Outcomes of Adults with Childhood Emotional and Behavioral Problems

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Descriptive Report

Outcomes of Adults with Childhood
Emotional and Behavioral Problems

In Fall 2007, the Home, School, and Community Collaboration Research Team from Loyola University in Chicago conducted a research study examining the adult outcomes for children and adolescents who had emotional and behavioral problems. This report gives a detailed overview of the study, the findings, and potential implications for other children who have emotional and behavioral problems. A discussion of relevant background research is followed by a description of this study, its methodology and participants, detailed results, an analysis of these results, and finally, by recommendations for future research and for school personnel serving this population.

Purpose of the study

There are two main purposes in conducting this study:

1. To develop a description of adult outcomes for children with serious emotional and behavioral problems; and
2. To examine variables associated with successful and unsuccessful adult outcomes.

Introduction

The existing literature is not encouraging regarding adult outcomes for children and adolescents who experienced significant emotional and behavioral disorders (EBD) (OSEP, 2003). In addition, traditionally parents of children with EBD are depicted in the literature as having little or no education beyond high school, largely as single parents, and as low-income or reliant upon public assistance (Keller, et al., 2005). This stereotype is widespread and may affect home-school collaboration for this population because school staff may feel that students with EBD are hard to work with and parents are unsupportive or difficult. The existence of parent support groups has opened to researchers a new sample of parents of children with EBD that contrasts to the samples of parents represented in many prior studies. In particular, on-line Internet support groups tend to have parent members who are more efficacious as parents, have higher socioeconomic status (SES), and are better educated than the general population.

More recent literature suggests that familial and environmental factors within the home, school, and community can be manipulated to mitigate the adverse effects of risk factors such as the presence of psychiatric disorders, attention deficit hyperactivity disorder (ADHD) and learning disabilities (LD). In contrast, protective factors such as strong parent-child relationships, a positive relationship with an adult outside the home, positive peer relationships, and participation in activities which bring positive recognition are believed to help at-risk children achieve more successful outcomes (Smokowski, Mann, Reynolds, & Fraser, 2004; Carr & Vandiver, 2001). Whether the same protective factors affect the outcomes for children with severe EBD has not been widely investigated

Methodology

A retrospective approach was selected because a 30 year prospective study is not feasible (Brewin, et al., 1993). Further, the biggest limitation of retrospective studies, which is the

inability of respondents to recall information accurately, may not apply to this sample as much as for parents in the general population because the parent participants belong to on-line support groups in which many of the topics covered in the survey are discussed in general ways on a daily basis. This may serve to reduce the difficulty of recalling facts for the participants.

An on-line survey was utilized to collect parent recollections of their past parenting practices, their child's behavior problems, and risk and protective factors in their child's home, school, and community. In addition, parents were asked about interventions tried in the home, school, and community as well as detailed demographic information. Many questions were divided into three age levels in order to avoid responses that were very general or describing long time spans in the child's life. Requesting information for preschool, grade school, and high school greatly increased the length of the survey. This in turn reduced the response rate, although collecting information at three age levels appears to have been valuable as fully completed surveys often showed marked differences among the levels.

Participants included parents of children 17 or older who experienced emotional or behavioral problems in childhood or adolescence. In an attempt to increase the sample size, 17 years olds who were *no longer in school and not living in their parents' home* were included in the sample. Parents of 17 year olds still living at home and attending school were NOT included. Due to the length of survey, 143 parents partially completed the survey while 98 fully completed it; therefore the number of responses for questions varies.

As indicated in the Introduction, this sample of parents differs from the population of parents of children with EBD typically depicted in the literature. Table 1 displays demographic data for parent respondents.

Table 1: Demographic Data		
Gender (N=96)	90 Females (93.8%)	6 Males (6.3%)
Age (N=97) *Mean Age = 51 – 55 years*	30 - 35	2 (2.1%)
	36 - 40	12 (12.4%)
	41 - 45	23 (23.7%)
	46 - 50	20 (20.6%)
	51 - 55	23 (23.7%)
	56 - 60	11 (11.3%)
	61 - 65	3 (3.1%)
	Over 65	3 (3.1%)
Race/Ethnicity (N=96)	Caucasian	90 (93.8%)
	African American	3 (3.1%)
	Latino Hispanic	1 (1.0%)
	Native American	1 (1.0%)
	Bi-or Multi-Racial	1 (1.0%)
Highest Education Level Achieved (N=97) *Mean = College Graduate*	High School Graduate	5 (5.2%)
	Some College	41 (28.9%)
	College Graduate	25 (17.6%)
	Some Graduate Courses	6 (4.2%)
	Graduate or Professional Degree	20 (14.1%)

The respondents were overwhelmingly female, over 90% Caucasian, and had a mean educational level that fell within the "college graduate" range. Twenty of the respondents had received graduate or professional degrees. Similar to parent education level, the socioeconomic status of the respondents was also skewed positively in comparison to the general population. As shown below in Table 2, 68% of the sample was middle class or above by the time the child graduated from high school.

