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Federal Special Education Disability Categories

IDEA (2004)

Individuals with Disabilities Education Act (IDEA), is a federal law that regulates all special education services in the United States. IDEA provides federal funding to state and local education agencies to guarantee appropriate special education and related services for those students who meet the criteria for eligibility. The federal guidelines for special education, defined in the 2004 reauthorization of IDEA, recognizes 13 different disability categories through which students may be deemed eligible to receive special education and related services. Individual states may break some of these disabilities into separate categories; however, determination of qualification in any of these categories requires that a complete, appropriate evaluation be conducted, utilizing a variety of assessment tools and strategies. IDEA states that functional, developmental, and academic information about the child must be gathered to assist in making eligibility determinations.

■ THE 13 QUALIFYING CATEGORIES

1. Autism
2. Deaf-Blindness
3. Deafness
4. Emotional Disturbance
5. Hearing Impairment
6. Mental Retardation
7. Multiple Disabilities
8. Orthopedic Impairment
9. Other Health Impairment
10. Specific Learning Disability
11. Speech or Language Impairment
12. Traumatic Brain Injury
13. Visual Impairment (Including Blindness)

On the following pages, you will find specific definitions of the 13 alphabetically organized disability categories, along with specific examples of possible medical conditions that may fall under each category, useful educational approaches to utilize while working with children who qualify for services in these categories, and teacher resources to guide you in developing further understanding of each category.

■ AUTISM

Autism, also referred to as Autism Spectrum Disorder (ASD) and/or Pervasive Developmental Disorder (PDD), is a developmental disability that affects a child's ability to communicate, understand language, play, and interact with others. Autism is a behavioral syndrome, which means that its definition is based on the pattern of behaviors that a child exhibits. To help better understand the autism spectrum, it should be noted that there are five disorders listed under ASD or PDD in the DSM-IV manual by the American Psychiatric Association (1994). These disorders include Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder, Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder. All disorders in this category exhibit abnormalities in socialization skills, use of language for communication, and behavior, but each group differs in the severity of the deficits.

Autism is not an illness or a disease and is not contagious. It is a neurological and developmental disability that is presumed to be present from birth and is always apparent before the age of three. Although autism affects the functioning of the brain, the specific cause is unknown. It is widely assumed that there are multiple causes, each of which may manifest in different forms. Children who have any diagnosis which fall in the autism spectrum may qualify to be eligible to receive special education and support services.

GENERAL AUTISM

Symptoms of Autism

As described by Nielsen (2009), autism has many varied symptoms and characteristics. Although not all people with autism manifest every characteristic, the following areas and specific behaviors are typical.

Social Interactions and Relationships

- Significant difficulty developing nonverbal communication skills
 - Eye-to-eye gazing
 - Facial expressions
 - Body posture
- Failure to establish friendships with children the same age
- Lack of interest in sharing enjoyment, interests, or achievement with other people
- Appearing to be unaware of others
- Lack of empathy
- Difficulty relating to people

Verbal and Nonverbal Communication

- Delay in or lack of learning to talk
- Problem taking steps to start and/or continue a conversation
- Nonspeech vocalizations
 - Grunting
 - Humming
- Stereotyped and repetitive use of language
 - Echolalia
 - Repeated what one has heard again and again
- Difficulty understanding listener's perspective
 - Does not understand humor
 - Takes conversation literally (communicates word for word)
 - Fails to catch implied meaning

Activities and Play

- An unusual focus on pieces (e.g., focus on the wheels on the toy car rather than on the entire car)
- Using toys and objects in an unconventional manner
- Preoccupation with certain topics
 - Fascination with train schedules
 - Weather patterns
 - Numbers
- A need for sameness and routines.
 - Insists that environment and routine remain unchanged
 - Insists on driving the same route to school everyday
- Stereotyped behaviors
 - Body rocking
 - Hand flapping

- Self-stimulatory behavior
- Self-injurious behavior (head banging)
- Preoccupation with hands

Treatment Options for Autism

According to the Autism Speaks Web site (2008), there is no single treatment protocol for all children with autism; however, most individuals respond best to highly structured behavioral programs. Brief statements of the most commonly used behavior programs include the following aspects.

Applied Behavior Analysis (ABA)

The use of positive reinforcement and other principles are used to build communication, play, social, academic, self-care, work, and community living skills and to reduce problem behaviors in learners with autism of all ages. The final goal of ABA intervention is to enable the child to function independently and successfully in a variety of settings.

Verbal Behavior Intervention

The verbal behavior approach focuses on teaching specific components of expressing language (mands, tact, intraverbals, and others). This approach begins with mand training, which teaches a child to request desired items, activities, and information—teaching the child that “words” are valuable and lead them to getting their wants and needs met.

Floortime

Developed by child psychiatrist Stanley Greenspan, Floortime is a treatment method and a philosophy for interacting with autistic children. The goal and purpose for this strategy is to move the child through the six basic developmental milestones in emotional and intellectual growth. Those six include (1) self-regulation and interest in the world, (2) intimacy, (3) two-way communication, (4) complex communication, (5) emotional ideas, and (6) emotional thinking. The intervention is called *Floortime* because those working with the child get down on the floor to engage with the child at his or her level.

Gluten Free, Casein Free Diet (GFCF)

This is a very popular dietary intervention that consists of the removal of gluten (a protein found in barley, rye, oats, and wheat) and casein (a protein found in dairy products). This theory is based on the hypothesis that these proteins are absorbed differently in children with autism spectrum disorder. There is no scientifically based research indicating the effectiveness of this intervention; however, families report that dietary elimination of gluten and casein has helped to regulate bowel habits, sleep, activity, habitual behaviors, and enhance overall progress in their child.

Occupational Therapy

The focus of utilizing occupational therapy as treatment for children with autism is to maintain, improve, or introduce skills that allow an individual to participate as independently as possible in meaningful life activities. Coping skills, fine motor skills, play skills, self-help skills, and socialization are all targeted areas that can be addressed in this setting.

Picture Exchange Communication System (PECS)

PECS is a type of augmentative and alternative communication technique where individuals with little or no verbal ability learn to communicate using picture cards. Children use the pictures to “vocalize” a desire, observation, or feeling. Many children with autism learn visually, and therefore, this type of communication technique has been shown to be effective at improving independent communication skills. A formalized training program is offered to ensure the best utilization of the program (Bondy & Frost, 2002).

Note: More information regarding PECS, the Pyramid Approach to Education, or Pyramid Educational Consultants Inc. is available on www.pecs.com.

Relationship Development Intervention (RDI)

This intervention is based on the work of psychologist Steven Gutstein and focuses on improving the long-term quality of life for all individuals on the spectrum. It is a parent-based treatment that focuses on the core problems of gaining friendships, feeling empathy, expressing love, and being able to share experiences with others (Gutstein & Sheely, 2002).

Note: Further information regarding RDI is available on www.rdiconnect.com.

The SCERTS Model

The SCERTS model is a comprehensive, team-based, multidisciplinary model for enhancing abilities in social communication and emotional regulation and implementing transactional supports for children with autism. This model is mostly concerned with helping persons with autism to achieve “authentic progress,” which is defined as the ability to learn and apply functional skills in a variety of settings and with a variety of partners (Prizant, Wetherby, Rubin, Rydell, & Laurent, 2006).

