see Forness, Freeman, Paparella,
Beyond historical concerns about the substantial underidentification of youth for EBD services, in the past decade there has been a significant decline in the identification of students for EBD. Annual statistics on the number of youth served in special education show that after the passage of IDEA, 283,000 students were identified for EBD services in 1976 (NCES, 2013). By 2005, this number grew to 489,000 which marked a 73% increase and an annual growth rate of 2.5%. Since 2005, the number of students has steadily dropped, and by 2012 only 373,000 youth were served for EBD, which represents a 25% decrease and an annual decline rate of 3%.

Part of this decline may reflect the movement of youth from the EBD classification to new IDEA disability categories (i.e., Autism, Other Health Impaired). However, to put this decline in perspective, it should be noted that only 90,000 more students are served now than when the field began in the 1970s, and during this period there has been an increase of about 5 million students in the general population. Although it is possible that fewer youth have EBD, epidemiological data do not support this view (Forness et al., 2012). A more parsimonious explanation is that school districts are increasingly hesitant to identify youth for EBD special education services. In the past two decades, my research team has worked in hundreds of schools across the United States. When we talk with school personnel about their special education services it has become increasingly common for districts to say they rarely or no longer identify students for EBD. School leaders often refer to concerns about stigma and they indicate that as alternatives they use SWPBIS and school-based mental health services or they identify students for other disability classifications and provide noncategorical services.

To illustrate this point, in a national study of over 7,000 rural high school students (including 512 with LD, 70 with EBD), we identified configurations of youth with distinct patterns of teacher-rated school adjustment. Students with EBD were overrepresented in multirisk (62%: aggressive with multiple academic, social, and emotional problems) configurations, while students with LD were overrepresented in both multirisk (23%) and disengaged (28%: nonaggressive with multiple academic, social, and emotional problems) configurations (Farmer et al., 2011). Further, 830 nondisabled students (13%) were identified in the multirisk configuration. In companion work with a subsample that included 78 students with EBD and 352 nondisabled matched control classmates, we compared students on their self-reports of school belonging and school valuing and teacher ratings of their academic performance and expected educational attainment, including perceived likelihood of completing high school and continuing their education (Farmer et al., in revision). Girls with EBD and girls in multirisk configurations were lower on teacher-rated academic performance than all other girls, multirisk girls had lower levels of school belonging than all other girls, and girls with EBD had lower levels of teacher expectations for educational attainment. Boys with EBD and boys in multirisk and disengaged configurations had lower school belonging than other boys, boys with EBD and boys in multirisk were lower on teacher-rated academic performance, and boys with EBD and boys in multirisk and tough (i.e., popular-aggressive) configurations were lower than other boys on teachers’ expectations for educational attainment.

Together, these two studies demonstrate that youth with EBD have significant adjustment problems in high school, struggle academically, and are at risk for not completing school and not continuing their education after high school. Further, these studies suggest that many students with learning disabilities and many nondisabled students have school adjustment problems that are highly similar to youth with EBD and are also at risk for poor outcomes. Therefore, while these findings suggest that many youth with EBD need more intensive services to support their school adjustment, they also suggest that many youth who have similar adjustment difficulties are not being identified for special education services for EBD and also appear to need more intensive and comprehensive services to promote their adaptation and productive outcomes.

**Fostering Adaptation and Productive Futures of Youth with EBD**

Kauffman and Badar point out that some opponents of special education for EBD argue that such services are both stigmatizing and unnecessary because, the opponents claim, problem behavior is culturally defined, socially constructed, and not a disability. The view that chronic adjustment problems are not disabilities reflects a critical misunderstanding.
of the role of behavior in development. Developmental science indicates that youth develop as an integrated whole with a synthesis of contributions from behavioral, biological, psychological, and social-ecological subsystems (Cairns, Elder, & Costello, 1996). These subsystems work together as a coactive system in which no single factor operates as a cause in the developmental process (Gottlieb, 1996). However, behavior functions as a leading edge in development by serving as a conduit between various subsystems and aligning factors internal and external to the individual (Cairns, 2000). The offshoot of this process is that behavior is the mechanism that facilitates adaptation. When youth have chronic adjustment problems these problems indicate difficulty in the capacity of the subsystems to align in positive ways and the ability of behavior to foster productive adaptation and reorganization of the developmental system (Farmer & Farmer, 2001).

