As special educators you will be working with a wide variety of students with developmental and psychological disorders. One of the main concerns from teachers in special education involves the educational implications for children with these disorders. This course was developed to discuss and provide information on educational implications and what can be done for students with psychological and developmental disorders.
1-Developmental Disorders

A-Mental Retardation

Description
This group of disorders is characterized by severe delayed development in the acquisition of cognitive, language, motor or social skills. The general characteristics of this diagnostic category are:

1. Consistent and significant subaverage intellectual performance
2. Significant deficits in the development of adaptive functioning
3. Onset prior to the age of 18

Educational Implications
The more severe the category, the greater the possibility of associated features being present like seizures, visual, auditory or cardiovascular problems. Other educational implications involve poor social skills, severe academic deficits and possible behavioral manifestations such as impulsivity, low frustration tolerance, aggressiveness, low self-esteem and in some cases self injurious behavior.

A child with mental retardation can do well in school but is likely to need individualized help. Fortunately, states are responsible for meeting the educational needs of children with disabilities.

For children up to age three, services are provided through an early intervention system. Staff work with the child's family to develop what is known as an Individualized Family Services Plan, or IFSP. The IFSP will describe the child's unique needs. It also describes the services the child will receive to address those needs. The IFSP will emphasize the unique needs of the family, so that parents and other family members will know how to help their young child with mental retardation. Early intervention services may be provided on a sliding-fee basis, meaning that the costs to the family will depend upon their income. In some states, early intervention services may be at no cost to parents.

For eligible school-aged children (including preschoolers), special education and related services are made available through the school system. School staff will work with the child's parents to develop an Individualized Education Program, or IEP. The IEP is similar to an IFSP. It describes the child's unique needs and the services that have been designed to meet those needs. Special education and related services are provided at no cost to parents.

Many children with mental retardation need help with adaptive skills, which are skills needed to live, work, and play in the community. Teachers and parents can help a child work on these skills at both school and home. Some of these skills include:

- communicating with others;
- taking care of personal needs (dressing, bathing, going to the bathroom);
- health and safety;
- home living (helping to set the table, cleaning the house, or cooking dinner);
- social skills (manners, knowing the rules of conversation, getting along in a group, playing a game);
- reading, writing, and basic math; and
- as they get older, skills that will help them in the workplace.

Supports or changes in the classroom (called adaptations) help most students with mental retardation. Some common changes that help students with mental retardation are listed below under "Tips for Teachers." The resources below also include ways to help children with mental retardation.
**Tips for Teachers**

- Learn as much as you can about mental retardation. The organizations listed at the end of this publication will help you identify specific techniques and strategies to support the student educationally. We've also listed some strategies below.

- Recognize that you can make an enormous difference in this student's life! Find out what the student's strengths and interests are, and emphasize them. Create opportunities for success.

- If you are not part of the student's Individualized Education Program (IEP) team, ask for a copy of his or her IEP. The student's educational goals will be listed there, as well as the services and classroom accommodations he or she is to receive. Talk to specialists in your school (e.g., special educators), as necessary. They can help you identify effective methods of teaching this student, ways to adapt the curriculum, and how to address the student's IEP goals in your classroom.

- Be as concrete as possible. Demonstrate what you mean rather than just giving verbal directions. Rather than just relating new information verbally, show a picture. And rather than just showing a picture, provide the student with hands-on materials and experiences and the opportunity to try things out.

- Break longer, new tasks into small steps. Demonstrate the steps. Have the student do the steps, one at a time. Provide assistance, as necessary.

- Give the student immediate feedback.

- Teach the student life skills such as daily living, social skills, and occupational awareness and exploration, as appropriate. Involve the student in group activities or clubs.

- Work together with the student's parents and other school personnel to create and implement an educational plan tailored to meet the student's needs. Regularly share information about how the student is doing at school and at home.

**Possible Least Restrictive Educational Setting**

Least restrictive educational settings for this type of student usually range anywhere from either inclusion or self contained in a general education school with mainstreaming options for higher functioning students to residential school and institutionalization for lower functioning individuals.

**B-Autistic Disorder**

**Description**

A very serious developmental disorder characterized by severe impairment in the development of verbal and nonverbal communication skills, marked impairment in reciprocal social interaction (a lack of responsiveness to, or interest in people) and an almost non existent imaginative activity. Also known as Infantile Autism or Kanner's Syndrome.

**Educational Implications**

Children with this disorder may normally exhibit poor social skills, impaired cognitive functioning and language. The onset of puberty may increase oppositional or aggressive behavior. Other complications may include seizures and low intellectual development.
The following list of teacher suggestions for working with children with autism is adapted from Teaching Tips for Children and Adults with Autism, Grandin (2002):

1.) Avoid long strings of verbal instructions. People with autism have problems with remembering the sequence. If the child can read, write the instructions down on a piece of paper.

2.) Many children with autism are good at drawing, art and computer programming. These talent areas should be encouraged. Talents can be turned into skills that can be used for future employment.

3.) Many autistic children get fixated on one subject such as trains or maps. The best way to deal with fixations is to use them to motivate school work. If the child likes trains, then use trains to teach reading and math.

4.) Use concrete visual methods to teach number concepts.