Note: For further information, see www.scerts.com.

Sensory Integration Therapy

This intervention involves the process through which the brain organizes and interprets external stimuli such as movement, touch, smell, sight, and sound. It is often common for children with autism to exhibit symptoms of Sensory Integration Dysfunction (SID), making it difficult to process information brought in through the senses. Children can have mild, moderate, or severe SID deficits, manifesting in either increased or decreased sensitivity to sound, touch, and movement. The goal of sensory integration therapy is to facilitate the development of the nervous system’s ability to process sensory input in a more typical way. When successful, this has been known to improve attention, concentration, listening, comprehension, balance, coordination, and impulsivity control in some children.

Note: For additional information, see www.sensorynation.com.

Speech Therapy

The communication difficulties of children with autism vary depending on the intellectual and social development of the individual. Some children are unable to speak, whereas others have well-developed vocabularies and can speak at length on topics that interest them. Although some children have little difficulty with pronouncing words, most children with autism have difficulty effectively using language.

Children with autism frequently exhibit difficulties in the pragmatic use of language such as knowing what to say, how and when to say it, and how to use language to socially interact in an acceptable way with others. Many children with autism will repeat verbatim what they have heard (echolalia) or repeat irrelevant scripts they have memorized. Others will speak in a high pitched voice or use robotic sounding speech.

Educational Strategies and Approaches for Teaching Students With Autism

- Directions should be given one at a time.
- Avoid giving repetition of the directions.
- Break instructions down into smaller chunks.
- Confer with other support teachers.
- Provide positive behavior management opportunities.
- Provide clear expectations and rules.
- Use concrete, tangible visual aids (e.g., pictures and charts).
- Encourage the use of talent areas and provide additional learning opportunities in these areas.
- Practice functional real life skills (e.g., use real money rather than play money when learning to count money).
- Use real places when learning about acceptable public behavior.
- Use field trips to provide concrete learning experiences.

Web Sites

Autism Research Institute: www.autism.com

Autism Society of America: www.autism-society.org

Resource Books

Title: *1001 Great Ideas for Teaching and Raising Children With Autism Spectrum Disorder*

Authors: Veronica Zysk and Ellen Notbohm

Publisher: Future Horizons, 2004

Story Profile: This resource offers pages and pages of immediately ready solutions that have worked for thousands of children with autism spectrum disorder struggling with social, sensory, behavioral, and self-care issues, plus many more.

Title: *Autism Spectrum Disorders*

Author: Richard Simpson

Publisher: Paul Brookes Publishing Company, 2005

Story Profile: Autism Spectrum Disorders (ASD) was developed to respond directly to the difficulty school professionals and families face in selecting and applying appropriate interventions and treatments for the children in their care.

Title: *Demystifying Autism Spectrum Disorders—A Guide to Diagnosis for Parents and Professionals*

Author: Carolyn Thorwarth Burey

Publisher: Woodbine House, 2004

Story Profile: This guide for parents, educators, and caregivers describes the five types of autism that fall under the ASD umbrella, spells out the distinctions among them, demystifies the technical jargon, and provides an overview of treatment.

Title: *Ten Things Every Child With Autism Wishes You Knew*

Author: Ellen Notbohm

Publisher: Future Horizons, 2005

Story Profile: Framed with both humor and compassion, this book defines, from a child's perspective, the top ten characteristics that illuminate the minds and hearts of children with autism.

Title: *"You're Going to Love This Kid!" Teaching Students With Autism in the Inclusive Classroom*

Author: Paula Kluth

Publisher: Paul Brookes Publishing Company, 2004

Story Profile: This is a strategy-filled guidebook for including students with autism in both primary and secondary school classrooms. The publication demonstrates how educators can adapt their own classrooms to support student participation, school routines, social activities, and more.

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Children's Resources

Title: *Andy and His Yellow Frisbee*

Author: Mary Thompson

Publisher: Woodbine House, 1996

Story Profile: This book tells the story of a new girl at school who tried to befriend Andy, an autistic boy who spends every recess by himself.

Title: *The Autism Acceptance Book: Being a Friend to Someone With Autism*

Author: Ellen Sabin

Publisher: Watering Can Press, 2006

Story Profile: An interactive, educational, and character building book that introduces children to the challenges of living with autism. It uses informative narrative and engaging activities that invite children to "walk inside someone else's shoes" as they learn to treat others in the same ways they would like to be treated themselves.

Title: *Mori's Story: A Book About a Boy With Autism*

Author: Zachary Gartenber

Illustrator: Jerry Gay

Publisher: The Lerner Publishing Group, 1998

Story Profile: A young boy discusses his home life and schooling with his autistic brother, Mori. He discusses how his family learned that Mori was autistic, the kinds of treatment Mori receives, and how it affects all of their lives.

Title: *My Brother Sammy*

Author: Becky Edwards

Publisher: Millbrook Press, 1999

Story Profile: This book's narrator longs for a brother who can talk to him, build towers with him, and join his friends at play. His autistic brother, Sammy, mimics his speech, knocks down his building blocks, and lies alone on the grass staring at the leaves on trees. As the older boy tries doing and seeing things Sammy's way, a special relationship develops between them.

Title: *Since We're Friends: An Autism Picture Book*

Author: Celeste Shally

Illustrator: David Harrington

Publisher: Awaken Specialty Press, 2007

Story Profile: Children with autism struggle to make friends and find it very difficult to interact appropriately in social situations. In this book, one child makes a significant impact in the life of a child with autism by offering compassion, understanding, and friendship.

ASPERGER SYNDROME (ASPERGER DISORDER)

Asperger syndrome (AS) refers to the mildest and highest functioning on the spectrum and is characterized by higher cognitive abilities ranging from average to superior intelligence. There are many similar characteristics that can be seen between

Asperger syndrome and autism, but the characteristics differ in the degree of severity and overall ability of the child. Nielsen (2009) explains that children with Asperger syndrome have a higher verbal IQ than performance IQ, which is opposite for children with autism who have a higher performance IQ than verbal IQ. Children with Asperger syndrome can also be found to have more normal language ability than children with autism, and the onset of Asperger is generally later than the onset of autism. Asperger, just like autism, is characterized by deficits in social and communication skills; however, the deficits are to a lesser severity with Asperger syndrome, and the long-term outlook for these children is more positive as well.

Symptoms of Asperger Syndrome

Nielsen (2009) also describes the work of Christopher Gillberg, a Swedish physician who expanded the list of characteristics to better diagnose a child with Asperger syndrome. According to Gillberg's list, all of the following six criteria must be met before a child is diagnosed with Asperger syndrome.

