You will soon be seeing the new logo on all our correspondence, publications, and materials as well as on our web site.

And we are "stepping out." For the first time in AET's history our national conference will take place outside of California. The 24th Annual Conference of the Association of Educational Therapists will be held in Chicago on October 18–20, 2002. Chicago is home to Chicago pizza and the Blues, the Magnificent Mile, and world-class museums. It promises to be quite a time!

NEEDING GROWN-UPS

In closing, today, perhaps more than ever before, the world needs grown-ups, especially grown-ups who value understanding, cooperation, and acceptance of difference. Educational therapists are committed to these values. AET members are the trailblazers, the leaders of the profession. Your membership in AET demonstrates your commitment to increasing your professional knowledge and your appreciation of the community that AET creates. We draw strength from each other. It is through sharing and mutual support that we build a distinguished profession and a better world.

Educational Therapy

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Educational Therapy is the clinical arm of special education. It is the process of evaluation, intervention, and remediation of learning problems. (Directory of Occupational Titles, 1977) The educational therapist serves a population that comprises young children, adolescents, and adults, and includes those who demonstrate dyslexia, test anxiety, reading/writing/language/math problems, Attention-deficit Hyperactivity Disorder, and other problems affecting school performance.

Educational Therapists are skilled practitioners who have pedagogic and experiential training that has been extensive enough to ensure the development of 1) a theoretical base in human development, psychology and learning theory; 2) competency in the understanding and facilitating of assessment, remediation, interviewing, interpersonal and interprofessional communication, advocacy, and psychoeducational intervention; and 3) exposure to the realities and politics of schools, curricula, and educational bureaucracies.

Generally, this is a master's level field with continuing education needed because of the ongoing development of the field. The therapist works in the educational domain (private practice, schools, hospitals, or public agencies) and is skilled in the following areas:

1) administering and/or interpreting formal and informal educational assessment;
2) synthesizing information from other specialists and from parents as a case manager;
3) developing and implementing appropriate remedial programs for school-related learning and behavior problems within the school setting;
4) forming supportive relationships with students and with those involved in their educational development and rehabilitation;
5) applying strategies for addressing social and emotional aspects of learning disabilities outside of school;
6) facilitating communication between the individual, the family, the school, and involved professionals.

While the main emphasis is on individual therapy, the profession is not limited to therapists who work with individual students, but includes those who

work with groups, such as resource specialists[1] and special education teachers in the school system. Unique to the field is the emphasis on psychoeducational intervention, defined as: "Any intervention or coming between that fosters and enables the acting, thinking, and feeling necessary for learning to take place (Ungerleider, 1991)."

Individuals who enter into educational therapy are often being seen concurrently by other specialists. Often the primary physician makes the original referral to a neurologist, psychiatrist, or clinical psychologist. Subsequent intervention by a speech and language therapist, educational psychologist, or guidance counselor is common. The educational therapist prioritizes and coordinates the interventions and clarifies the needs of the client.

TYPICAL CASES

There are several situations in which psychoeducational intervention is indicated:

I. Learning-disabled children with deficits in language/auditory/visual processing and/or memory deficits, which interfere with academic achievement. [2, 3, 4]

Barry was a 9-year-old boy functioning at least 2 years behind his 4th grade class in reading and math. He had an above average IQ, but significant visual and auditory processing deficits, as well as poor fine-motor coordination.[5] He always forgot to bring home his assignments and had difficulty with long-term assignments, such as book reports.

Over a two-year period, Barry was seen twice weekly. Sessions consisted of specific reading exercises, identifying the main idea, and oral reading. Barry was asked to begin reading a book at home, and a home reading log was designed to follow up his work. Mom was instructed to daily check the log and reward Barry with a star for appropriate reading. A weekly reward was issued for completion of this task. The therapist followed up the reading with contextual clues[6] and summary work[7] in the sessions. The therapist gave Barry a monthly calendar to be used for long-term assignments. The therapist encouraged Barry to do as much work as possible on the family computer, while also working in the sessions on his handwriting. As a result Barry began to turn in neat, legible papers and was praised by his teacher.

