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Disruptive Mood Dysregulation Disorder in the Classroom

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Abstract

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MS, Walden University, 2007

MS, Southern Connecticut State University, 1997

BA, Southern University at New Orleans, 1993

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Researchers have identified emotional disturbance (ED) as the fastest growing diagnosed disability among school-age children. The National Institute of Mental Health estimated that of the 473,000 school-aged students who would qualify as having an ED, the school systems formally identify only 1%. Disruptive mood dysregulation disorder (DMDD) is the most recent depressive disorder added to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) and the newest subcategory of ED. There have been few studies on student populations with DMDD, and a significant gap exists in the literature supporting this population in the classroom. The purpose of the study was to interview eight special education teachers selected from a local school district in a northeastern state and from a special education social media website to understand their lived experiences supporting the individualized education plans (IEPs) of students with DMDD. The theoretical frameworks that provided support were phenomenology and Adlerian social feeling. The interviews included asking them how they managed their emotional regulation when students with DMDD were volatile. The data were analyzed using interpretative phenomenological analysis. Three themes emerged from the analysis: Managing the Student, Impact on the Student, and Supporting Diagnosis/Training. Implications for positive social change include the provision of professional development opportunities for special education teachers and awareness of the complex nature of DMDD to improve students' IEPs and their academic success.

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Dedication

I dedicate this hard-fought journey to my children, their partners, and my grandchildren, all of whom are the soft breezes that have lifted my spirits and have been the driving force and purpose in my life. I thank God for allowing me to be a mother, a mother-in-law, and a grandmother to Janelle and Tamar, Johnny Jr., Joshua and Kristen, Jarreau, Jordan, Gabrielle, Marcel, Elijah, and Emerson. I also dedicate this endeavor to Khalid B. Scott; Johnny, Sr.; Judi and Flo; and all of my family members, bosom buddies, and coworkers who have supported me through tears and life struggles. Most of all, I dedicate this dissertation to my mother, Sheila Marie, whose undying love and pride remain profound influences in my life.

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Chapter 1: Introduction to the Study

The National Institute of Mental Health (NIMH, 2009) reported that most life-long cases of mental health are diagnosed by the age of 14 years. According to policies of the NIMH (2009) and the [Name of state redacted] State Department of Education (SDE), educational performance must be affected to require treatment for mental health conditions. Students with the educational category of emotional disturbance (ED) experience the least amount of school success (Lambert et al., 2014). Lambert et al. (2014) found that there has been an overall failure to identify students at high risk early in their education for optimal intervention. Moreover, they suggested that early identification could reduce the likelihood of mental health disturbances through the adult years. These comparative statistics and suggestions have pointed to an increased need for therapeutic services for populations with ED.

To qualify for disability, the Individuals with Disabilities Education Improvement Act of 2004 classified tiered behavioral interventions from the least intrusive to the most intensive. In the school setting, the qualifying characteristics of ED that interfere with students' education cover a variety of sequelae: inability to learn, establish relationships, and self-regulate; poor self-concept and self-esteem; depression; aggressive outbursts; and physical ailments. Following are the criteria listed by the [Name of state redacted] SDE in 2020 for the identification of ED:

1. An inability to learn that cannot be explained by intellectual, sensory, or health factors despite the support of tiered interventions or appropriate instructional strategies, a student demonstrates difficulty in learning.

2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers … the student shows an inability to develop a satisfactory interpersonal relationship with teachers or peers. Acceptable relationships include the ability to empathize, sympathize, and show warmth.
3. Inappropriate types of behaviors or feelings under normal circumstances … a student demonstrates inappropriate behavior or feelings that are significantly different from the expected age, gender, and or culture, as shown by difficulties with self-esteem, self-control, or rapid changes in mood and behavior.
4. A general pervasive mood of unhappiness or depression … the student must demonstrate depression or unhappiness across all life situations. Depression and unhappiness are not due to situational or temporary factors.
5. A tendency to develop physical symptoms or fears associated with personal or school problems … the student must exhibit physical symptoms or fears across personal or school environments. Some examples of physical symptoms are headaches, stomachaches, heart rate and breathing difficulty, and panic attacks. (p. 20)

ED has become an all-encompassing term for a wide range of characteristics. A new diagnosis has been added to the American Psychiatric Association's (APA, 2013) *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) that will become a subcategory for ED in the educational setting: disruptive mood dysregulation disorder (DMDD).

Background

Behavioral and postschool outcomes for students with ED result in small gains when compared to other special education categories (Bradley et al., 2008; Duchnowski et al., 2012; Puddy et al., 2012). In addition, ED students experience increased disciplinary action for reasons that include manifestations of their disability and higher number of reported incidents of fighting. They also are 3 times as likely to be subject to expulsion and suspension (Duchnowski et al., 2012). The most recent diagnosis for children in the category of depression in the *DSM-5* (APA, 2013) is DMDD, defined as having the following criteria:

1. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
2. The temper outbursts are inconsistent with developmental level.
3. The temper outbursts occur, on average, three or more times per week.
4. The mood between temper outbursts and persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).
5. Criteria A–D has been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A–D.

6. Criteria A and D are present in at least two of the three settings (i.e., at home, at school, with peers) and are severe in at least one of these.
7. The diagnosis should not be made for the first time before age 6 years or after age 18 years.
8. By history or observation, the age of onset of Criteria A-E is before 10 years.
9. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met. Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.
10. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]).

    Note: This diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, attention-deficit/ hyperactivity disorder, conduct disorder, and substance use disorders. Individuals whose symptoms meet the criteria for both disruptive mood dysregulation disorder and oppositional defiant disorder should only be given the diagnosis of disruptive mood dysregulation disorder. If an individual has ever experienced

a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.

11. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition. (p. 156)

Since its inclusion in the *DSM-5* in 2013 by the APA, there has been limited research documenting the outcomes for these children and managed services offered in the academic setting. I followed the suggestions of Duchnowski et al. (2012) and Puddy et al. (2012) that more research in the elementary student population with ED is necessary. Results of my study provided behavioral descriptions and applied interventions, and from the eight special education teachers who were interviewed, the shared services and interventions that offered a measure of success in the classroom.

Problem Statement

Even with a variety of interventions, the broader category of students with ED continues to demonstrate limited gains in behavioral outcomes (Duchnowski et al., 2012; Puddy et al., 2012). Widely employed interventions include instructional strategies (i.e., addressing learning styles, cultural competencies, experiential learning activities, diversity, etc.) and classroom and assignment accommodations (e.g., computer-assisted technology; exams in an alternate form, feedback on performance, extended time to compete tasks). In addition, much of the research dedicated to ED has been focused on older students from middle school through high school (Duchnowski et al., 2012; Puddy et al., 2012). The introduction of DMDD as a subcategory of ED presented the need for research. I addressed the lived experiences of eight special education teachers who were

responsible for managing the IEPs of students with DMDD by obtaining their perspectives of the ways that they managed their emotional regulation when students with DMDD were volatile.

The diagnosis of interest in my study was DMDD. As cited in the *DSM-5* (APA, 2013), this new diagnosis was researched and developed to reduce the overdiagnosis and treatment of bipolar disorder in children (Chen et al., 2016; Leibenluft, 2011). As reported by Leibenluft (2011), the diagnosis of bipolar disorder has increased in the last 20 years by 400% in children and adolescents in the United States. The diagnostic criteria for DMDD cover children between the ages of 6 and 17 years and must be observed by age 10 years. The children must demonstrate persistent irritability with extreme and frequent dysregulation of behavior (APA, 2013; Chen et al., 2016; Margulies et al., 2012; Perich et al., 2017; Stringaris, 2011). The prevalence of DMDD is noted in the *DSM-5* as 2% to 5% of the population with ED, with rates higher among male individuals than female individuals. Conducting this study helps to expand the limited body of research on this disorder. The extant research does not provide clarity in understanding the best management or self-regulation strategies in the classroom by special education teachers.

In summary, there has been limited research into DMDD as supported by special education teachers in the classroom. More research was needed to understand students with DMDD in the classroom setting. Because of the limited amount of research, a universal model may have resulted in poor outcomes for some individuals. By focusing on the new *DSM-5* (APA, 2013) diagnosis of DMDD, I interviewed a sample of eight

special education teachers to identify their lived experiences and perceptions of students with DMDD.

Purpose of the Study

The purpose of this phenomenological study was to examine the lived experiences of eight special education teachers who supported students with DMDD. The interview questions were developed to obtain the teachers' perspectives regarding the ways that they managed their emotional regulation when students with DMDD were volatile. The special education teachers provided individualized education plan (IEPs) to support students with DMDD. Given that few studies have addressed the topic under investigation, conducting a phenomenological study was appropriate to examine these experiences.

Research Questions

Based on the aforementioned problems and purposes, the study was guided by one research question (RQ) and one subquestion (SQ):

RQ: What were the lived experiences of special education teachers who supported students with DMDD regarding a typical academic day, social challenges and needs, challenges as providers, student challenges as learners, and social feeling for students with DMDD?

SQ: How did special education teachers manage their emotional responses in the classroom when working with students with DMDD who were volatile?

Conceptual Framework for the Study

Husserl (as cited in Kafle, 2011) developed the philosophy of phenomenology in the 19th century. A mathematician and logician in the early 20th century, Husserl wanted to demonstrate the possibility of securing human knowledge independent from human modes of thinking. The notion of epoche, or the limiting of researchers' beliefs and true lived experiences of consciousness, opened the disclosure of experiences. Later in the 20th century, phenomenology found a voice through individual psychologists such as Alfred Adler (as cited in Bitter & Carlson, 2017).

Adler, who developed the notion of social feeling early in the 20th century, believed that all human beings are goal directed, knowingly or unknowingly (as cited in Bitter & Carlson, 2017). All human beings have goals that either move positively or negatively or from a social feeling of superiority or inferiority. Those early years of developing a social feeling and the schemas that are built during this progress guide human beings along this path; Adler termed these initial ideas *private logic*.

Soheili et al. (2015) noted that Adler saw children's personal beliefs as significant to the blueprint of interindividual and intergroup harmony. If children do not have a feeling of belonging, they will use a weak and useless manner to belong. When individuals do not develop this social feeling, psychological disturbances have a higher probability of manifesting. For example, temper tantrums, irritability, and anger are more likely to occur.

Nature of the Study

I conducted confidential video interviews to discuss with the participants their classroom experiences with students with DMDD (see Chen et al., 2013). The eight special education teachers in the sample provided details about the classroom experiences of students with DMDD. The interviews captured information about the most significant influence on service delivery and outcomes. The qualitative approach gave a sense of social feeling or being connected to the environment and persons in the environment.

I used the qualitative methodology that Marshall and Rossman (2011) described as a phenomenological approach, or a cultural study. A cultural study can serve as a lens into the perspective of providing mental health services to include students feeling accepted in their environment, regardless of disability (Marshall & Rossman, 2011). Alfred Adler was an early contributor to social feeling (as cited in Bitter & Carlson, 2017).

Definitions of Terms

Gemeinschaftsgefuhl: Adler's overall tenet translates as social interest or community feeling. Adler held that clients and therapists create a community feeling or a therapeutic alliance that helps to develop a foundation for positive treatment outcomes (as cited in Watts & Ergüner-Tekinalp, 2017).

Individualized education plans (IEPs): IEPs are blueprints of students' educational programs that guide and manage the appropriate instruction and delivery of services (Cavendish & Connor, 2018).

Self-regulation: Self-regulation is the ability of individuals to control feelings of irritability and distress (Althoff et al., 2016; Leibenluft, 2011; Martin et al., 2016; Rao, 2014).

Service coordination: Service coordination refers to services developed through IEPs to address students' identified needs (Puddy et al., 2011).

Social feeling: This Adlerian term references students feeling accepted into the community and feeling a part of the social milieu (Watts & Ergüner-Tekinalp, 2017).

Assumptions, Scope, and Limitations

Assumptions

The first assumption was that the participants would provide honest answers to their experiences as service providers in the elementary setting who were working with students with ED. The secondary assumption was that similarities and differences in the participants' experiences would be gathered through the interview process.

Scope

The scope of this study was to gain insight into the lived experiences of special education teachers of students with DMDD who were responsible for teaching them and to gain the teachers' perspectives of the ways that they managed their emotional regulation when students with DMDD were volatile. The students were enrolled in the early elementary school setting. The problem identified in previous research has been that despite the gains in interventions for students with ED, there has been little improvement in long-term outcomes (Gable et al., 2012). Because DMDD is a relatively new identification in the *DSM-5* (APA, 2013), there was much to learn and develop. I

anticipated that this dissertation would shed light on the clinical experiences of the professionals who provide treatment to the student population with DMDD. In my search of the literature, I could not find any qualitative studies regarding the experiences of special education teachers working with students with DMDD.

Limitations

Identifying a target population with DMDD had its challenges. The diagnostic category DMDD is relatively new, so there was a limited target population from which to draw the convenience sample of special education teachers of students in Grade 2 or 3. I sought to provide insight into the daily experiences, interventions, and self-regulation of special education teachers working with students with DMDD.

The results were limited to qualitative interpretation rather than quantitative analysis. This phenomenological inquiry involved conducting interviews with a sample of special education teachers directly providing service to shed light on the daily psychological barriers that may have inhibited the academic success of students with DMDD. Another limitation was the concept of epoche. My perspective of the phenomenon under investigation was that of a special education teacher with more than 20 years of experience. One method to gain clarity was bracketing, or self-examination, which involved my writing a full description of my experiences as a special education teacher working with students with DMDD. I bracketed my personal experiences from the collected data to view the phenomenon as if for the first time (see Marshall & Rossman, 2011).

Transferability, external validity, and generalizability are weaknesses in qualitative studies (Marshall & Rossman, 2011). This study came from public school districts in the United States with certified special education teachers. Eight female special education teachers discussed their experiences working with male students in the elementary school setting. Thus, the findings may not be generalizable to other populations.

Significance of the Study

Leibenluft (2011) asserted that research with children and adolescents pointed to a 400% increase in bipolar identification between 1994 and 2003. Leibenluft, who found this increase in bipolar identification alarming, noted that the *DSM-IV-TR* (APA, 2000) did not describe childhood irritability accurately, something that may have been the reason for the rise in the bipolar identification in children and adolescents.

Leibenluft (2011) focused on the ways that nonepisodic irritability was related to bipolar disorder. Leibenluft and colleagues developed the term *severe mood dysregulation*, or SMD. Leibenluft's research was an effort to focus on adolescents and children whose bipolar identification was in doubt, as well as a way to reduce their overidentification of bipolar. Table 1 highlights the characteristics of DMDD and SMD.

