Brief Note


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Inadequate support and neglect of children with developmental disabilities often engenders "secondary symptoms", such as school non-attendance, withdrawal, and criminal acts. Through a questionnaire survey of resource rooms in elementary and lower secondary schools in the Tokyo metropolitan area, the present study assessed the actual conditions that students with developmental disabilities confront, focusing on maladjustment problems of and problems of educational support for students with mild developmental disabilities. The survey results revealed many possible reasons for these students' school maladjustment. Suggestions for improvement were also described. Furthermore, the results revealed that cooperation among guardians, schools, resource rooms, counseling organizations, and medical institutions is extremely insufficient. It is strongly urged that schools and related organizations promote guardians' understanding of their children's disabilities.

Key Words: school maladjustment, resource rooms for students with emotional disturbances, Tokyo metropolitan area, students with mild developmental disabilities

Introduction

The Ministry of Education, Culture, Sports, Science and Technology (2003) raised the following issues as "problems newly indicated in relation to school non-attendance" in its "Concerning the Ways of Support for School Non-attendance in the Future (report)" released in 2003:

Some point out that there are many cases in which schoolchildren and pupils with learning disabilities (LD), attention deficit hyperactivity disorders (ADHD), and so on come to refuse to go to school as a result from which the
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following conditions get worse: Unable to develop personal relationships with surrounding people, or unable to overcome failures at learning.

Although school non-attendance is often considered as a rational decision such as "I want to go to school, but I cannot", causes of school non-attendance include truancy attributable to thrill-seeking and/or delinquency, maladjustment because of LD and ADHD, illness, and cruelty. Therefore, measures for school non-attendance must be taken in consideration of those diverse actual conditions.

With such indications, recent studies of developmental disabilities have begun to point out that inadequate support and neglect of children with developmental disabilities often engender various types of maladjustment problems, related to extreme difficulties of adjustment in human relations and social behaviors other than school non-attendance, such as withdrawal, psychoneurotic symptoms (apathy, depression, schizophrenia-like states, dissociative disorders, and obsessive-compulsive disorders), bullying and being abused, violent outbursts, delinquency, conduct disorders, and criminal acts. Nonetheless, empirical studies of the actual maladjustment problems at school of children with developmental disabilities remain in a state of stagnated infancy.

Studies of the relationship of developmental disabilities and maladjustment are increasingly drawing attention in the field of medicine as well. Sugiyama (2000) points out the following: (1) Support in education is insufficient: teachers do not provide appropriate support because of a lack of knowledge, creating a vicious cycle of inspiring resentment of the problematic behaviors of children with mild developmental disabilities, and consequently, (2) secondary reactive emotional problems and psychiatric problems supervene.

Koeda (2002, 2003) states that "many children with learning disabilities who visit pediatric outpatient clinics have complications of psychosomatic disorders or refuse to go to school". He indicates the following points: (1) Although academic underachievement caused by cognitive disorders is the primary problem for children with learning disabilities, secondary problems such as school-maladjustment become the chief concern in the higher grades of elementary school and afterwards. (2) There are psychogenic reactions resulting from low self-esteem and a lack of a feeling of accomplishment because of not being rewarded no matter how hard they work. (3) Such secondary maladjustment occurs at a high rate in children with developmental disabilities; in particular, school non-attendance rapidly increases around the time of promotion to middle school.

In addition, the following are reported from the field of medicine: "Approximately 10% of children diagnosed as AD/HD — refuse to go to school in adolescence" (Ichikawa, 2004). "An examination of concurrent diseases in 354 children with high-functioning pervasive developmental disorders revealed that, of them, 33 children (9.3%) refused to go to school" (Sugiyama & Kawabe, 2004).
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In the field of clinical psychology, Aizawa (2004) describes the present situation through clinical examinations of school non-attendance and withdrawal as follows: A lack of understanding of high-functioning pervasive developmental disorders affects the modes of welfare support. Despite difficulties in their lives, people with high-functioning pervasive developmental disorders are not eligible for welfare support that is provided to other persons with disabilities. Aizawa (2004) also lists the following points and explains the necessity of expanding and developing special classes for children with maladjustment for the improvement of school non-attendance and withdrawal: Adjustment guidance class users throughout Japan comprise only about 10% of all schoolchildren and pupils who refuse to go to school; few counseling staff members are experts in developmental disabilities; and special classes for children with maladjustment are available only for students who are in compulsory education.

