

OVERVIEW OF SPECIFIC LEARNING DISABILITIES

Marlene Sotelo-Dynega

Dawn P. Flanagan

Vincent C. Alfonso

The purpose of this chapter is to provide a brief overview of the definitions and classification systems of and methods for identification of specific learning disabilities (SLDs). Historically, children who did not perform as expected academically were evaluated and often identified as having a learning disability (LD) (Kavale & Forness, 2006). The number of children in the United States identified as having LD has “increased by more than 300 percent” since the enactment of the Education for All Handicapped Children Act of 1975 (P.L. 94-142; Cortiella & Horowitz, 2014). This landmark legislation included criteria for the identification of exceptional learners, including children with LD, and mandated that they receive a free and appropriate public education (FAPE). Each reauthorization of P.L. 94-142 maintained its original intent, including the most recent reauthorization, the Individuals with Disabilities Education Improvement Act of 2004 (P.L. 108-446; hereafter referred to as *IDEA 2004*). Rapid Reference 1.1 highlights the most salient changes to this legislation through the present day.

The US Department of Education (USDOE) has collected data on students who have qualified for special education services since 1975. The most current data show that over 2.3 million school-age children are classified as SLD. This figure represents nearly 5% of the approximate 50 million students currently

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Salient Changes in Special Education Law from 1975 to 2004

1975	Education for All Handicapped Children Act (EHA) P.L. 94-142	Guaranteed school-age (5–21 years) children with disabilities the right to a FAPE.
1986	EHA P.L. 99-457	<p>Extended the purpose of EHA to include children from birth to 5 years:</p> <ul style="list-style-type: none"> • FAPE was mandated for children ages 3–21 years. • States were encouraged to develop early-intervention programs for children with disabilities from birth to 2 years.
1990	EHA renamed the Individuals with Disabilities Education Act (IDEA) P.L. 101-476	<p>The term <i>handicapped child</i> was replaced with <i>child with a disability</i>.</p> <p>Autism and traumatic brain injury classifications were added.</p> <p>Transition services for children with disabilities were mandated by age 16 years.</p> <p>It defined assistive technology devices and services.</p> <p>It required that the child with a disability be included in the general education environment to the maximum extent possible.</p>
1997	IDEA P.L. 105-17	<p>Extended the least-restrictive environment (LRE) to ensure that <i>all</i> students would have access to the general curriculum.</p> <p>Schools are required to consider the inclusion of assistive technology devices and services in the individualized education plans of all students.</p> <p>Orientation and mobility services were added to the list of related services for children who need instruction in navigating within and to and from their school environment.</p>
2004	IDEA renamed the Individuals with Disabilities Education Improvement Act (IDEIA) ¹ P.L. 108-446	<p>Statute is aligned with the No Child Left Behind Act (NCLB) of 2001.</p> <p>Focus of statute is on doing what works and increasing achievement expectations for children with disabilities.</p> <p>Changes are made to the evaluation procedures used to identify specific LDs.</p>

¹ *IDEA* (rather than *IDEIA*) is used most often to refer to the 2004 reauthorization and, therefore, will be used throughout this book.

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Students Ages 6–21 Years Served Under IDEA 2004

IDEA Disability Category	Percentage of All Disabilities¹	Percentage of Total School Enrollment²
Specific Learning Disability	38.82	3.50
Speech or Language Impairment	17.26	1.56
Other Health Impairments	14.99	1.35
Autism	9.10	.82
Intellectual Disability	6.92	0.62
Emotional Disturbance	5.73	0.52
Developmental Delay (Ages 3–9 years only)	2.47	0.22
Multiple Disabilities	2.07	0.19
Hearing Impairments	1.11	0.10
Orthopedic Impairments	.68	0.06
Traumatic Brain Injury	0.42	0.04
Visual Impairments	0.41	0.04
Deaf-Blindness	0.02	0.00

¹ US Department of Education (2016a).

² US Department of Education (2016b).

enrolled in the nation's schools (Kena et al., 2015). Furthermore, of all school-age students who have been classified with an educationally disabling condition, 39% are classified as SLD (USDOE, 2016a). Rapid Reference 1.2 shows that none of the other 12 IDEA 2004 disability categories approximates the prevalence rate of SLD in the population, a trend that has been consistent since 1980 (USDOE, 2016b).