Table 1

Characteristics of DMDD and SMD

DMDD (Perich et al., 2017)	SMD (Leibenluft et al., 2011)
1. Severe recurrent temper outbursts manifested verbally and/or behaviorally that are grossly out of proportion to the situation or provocation. 2. The temper outbursts are inconsistent with developmental level. 3. The temper outbursts occur three or more times per week. 4. The mood between temper outbursts is persistently irritable or angry most of the day and is observable by others. 5. Criteria 1–4 have been present for at least a year. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all the symptoms in Criteria 1–4. 6. Criteria 1 and 4 are present in at least two of three settings and are severe in at least one of these. 7. The diagnosis should not be made for the first time < 6 years or > 18 years. 8. Age at onset of Criteria 1–5 is < 10 years. **Exclusion criteria** • Distinct period(s) lasting > 1 day during which the full symptom criteria for a manic or hypomanic episode have been met. • The behaviors occur exclusively during an episode of major depressive disorder or are better explained by another mental disorder. • The symptoms are attributable to the physiological effects of a substance or to another medical or neurological condition.	1. Aged between 7 - 17 years, with the onset of symptoms before age 12. 2. Abnormal mood (specifically, anger or sadness) present at least half of the day most days and of sufficient severity to be noticeable by people in the child's environment (e.g., parents, teachers, and peers). 3. Hyperarousal, as defined by at least three of the following symptoms: insomnia, agitation, distractibility, racing thoughts or flight of ideas, pressured speech, intrusiveness. 4. Compared to peers, the child exhibits markedly increased reactivity to negative emotional stimuli that is manifest verbally or behaviorally. For example, the child responds to frustration with extended temper tantrums (inappropriate for age and/or precipitating event), verbal rages, and/or aggression toward people or property. Such events occur, on average, at least three times a week for the past 4 weeks. 5. The symptoms noted in the previous three items are currently present and have been present for at least 12 months without any symptom-free periods exceeding 2 months in duration. 6. The symptoms are severe enough in at least one setting (e.g., violent outbursts or assaultive at home, at school, or with peers). In addition, there are at least mild symptoms (distractibility, intrusiveness) in a second setting. **Exclusion criteria** • The individual exhibits any of these cardinal bipolar symptoms: elevated or expansive mood, grandiosity or inflated self-esteem, episodically decreased need for sleep. • The symptoms occur in distinct periods lasting more than 4 days. • The individual meets criteria for schizophrenia, schizophreniform disorder, schizoaffective illness, pervasive developmental disorder, or posttraumatic stress disorder.

DMDD (Perich et al., 2017)	SMD (Leibenluft et al., 2011)
	• The individual has met the criteria for substance use disorder in the past 3 months. • IQ < 80. • The symptoms are due to the direct physiological effects of a drug of abuse or to a general medical or neurological condition.

According to the literature, subsequent to the inclusion of DMDD in the *DSM-5* (APA, 2013), research has not provided adequate treatment findings for students with ED (Althoff et al., 2016; Chen et al., 2016; Copeland et al., 2013; Dougherty et al., 2014; Rao, 2014). More specific to the present study, the literature suggested that DMDD needs higher specificity regarding its identification and greater diagnostic precision (Chen et al., 2016; Mayes et al., 2016; Stringaris, 2011). The research has included psychopharmacology, family dynamics, and other treatment-related approaches (Chen et al., 2016; Dougherty et al., 2014; Leibenluft, 2011; Tourian et al., 2015; Tudor et al., 2016).

Summary

The NIMH (2009) estimated that more than 471,000 students have been identified with a general educational identification of ED. Of these students, at least 1% has been diagnosed with severe ED (Bradley et al., 2008; NIMH, 2009). In 2013, the APA added DMDD to the *DSM-5* as the newest diagnosis for children under the category of depression. The *DSM-5* estimated the prevalence of DMDD as 2% to 5% among children and adolescents. Since the inclusion of DMDD in the *DSM-5*, there has been limited general research on the topic and no research on treatment outcomes for the disorder. The purpose of my study was to examine the lived experiences of eight special education

teachers who provided support to students with DMDD and to obtain the teachers' perspectives about the ways that they managed their emotional regulation when students with DMDD were volatile. Presented in Chapter 2 is a review of literature relevant to the topic under investigation.

Chapter 2: Literature Review

The review of the literature found that despite inclusion of DMDD in the *DSM-5* (APA, 2013), research has remained limited. Much of the literature suggested that more research is needed to understand this complex diagnosis (Chen et al., 2016; Eagan et al., 2018; Nagourney et al., 2014; Palmer, 2014; Rao, 2014; Rojas & Hussey, 2018; Tourian et al., 2015; Tudor et al., 2016). When searching for studies that focused specifically on DMDD and special educators, no returns were recorded, highlighting the need for research focusing on the interactions and support from special educators for students with DMDD.

Marshall and Rossman (2011) asserted that the goal of phenomenological research is to arrive at the essence of the phenomenon being studied. The roots of phenomenology lie in the philosophical perspectives of Husserl and leading philosophers of the 20th century: Heidegger, Sartre, and Merleau-Ponty. Since its inception, phenomenology has been used in social and human sciences, nursing, psychology, and education. Phenomenology encompasses philosophy and a range of research approaches, with the three Western traditions of phenomenology being transcendental (Husserl), hermeneutic (Heidegger), and existential (Sartre; as cited in Kafle, 2011). I adopted Heidegger's hermeneutic approach.

Merlot-Ponty (as cited in Kafle, 2011) identified four qualities that are "celebrated characteristics" (Marshall & Rossman, 2011, p. 148) common to phenomenology: description, reduction, invariant structures (essences), and intentionality. Merlot-Ponty (as cited in Kafle, 2011) explained that describing the phenomena under investigation is

the aim of phenomenology and that reduction involves suspending or bracketing the researchers' experiences from those of the interviewees, the essence is the core meaning of the participants' experiences, and consciousness refers to intentionality of individuals' ideas.

Literature Review Research Strategy

Kafle (2011) proposed five steps to a qualitative research review to mirror the steps of phenomenological research:

Step 1: Bracketing the researcher's personal experience is part of the phenomenon to be investigated. In phenomenological research, the researcher identifies the phenomenon to be studied and then brackets personal experiences relevant to the phenomenon. For example, as a special education teacher with more than 20 years of experience, I was expected to understand that my experiences were separate from those of the participants.

Step 2: Conducting interviews with people who have experienced the phenomenon. As a literature review tool, the researcher would read the literature and decide what information would be selected and inclusive to the research phenomenon with a defined research strategy.

Step 3: Identifying meaningful statements that are empirical themes pertinent to the research phenomenon that are gathered from the selected research literature.

Step 4: Putting the meaningful statements into categories and interpreting them.

Step 5: Creating a thick and rich description, or the essence, of the phenomenon being investigated. The researcher describes the essence of the phenomenon as reported in the literature review.

For this literature review, I used several sources to collect relevant literature. Literature obtained from Walden University's Library of databases included ERIC, Education Research Complete Simultaneous Search, and Psychology Databases Simultaneous Search. Some search terms were *emotionally disabled*, *elementary-age emotionally disabled*, *behaviorally challenged students*, *severe emotional disability*, *special education teachers*, *teachers*, *DMDD with specifier intervention*, *disruptive mood dysregulation disorder*, and *primary emotionally disabled*. Aside from the search engines, news articles were collected through Google. Federal and state government resources supplied some of the reviewed sources: NIMH, U.S. Department of Education, and SDE. Most of the studies focused on pharmaceutical approaches to the treatment of DMDD. Consequently, interviews with and behavioral treatment approaches and classroom implementation with students with DMDD were not found.

For theoretical searches, I used the search terms *social feeling*, *social interest*, *social belonging*, *Gemeinschaftsgefuhl*, *lifestyle*, and *goals of misbehavior*, along with the name *Adler* as an additional search component. With limiters and more recent studies dating from 2010 to 2020, the number was reduced to 42. The search for *Alfred Adler phenomenology* and *Adlerian theory* produced 1,440 literature returns.

Conceptual Framework

I conducted this phenomenological study to examine the lived experiences of eight special education teachers who supported students with DMDD and their perspectives of the ways that they managed their emotional regulation when students with DMDD were volatile. The history of phenomenology began with Husserl (transcendental phenomenology). Husserl introduced phenomenology as an alternative to empirical science. In earlier research, phenomenology provided insight into the lived experiences in the field of nursing (Cronin et al., 2008). Husserl's student, Martin Heidegger, broke with his mentor and introduced hermeneutic phenomenology (as cited in Kafle, 2011). Meanwhile, in the early 20th century, Adler was developing his theory of Gemeinschaftsgefuhl, or social feeling. He purported that "the individual interprets situations from his or her lived experiences" or our lifestyles are the essence of our reality (as cited in Carlson et al., 2006, p. 12).

Prephenomenological History

The earliest precursors to phenomenology are found in Eastern philosophies. The philosophical differences between Eastern and Western philosophies lie in the terms of "being" in the West and "ethics" in the East. In Buddhism, the goal is to lessen human suffering by examining the conscious, or Parmartha Satya, meaning real, and Samvriti Satya, meaning the individual or practiced truth. In Hindu, Brahman, meaning the infinite truth, and Atman, meaning the individual one, point to the ontology of the individual setting the self free from desires, called liberation Samadhi or Mokshya (as cited in Kafle, 2011). What brings this into Western philosophy is Advaita Vedanta. Wilberg (2006)

noted that Heidegger's focus on the principle of awareness is what creates reality, and Hindu philosophy makes this connection with Advaita and Chit (Awareness) over Sat (Being; Kafle, 2011). These philosophies all point to individuals being set free to become aware of their personal realities.

Husserl and Phenomenology

Husserl was a German philosopher and mathematician whose radical split from the natural sciences was the result of his disillusionment with the approach of studying human experiences (as cited in McConnell-Henry et al., 2009). Husserl asserted that the lived experience, or human experiences in the life-world (i.e., Lebenswelt), is the result of conscious awareness and that the mind is directed toward objects, or intentionality (Erciyes, 2019; Kafle, 2011; as cited in McConnell-Henry et al., 2009). Husserl emphasized that the world should be examined prereflectively through the use of epoche. He asserted that researchers must bracket any prejudgments and rely on intuition and imagination to fully understand the true essence of the participants' experiences with the phenomena being studied (as cited in McConnell-Henry et al., 2009); this suspension of researchers' experiences is called epoche (Erciyes, 2019).

There are four tenets of transcendental phenomenology and its application to procedural issues when using phenomenology. The first tenet is a return to the traditional tasks of philosophy, or Scientism, as the empirical approach to exploring the world. Husserl advocated for a return to the traditional Greek conception of philosophy as a search for wisdom. The second tenet is the suspension of all judgments about reality to pursue the natural attitude, or Husserl's epoche. The third tenet is the intentionality of

consciousness, meaning that consciousness is always directed to an object that is part of an individual's reality. The fourth tenet is the joining of consciousness with reality rather than the separation of the person from the experience. Overall, reality is perceived only within the meanings of the individuals' own experiences (Erciyes, 2019).

Husserl's transcendental phenomenology was a radical departure from the Descartes philosophy of duality (Erciyes, 2019; Kafle, 2011). Husserl saw the neutral state of the noesis (i.e., act of intentionality) and the noema (i.e., intended object) as the underlying components of reduction. Individuals must first separate intention from existence to realize its transcendence. The transcended ego begins to reflect the self toward the essence of the phenomenon (Erciyes, 2019).

Heidegger and Phenomenology

In contrast to Husserl's epoche, Heidegger broke away to propose hermeneutics. Hermeneutics comes from the Greek word hermeneusin, meaning to understand or interpret. It is inspired from the character Hermes in Greek mythology; Hermes was the messenger between the people and the Greek gods (as cited in Gadamer, 2006). Heidegger's hermeneutic phenomenology was the process of creating rich and deep accounts of phenomena through understanding the textual language or intuition (as cited in Kafle, 2011).

Heidegger's Dasein, or beings of being, had its foundations more in Eastern philosophies (as cited in Kafle, 2011). This approach acknowledged the challenges of bracketing and embraced the implicit assumptions by making the researchers' experiences explicit, not suspended. Heidegger rejected Husserl's bracketing and

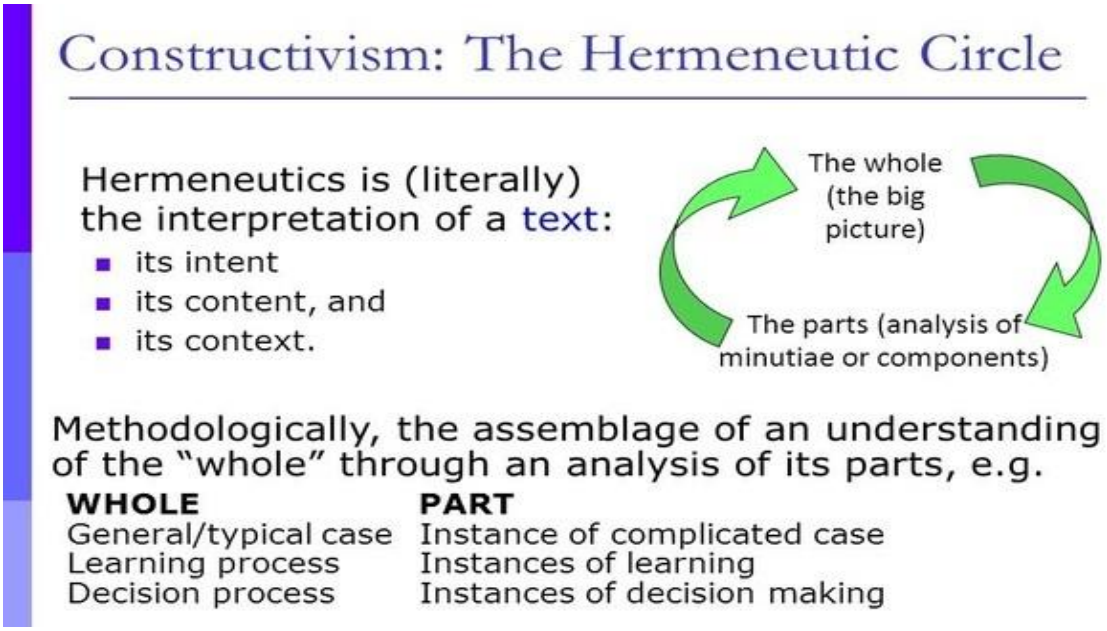
considered researchers to be legitimate components of the research phenomena; he held that context helped to shape understanding (as cited in McConnell-Henry et al., 2009).

In Heidegger's criticism of Husserl, he recognized that Husserl had failed to acknowledge the importance of the researchers' experiences, which were left out through bracketing or epoche (as cited in McConnell-Henry et al., 2009). It is the circular movement of the whole of the interpreter and the parts of the participants that incorporate and contribute to reading, reflective writing, and interpretation (Kafle, 2011). Heidegger's phenomenological approach with back-and-forth questioning and reexamination of the text is what is known as Heidegger's hermeneutic circle (as cited in Farrell, 2020).

Heidegger's hermeneutic circle is best described as the process of understanding the whole from the individual and the individual as being part of the whole; therein lies the art of speaking and understanding in a circular movement (Gadamer, n.d,). Gadamer (n.d.) further explained this process by providing the example of learning a new language. When individuals learn a new language, they parse out the meaning through the expectation of meaning and the preceding context. The task of understanding then becomes the concentric circles of movement back and forth to reach a unified meaning. It moves from whole to part and back to whole (Gadamer, n.d.). Figure 1 is an illustration of Heidegger's hermeneutic circle.

Figure 1

The Cycle of Heidegger's Hermeneutic Circle



Gellweiler et al. (2018) interviewed volunteers to understand the meaning of their experiences as volunteers at sporting events. The data collection steps were as follows:

1. The researchers presented the whole of the experiences as volunteers.
2. The researchers extracted significant subthemes or parts from the descriptions.
3. The descriptions were put into meaningful statements and clustered for themes.
4. The researchers integrated these themes into overarching themes.

This study concluded with Gellweiler et al. (2018) returning to the RQ to discuss how the results impacted the volunteers. Moreover, this study highlighted the psychological aspect of using a phenomenological approach to tell the individual stories as they related to the RQ.

Phenomenology and Alfred Adler

Adler understood the importance of Heidegger's hermeneutic circle put forth by Gadamer (n.d.). Adler paralleled this approach by reinforcing that the development of a strong and respectful therapeutic relationship aids in open dialogue, understanding, and perspective. Adler understood that it was important to instill in early life the notion of community (as cited in Watts & Ergüner-Tekinalp, 2017). Adler described the need for children to find their sense of worth and importance in the community. Adler's social constructionist perspectives created a connection with learning and psychological development as conversational and interrelational (as cited in Ferguson, 2010). Adler understood how human beings derive personal worth through their social experiences. It could be posited that Adler saw human relations phenomenologically in the context of Dasein, or beings of being (as cited in Erciyes, 2019). I derived my themes from the analysis of the interview responses from a sample of special education teachers who described the lived experiences of working with students with DMDD.