Table 2: Parent Income Data

Parent Income	Child Entering School (N=97) *Mean = Between Lower Middle & Middle Class*	Child Leaving School (N=96) *Mean = Middle Class*
Very Poor, Unemployed	5 (5.2%)	0 (0.0%)
Working, but Poor	13 (13.4%)	6 (6.3%)
Working Class	11 (11.3%)	7 (7.3%)
Lower Middle Class	8 (8.2%)	8 (8.3%)
Middle Class	36 (37.1%)	38 (39.5%)
Upper Middle Class	24 (24.7%)	35 (36.5%)
Upper Class	0 (0.0%)	2 (2.1%)

Definition of Successful and Unsuccessful

Within the context of the survey, parents were not told how to define whether their child was "successful" or "unsuccessful" as an adult. This was a carefully considered decision that was made because no *a priori* list of criteria or examples would be universally applicable to this very diverse sample of adults who experienced EBD as children. It is acknowledged that one parent's idea of "success" might not align with another parent's, and certainly would not necessarily be comparable to success for typical same-aged peers. We wanted parents to evaluate their adult child's success or lack of success with "all things considered," knowing that for example, if one of the things considered was drug addiction, an outcome could be considered successful with far fewer "developmental progress markers" than for an adult whose ADHD was largely controlled by high school age and is attending college.

Therefore, because each parent judged success individually with "all things considered," there was no universal definition of what constitutes "success" or "lack of success." However, three types of ratings were used and although all data were obtained by parent report, relatively objective data, such as current living arrangements or child's educational attainment, were used to better understand what "success" means for each parent and child.

The three types of parent measures of successful and unsuccessful adjustment to adulthood include:

- A 7-point index that ranged from Extremely Successful to Extremely Unsuccessful
  - Due to small number of ratings of "extremely successful," the index was collapsed to 6-points combining those who selected "successful" and "extremely successful."

- Dichotomous forced choice: Successful-Unsuccessful
  - Parents were asked to make a decision between just two choices, “successful” or “unsuccessful.” All of the assumptions described above about parents taking “all things considered” into account were assumed to apply to their selection.

- A qualitative narrative question was also included to attempt to verify what parents meant by “success” or “lack of success” and also to what they thought their child’s successful or unsuccessful adult outcome was attributable.

Tables 3 and 4 below present the distribution on the 6 point index and the dichotomous choice questions.

Table 3: Parent Ratings of Child Adjustment to Adulthood (N = 125)	
Extremely Unsuccessful	16 (28.0%)
Unsuccessful	27 (21.6%)
Somewhat Unsuccessful	18 (14.4%)
Neutral	17 (13.6%)
Somewhat Successful	28 (22.4%)
Successful	19 (15.2%)

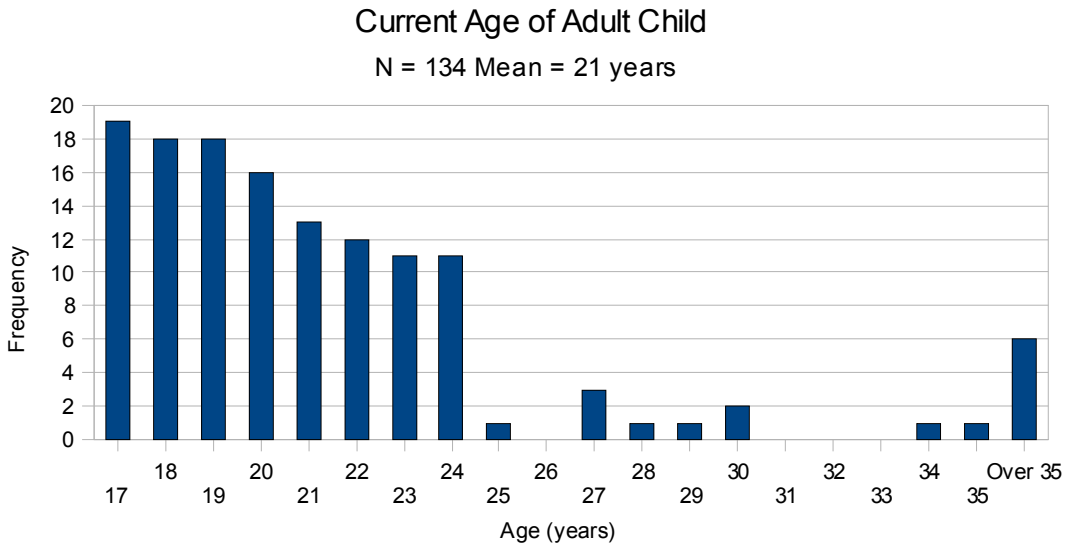
Table 4: Distribution of Successful or Unsuccessful Child Adjustment to Adulthood (n=122)	
Unsuccessful	79 (64.8%)
Successful	43 (35.2%)

Adult Child Demographics

The demographics of the adult children are presented to inform the reader of the current status, based on parent report, of the adults who had EBD as children and adolescents.