A BRIEF HISTORY OF THE DEFINITION OF LEARNING DISABILITY

Definitions of LD date back to the mid- to late 1800s within the fields of neurology, psychology, and education (Mather & Goldstein, 2008). The earliest recorded definitions of LD were developed by clinicians based on their observations of individuals who experienced considerable difficulties with the acquisition of basic

academic skills, despite their average or above-average general intelligence, or those who lost their ability to perform specific tasks after a brain injury that resulted from either a head trauma or stroke (Kaufman, 2008). Given that clinicians at that time did not have the necessary technology or psychometrically defensible instrumentation to test their hypotheses about brain-based LD, the medically focused study of LD stagnated, leading to the development of socially constructed, educationally focused definitions that *presumed* an underlying neurological etiology (Hale & Fiorello, 2004; Kaufman, 2008; Lyon et al., 2001).

In 1963, Samuel Kirk addressed a group of educators and parents at the Exploration Into the Problems of the Perceptually Handicapped Child conference in Chicago, Illinois. The purposes of the conference were to (1) gather information from leading professionals from diverse fields about the problems of children who had perceptually based learning difficulties and (2) develop a national organization that would lobby to secure services for these children. At this conference, Kirk presented a paper entitled “Learning Disabilities” that was based on his recently published book, *Educating Exceptional Children* (Kirk, 1962). In this paper, Kirk defined LD as

a retardation, disorder, or delayed development in one or more of the processes of speech, language, reading, writing, arithmetic, or other school subjects resulting from a psychological handicap caused by a possible cerebral dysfunction and/or emotional or behavioral disturbances. It is not the result of mental retardation, sensory deprivation, or cultural and instructional factors. (p. 263)

Not only did the conference participants accept Kirk’s term *LD* and corresponding definition but also they formed an organization that is now known as the Learning Disabilities Association of America (LDA). The LDA continues to influence the “frameworks for legislation, theories, diagnostic procedures, educational practices, research and training models” as they pertain to identifying and educating individuals with LD (LDA, n.d.a, ¶ 2).

Kirk’s conceptualization of LD influenced other organizations’ definitions of LD, including the Council for Exceptional Children (CEC), as well as federal legislation (e.g., P.L. 94-142). In addition, 11 different definitions of LD in use between 1982 and 1989 contained aspects of Kirk’s 1962 definition. Therefore, it is not surprising that a comprehensive review of these definitions revealed more agreement than disagreement about the construct of LD (Hammill, 1990). Interestingly, none of the definitions strongly influenced developments in LD identification, mainly because they tended to focus on conceptual rather than operational elements and focused more on exclusionary rather than inclusionary criteria. Rapid Reference 1.3 illustrates the salient features of the most common

definitions of LD that were proposed by national and international organizations and LD researchers, beginning with Kirk's 1962 definition. The majority of definitions depict LD as a neurologically based disorder or a disorder in psychological processing that causes learning problems and manifests as academic skill weaknesses. In addition, most definitions indicate that LD may co-occur with other disabilities.

Although the definitions of LD included in Rapid Reference 1.3 vary in terms of their inclusion of certain features (e.g., average or better intelligence, evident across the life span), the most widely used definition is the one included in IDEA 2004 (Cortiella, 2009). Unlike other definitions, the IDEA 2004 definition refers to a *specific* LD, implying that the disability or disorder affects specific academic skills or domains. According to IDEA 2004, SLD is defined as follows:

The term “specific learning disability” means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in the imperfect ability to listen, think, speak, read, spell, or do mathematical calculations. Such a term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Such a term does not include a learning problem that is primarily the result of visual, hearing, or motor disabilities; of mental retardation; of emotional disturbance; or of environmental, cultural, or economic disadvantage. (IDEA 2004, §602.30, Definitions)

Because definitions of LD do not explicitly guide how a condition is identified or diagnosed, classification systems of LD were developed. Three of the most frequently used classification systems for LD are described next.

CLASSIFICATION SYSTEMS FOR LD

“Classification criteria are the rules that are applied to determine if individuals are eligible for a particular diagnosis” (Reschly, Hosp, & Schmied, 2003, p. 2). Although the evaluation of LD in school-age children is guided by the mandate of IDEA 2004 and its attendant regulations, diagnostic criteria for LD are also included in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) (*DSM-5*; American Psychiatric Association, 2013), and the *International Classification of Diseases* (*ICD-10*; World Health Organization, 2016). Rapid Reference 1.4 includes the type of LDs

CAUTION

Because the three major classification systems use somewhat vague and ambiguous terms, it is difficult to identify SLD reliably and validly. Thus, multiple data sources and data-gathering methods must be used to ensure that children are diagnosed accurately.