Adler and Social Feeling

Adler's motivational theory provided a foundational theory in conjunction with the term social feeling (Ferguson, 2010). His motivational theory supports the direct contextual social learning that many students with DMDD experience. As Ferguson (2010) referenced, all behavior is goal and future oriented. Adler's motivational theory describes how the group environment, or the classroom in this case, can lend support and aid in the development of social skills through experiential and brief intervention methods (as cited in Carlson et al., 2006). Brief intervention methods of working with

students with DMDD include cognitive behavioral therapy (CBT), an evidence-based treatment that has been found effective with children (NIMH, 2009). CBT can support the students' individuality. When the emotional and social needs that derive from Adler's motivational theory are supported and nurtured, positive social and academic outcomes are produced for students with DMDD (Dougherty et al., 2014; Leibenluft, 2011; Tourian et al., 2015).

Social Feeling and DMDD

Adler proposed three life tasks that human beings strive to master: work, friendship, and love-intimacy (as cited in Carlson et al., 2006). First, the application of work for children equates to children beginning to crawl with encouragement and support. The children are encouraged and supported, and reciprocally, they learn from the environment and their nurturers that they are thriving. According to Adler, children's private logic, or personal beliefs, develop from these beginning experiences and can dictate positive or negative life goals for the future. For example, when children grow up with negativity and neglect, the private logic that develops is that "the world is a cruel and lonely place; I do not matter, and I am not worthy" (Carlson et al., 2006, p. 15; Ferguson, 2010).

Adler's second life task of friendship comes through the development of successful relationships (as cited in Carlson et al., 2006; Ferguson, 2010). The successful early relations of parents and caretakers support mastery of this task. Once children enter school, they continue to use their private logic to develop and negotiate ways to create and manage friendships. Each stage of developing relationships builds on the last.

Adler's final life task is love-intimacy (as cited in Ferguson, 2010). Once children feel supported and confident to establish strong friendships, they are more capable of progressing to love and intimacy (Carlson et al., 2006; Ferguson, 2010). These constructive tasks build on the ability to reflect the self-love that is within.

In education, Adler discussed students as striving for power and importance (as cited in Maniacci & Johnson-Migalski, 2013). Adler posited two major motivations for children, namely, strive for superiority and strive for community embeddedness. All human beings feel the need to belong on a macro- (i.e., school) and a microlevel (i.e., family). Adler considered this connection as the major desire for change. One philosophical tenet ascribed to Adler is the notion of equilibrium, which states that "if life feels status quo without much of a challenge, upset or unsettled feeling, then there is not much motivation for change to occur" (as cited in Maniacci & Johnson-Migalski, 2014, p. 175). Adler also purported that human behavior is socially embedded (as cited in Ferguson, 2010) by arguing that children have a desire to exercise innate independence from the group through social feeling (Sperry, 2010). Moreover, through children's development of private logic, or how they see themselves based on these feelings, children pursue goal-directed behavior that may be functional or dysfunctional; Adler termed these the *goals of misbehavior* (as cited in Carlson, et al., 2006).

Adler believed that behavior is goal directed through social belonging (as cited in Ferguson, 2010) and that individuals possess an innate desire to belong that compels them to engage in social relationships (as cited in Sperry, 2010). For children, these social relationships begin with family and expand into the school environment and the

classroom (Ferguson, 2010). Children with DMDD manifest complex and volatile displays of emotion and behavior. Adler posited four goals of misbehavior: attention, power, revenge, and display of inadequacy. Considering the concept of social belonging, the behaviors of students with DMDD may be misdirected goals that are compensating for perceived inferiority (Ferguson, 2010; Sperry, 2010).

Marshall and Rossman (2011) suggested that phenomenological research be conducted to learn from the participants' experiences rather than answer questions developed by the researchers. After all, the lived experiences are those expressed by the participants, not the researchers. In this chapter, the review of the literature suggested that despite evidence-based interventions, not enough students with ED are experiencing successful academic outcomes (Durlak et al., 2011; Gable et al., 2012; Puddy et al., 2011).

Phenomenology and Special Education Teachers

Providing classroom support for students diagnosed with DMDD can be told from the perspectives of special education teachers. Becker and Bowen (2018) followed an interpretive phenomenological approach to obtain the perspectives of service providers educating students who were deaf or hard of hearing and English language learners. Becker and Bowen obtained their information from interviews with service providers regarding the unique population of students who were deaf or hard of hearing and English language learners. The purpose of my study was to interview a sample of special education teachers to learn about their experiences in the classroom with students with DMDD.

Review of Literature

Identifying Students Earlier

Early identification of ED has long been promoted as one way to ensure successful academic outcomes. Bradley et al. (2008) focused on three longitudinal studies whose participants were as young as 9 years of age and as old as transitioning into young adulthood. Bradley et al. examined the outcomes over a 10-year period of school services for students identified with ED, and they found that the students as a group showed little or no academic or social improvement. For this reason, research was needed to address and better understand the experiences of students with DMDD from the perspectives of a sample of special education teachers.

Current researchers of DMDD such as Chen et al. (2016) have suggested that the complexity of chronic and severe irritability may cloud other salient features of students diagnosed with DMDD. For example, the persistent irritability and anger of DMDD do not include the features of severe SMD noted by Leibenluft (2011), who described the complex symptoms that present in pediatric bipolar disorder. Leibenluft cited the extreme irritability and rapid cycling from elevated mood to depression that resulted in a 400% increase in this diagnosis.

Chen et al. (2016), among other researchers, conducted research to reduce the overdiagnosis of bipolar disorder in children. This complex nature of DMDD has opened the door to more research. Features that are considered activation, such as insomnia, distractibility, increased speech, and racing thoughts, are the criteria for attention deficit

hyperactivity disorder (ADHD). Hence, more studies may help to better categorize and improve earlier intervention methods.

Chen et al. (2016) posited that behavioral approaches could be included in treatment protocols for DMDD. Chen et al. proposed programs such as the Webster-Stratton technique, which teaches parents different strategies to temper children's emotional irritability. Chen et al. also indicated that behavioral therapies used in combination have been found to improve children's cognitive functioning.

Some intervention strategies have resulted in improvements in students with DMDD. In a phenomenological study by Ware et al. (2012), group social instruction improved the social functioning of students diagnosed with mood disabilities. The outcomes reported by the participants were unconditional acceptance and support, positive experiences from the group, and the ability to understand the experiences of others (Ware et al., 2012). I designed the current study to conduct interviews with a sample of special education teachers to examine their lived experiences of supporting students with DMDD and their perspectives of the ways that they managed their emotional regulation when students with DMDD were volatile.

Pham et al. (2014), Puddy et al. (2011), and Ware et al. (2012) found that coordinated school services that resulted in positive outcomes were research-based behavioral strategies and support from school psychologists for special education teachers and parents. The NIMH (2009) suggested that although diagnosing young students may be challenging, focusing on problematic behaviors early can help to diagnose ED such as DMDD. Typically, students who are 10 years of age and younger

are considered unreliable in providing insight into their own behaviors and struggles (Rudy & Levinson, 2008). However, through rapport building, children can more readily articulate their needs and concerns (Rudy & Levinson, 2008; Ware et al., 2012).

Some studies have shown that without early intervention, some students may experience long-term difficulties. Ware et al. (2012) reported that of 65% of youth diagnosed with behavioral disorders who exited school in Grades 9 to 12, 28% of these students had been arrested at least once before leaving high school and 58% had been arrested within 5 years of withdrawing from high school. Two newsworthy examples of how the behaviors indicative of DMDD were observed in two early elementary education students were Adam Lanza (AL) and Elliot Rodger (ER; Eagan et al., 2014; Griffin & Kovner, 2013a; Nagourney et al., 2014; Palmer, 2014; Rojas et al., 2018; Roussey, 2013).

Emotionally Disabled in the Media

Over the last 7 years, violent mental health issues have been the focus of media attention (Griffin & Kovner, 2013b; Palmer, 2014; Roussey, 2013). Violent shootings by young adults diagnosed with conditions involving irritability, the inability to maintain relationships, and the tendency to be socially withdrawn have led to a firestorm of attention across the United States. Two of these noted young adults were diagnosed in elementary school. AL was diagnosed with autism spectrum disorder in 1999 and obsessive-compulsive disorder in 2005 (Griffin & Kovner, 2013a; Roussey, 2013). ER was diagnosed with ED.

Adam Lanza: Connecticut

On December 14, 2012, in Newtown, Connecticut, 20-year-old AL gained entrance into Newtown Elementary School armed with a semiautomatic rifle, multiple firearms, and more than 253 live rounds of ammunition. He killed six adults and 20 students enrolled in Grade 1. AL then killed himself. Prior to coming to the school, AL shot and killed his mother while she was sleeping. Twenty-eight people, including AL, died that day (Griffin & Kovner, 2013a; Roussey, 2013).

AL's mental health issues did not begin the day that he walked into the elementary school. A neurological/developmental evaluation in early April 1997 just before AL's 5th birthday noted that AL was an extremely active young child: He never slept through the night; continued to make up his own language; and reportedly did not like to be held, kissed, or hugged. According to evaluators, AL was observed demonstrating behaviors reflective of DMDD, one of which is severe temper tantrums. Further corroboration of the preschool observations was held in Grade 5, when AL was reported to have symptoms suggestive of DMDD (e.g., difficulty understanding social situations; maintaining interpersonal relationships, including the ability to show warmth and empathy; and pervasive mood of unhappiness or depression). Because of the protective nature of his mother and few educational records, there was scant history to proceed with mental health identification.

Dr. Paul Fox, a now-retired psychiatrist at the Yale Child Study Team, reported that the psychological assessment found AL to be "very rigid" and "resistant to engagement" and recalled "aggression problems" (as cited in Roussey, 2013). A

collaborative effort by a school team comprising service providers, teachers, and parents could have provided social instruction and programs such as Parent Management Training to decrease mood dysregulation and anger outbursts. Another parent training approach could have been the Webster-Stratton technique, which provides parental skills development, as part of a comprehensive approach for AL and his family, as suggested by Kirby et al. (2016) and Rao (2014). According to the literature, if AL's family had been provided with more open communication and supportive programs such as Parent Management Training, it could have made a difference in positive growth and development in behavioral and academic goals (Ditrano & Bourdeaux-Silverstein, 2006).

An article in *The New York Times* by Rojas and Hussey (2018) featured updated information by *The Hartford Courant* after a 5-year deliberation with the Connecticut Supreme Court. The article detailed research and reports that reflected AL's deteriorating state of mind beginning in preschool. It was noted in the reports by psychologists and school administrators, along with AL's personal writings, of separation from peers beginning in preschool. The records intimated how Adam's developmental speech difficulties foreshadowed the tragedy of December 12, 2012.

Rojas and Hussey (2018) wrote in *The New York Times* that the information collected served to support early intervention:

> The state hid the writings, reports and records not just from the press, but from researchers, experts and clinicians who could have learned more about what early warning signs might have been missed; what educators and clinicians need to pay

attention to when dealing with angry, lonely children; what prevention strategies might be helpful in preventing another such tragedy from ever happening again.

Elliot Rodger: California

On May 23, 2014, in Isla Vista, Santa Barbara, California, 22-year-old ER killed six people and injured 13 others. Eight victims had gunshot wounds, four victims were hit by his vehicle, and another victim suffered an injury of unknown origin. When the police pulled ER from his car, they found three handguns and 400 rounds of ammunition in his possession. He died of a self-inflicted gunshot wound.

Unlike AL, ER's early elementary intervention services prior to the age of 8 years had been limited. Nagourney et al. (2014) pointed to a delay in services that was paramount around his 8th birthday. A family friend whose son was in elementary school with ER described him as "emotionally disturbed" and "they would not want their son with [ER]" (as cited in Nagourney et al., 2014).

ER's treatment interventions were increased in high school, but they had little success. What has been consistent in what has been written about ER as well as AL is that the parents would have benefitted from support such as the Parent Management Training program to decrease mood dysregulation and anger outbursts as well as the Webster-Stratton technique. Comprehensive and early intervention may have helped to support the parents and bridge services (NIMH, 2009; Puddy et al., 2011).

AL and ER displayed DMDD phenotypes that were addressed as concerns by the special education teams: withdrawn, isolated, unable to maintain peer relationships, aggressive, and manifestation of a persistent mood of unhappiness and depression. Even

with all of these symptoms, it was still not possible to render a diagnosis and offer effective interventions to support the parents. I investigated what has changed since these cases by interviewing a sample of special education teachers.

Researchers have argued that early identification is critical to improving behavioral outcomes (Dougherty et al., 2016; Ware et al., 2012). Dougherty et al. (2016) and Ware et al. (2012) asserted that early patterns of aberrant behavior are intractable if left untreated but are more amenable to interventions at early ages. In the cases of AL and ER, it is reasonable to speculate that a diagnosis and consistent support with early interventions may have provided more adaptive behavioral patterns.

Special Education Teachers

The literature has held information about the overidentification of DMDD under the umbrella category of ED. Researchers have posited that the required broad training of special education teachers may inhibit provision of the best practices and complex interventions required for students with DMDD (Copeland et al., 2013; Dougherty et al., 2016; Puddy et al., 2011; Ware et al. 2012). A metastudy by Bradley et al. (2008) that included the Special Education Elementary Longitudinal Study, the National Longitudinal Transition Study-2, and the National Adolescent and Child Treatment Study, noted that students with mood disorders are more likely to receive interventions outside of the classroom rather than with their nondisabled peers.

When viewed from an Adlerian perspective, modern psychological and behavioral approaches in education have not focused on children's private logic. Removing children from the classroom and not giving them the opportunity to learn alongside their peers can

send a negative message: “You are worthy to participate in the school community only under certain circumstances, given the lack of trust in you and your inferiority.”

Students may be striving for superiority, but because of the acquired perception of inferiority, they ultimately may begin to lack the courage to persevere. Each time that the students are removed under certain conditions, the inferiority that the children harbor is being reinforced (Ferguson, 2010). Bradley et al. (2008) found that increased opportunities in the classroom correlated with increased student achievement and behavioral outcomes. However, they also found that children identified with a mood disorder had limited participation rates with instructional time because of behavioral dysregulation. Bradley et al. also asserted that special education teachers who were confronted by inappropriate behaviors and had not been trained clinically to understand the complexities of ED were more likely to send students who were emotionally challenged to alternate settings, with the result being time outside the classroom and lost interactions with regular education peers. In addition, Bradley et al. and Ferguson (2010) suggested that one of the most salient approaches for improving behavioral outcomes is through positive interactions between special education teachers and students with DMDD.

Building on positive outcomes, Adler described how children strive for superiority with an “I can do it” attitude and derive pleasure, acceptance, and growth from the acceptance of the group, society, or the classroom (as cited in Ferguson, 2010). Ferguson (2010) also pointed out that special education services should foster feelings of community and encourage functional psychological development. Therefore, developing

positive relationships should be important for students with DMDD who demonstrate Adler's goals of misbehavior: seeking attention, power, or revenge, and experiencing feelings of inadequacy. My search of the literature did not return any studies focused on obtaining the experiences of special education teachers working with elementary students with DMDD. I sought to understand how special education teachers managed the dysregulated behaviors of students with DMDD. Along with building positive relationships for success, the literature has identified other factors that are important to the success of students with DMDD: school advocacy, teachers' knowledge of the clinical diagnosis, and therapeutic services geared to the specific needs of the students and their families (Bradley et al., 2008; Durlak et al., 2011; Gable et al., 2012; Rao, 2014; Tudor et al., 2016).

