The vague and incomplete federal definition of emotional disturbance has caused a great deal of controversy and debate since the inception of Public Law 94–142. The lack of resolution among professionals attempting to elucidate the distinction between emotional disturbance and social maladjustment has resulted in continued conflict. Included in this debate are (a) whether students who are socially maladjusted should be included in the federal definition of emotional disturbance; (b) whether students identified as socially maladjusted should receive services; and (c) whether differential treatment for the two groups is warranted. In this article we provide a rationale for differential treatment between these two disorders as well as pertinent interventions tailored to meet the needs of individuals identified with emotional disturbance (ED) and social maladjustment (SM). © 2004 Wiley Periodicals, Inc.

The advent of Public Law 94–142 and its subsequent reauthorization, the Individuals with Disabilities Education Act (IDEA 1997) formally established emotional disturbance (ED) as a distinct special education category. The definition of ED however, excludes children who are socially maladjusted (SM) from receiving special education services unless they are also deemed seriously emotionally disturbed (Clarizio, 1992a). Not surprisingly, the federal criteria have been admonished for its vague and incomplete definition. There has been and continues to be a great deal of debate and controversy with respect to whether students who are socially maladjusted should be included in the federal definition of emotional disturbance. In the same vein, there is conflict surrounding the issue of whether students identified as socially maladjusted should receive services. Consequently, there is the pivotal question of whether differential treatment for the two groups is warranted. Our purpose here is to provide a rationale for the differentiation of treatment as well as provide relevant interventions for individuals identified with ED and/or SM.

**Definition**

The diagnosis of Emotional Disturbance as stipulated by IDEA (1997) is characterized by the identification of one or more from the following five domains: (a) an inability to learn; (b) an inability to build or maintain relationships; (c) inappropriate behavior or feelings; (d) pervasive mood of unhappiness or depression; and (e) a tendency to develop physical symptoms or fears. Eligibility further requires that the characteristics be evidenced frequently and intensely, as well as negatively impact students’ academic functioning. Based upon this current functional blueprint, students whose behavior and learning characteristics meet the qualifying criteria come under the official purview of IDEA.

What is not addressed and clarified is the definition of social maladjustment. Further, the equivocal nature of the social maladjustment exclusionary clause lends an element of uncertainty to the diagnostic process. Since its inception, individuals have argued regarding the distinction between emotional disturbance and social maladjustment (Clarizio, 1992a). In the absence of such a definition, individuals have attempted to formulate a working interpretation of social maladjustment. These definitions have included an explication of social maladjustment based on the
taxonomy of the *Diagnostic and Statistical Manual of Mental Disorders* (Slenkovich, 1983) as well as equating social maladjustment with terms such as conduct disorder (CD), delinquency, behavior disorders, and antisocial disorders (Costenbader & Buntaine, 1998).

Unfortunately, the loosely operationalized terminology that has been employed in the literature has met with confusion and continued attempts for modification. Generally, professionals discriminate these two disorders based upon evidence of an emotional disturbance versus manifestation of severe antisocial behavior.

**Differentiation of Social Maladjustment and Emotional Disturbance**

Proponents for the exclusion of students who are socially maladjusted from receiving special education services underscore the notion that these individuals engage in deliberate and purposeful behavior. These students typically exhibit a constellation of behaviors that include lying, intimidation, engage in acts designed to net personal gain, avoid responsibility, engage in illicit substance abuse, and destruction of property (Clarizio, 1992a; Clarizio, 1992b; McGhee & Short, 1991). In addition, they demonstrate little remorse for their behavior, are considered to be “streetwise,” and are unwilling to comply with rules (Clarizio, 1992b; Stein & Merrell, 1992). With respect to the social milieu of the classroom, students who are socially maladjusted appear to need a great deal of novelty and excitement (Clarizio, 1992b). Their manner may be further characterized as noisy, with frequent use of acidic language, and aggressive behavior (Clarizio, 1992b). Finally, and particularly noteworthy, students themselves as well as the legal establishment view the behaviors of individuals who are socially maladjusted as being squarely within normal psychological parameters (Clarizio, 1992b; Kelly, 1990). In sum, these students eschew conventional standards of behavior and their behavior may be considered strategic and consciously mediated.

