Learning Disabilities: A Team Approach to Diagnosis and Prescription

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This article holds that the basis for the thorough diagnosis and successful educational prescriptive remediation for the learning disabled child is to be found in the process of interdisciplinary teaming. There is wide diversity of opinion among professionals involved in the field of childhood learning disabilities as to the accurate boundaries and definitions of the terms. Myklebust defines "psychoneurological learning disorders to include deficits in learning, at any age, which are caused by deviations in the central nervous system and which are not due to mental deficiency, sensory impairment, or psychogenicity" (7).

Kirk's definition goes somewhat further suggesting that a learning disability refers to a retardation, disorder, or delayed development in one or more of the processes of speech, language, reading, spelling, writing, or arithmetic resulting from a possible cerebral dysfunction and/or emotional or behavioral disturbance and not from mental retardation, sensory deprivation, or cultural or instructional factors (6).

The author of this article has added minimal brain dysfunction with hyperactivity or autistic qualities; primary emotional disorders; cultural deprivation; and emotional, educational, and developmental immaturity to the causative factors (2). The true definition very likely lies somewhere within these varied interpretations of the term and the disorder. What becomes increasingly clear to the practitioner in the field of learning disorders is that the need for definitions becomes obsolete when a task-oriented, interdisciplinary, multiprofessional team assesses the individual child who suffers from an obstructed educational pathway.

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Diagnosing the etiological basis of the individual child’s learning disability has created yet another major controversy among the professionals responsible for the development of remedial learning prescriptions. There is a justifiable cry against “labeling” a specific child with an adynamic and unchanging singular diagnosis which will permanently “brand” his or her educational records. The labeling early in the child’s educational career does not, in any way, take into consideration the dynamic nature of every child’s intellectual growth and development during the evolutionary educational years. Without constant reassessment, the label given years before will become as obsolete and useless as will the same continued educational approach to the child.

**Danger in “Labeling”**

However, a resolute and total disregard toward any attempt at making specific diagnoses relative to the individual child’s strengths and weaknesses leaves the educator in the midst of a forest of educational symptoms without any map or compass to help the teacher guide the LD child in the right direction. It must be known where the child’s problems lie and to what severity they are hampering his or her education before a rational and sane attempt can be made to program a remedial educational program for that particular child. Therefore, the diagnostic process must culminate in a definitive profile of the specific child’s educational strengths and weaknesses (1). These need not be permanent “labels” but those educational and behavioral qualities which are felt to be integral to the child’s learning disorder. The ability of the task-oriented interdisciplinary team to clearly define these specific strengths and weaknesses will overcome any controversy about “labeling” because each child will be evaluated as a separate entity, assessed by the many faceted professional views of the I/D team.

A major consideration in the diagnostic evaluation of the child with learning problems is the discovery by many investigators, including the author of the article, that the learning disabled child often has more than one significant etiologic cause for his or her educational handicap. In a recent study, done by the Behavior and Learning Interdisciplinary Team which the author directs at the University of Maryland Hospital, of children found to possess minimal brain dysfunction with hyperactivity as the primary basis for their inability to learn at the time of referral, 81 percent were also found to possess serious perceptual or processing problems which would seriously hamper learning once the random dysactivity was brought under control by appropriate drug therapy. In addition, 34 percent of these children were found to have communication disorders and 22 percent were found to have significant additional medical problems.

Those youngsters possessing perceptual-processing problems as the major educational weakness at the time of referral constituted 11.4 percent of the total sample (n=132). These children were noted in...
addition to suffer from emotional problems (21 percent); MBD (minimal brain dysfunction) with hyperactivity (21 percent); and communication problems (21 percent). By team analysis, 29 percent had evidence of some degree of minimal to moderate mental retardation (5). Thus there is an urgency to carefully separate the specific and definitive educational weaknesses as distinct etiologic entities before a rational and accurate educational prescription can be written for the learning disabled child.

Thus the pressing need to circumvent the controversy over the varied definitions of LD, the requirement to focus on the individual child’s strengths and weaknesses, and the complexity and multiplicity of diagnoses in LD children creates the appropriate background for the task-oriented, multiprofessional, interdisciplinary team approach to learning disabilities. This is the basis of the University of Maryland Hospital’s Behavior and Learning Interdisciplinary Team, funded for five years via Title VI through a grant from the Special Education Division, State of Maryland Department of Education (3). This project will be totally absorbed by the local school system after this final year of funding. Gradual absorption has occurred over the past three years.