- Severe impairment in reciprocal social interaction
 - Inability to interact with peers
 - Lack of desire to interact with peers
 - Lack of appreciation of social cues
 - Socially and emotionally inappropriate behavior
- All-absorbing narrow interest
 - Exclusion of other activities
 - Repetitive adherence
 - More rote than meaning
- Imposition of routines and interests
 - On self, in aspects of life
 - On others
- Speech and language problems
 - Delayed development
 - Superficially perfect expressive language
 - Formal, pedantic language
 - Odd prosody, peculiar voice characteristics
 - Impairment of comprehension, including misinterpretations of literal/ implied meanings
- Nonverbal communication problems
 - Limited use of gestures
 - Clumsy, gauche body language
 - Limited facial expression
 - Inappropriate expression
 - Peculiar, stiff gaze
- Motor clumsiness
 - Poor performance on neurodevelopmental examination

Treatment of Asperger Syndrome

There is no cure for Asperger syndrome; however, children with Asperger's will benefit from psychosocial and psychopharmacological interventions. The

medications used are to help reduce the symptoms that accompany Asperger. The Autism Society has provided the following intervention opportunities.

Psychosocial Interventions

- Individual therapy to help the individual process the feelings aroused by being socially handicapped
- Parent education and training
- Behavioral modification
- Social skills training
- Educational interventions

Psychopharmacological (Medications)

- Stimulants—to assist hyperactivity, inattention, and impulsivity
- Mood stabilizers—to assist irritability and aggression
- Selective Serotonin Reuptake Inhibitor (SSRIs)—to assist preoccupations, rituals, compulsions, and anxiety

Educational Strategies for Asperger Syndrome

Assist the Student in Developing Communication Skills

- Have patience.
- Listen to all attempts made by the student.
- Allow extended time for processing after a question has been asked to the student; refrain from rephrasing the question or interrupting.
- Accept the child's language pattern and word choice; refrain from correcting the child's speech.
- Continually model appropriate and correct format of speech.
- In conversation, listen for message behind the words and *not* how the message was conveyed. Ignore peculiarities in the volume of speech, intonation, and inflection of the child's voice.
- Encourage continued communication through positive and accepting responses.
- Be concise, concrete, and specific with the language that you use.
- Avoid using vague terms such as *maybe*, *later*, or *perhaps*.
- Specifically state questions (e.g., "Why did you get out of your chair?" rather than, "Why did you do that?").
- Specifically state requests (e.g., "Please sit with all four legs of your chair on the floor," rather than, "Please don't do that.").

Provide a Well-Structured, Consistent Environment

- Have a seating plan in place.
- Post the class schedule either in the classroom, or if the student with AS is different than the rest of the class, post the schedule on the student's desk or notebook planner.
- Post classroom rules either in the classroom, or if the student with AS is different than the rest of the class, post the rules on the student's desk or notebook planner.
- Inform the student if a change is coming in the seating plan or class schedule.
- Provide prior notification for any change in the normal school day, such as special events, vacation dates, lyceums, or days when a substitute teacher may be in the classroom.

Promote Self-Confidence

- Encourage students to assist other students in academic areas.
- Highlight students' areas of strengths in cooperative learning situations; in return, foster respect among the peer group.

Other Accommodations Inside the Classroom

- Present assignments visually and verbally.
- Provide copies of teacher notes.
- Tape record the lecture.
- Provide headphones or earplugs in the classroom to reduce noises.
- Allow homework to be typed rather than handwritten.
- Allow students to tape record answers to written examinations.

Web Sites

ASPEN Society of America, Inc. Asperger Syndrome Education Network: www.asperger.org

Asperger's Disorder Homepage: www.aspergers.com

Collection of resources pertaining to Asperger syndrome: www.udel.edu/bkirby/asperger

Resources

Title: *School Success for Kids With Asperger Syndrome: A Practical Guide for Parents and Teachers*

Authors: Stephan Silverman and Rich Weinfeld

Publisher: Prufrock Press, 2007

Story Profile: Kids with Asperger syndrome have average to above-average intelligence; however, they often have obsessive interests, are socially awkward, and do not understand the subtleties of language and conversation. With concentrated effort on the part of parents and educators, these children can begin to overcome the difficulties of this disorder and find success in school and life.

Title: *Freaks, Geeks, and Asperger Syndrome: A User's Guide to Adolescence*

Author: Luke Jackson

Publisher: Jessica Kingsley, 2002

Story Profile: Luke Jackson is 13 years old and has Asperger syndrome. Over the years, Luke has learned to laugh at such names that he has been called such as "freak" or "geek." Adolescence and the teenage years are a minefield of emotions, transitions, and decisions, and when that is coupled with Asperger syndrome, the results can be explosive. Luke wrote this enlightening, honest, and witty book in an attempt to address difficult topics such as bullying, friendships, when and how to tell others about AS, school problems, dating, relationships, and morality.

Title: *Asperger Syndrome and the Elementary School Experience: Practical Solutions for Academic and Social Difficulties*

Author: Susan Thompson Moore

Publisher: Autism Asperger Publishing Company, 2002

Story Profile: A great resource and guide for a classroom teacher that fully incorporates all needed information to assist kids with Asperger syndrome to be successful in the general education classroom.

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Children's Resources

Title: *Can I Tell You About Asperger Syndrome? A Guide for Family and Friends*

Author: Jude Welton

Illustrator: Jane Telford

Publisher: Jessica Kingsley Publishers, 2002

Story Profile: In this book, Adam helps children understand the difficulties faced by a child with AS; he tells them what AS is, what it feels like to have AS, and how readers can help children with AS by understanding their differences and appreciating their many talents. This book serves as an excellent starting point for family and classroom discussions.

Title: *Different Like Me: My Book of Autism Heroes*

Author: Jennifer Elder

Illustrator: Marc, Thomas

Publisher: Jessica Kingsley Publishing, 2005

Story Profile: This book, told from the perspective of a young boy named Quinn, describes the achievement and characteristics of the lives of autism heroes, both famous and historical, who found it difficult to fit into society. From Albert Einstein, Dian Fossey, and Wassily Kandinsky to Lewis Carroll, Benjamin Banneker, and Julia Bowman Robinson, among others. All excelled in different fields but are united by the fact that they often found it difficult to fit in—just like Quinn.

Title: *I Am Utterly Unique: Celebrating the Strengths of Children With Asperger Syndrome and High-Functioning Autism*

Authors: Elaine Larson and Vivian Strand

Publisher: Autism Asperger Publishing Company, 2006

Story Profile: The ABCs of Asperger syndrome and autism. Using the alphabet, the authors find 26 unique traits shared by many children who have Asperger syndrome or high-functioning autism.

PERVASIVE DEVELOPMENTAL DISORDER, NOT OTHERWISE SPECIFIED (PDD-NOS)

According to the National Dissemination Center for Children with Disabilities (NICHCY) fact sheet 20, (2003), PDD-NOS has been referred to as a “milder” form of autism where some but not all features of autism are identified. PDD-NOS is often called simply “PDD”; however, the term PDD refers to the umbrella under which the various diagnoses fall—PDD-NOS being one diagnosis that falls under the PDD umbrella. There are no set patterns or symptoms and signs in children with PDD-NOS, and there is a very wide range of diversity seen in children with PDD-NOS. The diagnosis of PDD-NOS should be used when a child exhibits a severe and pervasive impairment in the development of social interaction or verbal and nonverbal communication skills, but when not all criteria are met for a specific PDD.

Treatment for PDD-NOS

Treatment for a diagnosis of PDD-NOS is the same as the treatments used to treat the other PDD. Each child will demonstrate individual and unique needs, and therefore, treatment will be determined accordingly.