History of DMDD

This section presents a brief history of the development of DMDD and its inclusion in the *DSM-5* (APA, 2013). Then the nosology of DMDD and its precursors is addressed. Rao (2014) wrote about the ways that the manic behavior of children and adolescents manifests differently from that behavior in adults. Rao indicated that even though this debate began in 2010, it was not until a special task force for *DSM-5* (APA, 2013) suggested the condition as temper dysregulation disorder with dysphoria. Rao's discourse supported earlier arguments by Stringaris (2011) and Leibenluft (2011). Stringaris credited Leibenluft with developing the earlier ad hoc reference of SMD.

In 2011, Leibenluft reported studies indicating that severe nonepisodic irritability in children and adolescents impacted functioning at home, at school, and with peers.

During this period, the *DSM-5* (APA, 2013) was being prepared for publication, so SMD presented difficulty in classifying the severe irritability of this condition that did not match the criteria for bipolar disorder. Leibenluft realized that children and adolescents were being diagnosed with bipolar disorder at alarming rates. Chen et al. (2016) reported Leibenluft's data collection as an alarming increase of 400% over previous periods.

Interesting commentary regarding inclusion of DMDD in the *DSM-5* (APA, 2013) came from Leibenluft (2011), who indicated that even though DMDD symptoms did not specifically meet Criterion A for bipolar disorder of distinct periods of elevated and expansive, or irritable mood, having the disorder under bipolar disorder would have facilitated provision of the necessary mental health treatment for children and adolescents. As reported by Chen et al. (2016), studies such as the one by Leibenluft prompted the *DSM-5* task force to create a new diagnostic category of DMDD (APA, 2013).

Psychiatric Nosology

Assessing psychopathology in children is complex because of developmental variations (McTate & Leffler, 2017). DMDD has presented its share of complex nosology partly because of variations in the developmental stages in children. In early research, Leibenluft (2011) presented results supporting symptoms of SMD as a precursor to DMDD: temper outbursts that are developmentally inappropriate, frequent, and extreme, and a negatively balanced mood of either anger or sadness between outbursts. Leibenluft stated that the impairment must be present in one of three contexts: at home, at school, or with peers. Even more, Leibenluft found that children were being diagnosed as bipolar

because of the need to have a category that would fit the behavioral sequelae. Leibenluft also noted that without a diagnosis, mental health treatment was not being rendered. According to Rao (2014), very little research has been published to support DMDD and that the criteria for SMD are related, but not a match.

Exclusions in the definition of DMDD found in the *DSM-5* (APA, 2013) rule out major depression that cannot be explained by any other mental disorders, including autism spectrum disorder, persistent depressive disorder/dysthymia, posttraumatic stress disorder, or separation anxiety disorder. DMDD cannot coexist with bipolar disorder, intermittent explosive disorder, or oppositional defiant disorder (APA, 2013; Rao, 2014). Compared to SMD, DMDD requires only three of the five hyperarousal states to be identified as present: insomnia, pressured speech, agitation, a flight of ideas, and distractibility. In addition, according to Rao (2014), the age of onset for SMD was prior to age 12 years, the consecutive symptom-free period was 2 months, and comorbid issues impacted the pure identification of DMDD.

Althoff et al. (2016) found that neurodevelopmental and learning disabilities correlated in their study of adolescents. They also reported a steep decline in DMDD in adolescents, an outcome that suggested a maturational effect. A drop in demonstrated behaviors in adolescents suggested that irritability and behavioral outbursts may have been associated with learning and/or developmental disorders and that further research in this area should be considered.

Similar results were noted in earlier studies by Copeland et al. (2013) and Rao (2014), both of whom found that even though DMDD shared correlates with all

psychiatric disorders, the most prevalent levels were depressive and oppositional defiant disorders. Moreover, the students in Copeland et al.'s study had more social impairments, more school suspensions, less access to treatment, and higher levels of poverty. One issue in McTate and Leffler's (2017) study was the lack of an assessment instrument that could navigate through the complex symptoms when trying to diagnose DMDD. They argued that in their analysis of previous research, no specific instrument had been used to account for the complex features of DMDD.

Diagnosing a mood disorder in children is difficult, as indicated by the varied and inconsistent oscillation between elevated and depressed moods. To reduce the impact of diagnosing and to ensure validity, reliability, and better interrater reliability, McTate and Leffler (2017) suggested using structured and semistructured interviews such as the Children's Interview for Psychiatric Syndromes or the Mini-International Neuropsychiatric Interview for Children and Adolescents. They found that the use of these instruments with some modification could help to diagnose DMDD symptoms. However, McTate and Leffler did caution that these two measures should not be used in isolation, but as part of an integrated approach, along with personal, educational, and occupational histories as well as clinical interviews to support a diagnosis of DMDD.

Issues of Category

The categorization of DMDD and subsequent inclusion in the *DSM-5* (APA, 2013) presented difficulty because of its complex symptoms (Copeland et al., 2013; Freeman et al., 2016). Similarly, Rao (2014) presented two arguments about the ways that clinical irritability is manifested differently in children and adolescents than in

adults. Rao asserted that children and adolescents manifest persistent, nonepisodic, and severe irritability rather than distinct euphoria or irritable episodes. The other inconsistency observed daily was the rapid cycling of elevated to depressed moods in children and adolescents. The severe irritability seen in children and adolescents prompted a 400% increase in bipolar diagnosis in the United States.

This increase in the number of bipolar diagnoses was the motivation for Leibenluft (2011) to find a category that would support immediate and supportive treatment for children and adolescents. The narrow symptom of chronic irritability fell under bipolar disorder and provided a much debatable home (Benarous et al., 2020; Leibenluft, 2011; Mulraney et al., 2015; Stringaris, 2011; Rao, 2014). The symptoms for diagnosing presented with difficulty, but methods of assessment also were challenging.

Prior to diagnosis, there must be a collection of data obtained through assessment. McTate and Leffler (2017) suggested using structured and unstructured methods to avoid rater-reliability and issues of bias. According to the research, and given the most recent inclusion of DMDD in the *DSM-5* (APA, 2013), extant instruments have not been evaluated, calling into question the reliability and validity of the assessment results for DMDD (Dougherty et al., 2014; Rao, 2014; McTate & Leffler, 2017). Structured interviews provided a template for interviewers to use that had the same wording and directions for improved rater-reliability.

Current Treatments

Even though the current study examined the lived experiences of special education teachers who supported students with DMDD and their perspectives of the

ways that they managed their emotional regulation when students with DMDD were volatile, there have been limited randomized trial studies on precise treatment outcomes. No specific pharmacologic treatment has yet been recommended for DMDD (Chen et al., 2016; Leibenluft, 2011; Rao, 2014; Tourian et al., 2015; Tudor et al., 2016). When Leibenluft (2011) began detailing and researching the SMD nosology to find a treatment approach to decrease the diagnosis of bipolar disorder in children and adolescents, pharmacological treatment was the initial approach to reducing the complex and severe mood symptoms. Subsequently, the literature has been dedicated to treatment approaches that have included pharmacological but few behavioral approaches for DMDD.

Pharmaceuticals

In their 2015 peer-reviewed study, Tourian et al. suggested that the literature was lacking in randomized control trials supporting treatment options for DMDD. This suggestion has been reflected in other studies (see Chen et al., 2016; Mayes et al., 2016; McTate & Leffler, 2017; Rao, 2014; Tourian et al., 2015).

To decrease aggression, methylphenidate is suggested when comorbid with ADHD; risperidone has been found effective with diagnoses of conduct disorder, autism, and intellectual disability. Low responses to treatment have been found with lithium, anticonvulsants, SSRI, SNRI, and alpha-2 antagonists. A note of caution to inducing mania was indicated in Rao (2014) regarding the use of SSRIs or stimulants in youth.

Tourian et al. (2015) suggested that further studies are needed to replicate the findings of chronic irritability associated with a depressive disorder in children and adolescents. If these finding hold to be associated with pediatric depression, possible

options could be citalopram and fluoxetine. In combination with psychopharmacology, some psychotherapeutic methods have had some success and have been recommended.

Leibenluft (2011) noted the difficulty in treatment modalities to address the complex and severe symptoms of irritability and mood disorder associated with DMDD. There has been agreement in the literature regarding the pharmaceutical medications suggested for decreasing the severity of DMDD symptoms (Chen et al., 2016; Rao, 2014; Tourian et al., 2015). In addition, Tourian et al. (2015) noted that because it may be a few years before more consistent and reliable guidelines will be available, pharmaceutical management will have to target symptoms.

Caution was offered by researchers regarding DMDD and its early inclusion in the *DSM-5* (APA, 2013) as it pertained to the treatment of children and adolescents. Copeland et al. (2013) cautioned against inappropriate or untested treatment being no less of a concern as the absence of treatment. When considering intervention measures, Tourian et al. (2015) recommend that pharmacologic treatment be considered as an adjunct, not a standalone measure, to psychotherapeutic modalities with children and adolescents.

Psychotherapeutic Behavioral Approaches

Chen et al. (2016) reviewed treatment strategies and approaches to DMDD and concluded that certain behavioral approaches were useful as part of combined treatment. For example, a team from the Yale Child Study Team led by Tudor et al. (2016) conducted a case study of a 6-year-old girl that included CBT. Prior to their study, no other studies had attempted to use CBT as an intervention. Tudor et al. integrated

genetics, neurology, molecular biology, and cognitive science to secure their findings. Tudor et al. reiterated that medication alone may not yield the expected outcomes of regulating behavior. They concluded that the more integrated and team discipline approach, along with the Parent Management Training program, produced a decrease in mood dysregulation and anger outbursts.

The Webster-Stratton technique is a parent training program that provides not only parent skills development as part of a comprehensive approach to treatment but also systematic data for intervention outcomes (Kirby et al., 2016; Rao, 2014). Dougherty et al. (2017) found that the risk factors for future psychopathology for children diagnosed with DMDD that included a maternal history of depression combined with a child's emotional and behavioral lability/dysregulation were greater predictors for poor outcomes. The Webster-Stratton technique would provide support to DMDD parents whose children presented with emotional dysregulation and headstrong characteristics (Dougherty et al., 2017; Rao, 2014).

Suggested Research

The future direction of the literature points to providing more insight into the complexity of DMDD and the need to clearly define phenotypes (Chen et al., 2016; Dougherty et al., 2017; Rao, 2014; Tourian et al., 2015; Tudor et al., 2016). Leibenluft (2011) asserted that future researchers need to provide clarity on treatment modalities. Researchers continue to struggle to understand which treatment modalities are the most effective with students with DMDD.

Summary and Conclusions

I conducted the study to fill gaps in the literature by conducting interviews to examine the lived experiences of special education teachers who supported students with DMDD and their perspectives of the ways that they managed their emotional regulation when students with DMDD were volatile. The intent of the study was to provide some direction in delivering early intervention services to students with DMDD. Supporting students with DMDD with coordinated and balanced support would provide holistic success within the school and home environments.

Presented in Chapter 2 was information about the history of phenomenology, DMDD, and the addition of DMDD to the *DSM-5* (APA, 2013). A brief history was offered of the origins of phenomenology with Husserl and Heidegger, Adler's social feeling, and Heidegger's hermeneutic circle (Gadamer, n.d.). The early research of Leibenluft (2011) highlighted the complexity of diagnosing DMDD and the ways that she sought to curb the overidentification of bipolar disorder in children and adolescents. The stories of two young adults who had histories of phenotypes ascribed to DMDD and their tragic outcomes were discussed. Efforts at pharmacologic and behavioral approaches have been documented through limited research (see Chen et al., 2016; Leibenluft, 2011; Rao, 2014; Tourian et al., 2015; Tudor et al., 2016). Finally, future research focusing on more behavioral and parental support programs, as well as pharmaceutical trials, should be conducted to support positive outcomes for students with DMDD. Chapter 3 provides details of the methodology used to conduct the study.

Chapter 3: Research Methods

The purpose of this phenomenological study was to examine the lived experiences of special education teachers who supported students with DMDD and their perspectives about the ways that they managed their emotional regulation when students with DMDD were volatile. The special education teachers had direct knowledge of the phenomenon under investigation. As Heidegger suggested, participants bring their "preconceptions to a study" or personal experiences to make sense of a phenomenon (as cited in Behal, 2014, p. 40).

Research Design and Rationale

The guiding RQ and SQ were as follows:

RQ: What were the lived experiences of special education teachers who supported students with DMDD regarding a typical academic day, social challenges and needs, challenges as providers, student challenges as learners, and social feeling for students with DMDD?

SQ: How did special education teachers manage their emotional responses in the classroom when working with students with DMDD who were volatile?

When conducting qualitative research, it is important to interpret the nature of "being" (Behal, 2014, p. 40). Heidegger believed that people develop meanings from their experiences. Meanings can be visible in that they are manifested through more overt actions, but they also can have private meanings that come from the development of private logic in how individuals see themselves through their interactions and relationships (Behal, 2014). In this research, I sought to convey the experiences of special

education teachers who supported students with DMDD. Conducting a qualitative study helped to facilitate an understanding of the lived experiences of the participants (Behal, 2014; Marshall & Rossman, 2011).

The experiences of the participants were different from each other. The special education teachers' perspectives of working with students with DMDD took on different meanings depending on the setting, situation, and moment in time. Phenomenology enabled the participants to present themselves in the environment and freely share the nuances of their experiences. For example, support for students with DMDD during morning classes may have had to change later in the day, and if the students were on medication, their effectual needs also may have needed to change in the latter half of the day. Students with DMDD may benefit from immediate therapeutic support, but once those needs have been addressed appropriately, the students may continue to assume their academic responsibilities either in the classroom or in another supportive learning environment. The results of this study provided insight into students with DMDD, as told from the perspectives of eight special education teachers.

Role of the Researcher

Kafle (2011) noted that qualitative research focuses on the meaning of the human experience and the ways in which that meaning arises. Qualitative researchers are the primary data collection instrument. They conduct interviews and make observations. With this sustained contact come potential ethical and personal issues, and Marshall and Rossman (2011) suggested that researchers who conduct phenomenological studies should bracket their experiences so that they remain separate from those of the

participants. This neutral position is referred to as epoche, or bracketing, of personal experience from those of the interview respondents (Behal, 2014, p. 52).

My experiences shaped my perceptions of the therapeutic and academic needs of students with DMDD. I was a special education teacher for 20 years. Before teaching in the public school system, I spent 4 years teaching in a clinical school. The student population, which spanned Kindergarten to Grade 12, came from neighboring districts. The annual tuition in one of these clinical schools could cost $50,000. In extreme behavioral cases, school districts removed students from everything that was familiar to them (i.e., family, school, friends, and community) to ensure the success of treatment (Durlak et al., 2011; Puddy et al., 2011).

Over the years, the students whom I had been called to support had manifested problem behaviors. Possessing degrees in psychology and special education allowed me to see the need for qualified individuals to work with students with ED. Because I brought this background knowledge to the study, I made every effort to ensure objectivity to understand and interpret the collected data. Researchers have asserted that efforts to support these students have failed because of the lack of qualified individuals and research-based interventions (Bradley et al., 2008; Durlak et al., 2011; Puddy et al., 2011).

Methodology

The methodology that I used had three steps (see Marshall & Rossman, 2011): the plan, an explanation of the importance of the study, and the creation of a foundation of flexibility in carrying out the research. I followed a phenomenological design to conduct

this qualitative study. Marshall and Rossman (2011) categorized qualitative research as three major genres: (a) society and culture studies, as evidenced in ethnographic studies, case studies, and grounded theory; (b) individual lived studies describe the participants' experiences; and (c) language and communication studies, as found in sociolinguistic methods of narrative analysis. I conducted video interviews to collect the data. The open-ended interview questions (see Appendix) gave the participants the opportunity to describe their experiences through a semistructured process (see Behal, 2014). This approach also allowed me to probe the interests and concerns of the teachers who participated in the study. I transcribed the recordings of their interview responses to find common themes.

