

Special Education Terminology

IDEA - The Individuals with Disabilities Education Act

This is the federal legislation which mandates that all students, regardless of abilities or disabilities, are to receive a free and appropriate public education. It spells out specific requirements under which all states must function.

IEP - Individualized Education Program

The IEP is an annual plan which must, by law, be written for each student receiving special education services. It describes the unique needs of the student and the manner in which those needs will be met. The IEP is a legal document so adherence to regulations for its development and its content is critical.

IEP Team - Individualized Education Program Team

This is the group of people who meet to write the Individual Education Program. Members generally include the student's special education teacher(s), at least one regular education teacher who has contact with the student during the day (now required by law), an administrative representative, support personnel and the parent(s), guardian and/or whoever has educational rights (Who has the legal right to sign educational paperwork?). Anyone else having special expertise or specialized knowledge of the child may also be invited.

LEA - Local Education Agency

This refers to the school district, special education cooperative or interlocal that is responsible for providing the education for the special education student.

Extended School Term

This is a state-approved special education program that extends beyond the regular school year and which is designed for disabled students who are anticipated to require at least 45 days to regain their year-end competency levels if they do not receive the services outlined in their IEPs over the summer. This is not a typical summer school program.

Due Process

This is the process through which parents, guardians and/or LEA's (Local Education Agencies) can move to resolve differences related to the students need for or services in special education. Disputes are brought to a hearing officer or mediator (following a specified procedure) who will make a decision after evaluating the evidence provided by both sides. If either side disagrees with the hearing officer, the case can then be moved to district court.

FAPE - Free and Appropriate Public Education

All special education students are by federal and state law guaranteed an education that meets their specific needs at no charge to the parents regardless of the setting in which the student needs to be served.

LEA - Least Restrictive Environment

State and federal law specifies that each special education student has the right spend as much of his/her day in the general education environment with regular education students as possible. IEP teams must determine how the student's disability can best be accommodated in the regular education classrooms using assistive devices, special education staff support and/or curriculum adjustments.

Removing a student from the general education environment for any period of time is to be considered only after all other in-class interventions have been documented as unsuccessful.

Functional Curriculum

This curriculum is designed for students who, because of their disability, need to work on basic daily living skills and/or simple employment skills. Students in this category are usually those who are mentally retarded or severely multiply disabled.

Adapted Curriculum

This curriculum is designed for students who, because of their disability, are performing several years below grade level in a particular subject. They are still working on general education objectives and outcomes but not on those at their chronological grade level. A student may be in an adapted curriculum in one or several academic subjects.

Modified Curriculum

This curriculum is designed for students who are working at the same level and on the same general education objectives and outcomes as their regular education peers but who, because of their disability, require some accommodations in order to succeed. Examples of such accommodations could include books on tape or reading tests aloud for a visually impaired student or a student with a reading disability, word processing equipment for a student with a writing disability or a physical handicap, or helping a student with a learning disability to organize information and study for tests or even creating alternative assignments to assess their knowledge/skills.

General Education Curriculum

This is the curriculum for a given subject or grade that has been established by the local school district (or cooperative or interlocal) and adopted by the school board.

Categorical Terms

While the new special education standards (State Plan) will probably not contain criteria for placement of students in specific exceptionalities, what follows is a description of the most common categorical labels.

MR - Mental Retardation

This category represents students who exhibit poor academic and/or behavioral functioning due to:

- significantly below average intelligence
- significantly below average adaptive behaviors present in more than 1 environment
- limitations in areas such as communication, self-care, home living, social skills, community use, self-direction, health and safety, functional (life-skills)-based academics, leisure activities, work

In past years, this category has been divided into students who were considered to be Educably Mentally Retarded (EMR) and those who were considered to be Trainably Mentally Retarded (TMR). EMR students were generally involved in the general education curriculum but at grade levels significantly below the grade they were actually in. TMR students were generally involved in a curriculum which focused on teaching life skills and basic employment skills.