5.) Many autistic children have problems with motor control in their hands. Neat handwriting is sometimes very hard. This can totally frustrate the child. To reduce frustration and help the child to enjoy writing, let him type on the computer. Typing is often much easier.

6.) Some autistic children will learn reading more easily with phonics, and others will learn best by memorizing whole words. Children with lots of echolalia will often learn best if flash cards and picture books are used so that the whole words are associated with pictures. It is important to have the picture and the printed word on the same side of the card. When teaching nouns the child must hear you speak the word and view the picture and printed word simultaneously. An example of teaching a verb would be to hold a card that says "jump," and you would jump up and down while saying "jump."

7.) Children with autism need to be protected from sounds that hurt their ears. The sounds that will cause the most problems are school bells, PA systems, buzzers on the score board in the gym, and the sound of chairs scraping on the floor. In many cases the child will be able to tolerate the bell or buzzer if it is muffled slightly by stuffing it with tissues or duct tape. Scraping chairs can be silenced by placing slit tennis balls on the ends of the legs or installing carpet.

8.) Some autistic people are bothered by visual distractions and fluorescent lights. They can see the flicker of the 60-cycle electricity. To avoid this problem, place the child's desk near the window or try to avoid using fluorescent lights. If the lights cannot be avoided, use the newest bulbs you can get.

9.) Some hyperactive autistic children who fidget all the time will often be calmer if they are given a padded weighted vest to wear. Pressure from the garment helps to calm the nervous system. For best results, the vest should be worn for twenty minutes and then taken off for a few minutes. This prevents the nervous system from adapting to it.

10.) Some individuals with autism will respond better and have improved eye contact and speech if the teacher interacts with them while they are swinging on a swing or rolled up in a mat. Sensory input from swinging or pressure from the mat sometimes helps to improve speech. Swinging should always be done as a fun game. It must NEVER be forced.

11.) Some children and adults can sing better than they can speak. They may respond better if words and sentences are sung to them. Some children with extreme sound sensitivity will respond better if the teacher talks to them in a low whisper.
12.) Some nonverbal children and adults cannot process visual and auditory input at the same time. They are mono-channel. They cannot see and hear at the same time. They should not be asked to look and listen at the same time. They should be given either a visual task or an auditory task. Their immature nervous system is not able to process simultaneous visual and auditory input.

13.) Some children and adults with autism will learn more easily if the computer key-board is placed close to the screen. This enables the individual to simultaneously see the keyboard and screen. Some individuals have difficulty remembering if they have to look up after they have hit a key on the keyboard.

14.) Nonverbal children and adults will find it easier to associate words with pictures if they see the printed word and a picture on a flashcard. Some individuals do not understand line drawings, so it is recommended to work with real objects and photos first. The picture and the word must be on the same side of the card.

15.) Some autistic individuals do not know that speech is used for communication. Language learning can be facilitated if language exercises promote communication. If the child asks for a cup, then give him a cup. If the child asks for a plate, when he wants a cup, give him a plate. The individual needs to learn that when he says words, concrete things happen. It is easier for an individual with autism to learn that their words are wrong if the incorrect word resulted in the incorrect object.

16.) Many individuals with autism have difficulty using a computer mouse. Try a roller ball (or tracking ball) pointing device that has a separate button for clicking. Autistics with motor control problems in their hands find it very difficult to hold the mouse still during clicking.

17.) Several parents have indicated that using the closed captions on the television helped their child to learn to read. The child was able to read the captions and match the printed works with spoken speech. Recording a favorite program with captions on a tape would be helpful because the tape can be played over and over again and stopped.

18.) Some autistic individuals do not understand that a computer mouse moves the arrow on the screen. They may learn more easily if a paper arrow that looks EXACTLY like the arrow on the screen is taped to the mouse.

19.) Children and adults with visual processing problems can see flicker on TV type computer monitors. They can sometimes see better on laptops and flat panel displays which have less flicker.

20.) Individuals with visual processing problems often find it easier to read if black print is printed on colored paper to reduce contrast. Try light tan, light blue, gray, or light green paper.

Possible Least Restrictive Educational Setting

Most children with this condition require the most restrictive educational setting possible. The student teacher ratios are usually 6:1:2 or smaller because of the close supervision required. Those that are not capable of maintaining this type of setting may have to be institutionalized. In rare cases the individual may improve to the point of completing formal education or advanced degrees.
**C-Developmental Arithmetic Disorder**

**Description**
This condition is marked by a serious marked disability in the development of arithmetic skills. This condition, often called dyscalculia, cannot be explained by mental retardation, inadequate teaching or primary visual or auditory defects and may be consistent throughout school.

**Educational Implications**
Children with this condition exhibit seriously impaired mathematical ability which may require modifications like extended time, use of a calculator flexible setting for tests and revised test format. Other implications may involve poor self esteem, social self consciousness and avoidance which may increase secondary problems.

Geary (2003) states that the ultimate goal of learning disabilities research is to develop instructional techniques that remediate, or at least compensate for, the learning difficulty. Perhaps it is needless to say, but, in comparison to remediation studies in the reading disability area, very little research has been done on remediation in the math disability area. Part of the difficulty stems from the fact that, except for the areas described above, little is really known about the nature and course of math disabilities -- it is hard to develop effective remedial techniques for a disorder that is not well understood. Nonetheless, this is an area of great need and an area in which we can probably begin to develop remedial programs, at least for basic counting and arithmetic.