Rapid Reference 1.3

Salient Features of Learning Disability Definitions

Source	Ability-Achievement Discrepancy	Average or Above-Average Intelligence	Neurological Basis	Disorder in a Psychological Process	Evident Across the Life Span	Listening and Speaking	Academic Problems	Nonacademic, Language, or Conceptual Disorders as LD		Potential for Multiple Disabilities
								Conceptual Problems	LD	
Samuel Kirk (1962)	—	√	√	√	√	√	—	—	√	√
Barbara Bateman (1965)	√	—	√	√	—	—	—	—	—	√
National Advisory Committee on Handicapped Children (1968)	—	—	√	√	—	√	√	—	—	√
Northwestern University (Kass & Myklebust, 1969)	√	—	—	√	—	√	—	—	√	√
Council for Exceptional Children, Division for Children with Learning Disabilities (1967)	—	√	√	√	—	√	—	—	—	—
Joseph Wepman and colleagues (1975)	—	—	—	√	—	—	√	—	—	—
Education for All Handicapped Children Act (1975)	√	—	—	√	—	√	—	—	—	√

US Office of Education (1977)	—	—	✓	✓	✓	✓	—	—	✓
National Joint Committee on Learning Disabilities (1981, 1982, 1991, 1998)	—	—	✓	—	✓	✓	✓	—	✓
Learning Disabilities Association of America (n.d.b)	✓	✓	✓	—	✓	✓	✓	✓	—
Interagency Committee on Learning Disabilities (1987)	—	—	✓	—	✓	✓	✓	✓	✓
Individuals with Disabilities Education Act (1986, 1990, 1997, 2004)	—	—	✓	✓	✓	✓	—	—	✓
Kavale, Spaulding, and Beam (2009)	✓	✓	✓	✓	—	✓	✓	—	✓
Flanagan and colleagues (2002, 2006, 2007, 2011, 2013)	✓	✓	✓	✓	✓	✓	—	—	✓

Note: This table was adapted from Hammill (1990). A recent review of these definitions has shown that none of the definitions that were originally presented have been updated. Currently, although the NCLD continues to use the definition that was published in 1990, they recently published a 52-page document titled "The State of Learning Disabilities" (Cortiella & Horowitz, 2014) summarizing the current research available regarding the nature of LD across the life span. Furthermore, some additional definitions that were published after the Hammill article was published were added to this table.

Rapid Reference 1.4

Three Frequently Used Diagnostic Classification Systems for Learning Disability

Classification System	Types of Learning Disorder	Examples of Classification Criteria¹
<i>Diagnostic and Statistical Manual of Mental Disorders</i> (5th ed.) (DSM-5, 2013)	<p>Specific learning disorder:</p> <ul style="list-style-type: none">• With impairment in reading• With impairment in written expression• With impairment in mathematics	<p>Specific learning disorder:</p> <p>A. Difficulties learning and using academic skills, as indicated by the presence of at least one of the following . . . that have persisted for at least 6 months, despite the provision of interventions that target those difficulties:</p> <ol style="list-style-type: none">1. Inaccurate or slow and effortful word reading2. Difficulty understanding the meaning of what is read3. Difficulties with spelling4. Difficulties with written expression5. Difficulties mastering number sense, number facts, or calculation6. Difficulties with mathematical reasoning <p>B. The affected academic skills are substantially and quantifiably below those expected for the individual's chronological age and cause significant interference with academic or occupational performance . . . as confirmed by individually administered standardized achievement measures and comprehensive clinical assessment.</p>

- C. The learning difficulties begin during school-age years but may not become fully manifest until the demands for those affected academic skills exceed the individual's limited capacities.
- D. The learning difficulties are not better accounted for by intellectual disabilities, uncorrected visual or auditory acuity, other mental or neurological disorders, psychosocial adversity, lack of proficiency in the language of academic instruction, or inadequate educational instruction.