Children with ED, however, generally show evidence internalizing behavior disorders and it is likely that emotional factors are implicated in their difficulties. In contrast to children who are socially maladjusted, the behaviors of students who are seriously emotionally disturbed are considered to be involuntary (Constenbader & Buntaine, 1999). More specifically, these students are extremely remorseful, self-critical, experience feelings of inadequacy, are anxious, do not have many friends, experience emotional difficulties, are inappropriately naïve, and are guilt-laden (Clarizio, 1992b; Stein & Merrell, 1992). Individuals with ED are typically quiet and reserved and generally dislike being the focus of attention (Clarizio, 1992b). Further, whereas students with SM have a need for excitement and change, individuals with ED prefer established routines (Clarizio, 1992b). Thus, it could be stated that their emotional needs are effectively competing with and utilizing other resources that might otherwise be utilized by academic and school demands. Hence, it appears that a key differentiation between these two disorders is the voluntary nature of the behaviors manifested. That is, are the behaviors considered to be strategic and deliberate or more emotionally driven?

It seems then, that a practical challenge confronting treatment is the certainty of differentiation between emotional disturbance and social maladjustment. Most certainly, the absence of a formal definition as well as the loosely operationalized terminology for social maladjustment has been historically problematic. Diagnosis is further complicated in that both disorders also evidence similar behavioral manifestations, such as delinquency and externalizing behaviors (Constenbader & Buntaine, 1999). Further, one of the characteristics of emotional disturbance, the inability to maintain relationships, may typify both social maladjustment and emotional disturbance. Thus, social maladjustment has been noted to be both included and excluded in the federal definition (Forness, 1992). The commonality of these behaviors has caused difficulty as well as disagreement with respect to the identification of emotional disturbance (Constenbader & Buntaine, 1999; Stein & Merrell, 1992). Hence, the overlap between students who manifest symptoms
of emotional disturbance and social maladjustment suggests that diagnosis is a matter of clinical judgment. Also, due to the absence of a definition for social maladjustment, determination of services is often rendered at a very local level (Skiba, Grizzle, & Minke, 1994).

**Differential Treatment**

A discussion of differential treatment of social maladjustment (SM) and emotional disturbance (ED) must begin with the argument over whether differential treatment is necessary. Some have also argued that differential diagnosis efforts rarely result in effective behavior change in terms of these specific diagnoses leading to effective treatment (Gresham & Gansle, 1992). Some even aver that the distinction is irrelevant with regard to treatment (Nelson & Rutherford, 1990). Further, most effective treatments should be tailored to the specific needs of the child. Therefore, it is possible that treatment based on differential diagnosis is unnecessary and may impede best practice. However, other authors have argued for differential treatment (Clarizio, 1992a). Stating that in order for treatment to be at maximum effectiveness, clinicians must identify target behaviors that differ significantly for the two groups. It is also maintained that treatment for children with ED may be counterproductive for children with SM. For our purposes here, the assumption is made that there is a clear distinction between the two groups, with ED children exhibiting internalizing behaviors (e.g., anxiety, depression) and SM children exhibiting behavior more commonly referred to as externalizing (e.g., CD, oppositional defiant disorder). Differential treatment will be discussed based on those classifications.

Although students who are socially maladjusted and thus not suffering from emotional disturbance are ineligible for special education services, they do present with some very real educational and behavioral needs. Clearly, the behaviors exhibited by both disorders warrant intervention. Thus, the subsequent logical question is whether treatment should be uniquely tailored to meet the requirements of the socially maladjusted and seriously emotionally disturbed populations. The rationale for differential treatment stems primarily from the differential behaviors exhibited by students identified with ED and SM (Clarizio, 1992b). That is, the purposeful and consciously mediated pattern of antisocial behavior that is characteristic of students who are socially maladjusted may contribute significantly to the disruption of demand-centered activities such as those typical of the expectations and demands found in school. In contrast, the emotional status and manner in which affective issues of students identified as seriously emotionally disturbed may contribute to the responses in school and educational development seems to suggest that these students are not capable of adhering to the demands placed upon them. That is, although certain behaviors of individuals with ED may parallel those of SM, the manner in which they are effectively treated is crucial. For instance, given the propensity for students with ED to suffer from guilt and anxiety and the socially maladjusted to deliberately engage in inappropriate behavior, the method by which professionals would handle rule violations between these two groups would differ. Therefore, the observed discrepancy in behavioral manifestations as well as the voluntary/involuntary nature these behaviors would suggest differential treatment of these groups. Moreover, the disparity of behaviors exhibited by students with ED and SM argues against a monolithic rubric of treatment.