**Possible Least Restrictive Educational Setting**
Children with this disorder may receive assistance through special educational services like resource room or a consultant teacher, and are usually able to maintain placement within a general education setting.

**D-Developmental Expressive Writing Disorder**

**Description**
This disorder is characterized by a serious impairment in the ability to develop expressive writing skills that significantly interfere in the child's academic achievement. This condition is not the result of Mental Retardation, inadequate educational experiences, visual or hearing defects or neurological dysfunction.

**Educational Implications**
Teachers should be aware that these children may exhibit a series of symptoms including avoidance, procrastination, denial and possibly disruptive behaviors when written assignments are involved as a means of covering up the seriousness of the disorder.

Bernstein and Luttinger (2006) indicate that the process of writing includes prewriting activities, the writing itself, and postwriting activities. Prewriting begins with planning, which includes analyzing the purpose of the writing and generating and organizing ideas. To develop prewriting skills, the child is taught to recognize types of recurring patterns and structures that relate to types of text. Narrative text (e.g., a temporally ordered story) differs from expository text. The child is taught to include elements that match the identified text structure. Discussion and interaction appear to benefit the development of prewriting planning skills. In some instructional approaches, teachers model brainstorming or think-aloud techniques.

The teacher should also be aware that accommodations and modifications to the child’s learning environment will be necessary and most likely will appear on the child’s IEP. These could include:
Seating closer to the board and the teacher’s desk
A scribe or peer to assist with note taking (e.g., using a buddy system, teacher prepared notes, technologies such as tape recording and laptop computers)
Extended time for class and standardized tests where writing is required
Alternate expressive options such as oral reports, dioramas, video presentations etc.
Use of a word processor
Voice recognition software

Especially in later grades when the need for producing longer written assignments and note taking increases, these accommodations can have an important positive effect.

Possible Least Restrictive Educational Setting
Children with this disorder may receive assistance through special educational services like resource room or a consultant teacher, and are usually able to maintain placement within a normal class setting.

E-Developmental Reading Disorder

Description
The more common features of this disorder include a marked impairment in the development of the child's decoding and comprehension skills which significantly interfere in the child's academic performance. As with most developmental disorders, this condition is not the result of mental retardation, inadequate educational experiences, visual or hearing defects or neurological dysfunction. This is sometimes commonly referred to as "dyslexia".

Educational Implications
Teachers should be aware that early diagnosis of this disorder is crucial to avoid serious secondary symptoms of poor self-esteem, behavior disorders and educational failure. Teachers should focus on the possible symptoms exhibited by children with this disorder so that they can assist in early identification of this high-risk child. Teachers should also be aware of the various reading techniques used to assist children with this disorder.

Teachers should be aware that several accommodations can facilitate the learning of a child with a developmental reading disorder. These may include:
- Taped textbooks available through Recording for the Blind
- Extended time on tests
- Peer tutoring
- Use of a note taker, for students who have trouble listening in class and taking notes
- Use of a scribe during test taking, for students who have trouble writing but who can express their answers verbally to the scribe, who writes down the responses
- Use of a reader during test taking, for students who have trouble reading test questions;
- Tape recording of class lectures; and
- Testing in a quiet place, for students who are easily distracted. The suggestions presented in the remainder of this article focus upon what parents can do to help a child with a learning disability learn and function within the home.
- Oral examinations
- Large print type
- Questions read on tests
Possible Least Restrictive Educational Setting

Children with this disorder may receive assistance through special educational services like resource room or a consultant teacher, and are usually able to maintain placement within a normal class setting.

**G-Developmental Expressive Language Disorder**

**Description**

This disorder is characterized by a serious impairment in the child's ability to develop expressive language. This condition is not the result of mental retardation, inadequate educational experiences, visual or hearing defects or neurological dysfunction.

**Educational Implications**

Teachers should be aware that from 3-10% of school-aged children suffer from this disorder and may greatly hamper a child's social interaction skills as well as academic performance.

The Kaufman Children’s Center (2003) suggests the following strategies to improve expressive language:

- **Gain Attention**
  
  Obtain the child's attention before giving instructions. This can be done by calling the child's name or by a gentle touch.

- **Monitor Comprehension**
  
  Periodically, ask the child questions related to the subject under discussion.

- **Rephrase**
  
  Restate what has been misunderstood rather than repeating the information. The speaker should consider reducing the complexity of the message as well as the vocabulary level.

- **Use Brief Instructions**

- **Pretutor**
  
  Familiarize the child with new vocabulary and concepts to be covered in class. Parents can be particularly helpful in this activity.

- **List Key Vocabulary**
  
  Before dealing with new material; write key vocabulary on the chalkboard. The discussion should center on these words.

- **Write Instructions**
  
  Write assignments on the board. Another child can be assigned as a "buddy" to make sure the child is made aware of assignments made during the day.

- **Visual Aids**
  
  Jotting key words on the blackboard, or providing simple written/picture outlines may be useful in presenting information.

- **Individual Help**
  
  One-to-one teacher tutoring will help fill in the gaps in understanding.