International Classification of Diseases (ICD-10, 2016)

Specific reading disorder:

- Specific spelling disorder
- Specific disorder of arithmetical skills
- Mixed disorder of scholastic skills
- Other developmental disorders of scholastic skills
- Developmental disorder of scholastic skills, unspecified

Specific reading disorder:

- Specific reading disorder is a specific and significant impairment in the development of reading skills that is not solely accounted for by mental age, visual acuity problems, or inadequate schooling.
- Reading comprehension skill, reading word recognition, oral reading skill, and performance of tasks requiring reading may all be affected.
- Spelling difficulties are frequently associated with specific reading disorder and commonly remain into adolescence even after some progress in reading has been made.
- Specific developmental disorders of reading are commonly preceded by a history of disorders in speech or language development.
- Associated emotional and behavioral disturbances are common during the school-age period.
- This diagnosis includes backward reading, developmental dyslexia, and specific reading retardation.
- This diagnosis excludes alexia, dyslexia NOS, and reading difficulties secondary to emotional distress.

(continued)

Types of Learning Disorder

Classification System

Individuals with Disabilities Education Improvement Act (IDEA 2004)

Specific learning disability in:

- Oral expression
- Listening comprehension
- Written expression
- Basic reading skill
- Reading fluency
- Reading comprehension
- Mathematics calculation
- Mathematics problem-solving

Examples of Classification Criteria¹

Specific learning disability:

1. A disorder in one or more of the basic psychological processes.
2. Includes conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia.
3. Learning difficulties must not be primarily the result of
 - A visual, hearing, or motor disability
 - Mental retardation
 - Emotional disturbance
 - Cultural factors
 - Environmental or economic disadvantage
 - Limited English proficiency

¹ For the *ICD-10* diagnostic classification system, there are specific criteria for each disorder that are listed in the second column of this Rapid Reference. Criteria for only one of these disorders are included in the third column to serve as an example.

and classification criteria for LD in each system. Noteworthy is the fact that all three systems use somewhat vague and ambiguous terms, which interfere significantly with the efforts of practitioners to identify LD reliably and validly (Kavale & Forness, 2000, 2006).

Despite the existence of various classification systems, students ages 3 to 21 years who experience learning difficulties in school are most typically evaluated according to IDEA 2004 specifications (IDEA 2004, §614) to determine if they qualify for special education services. Because the classification category of SLD as described in the IDEA statute includes imprecise terms, the USDOE published the federal regulations (34 CFR, Part 300) with the intent of clarifying the statute and providing guidance to state educational agencies (SEAs) as they worked to develop their own regulations. The guidelines provided by the 2006 federal regulations were more detailed in their specifications of *how* an SLD should be identified.

METHODS OF SLD IDENTIFICATION AND THE 2006 FEDERAL REGULATIONS

Although the definition of SLD has remained virtually the same for the past 30 years, the methodology used to identify SLD changed with the last revision of IDEA 2004. According to the 2006 federal regulations (34 CFR §300.307–309), a state must adopt criteria for determining that a child has SLD; the criteria (1) must not require the use of a severe discrepancy between intellectual ability and achievement; (2) must permit the use of a process based on a child's response to scientific, research-based interventions; and (3) may permit the use of other alternative research-based procedures for determining whether a child has SLD. Many controversies have ensued since the publication of the three options for SLD identification. The controversies have been written about extensively because they pertain to the exact meaning of the guidelines, the specifications of a comprehensive evaluation, the implications of using Response to Intervention (RTI) as the sole method for SLD identification, and the lack of legal knowledge among decision makers and, therefore, will not be repeated here (see Chapters 7 and 8 in this book and refer to Gresham, Restori, & Cook, 2008; Kavale, Kauffman, Bachmeier, & LeFever, 2008; Reschly et al., 2003; Reynolds & Shaywitz, 2009a, 2009b; Zirkel & Thomas, 2010, for a summary). The remainder of this chapter focuses on clarifying the three options for SLD identification, because these three options are currently being implemented across states (see Rapid Reference 1.5).

Rapid Reference 1.5

Methods for Identifying SLD Across States

- Coomer (2015) surveyed the 50 state education agencies to determine which of the three options included in the 2006 federal regulations was selected for SLD identification.
- All 50 states have adopted the federal definition of SLD.
- All 50 states “allow” RTI as a method to identify SLD.
- Eleven states solely use RTI to identify SLD.
- Thirty-nine states also allow the discrepancy model or PSW approach.

Note: For state-by-state details regarding SLD eligibility determination, see Coomer (2015; Table 3, pp. 30–31).

Source: Coomer (2015).