The state of Kansas no longer uses the EMR or TMR designations. It uses the terms “adapted curriculum” and “functional curriculum” to describe the needs of individual mentally retarded students. These designations are, however, still frequently used in the field.

LD - Learning Disabilities

Students in this category are those who experience a significant discrepancy between their actual academic achievement and their academic potential in one or more subject areas usually resulting from an impairment in their ability to either process or express information. These students are not mentally retarded. There are a variety of specific learning problems that an individual with a learning disability may have. This information should be spelled out in the student’s IEP under the Present Levels of Performance section and/or in the goals and objectives.

BD - Behavior Disorders

This category includes students who exhibit behaviors at either a much higher or much lower frequency than is appropriate for their age, for an extended period of time and in more than one environmental setting. These behaviors must be documented as interfering with the student’s ability to progress in the general education curriculum and cannot be due to intellectual, cultural or health/medical factors that have not been dealt with. This category is NOT to include students who are socially maladjusted unless they are determined to have a behavior disorder as well.

Students in this category may suffer from mental illnesses such as obsessive/compulsive disorder, schizophrenia, depression or bipolar disorder or may exhibit symptoms of particular behavioral disorders such as Oppositional/Defiant Disorder or Conduct Disorder.

OHI - Other Health Impaired

Students in this category have been determined by a therapist, nurse, physician and/or other qualified health providers to exhibit a chronic, medically related condition which limits their strength, vitality or alertness and interferes with their learning to the extent that they need special services in order to progress appropriately in the general education curriculum. Such conditions could include, severe asthma, Attention Deficit Disorder and autism.

SPL - Speech and Language

Students in this category are documented as having disabilities in at least 1 of 4 areas related to speech and language.

1. a difficulty or an inability to process or express thought which impairs their academic functioning, social adjustment, self-help skills or communication skills
2. a deviation or impairment of voice which causes an abnormality in pitch, volume or voice quality and which results from a pathological condition or inappropriate use of the vocal mechanism. The problem is severe enough to impair the student's academic functioning, social adjustment, self-help skills or communication skills.
3. a deviation or impairment of fluency that is not readily controllable by the student, occurs frequently or is markedly noticeable and occurs to the degree that it impedes communication
4. a deviation or impairment in articulation related to defective production of phonemes (letter or letter combination sounds) that interferes with the intelligibility of the student's speech.

TBI - Traumatic Brain Injury

Students in this category have sustained an injury to the brain from an external force which has resulted in a significant impairment in brain function that adversely affects their academic performance. The impairment can result in intellectual and/or behavioral disabilities.

PI - Physical Impairment

This category is for students who suffer a physical disability which interferes with their ability to function in the general education curriculum.

VI - Visual Impairment

This category includes two types of disabilities. Students who are "partially seeing" have a visual limitation but are still able to use printed materials (with adaptations) as their primary means of receiving instruction.

Students who experience "blindness" are dependent on tactile and/or auditory materials for instruction.

HI - Hearing Impairment

Students in this category experience a loss of auditory functioning that interferes with their ability to communicate and function in the general education curriculum.

SMD - Severe Multiple Disability

Students in this category have multiple handicapping conditions that significantly impact their education. Generally these conditions involve profound retardation in conjunction with severe sensory disabilities, motor disabilities, severe emotional disturbances, chronic health conditions or severe communication disorders.

This category does not include students who are deaf/blind. They have a separate label.

Psychological Terms

The terms in this section represent specific emotional or behavioral disorders. Causes for individual disorders may be organic (neurological or biological), emotional or learned behaviors. Specific diagnostic criteria for each disorder can be found in the Diagnostic and Statistical Manual - VI (DSM-IV) published by the American Psychiatric Association. Your school psychologist or social worker probably has one. The included information is not meant to diagnose any individual, rather to provide a basic level of understanding.