The implication for special education for youth with EBD is that sustained adjustment problems reveal a disability in one of the primary features of human functioning—the ability of the individual to synchronize his or her abilities and needs with the resources and demands of the ecology in which he or she is embedded. Simply put, EBD is a disability in the capacity to adapt. Chronic emotional and behavioral problems are not simply cultural differences, inappropriate demands of the environment, or poor learning. Instead, they reflect a system of correlated risks across multiple developmental subsystems that constrain behavior patterns and maintain stability in each other (Farmer, Quinn, Hussey, & Holahan, 2001). As suggested above in the discussion of developmental psychopathology, there is clear evidence that chronic EBD and associated poor outcomes are products of the dynamic interplay between neurobiological, behavioral, ecological, psychological, and sociological subsystems (Bergman & Magnusson, 1997; Cairns & Cairns, 1994; Cicchetti & Toth, 2009; Robins & Rutter, 1992). However, differences in conceptual frameworks about how these subsystems work together to contribute to disorder can impact our understanding about the treatment of EBD and the potential for enhancing students’ outcomes.

To facilitate more effective treatment and to promote more positive outcomes for youth with EBD, it is necessary to distinguish between two models of the development of disorder. As discussed above, a cascade model of development posits that risks factors accumulate over the course of development and spread to other levels and subsystems until a disorder is manifested (Masten & Cicchetti, 2010). This metaphor provides an image of a waterfall and gives a sense that intervention needs to occur before problems become so pervasive the child’s development passes a point of no return—the development of disorder. The cascade model is helpful for understanding the processes and pathways of the development of disorder and provides an excellent guide for creating preventive interventions. However, this model does not depict how the developmental processes experienced by youth with EBD can help guide treatment to foster their developmental adaptation and corresponding productive outcomes.

A developmental synthesis/correlated constraints perspective (Cairns & Cairns, 1994) offers an alternative to the cascade model and is particularly well suited for guiding efforts to treat EBD. From this perspective, multiple subsystems operate together in a coalesced system so each subsystem bidirectionally influences the features of the others (Sameroff, 1995). In this way, development tends to be conservative and promotes continuity in the characteristics of the developmental subsystems and stability in behavioral patterns (Magnusson & Cairns, 1996). However, a paradox of the developmental synthesis perspective is that the mechanisms that promote continuity in the system and in behavior also promote change in both. This is because these subsystems are bidirectionally aligned with each other so change in one factor can foster developmental adaptation by promoting change in the entire system. For this to occur, change in a subsystem must promote change in behavior, and change in behavior must promote change in one or more other subsystems and facilitate the eventual reorganization of the developmental system (Farmer et al., 2001). An important aspect of this perspective is that the potential for major adaptation can occur even after significant problems are manifest as EBD.

The cascade and correlated constraint models are not competing perspectives. Rather, they are complementary theories that collectively explain the development of disorder from the presence of general risks to the manifestation of chronic syndromes and, as such, serve as a guide for the development of a system-of-care ranging from universal prevention to comprehensive multiagency treatment.
services (Farmer, Farmer, Estell, & Hutchins, 2007). Specifically, the cascade model focuses on intervening before one or more risks become a catalyst that promotes the negative reorganization of the developmental system (i.e., the manifestation of disorder), whereas the correlated constraints model provides a framework to guide interventions aimed at reorganizing the developmental system when a child experiences problems across multiple subsystems that reflect the presence of EBD (Farmer & Farmer, 2001).