Ability-Achievement Discrepancy

A discrepancy between intellectual ability and academic achievement continues, in one form or another, to be central to many SLD identification approaches because it assists in operationally defining *unexpected underachievement* (e.g., Kavale & Flanagan, 2007; Kavale & Forness, 1995; Lyon et al., 2001; Wiederholt, 1974; Zirkel & Thomas, 2010). Despite being a laudable attempt at an empirically based method of SLD identification, the traditional ability-achievement (or IQ-achievement) discrepancy method was fraught with problems (e.g., Aaron, 1997; Ceci, 1990, 1996; Siegel, 1999; Stanovich, 1988; Sternberg & Grigorenko, 2002; Stuebing et al., 2002), many of which are identified in Rapid Reference 1.6. The failure of the ability-achievement discrepancy method to identify SLD reliably and validly was summarized well by Ysseldyke (2005), who stated,

Professional associations, advocacy groups, and government agencies have formed task forces and task forces on the task forces to study identification of students with LD. We have had mega-analyses of meta-analyses and syntheses of syntheses. Nearly all groups have reached the same conclusion: There is little empirical support for test-based discrepancy models in identification of students as LD. (p. 125)

Thus, the fact that states could no longer require the use of a severe discrepancy between intellectual ability and achievement (IDEA 2004) was viewed by many as a welcomed change to the law. The void left by the elimination of the discrepancy

Rapid Reference 1.6

Salient Problems with the Ability-Achievement Discrepancy Method

- Fails to adequately differentiate between students with LD from students who are low achievers
- Based on the erroneous assumption that IQ is a near-perfect predictor of achievement and is synonymous with an individual's potential
- Applied inconsistently across states, districts, and schools, rendering the diagnosis arbitrary and capricious
- A discrepancy between ability and achievement may be statistically significant but not clinically relevant.
- Is a wait-to-fail method because discrepancies between ability and achievement typically are not evident until the child has reached the third or fourth grade
- Does not identify the area of processing deficit
- Leads to overidentification of minority students
- Does not inform intervention

mandate was filled by a method that allowed states to use a process based on a child's RTI to assist in SLD identification.

Response to Intervention (RTI)

The concept of RTI grew out of concerns about how SLD is identified. For example, traditional methods of SLD identification, mainly ability-achievement discrepancy, were applied inconsistently across states and often led to misidentification of students as well as overidentification of minority students (e.g., Bradley, Danielson, & Hallahan, 2002; Learning Disabilities Roundtable, 2005; President's Commission on Excellence in Special Education, 2002). Such difficulties with traditional methods led to a "paradigm shift" (Reschly, 2004) that was based on the concept of *treatment validity*, "whereby it is possible 'to simultaneously inform, foster, and document

DON'T FORGET

Although RTI may be permitted under IDEA 2004, the driving force behind promoting RTI was found in the No Child Left Behind (NCLB; P.L. 107-110, 2001) legislation. In December 2015, the Every Student Succeeds Act (ESSA) replaced NCLB and removed all mention of RTI.

the necessity for and effectiveness of special treatment” (Fuchs & Fuchs, 1998, p. 207).

At the most general level, RTI is part of a multitiered system of support (MTSS) approach to the early identification of students with academic or behavioral difficulties. For the purpose of this chapter, we will focus on RTI for academic difficulties only. The RTI process begins with the provision of quality instruction for all students in the general education classroom, along with universal screening to identify students who are at risk for academic failure, primarily in the area of reading (Tier 1). Students who are at risk for reading failure—that is, those who have not benefitted from the instruction provided to all students in the classroom—are then given scientifically based interventions, usually following a standard treatment protocol (Tier 2). If a student does not respond as expected to the intervention provided at Tier 2, he or she may be identified as a *nonresponder* and selected to receive additional and more-intensive interventions in an attempt to increase his or her rate of learning. When one type of intervention does not appear to result in gains for the student, a new intervention is provided until the desired response is achieved.

The inclusion of RTI in the law as an allowable option for SLD identification has created perhaps the most controversy since IDEA was reauthorized in 2004. This is because, in districts that follow an RTI-*only* approach, students who repeatedly fail to demonstrate an adequate response to increasingly intensive interventions are deemed to have SLD *by default*. Such an approach does not appear to be in compliance with the regulations. For example, according to the regulations, states must (1) use a variety of assessment tools and strategies to gather relevant functional, developmental, and academic information (34 CFR §300.304(b)(1)); (2) not use any single measure or assessment as the sole criterion for determining whether a child has a disability (34 CFR §300.304(b)(2)); (3) use technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors (34 CFR §300.304(b)(3)); (4) assess the child in all areas related to the suspected disability (34 CFR §300.304(c)(4)); (5) ensure that the evaluation is sufficiently comprehensive to identify all of the child’s special education and related service needs (34 CFR §300.304(c)(6)); and (6) ensure that assessment tools and strategies provide relevant information that directly assists persons in determining the needs of the child (34 CFR §300.304(c)(7)).