Pervasive Developmental Disorder (PDD)

Pervasive Developmental Disorder is a category of disorders which is characterized by impairment of basic, developmental skills such as communication and socialization. The specific disorder generally appears between 30 months of age and 12 years. Depending on the particular disorder present, students with PDD may have difficulty processing and using language, repetitive movements, speech or play, difficulty socializing, difficulty handling a change in routine, unusual responses to stimuli such as sights, sounds and touch, and difficulty relating to the world around them. Some students may also experience unusual fantasies or bizarre ideations. This diagnostic category includes Autism, Asperger Syndrome, Rett's Disorder and Childhood Disintegrative Disorder.

Autism

Autism is one type of Pervasive Developmental Disorder (PDD). Estimates indicate that it affects 2-10 of every 10,000 people. Although the causes of autism aren't yet known, indications are that it is caused by abnormal brain development in early fetal development. It is NOT caused by poor parenting as was once thought. The onset of autism is usually between birth and 3 months of age. Parents usually notice that their infant doesn't cuddle or want to be held and may even cry when touched or may appear excessively agitated and cry for a large portion of his/her waking hours. As time passes, the child appears to withdraw into his/her own world and usually doesn't develop language skills at a normal rate. At this stage, autism can be easily confused with deafness.

It is important to note that autistic individuals can range from profoundly to mildly disabled. While there is no cure for autism, many individuals respond to a combination of educational/behavioral interventions and medication and can lead normal or near-normal lives including holding a job and living independently or semi-independently.

Educational concerns usually involve improving language skills, social skills and life skills.

Asperger Syndrome

Asperger Syndrome is also a Pervasive Developmental Disorder. It is similar to autism but the onset is usually after age 3. An inability to socialize appropriately is a primary symptom of Asperger Syndrome. Children with this disability may also fixate on one or two particular subjects or on specific routines to the exclusion of virtually everything else. They have limited facial expressions, may evidence poor motor control and may appear withdrawn.

As with autism, there is no cure for Asperger Syndrome. Treatment usually takes the form of educational/behavioral interventions and medication. Fortunately, the prognosis of this disorder is generally better than that for most other Pervasive Developmental Disorders. Although most individuals will continue to exhibit some symptoms, particularly in the area of socialization, throughout their lives, they are more likely than other individuals with PDD to become independent, functioning adults.

Mood Disorders

Mood disorders are exactly what they sound like. They are disorders which effect the individual's emotional states. The most well-known mood disorders are Major Depressive Disorder and Bipolar Disorder (formerly known as Manic/Depressive Disorder).

Bipolar Disorder

Bipolar Disorder is a condition in which and individual will experience episodes of severe depression and episodes of mania. In depressive episodes, the individual symptom can include feeling depressed all and every day for an extended period, a significant lessening in interest or pleasure in previously enjoyable activities, significant weight loss (in children, a failure to make expected weight gains), insomnia or sleeping most of the time (hypersomnia), restlessness or lethargy (as reported by others), daily fatigue, feelings of excessive worthlessness or guilt, decreased capacity to concentrate or make decisions, or recurring thoughts of death and/or suicide.

It is important to note that, in children, depression often takes the appearance of excessive irritability and agitation along with the other symptoms.

In a manic episode, the individual will usually experience inflated self-esteem or grandiosity, a decreased need for sleep, increased talkativeness, racing thoughts, distractibility, increased activity levels and/or agitation and/or increased participation in pleasure driven but risky behaviors such as excessive spending, sexual activity or impulsive business investments.

Bipolar Disorder occurs in approximately 1.2% of all children and approximately 1% to 1.6% of all adults. About 25% of individuals with the disorder attempt suicide while in a depressive state.

Studies indicate that Bipolar Disorder is probably caused by a major imbalance in brain chemistry. Symptoms of the disorder can be exacerbated by stress at home, at school or in the community.

Bipolar Disorder is most effectively treated with medication. Educational and behavioral programs are most effective when they concentrate on adherence to the medication regime.