Also in the area of forensic clinical psychology, through case examples in the family court medical office system, there is an indication that many criminal cases involving juveniles with high functional autism are managed with no problem because of the invisible nature of their disorder (Sakihama, 2004). Fujikawa (2007) describes the results of an epidemiological investigation conducted in the Tokyo Family Court in 2004 as follows: Persons suspected of having pervasive developmental disorders, ADHD, and intellectual disabilities were selected from among 862 persons whom an investigator interviewed. Of them, persons who had been diagnosed or suspected of having pervasive developmental disorders were 24 cases (3%). This value is two to four times greater than the commonly believed incidence rate of pervasive developmental disorders (0.6–1.2%) in the general population. According to Toichi and Sakihama (2002), criminal acts committed by persons with pervasive developmental disorders reflect the characteristics of the disorders in the style of their crimes, but the disorders themselves are not necessarily the cause of their criminal acts. Toichi and Sakihama (2002) provide some case examples that suggest that stress caused by secondary disabilities, such as isolation and alienation, became a cause of those individuals’ delinquency.

As described above, it has been increasingly pointed out that inadequate support and neglect of children with developmental disabilities often causes secondary symptoms (niji shojo), such as school non-attendance, withdrawal, and criminal acts (Sugiyama, 2005, 2007; Toichi (2004) describes them as secondary disorders (niji saigai). However, the number of studies in school education that have dealt with children with developmental disabilities and their problems of maladjustment is highly insufficient. When developmental disabilities are taken up as a topic in school education, problems of a failure of learning and human relations tend to be centrally addressed. Nonetheless, empirical studies of maladjustment problems that children with developmental disabilities confront have barely and only slowly begun to be done (Takahashi, Uchino, & Tanita, 2007).
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Method

Information for the present study was obtained by a questionnaire survey of the teachers of resource rooms in elementary and lower secondary schools in the Tokyo metropolitan area. The instrument focused on maladjustment problems of students with mild developmental disabilities (including LD, ADHD, Asperger syndrome, high functional autism, mild intellectual disabilities, and other overlapping or adjacent disabilities). The present study was designed to examine actual adjustment difficulties and needs that such students face in their school life, and to elucidate problems of educational support for them.

Students' maladjustment was defined as pronounced adjustment difficulties in human relations and social behavior, such as school non-attendance, withdrawal, psychoneurotic symptoms (apathy, depression, schizophrenia-like state, dissociative disorders, and obsessive-compulsive disorders), bullying and being abused, violent outbursts, delinquency, conduct disorders, and criminal acts. To make the concept of maladjustment easier for the respondents to understand, we included a case example of maladjustment in the questionnaire (see Table 1).

The questionnaire was sent to teachers of 125 resource rooms (81 in elementary schools and 44 in lower secondary schools) for students with emotional disabilities in elementary and lower secondary schools in the Tokyo metropolitan area. The survey forms were mailed, and teachers responsible for those classes were asked to fill them out and return them.

The questionnaire consisted of the following questions: (1) General descriptions of the students with mild developmental disabilities in the resource room, including grade, gender, frequency of attending class per week, number of teaching hours per week, diagnosis, name of the medical institution or counseling organization that did the diagnosis (or the class’s perspective if there had been no formal diagnosis), and intelligence test scores. (2) Individual survey forms were completed on students who exhibited pronounced maladjustment, such as episodes of maladjustment in school, support from the classroom teacher; episodes of maladjustment at home and support from guardians; episodes of maladjustment in the resource room and support from the teacher responsible for the resource room; improvements that result from the support of the resource room teacher, and points showing no improvement because of difficulties; support needed in resource rooms in the future for students with maladjustment; and cooperation with medical institutions and counseling organizations.