Although the use of RTI as a stand-alone method for SLD identification is inconsistent with the intent of the law, this type of service delivery model has been an influential force in the schools in recent years, particularly with respect to shaping Tier 1 and Tier 2 assessments for intervention in the general education

setting. The emphasis in an RTI model on ensuring that students are benefitting from empirically based instruction and verifying their response to instruction, via a systematic collection of data, has elevated screening and progress monitoring procedures to new heights and has led many to embrace this type of service delivery model for the purposes of prevention and remediation.

In a landmark study, Balu and colleagues (2015) studied the impact of RTI across 13 states and 20,000 students. Considering that one of the main purposes of RTI is prevent reading issues for students who are at risk, the study found that in a sample of first-graders who were selected to receive interventions at Tiers 2 and 3 had negative results on a grade-level comprehensive measure of reading. Furthermore, second- and third-graders who were slotted to receive Tier 2 interventions did not show progress that was significant either. The results of this study have raised much concern among school personnel given the amount of time and funding necessary to implement an RTI process (Sparks, 2015). Additionally, these results also allude to the potential effect of individual differences among the students who are in need of further intervention. It is challenging to understand why a student is not responding to scientifically based instruction or interventions without investigating their profile of cognitive strengths and weaknesses. Regardless, RTI can be helpful in determining why a student is not responding. Rapid Reference 1.7 highlights some of the most salient strengths and weaknesses of the RTI service delivery model regarding its use in the SLD identification process.

Alternative Research-Based Procedures for SLD Identification

The third option included in the 2006 regulations allows “the use of other alternative research-based procedures” for determining SLD (§300.307[a]). Although vague, this option has been interpreted by some as involving the evaluation of a pattern of strengths and weaknesses in the identification of SLD via tests of academic achievement, cognitive abilities, and neuropsychological processes (Hale et al., 2008, 2010; Zirkel & Thomas, 2010). Several empirically based methods of SLD identification that are consistent with the third option are presented in this book, such as Alston-Abel and Berninger’s “Integrating Instructionally Relevant Specific LD Diagnoses, Patterns of Strengths and Weaknesses, and Positive Home-School Partnerships: Free and Appropriate Public Education for *All*” (Chapter 10); Flanagan and colleagues’ “Dual Discrepancy/Consistence Operational Definition of SLD: Integrating Multiple Data Sources and Multiple Data-Gathering Methods” (Chapter 11); and Naglieri and Feifer’s “Pattern of Strengths and Weaknesses Made Easy: The Discrepancy/Consistency Model” (Chapter 12). Readers may also be interested in a comparison of Schultz and

Rapid Reference 1.7

Strengths and Weaknesses of RTI

Salient Weaknesses of RTI as a Stand-Alone Method of SLD Identification

- Lack of research regarding which RTI model works best, standard treatment protocol, or problem-solving model, or under what circumstances each model should be used
- Lack of agreement on which curricula, instructional methods, or measurement tools should be used
- Confusion surrounding what constitutes an empirically based approach
- Lack of agreement on which methods work across grades and academic content areas
- Different methods of response-nonresponse, leading to different children being labeled as responders-nonresponders
- No consensus on how to ensure treatment integrity
- No indication of a true positive (SLD identification) in an RTI model

Salient Strengths of an RTI Service Delivery Model

- Focus is on the provision of more effective instruction
- Allows schools to intervene early to meet the needs of struggling learners
- Collected data better inform instruction than data generated by traditional ability-achievement discrepancy method
- Helps ensure that the student's poor academic performance is not due to poor instruction
- Holds educators accountable for documenting repeated assessments of students' achievement and progress during instruction

Source: Data from Learning Disabilities Association of America, White Paper (Hale et al., 2010).

Stephens's (2015) core-selective evaluation process and the Flanagan and colleagues DD/C model (Chapter 13).

Figure 1.1 provides an illustration of the three common components of third-method approaches to SLD identification (Flanagan, Fiorello, & Ortiz, 2010; Hale et al., 2008). The two bottom ovals depict academic and cognitive weaknesses, and their horizontal alignment indicates that the level of performance in both domains (academic and cognitive) is expected to be similar or consistent.