- **Provide Breaks**
  
  Children with auditory processing problems will need frequent breaks. This child will expend more effort in paying attention and discriminating information than other children. Therefore, they must have a chance to relax. Once a child is fatigued, further instruction will lead to frustration on the part of both teacher and child.
Possible Least Restrictive Educational Setting

Children with this disorder may receive assistance through special educational services like resource room, a consultant teacher or services from a speech therapist, and are usually able to maintain placement within a general education classroom setting.

2-Behavior Disorders

A-Attention Deficit Hyperactive Disorder

Description

Children with this disorder exhibit behaviors of inattention, hyperactivity and impulsiveness that are significantly inappropriate for their age levels. These behaviors may be severe and have an adverse affect on the child's academic achievement. (A more in depth discussion of this condition can be found in this section)

Educational Implications

Teachers should be aware of the academic as well as the social difficulties experienced by students with this disorder. Social rejection is common which may contribute to low self esteem, low frustration tolerance and possibly aggressive or compulsive behavior patterns.

Teachers who have children with AD/HD in their classroom can try the following accommodations:

- Try to place the student with teachers who are positive, upbeat, flexible, and highly organized problem-solvers. Teachers who praise liberally and who are willing to "go the extra mile" to help students succeed can be enormously beneficial to students with AD/HD.
- Provide more direct instruction and as much one-on-one instruction as possible.
- Use guided instruction.
- Teach and practice organization and study skills in every subject area.
- Lecture less.
- Design lessons so that students have to actively respond-get up, move around, go to the board, move in their seats.
- Design highly motivating and enriching curriculum with ample opportunity for hands-on activities and movement.
- Eliminate repetition from tasks or use more novel ways to practice.
- Design tasks of low to moderate frustration levels.
- Use computers in instruction.
- Challenge but don't overwhelm.
- Change evaluation methods to suit the child's learning styles and strengths.
- Pair the student with a study buddy or learning partner who is an exemplary student.
- Provide frequent feedback.
- Structure tasks.
- Monitor independent work.
- Schedule difficult subjects at the student's most productive time.
- Use mentoring and peer tutoring.
- Provide frequent and regularly scheduled breaks.
- Set timers for specific tasks.
- Call attention to schedule changes.
- Maintain frequent communication between home and school.
- Do daily/weekly progress reports.
- Teach conflict resolution and peer mediation skills.
- To support planning:
Teach the student to use assignment pads, day planners or time schedules, task organizers and outlines
Teach study skills and practice them frequently and in all subjects
To increase organization:
Allow time during school day for locker and backpack organization
Allow time for student to organize materials and assignments for homework
Have the student create a master notebook-a 3-ring binder where the student organizes (rather than stuffs) papers
Limit number of folders used; have the student use hole-punched paper and clearly label all binders on spines; monitor notebooks
Have daily and weekly organization and clean up routines
Provide frequent checks of work and systems for organization
To improve follow through:
Create work completion routines
Provide opportunities for self-correction
Accept late work
Give partial credit for work partially completed
To improve self-control:
Prepare the student for transitions
Display rules
Give behavior prompts
Have clear consequences
Provide the student with time to de-stress
Allow doodling or other appropriate, mindless motor movement
Use activity as a reward
Provide more supervision
To assist with working memory:
Focus on one concept at a time
List all steps
Write all work down
Use reading guides and plot summaries
Teach note-taking skills-let the student use a study buddy or teacher-prepared notes to fill in gaps
List all key points on board
Provide summaries, study guides, outlines, and lists
Let the student use the computer
To assist with memory retrieval:
Teach the student memory strategies (grouping, chunking, mnemonic devices)
Practice sorting main ideas and details
Teach information and organization skills
Make necessary test accommodations (allow open book tests; use word banks; use other memory cues; test in preferred modality-e.g., orally, fill in blank; give frequent quizzes instead of lengthy tests)

Possible Least Restrictive Educational Setting
Children with mild forms of this disorder may be able to maintain a general education class placement with the intervention of medication. More serious cases may require more restrictive settings, especially those children with associated oppositional or conduct problems. In such cases, special schools or residential settings may be the least restrictive setting.
B-Conduct Disorder

Description
This condition is characterized by a persistent pattern of behavior which intrudes and violates the basic rights of others without concern or fear of implications. This pattern is not selective and is exhibited in the home, at school, with peers and in the child's community. Other behaviors present with this condition may include vandalism, stealing, physical aggression, cruelty to animals and fire setting.

Categories:

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<thead>
<tr>
<th>Type</th>
<th>Description</th>
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<tr>
<td>Solitary Aggressive Type</td>
<td>aggressive behavior towards peers and adults</td>
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<tr>
<td>Group Type</td>
<td>conduct problems mainly with peers as a group</td>
</tr>
<tr>
<td>Undifferentiated Type</td>
<td>For those not classified in either above group</td>
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Educational Implications
Children with this condition may be physically confrontational to teachers and peers, have poor attendance, have high levels of suspension thereby missing a great deal of academic work and exhibit other forms of antisocial behavior.

For suggestions on dealing with this disorder see the recommendations listed under Oppositional Disorder.

Possible Least Restrictive Educational Setting
Children with this condition may be educated in a special class within a regular school if the condition is mild. However, the majority of students with this disorder are educated in a more restrictive program housed within special schools, residential schools or institutions if the antisocial behavior is extreme.