The majority of the sample is under age 25 and ranges from 17 (if living outside the parents’ home and not in school) to over 35, with a mean of 21 years. When compared to the male-female distribution in the general population, the sample contains an excess of males (58.4%) that is statistically significant [$\chi 2(1) = 96.198$, $p < .001$]. This finding is entirely consistent with the existing literature which indicates that boys have more behavioral problems than girls and are more often educated in separate classes or schools for students with EBD (Westat, 2003). In contrast, however, this sample has a statistically significant excess of females in comparison to the male to female ratio typically found in EBD classes [$\chi 2(1) = 96.198$, $p < .001$] . This suggests that females in this sample were under-identified in public schools and therefore, not eligible to receive the support and services at the same rate as males (Westat, 2003).

Chart 1: Current Age of Adult Child



In addition to gender distribution contrasting with existing literature, the sample is predominantly Caucasian. Despite majority status and parents with above average financial resources, nevertheless, there was a wide range of educational outcomes, ranging from an adult child who was "pushed out" of the third grade to an adult child with a graduate degree. See Table 5 below:

Table 5: Adult Child Demographics		
Gender (N=137)	57 Females (41.6%)	80 Males (58.4%)
Race/Ethnicity (N=136)	Caucasian	113 (83.1%)
	Bi- or Multi-Racial	13 (9.6%)
	African-American	4 (2.9%)
	Asian	3 (2.2%)
	Latino/Hispanic	2 (1.4%)
	Native American	1 (0.7%)
Highest Educational Level Achieved (N=130) *Mean = 12th Grade*	8th Grade or Below	8 (6.2%)
	9th Grade	10 (7.7%)
	10th Grade	15 (11.5%)
	11th Grade	14 (10.8%)
	12th Grade	59 (45.4%)
	Some College	18 (13.9%)
	College Grad or Above	6 (4.7%)

Despite the positively skewed educational and socioeconomic levels of the parents, current employment/education, living situation, and financial status outcomes for the adult children are negatively skewed, which means that the outcomes are more negative than one would predict

from a normal distribution (the bell-curve).

Parents responded to many questions regarding their adult child's current living situation, employment, and educational activities. A coding system was devised that attempted to capture the nuances of the employment or postsecondary school status of the adult children. All possible combinations of work and school were tallied to determine whether an adult is "fully positively occupied" or "partially positively occupied." For example, the highest category would be assigned to an adult child who works full time or attends school full time or does both part time, in order to meet the criterion of "fully occupied." Partially positively occupied may represent positive progress relative to a prior status or may be clearly an undesirable outcome from the parent's perspective For example, "he has returned to school part-time and seems motivated now;" contrasted with "skips from one part-time job to another—nothing last more than a few weeks." This information was obtained from open- ended comments that parents made in response to specific questions. Finally, the third category was reserved for clearly negative outcomes such as incarceration or long-term unemployment.

Table 6: Current Employment/School Status (N = 121)
Mean = Partially Positively Occupied

Fully Positively Occupied (School and/or Work/Parent Full-time)	61 (46.9%)
Partially Positively Occupied (School or Work/Parent Part-time)	29 (22.3%)
Not Positively Occupied (Unemployed, Incarcerated)	40 (30.8%)

In a similar fashion, residential living situations were coded into four levels that include living independently, living with parents, living with others, and living in situations that are clearly negative such as in prison or homeless. Table 7, below, shows information on the adult children and their residential living status. Given the age of the sample, living with parents is not necessarily negative although the meaning of a totally dependent 20 year old and 30 year old living in the parent's home may be quite different. Similarly, the group "dependent on others" may be positive or negatively interpreted, e.g., "he lives with his aunt in another city," or "she lives with her boyfriend who is a drug dealer." Even when the relatively young age of the sample is considered, it is clear that the IDEIA 2004 goal of independent living is not being met since over 75% of the sample remains dependent on others and 12.6% reside in clearly negative situations.