A correlated constraint model provides insight into developmental processes that can be leverage points in treatment. From this perspective, the development and maintenance of EBD involves coalesced contributions of difficulties in a combination of subsystems that may include neurophysiological problems (Gatzke-Kopp, Jetha, & Segalowitz, 2014), emotional/behavioral regulation problems (Beachaine et al., 2013), social-cognitive deficits (Dodge, 2009), trauma-related sequelae (Burris, 2013), coercive family processes (Patterson, 1982), coercive interactions with teachers or peers (Shores & Webby, 1999; Webby, Symons, & Shores, 1995), and problematic social roles and affiliations (Farmer & Hollowell, 1994). To address these problems, it is critical to have strong behavioral interventions that focus on both the proximal functions (Umbreit, Ferro, Liaupsin, & Lane, 2007) and the social functions of behavior (Farmer, Lane, Lee, Hamm, & Lambert, 2012).

Although behavioral interventions are necessary, for many students such interventions may be insufficient without other forms of treatment (see Farmer et al., 2001; Forness, 2011). Unitary behavioral interventions may be most effective when behavior problems have not been manifested as EBD and the student experiences a developmental system comprised primarily of positive correlated constraints that fits within a cascade model of intervention (Farmer & Farmer, 2001). However, youth with EBD have neurophysiological difficulties that may impact their processing of rewards and the outcomes of some forms of behavioral intervention (see Gatzke-Kopp et al., 2009). Further, because the developmental system of youth with EBD is composed of a variety of problematic subsystems that collectively constrain and support problems in each other, intervention should be carefully coordinated to promote behavioral change, change in potentially malleable factors, the reorganization of the developmental system, and the eventual realignment of the youth's developmental trajectory (see Beachaine, Neuhaus, Brenner, & Gatzke-Kopp, 2008; Farmer & Farmer, 2001; Gatzke-Kopp, Greenberg, Fortunato, & Coccia, 2012). This is likely to be a very long, intensive, and dynamic process, and for many youth it may require services and supports into adulthood (Farmer et al., 2007). Yet, with careful coordination and sustained supports involving evidence-based services within a system of care, the impact of EBD may be reduced and youth may establish productive adult roles and lifestyles.

Categorical Services and Training for EBD Specialists

Since the 1990s, special education teacher training, professional development programs, and school-based services have become increasingly noncategorical. Further, in the past decade, many preparation programs for general education teachers infuse training on the characteristics and instructional needs of diverse learners including students with disabilities. Collectively, these changes are designed to help create a general context that is supportive of all students regardless of their disability status and learning difficulties. The rationale for such changes include concerns of equity, perceived advantages of creating universal social ecologies that promote diversity and tolerance of differences, and the belief that the concept of accessibility should span all levels of human functioning and not just physical barriers. However, as Kauffman and Badar suggest, the proliferation of generic services also reflect concerns about stigma and the view that special education is in some way less effective and less desirable than general education.

Although the concept of universal services and inclusive school ecologies are significant advances in education, I do not believe generic special education services coupled with universal SWPBIS and school-based mental health services can replace the types of supports necessary to address intensive, complex, and multifactored intervention needs of students with chronic EBD. In noncategorical university courses I have recently taught on behavior management, I am not able to provide coverage at a level I believe is adequate preparation for teachers who will work with students with EBD. In addition, as
compared to preservice students I taught in categorical programs in the 1990s, students in noncategorical training programs have less of a background in the theory and characteristics of EBD and do not have the foundation necessary to learn about how to conduct and coordinate intensive and comprehensive interventions students with chronic EBD need. The complexity of the problems students with EBD experience and the corresponding types of interventions they need requires the supports of highly trained specialists who can work across a range of strategies and contexts. Reducing stigma should not occur at the cost of the intensive services that are necessary to enhance the adaptation and outcomes of youth with EBD or the preparation of the types of professionals who have the skills to provide such interventions.