Participant Selection Logic

I used a criterion sample in this phenomenological study (see Ware et al., 2012). I obtained the sample of eight special education teachers from two local school districts and two local special education social media groups. I sent email letters to special education teachers and two local special education social media groups. Once all participants signed and returned their consent forms, along with copies of their current special education certification, I conducted the video interviews through Zoom. The eight special education teachers described their experiences working with and supporting students with DMDD.

Researcher-Developed Instrument

I prepared a letter of introduction to explain my role as the researcher, provided details about the study, and clarified any other information as necessary. I also wrote the

interview questions. I obtained my study data from the interviews, notes, and observations.

The study was guided by one RQ and one SQ:

RQ: What were the lived experiences of special education teachers who supported students with DMDD regarding a typical academic day, social challenges and needs, challenges as providers, student challenges as learners, and social feeling for students with DMDD?

SQ: How did special education teachers manage their emotional responses in the classroom when working with students with DMDD who were volatile?

Data Analysis

I analyzed the collected data through interpretative phenomenological analysis (IPA), a method developed by Smith et al. (2009). IPA is a qualitative data analytic strategy that focuses on how study participants interpret the given phenomena from the lived context (Behal, 2014). The essential factor in capturing the natural attitudes of the participants in the current study was to tell their real stories. I conducted in-depth interviews to convey the experiences of a sample of special education teachers who supported students with DMDD.

Using IPA (Behal, 2014), I validated the experiences of the participants. The use of convergence and divergence, as suggested by Smith et al. (2009), helped to identify the themes that emerged from the analysis of the participants' responses regarding their experiences (Behal, 2014; Chan et al., 2013). The special education teachers who

participated in this study shared their diverse experiences working with students with DMDD.

Through the process of horizontalization, I read the interview transcriptions thoroughly to look for meaningful themes that would answer the RQ and subquestion. Then, I grouped meaningful units to create a textual description that included narrative examples from the transcriptions (Ware et al., 2012). Finally, I developed a concise statement to describe the overall experiences of the interviewees.

Issues of Trustworthiness

Ware et al. (2012) suggested verification strategies to enhance researcher trustworthiness. The process of bracketing assumptions and beliefs about the topics being investigated was mentioned earlier in this study. Bracketing helped me to understand that my experiences were separate and individual from those of the participants. Bracketing also allowed me to take a neutral stance in interpreting and analyzing the data. I conducted the interviews with impartiality. Triangulation involved gathering information from participants and looking for common themes within their personal experiences. The detailed descriptions from the interviewees provided a glimpse of what the teachers experienced working with students with DMDD. The themes and perspectives identified gave me in-depth knowledge of the phenomenon. The final step was to share the results with the participants to support and validate their experiences. I transcribed all of the recorded interviews with the support of Rev, a Microsoft Word recording program.

Ethical Procedures

I requested permission from Walden University's Institutional Review Board (IRB approval #12-16-20-0029945) to conduct the study. The participants were eight special education teachers employed by the public school system. The open-ended interview questions allowed the participants to provide rich and in-depth responses about their experiences associated with the phenomenon. All notes, including video, were transcribed through the Rev Microsoft Word recording program.

The initial meetings with the special education teachers helped to build rapport by explaining the purpose of the study, signing the consent form, and scheduling the interviews. The interview questions asked about the special education teachers' experiences working with and supporting students with DMDD. I also asked the special education teachers to describe how they managed their emotions when dealing with volatility manifested by students with DMDD. Permission forms were signed, and assurances of privacy and confidentiality were reviewed. The time frame of the study was 4 weeks. Each interview lasted 35 to 40 minutes. Data management, including notes recorded in a lined notebook and video, were kept in a secured laptop with all other materials when not in use.

Summary

I conducted this phenomenological study to examine the lived experiences of eight special education teachers who were working with students with DMDD. I interviewed the teachers to obtain their perspectives regarding ways that they managed their emotional regulation when students with DMDD were volatile. I collected data in a

nonbiased approach and triangulated to identify themes. In Chapter 4, I present the results of the study and the emergence of three themes supported by quotes from the participants' interview responses.

Chapter 4: Results

I conducted this phenomenological study to obtain the lived experiences of eight special education teachers who supported students with DMDD. The present research contributes to the field of psychology by providing the meaningful perspectives of eight special education teachers about the resources that they considered necessary when managing the IEPs of students with DMDD. Moreover, the special education teachers shared the ways that they managed their emotional regulation when working with students with DMDD who were volatile.

RQ: What were the lived experiences of special education teachers who supported students with DMDD regarding a typical academic day, social challenges and needs, challenges as providers, student challenges as learners, and social feeling for students with DMDD?

SQ: How did special education teachers manage their emotional responses in the classroom when working with students with DMDD who were volatile?

Presented in Chapter 4 are the results of the study, along with demographic details about the participants and information about the data analysis, trustworthiness, credibility, transferability, dependability, and confirmability. The chapter concludes with a discussion of the findings.

Setting

Thirty-two special education teachers expressed initial interest in joining the study; eight of them signed the consent agreeing to be interviewed. I interviewed them through the Zoom application, as outlined in the data collection procedures. Once I

received the signed consent forms, I interviewed the eight participants without interruption or intrusion. No participants withdrew early from the study, and no participants experienced any psychological or emotional distress while being interviewed. All participants received copies of their respective transcriptions to review for accuracy and amend as necessary. All participants approved the transcribed interviews.

During the interviews, I set aside a few minutes for the participants to ask any questions to clarify concerns that they might have had about the study. I also gave them the opportunity to withdraw from the study, and I discussed with them the possible need for any follow-up interviews. I advised the participants that they would receive their respective interview transcriptions to review for accuracy and to contact me to refine any responses in the transcriptions. After completing the interviews, I ensured that the participants received their transcriptions within 3 hours. I reminded them to contact me in case they wanted to change any of their responses to the interview questions. No revisions to the transcriptions were requested or made.

Demographics

All eight participants were female special education teachers working in a public school setting, and their students identified in this study were male children. None of the teachers discussed female students during the interviews. The special educators managed the IEPs of students with DMDD, and all of them were certified to teach special education. The interviewees emailed copies of their current certification to me (see Table 2).

Table 2

Demographics of the Study Sample

Participant	Certified in special education	Public school	Managed IEPs of students with DMDD
1	Yes	Yes	Yes
2	Yes	Yes	Yes
3	Yes	Yes	Yes
4	Yes	Yes	Yes
5	Yes	Yes	Yes
6	Yes	Yes	Yes
7	Yes	Yes	Yes
8	Yes	Yes	Yes

Data Collection

After receiving IRB approval to conduct the study, I sent emails containing the consent form, research flyer, and interview questions for review to the local special education teachers' mailboxes and three local social media special education groups. I followed up with the eight teachers to schedule their interviews. The interviews began on January 18, 2021, and concluded on February 1, 2021. I also asked all participants to send me copies of their current special education certification. All participants agreed to do so. I assured the participants that I would keep the copies of their certification documentation in a locked file on a password-protected laptop. I also assured them that once the final study is approved and published, I will delete or destroy all of the data collected during the study.

All participants responded well to a 10-minute preparation before recording began to discuss any issues or concerns and to answer any questions about the study. The interviews lasted 30 to 40 minutes. I recorded the interviews using the Zoom application with my laptop. I used Rev.com, a Word Microsoft recording program, to transcribe the responses. I kept the recorded interviews on a password-protected laptop. I coded the

interviews using alphanumeric identifiers (i.e., P1-P8). Table 3 shows the dates of and application used for the interviews. Audio playback was used to correct any transcribed responses that were not clear.

Table 3

Interview Schedule

Participant	Date of interview	Recording app/Transcription program
1	1/18/21	Zoom/Rev
2	1/18/21	Zoom/Rev
3	1/19/21	Zoom/Rev
4	1/21/21	Zoom/Rev
5	1/21/21	Zoom/Rev
6	1/23/21	Zoom/Rev
7	1/31/21	Zoom/Rev
8	2/01/21	Zoom/Rev

The interview responses were recorded manually, and the coding process began once the interviews had been conducted. I read the transcriptions, coded the information, and made notes in the margins of the notebook that I kept about possible themes. The use of a notebook also facilitated keeping count of repetitive phrases and words.

Data Analysis

I analyzed the data using IPA, as suggested by Behal (2014) and Smith et al. (2009). I used the video Zoom link platform to conduct the interviews and Rev.com to transcribe the audio-recorded interviews. Immediately following each interview, I emailed the transcriptions to the participants for member checking. Prior to conducting the interviews, I followed Behal's suggestion of bracketing my assumptions, preconceptions, and biases, as well as examining the data to understand the experiences of the participants. The following list details how I bracketed my assumptions:

1. I understood that the diagnosis of DMDD has been in the *DSM-5* (APA, 2013) only since 2013, so given the paucity of research, some of the special education teachers may not have a good foundational understanding of the psychological underpinnings of the disorder.
2. I taught in public schools for more than 20 years prior to conducting the study, so my experiences were different from those of the teachers who were working with this student population. Even though I specialized in behavioral disorders, some of the special education teachers may have had little to no psychological training in mental health.
3. The term *Gemeinschaftsgefuhl* is a German term coined by Alfred Adler that the participants may not have understood.

After I completed the interviews via Zoom and had the interviews transcribed through Rev.com, I emailed all participants their respective transcriptions for final interview and approval. The recorded interviews and transcriptions are stored on a password-protected laptop. I will destroy all video and audio documentation, along with the transcriptions, once the study has been completed and approved by Walden University.

Following the IPA procedure described by Behal (2014) and Smith et al. (2009), I completed my analysis of the data:

1. Reading and rereading. I immersed myself in the original data. While reading the transcriptions, the original recordings were played for review and clarification. Smith et al. suggested that for any subsequent readings,

researchers should imagine the voices of the participant to obtain a more complete analysis.

During the first stage, I wanted to ensure that the participants were the focus of the analysis. Behal and Smith et al. advised researchers to take it slow and to even recall some of the interactions between interviewers and interviewees to capture some of the most powerful recollections of the interviews. Keeping a notebook during the interviews allowed me to reflect on my thoughts and feelings. I found the initial review of the transcriptions overwhelming because there were so many words and so much context to extract. At this stage, patterns in the responses began to from generic to specific events (e.g., some participants explained general duties carried out on a daily basis; others expressed their direct feelings of helplessness during volatile episodes).

2. Initial noting. I conducted a thorough review of all of the interview transcriptions to extract phrases and words, then separated them under specific interview questions. I made notes in the margins and referred to my written notes during the interviews. As I moved through the transcriptions, I made notes about similarities and differences in the responses. At this step, I maintained an open mind, became more familiar with the transcriptions, and paid attention to any phrases and words that “jumped out” at me.

3. Developing emergent themes. Next, I looked for emergent themes by pulling all of the comments, phrases, and words together into themes. I went back through the list and looked for similar words to connect to themes.
4. Searching for emergent themes across responses. Once the themes started to come together, I began to look for connections across those themes. I wrote the themes in chronological order in a list. As I scanned the list, I moved similar themes together as some words in the themes began to become more obvious.

Table 4

Codes, Frequencies, and Themes

Themes	Codes (Frequency)
Theme 1: Managing students	
	Student support (25)
	Student environment (15)
	General education (13)
	Program related (8)
	Flexible schedule (6)
Theme 2: Impact on student	
	Peers (13)
	Social skills (10)
	Ability based (9)
	Control choices /self-empowerment (6)
	Sense of belonging/safety (6)
	Modified work/earned pts. (4)
	Unstructured (3)
	Self-contained/pullouts (2)
Theme 3: Supporting diagnosis/training	
	IEP/program (5)
	Mental health (24)
	Inability to regulate (23)
	Home-school connection (11)

Evidence of Trustworthiness

Credibility

As described by Alase (2017), the purpose of IPA is to bring out the lived experiences of the participants. I conducted interviews with a sample of eight special education teachers who were working directly with students with DMDD and providing direct educational support through IEPs. I began the process by bracketing assumptions and beliefs about the phenomenon being investigated. Bracketing allowed me to understand that my experiences were separate and individual from those of the participants. Through thick descriptions of their experiences, I was able to achieve credibility (Smith et al., 2009).

Along with the iterative process of triangulation, I gathered information from the participants to identify common themes in their personal experiences. With convergent themes established and detailed descriptions from the interviewees, I was able to glimpse their experiences working with students with DMDD. Finally, I shared the results with the participants to support and validate their experiences.

Transferability

Transferability in qualitative research means generalizing the findings to other settings. In IPA, transferability allows the reader to judge how applicable these experiences are in the general population (Behal, 2014; Smith et al., 2009). Triangulation allowed the participants to tell their experiences. Through an inductive approach, the participants shared their experiences of supporting students with DMDD by providing in-depth descriptions that led to the emergence of themes. The goal of qualitative studies is

to shed light on the phenomena being investigated by obtaining the experiences of the participants with those phenomena.

Dependability

Behal (2014) and Smith et al. (2009) asserted that the idiographic approach in IPA improves the credibility of studies. Beginning with the first step, the rich descriptions of the participants' experiences with the phenomena are analyzed. Smith et al. suggested beginning the analysis with the most complex and/or engaging interviews to reduce the volume of data. I used a notebook to record my thoughts as I reviewed and listened to the transcriptions of the recorded interviews. To remain immersed in the energy of the interview, I wrote immediate codes and potential themes in the margins of my notebook as they emerged.

Confirmability

Marshall and Rossman (2011) described confirmability as the process of being able to confirm the findings based on the participants' responses to the interview questions rather than on potential researcher bias. The participants' direct experiences helped to tell the story directly. Their lived experiences gave substance to the phenomenon of supporting students with DMDD. Their review and subsequent approval of their respective transcriptions validated their experiences. My dissertation chair acted as another source of confirmation for this study, and bracketing my experiences also ensured further credibility of the results.

Results

This section provides the results of the study, which was guided by one RQ and one subquestion. Several interview questions were asked to answer the RQ: What were the lived experiences of special education teachers who supported students with DMDD regarding a typical academic day, social challenges and needs, challenges as providers, student challenges as learners, and social feeling for students with DMDD? Several other interview questions were asked to answer the research SQ: How did special education teachers manage their emotional responses in the classroom when working with students with DMDD who were volatile?

As mentioned in the Trustworthiness section, rich details described the experiences of special education teachers charged with managing the IEPs of students with DMDD. The responses to the interview questions revealed that the participants were using resources available to them and their knowledge as special education teachers. Even though they found the task of supporting students with DMDD a challenging one, they were dedicated individuals who cared about their students and understood their difficult role. Experiences ranged from being somewhat familiar with to learning on the job about DMDD as a diagnosis and strategy development. The themes that emerged from the interview questions supported the RQ and the subquestion.

Theme 1: Managing the Student

Theme 1: Managing the Student emerged from the responses to Interview Question 1 and Interview Question 4. Providing flexibility in the school day gave students a sense of empowerment and control. The special education teachers found that

enriching the students' programs with support from general education teachers, allowing the environment to meet the students' needs, and implementing IEP modifications provided the scaffolding needed for students to have a "sense of belonging, or Gemeinschaftsgefuhl."

Interview Question 1

Describe a typical academic day for a student identified as DMDD. In general, the teachers agreed that an academic day needed to include some level of autonomy and control by the students and was needed to support the students' ability to learn how to self-regulate.

P1 described the student as being mainstreamed. He received services in the classroom, and the only out-of-classroom service was with a psychologist. This was his second year with DMDD, and according to P1, his self-regulation had improved since last year.

P2 had three students identified with DMDD. P2 focused on the Grade 2 student, who came to her classroom of his own accord in the mornings, even though he was supposed to be in the general education setting. She believed that he came there to get centered to begin the school day.