The survey period was August 25 to September 31, 2005. We received responses from 52 resource rooms (38 in elementary schools and 14 in lower secondary schools). That is, the return rate was 42%.

The present study focused on resource classes in the Tokyo metropolitan area because the unit of special support services in resource rooms in the national standard is a “resource room”; the standard of allocation of teaching staff is not
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<table>
<thead>
<tr>
<th>TABLE 1 Case Example of Maladjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having a tendency to refuse to go to school, starting in a higher grade of elementary school, A began to go to a resource room twice a week in the middle of the eighth grade. Before going to the resource room, A attended school but then went to the school nurse’s office, avoiding attending class during the first class in the morning, and then after that, went home. A spent almost all day at home. The staff of the school at which A was enrolled, however, thought that there was nothing they could do. By that time, A had been examined at three hospitals and had been diagnosed as having LD and autism. The third hospital mentioned the possibility of schizophrenia as well. A’s older brother was also in a condition of withdrawal through school non-attendance. When A first went to the resource class, A avoided eye contact when being talked to, and answered with only one word in a low voice. A’s mother, who was very protective of A, took care of A by treating A like a young child, which gave the impression of a weak nurturing power in A’s family. In the resource room, A avoided textbook learning. A had taken only a few lessons starting from the middle of elementary school. In addition, because A was going to school at around 9:30 AM and going home by 11:00 AM, A could scarcely interact with the other resource class children. Within about three months, A came to look at picture books and draw illustrations of creatures that were of interest. Later, A also started to play card games with the other pupils in small group activities. Even so, the time spent in the resource class did not increase, and A was only working on textbook learning only a little. Subsequently, A was promoted to the high school division of a school for children with disabilities who had an IQ score greater than 80.</td>
</tr>
</tbody>
</table>

clarified. On the other hand, in the Tokyo metropolitan government, resource room have a standard for the allocation of teaching staff, and the metropolitan government has numerous support achievements related to students with developmental disabilities.

Results

Description of the Students Enrolled in the Responding Resource Rooms

The number of students enrolled in 52 resource rooms at the 51 responding elementary and lower secondary schools was 1,094: 952 in the elementary school rooms (87%), and 142 in the lower secondary school rooms (13%). Table 2 summarizes those students by gender and disability. By disorder, Asperger syndrome and high functional autism was the most common diagnosis (387 students, 35%), followed by ADHD (176 students, 16%), intellectual disabilities (87 students, 8%), LD (86 students, 8%), and other pervasive developmental disorders (PDD; 74 students, 7%). Of 91 students categorized as “other”, 35 (8%) were suspected of having neuropsychiatric disabilities, such as neurosis, emotional anxieties, and anxiety disorders. In addition, some students had been diagnoses as having of Down syndrome, cerebral palsy, physical disabilities, and so on. These responses imply that the resource rooms for emotionally disturbed students are now receiving children with
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**Table 2** Description of the Students Enrolled in the Responding Resource Rooms (N = 1094)

<table>
<thead>
<tr>
<th>Description of the Students</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asperger syndrome and high functional autism</td>
<td>330</td>
<td>57</td>
<td>387 (35%)</td>
</tr>
<tr>
<td>ADHD</td>
<td>156</td>
<td>20</td>
<td>176 (16%)</td>
</tr>
<tr>
<td>Intellectual disabilities</td>
<td>57</td>
<td>30</td>
<td>87 (8%)</td>
</tr>
<tr>
<td>LD</td>
<td>66</td>
<td>20</td>
<td>86 (8%)</td>
</tr>
<tr>
<td>Other pervasive developmental disorders</td>
<td>64</td>
<td>10</td>
<td>74 (7%)</td>
</tr>
<tr>
<td>Other</td>
<td>52</td>
<td>39</td>
<td>91 (8%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>152</td>
<td>41</td>
<td>193 (19%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>877 (80%)</strong></td>
<td><strong>217 (20%)</strong></td>
<td><strong>1094</strong></td>
</tr>
</tbody>
</table>