**Realizing the Promise of Minimizing Stigma: The Suggestions of Kauffman and Badar**

Kauffman and Badar identify four ways in which special education for students with EBD can be made less stigmatizing. First, they suggest that, as a field, we talk about differences in plain language. They contend that efforts to find the "right" word or to "rebrand" a particular phenomenon with a less stigmatizing label is likely to have little sustained impact over time as people come to understand that the new word represents the same construct as the less favorable word it replaces. Further, they suggest that euphemisms for disabilities can cause harm when it is perceived that the goal is to conceal the shame associated with the term that is avoided. Instead, they argue for changing people's minds about the referent and helping them see it in a positive light. To do this, Kauffman and Badar maintain that words to describe and discuss disability should reflect directness and promote the public's understanding of the condition, and they argue that empirical work is needed to clarify how different approaches impact perceptions of EBD.

I agree that the focus should be on "plainness and understandability" and I concur that research can help to elucidate how to promote productive perceptions of EBD. However, I offer one caveat: plainness and directness should not be confused with simple. The development of EBD is a complex process, but the problematic emotions and behaviors that characterize EBD are seen in all children. Such concepts as frequency, intensity, and duration help distinguish between a transitory problem and a disorder. Our understanding of the differences between the two in terms of etiology and development are now much clearer than when special education began. I contend we need plain, direct language to make the developmental complexity of EBD understandable, and to help promote public awareness that when effective treatment is provided, adaptive pathways for youth with EBD can be fostered and positive outcomes can be realized.

Kauffman and Badar's other three suggestions come together to consider how a focus on reducing stigma involves enhancing special education services for students with EBD. First, Kauffman and Badar propose we accept the reality of what EBD means for education and they argue that educators should not treat all students the same despite differences that impact their learning, but instead need to understand the implications of distinct student characteristics that are meaningful for instructional and educational practices. They emphasize that to reduce stigma, the field must accept that youth with EBD do not have typical instructional needs and ordinary services will not improve their lives or educational outcomes. I strongly agree with these points, but I believe we need to take our understanding of differences a step further. Differences are not simply in students' learning characteristics and social behavior. I contend the field must also recognize that interventions for EBD should involve a different approach from those that are effective with youth who are on a typical developmental trajectory. We must acknowledge that a system of problematic correlated constraints (i.e., the manifestation of EBD) requires treatment that: (a) fosters rather than prevents reorganization of the developmental system of youth with EBD; and (b) promotes rather than prevents the realignment of their developmental trajectories.

Next, Kauffman and Badar suggest that the field should emphasize benefits and the skills needed to provide them. Here they argue that better research is needed to understand and clarify the benefits of special education services for youth with EBD, and to identify the types of skills that teachers need to best realize these benefits. They contend the stigma of special
education for students with EBD can be reduced when we make clear why it is needed, we document benefits students experience by receiving it, and we emphasize the unique skills teachers need to promote positive outcomes in students with EBD. Again, I concur with Kauffman and Badar’s points and I agree with their contention that it is not appropriate to gauge the effectiveness of outcomes of students with EBD by comparing them to outcomes of students in other groups. As they imply in this discussion, we need more realistic definitions and measures of what constitutes success for students with EBD. As I argue above, I believe students with chronic EBD have a disability in the capacity to adapt. The very nature of this disability is that it constrains adjustment and associated success in typical functioning. This does not mean youth with EBD cannot adapt and achieve positive outcomes, but it does mean they are likely to need continued supports and a range of services that focus on meeting their dynamic developmental needs and corresponding iterative assessments of success to help guide them toward achievable productive outcomes.