Table 7: Residential Living Status (N= 135) *Mean = Independent Living*	
Independent Living	33 (24.4%)
Dependent Living – Depends on Parent	58 (43.0%)
Dependent Living – Depends on Others	27 (20.0%)
Negative Residential Outcome (Prison, Psychiatric Facility, Homeless)	17 (12.6%)

Another major goal of IDEIA 2004 is financial independence in adulthood for students who receive special education services. As can be seen in Table 8 below, in this sample, only 16.5% of the adult children are financially independent; another 14.3% receive only "minor assistance" from family or friends. Nearly half (46.6%) are totally financially dependent and of these, 20 subsist only on welfare or Supplementary Security Income (SSI). These findings are even more negative when two factors are considered: two-thirds of the parents of these adult children are middle class or above, and without exception, the adult children have at least average cognitive functioning. Therefore, the reasons for such high dependency levels are **not** attributable to either lack of social capital in families of origin or cognitive deficits that would limit employment opportunities.

Table 8: Financial Status (N = 129) *Mean = Partially Dependent*	
Completely Independent	22 (16.5%)
Partially Independent (Receives Minor Assistance)	19 (14.3%)
Partially Dependent (Receives Major Support)	26 (19.5%)
Totally Dependent	62 (46.6%)

Childhood Behavioral History

As reported by parents, most adult children exhibited very serious emotional or behavioral problems as children and adolescents. Many parents noticed atypical behaviors when children were between ages 2 and 3. For children who did not have serious childhood problems, the typical age at which parents reported problematic behavior was 14 years. Of this adult child sample, 76% have one or more diagnoses from The Diagnostic and Statistical Manual of Mental Disorders (DSM) and not surprisingly, the most typical ages for receiving diagnoses were between ages 5 to 6 and 14 to 16. These ages reflect the point in time of the parents' concerns with lag-time added for obtaining an evaluation and subsequent diagnosis.

Parents rated a large number of behavior problems in both grade school and high school using

items selected from the Achenbach Childhood Behavior Checklist (CBCL) (Achenbach, 1991) with an expanded rating system. The items were organized into 5 indices based on a previous factor analysis of this modification of the checklist. The five factors are:

- Externalizing Behaviors
- Internalizing Behaviors
- Inattention/Impulsivity/Executive Functioning Deficits
- Learning Problems
- Immature/Inadequate Coping Skills

Behaviors were rated using a 7-point scale ranging from (1) “never a problem to (7) “always a problem.” Table 9 presents the item means and the mean for each index. Note: the higher the item mean, the more problematic the behavior.

Table 9: Childhood Behavior Scales Derived from Achenbach Items

Scale	Item	Item Mean
Externalizing Behaviors Grand Mean = 4.23	Opposition/Defiance at Home	5.35
	Opposition/Defiance at School	4.61
	Lying	5.28
	Stealing	3.90
	Dangerous to Others	2.76
	Inappropriate Friends	5.06
	Meltdowns	4.43
	Drug Abuse	3.65
	Deliberately Destroyed Property	3.05
	Truancy	4.24
Internalizing Behaviors Grand Mean = 4.05	Depression	4.47
	Anxiety	4.59
	Slept Too Much	4.47
	Dangerous to Self	3.73
	Obsessive Behaviors	3.44
	Specific Fears or Phobias	2.83
	Complained of Aches/Pains (No Medical Cause)	3.41
	Mood Swings	5.10

Table 9 Continued: Childhood Behavior Scales Derived from Achenbach Items		
Scale	**Item**	**Item Mean**
Inattention/ Impulsivity/ Executive Functioning Problems Grand Mean = 4.13	Inattention	5.34
	Impulsivity	5.63
	Executive Functioning Deficits	3.96
	Slept Too Little	2.70
	Talked Too Much	4.33
Immature/ Inadequate Coping Skills Grand Mean = 3.72	Acted Immature for Age	5.02
	Disordered/Bizarre Thoughts	3.35
	Poor Social Skills	4.39
	Had Few or No Friends	3.75
	Too Dependent for Age	3.55
Learning Problems Grand Mean = 4.20	Learning Problems at School	4.22
	Learning Problems at Home	3.86
	Homework Difficulties	5.30

Items with Means above 5.0 are shown in Red,
Means near or above 4 are shown in Green

The large number of items with ratings over 4 indicates that parents found their children's behavior to be extremely difficult. Although there were age specific differences between grade school ratings and high school ratings, the patterns of difficulty were similar, so the age level ratings were combined in this table. For example, drug abuse and truancy are much more common in high school, while sleeps too little and fears and phobias were more problematic in grade school.

Childhood Risk and Protective Factors

The concept of risk factors and protective factors is widely supported in the literature (Crews, Bender, Cook, & Gresham, et al., 2007; Smokowski, Mann, Reynolds, & Fraser, 2004) Risk factors are things that increase the likelihood of a negative outcome and protective factors increase the likelihood of a positive outcome.