**Table 3** Summary of Disability and Grade in School of Students who Showed Severe Maladjustment at School

<table>
<thead>
<tr>
<th>Grade</th>
<th>1st &amp; 2nd grade</th>
<th>3rd &amp; 4th grade</th>
<th>5th &amp; 6th grade</th>
<th>Lower secondary school</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asperger syndrome and high functional autism</td>
<td>6</td>
<td>9</td>
<td>17</td>
<td>11</td>
<td>43 (46%)</td>
</tr>
<tr>
<td>ADHD</td>
<td>5</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>24 (26%)</td>
</tr>
<tr>
<td>Other PDD</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>8 (8%)</td>
</tr>
<tr>
<td>LD</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>7 (7%)</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>12 (13%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15 (16%)</strong></td>
<td><strong>25 (27%)</strong></td>
<td><strong>32 (34%)</strong></td>
<td><strong>22 (23%)</strong></td>
<td><strong>94</strong></td>
</tr>
</tbody>
</table>

diverse disabilities and special needs. The ratio of boys to girls was approximately four to one.

**Disability, Grade, and Main Problem of Students who are Maladjusted at School**

Responses were received from 94 teachers of 45 resource rooms in 44 schools (35 in 34 elementary schools and 10 in 10 lower secondary schools) describing students who showed severe maladjustment at school. As the data in Table 3 indicate, Asperger syndrome and high functional autism was the most common diagnosis, with 43 students (46%), followed by 24 students diagnoses as having ADHD (26%), 8 with other pervasive developmental disorders (8%), and 7 students with LD (7%). Of those, 71 students (76%) had had a diagnosis or assessment by a physician. Twelve students (13%) categorized as “Other” mainly had psychoneurotic problems, such as psychosomatic disorders, depressive disorders, schizophrenia, and dissociative disorders. Four of those had had a diagnosis or assessment by a physician.

Of those students, 78 (83%) were boy, and 15 were girls (16%). The number of 5th and 6th grade elementary school children was the largest (32 students, 34%).
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### Table 4: Main Reported Problems of the Students who are Maladjusted at School

<table>
<thead>
<tr>
<th>Problem</th>
<th>LD</th>
<th>ADHD</th>
<th>Asperger syndrome and high functional autism</th>
<th>Other pervasive developmental disorders</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal abuse/violence</td>
<td>3</td>
<td>12</td>
<td>15</td>
<td>4</td>
<td>0</td>
<td>34</td>
</tr>
<tr>
<td>Psychoneurotic symptoms</td>
<td>0</td>
<td>7</td>
<td>13</td>
<td>2</td>
<td>7</td>
<td>29</td>
</tr>
<tr>
<td>School non-attendance/withdrawal</td>
<td>3</td>
<td>1</td>
<td>9</td>
<td>2</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>Bullying/being abused</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Delinquencies/conduct disorders/criminal acts</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>No description</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7</td>
<td>24</td>
<td>43</td>
<td>8</td>
<td>12</td>
<td>94</td>
</tr>
</tbody>
</table>

followed by 3rd and 4th grade elementary school children (25 students; 27%), lower secondary school pupils (22 students; 23%), and 1st and 2nd grade elementary school children (15 students; 16%).

Table 4 is arranged by the main problem and the disability of the students who are maladjusted at school. The most common complaint was verbal abuse and violence (34 students; 36%), followed by psychoneurotic symptoms (29 students; 30%), and school non-attendance and withdrawal (19 students; 20%). These three complaints account for 90% of the total.

In what follows, the main problems of those students who are maladjusted at school and have developmental disabilities are discussed.

**Verbal Abuse and Violence**

In all, 34 pupils were described as engaging in severe verbal abuse and violence against surrounding people. This was the most common main problem reported. Most of these students were boys (32 boys, 2 girls). Case examples were reported from all grades: 10 children in the 1st and 2nd grades of elementary school, 11 children in the 3rd and 4th grades, 8 children in the 5th and 6th grades, and 5 lower secondary school pupils. Asperger syndrome and high functional autism was the most common diagnosis (15 students, 44%), followed by ADHD (12 students, 35%), other pervasive developmental disorders (4 students, 12%), and LD (3 students, 9%).