P3 described the student with whom she was working as having a difficult time problem solving. She said that because he got into altercations with his peers, he had to start his day in her resource classroom for at least an hour. One he was regulated, he could transition to the general education classroom.

P4 said that her student was in the general education classroom all day long, except when he was pulled out to receive academic support in small groups. He was on a point system to earn free time to decompress during the day. He had a one-on-one paraprofessional who worked with him on his academics and helped to manage his behavioral management plan.

P5 explained that her student was very inconsistent and was in her resource room most of the day. He was mainstreamed for specials (e.g. music, art, library, etc.). His academic day was flexible, but his triggers were so different and sometimes inconsistent. His schedule saw him working for 10 minutes and breaking for 5 minutes. If he was having a difficult time regulating, his breaks were longer.

P6 stated that her student's day was flexible and that he started in her room with social skills instruction. She said that his academics "kind of go to the side" while she focused on his social skills. His triggers were inconsistent, making it difficult for him to be mainstreamed for an extended time. P6 said, "If he is starting to become dysregulated or if he needs a break, he comes to the resource classroom when he is overwhelmed."

P7's student spent most of his time in the general education classroom. He came to resource for a check-in on his mood before he was mainstreamed. He was on a point system based on acceptance-commitment therapy. He was responsible for bringing his point sheet to all his classroom specials, such as music, physical education, and art, and his general education teachers.

P8 explained that her student had been mainstreamed initially. He started attending the school in the middle of the school year, so she did not learn of his

identification until his behaviors surfaced and his mother finally sent a form detailing the DMDD diagnosis. After that, his schedule became flexible to have him start with resource and be mainstreamed if appropriate.

Interview Question 4

"Gemeinschaftsgefuhl" is translated as "social feeling," or a feeling of being an important contributor to a community. In your experiences, do you feel that students identified with DMDD have a sense of belonging and being a part of the school community? Give an example of how a student identified with DMDD has demonstrated or expressed a sense of belonging, or Gemeinschaftsgefuhl.

P1 shared the sense of "crew" as a philosophy in her student's school. The premise is to be able to have an open and safe dialogue with students about feelings and having those concerns addressed by caring adults. P1 described her student having trouble in Grade 1 with students sharing feedback in constructive ways. In particular, the students felt scared when there were volatile episodes. By her student's Grade 2 year, he had adjusted to the open communication from the students and constructive handling by the teachers and staff. He was doing very well, and his behaviors had improved as part of that whole program of social skills' development.

P2 cited a personal sense of belonging for the student. As a student in Grade 3, he took to a Kindergartner who was assigned to their resource room. He had been allowed to read to the student whenever she was upset, and this calmed her. P2 noted, "He has found his place as a caregiver and reads social stories to the student." P2 felt that this gave the student responsibility, and he was proud to teach skills that he had learned.

P3 felt that “her student desperately wants a sense belonging and seeks out his peers.” Unfortunately, when he had a behavioral episode, he felt disappointed in himself when he got triggered and handled situations poorly.

P4 stated that her student had a sense of belonging but was always guarded. Her student had a good friend at the school, but the student moved. He told her that he did not have a lot of friends, but he was very connected to his social skill group, where he was more open with his feelings.

P5 explained that her student had a better sense of belonging with their mentor program. Her student has been matched with one of the office managers. He had formed a bond with the “job coach” and he never had issues during that time.

P6 found that the student had found a sense of belonging through more realistic demands:

> I think the biggest barrier with that is just being accepted for who they are and everything that encompasses them because while their behavior doesn’t define them it as a part of them. And more often than not, I see that they, um, kind of perseverate on, I did this, I’m a bad person. I just have that negative self-perception because of the things that they did. And so the biggest success that I found with that is, you know, giving them a purpose, giving them a job, um, giving them a role within the school or a home or, you know, community, whatever that may be and helping them find, you know, where they can be successful because more often than not, they’re unsuccessful because of their mental health disorder and the demands that are placed on them in various

> settings. And so if you can increase the amount of success that they have, then I've seen the amount of times that they're unsuccessful decrease. So just having them find their place is the biggest thing I can say to help promote that.

P7 offered that praising effort encouraged growth and ability-based success:

> Also just offering choices in how things are done to create that sense of community. So for example, I get, let every student choose what color they want, the starred words that they're going to have on. I'm like, Oh, should I give you red stars, blue stars. And every child gets to pick the color of their star. So they feel like they're part of the activity and they get to design part of it. Um, and just like, if somebody is struggling and refusing to do something and kids are always going to comment on it, how you model your response also, um, impacts how they feel as part of the community. Like if somebody, if one of the kids tells me, um, oh, so-and-so is doing this. Yeah. They're just having a hard time right now. But I believe in them, I know that they're going to come back to us and they're going to try, and I can't wait for that moment. Um, and so just making it as part of a community, like as part of this community, we don't call others out. We encourage them and we try to bring them in.

P8 described her student feeling more connected to school rather than home. She described her student as having pulled a knife on his mother. He has tried to hurt his mom several times. It actually happens more at the house, and then, it carries over sometimes into school. Well, I felt like, like the times he'd come to my classroom, he wanted to hide

and he would fit in because it, cause I will let him sit beside his friend, and he will talk again. I felt like my classroom was more structured.

Theme 2: Impact on the Student

This theme emerged from the responses to Interview Question 2 and the research subquestion. The teachers described some impacts on students' daily functioning such as poor communication skills and the inability to have perspective and empathy. The teachers also highlighted ways the impact of the ways that the students interacted with peers, teachers, and support staff in the community. All eight special education teachers realized that volatility was an identified behavior of students with DMDD. The volatility could manifest as tantrums, swearing, throwing of objects, and even self-harm. The teachers were committed to supporting the dignity of the students and knowing how their own responses influenced the students' responses.

Interview Question 2

Describe a situation with social challenges for that identified DMDD student.

P1 noted that most of the challenges for this student were in the general education classroom. His inability to transition and understand methods of communication, and even the impact of his home instability created difficulties for this student. P1 reflected on being "vigilant for triggers. His biggest issues were that we could tell when they were playing with his medications. His family is so guarded and super private."

P2 described the student as ego driven. The student's challenge was with perspective taking. He would get into verbal altercations with peers. P2 explained that

"he can't see through the lens of his peers to understand how he's perceived by them. He shuts down."

P3 noted that the student had a need for structure. The student misinterpreted the social behavior of his peers such that even if a peer was looking at him, it would precipitate a violent lunge at the peer. Even on the playground, P3 said that "if a student kicked the ball, and if came his way, he would misinterpret that as aggression, and he would attack the student."

P4 stated that the student had issues with self-reflection. This student tended to get angry with peers if they shouted out answers, but he did not have the ability to regulate himself not to do the same. He would even swear at them.

P5 portrayed the student as having social situation challenges. She noted that "the expectations are a little different in [the] general education classroom."

In P7's resource room, sitting on the floor was acceptable if it made the work-time better. This flexibility was not as attainable in the regular education classroom. When her student needed a little change to manage his mood, and flexibility was not possible, he would have a meltdown, and his peers would not understand; this created social anxiety.

P6 described the social challenge for the student was not having peers understand his explosions. P6 explained that even though this student wanted peers to accept him, his disability made his classmates fearful of him. This behavior created a social barrier to maintain friendships.

P7 mentioned that the student had difficulty taking turns. He would get very upset and throw a tantrum, cry, scream, and even threaten when a game or situation did not go his way. P7 noted, “He likes rules to be followed rigidly, and he does not like it when somebody doesn’t follow the rules perfectly.” His inability to be flexible and adapt to change was a social barrier.

P8 said that the student’s “mood would switch immediately to physical violence.” This erratic behavior and limited communication skills created social challenges in establishing friendships. As P8 noted, “He possessed social skills deficits.”

Research Subquestion

Think of a time when a DMDD student has been in a volatile state. What are your emotional responses to DMDD students when they may be in volatile states? Give an example(s) of a situation(s) and how you manage your emotional response(s).

P1 shared that she maintained the “script” when a student was volatile. This helped to keep her focused:

> Well, we’re all CPI trained. So, after you’ve had a few kiddos decide that throwing things, swearing at you, all of those things, you grow at handling how you ... because you have to walk, you have to do it the way it’s outlined. You can’t go off script with CPI. Otherwise you end up in trouble with the school district.

P2 maintained a team approach. She referenced “masking my feelings” even when there had been times that she had been hurt:

> I'm really good at masking my, my feelings, but there are times where we can't, um, like if you're hurt, um, and those kinds of things. So this student has probably been my most violent student. Um, so with him, I've actually gotten hurt and had to go through physical therapy with him. So when, when it's those kinds of instances, like you can't stop that like reaction, you know, but when he's volatile, he wants that reaction. And so you have to be very careful not to do it, but you can't help it sometimes. So when that happens, um, we'll do a tap out kind of situation. So my IAS [support staff] is always in the room with me, but whenever a kid's in this state, we have two people in."

P3 used self-talk to remind herself that she was there to support and keep the student safe, even in times of restraint. There was a supportive team to assist in volatile situations so that a tap-out was available:

> I feel very protective of the students since I've had him for so long, there's a history and like students, family, of people just leaving, when they get tired of him and, you know, I don't want to be that person. And I want to show him that even when people are frustrated with him, or even when he's frustrated that there's someone who still cares.

P4 approached her volatile situations with the mind-set of a checklist of sorts, like First Aid. She recalled having to deescalate an OT session with a student in the computer room:

> So typically going into this situation, I kind of stepped back to kind of assess the situation and kind of try to figure out what is what's going on before saying

> anything. I'm obviously looking for safety first, making sure you know, to safe. Recognizing the occupational therapist was very upset as well. So I just said to her, "I'm like I said, go ahead," and you know, um, so I went to, I didn't want him to see her emotionally as well. So you try to balance it. You try to find that balance for yourself as well as the child, as well as the, the, the support staff, the service providers, Plus you have that adrenaline rush as well. Like you go in and you're like trying to process everything in the middle of a storm.

P5 was committed to not personalizing any volatile situations. She used "rational detachment" to support. She explained, "This is probably one of my, my strongest areas in working with these students is that rational detachment, just that knowing that it's not, you not blaming yourself, not thinking you did something wrong." She supported a nonjudgmental environment.

P6 uses the mind-set of depersonalizing the situation:

> I think the biggest thing is not taking the things that they say personally and putting yourself in their mind-set of this. This child is not what they typically are right now. This isn't the same child that you're dealing with on a regular basis. This is, you know, a child that's running on brainstem level functioning. This is a child that is in survival mode, and this child's going to do what this child needs to do to find comfort in that moment. And when they're in a state of complete dysregulation, um, finding those strategies that you've taught them explicitly when they're regulated, um, and utilizing those, using things that are familiar to them, making it a familiar environment, um, taking away the unknowns for them,

> eliminating any anxiety that you can just planning that students who are DMDD need somebody to co-regulate with a lot of times they can't self-regulate.

P7 believed that the dignity of the student always had to be at the forefront, along with clear and explicit rules:

> I mean, how many times have you cried and you don't want a drawn attention to him that somebody was like, "Why are you crying? Are you sad?" Right. And then you dumbness and then you feel angry. You're embarrassed and it's a whole cycle. Right. Um, and so I'm, I prefer personally yeah. Give them that space and then put it on them to check in when they are ready. And again, just, that's the thing with like having very clear explicit rules as well, set up is just knowing what to expect, because it's not fair if your goal is vaguely stated in the violate something. Whereas if it's stated, and then the response is explicitly stated as well.

P8 kept reminding herself that the student's volatile issues were a manifestation of any trauma that had happened to him, and she just wanted to be a comfort:

> Um, it was one incident. He had got mad at us, and again, he was in the life skills room, and I walked down there to try to calm him down because he seemed to relate to me really good. So when I went in there, and he was, he was cussing, the life skills teacher, well, he had tucked the sticks and he had threw them down on the ground. And I mean, he was like throwing like a baby tantrum. And I mean, I was, I felt like it was something going on that it was like in a, in a feeling that I, I couldn't reach it as a mother. I want to just take him and just hold him and tell

him that it is okay. But as a, as a professional, I have to stand my ground and said, "Okay, hey that you need to do this."

Theme 3: Supporting Diagnosis/Training

This theme emerged from the responses to Interview Question 3 and Interview Question 5. Most of the special education teachers felt that training in mental health diagnosis would be more beneficial supporting students. Understanding the environmental needs and staffing also were seen as personal challenges. All eight special education teachers felt that receiving timely support and cooperation from providers such as psychologists, social workers, and physical and occupational therapists was challenging. Special education teacher preparation was mentioned as another challenge. The teachers felt that more preservice programs should focus on mental health diagnoses and how students with these diagnoses could be supported in the classroom.

Interview Question 3

In your experiences, what are any therapeutic needs and challenges for students with DMDD?

P1 expressed that the inconsistency of the psychologist and social workers in providing clinical support was challenging. The general education teacher needed to be consistent and flexible in the management of the classroom. If the student wanted to take a supply item from a station to a place that was more comfortable, the general education teacher found it difficult to give that latitude to the student. Even if the student were quiet and not making a disturbance, the inflexibility was evident.

P2 felt that having consistent providers was challenging. P2 said, “The social workers, psychologists, and even paraprofessional need to be consistent.” P2 felt that for students with DMDD, the need for rapport building was vital, P2 stated, “If providers are moving in and out and not being consistent, the student is not going to feel connected.”

P3 believed that the lack of parenting skills at home was a challenge. She noticed that some of the parents had difficulty in their parenting skills. This created mood instability, and the student brought that to school. Parental training support for these families could make coordination and communication between school and home more consistent for the student. If everyone was a “tight team,” this would show the child that everyone cared about him.

P4 saw the therapeutic challenge for this student as one in which “he lives in his own reality.” She relayed that the “student saw the social worker once weekly, and the psychologist, but he still had difficulty owning his behaviors. He gets social skills, but he is not applying what is being taught. This student has a challenging time accepting feedback.’

P5 viewed the underlying causes for the student’s behavior as a therapeutic challenge. P5 explained, “His explosive behaviors are difficult to predict. The antecedents were always changing.” P5 saw this as a safety issue not only for the student but also for his peers. She felt that because she did not have a better understanding of the student’s underlying mental health, it was difficult to know how to create a functional plan that would be successful.

P6 mentioned that wrap-around services were a challenge. She stated, “We wait until a student is on brain-stem functioning before we offer more comprehensive services to include social skills. Once a student is escalated, there not absorbing anything.” She believed that being proactive teaching social skills would help the student to self-regulate through cognitive processing.

P7 focused on teacher preparation and training, noting that “oh, my god, my teacher preparation program didn’t even touch on any of this. It was like eyes wide open.” She believed that the focus in public school is too punitive and not enough on evidence-based science when mental health is the primary issue for a student.

P8 believed that the mental health provider support is challenging. She did not learn of her student’s DMDD from the psychologist, but from the mother, and that about a month after the student was registered for school. She felt a lot of valuable programming time was lost due to the delay in gaining the information and implementing his IEP. There needs to be more timely service support.

Interview Question 5

Describe your challenges as a provider.

P1 found that her lack of mental health training was her biggest challenge. Having a better understanding of mental health strategies with DMDD-identified students would support her ability to provide more options for IEP development and implementation in the classroom for student success.

P1 stated:

> With him, I think the biggest thing is, is that I do not possess the skill set. I've had some training, but not sufficient to help kiddos like him with that diagnosis, plus other sort of similar to him that dig their heels in so much that whatever tricks you have to get them to use those strategies within the classroom, and you're like, "We need to get this audience out of the room. We need to leave, we need to do whatever, because we aren't going anywhere."