Web Site

Disability information on Pervasive Developmental Disorders: www.nichy.org/pubs/factshe/fs20txt.htm

Resource

Title: *Pervasive Developmental Disorders: Diagnosis, Options, and Answers*

Author: Mitzi Waltz

Publisher: Future Horizons, 2003

Story Profile: Written for professionals, parents, or newly diagnosed adults who struggle with PDD, this book is considered the definitive resource on this neurological condition.

RETT SYNDROME

Rett syndrome is an extremely rare medical condition that has only been reported in females. It has been added to the ASD category because in addition to the medical symptoms, children with Rett syndrome tend to display social, communication, and play difficulties associated with ASD.

Symptoms of Rett Syndrome

The physical development of children with Rett's syndrome is very distinct. Children have normal prenatal and perinatal development with typical early motor growth and head circumference. Between five and 30 months of age, mental and physical breakdowns begin to appear, and children begin to exhibit some of the following characteristics:

- Loss of purposeful hand movement, such as grasping with fingers, reaching for things, or touching things on purpose
- Loss of speech
- Balance and coordination problems, including losing the ability to walk
- Stereotypic hand movements, such as hand wringing
- Breathing problems, hyperventilation, breath holding, or sleep apnea
- Anxiety and social-behavioral problems
- Intellectual disability/mental retardation

Treatment of Rett Syndrome

There is no cure for Rett syndrome; however, treatments are available for some of the problems associated with the syndrome. These treatments generally aim to slow the loss of abilities, improve or preserve movement, and encourage communication and social contact. The team approach is the most beneficial form of care for children with Rett syndrome. Along with the family, members of this team may include the following professionals.

Physical Therapists

- Help patients improve or maintain mobility and balance
- Reduce misshapen back and limbs

Occupational Therapists

- Help patients improve or maintain use of their hands
- Reduce stereotypic hand movements

Speech and Language Therapists

- Assist patients in the use of nonverbal ways of communication
- Improve social interaction

Medical Doctors

- Provide medication for some symptoms such as constipation, irregular heartbeat rhythm, or seizure, or to reduce breathing problems

Web Sites

International Rett Syndrome Foundation: www.rettsyndrome.org

We Move—Rett Syndrome: www.wemove.org/rett

Resources

Title: *Understanding Rett Syndrome: A Practical Guide for Parents, Teachers, and Therapists*

Author: Barbro Lindberg

Publisher: Hogrefe and Huber Publishing, 2006

Story Profile: This brand new edition of this book describes the difficulties and challenges of girls and women with Rett syndrome. The book proposes solutions that can help them in everyday life and is primarily intended for people who work with people with Rett syndrome on a frequent basis.

Title: *Your Daughter Has Been Diagnosed With Rett Syndrome*

Author: Kim Isaac Greenblatt

Publisher: Kim Greenblatt, 2006

Story Profile: A personal account by the author on what it is like to receive the information that your daughter has been given a diagnosis of Rett syndrome. The book provides different ways of dealing with the diagnosis, provides coping mechanisms, and encourages readers to celebrate life!

CHILDHOOD DISINTEGRATIVE DISORDER (CDD)

CDD is a condition in which young children develop normally until age three or four but then demonstrate a severe loss of social, communication, and other skills. Doctors sometimes confuse this rare disorder with late-onset autism because both conditions involve normal development followed by significant loss of language, social, play, and motor skills. However, autism typically occurs at an earlier age. There's also a more dramatic loss of skills in children with CDD and a greater likelihood of mental retardation. In addition, CDD is far less common than autism.

Symptoms of Childhood Disintegrative Disorder

NICHCY fact sheet 20 (2003) suggests that specific symptoms of CDD typically include the following.

- Normal development for at least the first two years of life
 - Normal development of verbal and nonverbal communication
 - Social relationships
 - Motor skills
 - Self-care skills
- Significant loss of previously acquired or learned skills
 - Ability to say words or sentences
 - Ability to understand verbal and nonverbal communication
 - Social skills and self-care skills
 - Bowel and bladder control
 - Play skills
 - Motor skills (ability to voluntarily move the body in a purposeful way)
- Lack of normal function or impairment
 - Social interaction—this may include impairment in nonverbal behaviors, failure to develop peer relationships, lack of social or emotional reciprocity
 - Communication—this may include delay or lack of spoken language, inability to initiate or sustain a conversation, stereotyped and repetitive use of language, lack of varied imaginative or make-believe play
- Repetitive and stereotyped patterns of behavior, interests, and activities
 - Hand flapping
 - Rocking
 - Spinning (motor stereotypes and mannerisms)
 - Development of specific routines and rituals
 - Difficulty with transitions or changes in routine
 - Maintaining a fixed posture or body position (catatonia)
 - Preoccupation with certain objects or activities

Treatment of Childhood Disintegrative Syndrome

There is no cure for CDD. Treatment for this disorder is much the same as treatment of autism. Specific treatment options may include the following medications.

- The medication will not directly treat the disorder.
- Antipsychotic medications may help control severe behavior problems such as aggression and repetitive movements.
- Anticonvulsant drugs may help control epileptic seizures.

Behavior Therapy

- This therapy technique may be utilized by psychologists, speech therapists, physical therapists, occupational therapists, parents, teachers, and caregivers.
- Behavior therapy programs may be designed to specifically meet the needs of each child.

Behavior therapy programs can be designed to help children learn or relearn language, social, and self-care skills. These programs use a system of reward to

reinforce desirable behaviors and discourage problem behavior. Consistency among all members working with the child is very important in behavior therapy.

The outcome for children with childhood disintegrative disorder is usually very poor and even worse than for children with autism. The loss of language, cognitive, social, and self-care skills tends to be severe and permanently disabling. As a result, children with the disorder often need residential care in a group home or long-term care facility.

Web Sites

Childhood Disintegrative Disorder: www.mayoclinic.com/health/childhood-disintegrative-disorder/DS00801

Definition, description, causes and symptoms, and treatments: www.minddisorders.com/Br-Del/Childhood-disintegrative-disorder.html

Resources

Title: *Identifying, Assessing, and Treating Autism at School*

Authors: Stephen E. Brock, Shane R. Jimerson, and Robin L. Hansen

Publisher: Springer, 2006

Story Profile: An invaluable resource for school psychologists, educational professionals, and parents. It provides an excellent overview of the assessment and treatment of autism and related disorders and outlines the interventions that can be provided for students with autism in school.

Educational Strategies and Approaches for Teaching Students With PDD-NOS, Rett Syndrome, and Childhood Disintegrative Disorder

- Directions should be given one at a time.
- Avoid giving repetition of the directions.
- Break instructions down into smaller chunks.
- Confer with other support teachers.
- Provide positive behavior management opportunities.
- Provide clear expectations and rules.
- Use concrete, tangible visual aids (e.g., pictures and charts).
- Encourage the use of talent areas and provide additional learning opportunities in these areas.
- Practice functional real life skills (e.g., use real money rather than play money when learning to count money).
- Use real places when learning about acceptable public behavior.
- Use field trips to provide concrete learning experiences.