C-Oppositional Defiant Disorder

Description
This disorder is usually characterized by patterns of negativistic, hostile and defiant behaviors with peers as well as adults. This disorder is considered less serious than a conduct disorder because of the absence of serious behaviors which violate the basic rights of others. Children with this disorder usually exhibit argumentative behaviors towards adults which may include swearing and frequent episodes of intense anger and annoyance. These symptoms are usually considered to be more serious and intense than those exhibited by other children of the same age.

Educational Implications
Teachers who have children with this disorder in their classes may observe low frustration tolerance, frequent temper outbursts, low sense of confidence, and an unwillingness to take responsibility for their actions, consistent blaming of others for their own mistakes or problems, and frequent behaviors associated with Attention Deficit Hyperactive Disorder.
Millette (1996) suggests the following when dealing with children with oppositional disorders:

1. **Set rules; make them simple and straightforward.** Trying to reason with or lecture to an oppositional child, especially one who is very verbal, is usually counter-productive. Many oppositional children love a good debate or even a bad one, which will end up with you, a sputtering and frustrated foster parent.

2. **Avoid power struggles.** These are situations where, even if you win, you lose. Don't give the child a chance to feel martyred. You will still feel frustrated and often feel you have sunk to the child's level. You are the adult and you can remain in authority without engaging in a power struggle. If you have a tendency to engage in power struggles with children or other adults, take a good look at what makes you tick.

3. **Be consistent.** Don’t give a child the opportunity to play one foster parent against another or to be able to point out that you said something different last week.

4. **Communicate.** This will help in #3 and it will also help with behavior in school. It is good for the teachers, guidance counselors, etc. to know your rules and vice versa. Let them know what works best for your child. Communication with respite parents is also important and will help produce better results with suggestion #5.

5. **Make the child accountable.** When the child is with another caregiver (and this could include teachers as well), they may give different interpretation of your rules (e.g., “my bedtime is midnight”, “I can watch TV before I do my homework”, “I always eat two Snickers Bars before supper,” “My teacher lets me do my homework in school,” etc.). Let the child know that the teacher or respite parent knows your rules and that they let you know what the child says and does while with them.

6. **Write things down and let the child know that this is part of your communication system.** S/he may conclude that there is no way to get away with anything. It may even become a greater incentive for the child to learn to read and write.

7. **Remember, Oppositional Disorder is often a “cut your nose off to spite your face” situation,** because of the tendency for the child to hold onto behavior that is often destructive to his or her own interests or relationships. It is often chronic and can last for several years. If it continues into adulthood, Passive-Aggressive Personality Disorder may result. In dealing with it as a foster parent, you must be patient, yet deliberate.

**Possible Least Restrictive Educational Setting**

Children with this condition may be educated in a special class within a general education school if the condition is mild. However, the majority of students with this disorder are educated in a more restrictive program housed within special schools, residential schools or institutions if the antisocial behavior is extreme.
3-Disorders of Childhood and Adolescence

A-Anorexia Nervosa

Description
Children with this condition show a marked disturbance and unwillingness to maintain a minimal body weight for their age and height. An extreme distorted sense of body image exists and intense fears and worries about gaining weight become obsessive. It is not uncommon for Bulimia Nervosa (discussed later) to be an associated feature. In more severe cases death may occur.

Educational Implications
Teachers should be aware of frequent absences because of medical complications. These children are usually high achieving individuals but because of their medical conditions academic consistency may be difficult.

Levine (1994) suggests the following tips for teachers who are involved with a student with an eating disorder:

1. Don’t cast a net of awe and wonder around the existence of an eating disorder. Keep the focus on the reality that eating disorders result in:

   Inefficiency in the fulfillment of academic, familial, occupational, and other responsibilities.
   Misery in the form of food and weight obsession, anxiety about control, guilt, helplessness, hopelessness, and extreme mood swings.
   Alienation in the form of social anxiety, social withdrawal, secrecy, mistrust of others, and self-absorption.
   Disturbance of self and others through loss of control over dieting, body image, eating, emotions, and decisions.

2. Don’t oversimplify. Avoid thinking or saying things such as “Well, eating disorders are just an addiction like alcoholism,” or “All you have to do is start accepting yourself as you are.”

3. Don’t imply that bulimia nervosa, because it is often associated with “normal weight,” is somehow less serious than anorexia nervosa.

4. Don’t be judgmental, e.g., don’t tell the person that what they are doing is “sick” or “stupid” or “self-destructive.”

5. Don’t give advice about weight loss, exercise, or appearance.

6. Don’t confront the person as part of a group of people, all of whom are firing accusations at the person at once.

7. Don’t diagnose: keep the focus on IMAD (Inefficiency, Misery, Alienation, Disturbance) and the ways that the behaviors are impacting the person’s life and well-being.

8. Don’t become the person’s therapist, savior, or victim. In this regard, do not “promise to keep this a secret no matter what.”

9. Don’t get into an argument or a battle of wills. If the person denies having a problem, simply and calmly:
   - Repeat what you have observed, i.e., your evidence for a problem.
   - Repeat your concern about the person’s health and well-being.
   - Repeat your conviction that the circumstance should at least be evaluated by a counselor or therapist.
   - End the conversation if it is going nowhere or if either party becomes too upset. This impasse suggests that the person seeking help needs to consult a professional.
- Take any actions necessary for you to carry out your responsibilities or to protect yourself.
- If possible, leave the door open for further conversations.