Risk Factors

School Risk Factors included: suspensions, expulsions, bullying/negative peer interactions, and negative peer group influence. See Table 10 for frequency data for these school risk factors. The number of elementary and middle school suspensions were significantly associated with unsuccessful outcomes [$\chi 2(1) = 4.99$, $p < .025$]. Table 10 below summarizes the data on School Risk Factors:

Table 10: Childhood School Risk Factors	
Risk Factors	**Descriptive Information [N (%)]**
Elementary or Middle School Suspensions (N = 99)	41 (41.4%)
Elementary or Middle School Expulsion (N = 99)	11 (11.1%)
High School Suspensions (N = 95)	50 (52.6%)
High School Expulsion (N = 99)	19 (19.2%)
Middle School Negative Peer Group Influence (N = 97)	52 (54.2%)
High School Negative Peer Group Influence (N = 97)	70 (73.7%)
Middle School Frequently Teased/Bullied (N = 97)	33 (34.0%)
High School Frequently Teased/Bullied (N = 97)	22 (22.7%)

Home Risk Factors included: premature birth, prenatal drug exposure, abuse, single parenting, divorce, negative discipline, and death in immediate family. Table 11 shows data on the frequency of these events. It should be noted that the questions were worded to include instances of abuse which occurred in any home or the child's community and did not necessarily occur in the presence of the parent who was reporting the event, e.g., prenatal drug exposure in an adopted child.

Table 11: Notable Childhood Home Risk Factors	
Risk Factors (N = 97)	**Descriptive Information [N(%)]**
Neglect	13 (13.4%)
Physical Abuse	25 (25.8%)
Verbal Abuse	47 (49.0%)
Sexual Abuse	21 (21.6%)
Divorce	45 (46.4%)
Prenatal Drug Exposure	12 (12.2%)
Death in Immediate Family	43 (43.9%)

Negative discipline practices by parents has been shown to be strongly associated with EBD and poor outcomes (Wagner, Kutash, Duchnowski, Epstein, et al., 2005), however in this sample parents reported that they did not use negative discipline practices (Mean = 2.42 on a 7-point scale.) None of the above events or conditions was significantly associated with successful or unsuccessful adult outcomes.

Community Risk Factors included: witnessing a violent or traumatic event and gang activity or involvement with a gang. The infrequency of these negative events reflect the relatively good socioeconomic status of the parents: 29 (29.9%) witnessed a violent or traumatic event but only 3 parents reported youth gang involvement, although 14 selected “Not Sure” since close supervision of older adolescents and young adults often is not realistic. Neither witnessing traumatic events nor gang activity was significantly associated with a successful or unsuccessful adjustment to adulthood.

Protective Factors

- School Protective Factors included: having an IEP, having a Behavior Support Plan, attending a Pre-Kindergarten program, or receiving early intervention services through Child Find.

- Home Protective Factors included: parental use of positive discipline techniques, parental involvement in the child’s life at school and in the community, and parental use of resources.

- Community Protective Factors included: having a mentor or helpful adult relationship outside of the family, positive peer support/influence, receiving a mental health assessment, use of individual or family therapy, or participation in sibling or parent support groups.

The table below shows results for home, school, and community protective factors for this sample of parents and children. Using the same scale and in contrast to negative discipline, parents endorsed positive discipline techniques (Mean = 4.02) and a high level of involvement in their child's life (Mean = 4.24). No significant associations with adult adjustment were found, either positively or negatively.

Table 12: Childhood Protective Factors

Protective Factors	Descriptive Information [N(%)]	
Parent Resources (N = 109)	**Read Books/Materials About Child's Problems**	101 (92.7%)
	Learned about Special Education Law	80 (73.4%)
	Support Group Participation	89 (81.7%)
	Consulted Friends/Family/Other Families with Similar Problems	93 (85.3%)
IEP	**Elementary/ Middle School (N = 103)**	39 (37.9%)
	High School (N = 99)	40 (40.4%)
Behavior Support Plan	**Elementary/ Middle School (N = 98)**	20 (20.4%)
	High School (N = 93)	25 (26.9%)
Pre-K (N = 102)	84 (82.4%)	
Early Intervention Services (IFSP, IEP, or Other) (N = 100)	13 (13.0%)	

Table 12 (Continued): Childhood Protective Factors		
Protective Factors	**Descriptive Information [N(%)]**	
Helpful Adult Relationship (N = 104)	61 (58.7%)	
Positive Peer Group Influence (N = 97)	**Middle School**	20 (20.8%)
	High School	9 (9.5%)
Mental Health Assessment (N = 97)	74 (76.3%)	
Therapy (N = 99)	91 (91.9%)	
Support Groups (N = 98)	54 (55.1%)	