Other Areas That Need Specific Consideration in the Classroom

Physical structure is the way the classroom is set up and organized. A child with autism needs clear physical and visual boundaries in the classroom environment. Minimizing visual and auditory distractions is also important to help the child focus on learning concepts and not irrelevant details. The child also needs to know the

basic teaching areas of the room. There should be specific, designated areas that the child uses daily for a snack, playtime, and transition times as well as individual and independent work times. These areas should be consistent so there are no “surprises” in the child’s routine. If a child with autism is accustomed to having a snack on the carpeted area at the front of the room every day and suddenly is expected to eat a snack at his desk, this will likely cause agitation. Children with autism require consistency in all aspects of their day.

Daily schedules are essential. Visual schedules help the child to see what activities will occur and the order of events for the day. The child will work best if a concrete reference of the daily schedule is in view. This will help the child to better accept change and become a bit more flexible, as long as the child knows in advance of a schedule change. A fire drill, for example, may be a devastating addition to the day, since the child is unaware that it will occur. In the eyes of an autistic child, if an event is not written on the schedule, then the event should not occur. Helping the child to become aware of upcoming event changes will ensure easier transition times when those events occur.

Visual structure helps children with autism to capitalize on their visual aptitude and strengths and minimize their deficits in auditory processing. Visually highlighting important information will help to clarify the relevant concepts of which the child should be aware. This may include color-coding areas and labeling things to visually draw the child’s attention. Providing visual instructions for the child is also helpful when presenting the child with an assignment or task.

■ DEAF-BLINDNESS

Deaf-blindness is a medically verified hearing impairment coexisting with a medically verified visual impairment. Together, these two impairments must cause severe communication difficulties and other developmental and education problems that cannot be accommodated in special education programs solely for children with exclusive blindness or deafness.

■ DEAFNESS

Deafness is a hearing impairment so severe that the child cannot understand what is being said even with a hearing aid. The causes of a child being or becoming deaf are described in terms of exogenous or endogenous. Exogenous causes stem from factors outside the body such as disease, toxicity, or injury. Endogenous hearing impairments are genetic.

Educational Considerations for a Deaf Child

Today, more than 60% of deaf children in the United States attend local school programs, and many are included in the regular classroom at least part of the day. Deafness does not affect a person’s intellectual capacity or ability to learn; however, children who are deaf generally require some form of special education services in order to receive adequate instruction. The most difficult challenge in educating deaf students is teaching spoken language to children who cannot hear. Many deaf students are not able to communicate effectively with classmates and therefore benefit by having a sign language interpreter to assist with the communication barrier. It is important for teachers and audiologist to work together to

teach the child to use his or her residual hearing to the maximum extent possible, even if the preferred means of communication is manual. For more in-depth information concerning hearing impairments, see that section following "Emotional Disturbance" as IDEA separates deafness and hearing impairments and organizes them alphabetically.

Web Sites

American Speech-Language-Hearing Association: www.asha.org

Raising Deaf Kids: www.raisingdeafkids.org

Resource Books

Title: *Helping Deaf and Hard of Hearing Students to Use Spoken Language: A Guide for Educators and Families*

Authors: Susan Easterbrooks and Ellen L. Estes

Publisher: Corwin, 2007

Story Profile: As a result of IDEA 2004 and NCLB, students with hearing loss are frequently being educated alongside their peers in the general education classroom. This book provides teachers and service professionals with the knowledge and skills in spoken language development to meet the needs of students who are deaf or hard of hearing. It is an essential resource that addresses creative and scientific ways of interacting with children and provides effective approaches, techniques, and strategies for working with children to develop spoken communication.

Title: *Raising and Educating a Deaf Child: A Comprehensive Guide to the Choices, Controversies, and Decisions Faced by Parents and Educators*

Author: Marc Marschark

Publisher: Oxford University Press, 2007

Story Profile: The book focuses on the choices and decisions faced by parents and educators and analyzes many important influences on a child's successful rearing.

Children's Resources

Title: *I'm Deaf and It's Okay*

Authors: Lorraine Aseltine, Evelyn Mueller, and Nancy Tait

Publisher: Albert Whitman & Company, 1986

Story Profile: A story about an elementary-aged boy who expresses his feelings about deafness. He describes his experiences with fear, jealousy, anger, and frustration until he meets a teenage boy who is also deaf and helps him to see that he can lead a normal life.

Title: *I Have a Sister—My Sister is Deaf*

Author: Jeanne Whitehouse Peterson

Illustrator: Deborah Kogan Ray

Publisher: Harper Trophy

Story Profile: An excellent book for explaining the world of the totally deaf to very young children.

■ EMOTIONAL DISTURBANCE

Serious emotional disturbance, also referred to in the law as emotional disturbance, refers to an established pattern exhibiting one or more of the following characteristics.

- An inability to learn that cannot be explained by intellectual, sensory, or health factors
- An inability to build or maintain satisfactory interpersonal relationships with peers and teachers
- Inappropriate types of behavior or feelings under normal circumstances
- A general, pervasive mood of unhappiness or depression
- A tendency to develop physical symptoms or fears associated with personal or school problems

Symptoms of Emotional Disturbance

According to Nielsen (2009), some basic characteristics and behaviors are commonly seen in children who have been diagnosed with emotional disturbance. Such characteristics include the following:

- Hyperactivity
- Short attention span
- Impulsiveness
- Inconsistencies of behavior
- Low frustration tolerance
- Aggression (acting out, fighting)
- Self-injurious behavior
- Withdrawal from interaction with others
- Inappropriate social skills
- Immaturity (inappropriate crying, temper tantrums)
- Poor coping skills
- Learning problems
- Unfocused
- Unexplainable mood shifts

Children with the most serious emotional disturbances exhibit distorted thinking, excessive anxiety, bizarre motor acts, and abnormal mood swings. This may include children with schizophrenic disorders, affective disorders, anxiety disorders, and other sustained disorders of conduct or adjustment when an established pattern adversely affects educational performance and results in an inability to build or maintain satisfactory interpersonal relations necessary to the learning process. It should be noted that the established pattern of behavior must occur to a marked degree and over a long period of time.

Educational Strategies for Serious Emotional Disturbance

It is important to remember and understand that all children will misbehave at some time, but students who meet the Serious Emotional Disturbance criteria have a continuous pattern of misbehavior that consistently disrupts the classroom

environment. Unfortunately, the teacher is required to devote much time and attention to the student and behaviors in an attempt to restore and maintain order to the learning environment. Challenging behaviors can be overwhelming and cause frustration. Nielsen (2009) provides a detailed list of strategies for teachers to use when educating students with serious emotional disturbances.

Structure the Classroom

- Define clear and explicit limits and consequences for unacceptable behaviors.
- Ensure that the system also provides opportunity for positive reinforcement for acceptable behavior.
- Ensure that the student is aware of and understands the system in place.
- Post a written copy of Rules/Consequences/Rewards in the classroom for easy reference.
- The teacher is always in charge, never the student.
- Ensure consistent follow through of consequences and rewards when appropriate.

Develop a Good Rapport With Students

- Take every advantage possible throughout the day to reinforce feelings of self-worth.
- Make eye contact and smile at the child.
- Provide praise for good work.
- Exhibit close proximity.