10-Don’t be inactive during an emergency: If the person is throwing up several times per day, or passing out, or complaining of chest pain, or is suicidal, get professional help immediately.

**Possible Least Restrictive Educational Setting**
Children with this type of disorder can be maintained in the regular school setting unless the condition becomes severe enough to warrant hospitalization. In some cases where the child is at home and unable to attend school, homebound instruction is utilized.

**B-Bulimia Nervosa**

**Description**
A condition characterized by recurrent episodes of uncontrolled consumption of large quantities of food (binging) followed by self induced vomiting (purging), use of laxatives or diuretics over a period of at least two months.

**Educational Implications**
Most teachers might not even know that a student is bulimic. Individuals hide this "secret" well and may not divulge the problem to anyone, not even a best friend. This is usually a private disorder until the person feels so out of control that they seek help and support. Consequently, teachers should be aware of frequent trips to the bathroom especially in the morning after breakfast or after lunch. Changes in skin color and look may give some indications of problems. However if you suspect anything, let the nurse investigate this further.

**Possible Least Restrictive Educational Setting**
Unlike anorexia nervosa, children with bulimia nervosa seldom suffer incapacitating symptoms except in rare cases when the eating and purging episodes run throughout the day. Consequently, in most cases these children can be maintained in the general education school setting unless the condition becomes severe enough to warrant hospitalization.

**C-Selective Mutism**

**Description**
This disorder is characterized by persistent refusal to talk in one or more major social situations, including school, despite the ability to comprehend spoken language and speak. The resistance to speak is not a symptom of any other major disorder.

**Educational Implications:** This condition may create a difficult situation for the classroom teacher. The teacher will not be able to measure certain language or social levels, will have to deal with social concerns and comments from classmates, and have a difficult time encouraging the child to participate in necessary class activities or group projects. If a teacher has such a child in the classroom, he/she should contact the school psychologist as soon as possible. Individual and family counseling in highly suggested for such a disorder. The child with Selective Mutism is usually treated with Cognitive Behavior Therapy (CBT) and Behavioral Therapy i.e. desensitization, positive reinforcement, administered by trained professional in this...
technique. As a classroom teacher you would not be directly involved in CBT but might be asked to carry out some recommendations by the professional in the classroom.

According to the Selective Mutism Group (2003) CBT therapists help children change their thoughts (that’s the cognitive part) and their actions (that’s the behavioral part). CBT therapists recognize that anxious children tend to exaggerate the frightening aspects of certain situations, so they help the children gain a more realistic perspective in order to decrease anxiety.

You may want to take the following suggestions into consideration when working with a student with selective mutism:

1-Reduce the child's anxiety by not forcing him/her to speak. It is important that you do not blame the child. No matter how frustrated may become, remember that it’s not something that the child wants. Consider it a “speech block.”

2-Encourage the child to develop independent skills. Give the child classroom responsibilities. While they may not speak, they are still very capable.

3-Improve communication: help reinforcement speech in school by providing rewards and incentives. But do not force the child into speaking. "If you can smile at me , I will give you a star" Develop a step by step approximation towards actual speech. For example the steps could be; smile at the teacher, raise hand to say hello, whisper "hello" to teacher, say "hello" to teacher.

4-Have the parent speak to the child in the school environment. Have the parent ask him/her questions about what is going on in school. By getting the selectively mute child to talk, you are also reducing his/her sensitivity to the unfamiliar environment at school.

5-Do not reinforce the gains that a selectively mute child receives. In many cases, and without awareness, parents, siblings, teachers and classmates have accommodated the child's mute behavior by doing things for them and treating them as if they are really mute.

6-Take the opportunity to encourage the child to do things for themselves.

7-Work closely with professionals, i.e. speech and language pathologist, psychologist and psychiatrist can help you. Seek their help and advice.

**Possible Least Restrictive Educational Setting:** This type of child can usually be maintained in the general educational setting as long as the child maintains sufficient performance levels. However, if the child's academic performance becomes discrepant, and/or social and intellectual factors interfere in performance, then a more restrictive placement may have to be explored.

**D-Tourette's Disorder**

**Description**
This disorder is characterized by motor and vocal ticing which may be exhibited in the form of grunting, coughs, barks, touching, knee jerking, drastic head movements, head banging, squatting and so on.

**Educational Implications**
Teachers of students with Tourette's Disorder should be aware and sensitive to the social difficulties and confusion exhibited by the student's peers. Social rejection, isolation and victimization may be common and the teacher needs to step in to prevent these situations from occurring. In older students with this
disorder teachers should be aware of the child's use of a great deal of energy in an attempt to control the tics because of social pressure at the cost of attention and consistent academic performance. If you have a student with this condition contact the local Tourette's Association in your area for further literature.

**Possible Least Restrictive Educational Setting**

Children with mild forms of this disorder can easily be maintained in a regular educational setting with supportive services. Since the condition does affect performance in many cases, children with this disorder are usually classified as disabled and do receive special education services including modifications. More severe cases which do not respond to medication may require a more restrictive setting. Medication, counseling and special education services provide a good treatment plan. However, the child may have to try many medications before finding one that relieves the ticcing. Medications are also taken if OCD symptoms are associated.