Intra-individual Childhood and Adolescent Risk Behaviors

Risk behaviors such as drug and alcohol use/abuse and juvenile arrests were examined. Drug use, but not alcohol abuse, was significantly associated with unsuccessful adult adjustment [$\chi 2(1) = 4.071$, $p < .05$]. In addition, arrest as a juvenile was associated with an unsuccessful adult outcome [$\chi 2(1) = 12.94$, $p < .002$]. Risk behavior data are displayed in Table 13 below:

Table 13: Childhood and Adolescent Risk Behaviors	
Drug Abuse (N = 131)	72 (55.0%)
Alcohol Abuse (N = 131)	49 (37.4%)
Juvenile Arrest (N = 133)	29 (38.2%)

Data Analysis

Given the large number of variables that were queried, and how closely the questions followed the risk and protective factor literature, the researchers were surprised to note that there were few variables associated significantly with successful or unsuccessful adult outcomes. However, since there was variance in adult outcomes (although it was negatively skewed), the belief that different factors in childhood still may have led to different outcomes caused a re-examination of the study sample size and the definition of successful and unsuccessful adult outcomes used. The sample size is not large from a statistical standpoint although, in this difficult to access population, parents of adults who experienced EBD in childhood or adolescence, a sample between 98 and 125 is larger than might be attained by other data collection methods. Regardless, nothing can be done to increase this sample size now. Therefore, the method of defining successful and unsuccessful outcomes was re-examined.

Examination of the distribution of parent ratings and accompanying qualitative attributions suggested great variability in judgments of what constituted a successful adult adjustment. This observation is especially true for the mid-points of the scale. Clearly one parent's "somewhat successful" is another parent's "somewhat unsuccessful." While this is what was intended when parents were asked to rate their child's adjustment to adulthood with "all things considered," it likely resulted in an index with a lot of "clutter" in the middle categories. Therefore, the 19 "very successful" and "successful" adults were examined for supporting evidence that they could be considered objectively "successful" in comparison to a general same-aged population. The levels of education and financial independence, being "positively occupied" full time, and freedom from negative outcomes such as incarceration or homelessness suggest that these 19 adults are, indeed, successful. There were 43 adults who were rated by their parent as "extremely unsuccessful" or "unsuccessful" in their adjustment to adult living. From among this group of 43, a statistical software program was used to randomly select 19 of the 43 to create a matched sub-sample for comparison to the 19 successful adults. Examination of the qualitative responses for the random draw of 19 adult children rated as unsuccessful by their parent strongly suggested that they would be considered "unsuccessful" by objective criteria which are applicable to the general population, and they were likely not being negatively labelled by their parents arbitrarily. A comparison of the two groups as children revealed them to have equally problematic behaviors at young ages and in adolescence.

Quantitative data analyses examining potential relationships between factors in childhood and adult outcomes were repeated using the sub-sample of 38 (19 successful and 19 unsuccessful adult children). Due to the reduced sample size, statistical significance was not often achieved, but nonetheless, clear results did emerge from the *qualitative* data analyses. Comparing the 19 most successful to the 19 least successful adults showed outcomes were significantly better for the successful group in educational attainment, current employment, residential status, and financial independence. To some degree, this may seem tautological because these factors, or their inverse, are likely what caused the parents to make an attribution of "successful" or "unsuccessful." Although it is not possible to establish causality using retrospective methods, it appears that several factors distinguish the most successful from the least successful. The strongest statistical finding was that higher levels of educational attainment are associated with successful outcomes. This was true whether the child attended public or private school and whether or not the child received special education support. It might seem obvious that education matters, but in this group, with an 11% expulsion rate in grade school and a 20% expulsion rate in high school, staying in school is not a foregone conclusion.
As found in the larger sample, juvenile drug use and arrests were associated with unsuccessful

outcomes for the sub-sample of 38 adult children, while higher levels of academic attainment were associated with successful outcomes.

Examining childhood and adolescent behavior patterns, statistically significant differences were found for the Executive Functioning/Attention/Hyperactivity index as well as the Learning Problems Index and Immature/Inadequate Coping Skills Index. This suggests that the differences between adults rated as successful and unsuccessful may be made somewhat clearer when examining the most successful and least successful adult children. Parent attributions of variables leading to successful or unsuccessful adjustment to adulthood were examined qualitatively for the entire sample as well as for the sub-sample. Parents identified a number of variables within their child as well as their environment as contributing to either a successful or unsuccessful outcome. See Tables 14 and 15 below for the most commonly named factors.