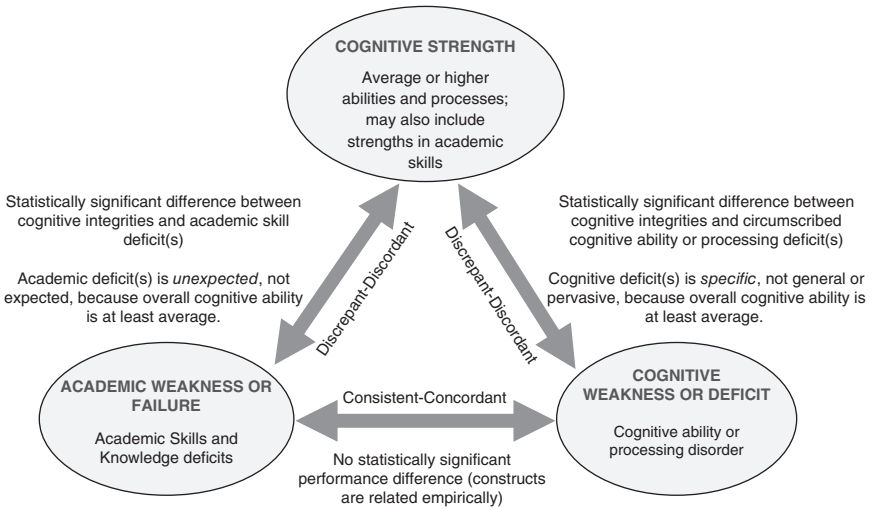


Figure 1.1. Common Components of Third-Method Approaches to SLD Identification

Source: Flanagan et al. (2010); Hale, Flanagan, and Naglieri (2008).

The double-headed arrow between the bottom two ovals indicates that the difference between measured performances in the weak academic area(s) is not significantly different from performance in the weak cognitive area(s). Again, in children with SLD there exists an empirical or otherwise clearly observable and meaningful relationship between the academic and cognitive deficits, because the cognitive deficit is the presumed cause of the academic deficit. The oval depicted at the top of Figure 1.1 represents generally average (or better) cognitive or intellectual ability. The double-headed arrows between the top oval and the two bottom ovals in the figure indicate the presence of a statistically significant or clinically meaningful difference in measured performance between general cognitive ability and the areas of academic and cognitive weakness. The pattern of cognitive and academic strengths and weaknesses represented in Figure 1.1 retains and reflects the concept of unexpected underachievement that has historically been synonymous with the SLD construct (Kavale & Forness, 2000).

CONCLUSION

In this chapter we reviewed briefly the prevailing definitions, diagnostic classification systems, and methods of identifying LD. The federal definition

of SLD has remained virtually the same for the past 30 years, and SLD remains the most frequently diagnosed educationally disabling condition in our nation's schools. Despite no change in the definition of SLD in the most recent reauthorization of IDEA, the methods for identifying SLD, as per the 2006 federal regulations, have changed. For example, ability-achievement discrepancy can no longer be mandated, although it remains a viable option in the majority of states. RTI has been adopted by several states as the required approach for SLD identification, despite the fact that using this method alone is inconsistent with the federal law. Third-option or research-based alternatives to SLD identification are permitted in more than 20 states throughout the country and hold promise for identifying SLD in more reliable and valid ways than was achieved via previous methods (e.g., the traditional ability-achievement discrepancy method).

The remainder of this book addresses in greater detail the topics discussed briefly in this chapter. For example, Chapters 2 through 6 provide in-depth coverage of how SLD manifests in reading, math, writing, oral language, and nonverbal learning disabilities. Chapters 7 through 13 include discussions of RTI and several third-method approaches for SLD identification. Chapter 14 describes how practitioners can distinguish cultural and linguistic differences from SLD in the evaluation of English language learners. Finally, Chapter 15 covers the differential diagnosis of SLD, and other issues related to the acquisition of academic skills and the identification of nonverbal learning disability. The confusion that has surrounded methods of SLD identification for many years, along with the obvious disconnect between the definition of SLD and the most typical methods of identifying it, continue to spark controversy. The chapters that follow, written by leading experts in the field, have the potential to shape future reauthorizations of IDEA and bring greater clarity to the definition of and methods for identifying SLD.

RESOURCES

Center on Response to Intervention: www.rti4success.org. The center provides technical assistance to states and districts and builds the capacity of states to assist districts in implementing proven models for RTI/EIS.