Depression

A clinical diagnosis of depression means that the individual has experienced a prolonged period of excessive sadness accompanied by emotional symptoms such as fatigue, lethargy, significant pessimism, irritability and physical symptoms such as weight loss, diminished appetite, insomnia or excessive sleeping and difficulty concentrating or making decisions to the point that the individual's ability to function is seriously impaired. In it's most severe form, the depression is termed Major Depressive Disorder.

It is again important to note that, in children, depression often expresses itself as irritability or agitation instead of overt, recognizable sadness.

Studies indicate 10-25% of women and 5-12% of men are at risk for a Major Depressive Disorder during their lifetime. Major Depressive Disorder is usually treated with a combination of medication, behavioral and educational interventions and therapy.

Personality Disorders

Personality consists of the psychological characteristics that are deeply embedded in us and that influence every level of our functioning. When a particular characteristic becomes dominant to the point that it impairs the individual's ability to function successfully, psychiatrists and psychologists may diagnose that person as having a personality disorder. Examples of such disorders would include Oppositional/Defiant Disorder, Conduct Disorder, Anti-Social Personality Disorder, Borderline Personality Disorder, Obsessive/Compulsive Disorder, Narcissistic Personality Disorder, Schizotypal Personality Disorder, Schizoid Personality Disorder and others.

Oppositional/Defiant Disorder

All people exhibit oppositional and defiant behaviors sometimes. When those behaviors exceed in severity and duration (usually at least 6 months) what is considered normal for the individual's age or developmental level, that individual could be diagnosed by a psychiatrist or psychologist as having Oppositional/Defiant Disorder (ODD). It is estimated that between 5% and 16% of children have this disorder and that 60% to 70% of those children are also diagnosed with Attention Deficit with Hyperactive Disorder.

The exact cause(s) of ODD are not known. Theories include chemical imbalances, neurological problems, genetic temperament and family/community dysfunction. Specific behaviors seen with ODD include, difficulty handling frustration, procrastination, irritability (which as you recall can actually be a manifestation of depression in children), fear, hostility, aggression, blaming, arguing, noncompliance, provoking others, forgetfulness, underachieving, and difficulty with concentration.

Children with ODD have an overwhelming need (not necessarily a want) for autonomy and their inappropriate behaviors almost always result from frustration NOT meanness or spite. When working with a child with ODD behaviors, staff can help him/her by:

- giving the child a chance to meet that need for autonomy by providing him/her with real choices
- whenever possible, praising compliance and ignoring noncompliance. Remember that the child is reacting out of a need and/or frustration and not really out of a desire to make your life miserable.
- making sure that the child is not overwhelmed academically. Many ODD kids secretly think that they are stupid and worthless. It is safer for them to refuse to work than to take the risk of making a mistake or looking bad. Give them assignments in small pieces (say 5 math problems at a time instead of 25 all at once) that you know they can do until they start feeling safe enough to take some academic risks.
- using humor to defuse difficult situations

Things that do NOT work with ODD kids include:

- ignoring their existence
- pleading with them
- sitting one-on-one and giving them too much help (In this case what usually happens is the adult unconsciously ends up doing the work for the child.)
- threatening
- displaying anger
- getting into a power struggle

Conduct Disorder

Students diagnosed with Conduct Disorder (CD) exhibit behaviors that may initially look like Oppositional/Defiant Disorder but the behaviors, particularly those involving aggression, are usually more severe and have a different motivation. Estimates are that about 10% of children with ODD will later move to Conduct Disorder.

The criteria for labeling a student as having a Conduct Disorder include a repetitive pattern of violating the rights of others or violating societal rules by committing status offenses, being consistently truant, consistently refusing to follow directions, lying, breaking into houses, buildings or cars, stealing, committing acts of vandalism, setting fires that cause damage, confrontational theft, cruelty to animals or people, or committing assault (serious threat of physical harm) or battery (physical touch/harm). A child must have exhibited at least 3 of these behaviors over the last 12 months (with at least 1 in the last 6 months) in order to be determined to have a Conduct Disorder.

