

The IDEA Classification Debate: ED or OHI?

By Donna Gilcher, Ruth Field and Martha Hellander

What is the most appropriate classification for students with bipolar disorder under the Individuals with Disabilities Education Act (IDEA)? Parents and schools face this question each time they meet to develop a student's Individual Educational Plan (IEP). Although IDEA states that special education services are *not* categorically driven but must instead be driven by student need, parents often are told that appropriate accommodations for behavioral issues are not possible without an Emotionally Disturbed classification. This belief may arise from a misunderstanding of how IDEA defines these categories.

IDEA defines Emotionally Disturbed (ED) as follows:

“Emotionally Disturbed means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:

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

The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.” (IDEA sec. 300.7c4)

IDEA defines Other Health Impaired (OHI) as follows:

“Other Health Impaired means having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that—

- (a) is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, and sickle cell anemia; and
- (b) adversely affects a child's educational performance.” (IDEA sec300.7c9)

Looking at the above guidelines, it is apparent that children with pediatric bipolar disorder are most appropriately categorized as OHI. Pediatric bipolar disorder is

a medical condition that can be explained by intellectual, sensory, and general health factors, in contrast to the definition of ED. All of the symptoms of ADHD, a condition specifically named under OHI, are also seen of bipolar disorder.

The biological nature of bipolar illness as a disorder of the brain like epilepsy or ADHD is manifestly clear from research published in leading medical journals. Both structural brain development and the functioning of neural networks are affected. For example, recent studies have demonstrated regional volume reductions, enlargements, or other abnormalities in the temporal lobes, caudate nuclei, amygdala, hippocampus, neocortex, and other structures of the brain in patients with bipolar disorder. (El-Badri, et al, 2000; Cecil, et al, 2002) Recent work done by Husseini K. Manji, M.D., Chief, Laboratory of Molecular Pathophysiology at the National Institute of Mental Health, and colleagues has demonstrated that cellular plasticity and resilience is also abnormal, with accumulating evidence showing alterations in the mitochondria, reduced brain cell growth factor, and accelerated brain cell atrophy and death. Some of these abnormalities appear to be reversible by treatment with lithium and other medications used to treat the illness in adults.

Bipolar disorder is clearly a disability, as defined by OHI, that demonstrates “having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that result in limited alertness with respect to the educational environment.” The physical energy and alertness of a child with bipolar disorder can fluctuate dramatically by season, by cycles, which may last from days to months, and even just a few hours during the course of a day. Children with this disorder typically have a disturbed sleep/wake cycle that includes low arousal and difficulty awakening from sleep in the morning (much more so than a normal child of the same age), and may include increasing energy throughout the day with extreme hyperactivity in the late evening that prevents normal sleep. During hypomania or mania, the child may move very quickly with heightened concentration and focus, during which time academic progress may occur in leaps and bounds. An outpouring of creativity may occur during mania in some children, with attention hyper-focused upon topics that engage the child’s interest. When depressed, the child may move extremely slowly and experience fatigue, reduced concentration and alertness, during which time little or no academic progress may occur. Disturbances in endocrine functioning, which affect body weight, growth, puberty, and energy, are also common.

Cognitive abilities are also impaired. Attention, shifting tasks, verbal learning, declarative memory and visuospatial memory are often found to be impaired on neuropsychological testing of bipolar students. (Dickstein, et al, 2004) A lack of ability to easily recall information or process it correctly within the classroom, which in some children may be a constant trait but seen in others only during acute episodes, often leads students to experience distress and failure on academic testing. Executive functioning difficulties are common in students with

bipolar disorder, leading to poor organizational skills. (Clark, 2001; Chowdhury, et al, 2003) Stress exacerbates these cognitive problems. Such deficits can lead to impulsivity, distractibility, and poor decision-making, just as they do in ADHD, which is specifically listed under OHI.

Some children appear to lose cognitive abilities as the illness progresses, although some do not, and recovery between episodes is possible. A study examining school functioning in bipolar adolescents showed a significant decline in academic abilities after onset of the illness. Researchers at the Sunnybrook Health Science Center in Toronto, Canada, concluded that the “onset of bipolar illness negatively impacts a child’s ability to function effectively in the school environment and that very specific program modifications are required in order to optimize the child’s success at school.” (Quackenbush, et al 1996). Medication to control symptoms of the illness may impair or improve cognition and have other unavoidable side effects. Difficult treatment decisions must be made by physicians and parents.

Behavioral symptoms that impair learning are often produced by the illness. Rages, negative peer relationships, and the inability to interpret social situations and react appropriately, are common. Some children with the illness experience powerful social anxiety that prevents them from attending regular school at times. Impulsivity can lead to verbal outbursts that the child may not be able to control. Some children manage to contain their behavioral symptoms during school but are unable to do so at home. Some children (more often boys but some girls) will show more externalizing behaviors, while others (more often girls but some boys) will internalize their distress. Children with bipolar disorder tend to interpret neutral facial expressions as negative, which affects relationships. Since no two children are alike, behavioral symptoms vary widely both between students, and in each child, during different episodes of the illness.

Furthermore, the central nervous system dysfunction appears to be an underlying factor in both the expression of mood and the cognitive disturbances noted in the disorder. (Chowdhury, Ferrier, Thompson. 2003) Repeated episodes of the disorder can produce large deficits in social and vocational functioning. Thus, the combination of mood, cognitive, energy, and behavioral effects of this illness negatively impact academic functioning in affected children. Without appropriate educational accommodations and modifications designed to decrease this negative impact, these students are at risk for school failure. Fortunately, once the illness is properly diagnosed and treated with appropriate medical interventions, these symptoms tend to subside.

These studies indicate that children with pediatric bipolar disorder (PBD) have a serious brain disorder that is a medical condition. In addition, the findings satisfy the OHI requirement that the disability demonstrates “having limited

strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment.” .

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Why does the IDEA designation matter? It matters for several reasons. Sometimes the classification leads to an inappropriate placement. When a child with bipolar disorder is placed in a program for emotionally disturbed children (in which traditional behavior modification techniques are utilized), the child will frequently experience increased instability, negative self concept, and feelings of worthlessness, helplessness and poor self-esteem. The stigma that these children are “bad” is a grave injustice of the ED classification. We must accept that some of the most explosive and puzzling behaviors are beyond the child’s control and that those behaviors are symptoms of medical instability, not purposeful or malicious conduct. Another injustice of the ED classification is the often-limited educational opportunity it provides. In the majority of ED classrooms, addressing behavior is the primary focus, in contrast to an academically enriching or challenging environment needed by the often highly creative children with bipolar disorder.

OHI classification signals educators to provide the student with compassion and acceptance, and allows for an understanding that this illness is beyond the student’s control, as are the symptoms of diabetes, cancer, epilepsy or sickle cell anemia.

Everyone in the child’s life must work cooperatively to manage pediatric bipolar disorder. Doctors, parents, mental health providers, educators and the student must collaborate to meet the child’s individual educational needs and develop creative modifications to accommodate the child’s fluctuating medical condition, including periods of relative wellness and academic progress and periods of relapse and medical crisis. Students with pediatric bipolar disorder need non-punitive behavioral interventions for inappropriate behavior. They need instruction in appropriate behaviors in a variety of educational and social situations, as well as practical strategies that reduce stress at school. These considerations will ultimately increase the attendance and graduation rates among students with bipolar disorder, and will provide them the opportunity to find joy in the learning.

For more information, see: [hotlink to <http://www.bpkids.org/learning/educational/>] Education Issues of Pediatric Bipolar Disorder [end link] on the Web site of the Child & Adolescent Bipolar Foundation.

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