

# 1

## Defining overlapping and co-existing conditions

This chapter sets the scene for the rest of the book by:

- presenting case studies of two children as illustrations of overlapping and co-existing disorders
- explaining how the terms used to describe childhood disorders have changed over time
- discussing the meaning of overlapping disorders and ones that co-exist
- defining the four main groupings of developmental disorders that are the focus of this book.



### What's in a label?

It is a comparatively recent phenomenon that children with **developmental disorders** may be given not just one diagnosis but two or more. This has happened at a time when the number of terms being used to describe different disorders has increased. For instance, '**specific learning difficulties**' now covers not just **dyslexia**, but **dyspraxia**, **dyscalculia** and **dysgraphia** as well. Other terms, such as **autism**, have broadened their definition to become '**autistic spectrum disorders**' (ASD), which includes **Asperger's syndrome**. As the numbers of **labels** being used have both increased and expanded, it has become apparent that children with different disorders may exhibit some of the same symptoms. It has also become clear that there are certain conditions that quite often go together, so that what were once seen as entirely separate disorders now need to be viewed as ones that may overlap or co-exist. The question then arises as to how to educate these more complex children, while not detracting from the educational experiences of their peers. This book has been written to shed light on the current situation, to consider the impact of certain conditions on children's ability to learn effectively, and to look at the approaches and strategies that might assist all children to become successful learners.



### Case study 1.1: Tommy, 8 years old

Tommy was seven years old when he received a diagnosis of attention deficit hyperactivity disorder (ADHD) from the family doctor. He had struggled to cope in his infant school, and the staff had struggled to cope with his behaviour, which combined impulsiveness with an inability to concentrate on anything for more than a few minutes. As he moved to his junior school and the same pattern of behaviour continued, his parents agreed with the doctor that it would be worth putting him on medication for a trial period. Unfortunately, this seemed to have little effect, so after a few months the medication was stopped. Tommy's behaviour continued to be erratic. When he was eight, and after being involved in several playground fights, the school excluded him for lashing out at a member of staff who was trying to direct him to go back to class at the end of playtime.

On his return to school after his fixed-term exclusion, he was seen by the school's educational psychologist (EP), who sent him to a paediatrician. After assessing Tommy, the paediatrician explained to his parents that their son met the criteria for a diagnosis of Asperger's syndrome and that ASD would be a more accurate description of Tommy's difficulties than ADHD.



### Case study 1.2: Sylvie, 12 years old

Sylvie had been diagnosed with dyslexia when she was eight years old. Her teachers had always expressed surprise that someone who was so keen to do well had struggled to get off the ground with both reading and written work. Not only was her spelling very weak, but her handwriting was almost illegible. For the rest of her time in primary school, Sylvie received extra help twice a week from a teaching assistant who worked with a small group and concentrated on improving the pupils' reading ability. Although Sylvie made some progress, as the gap between her and her peers widened, she became less motivated and her behaviour deteriorated. She also found it hard to make friends and was often the last one to be picked for team games, mainly because she was slow at running and her ball skills were poor.

When she reached secondary school, Sylvie was placed in the learning support unit (LSU), where the teacher in charge decided to look more closely at the nature of her difficulties. From the assessments the teacher carried out in conjunction with a specialist teacher for dyslexia, there seemed to be no doubt that Sylvie had severe dyslexia. However, in addition, she was referred to the local child development centre, where her difficulties with coordination resulted in the physiotherapist and the occupational therapist agreeing that she had dyspraxia in addition to her dyslexia.

In the first of these case studies, Tommy begins by having a diagnosis of ADHD, which is later replaced by one of ASD. This is an example where a label is changed over the course of time, as the child's development seems to indicate that a different term might be a more accurate one. At first glance, it may seem that ADHD and ASD are two very different conditions; yet, children with either condition can appear to be inattentive and socially inept. In Tommy's case, as he