P2 thought that not having mental health training had been a personal challenge as a provider:

> I'm saying therapeutic is, is difficult in my situation just cause I'm, I have so many kids and trying to do those things when that's not even like really my forte, I'm a spec ed teacher, yes, but I wasn't trained in any type of therapy, which I guess would be another challenge. You know, I haven't been really trained in anything like that.

P3 was frustrated exhausting all of the strategies that she could use to make a behavioral difference:

> I have been thinking out of the box for 2 years, and I'm still not getting anywhere. My challenge is internal frustration that I'm not able to break through whatever the hair trigger responses to really make some positive change for this kiddo. The actual challenge is getting him connected and engaged.

P4 identified her personal challenges as getting her student to trust more and not be as guarded:

> So one of the biggest challenges is when we need to talk about something and he does that escape, and the avoidance where he says, "That's private, I'm not talking about private things." A lot of that, um, we understand it because we have had several DCF referrals because of stories he has come with. And unfortunately, we have to report what he says. And like I said, he takes parts of different stories and he puts it together. Um, and he's believable. Like you believe them. So I think a lot of that is from his parents saying you don't discuss things about home."

P5 reported understanding trauma as a personal provider challenge:

> I think the challenges are that, that additional mental health support beyond us, I can read all about it and I can learn it from an educator's standpoint, but I'm, I'm not in any way, um, qualified to deal with some of the trauma and just some of just, yeah, the trauma is a lot of it.

P6 identified "educating the population" as a provider challenge. She wanted to have adequate staffing to meet the unpredictable needs of her identified student:

> Letting them know, and also providing adequate staffing, you know, my students with DMDD, it's been the hardest to staff for them because they don't always need support, but they always need support available. So you kind of have to stay on those behaviors and be ready for them to occur, but you never know really when they're going to occur or what, what all the triggers are going to be.

P7 wanted to make sure that the identified student and the general education teachers were supported. She felt that general education teachers were handed a piece of paper (IEP) and a behavioral plan and expected to make it work:

> I'll follow with sitting down with the teacher, designing it with the teacher, coaching the teacher. So that's one of my biggest challenges is like I have a huge caseload because I'm RSP. I have like 27 kids. But I mean, like finding that time and making sure that both the child and the teacher are included in the plan and being efficiently trained because teachers are people and automatically fall back on what they know, unless you're constantly coaching, training, and support. Adults need support to change behavior, no, blaming and complaining are not going to get the teacher to follow the behavior plan and support the student.

P8 found that her challenge was providing her student with a smaller environment. He was able to have more structure in a smaller environment, but he was being mainstreamed. She felt that whenever he was in a larger setting, she had to "walk on a thin line around him." Her school wanted to mainstream him, but his ability to self-regulate was at a minimum in the general education classroom.

Summary

The purpose of this study was to understand the lived experiences of special education teachers who managed the IEPs of students with DMDD. Three themes emerged to answer the RQ and support the subquestion: Theme 1: Managing the Student, Theme 2: Impact on the Student, and Theme 3: Supporting Diagnosis/Training. In Chapter 5, I present my interpretation of the data, discuss the implications for social change, and offer recommendations for future research.

Chapter 5: Conclusion

The purpose of this phenomenological study was to examine the lived experiences of eight special education teachers who supported elementary students with DMDD. I asked semistructured interview questions to obtain the teachers' perspectives of the ways that they managed their emotional regulation when students with DMDD were volatile. The special education teachers managed the IEPs of students with DMDD. Few other researchers have addressed the topic under investigation, so conducting a phenomenological study was considered appropriate to examine the teachers' experiences.

The nature of the study was to conduct confidential video interviews via Zoom to discuss with the participants their classroom experiences with students with DMDD (Chen et al., 2013). The eight special education teachers provided details about their experiences with students with DMDD. Using a qualitative interview approach ensured that the most powerful experiences with the most significant influence on service delivery and outcomes were being expressed. The qualitative approach to this study gave a sense of being connected with those special education teachers in the environment and understanding the experiences of the participants in the environment.

I used a qualitative methodology that Marshall and Rossman (2011) described as a phenomenological approach or a cultural study. Conducting a cultural study gave eight special education teachers the opportunity to share their perspectives of providing services to students in their environment, regardless of disability (Marshall & Rossman, 2011).

One RQ and one SQ guided the study:

RQ: What were the lived experiences of special education teachers who supported students with DMDD regarding a typical academic day, social challenges and needs, challenges as providers, student challenges as learners, and social feeling for students with DMDD?

SQ: How did special education teachers manage their emotional responses in the classroom when working with students with DMDD who were volatile?

When discussing with P4 the approach to maintaining emotional regulation when involved in a volatile situation with an identified student, P4 shared thinking of the situation as a checklist of sorts, similar to First Aid. This gave me the idea to prepare a mental health first aid checklist that could be referenced when preplanning responses to volatile moments. I gave this the acronym A-PIE (Assess, Plan, Implement, Evaluate). Based on the suggestion from the American Red Cross (2021) detailing four basic steps in first aid, I proposed the following steps:

1. Before administering support to a student experiencing a volatile episode, check the scene and the person. Size up the scene, and form an initial impression:

Pause, look at the scene, and ask the following questions:

a. Is the scene safe to enter?

b. What happened?

c. How many people are involved?

d. What is my initial impression of the student, his emotional state? Is it a life-threatening condition, such as bleeding, possible item used as a weapon that may injure student or others?
e. Secure available/extra support ALWAYS!
f. Debrief with staff and student.

Several key findings were derived from this study:

1. The special education teachers found that issues involving the home-school connection and communication impacted the instability for their identified students.
2. Providing students with an environment to experience "social feeling" and improved training and teacher preparation, along with ancillary provider commitment, were salient factors in developing a program that would promote student success.
3. All interviewees were confident and friendly, and they allowed themselves to be vulnerable as they shared their lived experiences supporting students with DMDD.

Interpretation of the Findings

As noted in Chapter 2, in the review of the literature, I found that despite its inclusion in the *DSM-5* (APA, 2013), research on DMDD has remained limited. Many of the researchers mentioned in the literature review have suggested that more research is needed to understand this complex diagnosis (Chen et al., 2016; Eagan et al., 2018; Nagourney et al., 2014; Palmer, 2014; Rao, 2014; Rojas & Hussey, 2018; Tourian et al.,

2015; Tudor et al., 2016). This study emerged from the need for a focus on the interaction and support from special educators for students with DMDD.

Chen et al. (2016) discussed the behavioral approaches that could be included in treatment protocols for DMDD. These approaches could include teaching parents various strategies to manage children's emotional irritability. Further, by supporting parents with parenting skills, Chen et al. noted that this extra support also could improve children's cognitive functioning. The teachers mentioned that the home-school connection and coordination with service providers needed to be improved because of their direct influence on the daily mood of students. P1 noted that the impact of the student's home instability made for difficulties with this student.

Bradley et al. (2008) looked at the outcomes of school services for students identified with ED over a 10-year period, and they found that the students as a group showed little or no academic or social improvement. Chen et al. (2016) found that the combination of improvements in the home-school rapport and behavioral therapies improved students' cognitive functioning.

P1 spoke of the importance of social skills instruction and the positive response by students, stating that "he is doing very well, and his behaviors have improved as part of that whole program of social skills development."

P6, who mentioned that providing wrap-around services was a challenge, explained, "We wait until a student is on brain-stem functioning before we offer more comprehensive services to include social skills. Once a student is escalated, they're not absorbing anything."

The teachers believed that teaching social skills would help the students to self-regulate through cognitive processing. This belief was similar to Ware et al.'s (2012) assertion that group social instruction improved the social functioning of students diagnosed with mood disabilities. The outcomes reported by Ware et al. were unconditional acceptance and support, positive experiences from the group, and the ability to understand the experiences of others.

The special education teachers strongly believed in the importance of having a strong program with consistent services and personnel. The teachers expressed that when ancillary service providers, including general education teachers, were not committed in word or deed, it was difficult for students to feel a "team" sense of security and care.

P2 mentioned that having consistent providers was challenging, noting that "the social workers, psychologists, and even paraprofessional need to be consistent." P2 felt "that with students identified as DMDD, rapport building was vital. If providers are moving in and out and not being consistent, the student is not going to feel connected."

P4 found that the therapeutic challenge for her student was that "he lives in his own reality." Her student saw the social worker once weekly and the psychologist monthly, but he still had difficulty owning his behaviors. P4 stated, "He gets social skills, but he is not applying what is being taught. This student has a challenging time accepting feedback." Even though the special educators found other areas challenging, the issue of consistent and comprehensive services seemed paramount to program success for students.

Adler's phenomenon of Gemeinschaftsgeful, or social feeling, came from different loci (as cited in Carlson et al., 2006). The teachers found that social acceptance for students ranged from personal introspection to school-based programs. All eight teachers observed "social feeling" with their students. Adler identified three life tasks that human beings strive to master: work, friendship, and love-intimacy (as cited in Carlson et al., 2006). In the first task of work, children are encouraged and supported, and reciprocally, they learn from the environment and their nurturers that they are thriving. According to Adler, children's private logic or personal beliefs develop from these beginning experiences and can dictate positive or negative life goals for the future.

P7 saw this demonstrated by offering to praise effort and encourage growth as well as ability-based success:

> Also just offering choices in how things are done to create that sense of community, but I believe in them, I know that they're going to come back to us and they're going to try, and I can't wait for that moment. Um, and so just making it as part of a community, like as part of this community, we don't call others out. We encourage them and we try to bring them in.

In the second task of friendship, the teachers found that students sought out peers for reinforcement or regulation. This was shared by P4, who stated that her student has a sense of belonging but was always guarded. In the third task of love-intimacy, P5 explained her student has a better sense of belonging with their mentor program. These examples showed that Gemeinschaftsgefuhl could be demonstrated in different ways to achieve social feeling.

Adler understood that it was important to instill in early life the notion of community (as cited in Watts & Ergüner-Tekinalp, 2017). Adler described the need for children to find their sense of worth and importance in the community. Watts and Ergüner-Tekinalp's (2017) findings reinforced Adler's social constructionist perspectives with learning and psychological development as interrelational (as cited in Ferguson, 2010). This means that the social feeling that is developed hinges strongly on how students perceive the external environment. If this environment is caring and consistent, it can aid in the development of caring and regulated students. Adler understood how human beings derive personal worth through their social experiences. The lived experiences shared by the special education teachers highlighted the need to have an environment connecting ancillary services and providers to improved teacher preparation and professional development opportunities.

Limitations of the Study

This study had three limitations. The eight teachers who interviewed were women, a fact that was representative of the number of female special education teachers. The second limitation was that only male students with DMDD were identified and discussed by the teachers. DMDD is a new diagnosis in the *DSM-5* (APA, 2013), but as the diagnosis becomes more recognized, female students may be included in future studies. The third limitation was that the study was conducted only with public school teachers of elementary students, so the results may not be generalized to the private school or secondary school setting. The results were derived from the lived experiences of a small sample of special education teachers. Along with the iterative process of

triangulation, I gathered information from the participants to identify common themes based on their personal experiences with the phenomenon.

Recommendations

Future researchers could focus their studies on other aspects. All eight participants in my study were female special education teachers. Future researchers might wish to expand the scope of their studies by including male special education teachers. Including or focusing solely on female students might be another future consideration. I found that the special education teachers felt that having more cooperation with service providers would be beneficial Future researchers also might consider interviewing general education teachers, psychologists, and social workers to obtain information about their lived experiences supporting students with DMDD.

Regarding the actual interview process, the questions could focus on specific training or support services. For example, the teachers expressed the need to improve the preservice preparation of special education teachers and offer more opportunities for professional development. Some of the teachers felt that they were not prepared to provide mental health support in the classroom. Dealing with students diagnosed with DMDD was a challenge for all the teachers.

Future researchers also might want to explore the mind-set of special education teachers when in volatile situations with students. A first aid mental health checklist similar to the one mentioned at the beginning of Chapter 5 might help staff and special education teachers to focus on specific points to help them in volatile situations.

Researchers also could study the ways that IEPs support the transition of students to the middle and high school settings.

Implications

Data have shown poor outcomes for students identified as having behavioral disorders. For example, Ware et al. (2012) noted that of the 65% of youth diagnosed with behavioral disorders who exited school in Grades 9 to 12, 28% had been arrested at least once before leaving high school and 58% had been arrested within 5 years of withdrawing from high school. I discussed two newsworthy examples in this study that behaviors indicative of DMDD were observed in two early elementary education students, AL and ER (Eagan et al., 2014; Griffin & Kovner, 2013a; Nagourney et al., 2014; Palmer, 2014; Rojas et al., 2018; Roussey, 2013). According to the results of my study, the implications for social change include professional development for special education teachers and awareness of the complex nature of DMDD to improve students' IEPs and their academic success.

As shared by the special education teachers, they wanted better teacher preparation and preservice programs to understand students identified as having severe behavioral issues. The teachers also indicated that coordinating consistent services with providers such as psychologists, general education teachers, and specialists would benefit the holistic approach supporting students' IEPs. This coordination also would help to support and develop ideas relevant to the home-school connection. A mental health checklist similar to the one already described in this chapter for volatile situations could be developed and reviewed by the coordinating team or possibly shared as a general plan

to deal with all volatile situations in and out of the classroom. Training programs could provide parents with the skills needed to decrease their children's mood dysregulation and anger outbursts. Having the students generalize behaviors in all settings is paramount because taking the same approach at home and at school could provide students with more consistency. The Webster-Stratton technique can be a comprehensive approach, as suggested by Kirby et al. (2016) as well as Rao (2014).

Another focus of positive change is the positive effort and dedication by special education teachers to support students with DMDD. All eight teachers agreed how difficult it could be for students identified with DMDD to complete daily tasks, given their emotional volatility. Rather than complain, the interviewed special educators spoke only about the needed changes that would increase the academic success of their students.

Special education teachers are sometimes silent heroes in the teaching profession. They plan and develop programs for student with diverse abilities. One standout suggestion by the special educators was the notion of specialization. The teachers spoke of having to switch responsibilities from offering only academic support to also providing behavioral support. Their suggestion was that special education teacher be given the option to specialize in academic or behavioral support.

Conclusion

Since the early research in 2011 by Leibenluft, indications have been that severe nonepisodic irritability in children and adolescents impacts their functioning at home, at school, and with peers. At this same time, the *DSM-5* (APA, 2013) was being prepared for publication. These symptoms presented difficulty in classifying severe irritability that

did not match the criteria for bipolar disorder. Leibenluft realized that children and adolescents were being diagnosed with bipolar disorder at an increased rate of 400% over previous periods.

Assessing psychopathology in children is complex because of developmental variations. Paucity in the number of previous studies gives this study the opportunity to make an important contribution to understanding the lived experiences of special education teachers and their efforts to support students with DMDD. This study might lead to more research endeavors supporting the daily educational needs of students with DMDD. It was evident that the special educators in this study gave their best efforts to ensure the success of their students, about they expressed that so much more is needed. There have been great accomplishments, but great challenges lie ahead. The satisfaction of special education teachers comes when the children under their care ask only for dignity and more importantly, “not to be forgotten.”