The Center for Applies Research in Education (1995) suggests the following classroom strategies when working with children with Tourette’s Syndrome:

1. Keep in mind that motor or vocal tics are occurring involuntarily.
2. Try not to react with anger or annoyance.
3. Try to be a role model for the students on how to react to the Tourette's symptoms.
4. Provide the child with opportunities for short breaks out of the classroom.
5. Try to find a private place somewhere in the school where the child can "let out" the tics, since the effort to suppress the tics causes a buildup of tension.
6. Allow the student to take tests in a private room so that he or she does not waste energy suppressing the tics--interfering with the student's concentration.
7. Work with the student's classmates to help them understand the tics and to reduce, ridicule and teasing.
8. Secure materials (e.g., audiovisuals or pamphlets to provide information for your pupils and colleagues.
9. If the student's tics are particularly disruptive, avoid recitation in front of the class.
10. Have the student tape-record oral reports.
11. Keep in mind that students with Tourette's often have visual motor difficulties.
12. Modify written assignments by reducing the number of problems presented or required to copy.
13. Allow parents to copy down work so that the pupil can dictate his or her ideas to facilitate concept formation.
14. Allow the student to write the answers directly on a test paper or booklet rather than use computerized scoring sheets.
15. Allow the child un-timed tests to reduce stress.
16. Allow another child to take notes for the student so that she or he can listen to the lecture without the added stress of copying notes
17. Try not to penalize for spelling errors.
18. Try to use a multi-sensory approach whenever possible.
20. Use graph paper for math so that the student can place one number in each box.

**E-Functional Encopresis**

**Description**

The major symptom of this disorder is repeated involuntary or intentional passage of feces into clothing or other places which deem it inappropriate. The condition is not related to any physical condition, must occur for a period of six months on a regular basis and be present in a child over the age of 4 for diagnosis to take place.
Educational Implications

Children with this disorder may experience social ridicule if the occurrences take place in school. The teacher needs to be sensitive to the condition and involve the school psychologist and parents. Try to intervene as quickly as possible if a pattern exists to avoid further embarrassment for the child and secondary complications i.e. avoidance.

Classroom teachers who may experience a child with this condition should keep the following in mind:

• Maintain low key responses
• Have a change of clothes available at school in the clinic or alternative location
• Plan a consistent response to events; send student to clinic or alternative location for clean-up and change of clothes; while wearing latex/rubber gloves, place soiled clothes in a plastic bag; call parent and make arrangements for soiled items to be returned home
• Observe for consistent trigger events
• Support bowel/bladder retraining program that is recommended by the physician

Possible Least Restrictive Educational Setting

Children with this condition should have no problem maintaining a general educational setting unless the condition is associated with other disabilities which require special education placement. However, this condition may create social pressures and isolation for the child.

F-Functional Enuresis

Description

This disorder is characterized by repeated involuntary intentional elimination of urine during the day or night into bed or clothes at an age which bladder control is expected. A frequency of at least two times per month must be present for the condition to be diagnosed between the ages of five and six and at least once a month for older children.

Educational Implications

Children with this condition should have no problem maintaining a regular educational setting unless the condition is associated with other disabilities which require special education placement. However, this condition may create social pressures and isolation for the child.

Possible Least Restrictive Educational Setting

Children with this condition should have no problem maintaining a regular educational setting unless the condition is associated with other disabilities which require special education placement.

4-Anxiety and Mood Disorders

A-Separation Anxiety Disorder

Description

This disorder is characterized by extreme anxiety associated with separation from someone with whom the child views as a significant other. While this reaction may be common with very young children on their first day of school, continuation of the anxiety for more than two weeks indicates a problem that needs to be addressed. This separation anxiety is frequently exhibited at school and at home. It should be noted that if symptoms of separation anxiety occur in an adolescent, other factors such as social or academic pressure may be the contributing cause.
Educational Implications

Children with this disorder may require a great deal of the teacher's attention. The child may cling, be afraid to try new things, requires a great deal of reassurance and may cry frequently. Panic attacks are common and the teacher may find that reason does not reduce the anxiety. Physical complaints are common and should never be ignored. However, in cases of separation anxiety these "physical" symptoms are usually manifestations of the anxiety once medical causes are ruled out.

Watkins (2001) suggests the following:

- Teacher should introduce self to child and invite the child to play with toys or have a snack.
- Offer to have the parent stay a while; leave the child alone briefly with the teacher and then return.
- Suggest to the parent that he or she try role playing with the child to rehearse the separation.
- Teacher could have a ritual for the parent leaving the child.
- If the child is in an absolute panic, ask parent to stay until the child is quieter. Teacher should ask parent to comfort child in a firm, loving voice.
- Teacher should never criticize child for feeling sad or anxious.

Possible Least Restrictive Educational Setting

Children with this disorder can usually be maintained in the general education class setting through the help of the school psychologist working with the child and parents. If the condition persists and the diagnosis changes i.e. Major Depression, then outside professional help may be required and a more restrictive program, sometimes even homebound instruction if attendance at school is not possible, may have to be instituted.

B-Avoidant Disorder of Childhood or Adolescence

Description

This disorder results in the child withdrawing from social contact or interaction with an unfamiliar peer or adult to the point of becoming a significant factor in social development.

Educational Implications

Children with this disorder can maintain regular class placement as long as achievement levels do not present problems possibly signifying some other condition. Teachers with this type of student should be aware of social isolation, withdrawal from activity based assignments, and a complete unwillingness to try new situations involving social interaction with unfamiliar peers.

