Special Education Alert

by Nancy Rappaport, M.D.

Child and adolescent psychiatrists who consult schools often spend a majority of their time considering the needs of children and adolescents receiving special education services. There is a large range of tasks that psychiatrists may face when approached by a school district for help. These can include: identifying learning barriers, assessing students for medication, helping an administrator or an educational team determine if the school setting is appropriate for individual students, translating psychiatric diagnoses for individual students, meeting with frustrated parents and even helping to design successful alternative school programs (Adelman and Taylor).

Ten to 20 percent of U.S. students receive special education services. However, there is evidence that these students are not necessarily receiving adequate services (Mattison). A large percentage of special education students, particularly those children with a combination of learning disorders and emotional disturbances, lack psychological treatment and adequate medication trials. As child adolescent psychiatrists, many of our at-risk patients will also be special education students. The school setting is increasingly the focus of our efforts to serve children. It is our challenge to support teachers' and parents' efforts to advocate for these children and optimize their learning opportunities.

Federal and state legislation outlines for all children the right to free public education in the least segregated setting possible. The "least restrictive environment" is part of the 1990 Individual with Disabilities Education Act (IDEA). The regulations and laws are designed only to help students who meet special criteria by 1) having an identified disability and 2) being unable to effectively progress in regular education. (Gordon, 1999)

There is no consensus or strong evidence for how best to serve children with learning disabilities and emotional disabilities in school settings. Inclusion, or the integration of special education students into the regular classroom, is the most recent trend. It is not clear whether inclusion demonstrates a "business as usual" attitude, which is a cost-saving measure for districts but does not necessarily provide students with the resources to reach their academic potential.

The political pressure for inclusion frequently comes from parents of children with disabilities who see this as an opportunity for their child to be positively challenged by high-functioning peers. They hope that their child may then model more age-appropriate behavior (Siegel). Unfortunately, despite noble intentions, the implementation of inclusion has often added to the stress of regular education classroom teachers who are also under increasing pressure by states to cover large amounts of content and raise the performance of students despite large class sizes and little or no meaningful planning time during the school day (Joint Committee on Teacher Planning). Many of these teachers do not have a basic understanding of what the special education children's difficulties are or how to help them. Their students are set up for failure.

My experience as the mental health director of the Teen Health Center and consultant to an urban high school for the last five years has forced me to recognize the limitations of special education within my school system. An astounding 23 percent of the students in this district receive special education service (one of the communities in Massachusetts with the highest proportion of special education students) (Gordon p. 39, 1997). The district spends a quarter of its budget on special education, with the dismal result that a majority of special-need students are failing half of their courses and are increasingly disenchanted. (Gordon p. 81, 1997).

For regular class teachers, there is an extensive and daunting list of expectations for meeting the needs of students with learning disabilities (Mattison). These beliefs include understanding the nature and needs of students with LD, making curriculum modifications and adaptations to maximize participation, using appropriate assessment methods and classroom management. A significant growth field is to adequately prepare general education teachers to modify their instructional approach. Many of our patients are directly impacted by instructional shortcomings because they may be in sub-optimal educational settings that are exacerbating their low self-esteem and frustration tolerance.

There is a critical need to expand the knowledge base for practitioners, parents and policymakers about academic advantages and indicators of successful outcomes for children with special needs. Sue Gordon and Maureen Ricky did an extensive review of literature spanning two decades to identify methods and strategies that show successful outcomes

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defenseless parts of oneself can, with the right direction and training from the ego, become powerful and effective ego defenses. The ego learns how to channel and harness its resources to achieve its goal.

Pokémon provides a safe place for a child to achieve mastery through play. The characters in the cartoon series are children. Unlike many popular cartoon characters, Ash is not a superhero and the villains (Team Rocket) are not super-villains (and are occasionally allies). The Pokémon trainer is never injured in battles involving his Pokémon and the Pokémon themselves only "faint" to be revived again later in Pokémon hospitals. Many children have the experience of being intimidated by the playground bully. Pokémon is all about power. The child owns the creatures (in the form of the cards) who have various levels of strength, and vicariously experiences being powerful and being able to stand up for himself. In the strategy game, he can beat his opponents if he has enough of the "right stuff"; on the playground he becomes popular simply by owning the cards and being knowledgeable about the special attributes of each Pokémon.

Finally, Pokémon builds self-esteem. For many of the above-mentioned reasons, the Pokémon player is accepted by peers and included in group activities. The core aspiration for every Pokémon trainer is heard in the theme song from the cartoon series: "I want to be the very best."

We end with a quote from Caroline Myss, Ph.D., as she attempts to understand the meaning of life energetically, by integrating the Judaic-Christian tradition with the Eastern concept of chakras (Anatomy of the Spirit, 1996): "If someone were to say to me, 'How would I define the reason we were born?' I would say this. We are born to manage power." Any Pokémon enthusiast would hold this truth to be self-evident. ■

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for students with disabilities in regular classes. They found that only a small percentage of articles demonstrated appropriate designs. Most articles lacked independent comparison groups of students with similar disabilities, pre- and post-test assessments or proof of replication.

Many studies do not address degree of integration, consistent implementation of procedures or examiner bias. There is no formula, and the sole findings to guide teachers are some common-sense pedagogy such as integrated services, behavioral plans or teaching to different learning styles.

Time can be limited for child and adolescent psychiatrists with busy practices. However, guiding a parent through what can often be a bewildering special education system is enormously helpful. All parents should be aware of their child's rights and may need to find an educational advocate. They may need help clarifying the diagnostic assessment and making sure that if there is an emotional component, projective tests are done. Also, they may need help to discern whether high quality services are started in a timely fashion and whether the services are implemented as recommended. Often, their child may need greater support to acquire organizational skills. Frequently, special education children need both more time to master certain activities and greater reinforcement. When working with the schools, parents or individual children, clinicians need to be honest about what the child is capable of at this point, and should create some benchmarks to see if the approach is working. Interventions must match specific disabilities.

As with many of the issues associated with public school systems, the mixture of political rhetoric, pedagogy and common clinical sense can create a confusing picture. As child and adolescent psychiatrists, we can provide a sophisticated diagnostic assessment while still encouraging school systems to provide meaningful education for these children. ■

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Footnotes

1 Adelman, H.S., & Taylor, L. (1997) Addressing barriers to learning: Beyond school-linked services and full service schools. American Journal of Orthopsychiatry,67, 408-421.

2 Gordon, S.M., & Miller,(1999) Assessment of Special Education Services in Cambridge Center for Informed Practice, Policy and Research

3 Gordon, S.M. & Riley, M. (1997) Synthesis and Dissemination of Knowledge Base regarding Outcomes from the Placement of Students with Disabilities in General Education Classrooms-Final Report Education Development Center.

4 Mattison, R. (1999) Special Education Students with Serious Emotional Disturbance. Journal of Child and Adolescent Psychopharmacology Vol. 9. No3, 1999. 149-155.

5 Planning for Academic Diversity in America's Classrooms: Windows on Reality, Research, Change, and Practice produced by The Joint Committee on Teacher Planning for Students with Disabilities. 1995. University of Kansas Center for Research on Learning.

6 Siegel, B., Is the Emperor Wearing Clothes? Social Policy and the Empirical Support for Full inclusion of Children With Disabilities in the Preschool and Early Elementary Grades. Social Policy Report Society for Research in Child Development Vol X, Number 2&3.