The triggers that were reported to have led to violence and/or verbal abuse were different, depending on the students’ diagnosis. Reporting about the students with Asperger syndrome and high functional autism, the teachers described 12 out of 15 as having some reason, derived from the characteristics of Asperger syndrome and high functional autism, such as persistence and hyper-sensitivity, for the behavior. For example, “when he fell down while mountain climbing, one boy shouted, ‘The mountain is wrong’, and kept on saying ‘Baka Shine! (Drop dead, Stupid!)’” (2nd
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grade elementary school boy). "When a bit of water splashes on his body, he gets angry" (3rd grade elementary school boy). "He takes criticism or teasing seriously and starts fistfights" (5th grade elementary school boy). "When he loses a game, he lifts one of the desks with a deep feeling of failure" (3rd grade lower secondary school boy).

By contrast, teachers did not have a clear explanation for verbal abuse and/or violence by most of the students with ADHD. They seemed to assume that the occurrence of the maladjusted behaviors was highly accidental, as follows: "He walks around randomly hitting his friends in the class" (1st grade elementary school boy). "He becomes unable to stop shouting and verbally abuses his friends" (4th grade elementary school boy). "There have been many disturbing situations, such as sudden violence" (5th grade elementary school boy).

In the case of students with LD, teachers' comments related to the students' failures or difficulties in learning could lead to verbal abuse and/or violence: "During an arithmetic test, a teacher was standing by him and showing, in advance, the parts that he probably would not understand. He crumpled his test paper" (2nd grade elementary school boy). "When he cannot understand the contents of a lesson, he tips over a desk or throws other children's papers" (4th grade elementary school boy).

In addition, "from nursery years, he has drawn criticism from friends and guardians as 'selfish' and 'rough'" (2nd grade elementary school boy with ADHD). "Because a volunteer student for special support had been constantly with him, he felt a sense of detachment from the class. Eventually, he transferred to another school" (3rd grade elementary school boy with ADHD). "When he was in the 1st grade, the home-room teacher responsible for the boy tried vainly to suppress his behavior strictly" (5th grade elementary school boy with ADHD).

In some of the case examples, inadequate responses against the problematic behaviors by other people seemed to provoke outbursts of verbal abuse and/or violence and make the problematic behaviors worse.

Furthermore, some case examples of middle school pupils were related to an escalation of secondary disabilities: "The following situations were repeated: putting foreign materials in others' school lunches; hiding others' milk; slapping others, and running away" (2nd grade lower secondary school boy with Asperger syndrome). "At home, he brandishes a kitchen knife saying, 'I am unworthy to live because of the way I am'" (3rd grade lower secondary school boy with LD).

Psychoneurotic Symptoms

There were 29 examples of children with psychoneurotic symptoms, of whom 20 were boys, and 8 girls, with 1 of unreported gender. By grade, five children were in the 1st and 2nd grades of elementary school, 10 in the 3rd and 4th grades, and 10 in the 5th and 6th grades; four were lower secondary school pupils. By disability, Asperger syndrome and high functional autism (13 children) was the most common diagnosis, followed by ADHD (seven children). Of seven students whose disabilities were categorized as "Other", six had psychoneurotic diseases, such as psychosomatic
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disorders, depressive disorder, schizophrenia, and selective mutism. A breakdown of the 22 students with developmental disabilities shows that studies with a obsessive-compulsive disability-like state were the most common (15), followed by apathy (2), depression and dissociative disorder (1 each), and other (3).

Although most of the students reported to have obsessive-compulsive disabilities had Asperger syndrome and high functional autism, their behavior seemed very much to be that characteristic of people of autism, such as persistence and being poor at dealing with change, rather than severe maladjustment, for example: “When failing to learn, he becomes obsessed with self-hatred; ‘I cannot do this anymore.’ In addition, when losing in the rock-scissors-paper game, he rushes out or strips his clothes off” (3rd grade elementary school boy). “When such an event approaches, she complains of headaches and stomachaches because of being unable to follow life” (4th grade elementary school girl). It was pointed out that seven students out of 22 experienced maladjustment from the stress of school lessons, such as failure in learning and dislike for physical education class.