The treatment plan included parent counseling and coordination between parents and teachers. On a weekly basis the therapist would speak to the teacher and then give feedback to the parents. Such communication facilitated the accomplishment of common goals. The parents began to see the teacher as an ally, not an enemy. Barry improved his reading and math skills, developed compensatory strategies for his deficits, and learned how to structure his time so that his assignments were completed and handed in on time.

II. Children with Attention-deficit Hyperactivity Disorder whose inability to focus makes them unable to achieve age-appropriate academic performance.

Bobby made his first grade teacher throw up her hands in despair. He was obviously bright but he was constantly asking questions and volunteering information without raising his hand. During reading, he was easily distracted by noise, movement, or other children. He played with his pencil, looked around, spoke to others, and generally missed the lesson being presented.

Bobby was seen twice weekly during the summer and weekly during the school year. In addition, Bobby was referred for an ADHD evaluation by a pediatric neurologist, who began treatment with Ritalin. The referral was preceded by two sessions with the parents to help them overcome their fears of "drugging" their son. They refused a referral until the therapist gave them articles about the efficacy of the medication and Bobby's prognosis with its use. There was a four-month interval between these two sessions, as the parents were convinced he would improve without this intervention. The therapist coordinated their visit with the medical doctor, to whom they sent relevant observations on the child before their visit.

The educational therapist held monthly school meetings with the teacher and counselor to ameliorate any problem areas. A home visit was conducted to teach the parents how to deal with homework problems. At the house, the therapist explained the necessity of a large clean desk, proper lighting, a quiet study area, and a regular study time. This helped the student complete his assignments in a timely fashion.

At the end of the second grade, Bobby was on grade level and able to complete his work without any special help. His self-image had improved and he had developed a positive attitude toward school. In addition, his parents were pleased with the changes made by medication and were less anxious about this treatment.

III. Children who could function well in many school settings but who are attending a school that is inappropriate for their needs and talents

John's parents had enrolled him in the same private school his siblings attended. "This is our school. We have contributed financially and emotionally and expect him to succeed," said his physician father.

At the outset, John did not fit into the very structured, fast-paced academic atmosphere. He was struggling, even at the bottom of his first grade class. Informal evaluation of John's skills, weekly educational therapy sessions from September to November, and consultation with school personnel yielded data indicating some changes had to be made. From the school's point of view, the student was taking too much teacher time and could not keep up with the work.

When asked, John readily admitted to disliking school because "the work is hard, the teacher yells, and I am bored." John's parents met with the educational therapist, who advised a school change and promised to help them select the most appropriate school. The parents were encouraged to deal with their disappointment in John's inability to fit in and to focus on his very many good qualities. The therapist visited and evaluated several appropriate alternative schools and made recommendations. John made a good adjustment to the 2nd grade in a less structured, more humanistic neighborhood school.[8]

IV. Slow learners whose need for extra help with academic subjects is not met by the school.

Billy had a low average IQ and a severe auditory processing deficit. He was a pleasant, quiet boy from a high-achieving family. In the fifth grade, he was reading and writing at about the second grade level. His parents were very concerned about his future vocational opportunities.

During a two-year period Billy was tutored in academic subjects and word processing skills. Goals were set that would enable Billy to function independently once he left school. With the use of the computer, Billy learned to compose letters, use a spell checker, and touch-type. The therapist met with his parents to outline realistic job situations and the needed skills he had to have at this point in his academic career. For example, he was taught to use a calculator and a Franklin Speller[9] so that he could be more independent and correct in his math computations and spelling.

Billy continued to need supportive intervention throughout his high school career. He was in a program at school where he met in a separate room with a resource specialist for one hour per day. Upon graduation, he enrolled in a learning disabilities program[10] at a local community college. Throughout this process, the therapist facilitated communication between Billy, his support personnel, and his family.

V. Children who fail to achieve their academic potential because of poor organizational skills or poor study habits.

Josh was a bright boy in the tenth grade whose backpack, notebooks, and room were in disarray. He complained that his parents were forever planning dinners or family events that interfered with his studies or took place when he had work due at school. He never read a book in the scheduled time and usually turned in assignments late. His room contained a radio, a television, a VCR, a telephone, and a guitar—all of which were used at times while he was studying.