Students with CD, have an overwhelming need to protect themselves physically and emotionally by controlling all situations. They need power in order to feel safe. Most come from situations in which, for some period of time, they had no control over anything. They couldn't control when (or if) they would be fed, nurtured or beaten. There is also some evidence that there may be a genetic and/or chemical/neurological component to this disorder. Estimates are that 4-10% of children suffer from Conduct Disorder. If the disorder is not corrected, it can lead to an adult diagnosis of Anti-Social Personality Disorder (formally referred to as a psychopathic or sociopathic personality).

Ways to help students with CD include:

- praising appropriate behavior
- treating the student with respect even if he/she doesn't treat you that way
- set clear rules and consequences and enforce them consistently and matter-of-factly
- use humor to defuse difficult situations

Things that don't work with CD kids include:

- showing anger or fear
- preaching and lecturing
- searching for the "truth" or "court-of-law" evidence ("You didn't see me do it so you can't prove it.") These students love to engage you in arguments that you can't win and will often intimidate peers who may have witnessed the event in question. Look at what is reasonable, explain that you may be right or you may be wrong but this is your judgement in this situation.

Obsessive/Compulsive Disorder

This disorder involves recurrent, unwanted thoughts or images and/or repetitive actions which significantly interfere with the individual's ability to function. Common obsessions include excessive worries over cleanliness and germs, fire, orderliness, and doing things perfectly. Some people experience the obsessive aspect of the disorder without the accompanying compulsions.

Compulsions are repetitive behaviors that, for a brief time, decrease the anxiety and discomfort the individual feels as a result of the his/her obsessions. Common compulsions include hair pulling, hand washing, turning appliances off repeatedly, touching items repeatedly and opening and closing doors/locks. While most of us exhibit these behaviors to some degree, an individual suffering from a compulsive disorder will take the behaviors to the extreme. For example, some will pull their hair until they have bald spots while others will wash their hands until they bleed and still others may have to turn the stove on and off dozens or even hundreds of times before they can leave the house. While the individual knows that these behaviors are unnecessary and are interfering with his/her life, the psychological need (compulsion) to exhibit the behavior is usually overwhelming. Without treatment, denying the compulsion usually leads to debilitating anxiety.

Estimates are that Obsessive/Compulsive Disorder affects approximately 2.5% of the population and is about evenly divided between men and women. Although the disorder can develop at any age, approximately 33%-50% of people report that it began in childhood.

Treatment of this disorder usually involves a combination of behavioral/educational interventions, therapy and medication. The most effective intervention currently appears to be "exposure and response prevention". This intervention involves exposing the individual to the anxiety-producing situation/thought and then having them refrain from performing the compulsive behavior for as long as possible.

Borderline Personality Disorder

The term "Borderline" was first coined in 1938 and used to acknowledge a group of individuals who were considered to be on the borderline between neurosis and psychosis.

Currently, individuals diagnosed with Borderline Personality Disorder (BPD) exhibit serious problems with interpersonal relationships, self-image, emotional boundaries and impulsiveness. These difficulties usually begin in the late teen or early twenties. Specific behaviors include frantic efforts to avoid real or perceived abandonment, a pattern of unstable and intense relationships, an unstable self-image, dangerous impulsivity (spending, unsafe sexual encounters, substance abuse, reckless driving, bingeing), excessive mood swings not caused by Bipolar Disorder, chronic feelings of emptiness, inappropriate anger, transient paranoia and, most serious, recurring suicidal behavior, threats or self-mutilation (70%-75% of people with BPD have a history of these last behaviors and approximately 9% do commit suicide.) Studies have determined that approximately 75% of all individuals with BPD are female.

The causes of BPD are unknown but there is some evidence that individuals may have a genetic predisposition for it. Currently, the most effective intervention for the disorder seems to be one known as Dialectical Behavior Therapy. It involves both individual and group therapy sessions which focus on specific issues unique to the individual and on interpersonal skills development.