Table 14: Parent Attributions of Child's Successful Adjustment to Adulthood (N=110)

Rank	Attribution Category	Frequency (%)
1	Motivation, Work Ethic	17 (15.5%)
2	Family Support, Financial Support from Family	17 (15.5%)
3	Intelligence, Maturity, Creativity, Talent, Positive Attitude	16 (14.5%)
4	Tough Love, Forced Independence, Removal of Financial Support, Structure	15 (13.6%)
5	Therapy, Psychiatric Treatment, Medication, Home Counseling, Residential Treatment, Group Home	11 (10.0%)
6	Independence, Moving Away from Parents' Home	8 (7.3%)
7	Becoming a Parent, Starting a New Family	7 (6.4%)
8	Discontinuing Drug Use, AA Participation	6 (5.5%)
9	Employment, Military	4 (3.6%)
10	Education, Special Education, 504 Plan	3 (2.7%)

Table 15: Parent Attributions of Child's Unsuccessful Adjustment to Adulthood (N=110)		
Rank	**Attribution Category**	**Frequency (%)**
1	Emotional Problems, Stubbornness, Impulsivity, Refusal to Listen, Impatience, Oppositional/Defiant, Manipulative, Poor Coping Skills	27 (24.5%)
2	Negative Life Choices, Refusal of Treatment, Non-Compliance with Treatment or Recommended Medication, Unsafe Sexual Activity, Poor Judgment, Ignorance of Rules, Removal from Residential Treatment Facility	24 (21.8%)
3	Immaturity, Failure to Take Responsibility for Actions	20 (18.2%)
4	Alcohol or Substance Abuse	18 (16.4%)
5	Mental Illness, Symptoms of Previously Diagnosed Disorder	15 (13.6%)
6	Financial Problems, Over-Dependence on Family or Others for Financial Assistance	13 (11.8%)
7	Inability to Hold a Job, Lack of Respect for Authority Figures, Employment-related Inattention	13 (11.8%)
8	Lack of Motivation	9 (8.2%)
9	Inadequate Education or Academic Supports, Poor School Environment	7 (6.4%)
10	Antisocial, Avoidant, Withdrawn from Family or Friends, Lack of Communication with Family	7 (6.4%)

Traditional views of resiliency, which is the ability to succeed despite adverse conditions, focus upon factors or qualities inherent in the individual that allow him or her to surmount adverse environmental factors. Risk and protective factors have become interwoven with the notion of resiliency in research (Stouthamer-Loeber, Loever, Farrington, Zhang, et al., 1993). Contemporary views suggest protective factors in a child's home, school, and community can affect resiliency and aid a child in achieving a successful outcome. The qualitative data described in the previous two tables suggest that, for this sample, both explanations are functioning and interactive. According to parents, variables most often mentioned as accounting for a successful outcome are internal to the adult: motivation, intelligence, creativity or talent, and perseverance. Conversely, unsuccessful adults have internal problems such as impulsivity or a variety of negative attributes such as being oppositional, stubborn, or refusing to listen to others. Parents also indicated that family support, particularly financial support and mental health treatment services purchased by the parent, contributed to their child's success in adulthood. A child's refusal of treatment, non-compliance with medication and treatment, and general negative life choices were noted as contributing to an adult being unsuccessful.

Neither group rated educational support as particularly helpful or harmful, perhaps because most parents in this sample were providing many services privately and may have felt unsupported by the schools. It is noteworthy, however, that staying in school was strongly associated with success. This finding was one of the few from this study that was statistically

significant, suggesting this result was likely not obtained by chance. In the entire sample, only three students who were expelled were rated as “somewhat successful” by their parent, and none were rated as being successful. Examination of these three cases revealed that these were examples of parents who felt their child was somewhat successful with “all things considered,” because all three of the adults had drug or alcohol abuse problems and two of three had been incarcerated. Since their outcomes would not generally be considered a “successful” outcome in a typical population, it seems warranted to conclude that expulsion is clearly associated with negative outcomes for children and adolescents with EBD.

Finally, one wonders why the protective factors cited extensively in the literature did not seem to lead to positive outcomes for this sample. Two general types of explanations should be considered: one is that not every child with the severity of symptoms that the children in this sample experienced can succeed even with grossly normal levels of cognitive functioning and many services. Another explanation is that research on “risk” and “protective” factors have been applied to “at-risk” populations that are comprised of students who have a higher likelihood of problems due to circumstances either of the child’s life or environment. At-risk populations of students may, for whatever reason, exhibit different responses to the same protective factors experienced by students from this EBD sample. The adults in this study HAD serious problems rather than just the potential for a negative outcome. Therefore, programs directed toward helping “at-risk” youth may be effective for children and adolescents with similar risk factors. However, generalized programs such as mentoring or participation in extra curricular activities are unlikely to affect a child with serious EBD in the same ways. Further, the clear differences in executive functioning and attention/impulsivity between the successful and unsuccessful groups may indicate that even when specialized programs such as “social skills training” or “classroom modifications” are offered, the services may not be processed or utilized by the child as intended. To be effective with children and adolescents who have both behavior problems at an early age and problems that may have a neurological basis, interventions would need to be highly specific, intensive, and data driven to be effective.