Josh was seen weekly for a year, with emphasis on organizational skills. He was taught to keep a weekly calendar, plan out study in advance of tests, and keep a record of time spent daily doing work. He learned to take responsibility for his own work. A home visit[11] and consultation with his parents resulted in the removal of the TV and telephone from his room.[12] A behavior modification chart with reward system was set up on a weekly basis with the family, the student, and the school. This provided clear, consistent feedback of his work and helped the parents motivate him to get his work in on time rather than being manipulated by him to approve unacceptable behavior. Josh finished the school year with excellent grades and much improved study/organizational skills.

VI. Children whose dysfunctional families are unable to provide the support and guidance for learning.

Janice was a fifteen-year-old high school student with a history of average school grades. Her parents were concerned about her college plans. Janice's father was an alcoholic who worked long hours and then isolated himself in his study. Her mother was depressed and contemplated separation from her husband. Neither parent was available on a regular basis to monitor study habits or to help her set goals.

Janice was seen weekly for nine months and encouraged to become more responsible for her own actions. The first few sessions were centered on her identifying appropriate colleges, sending for information, and analyzing her own preferences for type of school. She identified three schools in the immediate area that she could visit to compare their size and facilities. A joint session was held with her parents and the therapist so that Janice could discuss the financial aspect of college with them. The therapist also held individual sessions with each parent, recommending marital counseling to them both as well as an AA program for the father and an Alanon program for the mother. Throughout the therapy, the therapist monitored Janice's grades and college testing needs.

Upon graduation from high school, Janice enrolled in college and eagerly looked forward to living in a dorm. The therapist remained an ally during her parents'

subsequent divorce, and helped Janice make a good college adjustment.

VII. Children who are inadequately motivated to achieve academically

Bill was a fifth grade student referred by his private school because of poor performance. His family was extremely wealthy and his parents were not well educated. Bill was seen weekly for nine months. His parents were seen additionally in counseling sessions regarding their role in motivating Bill. They had been giving him the message that upon graduation he would take over their successful air conditioning business. It was pointed out to them that, if in fact he did take over the business, he would need adequate math and reading/writing skills to run the business. They were resistant at the beginning but after several months began to see Bill's needs. Once their message to Bill began to change, he became more accessible to remedial work. The therapist taught him more efficient ways to do calculations and helped him memorize his times tables. In the area of writing, he was taught how to write a power paragraph[13] and how to proofread his work. He began to work on his computer and found that this facilitated his ability to edit his work.

By reading athletes' biographies and the newspaper sports page, Bill began to get more comfortable with reading. The next step was to limit his free choice reading to every other book, with the therapist or teacher supplying the alternate books so he read a variety of material. The therapist also worked with the classroom teacher to make Bill a peer tutor to a first grade student. This improved his self-esteem. After nine months of therapy Bill was eagerly looking forward to a summer program where he would be helping other children with their reading. His basic skills were much improved.

VIII. Children whose parents have not given them the structure and support needed for academic achievement.

Allan was a bright boy in the second grade at a liberal, fairly unstructured private day school. His mother had attended parochial schools, which she thought were too rigid. She wanted her son's education to be more individualized. The school was concerned that his moderate visual perceptual problems might interfere with his learning. Assignments were rarely completed at home, and Allan was frequently absent from school.

Allan was seen twice weekly to strengthen his visual perceptual skills. Materials that helped him with visual discrimination, letter identification, figure/ground work and mazes were used. Allan was encouraged to keep a copy-book, where he did daily copying exercises to help his writing become more automatic. In addition, mother and father were instructed to read to Allan on a daily basis. They were to use material that was interesting but too difficult for Allan to read himself in order to stimulate his interest in reading. Weekly consultations were held with his mother to help her understand limit-setting and structure with relation to the educational process. It was explained to her that students behave in school generally as they do at home, so he needed a consistent approach in order to succeed at school.

Through parent education, appropriate student activities, and teacher/therapist/parent coordination, Allan made great gains in internalizing structure and organization and began to function better in school.

IX. Children who have not learned to be independent learners owing to overprotective parents

Susan was experiencing moderate school problems in the sixth grade. Her mother sat next to her at home while she did all her assignments. In addition, Susan was not allowed to participate in after-school activities. Initially, in reporting on Susan's work to the therapist the mother would state, for example, "We didn't finish our book report this week."