The team consists of the following professionals who may be hired and funded through the local school system, special state and federal grant monies, the supporting hospital, or the local health department (school health division): the school nurse; the school physician (who may be specially trained in the area of behavior and learning or a regularly assigned school physician who is clinically alert to the latest advances in behavioral and educational pediatrics); the diagnostic and prescriptive educator; the psychologist; the communications specialist; and the social worker.

Also on each child’s “team” are his or her teacher, guidance counselor, and principal where available. Consultations with the child psychiatrist or neurologist are accessible though infrequently felt to be necessary by the group. The “team” is by no means a medical model; nor is it an educational, psychiatric, or social work model. It is an interdisciplinary team model in which each member works assiduously to put together parts of the learning disorder puzzle presented by the individual child. The process is one in which the team functioning together writes a practical, thorough, and meaningful educational prescription for each child.

A Flexible Team Approach

The interdisciplinary team has worked on-site in 18 elementary schools in the region surrounding the University of Maryland Hospital. Services are offered to the selected schools on a bi-weekly basis. Complex cases are referred by the team to be seen once weekly in a specially organized “team” clinic within the Hospital’s Pediatric ambulatory area. There they are fully reassessed and conferenced by all of the team’s professionals plus consultant supervisors. Only about 10 percent of the children require work-up and conferencing within the special hospital clinic. The remaining 90 percent are thoroughly investigated and conferenced by the team within the school environment where the educational prescription is discussed, written, and implemented on site.

The educational prescription may be singular or multifaceted in the team approach to the child’s problems. Any one member of the team or a combination of the team’s professionals may become responsible for the implementation and monitoring of the specific team suggestions which emanate from the individual child conference. Re-evaluation and reassessment of diagnosis and child progress are undertaken by the team on a regular basis (usually every three to six months) so that dynamic alteration in the child’s educational and emotional responses to his or her changing environment can be incorporated into the ongoing prescriptive process. Such teaming has resulted in positive responses from the educational system which it assists as well as positive results from the children whom it serves.

During one year (1971), 52 percent of those LD children serviced by the interdis-
ciplinary team demonstrated observable educational improvement (4). During 1973, 91.4 percent of those children who received drug therapy for hyperactivity after careful assessment by the team demonstrated positive responses as measured by parent-teacher interviews (5). Both the author's interdisciplinary team activity and the similar interdisciplinary school health team of Dr. Philip Nader in the Rochester, New York, area (8) resulted in increased teacher referral, shortened referral-diagnostic time for each child, plus improved student performance. The best medication found for most of the youngsters seen by the University of Maryland Interdisciplinary Team has been "success." Children can move forward from success; continual failure has an unmistakably paralyzing effect on the child.

**Much Depends Upon the Classroom**

Not all of the recommendations for educational and emotional remediation can be accomplished by the "team" itself. Much therapy must occur within the classroom. Here the diagnostic and prescriptive teacher and the communications specialist assist the classroom and resource room teacher in constructing and implementing practical and remedial programs for the individual child. Nurse-doctor-teacher conferences are designed to inform the teacher about the organic nature of the child's problem. Much in-service training has been accomplished while the team has functioned on-site within the schools.

This teacher training has included earlier child identification, appropriate assessment of test measurements, specific prescriptive techniques, new methods of expanding communication skills, and appreciation of the positive and negative aspects of drugs for hyperactivity and behavior modification for learning deficiencies. Outside resources for the emotionally disturbed child, the physically handicapped child, the sensory impaired child, and the severely perceptually disabled child must often be located and programmed for the more serious LD problem. Where these resources are not readily available, the on-site interdisciplinary team may serve as an active catalyst to assist the local school system in acquiring the necessary outside professional help.

The University of Maryland I/D Team has replaced the traditional school health-school physician model and the fragmented, periodic LEA supported professional services of social worker, speech therapist, and psychologist which have until this time functioned with inconsistent success in our national school scene. In the model described here, there is a union of all professionals—an interdigitation of available professional skills and languages to form an I/D team which works primarily on-site to remedy the outstanding elementary school health problem, the serious learning disorders of childhood. The interdisciplinary task oriented team mechanism may be the first step toward a comprehensive successful approach to the yet unsolved dilemma of the handicapped child in our educational society.

**References**