Summary:

The findings of this retrospective study of approximately 100 adults who as children or adolescents experienced emotional or behavioral disorder include:

- Staying in school was strongly associated with positive outcomes and no adult who was expelled from school had a positive outcome using a typical definition of “positive.”
- Higher executive functioning skills were associated with positive outcomes and problems with executive functioning were associated with negative outcomes.
- Parents attributed both success and lack of success to internal factors (e.g., work ethic, motivation, maturation, intelligence, ADHD, drug abuse).
- Parents' lack of specific attribution to home, school, and community factors was not due to parents’ passivity: most parents tried “everything” to help their child succeed.
- Parental purchase of service outside of school was high and parents frequently attributed their child’s success to their financial support.

Recommendations:

School personnel should realize that not all parents of children with EBD are ineffective, uncooperative, and closed to home-school collaboration.

The existence of the group of parents in this study does not mean that the stereotypic parent of a child with EBD does not exist. However, the existence of this group of parents does demonstrate that parents who are very well educated, use “positive discipline techniques,” are well-versed in special education law, and who have the financial resources to pursue therapies outside of the school, STILL may have a child with intractable behavior problems. Such parents need support, not blame, to help their children attain independence and productivity in adulthood.

The suspension and expulsion rates found in this study are very high and are associated with negative outcomes. School personnel should try to keep all students in school, especially those most at risk for negative disciplinary procedures. Although special education in itself did not predict a more successful outcome, in an indirect way, it may contribute positively: A child with an IEP is more difficult for administrators to remove from school through punitive disciplinary action and is entitled to a transition plan that has as its goal independent functioning as an adult. If more students with EBD were identified and served through special education, the expulsion rate might drop and children would have greater access to services aimed at building skills for functional living in adulthood.

This is a very difficult group of students to serve. Most of the adult children in the sample had multiple diagnoses as children, and then often developed secondary problems such as drug or alcohol abuse, truancy or criminal behavior, all of which predict a negative outcome later in life. Schools and communities need to serve students with EBD more effectively not only because it is a humane and socially just approach, but also because it is the most cost-effective and safest for society: “unsuccessful” students with EBD easily turn into socially expensive and difficult to serve adults who are in danger of becoming permanently dependent upon either the social service system, the mental health system, or the penal system in order to survive.

References

Achenbach, T. M. (1991).Manual for the Child Behavior Checklist/4-18 and 1991 Profile. Burlington, VT: University of Vermont, Department of Psychiatry.

Brewin, C., Andrews, B. & Gotlib, I. (1993). Psychopathology and early experience: A reappraisal of retrospective reports. *Psychological bulletin,* 113*,(1),* 82-98

Crews, S.D., Bender, H, Cook, C., Gresham, F., Kern, L., & Vanderwood, M. (2007). Risk and Protective factors of emotional and/or behavioral disorders in children and adolescents: a mega-analytic synthesis. *Behavioral Disorders,* 32,*(2),* 64-77*.*

Carr, M.B. & Vandiver, T.A. (2001). Risk and protective factors among youth offenders. *Adolescence,* 36*(143),* 409-424.

Keller, T.E., Bost, N.S., Lock, E.D., & Marcenko, M.O., (2005). Factors associated with participation of children with mental health problems in structured youth development programs. *Journal of Emotional and Behavioral Disorders,* 13*,*141-151.

Smokowski, P.R., Mann, E.A., Reynolds, A.J., & Fraser, M.W. (2004). Childhood risk and protective factors and late adolescent adjustment in inner city minority youth. *Children and Youth Services Review, 26(1),* 63 – 91.

Stouthamer-Loeber, M., Loever, R., Farrington, D., Zhang, Q., Van Kammen, W. & Maguin, E. (1993). The double edge of protective and risk factors for delinquency: Interrelations and developmental patterns. *Development and Psychopathology, 5,* 683-701.

Wagner, M., Kutash, K., Duchnowski, A.J., Epstein, M.H., & Sumi, W.C. (2005). The children and youth we serve: A national picture of the characteristics of students with emotional disturbances receiving special education. *Journal of Emotional and Behavioral Disorders, 13*(2), 79-96.

Werner, E.E. (1989). High-risk children in young adulthood: A longitudinal study from birth to 32 years. *American Journal of Orthopsychiatry,* 59*(1),* 72-81.

Werner, E.E. (1993). Risk and resilience in individuals with learning disabilities: Lessons learned from the Kaui longitudinal study. *Learning Disabilities Research and Practice,* 8*(1),* 28-34.

Westat for Office of Special Education and Rehabilitative Services. (2003). Twenty-Fifth Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act; Section 1, Volume 1:The National Picture. Available Online at <http://www.ed.gov/about/reports/annual/osep/2003/index.html>