With respect to treatment, it would appear that interventions for these two groups should not only differ, but also occur in different settings. It has been suggested that the implications stemming from treating both populations in the same environment would result in intimidation and bullying by those students who are socially maladjusted (Stein & Merrell, 1992). In light of the differential needs and behavioral manifestations of these two groups, the class climate and behavioral ecology should be conducive to amelioration of target behaviors. Further, the method in which these behaviors are addressed attest to the need for intervening with these individuals in
different environments (Clarizio, 1992b). The combination of students with a pattern of rule-violating behavior and who demonstrate little remorse for their actions with students who evidence emotional disorders and are naïve may result in bullying (Stein & Merrell, 1992). This gives further support to the notion that these two groups be treated in different settings.

**Social Maladjustment**

Many of the characteristics and behaviors typical of SM meet the criteria for CD diagnosis. These include habitual lying, frequent stealing, substance abuse, truancy, excessive use of profanity, and physical aggression (Clarizio, 1992a). Kazdin (1998) notes that a variety of approaches have been applied to the treatment of children and adolescents with CD. He identifies over 230 methods including psychotherapy (individual and group), community-based treatments, residential treatments, pharmacotherapy, psychosurgery, and cognitive-behavioral interventions. Unfortunately, many of these treatments have yet to be empirically validated. Kazdin does, however, present four approaches that meet his criteria for identifying promising treatments. These criteria include a theoretical rationale for etiology and treatment, research that supports this approach, and outcome data that illustrates the treatment achieves behavior change. The following four treatments are identified by Kazdin as meeting his criteria: cognitive problem-solving skills training (PSST), parent management training (PMT), functional family therapy (FFT), and multisystemic therapy (MST).

**Cognitive Problem-Solving Skills Training**

Problem-solving skills training consists of the therapist assisting in the development of interpersonal cognitive problem-solving skills. In this approach the client is taught a step-by-step problem-solving strategy using modeling, role-play, and direct reinforcement. In addition, this treatment also usually combines a token or point system and gradually shapes increasingly more complex social responses.

**Parent Management Training**

Parent management training focuses on changing parental behavior in an attempt to alter the child’s behavior. Many variations of PMT exist; however, all models focus on providing treatment/training to parents who then implement the procedures taught in their interactions with their child. The therapist rarely provides direct intervention with the child. Parents are trained in new ways to conceptualize problem behaviors and to respond more appropriately. The focus is frequently on developing parent-managed reinforcement programs for child behavior at home and behavior and performance at school. Similar techniques may also be utilized with teachers.

**Functional Family Therapy**

Functional family therapy takes a systems, behavioral, and cognitive approach in attempting to understand and treat children and adolescents with SM. Child behavior is viewed in the context of the function that it serves in the family as a system. “The goal of treatment is to alter interaction and communication patterns in such a way as to foster more adaptive functioning” (Kazdin, 1998, p. 295). Social learning theories provide the conceptual framework for these approaches. Interventions developed based on Patterson, Reid, and Dishion (1992) coercion model would be examples of the FFT approach.

Patterson et al. (1992) believe that there is a direct relationship between parenting practices and children’s antisocial (i.e., SM) behaviors. This model emphasizes the development of the coercive, controlling nature of conduct-disordered children and youth. The parent’s responses to coercive behavior are thought to perpetuate its development through the mechanisms of both
negative and positive reinforcement. Additionally, Patterson and colleagues have identified two types of parental discipline styles that lead to an increased likelihood of delinquent behavior. “Inept discipline” is characterized by failure to back up threats and persistent nagging about both trivial and major behavior deviations. “Faulty monitoring” is a failure to be aware of or believe reports of conduct-disordered behavior occurring outside the home. In their treatment, Patterson et al. focus on training positive parenting and children’s prosocial skills.

**Multisystemic Therapy**

Multisystemic therapy is a family systems based approach, which maintains that behavior problems of the child develop within the context of the family and treatment should focus on the family. The intervention also affirms that the child is a member of multiple systems (e.g., family, peers, school, neighborhood, etc.) and intervention should include individual treatment of the child, as well as family-based treatment and systematic intervention. Subsystem issues may also develop and also need to be dealt with. Because multiple influences are present, many different treatment techniques are utilized.