1970s	1994	2001	Current terms
Educationally subnormal	Learning difficulties  Specific learning difficulties: dyslexia	Cognition and learning: MLD, SLD, PMLD  Cognition and learning; specific learning difficulties: dyslexia and dyspraxia	Global or general learning difficulties: MLD, SLD, PMLD  Specific learning difficulties: dyslexia, dyspraxia, dyscalculia, dysgraphia
Maladjusted	Emotional and behavioural difficulties (EBD)	Behavioural, emotional and social difficulties (BESD)	BESD, including ADHD
Blind	Sensory impairment: visual difficulties	Sensory and/or physical needs: visual difficulties	Visual impairment (VI)
Partially sighted	As above	As above	As above
Deaf	Sensory impairment: hearing difficulties	Sensory and/or physical needs: hearing difficulties	Hearing impairment (HI)
Partially deaf	As above	As above	As above
Physically handicapped	Physical disabilities	Sensory and/or physical needs: physical impairments	Physical impairment or disability (PI/PD)  Multisensory impairment (MSI)
Speech defects	Speech and language difficulties	Communication and interaction: speech and language delay/disorder  Autism	Specific language impairment (SLI); speech, language and communication needs (SLCN); autistic spectrum disorders (ASD)

**Figure 1.1** Changing terms in SEN between the 1970s and the present

# 3

## Fitting labels to children and children to labels

### **This chapter covers:**

- **the meaning of labels, different approaches to labelling and who is involved in the process**
- **the advantages, disadvantages and complications of labelling, including controversial issues around defining children's needs**
- **how the process of labelling is expanding to recognise more disorders**
- **the need to keep labelling in perspective, so that meeting the child's needs is seen as paramount.**



### The meaning of labels

In terms of their education, pupils who have any kind of learning or behavioural difficulties will fall within the general label of having special educational needs (SEN). The majority of pupils with SEN will acquire a further label, which will help to clarify more precisely the nature of their difficulties. Neurodevelopmental disorders are defined by clusters of symptoms and, as more is discovered, the disorders are not being seen as entirely discrete, but as having overlapping symptoms. This can lead to some confusion about:

- which is the right label to give
- whether to give more than one label
- what to do about the child or young person who does not fall clearly within any diagnostic label, yet clearly has difficulties.

Diagnosis relies heavily on observing the child's behaviour, together with hearing accounts by others who know the child, of the behaviours they have observed. This means that much will depend on the skill of diagnosticians, their background, training and experience, particularly if they are working on their own rather than as part of a group of professionals.

A disorder or syndrome may be named after the cluster of symptoms, such as in the case of attention deficit hyperactivity disorder (ADHD), obsessive–compulsive disorder (OCD), or oppositional defiant disorder (ODD), or named after the person who identified it, as in the cases of Kanner’s autism, Asperger’s syndrome, and Gilles de la Tourette’s syndrome.

## Approaches to labelling

In the context of SEN, labelling children’s behavioural patterns has been guided by a *medical model*. This model is characterised by a performance deficit approach, whereby the focus is on identifying what the child is unable to do. In this model, the limitations a child is seen as having are viewed solely in terms of biological deficits. As well as providing an assessment of the nature of a child’s difficulties, the label may be used to indicate the educational provision or support that is felt to be necessary, including any interventions that will help remediate the child’s difficulties.

For many years, the medical model has been challenged by a value-based approach known as a *social model*. In contrast to the medical approach, this approach sees the problems being caused by societal attitudes to those who are different. Therefore, it is society itself that needs to make changes rather than the individual. Although the social model has not replaced the medical model, it has helped to raise public awareness of what needs to be done to ensure that those with SEN and disability are included as fully as possible in society.

More recently, approaches have been developed which draw on both the medical and social models. These include a *cognitive neuropsychological model* which accepts the need to investigate neurological causes as well as environmental factors, in order to discover how the brain works. This approach is the most holistic, as it allows for the plasticity of the brain and the child’s ability to change to be recognised, as well as broader environmental factors, including the influence of the home, the school and the wider community. Applying this approach to education means that knowledge about the brain–behaviour relationship seems crucial in understanding how to help pupils to learn.

It was, perhaps, unhelpful that the social model swung too far away from the medical model by suggesting that a change in attitude on the part of society, even accompanied by the necessary legislation, was all that was needed. The biological and neurological aspects of SEN and disability cannot be ignored, any more than it is sensible to ignore the changes that society needs to make in its attitude to those with SEN and disability, who should be afforded the same opportunities as the non-disabled, in as far as this can be made possible. In education, a more integrated approach is needed, which takes account of both facts and values.

It could be seen as unfortunate that a more complex population has arrived in schools, both special and mainstream, before sufficient training has been put in place to help staff understand children they may not have come across before. The need for such training was identified in the government’s SEN strategy of 2004 (*Removing Barriers to Achievement*), but has been delayed (see Chapter 6, page 87).