School Non-Attendance and Withdrawal

There were 19 students whose main problem was non-attendance and/or withdrawal: 16 boys and 3 girls. By grade, most were in the higher grades of elementary school: none were in the 1st or 2nd grade, two children were in the 3rd and 4th grades, and nine in the 5th and 6th grades; eight were lower secondary school pupils. By disability, Asperger syndrome and high functional autism was the most common diagnosis (9 students), followed by LD (3), and other pervasive developmental disorders (2).

Triggers for school non-attendance that were reported included aversion to classrooms with numerous students, and attending school but going to the school nurse’s office because of being unable to enter classrooms, attending school but being in a separate classroom—locking from the inside when feeling someone is outside. Unique persistence such as the following was described as triggers for 5 of the students: “persistence to a role in a school play”, “persistence to schedule and dislike for change”, and “overreaction to friends’ comments”. All but one of these students had Asperger syndrome and high functional autism; the remaining student’s diagnosis was unknown.

There were also indications that inadequate teaching or bullying led to school non-attendance. Case examples were as follows: “The trigger was that a teacher forcefully put his head into a swimming pool at the final year in kindergarten” (6th grade elementary school boy with LD). “Because of information about disabilities, he came to refuse go to school and obtained a diagnosis of pediatric depression” (6th grade elementary school boy with LD). “He started frequent urination because of a drug for hyperactivity, which resulted in school non-attendance” (4th grade elementary school boy; name of disability unknown). “After panicking when an emergency bell was rung as a prank, he came to refuse to go to school” (3rd grade lower secondary school boy with Asperger syndrome).
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Bulling and Being Abused

Nine cases of bullying and abuse were reported (7 boys and 2 girls). This was reported most often in the higher grades of elementary school: no children in the 1st and 2nd grades, one in the 3rd and 4th grades, four in the 5th and 6th grades, and four lower secondary school pupils. By disability, five of those children had Asperger syndrome and high functional autism, three ADHD, and one, “emotional disturbance”.

Of the three students with ADHD, one was a case of abuse and neglect at home (6th grade elementary school boy). Two others were case examples of teasing and bullying at school. The following impulsive behavioral characteristics were reported to be subject to teasing or bullying: “Because she cannot grasp the surrounding circumstances, she suddenly takes odd actions, such as shouting, in class. Consequently, she did not fit in with the other students, and was teased by her classmates” (2nd grade lower secondary school girl). “He cannot accept lessons properly and goes out the classroom. When students tease him, he challenges them, but often cries” (2nd grade lower secondary school boy).

Characteristics of Asperger syndrome and high functional autism, such as persistency or hyper-sensitivity, were subject to teasing and bullying: “He is sometimes teased, which was recognized as bullying. Because of persistence to friendships, he felt insecure to go to school by himself” (5th grade elementary school boy with Asperger syndrome). “He could not understand teachers’ instructions, so he made movement with friends and extemporized. However, being touched on his hands and legs was painful for him, and was recognized as bullying” (6th grade elementary school boy with high functional autism). “Because switching actions is difficult for him, he cannot change classrooms and go home. He is teased and verbally bullied by other children who say ‘Refuse to go to school!’” (3rd grade lower secondary school boy with Asperger syndrome).

Furthermore, some examples underscore the fact that inadequate response or a lack of cooperation with resource classes by the schools worsened the bullying or teasing, such as bullying or discrimination against children’s nationality, in addition to their developmental disabilities: “He transferred to a Japanese elementary school, where the language and customs were different, in the middle of the 1st grade. Immediately after that, 6th grade elementary school girls teased him and some of them used violence on him” (4th grade elementary school boy with high-functioning autism). “Although the school in which he enrolled was aware that the child suffered from pistol-shot sounds because of her/his hyper-sensitivity and kept on washing his hands, they seemed to not have very much consciousness of the problem. Consequently, when we visited the school, people in administrative positions did not even know about the existence of the child”.