After several consultations with the mother, a home visit was conducted by the therapist to model behavior for mother while Susan was doing her work. At first, mother would go over work plans with Susan and be available to help. After several weeks, she was able to let Susan plan her own work schedule and ask for help if needed. The teacher was made aware of this change so that the work in this transition period could be monitored. Mother became less anxious as Susan proved her ability. The family was encouraged to allow Susan one after-school activity as long as her homework was completed. The therapist shifted the focus to remediating specific reading and math areas of weakness. In reading, work was done on answering inferential questions[14] and identifying main idea. In math, Susan was given extra help with word problems, starting with easy one-step problems to give her confidence as she attacked more difficult problems.

Susan gradually improved her school performance. However, the therapist felt that the parents were continuing to have difficulty letting their only child become independent. They refused, however, the recommendation for conjoint psychotherapy. Therapy was terminated with the issue of separation only partly resolved.

Professional Parameters

In educational therapy, the goals and objectives of the therapist must reflect the client's long-term needs. These needs must be realistic for the client's cognitive/social/emotional potential. Such needs are at times in

conflict with the wishes of the parents. Following evaluation of the learning problems and current concerns, the therapist formulates goals with the client and parents or other involved family members. There are usually short-term and long-term goals, which need to be reevaluated on a regular basis. It is not uncommon for changes in goals to take place because new information originally withheld by the family is revealed. There also are changes in current school situations as a result of medical evaluations or psychoeducational testing.

As a professional, the educational therapist has unique training and expertise in the treatment of individuals with learning disabilities and learning difficulties. Frequently, there are consultations and cross-referrals between them and professionals in related fields. Not uncommonly, clients are seen concurrently by an educational therapist and another professional, most frequently a speech and language therapist, educational psychologist, guidance counselor, clinical psychologist, or psychiatrist.

In general, most educational therapists see clients in an office or in a school setting. Their equipment consists of assessment materials; reading/math/language/writing books and workbooks; games—educational, therapeutic and social; electronics—calculators, computers… and tactile/kinesthetic/art supplies.

There are no absolute contraindications to educational therapy. Candidates first need to be adequately evaluated so that the appropriateness of this treatment can be ascertained. Because these children often have multiple and complex problems, treatments need to be prioritized to determine whether educational therapy is indicated. It is most important that the therapist be aware of when and how to refer to other professionals. A thorough intake with both parents, if possible, and an initial few sessions with the child provide information so that the therapist can begin a course of treatment or immediately refer to another professional. For example, this would rule out any eye, ear, neurological or speech problems that might be interfering with learning. In addition, the therapist must confer with the teacher and other professionals working on the case. It is very helpful for the therapist to have a referral network in place so that recommendations can be made appropriately. In addition, as the case progresses, issues come up and goals sometimes need to be changed. It is not uncommon to refer to psychotherapists, psychiatrists, neurologists, speech and language therapists, and educational psychologists after having worked for some time with the child. Risks to the client are minimal in this type of non-invasive therapy.

Sue was a fourteen-year-old girl who had a history of learning problems. She had been in educational therapy for three years, making good gains in her basic skills. Her performance reached a plateau and further progress seemed difficult. During a course of psychotherapy, the girl revealed that her mother was suicidal and was using Sue as a sounding board for her unhappiness. The girl could not concentrate on her school work until she was able to separate from her mother's anxieties. Consequently, the mother, not Sue, became the psychotherapy patient and Sue began to make continued progress in educational therapy.

Bill was in the sixth grade and very resistant to educational therapy and general school work. He was cognitively able and had no other apparent deficits. His teachers reported that he did not put out any effort in daily assignments. Parents were cooperative but had no ideas as to how to change his attitude. The therapist used materials related to sports and rock stars that he liked, played games such as scrabble, and used the computer to write stories. None of these were effective tools. As his behavior at home became more belligerent, the family was referred to a psychologist. During the course of therapy the parents revealed their feelings of inadequacy regarding school work. Neither had gone to college and both were afraid their son would be ashamed of them if he were a college graduate. They had been giving him an unconscious message not to succeed in school work. Only after working through their own feelings of inadequacy were they able to be effective parents and motivate their son toward learning.