Focus Attention on Desired Behavior and Not on Unacceptable Behavior

- Provide praise, even for approximation of the desired behavior.
- Provide consistent, positive reinforcement for acceptable behavior.
- Reward positive behavior by using a token system.
- Begin with tangible, extrinsic rewards and eventually replace them with intrinsic rewards.
- Ensure that the student is aware of and understands the token system in place.
- Withhold the reward, if necessary, as a consequence for inappropriate behavior.

Prepare a Behavior Plan to Address Physically Aggressive Behavior

- Write a plan that will include removal from the classroom if student behavior becomes aggressive and threatens the safety of others.
- Make arrangements with a support person to assist you (e.g., teacher next door, principal, special education teacher).
- Utilize the Nonviolent Crisis Intervention movement and restraint techniques to ensure the care, welfare, safety, and security of yourself, the student, and others around you.

Be Alert to Any Indication That the Student May Be Experiencing Difficulty

- Provide a predetermined time-out area or place where the student can go.
- Allow the student to go to that area in order to regain composure or side-track an incident.

- The student is not required to ask permission to go to the time-out place.
- Divert attention away from the source of difficulty as much as possible.
- Send the child for a walk, to run an errand, get a drink, or any other reason to leave the classroom to provide time for the child to regain composure.

Go Slowly, Prioritize Behaviors, Be Patient, and Praise Baby Steps When Attempting to Change Behavior

- Accept the need for possible change in your behavior pattern.
- List behaviors to be changed and prioritize by importance.
- Determine one behavior to focus on at a time.
- When appropriate and possible, ignore nonpriority, undesirable behaviors, as annoying behavior that receives attention tends to be repeated.
- Praise and reward appropriate, priority behaviors to continue improvement of the behavior.

Web Sites

Center on Positive Behavioral Interventions and Supports: www.pbis.org

National Alliance on Mental Illness (NAMI): www.nami.org

National Mental Health Information Center: www.mentalhealth.org

Resource Books

Title: *The Effective Teachers' Guide to Emotional and Behavioral Difficulties: Practical Strategies*

Author: Michael Farrell

Publisher: Routledge, 2005

Story Profile: A guide for teachers that provides an overview of the basic theories surrounding behavior. The book also provides a variety of strategies to be used in the classroom to increase acceptable behavior and decrease unacceptable behavior. Ideas are also provided to assist in monitoring the effectiveness of the strategies on the specific behaviors.

Children who have been diagnosed with the medical disorders listed below may be deemed eligible to receive special services under the Serious Emotional Disturbance category.

Title: *The Explosive Child: A New Approach for Understanding and Parenting Easily Frustrated, Chronically Inflexible Children*

Author: Ross W. Greene

Publisher: Harper Paperbacks, 2005

Story Profile: A book for those who are trying to parent, guide, and lead a difficult child. This book provides a description of a more contemporary approach to understanding and helping the inflexible and easily frustrated child at home and school.

SCHIZOPHRENIA

Schizophrenia is a psychosis or impairment of thinking in which the interpretation of reality and of daily events is severely abnormal. Childhood Schizophrenia affects about 1 in 40,000 children and in general, the earlier the diagnosis, the more severe the disorder tends to be. The symptoms of Childhood-Onset Schizophrenia can overlap quite a bit with common symptoms to bipolar disorder, autism, or Asperger syndrome.

Signs and Symptoms of Schizophrenia

- Delusions (talking with people who do not exist)
- Incoherence
- Lack of or inappropriate display of emotions
- Inability to concentrate
- Disorganized thinking or behavior
- Inability to read social cues
- Excessive fatigue
- Emotional withdrawal
- Extreme moodiness
- Odd behavior

Schizophrenia usually appears during adolescence or early adulthood. The cause is unknown; however, many believe that it is an inherited disorder.

Medical Treatment of Schizophrenia

The National Institute of Mental Health (2008) states that the treatment of schizophrenia includes pharmacotherapy (medications) using antipsychotic medications such as Risperdal, Risperidone, and Haldol (three of many prescribed medications) combined with psychosocial interventions: cognitive therapy, rehabilitation day programs, peer support groups, or nutritional supplements. The psychosocial interventions include supportive therapy with family, educational interventions, and vocational rehabilitation when appropriate.

Educational Strategies for Schizophrenia

It is essential to remember that schizophrenia is an illness just like diabetes. Children who experience schizophrenia need to realize that something is wrong in their body, and they have no control over what is happening. Even if the symptoms are well controlled by medication, extra support from the school system may be necessary, or a completely different educational program may be appropriate.

- Understand that the child may miss a lot of school due to medication issues or the illness itself.
- Relieve pressure and stress if possible.
- Expect the child's attention, energy, and abilities to rise and fall
 - Provide sympathy, encouragement, and understanding rather than forcing the child to behave and shape up on an "off day."
- Base the student's grades on what *has been* done rather than what *has not been* done, as these children are very sensitive to criticism.
- Medications *may* make the child less tolerant of heat and sunshine.
- Noise and activity of the normal school day may become overwhelming.
- Provide and allow use of a refuge when the student feels it's necessary.
- If a psychotic episode or breakdown occurs at school, remain calm, speak softly, and be available to the child—do not try to talk the child out of the episode, belittle the child, or point out that he or she is being ridiculous.
- Allow partial school day attendance.

Web Sites

Schizophrenia Education Center: Facts, Symptoms, Treatment, More: www.healthcentral.com

Schizophrenia Home Page: www.schizophrenia.com

Schizophrenia in Children: www.puberty101.com/aacap_schizo.shtml

Resource Books

Title: *I Am Not Sick, I Don't Need Help!*

Authors: Xavier Amador and Anna-Lica

Publisher: Vida Press, 2000

Story Profile: This book explains in simplistic language how a family can work with a family member who is struggling with a mental illness. The authors translate the research on mental illness into a highly readable and very practical book.

Title: *Me, Myself, and Them: A Firsthand Account of One Young Person's Experience With Schizophrenia*

Authors: Kurt Snyder, Raquel W. Gur, and Linda Wasmer Andrews

Publisher: Oxford University Press, USA, 2007

Story Profile: Written by a man with schizophrenia, this book provides a realistic peek at what schizophrenia looks like. Not only does it tell a story, it also provides an explanation for how to recognize warning signs, where to find help, and what treatments have proved to be effective. This book offers practical advice on topics of particular interest to young people such as suggestions on managing the illness at home, school, and work and in relationships with family and friends.

Title: *Mental Health and Growing Up: Fact Sheets for Parents, Teachers, and Young People*

Author: Ann York

Publisher: American Psychiatric Publishing, 2004

Story Profile: The book is filled with short, informative leaflets that offer parents, teachers, and young people practical and up-to-date information on what you can do if you are worried about your child, student, or friend.

Children's Resources

Title: *Helicopter Man*

Author: Elizabeth Fensham

Publisher: Bloomsbury USA Children's Books, 2005

Story Profile: Peter and his dad are homeless and live on the run, trying to stay one step ahead of the helicopters. Pete's dad is convinced that the helicopters are a secret organization that is after him. As Pete gets older, he questions his father's reality and eventually realizes he must come to terms with his father's mental illness of schizophrenia.

Title: *Sometimes My Mommy Gets Angry*

Author: Bebe Morre Campbell

Publisher: Putnam Juvenile, 2003

Story Profile: Told from Annie's perspective, the story tells of the confusion and responsibility of living with a parent with a mental illness. The author introduces coping strategies and helps the readers to understand that they are not to blame for their parents' difficulties.