Dishion, McCord, and Poulin (1999) caution against the use of peer-training group interventions for early adolescents at high risk for delinquency. They present evidence from two intervention studies that suggest possible iatrogenic effects of treatment. Bringing these peers together provides subtle but powerful reinforcement for deviant talk and subsequent deviant behavior. They propose that reinforcement for verbalizations of deviant behavior in the form of laughter and attention will likely increase the frequency of that behavior and that these adolescents acquire meaning and value from this process that provides the cognitive motivation to engage in future incidents of delinquent behavior. They recommend against aggregating high-risk adolescents into intervention groups. As indicated in the above examination of specific treatments, a program that focuses on parents or other adult caregivers may be a more efficacious treatment approach.

A final, but very important, treatment issue to consider is the school psychologist’s judgment of the individual’s risk of harm to others. Grisso (1998) identifies critical factors that need to be considered. These include (a) Past Behavior: There are several dimensions of past behavior that must be considered. The first is chronicity of the violent behavior. As mentioned earlier, aggressive behavior that predates adolescence suggests greater risk of the continuation of these behaviors. A second dimension is the context in which the aggressive behavior occurred. If violent and aggressive behaviors appear situation specific, and if those situations can be avoided and controlled, risk is diminished. Other important factors to consider are recency (more recent episodes indicating greater risk) and frequency (frequent aggression indicating greater risk). (b) Substance Use: Overall, substance use by violent and aggressive youth increases the risk of future violence. (c) Peers and Community: Individual’s who have a history of associating with a violent peer group (i.e., gangs) are at higher risk for future violence as these groups place the individual in situations that may call for an aggressive response. They also provide the individual with greater accessibility to weapons. (d) Family Conflict and Aggression: A history of aggression and conflict within the individual’s family increases the risk of that individual engaging in future violence. In addition, it makes family approaches to treatment more difficult. (e) Social Stressors and Supports: Factors in the family such as divorce, illness, or economic difficulties all place stress on the individual and family and place the individual at greater risk for future violence. It is important to consider potential future, as well as past, stress in evaluating risk. (f) Personality Traits: Anger, impulsivity, and lack of empathy are all personality traits that increase the risk of future violence. (g) Mental Disorders: While the connection is not clear between mental disorders and risk for aggression there are factors associated with a number of disorders such as Depression, ADHD, Schizophrenia, and Post-Traumatic Stress Disorder (PTSD) that may increase the risk for future
aggression. (h) Opportunity: Much violent behavior is situation or person specific. If that is the case, and those conditions have changed, risk may be diminished. One must consider, however, that even in some situations where the target may no longer be available, aggression may be directed toward a substitute (e.g., a family member).

**Emotional Disturbance**

Emotional Disturbance has generally been associated with internalizing behavior disorders (Katsiyannis & Maag, 2001) such as anxiety and/or depression. While most practitioners would agree that SM can be directly linked to CD-type behaviors and thus interventions tailored specifically for CD are appropriate for the child with the SM label, the same is not true for treatment and the ED label. Anxiety and depression constitute a wide variety of disorders. Thus, treatment for ED will be discussed in much more general terms than treatment for SM.

**Anxiety Disorders**

All children experience anxiety. Anxiety in children is expected and normal at specific times in development. For example, from approximately age 7 months through the preschool years, healthy youngsters may show intense distress (anxiety) at times of separation from their parents or other persons with whom they are close. Young children may have short-lived fears, (e.g., fear of the dark, storms, animals, or strangers). However, when anxieties become severe and begin to interfere with the daily activities of childhood, such as separating from parents, attending school, and making friends, treatment is advised. Treatments may include a combination of cognitive behavioral treatments, individual psychotherapy, family therapy, medications, and consultation with the school (Silverman, & Ginsberg, 1998).

**Depression**

Up to 75% of clinically depressed youth also meet criteria for an anxiety disorder (Kovacs, 1989). Anxiety in a person with major depression leads to a poorer response to treatment, poorer social and work functioning, greater likelihood of chronicity, and an increased risk of suicidal behavior. Similar to anxiety disorders, depressive disorders cover a broad range including major depression with or without psychotic features, with or without melancholic features, with or without catatonia, single episode, recurrent, seasonal affective disorder, and dysthymia (APA; American Psychiatric Association, 1994).