Measures of clinical progress are not standardized and tend often to be anecdotal. There are educational therapists who do pre- and posttests of basic school subjects on an annual basis. Usually, a combination of tests, school reports (formal and informal), student feedback, and parent reports serves as the basis of ascertaining clinical progress.

Sessions are generally fifty to sixty minutes in duration, once or twice a week. There is no standard duration of therapy. In general, clients remain in treatment one to two years. There are cases where brief intervention is satisfactory and others where prolonged support during school years is necessary. Termination, ideally, takes place with consent of the client, family, and therapist. There are, of course, premature terminations due to financial limitations, family relocations, or family pathology, or when the therapist's style or personality does not fit the client or the family.

For the most part, educational therapy is currently available primarily to those clients who can pay private practice fees. Insurance reimbursement is sometimes available, especially for cases that have been

medically diagnosed as Attention-deficit Hyperactivity Disorder. There are limited one-to-one services available for the poor through volunteer programs and school special education programs.

Ethically, educational therapists operate under guidelines similar to those established by other helping professions. These include integrity and competence, commitment to clients, validation of ethical practice, and collaboration with other professionals.

There have been no scientific studies measuring the outcome of this treatment modality. This is due in part to the newness of the field and to the multiple intervention techniques. There have been, however, studies of the efficacy of various individual treatment techniques such as behavioral intervention, sensory integration techniques, biofeedback, metacognitive strategies, the effects of colored filters on reading, and memory tools.

The future of educational therapy depends upon improved and clarified training programs, research on the efficacy of techniques, (Johnston, 1984), and the growing acceptance of this treatment model by the professional community and the public. With advances in modern science and technology, more precise knowledge of brain functioning should provide the educational therapist with increasingly effective diagnostic and remedial tools. While the efficacy of the field continues to grow, the widespread availability of the modality is hampered by the current move toward reduced insurance payments and HMOs that do not offer these services.

Currently, we are seeing more babies born with psychological handicaps and learning disabilities caused by their mothers' abuse of drugs and alcohol. In addition, public funding for school programs in special education is constantly being reduced. This means that students will receive less remedial work in school and need more work with therapists outside of the classroom. An expanded collaborative role and continued multidisciplinary training should assure the educational therapist a unique role in helping the various professionals committed to the evaluation and remediation of individuals with learning disabilities.

References

Code of Ethics. (1985). Burbank, CA*:* Association of Educational Therapists.

Directory of Occupational Titles. (1977). Washington, D.C.: U. S. Department of Labor.

Johnston, C.L. (1984). Educational therapy: Past perspectives, current practices and a proposal for change. *Journal of Learning Disabilities*, *17*(4):200–204.

Ungerleider, D. (1991). Psychoeducational perspectives. Burbank, CA: *Association of Educational Therapists*.

Notes

[1] Special education teachers who work temporarily with a small group of children outside the regular classroom.

[2] Auditory perceptual problems are difficulties in understanding what is heard despite normal hearing.

[3] Visual perceptual problems are difficulties in interpreting what is seen.

[4] Processing disorders are difficulties in extracting meaningful information from sensory impressions.

[5] Fine-muscle control of the fingers and hands is crucial in successful written work.

[6] The reader learns to use clues in the sentence to help figure out the meaning of new words.

[7] "Summary" means being able to complete a sentence such as "The story is about.." with a brief statement.

[8] Humanistic neighborhood schools stress the visual arts, have little or no homework, and place little emphasis on grades.

[9] A Franklin Speller is an electronic hand-held dictionary and thesaurus.

[10] Many colleges and universities provide counseling and tutorial help to individuals who have been diagnosed as learning disabled.

[11] Because the student is expected to do a good deal of work at home, the therapist needs to see what the work environment is like, and suggest changes if needed.

[12] Parents often need guidance on the appropriateness of distractors in their children's rooms.

[13] In a power paragraph the first sentence contains the main idea, the next two or three are supporting details and the final sentence is a conclusion.

[14] Inferential information is not directly stated in the story. The reader must learn to pick out relevant clues and infer data.

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