References

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *Journal of Education Literacy Studies, 5*(2), https://doi.org/10.7575/aiac.ijels.v.5n.2p.9

Althoff, R. R., Crehan, E. T., He, J.-P., Burstein, M., Hudziak, J. J., & Merikangas, K. R. (2016). Disruptive mood dysregulation disorder at ages 13-18: Results from the National Comorbidity Survey: Adolescent Supplement. *Journal of Child and Adolescent Psychopharmacology*, *26*(2), 107-113. https://doi.org/10.1089/cap.2015.0038

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

American Red Cross. (2021). *First aid steps.* https://www.redcross.org/take-a-class/first-aid/performing-first-aid/first-aid-steps

Becker, S. J., & Bowen, S. K. (2018). Service providers' perspective on the education of students who are deaf or hard of hearing and English learners. *American Annals of the Deaf, 163*(3), 356-373. https://doi.org/10.1353/aad.2018.0023

Behal, A. (2014). *Negative capability: A phenomenological study of lived experience at the edge of certitude and incertitude.* Amazon.com

Benarous, X., Renaud, J., Breton, J. J., Cohen, D., Labelle, R., & Guilé, J.-M. (2020). Are youths with disruptive mood dysregulation disorder different from youths with

major depressive disorder or persistent depressive disorder? *Journal of Affective Disorders, 265*, 207-215. https://doi.org/10.1016/j.jad.2020.01.020

Bitter, J. R., & Carlson, J. (2017). Adlerian thought and process in systems of family therapy. *Journal of Individual Psychology*, *73*(4), 307-327. https://doi.org/10.1353/jip.2017.0026

Bradley, R., Doolittle, J., & Bartolotta, R. (2008). Building on the data and adding to the discussion: The experiences and outcomes of students with emotional disturbances. *Journal of Behavioral Education*, *17*, 4-23. https://doi.org/10.1007/s10864-007-9058-6

Carlson, J., Watts, R. E., & Maniacci, M. (2006). *Adlerian therapy: Theory and practice.* American Psychological Association.

Cavendish, W., & Connor, D. (2018). Toward authentic IEPs and transition plans: Student, parent, and teacher perspectives. *Learning Disability Quarterly*, *41*(1), 32-43. https://doi.org/10.1177/0731948716684680

Chan, C. Y. Z., Fung, Y., & Chien, W. (2013). Bracketing in phenomenology: Only undertaken in the data collection and analysis process? *Qualitative Report*, *18*(59), 1-9. https://doi.org/10.46743/2160-3715/2013.1486

Chen, J., Wang, Z., & Fang, Y. (2016). The history, diagnosis and treatment of disruptive mood dysregulation disorder. *Shanghai Archives of Psychiatry*, *28*(5), 289-292.

Copeland, W., Angold, A., Costello, E., & Egger, H. (2013). Prevalence, comorbidity, and correlates of *DSM-5* proposed disruptive mood dysregulation disorder. *American Journal of Psychiatry*, *170*(2), 173-179. https://doi.org/10.1176/appi.ajp.2012.12010132

Cronin, P., Ryan, F., & Coughlan, M. (2008). Undertaking a literature review: A step-by-step approach. *British Journal of Nursing*, *17*(1), 38-43. https://doi.org/10.12968/bjon.2008.17.1.28059

Ditrano, C. J., & Bourdeaux-Silverstein, L. B. (2006). Listening to parents' voices: Participatory action research in the schools. *Professional Psychology: Research and Practice*, *37*(4), 359-366. https://doi.org/10.1037/0735-7028.37.4.359

Dougherty, L., Barrios, C., Carlson, G., & Klein, D. (2017). Predictors of later psychopathology in young children with disruptive mood dysregulation disorder. *Journal of Child and Adolescent Psychopharmacology, 27*(5), 396-402. https://doi.org/10.1089/cap.2016.0144

Dougherty, L., Smith, V., Bufferd, S., Carlson, G., Stringaris, A., Leibenluft, E., & Klein, D. (2014). *DSM-5* disruptive mood dysregulation disorder: Correlates and predictors in young children. *Psychological Medicine*, *44*(11), 2339-2350. https://doi.org/10.1017/s0033291713003115

Dougherty, L., Smith, V., Bufferd, S., Kessel, E., Carlson, G., & Klein, D. (2016). Disruptive mood dysregulation disorder at the age of 6 years and clinical and functional outcomes 3 years later. *Psychological Medicine*, *46*(05), 1103-1114. https://doi.org/10.1017/s0033291715002809

Duchnowski, A. J., Kutash, K., Green, A. L., Ferron, J. M., Wagner, M., & Vengrofski, B. (2012). Parent support services for families of children with emotional disturbances served in elementary school special education settings: Examination of data from the Special Education Elementary Longitudinal Study. *Journal of Disability Policy Studies*, *24*(1), 36-52. https://doi.org/10.1177/1044207312460889

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Shellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Journal of Child Development, 82*(1), 405-432. https://doi.org/10.1111/j.1467-8624.2010.01564

Eagan, S. H., VosWinkel, F., Ford, J. D., Lyddy, C., Schwartz, H. I., & Spencer, A. (2014). *Shooting at Sandy Hook Elementary School.* https://www.ct.gov/oca/lib/oca/sandyhook11212014.pdf

Erciyes, E. (2019). *Three pillars of phenomenology: Husserl, Heidegger and Merlau-Ponty.* https://www.memphis.edu/philosophy/opo2019/pdfs/erciyes-erdem.pdf

Farrell, E. (2020). Researching lived experience in education: Misunderstood or missed opportunity? *International Journal of Qualitative Methods.* https://doi.org/10.1177%2F1609406920942066

Ferguson, E. D. (2010). Adler's innovative contributions regarding the need to belong. *Journal of Individual Psychology*, *66*(1), 1-7. https://web.a.ebscohost.com/

Freeman, A., Youngstrom, E., Youngstrom, J., & Findling, R. (2016). Disruptive mood dysregulation disorder in a community mental health clinic: Prevalence, comorbidity and correlates. *Journal of Child and Adolescent Psychopharmacology*, *26*(2), 123-130.

Gable, R. A., Tonelson, S. W., Sheth, M., Wilson, C., & Park, K. L. (2012). Importance, usage, and preparedness to implement evidence-based practices for students with emotional disabilities: A comparison of knowledge and skills of special education and general education teachers. *Journal of Education and Treatment of Children*, *35*(4), 499-519. https://doi.org/10.1353/etc.2012.0030

Gadamer, H. G. (n.d.). *On the circle of understanding.* http://faculty.washington.edu/ewebb/R528/Gadamer.pdf

Gadamer, H. G. (2006). Classical and philosophical hermeneutics. *Theory, Culture & Society*, *23*(1), 29-56. https://doi.org/10.1177/0263276406063228

Gellweiler, S., Wise, N., & Fletcher, T. (2018). Understanding the "lived experience" of sport event volunteers: Using the hermeneutic circle as a guiding conceptual framework. *Event Management, 22*(4), 629-641. https://doi.org/10.3727/152599518X15300559276976

Griffin, A., & Kovner, J. (2013a, February 13). Courant/FRONTLINE Investigation: Raising Adam Lanza. *The Courant*. https://www.courant.com/

Griffin, A., & Kovner, J. (2013b, December 28). Lanza's psychiatric treatment revealed in documents. *The Courant*. http://articles.courant.com/

Individuals with Disabilities Education Improvement Act of 2004, Pub. L. 108-446, 118 Stat. 2647 (2005).

Kafle, N. P. (2011). Hermeneutic phenomenological research method simplified. *Bodhi: An Interdisciplinary Journal*, *5*, 181-199. https://www.phenomenologyonline.com/

Kirby, J., Sanders, M., & Mazzucchelli, T. (2016). A clinician's quick guide of evidence-based approaches: Childhood disruptive disorders. *Clinical Psychologist*, *20*(3), 154-155. https://doi.org/10.1111/cp.12076

Lambert, M. C., Garcia, A. G., Epstein, M. H., & Cullinan, D. (2018). Differential item functioning of the Emotional and Behavioral Screener for Caucasian and African American elementary school students. *Journal of Applied School Psychology*, *34*(3), 201-214. https://doi.org/10.1080/15377903.2017.1345815

Leibenluft, E. (2011). Severe mood dysregulation, irritability, and the diagnostic boundaries of bipolar disorder in youths. *American Journal of Psychiatry, 168*(2), 129-142. https://doi.org/10.1176/appi.ajp.2010.10050766

Maniacci, M., & Johnson-Migalski, L. (2013). Conceptualizing and treatment of trauma and self-destructive behavior: The individual psychology perspective. *Journal of Individual Psychology*, *69*(3), 169-185.

Margulies, D., Weintraub, S., Basile, J., Grover, P., & Carlson, G. (2012). Will disruptive mood dysregulation disorder reduce false diagnosis of bipolar disorder in children? *Bipolar Disorders*, *14*(5), 488-496. https://doi.org/10.1111/j.1399-5618.2012.01029.x

Marshall, C., & Rossman, G. B. (2011). *Designing qualitative research* (5th ed.). Sage.

Martin, S. E., Hunt, J. I., Mernick, L. R., DeMarco, M., Hunter, H. L., Coutinho, M. T., & Boekamp, J. R. (2017). Temper loss and persistent irritability in preschoolers: Implications for diagnosing disruptive mood dysregulation disorder in early childhood. *Child Psychiatry and Human Development, 48*(3), 498-508. https://doi.org/10.1007/s10578-016-0676-x

Mayes, S., Waxmonsky, J., Calhoun, S. & Bixler, E. (2016). Disruptive mood dysregulation disorder symptoms and association with oppositional defiant and other disorders in a general population child sample. *Journal of Child and Adolescent Psychopharmacology, 26*(2), 101-106. https://doi.org/10.1089/cap.2015.0074

McConnell-Henry, T., Chapman, Y., & Francis, K. (2009). Husserl and Heidegger: Exploring the disparity. *International Journal of Nursing Practice, 15*(1), 7-15. https://doi.org/10.1111/j.1440-172X.2008.01724.x

McTate, E. A., & Leffler, J. M. (2017). Diagnosing disruptive mood dysregulation disorder: Integrating semi-structured and unstructured interviews. *Clinical Child Psychology and Psychiatry, 22*(2), 187-203. https://doi.org/10.1177/1359104516658190

Mulraney, M., Schilpzand, E. J., Hazell, P., Nicholson, J. M., Anderson, V., Efron, D., Silk, T. J., & Sciberras, E. (2015). Comorbidity and correlates of disruptive mood dysregulation disorder in 6-8-year-old children with ADHD. *European Child & Adolescent Psychiatry*, *25*(3), 321-330. https://doi.org/10.1007/s00787-015-0738-9

Nagourney, A., Cieply, M., Feuer, A., & Lovett, I. (2014, June 2). Before brief, deadly spree, trouble since age 8: Elliot O. Rodger's killings in California followed years of withdrawal. *The New York Times.* http://www.nytimes.com/2014/06/02/us/elliot-rodger-killings-in-california-followed-years-of-withdrawal.html

National Institute of Mental Health. (2009). *Treatment of children with mental illness: Frequently asked questions about the treatment of mental illness in children.* http://www.nimh.nih.gov

Palmer, B. (2014, May 27). Did Elliot Rodger's therapists fail? What prevents law enforcement and mental health professionals from stopping a killer? *Health and Medicine Explained.* http://www.slate.com/technology/2014/05/elliot-rodger-therapists-why-did-they-and-law-enforcement-fail-to-recognize-his-threat.html

Perich, T., Frankland, A., Roberts, G., Levy, F., Lenroot, R., & Mitchell, P. B. (2017). Disruptive mood dysregulation disorder, severe mood dysregulation and chronic irritability in youth at high familial risk of bipolar disorder. *Australian and New Zealand Journal of Psychiatry*, *51*(12), 1220-1226. https://doi.org/10.1177/0004867416672727

Pham, S., Resnick, M., Yoon, J.-Y., Dixon, T. A., Boden, J., & Pendergast, L. L. (2014). *Classroom accommodations and school-based interventions for students with DMDD diagnosis.* Roundtable accepted for presentation at the American Psychological Association annual convention, Washington, DC. https://doi.org/10.1037/e557572014-001

Puddy, R. W., Roberts, M. C., Vernberg, E. M., & Hambrick, E. P. (2012). Service coordination and children's functioning in a school-based intensive mental health program. *Journal of Child and Family Studies*, *21*(6), 948-962. https://doi.org/10.1007/s10826-011-9554-0

Rao, U. (2014). *DSM-5*: Disruptive mood dysregulation disorder. *Asian Journal of Psychiatry*, *11*, 119-123. https://doi.org/10.1016/j.ajp.2014.03.002

Rojas, R., & Hussey, K. (2018, December 10). Newly released documents detail Sandy Hook shooter's troubled state of mind. *The New York Times.* https://www.nytimes.com/2018/12/10/nyregion/documents-sandy-hook-shooter.html

Roussey, T. (2013, November 25). Adam Lanza "undoubtedly afflicted with mental health problems." *The Associated Press.* http://www.wjla.com/news/nation-world/adam-lanza-undoubtedly-afflicted-with-mental-health-problems--97360

Rudy, H. L., & Levinson, E. M. (2008). Best practices in the multidisciplinary assessment of emotional disturbances: A primer for counselors. *Journal of Counseling and Development*, *86*(4), 494-504. https://doi.org/10.1002/j.1556-6678.2008.tb00537.x

Smith, J. A., Flowers, P., & Larkin, M. (2009) *Interpretative phenomenological analysis: theory, method, and research*. Sage.

Soheili, F., Alizadeh, H., Murphy, J. M., Bajestani, H. S., & Ferguson, E. D. (2015). Teachers as leaders: The impact of Adler-Dreikurs classroom management techniques on students' perceptions of the classroom environment and on academic achievement. *Journal of Individual Psychology*, *71*(4), 440-461. https://doi.org/10.1353/jip.2015.0037

Sperry, L. (2009). Selecting psychotherapeutic interventions: Enhancing outcomes in Adlerian psychotherapy. *Journal of Individual Psychology*, *65*(3), 286-297. PsycINFO database.

Stringaris, A. (2011). Irritability in children and adolescents: A challenge for *DSM-5*. *European Child & Adolescent Psychiatry*, *20*(2), 61-66. https://doi.org/10.1007/s00787-010-0150-4

Tourian, L., LeBoeuf, A., Breton, J.-J., Cohen, D., Gignac, M., Labelle, R., Guile, J. M., & Renaud, J. (2015). Treatment options for the cardinal symptoms of disruptive mood dysregulation disorder. *Journal of the Canadian Academy of Child and Adolescent Psychiatry/Journal de l'Académie canadienne de psychiatrie de l'enfant et de l'adolescent*, *24*(1), 41-54.

Tudor, M., Ibrahim, K., Bertschinger, E., Piasecka, J., & Sukhodolsky, D. (2016). Cognitive-behavioral therapy for a 9-year-old girl with disruptive mood dysregulation disorder. *Clinical Case Studies*, *15*(6), 459-475. https://doi.org/10.1177/1534650116669431

Ware, J. N., Ohrt, J. H., & Swank, J. M. (2012). A phenomenological exploration of children's experiences in a social skills group. *Journal for Specialists in Group Work, 37*(2), 33-15. https://doi.org/10.1080/01933922.2012.663862

Watts, R. E., & Ergüner-Tekinalp, B. (2017). Positive psychology: A neo-Adlerian perspective. *Journal of Individual Psychology, 73*(4), 328-337. https://doi.org/10.1353/jip.2017.0027

Wilberg, P. (2006). *The awareness principle, Advaita and European phenomenology.* http://www.thenewyoga.org/advaita.pdf

Appendix: Interview Questions

Let us talk about your experiences in the classroom with DMDD students:

1. Describe a typical academic day for a student identified as DMDD.
2. Describe a situation with social challenges for that identified DMDD student.
3. In your experiences, what are any therapeutic needs and challenges for students identified as DMDD?
4. “Gemeinschaftsgefuhl” is translated as “social feeling,” or a feeling of being an important contributor to a community. In your experiences, do you feel that students identified with DMDD have a sense of belonging and being a part of the school community? Give an example of how a student identified with DMDD has demonstrated or expressed a sense of belonging or “Gemeinschaftsgefuhl.”
5. Describe your challenges as a provider.
6. Think of a time when a DMDD student has been in a volatile state. What are your emotional responses to DMDD students when they may be in volatile states? Give an example(s) of a situation(s) and how you manage your emotional response(s).