There have been doubts expressed about whether depression is manifested as a syndrome in children. As such, there is not nearly the amount of work on childhood depression as there is for depression in adults. No one doubts that depressive symptoms exist in childhood, but as a symptom, depression refers merely to sad affect. By that definition, it is therefore quite common. As a syndrome, depression refers to a constellation or group of symptoms that go together such as loss of interest in activities, feelings of worthlessness, sleep disturbance, changes in appetite (Schwartz, Gladstone, & Kaslow, 1998). Notably, some have contended that depression is present in childhood but it is not manifested in a similar manner to adults (i.e., dysphoric mood, loss of interest). Rather, the symptoms are masked by other clinical problems. For example, the depressed child may exhibit depression as temper tantrums, hyperactivity, disobedience, running away, phobias, somatic complaints, and underachievement. However, this idea has been abandoned as it makes separating true behavior problems from true depression virtually impossible (Kaslow, Morris, & Rehm, 1998). It is important to note, though, the *Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV; APA, 1994)* lists irritable mood in children and adolescents as a substitute for depressed mood in adults; the point being that depression may manifest differently for children and youth than adults.
There are a wide number of different types of effective therapeutic approaches utilized for the treatment of depression. These include cognitive behavioral therapy, behavioral therapy, and family approaches. Both individual and group modalities are commonly used, depending upon the severity of the depressive episode and the local resources within an individual’s community. Cognitive behavioral therapy has proven efficacy for both anxiety and depressive disorders and is the most popular and commonly used therapy for the effective treatment of depression. Hundreds of research studies have been conducted to date that verify its safety and effectiveness in use to help treat those who suffer from this disorder. Consisting of a number of useful and simple techniques that focus on the internal dialogue, cognitive-behavioral therapy is not concerned with causes of the depression so much as what a person can do to help change the way they are feeling.

Therapy begins by establishing a supportive therapeutic environment that is positive and reinforcing for the individual. Educating the client about how depression is frequently caused by faulty cognitions (e.g., “all or nothing thinking,” “misattribution of blame,” “overgeneralization,” etc.) is usually the next step. The client is encouraged to begin noting his or her thoughts as they occur throughout the day to illustrate how common and often these thoughts occur.

In cognitive-behavioral therapy, emphasis is placed on discussing these thoughts and the behaviors associated with depression/anxiety. While emotions are addressed throughout therapy, it is thoughts and behaviors that are more likely to be the primary focus. Because of this approach, cognitive-behavioral therapy is short-term (usually conducted under two dozen sessions) and works best for people experiencing a fair amount of distress relating to their depression. Individuals who can approach a problem from a unique perspective and those who are more cognitively oriented are also likely to do better with this approach (i.e., adolescents as opposed to children).

Depression may also be treated pharmacologically. Selective serotonin re-uptake inhibitors (SSRIs) are the most commonly prescribed medication for depression. Prozac (fluoxetine), Paxil (paroxetine), Zoloft (sertraline), and Luvox (fluvoxamine) are the most commonly prescribed brand names. The preponderance of the available scientific evidence shows that psychological interventions, particularly cognitive-behavioral therapies (CBTs), are generally as effective or more effective than medications in the treatment of depression, especially when patient-rate measures and long-term follow-up are considered (Kaslow et al., 1998).

The previous paragraphs have discussed differential treatment for SM and ED. However, clinicians should be aware that differences are tenuous and each child/youth should receive treatment based upon his/her own particular presenting problem(s). Treatment specificity should always be of paramount importance in any intervention design.

Conclusion

It appears that the absence of a formal definition of social maladjustment in conjunction with the similar behavioral manifestations of emotional disturbance and social maladjustment have caused controversy with respect to differential diagnosis and subsequent treatment. The rationale for differential treatment stems primarily from the differential behaviors exhibited by students identified with ED and SM. In the present article we provide a rationale for the differentiation of treatment of emotional disturbance and social maladjustment as well as relevant interventions for these two groups. In addition, we lend further support to the qualitative differentiation of emotional disturbance and social maladjustment. Regardless of the treatment, it would seem that the primary intent of intervention is to expand upon the social–emotional, academic, and behavioral presentation associated with their condition, which would help contribute to benefits and expansion of their accomplishments within both the socialization and academic domains.

Certainly, the literature affirms the need for development of a definition of social maladjustment. In particular, it would seem that these efforts would have wide-ranging diagnostic implications.
as well as facilitate future research and practice. If managed and articulated in a responsive manner, the definition would work both as the foundation for further change and the bridge towards working more closely to the sensitivity surrounding the previously mentioned depth-related issues.

References