AFFECTIVE DISORDERS

MANIC-DEPRESSIVE ILLNESS (BIPOLAR DISORDER)—AN AFFECTIVE DISORDER

Bipolar is an alternating pattern of emotional highs and high-spirited behavior (manic) and emotional lows (depression). The manic episodes and depressive episodes may alternate rapidly every few days. The mood swings experienced with this illness are unlike the mood swings that most people experience. Extreme and unpredictable mood swings from highly excited euphoria to the darkest depths of despair and depression are likely to be experienced by those affected by bipolar disorder. The elation and depression occurs without relation to the circumstances. It is common to experience two or more complete cycles (e.g., a manic episode with a major depression episode with no period of remission) within a year (Juvenile Bipolar Research Foundation, n.d.).

Symptoms of Bipolar Disorder

Manic Phase

- Inflated self-esteem
- Increased performance of goal-directed activities
- Alcohol or drug abuse
- Irritability or anger
- Irresponsible spending
- Engaging in dangerous acts
- Hyperactivity
- Flight of ideas, racing thoughts
- No need or little need for sleep
- Rapid speech that others can't understand

Depressive Phase

- Low self-esteem or self-loathing
- Fatigue, lethargy, or feeling slowed down
- Increased need for sleep or the ability to sleep as many as 18 hours without feeling refreshed
- Social withdrawal
- Loss of emotional control—cries easily or for no reason
- Headaches, backaches, or digestive problems
- Unable to concentrate, make decisions, or remember details
- Suicidal thoughts
- Inability to feel pleasure or happiness

Medical Treatment of Bipolar Disorder

Treatment of bipolar disorder is most effective through the use of medications along with psychosocial therapy. The medication treats the illness directly, and the psychotherapy provides the skills needed to manage it and avoid new episodes. The primary goal of drug treatment is to stabilize the extreme mood swings of mania and depression. Antidepressants, such as Prozac, Paxil, and Zoloft, are used to treat symptoms of depression, and lithium has been the primary form of treatment

to regulate and prevent manic episodes. Seroquel is used by some to treat the symptoms of both the manic and depressive episodes. Antiseizure and antipsychotic medications are also used to combat side effects depending on individual symptoms.

Educational Strategies for Bipolar Disorder

- Be flexible and willing to adapt assignments, curriculum, and presentation style as needed.
- Be patient and ignore minor negative behaviors.
- Provide encouragement to promote positive behaviors.
- Provide positive behavioral choices.
- Remain calm and be a good model of desired behavior.
- Obtain good conflict management skills to resolve conflicts in a nonconfrontational, noncombative, safe, and positive manner.
- Be able to laugh at oneself and situations (not at the child)—teachers who can laugh at their own mistakes and bring fun and humor into the classroom reduce the level of stress that students feel.
- Be receptive to change and to working collaboratively with the child's parents, doctors, and other professionals to best meet the needs of the child.
- Reduce stress by providing the following.
 - Consistent scheduling that includes planned and unplanned breaks
 - Seating with few distractions
 - Shortened assignments and homework focusing on quality not quantity
 - Prior notice of transitions or changes in routine, minimizing surprises
 - Scheduling considerations so the student's most challenging tasks are scheduled at a time when the child is best able to perform

Web Sites

The Bipolar Child: www.bipolarchild.com

Juvenile Bipolar Research Foundation: www.bpchildresearch.org

Resource Books

Title: *Bipolar Disorder in Childhood and Early Adolescence*

Editor: Barbara Geller and Melissa P. DelBello

Publisher: Guildford Press, 2003

Story Profile: This book provides an overview of the theory, research, and knowledge in childhood-onset bipolar illness. It addresses such topics as epidemiology diagnosis and assessment and the life course of the disorder. It describes ways in which the bipolar illness presents itself differently in children than in adults.

Title: *The Childhood Bipolar Disorder Answer Book*

Authors: Tracy Anglada and Sheryl Hakala

Publisher: Sourcebooks, 2008

Story Profile: This book provides practical answers to the top 275 questions parents ask about the bipolar disorder and how it relates to their child. The book has been written to provide answers to these questions based on the most up-to-date information in the medical field. This book combines personal experience and medial expertise to result in a medically accurate picture with firsthand knowledge of what parents really want and need to know.

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Title: *The Life of a Bipolar Child: What Every Parent and Professional Needs to Know*

Author: Trudy Carlson

Publisher: Benline Press, 2001

Story Profile: Mood swings? Behavioral problems? Attention Deficit Hyperactivity in children? This book describes effective methods of helping youth to cope with their problems.

Children's Resources

Title: *Brandon and the Bipolar Bear: A Story for Children With Bipolar Disorder*

Author: Tracy Anglada

Publisher: Trafford Publishing, 2004

Story Profile: This book provides an opportunity to help children with bipolar disorder understand the illness in using child-friendly, truthful language. The book explains the disorder itself as well as treatment options using illustrations that allow the child to see him or herself in the story.

Title: *My Bipolar Roller Coaster Feelings Book*

Author: Bryna Herbert

Publisher: Trafford Publishing, 2005

Story Profile: This children's story is written from the perspective of Robert, a boy with bipolar disorder. Robert helps us understand his strong emotions and the strategies his parents and doctor have taught him for coping with them. The purpose of this book is to help the child with bipolar disorder better understand his or her feelings, learn coping strategies, and feel less alone in this world.

Title: *Turbo Max: A Story for Siblings and Friends of Children With Bipolar Disorder*

Author: Tracy D. Anglada

Illustrator: Deirdre Baxendale

Publisher: BPCChildren, 2008

Story Profile: This book describes the summer events of a young boy who is struggling to understand his sister's illness of bipolar disorder. The story describes a journey from confusion to understanding, embarrassment to advocacy, and from anger and guilt to acceptance.

CHILDHOOD DEPRESSION

A major depressive disorder is not simply sadness or grief but is a genuine psychiatric illness that affects both the mind and body. Because children are not as articulate as adults in expressing their emotions, it is unlikely that they will be able to say, "I'm depressed." The National Alliance on Mental Illness (2008) indicates that it is important to know what signs to look for in order to help these children cope. The warning signs fall into four different categories: emotional signs, cognitive signs (those involving thinking), physical complaints, and behavioral changes. Not every child who is depressed will experience every symptom listed.

Symptoms of Childhood Depression

Emotional Symptoms

- Sadness—feelings of hopelessness—may cry easily
- Loss of pleasure or interest—those who have enjoyed playing sports may suddenly decide not to try out for the team; they may complain of feeling bored and choose not to participate in activities which they've always enjoyed in the past
- Anxiety—the child may become anxious, tense, and panicky—the source of the anxiety may provide a clue to what's causing the depression
- Turmoil—the child may feel worried and irritable

Cognitive Symptoms

- Difficulty organizing thought—this may be evidenced by problems in school or an inability to complete tasks
- Negative view—may become pessimistic perceiving themselves, their life, and their world in a very negative light
- Worthlessness and guilt—may obsess over their perceived faults and failures, feel tremendous guilt, and declare themselves worthless.
- Helplessness and hopelessness—often believe that there is nothing they can do to relieve their feelings of depression
- Feelings of isolation—may become very sensitive to slights from peers
- Suicidal thoughts—express thoughts and wishes of being dead

Physical Symptoms

- Change in appetite or weight—appetite will decrease or increase—children with a normally healthy appetite may suddenly lose interest in eating, or children may respond the opposite way and will begin eating too much to self-medicate feelings
- Sleep disturbances—may have difficulty falling asleep and staying asleep once they do—they may wake too early or oversleep; they may have trouble staying awake during the day at school
- Sluggishness—may talk, react, and walk slower, or they may be less active and playful than usual
- Agitation—exhibit fidgeting or not being able to sit still

Behavioral Symptoms

These signs will be the most obvious and easiest to detect.