Intermittent Explosive Disorder

This is an impulse-control disorder characterized by several episodes (they may be many months apart) of temper outbursts that are significantly out of proportion to the situation and results in serious acts of assault or destruction of property. Generally people describe an individual with this disorder as having a “hair trigger”. After the episode, the individual is sincerely remorseful and may be agitated by his/her out of control behavior. He/she may also be unable to recall details of the event. Outside of the temper outbursts, the individual is generally cooperative, pleasant and well-behaved.

Intermittent Explosive Disorder is still a somewhat controversial diagnosis. It is very important that, before it is used, all other physical and psychological disorders be ruled out.

Organic Disorders

This category includes disabilities which appear to result from impairments of the neurological or chemical processes of the brain. This includes Tourette’s Syndrome, Attention Deficit Disorder and Attention Deficit with Hyperactivity Disorder.

Tourette Syndrome

This syndrome occurs in approximately .05% to 1% of the population and affects boys 3 to 4 times as often as girls. It is characterized by repetitive muscular movements (tics) usually of the head, face and/or upper body and vocal outburst (sounds, noises or words).

Although these tics and outburst are referred to as involuntary, many individuals with Tourette’s can suppress them for some periods of time. Unfortunately, just as when you try to suppress a sneeze, when the tics or vocalizations do reemerge, their frequency and severity can be even more extreme for awhile.

It is generally believed that Tourette’s is caused by a chemical imbalance in the brain and that it is aggravated by stress. Treatment usually involves medication, stress reduction techniques and exercise.

Probably the most disruptive element of Tourette’s lies in the involuntary vocalization of profanity and racial, sexual or religious slurs. Not everyone with Tourette’s exhibits this particular behavior. What is important to note is that, just because derogative words or phrases come out of Tourette sufferers mouth does not mean that they express his/her actual beliefs. We all “tease” ourselves with inappropriate thoughts on occasion, things we don’t believe and would never say but are just there sometimes. It’s like repeatedly touching you tongue to a sore tooth, you don’t want to do it but it just keeps happening. Unfortunately, with a Tourette’s sufferer, the mechanism in the brain which inhibits the expression of such words and phrases doesn’t work properly and the more the individual tries to suppress these words and phrases, the worse the vocalizations can get. Try concentrating on not blinking your eyes and you will get a small taste of what these individuals go through.

Attention Deficit Disorder

This is a disorder generally believed to result from a chemical imbalance which impairs the brain's ability to filter out nonessential stimuli. Individuals with Attention Deficit Disorder (ADD) have serious difficulty concentrating because they see, hear and feel almost everything in their environment and are therefore constantly being distracted from the task at hand. More importantly, it is difficult for them, especially children, to determine which stimuli to pay attention to and which to try to ignore. With most of us, such a decision is automatic. Individuals with ADD must often make a conscious choice. When a child with ADD hears the buzz of the florescent lights above his head and his teacher's voice, both seem equally important to his brain. He/she must choose which sound should take precedence. This takes both time and energy.

Behaviors exhibited by children with ADD include high levels of distractibility, missing details, poor school work, doesn't appear to listen when spoken to, low tolerance for frustration, disorganization, difficulty completing tasks and irritability. Interventions often include medication and behavioral/educational skills training.

Attention Deficit with Hyperactivity Disorder

Individuals with this disorder manifest the same behaviors as those with Attention Deficit Disorder with the added element of an increased activity level. They have difficulty being still and are highly impulsive. It should be noted that the Diagnostic and Statistical Manual - IV does not make a distinction between Attention Deficit Disorder and Attention Deficit with Hyperactivity Disorder (ADHD).

Prevalence estimates for this disorder range from 3% to 10% with boys being affected more often than girls. Again, treatment usually focuses on medication and/or behavioral/educational interventions.

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