Delinquency, Conduct Disorders, and Criminal Acts

Two examples of shoplifting, nighttime wandering, and fare cheating (4th grade boy elementary school with LD) and staying out overnight, shoplifting, and theft (6th
grade elementary school boy with ADHD) were reported. The 4th grade elementary school boy was said to show violent outbursts as well: “Because he has LD in writing, when a home-room teacher insists that he write, he throws things that were on his desk or kicks the teacher.” In this child’s case, he had been severely abused by his mother in early childhood. Accordingly, he had been taken from his home and raised in a child care institution from the age of four to when he was seven years old. In his current situation, he still receives some psychological abuse. There was concern about secondary disabilities attributable to his home environment.

A 6th grade elementary school boy was reported to have hyperactive tendencies characteristic of ADHD: “When something which he does not like happens, he bursts out from the classroom, wanders about the school, or goes to the school nurse’s office”. Since he also has only slightly caught up with learning, “he does not do things which he is poor at, writing in particular” in the resource class. A failure of learning is assumed as one reason leading to his delinquent acts.

**Actual Condition and Problems of Cooperation and Collaboration with Counseling Organizations and Medical Institutions**

We asked respondents to describe the actual conditions of cooperation and collaboration with counseling organizations and medical institutions related to support for students with school-maladjustment problems. The results were categorized into the following three groups: Cooperative, Insufficiently cooperative, and Not cooperative (see Table 5).

**Cooperative.** “We obtain advice from medical doctors and speech therapists. In addition, we hold case meetings about students with university professors, undergraduates, and postgraduates, we obtain opinions and advice from many people.” “Resource rooms for students with emotional disturbances in the ward cooperate with the Department of Pediatrics, University School of Medicine, on a regular basis, three times yearly. If we identify a student of concern, we mutually liaise and obtain advice on a case-by-case basis. Our educational counseling is also rewarding. We take a stance of allowing casual consultation with various groups, including the educational affairs section and the lifelong learning center”. 

**Insufficiently cooperative.** “We had case meetings with hospitals, child guidance centers, and schools, and thought about future support. Not only did we have meetings at special occasions; we also must hold them continuously. If not, we cannot improve the substance of meetings and obtain a mutual understanding.” “Because
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feeling that our cooperation is insufficient, we might need more close liaison meetings (information exchange, etc.)."

Not cooperative. "Cooperation with medical institutions is an issue for the future." "They do not visit medical institutions. We seek to obtain opinions from specialists in disabilities".

Only about a quarter of all respondents indicated smooth implementation of cooperation and collaboration with counseling organizations and medical institutions regarding support for students with school-maladjustment. The majority reported "insufficient" or "not" cooperative and/or collaborative. It can be said that promoting smooth cooperation and collaboration with counseling organizations and medical institutions is an issue that remains for future study.

The following were some of the descriptions of insufficient cooperation and collaboration: "We can say that we cooperate with various specialized organizations because we involve doctors in charge, school counselors of the school enrolled, and educational counseling rooms in the ward. In addition, guardians meet and talk with counseling doctors in the resource room. The current condition, however, is that they offer support from their respective positions and ideas. It would be ideal if specialized organizations could cooperate with each other and be organically and mutually supportive, but that is difficult in the present circumstances." "Many adults surround this child, such as those in a special support project in the ward, school counselors, and the resource class. For that reason, we are in a situation where we are unable to direct the traffic." These are an indication that although diverse organizations are involving in support of students, too many organizations render liaison and coordination rather difficult. How to coordinate their efforts at the stage of initiating support is an important issue.

The following descriptions were also given: "It is difficult because guardians refuse to cooperate and provide information," and "Because guardians do not accept the student's disabilities, our efforts are not at the level of cooperation." The problem of promoting guardians' understanding of the students' disabilities is a salient issue for advancing cooperation and collaboration with counseling organizations and medical institutions.