Child Mind Institute: <https://childmind.org/>. This website provides resources for the families and educators of children with mental health and learning disorders.

Council for Exceptional Children: www.cec.sped.org. This website provides professional development resources, including a blog on RTI and a side-by-

side comparison of the IDEA regulations and information about how the changes will affect students and teachers.

Early Childhood Technical Assistance Center: <http://ectacenter.org/sec619/stateregs.asp>. This page provides links to state regulations and other policy documents (statutes, procedures, and guidance materials) for implementing Part B of IDEA.

IDEA 2004: <https://sites.ed.gov/idea/>. Statutes, regulations, and other documents related to IDEA 2004 are found here.

IDEA Partnership: www.ideapartnership.org. This website offers resources developed by the IDEA Partnership (a collaboration of more than 55 national organizations, technical assistance providers, and organizations and agencies at state and local levels) and the Office of Special Education Programs (OSEP).

LD Online: www.ldonline.org. This website provides comprehensive information about learning disabilities and ADHD, with valuable resources for parents, educators, and students.

Learning Disabilities Association of America: <https://ldaamerica.org/>. The LDA is an organization that has provided support for people with LD and their families since the 1960s.

National Association of School Psychologists (NASP): www.nasponline.org/research-and-policy/professional-positions/position-statements. This is a position statement on the identification of students with SLDs (adopted in July 2011).

National Association of State Directors of Special Education (NASDSE): www.nasdse.org. This is the official website of the NASDSE, with up-to-date information about projects and initiatives related to RTI, charter schools, and the IDEA Partnership.

National Center for Learning Disabilities: www.ld.org. The NCLD works to ensure that the nation's 15 million children, adolescents, and adults with LDs have every opportunity to succeed in school, work, and life.

National Committee on Learning Disabilities (NJCLD): www.ldonline.org/about/partners/njclcd. This website describes the mission of the NCLD and its member organizations. It provides research articles and contact information for associations that offer assistance to individuals with SLD.

National Resource Center on Learning Disabilities (NRCLD): www.nrclcd.org. This website provides resources for educators and parents, including a toolkit on using RTI in SLD determination.

RTI Action Network: www.rtinetwork.org. This is a website dedicated to the effective implementation of RTI in districts nationwide.

Understood: www.understood.org/en. This is an organization that is dedicated to helping the parents of children who are struggling to learn.

What Works Clearinghouse, Institute of Education Sciences: <https://ies.ed.gov/ncee/wwc/>. This website offers scientific evidence about best practices in education.

Each state has a special education advisory panel that provides the state's Department of Education with guidance about special education and related services for children with disabilities. Check your own state's Department of Education website for specific information about your area.

US Department of Education (USDOE): www.ed.gov. This is the home page of the USDOE, which provides current information about education policies and initiatives in the United States.



TEST YOURSELF



1. **The number of children identified with SLD has remained relatively consistent since the enactment of P.L. 94-142 in 1975. True or false?**
2. **Historically, definitions of LD have strongly influenced how we have identified LD. True or false?**
3. **In the public schools, SLD is identified primarily by the following:**
 - (a) *DSM-5* criteria
 - (b) IDEA and its attendant regulations
 - (c) *ICD-10*
 - (d) All of the above
4. **According to the 2006 federal regulations, a district must not require use of the following procedure to identify SLD:**
 - (a) Response to intervention (RTI) process
 - (b) Ability-achievement discrepancy model
 - (c) Alternative research-based procedures
 - (d) Psychoeducational assessments
5. **RTI has not been validated as a method for SLD identification. True or false?**
6. **Which of the following is not a salient strength of RTI?**
 - (a) Focus is on the provision of more effective instruction.
 - (b) It allows schools to intervene early to meet the needs of struggling learners.
 - (c) It collects data that better inform instruction than data generated by traditional ability-achievement discrepancy method.
 - (d) A true positive (SLD identification) is evident in an RTI model.

- 7. More than half of the states allow the use of the discrepancy model or a research-based alternative to SLD identification (PSW). True or false?**
- 8. SLD has an underlying neurological etiology. True or false?**
- 9. According to IDEA 2004, a child may have SLD in any of the following except:**
 - (a) Written expression
 - (b) Reading fluency skills
 - (c) Mathematics calculation
 - (d) Spelling
- 10. A child can have an SLD in only one academic area. True or false?**

Answers: 1. False; 2. False; 3. b; 4. b; 5. True; 6. d; 7. True; 8. True; 9. d; 10. False.

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