The following suggestions should be tried when involved with a student with this condition:

- Trying to force the child into new social interaction situations may only result in further withdrawal socially as well as verbally
- Work alone with the child or along with familiar peers only for awhile
- Slowly increase the time that you allow the child to work with another student
- Provide success oriented tasks for the child and his working mate
- Once a trust relationship is developed your influence may be more rewarding
- Referring the child to the school psychologist is also highly recommended
Individual outside counseling with a slow lead into small group counseling should be explored in consultation with the school psychologist. However, be aware that this transition may result in a great deal of resistance on the part of the child.

**Possible Least Restrictive Educational Setting**

Children with this disorder can usually be maintained in the regular class setting through the help of the school psychologist working with the child and parents. However, children with other disabilities may also exhibit this disorder.

### C-Obsessive Compulsive Disorder

**Description**

The major characteristics associated with this disorder are persistent obsessions (persistent thoughts) or compulsions (repetitive acts), that significantly interfere with the individuals normal daily social, educational, occupational or environmental routines.

**Educational Implications**

Children or adolescents with this disorder will have difficulty concentrating and maintaining consistent academic performance. These individuals may also experience depression as a result of their difficulties and medication may be instituted to relieve the anxiety associated with this disorder.

The following list was adapted from Packer (2002) who suggests the following tips for teachers when dealing with children with obsessive compulsive disorder:

1. Allow more time for completing tasks and tests. Other testing accommodations may include testing in an alternate location, providing breaks during testing, and allowing the student to write directly on the test booklet. In some cases you may need to allow the student to take tests orally.
2. For students with compulsive writing rituals consider limiting handwritten work. Common compulsive writing rituals include having to dot I’s in a particular way or retrace particular letters ritualistically, having to count certain letters or words, having to completely blacken in the circles on test forms etc. In such cases, a reasonable test accommodation would be to have the student circle their answers or record the answers directly on the test booklet.
3. If the student’s compulsions are not triggered by keyboarding; have the student use a word processor or notebook computer.
4. If reading rituals and intrusive thoughts are severe, consider going to books on tape or recording the material for your student to listen to.
5. Try to reduce triggers to compulsive rituals, if possible. If you know that a student will “have to” engage in a ritual if they see the pencil sharpener, can you put the sharpener out of sight?
6. Whenever it does not endanger the student or anyone else, accommodate situations over which the student has little or no control. If the student is late to school every day because their rituals are interfering with them getting to school on time, discipline them or punishing them i.e. detention, is likely to only make things worse. Remember that the student is more frustrated with the situation than you are.
7. Be aware of the peer problems or emotional needs of the student with OCD.
8. Identify the child’s strengths and talents, and be sure to point them out to the student. Also try to compliment the student in front of his/her peers, as social problems are common in this population.
9. If the student is being ridiculed for their rituals or obsessive fears, consider conducting a peer education program. Many videos are available on this topic.
10. Consult often with the parent and the school psychologist.
Possible Least Restrictive Educational Setting

This type of child can usually be maintained in the general educational setting as long as the child maintains sufficient performance levels. However, if the child's academic performance becomes discrepant, and/or social and intellectual factors interfere in performance, then a more restrictive placement may have to be explored.

D-Childhood Depression

Description

A mood disorder among children that resembles depression in adults, but shows up in very different ways in children. It is the persistent experience of a sad or irritable mood and the loss of interest or pleasure in nearly all activities. These feelings are accompanied by a range of additional symptoms affecting appetite and sleep, activity level and concentration, and feelings of self-worth.

Educational Implications

Teachers can help to lighten a depressed student's load by creating a comfortable classroom where the student knows he/she is cared for and where the student doesn't have a time limit to suddenly cheer up. Depression takes a lot of time to get over, and school does not have to be a negative place of responsibility. If I had had a teacher that did at least one of the following things during the period of time I was depressed, I might have turned my act around a little sooner, or I might have had a more positive outcome in school.

Three tips for dealing with students who are depressed in the classroom:

1. Don't ignore depressed students. It shows that you don't care and invites the students to give up, guaranteeing their failure. Draw them out in class discussion and do whatever it takes to stimulate their minds so that they don't, in turn, learn to ignore you.

2. Let them know that you care, but without getting too personal. Help them to update any missing assignments, or set up extra study time - whether they accept your efforts or not all depends upon the severity of the depression. The fact that you've proven you care can make all the difference in the world.

3. Never give up on the student - regardless of how long they haven't wanted to put forth any effort in your class. Students can tell when a teacher no longer believes in them and expects them to fail, and it only ends up making the situation worse than necessary.

Possible Least Restrictive Educational Setting

Students with this disorder can usually be maintained in either a regular setting or a more restrictive special education program, if the symptoms become more intense. The severity of this condition will determine the ability of the child to maintain a regular school setting. Hospitalization is not uncommon in severe cases unless the condition can be controlled with medications.

The above disorders represent only a cross section of the conditions which you may encounter in the classroom. While expertise is not suggested, an understanding and awareness of such disorders can only increase your effectiveness with these children. As previously stated, a more elaborate explanation as well as further disorders associated with this developmental period, can be found in DSM-IV-TR (2003).
References