Discussion

Different tendencies were observed among schools and resource rooms with respect to support for students who are school-maladjusted. For example, for students' violent outbursts, the majority of respondent schools gave case examples of emergency evacuation-like support such as: "taking a cool-down period in a separate room", "taking them away from the scene and calming them down". In contrast, resource classes taught the following ways to students with Asperger syndrome and high functional autism according to each student's cognitive characteristics, such as "explaining the situation verbally" or "writing as much as possible, and using picture cards": "Before competing, we have a rehearsal of how to behave in case of not
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finishing in first place”, “We teach how to stay out of trouble”, “We prepare a
guidance card for absence from school in the case of feeling sick and help the
students realize that absence is not a bad thing”.

Their way of teaching students with ADHD was to encourage them do what they
were good at, in order to become confident: “When seeing good behavior, we admire
and approve as much as possible”, “We set them to solve as many as problems
possible”. The resource teachers made efforts to restore the confidence in learning
and a sense of self-affirmation of students with LD, through individual learning
support. Many respondents indicated that the teachers responsible for resource
classes prevented violent outbursts of students with developmental disabilities.
Consequently, students gradually came to feel calm because of such meticulous
individual support according to their disabilities.

In the case of students displaying psychoneurotic symptoms, individual teaching
primarily after worsening conditions was noted as supportive by the resource teachers
in many of the schools. Resource rooms attempt to prevent worsening of the students’
conditions by the following: They use teaching tailored to the cognitive characteristics
of students with Asperger syndrome and high functional autism: “showing a sched-
ule”, “calling to them in advance”, “preparing challenging tasks”. For students with
ADHD, they foster concentration of attention and impulsive control, such as “consider-
eration for seating position” and “verbalizing before action”.

However, there are actual conditions in which teaching in resource rooms has
not been generalized to the students’ other environments: “Although the students can
live a mentally stable life in the resource room, the same procedures are not used in
the regular school” and “We can see advancement related to violence in the resource
room, but no change is seen in the rest of the school.” Many descriptions indicated
that the reason for this lack of generalization was insufficient cooperation and
 collaboration between the resource rooms and the regular classrooms: “We cannot
take time to coordinate with the students’ regular classroom teachers”. Many chal-
 lenges remain, including sharing information between resource rooms and regular
classrooms, in relation to the students’ entire school life.

Furthermore, the results revealed that cooperation and collaboration among
guardians, schools, resource rooms, counseling organizations, and medical institu-
tions are extremely insufficient, including the area of sharing information related to
support of students with school-maladjustment. In addition, it is also strongly urged
that schools and related organizations promote guardians’ understanding of their
children’s disabilities in order to communicate with them and support them as well.

Conclusions

It has begun to be pointed out that inadequate support and neglect of children
with developmental disabilities often engenders secondary symptoms, such as school
non-attendance, withdrawal, and criminal acts. Nonetheless, accumulated studies
dealing with children with developmental disabilities and their problems of mal-
adjustment are extremely insufficient in the area of school education; empirical studies of maladjustment problems that they confront remain in a state of stagnant infancy.

For those reasons, through a questionnaire survey of resource rooms in elementary and lower secondary schools in the Tokyo metropolitan area, the present study assessed actual conditions of difficulties and needs that students confront. We particularly investigated maladjustment problems of students with mild developmental disabilities. In addition, we elucidated problems of educational support for them.

The survey responses included many descriptions stating that the reasons for school-maladjustment were considered to be students with developmental disabilities' school life itself: in particular, the stress of lessons and events; hyper-sensitivity derived from the school environment; and teasing and bullying arising from classmates' lack of understanding of characteristics of disabilities.

To begin with, the following are required: improvement of lessons, events, and other parts of school life, so that they sufficiently consider the unique cognitive and behavioral characteristics, likes and dislikes, hyper-sensitivity and insensibility, and so on, that students with developmental disabilities have. Furthermore, relevant training of regular class teachers and implementation of education for understanding students with disabilities are essential.

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