Kauffman and Badar’s final point is that we need to try to make special education for students with EBD what it should be. Here they acknowledge the need for improvement in all of special education and they assert that, as a concept, special education is an appropriate response to the needs of students with EBD but the services are not always what they should be. They emphasize that concerns about who is identified for EBD services and who is not should be reframed with the view of providing youth who have emotional and behavioral problems the types of instructional and school experiences that are scientifically supported to be most effective for them. As they suggest, this is an ongoing process of research and refinement of the scientific evidence to make the process and delivery of special education services align with the treatment needs of youth with EBD. A major point here is that the stigmatization of EBD services will be reduced when they are perceived to be effective approaches that enhance the lives of youth who need and receive them. This is a critical point and implicit in this view is that we must recognize our efforts as being an ongoing process that should be continually guided by advances in science. On this score, my own view is that while we continue to make advances in the field, we are, in some ways, too limited in our focus with an overemphasis on strict applied research that centers on validating intervention approaches at the cost of more basic research on the developmental processes that impact the effectiveness of such approaches. Tremendous advances have been made in developmental science/developmental psychopathology that have direct implications for the education and treatment of students with EBD. We not only need to learn and build from such advances, we should also be part of the conversation on basic research to ensure that our knowledge and understanding of working with youth with the most significant and chronic disorders is effectively included in research to clarify the processes that contribute to EBD.

Conclusion: A Community of Research and Caring for Youth with EBD

The issues and considerations raised by Kaufman and Badar bring to the forefront the potential impact of the stigmatization of special education for students with EBD. This includes the likely underidentification of students who experience EBD as well as the underutilization and truncated delivery of the services that students with EBD need to enhance their adjustment and long-term outcomes. But the issues go beyond this. Specifically, with the focus on providing generic universal services and avoiding categorical approaches to special education services, we are not only not preparing the types of professionals that are needed, we are also not moving the field forward in terms of taking advantage of research on the development and maintenance of emotional and behavioral problems and the corresponding processes that lead from emerging difficulties to the manifestation of disorder. Much has been learned over the last three decades. However, special education has been slow to incorporate findings from developmental science and developmental psychopathology into the establishment and delivery of services to students with EBD. Likewise, the field can benefit by embedding this knowledge into preservice and professional development training for special education teachers and related services providers.

Kaufman and Badar are forcefully telling us we must accept EBD for what it is. It is a chronic disorder in the ability to adapt and it has the potential to have an extremely
debilitating impact on individuals across their life course. However, they are also telling us that EBD does not need to have devastating consequences and special education is uniquely well situated to help ameliorate these consequences. But most importantly, Kauffman and Badar are encouraging the field to be cognizant of the need to systematically focus on reducing the stigmatization of special education services for students with EBD by ensuring the provision of effective services and conducting research to not only improve such services but to also identify ways that reduce the stigma of these services.

In reading this article, I repeatedly had strong feelings I previously had over two decades ago when my wife and I were treatment foster parents for an early adolescent with severe EBD. During the years he was with us, we routinely struggled with peoples’ perceptions about three things that are relevant to the present discussion. First, people we came in contact with (the public, friends, and relatives) routinely had difficulty understanding that this child was not like everybody else and that he needed very different types of supports than most youth his age. Second, others (i.e., nonprofessionals) would often think positive changes in his behavior in the short-run meant he was cured and no longer needed intensive services. Third, everyone (both nonprofessionals and professionals) looked at this youth from the perspective of how to make the present moment work, whereas we were constantly thinking about his future and considering how what we did now might impact his adaptation into adulthood. As I look back now at those feelings through the lens of this article, I realize that we were constantly fighting a battle between stigmatization, misperceptions, and our own strong desires to the right thing and make a difference when it wasn’t always clear to us what the right thing was.

Kauffman and Badar are telling us that this battle continues, but they are offering us a message and a pathway. The message is that it is up to us as a community of professionals to address concerns about stigmatization and corresponding misperceptions, and to clarify for both ourselves and the public how what we do makes a difference. The pathway is conversation and research. The conversation needs to be both among the community of professionals including teachers, other related service providers, program directors, research-ers, and university faculty and between the community professionals, our students and their families, and the public. The conversations need to be about perceptions and solutions, but it also needs to be about successes and it needs to have at its core a sense of caring—a sense that youth with EBD need the care of a community. The research aspect of the pathway needs to involve the systematic examination of stigma and how to reduce it. But this goes beyond the explicit focus on understanding stigma and includes an agenda of continual improvement in special education by conducting both basic and applied research that enhances our knowledge about the development and treatment of EBD.

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