- Avoidance and withdrawal—may avoid everyday or enjoyable activities—they may withdraw from friends and family, and the bedroom can become a favorite place to escape
- Clinging and demanding—may become more dependent on some relationships and behave with an exaggerated sense of insecurity
- Activities in excess—may appear to be out of control in regard to certain activities (e.g., playing video games for long hours or overeating)
- Restlessness—may exhibit fidgeting, acting up in class, or reckless behavior
- Self-harm—may cause themselves physical pain (self-injury) or take excessive risks

Medical Treatment of Depression

Treatment for depression involves a multifaceted approach. The first line of treatment is pharmacotherapy (medication) intervention. Effective antidepressant medications such as Wellbutrin, Serzone, Desyrel, Effexor, and Remeron have been shown to help a significant number of people experience complete remission or at least significant improvement in their symptoms. Psychotherapy (counseling) is another important component of the treatment of depression. This is thought to be the most effective form of treatment, especially when it is coupled with medication.

Educational Strategies for Depression

Given the statistics on the incidence of depression in children and adolescents, it is likely that all teachers will encounter students with depression at some time in their teaching careers. Students will remain in school throughout the assessment process, and after a formal diagnosis of depression, most students remain in school. It is therefore imperative that teachers are provided with strategies that will best support the child. The British Columbia Ministry of Education (2001) provides the following strategy suggestions.

Create an Inviting Classroom

All students must feel safe to take healthy risks. Students with depression may avoid school if they feel threatened or insecure there. Teachers *must* believe that they can make a difference in the lives of students. The emotional tone of the classroom is powerful.

- Demonstrate unconditional acceptance of students.
- Be a good listener.
- Avoid singling out the student with depression.
- Keep a positive tone—humor is great; sarcasm is hurtful.
- Keep suggestions for improvement constructive, specific, and brief.
- Avoid overgeneralizing—using words like “always” and “never.”
- Be specific when providing feedback regarding academic or behavior improvement.
- Develop routines that are conducive to learning.

Teach and Require the Use of Organizational Strategies

Students with depression may need help keeping materials and assignments organized. Use the following strategies to help students be better organized.

- Provide reminders to students to use assignment books to record assignment and test requirements. For example, say, “Write this in your assignment book,” each time an assignment is given. Memory is not reliable when a person is depressed.
- Provide opportunities and assistance with keeping desks, binders, backpacks, and lockers organized.
- Encourage students to use positive self-talk and problem solving when confronted by difficult work.
- Help students organize assignments, especially longer projects. Set a project timeline and check back frequently with the students to provide verbal reminders or deadlines and ask if the students need assistance to meet the deadline.

Provide Positive Interaction Experiences

While teachers are not responsible for providing specific therapy, appropriate interaction with students and portraying understanding of the disorder are essential for a supportive environment in which the student can learn.

- Maintain a pleasant, interested tone and be prepared to listen; do not press students for details on family problems.
- Find out what motivates students, such as working with pets or younger students, and how they learn best.
- Be aware of any special needs or learning problems.
- Initiate conversation when students arrive, leave, or during breaks, as students with depression are not likely to do so.
- Stop by student's desk during seatwork or sit in on small groups.
- Make accommodations for assignments and exams using the following:
 - Allow student to go to a quiet space.
 - Extend the amount of time given.
 - Allow more time to formulate answers and respond.
 - Check regularly to ensure class assignments are done.
 - Use a variety of assessment methods so students can demonstrate knowledge using their stronger skills.

Web Sites

Childhood Depression: Guidelines for Parents and Teachers: [www.accg.net/Childhood Depression.htm](http://www.accg.net/Childhood%20Depression.htm)

Resources for Parents and Teacher to Help Understand and Treat Depression: www.pbskids.org/itsmylife/parents/resources/depression.html

Resource Books

Title: *Beating Depression: Teens Find Light at the End of the Tunnel*

Authors: Faye Zucker and Joan E. Huebl

Publisher: Franklin Watts, 2007

Story Profile: A new and up-to-date resource for parents and children who are trying to find answers behind their feelings of despair and hopelessness. The book defines depression and gives guidance to what it looks and feels like. It also provides a scientifically based explanation as to what is happening inside the body causing depression as well as newly researched treatments that are being discovered everyday.

Title: *Help Me, I'm Sad*

Authors: David G. Fassler and Lynne S. Sumas

Publisher: Penguin USA, 1998

Story Profile: A reassuring guide for parents of adolescents whose lives are darkened by depression. This book helps to recognize, treat, and prevent childhood and adolescent depression.

Title: *My Depression: A Picture Book*

Author: Elizabeth Swados

Publisher: Hyperion, 2005

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Story Profile: Elizabeth Swados candidly presents this zingy cartoon memoir in which she chronicles her struggles with severe depression. In expressively scribbled drawings and scrawled, to the point commentary, Swados charts the course her depression takes and itemizes the symptoms, which range from insulting her friend to failing to get out of bed. This seemingly simple talk conveys a wealth of helpful information and dispels the gloom a bit by making readers laugh.

Children's Resource

Title: *When Devon Met Oz: Helping Children Cope With Depression*

Authors: Mary Martin, Don Martin, and Erin Martin

Publisher: New Horizon Press, 2008

Story Profile: A friendship between a boxer dog named Oz and a boy named Devon develops at the park. Oz begins to realize that Devon is both sad and angry and follows Devon home so that he can make Devon's family aware that the boy needs help. Devon is sad, sleeps a lot, does not eat, worries about schoolwork, thinks he's bad at sports, and feels like the other kids don't like him. This sympathetic book includes reassuring advice and important tips from both children and parents on finding help.

SEASONAL AFFECTIVE DISORDER (SAD)

SAD is a depression caused by a specific season of the year, most often winter. Symptoms most often start in September or October and end in April or May. Specific symptoms of SAD may include the following.

- Feeling sad, grumpy, moody, or anxious
- Crying spells
- Loss of interest in usual activities
- Low energy level
- Increase in appetite
- Craving of carbohydrates, such as breads and pasta
- Weight gain
- Increase in sleep, feeling drowsy during the daytime

The depression experienced by people who have SAD is much more significant than the gloomy dullness felt by many people during the winter months. This disorder is one that is not taken seriously by many people.

Treatment of Seasonal Affective Disorder

SAD most often is treated by a doctor-prescribed light therapy. There are two types of light therapy.

Bright Light Treatment

- Patient sits in front of a "light box" for approximately a half hour, usually in the morning